Inner North West
PRIMARY CARE PARTNERSHIP

RESPIRATORY SERVICES REVIEW COLLABORATIVE PROJECT

SERVICE MAPPING AND CONSUMER CONSULTATIONS REPORT

August 2016

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BACKGROUND

Increasing prevalence of respiratory and other related health complications, combined with growing service demands, were the impetus for Inner North West Primary Care Partnership (INW PCP) member agencies to agree to work together on developing a more coordinated approach to service delivery. The aims of this project align with one of the key strategic directions of the INW PCP, which is to improve system capacity to increase prevention and support people from priority populations with chronic disease and its co-morbidities (INW PCP, 2013).

Based on the 2014–15 National Health Survey, an estimated 7.1 million Australians suffer from a chronic respiratory condition (ABS 2015).

Respiratory conditions are believed to be the most commonly managed problems in general practice. Data from the Bettering the Evaluation and Care of Health survey of general practitioners suggest that respiratory conditions were managed in approximately 1 in 5 encounters from 2005–06 to 2014–15 (Britt et al. 2015).

In 2013, there were 12,465 deaths where the underlying cause was a respiratory condition (acute or chronic) (ABS 2015). Chronic obstructive pulmonary disease (COPD) is a leading cause of death in Australia and internationally, and asthma deaths rates in Australia are high in comparison with many other countries (AIHW: Poulos et al. 2014).

People living in Melbourne's Inner North West experience high rates of chronic respiratory conditions in comparison with both the Victorian and national average rates (Inner North West Melbourne Medicare Local, 2014).

Much of the death and disability caused by chronic respiratory disease is largely preventable and more effort is required to reduce the impact of chronic respiratory disease in the community.

Understandably, there is a growing emphasis on keeping people well and out of hospital. It is widely recognised that people experience better health outcomes when they receive effective treatments, self-management support, and regular follow-up through organised systems of care (World Health Organisation, 2002). Integrated care can be achieved through service coordination practices which act to reduce service fragmentation and maintain consumers at the centre of service delivery. Service coordination involves agencies working cohesively to provide a seamless and integrated service response (Primary Care Partnerships Victoria, 2012).

Improving systems of care for chronic conditions requires a collaborative effort between service providers in partnership with consumers of care. Implementation of truly integrated models of care is recognised as an essential element in reducing the impact of chronic conditions on the health of communities and on health care systems and economies, together with reorientation of care around the consumer and family (WHO, 2002). Integrated care is vital to ensure shared information across service settings, providers and time. The outcome of integrated services is improved health, less waste, less inefficiency and an improved consumer journey through the care system (WHO, 2002).

The INW PCP undertook a service mapping and consultation exercise during the first phase of the project, to assist stakeholders to identify strengths, gaps and pressure points in the current service system and identify opportunities for improvement.

Consumer consultations were also completed to understand the consumer perspective and understanding of available services.

SERVICE MAPPING

The aim of the service mapping is to build an accurate picture of the current respiratory service system in the Inner North West Melbourne Catchment which includes the local government areas of Melbourne, Moreland, Moonee Valley and Yarra.

The objectives of the service mapping were to:

- improve the understanding of local referral options and pathways between General Practice, Community Health Services, Local Government, HARP and hospital based services
- determine the barriers to and enablers of, respiratory care access in the catchment

The major health services in the region with programs/groups delivered to assist patients with chronic respiratory disease were invited to complete a service mapping tool. The tool includes service scope and profile; service strengths, gaps, opportunities and future priorities.

The following agencies participated in the service mapping exercise and provided data:

- St Vincent's Hospital
- Merri Health/Royal Melbourne Hospital (RMH) Admission Risk Program (HARP);
- cohealth
- Asthma Foundation

Respiratory service profiles are included in Appendix 1. Data from the consultations including referral processes information, service strengths, gaps, opportunities and future priorities is included in Appendix 2 and 3.

FINDINGS FROM SERVICE MAPPING

STRENGTHS

The data from service mapping and consultations highlights a number of common strengths amongst participating services including:

- Highly qualified and dedicated staff
- Flexibility of some of the programs e.g. home visits
- Availability of wide scope of HARP multidisciplinary, multi-team services for advice, support and direct services provision
- Good communication between HARP programs
- Broad eligibility criteria and minimal waiting time

GAPS

The following current service gaps and weaknesses were identified:

- Need for a good quality education for General Practitioners and Practice Nurses in areas of respiratory conditions and available services
- Lack of strong links with other service providers including GPs
- Lack of suitable services to refer to after the pulmonary rehabilitation program
- Lack of transport
- Different HARP models
- Lack of funding and resources

OPPORTUNITIES

The following opportunities were identified:

- Improving communication between all services
- Raising awareness among General Practitioners about available respiratory services
- Establishing a special interest group of local providers of respiratory services for education and communication
- Developing shared agreed respiratory pathway with agreed and standardised criteria for entry and discharge
- Developing a list of all available services
- Establishing easily accessible pulmonary rehabilitation programs at local gyms
- Developing standardised flyer for all pulmonary rehabilitation programs in the local area
- Establishing links with local media to raise awareness about chronic respiratory conditions among the local community

CONSUMER CONSULTATIONS

In addition to the consultations with the major service providers three consumer focus groups have been conducted. 13 consumers with a range of chronic lung conditions took part in consultations. The participants were recruited through Royal Melbourne Hospital, St Vincent's Hospital, Merri Health HARP Program and Support Group in Coburg.

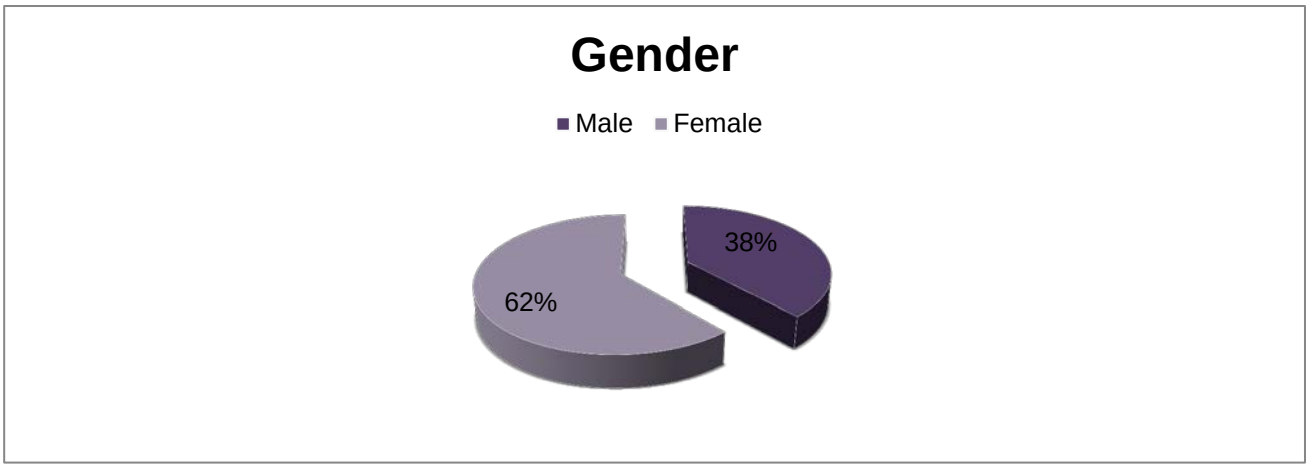
The aim of the consumer consultations was to explore the information needs, service gaps and service preferences of consumers with chronic respiratory conditions including conditions such as chronic obstructive pulmonary disease, asthma and chronic bronchitis. Information looking at the following criteria has been collected:

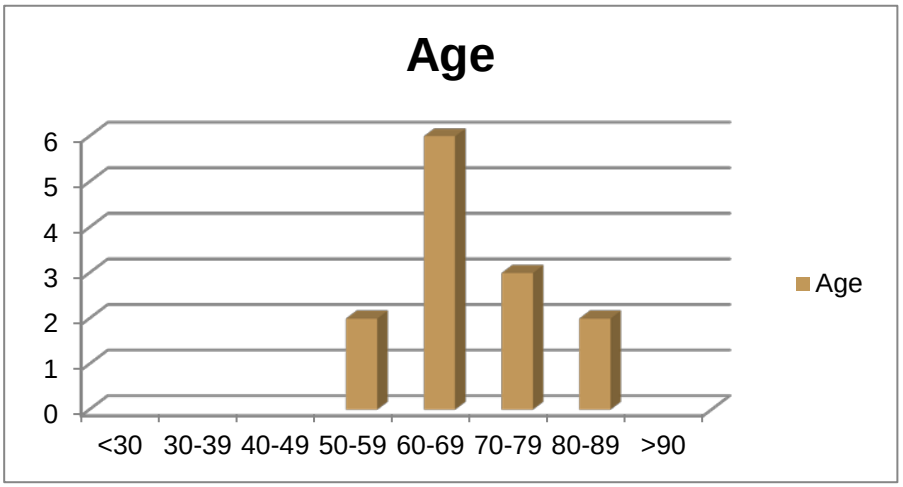
- Basic demographic and condition information
- What services consumers use and in what circumstances
- What experiences they have had with health services management of their condition
- What services would best meet their needs

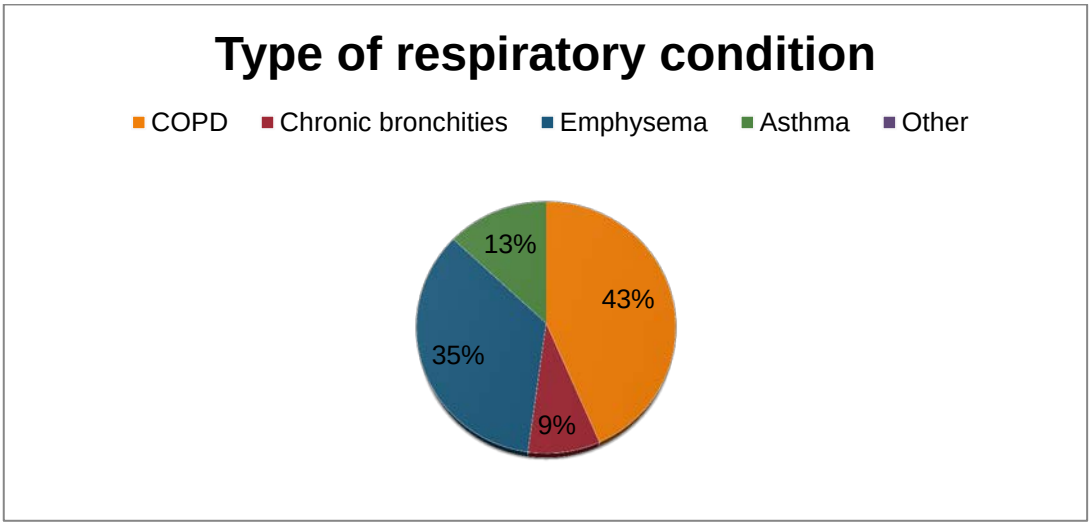
FINDINGS FROM CONSUMER CONSULTATIONS

DEMOGRAPHIC AND RESPIRATORY CONDITION

Demographics of the participants are presented below.







KNOWLEDGE OF AVAILABLE SERVICES

Among the participants there was a lot of confusion about the services available and there was a lot of discussion trying to identify the different services they had been to and how they were different and how they were the same. According to some, it depended on where you 'landed' as to the quality of care you received.

"It's where you seem to 'land' which is about how you are taken care of because I have a cardiac condition that I have had for a lot longer which I receive absolutely zip support with and as soon as my bronchiectasis was identified I was put in contact with HARP – happy days! And it's helped me so it is exactly where you happen to fall..."

"I've been with HARP for about 6 years … then I just finished the course and then they have no other course for us at the moment because they have other people coming in and at a later date I'll go back but what they're doing there with the physio … the physio at the health community centre … is organising other things to do at the Leisure centre and she's organising me to go and do another assessment."

Consumers were aware of some services but were confused by the many services and whether they could qualify for certain programs. Some were also referred to services that didn't match their geographic location.

There were comments that the GPs didn't understand the services that were available and all people with COPD were treated in the same way despite the complexities of the condition

"They [the GPs] understand the basics … I've told my specialist you do not understand what people have, you may know what they have and you might know how to treat it but you've never experienced… what I have, what you have, what they have are three different things [pointing to people with COPD] and they treat it the same way. It's bulk dealing – and these are professors"

Some consumers found services via the individual relationships that they had with various health care professionals and these strong relationships meant they were reluctant to go anywhere else. Other participants relied on family members and support groups to find the right services for them. One participant used the internet to find services.

Some of the consumers reported that they have been referred to the local council to receive home help and delivered meals. The majority of participants stated that they need help with the daily activities such as cooking and cleaning but were not sure where to access them or if they are eligible. Most of the participants didn't know what other services they could be using.

The participants reported that the messages from services were inconsistent. Sometimes you were eligible for a service and sometimes you weren't.

"Some of the services have been good and some have been non-existent and this is the problem. I don't think there is enough information out there for people with lung complaints that is available to them easily or to the full extent of what's available is not known by GPs because they work within a narrow field which is what they specialise in… they are ignorant of a lot of things that are happening in the lung department."

Consumers commented that they access services when they experience acute flare ups but also for regular check-ups. The participants reported that services are not well set up to manage chronic conditions – there is not enough ongoing support and not enough information provided by their GPs and other healthcare providers about their condition and how they can prevent them.

"I think GPs and even specialists it is an 'in the box' sort of thing you know you've got... medications and that is alright but you sort of do need something else to support and try to work towards making things better or getting people more involved in things and there's not a great deal that you can find without say HARP or something like that."

Patients at the hospital reported accessing services for asthma only when unwell. They praised the hospital staff and their commitment to their service. They were very grateful to all the staff at the hospital.

All participants spoke highly of HARP specialised exercise programs however once the program was done there was confusion about where to go and what to do next.

COMMUNICATION

Overall the services were reported as having poor communication between them and to the consumer.

"When you've got different organisations you've often find that they are overlapping in what they are doing with each other but they are not aware of what the other person is doing and there seems to be a lack of distribution of information that is suitable. You go to your local councils and they have their little view, you go to your doctor and he has a different view and you go to your specialist and he has yet another view. There doesn't seem to be any coordination to put all the information for people whether it is lung, heart diabetes or whatever into one pot where the information can be given out as required"

The GPs were reported as not very good at explaining their condition or communicating very well. One person stated there was a lack of information provided and lack of discussion about prevention *"if only I had known what I know now 8 years ago I would be in a lot better condition today"*. It was implied that this information isn't given freely and that it had to do with time limitations of appointments with GPs and specialists.

According to the second focus group the GP has nothing to do with their chronic respiratory condition and while they use the GP for other things the GP was not part of the plan and was not referred to.

"My GP has absolutely nothing to do with this [chronic respiratory condition] I take a copy of the results of the lung function tests because I see my doctor every Monday because I have so many other things… but that is as far as it goes. She has no contact with the outside services; she has very little if nothing to do with the hospital itself… although the hospital sends copies of the results to the doctor"

The third focus group participants were happy with the level of communication between their GPs, HARP program and specialist services.

The preferred information source was the GP or specialist however there was not a lot of information given by the GP/specialist due to time or other restrictions.

"If your GPs and your specialist were also in the picture as to where you were and where you were up to. HARP do write back to my GP to let them know what's happened and then they put it on the file and forget about it – well it depends on your GP I suppose but 90% of them would. If they could share the information that was given and talk about a new direction that would be good. I've since changed my GP and the new one there hasn't been a lot of discussion."

ACCESS TO SERVICES

The main issues mentioned were lack of reliable transport to get to specific locations and lack of available parking at certain venues.

"I enquired through the council to see what they had available. They have chair exercise available once a week. As of last year, I haven't been this year, sitting in a chair and using your legs etc… but there's no parking. You try getting a park around Queens Park or this was where this was taking place in … Avenue and it's very crowded around there so I tried 3 times and I was so sick that I couldn't walk miles – I mean I couldn't walk 200m to a carpark so I've stopped doing that. And there are lots of other difficulties"

"What used to be down at the YMCA in Ascot Vale near the showgrounds they run all those sort of programs but you need a recommendation by your doctor or health fund to go in there... and it's not an easy place to get at. There is no transport, no trams up there, no buses – it's awkward to get to. Once you're there you have to get out. As I've given up driving I can't get there"

Also maintenance is reported to be an issue as after the HARP program there was 'nowhere else to go' despite the desire to continue with specialised exercise groups that were designed for people with COPD.

"You've got all these wonderful things but where do you find the information? And what happens when you get discharged from HARP? What happens then?"

"The problem is once you've finished your program – finished – gone – goodbye! There's no follow up. And when there are follow up things there are things that don't necessarily suit."

Additionally the participants expressed embarrassment at times when they could not perform the exercises to the same capacity as their peers or others that don't have COPD. The need to feel safe was also a theme – consumers mentioned that it is really hard keeping up with some exercise groups as while you don't look any different on the outside limited lung capacity can impede engagement in simple activities. People also lack an understanding of their condition and they feel judged and as if they are not 'trying hard enough'.

"It's a bit hard to explain – for example there is a course called 'Living longer, living stronger' but it's too hard. I can't do it it's just beyond me and I try I mean I really have tried– there are only certain things I can do and the rest of the time I stand there looking like an idiot"

"I had a similar experience after the HARP program finished for me I went for gentle exercises and they weren't excessive or hard exercises but I couldn't keep up with it... um the breathlessness – and I have a bad neck and shoulder too – and everything worked against me in that sense but the breathing I was affected with and you don't want to just step out and they say do it and you automatically try to keep up but ideally a place where you are monitored and you feel safe is important"

"I tried the hydrotherapy down at the Y – did the hydro work pretty good… no problems. It was when I had to walk from the pool to the dressing rooms and get changed I ran out of air and I said to myself – that's it, finished. I wasn't going to pick myself up off the floor again. I could fall and injure myself."

"Yes like they said knowing that somebody was aware when you were there of that possibility of need that you knew right they're watching me or they will walk with me to the change room or something. I need to have my medications near me

beside the pool I can't be expected to get out of the pool, walk to the change room get my medications that kind of thing – I won't make it."

Hospital participants reported being completely reliant on the hospital staff to access other services. Access to the hospital is excellent – easy to get to by transport.

The participants in the third focus group were not sure what other services apart from the HARP rehabilitation program are available to them.

GAPS

The participants reported that access to a local and regular exercise program in a safe environment would help them to manage their condition better.

"My lungs have had it and the thing I need is regular exercise. Like most people you don't tend to do it when you're by yourself. To maintain my lifestyle I need to exercise – I know that but I don't do it unless... if you go to the exercise classes you just do it."

"When you are monitored and you feel safe you are more likely to push yourself. You push yourself probably more than you would if you were by yourself or if you're having your blood pressure monitored … there's a nurse there is three physios there is at least 3-4 staff each time you go and they are there. And that's important because with our condition things can happen in a blink. They've got oxygen there and everything."

According to the participants in the third focus group a very important factor for managing their condition better was social interaction and mental stimulation such us going to the senior citizen clubs, playing bingo or spending time with their family. Some of the participants also mentioned that help with household tasks such as cleaning and cooking would be very beneficial to them.

Some of the consumers expressed the desire for more thorough follow up after the discharge from a program and more information about management of their condition.

"More open discussion between your specialist and your GPs, more information available and follow up on anything that must be done. If you have been in hospital they send you to rehab and once you have been to rehab it is 'goodbye Charlie'. They don't follow anything up – they don't follow up to see if you are doing any exercises or to see if you had died. It's just not there. There are gaps in the system that need to be filled."

"We've got chronic conditions and that seems to be a word that has not gelled in the medical professions mind. They cannot kiss you goodbye because you have a chronic condition and mine are multiplying now and that's why I had a little hissy fit at HARP because if I had been given this support 8 years ago when I started I wouldn't have the problems I have now and I think what a waste. They give you the terminology but they don't explain it means life duration and they don't explain that you need to act now."

In addition the participants stated that there needs to be a more holistic and flexible approach to managing chronic respiratory conditions because most of them have multiple and complex health, social, emotional and economic issues. One example of that would be a hub where they could access most of the services they need in one place.

"I just think we have to be careful about segmenting things too much because if you go in that direction I think it's endless. We're actually one person and we have a range of different things that people have and the fundamental exercise program … with the way the ageing is going it would never end you would have to go to a different type of exercise program everyday"

"The services are quite good. I'd put a lot more money into it and expand it. HARP for example works quite well – but I think more funding because when you have a chronic disease like this. Doctors realise but they don't realise – they always

say go to your GP. GP is difficult for people that can't get around properly. When people get to a certain stage – even if there was a clinic somewhere where they could get all the equipment. It needs to be all under one roof where people don't have to go the GP first."

"If I had a magic wand I would have a central place for the north western suburbs that was easily accessible by public transport and have a day thing that went between 9 and 4 each day and people could be supervised, one physio there and one nurse there. Anytime, one at 11am or that's what would be fantastic."

SUMMARY OF CONSUMER CONSULTATIONS

STRENGTHS

The consumers identified the following strengths in the current respiratory service system:

- Good quality service provided by the HARP programs
- Qualified and dedicated staff
- Personal relationships with health care professionals

GAPS

The following gaps have been identified:

- Consumers' lack of knowledge of available services
- GPs' lack of knowledge of available services
- Lack of accessible information about available services
- Lack of local maintenance exercise programs in the community
- Insufficient communication between GPs, other service providers and consumers
- Lack of reliable transport and parking
- Lack of home support services
- Need for more holistic and flexible approach to respiratory management

OPPORTUNITIES

The consumers identified the following opportunities for improvement:

- Improving communication between GPs, other service providers and consumers
- Establishing local maintenance exercise programs in the community
- Establishing or linking in with support groups where people can socialise, talk about their condition and feel safe
- Establishing a local hub where people access most of the services they need in one place

STAKEHOLDER WORKSHOP

On 4th August 2016 a workshop was held with most of the key respiratory service providers and peak bodies in the Inner North West catchment. The purpose of the workshop was to:

- present the results of the consultations with agencies and consumers
- identify and agree on the priorities and focus of the project
- network with others who work in this space

14 representatives from the following agencies participated in the workshop:

- Inner North West PCP
- Melbourne Health/Merri Health HARP
- Merri Health
- North Western Melbourne PHN
- Quit Victoria
- St Vincent's Hospital Melbourne - Complex Care Services
- The Asthma Foundation

AREAS OF IMPROVEMENT

The participants had a facilitated discussion regarding improvements needed in the respiratory care system. The following key themes emerged during the discussion:

COMMUNICATION

- Accurate diagnosis
- Info sharing (especially with hospitals in other catchments)
- Consistent information and communication (everybody on the same page)
- Good quality referrals with all information needed
- A lot of conflicting advice
- Community of practice re respiratory conditions

REFERRAL PATHWAYS

- Promoting Health Pathways to GPs (finding out what is it working for GPs and what information do they need)
- Continuum of care
- What services exist within GP clinics e.g. respiratory education
- Education regarding pathways and available services
- Timeline for all the interventions at different stages and what is required and what is available pathways ☐ clear refe
- Coordination of services for individuals
- Promote guidelines to GPs
- Understand what GPs need to manage respiratory conditions
- Discharge guidelines and plans – agreed by GPs and specialists

EDUCATION

- Improving GPs knowledge on how to manage exacerbations and respiratory conditions in general
- Education of health professionals re respiratory condition

- Better education and support for patients to better manage their condition
- Building confidence of health professionals of other professionals

LINKAGES

- Linking with more general health & wellbeing services
- Linking in with social support services to social and emotional needs after completing the rehab program

RESOURCES

- More pulmonary rehab programs needed
- Long term maintenance programs needed (lifelong condition needs lifelong support)
- Better transport

CONSUMER ENGAGEMENT

- More consumer engagement with designing new programs (looking at different models e.g. home based exercise)
- Understanding of patients' behaviours
- Improving health literacy

PRIORITIES FOR THE PROJECT

The participant also identified the following priority areas that they would like to work on together through the project:

- Local respiratory referral pathways
- Communication between services

RECOMMENDATIONS

The findings outlined in this report suggest that the respiratory service system within the Inner North West catchment has many strengths. There are however, a number of areas which could form the focus of the INW Respiratory Services Review Collaborative improvement work.

The following recommendations are made for the second phase of the project:

- Establish a working group comprising of the key respiratory service providers and peak bodies in the Inner North West catchment the that will work on the following:
  - ✓ Improving communication between service providers including GPs
  - ✓ Developing local respiratory referral pathways by reviewing the existing pathways included in Melbourne Health Pathways

RESPIRATORY SERVICE PROFILES

SITE NAME: COHEALTH

Type of service	Description of service	Eligibility Criteria	Exclusion criteria	Description of referral processes	Current Wait time
Medical clinic	General Practitioners and Pharmacy	Registered cohealth client	N/A	Self-referral, internal and external referral form' Health practitioners and hospitals	Emergency, no waiting time, appointment can depend on individual practitioner
Nursing Clinic	Community Health, Clinical, Aged care nurses and Midwifery	Registered cohealth client	N/A	Self-referral , internal and external referral form,Health practitioners and hospitals	Appointments available, as well as drop in sessions where no appointments required
Allied Health Services	Full range of Allied Health services: Physiotherapy , Podiatry, Dietetics , Speech Therapy , Occupational therapy, Dental and Counselling	Registered cohealth client	N/A	Via Alllied health intake	Depends on which service is required different disciplines have variable waiting list lengths
General Exercise Groups	Not specifically for respiratory issues but do cater for anyone with chronic conditions or respiratory issues. These exercise groups are, gym, water exercise, circuit , yoga and hydrotherapy	Client registered with organisation and has been assessed by a physiotherapist	N/A	Self-referra , internal or external referral via Intake for an assessment physiotherapy appointment	No current waiting lists

SITE NAME: MERRI HEALTH HARP					
Type of service	**Description of service**	**Eligibility Criteria**	**Exclusion criteria**	**Description of referral processes**	**Current Wait time**
Pulmonary Rehabilitation Program	8 weeks education and exercise program	• HARP eligible • Medically stable • Safe to excursive • Diagnosed respiratory disease	• Acute respiratory condition • Unsafe to exercise • Not eligible for HARP	Initial referral to Direct Access Unit at Melbourne Health. Once admitted to HARP, referrals will be made internally to other components of the program the client requires	No waiting time currently however need to wait for commencement of next 8 week program
Transition Exercise Program	8-12 weeks program, follows on from the Pulmonary Rehabilitation Program	• Completed Pulmonary Rehabilitation Program • Safe to exercise	• Not completed Pulmonary Rehabilitation Program • Unsafe to exercise	Usually step down from PRP to this program (internal referral)	No waiting time currently
Home Exercise Program	Physiotherapist's home visit and tailored exercise program,	• HARP eligible • Medically stable • Safe to excursive • Diagnosed respiratory disease • Unable to attend the centre based program	• Unsafe to exercise • Not eligible for HARP • Acute respiratory condition	Decision that client needs home based exercise will be made after admission to the respiratory service. Client could be referred to DAU with specification that he/she requires home based due to disability or other circumstances.	No waiting time usually. Can depend on availability of physiotherapist
Respiratory Nurse and Physiotherapist	Education and information about disease to assist client to better self-manage in the community	• HARP eligible • Diagnosed respiratory disease	• Not eligible for HARP	This is an integral part of the respiratory service. Client is referred to HARP Complex care. After a thorough assessment, clients are referred to any of the suite of services they require. This includes a range of services in addition to respiratory-specific services – allied health (OT, generic physio, dietetics), pharmacy review, DNEs, diabetic foot podiatry and wound care, management of cardiac conditions, complex case management and review by physicians as required.	No wait time currently
Smoking Cessation Program	• Face-to-face individualised service, to at least initial and second follow up consult, and ongoing	Anyone able to travel to Coburg and Brunswick that: • would like to stop smoking	• client resides in a residential aged care facility (RACF) • children unaccompanied under	Refer via: • Fax: (03) 9495‑2599 • Email: serviceaccess@mchs.org.au • E-referral form: Connecting Care (available for some services)	

	support or face-to-face as required normally for up to 8 to 12 weeks. • Provides smoking cessation advice and medication support, including Nicotine replacement therapy (NRT) and GP-Prescribed Champix support using the Bittoun method for smoking cessation. • Liaison with general practise for prescribing, and local pharmacist for for ongoing management and support for clients. • Stop Smoking clinic does not provide Asthma or Chronic Obstructive Pulmonary Disease (COPD) education.	• who has previously tried to stop smoking without success but would still like to stop • who has stopped previously and has started again, who would like to stop again • pregnant women who would like to stop • children 16 years and over who would like to stop • accompanied children with consenting adult under 16 years who would like to stop	16 years of age	Self-referral by eligible patients is accepted. To seek advice or further information, phone (03) 9388‑9933 (Service Assess team).	

SITE NAME: ST VINCENT'S HOSPITAL					
Type of service	**Description of service**	**Eligibility Criteria**	**Exclusion criteria**	**Description of referral processes**	**Current Wait time**
Pulmonary Rehab	Exercise and education Smoking cessation support offered (but not a specialised, stand-alone service)		If unable to exercise appropriately in a group-based setting (e.g. requires too much supervision)	Central Intake (Oct 2016)	Aim for zero waitlist for urgent, 1-2 weeks for routine.
Complex and chronic care program	Intensive multidisciplinary home-based support	As per Victoria HARP guidelines: multiple hospital presentations			
Respiratory Function Testing		Referral by Specialist/GP			
Specialist Medical Services (e.g. Sleep Studies, Palliative Care Consultations in Outpatients) Outpatient Physiotherapy for sputum clearance					

SITE NAME: ROYAL MELBOURNE HOSPITAL

Type of service	Description of service	Eligibility Criteria	Exclusion criteria	Description of referral processes	Current Wait time
Respiratory function laboratory (including bronchial provocation, cardiopulmonary exercise testing and high altitude simulation test and home oxygen assessment service)					
Fibreoptic bronchoscopy with facilities for endoscopic bronchial ultrasound biopsy (EBUS)					
Overnight oximetry and sleep monitoring (home and hospital based) and sleep disorders clinics					
General respiratory medicine Clinic					
Lung oncology (multidisciplinary) clinic					
Specialist clinics: • CPAP Review Clinic • HARP Respiratory • Home Oxygen Annual Review • Oximetry • Pulmonary Arterial Hypertension • Respiratory Lab • Respiratory Oncology • Sleep Disorders					

SITE NAME: ASTHMA FOUNDATION

Type of service	Description of service	Eligibility Criteria	Exclusion criteria	Description of referral processes	Current Wait time
Community Support Program	• Live well with asthma education sessions for community members (recognising symptoms, asthma control, medication etc.) • Helping others to live well with asthma education sessions for professionals • Referral service • Asthma assist (up to 4 phone calls including setting goals, communicating with GPS) • Coach - 5 phone calls over 6 months covering a wide range of topics including nutrition and exercise			Referral to all the services available via phone, fax, website and an app	

Other services

Exercise programs

- Lungs in Action maintenance exercise programs at Northcote Aquatic and Recreation Centre and Dorset Rehabilitation Hospital Pascoe Vale.
- Heartmoves maintenance exercise program at the Moreland Council gyms – Coburg, Brunswick.

APPENDIX 2 REFERRAL PROCESSES

Please describe your intake processes

- Referral to Direct Access unit at Royal Park Campus – confirmation of eligibility, identification of conditions and priority needs – can be admitted to more than one team (e.g. Resp and Diabetes or Resp and cardiac)
- Require results of Lung Function test
- Referral to central intake, then an initial comprehensive/holistic assessment by a senior physio or CNC
- Central intake for all Allied health services via face to face , phone , fax or email

What mechanisms exist to discuss referral and clinical issues with GP's and other primary health care providers within your health service?

- Letter to inform of enrolment into the program
- Care plan is sent to GP
- Letter at end of program
- Clinicians call GPs as needed when patients are unwell or need clarification for treatment or to get results etc…
- GP informed by letter as soon as patient is enrolled in our program, so GP has clinicians 'contact details
- GP can call Direct Access Unit, or HARP Respiratory program clinicians to discuss potential referrals and eligibility if unsure
- Clinicians may communicate with GPs throughout episode as required when clients are unwell, have an exacerbation, need medication changes, blood tests ordered, for investigation results etc.
- Occasionally clinicians may accompany patients to GP consultations
- Discharge plan/letter sent
- Letter upon recruitment, disclosing the PHQ2 (depression screening score). Phone call directly to GP for urgent issues
- Individual consultations, Case conferencing , GP management plans, Goal Directed Care Plans

How do you promote/inform health professionals of your service?

- Through HARP Program at Melbourne Health. Don't specifically advertise to other service providers other than Melbourne Health.
- All acute public hospitals in Melbourne have an attached HARP service, so are aware of HARP services.
- Many HARP services are catchment-based. Non-Melbourne Health patients are accepted if they are out of area for the HARP service provided by their parent hospital.
- Our Pulmonary Rehabilitation program is listed with Australian Lung Foundation. We receive some phone calls via this, and advice patients or referrers of our eligibility criteria, and how to refer.
- Past patients have called us if they feel their disease has progressed further and need intervention. We direct them to their GP to refer via Direct Access unit.
- Some private physicians whose patients have attended our service tend to refer.
- Some GPs whose patients have attended our service tend to refer.
- Through HARP Program at Melbourne Health. We have a liaison team based at the RMH City campus that screens patients attending ED or admitted who are HARP eligible and would benefit from HARP services. They are approached during their hospital stay and consent obtained for a HARP clinician to call them at home regarding participation in the service.
- We have information leaflets provided to patients/families during hospital episode and on admission to HARP
- We have occasionally promoted HARP to GPs via NWM PHN newsletters - should do more
- Website and word-of-mouth, Australian Lung Foundation listing, in services to in-house Respiratory specialists at SVHM. We don't have a marketing plan as we are already at high capacity with our current level of staffing resources and we are already meeting targets.
- Websit , word of mouth referrals , partnerships with local agencies and community organisations

How do you promote/inform clients of your service?

- Send a letter on enrolment and explained during first phone call / visit – consent gained
- Written information about HARP Complex Care and HARP Complex Care – Respiratory Service given to clients at first meeting
- Send a letter on enrolment and explained during first phone call / visit – Consent obtained
- Patient information sheets (attached)

- Usually word-of-mouth and referred to our program by
- Website, word of mouth referrals , partnerships with local agencies and community organisations and community groups

Does your health service have a process in place for acknowledging referrals?

- Through direct access unit. Person on duty checks the Care Managers for any pending referrals every day. Referrals are being acknowledged within 3 working days. Letter of involvement sent to GP and c.c. to referrer (if not referred to GP) after initial assessment.
- Through direct access unit. Person on duty checks the Care Manager data for any pending referrals every day.
- 80% plus of referrals are acknowledged within 3 working days of receipt.
- Phone call in the first instance, if not contactable x1, then letter sent to patient inviting them to call us back to make an appt.
- Yes , all referrals acknowledged in 24 - 48 hours of receiving referral

Is there any contact with the client/patient to inform them of the referral?

- Patients receive phone call within 3 working days from the referral.
- Clients contact by HARP Liaison while in ED/hospital will be informed about HARP service, given an info sheet and invited to agree to being contacted by phone at home post discharge
- Patients receive phone call within 3 working days from the referral.
- Yes – as above
- Contact with client once appointment ready to be organised.
- Client consent gained before referral made

Are referrals redirected if inappropriate? How and where are they redirected?

- Referrals are being redirected if they are not appropriate but this doesn't happen very often.
- Patients who are not eligible are redirected to the most appropriate service which they are eligible for, e.g. EPC physio if all they require is a few sessions with a respiratory physio for airways clearance, patients who have private health insurance who can attend a privately funded Pulmonary Rehabilitation Program in their local area, or to a community-health based Early Intervention program if they have mild disease.
- Referrals may be redirected to another HARP service if out of catchment, Will be redirected to other SACS services by Direct Access unit if appropriate. Referrals to other HIP services (Specialist Sub-Acute clinics, Post Acute Care) may be directed to HARP if clients meet eligibility criteria.
- Yes, usually we will try to let the referrer know to refer elsewhere.
- Referrals are redirected if we do not provide the service , specialist clinic or if there is another service more appropriate

Describe how often your organisation receives inappropriate referrals? (regularly/not often/rarely/never)

- Not often
- Referrals are screened by the Direct Access Unit for eligibility before they are process, and registered with HARP Complex Care – Respiratory Service.
- Rarely, as we have very broad entry criteria
- Occasionally and they are redirected as required , or client contacted to receive more details of service required

APPENDIX 3 SERVICES, STRENGTHS, GAPS AND OPPORTUNITIES AND FUTURE PRIORITIES

What do you see as your service's strengths?

- Very good respiratory physician attending case conference once a week
- Very experienced physiotherapists and nurses
- HARP case coordinator being able to provide a comprehensive assessment and assist with other needs in the community
- Good communication between HARP programs
- HARP team leaders meeting on a weekly basis
- Opportunity for clinicians to provide a suite of services to clients, i.e. in-house Pulmonary Rehab and airways clearance interventions
- Opportunities for referrals within HARP for other services, e.g. OT, as well as other Specialist streams, e.g. cardiac, diabetes
- Able to provide Home Visits are many of these clients have difficulty with getting out
- Communications between Melbourne health via our HARP Liaison Team as well as links to the RMH Respiratory Department
- Dedicated and committed clinicians
- Very fortunate that a new Smoking Cessation Service has commenced at Merri Health
- Good links to Respiratory Department at RMH – specialist Respiratory physician involvement in service provision, case conferences
- Good links with RMH HARP Liaison and Respiratory Liaison nurses – good flow between acute-community and vice versa
- Good communication via RMH HARP Liaison team regarding our patients' presentations to ED and/or admission
- Experienced, highly skills Respiratory nurses and physios working in community team
- Availability of wide scope of HARP multidisciplinary, multi-team services (45 EFT) for advice, support and direct services provision regarding clients' clinical needs (cardiac, diabetes, aged care related issues) and broader psycho-social, behavioural, functional and environmental needs of clients.
- Access to dedicated HARP pharmacists who undertake comprehensive home medication reviews
- Addition of dedicated specialist care coordinators over past 18 months has broadened scope of first comprehensive assessment to identify issues earlier in the episode of care; has resulted in more assessments made from first assessment, so the client benefits earlier from the intervention which we hope enhances their capacity to respond the Respiratory specific service we deliver.
- Co-location in community health, with other component of HARP located in MPCN, RDNS and RMH. Organisational profile is complex but works well on the ground.
- Broad eligibility criteria and minimal waiting time as a team goal
- Highly skilled staff
- Referral rates to gyms high
- Access for clients of all complexities, socioeconomic, cultural backgrounds and diverse medical and social issues.
- Multidisciplinary approach , wide range of services , broad referral base , Client centred approach , access to interpreters and range of services
- Links to Exercise groups and community gym programs to encourage and help provide access for exercise equipment and options

What might be some of the weaknesses or gaps in your current service?

- Need for upskilling GPs in asthma management, medication and services available
- Raising awareness among the health professionals and community members about available support
- Lack of onsite asthma education programs in the Inner North West catchment
- Need for more good quality education for GPs and practice nurses regarding respiratory diseases
- Lack of funding for the respiratory management in the inner north west catchment
- Need for better respiratory management
- There is a cohort of people with respiratory conditions such as bronchiectasis and occupational lung disease who don't get the right service in the right time
- People who are on home oxygen experience a number of challenges such as access to transport to get to medical

appointments to review their oxygen
- Different models of HARP at different hospitals
- Lack of strong links with GPs
- Lack of strong links with other services providers
- Limited timeframe to work with clients
- Not a lot of services to refer to after clients complete the pulmonary rehabilitation program
- Very few maintenance exercise programs around.
- Transport or access issues for our clients who do not have the exercise capacity to attend many existing physical activity programs
- Transport or access issues for our clients to get around in the community due to their frailty, decreased exercise tolerance, and sometimes having to cart an oxygen cylinder as well.
- Taxis not very happy to transport clients for short distances to enable them to attend very local venues, hence very long waits for taxis
- Taxi drivers not very helpful with putting/taking out walking frames and oxygen cylinders in the trunk for patients
- What after HARP? – usually there is no service to refer these clients on to, to support adherence to their lifestyle habit and exercise compliance
- Need to strengthen links from HARP Respiratory to palliative care pathways. Currently good links to RMH Advanced Lung Disease clinics which is a joint Respiratory-Palliative care model.
- Variations between HARP services in different metropolitan health services
- No marketing plan as our staff resources are already saturated
- We have minimised our patient reassessment and evaluation measures due to resourcing
- Our communication with GPs is very minimal (resourcing issue, and also not very sure what they would like/prefer)
- We are a general Medical and health clinic , our services are for general health and chronic conditions, our exercise classes and groups are for general health improvement , not specific for respiratory conditions but will cover a range of chronic conditions

From you service perspective what other opportunities are there that could be harnessed to enhance the community access to cardiac services in your area?

- Advocate to funding bodies for more funding and resources to improve respiratory management in the inner north west catchment
- Raising GPs awareness regarding:
    - New medications and treatments for chronic respiratory conditions
    - Importance of pulmonary rehab
    - Importance of specialised smoking cessation clinics
- Making links with local media to raise awareness about chronic respiratory conditions among the local community e.g. providing information about different conditions, treatments and lifestyle changes
- Better communication between all services
- Development of a list with all pulmonary rehab programs and exercise programs that is regularly updated
- Better communication with hospitals from outside Merri Health catchment e.g. St Vincent's Hospital and Western Health in order to receive patient information in a timely manner
- Referrals from other hospitals are problematic as there is often limited information provided, and the referrer is not able to provide ongoing update of information, hence we have to rely on patients who often do not understand what they have been told
- More awareness from GPs of capacity to refer to HARP
- Establishment of agreed shared pathways between services – use of Melbourne Health Pathways
- GP referrals of clients with milder disease rather than waiting till it's too severe
- Standardise a marketing flyer and eligibility criteria for all PR programs in the area
- Partnerships between 2 health sites to run PR programs at a local gymnasium (which would then increase the number of people engaged in their local recreation centre)
- Access to education, health coaching to encourage support for behaviour change and goal setting to support specialist services.

From your services perspective and in line with the policy and the resources available, what would you see as a priority issues to be addressed across the catchment within the next two years?

- List of available services especially services available to people who completed the rehab program
- More airways clearance physiotherapy service provided by Melbourne Health
- Specialist respiratory physiotherapy service in the community where GPs and clients can access, as AHRP do not have the capacity to see these patients who are not HARP-eligible
- Medicare funded maintenance rehabilitation programs which can be accessed by ANYONE, not just HARP clients or those with private health insurance
- A special interest group of local providers of respiratory services for education, communication
- Shared agreed Respiratory pathway with agreed and standardised criteria for entry and discharge
- Ensuring Respiratory Services discharge to gym facilities more, rather than home exercise programs which are not effective.
- Smoking related illness and disease is one of the key health issues in our region , Asthma prevention and reduction of hospital admissions and ongoing related health issues

Does your agency engage consumers in their service improvement activities?

- Coordinating support group but no funding attached
- Merri Health specific surveys
- We undertake a phone survey of consumer by independent survey company every 2 years – clients whose first language is not English are phoned by someone who speaks their language.
- Consumer surveys (biannually), focus groups, currently running some research and evaluation projects about people's transition into gyms
- Codesign is embedded into the development of our policies and procedures where applicable for our service provision and future and program planning. Co design plays an integral role in our strategic plan and values at cohealth

How?

- HARP Respiratory initiated a Patient Support Group, which has been used as a focused group by the ALF and INPCP this year
- These consumer engagement activities then link straight on to improvement plans, as per normal QI methodology

Are there any other comments you would like to make about your service(s) in relation to the provision of respiratory care?

- Our service is not a respiratory specialist area but a general medical and health service. Our services and groups will deal with general chronic conditions but are not set up specifically for respiratory issues however as many chronic conditions are multifactorial the benefits of exercise and multidisciplinary care can be universal across a range of chronic health issues.