

Transforming Care Ovens Murray & Goulburn Chronic Care Strategy

Working Together To Improve Health



The Victorian Government and partners in this strategy proudly acknowledges Victoria's Aboriginal communities and their rich culture and pays respect to their Elders past and present.

We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we live, work and play. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches

our society more broadly. We embrace the spirit of self-determination and reconciliation, working towards equality of outcomes and ensuring an equitable voice.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

The development of this revised strategy has been an iterative process with the committee and partners since late 2017.

This final version of our second strategy was finalised in May 2019.

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Goulburn:

- Alexandra District Hospital (Jane Judd chairperson)
- Goulburn Valley Health
- Numurkah Health
- Primary Care Connect
- Goulburn Valley Primary Care Partnership
- Lower Hume Primary Care Partnership

Ovens Murray:

- Albury Wodonga Health
- Beechworth Health Service
- Benalla Health
- Gateway Health
- Northeast Health Wangaratta
- Central Hume Primary Care Partnership
- Upper Hume Primary Care Partnership

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This publication and implementation updates will be available on the websites of Goulburn Valley, Lower Hume, Central Hume and Upper Hume Primary Care Partnership's.

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STATEMENT OF INTENT

Our Vision

Communities of the Ovens Murray and Goulburn Areas are enabled to live healthier lives through improved prevention, partnerships that focus on outcomes, culturally responsive services and effective management of chronic conditions.

Our Objectives

To strengthen the consistency and sustainability of chronic conditions care and prevention and improved health outcomes for these areas, our objectives are to:

Objective 1: Deliver a transformative prevention platform to reduce future burdens from chronic conditions and align investments with priorities

Objective 2: Strengthen the efficiency, effectiveness, cultural responsiveness and appropriateness of services to support people with chronic conditions and optimise their quality of life; and

Objective 3: Target priority populations to ensure focus on those most in need of care and who are most likely to benefit from prevention initiatives.



Foreword

Since the first Hume Regional Chronic Care strategy 2012-2022 was launched, significant change has occurred in the landscape of chronic conditions. This document is the result of a review of that strategy, in response to the following changes in the landscape of chronic care:

- a) A broadening of the concept of chronic conditions and how they are defined;
- b) The transition from Medicare Locals to larger Primary Health Networks;
- c) The launch by the Council of Australian Governments, of the National Strategic Framework for Chronic Care (2017-2025);ⁱ
- d) Guidelines from Victoria's Department of Health and Human Services (DHHS) for planning and investments in health and wellbeing for the 2017-2021 planning cycle;
- e) Consistent messages in policies and from research about the need to bridge the gulf between care as it is and care as it should be;
- f) Transformational shift in how Aged Care and Disability care are structured in Australia;
- g) Shifting trends and expectations in engagement and empowerment of people in managing and living with chronic conditions;
- h) The transition from Hume Region to the Ovens Murray and Goulburn Areas which provides opportunities for local solutions and greater integration.

This strategy is intended to guide the actions of a wide range of public and private organisations and health professionals as well as organisations beyond the health sector who play critical roles in prevention of chronic conditions. The strategy is intended to improve the support, care and management of people living with chronic conditions in the Ovens Murray and Goulburn Areas.

This strategy uses the 'phased outcome approach' of the National Framework with a set of recommended short-term to mid-term outcomes against each Strategic Priority Area, that includes prevention and is localised for the Ovens Murray and Goulburn Areas.

Area based implementation will accompany this strategy. Successful enactment of this work will rest on how organisations and their workforce respond to developments in chronic conditions health service delivery in their local context.



PART 1: SETTING THE SCENE

1 Introduction & Background

One in two Australians now have a chronic disease and one in four have at least two chronic health diseases.ⁱⁱ In keeping with the National Chronic Care Framework, this Ovens Murray and Goulburn Chronic Care Strategy understands that chronic care needs to encompass a broad range of chronic and complex health conditions including diabetes, heart and lung conditions, oral health, arthritis, mental illness, cancer, trauma, disability and genetic disorders.

This strategy provides a collective focus on the management of chronic conditions to strengthen the consistency, sustainability and outcomes for its communities. It is focused on leveraging from the multiple networks across the Ovens Murray and Goulburn Areas, and aligning investments and actions to deliver best outcomes for local communities.ⁱⁱⁱ To do this, the strategy will strengthen alignment between chronic conditions, prevention and funded health promotion work to maximise the opportunities for efficiency, effectiveness and impact on health and wellbeing.

In recent years, evidence about the need for reform in chronic condition care has grown, highlighting the need to strengthen primary health care to improve effectiveness in the care of people with chronic conditions.

Key issues include:

- systems thinking for strategic vision around redesign and innovation;^{iv}
- the costs associated with avoidable hospital admissions, and the need to reduce demand for hospital services by improved primary care;
- better targeting of people with chronic conditions and the use of predictive tools to identify those at risk of hospitalisation, where more intensive managed primary care is warranted^v
- better coordination of care for people with complex and chronic conditions in primary care, and reduced fragmentation of services
- improve the integration, quality, coordination and timeliness of care received by people with complex chronic conditions because despite the government spending more than \$1 billion each year on planning, coordinating and reviewing chronic disease management, many people with chronic conditions do not receive best care;
- shift away from single disease issues and individual care models towards better management systems for the large numbers of patients with multiple chronic conditions;
- development and implementation of population health approaches to prevention at all levels (primary, secondary, tertiary)
- identification of outcomes and indicators for measurement of progress and change.^{vi, vii}
- strengthening information systems and data analytics to monitor and evaluate change;
- strengthening of systems to support self-management including proactive identification of people who have difficulty managing their condition and who are at risk of hospitalisation
- greater awareness of the need to strengthen health literacy environments and to develop health literate organisations;^{viii}
- integrate prevention across the lifespan, to improve quality of life and decrease future burdens on the health system from chronic conditions.^{i, iv, xiii}

2 Strategic Context

Federal and State governments create the strategic context and environment as well as the critical paths for transforming regional systems for chronic conditions. Key documents and plans, summarised in Table 1, have common conceptual foundations and themes which are the basis for the design elements of this strategy.

Table 1: National and Victorian strategic context

Strategic Documents & Plans		Key Messages
National	Australian Health Ministers' Advisory Council, 2017, National Strategic Framework for Chronic Conditions ^{ix}	<p>The National Strategic framework highlights the need to strengthen primary health care, particularly to better manage the large numbers of patients with multiple chronic conditions and identifies outcomes and indicators for measurement of progress and change.</p> <p>The Framework is built on eight (8) core principles: Equity, Collaboration and Partnerships, Access, Evidence-based, Person-centred Approaches, Sustainability, Accountability and Transparency, and Shared Responsibility. These Principles should be clearly evident in the planning, design and implementation of policies, strategies, actions and services aimed at preventing and/or managing chronic conditions.</p> <p>Health equity is recognised as a driver for strategy and actions, and there is a focus on priority populations. The Framework seeks to ensure that all Australians receive safe, high-quality health care irrespective of background or personal circumstance.</p>
National	Department of Health, Health Care Homes ^x	<p>Funding for Health Care Homes (HCH) is supporting about 200 existing general practices or Aboriginal Community Controlled Health Services to provide better coordinated and more flexible care for up to 65,000 Australians with chronic and complex conditions. The model is intended to resolve fragmented primary and acute care services for people with chronic conditions.</p> <p>Health Care Homes in the selected trial sites receive an upfront payment by the Government plus a regular bundled payment to provide care related to a patient's chronic and complex condition. HCH have not yet been evaluated but it is intended that the model provides flexibility in how care is delivered to enrolled patients without the constraints of Medicare's current fee-for-service model.</p>
National	National Disability Insurance Scheme	<p>The National Disability Insurance Scheme (NDIS) is progressively being rolled out across Australia with new methods of funding disability services and supports for an estimated 460,000 Australians with significant and permanent disability. Rather than funding services directly, it is designed to empower people with disability to identify the disability related support they need and to choose where they would like to buy their supports, in order to achieve their personal goals.</p>

Table 1: National and Victorian strategic context (*cont.*)

Strategic Documents & Plans		Key Messages
Victoria	Travis Review. Increasing the capacity of the Victorian Public Hospital System for better patient outcomes, 2015 ^{xi}	<p>This report included a state-wide census of bed and theatre capacity and provided 32 key recommendations about how to increase the capacity of Victorian hospitals. Key messages include:</p> <ul style="list-style-type: none"> • Reshape the paradigm from ‘more efficiency’ to ‘better outcomes for patients’. • Invest in innovation, rather than building bigger hospitals and doing more of the same. Innovation lacks a system wide strategy focus, has little scaling up capacity, a lack of overall coordination and focus for activities. • Focus on interfaces between hospital services and primary healthcare, aged care and community-based care. • Drive innovation through evidence and sharing of knowledge and expertise. • Collaborate with more intent: smaller health services with other local health services to ensure that innovations have system-wide impact.
Victoria	Department of Health and Human Services. Integrated Chronic Disease Management in Victoria/Care for people with chronic conditions - Guide for the Community Health Program, 2016 ^{xii}	<p>Care for chronic conditions occurs across a continuum from primary prevention to self-management of risks for hospitalisation. The principles call for high-quality and supported person-centred care that:</p> <ul style="list-style-type: none"> • is culturally responsive • is goal-directed • encourages health literacy • is health promoting • facilitates self-management • focuses on early intervention • uses evidence-based practice • takes a team approach.
Victoria	Victorian Health and Wellbeing Plan 2015-2019 ^{xiii}	<p>The plan articulates the government’s vision for a Victoria free of the avoidable burden of disease and injury. Priorities are:</p> <ul style="list-style-type: none"> • healthier eating and active living • tobacco-free living • reducing harmful alcohol and drug use • improving mental health • preventing violence and injury • improving sexual and reproductive health. <p>The plan also identifies platforms for health improvement:</p> <ul style="list-style-type: none"> • healthy and sustainable environments • place-based approaches • people-centred approaches. <p>This plan has a bold vision for the state: <i>a Victoria free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age.</i></p>

Table 1: National and Victorian strategic context (cont.)

Strategic Documents & Plans		Key Messages
Victoria	Victorian public health and wellbeing outcomes framework 2016 ^{xiv}	This framework provides a comprehensive set of public health and wellbeing outcomes, indicators, targets and measures for our major population health and wellbeing priorities and their determinants, as well as assessment of health inequalities. Program measures for short, medium and long-term outcomes have been developed at a population level. It aims to identify and quantify the public value created by departments and agencies across the Victorian Government.
Victoria	Health 2040 – advancing health, access and care.	This presents a clear vision for the health and wellbeing of Victorian and for the Victorian healthcare system. It is built around three pillars. Better health: focuses on prevention, early intervention, community engagement and people's self-management. Better access: focuses on reducing waiting times and delivering equal access to care via statewide service planning, targeted investment and unlocking innovation. Better Care: focuses on people's experience of care, improving quality and safety, ensuring accountability to achieve best health outcomes and supporting the workforce to deliver the best care.
Victoria	Victorian Health Priorities Framework 2012-2022	The framework provides the foundation for the Rural and Regional Health Plan. It has been applied to the rural and regional health system to drive the development of key actions that will deliver services in rural and regional Victoria that are more responsive to people's needs and rigorously informed and informative. This provides the blueprint for planning and development priorities for the Victorian healthcare system for the decade.
Victoria	Balit Marrup Aboriginal Social Emotional Wellbeing Framework 2017-2027	<i>Balit Murrup</i> means 'strong spirit' in the Woi-wurring language. It recognises that to reduce the growing mental health gap, we need new and different solutions to address what has been described as entrenched mental health crises. The vision of Balit Murrup is to support Victorian Aboriginal people, families and communities to achieve and sustain the highest attainable standard of social emotional wellbeing and mental health.
Victoria	Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027	The purpose of Korin Korin Balit-Djak is to realise the Victorian Government's vision for 'Self-determining, healthy and safe Aboriginal people and communities' in Victoria. It provides an overarching framework for action to improve the health, wellbeing and safety of Aboriginal Victorians.
Victoria	Dental Health Services Victoria Strategic Plan 2016-2021	Good Oral Health for all Victorians. The strategic plan will be achieved through five-year strategies, goals and four strategic themes which are: improve health outcomes, improve the experience, be global leaders with our local partners, and be a great place to work and a great organization to work with.
Hume (OM and G)	Hume (Ovens Murray and Goulburn Areas) Oral Health Strategic Plan 2018-2024	The Hume (Ovens Murray and Goulburn) Oral Health Partnership is a collaborative network of public oral health services, Government agencies and tertiary institutions. The intention of the Plan is to inform future investment of people and systems, to strengthen integration and increase preventative and outcome-based efforts delivering better oral and general health for Hume (Ovens Murray and Goulburn) communities. There are four key focus areas: person centred care; a dynamic workforce; access to services and a commitment to quality, safety and innovation.

Table 1: National and Victorian strategic context (cont.)

Strategic Documents & Plans		Key Messages
Victoria	Victoria's 10-year mental health plan ^{xv}	<p>This plan puts a focus on outcomes including psychological wellbeing for communities and vulnerable groups. It sets out strategies to achieve better results for people with mental illness, such as more social and economic participation, reduced contact with the criminal justice system and better access to safe, responsive services that join up to work as a whole. It lays out the reforms which the plan will underpin, and its connections to other relevant plans and strategies, alignment of the mental health system with the broader hospital and community health sector, and ways to ensure that the most vulnerable members of the Victorian community have access to the kinds of support and treatment services they need. The Victorian Royal commission into Mental Health, starting in 2019 and within two years, is tasked with providing a comprehensive set of recommendations on how best to support Victorians with mental illness, including Victorians at risk of suicide. It will also play a major role in raising public awareness about mental health as an issue.</p>
Victoria	Statewide design, service and infrastructure plan for Victoria's health system 2017– 2037 ^{xvi}	<p>This plan discusses the unprecedented challenges for health that require new and innovative ways of responding. The business as usual model is no longer sufficient - it is not enough to keep doing more of the same. Five priorities are identified to tackle the challenges and to chart Victoria's pathway over the coming 20 years:</p> <ol style="list-style-type: none"> 1. building a proactive system that promotes health and anticipates demand; 2. creating a safety and quality-led system; 3. integrating care across the health and social service system; 4. strengthening regional and rural health services; and 5. investing in the future—the next generation of healthcare. <p>The plan emphasises the need for capacity in the right places to respond to growth and to deliver more equitable outcomes. Government and service agencies must work with local communities to provide complete solutions that work across health and social care and link to employment, education and economic priorities (i.e.: - the social determinants of health).</p> <p>The plan emphasises the importance of ensuring that the health system delivers the same outcomes for people living in rural and regional Victoria as for people living in Melbourne. In doing this, it should be noted that generally, rural and regional areas have higher levels of socioeconomic disadvantage, residents have shorter life expectancy and poorer health outcomes such as lower cardiac and cancer survival rates. They also score poorly on lifestyle risk factors, all of which can have a big impact on health and wellbeing. Other points to note include:</p> <ul style="list-style-type: none"> • the need to work with private sector providers to develop new ways to fund and deliver healthcare; • the need to grasp the opportunities of new technology, new treatments and new ways of working to build the health system of the future, and • that the majority of health and social care in the future will be community- and home-based, making it more accessible for rural Victorians on a day-to-day basis.

Table 1: National and Victorian strategic context (cont.)

Strategic Documents & Plans		Key Messages
Victoria	Victoria's Rural and Regional Health System Design, Service and Infrastructure Plan ('the Rural Plan') ^{xvii}	This Plan (in development) cascades from the Statewide design, service and infrastructure plan framework. It will articulate how rural and regional health services should be designed, configured, and capacity and clinical capability developed over the next 20 years.
Victoria	Clinical Networks ^{xviii}	The Victorian Government is supporting statewide Clinical Networks which are groups of health professionals, health organisations and consumers who work collaboratively to provide leadership and clinical service development in specialty areas of healthcare. They help address common issues and improve the quality of care provided. The nine specialty areas supported are: cancer, cardiac, critical care, emergency care, maternity and newborn, palliative care, paediatric, renal, and stroke.



3 Communities of the Ovens Murray and Goulburn Areas

The Ovens Murray and Goulburn Areas comprise diverse communities of more than 280,000 people who reside in cities, multiple small towns, villages and rural areas. This presents both challenges and opportunities. The Ovens Murray and Goulburn Areas are in the DHHS East Division and within the Murray PHN except parts of Mitchell and Murrindindi Shires, which are within the Eastern Melbourne PHN catchment.

The Goulburn Area (shaded green in Figure 1) has a population of 157,873 people (2017) and includes the LGAs of Shepparton, Moira, Strathbogie, Mitchell and Murrindindi and the Primary Care Partnerships of Goulburn Valley and Lower Hume. The Ovens Murray Area (shaded purple in Figure 1) has a population of 124,380 people (2017) and includes the LGAs of Alpine, Benalla, Mansfield, Wangaratta, Indigo, Towong, Wodonga, Albury and the Central Hume and Upper Hume Primary Care Partnerships.

Figure 1: Ovens Murray and Goulburn Area

Goulburn – five local government areas

Ovens Murray – seven local government areas plus links to Albury in NSW



3.1 Health Profile of Ovens Murray and Goulburn Communities

The indicators provided here are relevant to chronic conditions.^{xix} Data in Table 2 is provided for whole areas with attention to those smaller areas with higher rates, all compared to Victorian non-metro rates, and some Victoria-wide rates.

Table 2: Demographic Snapshot and Health Profile

Albury is not included here for data purposes however is required to be considered as a key area for service system alignment and area planning.

Indicator	Goulburn area	Ovens-Murray
Population Projected population growth 2015-2037 ^{xx}	157,873 people Projected growth: 53,004 (3.4% p.a.) people	124,380 people Projected growth: 23,920 (2.4% p.a.) people
LGA's with largest population growth projections 2018-2036	Mitchell Shire: 2018 44,882 people 2036: 91,830 people (change = 104.60%) Greater Shepparton: 2018: 66,924 people 2036: 83,234 (change = 24.37%)	City of Wodonga: 2018: 41,666 people 2036: 57,314 people (change = 37.56%)
Aboriginal and Torres Strait Islander people Victorian non-Metro average 1.6%	Goulburn area: 3,632 (1.8%). Greater Shepparton: 2,186 (3.4%)	Ovens-Murray: 2,030 people (1.4%) Wodonga 975 people (2.4%)
People born in predominantly non-English speaking countries Victorian non-Metro rate 6.1%	Goulburn area: 6.3% or 12,435 people Greater Shepparton: 11.6%	Ovens-Murray: 6,510 people (4.9%) Wodonga 6.5%.
Children under 15 years living in low income families Victorian non-Metro rate 26.9%	Goulburn area, 27.5% or 9,586 children Greater Shepparton, 33.8%	Ovens-Murray: 23.4% or 6,107 children Benalla, 35.2% Wodonga 27.3%
Households in the two lowest income quintiles Victorian non-Metro rate 49.3%	Goulburn area: 46.4% or 27,816 households Moir: 51.3% Strathbogie: 50.3%	Ovens-Murray: 45.8% or 22,737 households Benalla 50.3% Towong 48.9%
Proportion of aged pensioners over 65 years Victorian non-Metro rate 75.1%	Goulburn area: 74.4% or 21,210 people Moir: 77.1% Mitchell: 76.7% Greater Shepparton: 76.5%	Ovens-Murray: 75.2% or 17,886 people Wodonga 80.5% Benalla 79.2%

Table 2: Demographic Snapshot & Health Profile *(cont.)*

Indicator	Goulburn area	Ovens-Murray
Diabetes Victorian non-Metro rate 3.9%	Goulburn area: 4.0% or 5,247 people Greater Shepparton: 4.3% Moir: 4.2% Mitchell: 4.1%	Ovens-Murray: 3.7% or 4,037 people Wodonga 4.7%
Respiratory system diseases Victorian non-metro rate 31.8%	Goulburn area: 46,322 people 30.8% Greater Shepparton 33%, 20,238 people	Ovens-Murray: 33.1% or 39,166 people Wodonga 35.6% Towong 34.4%
Circulatory system diseases Victorian non-Metro rate 17.1%	Goulburn area: 27,133 or 17.2% Mitchell and Moira 17.4% Strathbogie 17.3%	Ovens-Murray: 17.6% or 22,959 people Towong 18.1% Mansfield 18.0% Wodonga 18.0%
Current male smokers 18 years and over Victorian non-metro rate 23.2% Victorian rate overall 18.4%	Goulburn area: 24.6% or 12,542 males Moir 26.7% Mitchell 24.6%	Ovens-Murray: 22.5% or 8,643 males Benalla 25.2% Alpine 23.1%
Current female smokers aged 18 years and over Victorian non-metro rate 15.9% Victorian rate overall 12.7%	Goulburn area: 16.5% or 9,151 females Moir 18.2% Mitchell 16.6% Greater Shepparton 16.3%	Ovens-Murray: 15% or 6,458 females Benalla 17.3% Wodonga 15.7%
Dental extractions in children under 5 years Victorian rate 3.85 per 1000 population ^{xxi}	Goulburn area: 4.22/1,000 children Murrindindi 6.97/1,000 Greater Shepparton 5.26/1,000 Mitchell 4.51/1,000	Ovens-Murray: 3.36/1,000 children Benalla 6.65/1000 children Indigo 6.21/1000 children Wangaratta 4.41/1000 children
Number of family incidents recorded by police 2016-17	Goulburn: 3100 reports Shepparton 1392 (45% of total reports) Mitchell 928 (30% of total reports) Moir 496 (15% of total reports)	Ovens-Murray: 2002 reports Wodonga 778 (39% of total reports) Wangaratta 494 (25% of total reports) Benalla 371 (19% of total reports)
Clients that received Alcohol & Drug Treatment Services per 1,000 population ^{xxii} Victorian measure 5.0 per 1,000 population *note that access requires a service to be available and accessible	Goulburn: 5.6/1,000 Greater Shepparton: 7.5/1,000 Mitchell: 5.4/1,000 Moir: 3.6/1,000 Murrindindi: 3.2/1,000 Strathbogie: 3.6/1,000	Ovens-Murray: 2.5/1,000 Alpine: 1/1,000 Benalla RC: 3.2/1,000 Indigo: 2.1/1,000 Mansfield: 1.2/1,000 Towong: NA Wangaratta: 2.5/1,000 Wodonga: 3.4/1,000

Table 2: Demographic Snapshot & Health Profile *(cont.)*

Indicator	Goulburn area	Ovens-Murray
Registered mental health clients per 1,000 population Victorian rate 11.9 per 1,000 population	Goulburn: 16.8/1,000 Greater Shepparton: 19.4/1,000 Mitchell: 15.0/1,000 Moir: 15.4/1,000 Murrindindi: 15.1/1,000 Strathbogie: 14.6/1,000	Ovens-Murray: 21.7/1,000 Alpine: 19.1/1,000 Benalla RC: 26.3/1,000 Indigo: 22.1/1,000 Mansfield: 13.5/1,000 Towong: 15.4/1,000 Wangaratta: 23.7/1,000 Wodonga: 21.9/1,000

In summary:

- The areas with the largest projected population growth are Mitchell Shire, Greater Shepparton and Wodonga.
- The largest Aboriginal communities are in Shepparton and Wodonga.
- Greater Shepparton has about double the average number of people born in predominantly non-English speaking countries.
- Greater Shepparton, Benalla and Wodonga have higher numbers of children living in low-income households, than the Victorian non-metro average.
- Smoking rates are higher than the Victoria rate in many of the LGAs across the Ovens Murray and Goulburn Areas.
- The rates of diabetes are highest in Wodonga, Greater Shepparton, Moira and Mitchell - all have higher rates than the Victorian non-metro rate.
- Dental extractions in children under 5 years are happening at higher rates than the Victorian average in Indigo, Benalla, Murrindindi, Greater Shepparton, Mitchell, and Wangaratta.
- Most areas across the Ovens Murray and Goulburn Areas have lower rates of clients receiving drug and alcohol treatment which may be due to more limited access to AOD services in rural areas than for more populated areas of Victoria.
- All LGAs in Goulburn have higher rates of registered mental health clients than the Victorian rate overall.

4 Chronic Conditions and Potentially Preventable Hospitalisations

Data from the Australian Institute of Health and Welfare shows that too many people end up needing hospital admission due to their chronic disease, and too many people depend on emergency departments and hospital out-patient services for management of their chronic diseases. Many experience gaps in their care as services are stretched.

The Australian Institute of Health and Welfare describes Potentially Preventable Hospitalisations as follows: ^{xxiii}

Potentially preventable hospitalisations (PPH) are conditions where hospitalisation could have potentially been prevented through the provision of appropriate individualised preventive health interventions and early disease management usually delivered in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals). These are defined in accordance with the National Healthcare Agreement's definition of the PPH performance indicator. PPH rates are indicators of the effectiveness of non-hospital care. The rate of PPH in a local area may reflect the prevalence and severity of the conditions, or effectiveness and access to the non-hospital care system. There are three broad categories of PPH:

- 1. Vaccine-preventable** - diseases that can be prevented by vaccination. In this update, they are grouped as pneumonia and influenza (vaccine-preventable) and other vaccine-preventable conditions. Other vaccine-preventable conditions include chicken pox, diphtheria, haemophilus meningitis, hepatitis, measles, mumps, pertussis (whooping cough), polio, rubella and tetanus.
- 2. Acute** - conditions that theoretically would not result in hospitalisation if adequate and timely care (usually non-hospital) was received. These include cellulitis, convulsions and epilepsy, dental conditions, ear, nose and throat infections, eclampsia, gangrene, pelvic inflammatory disease, perforated/bleeding ulcer, pneumonia (not vaccine-preventable), urinary tract infections (including kidney infections) and mental health conditions.
- 3. Chronic** - conditions that can be managed effectively through timely care (usually non-hospital) to prevent deterioration and hospitalisation. These include angina, asthma, bronchiectasis, chronic obstructive pulmonary disease, congestive heart failure, diabetes complications, hypertension, iron deficiency anaemia, nutritional deficiencies and rheumatic heart diseases.

In other words, PPH's are those where the hospitalisation may have been prevented by timely and appropriate provision of primary or community-based health care. The data show that in 2015-16:

- Nationally there were nearly 680,000 hospitalisations for the 22 conditions for which hospitalisation is considered potentially preventable. This represented 6% of all hospital admissions to a public or private hospital in Australia that year.
- Potentially preventable hospitalisations accounted for nearly 2.7 million bed days nationally – equivalent to 9% of all public and private hospital bed days.
- Nationally, the age-standardised rate of potentially preventable hospitalisation was 2,643 per 100,000 people.
- Tooth decay is the most common chronic disease in Australia. ^{xxiv}

Table 3 provides data by the six Statistical Area level 3 catchments in the Ovens Murray and Goulburn Areas for Potentially Preventable Hospitalisation (PPH). This local-level information is an indicator of patients' access to primary health care services and the appropriateness or effectiveness of care.

It is informative about where to develop strategies for change in the context of Ovens Murray and Goulburn. Note that in the year 2015-2016, there were more than 45,000 bed days used in the Ovens Murray and Goulburn Areas for PPH, and the rates of admissions per 100,000 people is significantly higher across the Ovens Murray and Goulburn Areas than the national rate.



Table 3: Total Potentially Preventable Hospitalisations 2015-2016 for Ovens Murray and Goulburn Area LGAs

SA3 name	PPH per 100,000 people (age-standardised)	PPH per 100,000 people (crude)	Number of same day PPH	Percentage of PPH that are same day (%)	Total PPH bed days	Average length of stay (days)
Albury	2,660	3,000	577	31.1	7,252	3.9
Upper Goulburn Valley (includes Seymour, Alexandra, Nagambie, Euroa)	2,647	3,303	500	28.9	8,383	4.9
Wangaratta-Benalla	2,772	3,434	499	32.8	6,332	4.2
Wodonga-Alpine	2,819	3,265	646	29.0	9,551	4.3
Moira	3,026	4,008	289	25.0	5,001	4.3
Shepparton	3,096	3,427	738	34.1	8,665	4.0
Total	Ovens Murray & Goulburn Area average: 2,837	20,437	x	x	45,184	x

Heart failure patients accounted for the highest percentage of bed days for potentially preventable hospitalisations (15% of all potentially preventable hospitalisations). This was followed by Chronic Obstructive Pulmonary Disorder COPD (15%), kidney and Urinary Tract Infections UTIs (12%), cellulitis (11%), and diabetes complications (9%). Focusing on these five conditions may provide opportunities for local areas and PHNs to target efforts where the greatest improvements could be realised, in:

1. reducing the number of hospitalisations for high volume **acute** conditions such as kidney and UTIs, and
2. reducing the number of days patients spend in hospital for **chronic** conditions with longer lengths of stay such as heart failure and COPD.

The Grattan Institute reports that ineffective management of heart disease, asthma, diabetes and other chronic diseases costs the Australian health system more than \$320 million each year in avoidable hospital admissions. Further, at best, our primary care system provides only half the recommended care for many chronic conditions. Only a quarter of the nearly one million Australians diagnosed with type 2 diabetes get the monitoring and treatment recommended for their condition.^{vi} Again, these data can be extrapolated to the Ovens Murray & Goulburn Areas as a guide to the changes that need to be made.

5 Systems Thinking About Chronic Conditions & Prevention

Systems thinking is about working at scale, across many levels to achieve outcomes for communities and populations. It happens when there is a sharpened awareness of the big picture and the elements (which can be complex) that make up the whole, as well as the way that those elements inter-relate with each other. Systems approaches require understanding of complex problems and how to impact on them by encouraging a focus on the whole and on the relationships and connections between people, organisations and the services they provide for chronic care.^{xxv}

Systems approaches encourage a rethinking of organisations and structural issues, including how partners operationalise actions in relation to each other. A systems approach to chronic care requires strategic thinking about priorities and outcomes, and recognition that integrated approaches are necessary for effective primary health care. Specifically, the pillars of systems integration are organisational partnerships, professional interactions and consumer engagement, all of which are necessary elements for improved outcomes.

Further, system-level interventions for prevention and health improvement move away from a programmatic approach. System level interventions can also be emergent, where lots of small local changes (adaptations) add up to larger patterns overall, but they can only be undertaken by first understanding the properties of systems. This thinking underpins the Strategic Priorities of this strategy. Strategic planning is necessary to develop services in partnership between people needing care, their health care team and community supports. At individual levels, people's responses to self-management of chronic conditions are shaped and constrained by local system structures which they expect service providers to manage effectively.

Systems thinking for chronic conditions prevention is based on intersectoral action, and the knowledge that the health of populations is not determined by health sector activities alone but by social and economic factors and the policies and actions beyond the mandate of the health sector. Sectors including Education, Local Government, Justice, Environments, Sport and Recreation, Housing and Workplaces are important collaborative partners in prevention.

Investment in prevention is also critical, guided by planning to address fragmentation. Prevention strategies/interventions are delivered on a continuum from individuals, to communities or whole populations. Table 4 sets out the conceptual levels of action for both health promotion and clinical prevention that are different but complementary. These levels are reflected in the Strategic Priorities for this strategy.

Of the 22 conditions for which hospitalisation is considered potentially preventable, five conditions accounted for **almost half (47%)** of all potentially preventable hospitalisations and **almost two-thirds (62%)** of bed days for these admissions nationally – these figures are likely to be reliably extrapolated for the Ovens Murray and Goulburn Areas. The five conditions are:

- Chronic obstructive pulmonary disease (COPD)
- Diabetes complications (excluding gangrene)
- Heart failures
- Cellulitis
- Kidney and urinary tract infections (UTIs).

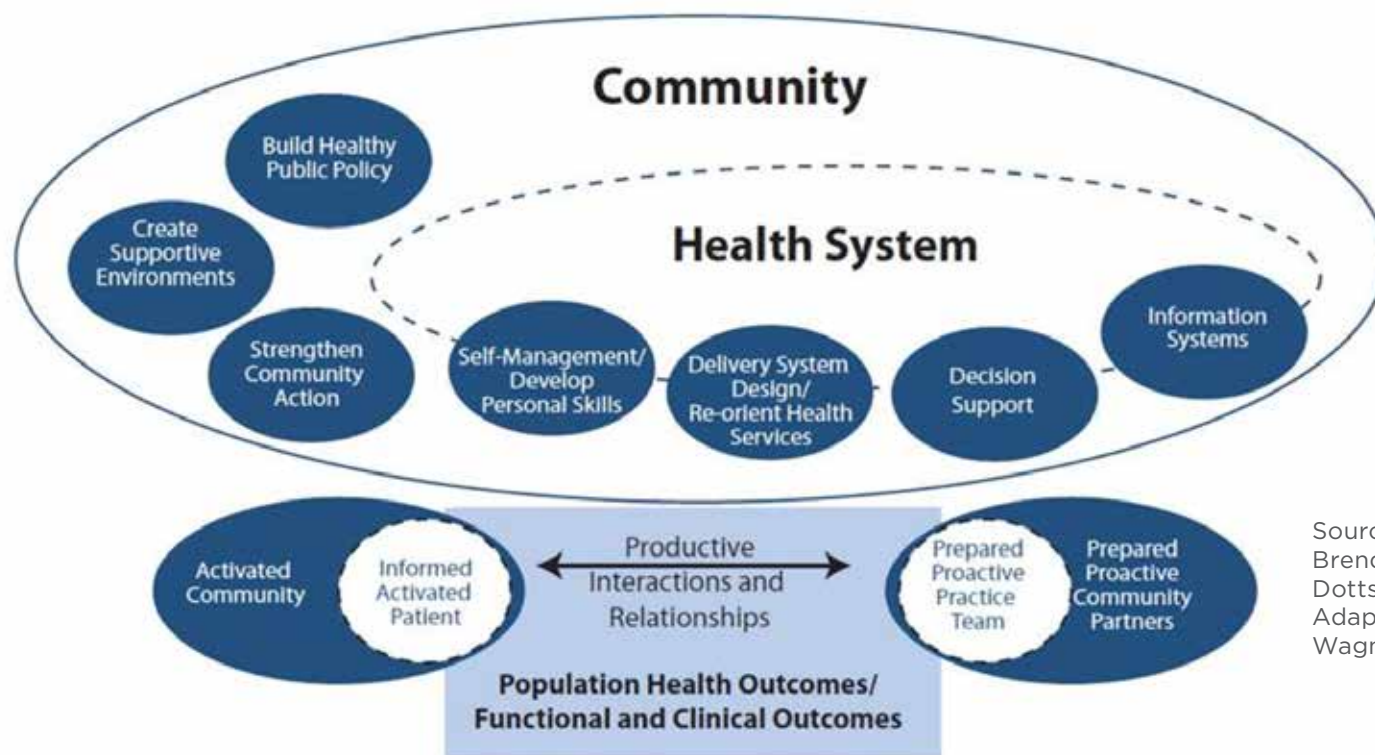
While many health gains have been made through individualised medical interventions, it is now recognised that population-level health gains have the potential for the widest reach but are only possible with approaches that widen the boundaries of intervention, to ‘systems’ that include sectors relevant to the social determinants of health. Systems thinking and prevention necessarily lead to outcomes thinking. In turn, outcomes thinking uses progress measures about what change is needed to achieve desired improvements, and then how that change will be measured. ^{xxvi}

The Expanded Chronic Care Model (Figure 2) recognises that change to chronic diseases will be less costly and more effective if both the prevention and ongoing management of chronic illnesses use a similar set of improvement strategies. The design elements of the Model highlight the need to improve the environments of care such as decision support and information systems to support providers and consumers. The goal behind the model is ‘to deliver care that is safe, effective, timely, patient-centred, efficient and equitable’. ^{xxvii}

Table 4: Prevention continuum for health promotion and clinical prevention

Levels of prevention	Population level health promotion	Clinical level
<p>Primary prevention</p> <p>Primary prevention is targeted at whole populations or specific communities.</p>	<p>Support healthy communities through health promotion action on the social determinants of health as well as access to high quality prevention initiatives including policy and regulation across sectors including local government, ensuring funding investments are aligned with strategic goals for the reduction of chronic conditions.</p> <p>Work across sectors including Local Government, Education, Justice, Environments, Sport and Recreation, Housing and Workplaces to promote health and strengthen prevention.</p> <p>Focus on the population as a whole, and the range of settings in which risk factors for chronic conditions. Through intersectoral partnerships, build systemic, organisational and community capacity to understand and act on, the unhealthy factors that cause poor health, and the protective factors that maintain good health and wellbeing, in the short and long term.</p>	<p>Support individuals and communities to prevent illness and disease that contribute to chronic conditions before they occur, by reducing or eliminating causal factors such as smoking cessation, exercise and nutrition recommendations.</p> <p>Focus on individuals and groups with a high risk of unhealthy behaviours and the factors contributing to that risk.</p> <p>Increase actions on health literacy across organisations and sectors^{viii}, about the causes of chronic conditions and prevention including mental health and oral health.</p>
<p>Secondary prevention and early intervention.</p> <p>Secondary prevention activities are mainly targeted at high-risk individuals who have multiple risk factors and/or established chronic diseases to increase wellbeing and quality of life.</p>	<p>Actively support communities to identify and act on risk factors that cause chronic disease.</p> <p>Work with General Practice, Pharmacy, Community Health Services and NGOs to promote concepts of wellbeing, and the value propositions behind active living and healthy eating.</p> <p>Actively promote self-management strategies that focus on wellbeing and quality of life through active living and healthy eating as well as self- and clinical assessment, goal-setting, action planning, problem-solving and follow-up.</p>	<p>Promote screening particularly among rural residents, and increase levels of early detection of chronic conditions, and treatment to prevent progression of disease.</p> <p>Provide early intervention services for adolescents and adults who may be at risk of mental health conditions such as depression and anxiety.</p> <p>Increase organisational health literacy in their work with communities, to explain the importance of active living, healthy eating and oral health.</p> <p>Increase health literacy among high-risk individuals about how to prevent complications, and about self-management.</p> <p>Increase strategies to reduce risk factors (smoking, poor nutrition, hypertension, insufficient physical activity, high cholesterol) in people with chronic diseases.</p>
<p>Tertiary prevention</p>	<p>Specialist services and hospitals plan for strategies to reduce the burden of chronic disease by increasing access to high quality services particularly for vulnerable groups.</p>	<p>Treatment, rehabilitation and self-management to prevent disease progression and complications to improve their ability to function, quality of life and life expectancy, through medical specialists, Allied Health, General Practice and Pharmacy.</p>

Figure 2: Expanded Chronic Care Model



Source: Victoria Bar, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts and Darlene Ravensdale (2002). Adapted from Glasgow, R, Orleans, C, Wagner, E, Curry, S, Solberg, L, (2001)

The Expanded Chronic Care Model demonstrates population health and clinical approaches which are intended to result in improved outcomes. This broader population health perspective requires analysis of the social determinants of health such as income, education, and transport which have effects on equitable access to care and clinical/functional outcomes.

This approach requires population-based health promotion investments to be aligned with strategic goals to reduce the prevalence of chronic conditions. The Model is designed to improve health care practice and for the delivery of care, but it may not be sufficient to transform the way systems work to prevent chronic conditions. To shift thinking and design for infrastructure planning, the Victorian government is proposing a bigger picture.

Various frameworks will be used to assist in the systems level work that will be needed to deliver required change and support intersectoral action. The Collective Impact Framework developed by the FSG (www.fsg.org) is such an example that is designed to support broad collaboration for change and delivers outcomes.

The Collective Impact framework contains five core conditions: the development of a common agenda; using shared measurement to understand progress; building on mutually reinforcing activities; engaging in continuous communications and providing a backbone to move the work forward.

5.1 The Role Of Partnerships And Collaboration For Success

Stakeholder collaboration and catchment-wide approaches are widely acknowledged to be essential for better outcomes in quality improvement for chronic conditions care.

The MacColl Institute built on its early work with the original Wagner Chronic Care Model to examine the notion that ‘It Takes a Region’ to improve the quality of care and outcomes for populations with chronic conditions. ^{xxviii}

Their Framework for ‘Creating a Regional Health Care System’ is a practical model that identifies four essential strategies:

- support for delivery system improvement
- sharing data to measure performance
- engaging consumers,
- aligning benefits and finances

The MacColl Framework also discusses the need to employ multiple strategies for regional transformation and offers a road map for getting started.

The Victorian Statewide Design and Infrastructure Plan, released in December 2017, promotes the development of Health and Wellbeing Hubs for quality improvement. ^{xvi} The design elements for hubs highlight the need to integrate the determinants of health with access to health care, involve the public and private sectors, include the full range of health care services with the community and social sector, and an integrated cross-sectoral health promotion/prevention platform. The system design principles emphasise integration, prevention, and person-centred care as well as the system elements of capacity and flexibility. Those elements are critical for the best use of resources as are the elements of prediction and proactive, personalised care. The predictive element is about maximising clinical resources using ‘big data’ from multiple sources including safety and quality data, new technologies and research, all leading to improved outcomes. The Plan outlines a vision for a more connected and networked service system, supported by regional and local partnerships across Victoria’s regional and rural health services. It articulates thirteen Local Area Health Partnership Areas that make up six larger Regional Partnership Areas, collectively referred to as Health Partnerships. In Goulburn the Local Area Health Partnership is led by Goulburn Valley Health in a West Hume Partnership. In Ovens Murray, Albury Wodonga Health cover the whole of area with Northeast Health as a Local Area (subregion) Health Partnership.

Implementation of the Ovens Murray and Goulburn Chronic Care Strategy will use design elements and principles that promote and support collaboration and the need for agility. The implementation of this strategy will require alignment with existing and emerging planning platforms and initiatives. Each area will determine the governance and leadership of the work required to deliver the outcomes of this strategy, with their respective Primary Care Partnerships to provide a backbone facilitation and support function. The Diabetes Clinical Network will align with and continue to focus on priorities identified in this strategy across both areas.

5.2 Priority Populations, Equity & The Determinants Of Health

Priority populations are those individuals, communities and populations who experience greater risk factors for chronic conditions, and among whom chronic conditions are more common. Priority populations in the Ovens Murray and Goulburn Areas are:

- Aboriginal and Torres Strait Islander people;
- children and adolescents growing up in disadvantaged circumstances;
- people who have limited health literacy and access to education and employment;
- migrant people born in non-English speaking countries;
- people who are rurally distant from services, particularly farmers;
- people with severe and continuing mental illness;
- people with disabilities; and
- older people especially pensioners.

Aboriginal and Torres Strait Islander people experience higher rates of chronic disease than any other group. Higher levels of risk factors are attributable to the determinants of health, which are based on understandings of the data about populations rather than individuals. The health of populations and communities is closely related to their socio-economic and social status because they play an influential role across the life-span, from early life experiences to subsequent opportunities for adult life.

In particular, early childhood is a critical life stage for targeted prevention to improve children's health and quality of life, and to prevent future risks of chronic conditions. The early years of life are the most profound in a person's life and there is abundant evidence that investment in early childhood is one of the most cost-effective investments in prevention that can be made, investments which have long-term effects on health across the lifespan.^{xxx} The evidence is very strong that we must work with whole of community strategies to re-shape early childhood experiences as well as ensuring that each child is receiving the health and social care that need for healthy development.

Adult responses to self-management of chronic conditions are shaped and constrained by their previous life experiences. In particular, education levels and health literacy are predictors of a person's engagement in health-damaging behaviours such as smoking and poor nutrition.

At community and regional levels, intermediary factors such as housing, employment opportunities and work conditions, access to services, and psychosocial stressors, also play major roles in determining health. These are many settings outside the health sector where prevention for chronic conditions can be most effectively targeted and for these reasons, place-based strategies can make a difference. Population health promotion works to improve the underlying conditions of people's lives which create poor health and seeks to reduce the prevalence of chronic conditions arising from conditions which create vulnerability, disadvantage and less than optimal health.

In turn, health equity is increased when initiatives tackle health disadvantage among priority population groups, and by addressing service access gaps.

6 Health & Wellbeing Partners

The major funded DHHS health care providers (Appendix 1), the Murray PHN and multiple sectors are integral partners in this strategy because they share responsibility for health outcomes. It is essential that partners understand, accept and fulfil their roles and responsibilities to ensure the desired outcomes from the Strategic Priority Areas and that best value is achieved from the use of public resources.

Key to the effectiveness of this strategy are that:

- Good governance and leadership are essential;
- Cross sector partnerships and collaborations are necessary to drive outcomes;
- Stakeholder groups see themselves as essential to effective collaboration;
- Stakeholders understand that change will not happen on the scale needed unless they are willing partners;
- Partners are the creators of strategic vision and of evidence-based shared decision-making;
- Collaborative plans and actions enhance health system performance particularly for design of delivery systems for chronic disease management and for prevention at scale; and
- Partnerships and collaborations are necessary to drive accountability and transparency among providers.

Partners in health and wellbeing work strategically at the population level as well as levels of prevention (Table 4) to achieve change within the community and in the ways that organisations work. The Victorian Department of Health and Human Services in collaboration with other government Departments including Education, Justice and Environment, Water and Planning, has adopted a 'whole of systems approach' to improve the health of the population and reduce preventable illness from chronic conditions.

The Victorian Public Health and Wellbeing Outcomes Framework aims to identify and quantify the public value created by departments and agencies. It defines outcomes at different levels, such as the population level, the system level, the program level or the individual level.

When a number of diverse organisations can commit to a common agenda and collaborate effectively, the collective impact of those efforts will far exceed the efforts of individual organisations.

Key alignment partners in the Ovens Murray and Goulburn Areas are:

- the Murray PHN who works closely with the primary health system to identify opportunities to improve health outcomes in our community, through better coordination and support of health services and by commissioning new services to address health needs of their area;
- the Primary Care Partnerships (PCPs) as voluntary alliances that bring together local health and human service providers and relevant stakeholders to work to support primary prevention initiatives and improve access to services and continuity of care for people in their community.



PART 2: THE OVENS MURRAY & GOULBURN STRATEGY FOR CHRONIC CONDITIONS

7 Our Vision

Communities of the Ovens Murray and Goulburn Areas are enabled to live healthier lives through improved prevention, partnerships that focus on outcomes, culturally responsive services and effective management of chronic conditions.

8 Our Objectives

This strategy draws on the objectives and design principles of the National Chronic Care Framework, contextualized and localised for the Ovens Murray & Goulburn Areas. To strengthen the consistency and sustainability of chronic conditions care and prevention and improved health outcomes for these areas, our objectives are to:

Objective 1: Deliver a transformative prevention platform to reduce future burdens from chronic conditions and align investments with priorities.

Objective 2: Strengthen the efficiency, effectiveness, cultural responsiveness and appropriateness of services to support people with chronic conditions and optimise their quality of life.

Objective 3: Target priority populations to ensure focus on those most in need of care and who are most likely to benefit from prevention initiatives.

Strategic priorities and outcomes are aligned with these Objectives. The objectives are adapted from those of the National Framework and are consistent with Victoria's planning context for chronic care. This ensures that investment decisions delivering these objectives support the priorities of all levels of government.

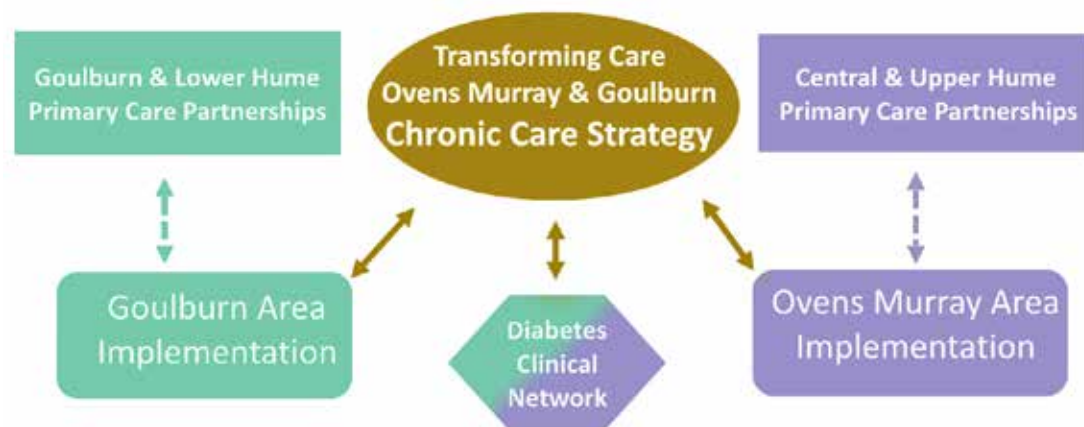
9 Our Work And How It Will Be Delivered

Ovens Murray and Goulburn Area based committees will work to leverage established relationships and networks to meet the outcomes agreed for this strategy. Refer to section 5.1 of this strategy.

Achievement of the outcomes will occur through implementation in each Area, putting into effect the strategy priorities and ensuring that the vision, values and outcomes are realised. Implementation will set out detailed actions including what will be addressed, time frames, resources (backbone and shared), how they will be organised and operate and the local partnership work necessary for effective actions.

Area based implementation will include agreed cycles of work and identify investment settings in which actions will be focused, monitored and measured. This strategy and the area implementation will be updated as needed.

Figure 3: Proposed Operating Approach



Our work will be informed by the literature about regional quality improvement which highlights that the following are necessary:

- Committed leadership;
- Collaboration among different stakeholders;
- A whole of population focus;
- Shared data and performance measurements;
- Infrastructure support;
- Active program of practice and organisational change; and
- Provider networking and vertical integration.^{xxix}

10 Our Quality Principles

The strategy is based on nine quality principles (Table 5) intended to influence the implementation of the strategy. They will be used as the basis for our management of the Strategic Priorities and the area-based implementation which will follow this strategy.

Table 5: Quality principles for chronic care

Principles	Which Means
Good governance and leadership	<p>The Ovens Murray Goulburn Chronic Care Strategy will be implemented through Area based and Area determined governance mechanisms and implementation approaches, these will incorporate:</p> <ul style="list-style-type: none"> • The use of strategic thinking, planning and responsible management of resources to deliver long-term improved health outcomes. • Governance that comprises organisations and individuals who are willing to contribute time and expertise in creating a shared learning environment and will work collectively towards achieving population-level outcomes for chronic conditions. • Acknowledgment that while services may be necessary for everyone at various points in our lives, services themselves are not sufficient for achieving community-level change, no matter how well they are delivered. • Accountability and transparency in relation to joint decisions and responsibilities and avoid repeating the things that have not worked in the past.
Population level approaches are integrated	<p>Population level approaches recognise that services themselves are not sufficient for achieving community- level change no matter how well they are delivered.</p> <p>Population approaches are about creating a regional response to chronic conditions that can be implemented regionally or locally. We recognise that there is no one correct way to improve our systems for chronic conditions but rather we must share knowledge, problem-solve with open minds, and support change and innovation.</p>
Access and equity are the centre of everything we do	<p>High quality, appropriate services are available, affordable and accessible to all who need them.</p> <p>Services are provided on the basis of need, regardless of age, gender, culture, ethnicity, socio-economic group, or geographic location.</p> <p>Services are flexible and provided at a time, venue and in a manner that meets the needs of participants and enables them to adopt and maintain self-management.</p>
Health literate organisations are essential for quality and safety	<p>People are supported to understand information about health and health care, to apply that information to their lives and to use it to make decisions and take actions relating to their health.</p> <p>Information provided is clear, current, written from health literacy principles and available in accessible formats. Organisational health literacy is widespread and aims to meet the National Quality Standards. ^{xxi}</p>

Table 5: Quality principles for chronic care *(cont.)*

Principles	Which Means
Our health and social services workforce are drivers of change	Our workforce is clear about their roles and how their work interconnects. We will provide appropriate training and resources across our workforce to support their efforts in prevention and in strengthening chronic condition management, particularly in self-management and assisting organisations to become health literate.
Evidence and research is meaningful	Meaningful measures are those that provide data on the elements for systems change. We will use rigorous, relevant and current evidence to inform our practice and strengthen the knowledge base about what is effective in the prevention and management of chronic conditions.
Data and information/ Technology to monitor change	Collaboration and partnerships support information-sharing and up-scaling of technological developments. Effective sharing of consistent, relevant and secure health information and data is used to demonstrate service delivery performance and improved health outcomes.
Self-management and person-centred care is accessible and appropriate	We will actively engage people with chronic conditions in their own healthcare. Our systems of care recognise and value the needs of individuals, their carers and families and always seek to provide holistic, comprehensive care and support. Our organisations will provide accessible, responsive and flexible services that meet the diverse needs and preferences of people living in their communities. Self-management programs will proactively identify people most in need of and likely to benefit from them and develop common language about self-management across and within sectors. We will ensure that consistent approaches to self-management are used, and access to self-management initiatives is widespread.
Prevention and health promotion are enabling, planned and well-coordinated	We will have a consistent and integrated approach to investments for effective health promotion and prevention. Ovens Murray and Goulburn Areas have agreed priorities in health promotion and prevention - 2018-2022 the two priorities of Active Living and Healthy Eating. We seek a transformation in practice and approach to create change at the population level that delivers measurable impacts with long term and sustainable outcomes. A broad range of stakeholders will be engaged. Prevention and health promotion measures will address social determinants of health.

11 Our Strategic Priorities – What We Will Do

This section identifies Strategic Priorities for each Objective, with short-term (1-2 years) and medium-term outcomes (2-5 years). These will be further articulated via work occurring to implement this strategy at areas in Ovens Murray and Goulburn.

Objective 1: Deliver a transformative prevention platform to reduce future burdens from chronic conditions and align investment priorities.

Strategic Priority 1.1: Population based Health Promotion and Prevention	
Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
Place-based and regional health promotion and prevention platform is integrated based on systems thinking, transformational change, best evidence and the social determinants of health.	Prevention platform at scale, is coordinated and implemented by Primary Care Partnerships. Intersectoral partnerships for Active Living, Healthy Eating and obesity prevention, are high-functioning and effective. Transformative prevention and health promotion are yielding positive outcomes for all communities in the Ovens Murray and Goulburn Areas.
Delivery of health education for people with chronic conditions integrates oral health, nutrition and physical activity programs, tailored for life stages.	There is increased population health literacy about chronic conditions prevention, risk factor identification and healthy behaviours.
Partnerships are established to develop and implement Ovens Murray and Goulburn-wide programs in population health literacy tailored for life stages, about the prevention of chronic conditions.	At-risk people and populations receive evidence-based targeted interventions from information platforms which are designed from health literacy principles. ^{xxxii}

Objective 1: Deliver a transformative prevention platform to reduce future burdens from chronic conditions and align investment priorities. (cont.)

Strategic Priority 1.2: Early childhood programs across the Ovens Murray and Goulburn	
Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
Early childhood screening and early intervention are coordinated and accessible particularly to low income families.	Services for early childhood are a priority in the plans of organisations responsible for early intervention and there are demonstrable improvements in access to needed services and reduction in waiting lists.
A community of practice is established that includes local governments to reduce the availability and promotion of sugary drinks and sports drinks in hospitals, health services, kiosks and cafe's at leisure centres, and sports venues.	Pathways into paediatric pre-school Allied Health and medical services are clearly articulated and there is cross sector engagement for improved early childhood outcomes.
Current coverage, current gaps and future opportunities for children's oral health programs across Ovens Murray and Goulburn Areas (coordinated by the Oral Health Partnership) are identified.	All public and private health services and local governments are proudly promoting water as the drink of choice, have reduced access to sugary drinks and improved access to water and healthy drinks.
	Key oral health messages are consistently promoted. Health providers/clinicians are confident in promoting oral health hygiene, identifying the early stages of oral disease and aware of the locations, referral pathways and eligibility criteria for public dental services.

Strategic Priority 1.3: Monitoring of success and effectiveness	
Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
Demand management frameworks are used and the provision of publicly funded services to priority populations is regularly reviewed.	Effective primary care services for chronic conditions are available, and delivered, to the most disadvantaged people in local communities who could not otherwise afford privately funded care.
The evidence base is strengthened about 'what works' in a rural and regional hub and spoke model for prevention and service delivery.	Recognition of, and evidence about, the contributions of multiple partners to better care of people with chronic conditions and their health and wellbeing.
Meaningful measures are developed and used to quantify outcomes that result from inputs with a watching brief to use Patient Reported Outcome Measures (PROMS) as they are developed.	Both Indicators (about whole populations) and Performance Measures (about client populations) are used to evaluate changes and dashboard reporting on those indicators is regular and commonplace.

Objective 2: Strengthen the efficiency, effectiveness, cultural responsiveness and appropriateness of services to support people with chronic conditions and optimise their quality of life

Strategic Priority 2.1: Chronic care systems are improving outcomes	
Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
Area based governance and organisation is established and providing effective and timely implementation against the priorities and agreed outcomes of this strategy.	A regional coalition approach is operating effectively and documenting stakeholder successes and learnings through six-monthly dashboard reporting.
Partnerships and collaborations are held accountable for delivery on specific improvements in health outcomes for people with chronic conditions.	Information sharing and cross- sector learning is routinely occurring via Primary Care Partnerships, the Diabetes Clinical Network and other Networks as they are established.
Innovation in the context of Ovens Murray and Goulburn is defined through a focus on improving system-wide efficiencies and patient outcomes.	People with chronic conditions in the Ovens Murray and Goulburn have improved access to safe, high quality health care.
Integrated cross-sector care is an organising principle of service delivery.	Health and social care services work together to provide appropriate, culturally responsive and effective care to people with chronic conditions.

Strategic Priority 2.2: Promote organisational health literacy to increase consumer engagement and knowledge	
Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
Primary Care Partnerships in the Ovens Murray and Goulburn Areas work together to build capacity for organisations to meet the criteria for health literate organisations.	All partners include health literacy in their organisational Strategic and Service Development Plans.
	Consumers are engaged in organisational health literacy strategies.

Strategic Priority 2.3: Streamlined access to self-management resources	
Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
The capacity of individual service providers to deliver evidence-based self-management is built and sustained.	Self-management education is core business for health care providers in the Ovens Murray and Goulburn Areas.
All strategy Partner organisations are equipped to deliver self-management interventions and resources that are appropriate, in accessible formats and at no cost to consumers.	Consumers with chronic conditions are aware of the resources available to them including public dental services.
	Consumers with chronic conditions navigate and use self-management information to meet their needs.
	Potentially preventable hospitalisations for chronic conditions are reducing.
A review of best practice in self-management is developed to guide organisation action planning.	Organisation Action Plans link the information needs of consumers for self-management to health literacy (2.2).

Objective 3: Target priority populations to ensure focus on those most in need of care and who are most likely to benefit from prevention initiatives.

Strategic Priority 3.1: Risks for potentially avoidable hospitalisations are targeted

Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
All people at risk of influenza are offered vaccination annually and meningococcal disease, coordination occurs with local governments, workplaces, hospitals and aged care facilities.	Vaccine preventable potentially avoidable hospitalisations have reduced.
People with chronic conditions living on low incomes have pathways into affordable chronic care and public dental care.	Winter planning by hospitals is coordinated and linked to primary prevention, tertiary and secondary sectors.
Clinical networks build information sharing and innovation into their core business.	Low income is not a barrier to access and care for chronic conditions and dental care for people in our catchment.
	Organisations and service providers are part of a learning environment for chronic conditions.

Strategic Priority 3.2: Aboriginal people receive culturally appropriate chronic condition care integrated with social care

Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
The Aboriginal community has been actively engaged to improve pathways and care of Aboriginal people with chronic conditions in the local area.	Organisation Cultural Action Plans include specific strategies to increase the quality of life and care for Aboriginal and Torres Strait Islander people with chronic conditions which are aligned with the self-determination principles of Korin Korin Balin-Djak. ^{xxxiii}
Organisations continue with cultural safety strategies to ensure their organisations are safe and welcoming and providing culturally appropriate care.	Chronic care services are integrated with social care needs.
	Equity of care is based on self-determination.
	Aboriginal population using services provide positive feedback on the services they have received.
	Every service has a culturally competent action plan and is meeting quality standards.

Strategic Priority 3.3: Care of people with mental illness challenges and chronic disease is integrated

Short-Term Outcomes 1-2 years	Medium-Term Outcomes 2-5 years
Mental health providers have developed a quality review of best practice in rural mental health care models including integrated mental illness and chronic care systems.	Action Plans include quality improvement based on best practice Trials of integrated mental illness and chronic care models are underway and being evaluated.
Capacity building needs of providers for integrated mental illness and chronic care are identified.	Training and other support about integrated mental illness and chronic care is routinely provided across the Ovens Murray and Goulburn Areas.

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