primary health TASMANIA

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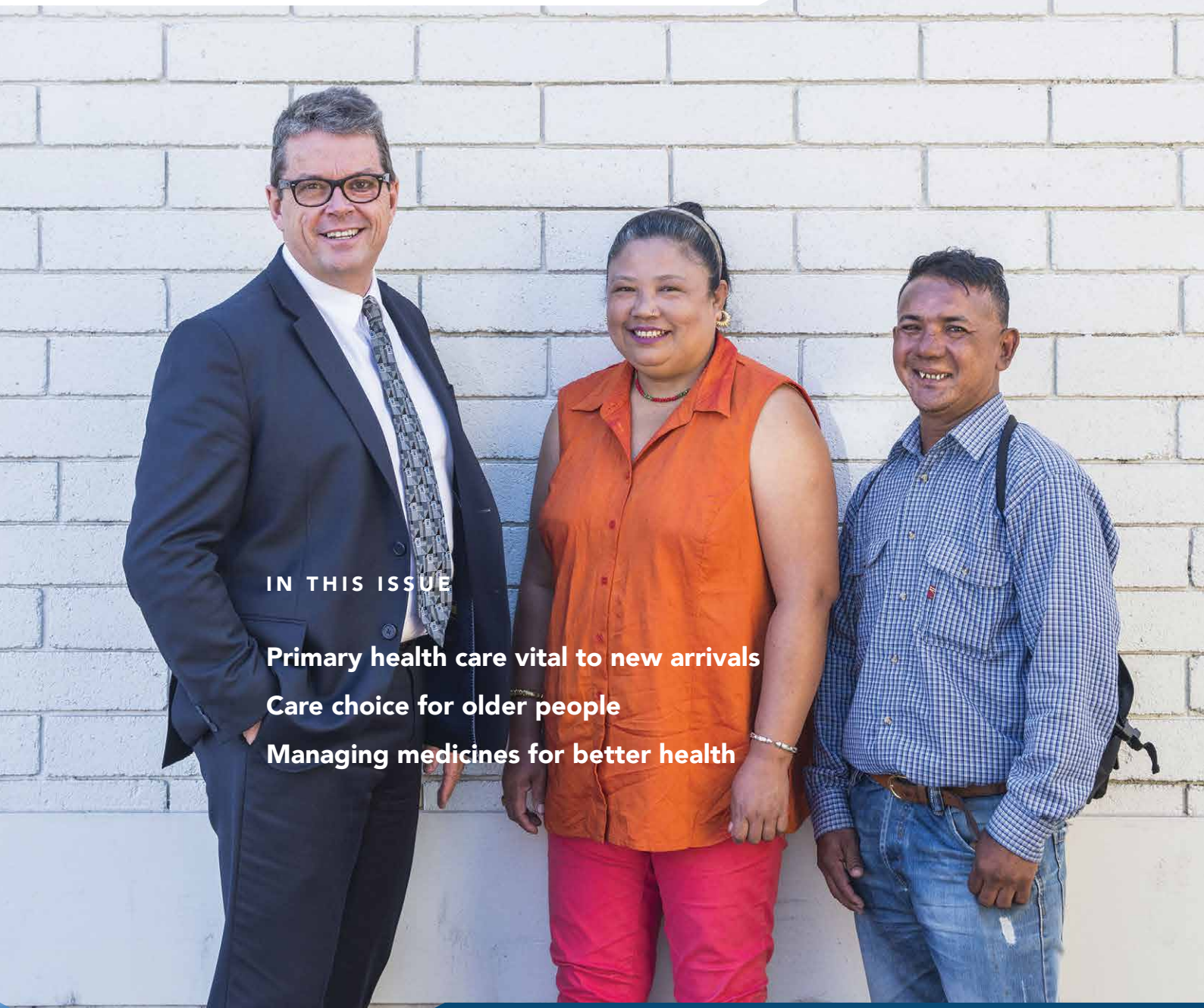
primary health matters

TASMANIA'S PRIMARY HEALTH MAGAZINE



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Cover image: Dr Andrew Jackson with patients Ashmaya and Gopal Bhujel

Primary Health Matters is produced by Primary Health Tasmania twice a year. It shows how innovation in primary health and social care is making a difference and contributing to healthy Tasmanians, healthy communities, and a healthy system. It focuses on the work of Primary Health Tasmania's member and partner organisations, as well as our own activities.

For more information about *Primary Health Matters* or to submit a story idea, please email **comms@primaryhealthtas.com.au** or call Jenny Denholm on 1300 653 169.

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Message from the CEO

WELCOME to the first issue of *Primary Health Matters* under the Primary Health Tasmania banner.

Our 1 July commencement as Tasmania's primary health network happened alongside a number of other system reforms, including the start-up of the Tasmanian Health Service and the next tranche of aged care changes.

The new 'consumer directed care' approach to the delivery of home care packages for older Australians is based on the person-centred philosophy that is at the heart of all that Primary Health Tasmania and its member organisations do. As our feature on pages 18 to 22 shows, implementation of this new way of working is not without its challenges. But the consumer experiences shared in these pages speak to its potential.

Mention 'eHealth' these days and many people working in the sector immediately think of the electronic health records system – soon to be renamed My Health Record. But the opportunities for technology to improve access to health services and information are wide-ranging; on pages 10 to 11, Huon Valley GP Prof Bastian Seidel urges general practices to consider adopting them. And our story on pages 12 to 13 explains how Tasmanian-first technology linking general practice, pharmacy and the state health department has had a dramatic impact on reducing 'doctor shopping' for narcotic drugs – a system that is now being implemented around the country.

New research shows the potential for national uptake of another Tasmanian initiative – our primary care refugee health clinics. With Tasmania looking set to increase its refugee intake in 2016 in light of the Syrian refugee crisis, we look at the health support new arrivals to Tasmania receive through these clinics and their ongoing care in mainstream general practice. See the feature on pages 4 to 9.

If you're aware of a story of innovation in primary health social care that deserves to be told, we'd love to hear from you.

Happy reading.

Phil Edmondson
CEO
Primary Health Tasmania

A round of applause for Encore

WHEN Laree Thorsby, of Kingston, received her breast cancer diagnosis in 2013 she was forced to put her life on hold.

Image courtesy YWCA's Encore program

"The chemotherapy was tough," Laree, 47, says.

"I was very ill throughout the treatment … there were days when I struggled to even walk.

"Looking back, I had lost all trust in my body's ability to do anything physical again."

A passionate swimming instructor, the prospect of being unable to return to the pool was a difficult one to face.

So when an opportunity came for Laree to regain her mobility and pave the way for a smoother recovery, she was ready.

In February 2014, Laree signed up to the Hobart Women's Health Centre's Encore program, which is delivered in Tasmania by Hobart Women's Health Centre.

She has just completed her third program at the centre in between a number of gruelling surgeries.

"When I started Encore I had just begun immediate reconstruction following my bilateral mastectomy," Laree says.

"While my scars had healed, I was very restricted in my upper body movements – any exercise I could do that would gradually stretch my muscles was encouraged."

The free eight-week Encore program involves gentle exercise specially designed for women recovering from breast cancer.

The YWCA national program, which runs statewide in Tasmania under the auspices of Hobart Women's Health Centre, targets the side effects of surgery and treatment to help increase strength and general fitness.

"Turning up on that first day and having to put on a pair of bathers in front of other women while knowing my body had changed completely was confronting," Laree says.

"But to be able to do so in an environment that was safe and supportive was wonderful."

Encore coordinator for southern Tasmania, Rosemary Kerrison, says the program is important for helping women cope with the after-effects of breast cancer.

"Current studies recommend fifteen minutes of any exercise per day can assist with reducing a recurrence of breast cancer in women," she says.

"Encore not only improves mobility, flexibility and strength through exercise, but helps women to regain a sense of control in their life by offering them the opportunity to meet and connect with women who have been through a similar experience."

Each weekly Encore session runs for two hours under the guidance of a fully trained YWCA facilitator, incorporating land and water-based activities with a focus on mobility, stretching, aerobic and resistance exercise and relaxation techniques.

Since her involvement in the program, Laree has gained more mobility, strength and confidence, as well as a will to gain control of her wellbeing.

"Having a double mastectomy takes a huge physical toll on your entire body, including the way you carry yourself," she says.

"Participating in Encore has taught me to listen to my body … I am aware of what I can do and what my restrictions are.

"I have much more freedom in my upper body, less pain than when I first started – and I can manage it better."

With her newfound sense of self-esteem Laree plans to continue her recovery through a mainstream aqua class in the community.

"Going through cancer you lose all dignity, but the support of the Encore group – including Rosemary and co-facilitator Wendy Hartshorn – made it much easier. It's a very liberating experience," Laree says.

The Encore program runs twice-yearly in Hobart, Launceston and the north west region.

The program also offers information through guest speakers and links into local services.

Participation is free by enrolment and women can refer themselves, but a completed medical approval form is required.

The Tasmanian program has no consistent ongoing funding but assistance is sought from a number of sources.

In the past 12 months Encore has received support from TasWater, Dragons Abreast Australia Hobart and Cancer Council Tasmania. ■

For more information, contact the Hobart Women's Health Centre on (03) 6231 3212

The Hobart Women's Health Centre is a member of Primary Health Tasmania.

TASMANIA receives around 500 refugees each year – two thirds settle in the south.

The State Government has promised to settle an additional 500 Syrians in 2016; part of a national commitment to accept 12,000 refugees.

Humanitarian entrants have unique health needs.

In this feature, *Primary Health Matters* looks at the health support they receive when they first arrive in Tasmania, and their ongoing care in general practice.

Primary health care vital to new arrivals

ASHMAYA and Gopal Bhujel spent 19 years in the Goldhap refugee camp in eastern Nepal after fleeing ethnic harassment in neighbouring Bhutan.

The couple's children were born in the camp and the family had come to regard itself as more Nepali than Bhutanese.

The Bhujel family arrived in Launceston in September 2008 with Gopal's parents.

According to the Migrant Resource Centre, around 700 former Bhutanese refugees now call Launceston home.

Ashmaya and Gopal (pictured left) were among the first to settle in Launceston.

"When we came, no Nepali – only English," Ashmaya says of the language spoken in her new home town. "For two months I cried."

Ashmaya studied English for two years before her ill health forced her to stop.

She has diabetes and suffers from chronic pain and gastroesophageal reflux. She also has vitamin B12, vitamin D and iron deficiencies.

When the Bhujel family arrived in Launceston they were referred to Primary Health Tasmania's Northern Refugee Health Clinic for a comprehensive health check and management of their initial health needs.

In 2009 they became patients at the Northern Suburbs Medical Service in Mowbray, where Dr Andrew Jackson is their regular GP.

The couple's now adult children live in Melbourne and Gopal's parents have settled in Adelaide. Ashmaya and Gopal experimented with a move to Melbourne to be closer to their children, but it was short-lived.

Andrew says it's because they couldn't bear to leave their GP. He's joking – they actually found the Victorian capital "too hot" – but Ashmaya can't be more serious about the importance and quality of care she and Gopal have received from their family doctor.

ALTHOUGH the Northern Suburbs Medical Service is recognised as a leading provider of health services to the refugee community in the north, practice principal Dr Andrew Jackson says there are no special arrangements in place for that to happen.

"We are a true general practice in that we accept unreferred patients and take them as they come," he says.

"The northern suburbs of Launceston constitute a lower socio-economic group and as a consequence housing costs are lower, so we find that our practice area has larger numbers of refugees settling here and looking for medical and nursing services.

"That said, I suppose that if the boss is well-disposed towards engaging with refugees, then that tends to filter through the rest of the practice."

Andrew says former refugees often have a unique medical profile, depending on where they are from, and Ashmaya and Gopal have problems very typical of many refugees who have come from Nepal.

"They often have multiple deficiencies including iron, vitamin B12 and vitamin D," he says. "Latent or dormant tuberculosis – non-infectious – is also very common.

"Most have been exposed to TB in the camps but only develop the non-infectious form.

"However, doctors here have to be on the alert as there is a ten per cent lifetime chance of it converting to the infectious illness-causing form as recently happened to one of my other patients.

"The good news is that TB sufferers rapidly become non-infectious once antibiotic treatment is started and so the overall risk of TB spreading into the local non-refugee community is very low."

Andrew says refugees also develop more conventional medical problems like diabetes and painful rheumatic conditions such as Ashmaya has.

"Unfortunately, this has meant that Gopal has to act as Ashmaya's carer when he would otherwise be very keen to secure paid employment to help support his family," he says.

Andrew says there is no special funding for private sector GPs who undertake to provide medical care to refugees – they must rely on standing Medicare rebates to pay for services.

He says the current Medicare rebate freeze, which commenced on 1 November, has already resulted in changes in his practice.

"My practice, like many others, chose to bulk bill refugees for the first three years or more after arrival in Australia – so they have no out-of-pocket expenses," Andrew says.

"We do this to assist in refugees' integration into the local community and ensure that what can be a raft of medical problems are remedied without contributing to unnecessary financial hardship early on.

"Because of the rebate freeze – at a time when the costs of providing GP services are rising – our practice has had to introduce a much less generous arrangement."

The practice's former refugee patients are bulk billed for their first 18 visits, then start paying a fee.

Andrew encourages his reception staff to try to greet former refugee patients in their first language.

"They probably feel a bit silly doing it, but the patients love it and respond warmly," he says. ▶

Dr Andrew Jackson

Dr Andrew Jackson's tips for practices caring for refugees:

- **liaise with your local refugee health clinic**
- **learn how to use interpreting services and a speaker-phone**
- **brush up on your tropical/third world medicine**
- **learn about the refugee's country, culture, and reasons for refugee status**
- **learn and use some key words in the refugee's first language**
- **be patient – consultation time can be prolonged.**

"And something amusing happens over time. The refugees all diligently go off to TAFE to learn English, and eventually they come in saying 'Hi' and 'See you later'.

"Meanwhile, I continue to struggle saying these words in their native language – we all have a laugh about that."

There can be some unexpected benefits of regular contact with former refugees.

On a family holiday to Cairo some years ago, Andrew made a welcome discovery when he realised he had little to worry about in terms of language barriers with the locals, thanks to his extensive work with migrant refugees back home.

His practice had cared for a number of Sudanese Arabic refugees in the late 'noughties' that gave him the local language edge in Egypt – he had made it his business to learn key words back home and use them every time a Sudanese refugee attended for medical care.

"Our Nile River cruise boat pulled in to Luxor to check out some fabulous ancient monuments and I set off alone, in search of some local colour – much to my wife and daughters' personal security consternation," Andrew says.

"This was in the year prior to the Arab Spring uprising with its attendant unrest, and the local situation was fairly tense.

"I found myself strolling along Salah El Deen and came across a large group of older Egyptian men sucking on their hookahs at a local outdoor cafe, and looking pretty fierce.

"Drawing on my best practised Arabic as taught to me by the Hababb refugee family back in Launceston, I put on a big Oz smile, waved, and shouted '*As-Salaam-Alaikum*' – 'peace be with you'.

"After getting over their initial shock, the Egyptian gentlemen put down their hookah pipes, waved with smiles, and shouted back '*Wa-Alaikum-Salaam*', which is the polite Arabic response.

"They indicated they wanted me to join them for a smoke but, being a doctor and mindful of the health risks, I gently declined and wandered on."

Andrew says many unexpected and memorable things can happen when you welcome migrant refugees into your medical practice.

"Some years later a young Arabic man presented to the practice to see me, and indicated that I looked familiar to him," he says.

"As it turned out he had tried, probably in vain, to sell me some tourist trinkets at the Great Pyramid in Giza near Cairo, a job he toiled at for three years before being accepted into Australia as a refugee."

WHEN refugees arrive in Tasmania, their first contact is with the settlement services contracted by the Australian Government Department of Social Services – the Migrant Resource Centre (MRC) in the north and CatholicCare in the south.

These services coordinate the settlement of new arrivals, which includes connecting them with schools, employment agencies and health services. Intensive support is provided for up to 12 months after arrival.

James Norman is the manager of CatholicCare's multicultural service programs, which includes the humanitarian settlement services program.

"The days and weeks immediately after arrival are chaotic and extremely confusing for new humanitarian entrants," James says.

"Many have never experienced similar services and struggle with a lot of the concepts we, as Australians, take for granted.

"We help people move into affordable accommodation in the private rental market and link new humanitarian entrants into Medicare, Centrelink and schooling within days of their arrivals.

"Our aim is to reach a level of 'core competency' in seven key areas that allows us to exit people from our program and refer them to other services for ongoing, but less intensive, support."

The settlement services refer all newly arrived refugees to Primary Health Tasmania's refugee health clinics in Hobart or Launceston, according to where they live.

Aitor Baonza manages these clinics. He says as well as providing comprehensive health checks, screening, full vaccination and necessary treatment, the clinics have an important role in helping people move from being refugees to being people with a refugee past.

"The clinics provide a solid introduction to the Australian heath care system and play a pivotal role in establishing the foundations for improved health literacy and self-care," Aitor says.

"Patients are assisted through an integrated approach which not only improves health outcomes but also facilitates health system navigation in the longer term."

He says the clinics work closely with settlement services and general practices to enable a smooth transition to mainstream primary care.

"The clinics are by design an interim service aimed at complementing, not replacing, mainstream general practice services," Aitor says.

"They are designed to relieve pressure on mainstream general practices by undertaking the more complex and labour-intensive initial screening, treatment and catch-up immunisation.

"Following discharge from our clinic, general practices are provided with a full medical record containing all the relevant screening, investigations and treatments undertaken.

"In addition, clinic staff are available for ongoing advice or support. This could range from help in using telephone interpreter services to practical advice on clinical or cultural issues."

Refugees are provided with access to the Translation and Interpreting Services, funded through the Department of Immigration and Border Protection.

Aitor says on the whole, mainstream general practices are very accommodating and happy to take on refugees following discharge from the clinic.

"There are, of course, capacity issues from time to time exacerbated by geographical settlement patterns, but these are only periodic," he says.

MRC (North) chief executive officer Ella Dixon says the clinics help create a 'soft landing' for new arrivals, guiding them through unfamiliar processes and educating them on how the different levels of care operate.

"The clinics help clients navigate the system as they transition into mainstream general practice services," she says.

"On exiting the clinics, clients receive high quality GP care, which is a vital component in helping them achieve successful settlement outcomes.

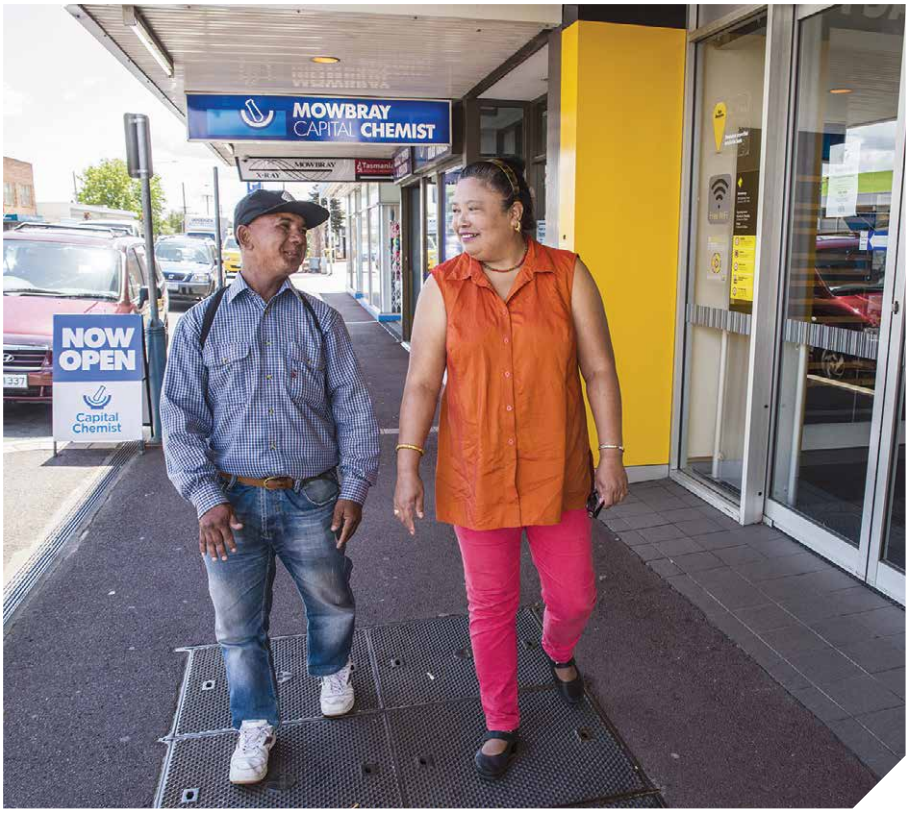
"Clients are often unfamiliar with western health and appreciate GP assistance in creating awareness and understanding on preventative health matters for them and their families.

"Access to ongoing GP care provides clients with peace of mind that they can continue to see a doctor if required."

James Norman from CatholicCare says thankfully, there are several doctors and practices who are willing take on this ongoing care role – but more are needed if Tasmania's response to refugee settlement is to grow.

He says it can be difficult to find enough GPs for all clients once they leave the southern clinic – which needs to happen to ensure the clinic has capacity to take on new patients.

James encourages any GPs interested in taking on humanitarian entrants to contact CatholicCare in the south, the MRC in the north, or Primary Health Tasmania. ▶



"Information and support is available and we know how important GP access is for our clients as they settle into their new lives," he says.

HOBART GP Dr Christine Boyce has 15 years' experience in refugee health, including the last two at Primary Health Tasmania's Southern Tasmania Refugee Health Clinic. ▶

She recently began a mentoring service offering free advice and support to practices in southern Tasmania who are caring for former refugees.

"Many GPs and other health professionals feel less than confident and under-supported in this area, and this can contribute to a reluctance to see people from a refugee background," Christine says.

"Most of what I know I've learnt the hard way, and I wanted to do something to make this area less challenging for other GPs and – ultimately – increase the number of practices willing to care for former refugees."

The mentoring service ranges from quick advice by phone, email or SMS, to practice visits to discuss cases or systems with medical, nursing or administrative staff.

Key areas of support include working with interpreters, chronic pain in refugees, medication management, mental health issues, working as a team with other support services, and the logistics of making refugee care work for a practice.

"I am hoping that GPs or other health professionals in southern Tasmania will take that extra step and contact me if they encounter issues in their work with refugees or would like to consider taking on a new family and need a bit of assistance," Christine says.

PRIMARY Health Tasmania has been looking at what more can be done to support the transition of new arrivals from specialist refugee health clinics to mainstream health services around the state.

Audrey van Wyk, a coordinator with Primary Health Tasmania's population health team, says: "We want to get a good understanding of the needs of this particular population group, as well as the needs of the service providers who care for them.

"We're doing this by talking to migrant communities, health care providers and others who have frequent contact with former refugees.

"We're looking at the resources that are available to facilitate the transition into mainstream general practice and the primary health system in general, and to determine whether there are gaps here that we can fill either by developing the resources that are missing or sourcing them from elsewhere."

Audrey says there will be education and networking opportunities to help primary health care providers contribute to integrated primary health care for the migrant population.

Primary Health Tasmania's HealthPathways team is exploring the development of pathways in refugee and migrant health with input from local clinicians and other service providers. ■

More information:

Primary Health Tasmania
1300 653 169

Migrant Resource Centre (north)
(03) 6332 2211

CatholicCare (south)
(03) 6278 1660

Research backs clinics model

Primary Health Tasmania's Northern Refugee Health Clinic could provide a useful model for the rest of the country, according to researcher Dr Faline Howes.

She says there is no consistent model for the initial provision of health care for refugees in Australia, with the transition of care to mainstream general practice providing an ongoing challenge.

Faline is a public health trainee leading research conducted by a team drawn from the Menzies Institute for Medical Research, the School of Medicine at the University of Tasmania, the School of Medicine at the University of Queensland and Primary Health Tasmania.*

The team undertook a literature review looking at the primary health care experience of refugees when they first arrive in Australia.

It then analysed a 12-month cohort of new arrivals that were seen at the Northern Refugee Health Clinic from April 2013.

Established in Launceston in 2007, the GP-led clinic sees new arrivals with the aim of providing comprehensive health checks, screening for common conditions, full vaccination and necessary treatment. Families are then transferred to mainstream general practice for ongoing care.

Faline says the clinic is a highly successful model, evidenced by universal screening rates and appropriate referral.

"It provides a centralised point of contact for comprehensive screening for families and offers a multi-disciplinary approach that engages qualified interpreters – all delivered at no cost to the client," she says.

The audit showed the diseases seen were primarily those associated with poverty, such as nutritional deficiencies.

"The infectious diseases seen were consistent with the country of origin or transit, which was expected," Faline says.

"In our twelve-month research period, the two dominant countries of origin were Afghanistan and Bhutan – a change from the past ten years which saw the majority of refugee entrants come from Africa.

"We are also seeing larger family groups – the larger the family group, the more likely they are to be from Afghanistan."

Faline says the most common condition diagnosed through screening is vitamin D deficiency followed by Helicobacter pylori (causes chronic low-level inflammation in the stomach); vitamin B12 deficiency; latent tuberculosis (not infectious) and enteric pathogens such as Giardia, which is very common worldwide.

"Every refugee is screened for TB, with all positive results referred to and managed by the TB clinic," she says.

"Other common health conditions at initial assessment were poor oral hygiene and skin conditions.

"There were very few mental health diagnoses recorded but conditions such as headaches and chronic pain may be a proxy and once trust is established, people may be more forthcoming."

While specific expertise in refugee health enabled the identification of these health issues by clinic staff, the majority were managed within the primary health setting – without the need to draw on specialist and hospital resources.

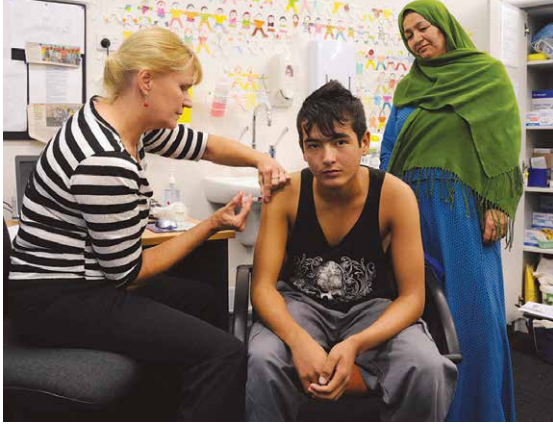
Faline and the team are now analysing the results of a similar 12-month audit of Primary Health Tasmania's Southern Tasmanian Refugee Health Clinic, which opened in late 2013, and plan to interview clinic staff involved with the care of refugees.

Despite some historical differences in the model of care provided in the north and south of the state, she says the southern service has screening rates that are equally as good.

After combining the data from both audits, Faline will compare the clinics with an *Australian Best Practice Framework for Coordinated Primary Health Care for Refugees* published in 2013.

Recommendations will also be made on improvements to the model of care for newly arrived refugees in Tasmania.

Faline says when compared to similar audits undertaken elsewhere in Australia, the Northern Refugee Health Clinic outperforms care provided by mainstream GPs with an interest in refugee health and performs at least as well as other established migrant health units.



Vaccinations are part of the service provided at the Northern Refugee Health Clinic

"The research supports the generalist, refugee-focussed health service model for the provision of initial screening and management of common health conditions," she says.

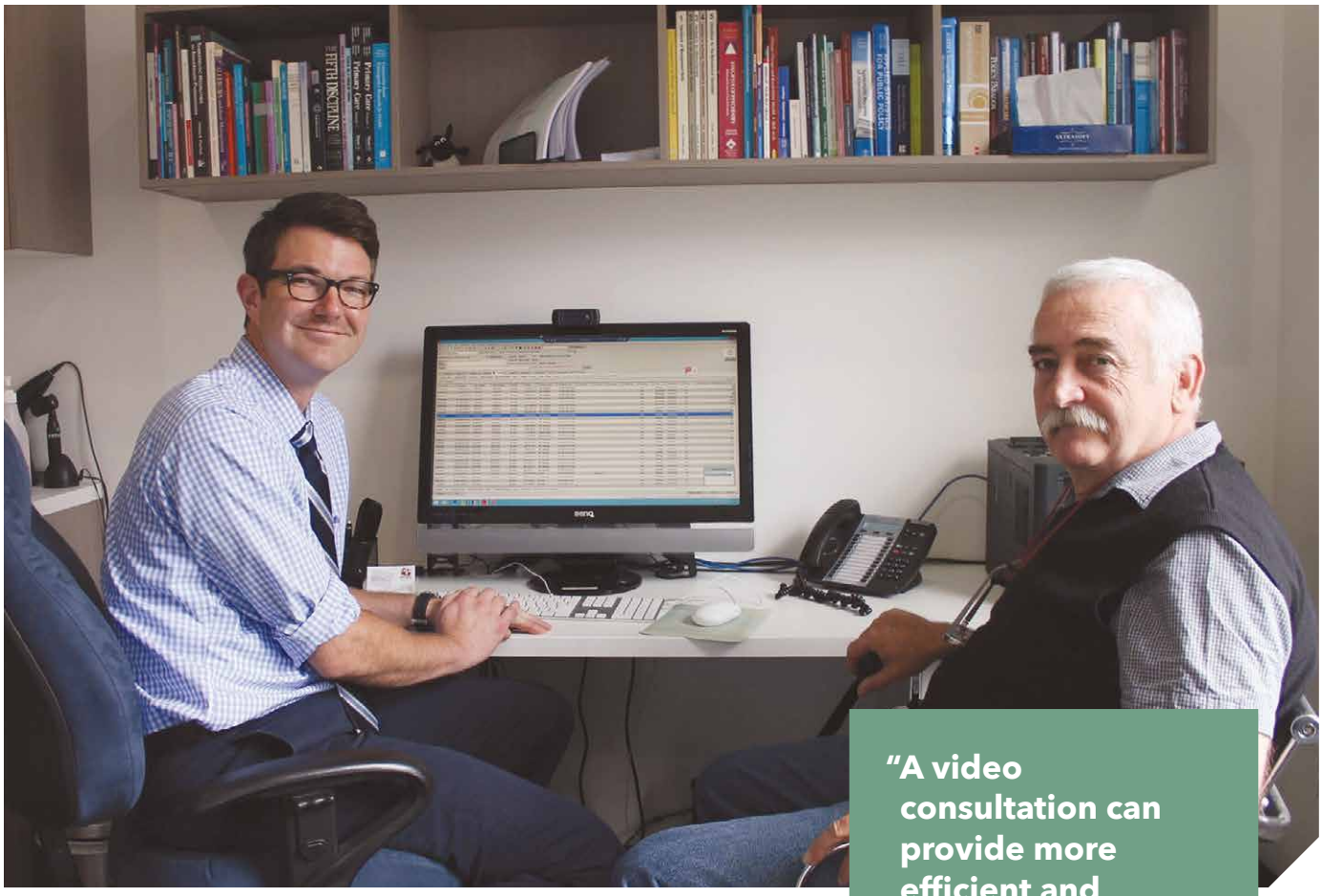
"Where appropriate, people can then be referred to specialist, refugee-focussed health services such as torture and trauma services and refugee paediatric clinics.

"The Tasmanian model is transferable to anywhere in Australia and provides a robust framework for initial screening and treatment, facilitating a smooth transition to mainstream general practice.

"Unfortunately this model of care is not yet available in all states and territories but hopefully our research will support its widespread implementation." ■

For more information, contact Dr Faline Howes on (03) 6213 8200 or fhowes@primaryhealthtas.com.au

**The research team comprises Dr Faline Howes (Menzies Institute for Medical Research, Tasmania and Primary Health Tasmania), Dr Andy Hodson, Dr Kath Ogden and Assoc Prof Kate McIntyre (School of Medicine, University of Tasmania), Dr Kelly Shaw (Primary Health Tasmania), Prof Mark Nelson (Menzies) and Dr Margaret Kay (School of Medicine, The University of Queensland)*



Professor Bastian Seidel with patient Peter Ramsey

Health technology a game changer for Huon Valley GP

"A video consultation can provide more efficient and effective care - reducing the time, cost and stress involved in travelling long distances for an appointment."

MORE than 13,000 kilometres and a laptop screen separated Professor Bastian Seidel and a patient in Mexico.

The Huon Valley-based GP, who was in Melbourne for a conference, received a text message from his patient who was experiencing chest pains.

"I suggested we link up via video consultation so we could discuss his symptoms in more detail," Bastian says.

In his hotel room, Bastian used his laptop to log into his practice records and connect with his patient using FaceTime.

He tracked down a cardiologist near where the patient was staying in Leon, Mexico and booked him in for an appointment.

"I then emailed the specialist, forwarding him all the necessary clinical information to ensure my patient received the most appropriate care," Bastian says.

Video conferencing is one of the main ways in which telehealth is improving access to healthcare services for patients in regional, rural and remote areas – or, in the case of Bastian's patient, a different geographic location altogether.

"Telehealth is part of the routine services we offer at Huon Valley Health Centre," Bastian says.

"For patients, a video consultation can provide more efficient and effective care – significantly reducing the time, cost and stress involved in travelling long distances for an appointment."

Bastian says the telehealth service is proving popular among his older patients and those originally from interstate who want to continue seeing their original specialist or physician.

He only accepts telehealth patients from outer regional areas or residential aged care facilities and bulk bills for consultations so they can receive a Medicare rebate.

Patient Peter Ramsey has had two video consultations at the practice with a cognitive neurologist in Melbourne.

The 58-year-old from Lonnavale says the service means he doesn't have to worry about having to make a two-day trip to Melbourne just to see the specialist.

Peter has a complex neurological condition, as well as prostate cancer.

"My condition affects my vision, which makes it very difficult for me to navigate the city and catch public transport," he says.

"Going into the clinic for an hour or so to discuss my condition is a much more convenient process."

Bastian says the technology set-up and administration is straightforward, only requiring the right software program, a desktop computer with built-in webcam, microphone and speakers.

"It works really well," he says. "If I am present when the patient speaks to the specialist, then I don't have to wait for a discharge letter that may take six weeks to arrive in the mail.

"This dual consult model saves time for specialists – there is less to-ing and fro-ing between departments – and it puts me in a better position to coordinate the patient's care.

"And patients love it because there are two doctors talking about their health."

FaceTime is a similar innovation Bastian believes is transforming workplaces in the healthcare sector.

He says more GPs should be open to using the popular application, which could be used over wireless (WiFi) or cellular connection.

"Often, specialists just want to see their patients briefly to evaluate their motor skills and any improvements.

"A real-time video of the patient enables specialist input while removing the need for the patient to leave the comfort of their own home.

"Huon Eldercare is one rural health organisation doing this quite well."

Bastian says many GPs and general practice managers are still very reluctant to fully embrace digital technologies in their day-to-day work.

"Much of this has to do with a distrust in the effectiveness of IT in improving patient care, along with concerns about patient privacy, information security and clinical safety," he says.

"It is well documented that medicine is the last profession to take advantage of email, despite the fact that far more people use it than any other means of communication.

"But many practices lack the specialist knowledge to deal with online or internal risks, and many are unaware that emails can be protected with high-level encryption and security.

"The same applies to electronic discharge summaries as an alternative to sending and receiving correspondence via mail or fax – these are also very straightforward and all GP practices are enabled to receive them."

Bastian says his patients expect the practice to be "eHealth ready."

"We regularly receive emails with prescription requests or appointment inquiries and our practice is integrated with online appointment technology and SMS reminders," he says.

"Online bookings and consultations help to free up primary care doctors to spend their face-to-face time treating people with more complex needs.

"And it saves money in the long-term by reducing the number of acute hospital admissions and need for community care."

Bastian says enhancing the security, storage and "retrievability" of clinical and business information and dealing with associated costs and complexities are key issues for health technology going forward.

However, he says its potential to revolutionise the industry is significant.

"We know for certain that there won't be one single system doing everything for patients and doctors, but one day, multiple platforms where all our systems will interlink," he says.

"The moment when I can link into hospital records and they can access mine will be the next big shift in eHealth." ■

Health technology support

PART of the brief for all primary health networks (PHNs) around the country – including Primary Health Tasmania – is helping general practices better understand and use health technology to improve the flow of patient information.

PHNs are also charged with supporting health information management to improve care.

Primary Health Tasmania has a small team of staff who can support better use of technology in primary health care.

Telehealth coordinator Tim Hynes is focusing on helping link general practices, specialists, aged care facilities and hospitals through telehealth technology.

Staff around the state provide a range of clinical software support to help practices maintain and improve quality and target patients for appropriate interventions.

This includes training staff in the use of clinical audit tools, working with GPs and specialists to use secure messaging and engage with the eHealth record system, and assisting with electronic discharge summaries and technology for data management.

Primary Health Tasmania has created more than 200 electronic referral templates that are available for download at **www.primaryhealthtas.com.au**

Training is also provided in use of Primary Health Tasmania's HealthPathways web portal, which helps health professionals plan and provide patient care across the Tasmanian health system. ■

For more information about health technology support, contact Gary Walker on (03) 6425 8500 or gwalker@primaryhealthtas.com.au

DORA helps address 'doctor shopping'

Dr Jerome Wilson-Muir says DORA has increased his confidence in the safe prescription of opioid analgesics (see story next page)

THE misuse of prescription pharmaceuticals is one of Australia's fastest-growing public health issues, but a Tasmanian program called DORA is tackling the problem head-on.

DORA, or Drugs and Poisons Information System Online Remote Access web application, provides real-time monitoring of narcotic prescription medication being dispensed around the state.

The program, which is the first of its kind in Australia, has been rolled out gradually across a number of general practices and pharmacies in Tasmania since its inception in 2011.

The Australian Government has since licensed the Tasmanian system for implementation around Australia under the name of Electronic Recording and Reporting of Controlled Drugs (ERRCD).

Sam Halliday, senior pharmacist in the Pharmaceutical Services Branch within the Tasmanian Department of Health and Human Services (DHHS), says DORA was developed to assist in the judicious prescribing and supply of drugs with a high abuse potential.

It aims to reduce illness and death associated with the misuse and diversion of narcotic prescription medication.

Also known as painkillers or opioids, these substances – which include morphine, oxycodone and pethidine – are legal to prescribe, but highly addictive.

"Tasmanian pharmacies are required to report all dispensing supplies of narcotic drugs to DHHS under the Tasmanian Poisons Regulations," Sam says.

"Usually, only one doctor can prescribe these substances to a particular patient, and if they wish to prescribe for more than two months they need to obtain an authority."

Sam says DHHS once relied on printed reports from pharmacies which evolved to a floppy disc sent in the post and then to a data file sent via email. The process now occurs in real time.

"With DORA, the reporting of dispensing events has moved from monthly to real time – twenty four hours a day, seven days a week," he says.

"DORA allows DHHS and clinicians to more easily identify patients who present with red flags for drug-seeking behaviour or adverse health outcomes.

"The system is secure and protected, and access to the database is restricted to registered prescribers and pharmacists.

"Registered users can determine what narcotic drugs have been dispensed for a particular patient, whether a doctor holds an authority to prescribe for the patient and whether the patient has ever been the subject of a circular restricting their access to drugs with a high abuse potential.

"By having a more up-to-date data set, we can enable more timely advice to clinicians and, in turn, help safeguard patient and community safety."

Sam says prescribers and pharmacists are only too aware of the difficulties that could arise when assessing requests for opioids.

"They report that it is sometimes difficult to assess whether a patient's description of their symptoms is genuine or fabricated," he says.

"DORA takes the blindfold off for prescribers and pharmacists, allowing them to tread safely when considering prescribing or dispensing drugs of a high abuse potential, especially if they are unsure of the patient's previous clinical history."

As of September 2015, more than 95 per cent of pharmacies securely report their narcotic drug data in real time. The remaining 5 per cent aren't able to do so because of technology issues beyond DHHS's control.

Sam says the project has significantly reduced the number of 'doctor shopping' events in Tasmania.

He says doctor shopping is a significant issue whereby patients present to multiple prescribers in a short period of time requesting drugs of a high abuse potential.

"These patients are at high risk of self-harm through medication misadventure or potential diversion for illicit use," Sam says.

"The combination of real time reporting, health practitioners using DORA and DHHS's high level of specialist regulatory-clinical advice allows attempts at doctor shopping to be identified very early and potential harm prevented."

Tasmania will convert to the national ERRCD system during 2016.

DORA users will notice little difference when accessing the site and all of the same relevant information will be available to all users. ■

For more information, contact the Department of Health and Human Services' Pharmaceutical Services Branch on (03) 6166 0400 or pharm.services@dhhs.tas.gov.au

Safe and secure information benefits drug-seeking patients

DORA has given GP Jerome Muir-Wilson the tools to identify and manage patients who exhibit drug-seeking behaviour.

Jerome says the web-based information system, which was implemented at the Launceston Medical Centre in mid-2014, has increased his confidence in the safe prescription of opioid analgesics.

"It is extremely helpful, especially when patients with drug-seeking behaviours who are not known to the practice turn up with a script request," he says.

"Usually, if I have any suspicions during business hours I can phone DHHS to check for warnings on the system.

"But DORA allows safe and secure access twenty four hours a day which is ideal for our practice, which operates after-hours.

"With just a few clicks of a mouse, I can sign into the database and retrieve the patient's previous clinical history relating to morphine or opioid drugs.

"I can find out when the patient was last prescribed pain medication, the specific medication they were supplied, exactly when it was dispensed and information about the quantity and dosage.

"The database also tells registered users whether there is an authority held by another doctor to prescribe it, whether any drug-seeking 'alerts' have been linked to the patient and whether they have – or had – a history of drug dependence."

Access to objective, real-time evidence at the point of dispensing is also beneficial for pharmacist Glenn Ward, of the Amcal Max pharmacy at Moonah.

"DORA will potentially save a lot of time for both doctors and pharmacists because it can immediately alert you to a problematic situation that could be declared reportable," he says.

"Having this comprehensive information right in front of me can help me to make an informed decision which, in turn, makes it safer for those walking in with a prescription for a narcotic substance, and also over-the-counter codeine sales requests."

Glenn says the real-time advantage of the software is useful in instances when there is a suspected disconnect between what is prescribed and what is dispensed, or a lack of patient history.

"If someone presents after-hours, we can log onto DORA using their identification and see what they've had dispensed in the past," he says.

"This allows us to intervene if we find the patient has been stockpiling scripts or doctor shopping.

"The great thing is we can also look up people on DORA who are new to the pharmacy.

"While there is still a while to go before we see a reduction in the number of opioid users in the state, there have certainly been fewer deaths as a result of the diversion of legitimate supply in Tasmania."

It can sometimes be difficult for doctors to determine whether the patient's drug use is medically appropriate or if it constitutes abuse.

Jerome says drug-seekers who falsely report their symptoms are still a growing problem for doctors.

"These people can rely on a number of tactics to pull the wool over their GP's eyes, including old scripts and supporting letters claiming to be from their local practitioner."

He once had a young patient go in to see him with her young children, asking for pain medication.

"She seemed to be in a great deal of pain and was holding what appeared to be an x-ray of her tailbone which she reportedly had recently broken," he says.

The patient explained to Jerome that she was in Tasmania visiting family but lived interstate.

"Alarm bells started ringing when I noticed the x-ray image was not consistent with her timeline of events," he says.

"When I asked the patient when she had last taken pain killers she told me 'two weeks ago'.

"However, when I logged into DORA to look at her records, I found she was prescribed morphine-based pain killers three times in the past five days – her file had a red flag against it."

The following day Jerome contacted DHHS and learned that the patient had been on a methadone replacement program two years before leaving the state.

DHHS advised Jerome not to prescribe at that stage and to direct the patient to specialist addiction medicine care for help with her drug-seeking behaviour.

Even if people have a genuine need for the medication, Jerome says it is always best for prescribers to be alert.

"If the doctor is ever concerned, DORA might provide an opportunity to express these concerns and to start a safe and meaningful clinical conversation with the patient," he says. ■

Community pharmacist Glenn Ward says DORA can save time for doctors and pharmacists

The Derwent Valley

Geography

Largest town is New Norfolk (approximately 5,700 people)*

6th largest local government area (LGA) by area, and 13th smallest by population

The Derwent River – the second longest in Tasmania – flows through the Derwent Valley

Population

9,997 people – 49% female, 51% male#

Median age 41 (state average 40)*

4.1% of population identify as Aboriginal (4% for Tasmania)*

Primary health care services (private)^^

3 general practices and 10 GPs

2 pharmacies, 1 allied health practice with 2 psychologists, 1 visiting podiatry service

1 aged care facility

Social determinants of health

Unemployment rate 11.1% (state average 6.8%)#

Median weekly household income $869 (state average $948)*

26.9% of eligible population completed year 12 (state average 39.6%)*

11.1% health care card-holders (state average 9.8%)**

Illness and death

17.6% of residents have three or more chronic conditions (state average 19.2%)^

Death rates due to circulatory and cerebrovascular diseases are higher than the state average+

Health risk factors

35.1% of pregnant women smoke (21.8% for Tasmania)++

7.5% of live births have low weight (7.1% for Tasmania)++

33.7% eat fewer than two serves of fruit a day (44.2% for Tasmania)^

Images courtesy of Derwent Valley Council

* 2011 Census
\# ABS Labour Force Survey, June 2015
** Department of Social Services, 2013
^ DHHS Tasmanian Population Health Survey, 2013
\+ Department of Health and Human Services, 2006–2010
++ Tasmanian Perinatal Database, 2009–2011
^^ Primary Health Tasmania data

Primary Health Tasmania supporting the Derwent Valley

Working with local service-providers and other community representatives on more **streamlined pathways** for people moving between health and community services

Working with local service-providers to improve community access to urgent **after hours medical care**

Partnering with the New Norfolk High School, Derwent Valley Council, Derwent Valley Community House, Real Action Forward Thinking and Workskills on the Tree2Sea project, which uses boat building to engage young people in further education and training – key **determinants of future good health**

Supporting local service-providers to provide the best possible **care for people experiencing poverty**, through our Bridges out of Poverty training workshops

Providing **care coordination** services for people with chronic health conditions and frail elderly people in the community through the Corumbene Nursing Home for the Aged

Providing access to **care coordination** services for **Aboriginal and Torres Strait Islander people** in the Derwent Valley via GP or nurse referral to our care coordination program

Offering local **Aboriginal and Torres Strait Islander people** practical assistance to **access health care services** through an outreach worker, and supporting service providers to improve access to mainstream services for Aboriginal people

Through Relationships Australia, giving people in the Derwent Valley access to short-term treatment for mild to moderate **mental health** issues

Through Diabetes Tasmania, working with the Derwent Valley Medical Centre and Dr Peters' General Practice to provide **diabetes education and dietitian services**

Providing **podiatry services** to Corumbene residents

Image courtesy Tree2Sea project

Building boats, skills, health

STUDENTS in Tasmania's Derwent Valley are building paddle boards and kayaks as part of a Primary Health Tasmania-funded project that aims to inspire young people to stay engaged in learning.

The 22 New Norfolk High School students from grades 7 to 10 are taking part in a boat-building program alongside 10 early school leavers from the job service agency Workskills.

The Tree2Sea project is part of Primary Health Tasmania's social determinants of health program, funded under the Australian Government's Tasmanian Health Assistance Package.

The social determinants of health are the conditions in which people are born, grow, live, work, play and age and can be underlying reasons why people experience poor health. They include low levels of education and employment.

Tree2Sea project officer Matt Hill says students are learning the craft from a professional boat builder and they are also gaining business skills and enterprise experience.

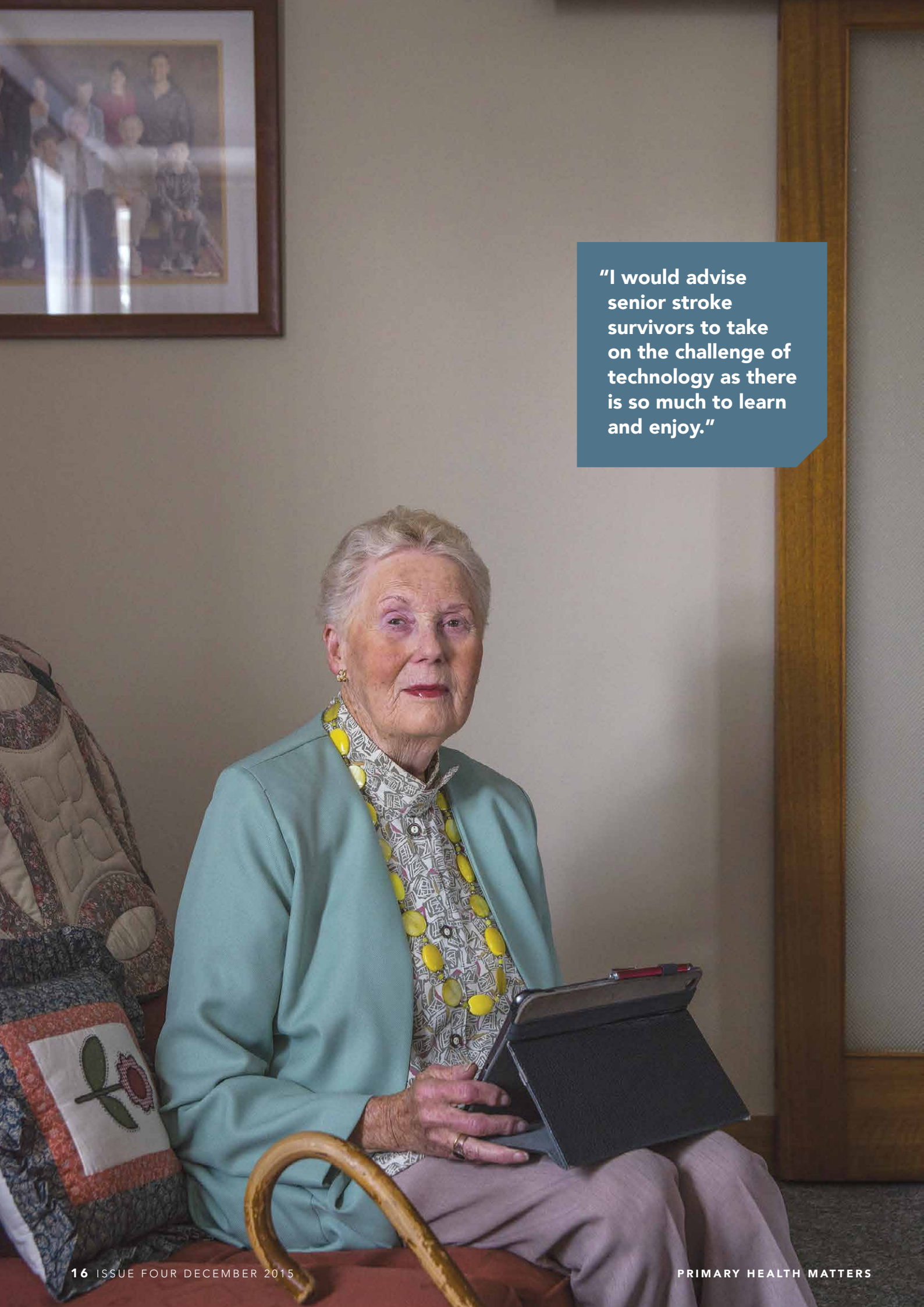
"The project links the district's timber heritage and Derwent River with education and training which are vital to future health and wellbeing," he says.

It's hoped that income generated from sale of the boats will help sustain operation of the boat-building program.

The idea for Tree2Sea was floated by the aptly-named Real Action Forward Thinking (RAFT) network, an initiative of the Derwent Valley Council, in an endeavour to address lower than average education retention in the district.

Other project partners are the Derwent Valley Community House, the Derwent Valley Council, Workskills and New Norfolk High School.

For more information, go to the Tree2Sea website at www.tree2sea.org.au, or contact the Tree2Sea project officer on (03) 6261 2687 or ypo@dfat.com.au



"I would advise senior stroke survivors to take on the challenge of technology as there is so much to learn and enjoy."

Jenny goes digital to aid stroke recovery

OCTOBER 16, 2012 is a date Tasmanian octogenarian Jenny Ferrier will never forget.

At half-past five that morning, Jenny collapsed on her bathroom floor after experiencing strange pains in her left leg.

After being rushed to hospital, the cause of her sudden collapse became clear – she had suffered a major stroke, which left her paralysed down one side of her body.

It was only after three months of arduous rehabilitation in hospital that Jenny was able to return home, where she says her real recovery journey began.

"The first three months were the hardest time … I could do so little around the home," the Launceston resident says.

"I lost my independence as I could no longer drive, and my husband had to become my carer as well as my taxi driver."

In addition to the physical impact of her stroke, Jenny found herself struggling to adapt to the emotional changes.

"My moods were up and down and my reactions to things felt out of proportion," Jenny says.

"I was bewildered as I'd never felt like this before my stroke."

Jenny says she also found it difficult to access information and support to help her manage the ongoing impact of her stroke.

She says she didn't know who to turn to and like many people her age, finding advice online was a daunting task.

This was until Jenny discovered a new digital resource for stroke survivors called 'enableme'.

enableme is a world-first digital resource created by the National Stroke Foundation to support the Australian stroke community.

It brings together information, advice, goal setting and connection with a community of peers.

Armed with an iPad her husband Jim bought her and a keen sense of determination, Jenny taught herself to use a computer so she could join the enableme community.

"I first read of enableme in the National Stroke Foundation newsletter – I thought that could really help me with post-stroke information," Jenny says.

"The idea of connecting with other survivors also really appealed to me.

"As a senior I wanted to enter the world of technology – a big learning curve – and after my stroke I wanted to challenge my brain.

"The hardest part was setting up the site, but with the Foundation's help I managed to do so. It was certainly worth it as enableme is wonderful.

"I've also discovered that my emotional changes are commonly experienced after stroke and that's helped me immensely."

National Stroke Foundation chief executive officer Dr Erin Lalor says enableme was developed specifically for stroke survivors like Jenny.

"We know that leaving the hospital after stroke can be incredibly daunting for stroke survivors and their families if they don't have the right support," she says.

"There are currently more than 11,300 stroke survivors living in Tasmania and sadly many do not have access to the services, support and information they need to ensure quality of life post stroke.

"enableme is making the transition into home easier with information, guidance and community support available at the click of a mouse."

enableme covers a wide range of topics impacting daily life after stroke, from pain management and sleeping to the types of strokes and treatments available.

It also includes an important goal-setting component to help survivors keep track of their short, medium and long-term recovery targets.

For Jenny, enableme has helped her and her husband come to terms with their 'new normal' life.

"As all strokes are different I have learned so much from other survivors – we all struggle with deficits all so different," Jenny says.

"I would advise senior stroke survivors to take on the challenge of technology as there is so much to learn and enjoy." ■

For more information or to join the enableme community, visit www.enableme.org.au

The National Stroke Foundation is a member of Primary Health Tasmania.

Jenny Ferrier with her husband, Jim

Care choice for older people

"It places the consumer squarely in the driver's seat, giving them the opportunity to identify what they want their package to provide for them."

AGED care reforms which came into force on 1 July this year aim to give more choice and control to older people needing care at home.

The 'consumer directed care' (CDC) approach to the delivery of home care packages forms part of 'Living Longer Living Better'– a 10-year aged care reform package which the Australian Government started rolling out in 2012.

CDC was introduced so consumers could choose which services and equipment would best support their independence and meet their lifestyle and wellbeing goals.

A home care package delivered on a CDC basis means consumers can also provide input into how these services are delivered, and by whom.

Importantly, with a government-subsidised CDC package, the care recipient – under the guidance of their service provider – is responsible for how the package is managed and how the funds are spent.

Rod Hunt, from Aged and Community Services Tasmania's Consumer Directed Care Project, says a CDC package extends beyond traditional home care.

"Consumer directed care is not one model of care, but rather a continuum of care with the consumer able to direct their involvement," he says.

"It places the consumer squarely in the driver's seat, giving them the opportunity to identify what they want their package to provide for them.

"This new focus on flexibility and creativity represents a fundamental shift from the way home care packages were delivered in the past.

"Providers are no longer just 'selling' a menu of services for clients to choose from – they are now facilitators whose role is to help consumers identify their current and future needs and goals."

Rod says home care providers now work with clients to come up with a care plan that identifies clients' goals and any changes that are needed to achieve them.

He says the funds in the home care package are then used to pay for assistance and services that can keep people safe and well at home and engaged in the community.

"These services can cover things like equipment to provide independence in providing your own meals or transport to leisure activities, along with help with personal care, domestic chores and home maintenance," Rod says.

A major change resulting from the introduction of CDC is an individualised budget.

The budget, which is delivered in partnership with the consumer and provider, lists the amount of subsidy the government is paying, the maximum amount of home care fees payable by the consumer and the cost of the agreed care and services.

Clients receive a monthly income and expense statement that details their available funds and the amount of money they have spent on each service.

Rod says it is important that the services identified in the care plan fit within the available budget for the consumer's package level.

"All the funds that come in must only be used for the individual package holder – organisations can no longer cross-subsidise the care and services they deliver to some consumers," he says.

"If a consumer's care needs are not able to be met using their package budget, their provider must work with them to consider other options, which might include reassessment for a higher level or topping up services using their own funds."

Recipients of a CDC package are assessed for eligibility through an aged care assessment.

Service providers undertake ongoing reviews to ensure the home package continues to meet client needs.

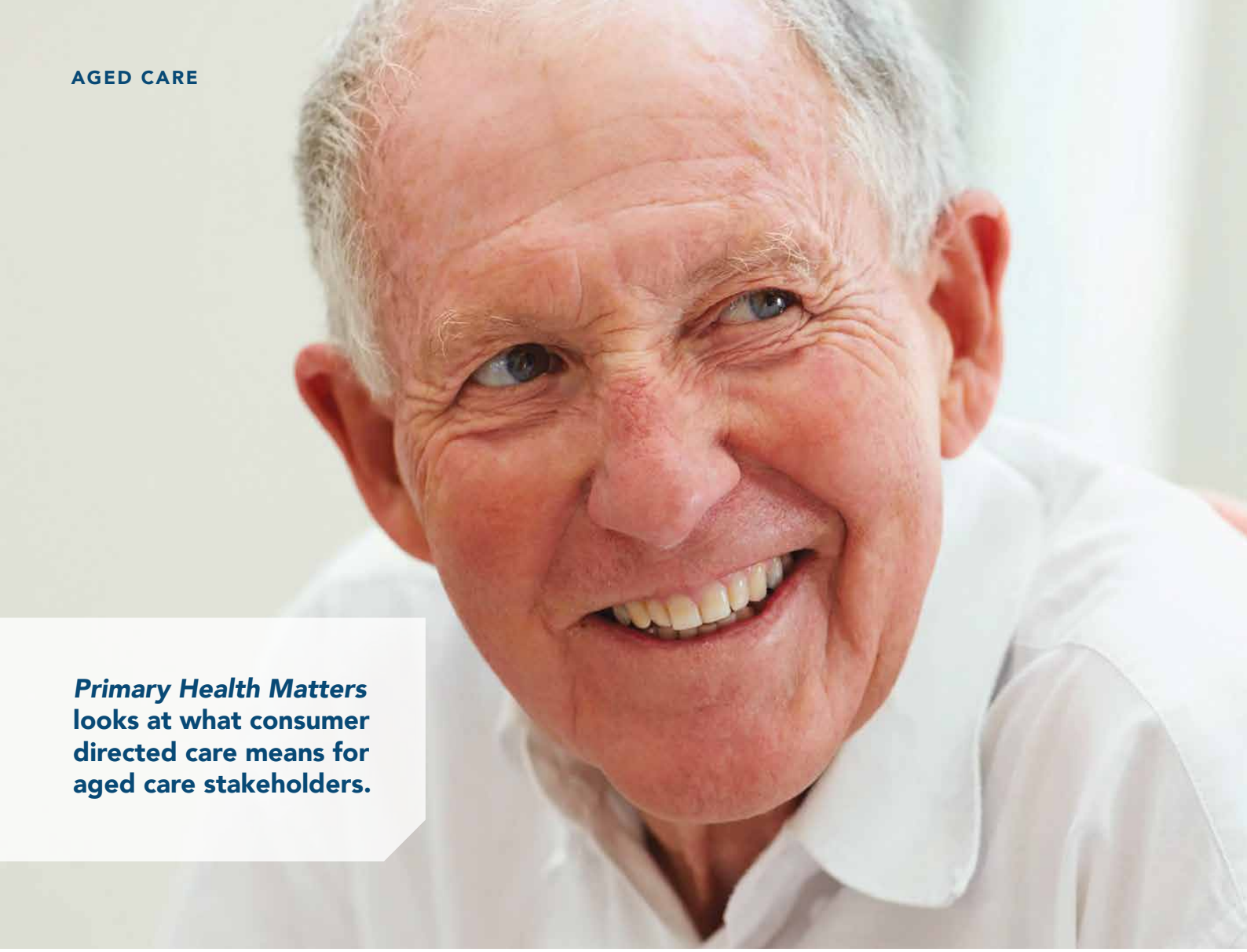
From February 2017, funding for home care packages will be allocated directly to the consumer rather than via a service provider.

The packages will also be portable, allowing consumers to change their service provider.

"Consumers will have even more power from February 2017 – providers will need to ensure their customer service is top-notch to thrive in the new marketplace," Rod says. ■

More information about consumer directed care is available online at www.myagedcare.gov.au

Rod Hunt



Primary Health Matters **looks at what consumer directed care means for aged care stakeholders.**

The consumer

"Frank"

Frank lives alone on a farm at Montubena, 20 kilometres from Somerset in the north west of Tasmania.

His family has moved from the area and his friends have died, leaving him isolated.

His best friend is Monty, his kelpie dog.

During his goal-planning session with his case manager, Frank indicated he was having trouble sleeping during the night as Monty would wake him up, wanting to go outside.

This is a problem for Frank because he is frightened of falling, but it is important to him that the dog sleeps inside.

As they discussed his priorities, Frank and his case manager also identified a number of goals.

These included doing the shopping once a fortnight rather than relying on his neighbour to get his groceries; preparing the occasional home-cooked meal as a change from Meals on Wheels; and "getting stronger in the legs" so he could carry his own firewood in from the shed.

For Frank, a long-term goal was to visit the annual sheep dog trial in Somerset in three months' time – something he really missed.

Using an electronic tablet equipped with a budget tool, Frank and his case manager worked out a budget that included:

- an independent visit to a physiotherapist to establish an exercise plan to strengthen his legs
- installation of a 'doggie door' to allow Monty independent access outdoors
- shopping and assistance with meal preparation every two weeks. Meals would be determined by what Frank fancied when visiting the supermarket. Meal preparation would involve cooking a larger quantity, with the remainder frozen for another day
- a one-off block of three hours to create a woodpile on an unused table adjacent to the back door
- a small contingency so he would have funds to attend the sheep dog trial.

The changes were then reflected in his revised care plan.

Three months later Frank was not only stronger in the legs, but he could retrieve wood from the shed in small quantities. Adjustments were made to the shed to make it easier for him to collect the wood, and an old pram was recycled as a wood carrier.

Frank's nutritional status had also improved and – importantly – Monty was happy.

And yes – Frank had a great day at the sheep dog trial. ▶

"Daisy"

"I believe that having more say in my support has been a good thing.

I have had to learn so much about the cost of services and understand my budget, but my case manager has helped me through this.

I was worried at first because I wanted to make the right decisions.

My case manager has encouraged me to try new things and I now volunteer by knitting for charity."

"Rita"

"It was a huge relief when I was given my package. I wasn't sure what I needed as my husband was doing all of my care.

My case manager talked to both of us and I feel that my support helps Bill out, as well as me.

Yesterday, he walked our dog for an hour and then picked up some shopping on the way home. Things like that were difficult for him as he was always worried that I would fall if I was left alone.

So it is a good thing for not just the person but also, the whole family.

I want to be able to do more for myself and one of my goals is to help with the housework."

"Lucas"

"I didn't want to admit that I was eating take-away food and mostly frozen pies.

My wife is in a nursing home and she was the one who did all the cooking. I am Polish and I miss the food that we used to eat.

My case manager talked about things that are important to me and she found a volunteer who also loves to cook Polish food. She comes to my home and we cook and freeze meals for the week.

We sometimes make something for my wife to enjoy and she looks forward to me taking something out of my bag that I have made for her.

I also find the extra washing hard to manage, as I like to bring some of my wife's clothes home to launder, so I also get some help with this."

The peak body

Darren Mathewson, Aged and Community Services Tasmania

Challenges

Consumer directed care has wide ranging implications for home care service providers, which Aged and Community Services Tasmania represents.

Darren says the challenges to date have been associated with managing growing administration loads, expanding service offerings to provide choice and supporting clients to understand the new user pays arrangements.

"One of the major challenges is shifting and supporting our workforce to embrace what is, essentially, a new approach," he says.

"Supporting individuals while engaging and partnering with families and carers is demanding new skills, enhanced knowledge and innovation.

"Investment in sustained and systemic workforce development will be crucial as aged services lead the way for other health and social sectors to follow."

Opportunities

Darren says while there will be challenges in implementation, it is appropriate and desirable to design and deliver services and support on the basis of the goals and decisions of consumers.

"This will ultimately mean that we will move to a quality of life focus, with individuals and their support networks taking more of a role in planning their own services and making key decisions on the mix of support, timing and providers," he says.

"The goals of the individual are the drivers, therefore the initial interaction between providers and potential consumers is crucial."

"Investment in sustained and systemic workforce development will be crucial as aged services lead the way for other health and social sectors to follow."

Next steps

As the next cohort moves into and through the aged services system, Darren says it will demand a greater say and diversity in services and support.

"The current reforms are clearly preparing the system for this," he says.

"What this means is a significant challenge for those in the system now and some bumps and bruises as both providers and consumers come to grips with the consumer directed approach in this transition phase.

"Support and education for consumers and the community on the benefits and opportunities of this approach is crucial, along with an understanding of the need to resource the industry to shift to the model. This is the challenge for the current Federal Government."

Darren says "real choice" for consumers will start on 1 February 2017 when home care packages will be attached to the person, giving them the ability to choose their service provider and move to another service if they are not happy.

"Work is also underway to determine the best approach for the implementation of a consumer directed model in residential care. In a ten-year reform process it's probably best not to do everything at once," he says.

The consumer advocate

Sue Leitch,
Council of the Ageing
Tasmania (COTA)

Challenges

Sue says one of the main challenges COTA faces in relation to consumer directed care is "striking the right balance between overhead costs and the delivery of a meaningful package for consumers."

"We have received feedback from consumers in the past expressing their frustrations about the percentage of costs that are not going into direct consumer care," she says.

"The My Aged Care web site has been experiencing some teething problems and as the system is bedded down, we expect to see a more streamlined experience for both consumers and providers.

"As the system matures, both providers and consumers will gain a more detailed understanding of the principles, benefits and practical implications of consumer directed care. Meaningful engagement is, therefore, essential."

Opportunities

Sue says opportunities exist for COTA to work alongside all stakeholders, including providers, allied health and consumers, to establish what she describes as "an age-friendly Tasmania."

"If the majority of care and support is being delivered in the community, we need to make our communities age-friendly," she says.

"This may be achieved formally through the WHO Framework, or through other public policy areas, such as active ageing.

"An opportunity also exists in the meaningful co-production of service delivery with older people – a lot of work has been done on this in the United Kingdom."

Next steps

"Let's get it right. There is a large number of baby boomers around the corner who are not going to tolerate being told what they are allowed to do," Sue says.

"I recently visited my Mum and Dad who live in a rural town in the north of Tasmania. Dad was pleased with himself – through his provider he had met up with a farmer in Launceston to buy four more chooks.

"Tending these chooks is a small joy in my parents' day – my parents have severe eyesight disabilities that, in conjunction with other issues, results in them receiving low-level packages.

"This is the type of reablement that can make a real difference to people's lives – and it was not that hard to make happen."

The service-provider

Jill Savell,
Southern Cross Care

Challenges

Jill says challenges for Southern Cross Care have included removal of the flexibility to reallocate funds from home care packages.

"Under the old system, we could use surplus funds from consumers who did not use all their funds to supplement those with higher needs," she says.

"Unfortunately, this can no longer happen. In some cases this loss of flexibility could result in premature admission to aged care because of the long wait for a high care package."

Since 1 July 2015, home care packages have moved to a user-pays system, and Jill says many people are unaware of what this can mean to them.

Traditionally, she says, people have paid very small amounts of money for packages "regardless of whether they were a pensioner or a millionaire".

"These days are gone. Everyone is expected to pay a 'daily home care fee' unless they can meet the hardship provisions, but if they have money tucked away they will be assessed for a 'daily income tested fee' as well.

"I have heard stories of people being assessed as having to pay nearly $200 per week for care because they have planned well for their future by saving hard.

"This has prompted a bit of backlash and some people are refusing to take up a package even though they need it because of the cost."

Opportunities

Jill says a key outcome of CDC is the flexibility it provides to place the client at the centre of their care, enabling them to "drive their own package".

She says this is shaping a workplace culture of "doing with" rather than "doing for" the consumer.

"Seeing the consumer understand exactly how their budget balances and being able to jiggle things around with them to best meet their goals is wonderful," she says.

Next steps

The challenge now for Southern Cross Care is to keep pace with the next tranche of reforms that are on the way, Jill says.

Analysing the effect of the changes to funding since 1 July 2015 is also a priority.

"It has only been a few months since these were introduced and although we had been planning for almost a year, there are some unexpected challenges," she says.

"We are also aiming to refine our model of consumer directed care in line with suggestions and feedback from the consumer."

The service-provider

Connie Bruckard, Anglicare

Challenges

Connie says there is some difficulty for providers who are trying to ensure clients in rural and remote areas get a fair outcome.

"These people have less access to health services and generally, fewer choices. And they have to travel larger distances to access these services, which results in more travel fees cutting into their budget," she says.

The shift from cross-subsidisation under the previous model to a model where the client is at the centre of their support and, in turn, their budget, is fundamental for providers.

"CDC gets people involved in the process and thinking about how they can best remain independent and get the most out of life, which is fantastic," Connie says.

"Of course, this increased level of choice and involvement is a welcome relief for many, but for others it can may cause some anxiety."

Other challenges for providers include meeting demand for higher levels of support when waiting lists are so high, and managing staffing with no funding security.

Opportunities

Greater innovation, more empowered clients and cost control are just some of benefits Connie says CDC delivers.

"The CDC approach is absolutely wonderful. Our clients have embraced it – we encourage clients to think outside of the square when considering the goals they want to achieve," she says.

"The relationship with the client is also shifting, which is a good thing, and there is more transparency around the cost of their care."

Connie says an individualised budget means the client's care must be managed within the budget.

She says for many providers, however, this will require ongoing conversations with the client to ensure wise choices are made regarding what is important to them and what services might be nice to have, but are not essential.

Next steps

Connie says the introduction of portable packages in 2017 will be another big change.

"It will mean clients moving region or interstate, for example, can take their package with them – or choose to move to another provider altogether," she says.

"This will be a big challenge for some providers. For instance, how will case management be delivered from an interstate provider? How will this impact on fees and charges, and quality of services?"

The system supporter

Rosie Beardsley, Primary Health Tasmania

Challenges

Rosie says the broad aged care reform agenda presents significant challenges for organisations who are needing to adapt their models of service.

Older people often seek advice from their GP and other members of their medical care team, and the changes are a lot to take on board.

"Primary Health Tasmania is supporting providers to better understand CDC, the aged services sector and current reforms," Rosie says.

"These health professionals are ideally placed to be a conduit of knowledge and support for older people and their families as they seek to understand the opportunities CDC brings.

"This helps people make decisions about what community aged care services they want, when they want them and who will deliver them."

Opportunities

Primary Health Tasmania has an ethos of person-centred care which closely aligns with the principles of CDC in aged care, Rosie says.

"A person-centred approach enables people and their families or carers to be involved in their own transfer of care and experience smoother journeys across health and care service boundaries," she says.

"We are working closely with the aged services sector to help organisations create a culture of partnership with consumers, families, carers and communities; support integration and collaboration around care; and innovate in redesigning roles in this intense reform environment."

Next steps

Rosie says Primary Health Tasmania will continue to work across the primary health and aged services sectors to help drive reform on the ground, to the benefit of older people, their families and communities.

"We also look forward to hearing details of the Australian Government's plans for primary health network activity in aged care," she says. ■

Team effort helps Carol stay in her home

CAROL* has lived in the same one-bedroom unit in Kingston for 22 years.

With friends a short distance away and a Jack Russell terrier to keep her company, she has never considered moving.

But after a succession of minor falls outside her home, it became obvious to those closest to the 49-year-old that her living environment was no longer suitable for her increasing medical needs.

Carol, who is legally blind and hearing impaired, also suffers from poor balance which, when combined with her chronic medical conditions, makes it difficult for her to move around her home safely.

Last year, Carol was referred to Primary Health Tasmania's care coordination program, which in her area is contracted to Community Based Support (CBS).

Care coordinators work with people with complex health needs, like Carol, and their care teams to assess clients' care requirements then put them in touch with the services they need to stay healthy and independent.

They also support clients to take a proactive role in the ongoing management of their chronic conditions.

Carol's care coordinator, Kate Faull, says Carol's rocky and uneven backyard meant she couldn't hang out her washing or simply sit outside without the risk of another fall.

"Carol was obviously very reluctant to move from somewhere that had been home for so long, so the most appropriate solution was to adapt her environment to meet her needs," she says.

As a first step, Kate consulted a community-based occupational therapist from the Tasmanian Health Service plus a rehabilitation specialist from Guide Dogs Tasmania on the design elements.

Together, the occupational therapist and rehabilitation specialist assessed how the existing set-up affected Carol's ability to perform day-to-day tasks and impacted on her personal safety. They made recommendations to Carol and the builder who would be doing the work.

Des Smith, lead pastor at Christian Reformed Church of Kingston, says the church agreed to fund all building materials and identify a labourer willing to volunteer time and skill towards the project.

"Carol is a long-time member of our church and a much-loved face in our community so when Kate approached us with her plans, we were more than happy to lend our assistance," he says.

Builder Anthony Kuilenberg, who leads the church's bible study group, says he was keen to tidy up Carol's garden.

"With advice from Guide Dogs, we painted the back steps and footpaths leading in and around the garden with white line paint so Carol could easily distinguish the concrete from the grass," he says.

"Changes were also made to external lighting.

"New turf was laid so there was nothing for Carol to trip over; we added in a lovely green garden hedge and we paved down the side of her house to create a smooth slope for walking, thanks to supplies donated by K&D Trade Kingston.

"Most importantly, we pulled out her old washing line and installed a new one that Carol can more easily reach – and there's also a shelf built beside it for her to rest her washing basket on.

"The result is a garden that is much more inviting and user-friendly … the way her face lit up when we revealed the finish product made it even more worthwhile."

Carol says she was overwhelmed with the transformation of her backyard, which took almost a year to complete.

"The garden looks lovely and I am so happy with it … I can see where I am going now."

Kate says the project demonstrated what could be achieved through hard work, generosity and a collaborative community effort.

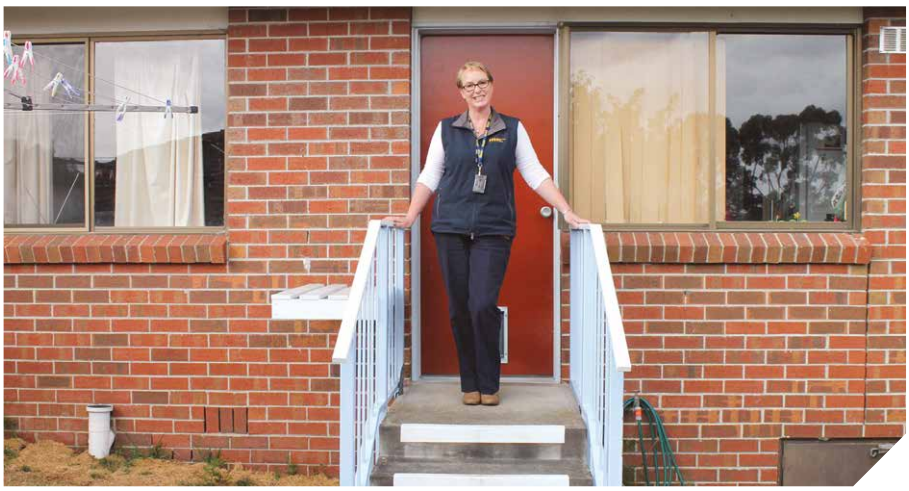
"We are very fortunate that everyone was willing to get on board and help make a difference for Carol," she says.

"The new yard has increased Carol's safety and independence – both of which are integral to her wellbeing."

Lynette Purton, who manages Primary Health Tasmania's care coordination program, says: "Carol's story is a great example of what can happen when different parts of the system come together around a common goal of improving a person's quality of life." ■

More information about Primary Health Tasmania's care coordination program is available at www.primaryhealthtas.com.au/programs-and-services/coordinating-care or by calling 1300 653 169

**Carol is a real person and a client of the care coordination program, but has requested that her real name not be used in this story.*



Care coordinator Kate Faull in Carol's new-look yard – painted white lines help guide Carol up the steps, and there's a shelf for her washing basket

Managing medicines for better health

A NEW education program is being rolled out across the state to help older Tasmanians avoid hospitalisation for medicine-related problems.

Deprescribing – the process of identifying and discontinuing potentially inappropriate drugs to improve patient outcomes – is a topical issue gathering pace in the medical community worldwide.

Primary Health Tasmania has partnered with Consultant Pharmacy Services (CPS) to research commonly prescribed drugs and to produce a suite of evidence-based guides to deprescribing.

In June this year, a series of educational workshops on deprescribing was delivered to about 120 GPs, pharmacists and nurses around Tasmania.

The workshops, presented by CPS consultant clinical pharmacist Dr Peter Tenni and geriatrician Dr David Dunbabin, provided an analysis of relevant research and discussion of case studies.

They were complemented by specific fact sheets to guide health professionals when considering polypharmacy in older people.

The initial resources targeted seven specific drug classes – antihypertensives, antiplatelet agents, antipsychotics in dementia, benzodiazepines, vitamin D and calcium, bisphosphonates and statins.

Peter says medicines in older people have the potential to provide great gains, as well as significant harms.

"The older you are, the more likely you are to have co-morbidities and functional impairments and therefore, the more likely you are to be on multiple medications," he says.

Peter notes that inappropriate prescribing and polypharmacy are significant issues in frail and high-risk older people, contributing to increased risk of falls, adverse drug events, hospital admissions and death.

"While GPs may be advocates for deprescribing, the 'how to do it' can be quite difficult."

"Therapy to delay or cure diseases in these patients is often not the most beneficial approach, which is why symptom control, maintaining function and addressing end-of-life issues become main priorities."

Peter says it is sometimes appropriate to take a number of medications if each one is meeting a specific need.

"Where it becomes complicated, however, is that the benefits (and harms) from these medications may change over time," he says.

"Taking multiple medications can become problematic if the medication no longer provides a substantial relief according to the person's goals and needs, if the medication increases the risk of adverse effects or the risk of the medication outweighs the benefits.

"Deprescribing aims to reduce these adverse effects and, potentially, drug burden in patients."

Optimising medicines is a time-consuming, multi-disciplinary process that requires extensive communication and frequent monitoring and review.

"A lot of GPs already use principles of deprescribing in their primary care of older patients – they understand that drug cessation should be considered in all patients as part of a regular medication review," Peter says.

Dr Peter Tenni says medicines in older people have the potential to provide great gains but also significant harm

Dr David Dunbabin says deprescribing should reduce hospital admissions and improve quality of life

"While they may be keen advocates for deprescribing and its benefits, the 'how to do it' can be quite difficult.

"The fact sheets we've developed for each drug class outline a recommended strategy to guide GPs in planning and initiating a withdrawal plan and tracking its progress in the patient."

Dr David Dunbabin, a geriatrician specialising in ambulatory care, says the strength of the program is in its systematic approach.

"The importance of drugs in preventing disease is obviously a key part of it, but what we are really trying to do is establish a more rational prescribing basis for GPs," he says.

"Essentially, we are asking GPs to apply the same rigour they would use when prescribing a patient with a new tablet to re-evaluating the performance of a drug that may no longer be necessary in an older person.

"As you age, your ability to metabolise certain drugs deteriorates and your risk of adverse events or side effects occurring increases.

"In some circumstances, one medication might influence another to result in possible unwanted drug interactions. The more drugs taken, the greater the risk.

"A slightly frail brain is more likely to be confused by medications that may not have the same effect in a younger person."

David says deprescribing does not necessarily mean stopping the medication altogether. It may just be a matter of rationalising the medication to achieve the same result with fewer pills.

He says the program doesn't only target prescribers.

"It is aimed at empowering pharmacists, nurses and especially people and their carers to look at things in a more critical way," he says.

"For instance, 'these are all the pills Mrs X has been on since she had her heart attack 15 years ago. Do you think she needs them all now?' – these are the questions we should be asking."

David says deprescribing is unlikely to cause harm to patients – there is a lot of potential for it to result in clinically meaningful outcomes.

"The ultimate hope is that it will work at a number of levels," he says.

"Aside from the cost-saving element of discontinuing medications, we anticipate a reduced number of hospital admissions for drug complications, and an improved quality of life for those taking the medications."

David says the program has been well-received in the Tasmanian medical community since its launch.

"I think most people appreciate the potential harms and the need to analyse critically what they are doing and are prepared to change and take on advice," he says.

To complement the service provider education program and in consultation with consumers, Primary Health Tasmania is developing two consumer support resources.

The first is a brochure to support prescribers to initiate conversations about medications with their patients. The second is a small card of suggested questions to help people discuss medicines with their GP.

CPS recently proposed an extension to the program that will target an additional nine drug areas for research. They will include proton pump inhibitors, analgesics, opioids and hypoglycaemic, ophthalmic, anti-rheumatic, and cardiovascular agents.

This work is expected to be completed by March 2016, with further statewide workshops scheduled for May.

The deprescribing initiative is part of Primary Health Tasmania's 'shared transfers of care' project, aimed at improving transfers of care between acute care, sub-acute care, general practice, community service providers and residential aged care.

It is funded under the Australian Government's Health Assistance Package.

Sam Laubsch, a manager with the Primary Health Tasmania team driving the deprescribing education program, says better medication management leads to fewer adverse events, less pressure on the health system, and better health for individuals.

"The program provides an opportunity to increase knowledge and inform practice in the area of medication management for service providers, and it also gives consumers a chance to be involved in the shared decision-making relating to this important aspect of their health care," she says. ■

For more information, contact Sam Laubsch on (03) 6213 8200 or slaubsch@primaryhealthtas.com.au

Putting training into practice

GP Clare Ballingall, pharmacist Mel Verbeeten and nurse practitioner Kerrie Duggan are among the 120 health professionals who have attended deprescribing workshops.

Clare practises at the Glenorchy Medical Centre. She says for a sustainable and efficient healthcare system, we need to be mindful of the evidence when ordering tests and writing scripts.

"I attended the deprescribing workshop around the same time as the RACGP-supported Choosing Wisely Australia initiative was launched, both advocating for evidence-based prescribing and less over-treating," she says.

"I found the workshop helpful at a very practical level – how to taper medications safely, by which increments, and over what timeframe.

"I feel more confident now initiating the doctor-patient conversation about the fact that sometimes, with medications, less is more. And patients rarely disagree!"

Mel, a pharmacist at Kings Meadows Capital Chemist, says it was important for her to know how to assess and communicate which medication doses could be reduced or ceased.

She says the use of case studies in the workshop provided an opportunity to discuss relevant issues with like-minded professionals.

"The workshop was very informative – it focused on commonly used medications and the current evidence used to implement best practice," Mel says.

She says she has no doubt that high-risk patients could benefit from the deprescribing of medications.

"Patients look to their health professionals for guidance about medications and are always happy to be told they can take less, meaning less adverse effects and less cost," Mel says.

Kerrie, a nurse practitioner at the Cygnet Family Practice, says part of her job is to review patients' compliance with their medication.

"This raises discussion with the patient about how relevant their medications are in the context of their current health," she says.

"I wanted to see what evidence there was regarding deprescribing. While it seemed to be a common-sense approach, I had not seen the process used systematically."

In addition to increasing her knowledge of deprescribing, Kerrie says she now has documented strategies to put the knowledge into action.

"The benefits for my patients have been more appropriate use of medication by using a holistic approach," she says.

"Patients have also benefited by having a practitioner who is better able to explain the pros and cons for not taking some medications." ■

Deprescribing: Key points

- **For people with multiple illnesses, applying the relevant clinical guidelines to manage each of their medical conditions often results in a significant medication load.**
- **The higher the medication load, the more likely that an adverse effect will occur as a result of interactions between the different medications and between the medications and the multiple conditions.**
- **Over a five-year period, one in four older people is hospitalised for medication-related problems.**
- **People with low reserve, typically older, frailer patients, are more likely to have adverse effects from medication.**

Primary Health Tasmania membership

Primary Health Tasmania has Tier 1 (organisation) members which are professional peak bodies or other statewide entities that work in close association with primary health care in the interests of improving the health outcomes of the Tasmanian community.

Individual (Tier 2) membership is also offered to the workforce that delivers and supports the delivery of primary health care services in the community.

More information about membership is on our website at **www.primaryhealthtas.com.au/about-us/getting-involved**

Royal Australian College of General Practitioners

THE Royal Australian College of General Practitioners (RACGP) is Australia's largest professional general practice organisation representing more than 30,000 urban and rural general practitioners nationally.

In Tasmania there are more than 600 members working in or towards a career in general practice.

As the sole organisation in Australia with a specific focus on GPs and general practice, the RACGP is well placed to support, advocate and defend evidence-based best practice in general practice and primary care, with a commitment to better outcomes for patients.

The RACGP supports GPs across the full continuum of their career, from undergraduate students to retirement from practice. It resources education, skills enhancement, collegial support and advocacy at all levels.

The RACGP has a proud history of achievements including the development of the Standards for General Practice and the introduction of continuing professional development.

Its mission is to improve the health and wellbeing of all Australians by supporting GPs, general practice registrars and medical students through its principal activities of:

- education, training and research, including assessing doctors' skills and knowledge
- supplying ongoing professional development activities, developing resources and guidelines
- assisting GPs with issues that affect their practice, and developing standards that general practices use to ensure provision of the highest quality healthcare.

The RACGP's Tasmania Faculty collaborates with Primary Health Tasmania and other primary health-focused bodies to consider issues and challenges affecting Tasmanian GPs and practices. The two organisations are members of the Tasmanian General Practice Forum, alongside the Australian College of Rural and Remote Medicine, Australian Medical Association (Tasmania) and Rural Doctors Association of Tasmania.

At the request of its members, the RACGP recently sought to raise its profile and that of the profession through a community awareness campaign including television advertising (go to **www.youtube.com/watch?v=1enfFuOEfa0**).

The campaign's 'The Good GP never stops learning' message is the first of a number of core messages aimed at enhancing community understanding of general practice as a speciality. GPs: Specialists in life.

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RACGP

Mental Health Council of Tasmania

THE Mental Health Council of Tasmania (MHCT) is the peak body representing and promoting the interests of mental health in the community.

The MHCT is strongly committed to improving mental health and wellbeing for all Tasmanians.

It seeks to achieve this by connecting with key stakeholders and engaging with services and governments to advocate for improvement in the care for people and families living with mental health issues, and strengthening and supporting mental health promotion and prevention.

The current challenge for the MHCT and the mental health sector more broadly is the degree of reform at both state and national levels that will have a direct impact on service provision and the way many community mental health providers have been working in Tasmania.

The MHCT is working hard to keep members and stakeholders abreast of developing policy and systems in order to plan and prepare for the changes to come.

Paramount to this is ensuring individuals and families are able to access the level of support they need now and into the future.

The focus for the MHCT in the coming months will be the rollout of Rethink, Tasmania's 10-year mental health plan; the development of the fifth national mental health plan; and the transition to a full National Disability Insurance Scheme.

From a primary health perspective, the MHCT will be looking towards engaging Tasmanians in better understanding how to maintain good mental health, improving the physical health of people living with mental illness and providing better access to timely community-based support.

It has been contributing to work by Primary Health Tasmania's HealthPathways team on the development of agreed local pathways for the care of people living with mental health issues.

The MHCT has a diverse membership of community organisations and individuals and welcomes new members who want to engage further with the mental health sector in Tasmania.

Chair: Patrick Carlisle
CEO: Connie Digolis (pictured)
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Mental Health Council OF TASMANIA

Primary Health Tasmania

Who are we?

Primary Health Tasmania is a non-government, not-for-profit organisation working to connect care and keep Tasmanians well and out of hospital.

We are one of 31 primary health networks (PHNs) established nationally on 1 July 2015 as part of the Australian Government's Primary Health Networks Program.

What are we doing?

The Australian Government has set the following objectives for PHNs nationally:

- increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improve coordination of care to ensure patients receive the right care in the right place at the right time.

How are we doing it?

We support general practice – as the cornerstone of the health care system – and other community-based providers to deliver the best possible care for Tasmanians.

We are driving a collaborative approach to ensure people moving through all parts of the health system receive streamlined care.

We engage at the community level to identify local health needs and work with health system partners and providers on innovative solutions to address service gaps.

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Your feedback matters

If you have feedback about this magazine or story ideas for future issues, we'd like to hear from you. Please email us at **comms@primaryhealthtas.com.au**

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