ISSUE FIVE AUGUST 2016

primary health TASMANIA

primary health matters

TASMANIA'S PRIMARY HEALTH MAGAZINE

IN THIS ISSUE

phn TASMANIA
An Australian Government Initiative

CONTENTS

Cover image: Joy Law and daughter Trinity Rogers

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.

To subscribe (no cost) or unsubscribe, email or call us using the contact details above. Remember to include your name, email and full postal address.

Primary Health Matters is available online at
www.primaryhealthtas.com.au/about-us/our-publications

Primary Health Tasmania ABN 47 082 572 629

Australian Government

phn TASMANIA
An Australian Government Initiative

Message from the CEO

I SAW a letter in the *Examiner* newspaper a while ago from a man whose wife had recently died of cancer.

He estimated that in the past six months, his family had been involved with seven care-providing organisations, five doctors, three occupational therapists, three social workers, seven other care providers, and more than 10 nurses.

"There seemed to be no coordination between the groups, so we had to fill out numerous forms that were duplicating what was already known," the man wrote.

The morning he penned the letter, a carer turned up to look after his wife. She had died 10 days earlier.

The man wrote that he was not criticising the individual health professionals who looked after his wife.

"I am critical of the system that operates."

In this issue of *Primary Health Matters* we have a series of articles on a Primary Health Tasmania-led program we hope will lead to better coordination to reduce stress and risk of harm for people receiving care from different parts of our complex health system. See pages 18 to 22 for an overview of the Shared Transfer of Care program and examples of how it's making a difference on the ground.

We also profile two new initiatives aimed to keep people well in the community, reducing pressure on our stretched hospital system. See our stories on the Launceston Medical Centre's after hours walk-in clinic (next page) and the Community Rapid Response Service (pages 4 and 5).

In recent months, Primary Health Tasmania and other primary health networks around the country have been winding down direct service delivery and adopting a model of commissioning services from other expert organisations. This is a new and very different way of working not just for us, but for the service providers and local communities we collaborate with to assess needs then plan, implement and monitor services. An article on pages 8 and 9 explains commissioning from the perspectives of Primary Health Tasmania general manager Mark Broxton and Mental Health Council of Tasmania CEO Connie Digolis.

I hope you enjoy this issue of our magazine.

Phil Edmondson
CEO
Primary Health Tasmania

Launceston clinic helps meet after hours need

GIVING patients better access to care in their own communities and taking the strain off local hospital services are the key drivers for a walk-in clinic in Launceston.

Launceston Medical Centre opened the dedicated after hours clinic in June 2015, offering GP services 6-9pm Monday to Friday and 2-5pm on weekends.

GP Jacyln O'Keefe says the after hours clinic stocks a wide range of medication and equipment with the ability to treat almost anything that doesn't require admission to hospital.

"We have an onsite pathology laboratory, bedside ultrasound and suturing facilities for lacerations," she says.

"We work well with community pharmacies that stay open for extended hours to assist with our walk-in clinic hours for patients to access prescription medication, as well as over-the-counter medication."

Jacyln says the clinic plays an important role in meeting demand for after hours medical and pharmacy services while reducing demand on hospital emergency services.

"Our patients are grateful they can access a doctor, especially at a time of day when there are usually very limited options," she says.

"GPs are able to work to their full capabilities as they are regularly exposed to the acute health needs of their patients."

Jaclyn says the clinic is designed to deal with a single, time-critical issue for a patient, rather than replace their ongoing, comprehensive general practice.

"Patients are educated that if they have a semi-urgent health concern they are seen in order of arrival," she says.

"If it's more serious, they are treated by the attending doctor as a matter of urgency.

"Of course, people should always go straight to the hospital or call triple zero if they have a life-threatening health emergency."

Arrangements are in place so the clinic can fast-track patients seamlessly to the hospital should the need arise.

Clinic staff have the emergency department consultant's mobile number on speed dial so any patients that require transfer to the hospital receive a formal handover and are bulk billed.

Dr Jaclyn O'Keefe

And it works both ways – people in the emergency department waiting room at the hospital who would prefer to not wait for an extended period of time are given a brochure with the option of attending the nearby walk-in clinic.

A grant from Primary Health Tasmania this year saw the centre work with the Launceston General Hospital to further explore the after hours clinic model, particularly in relation to the treatment of higher complexity patients.

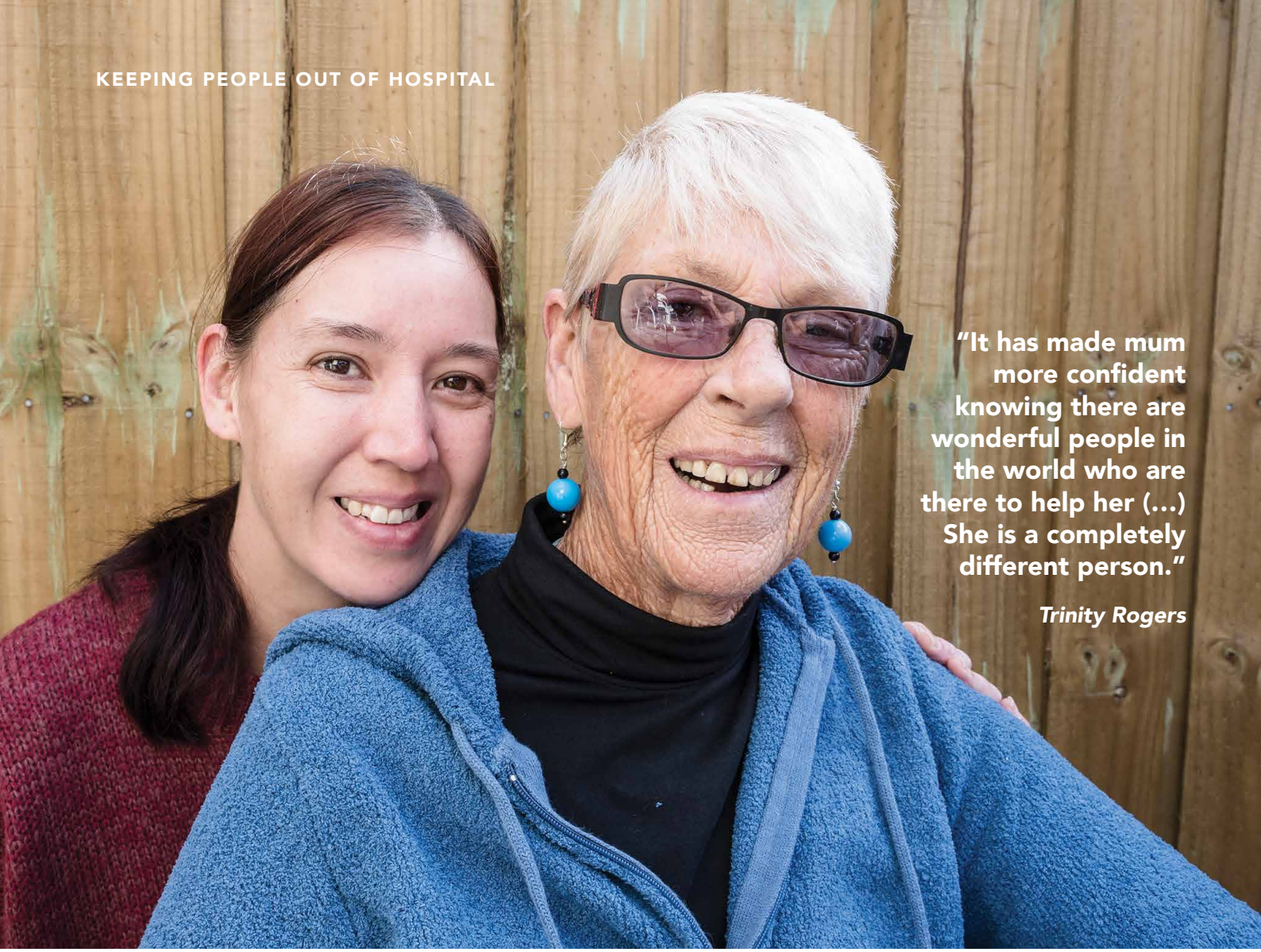
This helped refine the model and formalise communication and transfer arrangements with the hospital.

Jaclyn says by being able to promptly start treatment that would otherwise have been delayed, the after hours clinic model helps prevent conditions from worsening as well as avoiding potential hospital presentations and admissions.

"It addresses any health need that a patient feels cannot wait for either a booked appointment with their regular GP or a booked appointment with the Launceston Medical Centre, which we provide every day of the year for routine general practice issues," she says.

"It has also fostered other ideas that we have put into place to treat patients outside of the hospital, such as a weekly fracture clinic, a skin cancer clinic, and basic haematology services." ■

For more information, visit www.launcestonmc.com.au



"It has made mum more confident knowing there are wonderful people in the world who are there to help her (…) She is a completely different person."

Trinity Rogers

Trinity Rogers with her mother, Joy Law

Rapid response program gets Joy back on track

SINCE suffering two major strokes 20 years ago, Joy Law's life has never been the same.

The 76-year-old Launceston woman, who prides herself on her independence, has spent the past few years in and out of hospital as her health has progressively declined.

Her daughter, Trinity Rogers, says it has been tough seeing her mother's personality change in the face of her chronic illness.

"Mum has problems with memory loss, which we believe are a result of her strokes, and she gets confused and anxious easily," Trinity says.

"She also suffers from osteoarthritis and has had a number of falls over the years … she relies on a walking aid for mobility, but she is no longer confident on her own feet."

When it finally seemed as though the worst was behind her, Joy endured yet another setback - two serious falls in just one week, both of which saw her admitted to the Launceston General Hospital on three separate occasions.

"After mum was hospitalised we were told she had pneumonia and a urinary tract infection on top of everything else," Trinity says.

The mum of two says she had to put her own responsibilities aside to care for Joy which, at times, felt like an insurmountable task.

"I would sit by her side in the hospital nearly around the clock and when she was discharged, I would look after her at home," Trinity says.

Eventually, the physical and emotional toll proved too great for Trinity.

In May she phoned Joy's GP, Dr Alice Downie at the Launceston Medical Centre, "out of desperation".

"It was during this conversation that I first learned about the Community Rapid Response Service," Trinity says.

The Community Rapid Response Service (ComRRS), a State Government initiative, is available to people with acute illness or injury and to people whose chronic or complex condition has deteriorated in a way that would otherwise see them present at an emergency department and possibly be admitted to hospital.

The service works on the principle that a patient's care is shared between their usual GP, community nursing and other health professionals.

Treatment is provided wherever it best meets the patient's needs, which might be in their home, in a residential aged care facility, or in a community health centre.

"Dr Alice Downie asked if mum and I would be interested in participating in the pilot program, which would soon be launched in the Launceston area," Trinity says.

"At the time we had been seeing Alice quite regularly for blood pressure checks and wound treatments for skin tears, which would often require recurrent hospital and GP visits.

"So the opportunity for mum to safely receive short-term intermediate care in her own home, while we awaited an aged care assessment, made a lot of sense."

A referral was forwarded to the service and the following morning Trinity received a phone call from Meredith Prestwood, a nurse practitioner and ComRRs team leader.

"Meredith and another nurse visited mum at home that day - and every day that initial week. I could not have been more thankful for that support," Trinity says.

The ComRSS team also gave Joy quick access to an occupational therapist and physiotherapist, and helped Trinity organise an aged care assessment and personal carer for Joy.

"The carers would provide blood pressure checks and urine checks daily, keep an eye on her anxiety and administer her medications, but they were also there to just sit and chat with mum to ensure she was OK," Trinity says.

"If there was an emergency or if mum was feeling unwell, I could simply phone them."

Trinity says her mother has benefited enormously from the service.

"It has made mum more confident knowing there are wonderful people in the world who are there to help her," she says.

"She absolutely loves Meredith and the team. She feels very comfortable in their presence, and her eyes light up when her personal carer drops by. She is a completely different person."

Dr Alice Downie says the additional community nursing support Joy received through the service helped prevent her from representing to hospital.

"These multiple presentations can be very unsettling for patients," she says.

"As a high falls risk patient, the service addressed her needs around the home, ensuring there are no trip hazards and that bars and handles are installed to support her."

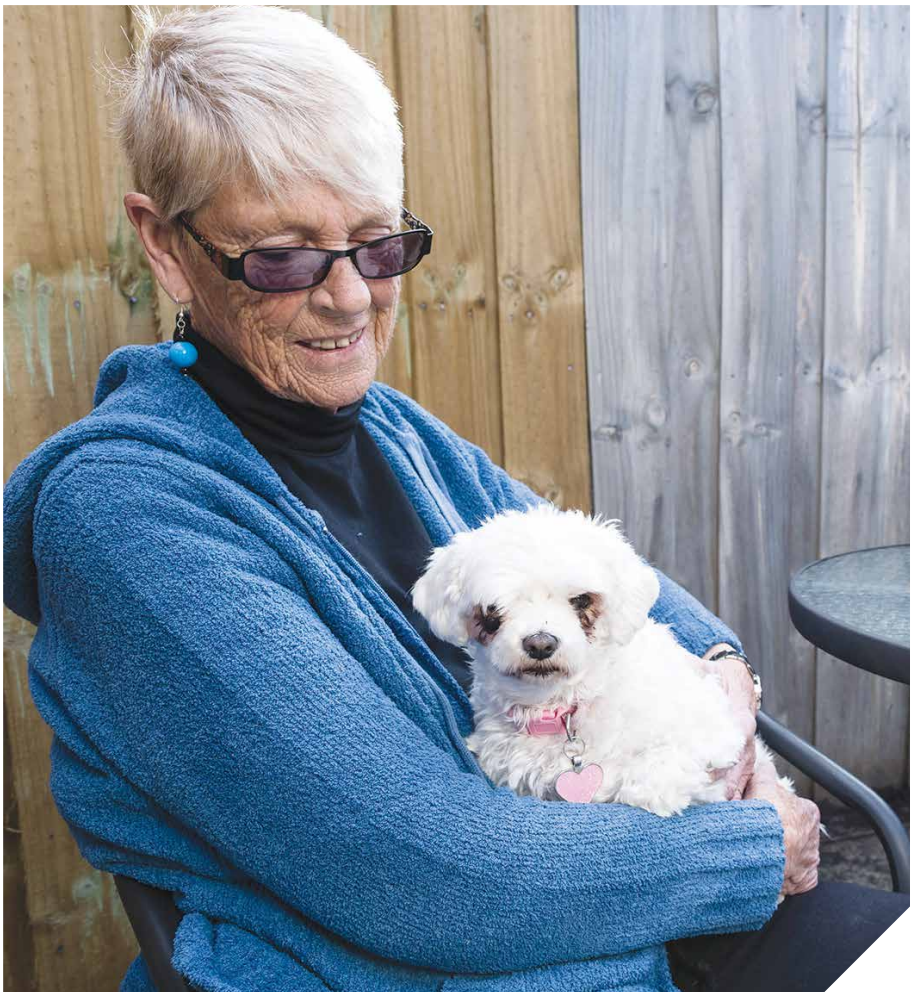
"The model also provides continuity in care - by seeing the same community nurses, Joy was able to form trusting relationships with them."

ComRSS is being rolled out to all general practices across the greater Launceston area, in close consultation with GPs and other key stakeholders.

The pilot will be evaluated to consider opportunities to provide this model of care outside Launceston.

Primary Health Tasmania chief executive officer Phil Edmondson is on the steering committee for the project. ■

For more information visit www.dhhs.tas.gov.au/gp, or contact Fay Walsh at the Department of Health and Human Services on 0428 556 979 or fay.walsh@dhhs.tas.gov.au



Assoc. Prof. Jan Radford

"The networks can help to identify problems in daily practice that create gaps between recommended care and actual care."

Assoc. Prof. Jan Radford

Practice-based research vital

GOOD health practice, health policy and health service planning all boil down to one simple, but crucial, factor - relevant, high-quality research.

And when it comes to building the evidence base that informs both primary health care practitioners and policy makers, it makes sense that this research is conducted where most people receive the majority of their care - in everyday general practice.

Practice-based research networks provide a model where general practices form the 'laboratories' in which research is conducted and used.

Practices are encouraged to take on medical students who become involved in all aspects of a particular research project, including data collection and data cleansing.

These networks are driven by research academics and primary health care practitioners who have the mutual goal of generating research that is relevant to both clinical practice and health policy.

Jan Radford, Associate Professor in General Practice at the University of Tasmania's Launceston Clinical School, says practice-based research is not merely clinical research conducted in practice settings.

"The networks provide the infrastructure to support practice-based research, but their value extends far beyond this … these networks are powerful learning communities," she says.

"By virtue of their structure, GPs can receive reliable data on issues relevant to their patients and at the same time collaborate with researchers and other like-minded practitioners to share ideas, acquire new research skills, and contribute to the science base of primary care."

Jan cites the success of local involvement in the international ASPREE randomised control trial of low dose aspirin for primary prevention in healthy older people.

The University of Tasmania's Professor of General Practice, Mark Nelson, is a chief investigator for this trial and leads the project-specific practice-based research network that has delivered it locally.

Mark says this type of research requires large numbers of patients and these patients are best found in general practice.

"The ASPREE network allows practices across the country or across the state to act as a collective to answer this important research question," he says.

Jan has developed the state's first non project-specific practice-based research network - the Northern Tasmanian Practice-Based Research Network.

The network was formally established in 2015 with funding support from GP North and Primary Health Tasmania. A statewide network is a future aim.

Facilitating the network is project manager Anne Todd, a clinically engaged pharmacist who has worked with local general practices and GPs for a number of years. Dr Kath Ogden works alongside Jan as an academic lead.

Jan says although most health care occurs in the community, research in community settings receives very little funding in comparison to hospital or laboratory-based research.

"This dependency on funding therefore makes establishing - and maintaining - networks like ours very challenging," she says.

"But the value of these networks for translational research in community-based settings is well documented.

"The networks can help to identify problems in daily practice that create gaps between recommended care and actual care.

"In doing so, they provide an environment for testing health system improvements and treatments in primary care."

The Northern Tasmanian Practice-Based Research Network has developed and implemented research engaging northern Tasmanian general practices, University of Tasmania-based researchers, and Tasmanians who use general practice.

This research ranges from observations, surveys and qualitative studies, with the Launceston Clinical School medical students involved in all aspects of the research projects.

"Connecting basic and clinical research to community-based practices and patients is our mission, but student learning and engagement is our main priority," Jan says.

"Students help collect data, interview patients and community members or contribute to the documentation of their findings, which is then used for conference presentations and research reports."

Jan says the response from the local medical community has, so far, been pleasing.

"Northern GPs are very keen for students to be involved in pilot projects and are encouraging of this model," she says.

"It is important for general practice to have a research capacity, especially at a time where they are crippled by under-funding."

Primary Health Tasmania chief executive officer Phil Edmondson says the organisation sees immense value in supporting the northern network.

"It's all about harnessing the coalface knowledge and experience of general practice in building a contemporary evidence base for approaches to clinical care at a local level," he says. ■

For more information, contact Jan Radford on 0419 885 285 or at j.radford@utas.edu.au, or Anne Todd on 0407 877 428 or at a.todd@utas.edu.au

Project snapshot

The Northern Tasmanian Practice-Based Research Network has developed or joined the following projects because they offer students an opportunity to gain research experience in answering questions of interest to GPs as they seek to improve the health outcomes of their patients.

- **Chronic kidney disease identification and management** in northern Tasmanian general practice: A pilot study of audit-based education intervention involving northern Tasmania's renal physicians.
- A pilot study of optimising health literacy in hard to reach populations for the primary **prevention of cardiovascular disease**. This research project in Launceston's northern suburbs targets men aged 30 to 60 years who are at risk of developing cardiovascular disease.
- A pilot project looking at the **barriers to pap smear collection for patients** in general practice. This enhances a practice's ability to audit and improve their service to these patients and attract quality improvement points from either the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine.
- Investigation of the **quality use of antithrombotics** (drugs reducing the risk of a blood clot) in primary care by a PhD candidate with the University of Tasmania's division of pharmacy.
- The National Prescribing Service's MedicineInsight project, aimed at **increasing effective prescribing** and use of medicines. This project looks at aspects of clinical practice including which treatments have been prescribed for which conditions and the impact this has had.

Commissioning for better health outcomes

THE NEW financial year has signalled the start of some big changes in the delivery of a range of community-based health services through primary health networks (PHNs).

In line with Australian Government requirements, the PHNs – including Primary Health Tasmania – are switching from direct delivery of a number of health services to the commissioning of services from expert organisations and individuals.

Primary Health Tasmania commenced a commissioning approach to the delivery of mental health and diabetes education and support services from 1 July – an approach that will lead to fit-for-purpose services designed and delivered to improve the health of Tasmanians.

The PHN is also progressively introducing service commissioning in the areas of care coordination, rural health, refugee health and drugs and alcohol. And the Australian Government has flagged a role for PHNs in commissioning of aged care services.

"It's not one action but many, ranging from health needs assessments for a population to service specification and contract negotiation or procurement."

Mark Broxton

What is commissioning?

Commissioning is the process of planning, buying, monitoring and continuously improving services that deliver improved outcomes for patients, meet population health needs and reduce inequalities within the resources available.

Mark Broxton, general manager - service solutions and performance management with Primary Health Tasmania, says commissioning is very different to the way the organisation procured health services in the past.

"It's not one action but many, ranging from health needs assessments for a population to service specification and contract negotiation or procurement," he says.

Mark says the transition to the commissioning model started some time ago when Primary Health Tasmania began discussions with communities, service providers, peak bodies and other stakeholders.

"A key issue arising from these consultations was the way commissioning and contracting arrangements can help - or hinder - the delivery of services to support better health outcomes," he says.

The key objective is to maintain and strengthen where things are going well and to clarify and address the issues, barriers, gaps and needs identified within the current health landscape.

As well as planning and purchasing, the new model involves a continuous cycle of researching, forecasting, listening, engaging, defining, collaborating, partnering, designing, innovating, goal-setting, evaluating, refining and improving.

How is it different to what has happened before?

Commissioning is more than just a simple transactional process.

It's not just about paying a certain amount of money to a certain service provider to book a certain number of sessions within a certain period of time.

Instead, successful health service commissioning focuses everyone involved on working together to achieve broader health outcomes, rather than the delivery of program outputs.

"The idea is that all stakeholders are engaged in the planning and evaluation of these services - it's a two-way communication process," Mark says.

All stages of Primary Health Tasmania's commissioning cycle involve engagement and collaboration with communities, service providers and other key stakeholders.

"Primary Health Tasmania is working closely with its partners to ensure that consultation and inclusiveness is the basis of our way of working," Mark says.

Everyone involved needs to rethink and restructure the way health services are delivered.

"We will need to be able to plan and deliver outcomes that drive value across the health system - from local consumers right through to the Australian Government," Mark says.

"These outcomes will not happen overnight, which is why we need to have a way to measure if we are on the right trajectory."

Primary Health Tasmania will provide support to build the capacity of service providers as they adapt to this new funding environment.

Stakeholder perspective: Mental Health Council of Tasmania

Connie Digolis

The National Mental Health Commission's 2014 report of the national review of mental health programs and services - *Contributing Lives, Thriving Communities* - made a range of recommendations that have resulted in a significant shift in mental health services policy direction.

The Australian Government's response to the Commission's recommendations was released in November 2015, announcing a significant role for PHNs in the commissioning of mental health services.

An aim is a more coordinated and tailored approach to the delivery of community-based mental health services across the state.

The State Government is also reforming mental health services under its control, guided by its 10-year plan *Rethink Mental Health Tasmania*.

Connie Digolis, chief executive officer of the Mental Health Council of Tasmania, says government commitment to implementing these reform plans allows providers to have a clear vision for the future of the mental health system.

"Each plan includes the need for integration and alignment so the reforms directly address the individual needs of patients at the centre of the mental health system," she says.

"There are certainly very strong indications from the State Government and Primary Health Tasmania that they want to ensure their work aligns as much as possible.

"This is integral to reform success so that services, programs and, most importantly, those accessing the services are not impacted negatively by the changes."

Connie says the reforms are designed to provide local responses that will ensure gaps are identified and addressed to ensure everyone's needs are met.

"There is general acknowledgement from consumers of mental health services, service providers and even policy makers that the current system has significant room for improvement," she says.

"The current approach needs to adopt a more integrated and connected model whereby Tasmanians experiencing mental ill health have their needs met across all stages of their lives, at all levels of their recovery.

"There is a lack of clarity about how to navigate the mental health system and all areas of the sector need to aid the process by communicating more effectively to develop a clear pathway for each person entering and moving through the system.

"We're striving for a system that provides Tasmanians with greater access to primary care services and a much more effective interface for us to improve GP knowledge and management of people with mental health issues or people who may be showing signs of mental illness."

Connie says the Council will work closely with its member organisations and Primary Health Tasmania to support the transition to commissioning mental health services through the PHNs.

"We see our role is to facilitate discussion between Primary Health Tasmania and service providers so it is a successful transition and we capitalise on this opportunity," she says.

"The fact that we are in a privileged position of having only one PHN to liaise with in the whole state means it should be a smoother and less challenging process for all involved." ■

For more information about Primary Health Tasmania's commissioning activity visit www.primaryhealthtas.com.au/commissioning, call 1300 653 169, or email info@primaryhealthtas.com.au

Primary Health Tasmania's commissioning model involves four phases in a cyclical process:

1. **Assessing needs** – understanding what local communities need and working out the local priorities we can address based on this information.
2. **Designing solutions** – working with others to identify the most efficient and effective ways we can address the identified priorities.
3. **Implementing solutions** – procuring quality health services and initiatives and proactively working with providers to monitor performance and progress towards agreed outcomes.
4. **Evaluating outcomes** – assessing the efficiency and effectiveness of services and initiatives (including value for both health gains and money) against outcomes and informing priorities for future investment in successive commissioning cycles.

"Water can provide as little or as much resistance as you like, which means the exercises can be easily adjusted to suit people with varied strengths and mobility."

Michael Geeves

Michael takes the plunge for better health

Michael Geeves

MICHAEL Geeves hasn't been able to run for 20 years - but he can dash across the swimming pool in chest-high water, and that is close to the same thing.

"I feel like a young man again," Michael, 58, says of his newfound ability.

Diagnosed with arthritis in 1996, the disease - which affects his right knee - has taken a major toll on his health and wellbeing.

"I played a lot of sport growing up which probably contributed to me developing the arthritis in later life," the Acton Park resident says.

"I've always been an active person, so being unable to exercise because of the chronic knee pain has made it hard for me to lose weight.

"I'm about ten kilos heavier than I should be and every kilo adds extra pressure on my joints."

Within a 12 month period, Michael's arthritis intensified to the point that "even my friends were commenting that I was always limping".

"Eventually, I tore the cartilage in my 'good' knee, which was bad news - I could barely walk," he says.

After two years of wearing a brace on his arthritic leg, Michael had a total knee replacement in 2015.

With advice from his specialist, he turned to physiotherapy and low-impact exercise to aid the rehabilitative process.

"A couple of months into my recovery post-surgery I learnt about a warm water exercise class being offered at Clarence Joint Therapy in Howrah," Michael says.

"My friend, who was participating in the program at the time, encouraged me to sign up. Six months and a GP referral later I was in."

Water exercise, or hydrotherapy, involves the use of water for pain relief and treatment.

The practice, which is usually conducted in an indoor pool heated to around 33 degrees Celsius, facilitates the restoration of normal movement and function to the body.

Arthritis and Osteoporosis Tasmania chief executive officer Jackie Slyp says the therapeutic benefits of hydrotherapy are limitless.

"Water-based exercise provides a safe way for people with joint injuries and related ailments to complete a cardiovascular and strength workout," she says.

"The heat, water and buoyancy combine to stimulate the body, helping to increase blood flow to damaged areas, loosen up stiff joints and relax sore muscles so they can move more freely.

"Warm water exercise is one of the most comfortable and effective ways that a person with arthritis can exercise, as the joints and muscles can be worked while supported in the water.

"It is particularly beneficial for people preparing for or recovering from (or avoiding the possibility of) joint surgery, and is a great referral pathway for people with arthritis and persistent pain."

Arthritis and Osteoporosis Tasmania has been offering warm water exercises programs for more than two decades.

Eleven sessions are conducted weekly in the greater Hobart area, each running for an hour and attracting a wide cross-section of men and women.

The structured program, which is run by skilled and trained volunteer leaders, incorporates an initial warm-up, gentle stretching, conditioning exercises and a warm-down.

Michael, who has not missed a session since joining last year, says he was surprised to discover how challenged he felt by applying the same intensity in the water that he would apply to land-based exercise.

"The best thing is it's up to you how hard you push yourself," he says.

"Water can provide as little or as much resistance as you like, which means the exercises can be easily adjusted to suit people with varied strengths and mobility."

Michael says everyone follows the same routine and the exercises cover the whole body, not specific joints.

"I'm a lot fitter than I was before and my flexibility has improved," he says.

"I can take my dog for a walk, ride my pushbike and I even started playing 18-hole golf again."

A new national exercise program, The Joint Movement, has been developed for people with arthritis and musculoskeletal conditions.

The Australian Government-funded program will be rolled out by Arthritis and Osteoporosis Tasmania (on behalf of Arthritis Australia) over the next 12-18 months. ■

For more information visit www.arthritistas.com.au, email info@arthritistas.org.au, or call the Arthritis Helpline on 1800 011 041.

Arthritis and Osteoporosis Tasmania is a member of Primary Health Tasmania.

The West Coast

Geography

Largest Tasmanian local government area (LGA) by area, and sixth smallest by population

Largest town is Queenstown (1,975 people) *

Features Macquarie Harbour and large sections of the Tasmanian Wilderness World Heritage Area

Population

4,527 people – 46% female, 54% male #

Median age 39 (state average 40) *

6.6% of population identify as Aboriginal (4% for Tasmania) *

Social determinants of health

Unemployment rate 10.5% (state average 6.6%) **

Median weekly household income $966 (state average $948) *

24.2% of eligible population completed year 12 or higher (state average 39.6%) *

13.9% households receive rent assistance from the Australian Government (state average 18.8%) ^

Health risk factors

34% are obese (state average 23.6%) +

96.2% of children are immunised at five years of age (state average 92.3%) ##

25.3% don't get enough physical activity (state average 31%) +

32.7% eat fewer than two serves of fruit a day (state average 44.2%) +

Images courtesy of West Coast Council

* 2011 Census
\# ABS, June 2014
** Department of Employment, September 2015
^ Department of Health and Human Services, 2014
\+ DHHS Tasmanian Population Health Survey, 2013
++ Department of Health and Human Services, 2007-11
^^ Department of Health and Human Services, 2009-13
Medicare Australia, 2014
*** Primary Health Tasmania data

Illness and death

45.6% of population self-assess their health as fair or poor (state average 19%) +

Potentially avoidable hospitalisations are significantly higher than the state average ++

Potentially avoidable deaths are significantly higher than the state average ^^

Primary health care services ***

4 general practices

2 community health centres

4 pharmacies, 1 optometry practice

Residential aged care provided at the West Coast District Hospital

Visiting (outreach) primary health services include mental health, women's health, exercise physiology and podiatry

Primary Health Tasmania supporting the West Coast

Mapping health services in the area, to help both Primary Health Tasmania and the local community prepare for future service commissioning

Consulting service providers and community representatives on **rural primary health** needs and priorities, to help inform future service commissioning

Supporting development of the West Coast Community Plan, with a particular focus on consultation and engagement around **health and wellbeing**

Providing access to **care coordination** services for people with chronic health conditions, frail elderly people and Aboriginal people on an outreach basis through Family Based Care

Giving people access to short-term treatment for mild to moderate **mental health** issues on an outreach basis through Psychology CAFFE

Providing access to **diabetes education and dietitian services** on an outreach basis through Diabetes Tasmania


The Skeletal System
STAFF
STAFF

Community clinic connects care

A NEW nurse practitioner-led clinic is changing the way healthcare is being delivered in Hobart's northern suburbs.

Run by The District Nurses, the Tasmanian Community Clinic at Moonah offers sessions with a nurse practitioner and registered nurses along with access to a range of visiting specialists and other health professionals.

As well as meeting simple health needs such as immunisations, foot care and wound care, it runs a 'review clinic' focusing on health promotion, disease prevention, chronic disease management and care coordination.

The District Nurses chief executive Kim Macgowan says the Tasmanian Community Clinic has an important role in increasing community-based service options and connecting care, both of which help people avoid unnecessary hospital visits.

"Too often we see people get left behind because of location, income or transportation, so we did something about it," she says.

"The other need we wanted to address was choice. We have a large baby boomer population who don't fit the traditional stereotype of sitting at home and waiting for a community nurse … many would prefer to make an appointment to see us at the clinic."

Kim says the nurse practitioner model aims to link the many arms of health care to support and empower the patient as they navigate their health journey.

"Between the different arms of what we do, we are able to get people out of hospital early, back into the community and keep them well."

Tammy Harvey

Tammy Harvey

As the clinic's nurse practitioner, Tammy Harvey works collaboratively with a patient's regular GP and medical specialists to improve access to the care they need.

She helps integrate health care provision across acute care, sub-acute care and the community.

"My role is to support early discharge from the acute care sector; to run review clinics, help with hospital avoidance and prevent people from re-presenting," she says.

"This enhances care that is provided by GPs and other primary health care providers."

Tammy communicates directly with the GP to ensure appropriate care is planned and duplication and fragmentation is avoided.

Outside the clinic, Tammy helps run the health and wellness program SASI (Staying Active Staying Independent), designed to help older people stay at home and live independently.

"Between the different arms of what we do, we are able to get people out of hospital early, back into the community and keep them well," Tammy says.

Since officially opening in February, the public's response to the clinic has been overwhelming, says Fiona Onslow, director of statewide operations.

"We didn't predict how much interest our programs would generate outside of the northern suburbs," she says.

"There are referrals coming in every day, which demonstrates that this is obviously something that is needed and makes absolute sense to people."

People can be referred by a health professional or a carer, or can self-refer. ■

For more information visit www.thedistrictnurses.org.au, or contact Kate Pendlebury at The District Nurses on (03) 6208 0500 or at kpendlebury@thedistrictnurses.org.au

Deborah Emslie helps a client at the Huon Community Health Centre

"It's important clients know that if they need more information or support they can come back to us at any time - the door is always open."

Deborah Emslie

The Right Place for streamlined care

A new program in the Huon Valley is improving access to health and community services for local residents.

THEY are the friendly faces that greet you as you tentatively step through the door.

Immediately, they look up from their computer screens. With warm, sincere smiles, they ask you how you are.

"What can we do to help you?" "Would you like me to make an appointment for you?" they gently probe. "Do you know how to get there or do you need us to show you the way?"

It doesn't matter if you are uncertain about what services are available or confused about where you should be. They reassure you, because "you have come to the right place".

The philosophy of 'no door is the wrong door' is what underpins The Right Place, a community-led initiative aimed at making it easier for Huon Valley residents to find and access the health and community services they need.

Stickers, posters and name badges identify participating organisations and staff, who receive training and toolkits aimed at helping them guide people to services.

The Huon Community Health Centre is one of around 40 local organisations taking part in the program.

"We had a gentleman come to our front desk whose wife had passed away several days earlier," recalls Felicity Giles, an administration assistant at Huon Community Health Centre.

"He told us his wife had arranged for someone to come and clean their house, but he was not sure of the company's name or how to go about cancelling the service.

"After speaking with him, my colleague was able to piece together enough information to phone HomeCare South and, on the client's behalf, cancel the cleaning service.

"She also provided him with HomeCare's telephone number so he could ring back when he was ready to arrange his domestic assistance requirements."

Deborah Emslie, who also works in administration at the Huon Community Health Centre, says most people's queries and concerns are easily addressed.

"But it's not a matter of handing them a phone number and sending them on their way," Deborah says.

"It's about taking it one step further to talk to them, and to really listen, so you can move them quickly to the right place.

"It's important clients know that if they need more information or support they can come back to us at any time - the door is always open."

The Right Place concept was born out of a community round table held in February 2015, where local service providers agreed it was an ideal fit for modelling integrated care and improving access to health and community services.

Felicty Giles

Michael Tucker, a social worker at the Huon Community Health Centre, has been involved with the project since its implementation at the centre in April last year.

"For this project to work, it needs to be seamless - it relies on a good flow of information between all partners and a mutual recognition of the project's principles and values," Michael says.

"The round table discussions highlighted a real need for stronger links between service providers and more effective sharing of information, which is what The Right Place aims to achieve.

"Sometimes the issues we are presented with might not be part of our core business, in which case we will direct the client to another provider who we know will be able to assist them."

Tracy Hemmings, former nurse unit manager at the Huon Community Health Centre, says the project reflects the principle of shared transfers of care by promoting communication, collaboration and engagement across all sectors.

"There are people in our community who don't usually seek help. So when they take the big step of asking for help, there is a small window of opportunity to offer it," she says.

"It can be upsetting for people to leave a service without the information they were intending to receive, which then means the client has to go to another business to ask the same question again.

"The Right Place makes sure everyone gets a positive response and easy-to-understand information, so they don't have to tell their story multiple times."

The Right Place received funding and support from Primary Health Tasmania under the Australian Government's Tasmanian Health Assistance Package.

A governance committee has been established under the auspices of Huon Eldercare to guide the expansion of The Right Place to other interested Tasmanian communities.

In the Derwent Valley, around 25 local service providers are already on board, and the Break O'Day community is also preparing to put the model in place. ■

For more information, contact Rebecca Moles at Primary Health Tasmania on (03) 6213 8200 or rmoles@primaryhealthtas.com.au, or Jen Wehnert at Huon Eldercare on (03) 6264 7100 or jwehnert@huoneldercare.org.au.

Elsie's story

ELSIE, 87, was living independently in a unit complex attached to an aged care facility.

Apart from some domestic assistance every two weeks, she was completely self-sufficient.

She was socially connected to her local community and still driving her own car, but suffered from heart disease, short-term memory loss and severe osteoporosis. Because of her osteoporosis, she needed a total hip replacement.

After the operation, Elsie's cognitive impairment became more apparent, and she struggled with any instructions or new information.

While still in a hospital - and with no family present - she was assessed for ongoing home care. When her daughter visited, Elsie asked her to interpret the information left behind by the service provider.

To Elsie, the three brochures the service provider had left were "meaningless" and "double Dutch". Elsie described her hospital stay as like "being in another world".

In the hospital, Elsie was taken off the heart medication (the "white pill" - as she described it) that she had been taking for the past 30-years. She was told to see her GP about this.

Her family arranged for Elsie to see her GP a week after discharge, but the practice had not received any information about her hospital stay, the medication changes or the care plan. Unfortunately, this lack of communication continued.

Over the next eight months, Elsie had 12 more interactions with health sector organisations, each one requiring a new assessment, with Elsie or her family having to repeat the same story over and over.

When the family was not present, Elsie's declining cognitive function meant that the details she provided were often fragmented, with important snippets of information forgotten.

It was only toward the end of this period that health providers began to actively review previous assessments and consult with each other.

Elsie's family included medical professionals who were ready to support and advocate for her. But even though they had an understanding of the health system and the services available, they were not able to prevent Elsie's repeated assessments, being told that these were procedural requirements of the organisations.

All of the clinicians involved in Elsie's care had good intentions and supported her where they could, but all were bound within their organisational processes.

In one incident, for example, Elsie had a fall while out in the community.

The paramedics who attended were very supportive in picking her up and assessing her condition. They patched up some broken skin and drove her home when she said she did not want to go hospital.

However, there were no established systems in place for them to alert other services or family members, and not having a full history, they were unaware of Elsie's declining cognitive functioning.

Elsie's family only found out about the incident when they later discovered her unconscious on the floor, and took her to the hospital emergency department.

Elsie eventually moved into an aged care facility, where she lives today. ■

Shared transfer of care: A way of working

NAVIGATING our health system is not always easy, even for people who are capable of coordinating their own care.

For older Tasmanians and those with chronic health conditions, moving between the acute, primary and aged care sectors as their condition and care needs change can put them at risk of harm.

When information is collected in isolation and not communicated to the next care provider, these people can be left feeling as though they have little involvement in their transfer planning.

A new program is working to alleviate some of the stress that poor quality transfer of care places on people, their carers and a system already under pressure.

The Shared Transfer of Care program offers a suite of evidence-based resources developed by Primary Health Tasmania with input from care providers across aged care, community and hospital services, and general practice.

Primary Health Tasmania's general manager – planning, design and evaluation, Susan Powell, says the program is setting the standard for the transfer of care.

"Improving transfer of care is a shared responsibility between organisations, service providers, communities and healthcare consumers and a key objective of primary health networks around Australia," she says.

"These resources - which we believe may be unique in Australia - will help service providers connect and coordinate care for Tasmanians so their care journey is as seamless as possible.

"It is hoped that the adoption of these resources, tools and training will mean a consistent, organised and

well implemented care experience for Tasmanians."

Murray Coombe, who lives with diabetes and has worked in the disability sector for more than 40 years, has been a consumer adviser on Primary Health Tasmania projects aimed at better connecting care.

"A chronic illness places you on the medical treadmill as inevitably you will have to find a way to access care across a broad spectrum of health care providers," Murray says.

"For those patients unable to understand or control the care they receive or the people they see, the health system can be a nightmare.

"Add to this the breakdowns and blockages in the transfer of care information between providers and many patients are floundering as their care is fragmented and clumsy."

While having the wellbeing of the patient as the central point of care seems obvious, it has not always been evident in the way services are provided.

As a practising GP and general practice liaison officer with the Tasmanian Health Service - Southern Region, Dr Annette Barratt says: "The shared transfer of care resources help services understand how to incorporate the patient's wants and needs into the care plan and how to share information so there can truly be a team approach to care across the services.

"The development of agreed and consistent principles for a shared approach to moving people between places, providers and levels of care is essential for the management of our rapidly ageing population.

"Having a common language and clear guidelines for sharing patient information removes a lot of confusion between services. This includes communication from the GP to the hospital and back again; from the community nurse to the GP; from patient to the home help."

Dr Nick Cooling is a practising GP and senior lecturer in the School of Medicine at the University of Tasmania.

He has been involved in the development of the Shared Transfer of Care eLearning platform which hosts an online course and is a partnership between Primary Health Tasmania and the university.

Murray Coombe and Dr Annette Barratt at the launch of the Shared Transfer of Care resources

"Attending a face-to-face workshop or participating in the online activity are two practical ways that GPs can learn more about Shared Transfer of Care," Nick says.

"The eLearning activity provides a whole-of-practice educational session, giving GPs the tools to increase patients' satisfaction with the services they receive and ultimately, improve their ability to manage their health and wellbeing on their own."

The Shared Transfer of Care resources were developed under the Australian Government's Tasmanian Health Assistance Package and will be maintained by Primary Health Tasmania as important tools to support system change and influence the way care is managed in Tasmania.

They include:

- Guidelines for Shared Transfer of Care
- Facilitator's Guide to the Shared Transfer of Care
- Shared Transfer of Care Online Course
- Passport to Better Health (a resource for consumers).

They are available online at **www.primaryhealthtas.com.au/shared-transfer-care**, or call Primary Health Tasmania on 1300 653 169. ■

The following five elements underpin the Guidelines to Shared Transfer of Care (Sharing Points):

1. Sharing with people
A person and their family and carers are involved in the transfer plan, which is based on the person's needs - physical, social, spiritual and cultural.

2. Sharing accountability
Shared accountability between service providers and including the person, to enable a person-centred approach to care.

3. Sharing communication
Communication (both routine and non-routine) between providers is timely and appropriate, and involves the person.

4. Sharing documentation
High-quality documentation is shared between providers and the person, regardless of the setting.

5. Sharing coordination
Care is coordinated, evidence-based and person-centred across sectors.

Shared transfer of care: In practice

During 2015-16, Primary Health Tasmania funded five services around the state to trial innovative approaches to embed the Shared Transfer of Care in practice. Three of these projects are profiled on the following pages.

Learnings from these projects will help other organisations apply the guidelines for shared transfer of care in practical, person-centred ways.

More information will soon be available as case studies on the Primary Health Tasmania website:
www.primaryhealthtas.com.au/programs-services/connecting-care/professionals/shared-transfer-of-care

Supporting safe hospital discharge

A DETAILED discharge summary that reaches GPs promptly can mean the difference between a patient recovering quickly or returning to hospital.

Meredith Prestwood, former nurse practitioner and care coordinator at Newstead Medical in Launceston, says discharge summaries are not always used effectively – despite their potential to aid seamless transfer of care.

"A quality discharge summary will support safe patient transfers between the hospital and the community, increasing the likelihood they will receive the follow-up care they need," she says.

"But sometimes the summary is not sent to the correct GP or practice after discharge or the document can be compromised by poor quality or delays."

Some even fail to contain vital information such as changes to medication, recommendations for follow-up care or pending tests, which Meredith says can be inherently risky.

A Newstead Medical project funded by Primary Health Tasmania aimed to identify and address the communication problems that arise between hospitals and general practices that can impact on patient health and safety.

The first activity was to encourage Newstead Medical staff to review and develop processes which would identify people who had been in hospital and were at high risk of adverse events.

> **"A quality discharge summary will support safe patient transfers between the hospital and the community, increasing the likelihood they will receive the follow-up care they need."**
>
> ***Meredith Prestwood***

"The grant funding allowed for a liaison nurse who would have the dedicated time to follow up any high-risk discharges," Meredith says.

As the liaison nurse, Meredith would ensure all appropriate documentation was sent to Newstead's GP, and would follow up with patients to ensure they were well supported at home during their recovery.

The project was rolled out in December 2015 and completed in April 2016, with a focus on patients with chronic and/or complex health conditions and frail elderly people.

"If the practice didn't receive a full summary within a week of discharge, I would request to obtain a copy from PIMS, the Patient Information Management System," Meredith says.

"When appropriate services were not established post-discharge, we would determine the best setting for the patient's ongoing care - I would organise their referrals, liaise with their specialists and check that their medication was correct.

Meredith Prestwood

"If the patient was at risk of further hospitalisation or presentation to the emergency department, we would refer them to Primary Health Tasmania's care coordination program."

Meredith says improving the transfer of care for these people can help save on costs associated with preventable hospital admissions or unnecessary tests.

"It not only enables the practice to provide more holistic care but it takes the anxiety and confusion out of the process for patients," she says.

"Many of our patients are elderly or in the high risk category and they don't always understand their condition or discharge instructions.

"The processes we adopted provided patients with more support, while allowing them to progress independently into community-based care."

Cassie Scolyer, practice manager at Newstead Medical, is working to enhance the practice's current systems so that this support will be routinely provided to all Newstead patients when they leave hospital. ■

Linking patients to better health

WHILE reducing readmissions is a priority for hospitals, it is by no means an easy task, according to Sharlene Meldrum.

Sharlene is social work manager and elder care team leader with the Tasmanian Health Service - North West.

"There are many factors that can contribute to a patient returning to the hospital," she says.

"Typically, older patients with chronic and complex conditions are more likely to be admitted, and they are more likely to re-present and be admitted again."

When looking at the risk factors for readmission, Sharlene says patients who re-present within 30 days often do so because they feel the hospital is where they need to be to help their condition, or because this is where they feel their family, GP or the hospital want them to go.

A project conducted by Tasmanian Health Service - North West has provided new insights into the management of people with chronic and complex illnesses who present frequently to the North West Regional Hospital emergency department.

'Health Links', which ran from January until May 2016, involved the appointment of a health navigator – senior occupational therapist Chantelle Purton - who would perform follow-up interventions with patients shortly after leaving the hospital.

Sharlene says the idea was not to build dependence on the role, but to create some sustainable processes for long-term staff to implement.

"We wanted to see whether the health navigator could improve patient outcomes and help reduce the number of emergency department re-presentations," she says.

"Having Chantelle in close contact helped patients build trust in the health system and know that their input was valued by health professionals."

Sharlene Meldrum

"A second priority was to improve staff satisfaction and quality of care around the management of these patients."

Once patients were identified, the health navigator worked closely with them to understand the reasons for the re-presentation.

Surveys were conducted with patients shortly after their emergency department presentation, with data gathered through face-to-face and phone contact.

While nearly all patients surveyed reported they were satisfied with their emergency department experience, almost half agreed that a follow-up phone call would be beneficial.

Sharlene says patients with poor health literacy were at risk of re-presenting and being readmitted.

"Only fifty five per cent of clients understood they had a chronic illness and most knew very little about their condition, including the contributing factors to their disease and management strategies," she says.

"Nearly all respondents didn't know whether they had a chronic illness management plan and a significant number didn't see their GP regularly."

An aim would be to develop closer partnerships and shared communication between GPs and emergency department staff.

Sharlene Meldrum (left) and Chantelle Purton

Sharlene says the patients responded positively to the health navigator, with many reporting they were more confident to discuss their health and take steps to manage their condition.

She says this was important as some clients needed at least two to four contacts with the health navigator before they even started to consider options to improve their own health.

"Having Chantelle in close contact helped patients build trust in the health system and know that their input was valued by health professionals," Sharlene says.

One of the main findings from the project was that clients who were re-presenting more frequently were more likely to be admitted to hospital.

Sharlene says these clients were less likely to be motivated to develop new strategies to manage their health condition and were often resigned to the fact that their condition was unable to be improved.

"As a follow-up from this project there is a need to look at whether identifying clients at their initial presentation to the emergency department for a chronic illness, and working closely on improving their self-management strategies and health literacy, will make a difference to their re-presentation rates in the future," she says.

The project has also increased the knowledge of emergency department staff about linking patients to chronic disease services available in the community, resulting in referrals to care coordination and other services.

"The hospital has developed processes to be implemented shortly that will help staff identify those clients who may need more help to manage their condition," Sharlene says. ■

Promoting choice in care

FOR Simon Hyvattinen, residential manager at Glenview Community Services, describing what 'shared transfer of care' means is simple.

"It's about people - understanding where they are in their care journey, what gives their life meaning and then being able to deliver the support that responds to their choices and preferences," he says.

"Central to this is developing strong, lasting relationships between our care staff and residents.

"We spend a lot of time chatting with residents and engaging with their families to understand what makes them tick."

Simon is responsible for overseeing Glenview's nursing and lifestyle care staff - including the activities team, which operate across the facility's six houses.

The Glenorchy aged care home received innovation grant funding program for its 'Residents Choice' project.

"Residents Choice provides residents with more say in the care they receive," Simon says.

"This can range from the way they go about their daily routines, when they would like to have their showers and how they wish to participate in activities."

At the system level, the project is driving change by improving communication and coordination between care staff and increasing work satisfaction.

There are also clear benefits for residents, who are partners in a person-centred approach and are treated as "more than just a number".

"We do this by focusing on the three domains of active ageing – identity, skills and ability, and mutual exchange," he says.

> **"We spend a lot of time chatting with residents and engaging with their families to understand what makes them tick."**
>
> ***Simon Hyvattinen***

Simon says the project, which was rolled out from September 2015, provides a dedicated staffing model with a stable multi-disciplinary and multi-skilled team.

Merton, Glenview's dementia support unit, was the initial focus of the project, but Simon says it has now been implemented across the entire facility.

"We have recruited additional staff to enable us to incorporate changes to create a safe and familiar environment for residents," he says.

"Our consistent staffing model ensures residents are always greeted by a familiar face and they know who to expect that day."

Simon says having staff on the same wave length helps to reduce any changes to residents' usual routines that can be confusing or distressing.

"It also makes it easier for staff to establish good routines for residents and to quickly identify and respond to any changing care needs."

Simon says staff members attend weekly house meetings where common challenges and day-to-day activities are discussed.

Simon Hyvattinen

Additional staff training in dementia has also been provided, and monthly family meetings are conducted to keep loved ones informed.

"Other mechanisms, such as a resident profile, provide small snapshots into the resident's background," Simon says.

"The profile is treated as a living document and is reviewed regularly.

"It is accessible to all staff, so that if a resident's personal care needs change, the support we provide runs in line with the care plan."

Simon says Glenview is working to ensure sustainability of the project.

"At our weekly house team meetings we review the support we are providing and assess our model of care, constantly considering how they can be improved to meet the needs of our residents," he says.

"We also hold resident and family meetings to understand their needs so we can customise care to align with residents' interests, wants and needs.

"Providing good clinical care is also a major focus."

Simon says while Glenview is the organisation providing the care, it is how the different teams of carers, activities and nursing staff come together with a consistent focus which really makes the program a success.

"We are very proud of our staff and what they are able to achieve for the benefit of our residents," he says. ■

Pharmaceutical Society of Australia

The Pharmaceutical Society of Australia (PSA) is the peak professional body representing Australia's 28,000 pharmacists working in all sectors and across all locations.

The PSA is committed to finding better ways to care for people with chronic and complex conditions and ensuring they receive the right care.

The large and growing pharmacist workforce has a younger age profile than most other health professions, and the PSA believes there is great potential for the workforce to contribute to emerging and innovative models of care.

The PSA advocates for expanded roles for pharmacists, such as providing immunisations and integrating pharmacists in general practices to deliver medication management services to improve health outcomes and cost-effectiveness of primary care.

The core functions of the PSA include providing high quality continuing professional development, education and practice support for pharmacists; developing and advocating standards and guidelines to inform and enhance pharmacists' practice; and representing pharmacists' role as frontline health professionals to improve the health of Australians.

The PSA provides an extensive program of education and professional development activities across Australia, including the PSA Intern Training Program.

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

The PSA supports pharmacists across the full continuum of their career in every field, ranging from community pharmacy and hospital pharmacy to general practice or performing home medication reviews.

The PSA's Tasmanian Branch collaborates with Primary Health Tasmania and other primary health-focused bodies to consider how to improve the state's health system by using the skills and knowledge of pharmacists.

Tasmanian Branch President: Rachel Dienaar (pictured)
Tasmanian State Director: Paquita Sutherland
(03) 6231 2636
tas.branch@psa.org.au
www.psa.org.au

Pharmaceutical Society of Australia

Diabetes Tasmania

Diabetes Tasmania is the peak Tasmanian body representing people living with diabetes.

A health charity and member of Diabetes Australia, its purpose is to reduce the impact of diabetes and to support Tasmanians affected by all types of the disease - including those at risk of getting diabetes - to stay well in the community.

Diabetes Tasmania collaborates with Primary Health Tasmania and other key stakeholders to determine how best to advocate for and support those living with diabetes.

The organisation delivers diabetes education and dietitian support services statewide with Australian Government funding through Primary Health Tasmania. It also runs DESMOND, the evidence-based diabetes self-management program.

Diabetes Tasmania also provides Diabetes Australia with national program coordination and leadership of various aspects of education and support programs for older people with diabetes.

The organisation administers the National Diabetes Services Scheme in Tasmania – an initiative of the Australian Government; runs Shop Well, Eat Well sessions - designed to help Tasmanians understand food labels and make healthy food choices; operates the telephone-based COACH program; and delivers a support program for children living with type 1 diabetes.

Diabetes Tasmania is a member of the Tasmanian Chronic Disease Prevention Alliance, which assists in advocacy efforts for policy change at a political level, and the organisation also hosts a Parliamentary Diabetes Support Group.

Diabetes Tasmania is also the charity partner for the City to Casino Fun Run and Schools Triathlon Challenge, both of which are important ways for the organisation to directly engage with the community on all aspects of healthy living.

Chair: Robert Manning
CEO: Caroline Wells (pictured)
(03) 6215 9200
mail@diabetestas.org.au
www.diabetestas.org.au

diabetes tasmania

Primary Health Tasmania

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.

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, including through commissioning services.

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.

Our Executive

Phil Edmondson
Chief Executive Officer

Executive assistant: Donna Harman
Email **pedmondson@primaryhealthtas.com.au**
Phone (03) 6341 8700

Mark Broxton
General Manager – Service Solutions and Performance Management

Email **mbroxton@primaryhealthtas.com.au**
Phone (03) 6341 8700

Susan Powell
General Manager – Planning, Design and Evaluation

Email **spowell@primaryhealthtas.com.au**
Phone (03) 6213 8200

Scott McKay
General Manager – Business and Finance

Email **smckay@primaryhealthtas.com.au**
Phone (03) 6341 8700

Our Board

More information about our Board is on our website at **www.primaryhealthtas.com.au/about-us/our-board**

Dr Judith Watson
Chair

Hugh McKenzie
Deputy Chair and Treasurer

Mary Bent

Sharon Bingham

Dr Graeme Bleach

Heather Francis

Jennifer Knox

Graeme Lynch

Dr Rob Walters

1300 653 169

info@primaryhealthtas.com.au
www.primaryhealthtas.com.au

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**

South / Central Level 4, 15 Victoria Street, Hobart TAS 7000 **Phone** (03) 6213 8200
North Level 5, 11 High Street, Launceston TAS 7250 **Phone** (03) 6341 8700
North West Level 1, 11 Alexandra Road, Ulverstone TAS 7315 **Phone** (03) 6425 8500