BNPCA
Promoting Better Access to Health Services

Banyule Nillumbik Primary Care Alliance (BNPCA)

Chronic Disease Collaborative Client Pathways Project

Introduction

The BNPCA Chronic Disease Collaborative is working towards developing an integrated approach to chronic disease care across the catchment; part of this work is identification of clear referral pathways for clients accessing services.

The Client Pathway Project explored consumers' experiences of accessing current services to inform the development of new approaches and models of care.

The project was undertaken by Pamela Halstead a social work student from Latrobe University. This summary report has been adapted from Pam's full project report which is available on the BNPCA website: http://www.bnpca.org.au/publications/items/2009/02/265387-upload-00001.doc

The Pathway Project

The study provides a snapshot of a group of people with a chronic disease who are accessing health services provided by members of the Chronic Disease Collaborative. The results of this project are not necessarily indicative of the entire population of people accessing these services, rather they provide an in depth look at the interviewee's individual experience of the health care system.

Client nominations for this study were obtained from the Royal District Nursing Service (RDNS) Diamond Valley and Heidelberg Sites, Austin Health's Hospital Admission Risk Program (HARP), Banyule Community Health (BCH) and Nillumbik Community Health Service (NCHS).

The interviewees were asked a series of questions focussed on their path to the service that they had been nominated by, involvement of other services and the management of their chronic disease.

Twelve people were interviewed:

- Age Range 55 – 81 (average age 69.9 years)
- 5 men (average age of 64.6 years)
- 7 women (average age 73.7 years)

Living arrangements

- 7 Living with partner (3 men and 4 women)
- 1 man lives independently in a shared house
- 4 Living alone (1 man and 3 women)

Transport

- 6 people had their own cars and drove themselves
- 6 relied on public transport, taxi services or other people to drive them.

Health Conditions

The people interviewed had a range of health conditions with diabetes and heart and lung issues predominating. Eight of the interviewees had been in hospital at some time during the past year, several of them more than once.

Importance of social contact

The importance of getting out and about was mentioned by almost all the people interviewed and most participated in a wide range of community and social activities.

Several people also mentioned the social aspect of involvement with informational groups for diabetes, heart and lung conditions and exercise classes.

Three of the interviewees were not involved in any outside activities. All of these people were visibly frail and relied on others or taxis for transport. Two of this group spoke at length about the impact of their health condition on their ability to access social activities and how much they missed this aspect of their lives.

Amongst the people who use taxi services, three people specifically mentioned the benefit of having either a half price or fully subsidised taxi voucher as, this meant that they were able to get out more.

Summary of Findings

Clients rely mainly on General Practitioners to provide them with information on programs and services and refer them to other services.

Referral pathways to services are broad and variable, but it would appear many clients remain reliant on their GP for referral to programs. Clients also indicated that their expectation was that their GP or service provider would tell them about other available services.

Providing clients with information on other services and programs appears to be limited and clients indicated that this area can be improved.

The interviewees reported that receiving information directly, via either word of mouth or information handed personally to them, was the most effective method of sharing health information. The majority of people interviewed indicated they would follow up on programs themselves if they were given the information.

The interviewees also reported telling other people about the services that they are involved with. It might be possible to harness existing client knowledge to share information with people who currently do not use services.

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Chronic Disease Collaborative

Having a key worker seems to increase the chances of clients being able to access multiple health care professionals.

Clients are not aware if communication occurs between services.

In general, interviewees indicated they were unaware of any communication that occurred between services.

Only two interviewees described communication about the effectiveness of their treatment or program being conveyed to their GP.

Clients are happy with services once they gain access.

Programs were seen as easy to access (particularly after being accepted for programs) and interviewees felt staff were able to provide appropriate help but they felt there was a tendency to only discuss the health issues that they were referred for.

Clients see that they are the "decision makers" about their health.

All interviewees, with one exception, said that they made the decisions about their health themselves. They indicated that they listened to the opinion of health professionals and then made choices about what they did.

Clients see social contact as vital to health and wellbeing

The importance of getting out and about was mentioned by almost all the people interviewed and most participated in a wide range of community and social activities.

Several people also mentioned the social aspect of involvement with informational groups for diabetes, heart and lung conditions and exercise classes.

Three of the interviewees who were reliant on others or taxis for transport spoke at length about the impact of their health condition on their ability to access social activities and how much they missed this aspect of their lives. This group specifically mentioned the benefit of having either a half price or fully subsidised taxi voucher as this meant that they were able to get out more.

Findings to inform BNPCA Chronic Disease Collaborative planning

The findings of the pathway project has informed BNPCA Chronic Disease Collaborative planning for improvements in chronic disease care across the catchment. In particular, the findings have reinforced the need for the group to consider:

- Improving the provision of information about available services to existing and potential clients
- Effective feedback tools and care planning processes to communicate with other agencies and GPs
- Capacity building in assessment, referral, care planning and self management support
- Improving organisational structures that support the underlying principles of self management and service coordination.

Austin Health

BANYULE Community Health

DAREBIN community health

Nillumbik Community Health Service

Northern Health

Royal DistrictNursing Service
Bringing healthcare to you™

Supported by:

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North East Valley Division of General Practice Ltd.

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