SOCIAL PRESCRIBING

IPC Health
improving and promoting community health

Presented By: Dinna Tayao
Social Prescribing Project Manager
5th April 2019

Introduction

The project is a partnership of the Brimbank Collaboration (Brimbank City Council and Australian Health Policy Collaboration, Victoria University), Northwest Melbourne Primary Health Network (NWPHN) and IPC Health.

The project is a small scale, three stage process of research, testing and full implementation at IPC Health Deer Park and Brimbank community. The development of service pathway and testing is fully supported by NWPHN through a grant.

Social Prescribing

- a mechanism for GPs and other health professionals to systematically build a pathway that makes use of community organisations as assets for the delivery of health and well-being interventions
- adopts an holistic approach using 'life' prescriptions (social, therapeutic and practical support) to complement traditional forms of medical and health care
- ensures that health professionals are not spending a large proportion of their time performing duties that do not require their level of qualification or expertise at the expense of responding to more-complex needs
- recognises the influence of socio-economic status and culture on wellbeing; and
- intentionally integrates individual services that currently exist but in isolation to each other.

Imison C and Bohmer R 2013, NHS and social care workforce: meeting our needs now and in the future? The Kings Fund, London. <http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf>.

Social Prescribing model

Social Prescribing is linking patients and community organisations, creating a pathway to deliver health and well-being interventions using life prescriptions to complement traditional forms of medical and health care.

In the test model, referrals from the clinical team are made to the Social Prescribing Community Linkworker who coordinates a plan and schedules access to local sources of support.

Other than linking clients to community services and interest groups, the Community Linkworker is also engaging community partners to support the program and build membership.

The collaborative partner is a volunteer from the community who actively co-designs the engagement processes and tools used by the program.

Social Prescribing at Brimbank

In the City of Brimbank the following rates of health risks are identified

- 1 in 5 people have poor to fair self -reported health status for (38% above Australian rate)
- 10.2% of adults have mental health conditions compared to 7.9% ave in Melbourne
- 27% of children overall assessed as developmentally vulnerable in one or more domains of the Australian Early Development Census (compared to 22% in Australia)
- 1 in 8 men with high or very high psychological stress (37% above the Australian rate)
- 6th highest rate of Diabetes in greater Melbourne (63% above Australian average)
- 2nd lowest participation in health enhancing physical activity
- High hospitalisation rates for children 0-14 yrs with asthma and dental caries; adults with chronic co-morbidity (CVD and Respiratory)
- Low learning achievement in early school leavers (15 yrs) and/ or young adults with poor employment prospects: 14.2 % of youth (15-24yrs) unemployed (16% greater than Australia)
- poor English proficiency in Brimbank 3 times that of Melbourne.

Correlated with these are 3rd lowest index of socio-economic disadvantage in Victoria (2016) and in particular a distribution in the corridor of Sunshine North, St Albans, Kings Park.

Brimbank Atlas of Health and Education. 2014. Australian Health Policy Collaboration, VU

Social Prescribing pathway

Pathway : GPs refer to linkworker

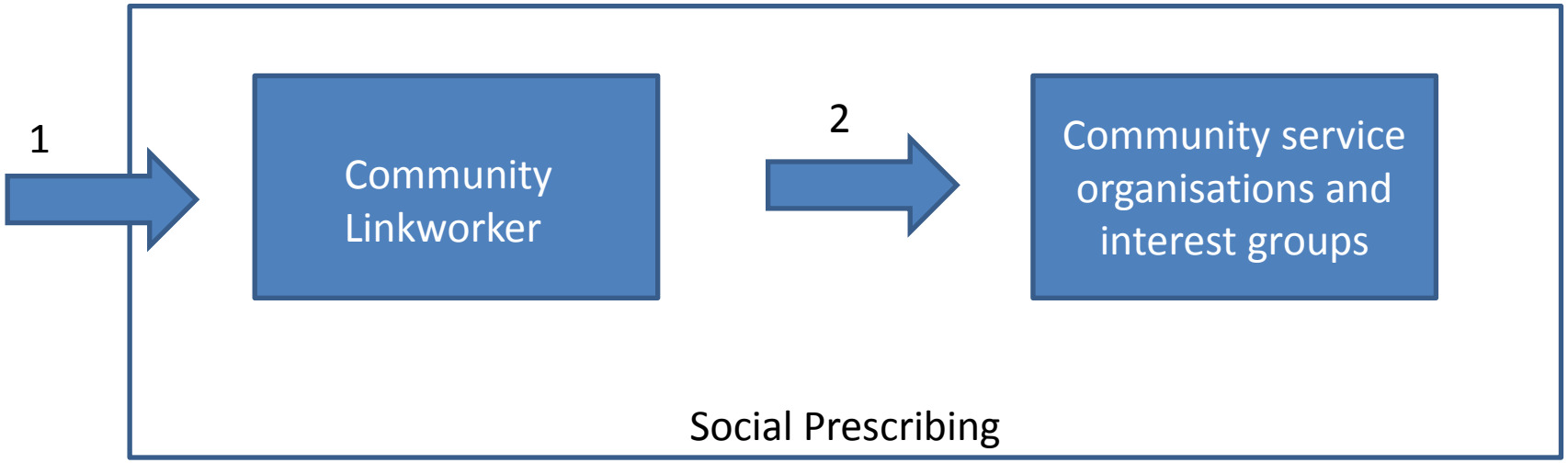
Targeting and identifying users, referrals to the service

IPC Health Deer Park - approx 3,500 active patients (ave 3 visits per year) with IPC Health Deer Park, with 1 or more diagnosis, chronic or other medical conditions, and are experiencing issues adversely impacting on their health and well being e.g. not socially connected (social determinants of health); 5 GPs, nurses and allied health

GPs - due diligence, perimeter of risk, patients agree to manage long term health conditions, agreement to undertake an activity, would like to improve condition

People with mental health conditions – SP community linkworker will have a say in accepting referral after discussion with GP and mental health worker

Referral point 1:	Clinical team (GPs, nurses, allied health)
Referral point 2: (linking)	Community linkworker to community services, interest groups and volunteering



Social Prescribing referrals

Other than the clinical team, SP referrals may eventually come from community service providers, Brimbank City Council and local agencies. Self-referrals can also be facilitated by the Social Prescribing community linkworker.

The SP worker is initially co-located at the primary healthcare service for greater visibility and ease of referral, and may accompany the client in the first visit to the community centre, until confidence is built.

Social Prescribing service pathway

Pathway: Linkworker to community services

- readiness of client to an activity
- working at client pace
- safe for provider and client to join group activity
- client may need to be accompanied to first few sessions until confidence is built
- Strong relationship with community groups supported by a partnership agreement
- Working with community partners to create a pathway for social prescribing

SP services and activities

Mainstream services are ready and available

- community asset map (community service hubs, libraries)
- askizzy.com
- events listing in https://www.brimbank.vic.gov.au/
- Brimbank Service Providers Directory https://www.brimbank.vic.gov.au/health-family-and-support/brimbank-service-providers-directory
- community service organisations offering low or no fees

(community legal, financial advice, managing budgets, adult english education, cultural groups, community gardening, walking groups, cooking classes, tai chi, homework, languages classes, active living, actionforhappiness.org)

Social Prescribing client journey

GP and clinical team education

match using set criteria

'tag' person in Best Practice clinical software (social isolation)

referral to SP Community Linkworker

Best Practice Clinical Software

Social Prescribing Community Linkworker

Social Prescribing Community Partners

Referrals

- connected
- still in the program?
- completed?
- impact

Network Meetings

- share utility, referral data, impact and client experience
- sustainability of programs

Planning

- community asset map
- service co-design

SP = suite of services to prevent risk and promote health and well being of vulnerable people

For more information

Dinna Tayao
Social Prescribing Project Manager
T: 03 9219 7122 M: 0419 340 074
E: Dinna.Tayao@ipchealth.com.au

Catherine Cotching
Social Prescribing Community Linkworker
T: 03 9219 7146
E: Catherine.Cotching@ipchealth.com.au

Questions?

Thank you. . .