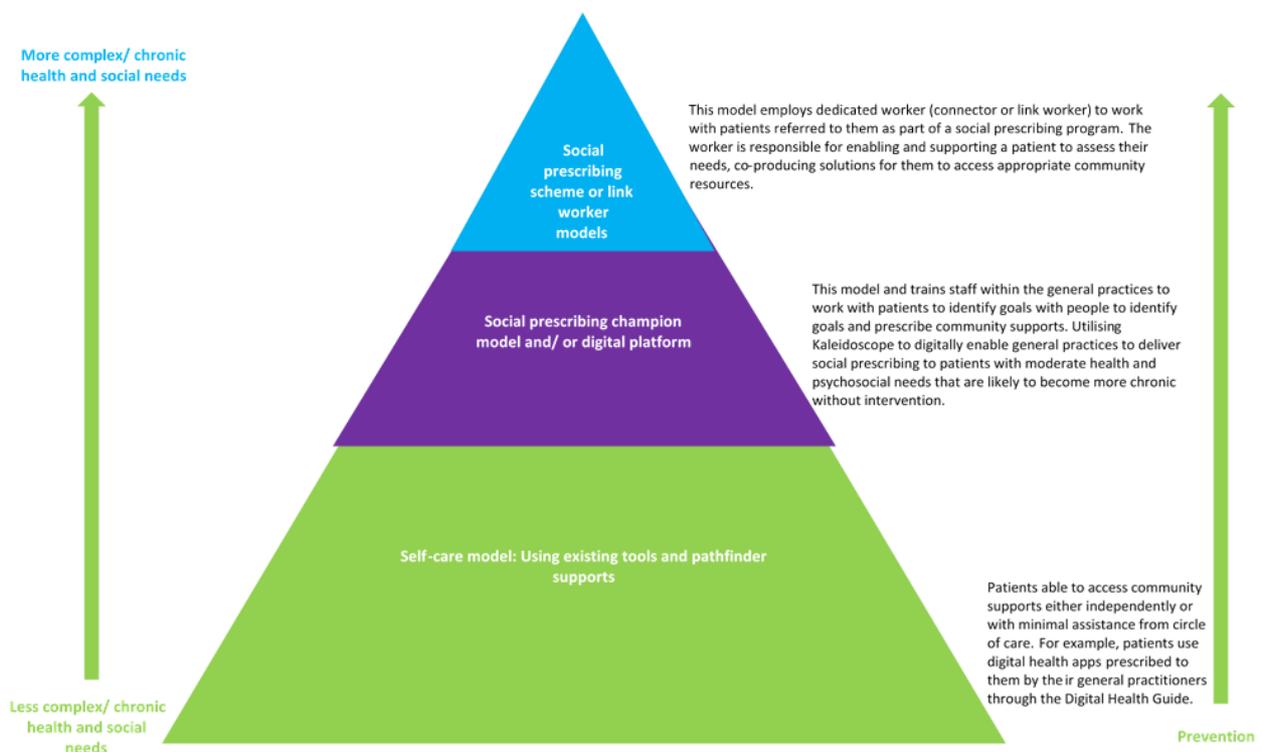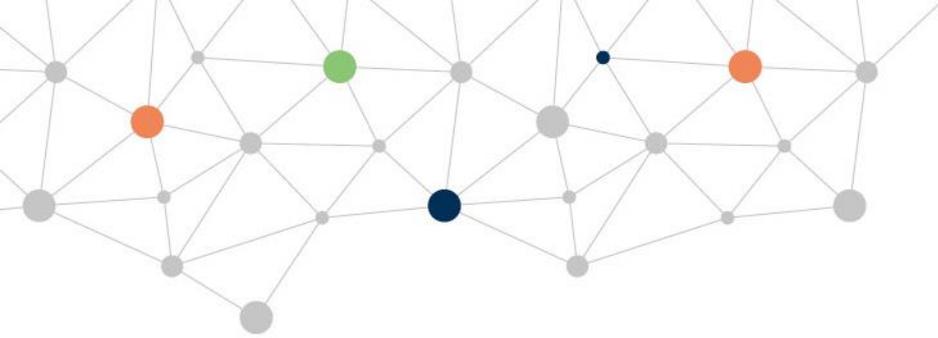# Gippsland PHN - Digitally enabled Social Prescribing

Gippsland Primary Health Network (Gippsland PHN) digitally enabled social prescribing project aims to:

- Improve the capability of primary health professionals to prescribe interventions that consider social determinants of health and support the patient's psychosocial wellbeing;
- Increase awareness and capacity of the primary health care sector using a social prescribing approach
- Increased awareness and capacity of and shift primary healthcare sector focus from illness to wellness to moving towards wellness models of care
- Improve connectivity and reduce siloed health responses to support the patient goals using digital technologies.

The project adopts a Social Prescribing champion approach. This approach focuses on people with moderate health, mental health and social support needs, that often fall outside of the referral criteria of a social prescribing connector scheme or link worker model and often become more complex without support. The model builds capacity within general practice staff to deliver social prescribing and embed a more holistic approach to health by building on the pre-existing relationships a patient has with their primary health provider.

Figure 1: Gippsland PHN Social Prescribing approach

More complex/ chronic health and social needs

Social prescribing scheme or link worker models — This model employs dedicated worker (connector or link worker) to work with patients referred to them as part of a social prescribing program. The worker is responsible for enabling and supporting a patient to assess their needs, co-producing solutions for them to access appropriate community resources.

Social prescribing champion model and/ or digital platform — This model and trains staff within the general practices to work with patients to identify goals with people to identify goals and prescribe community supports. Utilising Kaleidoscope to digitally enable general practices to deliver social prescribing to patients with moderate health and psychosocial needs that are likely to become more chronic without intervention.

Self-care model: Using existing tools and pathfinder supports — Patients able to access community supports either independently or with minimal assistance from circle of care. For example, patients use digital health apps prescribed to them by their general practitioners through the Digital Health Guide.

Less complex/ chronic health and social needs

Prevention

Gippsland PHN Digitally enabled Social Prescribing model of care

The Gippsland PHN Digitally enabled Social Prescribing model of care builds capability by engaging general practice staff in the delivery of social prescribing and utilises Kaleidoscope; a digital platform to support healthcare professionals develop a co-designed psychosocial care plan with a patient that tracks progress against agreed goals, referrals and patient outcomes.

Figure 5 below, illustrates the elements of model of care inclusive of needs identification, engagement, needs identification, goal setting and prescribing social and community supports to support improvements in patient outcomes.
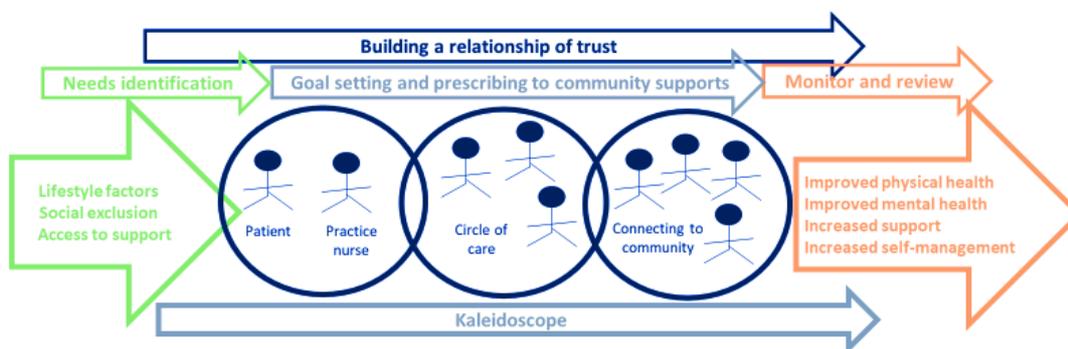

Figure 5: Elements of Digitally enabled Social Prescribing model of care
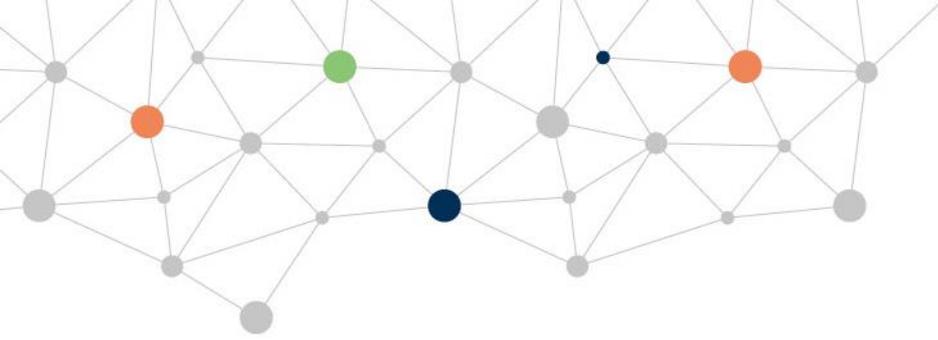
Patient identification

Participating general practices identify patients with mild to moderate chronic physical and social support needs that are likely to become more complex and would benefit from a social prescribing approach to care.

Need identification, goal setting and community prescribing

The practice nurse builds a relationship of trust with patient's, so they can engage in conversations about their health and wellbeing needs. The practice nurse using Kaleidoscope co-designs with the patient a psychosocial care plan with measurable goals and actions. Actions can include reading and understanding health literacy information, contacting a third-party organisation for support, using an app, and a variety of other interventions. Kaleidoscope further supports the practice nurse and patient to identify referral local referral options with a pre-built library of local community groups, activities and social organisations that healthcare providers can refer patients to.

Monitoring and review

The monitoring and review of a patients care plan can occur electronically or be printed out so that the patient can record their progress. The Practice Nurse then undertakes and maintains routine reviews with the patient. Where concerns arise, or the patient requires additional clinical care these are facilitated through the existing practice nurse, general practitioner relationship.

The monitoring and review of impacts of the goals the patient has set, and steps taken to engage with community supports enables the patient to celebrate improvements in their health and wellbeing but means the Practice Nurse can call a patient back in when progress is slow.

For further information

Gippsland PHN are currently supporting a number of general practices in Gippsland to implement and develop workflows supporting of digitally enabled social prescribing.

For further information, contact Gippsland PHN Digital Health and Integration Team digital.health@gphn.org.au