Commissioning a Social Work Service to Support GPs

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Sydney North Primary Health Network

- 3 Divisions • 2 Medicare Locals • 1 PHN
- Sydney North Primary Health Network is a local not-for-profit primary health organisation, one of 31 Primary Health Networks, covering a population of 907,000, with 38.9% born outside of Australia.
- Aligned with one Local Health District and 9 Local Government areas, our PHN supports 288 General Practices with 1,257 individual GPs and over 3,000 Allied and Community Health providers and 132 RACFs.
- Commenced operations in July 2015 with our budget and staff quadrupling in first 18 months.
- PHNs have bi-partisan support with role continuing to expand.
- Key commissioning remits in mental health, drug and alcohol, Aboriginal health, After Hours, vulnerable populations and potentially preventable hospitalisations.

Examples of Social Determinants of Health

- Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods
- Social norms and attitudes, such as discrimination
- Exposure to crime, violence, and social disorder, such as the presence of trash
- Social support and social interactions
- Exposure to mass media and emerging technologies, such as the Internet or cell phones
- Socioeconomic conditions, such as concentrated poverty
- Quality schools
- Transportation options
- Public safety
- Residential segregation

Examples of Social Determinants of Health

![Examples of Social Determinants of Health](image)
Background

SNPHN's After Hours plan includes several initiatives to improve access to community based services.

These include:
- Piloting a hospital discharge follow up service to facilitate transfer of care back to the community and ensure appropriate services are sourced to reduce the risk of readmissions and impact on after hours presentations
- Commissioning a social work service to address the social determinants of health and reduce the risk of unplanned hospital presentations

Social Work Service

Two services were commissioned to provide services in the PHN Region:
- CCNB is covering the Lower North Shore and beaches region
- Primary Community Care Services (PCCS) is covering the Northern region

GPs in the PHN Region can now send a referral to either of these services to access a social worker to support their patients with chronic/complex conditions

Eligibility Criteria

Having one or more of the following:
- Chronic and/or complex health care conditions, except people with a mental health diagnosis of an acute, persistent and/or severe nature
- Have carers whom require support and assistance
- Are experiencing difficulty navigating and accessing support services
- Have had recent hospitalisation and are at risk of being without support

Service Model

- The ability for a GP to refer to a community based social worker for patients with chronic and complex health conditions, improving their capacity to coordinate appropriate care
- Timely and flexible access to holistic, practical support to ensure the social determinants of good health are identified and managed to improve patient outcomes
- Regular sessional appointments and visits offered by a mobile Social Work team
- Support for patients to develop strategies to build their capacity to self-manage their condition, take control and reduce stress
Supporting Commissioned Services

- Website promotion of each organisation
- Promotion at SNPHN education events and to practices by the Primary Care and Integration Coordinators
- Development of clinical software templates
- GP visits
- Local hospital presentations
- Troubleshooting barriers
- Bi-monthly meetings

Service Data as 8/5/17

Social Work GP Referrals in SNPHN

Results

- Building awareness of the service in GP practices
- Utilising referral forms not developed for clinical software
- Changes in the Aged Care sector (My Aged Care) and the NDIS
- The social worker’s case mix has been predominately for quite complex issues which requires a significant amount of time especially contacting government departments

Successful patient outcomes:

- A patient receiving NDIS funding much sooner than anticipated through support and advocacy
- A patient having appropriate safety and family supports arranged so he could remain living in his own home longer
- Advocacy and coordination arranged to protect a patient from ongoing financial abuse
- A patient accessing care she is entitled to alleviate social isolation

Services Referred to or Accessed

The following are services referred to or that have been accessed as a result of support from the social work service, some of these are quite time consuming and have significant waiting times:
‘A neighbour’s view of the Social Work Service’

“She has been tireless in her efforts to assist our neighbour who has early onset dementia. She has gone beyond her call of duty to take him to medical appointments. She has arranged for his affairs to be managed by the NSW Public Trustee and the Guardianship Board. She is well on the way to having him registered for the NDIS and thence for appropriate sheltered accommodation”.

Local Coordinated Networks (LCNs)

Aligning needs and commissioned services to the 6 LCNs

LCNs provide an opportunity for general practices to have input into how commissioning funds are utilised, thus facilitating a direct impact on local service delivery and the health outcomes of their local population.

Next Steps

- Evaluating all the current services commissioned by the After Hours Program and working towards implementing the quadruple aim approach to all future services.
- Review identified gaps and barriers in partnership with the organisations to improve service models, and ultimately improve patient health outcomes and experiences.
- Engage all our services in an ongoing quality improvement cycle and initiate the utilisation of digital technology.