SYDNEY NORTH Health Network

WELCOME

The Nuts and Bolts of Social Prescribing in Action

Presented by A/Prof JR Baker and Dr James Ibrahim

Tuesday 22 March, 2022

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COVID ADVICE PHONE LINE

For GPs

SYDNEY NORTH Health Network

- The GP COVID clinical advice line allows GP's to seek clinical advice for escalation and/or referral to Sotrovimab clinic from GPs working in the Virtual Hospital.
- Available from Mon-Fri between 9am-5pm until June 2022.

0418 579 373

For referral for monoclonal antibody treatment

NSLHD-COVID@health.nsw.gov.au

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www.snhn.org.au

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COVID HOME SERVICE

WiSE Mobile Doctor

SYDNEY NORTH Health Network

Mobile medical service for people in isolation due to COVID-19 to access clinical assessment and treatment for COVID and non-COVID related matters.

Available to all household members at no cost.

GP referral only via Healthlink, Fax or Phone.

0412 617 276 | 02 9216 7677 | WISEMEDM (Healthlink)

For more information contact SNEOC@snhn.org.au

WiSE Mobile Doctor

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www.snhn.org.au

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COVID HOME ISOLATION SUPPORT SERVICE

SYDNEY NORTH Health Network

Offer social support for individuals in isolation due to COVID-19 to access local support services and community resources.

Provide practical assistance with daily living and lifestyle needs, support to access services etc.

No cost to patient

Referral required. Available at pccs.org.au/chiss

9477 8700 | 02 9477 8799 | GPSOCIAL (Healthlink)

For more information contact SNEOC@snhn.org.au

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SPEAKER INTRODUCTION

SYDNEY NORTH Health Network

A/Prof JR Baker PhD | CEO Primary and Community Care Services

Adjunct Associate Professor JR Baker is the CEO of PCCS and has over 20 years' experience in executive health management, education, and research. He has consistently introduced industry leading service improvements that always keep the client at the centre of change, pushing PCCS to become an Australian leader in social prescribing, complex care coordination and link work services, including almost 10 years of experience delivering social prescribing services across NSW and Queensland.

JR is driven by his ideas on providing optimal health services through innovation in the not-for-profit, health space. JR is committed to innovation, scoping out optimal health models and working with the community, government, politicians, and industry to collaborate and develop the best outcomes for people and communities.

Dr James Ibrahim | General Practitioner

Dr James Ibrahim practices as a GP at Terry Hills Medical Centre. Dr Ibrahim is the inaugural Chair for the RACGP Specific Interest group for Social Prescribing. The group that he chairs aims to support GPs by:

- Influencing general practice education and providing educational support about social prescribing
- Sharing and learning about local and international initiatives
- Promoting successful general practice models to decision makers
- Working as a reference group both within, and on behalf of, the RACGP in matters relating to social prescribing
- Assisting GPs with how to implement and seek funding for social prescribing initiatives they may wish to run in their practices.

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Social Prescribing

with phn NORTHERN SYDNEY An Australian Government Initiative SYDNEY NORTH Health Network

Adjunct A/Professor J.R. Baker, CEO
Dr James Ibrahim

Primary & Community Care Services Limited | the integrated care specialists

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The Nuts & Bolts of Social Prescribing

- What is it?
- Why do we need it?
- The RACGP journey
- Who does it help?
- How can it help?
- Patient Identification – A case study
- Does it work?
- Sydney North pathways
  - Head to Health
  - GP Social Work Connect
  - Back to Home Back to Life
  - COVID Home Isolation Support Service

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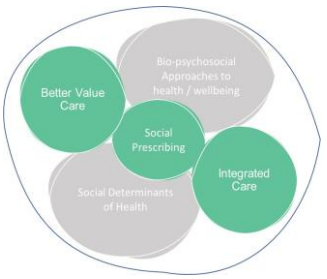
Social Prescribing - What is it?

Model of care that involves referring people to **non-medical and community-based supports**, to assist in reducing isolation, disadvantage and other unmet needs.

- **Non-clinical**
- **Patient directed**
- **Holistic**
- **Sustainable**



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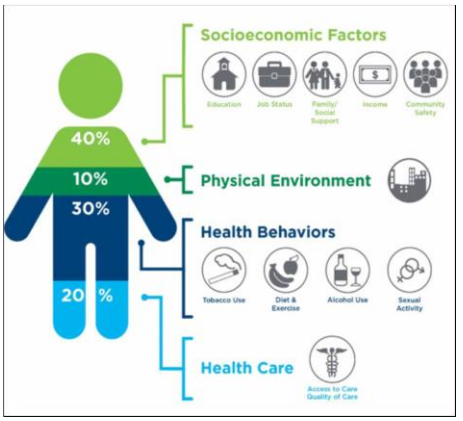
Addressing the Non-Medical Influences on Health

- Health care provision can't address many of the **socioeconomic** and **environmental factors** that result in ill health
- The **siloed funding** of health, social and welfare service systems further complicates this
- There are **time and capacity restraints** for GPs and Primary Care Nurses on assisting individuals to address their non-medical needs and take greater control of their own health and wellbeing



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Social Determinants of Health (SDOH) Domains

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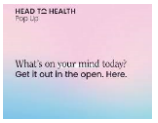
Addressing SDOH Domains

- **Basic Human Needs Resources** – including food and clothing banks, shelters, access to Centrelink / financial assistance
- **Work Support** – including financial assistance, job training, transportation assistance and education programs
- **Support for Older Australians and Persons with Disabilities** – including assistance accessing NDIS and My Aged Care, respite care, community meals, home health care, transportation, and homecare services
- **Children, Youth and Family Support** – including childcare, after-school programs, educational programs for low-income families, tutoring and child protection
- **Physical and Mental Health Resources** – including healthcare, DVA, helplines, crisis services, support groups, therapy, AOD interventions
- **Access to Services in Non-English Languages** – including language translation and interpretation services to help non-English-speaking people find public resources

centrelink

myagedcare

I ndis



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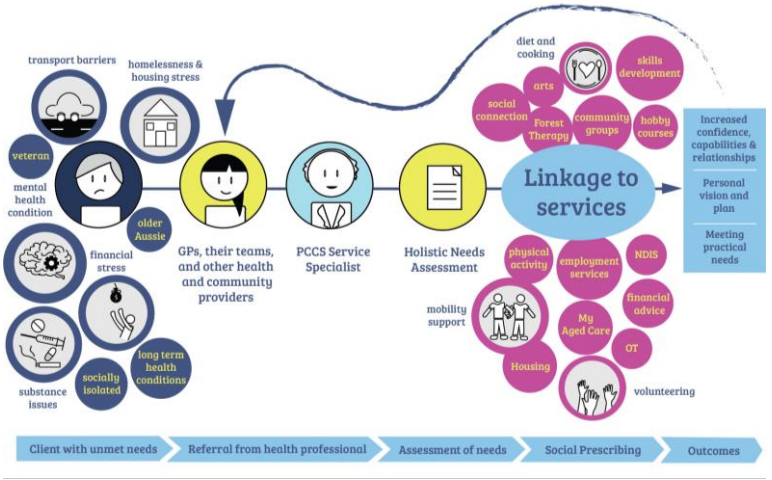
Social Prescribing - How does it work in action?



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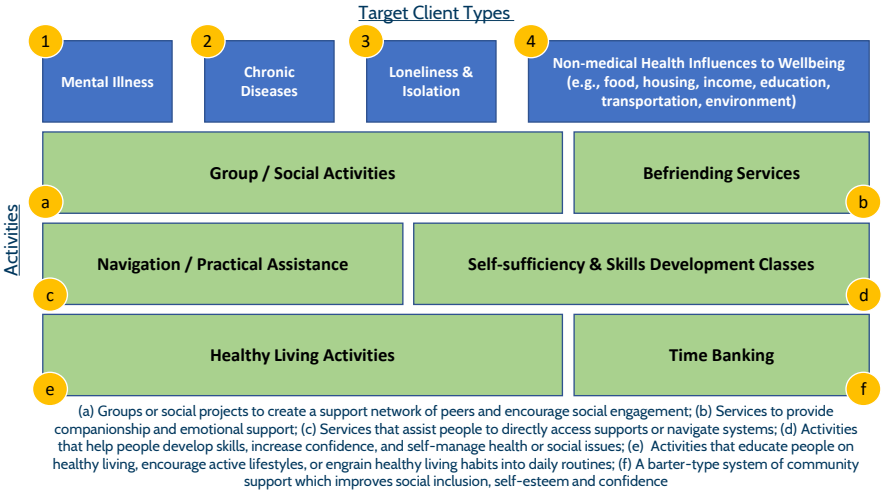
The Who & How of Social Prescribing on a Page



(a) Groups or social projects to create a support network of peers and encourage social engagement; (b) Services to provide companionship and emotional support; (c) Services that assist people to directly access supports or navigate systems; (d) Activities that help people develop skills, increase confidence, and self-manage health or social issues; (e) Activities that educate people on healthy living, encourage active lifestyles, or engrain healthy living habits into daily routines; (f) A barter-type system of community support which improves social inclusion, self-esteem and confidence

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Why do we need it? - with Dr James Ibrahim

Dr James Ibrahim practices as a GP at Terry Hills Medical Centre.

- How does Social Prescribing work in General Practice?
- When should we use it?
- How should we use it?
- Why should we use it?

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Social Prescribing – The RACGP journey

- **RACGP Social Prescribing Roundtable** recommended social prescribing in Primary Health Care for preventative and responsive care
- Rising-risk chronic disease population group is growing rapidly → may overtake high-risk chronic disease population in terms of health care spend
- 70% of GPs surveyed said they believe referring patients to community activities, groups or services helps to improve health outcomes

"Social prescribing does provide an opportunity to improve health outcomes and increase consumer participation and engagement."

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RACGP Special Interest Group

Dr Ibrahim is the inaugural Chair for the RACGP Specific Interest group for Social Prescribing. The group that he chairs aims to support GPs by:

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Patient Identification for Social Prescribing

Not always easy to get non-medical Information:

Easier to...		Harder to...
Provide a physical examination	⟷	Know if a person struggles to pay bills
Check BP / vital signs	⟷	Screen for loneliness, mental health
Provide education about health	⟷	Ask if a person can read or about schooling
Ask about and encourage exercise	⟷	Ask about housing safety and tenure
Encourage someone to lose weight	⟷	Ask about the ability to secure health food
Be put off when people don't show	⟷	Know about a person's access to transport

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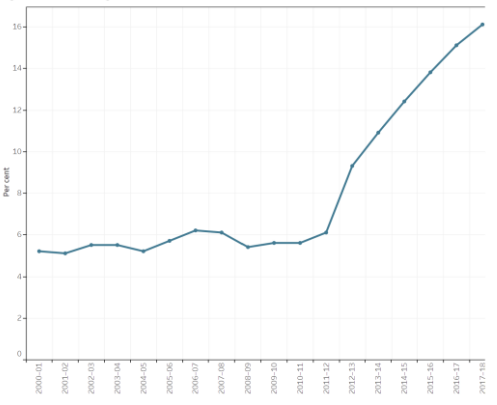
Case Study - Diabetes & SDOH (1)

- 1.2 million hospitalisations (11% of total) were associated with diabetes in 2017–18 (AIHW 2019d)
  - 4.5% recorded as the principal
- For Aboriginal and Torres Strait Islander population:
  - Diabetes **prevalence rate 2.9x higher** people
  - **Hospitalization rate 3.9x higher**
  - Death rate 4.0x higher
- For low socioeconomic areas:
  - Diabetes **prevalence rate 2.0x higher**
  - **Hospitalization rate 2.0x higher**
  - Death rate 2.3x higher

Figure 2: Incidence of gestational diabetes, 2000–01 to 2017–18



In last 20 years gestational diabetes rate has **tripled**

AIHW 2019. National Hospital Morbidity Database. Findings based on unit record analysis. Canberra: AIHW.

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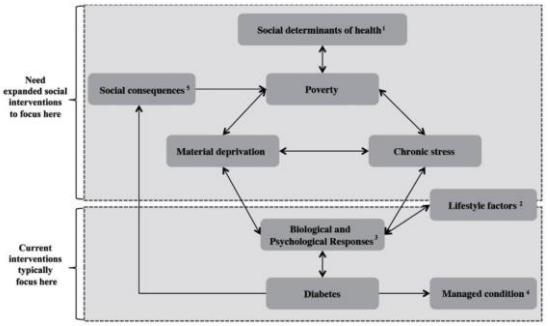
Case Study - Diabetes & SDOH (2)

- Lower income and less education **2x to 4x more likely** to develop diabetes than more advantaged individuals
- Higher density of unfavorable food stores associated with a **34% higher incidence**
- May not have sufficient access to the resources necessary to manage the condition, such as adequate housing, nutritious food, and health care services
- Other risk factors (chronic stress, alcohol usage, etc.)



Hill J, Nielsen M, Fox MH. Understanding the social factors that contribute to diabetes: a means to informing health care and social policies for the chronically ill. *Perm J*. 2013;17(2):67-72. doi:10.7812/TPP/12-099

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Case Study - Diabetes & Financial Resource Strain

Diabetes & Food Insecurity

- Food insecurity = not having adequate quantity and quality of food at all times for all household members to have an active, healthy life
- Risk factor for poor diabetes control
- Combination of health literacy and addressing SDOH results in overall improvements in diabetes management for marginalised groups

Access to:
- appropriate foods
- blood glucose monitoring
- health education
- self management support

Improvements in:
- glycaemic control/HbA1c (hemoglobin A1c)
- self-efficacy
- medication adherence

Seligman HK, Lyles C, Marshall MB, Prendergast K, Smith MC, Headings A, Bradshaw G, Rosenmoss S, Waxman E. A Pilot Food Bank Intervention Featuring Diabetes-Appropriate Food Improved Glycemic Control Among Clients In Three States. Health Aff (Millwood). 2015 Nov;34(11):1956-63. doi: 10.1377/hlthaff.2015.0641. PMID: 26526255.

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Case Study - Diabetes & Opportunities for Prevention

Diabetes & Food Insecurity

- Multiple points of intervention
- More sustainable / cost-effective / efficient to start at primary prevention

Primary Prevention	Identify people at risk of diabetes with strong family history, financial barriers	Nutrition programs, Health literacy, Financial literacy support
Secondary Prevention	Identify patient at-risk of hypoglycemia due to poor cash flow	Screening for poverty / financial assistance
Tertiary Prevention	Reduce ED use for patient who attends frequently due to diabetes	Referral to Food Support, Cooking Groups, Income Support (centrelink)

Adapted from Machanda (2014) & Health Begins (2018). 10 Domains of Capability Retrieved from http://healthbegins.com/

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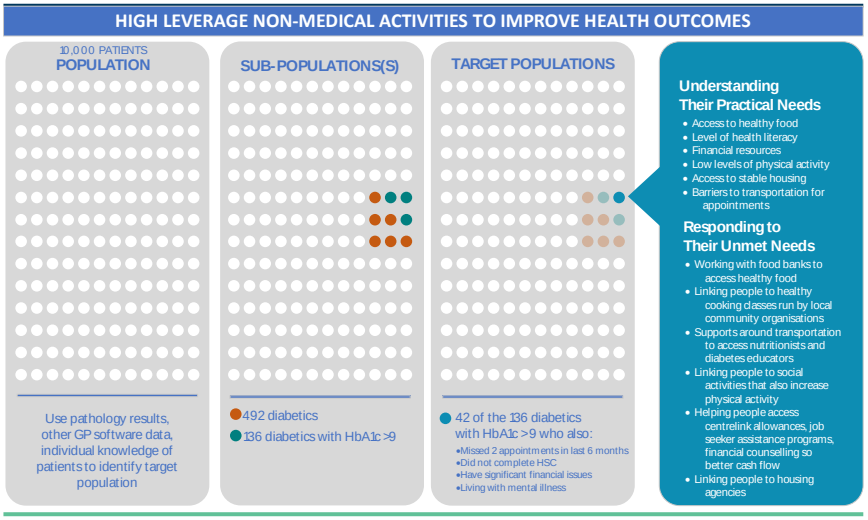
Case Study – Looking at Practice Data



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PCCS the Australian Experience of Social Prescribing

Award winning social prescribing models delivered for:

- Injured Workers with psychosocial needs
- People living with serious mental illness
- Aging people with psychosocial needs
- People with disabilities or Long Term Health Conditions
- People with social determinants of health needs

PCCS is acknowledged as industry expert & shares how to deliver a quality framework for social prescribing at the 2020 International Mental Health Conference.

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Does it work? (local results)

Reduced use of health services

- Reductions in hospitalisation (61-80%)[1,2]
- Health service contact of more than once a week reduced by 75%[1]

Improved quality of life and psychosocial wellbeing

- Improvements in quality of life and wellbeing[1,2]
- General improvements in psychosocial wellness[1]

Increased work readiness and social participation

- Increased vocational readiness / ability to work[1]
- Increased satisfaction with social support by 55%[1]
- Non-participation in social activities reduced by 77%[1]
- Participation in 5 or more activities a week increased by 63%[1]

Urbis evaluation evidenced return of $3.86 for every dollar invested

[1]see https://www.syncsci.com/journal/index.php/AHB/article/view/390/312 and https://www.researchgate.net/publication/341345561_Social_Prescribing_for_Individuals_Living_with_Mental_Illness_in_an_Australian_Community_Setting_A_Pilot_Study for examples of impact).

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PCCS current Social Prescribing in Sydney North region

In the Sydney North region social prescribing can be accessed via a number of pathways :

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PCCS current Social Prescribing Programs

NSW Workers Compensation System

People with long term workers compensation claims and unmet psychosocial or non-medical needs

"I've found the Social Prescribing Pilot Program so beneficial in helping myrecovery. It's also been one of my only positive social connections during the week."

Gold Coast PHN

People living with serious and enduring mental illness

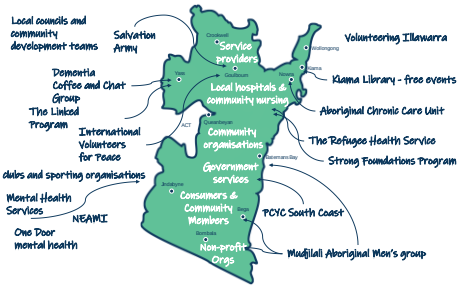
Well Together

SKILLNESS

Social Rx

South Eastern NSW PHN (Coordinare)

People with non-medical factors impacting wellbeing, living with chronic disease, lonely or isolated, or impacted by fires, floods, or COVID-19



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Head To Health – Who is it for?

In the **Northern Sydney region (and throughout NSW)**:

- Anyone of **any age** including children and young people whose mental health is suffering because of factors related to COVID and the management of the pandemic such as:
  - Loneliness, Stress, Anxiety, or Depression
  - Major adjustments (loss of job, family issues, AOD usage, housing insecurity, etc.)
- Who would benefit from
  - Information and assistance accessing mental health supports
  - Personalised assessment and planning
  - Supports around practical unmet needs with mental health concerns

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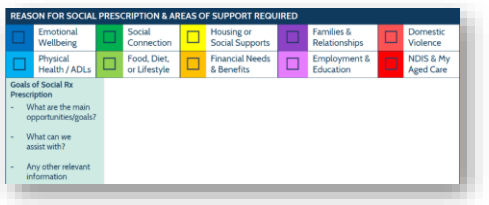
Head To Health – How can someone access it?

Easy referral form at pccs.org.au/h2h

- **Tick need domains** *and/or*
- **Let us know what we can assist with**



OR you or your patient can call 1800 595 212.

Our team will ask for information about the person and their story (to save them having to retell it) and we can reach out to help them:

- Find supports when there are capacity issues, access challenges, or financial barriers
- Help them navigate services or find services that meet their needs with capacity
- Provide practical assistance to address any other barriers to wellbeing

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Head To Health – Key Benefits Summary

- **Improves inclusion, equity** for all patients
- **Better access to services** (e.g., reduced time waiting for services, better access to low or no cost services for people with financial challenges)
- **Quicker time to supports** (and reduced distress, pain, loneliness, and unmet social and welfare needs)
- Provides access to social prescriptions, community navigation and **social work** services outside the hospital setting
- **Access to limited OT services** to provide assessments and assist people to access needed supports
- **Improves connectivity** between health, social, welfare, and community services

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GP Social Work Connect

GP Social Work Connect is a free-to-access, short-term service available to residents via home visits or at the GP's practice.

The program is a resource to assist with:

- Assessing and addressing psychosocial needs and issues
- Providing information to patients
- Liaising with social, welfare and community providers
- Arranging referrals and linkage to appropriate supports.

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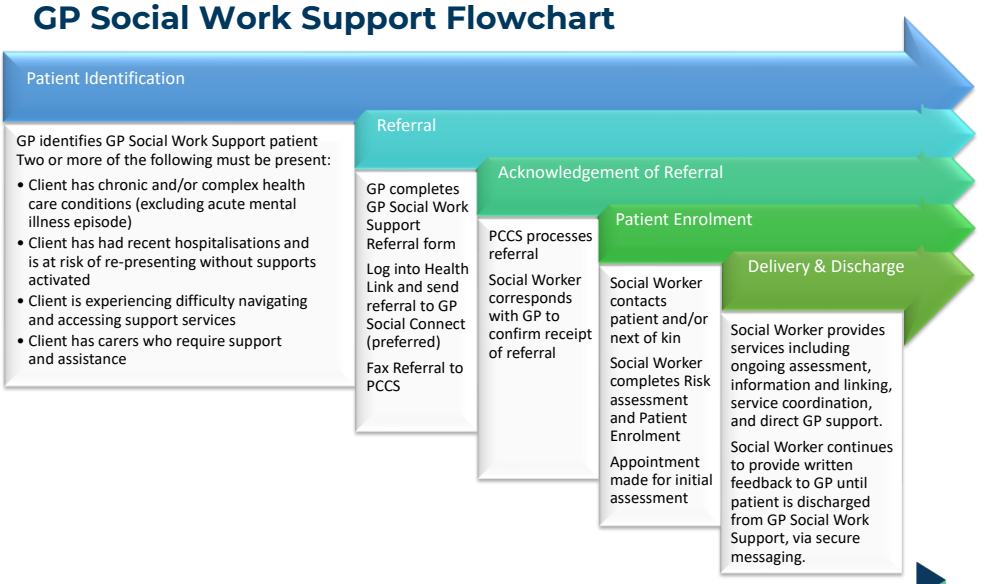
GP Social Work Support Flowchart



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Back to Home Back to Life

This short term program is designed to ensure a smooth and safe transition from hospital to home for older Australians living with multiple chronic health conditions. The service aims to:

- Support a safe and straightforward transition from hospital to home
- Help people identify short and long term needs, develop goals and strategies to meet those needs, and apply for supports that assist in returning to pre-hospital life
- Promote further health and disease prevention, with a view to stay well in the community and reduce the risk of future hospitalisations

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Back to Home Back to Life

We can help people in the process of being discharged from hospital and who meet one or more of the following criteria:

- They are living with three or more chronic health conditions/comorbidities
- They are at risk of readmission to hospital after transitioning home
- They would benefit from short term follow-up support

AND they are also residents of one of these local suburbs:

- Hunters Hill
- Lane Cove
- Mosman
- North Sydney
- Northern Beaches
- Ryde
- Willoughby

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COVID Home Isolation Support Service (CHISS)

CHISS is a short-term initiative to help your patients access supports and resources to aid their wellbeing during a period of COVID isolation. PCCS works with your patients, ensuring essential needs are met while supporting health and wellbeing. We can assist with things like:

- **Support to Access Services** such as help with applications for Centrelink emergency payments and other social/welfare services
- **Daily living & lifestyle needs** like grocery shopping and prescription delivery, and online or phone-based activities that promote health and wellbeing
- **Connecting between health professionals** to meet or escalate healthcare requirements, and assist coordination of appointments.

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COVID Home Isolation Support Service (CHISS)

CHISS is provided at no cost to anyone living in the Northern Sydney region who has tested positive for COVID-19 or is otherwise required to isolate at home, and:

- is experiencing social isolation or lack of connection, or
- may be at low risk of mental ill health or who has general health comorbidities.

*CHISS is not intended for people who are at greater risk of deteriorating wellbeing that would require hospitalisation

Easy referral form at pccs.org.au/chiss

OR you or your patient can call us on 9477 8700.

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PCCS – Thank You!

- Adjunct A/Prof JR Baker, PhD MPsych GAICD
  Chief Executive Officer
  Primary & Community Care Services Ltd
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  jbaker@pccs.org.au

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