Evaluation of Integrated Chronic Care pilot

Midterm Report
March 2021

Dr Chris Maylea, Susan Alvarez-Vasquez, Lucy Bashfield, Matthew Dale, Dave Peters, Rory Randall, Dr Caroline Johnson, Associate Professor Robyn Martin, Professor Russell Roberts & Erin Myers

Social and Global Studies Centre, RMIT University

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EQUALLYWELL Quality of Life Quality in Life

Charles Sturt University

THE UNIVERSITY OF MELBOURNE

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Executive Summary

This report presents the findings from the midterm evaluation of the Integrated Chronic Care (ICC) Service, conducted by RMIT University's Social and Global Studies Centre (SGSC). ICC is funded by North Western Melbourne Primary Health Network (NWMPHN) and delivered by Neami and cohealth. This evaluation is led by SGSC in partnership with Equally Well, Charles Sturt University and Melbourne University.

Neami run ICC in Hume, Moonee Valley and Moreland Local Government Areas (LGA) and cohealth run ICC in Brimbank and Maribyrnong LGAs. Both ICC sites employ one registered nurse and one mental health peer worker, both on fractional appointments. Neami National and cohealth have collaborated to jointly commission this evaluation.

The evaluation is in two parts, a midterm review and a final evaluation. This report presents the findings from the midterm review. Qualitative data have been collected using interviews and focus groups with people who have used ICC services, ICC staff and professional stakeholders. Quantitative data has been provided by Neami and cohealth.

Overall, consumers expressed very high levels of satisfaction with their experience of ICC and professional stakeholders reinforced the value of the programs. The success of ICC appears to be due to a focus on the consumer's own identified needs rather than clinically driven interventions, flexibility, compassionate and caring support, and assertive coaching built on trust and empowerment. Few tangible examples of physical health improvement were reported, however many consumers identified other positive outcomes which would promote better physical health. Outcomes included access to disability and welfare support, improved trust in the health system and some lifestyle changes.

As with any pilot program, there are areas for improvement and strengthening. In particular, there are important questions of program clarity and program drift, with key aspects of the program, including the basic model, target group, extent of support and referral networks that require consideration. The peer work aspect of the program is particularly in need of reclarification.

Any reclarifications or revisions to the program should take into account that the success of the program relies on its consumer-driven focus, rather than being dictated by clinical decision-making. Within this context, some clinical aspects, particularly screening, should be enhanced to increase the ability of ICC to provide information to consumers to support their decision-making.

The interim recommendations are in five parts:

1. Continue to deliver ICC
2. Review the ICC Model
3. Embed system integration
4. Ensure robust and efficient data collection
5. Recalibrate reporting requirements

Detailed interim recommendations are available on page 37 of the report.

The evaluation was limited by the quality and availability of quantitative data, by disruptions caused through Victorian coronavirus restrictions, and by issues of program clarity. The evaluation team will work with Neami and cohealth to address these limitations in the final stage of the evaluation.

Acknowledgments

The ICC program runs, and this evaluation was conducted on, the land of the Wurundjeri Woi Wurrung peoples of the Kulin Nation, which was never ceded. The Social and Global Studies Centre at RMIT University acknowledges the Australian Aboriginal and Torres Strait Islander peoples of the nations of Victoria, the custodians of this land. We pay our respects to ancestors and Elders, past and present. We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society.

The evaluation team acknowledge the lived experience of poor mental and physical health and foreground the expertise that comes from this lived experience. Equally Well is committed to improving the physical health and wellbeing of people who use mental health services in Australia.

The evaluation team would like to thank all participants who gave considered feedback, and Neami National, cohealth and the North Western Melbourne Primary Health Network for committing to an independent and transparent evaluation process.

Abbreviations and Terms

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
COPD	Chronic Obstructive Pulmonary Disease
DoH	Commonwealth Department of Health
DSP	Disability Support Pension
GP	General practitioner
HoNOS	Health of the Nation Outcome Scale
HREC	Human Research Ethics Committee
ICC	Integrated Chronic Care
LGA	Local Government Area
MPCN	Melbourne Primary Care Network
NWMH	NorthWestern Mental Health
NWMPHN	North Western Melbourne Primary Health Network
PMHC-MDS	Primary Mental Health Care Minimum Data Set
RACGP	Royal Australian College of General Practitioners
RMIT	RMIT University
SGSC	Social and Global Studies Centre

1 Introduction

This report presents the preliminary findings from the midterm evaluation of the Integrated Chronic Care (ICC) service, conducted by RMIT University's Social and Global Studies Centre (SGSC). ICC is funded by North Western Melbourne Primary Health Network (NWMPHN) and provided by Neami National (Neami) and cohealth.

This evaluation is led by SGSC in partnership with Equally Well, Charles Sturt University and Melbourne University. The evaluation team includes five lived experience evaluators and academic evaluators with professional backgrounds including peer work, general practice medicine, nursing, psychology, social work, law and mental health service management.

1.1 RMIT University's Social and Global Studies Centre

SGSC's strategic focus is on issues of social justice, transformative social change and consumer participation; we consider these to be central to all of our research, with these themes uniting researchers across our research programs. We have a strong multidisciplinary membership, including social work, justice and legal studies, law and social policy, and international studies, and are thus able to mobilise purpose-built research teams to address the unique needs and requirements of industry-based research and evaluation. A core focus of our research is analysing and informing the policy process and on conducting applied social science research that helps shape effective and equitable responses to social issues.

1.2 Equally Well

Equally Well seeks to improve the quality of life of people living with mental illness by providing equal access to quality health care. Based on the Equally Well National Consensus statement it champions physical health as a priority. Equally Well ultimately aims to improve the physical health and reduce the life expectancy gap that exists between people living with a mental illness and the general population. Equally Well is based on a model of collaborative action and collective impact, supported by a backbone group of consumers, clinicians, policy professionals and academics, driven by principles of co-design and co-production. This group mobilises, activates and supports other initiatives throughout the mental health sector and the broader community.

Supporters of Equally Well include over 80 organisations, including every Australian government, 14 professional colleges/societies, and numerous other organisations including many primary health networks and non-government organisations.

2 Background

2.1 The physical health of people who use mental health services

People who use *public* mental health services in north-western Melbourne have a life expectancy of 52 years, which is more than 30 years lower than the Australian population.[1] For all Australians receiving any kind of mental health care, the median age at death is closer to 69 years,[2] roughly 13 years lower

[1] Joanne Suggett et al, 'Natural Cause Mortality of Mental Health Consumers: A 10-Year Retrospective Cohort Study' [2020] *International Journal of Mental Health Nursing* ('Natural Cause Mortality of Mental Health Consumers').
[2] Grant Sara et al, 'Cohort Profile: Mental Health Living Longer: A Population-W- Ide Data Linkage to Understand and Reduce Premature Mortality in Mental Health Service Users in New South Wales, Australia' [2019] *Open access* 11.

than the Australian population. Recent studies identify the main contributors to early death for people using public mental health services as cardiovascular disease, respiratory conditions and cancers, together responsible for 82% of natural cause early death.[3] People given a diagnosis of psychotic illness are most at risk, accounting for 82% of natural cause early death, however other diagnoses, including bipolar disorder and major depression, are also major risk factors. Early death is often preceded by decades of poor health.

The reasons for the poor physical health of people who use mental health services are complex, but include barriers to accessing adequate healthcare, consequences of experiencing mental distress or other symptoms, and harm caused by interactions with the mental and physical health care systems, including medication side effects.[4] Diagnostic overshadowing, where health professionals focus on mental rather than physical health treatment, is a key contributor, as are compounding social determinants such as poverty, joblessness, homelessness, drug and alcohol use and discrimination. People who use mental health services visit their general practitioner *more* than the average for the Australian population but have worse health outcomes.[5]

In response, various Australian governments have initiated strategies to reduce early mortality and improve health outcomes for people who use mental health services. This includes chapter five in the Commonwealth *Fifth National Mental Health and Suicide Prevention Plan*, the Victorian Government's *Equally Well in Victoria: Physical health framework for specialist mental health services,* and the *Productivity Commission Inquiry Report into Mental Health*.

2.2 Establishment of ICC

In 2019 Neami and cohealth were funded by Melbourne Primary Care Network (MPCN) trading as NWMPHN, to deliver ICC Services from July 2019 to August 2021. Neami were funded for the Hume, Moonee Valley and Moreland Local Government Areas (LGA) and cohealth for Brimbank and Maribyrnong LGAs. Both ICC sites were to employ one registered nurse and one mental health peer worker, both on fractional appointments. Neami and cohealth collaborated to jointly commission this evaluation.

The overall objective of ICC, as stated in the original request for tender from NWMPHN, is:

> *That individuals experiencing severe and persistent mental illnesses who can be or are being appropriately managed in a primary care setting:*
>
> - *are supported to achieve improved outcomes, including better self-management, for their chronic conditions;*
> - *are offered access to physical and mental health services and supports.*

The original NWMPHN request for tender identified an 'enhanced care coordination service in a primary care setting to improve the physical health of people experiencing severe and persistent mental illness'. Specifically, the request for tender notes that the 'funding is to enhance existing service delivery, not to support the establishment of new service.'

[3] Suggett et al (n 1).
[4] Chris Maylea, Russell Roberts and Christine Craik, 'The Role of Social Workers in Improving the Physical Health of People Who Use Mental Health Services' (2020) 73(4) *Australian Social Work* 490.
[5] Qun Mai et al, 'Do Users of Mental Health Services Lack Access to General Practitioner Services?' (2010) 192(9) *The Medical Journal of Australia* 501.

There are some minor differences in the establishing documentation, as the cohealth logic model aims to *provide* care, whereas the Neami model only seeks to *offer access* to services (see program logic models in Appendix 1 and Appendix 2). As is detailed below, the actual implementation did not reflect this distinction, with Neami offering more health services while cohealth focused more on care coordination. In general, the services are delivered using very similar approaches with some differences arising from context.

3 Evaluation Methodology

This evaluation employed a mixed-methods approach, combining qualitative thematic analysis of primary and secondary data with descriptive statistical data to help address the range of evaluation questions.

3.1 Evaluation in partnership

The mid-term evaluation was undertaken in partnership between RMIT's SGSC and Equally Well, including evaluators from Charles Sturt University and the University of Melbourne. The partnership extended to Neami, cohealth and NWMPHN to provide an embedded and transparent evaluation process. Equally Well's expertise in the field of physical and mental health and the extensive network it brings provide essential components of the evaluation.

A broader network of stakeholders, in particular mental and physical health services, were consulted in the clinical and contextual aspects of the evaluation. This model fosters the integration of research in expertise in lived experience, human rights, social work, law, medicine and technical evaluation, and promotes objective evaluation of the data while ensuring a deep and broad understanding.

3.2 Lived-experience lens

The evaluation has been implemented using principles of participatory co-design and co-production, with a focus on valuing and responding to the lived experience of people who currently experience, or have in the past experienced, mental ill-health. The evaluation team includes five lived-experience evaluators. One or more lived-experience evaluators co-facilitated all consumer interviews, coded all interview transcripts, participated in the thematic analysis of the data, and reviewed the draft report.

3.3 Co-location

The lead consultant (Dr Maylea) was to be co-located on site with Neami and cohealth throughout the evaluation. Co-location allows the evaluation team to observe the service and organisational processes and provide ongoing feedback during the process. Due to the Victorian coronavirus restrictions, co-location was not possible. Communication instead took place via *Teams* video calls, via phone calls, and through email.

Anticipating an easing of restrictions in 2021, the team endeavours to co-locate with the Neami and cohealth services for the final evaluation report.

3.4 Aims and scope

Both Neami and cohealth ICC were within the scope of this evaluation, covering the Hume, Moonee Valley and Moreland LGAs, and the Brimbank and Maribyrnong LGAs, respectively. All people who had used the ICC service were within this scope of this project, as were consumers' family members or carers. Stakeholders who had referred consumers to the service, or who had received referrals from the service were also included.

3.5 Key evaluation questions

In response to the preliminary data, and in consultation with the services, the key evaluation questions shifted to meet the experiences of service consumers and the realities of implementation. In consultation with Neami and cohealth, the final key evaluation questions included:

- How have these programs contributed to the improvement of the physical and mental health of people who used them?
- What was the experience of people who used the programs?
- How did the services deliver the programs?
- Who did the services reach and to what extent were the services effective in reaching the target group?
- To what extent have the programs complied with their program logics?
- What refinements are required to the program logic models?
- To what extent did the services identify and meet the physical and mental health needs of consumers, including practical support where needed?
- To what extent did consumers develop skills for self-management of physical health? What factors were critical in the development of self-management skills?
- To what extent were the services integrated into existing primary care and other health services across the regions? What were the key enablers and barriers to integration and how were these supported or addressed?
- To what extent were effective partnerships established with health and other services? What factors were critical to their effective maintenance?
- How is lived-experience expertise valued and included in the program design and implementation?

The evaluation questions were revised multiple times during the initial stages of the evaluation in response to new data arising. The evaluation questions were cross-tabulated to maintain alignment of the interview and focus group questions and other aspects of data collection.

3.6 Data Collection

The evaluation employed a suite of data collection methods including:

- A review of NWMPHN, Neami and cohealth ICC documentation;
- Interviews with ICC staff;
- Interviews with people who used ICC (consumers);
- Interviews with family members/carers of people who used ICC;
- Interviews and focus groups with professional stakeholders; and
- Quantitative data from Neami and cohealth.

	Interviews	Participants in focus groups	File reviews	Total	Target
Consumers	16		16	**32**	**40**
Family/carers	2			**2**	**0**
ICC staff (including management)	9	6		**15**	**8**
cohealth/Neami staff (non-ICC)	6	5		**11**	**3**

External stakeholders	8			**8**	**3**
Total	**41**	**9**	**16**	**68**	**54**

Table 1 - participants by data collection method

In total, the evaluation team consulted with 48 individual participants. Some ICC staff were consulted multiple times, and consumers provided data both directly and via their files, resulting in 68 discrete sources of qualitative primary data, comfortably exceeding targets for this stage of the evaluation. Consumer recruitment was impeded by Victorian coronavirus restrictions which prohibited evaluators from attending ICC group programs.

A literature review was initially intended to accompany the midterm review report however this has been postponed to the final report following discussion with Neami and cohealth. Illustrative case studies have also been postponed to the final stage of the evaluation so as to include face-to-face service delivery and not be dominated by factors related to the Victorian coronavirus restrictions.

3.6.1 Review of ICC documentation

The evaluation team reviewed the original NWMPHN request for tender; cohealth's tender documents, position descriptions and establishment plan; Neami's peer work framework, progress reports, referral form and screening tool. All of these documents were then integrated into the analysis.

3.6.2 Interviews with people who used or are using ICC

All past or current consumers of the ICC service were invited to participate in the evaluation in September 2020. Neami and cohealth ICC staff sent an invitation to consumers inviting them to contact the evaluation team to participate. ICC staff followed this invitation by calling past and current consumers and provided consenting participants' details to the evaluation team. The evaluation team then contacted participants to discuss the project and provide detailed information about how their interview and health file data would be used. Upon verbal consent, participants were sent further information about the project, and an interview date was arranged to occur via video or phone call. Information about data use began each interview, and verbal consent was again obtained before the interview went ahead.

A total of 16 consumers participated in an interview. Of the 18 consumers referred by Neami, 11 participated, and of 7 consumers referred by cohealth, 5 participated. A total of 9 consumers referred by the ICC services were either unable to participate in an interview or were unable to be contacted. The total number of participants represents approximately 10% of all cohealth consumers and 20% of all Neami consumers who had used the program at the point of recruitment.[6] Qualitative data of this nature is never strictly representative however these percentages are high compared to similar evaluations and the evaluation team is confident in the findings based on this data.

Participants were diverse in age, ranging from 20 to 65 years, and background, with two using interpreters and several others who spoke a language other than English at home. There were no participants referred who identified as Aboriginal or Torres Strait Islander, despite making up 3% of ICC consumers. Three-quarters of consumers who participated were female, with only one participant identifying as transgender or gender diverse. This roughly correlates with the demographics of ICC consumers, although with qualitative interviewing of this nature no claims are made to statistical

[6] Due to inconsistent quantitative data provided by to the evaluation team the exact number of consumers who used ICC is unclear and not comparable between the two programs.

representation. Two consumers identified that their carers or family members were involved in their engagement with ICC and those carers were also interviewed.

Some professional interviews and focus groups were conducted by the lead evaluator or an academic evaluator, with all consumer interviews and most professional stakeholder interviews conducted by a lived experience evaluator in partnership with an academic evaluator.

3.6.3 Interviews with ICC staff

In total, all nine ICC staff were interviewed; five Neami ICC staff and four cohealth ICC staff. This included the two ICC nurses/care coordinators and two peer workers, as well as management at relevant levels. Nurses/care coordinators and peer workers from Neami and cohealth also participated in a focus group with the lead evaluator, and the ICC nurses/care coordinators completed follow-up interviews with the evaluation team's medical doctor and nurse.

3.6.4 File reviews

People who had used the ICC programs and who participated in interviews or focus groups were asked to consent to have their ICC files reviewed. All participants consented. To obtain the health files, the evaluation team liaised with Neami and cohealth ICC management staff who did not provide direct service to consumers. This meant that direct service ICC staff remained unaware of which ICC consumers participated in the evaluation project.

The team general practitioner (Dr Johnson) and nurse (Ms Myers) reviewed the files. Full files were not reviewed by any other member of the research team. Dr Johnson and Ms Myers wrote a short report on each file based on clinical best practice and relevant practice standards. These short reports were then synthesised by Dr Maylea. Each consumer's report was deidentified but linked to the original interview transcript so that the individual's own experience of the service could be incorporated into the analysis of their clinical file. For the final stage of the evaluation, files will also be reviewed by a lived experience evaluator.

Many of the files related to existing ICC consumers, making it difficult to determine if some tasks, for example, appropriate referrals or screening, had been undertaken or were still planned for the future.

3.6.5 Professional stakeholder interviews and focus groups

In total, 19 professional stakeholders were interviewed for this evaluation. Of these, 11 were employed by cohealth or Neami in programs other than ICC, while 8 were external. This reflects, as identified below, ICC's reliance on internal referrals. Professional stakeholders were recruited by referral from ICC staff. Five Neami and four cohealth stakeholders who were referred did not participate in an interview. Professional stakeholders who were interviewed included a range of professionals, including counsellors (n=2), a family violence worker (n=1), a nurse (n=1), physiotherapists (n=2) general practitioners (n=3), National Disability Insurance Scheme (NDIS) access workers (n=2), psychosocial support workers (n=3), a dietitian (n=1), a housing worker (n=1) and physical health care coordinators (n=2).

3.6.6 Quantitative data

Quantitative data were provided by Neami and cohealth, however, there were some issues with the data provided. Neami's data was complete but not standardised, diminishing its reliability. cohealth's data was standardised but was not complete, including only consumers referred to ICC prior to mid-July 2020. The data collection was also inconsistent between the two programs, making combination and comparison of the data difficult. The evaluation team have used the data provided within the identified limitations. For this reason, this demographic data is presented as percentages rather than absolute numbers so as to avoid confusion or misleading representation of the data.

The evaluation team understand that the current data collection processes have been time consuming and unwieldy for ICC staff, particularly for Neami who have been collecting data according to the Department of Health (DoH) Primary Mental Health Care Minimum Data Set (PMHC-MDS), as well as additional data in preparation for the evaluation. The evaluation team will work with Neami and cohealth to develop more appropriate data collection processes that minimise repetition and maximise utility.

3.7 Data analysis

The interviews and focus groups were audio-recorded, professionally transcribed, and loaded into NVivo qualitative analysis software. All qualitative data, including interviews and focus groups, were coded against the research questions by one evaluator, then all interview and focus group data were thematically coded by one academic and one lived-experience evaluator using well-rehearsed conventions of thematic analysis.[7] Another lived-experience evaluator provided a thematic analysis on a sample of consumer and stakeholder transcripts. The thematic coding was then synthesised by the lead evaluator. This ensured that the data were handled by at least two evaluators, not including those who conducted the interviews. There was general consistent agreement in the two thematic analyses. In analysing the interview and focus group data, the evaluation team coded 211,608 words to 2,935 discrete references resulting in 279 individual codes. These themes were resolved through discussion to develop the thematic structure for the preliminary findings section of this report.

Qualitative data were processed in Microsoft Excel by Dr Maylea and presented to the evaluation team for discussion and integration into the thematic structure.

Interim recommendations were produced in a series of team meetings drawing on all data sets.

3.8 Limitations

As identified above, the qualitative data is extremely robust however the quantitative data is either not complete or not standardised. The evaluation team have used the data provided within these limitations and will work with Neami and cohealth to address this before the final stage of the evaluation. This also made comparisons between the two programs difficult, compounded by limitations during the Victorian coronavirus restrictions. A more complete comparison between the two programs will feature in the final report, drawing on complete qualitative data and practice that is not limited by severe restrictions.

Also as identified above, the file review data is decontextualised and while it provides some very useful prompts it has not been presented in full in this report to avoid misinterpretation.

As 11 of 19 external stakeholders were employees of either cohealth or Neami there may be some bias in their responses. No apparent bias or substantive difference between the responses of these stakeholders was noted by the evaluation team.

No Aboriginal or Torres Strait Islander participants or representatives from Aboriginal and Torres Strait Islander health services were referred to the evaluation team for interviews. The evaluation team will seek to address this gap by working with Neami and cohealth before the final evaluation.

3.9 Ethics

This evaluation project is approved by the RMIT Human Research Ethics Committee (#HREC 22853).

[7] Virginia Braun et al, 'Thematic Analysis' in Pranee Liamputtong (ed), *Handbook of Research Methods in Health Social Sciences* (Springer Singapore, 2019) 843 <http://link.springer.com/10.1007/978-981-10-5251-4_103>.

4 Preliminary evaluation findings

The overall preliminary findings from the evaluation are very positive. ICC is highly valued by consumers, with consistent support from professional stakeholders. The two programs are not identical, however the quantitative data and disruptions to implementation caused by Victorian coronavirus restrictions made comparison difficult. Broadly, as cohealth is a largely physical health focused organisation, cohealth ICC was viewed more as a mental health service, while Neami's mental health focus led Neami ICC to be viewed as a physical health program. Other differences, such as intake and assessment processes, had no discernible impact on the program delivery. A more comprehensive comparison of the two programs will be attempted in the final evaluation.

The findings section begins with a brief overview of the program context. The consumer experience is then shown to be very positive, albeit lacking in many tangible mental or physical health outcomes. Stakeholder appraisals of ICC are also shown to be positive. The demographics of ICC consumers are then detailed, followed by an overview of the key elements of the ICC model in practice. These are system navigation, goal setting, coaching, increasing health literacy, NDIS access, peer support and groupwork. The findings then turn to issues for consideration, primarily being program clarification and program drift, with other specific issues relating to service promotion and integration, intake assessment and screening, package allocation and targets, brokerage funding, program logic review and links to social determinants.

The findings are structured thematically rather than correlating directly to individual evaluation questions or program logic structure (see program logic models in Appendix 1 and Appendix 2). This decision was made because several issues identified stemmed from a lack of program clarity and because Neami and cohealth have differently structured program logic models. All elements of the program logics and all evaluation questions have been cross-tabulated against the thematic analysis to ensure direct links between program planning and evaluation. This approach has also allowed the evaluation team to incorporate contextual issues into the overall analysis.

4.1 Program context

As with any health or welfare program, the success of ICC must be understood within its context. The two key factors which influenced the evaluation findings are the current state of the mental health service system in Victoria, particularly the gaps created by the NDIS, the social determinants of physical and mental health leading to ICC eligibility, and the Victorian restrictions related to the coronavirus. These factors both amplified the positive experiences of people using ICC and made achieving physical health outcomes more difficult.

4.1.1 Victoria's mental health service system

Even before the Victorian coronavirus related restrictions, the Victorian state government admitted that the mental health system was 'broken' and 'not fit for purpose'.[8] ICC was regularly identified as filling a gap that had existed for a long time:

[8] Sumeyya Ilanbey, 'Victoria's "broken" Mental Health System Gets $870m Lifeline', *The Age* (12 November 2020) <https://www.theage.com.au/politics/victoria/victoria-s-broken-mental-health-system-gets-870m-lifeline-20201112-p56e3y.html>.

> *I'd been looking around for something like this for years, and it's really difficult to find anything. (cohealth Consumer 4)*[9]

This was identified not just a function of systemic issues, but of the clinical focus of the health system itself:

> *A lot of consumers have great GPs but they feel like those appointments are quite quick, and they're just really medication focused, or other healthcare appointments are really clinical focused. (Neami ICC Staff 1)*[10]

Stakeholders agreed that there was a high level of demand for a service such as ICC, particularly from external stakeholders who had worked closely with ICC such as this manager of a psychosocial support service:

> *There's so many consumers who fit the bill that we have on our books that would benefit from [ICC] support who are outside the catchment. (cohealth External Stakeholder 7)*[11]

And this GP:

> *There's probably another maybe five to ten people actually, now I really think about it, that could benefit. (Neami External Stakeholder 7)*

Specifically, consumers noted that other services had exclusion criteria, drop-in formats or were 'siloed' which made them inappropriate or inaccessible. Payment was often identified as a barrier to service access. ICC's relatively short waitlist was considered unusual in a sector where people often wait months to access free services.

The introduction of the NDIS was specifically identified as creating gaps within an already fractured system. NDIS was the most frequently mentioned topic across all evaluation participant groups, raised 262 times.

> *NDIS, the difficulty of succeeding there [is] when you have both physical and mental health issues, because they seem to treat those separately. … And that's where having the integrated care approach was so fantastic, because this application will look at both aspects. (Neami Carer 1)*

Sometimes, ICC was viewed as specifically filling gaps created by defunded services in the wake of the introduction of the NDIS:

> *We lost our mental health service because of NDIS. So yes, I guess, that's then why we moved to [ICC] because that support went. So yes, it would be very helpful to have a person who can see people who don't qualify for NDIS. (Neami External Stakeholder 2)*

This context helps explain some of the positive responses noted below while reinforcing the high demand for services such as ICC.

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[9] Participant quotes are labelled to indicate participant group, with a small number of quotes deidentified to ensure anonymity. Quotes have been lightly edited for readability.
[10] 'ICC staff' include direct service ICC staff and managers with responsibility for delivering ICC.
[11] 'External' participants are external to ICC but may be employees of Neami or cohealth in other programs.

4.1.2 Social determinants of physical and mental health

The main goal of ICC, to improve physical health of people who use mental health services, must be understood in the context of the social determinants of both physical and mental health. The social determinants which have led people to become eligible for ICC are largely beyond the scope of clinical care coordination to address. These include socioeconomic position, early life, social exclusion, work, unemployment, social support, addiction, food, transportation, housing and disability.[12] Disadvantage, poor mental health and poor physical health have a compounding effect which multiply across the lifespan.[13] In Australia, a person in the most disadvantaged socioeconomic quintile is more than twice as likely to die early than a person in the least disadvantaged socioeconomic quintile.[14] This is particularly relevant when interpreting the evaluation findings related to program clarity in section 4.6, as ICC staff have prioritised addressing social determinants which have prevented, often over many decades, clinically appropriate health screening and intervention. This is also important context when interpreting findings related to package allocation and targets in section 4.7.3, as many, if not all, ICC consumers are presenting with underlying social issues that cannot be addressed in the context of a brief intervention.

4.1.3 Coronavirus restrictions

The evaluation was undertaken during Victorian stage 4 coronavirus restrictions which inevitably influenced participant responses and shaped the service delivery of ICC. Participants expressed particular gratitude for ICC in the context of many other services withdrawing or being more difficult to access:

> *It's scary when you don't have anyone to talk to, and someone that you can actually turn to. (cohealth Consumer 2)*

Some ICC groups or other program aspects did not run due to Victorian coronavirus restrictions while others were instead run online. The evaluation team have factored this context into the midterm review however it is evident that the ICC staff were particularly flexible and responsive to peoples' needs during the restrictions. The evaluation team will revisit some aspects of ICC in the second stage, assuming that the service is able to run more closely aligned to its original model. This will also provide an opportunity to consider which aspects of the online delivery were successful and might be incorporated into the ICC model into the future.

4.2 The consumer experience

The consumer experience of ICC is consistently and overwhelmingly positive. Every consumer who participated in an interview spoke positively about the service. It is difficult to understate just how much people responded positively to the service:

> *10 out of 10 for the people that they are. The calming wonderful approach they have. And their knowledge of what they're doing and also their ability to admit new areas that they*

[12] Australian Institute of Health and Welfare, *Social Determinants of Health* (Australian Institute of Health and Welfare) <https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health>.
[13] Jessica Allen et al, 'Social Determinants of Mental Health' (2014) 26(4) *International Review of Psychiatry* 392.
[14] Australian Bureau of Statistics, *4329.0.00.006 - Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 Data* (Australian Bureau of Statistics, 8 September 2017) <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4329.0.00.006~Analysis%20of%202011%20data~Main%20Features~Persons%20of%20all%20ages~4>.

have to look into and get back to. And I just found them very, very nice and good. (Neami Consumer 4)

This rating of 10 out of 10 was repeated, unprompted, by another consumer:

The experience is so good, very good indeed with [cohealth Nurse]. How can I say – they took me like a 10 out of 10. Always I'm happy with them. They are good. They are good them. And I'm proud of what she done to me. (cohealth Consumer 5)

Multiple consumers identified that ICC had a profound, even life-saving effect on them:

I needed someone to talk to. And if it wasn't for [cohealth Nurse 1] helping me, I'd probably – I don't know. It's not that I'm suicidal but I thought about it. (cohealth Consumer 2)

And:

They were so supportive; I can't express how wonderful all the support I got from all of them. I've never been supported like that. … And please thank them because I think they saved my life when I was there. (Neami Consumer 3)

While clearly favourable, the evaluation team struggled to identify exactly what elements of ICC led to this overwhelmingly positive feedback. Consumers consistently identified that ICC was doing something very different from other seemingly similar services. Consumers such as cohealth Consumer 4, who had a long engagement with the physical and mental health systems, reinforced this point:

It's not anything that I've really experienced before, and it's been the most helpful thing that I've ever interacted with, basically … I think my mental health improved a lot from being able to access these services. It was just really amazing to feel very supported in this process … it's the first time I ever had someone competent help me, and who I felt was able to do the things I needed, or willing to find out how to do the things I needed to do. And I never experienced that before. (cohealth Consumer 4)

Neami Consumer 3 echoed this sentiment:

They were so supportive; I can't express how wonderful all the support I got from all of them. I've never been supported like that. (Neami Consumer 3)

The evaluation team explored the factors that contributed to this positive experience. There are a variety of contributing factors, however, the only common factor is the positive relationships with the ICC staff. Consumers felt that unlike many other services, the ICC staff were really invested in them:

I feel like there's someone out there that cares. All this time I went to specialists and doctors, and it was always … I felt that they didn't care. (Neami Consumer 8)

ICC staff were described as 'really an angel, and like a guide to me because she given me my life back' (Neami Consumer 10). When asked to comment on this extraordinary feedback, ICC staff agreed that the success of the program was based on building genuine relationships. This relationship-building was identified as having intangible benefits, such as for Neami Consumer 6 who indicated that as a result of

working with ICC, they were now able to trust the service system in a way they had not been able to do before:

> *I've always been fairly self-sufficient, a fairly private person in that … By that I mean I don't want to talk a great deal about my mental health. And one of the things that's been very helpful is that I've actually developed a freedom to actually, it's OK to be able to ask for help and all that sort of stuff. So, it's allowed me to be drawn out a lot more, if you know what I mean? (Neami Consumer 6)*

4.2.1 Negative consumer experiences

The evaluation team explicitly sought negative feedback from consumers, but none was forthcoming. The only issues identified from a consumer perspective related to exiting the program:

> *Look, to be honest with you, they're all like family. That's how they came across. So now I feel like I'm going to lose someone from family when this is over and that's actually triggering my panic attack even more. (Neami Consumer 9)*

This resistance to exiting the program was not universal, with most consumers identifying that they had achieved the goals they had identified or that they could access the service again in the future.

4.2.2 No tangible mental or physical health outcomes

The overwhelmingly positive experience identified by consumers masks a lack of tangible health outcomes. The evaluation team addressed this with each consumer:

> *Interviewer 1:* *And as a result of the work that you did with [ICC], did your physical health get better or did your mental health improve?*
>
> *Neami Consumer 2:* *Oh, no it didn't. It's not their fault. Don't get me wrong.*

Many consumers identified that their mental health had improved in intangible ways, such as reduced stress due to NDIS access or similar. Neami Consumer 6 reported 'a vast improvement in disposition' and is now exercising regularly. Neami Consumer 10 reports eating more meat and vegetables. Neami Carer 2 reported a sense of 'eased responsibility' for their loved one.

These are potentially powerful changes in people's lives and are not to be underestimated, however the midterm review could not identify that ICC is having a demonstrable impact on the chronic conditions that are contributing to the high rates of mortality for people using mental health services. This does not mean that this impact is not happening and it is unlikely that any significant impact could be measured in the timeframe. This reinforces the need for a more effective assessment and evaluation tool, such as the Optimal Health Wheel or similar,[15] to provide quantifiable data to properly assess the pilot (Recommendation 17.1).

4.3 Stakeholder appraisals

External stakeholders, including Neami and cohealth professionals working in programs other than ICC, were also very positive about ICC. Stakeholders reported high levels of professionalism and expertise in the ICC program, noting the ease of referral and information sharing, the benefits of the holistic model, and the time and care ICC staff would take to engage with consumers. Stakeholders consistently noted

[15] Casey O'Brien et al, 'The Mental Health in Diabetes Service (MINDS) to Enhance Psychosocial Health: Study Protocol for a Randomized Controlled Trial' (2016) 17 *Trials* 444.

that the nursing background of the ICC nurses was a significant positive aspect of the program. This related to ease in translation, system navigation and clinical nursing expertise, as discussed elsewhere in this report (Recommendation 8).

Those external stakeholders who understood the program well gave the most positive feedback, such as Neami External Stakeholder 5, a peer support worker working for another Neami program:

> *I get a good sense that that person's got a really good understanding of the role and how to use their lived experience in practice. My consumers who are getting ICC support are doing really, really well. I can only say that that is actually helping a lot. (Neami External Stakeholder 5)*

The same positive experience identified by consumers was also noted by stakeholders:

> *I think one of the things that definitely stood out were her ability to create really strong connections with the consumers. This was something that came across when they would come to me, or vice versa when I'd refer to her. They often would say how proactive she is in terms of facilitating referral pathways, following things up. … Often consumers would say, "Oh, she seems like she knows what she's doing". (cohealth External Stakeholder 7)*

Even those who were not so familiar with ICC saw it as a valuable service:

> *I'm not clear on how it's funded or whether it's permanent … but I think it's definitely valuable service and it would be sad if it stopped. (cohealth External Stakeholder 9)*

As with consumers, stakeholders were unable to point to tangible health outcomes, but indicated successful outcomes that were highly likely to indirectly contribute to improved physical health:

> *And so Neami ICC Nurse 1's been able to help with accommodation, getting her some permanent accommodation that's in a reasonably pleasant environment. I've been able to get her to stick to one chemist to do her dispensing, and in fact delivery. Her drug use has settled down and has become much more regular, and much more within therapeutic ranges. And so, generally, her overall … we're hopeful, but this is settling down, and I think we're reducing costs within the health system quite a lot. (Neami External Stakeholder 6)*

Many stakeholders identified the benefits of having ICC available as secondary consultation, both physical health professionals looking for mental health expertise and vice versa. This appeared to be more often related to referral networks and general system knowledge rather than clinical issues. This is already happening regularly, if informally:

> *It would come about naturally through our conversations when we're dealing with mutual clients. … I wouldn't intentionally set aside time or reach out to her for secondary consultation because they'll naturally be part of our conversations. (cohealth External Stakeholder 7)*

This important function of ICC does not appear to have been envisaged by NWMPHN and should be considered for future program development (Recommendation 9).

No negative feedback was provided by any stakeholder, although, as detailed below, not all stakeholders fully understood the program.

4.4 Demographics

Demographic program data is generally consistent with expectations, with some areas of underrepresentation identified. As detailed below in 4.6.3, ICC's target group is fairly loosely defined, making assessing representation difficult.

Overall program numbers are lower than outlined in the service agreements, particularly for brief interventions, however this is likely to be a reflection of the performance indicators requiring revision. It is clear that ICC is more relevant for people requiring 'comprehensive' support rather than 'brief' support (Recommendation 18.1).[16]

As Figure 1 shows, Neami consumers are drawn from Hume, Moonee Valley and Moreland LGAs with cohealth consumers from Brimbank and Maribyrnong LGAs with minimal outliers. It is not unexpected that some people using ICC would have postal addresses outside the catchment area while still being eligible for the program. Much of Neami's catchment is rural, although the absence of consumers from Sunbury and Diggers Rest may warrant service promotion in those areas.

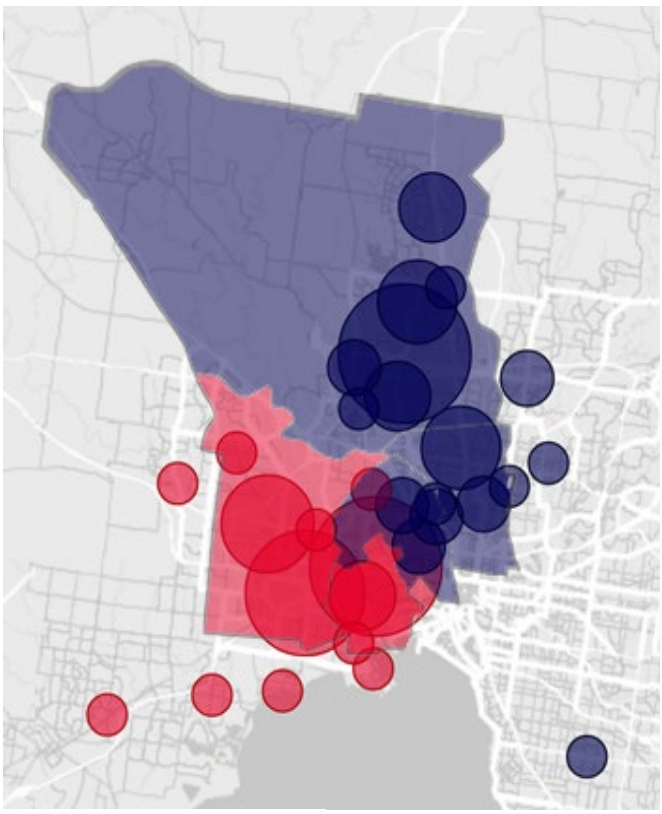

Figure 1 - Consumers by catchment

Age and gender data of all ICC consumers, shown in Figure 2 and Figure 3, highlight two points of consideration. Firstly, both programs are much more likely to be used by women than men. Given that men and women in the target both have massively reduced life expectancy,[17] the difference in usage is of some concern (Recommendation 3.1). Secondly, the Neami program appears to focus more on older consumers while cohealth has a flatter age curve. While there is no 'correct' age curve, both programs should consider their program offering to ensure it matches the age range and related needs of their consumers (Recommendation 3.2).

[16] Demographic data are presented as percentages to allow comparability between the two programs.
[17] Suggett et al (n 1).

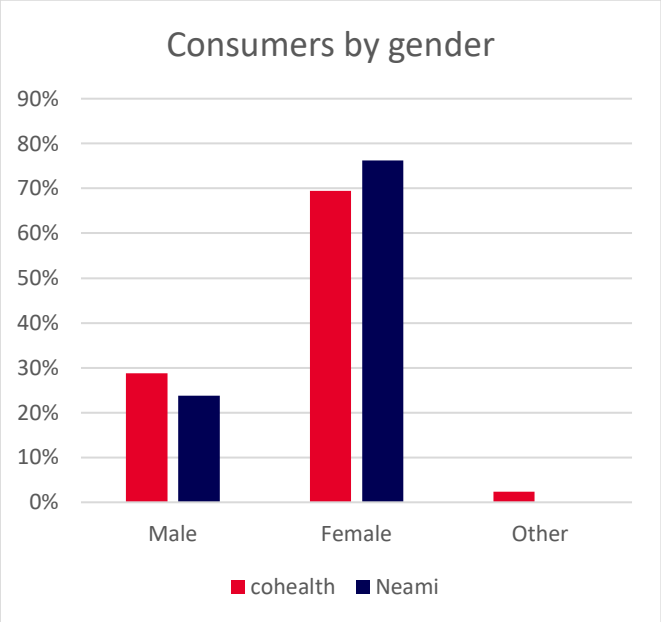

Figure 2 - Consumers by gender

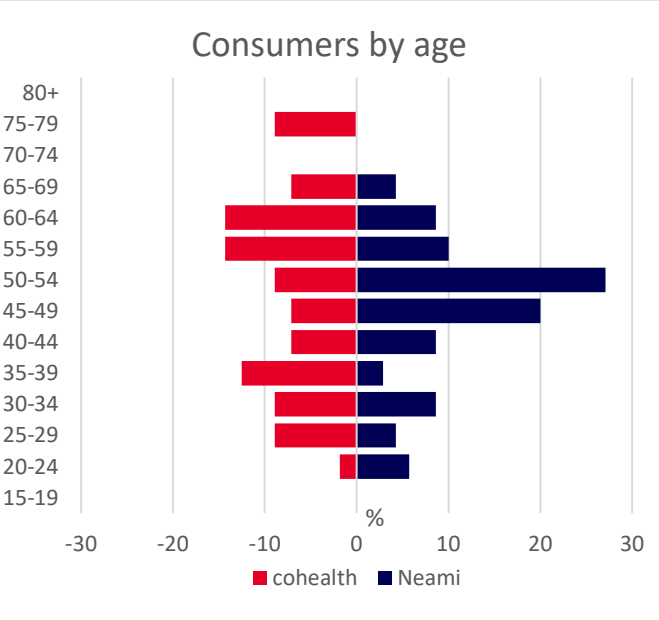

Figure 3 - Consumers by age

As Figure 4 illustrates, around 3% of consumers identified as Aboriginal. As the population of these areas is only 0.4-0.5% Aboriginal identifying, this is a significant overrepresentation.

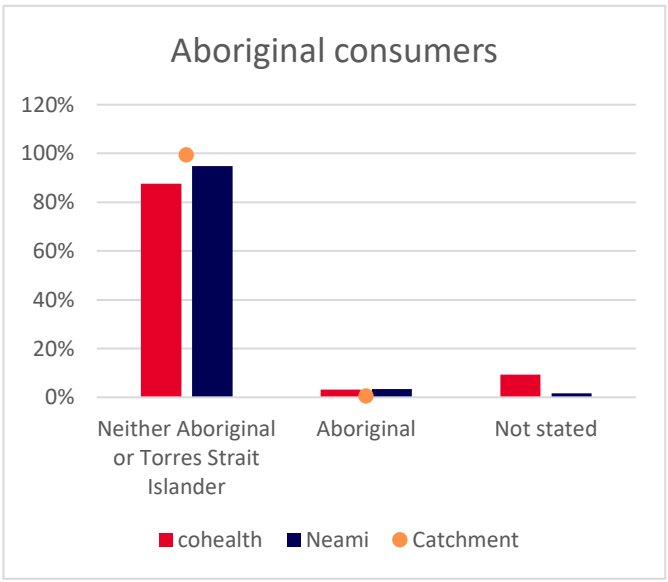

Figure 4 - Aboriginal consumers

Neami reported 36% of consumers as being 'culturally and linguistically diverse', whereas cohealth reported 38% of consumers as born overseas and 19% whose main language spoken at home was not English. While these collected data are not directly comparable with ABS data, in the Neami catchment 45% of residents did not speak English at home, and in the cohealth catchment, 47% of residents were born overseas. It may be that specific cultural services, such as the Refugee Support Program run by cohealth in Footscray, are contributing to this discrepancy, however this is unlikely to account for the whole of the difference, given the general underrepresentation of people of non-English speaking background in health services.[18] ICC is not receiving referrals that reflect the diversity of their catchment areas and should develop a strategy to address this (Recommendation 3.5).

[18] Saras Henderson and Elizabeth Kendall, 'Culturally and Linguistically Diverse Peoples' Knowledge of Accessibility and Utilisation of Health Services: Exploring the Need for Improvement in Health Service Delivery' (2011) 17(2) *Australian journal of primary health* 195.

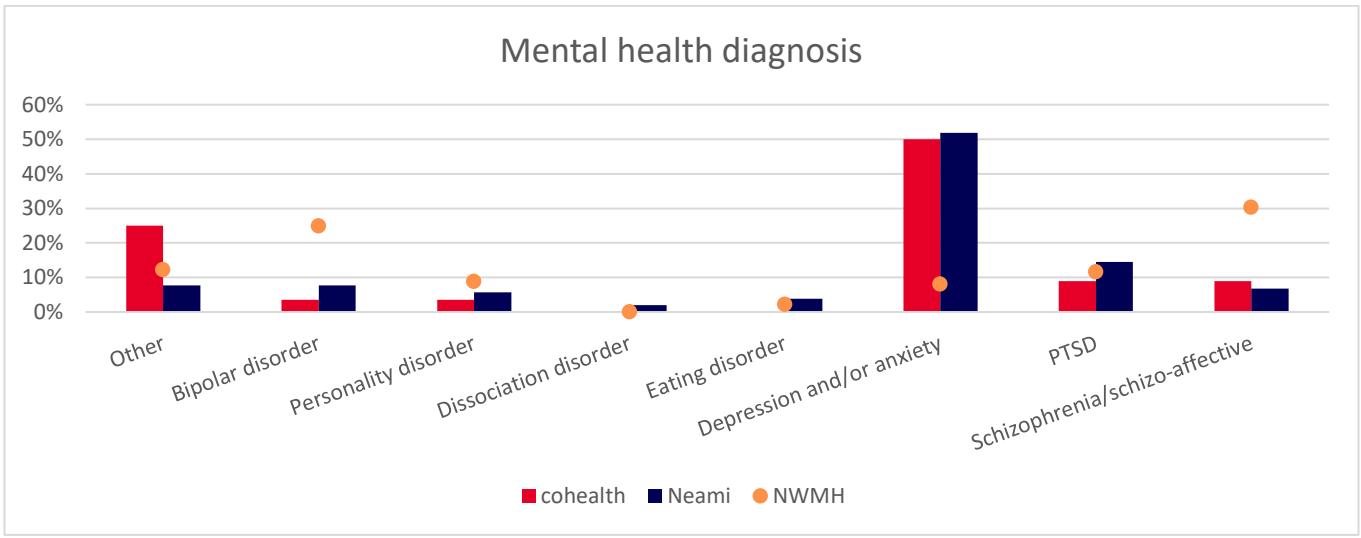

Figure 5 - Mental health diagnoses

For Neami consumers, 86% had two or more physical health diagnoses, and 44% had two or more mental health diagnoses. For cohealth consumers, 37% had two or more mental health diagnoses, with no data provided for physical health comorbidity. Figure 5, showing mental health diagnosis recorded, highlights that the majority of ICC consumers had received a diagnosis of depression and/or anxiety. This is distinctly different from NorthWestern Mental Health (NWMH) consumers, who were most likely to have been diagnosed with bipolar disorder or schizophrenia. Given ICC's target group is people diagnosed with 'severe and persistent mental illnesses', it is unclear to what extent ICC is reaching the intended population. This is discussed below in section 4.6.6.

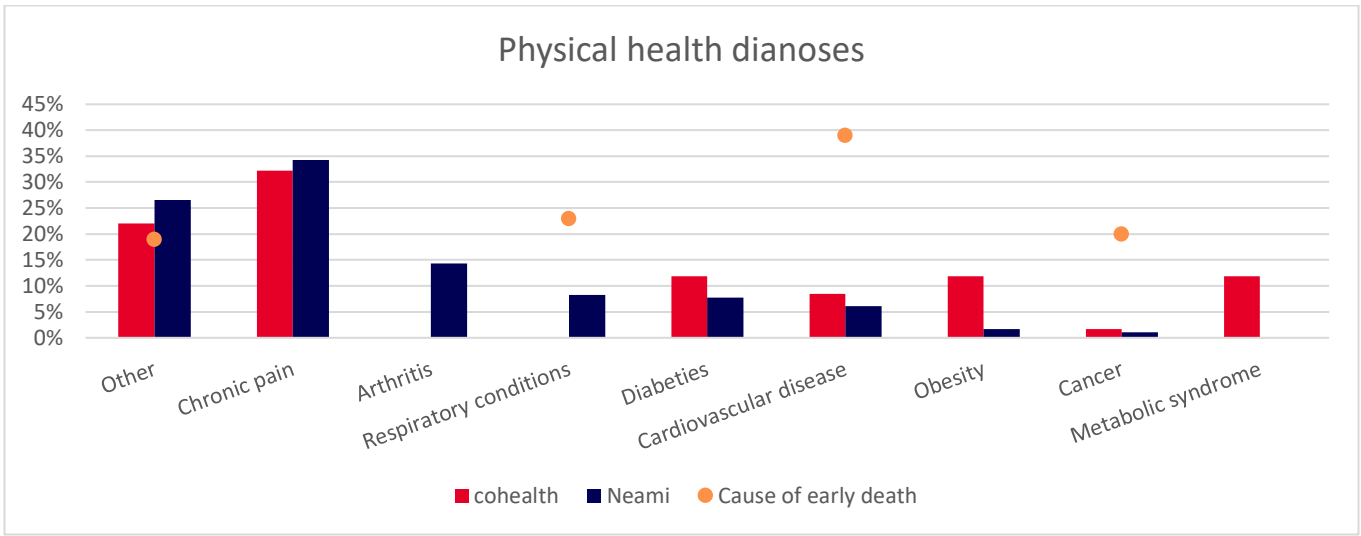

Figure 6 - Physical health diagnoses

Data relating to physical health diagnoses are not reported using a consistent framework (Recommendation 17.2) and are therefore not reliable (Recommendation 17.1), however two important conclusions may be drawn from available data. Firstly, the most common physical health diagnosis for both programs is chronic pain. Secondly, the physical health diagnoses that are associated with early mortality in this cohort; cardiovascular disease, respiratory conditions, and cancers;[19] are present but

[19] Suggett et al (n 1).

not the foremost focus. This raises questions relating to ICC's target group, discussed below in section 4.6.2.

4.5 ICC Model

The ICC model has been generally implemented in accordance with the establishing documentation. Its core elements are covered in this section, being system navigation, goal setting, coaching, increasing health literacy, peer support and groupwork. Due to issues of context and data quality, only the first four of these elements were able to be evaluated in detail for the midterm review.

4.5.1 System navigation

Central to the ICC model is system navigation. ICC appears to be combating issues of 'handballing' and 'incorrect disposal' where a consumer is referred on, but not necessarily to the most appropriate service. Consistently, consumers reported that ICC had assisted them to navigate the system successfully whereas before they had been unable to do so:

> *I was getting a lot of stuff from one doctor and then different things from another doctor. So it was just good to have, it's been really good to have [Neami Nurse] like juggle it for me, thank God I don't have to do it myself. So, yeah it's been really good. (Neami Consumer 5)*

This was reinforced by professional stakeholders, who saw ICC as providing an essential service:

> *People would get lost in the paperwork or get lost in the system, or just simply not be able to meet appointments, because of their disability or their psychosocial health issues. And so having that person there who can assist, who can liaise, all of my people have spoken about the good relationships they've had with their ICC worker and then other parts of the team, like the doctor or the psychiatrist, or whoever the health professional was. And having that – be able to share that information and speak – and to get the healthcare plan to work, I think, was really critical for our people. (cohealth External Stakeholder 11)*

The system navigation role included undertaking advocacy, case conferencing, information sharing and follow up, to ensure that the person was not lost to services and that services were coordinated as effectively as possible. The nursing background of the care coordinators was viewed as essential or at least highly beneficial in supporting this process. This was due both to the professional status Registered Nurses carry in physical health settings, and their ability to translate between clinical and non-clinical language. Having an experienced system navigator also reassured other health professionals that consumers were receiving appropriate support.

It is clear that the system navigation aspects of the ICC model are highly valued by consumers and professionals (Recommendation 2), however, as discussed below in section 4.7.2, it appears that with more rigorous physical health screening, this system navigation could be more targeted and effective (Recommendation 6.1).

4.5.2 Goal setting

Consumers consistently identified that goal setting and goal achievement were a key aspect of the ICC model. Goals were varied, driven by the preferences of the consumer:

> *It was really amazing to have someone help me for the first time in ways that really mattered … setting goals, which I felt were very lofty, like getting onto the DSP and NDIS. Finding some exercise group kind of option … finding some kind of comfortable clothing*

options … try and get some more hours of work. … We really just hit all the goals, which was pretty amazing. (cohealth Consumer 4)

Professional stakeholders also noticed the benefits of this goal-directed care coordination:

> *I noticed in the people that have had ICC care coordination is that it's helped them focus on goals a lot more, and maybe that's to do with linking many clinicians together to be on the same page. Because often, clients might see us individually and so having a care coordinator to help them focus in and get us speaking the same language and saying the same words, has helped our clients move forward. (cohealth External Stakeholder 5)*

This approach, of being directed by the consumer's goals and preferences, was highly valued, and should not be lost in attempting to address issues of program clarity discussed below (Recommendation 2.1).

4.5.3 Coaching

ICC also provided coaching, mainly focused on health education, diet and exercise. This aspect of the program was valued by those who had received it. Health coaching by ICC nurses yielded tangible lifestyle outcomes, with consumers identifying improved health choices:

> *I've changed in terms of managing my health; as part of my rehabilitation, I had been given a set of exercises and a training video. Now previously in the past, I've never been a fan of exercise. I was not lazy or anything like that, it's just that exercise has never been something. Now that I have the exercises, I do them religiously every day. (Neami Consumer 6)*

Coaching sometimes branched into a kind of assertive outreach paired with motivational interviewing, where ICC staff would follow up more assertively with people to support them to reach their goals. External stakeholders identified that for their own allied health services, they would not assertively follow up:

> *If you don't engage back or if you don't own for yourself, like we're not going to force feed these goals or force feed this intervention. (cohealth External Stakeholder 5)*

Conversely, for ICC, staff confirmed that their coaching included regular follow up to maintain engagement:

> *I'd send him a text to motivate him, 'Hey, remember to take your walk today', and then the next week would be 20 minutes a day, and then he did report back to me that that little shift, and just having me text him to remind him to do it. (Neami ICC Staff 1)*

The evaluation team were alert to the potential negative impact this kind of service provision can have on autonomy, however participants consistently identified that this supportive assertive approach was beneficial:

> *So her encouragement, and she said to me, "Come on, you're strong enough to do it. I'd like you to do it. You have a go". I did do it and she rang me a couple of days later to see how I feel and if I had done it, if I'd been encouraged or got enough – how can I put it – self-esteem to do it, and I had. But I appreciated, not so much her pushing me to do it, but I was*

able to run it past her first before I actually went and did it. As I said, it's all been support and it's been wonderful support. (cohealth Consumer 2)

ICC staff confirmed that this assertive model was always consensual and driven by the consumer's implicit and explicit needs:

I don't really say to every single person, 'Do you want me to text you on these days, and is this going to be helpful?', I just get a sense from that person whether it's going to be helpful for them or not. It's really just having a discussion about what's going on for them, and that's enough for that session, they might not have any follow up to do because they felt quite overwhelmed or quite tired by that session. (Neami ICC Staff 1)

The coaching element of ICC is clearly working as intended and should be emphasised in the ICC model (Recommendation 2.3). It appears that ICC is actively supporting consumer autonomy through proactive and compassionate support. This may be strengthened with reference to existing models of supported decision-making and motivational interviewing to ensure future consistency as staff turnover occurs or in any future expansion.[20]

4.5.4 NDIS access

As envisaged in the original request for tender from the NWMPHN, supporting consumers to access the NDIS featured significantly in ICC's model. It appears, however, that ICC is directly, and very successfully, assisting in NDIS applications rather than directing consumers to 'interface services that facilitate NDIS enquiries and applications' as indicated in the establishing documentation. Consistently, consumers and professional stakeholders reported that ICC had enabled NDIS access where other services had been unable to assist with this:

If I hadn't been in the [ICC], I would have given up on getting access to NDIS, to be honest. … I feel like everybody who's got complex health issues deserves someone like that. (Neami Consumer 7)

Sometimes ICC would refer consumers directly to NDIS access support services, and other times would work closely with these services, particularly in gathering evidence required:

In trying to support consumers to get onto the NDIS, it's about generating evidence for both [physical and psychosocial disability]. And so, I could focus on the mental health side of things, and then [cohealth Nurse] was really well placed to focus on the physical health side of things by being the role of an evidence – advocating for additional support, that sort of thing. (cohealth External Stakeholder 7)

Generalist physical care coordination services referred consumers to ICC to obtain NDIS access for psychosocial disability:

One of the reasons we do refer them to [ICC] because they're getting knocked back from us because we can't answer that [psychosocial disability] question properly. … we didn't get

[20] see e.g. Glyn Elwyn et al, 'Shared Decision Making and Motivational Interviewing: Achieving Patient-Centered Care across the Spectrum of Health Care Problems' (2014) 12(3) *Annals of Family Medicine* 270 ('Shared Decision Making and Motivational Interviewing').

anywhere with our physical health report, but once they're into ICC with a different slant of the report, she got NDIS. (Neami External Stakeholder 2)

One reason for this is that NDIS access services do not always actually conduct new assessments, but instead draw on what documentation is already available. In contrast, ICC nurses actually produced evidence which was then accepted in the NDIS assessment process:

> *They can definitely supply evidence for an NDIS application that we're seeing so that the nurse can actually write a report. … It has to come from a [health] professional. The nurse can actually write a detailed evaluation of how that person's chronic condition is impacting their day-to-day life and how it's also having an impact on their mental health. (Neami External Stakeholder 5)*

While the original intention was for ICC staff to refer consumers to an NDIS access service, the gathering and provision of new evidence by ICC staff is highly valued by consumers and professional stakeholders alike. It is possible that demand for this aspect of ICC will change over time as NDIS access and assessment policies change.

4.5.5 Increasing health literacy

Increases in health literacy as a result of ICC education are difficult to determine, as self-assessment can be a poor indicator of increased understanding unless rigorous pre/post assessments are implemented. Many consumers identified that they already had high levels of health literacy while for others, health literacy was not a concept that they were able to self-assess. Many responses to questions about improved understanding of physical health issues related to referrals or coaching rather than education. Only Neami Consumer 6 was the exception to this:

> *There's been an attitude, change of attitude in the way I've seen such things. So, I'm more proactive, I guess, in dealing with the health issues and so forth. … I know my limitations. I'm aware of the fact that the depression effects on the way I function and so forth. (Neami Consumer 6)*

This certainly does not mean that ICC is not increasing health literacy, but there is not sufficient data available at this time to comprehensively assess the impact.

4.5.6 Peer support

Both Neami and cohealth employed mental health peer support workers, however due to the cohealth peer worker being recruited in late 2020, as well as issues of program clarity discussed below at 4.6.5, the evaluation team were unable to evaluate the success of the peer support aspect of the program. It is clear that generic support received by consumers from peer workers was very highly valued, however consumers did not identify receiving peer support. Further, many professional stakeholders were not aware that the ICC did or intended to include a peer support aspect. When raised during interviews, all stakeholders agreed that peer work within the program would be beneficial.

The evaluation team noted that while there is significant evidence base for peer workers in mental health settings, this evidence base does not exist for physical health settings. ICC requires a clear model of peer work to be able to be evaluated in this setting (Recommendation 5).

4.5.7 Groupwork

Both Neami and cohealth had intended to run groups, however the first round of peer worker led groups for cohealth had not completed in time to be included in the midterm review, and Neami had postponed theirs due to Victorian coronavirus restrictions. The evaluation team did speak to two consumers who had participated in a 'smoothie' group prior to lockdown restrictions, both of whom found the group beneficial:

> *I wasn't really very willing to engage in a group again at the time. But, yeah, I loved it. Thought it was really, really good. (cohealth Consumer 1)*

Despite this overall positive feedback, when pressed for detail most of the feedback about the groups related to the quality of the smoothies rather than more substantive elements. Assuming that groups are able to continue into the future, the evaluation team will revisit this aspect of ICC in the final evaluation.

4.6 Program clarity and program drift

The primary area for consideration for the funder and service providers is that of ICC's clarity and program drift. *Program clarity* refers to the clarity of intention of the program, while *program drift* refers to the tendency of the program foci to change over time, potentially outside of the original conception of the program. These are not unexpected issues for a pilot of this nature but should be addressed early to ensure the program is successful going forward. Both consumers and stakeholders identified a lack of clarity around the program's intentions and the services it was able to provide:

> *I don't know if I was told much about what the ICC was. I don't know if it's just my memory, but I think I just assumed it was regular support coordination. (cohealth Consumer 4)*

The evaluation identified a number of examples of ICC providing support that sat either on the edges of care coordination or clearly outside of it. This confusion begins with the establishing documentation. For example, the cohealth program logic model and promotional material indicate that the cohealth ICC will 'provide integrated, flexible and tailored evidenced based health care' (see program logic models in Appendix 1 and Appendix 2) however the original tender, position description and establishment plan identify 'care coordination services' and health coaching. The issue of program clarity stems from this distinction between *care* and *care coordination*.

Issues of external program clarity, such as external stakeholders' unclear perception of ICC, are not considered in this section but are discussed at 4.7.1 in relation to program promotion. This section contextualises the importance of flexibility, noting the strain on ICC from the many gaps in the existing health system, before addressing the presence of casework and generic support in ICC, the inclusion of mental health support, the absence of a clear peer work model and ambiguity in the intended target group.

4.6.1 Flexibility is a strength

The ICC program is highly valued by consumers and has the support of professional stakeholders, largely on the basis of its flexibility and ability to meet consumers' needs where other aspects of the system have failed to do so. This flexibility is intentional, as both Neami and cohealth reported to the evaluation team:

> *Having a worker in the ICC program that can be flexible and fluid and responsive to need, rather than strict and rigid around boundaries and procedures, is probably a strength. I*

definitely come from a mindset where we should always try to be fluid, but I then also understand that there are set targets that we're contracted to meet and that sometimes this might undermine it. (Neami ICC Staff 4)

And:

There's no one size fits all anywhere in health, although we try to pigeonhole people. But it specifically does not work for people who have got a combination of chronic and complex physical health and mental health conditions. So, the grey is important. (cohealth ICC Staff 2)

This flexibility was specifically identified by multiple consumers as the key reason for its success:

Previously I was with domestic violence program, and they have a limited ability to help me out with things that I need. But with this program that I have right now they have unlimited ability, somewhat, to help me out with things that I may need. (cohealth Consumer 3)

This flexibility sometimes manifested as a lack of clarity, which some consumers identified as leading to less meaningful service engagement:

It would have been better if there was more clearer indication of exactly what was supposed to be done. For example, I would get a call from [Neami Nurse] asking how I was and then we would just have a general chat. If I actually knew what the program was trying to achieve and what its goals were, I would have perhaps tried to have gotten a little bit more out of the program. (Neami Consumer 9)

Overall, flexibility is clearly a strength of ICC, however this flexibility seems to have resulted in significant program drift when contending with the gaps in the fractured health system.

4.6.2 Filling gaps in the system

The issue of program drift must be understood in relation to the system ICC seeks to coordinate care within. There is, of course, the gap that ICC is intended to fill, that of care coordination. It is clear that ICC has also been drawn into filling larger sector gaps, particularly at the interface of physical and mental health systems. Consumers consistently identified that the health system was not meeting their needs:

I haven't been able to seek any mental health or get into the appropriate places that I need to be with my health, my mental health and everything else. It's just nothing's been happening. I'm being deterred from all the hospitals. No-one will take me on for my lungs. No-one will take me on for my other things, my mental health. The waiting list is too long and I'm just getting knocked back. (Neami Consumer 11)

Stakeholders agreed that even when services were available, the necessary spread or variety of approaches was limited:

I think because there is already so many clinical services out there, and there's not so many services out there to actually support people to implement health behaviours and to actually make those changes. (Neami ICC Staff 1)

The sense of the service system not fulfilling consumers' needs was not limited to service delivery but extended to the caring and compassionate way ICC provided the service. This can be thought of as a 'compassion gap' rather than a 'service gap'. These two themes, of ICC's flexibility and the gaps in the fractured health system, in the context of an initially imprecise program design, explain why the ICC has drifted. How this occurred is described in the remainder of this section.

4.6.3 Casework and generic support

Much of what consumers identified as positive about ICC is not actually care coordination and is more accurately described as case management or generic support. Examples include crisis support, advance care planning, linking consumers to education and resolving issues related to child custody, family violence, housing and hoarding. Specific examples included helping consumers with accessing the MyGov website, cancelling a pay tv subscription, and assistance to use the internet. When asked to comment on this, ICC staff identified a number of reasons for this, primarily pragmatic:

> *We're halfway working through their goals and suddenly, [a] domestic violence situation creates a risk of homelessness and we're not going to talk about our diabetes management until that's been dealt with. (Neami ICC Staff 4)*

This relates directly to the aforementioned gaps in the system. If the family violence and homelessness systems were able to respond immediately, ICC might not have to spend time supporting people with these issues. Reflecting this, another ICC staff member noted that this provision of casework and generic support stemmed from a need to provide services and support that the consumers actually needed:

> *I would love to be going to more GP appointments with clients, to be talking about their physical health, and helping to advocate for them in that space, absolutely. But that's not what these clients need first. (cohealth ICC Staff 2)*

Pragmatism was not the only reason for providing these services. Relational reasons for providing flexible support, rather than being bound to strict program limits, were highlighted by ICC staff:

> *What we're building there is trust. If you work with someone who's not travelling real well and you're spending time with them and working on that mental health, to get that mental health back to a stable condition, you've had a wonderful interaction where you've been able to build trust with that person. And the platform for then being able to do some really good work back in that physical health space because of the trust that person now has in you is invaluable. (cohealth ICC Staff 2)*

This reinforces the value of flexibility identified above. The experience of ICC consumers has shown that many barriers to improving health are social determinants and are not actually related to consumer's clinical care coordination needs. In addition, the lack of relational aspects and the ability to address these underlying issues dissuades consumers from engaging in some clinical services. This practice reality should be considered so that the provision of casework and/or generic support can be factored into the ICC model going forward (Recommendation 4).

A noted absence in the ICC model was any kind of clinical healthcare provision, particularly relating to clinical healthcare screening or assessments. This is reflected in the cohealth quantitative data. While nearly all cohealth consumers were listed as 'clinical care coordination', all contacts with cohealth consumers were categorised as 'psychosocial support', rather than 'clinical nursing services'. This may

be a missed opportunity for ICC, as the registered nurses have high level clinical skills, particularly relating to screening and assessment, which are not currently being well utilised. Neami's ICC program appears to be providing some clinical nursing services, however cohealth appear not to be. The evaluation team strongly recommend consideration of integrating nursing expertise into the ICC program model, particularly around physical health screening, as discussed in section 4.7.2 (Recommendation 8). The evaluation team do not recommend that ICC duplicate services provided or funded by other programs but should utilise clinical expertise where it will progress ICC goals, particularly in ensuring care coordination is targeted and effective.

4.6.4 Physical and/or mental health focus

A recurring theme in the evaluation data relates to the question of whether ICC is primarily a mental health program or a physical health program. The original request for tender from NWMPHN requires an 'integrated approach to supporting an individual's mental health and physical health needs', going on to specify that the program will 'utilise skilled mental health practitioners in the community and peer workers'. This integrated approach was not always reflected in the evaluation data, apparently reflecting the binary divisions, or 'siloing', of the mental and physical health systems. Sometimes, ICC was characterised as a physical health program:

> *…you do need to have a mental ill health diagnosis, but the support is for chronic physical health. (Neami ICC Staff 5)*

This perspective was echoed by the funding body:

> *It's definitely about physical health, it's about addressing the physical needs of people. … I don't think people getting referred for mental health needs to ICC was really an ambition [of the program]. (NWMPHN Stakeholder 2)*

Other times, ICC was understood as a mental health program, such as by this community health worker:

> *My work is fairly similar to ICC except for the mental health part. When people are struggling with their mental health and they can't manage general support systems that I offer, then I refer them onto ICC. (Neami External Stakeholder 2)*

As a general trend, physical health workers saw ICC as a mental health service, whereas mental health workers saw ICC as a physical health service. This was particularly stark when services had strict divisions in mental or physical health, such as accessing the NDIS:

> *Our service we can only support people if a psychosocial disability is the primary disability or impairment, as NDIS calls it. So … maybe ICC is supporting people with applications where physical health is the primary condition. (Neami External Stakeholder 4)*

A key contributor to this confusion is the nature of the referrals coming into ICC. As discussed in section 4.7.1, the majority of the referrals are internal:

> *cohealth has an abundance of allied health and that's where a lot of our referrals come from. So they're complex clients who need support in continuing to access the allied health in a more appropriate way, or they need linking in with mental health. Whereas I think the clients that are coming through to [Neami] are people whose mental health is pretty well managed because they have all of those clinicians supporting them. … in cohealth we've*

> *got a bit of messiness because it's the allied health referring to us and GPs who maybe have a client who isn't on top of mental health or chronic disease and isn't maybe supported with mental health. (cohealth ICC Staff 2)*

Ultimately, ICC staff themselves rejected the binary approach, noting the interrelationships between physical and mental health. This integrated approach was highly valued by consumers:

> *I have a mind attached to the body, and [ICC] would understand that. (Neami Consumer 10)*

ICC staff also noted the mixed messages from funders and their own organisations:

> *I just feel like there's a bit of a black and a white approach coming towards us to be focusing on one thing. But yet, it's not clear what that one thing really is. (Deidentified ICC Staff)*

As with the inclusion of casework and generic support, a focus on physical health or mental health should not exclude focusing on the needs of the consumer. The evaluation team proposes to reconcile these two issues with a model that includes some generic mental health support. This should only be provided if such support cannot be provided by other services and so long as that support can be shown to lead to improved physical health outcomes, even if only indirectly (Recommendation 4).

4.6.5 Peer support

The peer support elements of ICC have significant potential, however for a number of reasons the evaluation team were not able to evaluate if peer support has fully reached this potential. For cohealth ICC the peer worker was only employed part way through data collection, so many evaluation participants had concluded with the service before the peer worker had started. More fundamentally, for both service providers, there is no clear model for doing peer work in this context. Peer work is well established in mental health settings but has limited evidence base in physical health settings. It is not clear to what extent the principles of mental health peer work are transferable to physical health support. This was understood by Neami, which has a long history of employing peer workers:

> *I would agree with the notion perhaps from the other peer worker that there needs to be stricter framework. I think Neami does have pretty well-defined framework around its peer work. Is it implemented as thoroughly within the ICC space? Perhaps not. (Neami ICC Staff 4)*

The cohealth team in which ICC sits does not have as much organisational history with peer workers, which combined with the Victorian coronavirus restrictions to limit the potential of peer work during the first stage of the evaluation:

> *This is all new to us. So, our peer worker, initially what we wanted was for them to engage with clients and help facilitate our groups, or co-facilitate the groups with the EP. But obviously COVID is happening so we're not actually doing what we planned. (cohealth ICC Staff 3)*

Without clear guidance, much of the support provided by the Neami peer worker is better understood as generic support work, which, as identified above, was highly valued by consumers. Both Neami and cohealth staff identified that a model of peer work specifically adapted for this context would be beneficial (Recommendation 5).

The evaluation team noted that in some cases, peer workers were performing solely generic support work or largely administrative work. While generic support work and administrative work must comprise some of the peer work role, these should not dominate the role (Recommendation 5.2).

The evaluation team found that ICC peer work was not sufficiently promoted, and that when it was, it was not promoted with sufficient clarity:

> *I don't think I really ever got clear for myself what peer support was. I kind of asked her, "So are you a mental health practitioner?", and she said yes, but I don't think I was clear in my own mind about what her qualification was. (Neami External Stakeholder 1)*

When a peer work model has been developed and implemented, the role of peer work in ICC will require promotion to ensure stakeholder comprehension of the role (Recommendation 5.3).

For the above reasons, no external stakeholders or consumers were able to provide detailed feedback on the role of peer work in ICC. This will be a focus for the final stage of the evaluation.

4.6.6 Target group

As noted above in section 4.4, the people using ICC are likely only one subset of the intended target group. The target group for ICC is defined in the NWMPHN request for tender:

> *Individuals targeted by this commissioning service are required to meet the following criteria:*
>
> - *Severe and persistent mental illness including people with severely disabling forms of anxiety disorders and depression,*
> - *And with a diagnosis of one or more chronic condition such as diabetes, cardiovascular disease, musculoskeletal conditions, chronic pain, chronic kidney disease, chronic obstructive pulmonary disease (COPD), and chronic heart failure.*

'Severe and persistent mental illness' is not a clearly defined term.[21] Historically it was generally based on diagnoses of 'schizophrenia, schizoaffective disorder, bipolar disorder, major depression, autism, and obsessive-compulsive disorder',[22] however today is more often used to define 'a patient population rather than a disease entity'.[23] Others have proposed definitions based on 'dysfunction' and 'illness duration'.[24] The NWMPHN Mental Health Area Profile which was one stimulus for the introduction of ICC uses the National Mental Health Commission categorisation,[25] which excludes anxiety and depression other than 'severe depression', and further splits 'severe and persistent mental illness' into two further categories of 'severe episodic' and 'severe and persistent' resulting in psychosocial disability. A lack of clear and consistent definition makes assessing the target group difficult. It seems

[21] The Neami program logic uses both 'severe and persistent mental illness' and 'serious mental illness'.
[22] Michael P Carey and Kate B Carey, 'Behavioral Research on the Severe and Persistent Mental Illnesses' (1999) 30(3) *Behavior therapy* 345.
[23] Naomi Zumstein and Florian Riese, 'Defining Severe and Persistent Mental Illness—A Pragmatic Utility Concept Analysis' (2020) 11 *Frontiers in Psychiatry* <https://www.frontiersin.org/articles/10.3389/fpsyt.2020.00648/full>.
[24] Alberto Parabiaghi et al, 'Severe and Persistent Mental Illness: A Useful Definition for Prioritizing Community-Based Mental Health Service Interventions' (2006) 41(6) *Social Psychiatry and Psychiatric Epidemiology* 457.
[25] National Mental Health Commission, *2014 Contributing Lives Review* (National Mental Health Commission) <https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports/2014-contributing-lives-review>; North Western Melbourne PHN, *NWMPHN Mental Health Area Profile* (North Western Melbourne PHN, 2018) <https://nwmphn.org.au/our-community/community-and-population-health-profiles/>.

implied in the above definition that eligibility should require that the diagnosis is severe, persistent and severely disabling, although this is not currently represented in the ICC inclusion criteria.

The eligibility criteria require a clinical diagnosis; however, these diagnoses are self-reported by consumers either at referral or on intake. This gives a sense of clarity and clinical legitimacy which is not necessarily reflective of reality, while also potentially excluding consumers who do not have or reject their clinical diagnosis but still have complex interplay between their physical health and mental state. The evaluation team recommend that ICC staff are able to use discretion in applying the eligibility criteria to ensure that those who have eluded, rejected or are uncomfortable with, diagnosis are still able to access the program. This might, for example, include eligibility for people without formal diagnosis who experience disabling mental distress (Recommendation 3.4).

As noted in section 4.4, the most common mental health diagnosis for people in both programs is depression and/or anxiety. In the quantitative data, anxiety or depression are mentioned 33 times, while schizophrenia was only mentioned once and bipolar disorder not at all.[26] For Neami, half of people using ICC have a diagnosis of both chronic pain and depression and/or anxiety. cohealth comorbidity data was not provided, however in the qualitative data pain is mentioned 73 times, much more than diabetes (n=49), cancer (n=12) or heart disease (n=8). One stakeholder even misunderstood ICC as being primarily a pain management nursing service:

> *[Neami ICC Nurse] was in kind of a fairly clear pain management nursing role. (Neami External Stakeholder 1)*

Without diminishing the seriousness and impact of chronic pain, the overrepresentation of people with this experience may be masking ICC's limited connection with other eligible consumers. Complicating the issues is that people who experience chronic pain are much more likely to be subsequently diagnosed with depression and/or anxiety,[27] however it is not clear from the data if the poor mental health of this subgroup of ICC consumers is a result of chronic pain or if the relationship is not causal. It is possible that the high numbers of people seeking ICC assistance for chronic pain reflects gaps in mainstream care coordination services for people with chronic pain or a resistance in those services to work with people with mental health diagnoses. This may be further complicated by perceptions of 'drug seeking behaviour', diagnostic overshadowing or other barriers to access for this group.

Put simply, the group of people accessing ICC does not overlap significantly with the group of people at highest risk of early death, being those who experience psychosis and cardiovascular disease, respiratory conditions, and/or cancers,[28] although it does appear successfully to improve self-assessed quality of life for people living with chronic pain. As outlined below, ICC receives very few referrals from NWMH. NWMPHN, Neami and cohealth should confirm or refine the target group without detracting from the flexibility which makes ICC different from other services (Recommendation 3).

Neami and cohealth should ensure data collection and reporting which allows more detailed analysis to determine the extent to which this group is actually being reached (Recommendation 17). Success in

[26] Using qualitative data in this way is inconclusive however strongly indicates a focus from all participant groups on some diagnoses over others.
[27] Alex Holmes, Nicholas Christelis and Carolyn Arnold, 'Depression and Chronic Pain' (2013) 199(6) *The Medical Journal of Australia* S17.
[28] Suggett et al (n 1).

reaching a broader target group will relate to improved program promotion and a broader range of referrals as discussed below.

4.7 Other Specific Findings

As detailed above, the main findings of the evaluation for future consideration focus on program clarity and program drift. In addition to these, the evaluation team identified a number of other areas for consideration. These all require the above issues of program clarity to be resolved first. This section presents the evaluation findings related to program promotion and referrals, intake assessment and screening, package allocation and targets, brokerage funding, reviewing the program logic models and to linking to broader social determinants.

4.7.1 Program promotion and referrals

As is to be expected for a new program, ICC is not well known in the sector. Even consumers who had worked with ICC, some fairly extensively, found it difficult to distinguish between ICC and other parts of Neami or cohealth. Coronavirus restrictions have exacerbated this issue, leading to a preponderance of internal referrals.

Many professional stakeholders told the evaluation team that they were only passingly familiar with ICC, including this cohealth employee:

> *I have to say, I feel like we should be working together more. I only heard about one of the workers in ICC through a client that was referred to us. (cohealth External Stakeholder 12)*

Promotion was particularly difficult in relation to GPs. One GP reinforced this barrier:

> *The biggest problem with services like this is it's hard for GPs to find out about them. GPs get bombarded … with information and services all the time and maybe sometimes you get a bit distrustful because you're like what's going to be good and what isn't. And I think this is probably a real problem, how do you guys let GPs know that this is available? (Neami External Stakeholder 7)*

Both Neami and cohealth identified that due to the small size and limited resources of the pilot program, program promotion was not a significant feature of the implementation plan. This should be revisited as effective program promotion will address some of the issues related to the target group, discussed above at 4.6.6 (Recommendation 13). Increasing the number and appropriateness of incoming referrals will also assist with this. On exit, with the consumer's consent and where appropriate, ICC should provide a letter back to the initial referrer outlining what has been achieved, the ongoing health goals, health referrals that have not yet been completed and the opportunity to reengage if needed (Recommendation 14). This both improves continuity of care and promotes the success of the program.

Incoming referrals

As can been seen in Figure 7, referrals into both programs have maintained a steady progression over time.[29] Figure 8 and Figure 9 break down incoming referrals by source. While the Neami and cohealth data are not directly comparable, two trends are immediately clear. One is that the majority of the referrals are internal (this is not explicit in the cohealth data but is confirmed in the qualitative data). This reinforces the need to promote the program externally to ensure equity of access, in line with the key objective of ICC to ensure 'access to physical and mental health services and supports' (Recommendation 13).

Secondly, there are very few referrals from NWMH, the local public mental health service, or from external general practitioners. cohealth data records a total of four referrals from NWMH. Neami quantitative data indicates none, but qualitative data identifies a very small number.

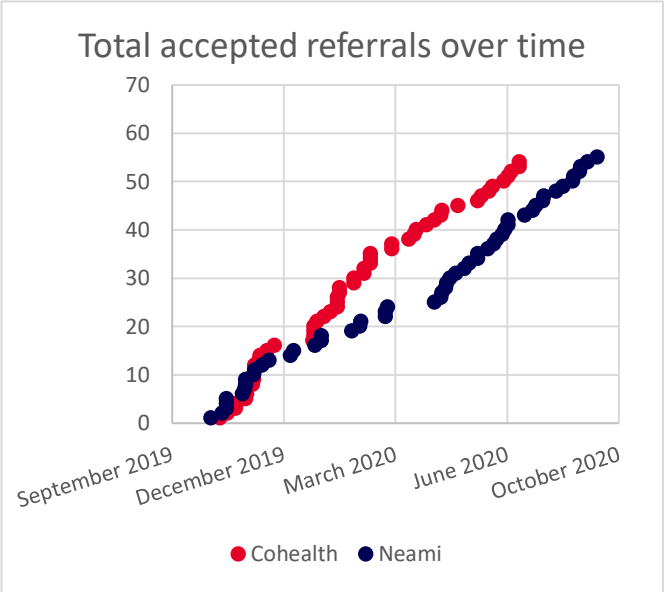

Figure 7 - Total accepted referrals over time

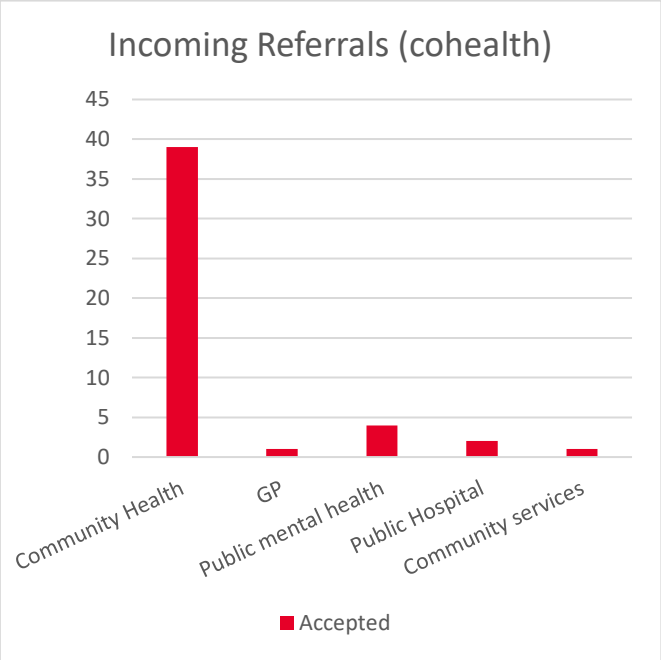

Figure 8 - Incoming referrals (cohealth)

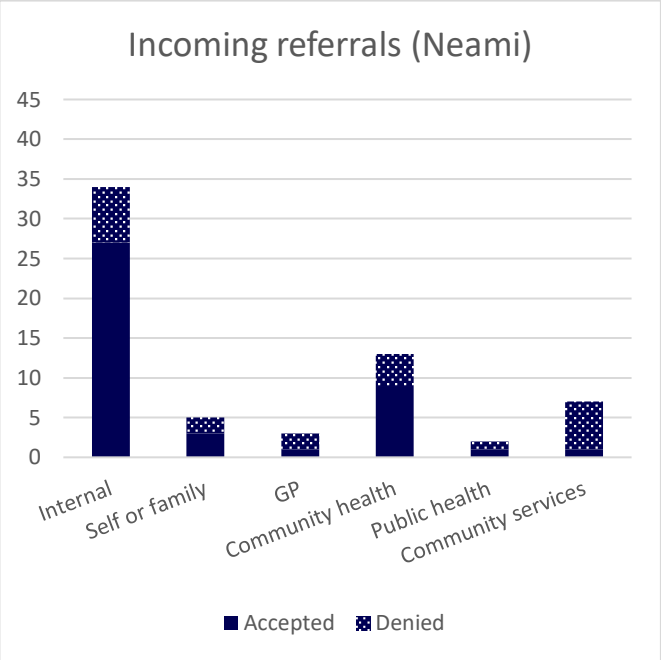

Figure 9 - Incoming referrals (Neami)

Neami noted that the lack of referrals from NWMH was not anticipated in the program planning:

> *When we started talking about implementing the program, we assumed that once the clinical services will know about this program there'll be floods of referrals. They would*

[29] Rejected referral data and data after June 2020 were not provided by cohealth.

want to discharge people and want to have someone else working with them. So that assumption wasn't correct. (Neami ICC Staff 5)

Similarly, NWMPHN anticipated that ICC would be working more closely with people exiting public mental health services:

This program should sit somewhere in a care pathway where, for people who are exiting [NWMH] but it's not exclusive. It's not a referral criteria. (NWMPHN Stakeholder 2)

cohealth also noted surprise at the lack of referrals from NWMH:

It seemed like a no-brainer … there's this demographic, all we have to do is wait and they will send them down to us. That didn't happen, I mean I think [cohealth ICC] has had three or four clients from [NWMH] in 12 months. (cohealth ICC Staff 1)

In explaining why these referrals were not forthcoming, a cohealth representative identified that the relationship may not have been fostered as well as it might have been:

Either the need was overblown, either the relationship just wasn't well built … perhaps a greater relationship should have been built up from the very first day between [NWMH] and [cohealth ICC]. … we still actually don't have a number at PHN who is supposed to be our direct contact where we have a familiar relationship and we can talk about how this is going. (cohealth ICC Staff 1)

The lack of referrals from NWMH is a cause for concern and should be addressed (Recommendation 13).

The low numbers of referrals from general practitioners are also a cause for concern. The evaluation team consulted with three general practitioners who had worked with ICC consumers in partnership with ICC staff. All three strongly supported the role of ICC and noted the benefits it had for their patients, confirming a very high demand:

I've got a heap of other patients who're in the same sort of situation. … And so I can see that there is a huge … there would be a huge demand for this. … We've got a clinic that has 17 GPs … who would all have probably 10 patients who could do with different accommodation, and supports, outside of just the general practice. (Neami External Stakeholder 6)

Given this high demand for ICC the low level of referrals from general practitioners is likely related to challenges with program promotion to this group. ICC should develop strategies to overcome these challenges (Recommendation 13). Closer relationships with general practice would also facilitate improved health screening, as discussed in the following section.

Outgoing referrals

Outgoing referrals appear to be being provided consistently and in line with best practice principles. The potential exception to this is physical health screening, as identified in the following section, but no consumers identified any concerns relating to the referrals organised by ICC.

Both Neami and cohealth provided some referral data however it is not of sufficient quality to develop a referral map as originally intended. The evaluation team will work with Neami and cohealth to ensure

the required data is collected prior to the final evaluation (Recommendation 17) and a referral map will be developed for inclusion in the final report.

One area for consideration is the requirement that ICC consumers be linked into GP care. ICC staff have found that virtually all consumers have a GP, however consumers identified that this GP care was not always ideal or supportive. The evaluation team recommend this performance metric be reconfigured to something more meaningful, such as a requirement to ensure consumers have a plan for ongoing GP care (Recommendation 16).

4.7.2 Intake, assessment and screening

ICC requires a much clearer and consistent intake and assessment process. This relates to some extent to program clarity and consistency, as the current intake and assessment tools and processes are unsatisfactory for either a physical health or mental health program. Poor physical health screening and subsequent lack of intervention for people who use mental health services is one of the most significant contributors to increased mortality in this group.

The cohealth establishment plan indicates that the assessment tools used will include the LSP-16 and other measures 'as devised with program independent evaluation'. The cohealth tender indicates that the K-10, Health of the Nation Outcome Scale (HoNOS), Health Prompt or other screening tools may also be used. Neami are also using, depending on the situation, Health Prompt, LSP-16 and K-10. Neami have developed a specific ICC Screening Tool which is essentially an intake tool with some high-level screening elements. The cohealth documentation does indicate that the ICC staff will undertake assessment, in places described as 'comprehensive' and 'individualised', however this is not detailed and may have intended to refer to physical health, psychosocial or some other assessment.

The evaluation team encountered some mixed understanding as to what level of screening and assessment ICC would undertake:

> *It's very unclear. And I think if the PHN could come back and say specifically this is only about health, then tell me why I need to be doing K10s on people. Because they're really quite invasive questions. Especially over the phone, especially when you've never met a person. And then you're never going to address any of those things again and you're just going to move on to talking to somebody about why they want to – how they're going to increase their walking or get on to the NDIS. What relevance is it? (Deidentified ICC Staff)*

ICC staff indicated a preference for thorough physical health screening and assessment, with psychosocial assessment included where they related to physical health concerns:

> *My understanding the RNs role was perhaps to start with people's physical health assessment. But also, holistic assessment and see where they were at and what supports that they needed with their chronic physical health condition. (Neami ICC Staff 5)*

The mix of physical and mental health screening and assessment tools reflects the lack of program clarity identified in above in section 4.6. If ICC ultimately aims to address physical health, then the primary assessment tools should not be the LSP-16 or the K-10. It appears that ICC staff are spending unproductive time conducting mental health assessments when their time and expertise would be more productively spent on physical health screening (Recommendation 7). Where appropriate, mental health assessments should be used when useful for understanding a person's experience and distress. These assessments may be consumer focused tools rather than psychometric assessments.

During the file analysis the evaluation team identified a number of possible missed opportunities for physical health screening. This analysis is limited due to the data, which included ongoing consumers where screenings may have been organised but not yet completed or documented. For cohealth files, it appears that screening data may be in cohealth GP files rather than in the ICC files provided to the evaluation team. One file was a brief intervention and not included in the analysis.

Understanding these limitations, the evaluation team identified significant gaps in health screening, particularly in assessing the risk of cancer, cardiovascular disease and diabetes. In many files the evaluation team was unable to find evidence of any comprehensive physical health screening. Family history, sexual health, dental and medication reviews were also not documented. In total, the evaluation team identified 50 potential missed opportunities across 15 files, however these may have been documented in other files, such as general practitioner files, which had not been provided to the evaluation team, or may have been offered and refused by the consumer. Some further missed opportunities were identified in following up referrals and ensuring continuity of care. Ideally, the formulation of health priorities should be undertaken by the person's general practitioner, although facilitation and implementation of the plan may be coordinated by ICC and documented in the person's ICC file.

This finding, from the file reviews, should be understood in the context of the consumer experience, which clearly showed that consumers felt cared for. The missed opportunities for improved screening are not a reflection on the quality of care provided by the ICC staff, but stem from program clarity issues identified above and variability in comprehensive care planning by the person's general practitioner. However, ICC does not have a clear model for screening based on clinical guidelines:

> *When I started in [ICC], it wasn't quite clear what kind of screening am I meant to be doing? Am I meant to be doing diabetes specific screening or whatnot? (Deidentified ICC Staff)*

The other complicating factor, also identified above, is the need to start where the consumer is:

> *It's consumer-driven. Because I will get referred a client who the GP is like "just get them to see a psychologist", or "they're just not taking their medications properly". You have a conversation with the client and you find out it's because they're experiencing family violence, so of course it's not their priority to do those things. They can't get to the pharmacy without their abusive partner or whatever it is. You need to address that stuff first. This is why these conditions are chronic and often mismanaged. (cohealth ICC Staff 3)*

ICC staff supported reforming the screening process, however this requires a comprehensive review, rather than just adding additional screening tools to the current requirements:

> *We already do so much screening and so many question asking processes with the consumer that once we do the registration and get their perspective on it, then we do the health prompt, then we do the LSP-16, I feel like we're just going checklist after checklist after checklist. (Neami ICC Staff 1)*

In addition to screening related to identified issues, the evaluation team identified the potential for ICC to screen and coordinate intervention as clinically indicated for issues not related to the main presenting physical condition. This requires an integration of a holistic primary, secondary and tertiary prevention

into the ICC model.[30] As noted in section 4.4, the majority of ICC consumers have multiple physical health diagnoses, and many are at high risk of developing other conditions. In partnership with the consumer's general practitioner, ICC should work to ensure that ICC consumers receive the same level and quality of screening that the general population receives and additional targeted screening according to clinical guidelines, such as those developed by the Royal Australian College of General Practitioners (RACGP) in the Red Book.[31] The high level of trust ICC consumers have in ICC will support effective screening and promote proactive follow up.

Using increased clinical judgement to determine appropriate screening requires an increased reliance on the nursing training of the ICC care coordinators (Recommendation 8). This requires ongoing support and safeguarding to ensure success. The evaluation team recommend targeted training in clinical screening interventions specifically for this cohort (Recommendation 8.1). Additionally, the ICC care coordinators should be able to access regular secondary consultation via a specialist general practitioner, both as a quality improvement measure and as a safeguarding measure (Recommendation 8.2). This is occurring already in some cases where ICC has an existing relationship with the consumer's general practitioner, but in cases where this is not occurring there should be some mechanism for ensuring expert clinical oversight.

Once issues of program clarity and drift are resolved, the ICC requires an appropriate and adaptable screening process (Recommendation 6). The evaluation team do not recommend that ICC staff necessarily undertake screening, but strongly recommend they coordinate screening and ensure that it has been undertaken by appropriate health professionals. This process should integrate the collection of data so that the effectiveness of the revised screening process can be evaluated in the final stage of the evaluation (Recommendation 17). Consumers exiting from the service should be supported to develop a clear plan for addressing ongoing issues which should be shared, with consent, with the person's GP (Recommendation 16).

4.7.3 Package allocation and targets

The evaluation team reviewed package allocations for ICC and recommend changes to service levels, overall numbers and geographic distribution.

ICC was originally conceived with 'brief', 'moderate' and 'comprehensive' service levels. Overwhelmingly, the evaluation team found that 'brief' interventions were not appropriate for ICC. Potential consumers who only required 'brief' interventions could and did receive these from their GP or other health practitioner and did not require ICC support. Chronic physical health conditions and disabling psychosocial experiences cannot be resolved with 'brief' interventions. The evaluation team recommend that the package allocations are reconfigured (Recommendation 18.1). This may include making ICC 'brief' interventions available as secondary consultation sessions to other mental and physical health professionals, creating a longer term 'more than comprehensive' service level, or simply redistributing the 'moderate' and 'comprehensive' targets. An alternative model might reconfigure brief interventions as periodic follow up or 'check in' sessions over a longer period of time when intensive support is no longer required. It does not appear that 'brief' interventions can be usefully recategorised as 'group' interventions as group participation inevitably led to 'moderate' or 'comprehensive' service support.

[30] Lisa A Kisling and Joe M Das, 'Prevention Strategies' in *StatPearls* (StatPearls Publishing, 2020) <http://www.ncbi.nlm.nih.gov/books/NBK537222/>.
[31] Royal Australian College of General Practitioners, *Guidelines for Preventive Activities in General Practice.* (2016).

Overall target numbers also require refinement. The Neami and cohealth targets appear quite different without clear justification. The evaluation team recommend that these targets are recalibrated to reflect more realistic service provision, with temporary allowances to reflect Victorian coronavirus restrictions (Recommendation 18.2).

Currently, ICC is expected to provide a consistent number of packages in each LGA. The justification for this is unclear, as health provision and socioeconomic experiences differ widely across the LGAs. The evaluation team recommend targets that reflect contributors to early mortality (see section 4.6.6) rather than geographic distribution (Recommendation 18.3).

4.7.4 Brokerage funding

The original request for tender from NWMPHN specifies the use of brokerage funds as part of ICC. cohealth appear to be using brokerage, however Neami do not appear to be. Neami appear to be instead referring ICC consumers to other Neami programs which have brokerage. Within the context of the Victorian coronavirus restrictions, brokerage appears to be used for slightly different needs than might otherwise be the case. The evaluation team recommend that Neami and cohealth develop a clear set of guidelines for using brokerage (Recommendation 10) and the evaluation team will revisit this in the final report.

4.7.5 Program logic review

The program logic models are generally fit for purpose but require review to ensure they are relevant (see program logic models in Appendix 1 and Appendix 2). For example, Neami's program logic refers to employment support and referrals and addressing welfare dependency, which have not been core foci of the program. The revised program targets should also be reflected in the revised program logic models.

In addition, it would be useful for evaluation purposes if the program logic models used the same outcomes measurement. The evaluation team understands that the programs are run differently, however most outcome measurements could be shared. This would allow the final evaluation to measure, for example, quality of life, and compare this measure across programs and across time (Recommendation 19).

4.7.6 Linking to broader social determinants

ICC was not conceptualised to target the underlying social determinants of physical and mental health that led people to become eligible for ICC. Despite this, much of the work ICC has had to do has been in response to these underlying issues. As noted above, the evaluation team recommend that the ICC model include an element of generic support work where that is required to improve a person's physical health and where that is not available elsewhere (Recommendation 4). Beyond this, ICC does not appear to be linked in any substantial way to addressing these underlying issues at a social level.

Both Neami and cohealth already undertake strategic advocacy, including through the Equally Well collaborative impact model,[32] however it is not clear that ICC has a structured role in contributing to this. For example, the ICC pilot has shown significant demand for pain management care coordination and further highlighted known gaps in the mental health and disability support systems, all of which require urgent attention to reduce ongoing demand on ICC and to allow ICC to focus on its intended purpose. The evaluation team do not suggest that ICC should be diverted from its key role of care

[32] Russell Roberts et al, 'Improving the Physical Health of People Living with Mental Illness in Australia and New Zealand' (2018) 26(5) *Australian Journal of Rural Health* 354.

coordination, but where opportunities exist to address underlying social determinants of physical and mental health they should not be missed (Recommendation 11).

5 Conclusion

In conclusion, preliminary findings show that ICC has had a very successful implementation and is highly valued by consumers. As with all pilot programs, ICC must continue to refine and reform to provide the most appropriate service. This requires increased program clarity, but this must not compromise the elements of ICC which make it successful.

6 Interim recommendations

These interim recommendations are based on the findings of the midterm review. They represent the professional opinions of the evaluation team, based on rigorous analysis of evaluation data against the key evaluation questions and program logic models. These recommendations are intended to support the implementation of ICC and enable a successful final evaluation.

Ownership and carriage of each recommendation will need to be determined by the relevant parties. The evaluation team suggest that an approach based on collaborative commissioning, rather than straightforward procurement, by NWMPHN, is most likely to address the identified issues.

Continue to deliver ICC

1. Continue to deliver ICC.
2. Maintain the elements of ICC that are highly valued by consumers, particularly:
   2.1. Consumer focused care and support.
   2.2. Flexibility.
   2.3. Assertive coaching.
   2.4. Compassionate and caring support.

Review the ICC Model

3. Review the ICC target group. Specifically:
   3.1. Address the gender imbalance and ensure equity of access for men, without limiting access to other eligible groups.
   3.2. Review the program offering to ensure relevance to the age range of consumers.
   3.3. Ensure ICC is targeting those who are most at risk of early death and poor physical health.
   3.4. Consider discretionary eligibility not based on clinical diagnosis.
   3.5. Ensure ICC is accessible to consumers born overseas or whose main language is not English.
4. Formalise the role of generic mental health support work and/or case management in the model, where there are clear indirect benefits for a consumer's physical health and no other services are available.
5. Develop or adopt an appropriate model for ICC peer work.
   5.1. Peer supervision should be integrated into any peer work model.
   5.2. Ensure that peer workers are conducting peer work and not overly focused on administrative or generalist support work.
   5.3. Promote the peer work model to ensure stakeholder comprehension.
6. Formalise an approach to physical health screening that incorporates a holistic primary, secondary and tertiary prevention approach. ICC nurses should either:
   6.1. Conduct physical health screening directly, where appropriate, or
   6.2. Ensure physical health screening is conducted by other health professionals and ensure appropriate follow up.

7. Screening tools should relate to physical, not mental health, other than when clinically indicated or therapeutically useful.
8. The clinical nursing skills of the ICC care coordinators should be utilised, particularly in physical health screening where clinically appropriate.
   8.1. The ICC care coordinators should be provided with training specific to this cohort.
   8.2. The ICC care coordinators should be able to access secondary consultation via a specialist general practitioner.
9. Providing secondary consultation to other health professionals should be formalised as part of the ICC model and included in performance reporting.
10. Develop a set of guidelines for brokerage funding.
11. Consider how ICC might contribute to the underlying social determinants of poor physical and mental health.

Embed system integration

12. Develop referral pathways with external agencies, particularly NWMH and general practice.
13. Promote ICC to other services to increase awareness and engagement with service partners.
14. Explore strategies for improved collaborative care and integration.
15. Consider co-location as a method of building incoming referral pathways.
16. Consumers exiting ICC should have a clear plan for addressing ongoing issues which can be provided to their GP.

Ensure robust and efficient data collection

17. Revise ICC data collection processes.
    17.1. Data collection should be embedded in an appropriate intake and assessment tool to minimise data handling.
    17.2. Collect data using a standardised framework building on PMHC-MDS.

Recalibrate reporting requirements

18. Review ICC targets and package allocations. Specifically:
    18.1. Review the utility of 'brief' interventions.
    18.2. Recalibrate performance targets to reflect more realistic service provision.
    18.3. Assess performance targets based on equity of access and broad target groups rather than geographical distribution.
19. Review program logics to ensure relevance.

Appendix 1. cohealth Program Logic

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
People experiencing serious mental illness have high rates of chronic disease compared to the general population. This has significant impacts on morbidity and mortality, as well as community participation. Population data shows that mental illness in the Brimbank and Maribyrnong LGAs is growing. People experiencing serious mental illness face significant barriers to achieving optimal physical health including medication side effects, psychiatric symptoms and access to services. There are evidence based interventions which have been shown to improve the health and wellbeing of this group. It is cohealth's experience that consumers even when linked to mental health services, are not well linked to physical health services which meet their needs.	*Funding – Integrated Chronic Care program plus in-kind contributions from existing services.* *Partnerships with GP's, Area Mental Health, Mental Health nurses, counsellors, psychologists and psychiatrists and hospitals.* *Collaboration with cohealth ATSI & Refugee Health teams.* *Care Coordination space, desks, telephone (landline and mobile), computers and group materials.* *Group venues (cohealth and community).* *Client management system.* *Qualified and accredited staff.*	*Provide care coordination to clients of the target group to develop care plans, liaise with care partners, coordinate case conferences and supported on referral.* *Develop a three-tiered support program for consumers with varying support needs.* *Deliver individual care coordination to clients in the catchment. Develop care plans, provide health information, referral and liaison with other health professionals involved in the care.* *Establish and maintain referral pathways inclusive of physical and mental health and which promote community participation.* *Using codesign principles provide two dedicated exercise group sessions per week and one group session with a dietitian a fortnight.*	*12-180 clients to have their care coordinated per year.* *It is proposed up to 12 clients a year may access the comprehensive package of care, 35 to access the moderate package of care and between 90-180 may access the brief level of care.* *All clients to have a goal directed care plan.* *Deliver 80 group exercise sessions per year and 20 sessions with a dietitian per year.* *Referral into the program is streamlined.*	*Short term* *For consumers to have improved skill and confidence in managing their chronic disease.* *Access to physical health services is improved.* *Group health education and exercise programs are developed which meet the needs of the target group.* *Long term* *To improve the physical health of people experiencing severe and persistent mental illness living in Brimbank and Maribyrnong.* *The cost from developing and worsening of chronic disease is reduced.* *Quality of life of participants is improved.* *Clients linked into longer term supports where necessary (i.e. NDIS).*	*Referrals made to other services.* *Relevant changes to consumer circumstances of physical health, mental health, personal safety, community networks, family functioning, money, employment and housing.* *Progress with achieving goals including: Changes in knowledge, skills, behaviours, change in confidence and / or engagement with service.* *Client satisfaction with service.* *Client demographic information including age, gender, location.* *Number of consumers in receipt of services, length of care episode, hours of service and level of support provided.* *Linkages and referral pathways developed.* *Brokerage use.*

Appendix 2. Neami Program Logic

AIM

Provision of an enhanced care coordination service in a primary care setting to improve the physical health of people experiencing severe and persistent mental illness across the Hume, Moreland and Moonee Valley LGAs.

OBJECTIVE

That individuals experiencing severe and persistent mental illnesses who can be or are being appropriately managed in a primary care setting:

- are supported to achieve improved outcomes, including better self-management, for their chronic conditions;
- are offered access to physical and mental health services and supports.

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
Describe the context and critical issues that the program intends to address.	*List all the resources (e.g. time, finances, partnerships, equipment and facilities) that are required to implement the program*	*List the particular actions or activities the program intends to undertake e.g. develop skills training, deliver counselling sessions, provision of health advice. To ensure the activities link to the outputs it might help to ask, 'what activities need to be undertaken to deliver the desired outputs?'.*	*Quantify how many actions or activities plan to be delivered by the program (e.g. 10 skills training sessions delivered) and identify all stakeholders the program plans to engage (e.g. 14 mental health partnerships formed, or 20 mental health community organisations engaged). To ensure the outputs link to the short- term outcomes it might help to ask, 'what products, services and engagement need to be delivered to achieve the short-term outcomes?' [Be careful not to confuse outputs (what is delivered) with outcomes (what changes are caused)].*	*Enter the outcomes or changes that are expected to occur as a result of the program. (In some cases, it may be useful to specify if there is a mix of short term and longer term outcomes - this may be variables that determine whether there is a short term or longer term focus).* *Consider the use of 'SMART' criteria to ensure outcomes described are: Specific Measurable Achievable and attributable Relevant and realistic Time bound and able to be tracked.*	*This may include specific qualitative and quantitative data reporting; KPIs.*

Appendix 2 - Neami Program Logic

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
People experiencing serious mental illness face higher risk factors for chronic physical conditions than the general population	Experienced Mental Health Nurse with Optimal Health Program (OHP) / chronic health management training	Individual and group coaching (OHP) designed to support consumer development of physical and mental health literacy	60 consumers p/a	People with severe and persistent mental illness have greater physical and mental health literacy	Number of hours / sessions provided across three support tiers Number of OHP Health Plans developed / reviewed IM-SA Self-reporting Measure and other tools Health Literacy Questionnaire uptake Number of OHP Health Plans developed / reviewed
	Experienced Mental Health Nurse with CRM / OHP / chronic health management training	Individual and group coaching (OHP) designed to support consumer development of physical and mental health self-management skills	60 consumers p/a	People with severe and persistent mental illness have greater physical and mental health self-management skills	IM-SA Self-reporting Measure and other tools
	Primary care partnerships	Consumer referral into existing primary care partner agencies	60 consumers p/a – all consumers will exit with a link to a primary care service	Consumers are successfully referred into primary care	Number of successful primary care referrals
	Time to develop additional primary care partnerships	Development of additional primary care partnerships	12 partnerships developed p/a	Robust primary care partnerships are identified and developed	Number of new partnerships developed

Appendix 2 - Neami Program Logic

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
	Time to map and engage GPs	Engagement of GPs in support of integrated chronic care	60 consumers p/a	Each consumer exiting the service is connected to a GP for ongoing chronic care support	Evidence of consumer / GP links
	Skills, tools and time to provide care coordination; support of a multi-disciplinary team, including PSWs (PSS)	Coordination of integrated physical and mental health care for consumers with chronic conditions	60 consumers p/a Each consumer will receive an Integrated Care Plan and a detailed Discharge Plan	Each consumer has an Integrated Care Plan	Number of Integrated Care and Discharge Plans Integrated Care Planning Protocols and Procedures documented for the service
	Time to map available programs and activities Funding for: ▪ Nursing FTE ▪ Vehicle ▪ IT equipment ▪ Co-location with existing team ▪ Supervision and professional development ▪ Promotional activity	Consumer access to Neami and external Health Promotion programs and activities	60 consumers p/a offered access to Neami Health Prompt and full health assessment	Consumers are engaged in a range of Health Promotion programs and activities as part of their Integrated Care Plan	Number of Health Promotion programs and activities identified Number of consumers offered Health Prompt and referred into external programs

Appendix 2 - Neami Program Logic

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
Consequences of higher rates of physical conditions for people with serious mental illness include: ▪ much shorter life expectancy ▪ higher levels of ongoing disability because of both physical and mental illness ▪ reduced workforce participation and productivity ▪ greater likelihood of welfare dependency and poverty	Experienced Mental Health Nurse with OHP / chronic health management training Knowledge and experience accessing and navigating the NDIS and disability services Experienced Mental Health Nurse with OHP training Experienced Mental Health Nurse with OHP training Funding for: ▪ Nursing FTE ▪ Vehicle ▪ IT equipment ▪ Co-location with existing team ▪ Supervision and professional development ▪ Promotional activity	Individual and group coaching OHP) designed to support consumer awareness of mid-to-long term consequences of co-morbid physical and mental illness Coordination of access to NDIS and other disability support initiatives Coaching support for consumers wishing to incorporate employment- related goals into their health management Coaching support and care coordination to address consumer experience of welfare dependency and poverty	60 consumers p/a All eligible NDIS consumers are supported to access NDIS Appropriate consumers referred to current partner agency, JobCo Appropriate consumers linked to PSWs with relevant lived experience of gaining education, training and employment for coaching support	Consumers are aware of the impact of comorbid physical and mental health issues Consumers are engaged in diverse, integrated disability support Consumers are actively working toward supported or open employment Consumers are actively addressing issues of welfare dependency and poverty	IM-SA Self-reporting measure and other tools Number of NDIS applications supported Number of referrals made Number of Integrated Care Plans that address welfare dependency and poverty Number of consumers linked with PSW / referred to external services

Appendix 2 - Neami Program Logic

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
People experiencing serious mental illness also face significant and specific barriers to achieving optimal physical health outcomes such as the side effects of medications, access to physical health services, low socioeconomic status, housing instability, and psychiatric symptoms	Access to existing Neami National partnerships; support of a multi-disciplinary team, including PSWs (PSS) Time to develop additional cross-sector partnerships Funding for: ▪ Nursing FTE ▪ Vehicle ▪ IT equipment ▪ Co-location with existing team ▪ Supervision and professional development ▪ Promotional activity	Consumer referral into existing cross-sector partner agencies to address barriers to achieving optimal physical health Development of additional cross-sector partnerships to address barriers to achieving optimal physical health	Consumers referred to existing cross-sector partners as required 6 – 8 additional cross-sector partnerships developed	Each consumer is aware of the barriers specific to them and is actively supported to address these barriers Additional barriers and partnerships are identified Integrated, systems level approach is underway to address barriers	Number of referrals to other sectors IM-SA Self-reporting measure and other tools Number of new partnerships formed Evidence of cross-sectoral engagement designed to address barriers
Mental illness in the NWMPHN catchment is growing rapidly	Experienced Mental Health Nurse with OHP training Funding for: ▪ Nursing FTE ▪ Vehicle ▪ IT equipment ▪ Co-location with existing team	Individual and group coaching (OHP) to ensure people with severe and persistent mental illness are engaged and have coordinated access to the stepped care system	60 consumers p/a	People experiencing serious, as well as low-to-moderate, mental illness are identified and engaged in coordinated care	Number of consumers engaged who were not previously engaged in regular Mental Health support

Appendix 2 - Neami Program Logic

CURRENT SITUATION	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	MEASURES
	▪ Supervision and professional development ▪ Promotional activity				

EXTERNAL FACTORS/CONTEXT

Assumptions – what unexamined beliefs do you have about how or why the program will work?

- Primary care providers will be willing to engage in integrated care planning processes
- Consumers will engage for the duration of their support package
- Consumers will act upon goals and planning developed in coaching and care coordination
- Consumers with chronic physical illness will be able to participate in integrated chronic care coaching

External Factors- What is outside your control but will impact your program/ activity? [Political; social; cultural and geographic environments that may influence program delivery and outcomes]

- Political trends around the funding of primary care, mental health, health promotion and other programs, impacting referral points and ongoing collaboration of service involved in integrated care planning
- Cultural preferences within priority groups around types / modes of engagement in care
- Continued success of the PSS program as the supporting framework for ICC activities