ST VINCENT'S
HEALTH NETWORK
SYDNEY

Inclusive Health Strategic Plan 2020 – 2025

The St Vincent's Way

"It's all well and good to come in here and get physically well, and get fed well here and sleep, get medicated if needed, but once we walk out that door, for those people that haven't got any plan in place, that's important. The follow up is important – have you got support? Have you got a support network in place?"

St Vincent's patient

Dalarinji – "Ours belonging to Us" painted and written by Lani.

Acknowledgements

We would like to acknowledge the land of the Gadigal & Burramattigal peoples of the Eora Nation; as well as the Dharug Nation on which our services are built. We pay respects to Elders past and present and we walk and work together in the journey of improving Aboriginal and Torres Strait Islander health outcomes.

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ST VINCENT'S HEALTH AUSTRALIA

ST VINCENT'S CURRAN FOUNDATION

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UTENSILS

Foreword

Our founders, the Venerable Mary Aikenhead and the Sisters of Charity had an overriding vision to serve people who experience poverty and vulnerability. This service comes out of a commitment to love the people they encounter, especially those experiencing trauma and rejection. The Sisters gravitated towards working with people who were marginalised or disadvantaged, be it by health, wealth or affliction, and they undertook to respond in practical ways, being as useful as possible.

They were prepared to roll up their sleeves, go where they saw a need - on the streets, in prisons or in brothels, spending time and providing care for those who were undervalued by society. As Catholic religious women, their ultimate inspiration, Jesus Christ modelled this approach of reaching out to others.

To this day, St Vincent's is known for identifying gaps in community need and setting our sights on finding a solution to support people who might otherwise fall through the cracks.

This plan cements our commitment to support people experiencing vulnerability in a systemic way so that we can better support our community. We will seek to build on our strengths, address our limitations and endeavour to deliver healthcare in new, innovative and sometimes controversial ways. It's the St Vincent's way.

We are grateful for the efforts of everyone who contributed to the development of this strategy. This includes the core St Vincent's Health Network Sydney teams from Mission, Strategy & Planning, our Inclusive Health Committee and our external delivery partner Deloitte. The project was made possible by a grant from the St Vincent's Health Australia Inclusive Health Program. The workshops conducted through the project were vibrant with the input of our senior leaders, clinicians and community partners who make the work of Inclusive Health possible every day. Finally we are indebted to the patients and clients who contributed to this project by sharing their stories and experiences, many of which are difficult and challenging.

A/Prof Anthony Schembri AM
Chief Executive Officer
St Vincent's Health Network Sydney

Matthew Kearney
Director of Mission & Inclusive Health

> With these professionals here, you get a lot more understanding and it's a very non-judgemental environment.
>
> St Vincent's patient

Strategy Overview

Our Strategy's Mission

SVHNS integrates services, organises its systems, and engages with the community in order to facilitate equitable health and access to healthcare with vulnerable people.

Our Strategy's Vision:

To not just provide access to meet the presenting health needs of the vulnerable, but to enable them to flourish, as an essential goal of human life, as an acknowledgement of human dignity and as a commitment to justice

Our Priorities

Care Beyond Hospital Walls
Develop new ways of offering services to the community beyond the hospital context

Identifying vulnerability
More consistently identify when patients in our care are at risk of vulnerability

Advocacy & Research
Build on our foundations in research and advocacy

Care Coordination
More effectively respond to the identified needs of patients through care coordination

Peer Workers
Increase and support our workforce of people with lived experience

Partnerships
Better engage with partner services to integrate the care that we offer

Co-Design & Participation
Advance our capacity to be attuned to the experience of members of the community who use our services

Leadership & Staff Development
Develop our leadership and staff capacity in order to improve care

Our Goals

Goal 1

To increase the efficacy of, and access to, services for people from vulnerable groups

Goal 2

To empower individuals and communities and support self-determination

Goal 3

To increase our understanding of the characteristics and lived experience of people from vulnerable groups

Goal 4

To influence public policy affecting the health needs of people from vulnerable groups

Goal 5

To improve flow, coordination and integration across the health system for people from vulnerable groups

Goal 6

To increase the capacity of SVHNS staff to work with people from vulnerable groups

Strength and Vulnerability

We recognise that vulnerability is something that is experienced by every one of us at some point. We also recognise that vulnerability is just one part of people's lives, and that people who experience or who are at risk of vulnerability also have strengths, are resilient in the face of adversity and should be afforded every opportunity to not just survive, but to thrive and flourish.

St Vincent's Mission

In 1814, Venerable Mary Aikenhead founded the Sisters of Charity in Ireland, a time in which many people experienced profound poverty. Mary's vision for her work was that 'the poor could have for love what the rich could buy for money.' The Sisters became known as the Walking Nuns because they chose to visit people in their homes and move among the community instead of remaining inside the convent walls. Five Sisters arrived in Sydney in 1839 and went straight to work with women at the Female Factory at Parramatta who had been transported to Australia as convicts.

St Vincent's Hospital was established in 1857 with a policy which stated that 'the sick poor are the only persons who can be admitted to this charity.' As Catholic religious women they opened their doors and hearts to all who experienced vulnerability, regardless of religion. From this background, St Vincent's Health Australia's (SVHA's) mission was developed – *'As a Catholic healthcare service we bring God's love to those in need through the healing ministry of Jesus. We are especially committed to people who are poor or vulnerable.'*

To further grow our mission SVHA established the Inclusive Health Program (IHP) in July 2015 whose vision is based on human dignity and flourishing. The IHP not only focuses on equity in health care but on a broad understanding of what health is; a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (World Health Organisation). Indeed, for the SVHA IHP, the aim is to not just provide access to meet the presenting health needs of the vulnerable, but to enable them to flourish, as an essential goal of human life, as an acknowledgement of human dignity and as a commitment to justice.

1 Background

1.1 What is Inclusive Health?

Inclusive Health seeks to change the structures and systems that lead to some people experiencing poorer health outcomes than others as a consequence of poverty, marginalisation or other vulnerability[1].

Vulnerable populations are individuals and communities at a higher risk of poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability[2].

1.2 Why Inclusive Health is Important

There is significant inequity in health outcomes and access to health services in the Australian community. Nationally, people from lower socioeconomic groups are likely to die 3.5 years earlier than the average Australian, have three times the number of avoidable chronic illnesses[3] and people living remotely have 1.4 times the burden of disease as those living in cities[4]. Life expectancy for Aboriginal and Torres Straight Islanders is 8 years lower than other Australians[5] (although the gap is narrowing), the life expectancy gap for people experiencing homelessness is 30 years[6]; and transgender people aged 18 and over are nearly eleven times more likely to attempt suicide than the average Australian[7].

Considering these differences, there is substantial research seeking to explain the differences in health outcomes. The social determinants of health are a significant contributor to health inequity. Social determinants are defined as the economic and social conditions that impact health, such as the circumstances in which people are born, grow, live and work[8]. They generally refer to factors that affect health outside of the health care system that are beyond an individual's control.

Compounding the social determinants, are a diverse set of barriers which prevent or restrict access to health care. The key barriers identified in the literature are summarised below, of which a number of these barriers (highlighted in bold) were specifically identified by our patients, partners and staff members as relevant to the community we serve:

Figure 1 Barriers faced by vulnerable accessing and using health services[12,13]

Barrier to seek	Barrier to reach	Barrier to pay	Barrier to engage
Poverty	**Place of living**	Income	Lack of empowerment
Stigma & discrimination	**Environments**	Assets	Information
Interpersonal violence	**Transport**	Social capital	Support (incl. carer, family)
System complexity	Mobility	Health insurance	Opening times
Competing priorities	Social support	Employment	Appointment scheduling
Health literacy	Food insecurity	Identification cards	Lack of respect
Health beliefs	Housing stability	Medicare ineligible	Intimidation
Literacy	Homelessness	Legal status	Language
Culture	System availability	Limitations of the funding model	Mental health / personality
Gender	Autonomy	Gap payments	Service provider inabilit to manage challenging behaviours
Personal and social values	Isolation		Lack of holistic care
Country of birth	Accessibility		Lack of integration / follow through
Nationality	Inflexibility of the external systems and services		
Fear	Inflexible service models		
Shame			
Knowledge of health system			
Lack of comprehensive public services			
Poor previous experiences			
Access to information			
Disability			

"Last night, coming into Gorman House and one of the staff members recognising me and putting his hand on my shoulder and saying I'm so glad that you're here and we'll look after you. That made me cry. You don't always get that. The staff in other departments don't always show that kind of understanding"

St Vincent's patient

The combination of inequities in the social determinants of health and barriers to access mean that vulnerable populations carry a disproportionately higher burden of disease. Cancer, cardiovascular disease and mental illness, have the highest incidence among people from a low socioeconomic status, with diabetes and mental illness in particular affecting individuals in lower rather higher socioeconomic status[9].

1.3 The People We Serve

By virtue of SVHNS inner city locations and the priority we place on preferential service of the poor and vulnerable from our Mission, we provide healthcare to a very diverse population. This includes a large number of people from vulnerable populations who are at higher risk of poor health outcomes. In addition, we do not have a defined geographic catchment for most of our services, and we have always served large numbers of rural patients, including through our partnership with Murrumbidgee Local Health District.

The following provides a snapshot of the diversity in the vulnerable populations we serve[10]:

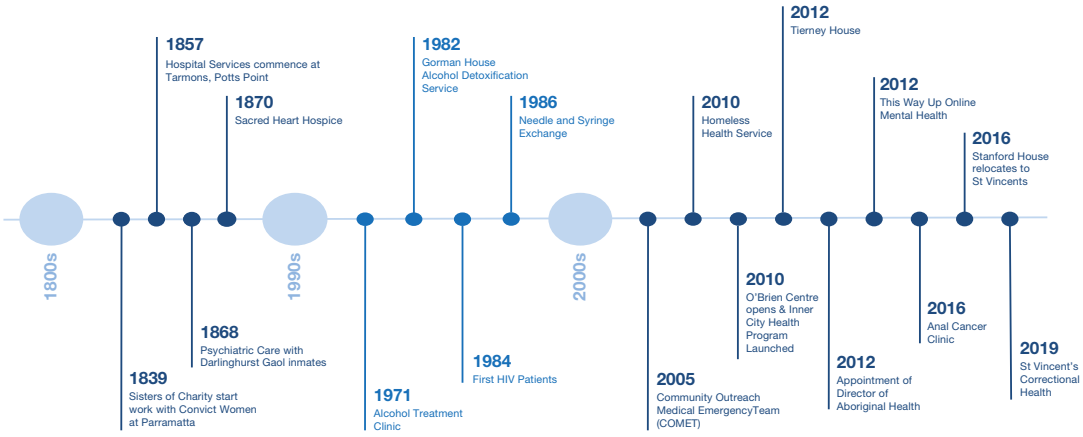
- 33% of patients attending SVHNS are from at least one of the priority groups identified in **enVision2025** (i.e. either people experiencing homelessness, mental illness, drug and alcohol issues or people identifying as Aboriginal and Torres Strait Islander). A large proportion of these patients have more than one clinical issue.
- In the period 2013 – 2017, SVHNS experienced an 18% increase in admissions for people in one **enVision2025** priority groups, compared with a 6% growth in admissions from the general population. St Vincent's Darlinghurst also has the highest number of mental health related Emergency Department (ED) presentations in the State.
- In 2017-18, St Vincent's provided 17% of the state's admissions for people with no fixed address, compared with 1.35% of all NSW admissions[11]:
    - 11% of our alcohol and other drug admissions are people with no fixed address
    - 17% of our acute mental health admissions are people with no fixed address.

There are a number of individuals attending SVHNS who have some form of vulnerability beyond the priority groups. The current challenges associated with identifying vulnerabilities in the people we serve means that the total vulnerable people in our patient population is likely to be much higher.

This strategic plan has been designed to take a broad view of vulnerability, including the priority groups outlined in **enVision 2025**, as well as others who face barriers to access, discrimination and health inequity. In the individuals and communities St Vincent's serves this includes but is not limited to: LGBTQI+ communities; culturally and linguistically diverse populations; people experiencing social isolation; older people with cognitive impairment and frailty; people with disability; sex workers; and people experiencing poverty. In addition, in 2019, St Vincent's started delivering health care within the correctional context, through St Vincent's Correctional Health.

We have served and will continue to serve a broad and diverse population. The shared vision of our organisation and the diversity of this population has delivered many significant milestones for SVHNS (Figure 2).

Figure 2 Significant St Vincent's Milestones supporting Inclusive Health

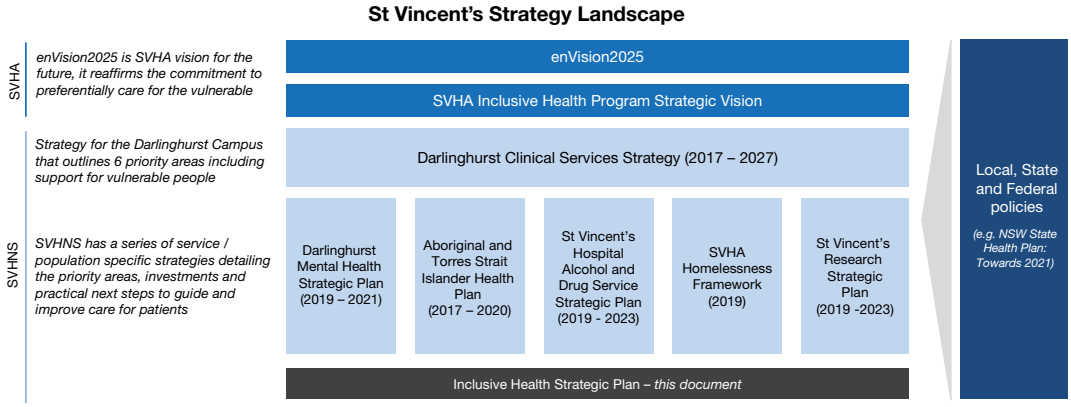


1.4 Strategic Context

This Inclusive Health Strategy reflects the St Vincent's Health Australia (SVHA) 10 year strategy – **enVision2025**, the SVHA IHP Strategic Vision, the St Vincent's Integrated Healthcare Campus Clinical Services Strategy to 2027 and the NSW State Health Plan: Towards 2021.

This strategy also accompanies other key organisational strategies that set direction and identify commitments for vulnerable groups.

Figure 3 Strategic context



1.4.1 enVision 2025

Serving something greater

SVHA's vision for the future, enVision 2025 reaffirms the commitment of St Vincent's to preferentially care for the poor and vulnerable, identifying five priority population groups:

- Those who are homeless
- Those with mental health conditions
- Those with drug and alcohol addiction
- Aboriginal and Torres Strait Islander People
- Those in the justice system.

Seeing something greater

From humble beginnings, SVHA has become the largest Catholic not-for-profit health and aged care provider in the country. **enVision 2025** invites the organisation to think big so we can see a much more profound impact on the lives of millions of Australians.

Striving for something greater

St Vincent's Health Australia has a reputation for innovation and clinical excellence. **enVision 2025** impels the organisation to constantly strive for something greater, to continue to develop cutting-edge research and translate this into better clinical practice.

1.4.2 Inclusive Health Program

In 2015, the SVHA Board allocated $5m in annual funding to the particular health needs of vulnerable people through the SVHA Inclusive Health Program. Since that point, the IHP has funded 125 initiatives, 25 of these have been delivered by SVHNS. This plan aligns with the strategic direction set by the IHP, but focuses specifically on local execution in the Sydney network.

St Vincent's Integrated Healthcare Campus Clinical Services Strategy St Vincent's is also in the process of executing our 10 year Clinical Services Strategy, which identifies six strategic commitments. One of the strategic commitments is to advocate for and deliver compassionate care of the 'poor and the vulnerable' in the Spirit of Mary Aikenhead and the Sisters of Charity.

Several complementary cohort or service specific strategies have been developed as part of this work, and are now being implemented, including:

Strategy Document	Key priorities
Darlinghurst Mental Health Strategic Plan	• Strengthening community based services • Creating an Urban Health Centre • Supporting digital mental health • Developing and maturing services, including improved complex care coordination, Prevention and Recovery Care (PARC), Police, Ambulance and Clinical Early Response (PACER) model and consultation and liaison services
Aboriginal and Torres Strait Islander Health Plan	• Establishing and strengthening partnerships • Ensuring services are informed by analysis of need and evidence of what works for Aboriginal people • Enhancing SVHNS' integrated planning and service delivery approach • Strengthening the Aboriginal workforce by attracting, developing and sustaining more Aboriginal people to work with SVHNS • Developing and implementing structures, policies and procedures that promote culturally safe and respectful work environments and health services • Strengthening performance monitoring, management and accountabilities
St Vincent's Hospital Alcohol and Drug Service Strategic Plan	• Working to develop, strengthen and optimise the alcohol and drug workforce • Striving to provide client-focused care • Aspiring to be a leading centre for research, innovation and advocacy • Providing an exceptional service to raise the standard for safe, high quality care • Increasing access to specialist support and treatment options
SVHA Homelessness Framework	• Establishing a Transitional Housing Service to fill the gap in current housing services that do not cater for people with complex needs • Establishing a Specialist Outpatient Clinic that supports physical health needs, in conjunction with services supporting psychological needs
St Vincent's Research Strategic Plan	• The Strategic Plan recognises the obligation and opportunity to align its research with the overarching mission of the organisation, particularly supporting vulnerable populations • St Vincent's research strategy is based around alignment of research strengths to clinical flagships and where appropriate, the research strengths of St Vincent's core collaborators

1.4.3 A Systems Approach

This strategic plan has been deliberately designed to address the inequities in outcomes and access for vulnerable people by taking a 'systems' approach. This means the plan focuses on the structures and systems that need to be in place to improve care for vulnerable people.

2 Strategy Mission, Vision and Goals

2.1 Mission

SVHNS Inclusive Health Strategy is based on the following mission.

SVHNS integrates services, organises its systems, and engages with the community in order to facilitate equitable health and access to healthcare with vulnerable people.

2.2 Vision

The vision for this strategy has been developed from the SVHA Inclusive Health Program, and tested with staff, users of our services and our partners.

To not just provide access to meet the presenting health needs of the vulnerable, but to enable them to flourish, as an essential goal of human life, as an acknowledgement of human dignity and as a commitment to justice.

2.3 Goals

There are six goals that underpin the strategic plan, with measurable outcomes associated with them. Current system limitations mean not all measures will be reported immediately as presently we are unable to isolate the experiences of our vulnerable populations from the general population we serve. The activities described in this strategy will make the identification of vulnerable people available and hence will support the measurement of the goals listed below.

The following measures will be used to drive the choices within this strategic plan, and to provide a sound framework for measuring the success of the strategy. As the Vulnerability Assessment Tool is implemented across the network, and/ or as data increasingly becomes available, each measure would be reported by vulnerability to allow for comparison with the general patient population. Where the capacity to measure currently exists we are committed, in the first six months of the strategic plan, to measure, report and evaluate our progress against each of the six goals.

Goal 1: To increase the efficacy of, and access to, services for people from vulnerable groups

Measures related to the goal:

- Reduced readmissions within 28 days
- Reduced presentation rates for potentially avoidable presentations in vulnerable groups

Goal 2: To empower individuals and communities and support self-determination

Measures related to the goal:

- Increased patient reported experience measures
- Reduced discharges against medical advice

Goal 3: To increase our understanding of the characteristics and lived experience of people from vulnerable groups

Measures related to the goal:

- Improved data completeness for capture of vulnerable status on admission/arrival
- Increased number and proportion of research projects that are mission focussed

Goal 4: To influence public policy affecting the health needs of people from vvulnerable groups

Measures related to the goal:

- Improved representation of SVHNS on working groups / committees with Government and other partners

Goal 5: To improve flow, coordination and integration across the health system for people from vulnerable groups

Measures related to the goal:

- Increased number and proportion of vulnerable patients referred for care coordination
- Improved experience of SVHNS' partner organisations working with SVHNS to jointly support patients

Goal 6: To increase the capacity of SVHNS staff to work with people from vulnerable groups

Measures related to the goal:

- Increased uptake of available education in inclusive health
- Increased number and range of lived experience of peer workers

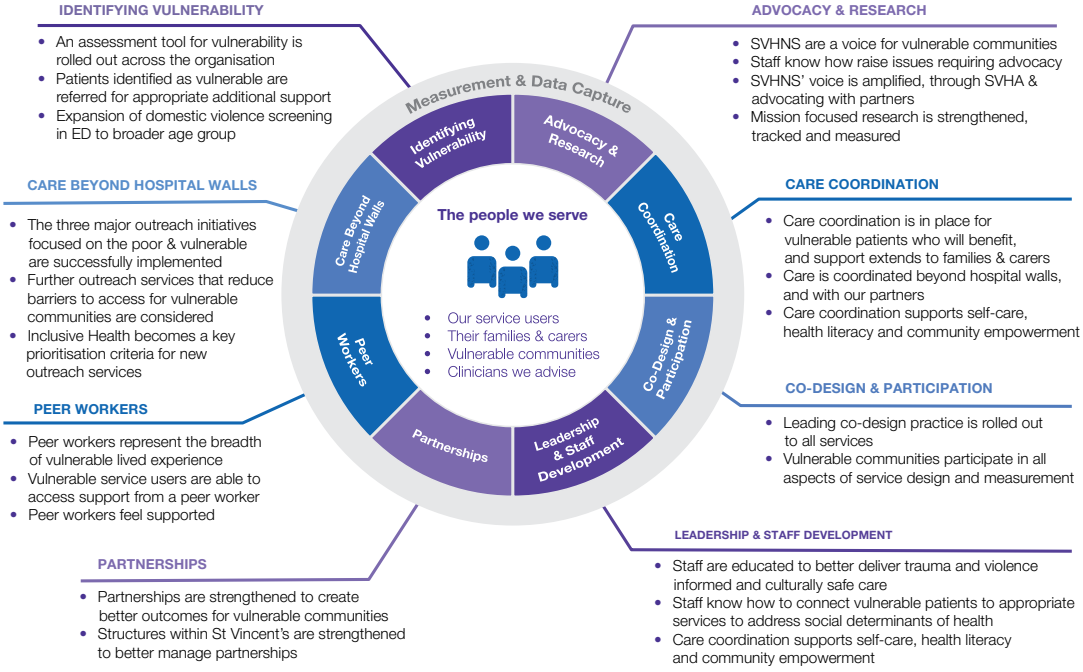
3 Delivering against our mission, vision and goals

3.1 A System for Inclusive Health

This strategic plan identifies those elements of our system where targeted effort will deliver the greatest benefit for our vulnerable communities. This includes driving excellence in the delivery of our existing services to better meet needs, and working in partnership to tackle barriers to access and the social determinants of ill health.

The priorities in this strategic plan are summarised below.

Figure 4 Our Future Focus



3.2 Our Priorities

3.2.1 Identifying Vulnerability

Effective assessment for, and identification of, vulnerability is critical to be able to holistically support a patient to address both their wellbeing. Currently, while certain types of vulnerability are often identified (e.g. language barriers), there are others that are not easily recognised and are inextricably linked to a person's opportunities to improve their health and wellbeing. Without a tool to systematically identify and then help address potential or known vulnerabilities, people may be left in positions where their immediate clinical needs are met, but the underlying or contributing causes are not.

St Vincent's already uses a variety of assessment tools –to help identify risk of falls, or those at risk of domestic violence are two examples. Critical to the success of an assessment tool is the ability to respond meaningfully to the findings; to provide or connect patients to appropriate services and tailored support for their needs beyond that of the delivery of hospital services. It is also essential that any assessment tool be integrated into care delivery and minimise any impact or burden on clinical and other service teams.

The benefits of systematically screening for vulnerabilities may include[14]:

- A better understanding and ability to address the social and economic factors impacting a patients' health
- A broadening of the information clinicians to assist with decision making
- An appropriate referral pathway for patients to community resources that address identified needs[15,16],
- Useful data about the types of vulnerabilities individuals we serve experience so that these can be better understood and addressed through service planning, advocacy and partnerships.

Service Innovation: Domestic Violence Screening in the ED

Domestic violence screening in the Emergency Department at St Vincent's was set up as part of an Inclusive Health Program Service Innovation Project. If a female patient is aged 16-45 and Triage Category 3, 4 or 5, and is capable of participating, they are invited to talk to a nurse and fill out a screening form. Patients who score high for at risk or experiencing domestic violence, or for whom the nursing staff have concern, are referred on to social work for support. To date 700 women have been offered screening, of which 106 were identified as at risk and provided with support. Staff reported increased confidence in identifying and speaking to women about domestic violence.

There are a number of clinically validated tools published that aim to screen patients in a relatively short time frame for a range of vulnerabilities and generally encompass biological state, psychological state, social situation and healthcare use[17]. These tools are suitable for a high volume, wide-ranging target population assessment and can take approximately 10 minutes to undertake[18,19] . The tools have flexible delivery options as they can be self-administered, or administered by any health worker with appropriate training. Any of these clinically validated tools will require customisation to suit our local requirements[20] and a process will be undertaken with input from our clinical teams to ensure it is appropriately designed, tested and evaluated with consumers and employees. The implementation of the tool will be staged over a period of time to ensure smooth integration into service and care delivery models.

The recently published analysis within St Vincent's Health Network Patient Data of vulnerability highlighted that '*improved assessment practices to identify people with vulnerability and those at risk of vulnerability are clearly required*'[21]. It will be essential to undertake this important element of the strategy in partnership with the SVHA network to deliver a consistent approach.

Our Commitment

An assessment tool for vulnerability is rolled out across the organisation	Patients identified as vulnerable are referred for appropriate additional support	Expansion of domestic violence screening in ED to broader age group

We will do this through:

1. *Comprehensive assessment*

By 2023 all patients (no matter which 'door' they enter through) will be identified and supported, through:

- Consistent application of the St Vincent's Vulnerability Assessment Tool (developed from a validated assessment tool from the literature) for all new patients, and at a minimum, annually for existing patients
- An identified referral and support pathway for all types of vulnerability captured by the assessment tool. For example, all patients with complex medical and/or psychosocial issues are automatically referred to case management
- The ability to 'flag' vulnerability, once identified, in the systems used to manage patient information
- Embedding the Vulnerability Assessment tool into our Electronic Medical Records specifications and system requirements
- Appropriately sharing data with our partners in a way which will enhance and support services to vulnerable communities.

2. *Expansion of existing screening programs*

We will focus on expanding our existing screening programs across the network. These programs provide vital information that enables clinical and other staff to provide the right support and deliver appropriate care.

- Expansion of domestic violence screening in ED to all genders and ages
- Implement processes, based on the lessons learned from the pilot period, to address the increase in the number of people identified as affected by domestic violence. This includes increasing the input from social work and improving our connections with community based care providers supporting victims of domestic violence

Over time, as the broader vulnerability assessment tool is rolled out, we will link the two tools to prevent duplication.

3.2.2 Care Coordination

Case management and care coordination can provide an invaluable service to vulnerable people when they have difficulties navigating the complexity of our services, and the broader health and care system. Care coordination is a broad term referring to the deliberate organisation of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services[22]. As an example, any of the following activities could fall under the function of care coordination:

- Finding post-acute housing for a patient
- Scheduling appointments
- Coordinating multi-disciplinary care interactions
- Resolving Centrelink issues
- Booking transport
- Providing health information
- Supporting self-care.

Care coordination looks different for every patient, dependent on their level of need. Some may only require minimal coordination such as help accessing a GP service, whereas others may require significant psychosocial, financial, cultural or logistical support. Our care coordination services will adapt to meet the specific needs of our patients, regardless of their level of need and will aim to seamlessly coordinate with community care coordination services as patients transition out of our network.

> "They keep in contact, the psychologist she keeps in contact with the social worker and also the health worker, IBAC. They already know what's going on, so there is some background interactions between the departments, which makes it much easier for me as often they've already spoken to each other. They have definitely have spoken to each other."
>
> St Vincent's patient

Our Case Management in Action

A 50 year old male (let's call him John) is one of SVHNS vulnerable people. He has a medical history of multiple incurable chronic health conditions, a cognitive as well as mobility impairment. He is able to walk about 80m with a four wheel walker; to access the community, requires a wheelchair and a carer/support person. He has a history of depression and previous suicide attempts.

'John' lives alone in a Housing NSW property and experiences significant social isolation due to the impact of his disabilities, inability to access the community and meaningful activities of his choosing. He has limited contact with family and whilst his mother lives in Sydney she is living with dementia. He has no other family or friends involved.

'John's' ability care for himself is considerably reduced due to co-morbidities and disabilities, therefore requiring case management to ensure physical and emotional safety within the home. His case management includes working with NDIS support coordinator to advocate and ensure he has ongoing access to appropriate and necessary service to maintain independence at home. This includes personal care, cleaning, food prep, shopping and access to the community. John also receives regular input from the Outreach Team, Bobby Goldsmith Foundation and the Langton Centre. Case management is essential for him to prevent missing medical appointments and ensure the multiple services participating are informed and aware of any issues or concerns.

The benefits of integrated and comprehensive care coordination tailored to the needs of vulnerable people are well reported and include[23,24,25,26]:

- Improved appropriateness, coordination and consistency of services
- Increased choice and flexibility in service delivery
- Improved service efficiency
- Improved coordination and reduction of siloes
- Cost savings, lower emergency department use and fewer follow up visits
- Lower rehospitalisation rates
- Better patient self-management
- Increased health literacy
- Smoother transition of patients into the community.

In parts of the Network, case management and care coordination is well-established with dedicated teams to support complex or vulnerable patients. As we better identify vulnerability in our patients, we need to ensure patients in all parts of our Network are well supported.

Our Commitment

Care coordination is in place for vulnerable patients who will benefit, and support extends to families and carers

Care is coordinated beyond the hospital walls, and with our partners

Care coordination supports self-care, health literacy and community empowerment

We will do this through:

1. *An increase in care coordination capacity*

Care coordinator capacity will increase each year from 2022, to provide a greater ability for the network to:

- Help vulnerable patients, their families / carers navigate network and community services
- Operate between clinical areas to support coordination within teams – this is especially important because of the significant crossover between vulnerable populations (for example nearly 50% of drug and alcohol admissions also have a mental health issue)
- Enable early discharge planning, and coordination of support outside of the network, beginning at a vulnerable patient's admission
- Build the relationships required with out-of-network services to support the smooth transition of care.

Coordinated care for vulnerable older people at home

St Vincent's delivers the Transitional Aged Care Program (TACP), a slow stream home-based therapeutic care program, funded by the Australian and NSW Governments. It provides short term intervention and support for older people upon discharge from hospital for approximately 8 weeks. The service helps clients improve and maintain independence and confidence so they can safely remain at home following a hospital stay. Clients are participating in planning their care and their goals, alongside their GP and family members. Clients are supported by a multi-disciplinary transitional care team including Registered Nurses, Pharmacists, Occupational Therapists, Physiotherapists, Social Workers, Dietitians and Community Aides.

After Hours Homeless Health Service

The Central Eastern Sydney Primary Health Network (CESPHN) has funded the After Hours Homeless Health Service. The team comprises of one Nurse Practitioner and one Clinical Nurse Consultant, two Peer Support Workers and two Aboriginal Health Workers. The after hour team run open-access nurse-led health clinics at various drop in centres and crisis accommodation in the Inner City area.

Our local partners support and facilitate referrals into these health clinics. They operate in the afternoons on week days and during the weekend. The premise of the after hour team is to facilitate greater access to health care for people who are homeless or at risk of becoming homeless; who have co-occurring health issues and who aren't accessing health services. The role of the team is to foster and facilitate linkages into mainstream health services including primary health services. Moreover, health coaching is a key feature of the service to ensure clients are given appropriate health promotion, education and support to better manage their health needs.

3.2.3 Care Beyond Hospital Walls

Vulnerable patients face particular barriers to accessing services in the acute hospital setting[27]. We already deliver a number of effective outreach and telehealth programs for vulnerable patients in more accessible locations to address these barriers. The benefits for serving people closer to their homes are numerous including[28]:

- Improved patient outcomes
- Improved access for remote or rural people
- Fewer cost and time barriers for vulnerable people
- Improved confidence and hence usage of the health system among vulnerable communities
- Upskilling of healthcare workers.

In the next five years, SVHNS plans to deliver several major new outreach services with a specific focus on some of our most vulnerable communities.

Our Commitment

Three major outreach initiatives will be successfully implemented

Further outreach services that reduce barriers to access for vulnerable communities are considered

Inclusive health is a key prioritisation criteria for new outreach services

> What's going to happen to me when I get out of here? Back to the park? If I go back to the park, I'll go drinking again to try to take the pain away. I know that, and I don't want that to happen.
>
> St Vincent's patient

We will do this through:

1. *New Outreach Services*

SVHNS provides a range of community-based health services for vulnerable people across many specialities including homeless health, drug and alcohol, mental health, hospital in the home, palliative care, rehabilitation and home support for seniors. We are building on these effective community-based service with new innovative services. The following three services are in the planning stage and aim to better meet the needs of our vulnerable communities outside the hospital walls.

Figure 5 Major SVHNS outreach services planned

Prevention and Recovery Care

The Prevention and Recovery Centre (PARC) will be a subacute 28-day residential step-up and step-down mental health service in the community. The PARC will improve mental health outcomes for people with a severe and persistent mental health issue who are becoming unwell. It will also prevent avoidable acute admissions and avoidable re-admissions following an acute episode.

Urban Health Centre

We will work with our community and partners to co-design an Urban Health Centre to deliver an early intervention and holistic approach to meeting the unique health and social care needs of our urban population. The Hub will be an extended hours centre to support consumers, carers and families, and provide connectivity, linkage and access to services.

Managed Alcohol Program

The Managed Alcohol Program (MAP) is a residential model for people who are experiencing both long-term homelessness and chronic alcohol dependence. The MAP will involve the supervised and scheduled dispensing of beverage alcohol, and will facilitate client's access to primary health care and social support services.

These new services are first of their kind in NSW or Australia and demonstrate our ongoing commitment to delivering care close to communities in a tailored and accessible manner.

> "I didn't know I was stressed. They picked up on something and they got hold of the chronic care nurse - she's on the ball, she gets everything about me, absolutely everything."
>
> St Vincent's patient

3.2.4 Advocacy and Research

St Vincent's has a strong tradition of advocating for the poor and the vulnerable. It is also a producer of world class medical research with our exceptional research partners.

Advocacy means using our experience in healthcare delivery and our expertise to raise a voice for the people we serve to influence public policy outcomes – from the original Sisters advocacy on behalf of female prisoners to our clinicians high-profile advocacy in recent years on alcohol-related violence in Kings Cross. Advocacy can include representations with government, media commentary and participation in government policy processes. The benefit of advocacy is powerful and can[29]:

- Create a channel to address issues
- Resolve issues and complaints more rapidly
- Change public perception
- Help achieve public policy outcomes for the populations we serve in line with our values
- Have the ability to impact on the social determinants of health which are usually beyond the scope of a health service.

Inclusive health research is seeking to change structures and systems that lead to some people experiencing poorer health outcomes than others as a consequence of poverty, marginalisation or vulnerability. SVHNS is working towards this, through its Research Strategic Plan which already commits to increase the:

- Number and proportion of research projects that are Mission focused
- Number of grants supporting research involving poor and vulnerable groups.

The St Vincent's Centre for Applied Medical Research currently works in partnership with SVHA's Inclusive Health Program to deliver a range of translational research grants through the annual peer reviewed grants program. Funding is usually made in $30k blocks and totals to $150k per annum.

SVHNS is fortunate to have a number of research partnerships with outstanding research organisations on and off the campus. Many of these, such as the Kirby Institute, the National Drug and Alcohol Research Centre (NDARC), and the Clinical Research Unit for Anxiety and Depression (CRUFaD), are specifically focused on research to support and reduce vulnerability. SVHNS is also a founding member of the Sydney Partnership for Health Education Research and Enterprise (SPHERE) which aims to improve innovation in healthcare, with a deliberate focus on Aboriginal health.

Advocacy on welfare changes for people with addictions

St Vincent's addiction medicine specialists identified that changes to welfare payments for people with substance use disorders proposed by the Commonwealth Government in 2018 – including drug testing of Newstart recipients and changes to the DSP for people with long-term addictions – would have adverse health outcomes, lead to increased poverty and increase barriers to accessing treatment for vulnerable people. Our clinicians advocated against the proposed changes in many ways – direct political representations, providing media interviews and comment, and participating in formal government inquiries – and were supported by the SVHA advocacy team. St Vincent's formed an informal advocacy partnership with the Royal Australian College of Physicians which was effective at increasing the advocacy impact and the legislation was not supported by the Parliament.

Our Commitment

SVHNS are a voice for vulnerable communities	Staff know how raise issues requiring advocacy
SVHNS' voice is amplified, through SVHA and advocating with partners	Mission focused research is strengthened, tracked and measured

We will do this through:

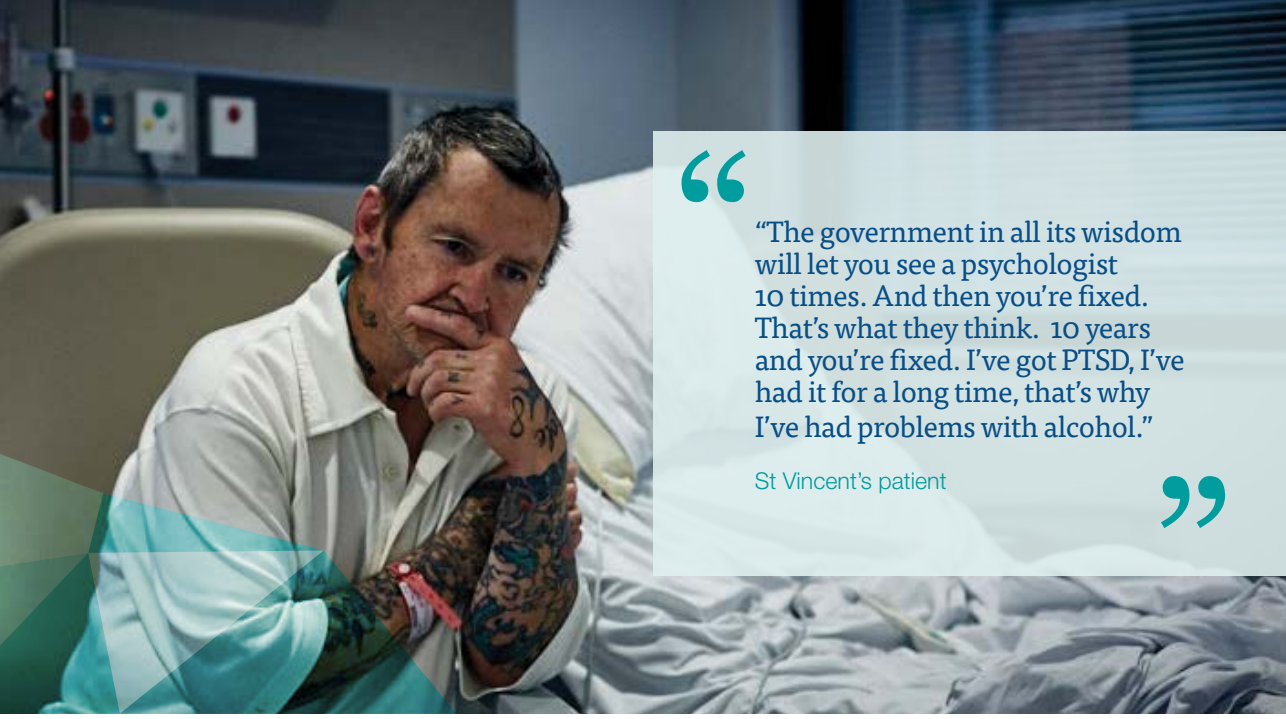
1. *Building advocacy capacity and partnerships*

By 2021 we will have implemented processes for staff, patients, families and carers to identify advocacy issues, through:

- Running roadshows to raise awareness of advocacy impacts and the resources available
- Publicising examples of impactful advocacy to promote awareness among our community, including our partner organisations
- Engaging with our partners to develop shared advocacy priorities and activation plans.

2. *Embedding as part of our teaching commitment*

We will embed Inclusive Health principles and raise awareness and education with new doctors, nurses and allied health professionals as part of our orientation program. Our SVH campus includes students from University of New South Wales and Notre Dame, from across many disciples, and will work with our partners to provide the opportunity for them to be provided education about Inclusive Health.



> "The government in all its wisdom will let you see a psychologist 10 times. And then you're fixed. That's what they think. 10 years and you're fixed. I've got PTSD, I've had it for a long time, that's why I've had problems with alcohol."
>
> St Vincent's patient

3. *Better usage of data and insights on vulnerable people*

We will release a snapshot of the vulnerability experienced by our patients at SVHNS, with recommendations for policy change. In due course, this report may link in with an organisation wide report on SVHA's vulnerable populations.

4. *Scaling our Inclusive Health Research*

We will build and scale our research capabilities during the first three years of this strategic plan, through:

- Continuing to deliver impactful research projects funding by translational research grants
- Bringing together the academic leads and research coordinators across key service areas already working in vulnerable community research (e.g. mental health) to identify significant opportunities for successful grant applications and cross-service research
- Raising awareness of the opportunities available to clinicians to support inclusive health research

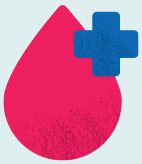
5. *Increasing representation of vulnerable groups in research*

Over the longer term we will seek to increase trust by vulnerable communities in research institutions, with the aim to increase participation in all aspects of research. We will do this through:

- Encouraging our research partners to employ a diverse range of researchers
- Redesigning research and recruitment processes across the network to remove the current barriers to participation by those who are disadvantaged
- Advocating to research partners and funders to support increased representation for vulnerable people in research cohorts.

3.2.5 Peer Workers

Peer Workers are people with lived experience of the health or social issues facing service users, who support clinical teams to deliver safe care to patients. Using their knowledge and experience, they are able to work alongside clinical teams to perform a range of roles resulting in more meaningful relationships, the expectation of recovery, trauma-informed and person centred care, and the better uptake of health services[30]. Research highlights the indirect financial benefits of peer workers –for every dollar invested in peer worker services, $3.27 of social and economic value is created[31]



Dried Blood Post Testing Project. NSW State Reference Laboratory for HIV, St Vincent's Hospital

Dried blood spot (DBS) is a self-collection method (rather than a self-test) and enables people to collect samples in their own home, post back and receive results without having to attend a health service. Additionally, as a blood sample is collected (rather than oral fluid) acute infections are more likely to be detected and the blood sample enables screening and confirmation to occur using the same sample. Appropriately collected and processed samples lend themselves to a postal type distribution network which may improve convenience for participants and increase uptake and frequency of HIV testing.

Self-sampling may support increased testing for HIV among high risk groups who may experience barriers to conventional testing, such as the need to attend a health service to access a test, time taken for test results to be available, difficulties accessing health care providers, stigma and the risk of discrimination. DBS HIV testing may address these barriers through increasing access, supporting autonomy, and providing added confidentiality, privacy and convenience.

For people who inject drugs, HIV and Hepatitis C virus share a transmission route. As this population group is a NSW priority population for both HIV and HCV testing including HCV testing in the DBS Project for this population group will support the implementation of the NSW Hepatitis C Strategy 2014-2020. In Australia, it is estimated that 230,470 people are living with chronic hepatitis C, with approximately 81,900 people from NSW. The rate of hepatitis C diagnosis among Aboriginal and Torres Strait Islander people in Australia is almost five times higher than the rate in the non-Indigenous population. Aboriginal and Torres Strait Islander people will be eligible for a dual HIV/HCV test within the DBS Project.

SVHNS employs six peer workers across Mental Health, Alcohol and Drug and Homeless Health services, in addition to a number of Aboriginal Health Workers. There are opportunities to expand this support for patients who experience a more diverse range of vulnerabilities and challenges.

Our Commitment

Peer workers represent the breadth of vulnerable lived experience	Vulnerable service users are able to access support from a peer worker	Peer workers feel supported

We will do this through:

1. *Increasing our peer workers*

By 2024 we will have increased our peer workforce across the network, deploying them in areas where peer support is not currently available, or where there is considerable demand. This may include:

- Lived experience in aged care facilities and/or with managing frailty
- Carers and family members
- Lived experience of managing chronic disease.

2. *Improving support structures to scale and develop the workforce*

We will rapidly implement the support structures required to enable our current and future peer workforce to succeed, through[32]:

- Improved learning and development opportunities
- Clear guidelines and support in the delivery of their roles, including access to funding and resources
- Regular opportunities for peer workers to gather together to share learnings and to improve how services are delivered and integrated
- Establishing professional management structures for peer workers, to provide access to supervisors who can support with skills development and managing challenging situations.

Tierney House

The recruitment of a 'Peer Support Worker' to work within Tierney House was viewed as an opportunity to engage residents on a whole new level and to provide an outreach arm for the service. The decision was also made to recruit the Peer Support Worker as an Aboriginal identified position, again enhancing the service being provided for our Aboriginal and Torres Strait Islander residents.

Residents of Tierney House, (those experiencing homelessness), are traditionally avoidant of mainstream services for many reasons. Many residents may have had previous negative experiences, an inability to communicate their needs or various other motives. The Peer Support Worker therefore advocates on their behalf, helping to provide a voice that would otherwise go unheard.

The objective of recruiting a Peer Support Worker is to ensure that residents felt appropriately heard, understood and offered suitable options. The ability for staff to identify such concerns and then engage the Peer Support Worker to provide support and comfort has meant that residents are seeing much more positive outcomes. Even something as simple as phoning a government service can be fear provoking. With the newly created capacity to be accompanied by a peer ensures that the correct message is conveyed and that the outcomes are more positive than previously realised.

For the staff within Tierney House, there are significant benefits from the Peer Support Framework. It allows for growth, education, and ultimately better service provision whilst also increasing the staff knowledge base and an ability to offer greater empathy. Peer Support is proving a game-changer in terms of the ultimate objective in Tierney House - to assist residents to stay healthy whilst providing insight and empathy towards the other factors in a resident's life.

3.2.6 Consumer Co-Design and Participation

Co-design refers to a process involving customers and users of products or services in their development or improvement. In healthcare, co-design combines the lived experience of patients with the professional expertise to identify and create an outcome, service or product[33]. Consumer co-design and participation is strongly supported by the literature and is increasingly used as a way to better engage vulnerable people. The benefits of co-design and participation are broad and include[34,35,36]:

- Improved services as they are more aligned with user needs
- Higher satisfaction levels and clinical outcomes
- Improved creativity
- Improved focus on users and outcomes
- Better cooperation across the organisation
- Improved customer relations.

Burton Street Centre Co-design

The Alcohol and Drug Service has recently set up the Burton Street Centre, a counselling service for young people experiencing issues with alcohol and other drugs, with a focus on methamphetamine and stimulants. The Centre utilised co-design principles in its setup and ongoing service delivery, with young people participating in the service steering committee. The Centre also partnered with the local Peer Education & Youth Advisory Committee (PEYAC) to design age appropriate documentation, as well as refurbishing clinic spaces to facilitate the needs of young people and their families.

While best practice co-design and participation methodologies are established, (the Agency for Clinical Innovation has a well-defined method and toolkit), the literature reports that flexibility and responsiveness to user needs is required when co-designing with vulnerable groups[37]. SVHNS has committed to overcoming some of the key challenges when engaging with vulnerable people. These include recruitment of service users, repeated participation with these users, economic and social circumstances, potential differentials in power and funding challenges[38].

We have established processes in place to ensure consumer representation on key governance committees, and to seek consumer views. However, with the exception of a small number of exemplar services, there is limited regular participation and co-design with vulnerable communities.

Our Commitment

Leading co-design practice is rolled out to all services	Vulnerable communities participate in all aspects of service design and measurement

1. *Establishing a core consumer team and capability focused on engaging vulnerable people*

Within the first year of this strategic plan, we will employ an additional consumer participation coordinator with a specific focus on vulnerable individuals and communities with responsibility for:

- Consumer coordination (to ensure vulnerable people providing a consumer voice are briefed and feel comfortable contributing in participation activities)
- Enabling consumers, especially those with vulnerable backgrounds, to meaningfully participate with confidence and knowledge by providing them with ongoing education and support
- Design and delivery of a SVHNS framework for consumer co-design and participation that considers the needs for more vulnerable consumers
- Ensuring consumer co-design and participation is embedded across all clinical teams
- Providing advice and guidance to clinical and non-clinical teams.

3.2.7 Partnerships

There are a large number of partner organisations working to improve outcomes for vulnerable people in the communities that SVHNS serves, across the very broad spectrum of services and the needs and barriers that vulnerable communities engage with.

Partnership emerged strongly from both the literature and stakeholder discussions as a critical success factor in delivering higher quality health, especially for vulnerable people using multiple services[39]. The key benefits for partnerships in health care are[40,41]:

- Improved integrated planning
- Increased organisational capacity for health promotion
- Healthier communities
- Better alignment of services around consumer needs
- Increased capacity of projects and services to broaden their reach on social determinants of health beyond the delivery of hospital services
- Ability for greater depth of expertise to be accessed.

NSW GOVERNMENT

NSW Aboriginal Health Partnership

The NSW Aboriginal Health Partnership was established in 1995, of which St Vincent's Health Network is a part to at the local level. The Partnership adheres to the principles espoused in the National Aboriginal Health Strategy 1989 and continued in the National Strategic Framework for Aboriginal and Torres Strait Islander Health – a Framework for Action by Governments. In particular, the parties commit themselves to the practical application of the principles of Aboriginal peoples' self-determination, a partnership approach and the importance of inter-sectoral collaboration.

The aim and role of this Partnership Agreement is to ensure that the expertise of the Sydney Metropolitan Aboriginal community is brought to health care processes in relation to National and State policy issues. The Partnership advocates for improving Aboriginal health outcomes and service delivery in the region of service provided by AMS Redfern. The Partnership works closely together to maximise procedures for improving information on Aboriginal health within the region and that, subject to ethical requirements, there is reciprocal sharing of information and data on Aboriginal Health at this level to enable immediate response to local health priorities.

The Partnership continues to support and advocate for best practice in ethics, in particular as it relates to research and study with, for or about Aboriginal people in the AMS Redfern region.

Stakeholders expressed a strong desire for SVHNS to play a role with partners in tackling the social determinants of health and the barriers experienced by vulnerable communities when accessing health care and services, over the longer term. SVHNS will in some cases be required to lead initiatives whereas in others play a more participatory role[42].

Our Commitment

Partnerships are strengthened to create better outcomes for vulnerable communities	Structures within St Vincent's are consolidated to better manage partnerships

We will do this through:

1. *Excellence in working in partnership*

By 2021 we will have an established and thriving partnership community, which we will achieve through:

- Assigned roles and responsibilities, by partner for partnership coordination and participation
- An annual assessment survey to measure the effectiveness and functioning of our partnerships.

2. *Leading in social determinants and reducing barriers*

By 2025 we will be a prominent partner in tackling social determinants of health beyond the delivery of hospital services and addressing the barriers to healthcare access. We will achieve this through:

- Establishing, or commissioning, new services that meet the needs of our vulnerable populations, support their wellbeing and address barriers to access
- Playing a key role in initiatives led by our partners to tackle social determinants and/or barriers to access. For example through the provision of clinical expertise and training to upskill external communities or teams
- Increasing our advocacy voice and impact.

3.2.8 Leadership and Staff Development

Our stakeholder participation has highlighted that SVHNS leadership in inclusive health is a key strength. SVHNS staff strongly support the vision and mission and are often seen as role models in the community[43]. The ambition of SVHNS is to foster this strength and apply it consistently across the network.

To achieve this, our teams need to have the skills required to support vulnerable people and ensure our culture is always considerate of their needs. SVHNS runs a number of relevant education programs, however, consultation conducted over the course of developing this strategy highlighted several other competencies that are required. These include:

- Trauma and violence informed care principles
- Diversity competent care principles
- Awareness of support services available to patients out of hospital
- Use of appropriate language and advanced communication
- Identification and response to vulnerability
- Putting person-centred care into practice
- Advocacy and championing change.

These skills will support our teams to feel empowered, confident and skilled at identifying and supporting those with vulnerabilities.

Our Commitment

Staff are educated to better deliver trauma and violence informed and culturally safe care	Staff know how to connect vulnerable patients to appropriate services to address social determinants of health	Outstanding inclusive health leaders within the organisation are supported and championed

We will do this through:

1. *Capability development*

By 2024 we will have delivered training on the skills required for our workforce to be better able to engage, and effectively support, vulnerable patients, their families and carers, with an ongoing program of education to maintain those skills. We will achieve this through:

- The creation and roll out of new internal learning and development modules across SVHA. These will be linked to the new initiatives being rolled out, including in the use of a St Vincent's Vulnerability Assessment tool
- Development of new micro learning approaches to support Inclusive Health, which may include:
  - **Micro learning sessions**[44]: Short, sharp training sessions delivered in the course of normal activities that aim to integrate learning into people's routines and to ensure key skills are refreshed and practiced by teams
  - **Consultant or leadership 'lunch and learn' sessions**: Senior leaders to lead learning sessions on topics such as culturally competent care and caring for vulnerable populations.

2. *Recognition for inclusive leaders*

In the first year of the strategic plan we will establish a recognition system that enables peers to nominate colleagues for awards or public recognition for championing inclusive health.

3.3 Essential Enabling Functions

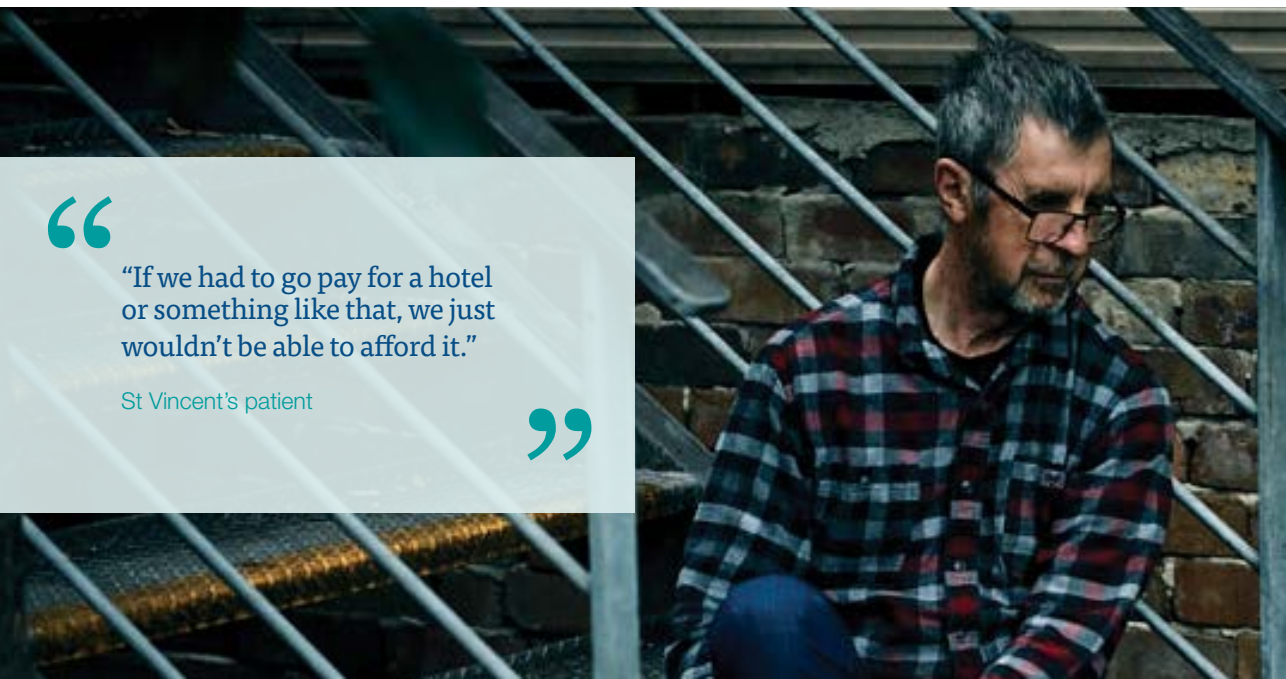
3.3.1 Governance, Implementation and Measurement

Governance, implementation and measurement processes are paramount to the impactful delivery of this strategic plan for the vulnerable individuals and communities we serve. While these processes, in some cases, are already established, there are opportunities to supplement this to demonstrate and instil a culture of transparency, accountability and impact.

A critical component will be capturing the experience and outcomes of vulnerable people, and then proceeding to act on it. Monitoring progress against these outcomes we have set relies on data completeness and quality, particularly in relation to the acquiring of vulnerable status. As with most healthcare networks, often system and process limitations make this a challenge.

To support this strategic plan, we will ensure:

- A set of minimum standards are in place for any proposal for Inclusive Health funding
- Reporting standards for the expenditure against funding provided for non-service revenue
- Regular evaluation to assess the activities of funded initiatives against their specified outcomes
- Establishment of an Inclusive Health Dashboard for the pre-defined outcome measures
- Systematically address the data completeness and quality issues that will arise in reporting on these measures
- Strong leadership for the delivery of this plan, through the Inclusive Health Committee.



> “If we had to go pay for a hotel or something like that, we just wouldn’t be able to afford it.”
>
> St Vincent’s patient

4 Our Strategy Into Action

4.1 Delivering Inclusive Health in Diabetes

This strategic plan is committed to delivering Inclusive Health for all of our vulnerable populations across our clinical service areas, and our roadmap sets out how we will achieve this. At the same time, we want to accelerate and demonstrate progress in the sphere that will have the biggest impact.

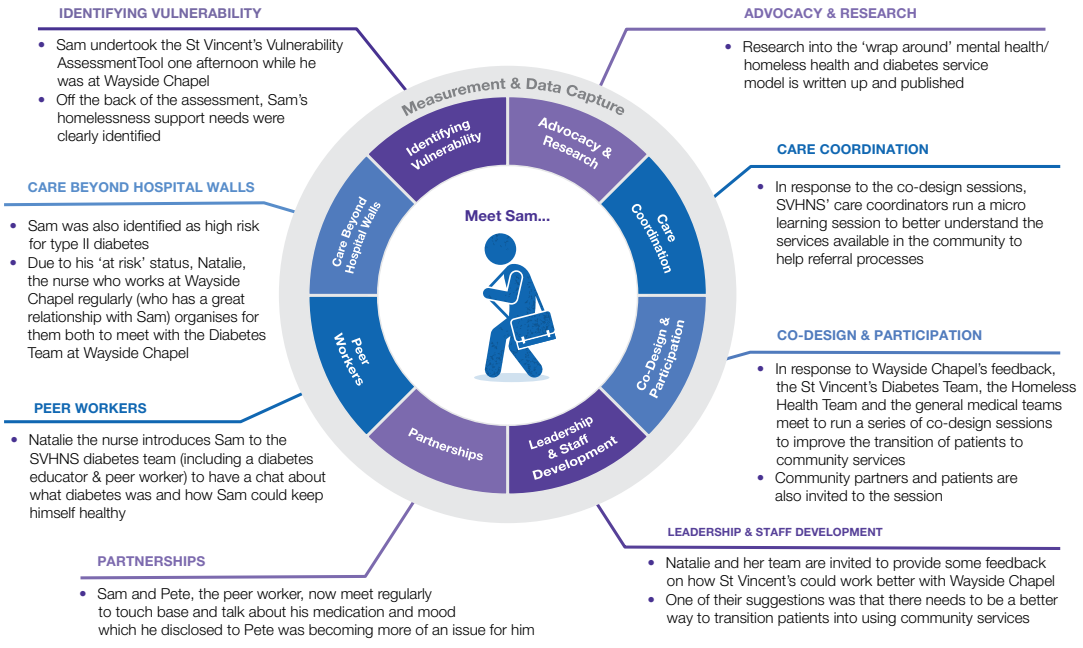
In Australia, approximately 1.2 million Australian adults have been diagnosed with diabetes, with a further 500 000 estimated to have undiagnosed diabetes[45]. Hospitalisations occur more frequently in individuals with diabetes than those without, and diabetes is the principal and/or additional diagnosis for 10% of all hospital admissions. The prevalence of diagnosed or newly diagnosed diabetes in admitted patients at St Vincent's Darlinghurst has been reported to be up to 25%, with almost half of those individual requiring insulin during their admission[46].

Diabetes also disproportionately affects vulnerable people. People in the lowest socioeconomic quintile in Australia are 2.6 times as likely to have diabetes compared to people in the highest socioeconomic quintile and patients with diabetes frequently have other psychosocial vulnerabilities or clinical issues[47].

4.1.1 Our Future Patient Experience

The diagram below illustrates how Sam, a person at risk of diabetes, might experience our services in the future.

Figure 6 Illustrative example of a diabetic patient's journey



4.1.2 Our Inclusive Health Priorities in Diabetes

As passionate advocates for our vulnerable populations, the clinical leadership in diabetes at SVHNS have committed to be 'first movers' in implementing this strategic plan for the benefit of existing patients but also people at risk in the community.

How will each priority be applied?	What are the outcomes we are trying to achieve?	How will this be done?
Identifying vulnerability		
Diabetes disproportionately affects vulnerable people. St Vincent's Vulnerability Assessment Tool will identify a wide range of vulnerabilities that will enable individuals to be appropriately supported. The tool will be undertaken by all patients entering the network	The Diabetes Service will have a clear idea of the vulnerabilities experienced by all patients to be able to better target care	The Diabetes Service will work with the Inclusive Health Program to develop, pilot and evaluate the Vulnerability Assessment tool in people with diabetes or at risk for diabetes. The results of this pilot will inform broader roll-out of the Vulnerability Assessment tool.
Care coordination		
Currently, there is an unmet need within the Diabetes Service to support people with diabetes who have mental health issues ranging from short term distress to chronic illnesses. The Service does not have psychology or social work support, despite having a patient cohort with high rates of and at high risk of mental distress	All patients with diabetes who experience psychosocial vulnerabilities have access to care coordination, education and support services to improve the management of their diabetes and any other issues faced	To address this need, there will be greater collaboration between the Diabetes Service, the Mental Health Service, the Drug and Alcohol Service and the Homeless Health Service. This will be achieved through a number of channels (e.g. multi-disciplinary teams) and/or coordinated clinics.
Care beyond hospital walls		
The Diabetes Service runs a number of outreach clinics, including a clinic at Matthew Talbot every six weeks. The model is currently funded as a 'case conference' through Medicare and all patients have SVHNS Medical Reference Numbers.	Improved access to services for people not otherwise interacting with the network. It will provide a way to 'close the loop' and to minimise the number of patients lost to follow up. It will also aid in upskilling of community health providers and teams.	The outreach clinic model of care will be taken to other sites with established relationships e.g. The Station and Wayside Chapel. Critical to the success of the model is the involvement of community pharmacy services to support medication management. Over time the option to expand services to other geographies areas through telehealth will be explored.
Consumer co-design and participation		
There is an eagerness to expand how the Diabetes Service engages with all patients, beyond foundational participation surveys, especially those in vulnerable positions	A greater awareness and knowledge of how to engage consumers, including those most vulnerable as well as ensuring services are tailored to the needs of individuals. A reduction in the barriers faced for individuals when accessing diabetes services.	The principles of the co-design process to design and improve the outreach model to ensure it meets the needs of people with vulnerabilities, including an Inclusive Health Multi-disciplinary Team.

How will each priority be applied?	What are the outcomes we are trying to achieve?	How will this be done?
Research		
Research is considered a key enabler to delivering evidence to support sustained service funding. The Diabetes Service is well integrated into research undertaken across the campus. However, an increased focus on research supporting vulnerable people with diabetes could be supported with improved collaboration between Mental Health, Homeless Health, Drug and Alcohol Services and Diabetes Services.	The publication of the joint model of care between diabetes, mental health, drug and alcohol and/or homeless health. This will provide learnings and evidence for the benefits of an inclusive health focus and multi-disciplinary approach, to support and enable sustained funding.	The Mental Health, Homeless Health, Drug and Alcohol and Diabetes Services will work together to plan and publish the results of the new multi-disciplinary model of care that will be trialed. This model will need to be established and evaluated with baseline reporting undertaken against confirmed measures.
Advocacy		
The Diabetes Service, in conjunction with Inclusive Health program, have the opportunity to advocate for issues that impact on and may limit people with diabetes who are vulnerable from achieving their optimal health outcomes	Raise awareness of issues affecting vulnerable people with the view to helping address and alleviate issues	There will be consultation process and prioritisation on key issues and barriers that require advocacy for change. (E.g. medication accessibility, housing instability). This will be done in collaboration with the SVHNS advocacy team to ensure a multi-pronged and appropriate approach to address issues.
Peer workers		
Currently peer workers are not an existing part of the multi-disciplinary care model for patients with diabetes at SVHNS or in Australia. As the peer workforce representation from a type I diabetic and a type II diabetic and/or someone with the lived experience of diabetes and mental illness may be beneficial.	Improvements in medication adherence and psychosocial support for vulnerable people with or at risk of diabetes.	The option of employing peer workers with a lived experience of diabetes and/or other chronic diseases will be explored. These peer workers would support vulnerable individuals with diabetes in their medication management and the prevalent psychosocial issues experienced by patients. In addition, there will be upskilling of existing peer workers and others (e.g. social workers operating in mental health) in providing diabetes education where relevant.
Staff development		
The Diabetes Service provides diabetes education to patients and staff at SVHNS.	Improved knowledge of available support services for patients (both within and external to the hospital). This will lead to improved confidence of staff to communicate and deliver care to vulnerable patients and/or those with diabetes in an appropriate and culturally safe way.	The Diabetes Service will deliver micro learning sessions to other teams in the hospital and inversely, have other teams from the hospital run micro learning sessions for the diabetes team to support knowledge sharing.
Partnerships		
The Diabetes Service will build on their strong and established community partnerships and continue to develop new ones to support outreach.	Better integration between St Vincent's and partner community organisations that will enable and sustain greater access to support services for vulnerable individuals in the community.	The Inclusive Health team and Diabetes Service will continue to develop community partnerships through the expansion of the current outreach model. Increasing the involvement of partner organisations in co-design opportunities will be essential to strengthen relationships and deliver services. Focus on collaboration with the CESPHN and local LHDs on the Diabetes Resources Hub, and the Ministry of Health on the Statewide Community Diabetes Initiative.

"If I'd had a buddy, a peer worker, that just walked me through the first day, it would have made a world of difference to making me comfortable, even just the first day, just to walk me arm in arm with someone it would have made a world of difference."

St Vincent's patient

Endnotes

1 https://www.svha.org.au/mission/inclusive-health

2 National Collaboration Centre for Determinants of Health, http://nccdh.ca/glossary/entry/vulnerable-population

3 Impact and causes of illness and death in Australia, *Australian Institute of Health and Welfare*, 2011

4 Impact and causes of illness and death in Australia, *Australian Institute of Health and Welfare*, 2011

5 ABS 2018b

6 Wood and Davies, 2018, Medical Journal of Australia, https://www.mja.com.au/system/files/issues/209_05/10.5694mja17.01264.pdf

7 National LBTI Health Alliance, accessed at https://lgbtihealth.org.au/statistics/, 17th July 2019

8 Brown L, Thurecht L and Nepal B 2012. The cost of inaction on the social determinants of health. Report No. 2/2012: CHA-NATSEM second report on health inequalities. Canberra: National Centre for Social and Economic Modelling. (3)

9 Impact and causes of illness and death in Australia, Australian Institute of Health and Welfare, 2011

10 Lethborg, C. et al., Analysis of vulnerability within St Vincent's Health Network Patient Data (2013 – 2017), Inclusive Health Research, July 2019

11 Patient residence data, provided by Director of Strategy and Planning, 2019

12 Corscadden et al., 2016, Barriers to accessing primary health care: comparing Australian experiences internationally, CSIRO Publishing: sourced from: Levesque J-F, Harris MF, Russell G (2013) Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health 12, 18. doi:10.1186/1475-9276-12-18

13 Validated by SVHNS staff, peer workers and community partners

14 LaForge, K. et al., 2018, How 6 Organisations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705433/

15 Garg et al., 2015, Addressing social determinants of health at well child care visits: a cluster RCT., Paediatrics.

16 Collecting and applying data on social determinants of health in health care settings.
Gottlieb L, Sandel M, Adler NE
JAMA Intern Med. 2013

17 Marcoux, V., et al., 2017, Screening tools to identify patients with complex health needs at risk of high use of health care services: A scoping review, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5708762/

18 National Association of Community Health Centers, PRAPARE, 2018, Frequently Asked Questions

19 Marcoux, V., et al., 2017, Screening tools to identify patients with complex health needs at risk of high use of health care services: A scoping review, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5708762/

20 LaForge, K. et al., 2018, How 6 Organisations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705433/

21 Lethborg, C. et al., Analysis of vulnerability within St Vincent's Health Network Patient Data (2013 – 2017), Inclusive Health Research, July 2019

22 McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

23 Kodner DL. All together now: a conceptual exploration of integrated care. Healthcare Quarterly (Toronto, Ont). 2009;13 Spec No:6.

24 Berkowitz et al., 2018, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2712183

25 Coleman et al, 2006, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410933

26 Primary Health Care Advisory group, Better outcomes for people with chronic and complex health conditions: Report of the Primary Health Care Advisory Group 2015, Department of Health [updated 2016], http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-report

27 Corscadden et al., 2016, Barriers to accessing primary health care: comparing Australian experiences internationally, CSIRO Publishing: sourced from: Levesque J-F, Harris MF, Russell G (2013) Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health 12, 18. doi:10.1186/1475-9276-12-18

28 Roodenbeke, WHO, 2011, https://www.ncbi.nlm.nih.gov/books/NBK310730/

29 The Children's Society, https://www.childrenssociety.org.uk/news-and-blogs/our-blog/why-advocates-matter

30 Peer Work Hub, http://peerworkhub.com.au/wp-content/uploads/2016/05/Business-Case.pdf

31 Social Ventures Australia, the Value of peer operated service, https://www.socialventures.com.au/sva-quarterly/the-value-of-a-peer-operated-service

32 Peer Work Hub, http://peerworkhub.com.au/what-is-peer-work/

33 NSW Council of Social Services, 2017, https://www.ncoss.org.au/sites/default/files/public/resources/Codesign%20principles.pdf

34 Health Consumers Queensland, 2017, www.hcq.org.au/wp-content/uploads/2017/03/HCQ-CCE-Framework-2017.pdf

35 P6, World Innovation Summit for Health 2013: Patient and family engagement: partnering with patients, families, and communities for health: A global imperative

36 Steen et al., 2011, Benefits of Co-Design in Service Design Projects, International Journal of Design

37 Mulvale et al, 2019, Health Expectations, https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12864

38 Mulvale et al, 2019, Health Expectations, https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12864

39 Vic Health, https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/strengthening-partnerships-tools-resources

40 HDG Consulting Group, 2008, https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/pcp-achievements

41 Tasmanian Department of Health and Human Services, https://www.dhhs.tas.gov.au/wihpw/principles/partnerships

42 Feedback received June 2019, External Stakeholder Breakfast held at St Vincent's Hospital Sydney

43 Feedback received June 2019, External Stakeholder Breakfast held at St Vincent's Hospital Sydney

44 Micro learning, https://www.edapp.com/microlearning/

45 Australian Institute of Health and Welfare Diabetes. Canberra: Australian Institute of Health and Welfare [updated 2018 Jan 18; cited 2018 Feb 3]. Available from URL: http://aihw.gov.au/diabetes

46 Taylor, J. E., Campbell, L. V., Zhang, L., & Greenfield, J. R. (2018). High diabetes prevalence and insulin medication errors in hospital patients. Internal Medicine Journal, 48(12), 1529–1532. doi:10.1111/imj.14124. https://onlinelibrary.wiley.com/doi/abs/10.1111/imj.14124

47 Impact and causes of illness and death in Australia, Australian Institute of Health and Welfare, 2011. (2) https://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/ (3) https://nccid.ca/publications/exploring-the-concept-of-burden-of-disease/

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