Strengthening connections:

Clarence

Executive Summary

ANTICIPATORY CARE PROJECT

ACTION LEARNING TO IMPROVE HEALTH IN TASMANIAN COMMUNITIES

help to health

UNIVERSITY of TASMANIA

SaxInstitute

The Australian Prevention Partnership Centre
Systems and solutions for better health

Tasmanian Government

The Anticipatory Care Action Learning Project research team acknowledges the palawa people of lutruwita upon whose lands we have conducted our research.

This project is funded by the Australian Government through the National Partnership Agreement on Improving Health Services in Tasmania.

The research reported here was produced by a collaboration between Clarence City Council and the Clarence community, the Tasmanian Government Department of Health, the University of Tasmania and the Australian Prevention Partnership Centre. The report was prepared by the University of Tasmania Anticipatory Care research team: Dr Susan Banks, Dr Robin Krabbe, Ms Miriam Vandenberg and Ms Thérèse Murray. We wish to thank Professor Richard Eccleston, Dr Therese Riley, Ms Flora Dean and Ms Sarah Hyslop for their insights and support throughout the project.

In brief

Anticipatory care can support people's current and future health needs. An effective anticipatory care system relies on a combination of accessible, locally-appropriate services and facilities, and collaborative, trusting relationships between services and between services and citizens. It is undermined by poor access to resources through stigma, cost and relationship disruption. The system is shaped by policy at all levels of government and within organisations but must reflect local ways of working and resources.

In Clarence, the AC system needs to be able to reach people across the municipality's 'villages', and to provide locally-relevant supports. Local government could play an important role. It is well-placed to do this because it can:

- reach across the municipality
- decide local policy and where to expend resources
- build on its existing role in community preventive health
- use its strong voice to lobby for better supports for the anticipatory care system
- support the necessary links between the many places and services, individuals, groups and organisations that make up the anticipatory care system.

Key points

This executive summary is formatted in four parts. For a high-level, short summary, read the **In brief** section. The **Key Points** section is a brief overview of what we have learned. The full summary is in the section, **Methods, Processes and Findings**. This document concludes with a series of **Recommendations**.

Context

Chronic illness is a major cause of ill-health and avoidable hospitalisations in Tasmania, and this burden is not equitably distributed. Chronic disease is linked with the social determinants of health: risk is reduced when people have reliable access to economic resources, secure and good quality housing, good diet, hygiene, health services, social networks and education. We need to reduce the risks for chronic illness and find better ways to manage existing conditions to keep people well. The Anticipatory Care (AC) Action Learning Project explored whether building a more effective local anticipatory care system could start to address this problem, in four Tasmanian sites. Anticipatory care identifies who is at risk of developing an illness and aims to keep people well. Effective anticipatory care may reduce the use of expensive health and social services.[1 2]

This summary report documents the project's aims, processes, activities, and findings for the Help to Health (H2H) site in Clarence.

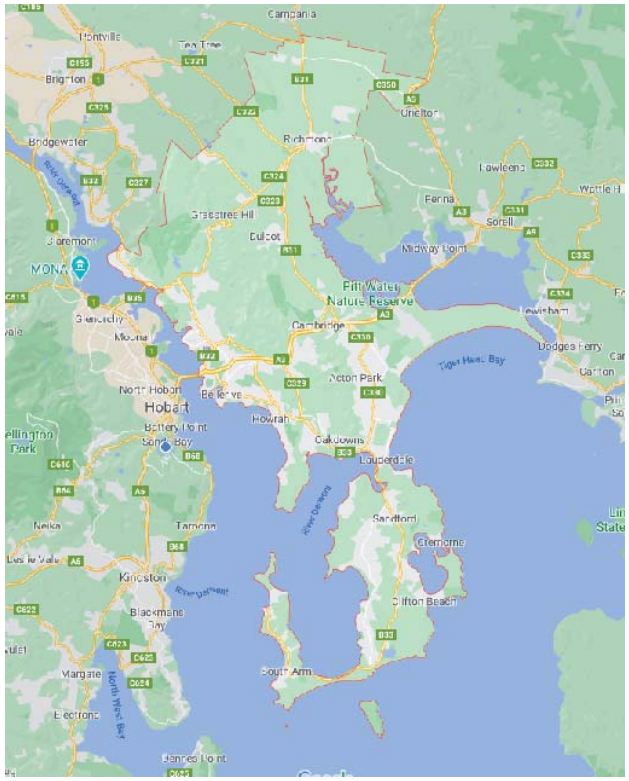

Figure 1: Map of Clarence City Council area (in red border)
(source, Google Maps)

What was already known

People living in some parts of the H2H area have higher rates of chronic illness, and potentially preventable hospitalisations than Tasmanians overall. They also have higher rates of risk factors for chronic illness, including smoking, overweight or obesity. Some of these factors are linked with being older (Clarence's median age is 43), but many are the product of the negative social determinants of health. Local government has a role in addressing these social determinants.

Some Anticipatory Care Project statistics for the H2H site

H2H and research activities:

Our data gathering and sharing activities	134 people
The Right Place training	41 people in 8 organisations
It's Okay to Ask training	6 sessions
Clarence Talks (from January 2019)	17 talks
Help to Health Friends	22 friends registered
The LG	19 members, meeting six-weekly

Figure 2: Emiliy McKinnon, H2H PSO, at a community workshop

What the AC project has added

Clarence's 'city of villages' nature calls for ways to share information and resources, and to enable collaboration across diverse communities. The Help to Health project enabled a Health Connector role to be trialled. The project showed significant promise as a means to improve the function of the anticipatory care system. The findings support locating the health connector role in local government, an organisation that has an established health and wellbeing role and reach into local communities.

Medical services (GPs) have historically been seen as central to anticipatory care, but in this community we have found that there are many other services that can play a part; examples include local council, neighbourhood houses, NGOs, pharmacies, public transport, libraries, gyms, local halls, clubs and community organisations, and infrastructure planners. Expanding our understanding of who is part of the anticipatory care system supports increased collaboration and coordination, and the overall effectiveness of the system.

The H2H project had four programs already planned:

- The Right Place: training for front-line staff to build a welcoming, caring and well-informed culture to support the health needs of community members
- It's Okay To Ask (IOTA): a health literacy training initiative to build people's ability to ask for and understand health information
- Clarence Talks: a program of locally targeted health and wellbeing information sessions in community settings
- Help to Health Friends (H2HF): a network of interested community members committed to being health literacy advocates among their friends, family and broader community.

Of these programs, The Right Place and It's Okay to Ask had started; Clarence Talks and the Help to Health Friends were rolled out in the early part of the AC Project. The AC Project aimed to build on all four programs through gaining greater understanding of the anticipatory care system via data gathering and sharing. These activities used an action learning and systems thinking approach.

Project activities identified a need for improved information sharing and collaboration amongst medical and service providers. As well as developing a Health Connector role, H2H launched the Clarence Services Online Forum after the project. The online forum aims to link GPs with other health and service providers, to improve information sharing, navigation, and access. The site launched on 12th August 2020.

Causal loop analysis (Figure 3) showed that actions taken in the H2H AC Project increased:

- connections and networks with other service providers and with the community
- effective communication through these connections/networks to share anticipatory care knowledge
- service provider capacity to create supportive environments for health (e.g., reception staff know about where people can get housing support), enabling the building of more connections and networks between service providers and with community
- capacity in the H2H team to reach more community members and to work safely and effectively with them
- engagement of some previously hard to reach people in health-promoting activities
- the effectiveness and authority of the lead agency in health

These gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project, but they are important short to intermediate markers that indicate positive changes to the anticipatory care system and a more enabling environment. A longitudinal study is needed to determine the full level of benefit from the changes to the local anticipatory care system.

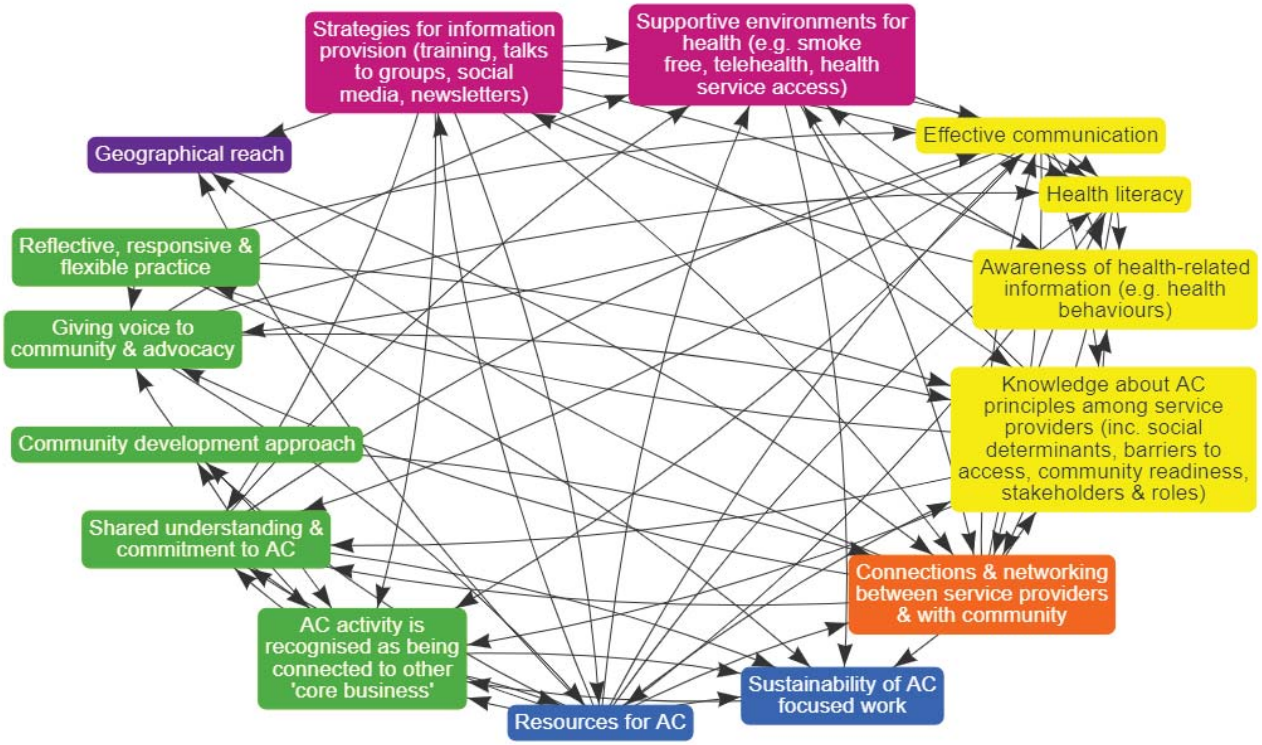

Figure 3: Causal loop diagram showing the factors and links between them in the local AC system at the end of the project.

The project identified places where change is needed to support anticipatory care. These include:

- historical stigma attached to some parts of the community that reduce external and internal opportunities to ensure equitable access to the anticipatory care system
- a hard infrastructure (buildings, paths, services) approach to public health in the lead organisation (CCC) that over-shadows support for soft infrastructure (relationships, knowledge, collaboration), which is essential for an effective anticipatory care system
- that government policies (e.g., for bulk-billing, welfare supports, and funding arrangements) actively work against taking a social determinants of health—including mental health—preventive approach
- local government is a critical actor in an effective anticipatory care system that should develop and embed a long-term strategy for promoting and supporting health and wellbeing in the community

Methods, processes and findings

Why

In 2018, the Chronic Conditions Working Group (Department of Health) funded lead organisations in four Tasmanian communities and a research team from the University of Tasmania to undertake the Anticipatory Care (AC) Action Learning Project. We worked together to:

- map the local anticipatory care system
- find out how to make anticipatory care work better, and what might get in the way
- trial actions to enhance the system
- learn what role the local lead organisations play in anticipatory care and whether their role can be strengthened.

We also trialled the usefulness of action learning and systems thinking for understanding and enhancing anticipatory care. The Tasmanian AC Project ran from July 2018 to December 2020. The local Help to Health (H2H) project in Clarence ran from February 2019 to January 2020.

Learning about anticipatory care

Anticipatory care is a population approach to health care that identifies and engages people who are at risk of developing chronic conditions with the aim of preventing or slowing health deterioration. Through relationship building and by recognising the social context in which they live, people are supported to be 'co-producers' of their own health.

The project framed anticipatory care as a system. The anticipatory care system's parts must work together effectively so we can identify and support people who are at risk of developing a chronic condition and anticipate their needs. An effective anticipatory care system includes ways to reduce risks and better manage existing conditions. It aims to keep more people healthy. We have defined health broadly in this project, guided by the social determinants of health (SDoH).[3 4] This means that our mapping of the anticipatory care system was not limited to health services, resources, or infrastructure.

What are the 'social determinants of health'?

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.[5]

The four communities in the AC Project have high rates of people being admitted to hospital for preventable conditions, including chronic illnesses. They also each have different demographical, social, cultural, and geographical characteristics, some of which may be contributing to the chronic illness load. These differences are helping us to learn what local anticipatory care systems have in common and what different agencies (services, groups, organisations) can do in the system to support better health outcomes.

The Help to Health site is located in the southern Tasmanian municipality of Clarence. The site's lead agency is the Clarence City Council (CCC), represented in the project by the Community Planning and Development Officer. CCC employed two officers (a project officer (PO) and a project support officer (PSO) to work with the community and the UTAS team. The PO had already been part of the H2H team; the PSO was employed specifically for the AC Project. There was also a Help to Health Leadership Group (LG) for the existing H2H project and this continued for the AC Project work. The Leadership Group is chaired by Clarence City Council and is made up of local residents and representatives from services working in the area. The leads, P/SOs, and LG members comprise the H2H team.

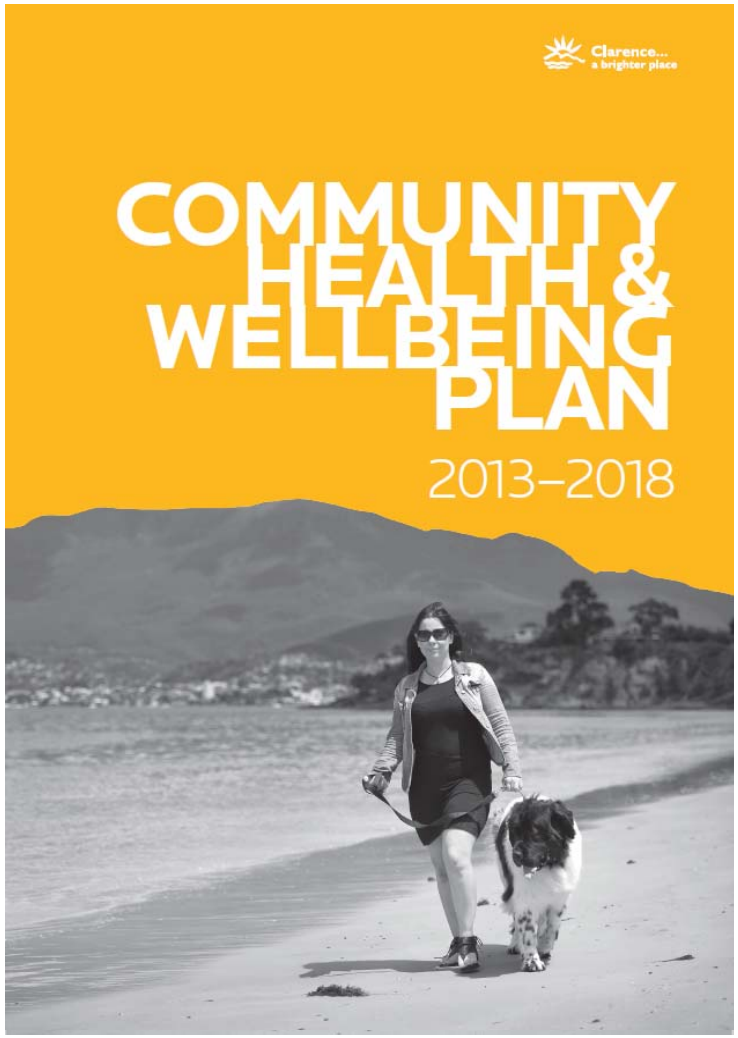

Figure 4: Clarence Council Health and Wellbeing Plan 2013-2018

How

We used action learning and systems thinking. Action learning is participatory and invites people affected by a phenomenon to work together to learn about it, to make sense of what its causes might be, and to try out different ways to improve the situation. To understand the anticipatory care system, we gathered and analysed quantitative and qualitative data from, and about, people who live or provide services in Clarence. We wanted to know how they understood health, about their experience of the health system, and what supports or gets in the way of better health outcomes for the residents of Clarence.

Our analysis helped us to understand what makes up the anticipatory care system in this community (our understanding of the system is being revised as we continue the analysis). Then we used a systems thinking tool, causal loop analysis, to explore, with the H2H team, how the parts of the system affect one another, and to find opportunities where acting on one part of the system might have the greatest benefit for the whole system.

We identified that the major opportunity for change was through increasing access in the following areas:

- Geographical and physical (quotes are from local participants):

> *Look at South Arm, … transport and getting around, because you've got an older population, you have people who aren't driving there …*

- Emotional and psychological

> *People have to feel safe. People have to know how to use it.*

- Resources:

> *There's the whole — because people are economically disadvantaged — their only choice is the Royal. Their only choice is being on the waiting list to have their hip replaced or their knees replaced.*

The findings show that place and belonging are very important for the effective function of the anticipatory care system. The research supports the description of Clarence as 'a city of villages'. Each village has particular characteristics, which affect how people think about or act on their own health. In some villages, a large proportion of community members are highly educated, and have moderate or high levels of agency and capacities that enable them to find their way into and through the anticipatory care system. In others, there is a heavier reliance on local resources (like neighbourhood houses) and resourcefulness. Similarly, people in the villages have different expectations and experiences of the anticipatory care system.

What does stigma look like?

Attitudes about a community or a person shape how they are treated and their expectations. Attitudes can be held by people outside the community, or be an expectation that you will be judged and found wanting. Stigma shows in inadequate services and supports in particular communities, in the demands that some communities or people do more for themselves, in judgmental responses to individuals, and in a person's unwillingness to approach particular services or places for fear of being treated poorly.

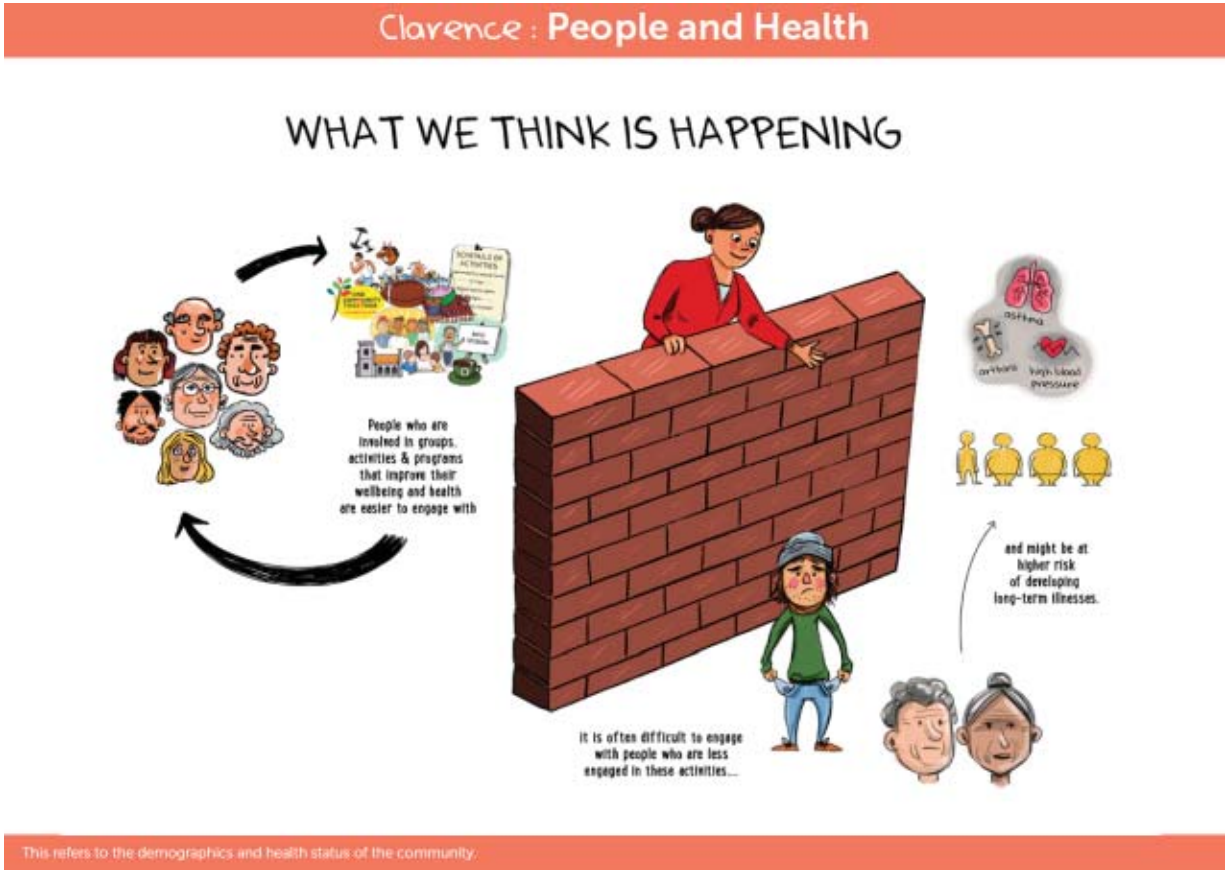

Figure 5: 'What we think is happening'

For too many, a fear of being judged affects how likely they are to attempt to use a service or visit a place. Poverty puts some services out of reach for some people, and fear of being judged plays a part, but the effects of personal poverty are made worse by lack of local services and infrastructure (e.g., sufficient GP services, low-cost or free and safe sporting or fresh food options), and a lack of personal and public transport. This was true in all the anticipatory care project sites, but in the Clarence municipality, residents' access to and through the anticipatory care system varies a great deal.

Trial actions to enhance the system

Each site developed action plans based on our shared understanding of where to intervene to strengthen or improve the system. The 'flag-ship' Help to Health activities were further developed and the H2H team explored:

- successful navigation of systems and services to address community needs
    - o improving connections between GPs and community via a reference group

- expanding The Right Place training to pharmacies

- quality relationships between actors in the anticipatory care system to address community and service needs
  - developing and describing the Health Connector role.

During the project, we have continued to gather data (more than 130 people have contributed) and to reflect on what we are learning with the H2H team. New knowledge helps us to review and adjust activities. Causal loop analysis (or causal loop diagramming, CLD) has been an important tool for this (see Figure 3). In CLD sessions, members of the team identify variables and the causal links between them to find strengths and weaknesses, and places where adjustments can be made or have been effective. CLD is part of the action learning approach.

What do we know now?

Mapping the local anticipatory care system

The project has made some changes to how anticipatory care is understood in this community, and in the lead organisation. The researchers and local team have a better understanding of what makes up the anticipatory care system, and have shown the importance of place and belonging (as a key system part) and the impact of policy and processes; these two additional parts of the system were identified during the project.

Through the project more people (and organisations) are seeing their role in supporting people's health as part of the broader anticipatory care system. There is also evidence among service providers of positive attitudinal shifts and practice changes aimed to support safer access to health for community members. This was evident in the data and demonstrated at our final CLD session, in May 2020, where participants included people in community development, health service and healthy policy roles.

What role do the local lead organisations play in anticipatory care and can their role be strengthened?

> *Clarence City Council aims to strengthen and improve the physical, mental, and social wellbeing of the community taking into account both individual and community needs in accordance with the Social Model of Health.*[6]

The lead organisation in the H2H site, Clarence City Council (CCC), has an existing role in preventive health. It does this through its responsibility for environmental health (water quality, sewage and sewerage, rubbish management), safe roads, immunisation clinics, parks, walking tracks and trails, swimming and other sporting infrastructure (formal and informal, e.g., Bellerive Beach pontoon), and land use management (including town planning decisions affecting housing, community halls and meeting places, incidental exercise, transport infrastructure and so forth).

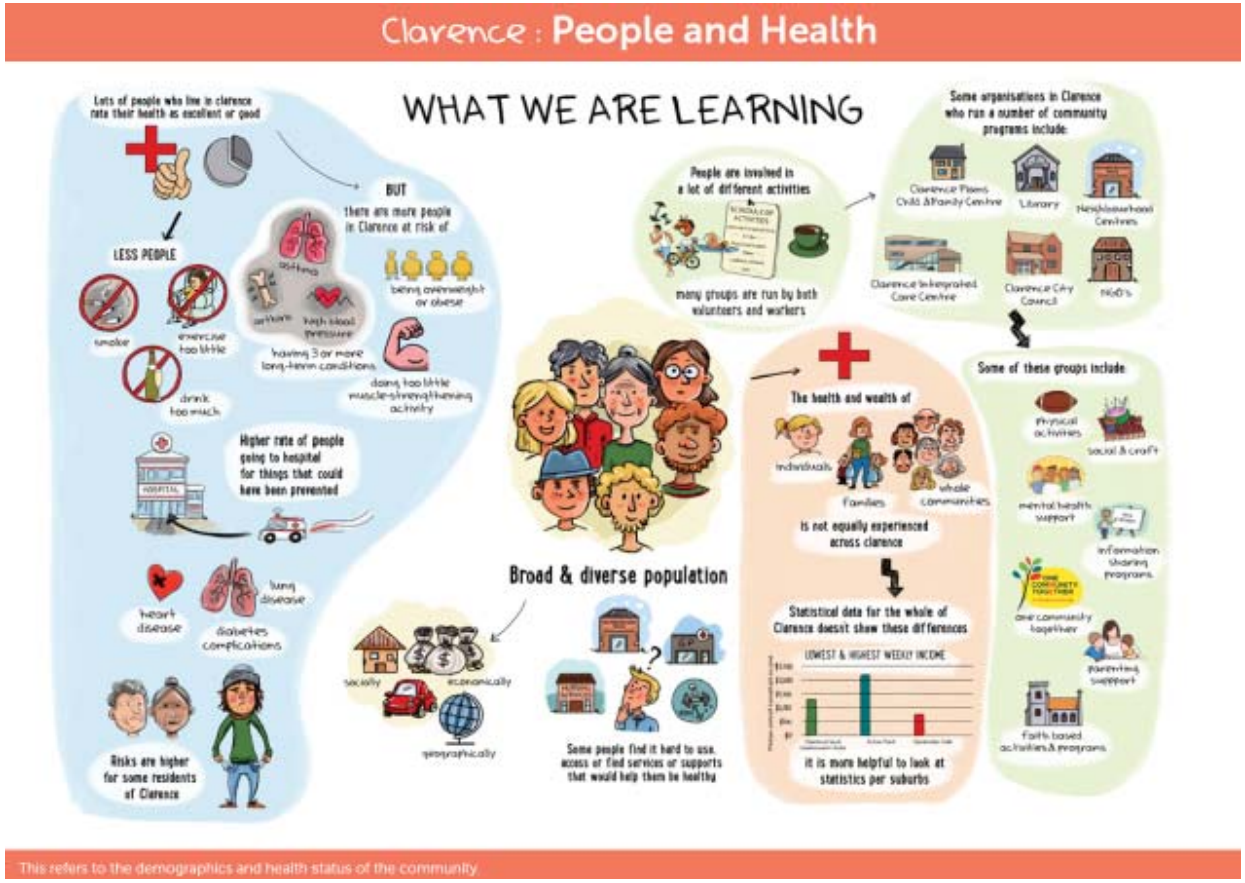

Figure 6: 'What we are learning'

CCC also delivers multiple health and wellbeing-related programs (e.g., Age-Friendly City, Fitness in the Park, Dog's Day Out, youth services, asylum-seeker and migrant services, holiday Outside School Hours Care, guided walks). Many of Council's existing functions affect the social determinants of health, putting local government in an ideal position to support anticipatory care here. Further, local governments—both alone or as part of the Local Government Association Tasmania (LGAT)—can shape state and national policy.

CCC's strengths include its existing preventive health actions and its potential to reach—exemplified by the PSOs taking a Health Connector role—communities and people who are not benefitting from services and supports. However, these strengths are undermined by:

- historical stigma attached to some parts of the community impeding equitable access to the anticipatory care system
- CCC's hard infrastructure (buildings, paths, services) approach to public health, over-shadowing support for soft infrastructure (relationships, knowledge, collaboration)

which is essential for an effective anticipatory care system

- policy settings within CCC and other funding organisations, including planning decisions, that do not take account of the social determinants of health
- CCC's lack of long-term strategies for promoting and supporting health and wellbeing in its communities despite its stated role in health and wellbeing.[7]

What did we learn; what could be changed to make anticipatory care work better (and for more people), and about what might get in the way of improvement?

We learnt that some business models are preventing equality of access to the anticipatory care system. Many types of performance measures and key performance indicators (KPIs) do not capture the whole picture, not accounting for things like new networks and relationships that are formed through activities. They privilege specific, tangible outputs rather than community outcomes. This includes models operating for GP and other health services, and for public transport. KPIs need to take account of the externalities, including social, environmental and community aspects of service provision. For example, an accessible, affordable local GP clinic not only supports acute and long-term health, but also has economic and social benefits for small communities.

It is also evident that local government is a vitally important part of the anticipatory care system as a key institution able to influence and shape the SDoH at the local level. Although it may not always identify 'health' as its core business, local government can act on the 'causes of the causes' of poor health. To do so would help strengthen the anticipatory care system overall.

Project gains were supported by:

- the provision of dedicated, anticipatory care focused resources within the lead organisations: the PO and PSO
- careful listening to community members, and acting on what has been heard (e.g., Clarence Talks and The Right Place training)
- very active outreach to services and residents, through the PO and the PSO
- engagement of a core of Leadership Group members and the project lead, Suzanne Schulz.

Barriers to improvement of the system are at local, state and national levels:

- KPIs and business models that ignore externalities, soft infrastructure measures, and experiential data cannot effectively support equitable access to health
- local historical stigmatising attitudes to some parts of the community reduce external and internal opportunities to change
- CCC's centralisation means that communities need to 'do the reaching', rather than local government finding ways to reach all the municipality's 'villages' and ensuring equitable access; people in some parts of the city feel ignored
- some local, state and national policies and processes actively work against taking a SDoH preventive approach; this is evident in competitive and short-term funding models that reduce connection and collaboration between parts of the anticipatory care system, a lack of resources to support outreach, and continuing poor distribution of necessary services (e.g., the continuing lack of adequate, local bulk-billing GP services).

Summary

The AC Action Learning Project in this site has resulted in increased:

- connections and networks with other service providers and with the community
- effective communication through these connections/networks to share anticipatory care knowledge
- service provider and H2H team capacity to create supportive environments for health (e.g., reception staff know about where people can get housing support), enabling the building of more connections and networks between service providers and with community
- engagement of some previously hard to reach people in health-promoting activities
- understanding of the importance of place and belonging in supporting anticipatory care and reducing the risk of and from chronic illness
- recognition of the effectiveness and health authority of the lead organisation.

Recommendations

The AC Project has demonstrated that enhancing the anticipatory care system is possible at the local level, through local government initiatives. The project has planted the seeds of new ways of thinking and working; we make the following recommendations to support long-term benefits to anticipatory care and the health of this community. There are opportunities to maintain and build on what has been gained.

H2H's four programs + Clarence Services Online Forum

The foundational H2H programs (The Right Place, It's OK to Ask, Clarence Talks, and H2H Friends) showed promise as activities that improve engagement, and access to services and information for the community, and foster networks and partnerships across the system. Clarence Services Online Forum may build on this.

Partnerships and collaboration across the system are essential. The LG, supported by Council, has a role in building and sustaining collaboration across this site, and in shifting attitudes to support anticipatory care.
They can also reach out to communities to understand local needs, people, and situations so that responses can be locally relevant, accessible, and meaningful.

- Council should adopt and embed a social determinants of health approach in all decisions and actions, including providing ongoing professional development in preventative health ways of working for all CCC staff and elected representatives
- Maintain the LG and links it is developing with services across Clarence (e.g., Community Nurses, health promotion groups)
- Encourage local service providers to incorporate outreach and collaboration as key tasks for all service providers working across the municipality

Performance measures or KPIs have historically ignored qualitative measures of 'soft infrastructure' and change in favour of quantitative 'number of services' measures. These cannot adequately reveal how the anticipatory care (or other health and wellbeing) system is performing.

- Revise CCC and health service KPIs to reflect externalities, soft infrastructure, and experiential dimensions of performance

P/SOs have supported the lead organisations and LG, reached out to community and to services, been involved in the research, and introduced new ways of working. Importantly, they have been the Council's 'eyes and ears' in the 'villages' and have enhanced CCC's ability to respond to local circumstances. They have developed capacity in action learning and systems thinking, and for gathering and interpreting evidence. Their links with the research team have been essential for our work, and for connecting the research with the reality and implementation.

- Establish the Health Connector as a dedicated function/role within CCC to support and enhance the anticipatory care system including through:
    - physical activity, social connection and information sharing initiatives (e.g., Clarence Talks, H2H Friends, IOTA, outreach to 'the villages')
    - relationships with existing and new service providers and researchers to strengthen coordinated approaches to improve health and wellbeing across Clarence
    - innovation to address anticipatory care needs.

For local, state, and national policy action

All levels of government have a role to play in efforts to alleviate chronic illness. These recommendations to build on the gains from the AC Action Learning Project—and to spread those gains more widely—rely to a greater or lesser extent on recognising that shared role and shifting policylandscape.

- Recognise that local government plays a central role as a connector across local anticipatory care systems
- Prioritise creating dedicated Health Connectors in local government
- Local, state and federal governments need to develop KPIs that reflect externalities, soft infrastructure and experiential dimensions of performance
- Factor the importance of place and belonging into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing
- CCC continue to advocate for funding arrangements that support and promote collaboration and long-term relationships

Project-specific funding models are damaging the anticipatory care system. To better support the health and wellbeing of the community, we need:

- To replace competitive funding models that reduce connection and collaboration between parts of the anticipatory care system with models that promote and support collaboration
- Flexible funding over longer periods
- Funders to set broad goal/s (e.g., improve health in this community) and allow communities/leads in consultation with their community to determine what success looks like, how it will be measured, and how to allocate and manage the funding
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- Trusting local communities to identify their own priorities and strategies to address those priorities

GPs' potential role in the anticipatory care system can be supported if they adopt clear, transparent information and easily understandable guidelines explaining their bulk-billing policy and practices:

- Continue bulk-billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities
- Review national and state regulation of GP services to counter supply shortages and increase equity of access to bulk-billed telehealth (e.g., the recent guideline that only people who have a regular GP can use bulk-billed telehealth reduces access to this service for many who do not have a 'regular' GP)
- Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities.

For future work on anticipatory care and preventive health

Gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project:

- A longitudinal study is needed to determine the level of benefit from the changes to the local anticipatory care system

Further flexible resourcing should be provided to continue to build on this work into the future.

Action learning and systems thinking have been effective here, but both rely on time and trusting relationships.

- Provide sufficient time in future anticipatory care work to develop relationships with local team and community, and to adapt processes and tools for maximising participation
- Introduce systems tools early and encourage their use—and adaptation—to suit local users. This could support the inclusion of more community members, first-hand learning about local systems (rather than through interpreters like researchers or members of the local site team), and thus support both genuine participation and local solutions.

There are clear mutual learning benefits for the University, the DoH and the H2H team in the approach taken here to working to enhance anticipatory care. The contributions made by each group are particular and cannot readily be 'swapped'. The ideal of equipping local communities to replicate the approach without these supports burdens them. Similarly, university researchers cannot ever become expert enough about a local site to work in ways that are inclusive and appropriate without partnering with locally embedded organisations.

- Future preventive health (including anticipatory care) projects should build in opportunities for mutual learning between community, university, and relevant government personnel.

References

[1] Baker, A., Leak, P., Ritchie, L. D., Lee, A. J., & Fielding, S. (2012). Anticipatory care planning and integration: A primary care pilot study aimed at reducing unplanned hospitalisation. *British Journal of General Practice*, 62(595), e113-e120. doi:10.3399/bjgp12X625175

[2] Tapsfield, J., Hall, C., Lunan, C., McCutcheon, H., McLoughlin, P., Rhee, J., Murray, S. A. (2016). Many people in Scotland now benefit from anticipatory care before they die: An after death analysis and interviews with general practitioners. *BMJ Supportive Palliative Care*. doi:10.1136/bmjspcare-2015-001014

[3] Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, 365(March 19), 1099-1104

[4] Marmot, M., & Allen, J. J. (2014). Social determinants of health equity. *American Journal of Public Health*, 104 Suppl 4, S517-S519. doi:10.2105/AJPH.2014.302200

[5] World Health Organization (WHO). (n.d.). Social determinants of health. Retrieved from https://www.who.int/genderequity-rights/understandingsdh-definition/en/#:~:text=Social%20determinants%20of%2health%E2%80%93The,global%2C%20national%20and%20local%20levels

[6] Clarence City Council. (n.d.). *Community Health and Wellbeing Plan 2013-2018*. Clarence, TAS: Clarence City Council, p. 5

[7] Clarence City Council. (n.d.). *Community Health and Wellbeing Plan 2013-2018*. Clarence, TAS: Clarence City Council