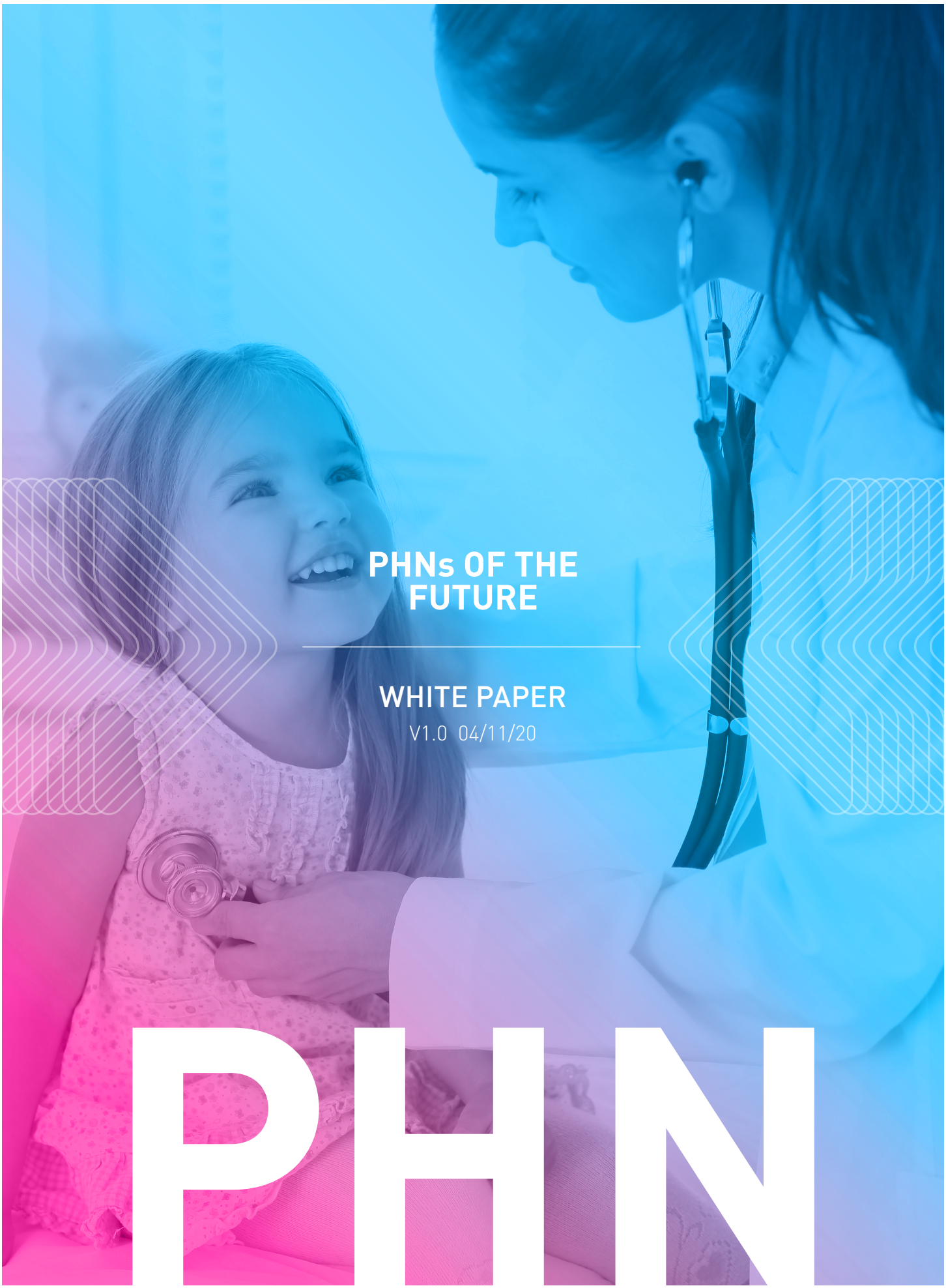
phn COOPERATIVE

An Australian Government Initiative



PHNs OF THE FUTURE

WHITE PAPER

V1.0 04/11/20

PHN

Acknowledgement

All 31 PHNs support the directions and views expressed in this White Paper and have contributed through comments, case studies and revisions. Western Sydney PHN (WSPHN) was the lead PHN with key input from Adelaide PHN, WAPHA and ACT PHN via a CEO Cooperative Working Group.

We acknowledge the Darug people as the First Nations peoples and the traditional custodians of the land on which we work. We pay our respects to Elders, past, present and future and extend that respect to all Aboriginal and Torres Strait Islander people within Western Sydney.

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1. BACKGROUND

Purpose of this document

This White Paper is the outcome of a strategic project undertaken by all 31 PHNs (the PHN Cooperative) to articulate a proposed future for the Primary Health Network (PHN) Program (the Program) over the next five years. It is intended to be a catalyst for further discussions with the Department of Health (DoH) and external stakeholders. The Paper outlines:

- The evolution of PHNs and readiness to take the next step.
- Insights to be gained from world leading primary health care organisations/systems.
- A preliminary PHN Program purpose and PHN Program principles.
- PHN roles and responsibilities in the broader health system context.
- Effective governance practices and structures to enable success.
- Recommendations on the change required to deliver on PHN Program ambitions.

2. THE EVOLUTION OF PHNs AND READINESS TO TAKE THE NEXT STEP

In 2015, the Commonwealth PHN Program established 31 PHNs nationally to strengthen primary care and improve patient centred service integration.

An evaluation of the PHN Program, completed in 2018, found that PHNs were well progressed in achieving early outcomes against the initial objectives. Through increased understanding of local health needs, the development of effective partnerships fostering integration (particularly with Local Health Networks (LHNs) and Local Health Districts (LHDs)) and innovative ways of commissioning services, the Program demonstrated that it could positively influence the efficiency and effectiveness of medical services.[1] Concurrently, a broad suite of activities, encompassing relationship building, system, patient and service level integration and Primary Care capacity building served to build a strong foundation from which to improve care coordination.[2]

A number of PHN reviews of activities undertaken across a range of sectors have revealed the true breadth of PHN contribution and an evolution well beyond the objectives set in 2015. Individually, PHNs are now taking a leadership position within their communities to foster the development and performance of the primary care sector and working strategically towards true integration across sectors. The national PHN Cooperative and state-territory PHN networks ensure the sharing of successful models, learnings and resources.

In recent years, there have been attempts by PHNs to redefine the Program objectives in alignment with true activity and impact. The recent Addendum to the National Health Reform Agreement (2020-2025) provides the latest iteration of these objectives (Figure 1):

Figure 1. PHN strategic objectives [3]

Addendum to National Health Reform Agreement 2020-2025 - Strategic Objectives of Primary Health Networks:

a) **Identifying the health needs of their local areas and development of relevant focused and responsive services**
b) **Commissioning health services to meet health needs in their region**
c) **Improving the patient journey through developing integrated and coordinated services**
d) **Providing support to clinicians and service providers to improve patient care**
e) **Facilitating the implementation of primary health care initiatives and programs**
f) **Being efficient and accountable with strong governance and effective management**

As appropriate as the Addendum objectives are, PHNs' strategic and operational scope has already moved well beyond this point: a reality this White Paper proposes to reflect.

Today, PHNs continue to improve the health outcomes of the communities they serve. PHNs now lead the commissioning of a wide range of services to address local needs across national health priorities, provide practice support for Primary Care providers and drive towards further system integration across state and federal health jurisdictions as well as the interface with disability, aged care and community services.

The PHN Program will be evaluated again in 2020/21. With the nature and shape of future PHNs currently under consideration by the Commonwealth Department of Health, now represents an opportune time to address these key challenges and clearly articulate the PHN Program of the future.

Informed by the Australian PHN experience and best practice examples from the global literature this White Paper sets out for discussion:

- A preliminary PHN Program purpose and PHN Program principles.
- Current and emerging PHN roles and responsibilities.
- Barriers with suggested ways forward to the realisation of PHN's full potential.

[1] https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Performance_Framework
[2] EY, UNSW, Monash University, 2018, Evaluation of the Primary Health Networks Program
[3] https://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

It will serve to guide the 31 PHNs moving forward whilst seeking to deliver outcomes aligned to the Quadruple Aim.[4] Achieving Quadruple Aim outcomes will rely on recognition of the PHN core roles articulated in this White Paper which will in turn facilitate PHNs in:

- Influencing state governments with their LHNs/LHDs to progressively shift models of care and investment to patient-centred, community-based care.
- Systematically building general practice quality and capability such that recognition and reward for quality and outcomes becomes an achievable and attractive investment for government.
- Working across services and sectors to influence the socio-economic determinants of health, thereby building individual, family and community capability.
- Mounting effective regional primary health care responses to whole of community challenges such as pandemics, bushfires and floods.
- Building regional hubs in close partnerships with local academic Departments of General Practice and Public Health, which integrate:

→ Primary health care and Public Health planning.

→ Innovation and creative commissioning with research, evaluation and development.

→ Primary health care planning with infrastructure planning and development.

→ Primary care workforce planning and development with education and training – potentially including GP vocational training.

However, a number of significant challenges remain to achieving these outcomes including:

- **Jurisdictional governance** – Commonwealth and jurisdictional barriers in policy, strategy and financing constitute long standing, well recognised barriers to integration of care and wider health system reform. Alongside this, national and state governance structures are inconsistent, with lack of formal recognition of PHNs and their potential contribution at all relevant forums.
- **National health policy and strategy** - The absence of agreed national health policy, principles and strategic priorities is a major barrier to good, regionalised health care across jurisdictions, organising entities services and most importantly, patients / consumers and communities.
- **PHN capabilities** - PHN capability has grown rapidly over the last five years and overall the Network capacity is considerable. However, the current PHN Program Performance and Quality Framework is not yet able to inform a consistent and meaningful assessment of PHNs which means a risk based approach cannot be applied.
- **PHN operational constraints** – These are significant and include Activity Work Plan (AWP) processes, the lack of notice and timing of Program contracts / schedules provided from the Commonwealth Department of Health to PHNs, PHN reporting requirements, timing and lack of clear processes in relation to deliverable (including requests for information and underspends) approvals and numerous/rigid barriers to financial management such as flexibility in operational costs.
- **Primary health care capability** - This includes variable practice/ service quality and capabilities, lack of access to appropriate blended funding models, and constraints on workforce capability and training requirements, infrastructure and patient centred medical home transformation processes.

The proposed strategies to address the barriers to PHNs achieving their full potential are outlined subsequently under (Section 5) 'Key Opportunities for PHNs'.

[4] Bodenheimer, Thomas and Sinsky, Christine, 'From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider', Annals of Family Medicine, 2014 Nov; 12(6): 573–576.

3. PHN PROGRAM OF THE FUTURE

PHN Program purpose

The PHN Cooperative has been working with the Department of Health on a PHN Program purpose and a set of PHN Program principles (see Appendix C – Preliminary (Draft) Purpose and Principles) concurrently to the development of this White Paper. Although the purpose and principles were in draft form at the time of writing, the preliminary purpose and principles has been referenced in this White Paper as they provide useful context and are seen to align to the roles, enablers and opportunities articulated. The preliminary PHN Program purpose is as follow:

The PHN Program furthers an integrated, coordinated primary health care system that delivers high quality, patient centred care.

PHNs are the experts on the primary health needs of their region and the central drivers for reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with Local Health Networks, Local Health Districts and other partners through innovative and consistent service delivery. PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.

PHN Program outcomes

The Program aims to holistically achieve individual, population and system outcomes in line with the Quadruple Aim. As outlined by Bodenheimer in 2014,[5] in a now universally accepted progression from the IHI's 2007 Triple Aim, there must be simultaneous pursuit of:

- Improved quality of care and population health outcomes.
- Enhanced patient experience of care.
- Sustainable cost.
- Improved provider experience.

PHNs are committed to delivering on the Quadruple Aim and measure the measure the outcomes of everything we do.

[5] Bodenheimer, Thomas and Sinsky, Christine, 'From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider', Annals of Family Medicine, 2014 Nov; 12(6): 573–576.

PHN Roles

Five core roles are proposed for PHNs (Figure 2 and 3), reflecting both the current and emerging activity of Australian PHNs and best practice examples from the global literature covered in Section 4:

1. **System coordination and integration:** reduce fragmentation and enhance coordinated, integrated care by working collaboratively across services and sectors.
2. **Regional commissioning:** bridge the jurisdictional, hospital-community-primary and cross-sector divides through collaborative commissioning with a focus on the primary health care system.
3. **Primary care system stewardship and management:** progressively improve system quality, access and equity.
4. **Primary healthcare education, training and workforce development:** build the general practice / primary care workforce of the future.
5. **Health system transformation and reform:** progress against agreed system reform objectives.

System enablers

Australian PHN activities and best practice examples from global literature also consistently identified five key enablers for success which are clearly recognised in, and generalisable to, the Australian context:

1. **Governance**
2. **Relationships and alliances**
3. **Health and system intelligence**
4. **Investment and financing**
5. **Freedom to innovate.**

Figure 2. The future PHN Program

NATIONAL PHN NETWORK PURPOSE STATEMENT (PRELIMINARY):

The PHN Program furthers an integrated, coordinated primary health care system that delivers high quality, patient centred care.

PHNs are the experts on the primary health needs of their region and the central drivers for reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with Local Health Networks, Local Health Districts and other partners through innovative and consistent service delivery. PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.[1]

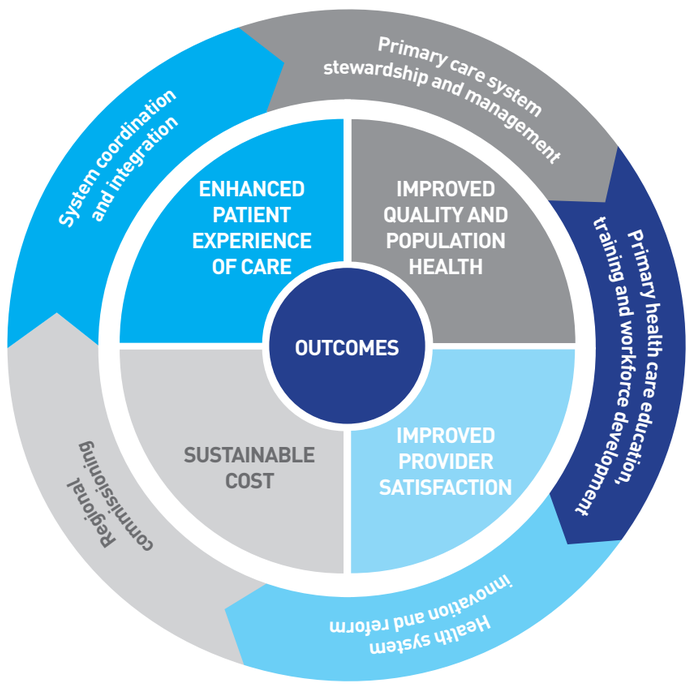
OUR ROLES

System coordination and integration

Reduce fragmentation and enhance coordinated, integrated care by working collaboratively across services and sectors

Regional commissioning

Bridge the jurisdictional, hospital-community-primary and cross-sector divides through collaborative commissioning



Primary care system stewardship and management

Progressively improve system quality, access and equity

Primary health care education, training and workforce development

Build the general practice / primary care workforce of the future

Health system innovation and reform

Progress against agreed system reform objectives

OUR ENABLERS

GOVERNANCE
Effective and inclusive governance that facilitates a coordinated approach from planning to evaluation

RELATIONSHIPS AND ALLIANCES
Enduring relationships within and across sectors, and all levels of government

HEALTH AND SYSTEM INTELLIGENCE
Embedded data to support commissioning drive continuing quality improvement and demonstrate outcomes

INVESTMENT AND FINANCING
Adequate investment that leverages existing funding and reflects the integrated nature of care

FREEDOM TO INNOVATE
Autonomy to adapt system elements to meet regional need, reduce barriers and eliminate perverse incentives

[1] Department of Health

Figure 3. Proposed future PHN roles

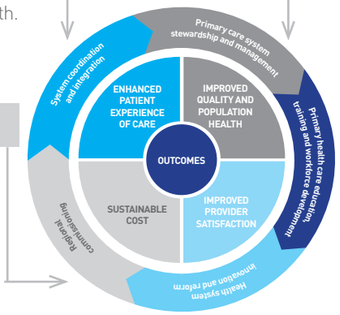
OUR ROLES

System coordination and integration

- Identify and build relationships with key regional stakeholders including LHNs, Clinical and Consumer Councils, other sector services (Families and Community Services, Education, Police, Local Councils), consumers and communities (local/condition group communities, Aboriginal, CALD and other disadvantaged communities).
- Engage with relevant stakeholders to collaboratively develop evidence based, integrated, coordinated care pathways appropriate to local needs.
- Incorporate advances in science, technology and health systems research into practice such that person centred, continuing, comprehensive care is strengthened.
- Close the Health-Social Care services gap and progress place-based initiatives to build individual, family and community health literacy and capability, thereby influencing the social determinants of health.
- Plan, develop and maintain agile, comprehensive primary health care pandemic and disaster management capabilities.

Regional commissioning

- In collaboration with LHNs and relevant key stakeholders undertake needs assessment and planning processes to identify unmet needs, gaps, duplication and fragmentation.
- Incorporate Patient Reported Measures (PRMs) in all relevant processes to embed the patient/consumer voice and track patient experience of care and health outcomes.
- Commission services on behalf of regional partners and Commonwealth-state-territory jurisdictions to provide integrated high value care, with priority placed on those with complex needs and at risk/disadvantaged groups.
- Progressively build provider capability and monitor performance over time to ensure best use of funds and achievement of outcomes-focused, value-based care.
- Collaboratively design innovative co-commissioning strategies to overcome jurisdictional and system barriers, reverse quality disincentives and demonstrate sustainable system gains.
- Disseminate learnings and scale up successful models across state and national PHN networks.



Primary care system stewardship and management

- Embrace PHNs' primary social purpose in pursuing whole-of-community health, wellbeing and equity through collaborative system re-design and system stewardship.
- Ensure PHN governance and operational arrangements accord with both PHNs' core purpose and contemporary best practice.
- Co-design and commission services, monitor performance and evaluate against Quadruple Aim objectives to progressively improve system performance and outcomes.
- Provide comprehensive business and Quality Improvement support services to General Practice and Allied Health according to their needs and change readiness.
- For the change ready, facilitate practice transformations to Patient Centred Medical Homes (PCMH) networked with Health Care Neighbourhoods (HCH).
- Support primary care system performance and act as the primary care system steward (the voice of regional primary care providers with LHN, ensuring primary care gains and potential are understood and utilised at regional, state and national levels and improving the quality and safety of primary care services).
- Share models of care, learnings and resources at all levels to progressively enhance PHN and Network effectiveness.

Primary health care education, training and workforce development

- Provide needs based ongoing professional development oriented towards future quality practice for GPs, practice teams and Allied Health Professionals.
- Provide intensive practice transformation support for GPs and practice teams pursing Patient Centred Medical Home (PCMH) goals.
- Support professional transitions into and out of regional practice and service settings.
- Collaborate with colleges, universities and regional training providers to enhance student education, GP registrar training and GP mentor-supervisor support.
- Work with general practice vocational training providers to better integrate training into networks (PHNs, general practices, hospitals, community health services and Aboriginal Health Services) with emphasis on quality future practice.
- Work with governments, colleges, universities, LHNs and others to map and plan for the future primary health care workforce.

Health system innovation and reform

- Provide ongoing strategic and policy advice to commonwealth and state governments to influence health system decision making and reform directions.
- Work with regional GP Leaders to advance quality care and to design, implement and evaluate new service and care models.
- Build on successful PHN-LHN re-design and co-commissioning initiatives to trial service, infrastructure and financing reforms in consultation with commonwealth and state governments.
- Underpin PHN and government reform-related decisions with advanced data analytics capacity at local, regional, state and national level.
- In collaboration with academic departments of general practice, colleges, RTOs and others, develop and trial regional PHN hubs integrating primary health care service planning, implementation and evaluation, with research, education and training.
- Act as an informed advocate for the local community, drawing on local relationships and knowledge to inform policy and practice.

2. PRIMARY CARE ORGANISATIONS: INTERNATIONAL AND DOMESTIC EVIDENCE DEMONSTRATING IMPACT

A literature scan was undertaken to explore the role of primary care organisations (PCOs) in the broader health landscape and to identify their core characteristics and key enablers, to inform future development of the PHN Program.

Three models were selected for more in-depth review as exemplars of high performing primary care organisations delivering on system transformations and integrated care systems thereby aligning well with PHNs' purpose and functions:

1. The Southcentral Foundation's 'Nuka' System of Care - Alaska, United States of America.
2. Primary Care Clusters - Wales, United Kingdom.
3. Accountable Care Organisations (ACOs) – Various (US, Europe).

These international case studies were then set alongside case studies from PHNs across Australia. We found, although unique in respective health and social care system contexts, five years on PHNs have rapidly matured and were delivering on some truly transformative initiatives.

For full case studies please refer to Appendix A – Literature Scan: Case Studies and Appendix B – PHN Case Studies.

Primary care organisation roles within the broader health context

International and domestic case studies revealed a core set of roles undertaken by primary care organisations or their equivalents. These roles align well with PHNs' existing and/or proposed roles:

1. System coordination and integration.
2. Regional commissioning.
3. Primary care system stewardship and management.
4. Primary healthcare education, training and workforce development.
5. Health system transformation and reform.

The following sections build on the articulated roles described in the previous section, providing a short list of the many concrete international and Australian examples of where primary care organisations or PHNs are currently playing these roles.

System coordination and integration

Primary care organisations in all settings act to improve coordination and integration of services across the continuum of care by using a patient-centred approach - engaging with consumers and relevant service providers. By locally reviewing and revising care processes, evidence demonstrates that system siloes, and fragmentation have been significantly reduced both in Australia and internationally.

Every PHN can demonstrate significant gains in system coordination and integration; work which continues to build on successes to date. When reviewing models globally, several have successfully coordinated care across the full continuum, from primary prevention to acute inpatient care. These include the 'Nuka' model in Alaska, which centres on an integrated primary care team supported by specialists, and the ACOs which consist of a closed system with all required providers. Many PHNs have achieved significant improvements in integration through the use of HealthPathways to outline locally agreed best practice, defining patient pathways and local referral pathways.

Similar to ACO's, some PHNs are now coordinating care across both health and social sectors, even despite holding separate budgets. Many PHN have joint governance and decision-making processes in place with their LHN/LHD counterparts, often involving service providers and consumers in co-design and commissioning processes.

EXAMPLE FOR AUSTRALIAN PHNS: COORDINATION AND INTEGRATION

HealthPathways in the PHN Network

In order to coordinate improved assessment and health care across primary and acute care settings, HealthPathways has been implemented across the majority of PHN regions in Australia since 2012 and involves partnerships between PHNs and local hospital networks and districts. Originally developed in Canterbury New Zealand, implementation in Australia has involved an ongoing relationship with Streamliners NZ. The initial development and implementation of HealthPathways has involved dynamic collaboration between local primary health care clinicians (predominantly GPs) and Local Health Districts (predominantly specialists), and has been utilized to improve care pathways for patients, reduce waiting times, and improve testing and referrals for a large range of medical conditions.

Utilised as an online health information portal for GPs and other primary health clinicians, to be used at the point of care. It provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the most timely way. However, its greatest benefit is in the working together of clinicians to improve health care and journeys for patients.

[Refer to Appendix B: Section 1 - Page 33]

Central Queensland, Wide Bay, Sunshine Coast PHN - Emerald Communities of Excellence Project

The mining town of Emerald in Central Queensland is one of the first in Australia to be involved in the Australian Digital Health Agency's Communities of Excellence program. The program aims to fully connect both health providers and community members with digital models of health (e.g. My Health Record, telehealth, electronic prescribing), resulting in a model which could then be replicated in similar communities. Central Queensland, Wide Bay, Sunshine Coast PHN is one of the lead delivery partners who are working to implement engagement activities on the ground in the Emerald community.

[Refer to Appendix B: Section 2 - Page 34]

Capital Health Network - Geriatric Rapid Acute Care Evaluation (GRACE)

The program trial was initiated by Capital Health Network (CHN) in 2017 with the aim of improving the healthcare journey and reducing presentations to the Calvary Public Hospital Bruce (CPHB) emergency department (ED). This is an outreach service located at CPHB that provides clinical support to residential aged care facilities (RACFs) and involves clinicians visiting RACFs to assess residents who are experiencing an acute health episode but are not in a clear medical emergency. This service acts as a point of liaison at the interface between RACFs, primary care and acute care. The GRACE program also provides after hours services.

[Refer to Appendix B: Section 6 - Page 44]

Regional commissioning

Regional commissioning services to provide care in the greatest areas of need and supporting providers within local markets to achieve intended outcomes is a key role of PCOs and, in some cases, PCOs do so across sector divides. The PCOs investigated aimed to address gaps in patient care through partnerships with region-specific health organisations and embed shared benefits and accountability while, ensuring care is truly integrated for their populations. For example:

- The primary care clusters in Wales are charged with local services spanning Mental Health, Allied Health, Optometry and Community services.
- Commissioned services were not always identified based on locality, with some American ACOs identifying service needs through other methods, e.g. providers linked with health insurance.

Many PHNs case studies demonstrate mature regional governance, joint accountability and collaborative commissioning arrangements.

Significant progress is being made across the PHN network on the use of data driven commissioning and working with local partners to ensure care is value based, person centred and co-designed with communities.

EXAMPLE FOR AUSTRALIAN PHNS: REGIONAL COMMISSIONING

A 'Health Alliance' between Brisbane North PHN and Metro North Hospital and Health Service

In 2017, Brisbane North PHN and Metro North Hospital and Health Service (HHS) jointly created the Health Alliance; an approach to tackling healthcare problems that transcend the mandate of either one organisation or part of the health sector, and that cannot be fixed by existing approaches. The Health Alliance aims to realign current resources and deliver care in a more coordinated and integrated way across institutional boundaries and focus on solutions that benefit both patients and the health system. To date, areas of focus include improving health outcomes for children in the Caboolture catchment, improving the health and wellbeing of older people, and embedding new virtual models to redirect care closer to home.

The Health Alliance enables a shared approach for decisions that will shape the way care is funded and delivered in North Brisbane. The Health Alliance creates the foundations for regional commissioning by working with stakeholders, including consumers and carers to co-design solutions. Governed by a Joint Board Committee of Brisbane North PHN and Metro North HHS, the Health Alliance is an example of what a joint regional commissioning mechanism between a primary health network and hospital and health service could look like. It connects local knowledge and planning directly to implementation, bringing decision making closer to the front line of health services and the community.

[Refer to Appendix B: Section 4 - Page 40]

Western Sydney Collaborative Commissioning

Western Sydney Collaborative Commissioning is defined as a whole of system approach designed to enable and support delivery of value-based healthcare in the community. It aims to incentivise integration across the entire care continuum, and embed local accountability for delivering value-driven, outcome-focused and patient-centred healthcare.

The Collaborative Commissioning model currently being implemented in Western Sydney includes 3 transformative models of care.

(1) Value-based Urgent Care (VBUC) – aims to reduce the number of low acuity conditions requiring "urgent" treatment presenting to Western Sydney Emergency Departments, through provision of sustainable alternative local patient centred urgent care services in the primary care setting.

(2) Cardiology in the Community (CIC) – Strengthen participation and screening to improve identification of people at risk of cardiovascular disease, in turn supporting ongoing management of Heart Failure, Chest Pain and Atrial Fibrillation in the primary care setting.

(3) Rapid Expansion of Care in the Community – Aimed at preventing the need for hospital admissions, by providing rapid access to care in the community, including the management of COVID-19 positive patients in the community with low or medium risk.

The LHD Chief Executive and the PHN CEO co-chair the Patient Centred Collaborative Commissioning Executive Steering Committee and each model sub-committee is co-chaired by a WSLHD clinician and a GP. Models are clinical designed considering primary, community and acute care options to design optimal integrated and patient centred services which are flexible to meet diverse patient needs.

Resources are pooled and jointly deployed to deliver the vision of 'one Western Sydney Health System'. Services gaps are collaboratively commissioned through the PHN's strategic commissioning function and LHD resources are realigned to support the models of care. Through integrated governance, delegations, shared culture, information sharing, community/consumer engagement and communications, WSLHD and WSPHN are able to overcome organisational and professional barriers to integration and focus care on the individual, family and carers who need that care.

[Refer to Appendix B: Section 3 - Page 37]

Primary care system stewardship and management

Another role for PCOs is to improve primary care quality, including the provision of Quality Improvement (QI) services. Examples include:

- In the Nuka model, system and clinical performance measures are monitored by staff, supported by investment in IT infrastructure and health intelligence.
- In the primary care clusters in Wales, quality improvement is the responsibility of all staff within the cluster and there is a strong emphasis on sharing good practice and learning from the experiences of cluster success and failure. Across all program's quality improvement is supported by investment in IT infrastructure, health intelligence and the resulting data that comes from it. Quality improvement techniques range from data feedback and interpretation, to self-reflection and benchmarking, to quality indicators and equity audits.

All PHNs are involved in Health System Improvement (HSI) activities, however, most if not all have enhanced this role from a support function to a quality improvement, practice development and transformation function. General Practice and primary care more broadly are engaged day to day in these activities with PHNs acting as the key integrator into LHD/LHN hospital and community-based services.

The value of these quality improvement functions have continually enhanced the capacity and capabilities of primary care, evidenced by data collected by all PHNs. At a system level the short term benefits were clearly evidenced during bushfires, floods, droughts and the currently evolving pandemic as reforms were implemented in record times. Regional primary care system stewardship and management allowed primary care to be represented in regional health system responses and enable information flows and customised support, contextualised to the local context.

EXAMPLE FOR AUSTRALIAN PHNs: PRIMARY CARE STEWARDSHIP AND MANAGEMENT

The Western Sydney COVID-19 Response

The COVID-19 pandemic has been the most significant health event of the century. The threat and presence of COVID-19 have both disrupted and radically transformed the health sector in a way never seen before. Western Sydney, home to a million people, presented an immediate need for specific and culturally appropriate resources to reduce the spread of the virus, while easing pressure on the health care system.

A number of key factors played a critical role in driving the Western Sydney COVID-19 response including:

- Leveraging the integration of existing services and collaboration across the health system.
- Expanding digital connectivity to broaden our communications reach and enable clinical shared care between hospital and primary care.
- The strength of our partnerships with communities which enabled rapid infrastructure deployments to create safe and well-resourced spaces for assessment, testing and treatment of COVID-19 positive patients.

[Refer to Appendix B: Section 5 - Page 42]

WA Primary Health Alliance - Stay Connected with telehealth

COVID-19 presented the risk that services supporting Australians with chronic health conditions, may become less accessible or even collapse, potentially disrupting the primary care of a significant cohort of vulnerable people.

While national data indicated that awareness campaigns had built high levels of understanding around telehealth overall, a decrease in GP, pathology, and specialist appointments indicated to WA Primary Health Alliance (WAPHA) a need to improve telehealth awareness and capacity among people diagnosed with chronic conditions.

Further investigation revealed patient anxiety and fear of infection, reluctance to overburden the health care system, and the patient perception that they could self-manage their medical conditions, as major contributors to the decrease in medical appointments.

As such, WAPHA commissioned ConnectGroups, a peak consumer body which promotes peer support and consumer empowerment, to develop Stay Connected with telehealth, a three month program to raise awareness, educate and increase the use of telehealth among people diagnosed with a chronic condition.

This program aimed to give health consumers the confidence and capacity to request telehealth from their GP, and ultimately ensure all Western Australians continued to have access to high-quality medical care.

[Refer to Appendix B: Section 13 - Page 63]

WA Primary Health Alliance - Choices Peer Workforce Service

In 2017-18 it was estimated that of the one million presentations to emergency departments (ED) in Western Australia, around 19 per cent of these presentations could have been avoided with treatment in primary care or community settings.

Choices is the first service of its kind in Australia, connecting people who frequently present in crisis, using a peer workforce model, with social and mental health support when they leave emergency departments and justice settings.

Since launching in late 2017, the Choices pilot has used peer and case workers to connect with over 3,000 individuals. A key focus of the service is to provide care coordination and support people to access and remain connected to primary health services in the community.

[Refer to Appendix B: Section 9 - Page 54]

Primary healthcare education, training and workforce development

Workforce development and education was a key role for several of the PCOs examined, ensuring regional primary care workforce capability uplift. For example:

- Southcentral's 'Nuka' system exemplified this when it pooled all the small pots of money being spent on external courses and brought training in-house to ensure all training and programs were tailored to its ethos and operating model, and so that it could focus training doctors, nurses, behavioural consultants and other staff to understand and deliver care in its new primary care model. Southcentral also developed strategic partnerships with medical training schools and universities to share knowledge and allow students and faculty to participate in training programs of service design.

All PHNs are involved in education, training and workforce development within their respective regions. The Australian Medical Association (AMA) recognised Patient Centred Medical Homes (PCMHs) as a key aspiration for Australia within their 10 Year Framework for Primary Care Reform, a view which is consistent with the RACGP's statement - a quality general practice of the future, endorsed by all general practice organisations, in 2012.

PCMH, or similar quality improvement programs, are in place in most PHNs despite limited funding. PHNs have recognised the importance of GP-led, patient centred, comprehensive, team-based, coordinated, accessible, equitable health care. To measure and achieve the highest quality care, in partnership with General Practice, thousands of education events are held each year. These programs are agile, responsive and integrated in many cases with LHD and state government programs, where relevant.

Being regional commissioners, with an intimate knowledge of community needs, PHNs are also cognisant of where there are gaps in primary care services. PHNs support workforce development and seek to attract the needed workforce to the region to ensure the health system of the future can service the community of the future.

EXAMPLE FOR AUSTRALIAN PHNS: PRIMARY CARE EDUCATION, TRAINING AND WORKFORCE DEVELOPMENT

WA Primary Health Alliance - Comprehensive Primary Care

PHNs recognise that a high performing primary care system holds the key to the wellbeing of people with high needs and the sustainability of the broader health care system. In many instances this can only be achieved by a transformation that represents a fundamental shift in the priorities, strategies, and culture of general practice. Nationally a significant number of PHNs have identified the Patient Centred Medical Home model as the key, with relevant local adaptation, to driving this transformational change. At its heart the model requires practices to shift to a truly-patient centred approach to care that is comprehensive, coordinated, accessible and committed to quality and safety. In most PHNs the 10 building blocks of high performing primary care (Bodenheimer et al) have been embraced to inform the required transformation with a wide range of supporting resources, training and human resource made available to support practices on the transformation journey.

Another commonality across the PHN network is the adoption of the Quadruple Aim to inform and evaluate the impact and outcomes of the PCMH transformation focusing on:

- Improved quality and population health.
- Enhanced patient experience of care and outcomes.
- Sustainable cost.
- Improved provider experience.

[Refer to Appendix B: Section 8 - Page 51]

Nepean Blue Mountains PHN - Coordinating the GP response to disasters

Disasters are part of the Australian landscape and General Practitioners (GPs) are scattered across Australia and are inevitably involved in some way or another when disasters strike their local communities. However, there is limited guidance on the systematic involvement of GPs within the broader disaster response system.

Nepean Blue Mountains PHN (NBMPHN) coordinates training for General Practice on disaster preparedness and in Major Incident Medical Management Support (MIMMS), which is an internationally recognised qualification. These GPs participate on a register of GPs willing to volunteer at evacuation centres if required during a disaster. NBMPHN updates this register annually (prior to the high-risk bushfire season). The PHN supports all practices to identify what they can do during a disaster (such as see other GP's patients if there are practice closures in surrounding suburbs, stay open longer, encourage vulnerable patients to have a plan and adequate scripts etc).

The NBMPHN has 'evacuation centre kits' ready to deploy to GPs if they are required to attend an evacuation centre. The kits contain resources and tools GPs would need in addition to their own doctor's bag. For example additional medical equipment and first aid supplies, identifying vest (fluoro/ reflective tabard with DOCTOR emblazon) so they could be easily identified, blank script pads and blank note pad, triplicate pad of patient summary forms, role descriptions, list of relevant contact numbers, local pharmacy locations and opening times etc.

[Refer to Appendix B: Section 7 – Page 48]

EXAMPLE FOR AUSTRALIAN PHNS: PRIMARY CARE EDUCATION, TRAINING AND WORKFORCE DEVELOPMENT

Coordinare (South Eastern NSW PHN) Geriatrician in the Practice: a person-centred approach to specialist access for dementia screening

The Shoalhaven region has an ageing population and a high prevalence of dementia; and insufficient geriatricians available to provide a timely service to patients. This has resulted in long waiting lists for local hospital clinics. Dementia is a serious chronic condition that requires expert clinical assessment, diagnosis and management.

The Geriatrician in the Practice (GIP) program is an innovative model of integrated care where the specialist hospital dementia care team and the general practice team conduct joint consultations in the GP clinic, rather than the traditional approach whereby the patient would be seen by the specialists in the hospital outpatient clinic.

This GIP involves a shared care approach, including a joint comprehensive consultation which includes the patient and carer, GP and geriatrician, practice nurse and a dementia clinical nurse consultant (CNC). In most cases an assessment is conducted by the dementia CNC and the practice nurse as part of the initial consultation. The assessment is comprehensive, aided by screening cognitive tools and is used to facilitate the development of a care plan. The patient, their carer, and the general practitioner and geriatrician are all involved in the development of the care plan. Patients and caregivers are encouraged to share their perspectives, and these serve as the organising principle for the medical recommendations.

[Refer to Appendix B: Section 14 – Page 66]

Health system transformation and reform

PCOs were found to play a critical role in health system reform, through the implementation of agreed reform objectives to change the way that care is delivered and funded, creating long-lasting and meaningful change. Examples included:

- ACOs changing the payment system through tailored payment plans.
- The Nuka system reforming their models to provide more integrated service delivery.

Providing ongoing strategic and policy advice to relevant government departments is also a critical avenue in which to pursue system reform. In Wales, the annual national primary care conference allows primary care clusters to share their past learnings and future direction with the Ministry of Health and Social Services.

Through the PHN CEO Cooperative and similar jurisdictional governance, the network has established effective mechanisms to share learnings, progress priorities together and form policy positions which recognise the variation across regions and at the same time the role of primary care.

These mechanisms are starting to be acknowledged but there is some way to go for them to be recognised consistently by all governments.

PHNs have demonstrated significant progress toward large transformational agendas through strong regional networks, governance and innovation. Regionally PHNs and LHDs are showing, when they work together, siloed funding and programs can be integrated on the ground. However, a lack of consistent recognition of PHN roles and responsibilities, significant operational constraints and inflexible funding remain significant barriers to progress.

EXAMPLE FOR AUSTRALIAN PHNS: HEALTH SYSTEM TRANSFORMATION AND REFORM

Western Sydney Health Alliance – Nepean Blue Mountains PHN and South Western Sydney PHN

'City Deals' are an Australian Department of Infrastructure, Transport, Regional Development & Communications initiative which aims to merge plans across federal, state, and local government for managing growth and delivering infrastructure in major cities. Once established, the City Deal creates a 20-year agreement between all parties to transform transport, technology, health, education, environment, government, and urban planning across the targeted region. The Western Sydney City Deal was announced in 2016 to coincide with the announcement of the site for development of the second Sydney airport at Badgerys Creek.

The Western Sydney Health Alliance is a formal partnership between the NBMPHN, SWSPHN, NBMLHD, SWSLHD and the local governments of the Blue Mountains, Camden, Campbelltown, Fairfield, Hawkesbury, Liverpool, Penrith & Wollondilly.

The Health Alliance aims to:

- Foster a shared regional understanding and work collaboratively on regional issues, within a placed-based approach through the delivery of locally focused projects and programs in keeping with a shared vision of healthier communities; and
- Include health planning and a coordinated approach in the pursuit of positive health and wellbeing outcomes for Western Parkland City. It will be a key platform for the co-design and co-creation of evidence-based integrated care according to need.

[Refer to Appendix B: Section 10 – Page 56]

WA Primary Health Alliance - Sustainable Health Review

In June 2017, the Government of Western Australia announced the Sustainable Health Review (the Review), to prioritise the delivery of patient-centred, high quality and financially sustainable health care across the State.

As the operator of the State's three PHNs, WA Primary Health Alliance (WAPHA) had the opportunity to play a key role in representing the voice of the primary care sector throughout the Review and will continue to do so throughout the Review's implementation as part of an agreed strategic partnership with the Department of Health WA.

Promoting and prioritising an integrated health system is one of WAPHA's strategic priorities, signalling its intent to adopt an approach that supports the delivery of seamless primary health care.

[Refer to Appendix B: Section 11 – Page 58]

EXAMPLE FOR AUSTRALIAN PHNS: HEALTH SYSTEM TRANSFORMATION AND REFORM

Western Sydney Service Delivery Reform

In 2014 the Service Delivery Reform (SDR) initiative was established in four sites across NSW giving those on the front line the mandate to work across agency boundaries, to innovate and deliver what is needed at the local level. In Western Sydney we have embraced this directive with open arms, harnessing our relationships and networks to build a robust coalition.

The following agencies and organisations are members of the local SDR:

- Western Sydney Primary Health Network (WentWest)
- NSW Department of Communities and Justice (DCJ)
- Sydney Children's Hospitals Network (SCHN)
- Western Sydney Local Health District (WSLHD)
- Mt Druitt Police Area Command
- Aboriginal Housing Office (AHO)
- Department of Education (DoE)

SDR projects and programs advances a system model that promotes integrated, cross-sector collaboration in order to build efficient and effective systems that mitigate the impact of adversity and support protective factors among families in Western Sydney.

The key features of the approach include:

- All levels of the system being engaged in an interagency approach to reduce barriers through localised governance, financial and decision-making capacity.
- The system being streamlined, integrated and collaborative; the focus is shifted from a reactive, treatment lens to preventative approach with early intervention that is individualised to the needs of both the child and the family.
- The solution being co-designed with families, tailored to the community based on self-determination and self-sustaining, family based and based on individual needs.
- Providers recognising all children and families require universal access to support and services.
- Monitoring and evaluation of outcomes is conducted across the network.

[Refer to Appendix B: Section 15 – Page 68]

Primary care organisational enablers within the broader health context

Five key enablers were identified as required for primary care organisations or their equivalent to fulfil their roles successfully:

1. **Effective governance**
2. **Relationships and alliances**
3. **Health and system intelligence**
4. **Investment and financing**
5. **Freedom to innovate.**

The following sections outline a summary of each enabler.

Effective governance

Governance in the systems reviewed show a strong partnership between primary and acute sectors, with joint representation of primary care and acute care interests on equal footings in relevant forums. For example, in the Welsh Primary Care Clusters, each cluster reports directly into the Health Board, which are in turn accountable to the Welsh government.

The case studies from Nuka and Wales are underpinned by legislated primary care outcomes, and formal consultation frameworks. For example, the legislative background for health service planning in Wales includes the Wellbeing of Future Generations (Wales) Act 2015, the Social Services and Wellbeing (Wales) Act 2014 and the Public Health (Wales) Act 2017.

Together, these three pieces of legislation place a firm emphasis on reducing health inequalities through long-term prevention and the delivery of sustainable, outcome focused services. The Wellbeing of Future Generations Act (Wales) in particular sets out the goals that the 44 public bodies in Wales must work together to achieve.

The impact of legislation has been clearly demonstrated in the case study of the Nuka System of Care from the late 1990s after legislation allowed Alaska Native people to take greater control over their health services, transforming the community's role from 'recipients of services' to 'owners' of their health system, and giving them a key role in designing and implementing services.

Relationships and alliances

Strong, respectful relationships served to drive system transformation in all PCOs reviewed and were found to be critical across all PHNs. For example:

- While most models are regionally based (such as the Welsh model), in line with the approach for local and place-based care, existing relationships were leveraged in the creation in several models e.g. in the American ACOs, where organisations nominate to form an ACO irrespective of geography.
- Respectful relationships based on trust were critical in enabling funding transformation in Collaborative Commissioning arrangements which sought to jointly commission services across primary, community and acute care. These arrangements are allowing those regions to transition away from pure fee-for-service to a capacity-based model where providers are jointly funded, incentivised and accountable.
- Peer relationships are also important with several models using shared platforms and alliances to share learnings and support quality improvement.
- Collaborative alliances and relationships were essential in the success of the Nuka System of Care.

COLLABORATIVE RELATIONSHIPS AND ALLIANCES IN THE SOUTHCENTRAL

Foundation's 'Nuka' System of Care

The Southcentral Foundation (SCF) recognises that health care is about people and relationships and from the very beginning, built its healthcare system around the understanding that building personal relationships were critical for success.

These relationships and alliances are evident at three levels in the Nuka system:

1. The direct relationship with the customer-owner/patient;
2. Relationships across the primary-acute divide, between the primary healthcare provider and acute service provider/hospital relationships; and
3. SCF's strategic alliances with governing bodies, health care institutions and medical schools.

Firstly, enduring productive relationships between the Nuka and the communities they serve is critical in the patient-centred paradigm. Nowhere is this better personified than the relationship cultivated between the Nuka system and their customer-owners – where focus on customer-ownership means continued and meaningful engagement that informs all elements of the model, from strategic planning to service design responds to reported needs, to service delivery, where providers in the primary care team build genuine relationships with their customer-owner. Providers are also specifically hired and trained to create trusting, accountable, long-term relationships with customer-owners.

This commitment to genuine long-term relationships, which engenders trust and collaboration is also seen in the relationships between primary and acute care providers. Strong relationships have been developed with local hospital doctors and specialists who work together to support patients in primary care and share a common vision of integrated, patient-centred care in Alaska.

Southcentral's leaders emphasise the importance of listening to community leaders and in maintaining long-standing organisational relationships, such as partnerships with other governing bodies and healthcare institutions (e.g. The Institute for Healthcare Improvement). Additionally, SCF also works collaboratively with organisations such as The Alaska Native Tribal Health Consortium who jointly own and manage the Alaska Native Medical Centre. Strategic partnerships with medical training schools such as Harvard Medical School have also been established and allow the school's students and faculty to participate in Southcentral's training programs.

Health and system intelligence

The use of health data is now critical in planning, designing and delivering evidence-based care for localised populations. High performing systems harness this capability by ensuring adequate investment in technology, including in initial infrastructure and then embedding the use of resulting data into decision making and care processes. This includes:

- The planning process – e.g. to inform the Primary Care Cluster Action plans in Wales.
- Electronic medical records and strategies to promote optimal use. For example, shared care planning tools, HealthPathways, eHealth integration and data linkage continue to provide continuing evidence-based education programs.
- Administrative management tools to assist with booking appointments, communicate to health team members on test results such as in the Nuka model.
- Data sharing between providers and practices to assist with clinical decision making, such as in Wales and in the American ACOs.
- Risk stratification tools to identify high risk cohorts.

Health intelligence is also key in driving cycles of clinician quality improvement, with use of data analytics such as provider dashboards to provide patient level data, benchmarking and the ability to provide peer-ranked performance feedback (used commonly in ACOs).

This approach is also used at an organisational/system level, e.g. the Nuka system uses a data mall to monitor both clinical and performance measures.

EXAMPLE FOR AUSTRALIAN PHNS: USE OF HEALTH/SYSTEM INTELLIGENCE

National PHN Primary Health Insights (PHI)

PHNs nationally have collaborated to create a single storage and analysis solution aligned with best practice security and data governance standards where individual PHNs will continue to store and maintain custodianship of their own data.

The PHI Program has created a secure, powerful and robust national data storage and analytics solution that assures data integrity and provides easy to use reporting and analytics, enabling PHNs and other stakeholders to make informed program and policy decisions about Australian primary healthcare delivery.

Key features of the solution and program are:

- A common data platform for storage and analytics of primary health care data and other data sets used by PHNs for the planning and commissioning of services.
- A highly secure space for each PHN to store data that will support work in analytics, predictive modelling and visualisations.
- Ensure strong cyber, network, data security, privacy and data governance for the primary health care data of all 31 PHNs.
- Maintain separation of the data sets in support of PHN sovereignty, independence and autonomy while supporting the appropriate sharing of selected data in support of broader health planning and policy initiatives.
- A key enabler of collaboration with LHNs/LHDs through data sharing and linkage to better inform system and service re-design and reform.

The Primary Health Insights (PHI) solution is a key enabler of the work of PHNs in understanding regional needs and commissioning or increasingly co-commissioning solutions with key regional partners. The analytics capability provided by PHI will also enhance the monitoring and evaluation capabilities of PHNs in collaboration with system partners such as LHN/LHDs.

The commissioning capability of the national PHN network has matured substantially over recent years with the following areas of focus:

- Driving outcomes that really matter to people.
- New and innovative approaches to providing health services.
- Client-and consumer-centric services.
- Strengthened engagement with clients, families, the Local Health District, the Commonwealth, NGOs, private sector and communities.
- Increased collaboration and transparency across Government on priority areas.
- A more efficient and effective use of resources.
- Building a better understanding of what works and what doesn't.

Increasingly concepts of Collaborative Commissioning are being applied taking a whole of system approach to support service design reform to enable and support delivery of value-based care in the community. Its aim is to deliver value-driven, outcome-focused, and patient-centred health care by leveraging the principles of the Quadruple Aim and developing pathways of care tailored to the community's needs. The NBMPHN and SWSPHN Western Sydney Health Alliance, Western Sydney Collaborative Commissioning and the WAPHA Sustainable Health Review case studies all indicate the move, in different ways, to an increasingly whole of system approach within PHN jurisdictions with a focus on local flexibility, innovation and co-investment.

[Refer to Appendix B: Section 12 – Page 61]

Investment and financing

Two aspects of investment and financing were found to be essential:

- Adequate investment at model establishment is crucial, reflected in large investment at the development for all models reviewed.
- The use of a singular funding pool, with integrated funding reflecting the intention for integration was seen in all models even if several funding sources were in play. Providing primary care organisations or their equivalents the full quantum of funding across the care continuum allows the most efficient use of resources.

Freedom to innovate

To provide true population-based integrated care, the models reviewed were afforded the freedom and autonomy to innovate and adapt various elements of their model to better meet their population's needs. For example:

- The Nuka system has undertaken a full system transformation, innovating all model components including funding, service delivery and strategic planning models.
- The Primary Care Clusters in Wales provided direct management of resources to the cluster, in the form of staff and budgets to provide more opportunities for redesign of pathways and services.
- The ACO model is highly tailorable, from the configuration of the ACO, agreed outcomes and payment model for providers, which allows each ACO to modify and adapt to local stakeholders and target populations.
- The Nuka system has also undertaken a full system transformation.

Example outcomes achieved

Where available, outcomes from Australian PHN case studies and the three best practice examples from the global literature were reviewed against the Quadruple Aim. Figure 4 below outlines examples of outcomes that were cited in international examples and Figure 5 shows outcomes from Australian PHN case studies in the same way. Figure 6 shows key opportunities for PHNs.

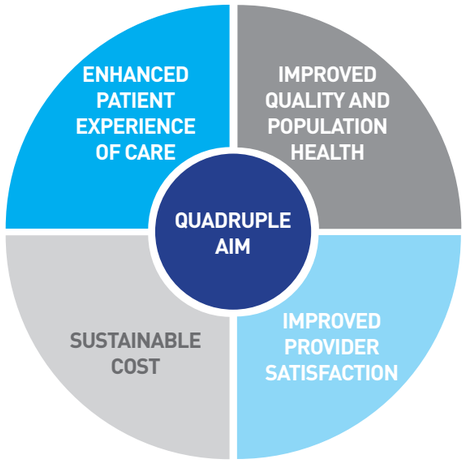
Figure 4. Example outcomes achieved by international primary care systems investigated

ENHANCED PATIENT EXPERIENCE OF CARE

- Dedicated clinicians who know the patient and provide continuity of care - 95% of customer-owners in the Nuka system have been enrolled with the integrated primary care team.
- Reduction in wait time for routine appointments – from four weeks to same day (Nuka).
- Increase in doctor–patient communication (ACO).
- Improved patient contentment with various aspects of care, wait times, better access to information (ACO).
- In a survey done from the North-west London integrated care pilot, the majority of respondents felt that the pilot improved inter-professional communication about their care needs (50% and 73% for all respondents and those with a care plan, respectively) and resulted in health care staff asking fewer questions about their medical history (54% and 77%, respectively).[2]

SUSTAINABLE COST

- Reduction in total healthcare costs: 2%-13% (ACO).
- In 2015, spend was reduced in 57% of ACOs in the US that were in the Medicare shared-savings program for three years. The mean differential change in per-patient Medicare spending was $474 for those that entered the program in 2012, $342 for ACOs that entered in 2013 and $156 for ACOs that entered in 2014. [3]
- Spending reductions in physician-group ACOs constituted a net savings to Medicare of $256.4 million in 2015. [3]
- The North-west London integrated care pilot projected acute savings of £10.9 m in its first year of operation. [2]



IMPROVED QUALITY AND POPULATION HEALTH

- Reduction in emergency department attendances for chronic illness by 45% and hospital admissions by 53% from 2000 to 2015 (Nuka).
- Improved, patient adherence rates to treatment plans, and disease management (ACO).
- Reduced length of stay and reduced readmission rates (ACO).
- 25% reduction in visits to primary care centres per person over a three-year period from 2008-2015 (Nuka).
- The majority of the ACOs in the US—82%—also improved the quality of care they provided, based on data 33 individual quality measures. [1]

IMPROVED PROVIDER SATISFACTION

- In 2015, provider satisfaction in the Nuka System of Care was above 90%.
- From 2003 to 2015, the workforce engagement indicator from an employee engagement and satisfaction survey scored from 1 to 5 rose from 3.83 to 4.22.

[1] https://www.modernhealthcare.com/article/20170829/NEWS/170829881/medicare-shared-savings-acos-cut-1-billion-in-costs-over-three-years

[2] Curry, N., et al.,. 2013. Integrated care pilot in North-west London: a mixed methods evaluation. International journal of integrated care, 13, e027. https://doi.org/10.5334/ijic.1149

[3] McWilliams, J. M., et al, 2018, 'Spending after 3 Years of the Medicare Shared Savings Program', New England Journal of Medicine},379, 12, 1139-1149,https://doi.org/10.1056/NEJMsa180338

Figure 5. Example outcomes achieved by Primary Health Networks with their partners

ENHANCED PATIENT EXPERIENCE OF CARE

HealthPathways: Clear and standardised assessment and management pathways provided confidence and quality in COVID-19 care.

Geriatrician in Practice: "This is a very good idea. Less travel, no parking hassles. Lots of time, GP in on the plan. Loved it.'

Geriatric Rapid Acute Care Evaluation: The independent review of the GRACE service found that, based on feedback provided to the GRACE service team and RACFs, family members were very satisfied with the service.

Coordinating the GP response to disasters: Patients are able to get more responsive care provided by the appropriate clinician which will result in better patient experience of care.

Comprehensive Primary Care: Feedback from the CPC supported program, Happy or Not, has led to increased consumer consultation, e.g. patient feedback groups and use of social media to inform practice improvements.

Stay Connected with telehealth: "Telehealth was an essential part of accessing the care I needed during the time I felt it wasn't COVID-19 safe for me to either go out or go into my GP waiting rooms," one participant said.

"It was very effective and in conjunction with some simple home equipment like a pulse oximeter and BP machine, everything I needed was covered," said another participant.

Collaborative Commissioning: Enhanced provision of patient-centered and integrated care managed and coordinated within the primary health care setting.

SUSTAINABLE COST

Geriatrician in Practice: One year after receiving the GIP program intervention, patients in the initiative attended an emergency department with a frequency 44% lower than in the year immediately prior to the.

Geriatric Rapid Acute Care Evaluation: The GRACE project was able to demonstrate an effect cost/benefit to its implementation, which include:

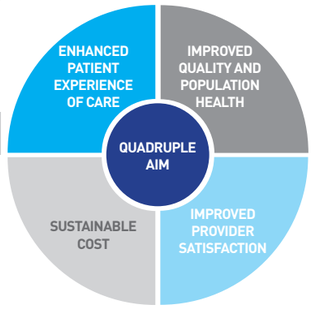
- The average length of stay is shorter for GRACE patients who are referred to the ED (15.01 hours vs 16.32 hours).
- The average length of stay was also shorter for those GRACE residents admitted as inpatients than non-GRACE residents (4.67 days vs 5.81 days).
- Decreased transfer to ED by 22%, acute inpatient admissions by 21%, average length of stay by 15% in ED SSU and 8% in other wards, with an estimated saving of $712,350 according to the scope of this trial.

Coordinating the GP response to disasters: The involvement of PHNs in the emergency response can reduce unnecessary emergency department presentations as demonstrated in the recent 2019/20 bushfires.

Comprehensive Primary Care: Practice business improvements have been used successfully to sustain rural and remote practices and to assist nimble and flexible responses to the COVID-19 pandemic. Workforce reform initiatives have enabled practices to consider other options in team-based care; develop greater awareness of non-traditional general practice staffing, for example non-dispensing pharmacists and social workers, and greater utilisation of team members within an MBS framework.

Stay Connected with telehealth: This short-term project showed the potential to influence behavioural change with long term benefits, at a relatively modest cost.

Collaborative Commissioning: Reduction in Triage 4 and 5 ED presentations and admissions to hospital.



IMPROVED QUALITY AND POPULATION HEALTH

HealthPathways: The ability to provide up to date information at scale and pace in consistent clinical formats across populations and geography has been otherwise unmatched.

Geriatric Rapid Acute Care Evaluation: During the trial period, there was a 22% decrease from baseline in ED presentations and a 21% decrease from baseline in admissions to the ward for residents from participating RACFs. There was a 15% decrease in the average length of stay for patients admitted to the ED Short Stay Unit and an 8% decrease in the average length of stay for admissions to other wards. Ambulance transfers from participating RACFs were decreased by 15%.

Coordinating the GP response to disasters: Disaster preparedness planning in primary care means providers can better support their patients and ensure ongoing appropriate care is provided to support better health outcomes for the community.

Comprehensive Primary Care: A focus on data has assisted CPC practices to measure improvement in cancer screening, immunisation rates and health checks for vulnerable groups including Aboriginal and Torres Strait Islander patients.

IMPROVED PROVIDER SATISFACTION

HealthPathways: GPs and other clinicians reported that they regularly checked HealthPathways for updates and information, which provided them with confidence and support in COVID-19 care.

Geriatrician in Practice: The intervention led to better integration within the region, with 100% of surveyed GPs reporting improved engagement and integration with the Local Health Network.

Geriatric Rapid Acute Care Evaluation: Stakeholders felt that the objectives of the initiative had been met through implementation to date. Highlights include:

- Better targeting resources while reducing the enormous stress and disruption caused by the chaos of a hospital admission to acutely unwell older people.
- Supporting stakeholders to make the right decisions about the patient's care to be made quickly and within an appropriate clinical governance framework, increasing the confidence of RACF care managers and communication with residents' families.
- Improving the relationship between RACFs and EDs.

Coordinating the GP response to disasters: General Practices reported high satisfaction with regular communication and support provided by the NBMPHN during the 2019/20 bushfires for example about services, the status of the fires, patient resources, how they could assist, service closures and evacuations including RACFs and local hospitals.

Comprehensive Primary Care: Central to high performing primary care is the notion of worker satisfaction or 'joy' at work. Leadership programs, communities of interest and other networking events demonstrate how practices achieve this, during normal times and including during the COVID-19 pandemic. Leadership programs focus on the needs of taking care of self and the team.

Stay Connected with telehealth: Some GPs reported an increase in appointments during the lock down period via telehealth.

Collaborative Commissioning: GPs and specialists working at top of license within multidisciplinary teams, rapid access to care when needed to enable easy referral, integrated systems, time saved and value delivered apparent and measurable.

5 KEY OPPORTUNITIES FOR PHNs

Addressing five key areas of opportunity will enable PHNs to fulfil their role within the Australian health system and deliver on the strategic objectives of the Program (Figure 6).

Figure 6. Key opportunities in realising PHN roles and Program objectives

OPPORTUNITY AREAS	OPPORTUNITIES
JURISDICTIONAL GOVERNANCE ISSUES Commonwealth and jurisdictional barriers in policy, strategy and financing, constitute long standing, well recognised barriers to integration of care and wider health system reform.	**The NHRA Addendum represents a major step forward that should lead to:** • **Progressive resolution of Commonwealth-state relationships,** responsibilities and financing processes. • **Increased clarity re state – territory government relationships with PHNs** and State Health Department expectations of LHNs working with PHNs. (example: NSW-PHN statement now in final stages of development). • **Creation of a PHN consultative body** to liaise with peak bodies and as a critical vehicle for stakeholder engagement to deliver system consistency and efficiency.
NATIONAL HEALTH POLICY AND STRATEGY The absence of agreed national health policy, principles and strategic priorities results in a lack of unifying integration pathways across jurisdictions and services impacting providers, patients / consumers and communities.	Implementation of the NHRA addendum should lead to: • **Development of an agreed vision and principles** for the Australian Health System including a national PHC strategy and primary care transformation blueprint. • **A PHN consultative body** to provide primary care inputs and regional perspectives to ongoing policy and strategy development. • **Review of current funding model** with the aim to move toward blended funding models, through PHNs and LHD regional partnerships, incorporating value and outcomes-based funding rather than solely focussing on activity based funding. • **Formalising collaborative commissioning governance** structures at national, state and regional level, in partnership with LHNs as regional joint system funders and managers. • **Increasingly address workforce availability** at a national and regional level.
PHN CAPABILITIES PHN capability has grown rapidly over the last five years, and overall the Network capacity is considerable. However, consistency across regions is yet to be achieved, representing a functional and political weak point.	• **Revision of the PHN Program Performance and Quality Framework** to create a fit-for-purpose framework to guide the ongoing development of PHN capabilities drawing on current PHN experience and operational challenges. • **Development of a core capability set for all PHNs, which acts to define baseline requirements and ensure consistency across all PHNs** - recognising that ultimate capability will enhance regional decision making and flexibility of response to identified regional needs. • **Use of the National CEO Cooperative as a champion of regional responsiveness underpinned by core consistency across the network and** – providing a vehicle for shared learning at state and national level to showcase and promote local innovation.
PHN OPERATIONAL CONSTRAINTS These are well recognised and have been documented in earlier reports (refs). Their impact on PHN operations and effectiveness as system mangers and change agents is substantial.	• **Enhance the assessment process against an updated PHN Program Performance and Quality Framework** to focus on metrics that matter and add value. • **Move to a triennial cycle** to allow PHNs to forward plan and more strategically address needs and engage consumers. • **Streamline AWP processes** including the timing of lodgement dates, template releases, approvals and removal of duplication in reporting. • **Progressively move** away from reporting inputs and activity to reporting value and outcomes. • **Improve the flexibility of funding across all contracts and programs** to allow for patient centred culturally appropriate co-design with consumers, health professions, providers and the community. • **Improve the capacity of PHNs to address rural place-based issues** adversely impacting access to health care and health outcomes. • **Recognise the importance of building cross-sector regional health and social care systems** in the delivery of value and outcomes through explicit allowances for pooled regional funding. • **Address challenges with the current PHN funding model** – in particular the disconnect between core funds (fixed cost) and operational charges (variable costs) to allow for streamlined PHN accounting, improved consistency across the network and efficient growth (as per the roles and responsibilities). • **Empower PHNs to lead health reform** where there is a clear joint acknowledgement of what a high performing PHN and regional health and social care system looks like, the barriers that exist in each region to achieving that system and an understanding of risk appetite and escalation pathways.
PRIMARY HEALTH CARE CAPABILITY Multiple reviews have demonstrated that primary health care does not operate as a coordinated, integrated system[1]. General practice is constrained by this and other factors, most importantly by financing that still predominantly rewards volume rather than quality.	Primary Health Care-General Practice capability will be improved with: • **Vision of, and transformation blueprint for the future PHC system** agreed between jurisdictions, relevant peak bodies and other key stakeholders. • **The high performing Patient Centred Medical Home (PCMH) networked within its Health Care Neighbourhood (HCN)** is recognised as forming the strong foundations of the future integrated primary health care system. • **PHNs are resourced – and have sufficient leverage,** to work collaboratively with peak bodies, jurisdictions, LHNs and GP Leaders in pursuit of agreed improvements in patient outcomes including : - **Support for regional-to-local system change** and PCMH practice transformations. - **Investment in data** that drives quality improvement and supports planned system change. - **Development and trialling of new integrated practice/service models** with GP financing modifications that recognise and reward quality improvement and outcomes. - **Better aligned General Practice vocational training** with regional PHN-university Departments of general practice functions to achieve both synergies and efficiencies. through shared roles, resources, and ultimately infrastructure. - **Joint PHC workforce planning,** professional and team development and career pathway options.

PHN OBJECTIVES & ROLES

Strategic objectives (National Health Reform Addendum 2020-25)

- Identifying the health needs of local areas and development of relevant focused & responsive services.
- Commissioning health services to meet health needs in their region.
- Improving the patient journey through developing integrated and coordinated services.
- Providing support to clinicians and service providers to improve patient care.
- Facilitating the implementation of primary health care initiatives and programs; and
- Being efficient and accountable with strong governance and effective management.

...are compatible with and incorporated into...

Proposed core roles in this white paper

1) System coordination and integration.
2) Regional commissioning.
3) Primary care stewardship and management.
4) Primary care education, training and workforce development.
5) Health system reform.

[1] Australian Government Productivity Commission, 2017, Shifting the dial, 5 year productivity review, Supporting paper no.5 – integrated care

APPENDIX

PHN

Appendix A – Literature Scan: Case Studies

Southcentral Foundations 'Nuka' System of Care (Alaska, USA)

Background

Southcentral is a not-for-profit health system in Alaska, USA owned and run by Alaskan Native people for Alaskan Native people. It assumed responsibility for primary care, community and mental health services for Alaskan Native peoples in the mid-1990s and took it from one of the worst localities in terms of the quality of care and outcomes to one of the most successful. It delivers broad range of services integrating primary, community and mental health services (primary care, dentistry, paediatrics, obstetrics, complementary medicine, traditional healing) in a model with primary care multidisciplinary teams, supported by specialists as required, and also co-owns and co-manages a 150 bed hospital. The uniqe primary care teams are integrated, multidisciplinary and work co-located in a model pioneered by SoutthCentral foundation. It is a state-funded health system with a $241.5 million operating budget plus funding from federal and state govt., third party billing and donations.

Roles of Southcentral Foundation

Primary health care education, training and workforce development

Southcentral has consolidated funding for all external education to bring training in-house to ensure all training is tailored to its ethos and operating model.

Southcentral also built a learning and development centre where small teams from the centre partner with other divisions to identify their training needs and develop courses for employees.

Strategic partnerships with medical training schools such as Harvard Medical School allow the school's students and faculty to participate in Southcentral's training programs.

Southcentral is focused on training doctors, nurses, behavioural health consultants and other staff to solve problems together within an 'adaptive system'. They place an emphasis on experimentation, dialogue, teamwork and multidisciplinary problem solving rather than standardisation.

Southcentral redesigned the roles of doctors, nurses and other healthcare staff to that each team member can spend most of their time on activities where they can add greatest value e.g. doctors are trained to hand tasks to nurse who hand tasks to medical assistants and administrators.

Primary care system stewardship and management

Improvement and innovation is one of the four competencies that employees across Southcentral are expected to demonstrate. Every employee is required to be familiar with basic quality improvement methods and to apply them in their work. The aim is to ensure that staff at all levels are committed to and participate in improvement, rather than relying on a small number of people with quality improvement skills to deliver change

System coordination and integration

Southcentral manages a single budget and responsibility for direct services within its locality

Health system reform

The Nuka system has successfully undertaken a full system redesign:

Funding pool re-design: The Southcentral Foundation manages a single budget which includes the initial task of service design for the whole model and it's iterations thereafter.

Service re-design: Orderly and intentional whole health system redesign began with careful consultation with the community, followed by the development of objectives and principles that inform the service delivery model and allocation of resources, which resulted in the creation of Nuka's unique primary care team, where each customer-owner how has a dedicated GP and multidisciplinary team, who are co-located locally.

Enablers

Governance

The SCF assumed the contract to manage primary and acute health services for Alaskan native people from the US Federal Government in 1985. Since then been able to be locally governed through customer ownership as the system is effectively beholden to the community. Whilst the Alaska Native Health Board (ANHB) exists to represent the Alaska Native Health Care System and is the state-wide voice on health issues, their relationship with SCF however is unclear. Nonetheless, the ANHB board of directors consults with SCF when preparing an annual set of priority issues for consideration by the U.S. Congress and the Alaska State Legislature. The Southcentral foundation also have a responsibility of reporting to tribal representatives

Health/System Intelligence

Southcentral has made substantial investments in informatics, data and analysis to support it's service model. Key investments in system intelligence include:

- Development of a 18-person data services team
- Electronic patient records
- Online health management tool for appointment bookings, test results and to communicate with their health care team.
- A data mall/data warehouse portal that provide employees with access to data showing a range of clinical and performance measures.

Relationships/ Alliances

A key defining feature is that strong relationships between SCF and the community, which engender trust and collaboration is a commitment to build strong relationships between care teams and their customer-owners. Strong relationships were also developed with local hospital doctors and specialists who work together to support patients in primary care. The Alaska Native Tribal Health Consortium and Southcentral also jointly own and manage the Alaska Native Medical Centre.

Southcentral's leaders emphasise the importance of listening to community leaders and in maintaining long-standing partnerships with other governing bodies and healthcare institutions (e.g. Institute for Healthcare Improvement).

Investment/Financing

Pooled funding including (majority) state government, third party billing and donations creates a singular funding pool.

Southcentral also invests heavily in employees, processes and systems to improve how it measure performance. This includes a significant focus on informatics and data.

Freedom to Innovate

Pooled funding provides autonomy for service planning and delivery.

Southcentral has successful undertaken a full system transformation encompassing strategic planning, service delivery and funding model as well as true community and stakeholder engagement.

Examples of outcomes achieved

Seamless patient-centred care from one system with coherent and complete patient-centric journeys: *Southcentral aimed to ensure* each customer-owner had a dedicated GP. Only 35% of patients had a GP in the late 1990s prior to this system of care. By 2013, 95% of the Alaskan Native population had an integrated primary care team. The was also a reduction of the 4-week average delay to schedule a routine appointment to same day access.

Improved clinical outcomes: By reducing its reliance on face-to-face consultations, increasing the use of phone, text and email communications with customer-owners, there was about a 25% reduction in visits to primary care centres per person from 2008-2015. Improving access and management of people with chronic conditions reduced emergency department attendances by 45% and hospital admissions by 53% from 2000 to 2015.

References

Collins, B. 2015, 'Intentional whole health system redesign: Southcentral's Foundations 'Nuka' system of care', *The Kings Fund*, November 2015.
Peiris, D et al, 2018, 'Accountable care organisations: an evidence check rapid review' brokered by the Sax Institute for the NSW Agency for Clinical Innovation

Primary Care Clusters (Wales, UK)

Background

In Wales, primary care clusters are networks that bring together all of the local primary care services involved in health and care across a specific geographical area. The primary care clusters model takes a whole system approach to redesign, driven by national quality standards but with flexibility to respond to local community needs. As at 2017, there are 64 primary care clusters across Wales, serving between 30,000 and 50,000 patients who each have their own vision, mission and principles. There are five functions of primary care clusters include: planning and engagement; integration and multi-disciplinary team working, quality improvement, pathway and service design and innovation.

Roles of Primary Care Clusters

System Coordinator and Integrator

Coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs is defined as the cluster's primary role -

Direct management of resources for the cluster allows for the expansion and delivery of primary and community services. Other functions of primary care clusters include assessing the needs of local populations, strategic planning, disease prevention and support for the maintenance and promotion of well-being improvements.

Primary care clusters facilitate communication and integration between local agencies, stakeholders and people so that local services are coordinated as much as possible

Primary care system stewardship and management

Quality improvement is the responsibility of all staff working for a primary care cluster, sharing good practice and learning from the experiences of cluster success and failure.

System quality assurance systems allow for local flexibility using data to identify local clinical and social priorities and to promote proper engagement with local communities.

The provision of Quality Improvement techniques including data feedback and interpretation; self-reflection and benchmarking, using quality indicators, PDSA cycles and equity audits ensure providers have the necessary skills to understand and address variations in quality.

A national Primary Care Conference is held annually, where past learnings are shared by clusters with the Ministry which to help inform future direction.

System Reformer

It is clearly articulated role that Health Boards, who are responsible for primary care cluster development, are to advise, coordinate and inform clusters of the wider implications of proposed service redesign and improvement schemes.

Regional Commissioning

Primary care clusters act as a commissioner of services based on the individual needs of the communities they service. Services may be sought from external providers, such as mental health practitioners, allied health (e.g. podiatry, optometry), or may be commissioned for cluster internal roles such as *Community* navigators, to assist with low-level patient needs. Clusters also have a key role in supporting local health needs assessments, allocating appropriate resources and forecasting the potential future demand on primary care. GPs in the Clusters play a key role in supporting the ongoing work of a Locality Network.

Enablers

Relationships/ Alliances

Cluster joint contracts are often made up primary care staff and also include social services, acute care services and paramedics. These relationships are necessary to establish locality networks and provide a route for two way communication between Primary Care / GMS Practices and the rest of the health and care system.

Primary care clusters promote integration between partner organisations through collaboration, partnerships, seeking to provide holistic, complex care closer to home and establish joint contracts

A primary care clusters yearbook also highlights the work that each of the individual clusters are undertaking and for Shared learning for quality improvement

Investment/Financing

Autonomous management of funds: direct control through health/social care budgets or allocated cluster funds

Government commitment to primary care clusters: In 2017-18 the Welsh Govt. established a £43m recurrent national primary care fund implemented to support the Welsh Government's broader development of primary care services in Wales. Another £10m of recurrent funding is handed directly to Wales' 64 clusters to develop further, and build existing work which confirms the government's commitment to deliver more care closer to a patient's home, and will also help with enabling a sustainable general practice going forward

Health/System Intelligence

Primary Care clusters use health intelligence to inform cluster action plans.

The primary care needs assessment (PCNA) tool was developed to support clusters with action planning based on review of data on local needs and evidence-informed improvement options.

Data sharing contracts exist allowing data to be shared between the GP Practices which make up a specific cluster network and other agencies and sectors to help drive integration and innovation.

Wales has a National Primary Care Board and National Primary Care Reference Group that provides a strategic forum for influence over the wider primary care agenda, including prioritisation of solutions to meet primary care intelligence needs.

Freedom to Innovate

The direct management of resources by the cluster, in the form of staff and budgets provides more opportunities for redesign of pathways and services.

Devolved management of services enables clusters to plan the transfer of appropriate services and resources into local communities and deliver care tin response to local needs.

Governance

The main lines of accountability for primary care clusters are to the Health Boards of whom are accountable to the Welsh Government for the delivery of the strategic vision for NHS Wales. Each Health Board, Local Authority and Primary Care Cluste r must ensure there are robust governance and monitoring arrangements in place to regularly report and monitor the effectiveness of both primary and acute services in Wales, including Cluster programs. To ensure this Clusters submit an annual report to the Health Board that demonstrates progress against their cluster plan, with evidence that priorities identified by their local n eed's assessments are being addressed. The annual report also serves as a vehicle to feed back to stakeholders on cluster programs. These reports are important as an assurance on delivery against cluster objectives but also directly influence Health Board planning priorities.

Examples of Outcomes achieved

A full evaluation is yet be undertaken for the model, however the Primary Care Clusters Assessment (PCCA) survey was developed to assess the system's progress. This assessment was developed in four stages: interviews with cluster leads, systematic literature review of instruments to assess primary care systems; evaluation among primary care experts and practitioners; piloting the PCCA in each of the 64 clusters. The first application of the PCCA tool assessed clusters on three overall dimensions these were: (1) structure-level dimensions including governance, economic conditions and workplace development; (2) process-level dimensions including access to care, continuity of care, co-ordination of care, comprehensiveness of care and cluster organisation; and (3)outcome-level dimensions including quality of care efficiency of care and equity of care. Initial results from the PCCA survey show early progress in the clusters with:

- High comprehensiveness of care and increased efficiency of primary care
- Cluster leads suggesting that clusters had the opportunity to enhance local primary care services, despite administrative battles in the relationship with health boards and occasional difficulties in engaging with other agencies in the community.
- High outcome-level (referring to quality, efficiency and equity dimensions) and operational dimension scores
- Oppositely, process dimensions scored low as did continuity of care.

References

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Wales, 2018, Primary care cluster governance ' a good practice guide' V16

Health, Social Care and Sport Committee, National Assembly for Wales, 2017, Inquiry into Primary Care Clusters, https://senedd.wales/laid%20documents/cr-ld11226/cr-ld11226-e.pdf

GigCymru, NHS Wales Public Health Wales, Primary care clusters 2019, http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/PHW_Yearbook2019-20_s3.pdf

Accountable Care Organisations/ACOs (Various)

Background

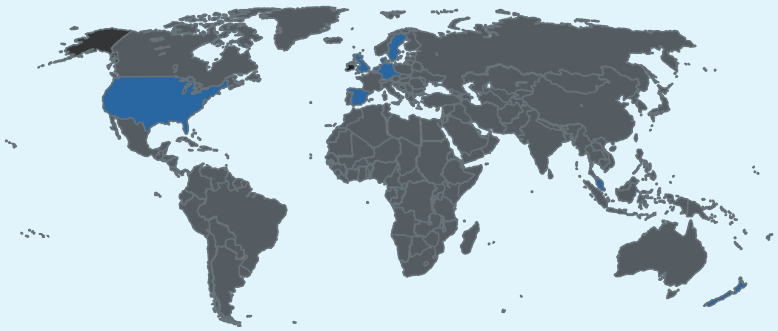
Accountable Care Organisations (ACOs) are care delivery systems, originating in the US, bring together multiple providers who agree to be held accountable for financial and quality outcomes, for a defined population. Today, the model is now used globally across various countries. They vary considerably in terms of provider make-up (integrated delivery systems, multi-specialty groups, primary care physician led), mechanisms to achieve desired outcomes (e.g. promotion of patient-centred medical homes) and contractual options (e.g. alliance contracting and contractual joint ventures). However despite the variable make up, all ACO models contain the following features:

- Providers contract with a payer/commissioner to take responsibility for the cost and quality of care
- A defined population and budget
- Care managed across the continuum ranging from primary and preventive services through to services delivered in hospitals and residential aged-care facilities.

Roles of the commissioner

System coordination and integration

The most impactful role in this model – coordinating the services to provide care across the full continuum from primary prevention to inpatient care, and in some cases, with cross-sectoral collaboration to engage with social care services



Health system reform

Direct effect on system funding and payment models through tailored ACO-specific payment options

Primary care system stewardship and management

The ACO structure inherently enables accountability and system performance through:

- Overseeing accountability for quality through generation of agreed, payment linked outcomes
- Development of locally derived quality improvement programs, supported by investment in IT infrastructure and resulting data

Regional commissioning

European models use region-based population models to commission local services while US models can be based on other arrangements to identify cohorts and service providers e.g. health insurance payers

Enablers

Governance

Strong representation of providers at all levels of ACO governance to inform strategic planning, funding and incentive structures

Strong consumer engagement e.g. use of citizen boards, recognised as central to leadership and governance activities

Freedom to Innovate

Freedom to tailor the:

- Make of the ACO
- Target population
- Agreed outcomes
- Payment structure, including incentivisation structure

Provides ACOs with the mechanism to provide needs-based care with all stakeholders in mind

Health/System Intelligence

Investment in information systems, development of appropriate metrics and engaging providers in regular use of data to analyse and act on areas of performance variation, initiatives include:

- Strategies to promote optimal use of electronic health records (EHRs)
- Data-sharing arrangements between providers and practice
- Use of data analytics such as provider dashboards that allow for drilling down to patient-level
- Information and for peer-ranked performance feedback
- Use of risk stratification tools to identify chronic and complex care patients.

Relationships/ Alliances

Essential for the initial formation of the ACO

Investment/Financing

Adequate initial investment in ACO setup either in the form internal funding from within the ACO, one-off grants from various funding bodies, allocation of a portion of private insurer budgets to support integrated care initiatives, and government investment, including infrastructure investment

The ***use of incentives*** when agreed outcomes were met in conjunction with maintenance fee-for-service payments during transition population-based payments were most effective

Examples of outcomes achieved

Reduction in total healthcare costs – about half the models across the globe report some form or reduction in total costs however there is a wide range of variation e.g. 2%-13%

Improved quality of care – most models show improvement in quality of care outcomes such as hospital admissions/re-admissions, unnecessary emergency department visits, outpatient clinic services, processes of care, patient adherence rates to treatment plans, and disease management

Improved patient experience – models that assess patient experience showed improved patient contentment with particular aspects of care, wait times, better access to information, and an increase in doctor–patient communication

References

Peiris, D et al, 2018, *Accountable care organisations: an evidence check rapid review brokered by the Sax Institute for the NSW Agency for Clinical Innovation*

Appendix B – PHN Case Studies
National Primary Health Network Case Studies

CONTENTS

1. HEALTHPATHWAYS IMPLEMENTATION IN AUSTRALIA

Background

To coordinate improved assessment and health care across primary and acute care settings, HealthPathways has been implemented across the majority of PHN regions in Australia since 2012 and involves partnerships between PHNs and local hospital networks and districts. Originally developed in Canterbury New Zealand, implementation in Australia has involved an ongoing relationship with Streamliners NZ. The initial development and implementation of HealthPathways has involved dynamic collaboration between local primary health care clinicians (predominantly GPs) and Local Health Districts (predominantly specialists), and has been utilized to improve care pathways for patients, reduce waiting times, and improve testing and referrals for a large range of medical conditions.

Utilised as an online health information portal for GPs and other primary health clinicians, to be used at the point of care. It provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the most timely way. However, its greatest benefit is in the working together of clinicians to improve health care and journeys for patients.

ROLES DEMONSTRATED

System Coordination and Integration

During 2020, PHNs worked with Public Health Units and Public Health Services to rapidly utilize HealthPathways as a source of truth for Primary Care Clinicians during the COVID-19 pandemic. This included daily updates, as well as pathways for all aspects of COVID-19 assessment management, including initial assessment and management, practice management, COVID-19 referrals, COVID-19 telehealth, COVID-19 ongoing assessment and management, COVID-19 Mental Health support, COVID-19 outbreak preparation and response for RACFs, and a range of other aspects. Through the HealthPathways community, pathways were rapidly single sourced, adapted or locally redeveloped for maximum agility and benefit for clinicians. The result of this was an enormous utilization of HealthPathways by GPs and other clinicians across Australia. On average, HealthPathways utilization more than doubled during COVID-19 with 100,000's of page views across Australia.

Regional Commissioning

The linkage of a significant range of services commissioned by PHNs with HealthPathways provided additional information and care integration. In turn this connected a broad range of services with COVID-19 pathways, for a strong reach of up to date information.

ENABLERS DEMONSTRATED

Relationships and Alliances

The rapid updates and developments were reliant on relationships between PHNs, primary care clinicians, local health networks/districts, and public health units (at local and jurisdictional levels). The HealthPathways community allowed a unique ability to single source or share pathways at pace.

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care

Clear and standardized assessment and management pathways provided confidence and quality in COVID-19 care.

Quality and Population Health

The ability to provide up to date information at scale and pace in consistent clinical formats across populations and geography has been otherwise unmatched.

Improved Provider Satisfaction

GPs and other clinicians reported that they regularly checked HealthPathways for updates and information, which provided them with confidence and support in COVID-19 care. Ultimately, the evidence of benefit is in the number of COVID-19 pages accessed by GPs, which validated the HealthPathways value.

References

HealthPathways Utilisation Data 2020

Gray J., Swan J., Lynch M., Tay T., Mackenzie M., Wiggers J., Harrison K., McDonald R., O'Dea I., Harrigan L., Fitzgerald S. (2017) Hunter and New England HealthPathways: a 4-year journey of integrated care. Australian Health Review 42(1) 66-71.

2. CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST PHN - EMERALD COMMUNITIES OF EXCELLENCE PROJECT

Background

The mining town of Emerald in Central Queensland is one of the first in Australia to be involved in the Australian Digital Health Agency's (ADHA) Communities of Excellence program.

The overarching aim of the program is to improve health outcomes in Australian communities through the use of technology to deliver better quality healthcare.

The Emerald Communities of Excellence program is a pilot project aiming to fully connect both health providers and community members with digital models of health (e.g. My Health Record, telehealth, electronic prescribing), resulting in a model which could then be replicated in similar communities.

Central Queensland, Wide Bay, Sunshine Coast PHN is one of the lead delivery partners who are working to implement engagement activities on the ground in the Emerald community. Emerald, along with Hedland in WA, have been part of this initiative since late 2019. Population size, strong local clinical and digital leadership, as well as community support made these two communities' ideal choices for the pilot.

The aim of the project is to deliver five core work streams:

- Connect healthcare providers within designated communities to the national My Health Record system;
- Support the expansion of telehealth capabilities across the care continuum;
- Drive greater use of secure messaging to exchange clinical information across different care settings;
- Enable the use of electronic prescriptions in general practices and community pharmacies; and
- Build digital health literacy and participation of healthcare practitioners, patients and their families.

The Emerald Communities of Excellence project is now in its second phase, where the key focus is on encouraging and supporting not only the uptake, but the meaningful use of the aforementioned digital health tools by local healthcare providers, as well as empowering the Emerald community to participate in their own health journey through the use of digital technology.

ROLES DEMONSTRATED

System Coordination and Integration

The Communities of Excellence project supports an integrated approach between primary and secondary care, ensuring clinical information is shared between providers in a safe and secure manner, to improve continuity of clinical care for the patient and to better support their decision making process.

The role of our PHN is to provide direct support to primary healthcare providers in Emerald in connecting and using digital health tools, and to act as the conjugate on the ground to keep providers informed with project updates and the latest information regarding digital health.

Along with supporting healthcare providers, our PHN is responsible for engaging with community members and community organisations within Emerald to raise awareness of the Communities of Excellence project and the benefits digital health can provide for them as health consumers.

Some of the lessons learnt so far have revealed how critical community participation is in driving the uptake and meaningful use of digital health systems, such as My Health Record, and the important role it plays in advocating for these systems to be utilised more meaningfully. Community participation has also demonstrated the importance of patient-centred care and highlighted how digital health tools can act as enabler to make that happen.

During this second phase of the project, our PHN is working closely with the ADHA digital inclusion and community engagement team to participate in the planning and to facilitate the delivery of patient and provider codesign activities for priority groups in Emerald. These groups include (but are not limited to) people living with a disability, chronic conditions, learning disorders/developmental delays, people with lived experience of mental health conditions, Aboriginal and/or Torres Strait Islander people, the elderly, as well as carers and representatives.

Primary Healthcare Education, Training and Workforce Development

This project offers a multitude of opportunities to upskill local health professionals to feel both competent and confident in using digital health tools. To date, education and training has been completed via one-on-one delivery, through virtual means (particularly in response to the COVID-19 pandemic), and larger education sessions held both in person and via an online webinar.

Health System Transformation and Reform

In the current phase of the Communities of Excellence project, our PHN is working to explore different models of care including a 'virtual care' model, which refers to the virtual visits that take place between providers and patients via digital health technologies, and can occur in real time from any location.

The deliverables for this specific piece of work, around virtual care, will be driven by local steering group members, along with the Clinical Reference Lead, Dr Ewen McPhee.

Another model of care that will have a key focus within the second phase of the project is the stepped care approach to mental health, exploring how digital health technologies can enable improved communication and a coordinated approach between GPs, specialists and allied health (psychologists).

ENABLERS DEMONSTRATED

Governance

Our PHN leads the coordination of the project's local monthly steering committee, chaired by Dr Ewen McPhee, a local GP and the President of Australian College of Rural and Remote Medicine (ACRRM).

The committee is comprised of key Emerald stakeholders, including the Director of Medical Services from Emerald Hospital, a local pharmacist/pharmacy owner, a local nurse navigator, representatives from the aged care and mental health sectors, as well as a consumer advocate.

Local influence and decision-making processes are integral in driving the project to its success and is an important component of the project governance structure.

Relationships and Alliances

Our PHN is working in partnership with the following organisations to collaboratively deliver the Communities of Excellence project in Emerald:

- Australian Digital Health Agency (ADHA)
- Australian College of Rural & Remote Medicine (ACRRM)
- Allied Health Professions Australia (AHPA)
- Central Highlands Regional Council
- Queensland Government
- Australian Library and Information Association (ALIA)

Health and System Intelligence

The PHN utilises Govdex data and reports created by the ADHA to keep track of project progress and help inform the direction of activity.

Investment and Financing

This project is funded by the Australian Digital Health Agency under the digitally enhanced models of care priority within Australia's National Digital Health Strategy, which was agreed by all states and territories in 2017.

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care

An important output of the Communities of Excellence project is obtaining good news stories from both providers and consumers in Emerald detailing how digital health has improved health outcomes or improved patient experiences.

These good news stories are shared with the ADHA and are utilised as examples to demonstrate the benefits of digital health more broadly.

An example of one of the good news stories our PHN obtained during the first phase of the project is as follows:

"I live in Emerald, Central Qld and have travelled to Brisbane for multiple specialist appointments, and surgeries for my daughter over the last four years, after she was diagnosed with a brain tumour. My Health Record has been extremely helpful reviewing overwhelming results, when initially received by the specialist as I never took information in. Also, having all her medical history in one location has enabled me to provide important information required to daycare/school for enrolments with ease."

– Taylah, Emerald Mother

Quality and Population Health

This project aims to improve integration between healthcare providers via digital means, through the safe and secure sharing of health information with those healthcare providers directly involved in a patient's care, and by improving access to care through the use of digital technologies such as telehealth and electronic prescribing.

A combined approach of the above aims to improve overall continuity of care, the efficiency of services, and health outcomes for patients.

Sustainable Cost

Building sustainability into the Communities of Excellence project has been a high priority, to ensure ongoing community support for digital health beyond the project's timeline and funding.

Our PHN is working with delivery partners to ensure a suite of resources are available to the community to support digital health long-term.

As a result of the project, the ADHA will create a toolkit based on the project learnings to support other communities to deliver a Communities of Excellence project.

Improved Provider Satisfaction

The PHN has been working with the ADHA Research and Evaluation team to develop the first provider-focused evaluation survey. While this survey is yet to be distributed in Emerald, capturing provider satisfaction will be a component.

References

https://conversation.digitalhealth.gov.au/communities-of-excellence

3. WESTERN SYDNEY COLLABORATIVE COMMISSIONING

Background

Western Sydney Collaborative Commissioning is a whole of system approach designed to enable and support delivery of value-based healthcare in the community. It aims to incentivise integration across the entire care continuum, and embed local accountability for delivering value-driven, outcome-focused and patient-centred healthcare.

Resources are pooled and jointly deployed to deliver the vision of 'one Western Sydney Health System'. Services gaps are collaboratively commissioned through the PHN's strategic commissioning function and LHD resources are realigned to support the models of care. Through integrated governance, delegations, shared culture, information sharing, community engagement and communications WSLHD and WSPHN are able to overcome organisational and professional barriers to integration and focus care on the individual, family and carers who need that care.

The Collaborative Commissioning model currently being implemented in Western Sydney includes 3 transformative models of care: Value-based Urgent Care, Cardiology in the Community and Rapid Expansion of Care in the Community.

Value-based Urgent Care

The overarching objective of the Value-based Urgent Care model is to reduce the number of low acuity conditions (T4 and T5) requiring "urgent" treatment presenting to Western Sydney Emergency Departments (EDs), through provision of sustainable alternative local patient-centred urgent care services, at the right time, in the right place. The model of care has been designed in line with the patient care continuum and has been divided into four distinct stages: (1) Awareness; (2) Intake and Access; (3) Treatment and Referral; and (4) Discharge and Ongoing care.

Key aspects of the model are:

- Networked approach to provision of Urgent Care Services (UCS), including access to a pooled network of resources and streamline referrals into HCN providers.
- General capability uplift of primary care skills and infrastructure to support UCS.
- Extended hours of operation in comparison to usual care practices.
- Focus on a range of higher acuity services, within scope of practice.
- Rapid access to specialists and Community Based Response Teams when required.
- Digitally enhanced functionalities to better support patients and the UCS team.
- Comprehensive large-scale community awareness campaign (driving consumer behaviour change).
- Clinical workforce supported Central Intake Line, an integral component of the model, designed with the primary function of ensuring that patients are assessed by a clinician prior to presenting at an UCS provider (or alternate care provider).

Cardiology in the Community

The objective of the Cardiology in the Community program is to deliver integrated and coordinated care in the primary health care setting, with appropriate access to, and support from the acute and community care sectors – delivering the right care, at the right time, in the right place - the first time.

The model will:

- Strengthen participation and screening to improve identification of people at risk of cardiovascular disease, in turn supporting management of Heart Failure, Chest Pain and Atrial Fibrillation;
- Enhance the ongoing management and treatment of patients with Atrial Fibrillation in a primary care setting;
- Improve access to the Rapid Access and Stabilisation Services (RASS) and enhance stabilisation of patients in the community;
- Upskill general practice and enhance capacity for cardiology management in the community; and
- Reduce the volume of avoidable ED presentations.

Rapid Expansion of Care in the Community

Stream 1: Care in the Community for patients referred by PCMH, RACF or through Acute Services (ED, Inpatient, RASS). Supported by community-based response teams (improving access to Allied Health and support services in primary care), mobile diagnostic services and a shared care planning tool to deliver true team-based care across organisational and professional boundaries.

This will avoid hospital attendance by patients with urgent, ongoing and/or chronic care needs as well as enhance the successful trial of COVID-19 management at home for low and moderate severity cases.

Stream 2: Care in the Community COVID-19 +ve Patients. Specific pathways to manage COVID-19 positive patients in the community with access to specialised medical services, escalation of care for deteriorating patients and transfer of care to primary health care providers have been developed.

The two models Care in the Community and COVID-19 Response provide clinical management, monitoring and care co-ordination for vulnerable and identified high risk residents of WSLHD as well as those with specific conditions which lend themselves to effective, safe and appropriate care in community (rather than in an acute setting).

It will also coordinate the comprehensive care for confirmed COVID-19 positive patients in the community. Specific focus on complex social situations will be an important element of community-based care delivery during the COVID-19 pandemic. Short term case management, psychosocial support and care-coordination will occur while awaiting engagement of other essential support services and agencies during periods of isolation and social distancing. Assistance with urgent welfare and social support needs following suspected or confirmed COVID-19 cases will reduce the risk of experiencing crisis, or requirement of social admissions to acute facilities.

ROLES DEMONSTRATED

System coordination and integration

Collaborative Commissioning is underpinned by a long-standing partnership between the Western Sydney Local Health District (WSLHD) and Western Sydney Primary Health Network (WSPHN). The NSW Health's Collaborative Commissioning Framework, will support this existing partnership to deliver change at the local level, focusing health care around the local priority population's health needs. Collaborative Commissioning is a whole of system approach designed to enable and support the delivery of value-based care in the community.

Regional Commissioning

Collaborative Commissioning has been designed to enable WSLHD and WSPHN to collectively deliver:

- 'one Western Sydney health system', which is value-based and patient-centred;
- right care, at the right time in the right place – in community and primary care wherever possible; and
- improve equity in health, reducing health risks, promote health lifestyles and respond to social determinants.

The models are underpinned by planned realignment of LHD non-admitted patient services and acceleration of the transformation of primary care to take on additional models of care down the track. It incentivises local partnerships and integration of care across the entire care continuum and embeds local accountability for delivering value-driven, outcome focused and patient-centred care.

WSPHN plays the role of the regional commissioner on behalf of NSW Health.

Primary Care System Stewardship and Management

These three initiatives put primary care at the centre of the system transformation and reform. They involve general practices acting as Patient Centred Medical Homes (PCMHs), drawing on multi-disciplinary teams within and outside of their organisation and integrated care pathways into community and acute care (i.e. implementing the principles of a patient centered medical neighbourhood).

The PCMH Program in Western Sydney is being expanded to include 30-35 General Practices (close to 10% of General Practices in Western Sydney) to support implementation of Collaborative Commissioning models and other integrated and community care models like Western Sydney Diabetes. The PCMH will sit at the centre of this model, with the aim of delivering integrated care, with patients' care managed and coordinated in the primary health care setting.

Health System Transformation and Reform

The approach is underpinned by the core partnership between WSPHN and WSLHD which together lead change at the local level, focusing health care around local priority population health needs and using local resources.

Leveraging the skills, ingenuity, and vision of clinicians, consumers, patients, modellers, analysts, academics, and commissioners, we are redesigning the local health system one specialty area at a time, learning from best practice elsewhere and harnessing the potential of digital and telehealth whenever practical.

Extensive co-design with key community members and stakeholders is an integral part of both arms of the program and extensive patient reported experience and outcome measures will be utilised.

ENABLERS DEMONSTRATED

Governance

Governance of the Collaborative Commissiong is a fully collective endeavor between the WSPHN and WSLHD and other key stakeholders including health consumers.

The LHD Chief Executive and the PHN CEO co-chair the Patient Centred Collaborative Commissioning Executive Steering Committee and each model sub-committee is co-chaired by a WSLHD clinician and a GP nominated by the PHN. Models are clinical designed considering primary, community and acute care options to design optimal integrated and patient centred services which are flexible to meet diverse patient needs.

Relationships and Alliances

The ability to mount an early successful submission and project plan for the NSW Health Collaborative Commissioning initiative was enabled by a long history of LHD / PHN collaboration and trust over a number of years. The shared values, culture and trust between the organisations and with the NSW Ministry of Health have allowed the reforms to flourish.

Health and System Intelligence

Collaborative Commissioning will draw heavily on the work of WSLHD and WSPHN having already established data sharing and linkage capability. This will provide a fuller picture of the patient journey and enable better use of big data and allow work on predictive analytics to identify and drive proactive improvements in care.

Investment and Funding

The Program allows for blended payment models, using MBS, block and activity based funding from both NSW Health and Commonwealth. The principle is that the model of care is designed around the patient, using the best available evidence and data, and then WSPHN and WSLHD work together to combine and pool funding sources to enable the model to be funded and resourced.

Freedom to Innovate

The very core of Collaborative Commissioning is to allow redirection of resources for maximum community benefit and delivery of cost-effective care.

EXAMPLES OF OUTCOMES EXPECTED

Patient outcomes – reduction of adverse events, prevention of deterioration of cardiac conditions, prevention of deterioration of other non-acute conditions due to improved access to allied health and mental health services in community through the community based response team (especially in RACFs), reduction in waiting times reduced risk of COVID-19 exposure in acute settings.

Patient experience – including improved involvement in care, greater knowledge of treatment and efficient mode of care.

Provider experience – including improved integration of care and clinician information sharing.

System sustainability – including benefits associated with reductions in ED presentations and improved capacity in hospital due to avoided admissions.

4. A 'HEALTH ALLIANCE' BETWEEN BRISBANE NORTH PHN AND METRO NORTH HOSPITAL AND HEALTH SERVICE

Background

In 2017, Brisbane North PHN and Metro North Hospital and Health Service (HHS) jointly created the Health Alliance; an approach to tackling healthcare problems that transcend the mandate of either one organisation or part of the health sector, and that cannot be fixed by existing approaches. The Health Alliance aims to realign current resources and deliver care in a more coordinated and integrated way across institutional boundaries and focus on solutions that benefit both patients and the health system. To date, areas of focus include improving health outcomes for children in the Caboolture catchment, improving the health and wellbeing of older people, and embedding new virtual models to redirect care closer to home.

ROLES DEMONSTRATED

System Coordination and Integration

Acting as a neutral space, the Health Alliance brings together stakeholders on equal footing to improve integration and coordination across the health system, paying particular attention to improving the tertiary and primary care interface. This process has allowed sector actors to engage in system redesign while maintaining a view of both the complexity of the health system, and the need for fit-for-purpose local solutions.

Regional Commissioning

The intention of the Health Alliance is to enable a shared approach for decisions that will shape the way care is funded and delivered in North Brisbane. The Health Alliance creates the foundations for regional commissioning by working with stakeholders, including consumers and carers to co-design solutions. Governed by a Joint Board Committee of Brisbane North PHN and Metro North HHS (explained further in 'Governance'), the Health Alliance is an example of what a joint regional commissioning mechanism between a primary health network and hospital and health service could look like. It connects local knowledge and planning directly to implementation, bringing decision making closer to the front line of health services and the community.

Health System Transformation, Reform and Freedom to Innovate

The Health Alliance is an innovative idea designed to focus on 'wicked problems' that cannot be resolved by existing approaches or by primary and acute care working in isolation. The Alliance process has uncovered that frontline clinicians, consumers and carers hold the key to solutions in the system and can be empowered to innovate and create change. Having a dedicated resource to create a neutral space and bring together stakeholders enables this innovation to come to the surface.

ENABLERS DEMONSTRATED

Governance

The Health Alliance is governed by a Joint Board Committee, consisting of members from both organisations including board chairs, board members and chief executives. The Committee meets at least four times each year with the Chair rotating annually between both organisations.

Relationships and Alliances

The Health Alliance was created from a strong relationship and proven track record of collaboration between Brisbane North PHN and Metro North HHS. It can be described as the sum of its parts; alliancing with partners through extensive stakeholder consultation and engagement, including with consumers, carers and families.

Health and System Intelligence

It was agreed early on that an alliancing process needed to take a holistic view of the patient journey and be supported by integrating health data from across the sector. This would provide a more comprehensive picture of population outcomes, patient experience, service utilisation and system performance. Known as the 'North Brisbane Health Information Initiative', the Health Alliance and partners worked on creating the IT architecture required for a shared data platform to ensure monitoring and decision making is informed by real-time population information.

Investment and Financing

The Health Alliance consists of a small team funded jointly by Metro North HHS and Brisbane North PHN.

EXAMPLES OF OUTCOMES ACHIEVED

Joint Commissioning Strategy

Through the alliancing process a joint regional commissioning strategy was developed to describe how outcome-focused prioritisation and purchasing decisions will be made at the regional level.

Blueprint for a 'North Brisbane Population Health Advancement Fund'

The Health Alliance developed the 'North Brisbane Population Health Advancement Fund', a blueprint for a virtual fund which would be collectively governed by the Joint Board Committee.

'Your Care Closer' – New Models of Care

Building on the fundamental shifts that have occurred as a result of COVID-19, the Health Alliance is supporting the co-design and implementation of three interlinked initiatives to enable care to be provided closer to or in a person's home.

New Pathway of Antenatal and Postnatal Care in Caboolture

A new pathway of care was co-designed focussed on increasing continuity of midwifery care, seamless transitions to the child health service and increased connections to the family GP. Implemented from February 2020, the pathway is supported by the co-location of midwives with the child health service in the community. Outcomes include significantly reduced fail to attend rates and increased engagement with the child health service.

Geriatrician Outreach into RACFs Trial

The Health Alliance and partners have implemented a new Geriatrician outreach service for residential aged care facilities (RACFs). GPs working in residential aged care can refer their patients for a comprehensive assessment with a hospital geriatrician. The trial aims to increase collaborative, proactive management of non-acute older people in RACFs. An evaluation is underway, with early positive feedback from participants.

5. THE WESTERN SYDNEY COVID-19 RESPONSE

Background

The COVID-19 pandemic has been the most significant health event of the century. The threat and presence of COVID-19 have both disrupted and radically transformed the health sector in a way never seen before. Western Sydney, home to a million people, presented an immediate need for specific and culturally appropriate resources to reduce the spread of the virus, while easing pressure on the health care system.

A number of key factors played a critical role in driving the Western Sydney COVID-19 response including:

- Leveraging the integration of existing services and collaboration across the health system.
- Expanding digital connectivity to broaden our communications reach and enable clinical shared care between hospital and primary care.
- The strength of our partnerships with communities which enabled rapid infrastructure deployments to create safe and well-resourced spaces for assessment, testing and treatment of COVID-19 positive patients.

ROLES DEMONSTRATED

System Coordination and Integration

All outcomes were driven through effective and efficient collaborations across Western Sydney, from local, state and federal government bodies to general practices, NGOs, private companies and other partners.

Key players across Western Sydney, including the Western Sydney Local Health District (WSLHD), local Councils, General Practices, and the federal Department of Health, joined us as we quickly secured existing infrastructure, or constructed newly developed infrastructure, to build and open COVID-19 GP-led Respiratory Clinics in Blacktown, Riverstone and Castle Hill. The Mount Druitt and Carlingford sites were hybrid clinics, being that they were three way collaboration between WSPHN/WSLHD and Outreach Clinical Teams supported by local General Practice.

These clinics were built from scratch or established within or adjacent to General Practices, with the ability to assess suspected cases of COVID-19, influenza and pneumonia, and provide early assessment, testing and management of patients.

Primary Healthcare Education, Training and Workforce Development

HealthPathways responded with a COVID-19 resource package including numerous pathways, partnered with neighbouring Primary Health Networks across NSW to create these pathways, with real-time updates as new information and best practice emerged.

These HealthPathways for COVID-19 included:

- Impact on Local Services
- Assessment and Management
- Telehealth
- Practice Preparation
- Referrals
- Impact on Clinical Care.

As of 30 June, these HealthPathways were viewed over 33,000 times by 1,900 health care professionals, with the most popular being Assessment and Management, Referrals, and Practice Preparation.

Other training included: Infection Control (multiple webinars delivered and made available to all health care providers across Western Sydney), practice preparedness i.e. PPE (mask distribution), Telehealth Guidance including access to equipment and training on video call platforms and Business Continuity support.

Health System Transformation and Reform

Australian software start-up, CareMonitor, partnered with WSPHN and WSLHD to free up hospital resources. As a result, patients with low to medium risk in Western Sydney were monitored remotely through a shared care platform accessible by all members of the patient's care team.

When a positive test is received, the local Public Health Unit is notified, and an assessment is typically done by a hospital community health team. Where it is most appropriate to care for the patient at home, clinical handover to the patient's General Practice is facilitated through CareMonitor. The software uses advanced algorithms to monitor patients using COVID-19-specific questionnaires developed by WSLHD, and collects biometric data such as temperature, oxygen saturation, blood pressure and heart rate. The COVID-19+ve contracted clinics providing Care in the Community have access to this shared-care platform.

Enablers demonstrated

Governance

Effective governance was provided under the umbrella of the existing shared approach developed by WSLHD and WSPHN to the collaborative commissioning work underway in the region. This was supported by a long history of partnership on initiatives with a broad and integrated community view.

Relationships and Alliances

Our experience with COVID-19 has reinforced our belief that we are 'one system' here in Western Sydney. As we mobilised as one to meet an unprecedented challenge, it was heartening to see health professionals across various sectors working together to deliver innovative and responsive health care to our community.

Investment and Funding

The Program leveraged Collaborative Commissioning funds which allowed it to use blended payment models, using MBS and COVID-19 specific state based funding from both NSW Health and Commonwealth. The principle is that the model of care is designed around the patient, using the best available evidence and data, and then WSPHN and WSLHD work together to combine and pool funding sources to enable the model to be funded and resource.

Health and System Intelligence

Drew heavily on the work of WSLHD and WSPHN having already established data sharing and linkage capability. This provides a fuller picture of the patient journey and enable better use of big data and allow work on predictive analytics to identify and drive proactive improvements in care. Analytical dashboards were used to monitor daily progress and make decisions on where to focus efforts.

Freedom to Innovate

To-date the Western Sydney COVID-19 response demonstrates that trusting, comprehensive PHN/LHD partnerships can enable an innovative and rapid response.

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care

Patients able to access care, support and testing close to home and for low to medium risk patients to be managed remotely by their GP.

Quality and Population Health

A rapid and coordinated response has ensured early and comprehensive care for patients at scale and as of 30 June, Western Sydney has completed almost 95,000 tests (90 per 1,000 population).

Sustainable Cost

Effective and early development of capacity in primary care has potentially eased pressure on the hospital system.

Improved Provider Satisfaction

HealthPathways viewed over 33,000 times by 1,900 health care professionals, with the most popular being Assessment and Management, Referrals, and Practice Preparation.

6. CAPITAL HEALTH NETWORK - GERIATRIC RAPID ACUTE CARE EVALUATION (GRACE)

Background

The Geriatric Rapid Acute Care Evaluation (GRACE) program trial was initiated by Capital Health Network (CHN) in 2017 with the aim of improving the healthcare journey and reducing presentations to the Calvary Public Hospital Bruce (CPHB) emergency department (ED). This is an outreach service located at CPHB that provides clinical support to residential aged care facilities (RACFs) and involves clinicians visiting RACFs to assess residents who are experiencing an acute health episode but are not in a clear medical emergency. This service acts as a point of liaison at the interface between RACFs, primary care and acute care. The GRACE program also provides after hours services.

The GRACE program trial was funded by Capital Health Network, and CPHB was engaged through a clinical services agreement to trial the implementation as an outreach service based at the hospital. The trial involved five RACFs in North Canberra. The trial concluded in February 2019, and the program was expanded across the ACT and funded by CPHB thereafter.

ROLES DEMONSTRATED

System Coordination and Integration

The GRACE service trial was focussed on integrating RACFs, GPs and hospitals to deliver a single entry, rapid response service for residents in RACFs. The program aimed to facilitate clinical care as close to the point of residence as possible to decrease transfers to ED or ensure an improved transition of care between acute care and residential aged care settings. The service includes a Clinical Nurse Consultant to coordinate a single-entry service for RACF residents and their GPs 7 days a week. The program includes services provided after hours.

The GRACE model of care provided a support system to coordinate the management of acute health episodes in RACFs. This enhanced the flow and coordination of care of residents who do require transfer between RACFs and ED and supported GPs in the community management of residents. This provided better integration between RACFs, acute care and primary care and improved coordination of care.

Regional Commissioning

The GRACE program was initiated based on findings from CHN's 2016 Baseline Needs Assessment that showed avoidable ED attendance and hospitalisation of people in RACFs as a priority area. CPHB was selected by CHN through a tender process to conduct the GRACE program trial.

This activity was planned under the umbrella of the ACT Coordinating Committee for Primary Health Care and Chronic Conditions, a cross-sectoral committee developed as a joint initiative between CHN, ACT Health, CPHB and the Health Care Consumers' Association.

Primary Care System Stewardship and Management

The program provided onsite assessment and clinical care for older people in RACFs to balance traffic to the right services through rapid treatment and/or support in the community as needed. This reduces unnecessary ED presentations and avoidable complications due to unsettling trips for older people to the hospital.

Primary Healthcare Education, Training and Workforce Development

A communication plan detailing support and education activities was developed for the project.

This involved:

- Training sessions for staff at participating RACFs including information on early recognition of acute health episodes, communication techniques and other patient assessment skills.
- Training in Advanced Care Planning and management of common issues for RACF staff.
- GP visits to establish professional relationships between GPs and RACF staff, inform GPs of the GRACE service and its objectives and discuss referral pathways.
- Training sessions for CPHB staff to introduce the GRACE service, provide updates on outcome data and obtain feedback on the model of care.
- Training for ED staff is provided by undertaking a staff mentoring role about aged care within ED. This assisted with the confirmation that aged care is a core business for ED and driving cultural changes.

Health System Transformation and Reform

- Improve efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, were improved. Patients can avoid preventable deteriorations thanks to being able to receive the right services in-time and rapidly. Continuity of care was ensured thanks to the coordination and follow-up work delivered by CNC.
- Focus on prevention and early intervention were enhanced, where GRACE advocates for patient's/family's preferred treatment options, community palliative care options and advanced care planning.
- Improve communication, exchange of information and service integration by providing aged care resources in the ED and providing hospital resources in RACFs.
- Improve efficiency of health system resource allocation. Reduced access block resulted in less elective procedures being cancelled. Reduced bed occupancy rates and length of stay can create better bed flexibility and access to services for those really in need.

ENABLERS DEMONSTRATED

Governance

CPHB was selected by CHN through a tender process to conduct the GRACE program trial. A service agreement between CHN and CPHB was developed which determined that CHN would supply funding for trial staff while CPHB would provide funding for the trial infrastructure and support systems.

A project board was developed to oversee the trial. This board was composed of high-level stakeholders, including CPHB, senior clinicians, the GRACE team, CHN managers, RACF staff, ACT Ambulance Service staff and the Hospital in the Home service team.

The GRACE program was intended as an extension of Health @ Home Unit during the trial period. Clinical governance was fluid during the trial given that the pathways for the patient cover both admitted and non-admitted periods of care. These aspects of clinical and corporate governance were incorporated into CPHB base operational systems.

Nursing governance was provided via the existing CPHB structure for the division of medical services. Primary medical governance remained with the GP for patients in the RACFs, but with the admitting consultant if the patient is admitted to hospital.

Project management methodology (Prince2) was used to manage the project.

Relationships and Alliances

The GRACE service and model of care was co-designed with CPHB, GPs, RACFs, ACT Ambulance Service and hospital staff. These local stakeholders worked in collaboration to ensure the service and model were regionally appropriate and promoted streamlined communication between services.

Health and System Intelligence

Custom-built activity data analysis based on real-time project status reporting, stakeholder satisfaction, cost benefit and sustainability analysis in the context of an activity-based management environment.

The GRACE service model of care was developed based on wide consultation with stakeholders as mentioned above.

Investment and Financing

CHN provided funding of a total of $625,000 (GST exclusive) over the 18-month trial, covering $200,000 for the first year, and $425,000 in the second year of operation. The funding covered staffing costs of the GRACE nurses and some minor administration costs. CPHB supported the cost of the clinical lead for the project as well as infrastructure costs.

Freedom to Innovate

The model offers freedom to innovate in terms of the ability to easily execute, learn fast and scale easily:

- Recommendations from the project evaluation were for more back-up arrangements to increase availability of services, better documentations, and clarity regarding clinical governance. No recommendation relates to the structural arrangement of the service, which proves the logical strength of the model, imperative to scalability.
- The model was easy and straightforward to implement. Capacity building activities for stakeholders were able to quickly and significantly improve service quality and providers' capacity to provide care.
- Although the trial only used primary technology solutions and encountered problems with communication across different data systems, it was able to produce significant results. With the potential to adopt cloud-based services to improve communication and reduce administrative burdens, the room to further innovate services to enhance capacity and quality is immense.

EXAMPLES OF OUTCOMES ACHIEVED

An independent review of the GRACE service was commissioned by CHN in September 2018. This acted as a formative qualitative evaluation of the service and largely used stakeholder interviews, excluding consumers and carers. A final report and evaluation was released by CPHB in February 2019, at the conclusion of the trial. These documents are used to inform the below.

Patient Experience of Care

The independent review of the GRACE service found that, based on feedback provided to the GRACE service team and RACFs, family members were very satisfied with the service.

In particular, family members were highly satisfied with the GRACE service's role in:

- Averting need for hospitalisation.
- Providing compassionate and professional care.
- Supporting residents during acute and relatively stressful periods of care.
- Assisting residents when they quickly shifted to an end of life stage.
- The considerate and continuing communication provided to family members to ensure they were kept informed.

Quality and Population Health

During the trial period, there was a 22% decrease from baseline in ED presentations and a 21% decrease from baseline in admissions to the ward for residents from participating RACFs. There was a 15% decrease in the average length of stay for patients admitted to the ED Short Stay Unit and an 8% decrease in the average length of stay for admissions to other wards. Ambulance transfers from participating RACFs were decreased by 15%.

Sustainable Cost

The trial period funded by CHN was an opportunity to review the tools and resources delivered by the service to ensure financial sustainability and update or amend the program after the pilot concluded. The ACT Government, through CPHB, have been the sole funder of the GRACE Service since the trial period ended in February 2019. The ACT Government allocated $9.6m over four years to sustain and expand the service across the ACT, starting in February 2019.

The GRACE project was able to demonstrate an effect cost / benefit to its implementation, which include:

- The average length of stay is shorter for GRACE patients who are referred to the ED (15.01 hours vs 16.32 hours).
- The average length of stay was also shorter for those GRACE residents admitted as inpatients than non-GRACE residents (4.67 days vs 5.81 days).
- Decreased transfer to ED by 22%, acute inpatient admissions by 21%, average length of stay by 15% in ED SSU and 8% in other wards with an estimated saving of $712,350 according to the scope of this trial.
- There was no readmission to hospital within 28 days for patients admitted from participating RACFs.
- The trial ceased one month earlier than expected so there were minor underspends.
- Reducing the number of residents from aged care facilities transferring to hospital for palliative / end of life care.

Improved Provider Satisfaction

Overall, stakeholders felt that the objectives of the initiative had been met through implementation to date.

Highlights include:

- Better targeting resources while reducing the enormous stress and disruption caused by the chaos of a hospital admission to acutely unwell older people.
- Supporting stakeholders to make the right decisions about the patient's care to be made quickly and within an appropriate clinical governance framework, increasing the confidence of RACF care managers and communication with residents' families.
- Improving the relationship between RACFs and EDs.
- The proactive nature of the service – moving into management of care before escalation of acute symptoms, unlike other more reactive services.
- Focused on common clinical interventions which are appropriate to outpatient support e.g. management of falls, chest infections, urinary tract infections.
- The model of care offered through the project is patient centred and can produce better outcomes.

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7. NEPEAN BLUE MOUNTAINS PHN - COORDINATING THE GP RESPONSE TO DISASTERS

Background

Wentworth Healthcare Limited is a not for profit organization and provider of the Nepean Blue Mountains Primary Health Network. The Nepean Blue Mountains region is located in NSW starting about 70km West of Sydney. It encompasses a mix of urban, rural, bushland, industrial and commercial lands, as well as the Hawkesbury/Nepean river system and vast tracts of National Parks. It covers 10,000 square kilometres with a population of approximately 360,000 people. There are approx. 450 GPs located in 135 practices scattered across the region.

The region experiences extreme weather conditions with extreme heat in Penrith and Hawkesbury areas and extreme cold and snow in the upper Blue Mountains and Lithgow. These conditions leave the region vulnerable to natural disasters and adverse weather conditions such as bushfires, flooding, heatwaves and snowstorms. For example, in October 2013 the region experienced major devastating bushfires. In contrast, 12 months later in October 2014 the upper Blue Mountains experienced a snow storm that saw the major highway closed. In 2016 the Hawkesbury experienced significant road closures and closure of major river crossing bridges, and last Summer Penrith recorded one of the hottest temps in NSW. In 2018/19 a large proportion of region was classified as drought affected and at the end of 2019 and early 2020, many homes, properties, bushland and wildlife were lost in the devastating black summer fires.

Disasters are part of the Australian landscape and General Practitioners (GPs) are scattered across Australia and are inevitably involved in some way or another when disasters strike their local communities. However, there is limited guidance on the systematic involvement of GPs within the broader disaster response system.

ROLES DEMONSTRATED

System Coordination and Integration

Nepean Blue Mountains PHN (NBMPHN) has developed local arrangements to incorporate primary care in the regional health response to natural disasters. They defined the roles of General Practice and the PHN in disasters incorporating this into regional health disaster response protocols. They are an active participant of the health executive emergency management committee lead by the Local Health District and participate in Emergency Operations Centre meetings during times of disasters. Primary Health Networks are unique in knowing their GP population. The NBMPHN acts as a conduit between General Practices, disaster management teams and others as well as mobilizing and coordinating the GP response during a disaster when required.

Regional Commissioning

NBMPHN commissions a wide range of health services, including General Practices to support them to deliver high quality care to the community.

Primary Care System Stewardship and Management

The NBMPHN supports approx. 450 GPs located in 135 practices scattered across the region to provide high quality care for the community. The NBMPHN coordinates the General Practice response during a natural disaster and this is integrated into the overall regional health response to disasters.

The NBMPHN has developed disaster management health pathways which is available to clinicians on the HealthPathway portal.

Primary Healthcare Education, Training and Workforce Development

Nepean Blue Mountains PHN coordinates training for General Practice on disaster preparedness and in Major Incident Medical Management Support (MIMMS), which is an internationally recognised qualification. These GPs participate on a register of GPs willing to volunteer at evacuation centres if required during a disaster. NBMPHN updates this register annually (prior to the high risk bushfire season). The PHN supports all practices to identify what they can do during a disaster (such as see other GP's patients if there are practice closures in surrounding suburbs, stay open longer, encourage vulnerable patients to have a plan and adequate scripts etc).

The NBMPHN has 'evacuation centre kits' ready to deploy to GPs if they are required to attend an evacuation centre. The kits contain resources and tools GPs would need in addition to their own doctor's bag. For example additional medical equipment and first aid supplies, identifying vest (fluoro/ reflective tabard with DOCTOR emblazon) so they could be easily identified, blank script pads and blank note pad, triplicate pad of patient summary forms, role descriptions, list of relevant contact numbers, local pharmacy locations and opening times etc.

Health System Transformation and Reform

The NBMPHN has developed a model that can be applied and adapted to other regions across Australia.

The lessons learned from the 2013 Blue Mountains Bushfires were the catalyst for better defining the role of primary care, in particular General Practitioners, in natural disasters and the important coordination role for PHNs. It led to the publication of "Planning for Disaster Management: An emergency preparedness guide for Primary Health Networks and others supporting the local General Practitioner response during emergencies" which was launched at the World Association for Disaster and Emergency Medicine (WADEM) Congress on Disaster and Emergency Medicine in Brisbane in May 2019 and has been shared extensively with other Primary Health Networks some of whom have adapted to their own region. The publication can be found here www.nbmphn.com.au/DisasterMgtGuide

The NBMPHN experiences have been shared as part of the Royal Commission into Natural Disasters and is contributing to shaping recommendations and reform of health arrangements in natural disasters.

ENABLERS DEMONSTRATED

Governance

Through PHNs, primary care has voice in planning for and responding to disasters as part of the region's overall health emergency response. The NBMPHN is a member of the health executive emergency management committee lead by the Local Health District and has a seat at the Emergency Operations Centre meetings during times of disasters. The GP response and PHN role fits within existing governance and command and control structures that are enacted in times of a disaster and this is essential so as to not create separate structures or confusion.

Relationships and Alliances

The Nepean Blue Mountains primary care disaster management arrangements are built on a strong partnership between the Primary Health Network and Local Health District and a shared understanding of the benefit for the community of ensuring primary care are involved in disaster planning, response and recovery. It is imperative that planning occurs at the local level but is supported at the State and National level and disaster preparedness and management systems are reformed to enable this.

Health and System Intelligence

Sharing of information across sectors is essential for responsive action and decision making in times of disasters. The NBMPHN acts as a conduit between General Practices, disaster management teams and others.

Health intelligence from 2013 bushfires, research conducted by Dr Penny Burns and input from peak bodies such as RACGP and AMA informed the scope of the role of General Practice in disasters and the role of PHNs.

Strategies to promote the benefit of the My Health Record with providers during disasters, de-briefing for primary care providers involved in the disaster response and sharing approaches, particularly what is working well in relation to integrating primary care providers and PHNs in natural disaster preparedness, response and recovery is recommended to avoid duplication of work.

Investment and Financing

Funding through the Department of Health PHN program and voluntary contributions from primary care providers has enabled preparedness and response work to be undertaken to date. There should be national consideration of item numbers for primary healthcare providers that can be utilised during a natural disaster response to ensure primary care services can be provided in alternative locations if required.

Freedom to Innovate

The 2013 Blue Mountains bushfires saw mass voluntary evacuations of whole suburb and neighbourhoods, with many residents re-locating to emergency evacuation centres. While there was a coordinated and well-resourced response from emergency services and the Local Health District, the role for General Practitioners was not clear and the need for primary health care support at the crowded emergency evacuation centres was identified early on. Many people had fled their homes without their regular medication or scripts, whilst others were experiencing minor cuts, wounds, respiratory complaints and elevated anxiety. It was recognized that without primary care support, the local emergency department would be overwhelmed with cases that would be better managed by General Practitioners.

With the support of Wentworth Healthcare, a GP volunteer roster was created. Wentworth Healthcare coordinated doctors to be stationed at the evacuation centres 24/7, to be available for people who required minor medical assessment and treatment.

Wentworth Healthcare also had a coordination function which required liaison with the LHD HSFAC, the GP Liaison Officer located at the State Health Emergency Operations Centre and local area GPs.

In the weeks following the disaster, Wentworth Healthcare worked quickly to secure additional funding for counselling services for local residents and focused on the immediate recovery phase of the disaster. This included liaison with organisations supporting the community following the bushfires.

The agility, creative response and lessons learned from the experience highlighted the need for GP preparedness to improve response and recovery. This led to further development of the role of primary care and PHNs in natural disasters, associated procedures, documented disaster health pathways and better integration into the regional health response. The guidelines developed were 'road tested' in the 2019/2020 bushfires and has meant that as an organisation NBMPHN were better prepared for this most recent crisis. Compared to 2013 response, this was much more coordinated.

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care

Patients are able to get more responsive care provided by the appropriate clinician which will result in better patient experience of care.

Quality and Population Health

Disaster preparedness planning in primary care means providers can better support their patients and ensure ongoing appropriate care is provided to support better health outcomes for the community.

Sustainable Cost

Care provided through general practice is much more cost effective than community members using the emergency department for non- acute care issues that could be addressed by a General Practitioner.

The involvement of PHNs in the emergency response can reduce unnecessary emergency department presentations as demonstrated in the recent 2019/20 bushfires. For example, throughout the bushfire crisis, NBMPHN maintained ongoing communication with the LHD. The PHN participated in the health Emergency Operations Centre meetings (sometimes up to three times a day), sharing information to assist in a more coordinated response. When an evacuation centre was established in Lithgow one weekend, there was concern that evacuees needing scripts and other minor issues addressed would be presenting to the hospital Emergency Department, which was already understaffed and reporting capacity issues with smoke inhalation from fire services personnel and others. The PHN was able to identify, liaise with, and share information about a General Practice in Lithgow close to the evacuation centre that was open extended hours and willing to see new patients/patients from other GPs. This meant that staff in the evacuation centre were able to refer evacuees to this practice rather than ED.

Improved Provider Satisfaction

Many General Practices are keen to assist their communities in times of crisis and having a clear role avoids confusion both for primary care providers and acute care clinicians who can become overwhelmed if they need to respond to all health concerns during a disaster as was seen in other regions across Australia during the recent 2019/20 bushfires. General Practices reported high satisfaction with regular communication and support provided by the NBMPHN during the 2019/20 bushfires for example about services, the status of the fires, patient resources, how they could assist, service closures and evacuations including RACFs and local hospitals.

References

www.nbmphn.com.au/DisasterMgtGuide

8. WA PRIMARY HEALTH ALLIANCE - COMPREHENSIVE PRIMARY CARE

Background

Designed by WA Primary Health Alliance (WAPHA) with GPs, the Comprehensive Primary Care (CPC) program works intensively with general practices across the state to identify and understand specific needs and offer tailored support to deliver a sustainable patient-centred model of care that improves patient outcomes.

Committed to achieving the highest standards in quality and safety, CPC is GP-led, place-based, and systematic, offering tailored, comprehensive support.

Aligning to the principles of the Patient Centred Medical Home (PCMH) model, it ensures care is co-ordinated, accessible and locally based, where possible. The program also aligns with the Bodenheimer Building Blocks for high performing primary care.

ROLES DEMONSTRATED

System Coordination and Integration

Care is organised across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports, and public health and utilising health IT systems to maximise system coordination and integration.

CPC offers workforce reforms to enhance team-based care, including introducing non-dispensing pharmacists and social workers directly into the care team of the partnership practice and upskilling reception staff as medical practice assistants. This has highlighted the benefits of team-based care and enabled practices to research financially sustainable models for implementation of similar initiatives independent of the PHN.

Social workers have exponentially assisted practices to understand the care system within their location (increased relationships and referrals to community based services) and non-dispensing pharmacists have improved the interface between hospital and primary care, reducing medication errors, building stronger relationships to community pharmacy and improving coordination across the health system.

Primary Care System Stewardship and Management

CPC has led quality improvement in practices, providing exemplars of practice outcomes and stakeholder engagement. Each practice commits to undertake Plan Do Study Act (PDSA) activities to achieve the Quadruple Aim.

Through communities of interest, information has been shared, networks consolidated, and peer learning achieved.

Primary Healthcare Education, Training and Workforce Development

CPC recognises the need for training across the practice e.g. leadership, practice software, nurse-led clinics, practice management, financial and business acumen and communication skills from the reception desk. Training is based on elements of high performing primary care (Bodenheimer Building Blocks) and responsive to current health care policy e.g. telehealth.

Analysis of practice data means data driven initiatives are the focus of quality improvement activities to improve access to care for vulnerable patients.

Health System Transformation and Reform

Following the Commonwealth introduction of the Health Care Homes trial, extensive consultation was undertaken to develop the CPC program with similar aims of the PCMH model. WAPHA conducted a two-part Naïve Inquiry to inform a local response to the challenges to health equity and health outcomes, insights of which have informed the ongoing development of care models and support to primary care services.

Naïve Inquiry Part 1 – A collaboration between WAPHA, Curtin University, WA General Practice Education and Training and The Royal Australian College of General Practitioners WA., explored general practice staff views of the current provision and models of care for patients with chronic disease and GP understanding of the PCMH model.

Naïve Inquiry Part 2 – A collaboration between WAPHA, Curtin University and the Health Consumers' Council (WA) gained insight into the experiences of adults with multiple chronic conditions who receive management support through primary care centred in general practice.

ENABLERS DEMONSTRATED

Governance

Effective consultation and codesign occurred with relevant stakeholders (the Naïve Inquiry). This included the evidence behind the PCMH model. Evaluation is ongoing, and a formal independent evaluation is being undertaken by Curtin University due later this year. Throughout the program, services commissioned, and training provided have also been evaluated.

Relationships and Alliances

During early development, WAPHA worked closely with WSPHN, with extensive networks now built across the PHNs.

Strategic relationships with Curtin University, Department of Health WA, Health Service Providers, Pharmaceutical Society of Australia, State Health CoNeCT – WAPHA SW Project, Royal Australian College of General Practice, Australian Medical Association, training providers including WA General Practice Education and Training, UNE Partnerships and other health programs have informed current and emerging strategies in primary care.

Health and System Intelligence

CPC facilitators work closely with partnership practices to utilise general practice data systems to track clinical, operational and patient experience metrics, and monitor progress.

Digital health initiatives to improve integration are promoted and well developed. For example, My Health Record integration exceeds targets; and telehealth and e-prescribing are two current initiatives that have been supported in terms of training, networking with partners and integrating across health systems.

Investment and Financing

N/A

Freedom to Innovate

Flexible funding has ensured that programs with limited success or programs that are no longer central to the continuous improvement cycle can be replaced with other initiatives.

EXAMPLES OF OUTCOMES ACHIEVED

Using the Quadruple Aim, the CPC program can be measured in terms of its impact on the participating practices. CPC has generated models for best practice which in turn have become standard models in other practices e.g. PDSAs in Practice Incentives Program Quality Improvement measures.

Initiatives include workforce reform within general practice, consumer engagement, communities of interest, motivational care planning for people with a chronic disease, integrated diabetes care, and education for practice teams on engaged leadership, integrated team care, and business performance and sustainability.

Patient Experience of Care

The CPC program supports patients and families to manage and organise their care and participate as fully informed partners in health system transformation at the practice, community and policy levels. Feedback from the CPC supported program, Happy or Not, has led to increased consumer consultation, e.g. patient feedback groups and use of social media to inform practice improvements.

Population Health

A focus on data has assisted CPC practices to measure improvement in cancer screening, immunisation rates and health checks for vulnerable groups including Aboriginal and Torres Strait Islander patients.

Sustainable Health Systems

Practice business improvements have been used successfully to sustain rural and remote practices and to assist nimble and flexible responses to the COVID-19 pandemic.

Workforce reform initiatives have enabled practices to consider other options in team-based care; develop greater awareness of non-traditional general practice staffing, for example non-dispensing pharmacists and social workers, and greater utilisation of team members within an MBS framework.

Worker Experience

Central to high performing primary care is the notion of worker satisfaction or 'joy' at work. Leadership programs, communities of interest and other networking events demonstrate how practices achieve this, during normal times and including during the COVID-19 pandemic. Leadership programs focus on the needs of taking care of self and the team.

9. WA PRIMARY HEALTH ALLIANCE - CHOICES PEER WORKFORCE SERVICE

Background

In 2017-18 it was estimated that of the one million presentations to emergency departments (ED) in Western Australia, around 19 per cent of these presentations could have been avoided with treatment in primary care or community settings.

Choices is the first service of its kind in Australia, connecting people who frequently present in crisis, using a peer workforce model, with social and mental health support when they leave emergency departments and justice settings.

Since launching in late 2017, the Choices pilot has used peer and case workers to connect with over 3,000 individuals. A key focus of the service is to provide care coordination and support people to access and remain connected to primary health services in the community.

ROLES DEMONSTRATED

System Coordination and Integration

Choices aims to facilitate access to community-based health services and primary care to address clients' underlying issues, unmet needs and divert them from attending ED. This was achieved by co-locating peer workers within ED to engage individuals on the spot and provide initial emotional support, brief intervention and service information and options. Choices has connected clients to over 44 external support agencies; the majority of these were community, mental health or accommodation services.

Mental health, accommodation and alcohol and other drug rehabilitation are the most common services Choices clients are referred to. The service also actively connects or reconnects clients to general practice (and a GP who can manage regular ongoing care) and facilitates Mental Health Care Plans as appropriate. Approximately 60 per cent of clients conclude the service with a Mental Health Care Plan in place.

Regional Commissioning

WA Primary Health Alliance (WAPHA) commissioned Ruah Community Services to develop Choices using a co-design approach and is the result of a ground breaking collaboration between primary care, tertiary care, social services and the justice system. Following the success and learnings from the pilot program, a similar service is being establishment at four additional hospitals in the Perth metropolitan area.

Primary Healthcare Education, Training and Workforce Development

As part of service development and quality improvement, the service provider recognised a gap in supporting a large and growing peer workforce. In response, Ruah developed a peer framework aligned with the PHN guidance for Peer Workforce Role in Mental Health and Suicide Prevention. Called, 'Lived experience alone, is not enough' it reflected the need for further understanding of the professionalisation of the peer workforce, and the need to develop a framework for the organisation to have in place the right level of management and support.

ENABLERS DEMONSTRATED

Governance

Choices was driven by a cross sector governance group, ensuring timely input from across the spectrum of primary care, tertiary care, social services and the justice system. In addition, a thorough evaluation process was built into the service design.

Relationships and Alliances

Bringing together hospital emergency departments, the justice system, social services and general practitioners is an essential component of the Choices service. Collaboration and utilising the expansive network of established connections has meant the teams can address the underlying issues that invariably impact on health and service engagement.

Health and System Intelligence

An independent evaluation of the pilot was conducted by the School of Population and Global Health, University of Western Australia and is informing the development of the expanded service. This evaluation draws on multiple sources of data, including linked administrative hospital and police data for Choices clients, focus groups with peer and caseworkers, research team observations of Choices in action, anonymised client data and case studies.

Investment and Financing

The Pilot is funded by WAPHA.

An additional $7 million in funding from the Australian Government's Community Health and Hospitals Program will allow the Choices service to expand to include four additional hospitals in the Perth metropolitan area.

Freedom to Innovate

Choices was developed in response to a need to break the cycle of presentations at ED and encounters with the justice system experienced by some of the most vulnerable groups in our society. WAPHA was able to put forward a different approach, being the first service of its kind in Australia, that enabled the various parties to co-design a solution to meet the needs of the clients that would also work within existing systems and organisational structures.

EXAMPLES OF OUTCOMES ACHIEVED

Reduction in emergency department presentations following support: The University of Western Australia evaluation examined the support provided to a subset of clients (~400) and their changes in hospital use and justice contacts after receiving support. Overall, emergency department presentations fell by 35 per cent among the client group in the twelve months following support.

Increase in hospital staff awareness and use of additional resources and services available: Hospital stakeholders noted the link with Choices enabled them to access additional resources and/or refer onto other services and that this helped to maximise the efficiency of limited resources.

HOSPITAL CASE STUDY:

Marcus, a man in his mid-twenties with a history of anxiety and depression, lacks family or community supports. Within a three-day period, his partner left him and he lost his job. This led to a sudden increase in ED presentations and hospital admissions between April and October 2018.

SUPPORT PROVIDED BY CHOICES

Choices first engaged with Marcus in October 2018 and provided him with immediate relief through shopping vouchers, liaising with Centrelink, advocating on his behalf to a property agency to wipe rent arrears, as well as and providing emotional support.

HEALTH SERVICE UTILISATION AND COST

In 2018, prior to Choices support, Marcus presented at ED 11 times and spent 15 days in hospital, equating to a cost of $52,853. Since engagement with Choices, he has not attended hospital.

CURRENT SITUATION

Marcus reports being inspired by the Choices Peer Community Workers. He has started a Certificate IV in Mental Health and Peer Work, improved his diet and is focussing on selfcare. He is making new friends who provide him with support.

References

https://news.wapha.org.au/empowering-people-with-choices-to-get-back-on-track/

https://news.wapha.org.au/choices-a-good-choice-for-many/

https://news.wapha.org.au/funding-secured-to-expand-choices-service/

10. WESTERN SYDNEY HEALTH ALLIANCE – NEPEAN BLUE MOUNTAINS PHN AND SOUTH WESTERN SYDNEY PHN

Background

'City Deals' are an Australian Department of Infrastructure, Transport, Regional Development & Communications initiative which aims to merge plans across federal, state, and local government for managing growth and delivering infrastructure in major cities. Once established, the City Deal creates a 20-year agreement between all parties to transform transport, technology, health, education, environment, government, and urban planning across the targeted region.

Sydney's outer west is now one of seven City Deals established to date across Australia. Others include Townsville, Launceston, Darwin, Hobart, Geelong & Adelaide (City Deals are also currently being scoped for Perth and South East Queensland).

The Western Sydney City Deal was announced in 2016 to coincide with the announcement of the site for development of the second Sydney airport at Badgerys Creek. This City Deal establishes policy alignment between the Commonwealth Smart Cities Plan and the Greater Sydney Commission's Western City District Plan, with a vision to create a 'Western Parkland City'. This region encompasses eight LGAs within the catchments of both the Nepean Blue Mountains and South Western Sydney PHNs (Blue Mountains, Camden, Campbelltown, Fairfield, Hawkesbury, Liverpool, Penrith & Wollondilly).

Subsequently responsibility to drive the Western Sydney City Deal has now been transferred to the newly created 'Western Parkland City Authority' (incorporating the Badgerys Creek Aerotropolis Authority).

At the time of announcing the Western Sydney City Deal, the two PHNs and their corresponding LHDs proposed to the City Deals Office (Prime Minister & Cabinet) & Greater Sydney Commission that it should consider long-term planning to improve coordination and effectiveness of health services in the region, supporting healthier neighbourhoods.

This proposal was accepted, with the establishment of a 'Western Sydney Health Alliance' to be one of the agreed priority areas (Commitment L5 within the 'Liveability and Environment' tranche) for the City Deal.

ROLES DEMONSTRATED

System coordination and integration

- The Western Sydney Health Alliance is a formal partnership between the NBMPHN, SWSPHN, NBMLHD, SWSLHD and the local governments of the Blue Mountains, Camden, Campbelltown, Fairfield, Hawkesbury, Liverpool, Penrith & Wollondilly.
- The Health Alliance aims to:
  - → Foster a shared regional understanding and work collaboratively on regional issues, within a placed-based approach through the delivery of locally focused projects and programs in keeping with a shared vision of healthier communities; and
  - → Include health planning and a coordinated approach in the pursuit of positive health and wellbeing outcomes for Western Parkland City. It will be a key platform for the co-design and co-creation of evidence-based integrated care according to need.
- The initial Western Sydney City Deal Health Alliance MoU was executed by all parties in March 2020. It is supported by:
  - → A strategic framework with agreed milestones & KPI; and
  - → A detailed project plan.

ENABLERS DEMONSTRATED

Relationships and Alliances

- The Alliance has established four working groups to drive agreed initial priority areas:
  - → Getting people active.
  - → Liveability – connecting and strengthening communities through healthy built, natural and social environments.
  - → Access to health and wellbeing services.
  - → Promoting healthy food access and choices.

EXAMPLES OF OUTCOMES ACHIEVED

Together the NBMPHN and SWSPHN are the nominated joint leads for the 'Access to health and wellbeing Services' working group. Agreed priorities for this group's implementation plan deliberately focus on a long-term multisectoral 'healthy public policy' approach, intended to have a legacy effect beyond the term of the initial MoU.

Prioritised activities include:

- Development of a social determinants of health framework, to be used as a decision support tool applied across associated activities of the Alliance & other City Deal priorities.
- Co-design of a social connectedness 'model' or 'framework'. This will apply to planning activities regarding access to and information about health services, with the aim to reduce the risk of social isolation.
- Adoption of a 'Greater Western Sydney health workforce recruitment and retention' statement. This will seek to support a unified approach with key stakeholders (e.g. universities and major employers) for health workforce planning and development across the region.
- Adoption of an 'Access to health services' impact statement. This will seek to inform a standardised approach to cross-sector planning documents (e.g. transport connections & health services; telecommunications & digital health etc.).

References

Australian Department of Infrastructure, Transport, Regional Development & Communications City Deals https://www.infrastructure.gov.au/cities/city-deals/ (last updated 23rd June 2020)

Western Sydney City Deal 2020 Annual Progress Report 2020, https://www.infrastructure.gov.au/cities/city-deals/western-sydney/files/western-sydney-progress-report-2020.pdf

Western Sydney Health Alliance 2019 Memorandum of Understanding 31st October 2019

KJA 2019 Western Sydney Health Alliance – Engagement Report October 2019

11. WA PRIMARY HEALTH ALLIANCE - SUSTAINABLE HEALTH REVIEW

Background

In June 2017, the Government of Western Australia announced the Sustainable Health Review (the Review), to prioritise the delivery of patient-centred, high quality and financially sustainable healthcare across the State.

As the operator of the State's three PHNs, WA Primary Health Alliance (WAPHA) had the opportunity to play a key role in representing the voice of the primary care sector throughout the Review and will continue to do so throughout the Review's implementation as part of an agreed strategic partnership with the Department of Health WA.

Promoting and prioritising an integrated health system is one of WAPHA's strategic priorities, signalling its intent to adopt an approach that supports the delivery of seamless primary health care.

ROLES DEMONSTRATED

System Coordination and Integration

As the operator of WA's three PHNs, WAPHA's statewide structure allows it to engage on a level playing field and in a coordinated way with other state-wide bodies.

Involvement in the Review is aligned with one of WAPHA's strategic priorities, to promote and prioritise an integrated health system by adopting an approach that supports the delivery of seamless primary care.

The Review committed to develop a partnership between WAPHA and the Department of Health leading to a 10-year State Health Plan, supported by partnerships between the state's three PHNs and Health Service Providers (HSPs) to facilitate joint planning, priority setting and commissioning of integrated care.

WAPHA also ensured the Joint Regional Mental Health Plan was embedded into the Review, as a Council of Australian Governments' requirement for PHNs and HSPs to formulate a joint approach to mental health.

The Review was a springboard to assigning WAPHA a clear leadership role and model for involving primary care in State Government election commitments, such as the WA Healthy Weight Action Plan, Voluntary Assisted Dying sand outpatient system reform.

Regional Commissioning

The implementation of the newly agreed partnerships between the state's three PHNs and HSPs will see future collaboration to jointly fund, design and commission health services.

The Review was a springboard to assigning WAPHA a clear leadership role and model for involving primary care in State Government commitments, such as the WA Healthy Weight Action Plan, Voluntary Assisted Dying and outpatient system reform.

These three examples of regional commissioning are already underway as a direct result of the Review, with WAPHA, general practice and consumer groups closely involved.

Primary Care System Stewardship and Management

WAPHA coordinated a series of primary care roundtables to ensure the voice of primary care was embedded into the Review, with an ongoing commitment to similar biannual forums as the Review is implemented.

Primary Healthcare Education, Training and Workforce Development

It is expected that a shared approach to care, particularly for people with more complex, chronic conditions, will be further developed, with the GP, allied health professional and specialist working together with the patient to keep on top of their condition and reduce the need for hospital care.

WAPHA, through its Comprehensive Primary Care program, is already working intensively with about 100 general practices to embed such an approach.

Health System Transformation and Reform

The Review is a once in a generation opportunity to reshape the WA health system, with a focus on providing more care in the community rather than the hospital system. It seeks to reverse the previous trend of building more hospitals and beds as the response to increasing demand. Through its involvement, WAPHA was able to drive this thinking and ensure primary care solutions were considered where relevant.

ENABLERS DEMONSTRATED

Governance

During the Review, WAPHA seconded one of its general managers to the Department of Health WA for 18 months to provide input on the role of PHNs in integrating care across the health system, but specifically between the HSPs. This also allowed the facilitation of timely GP and primary care stakeholder engagement into the Review.

WAPHA's Chair has been appointed to the Sustainable Health Independent Oversight Committee to oversee and guide the health system as it works to implement the Review.

Relationships and Alliances

Involvement in the Review forged alliances at all levels of the state health system, resulting in much closer working relationships with the HSPs.

In particular, the 18-month secondment of a WAPHA general manager to provide input into the Review on the role of PHNs in integrating care across the health system, but specifically between the HSPs, and to facilitate timely GP and primary care stakeholder engagement.

Health and System Intelligence

The Review's implementation will focus on key population groups with the greatest health needs and target the root cause of the demands on the system of people needing care.

Data analytics is considered one of the most valuable tools for transforming health care in the future, including in general practice.

Investment and Financing

The Review's Eight Enduring Strategies for Sustainability will lead to funding and investment in health that is more value and outcome driven, with greater flexibility to innovate and partner.

The system level agreement between the Department of Health WA and WAPHA, supported by the agreements between the HSPs and PHNs, will create a more efficient and sustainable funding model, minimise duplication of effort and services, and improve access and health outcomes for more Western Australians.

Freedom to Innovate

N/A

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care

The agreements between various parties within the health system will ultimately make patient care more accessible, seamless and transparent. One example is the movement of non-urgent and less complex outpatient care to the primary care system, supported by a more transparent, simpler booking system.

Quality and Population Health

N/A

Sustainable Cost

The thrust of the Review is to continue to provide high quality healthcare while striving towards a more sustainable future, including providing more appropriate care and support in the community setting delivered by the primary care system.

Improved Provider Satisfaction

N/A

References

https://ww2.health.wa.gov.au/Improving-WA-Health/sustainable-health-review

12. NATIONAL PHN PRIMARY HEALTH INSIGHTS (PHI)

Background

Through PHN Cooperative executive sponsorship PHNs nationally have collaborated to create a single storage and analysis solution aligned with best practice security and data governance standards where individual PHNs will continue to store and maintain custodianship of their own data.

The PHI Program has created a secure, powerful and robust national data storage and analytics solution that assures data integrity and provides easy to use reporting and analytics, enabling PHNs and other stakeholders to make informed program and policy decisions about Australian primary healthcare delivery.

Key features of the solution and program are:

- A common data platform for storage and analytics of primary health care data and other data sets used by PHNs for the planning and commissioning of services.
- A highly secure space for each PHN to store data that will support work in analytics, predictive modelling and visualisations.
- Ensure strong cyber, network, data security, privacy and data governance for the primary health care data of all 27 PHNs.
- Maintain individual PHN data sets in a secure lock box with appropriate PHN sovereignty, independence and autonomy while supporting the sharing of selected data in a shared zone to support broader health planning and policy initiatives.
- A key enabler of collaboration with LHNs/LHDs through data sharing and linkage to better inform system and service re-design and reform.

ROLES DEMONSTRATED

System Coordination and Integration

PHI will be a key vehicle in understanding regional health system dynamics and indicating areas where collaboration to drive coordination and integration efforts might be best targeted.

Regional Commissioning

Insights generated by the local application of PHI data and analysis will increasingly inform development of needs assessments within PHN regions. These will assist with improvement in identifying commissioning opportunities and priorities and enable improved monitoring and evaluation of programs and interventions.

Primary Care System Stewardship and Management

The highly secure PHI platform and associated data governance will assist with providing both a more granular and holistic view of the primary care system within the PHN region helping to identify quality improvement and service re-design priorities. It will also enable the tracking or progress against the population health outcomes that many PHNs have adopted.

At a regional level it will also help identify areas for operational efficiency and cost savings.

Primary Healthcare Education, Training and Workforce Development

Providing high quality data access and reporting to individual practices will assist with better uptake and utilisation of consistent data within the practice and identifying areas of focus for data-driven improvement and refinement of care in the practice.

This will be complemented by PHN staff supporting practice staff to upskill and utilize practice reports to assist with PDSA cycles.

Health System Transformation and Reform

PHI data coupled with other data sets and linkage such as the NSW Lumos program, AIHW dataset and ABS dataset will provide an unrivalled total system view to inform opportunities for innovation and system reform. Further developments with PHI will potentially enhance the ability to undertake predictive analysis and risk stratification at a practice and regional level lead to more pro-active and targeted care interventions at an individual and population level.

ENABLERS DEMONSTRATED

Governance

The PHI initiative has a comprehensive general and data governance framework that will ensure data protection, accountability of use and effective utilization to support improved patient outcomes at a PHN and national level.

Health and System Intelligence

The very basis of understanding of the primary health system will be underpinned by PHI.

Freedom to Innovate

With DoH support the PHI came about through the collective effort and innovation of the national PHN network through the sponsorship and leadership of PHN CEO Cooperative. This provides an excellent example and template for future initiatives that foster national consistency across the PHN network with regional flexibility.

EXAMPLES OF OUTCOMES ANTICIPATED

Quality and Population Health Outcome

High quality, accessible data to identify areas of need and opportunities for care interventions across participating PHNs.

Sustainable Cost

- Minimize resources in terms of workforce and timing. Knowledge and technology sharing amongst PHNs.
- Moving towards the future- machine learning & artificial intelligence.
- Availability of easily adoptable ML and AI through triangulation of external data sources.
- Research opportunities and creating quality evidence through aggregated large population base dataset.
- Creation of research hub for the researchers with a shadow dataset without breaching the security and sovereignty.
- Standardization of data governance for all participating PHNs by ensuring minimum requirements to on board.

13. WA PRIMARY HEALTH ALLIANCE - STAY CONNECTED WITH TELEHEALTH

Background

COVID-19 presented the risk that services supporting Australians with chronic health conditions, may become less accessible or even collapse, potentially disrupting the primary care of a significant cohort of vulnerable people.

While national data indicated that awareness campaigns had built high levels of understanding around telehealth overall, a decrease in GP, pathology, and specialist appointments indicated to WA Primary Health Alliance (WAPHA) a need to improve telehealth awareness and capacity among people diagnosed with chronic conditions.

Further investigation revealed patient anxiety and fear of infection, reluctance to overburden the health care system, and the patient perception that they could self-manage their medical conditions, as major contributors to the decrease in medical appointments.

As such, WAPHA commissioned ConnectGroups, a peak consumer body which promotes peer support and consumer empowerment, to develop Stay Connected with Telehealth, a three month program to raise awareness, educate and increase the use of telehealth among people diagnosed with a chronic condition.

This program aimed to give health consumers the confidence and capacity to request telehealth from their GP, and ultimately ensure all Western Australians continued to have access to high-quality medical care.

ROLES DEMONSTRATED

System Coordination and Integration

One of WAPHA's Strategic Priorities is to empower people and communities, thus engaging and advocating for Western Australians to be active participants in their health journeys.

Collaborating with Connect Groups allowed WAPHA to work with six different chronic condition support groups, and to play a leadership role in empowering people with chronic conditions to access telehealth during the pandemic and beyond.

Regional Commissioning

Taking a co-designed and co-produced approach with ConnectGroups and their members to program delivery, proved an effective way of rapidly accessing health consumers in an intentional, respectful, and collaborative manner.

This program brought consumers, carers and general practitioners together to determine the barriers to accessing telehealth and to develop educational materials.

Primary Care System Stewardship and Management

By commissioning this program, more individuals and carers of those with chronic conditions have been able to access care safely and conveniently, which has been particularly important for them during the COVID-19 pandemic.

Primary Healthcare Education, Training and Workforce Development

The results of this program will be used to educate general practice teams on the patient and carer perspective of telehealth's benefits, obstacles, and areas for improvement within the general practice setting.

Health System Transformation and Reform

The project enabled a new process of paying peer leaders to be involved rather than relying on voluntary capacity – an important recognition in future planning to involve consumers.

While this program was driven by the national reforms to telehealth, it shows the potential for consumer feedback to positively influence national policy development, improve local implementation by health practitioners, and increase uptake by individuals and carers.

ENABLERS DEMONSTRATED

Governance

WAPHA and ConnectGroups developed a clear strategy with deliverables and timelines, to ensure the program was able to mobilise quickly, and to produce much needed educational resources around the importance of using telehealth for continued quality care.

Relationships and Alliances

The expedient nature of this project (policy imperatives in short time frames) was enhanced by the long term relationship between WAPHA and ConnectGroups; and the effective governance from both organisations.

This program has created a strong framework for future initiatives that require extensive consumer and carer input, particularly among those who are frequent users of the health system.

Health and System Intelligence

Baseline results indicated members of the various groups were generally aware of telehealth and willing to use it, however some consumers could still benefit from increased confidence that it can meet their health care needs and improve their telehealth experience.

Following the education campaign, the metrics indicated consumers' positive experience engaging with telehealth:

- 89% felt the campaign was useful and provided sufficient information to understand telehealth.
- 61% of respondents had had telehealth offered when booking a GP appointment.
- 95% of respondents indicated they were confident requesting a telehealth appointment.
- 59% of respondents had used telehealth via a telephone appointment.
- 100% requested that telehealth continue to be made available after September 2020.

Investment and Financing

In the three months allocated to this program, ConnectGroups met the outcomes of building reassurance and competency in consumers around engagement with GPs through telehealth. They promoted the imperative of partnerships between GPs and consumers when it comes to the self-management of chronic conditions.

Freedom to Innovate

This program was developed in response to a rapidly evolving situation, with national telehealth policy developments often requiring interpretation for consumers.

The ability to commission an independent peak body with access to existing consumer groups, allowed us to rapidly respond to consumer and general practice needs.

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care

The majority of patients and carers reported positive experiences with the use of telehealth. The program enabled them to better understand telehealth and overwhelmingly, they felt supported, listened to and empowered.

"Telehealth was an essential part of accessing the care I needed during the time I felt it wasn't COVID safe for me to either go out or go into my GP waiting rooms," one participant said.

"It was very effective and in conjunction with some simple home equipment like a pulse oximeter and BP machine, everything I needed was covered," said another participant.

Quality and Population Health

N/A

Sustainable Cost

This short-term project showed the potential to influence behavioural change with long term benefits, at a relatively modest cost.

Improved Provider Satisfaction

With the increased knowledge of telehealth, patients were better able to request and use telehealth, thus increasing their willingness to see their GP and keep on top of their conditions.

Some GPs reported an increase in appointments during the lock down period via telehealth.

The information from the consumer surveys will be used to inform and support general practices in their future implementation of telehealth, particularly in regard to supporting people with chronic conditions.

References

https://connectgroups.org.au/stay-connected-with-telehealth/

14. COORDINARE (SOUTH EASTERN NSW PHN) GERIATRICIAN IN THE PRACTICE: A PERSON-CENTRED APPROACH TO SPECIALIST ACCESS FOR DEMENTIA SCREENING

Background

The Shoalhaven region has an ageing population and a high prevalence of dementia; and insufficient geriatricians available to provide a timely service to patients. This has resulted in long waiting lists for local hospital clinics. Dementia is a serious chronic condition that requires expert clinical assessment, diagnosis and management.

The Geriatrician in the Practice (GIP) program is an innovative model of integrated care where the specialist hospital dementia care team and the general practice team conduct joint consultations in the GP clinic, rather than the traditional approach whereby the patient would be seen by the specialists in the hospital outpatient clinic.

Patient-centred, shared care. This GIP involves a shared care approach, including a joint comprehensive consultation which includes the patient and carer, GP and geriatrician, practice nurse and a dementia clinical nurse consultant (CNC). In most cases an assessment is conducted by the dementia CNC and the practice nurse as part of the initial consultation. The assessment is comprehensive, aided by screening cognitive tools and is used to facilitate the development of a care plan. The patient, their carer, and the general practitioner and geriatrician are all involved in the development of the care plan. Patients and caregivers are encouraged to share their perspectives, and these serve as the organising principle for the medical recommendations.

Aim of the program. The Geriatrician in the Practice (GIP) program is based on the Physician in the Practice Clinic model, developed in Toowoomba and resulted in significant improvement of diabetes management and reduced hospital admissions. The aim of the GIP program is to improve patient care, upskill GPs and practice nurses in diagnosing and managing their own patients with dementia, while also reducing the waiting lists for hospital outreach clinics – as they will ultimately only be required to see the more complex patients. Overall, the GIP program aims to improve care coordination, communication and linkages between specialists at Shoalhaven hospital and local general practices, while involving people who may have dementia and their carers in the care and management of their condition.

This model has successfully provided dementia screening to over 662 patients in general practices and one Aboriginal Medical Service in the Shoalhaven region.

Funding. The GIP program is conducted collaboratively with the aged care services based at the Illawarra Shoalhaven Local Health District (ISLHD), COORDINARE – South Eastern NSW PHN, and general practices in the Shoalhaven area. The integrated care initiative is funded through the NSW Ministry of Health Integrated Care Planning and Innovation Fund.

ROLES DEMONSTRATED

Primary Healthcare Education, Training and Workforce Development

The GIP program strengthens the capacity of primary care through upskilling the primary care providers, during the shared care arrangements and also by the provision of an ongoing consultation and liaison service with the geriatrician. This can result in a more capable primary care service with the confidence to identify patients with dementia at an earlier stage and also to manage more complex patients on an ongoing basis.

ENABLERS DEMONSTRATED

Relationships and Alliances

To transform to a more person-centred and integrated way of working, changes are required at organisation, service and care delivery levels. To achieve this, there have been a number of key stakeholders involved in establishing and scaling the GIP Project, including:

- Illawarra Shoalhaven Local Health District.
- Coordinare South Eastern Primary Health Network.
- The NSW Ministry of Health - Planning and Innovation Fund.
- The 10 participating General Practices and 1 Aboriginal Medical Service comprising 54 GPs and 35 practice nurses.
- 662 patients and their carers.

The GIP Project is overseen by a GIP Working Party which meets monthly.

Freedom to Innovate

The aim of the Geriatrician in the Practice program is to upskill primary care clinicians and nurses to overcome structural difficulties within existing conventional models in order to increase patient access to specialist services. The program also includes the patient and their carer in development of the dementia management plan. The program uses an integrated, 'shared care' approach to reduce the number of patients waiting longer than clinically recommended for an initial appointment with a geriatrician, and reduce waiting lists and boost the capacity of the public health system to provide appointments to people with early stage dementia in a sustainable manner.

The Geriatrician in the Practice (GIP) program is an innovative 'shared care' model where the specialist hospital dementia care team and the general practice team conduct joint consultations in the GP clinic. Traditionally, the patient would be seen by the specialists in the hospital outpatient clinic, without the initial involvement of the general practice team. The GIP program has enabled GPs to practice to the top of their professional scope and has allowed patients to be seen by the most appropriate health professional, at the most appropriate time, in the most appropriate place for their clinical condition.

EXAMPLES OF OUTCOMES ACHIEVED

Patient Experience of Care / Sustainable Cost

A formal evaluation of the GIP program found that the level of patient satisfaction was very high, with patients and carers having more confidence in the treating team. The evaluation found through having geriatricians attend the practice, GPs were able to identify dementia patients with greater confidence and accuracy. GPs were twice as likely to refer a patient for cognitive assessment, and four times as likely to identify younger onset dementia in patients.

Successful implementation showed a significant decline in the likelihood of emergency department attendance, and a decline in the number of patient reviews required and received. One year after receiving the GIP program intervention, patients in the initiative attended an emergency department with a frequency 44% lower than in the year immediately prior to the intervention. The intervention led to better integration within the region, with 100% of surveyed GPs reporting improved engagement and integration with the Local Health Network.

CLIENT FEEDBACK:

'I brought my Dad today to this clinic. We have been trying to convince him forever to see someone about his memory. Having this clinic at the GP finally got us to convince him to be seen. He loves Dr..... and having him there made all the difference. As suspected Dad probably has Alzheimer's but at least we know and we have a plan, medication to try and community service referrals. I cannot rate this program high enough.'

'As an Elder in..... I thank you for your work and respect your decision to come to the practice and help my community. Much thanks.'

'This is a very good idea. Less travel, no parking hassles. Lots of time, GP in on the plan. Loved it.'

15. WESTERN SYDNEY SERVICE DELIVERY REFORM

Background

In 2014 the Western Sydney Service Delivery Reform (WS SDR) initiative was established in four sites across NSW giving those on the front line the mandate to work across agency boundaries, to innovate and deliver what is needed at the local level.

In Western Sydney we have embraced this directive with open arms, harnessing our relationships and networks to build a robust coalition. We have worked together to reform service pathways and commission models of care that protect and support children, young people and families at risk, through initiatives like Making a Safe Home, Vulnerable Families, Pregnancy Family Meetings and the Middle Years Project.

This work has made a difference to children, young people and families in Western Sydney and we are committed to sustaining our coalition, harnessing our collective mandate and building on existing reforms, including the First 2000 Days Framework and Their Futures Matter, to advance the service system in Western Sydney and deliver meaningful and measurable outcomes for all.

Western Sydney is experiencing significant demographic, social and economic changes. More than ever, we need responsive, integrated and comprehensive service systems that foster healthy, resilient and thriving children, young people, families and communities.

Through our Strategic Plan (2019-2023) member agencies and organisations are committed to working flexibly and collaboratively, taking collective responsibility for commissioning, delivering, reviewing and evaluating the services and supports that every child, young person and adult in Western Sydney needs.

ROLES DEMONSTRATED

System Coordination and Integration

System coordination and integration is at the heart of everything the coalition does every day. With cross agencies members (see Governance enabler for a list) representing heart and social care and supports from central agencies with links to government SDR has been able to achieve some truly inspiring outcomes.

Members of the coalition are committed to ensuring our service system meets the needs of all people in Western Sydney. Over the next three years, we will be working hard to make sure we can deliver on our vision so that all people in Western Sydney can access the services they need to be healthy, resilient and thriving.

Regional Commissioning

Joint commissioning is well embedded into the way of doing things in Western Sydney. Our coalition has recognised for a long time a more cohesive and systematically coordinated approach is necessary to enable collaboration and deliver care that is value based, person centred and can be delivered in scale across the system.

Collaborative Commissioning aims to remove organisational and professional barriers, alleviate the siloed fragmented nature of care and pursue our mutually shared vision of 'one Western Sydney care system'. This requires us to reimagine how Child and Family care is delivered.

Health System Transformation and Reform

SDR projects and programs advances a system model that promotes integrated, cross-sector collaboration in order to build efficient and effective systems that mitigate the impact of adversity and support protective factors among families in Western Sydney.

The key features of the approach include:

- All levels of the system being engaged in an interagency approach to reduce barriers through localised governance, financial and decision-making capacity.
- The system being streamlined, integrated and collaborative; the focus is shifted from a reactive, treatment lens to preventative approach with early intervention that is individualised to the needs of both the child and the family.
- The solution being co-designed with families, tailored to the community based on self-determination and self-sustaining, family based and based on individual needs.
- Providers recognising all children and families require universal access to support and services.
- Monitoring and evaluation of outcomes is conducted across the network.

ENABLERS DEMONSTRATED

Governance

The following agencies and organisations are members of the local SDR:

- Western Sydney Primary Health Network (WentWest)
- NSW Department of Communities and Justice (DCJ)
- Sydney Children's Hospitals Network (SCHN)
- Western Sydney Local Health District (WSLHD)
- Mt Druitt Police Area Command
- Aboriginal Housing Office (AHO)
- Department of Education (DoE)

This coalition extends now beyond agencies and organisations formally linked to the SDR, including support from Western Sydney University, Their Futures Matter, the NSW Treasury and the NSW Department of Premier and Cabinet. The Western Sydney Service Delivery Reform coalition has two tiers of governance, the Strategic Group and specific project/program operational groups as well as a Data Sharing and Information Management Working Group.

Relationships and Alliances

SDR has moved from just informal partnerships, to formal structures and evaluating the strength of the collaboration on an annual basis. The Collaboration Health Assessment Tool (CHAT) managed by the Centre for Social Impact (UNSW) is being utilised – it provides data for evaluation purposes but also inform decision making on governance arrangements and processes.

Health and System Intelligence

A formal Data Sharing Agreement across agencies allow us to leverage the collective data, analytics,

Investment and Funding

The Program allows for blended payment models, using MBS, blockand activity based funding from health agencies as well as program funds from DCJ and Education. The principle is that the model of care is designed around the individual and family, using the best available evidence and data, and then WSPHN and WSLHD work together to combine and pool funding sources to enable the model to be funded and resourced,

Freedom to Innovate

The very core of SDR is to allow redirection of resources for maximum community benefit and delivery of cost-effective, holistic care.

EXAMPLES OF OUTCOMES ACHIEVED

Vulnerable Families - improved identification of need, increased early intervention, and more integrated healthcare for over 428 families and 793 children.

Making a Safe Home - 70% of 105 cases closed with children deemed as safe and a minimum saving of $41,000 per child, per annum.

Middle Years Project - 10 of the 12 vulnerable children engaged in 2019 have transitioned to High School and are engaged in their learning (the 2 remaining children were in year 5) In 2019/2020 the speech pathologist delivered 66 screenings 34 speech assessments 104 therapy sessions 74 speech groups 23 teacher training sessions.

Thriving Families - the Thriving Families team has worked with a total of 53 families and in 2019/2020 has been worked with an additional 42 families.

Pregnancy Family Meetings - from 2015-2019 74% of the 92 families engaged have retained the care of their infants at birth. Four infants taken into care at birth have been restored to the care of their parents.

SDR is currently planning to scale its programs and extend the outcomes achieved to all vulnerable families in need over the next 3 years. We estimate there are around 20,000 families which need a more integrated, cross agencies approach - based on the human services dataset created under There Futures Matters reforms (in response to the Tune Review). This Program, referred to as the KEYS Network, will seek to achieve a series of outcomes including, but not limited to:

- Improved ante-natal and post-natal health, child physical health and development, child cognitive development and competence, child social/ emotional development.

- Strong parent/child relationships.
- Improved parenting competence and style.
- Improved family resources and capacity including gaining employment.
- Increased knowledge and skills related to family functioning, family safety or child development.
- Maintaining improved family relationships.
- Communities inclusive of all families and cultures.
- Reducing disadvantage – improved access to health, education, and other services.
- Increasing social, civic, and economic participation through provision of skills and support leading to improved connection to community.
- Improved community interest and capacity to own & respond to early childhood issues, and issues that relate to families and communities.
- Community members, its facilities and institutions work together to improve early childhood and children's health, development, and well-being.
- Reduce costs and increase availability and awareness for anything that is considered essential, a protective factor or best practice for children to succeed, especially in disadvantaged contexts.
- Have increased options of local courses, support, or resources for parents around parenting, how to support their child's development at various stages etc.
- Provide support for parents about how to manage these behavioural disorders, as well as education about the impacts of trauma, and counselling services for children.
- Have child health and allied health services as locally available and place based as possible to overcome barriers and increase engagement of at-risk families. Embed in existing community-based sites, schools, or preschools.
- Proactive social support referrals to other services such as social workers or parental support workers to meet broader family's needs outside health-related supports.
- GP's offering greater support and information to families with new babies about community health centres and child development information.

Appendix C – Preliminary (Draft) Purpose and Principles

SOURCE: DEPARTMENT OF HEALTH

The proposed purpose for the PHN Program reinforces the government's support for PHNs in the primary health care system and provides direction and certainty to the sector on the role of PHNs. The current purpose and principles are at Attachment A.

The proposed purpose is as follows:

The PHN Program furthers an integrated, coordinated primary health care system that delivers high quality, patient centred care.

PHNs are the experts on the primary health needs of their region and the central drivers for reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with Local Health Networks, Local Health Districts and other partners through innovative and consistent service delivery. PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.

The PHN Purpose is supported by a set of underlying principles that guide what is within the scope of the Program:

PRINCIPLE	RATIONALE
PHNs work collaboratively within their regions, focused on the quadruple aim to: to integrate health services at the local level to create a better experience for patients, encourage better use of health resources, and eliminate service duplication.	This is an existing principle of the Program. This includes working with state governments, Local Hospital Networks/Districts, and broader stakeholders across multiple sectors including through the new National Health Reform Agreement.
PHNs are well-positioned and have the flexibility to participate in and support coordinated responses to emergency or natural disaster situations to meet the primary care needs of their region.	Through the 2019-20 bushfire period and the COVID-19 pandemic response, PHNs have proven their abilities as essential coordinators for organising and disseminating primary care resources, equipment and other relevant information in their regions. They have been important in facilitating the linking of the primary care system with public health and emergency response structures. This principle formally recognises their role in emergency responses.
PHNs support capability, capacity and the sustainability of the primary care health workforce in their region.	PHNs are established providers of support to General Practice and are well positioned to extend this support to include all primary health care providers, including Allied Health and Aged Care.
PHNs support the availability of best practice, culturally-appropriate and evidence-based care that is aimed at quality improvement.	PHNs have demonstrated their ability to be a strong support to primary care professionals, utilising multiple data sources alongside the inclusion of community to provide robust needs assessments and drive innovation (such as the My Health Record expansion and PIP QI program).
PHNs design and deliver innovative, locally-based models of delivery to address the specific health needs of people in their region ensuring equity of access and working towards consistency of services across Australia.	PHNs possess the local expertise and data to be best-placed to develop and trial models of care that are most suitable for their regions. Successful models of delivery are then shared across the Program to support equitable access to services.

PRINCIPLE	RATIONALE
PHNs participate in and support programs designed by the Commonwealth to address specific health needs and priorities in their region.	The Department has piloted a number of Commonwealth initiatives through PHNs in the last five years (e.g. Health Care Homes, Primary Care Enhancement Program) that are distinct from PHNs' normal functions, with their own reviews, evaluation and funding and test new ways of operating in the primary care sphere. These initiatives may deviate from the competitive commissioning process and regional needs analysis requirements of normal commissioning. This should be formally recognised as a role PHNs are fulfilling.
PHNs are regional commissioners of services with a view towards achieving long-term sustainability of the service to meet the identified health needs of their community.	PHNs aim to address identified service gaps, and work as problem solvers through the flexible application of their funding. Commissioning should include co-design, collaborative and co-commissioning where appropriate. PHNs should not see their commissioning of a service as the solution in of itself.

CURRENT PHN PROGRAM PURPOSE AND PRINCIPLES

Current purpose:

- To improve the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.
- To improve the coordination of care to ensure patients receive the right care, in the right place, at the right time.

CURRENT PRINCIPLES

- They commission health services to meet the identified and prioritised needs of people in their regions and address identified gaps in primary health care. This may include working with others in the community to plan and deliver innovative services that meet specific health needs.
- Through practice support, they work closely with general practitioners (GPs) and other health professionals to build health workforce capacity and the delivery of high quality care.
- They work collaboratively within their regions to integrate health services at the local level to create a better experience for patients, encourage better use of health resources, and eliminate service duplication.

PHNs OF THE FUTURE

WHITE PAPER

PHN