Primary Health Networks' Response to the Draft Recommendations from the Primary Health Reform Steering Group

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Primary Health Network (PHN) Cooperative

Executive Summary

The Primary Health Network (PHN) Cooperative is pleased to provide our advice to the Primary Health Reform Steering Group in response to the Draft Recommendations – Discussion Paper Consultation.

The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs. It is a joint initiative of the PHNs and a commitment to collaboration and delivering on the national agenda in primary health priority areas.

The PHN Cooperative has sought input from all PHNs across the country to inform this response to the Steering Group's Discussion Paper consultation. As a collective, we are strongly encouraged by many of the findings and recommendations raised by the Steering Group and look forward to actively supporting implementation of the reforms that are ultimately accepted by the Australian Government.

The structure of this response has been guided by the key questions asked by the Steering Group as they relate to the implementation of the recommendations. Below, we provide a summary of the key focus of the PHN Cooperative position.

The PHN Cooperative commends the recommendations from the Primary Health Reform Steering Group to inform the Australian Government's Primary Health Care 10 Year Plan. The Steering Group's Discussion Paper contains a very comprehensive and detailed list of recommendations and actions that should be considered by the Australian Government for inclusion in the final Plan. We note the duplication and critical interdependency of recommendations and actions throughout the Discussion Paper and have consolidated our response accordingly. The role of PHNs is clearly evident across the majority of recommendations and actions and thus, it is imperative that PHNs are well represented in the implementation of the 10 Year Primary Health Care Plan.

Introduction

This submission is made by the Primary Health Network (PHN) Cooperative in response to the Primary Health Reform Steering Group (Steering Group) Draft Recommendations Discussion Paper (Discussion Paper).

In 2015, the Australian Government's PHN Program established 31 PHNs nationally to strengthen primary care, improve patient-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians; particularly those at risk of poor health outcomes. Our focus as a collective, and individually, is to co-design evidence-based, practical solutions in partnership with service providers to deliver the Australian Government's vision to provide better access to health services and better health outcomes for everyone.

The five core PHN roles are:

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

In 2017, the CEOs of the 31 PHNs formed the PHN Cooperative – a joint initiative to reflect their commitment to collaborating and delivering on a national agenda in primary health priority areas. The PHN Cooperative has coordinated this response to the Discussion Paper to provide the Steering Group with a consistent viewpoint from the PHN program.

We note the duplication and critical interdependency of recommendations and actions throughout the Discussion Paper and have consolidated our response accordingly. The role of PHNs is clearly evident across the majority of recommendations and actions and thus, it is imperative that PHNs are well represented in the implementation of the 10 Year Primary Health Care Plan.

The PHN Cooperative has structured this document in response to the specific recommendations and actions upon which PHNs will have an impact, based on the eight themes into which the Discussion Paper draft recommendations are grouped:

1. Person-centred health and care journey, focusing on one integrated system
2. Adding building blocks for future primary health care – better outcomes and care experience for all
3. Leadership and culture
4. Primary care workforce development and innovation
5. Innovation and technology
6. Research, data and continuous improvement of value to people, population, providers and the health system
7. Emergency preparedness
8. Implementation is integral to effective reform that delivers on the Quadruple Aim

The structure of the PHN Cooperative submission is as follows:

- An overview of the PHN Program
- PHN response to the eight themes overarching the draft recommendations (includes relevant Case Studies from PHNs across Australia). These PHN case studies can be contextualised to accelerate and demonstrate implementation.

PHN Response to Theme 1: Person Centred Health and Care Journey, Focusing on One Integrated System

Every PHN can demonstrate significant gains in system coordination and integration and work continues to build on successes to date. PHNs are coordinating care across both health and social care sectors whilst navigating the barriers of separate funding budgets. Today, PHNs continue to improve the health outcomes of the communities we serve and align our activity to deliver on the Quadruple Aim of healthcare. PHNs now lead the regional commissioning of a wide range of services to address local needs across national health priorities, provide practice support for primary health care providers and drive towards further system integration across state/territory and federal health jurisdictions as well as the interface with disability, aged care and community services.

Case Studies

Appendix 1. A 'Health Alliance' between Brisbane North PHN and Metro North Hospital and Health Service. Brisbane North PHN.

Appendix 2. Western Sydney Collaborative Commissioning. Western Sydney PHN.

Appendix 3. Sustainable Health Review. Western Australia Primary Health Alliance (WAPHA).

Appendix 4. Joint Governance Agreement. South Western Sydney PHN.

Appendix 5. Joint Mental Health System Planning Governance and Redesign in Tasmania. Tasmania PHN.

Appendix 6. Collaboration in a Complex Health and Social Environment - Hunter, New England and Central Coast. Hunter New England and Central Coast PHN.

Overall, the PHN Cooperative supports the intent of The Steering Group's recommendations 1, 2, 3, 4 and 5. In particular, we strongly support the intent to place primary care at the centre of the healthcare system and invest and redirect funding into primary health care. We recognise the importance of culture change, strong governance and recalibration of finance and resources across all recommendations in the Discussion Paper, and we recommend PHN engagement in further defining these recommendations and actions for implementation. PHNs can contribute to better definition of how this will be achieved and the roles of the Australian Government, State and Territory Governments and PHNs.

The PHN Cooperative notes the importance of agreeing a consistent and applicable definition of primary health care. We recommend that this is overt within the recommendations and actions, marking the clear distinctions between the terms 'primary care' and 'primary health care'. The Declaration of Alma-Ata provides a useful definition of primary health care, whilst primary care is used (mainly in the UK and North America) to describe primary medical care or general practice[1].

[1] World Health Organisation. (1978). Declaration of Alma-Ata. https://www.who.int/publications/almaata_declaration_en.pdf

One System Focus (Governance and Funding)

Governance

Within the Steering Group's recommendations 1-5 (inclusive), we endorse the actions that are intended to deliver governance and funding reform to support a one system approach to integrated care. As foreshadowed in the Addendum to the National Health Reform Agreement 2020-2025, agreements between Primary Health Networks (PHNs), and Local Hospital Networks (LHNs) or the equivalents (LHDs and HSPs), are to be established to provide consistent governance arrangements for regional needs assessments, priority setting and funding. This coordinates and integrates approaches to reducing preventable hospital admissions and presentations.

Many PHNs have joint governance and decision-making structures and processes in place with their LHNs or equivalents, often involving service providers and consumers in co-design and commissioning processes. In Western Australia, where one organisation (WA Primary Health Alliance) oversights the activity of the three State PHNs, this agreement encompasses all WA HSPs (WA's LHN equivalent) in the form of Protocols with WA Primary Health Alliance. Simultaneously, there are agreements in place in WA with the WA Department of Health as the State health system manager, the Aboriginal Health Council of WA and the WA Mental Health Commission.

To date, we have seen the onus of responsibility to undertake such agreements being solely on the PHNs, making it difficult to achieve the intent of delivering the long term joint reform agenda. The development of Joint Regional Mental Health Plans (JRPs), for example, is mandated under the National Health Reform Agreement (NHRA). Over the past two years, PHNs have led the way in the development of Foundational JRPs, in line with our accountabilities to the Australian Government under the National Health Reform Agreement. LHNs and equivalents, as our partners in regional planning, are only required to participate in the development of JRPs. They do not hold accountability for implementing the plans.

In many regions the PHNs have driven the planning, with the LHNs providing input and contribution in part. Further, following the development of the JRPs, cooperation from LHNs has been limited and there are few indications that the LHNs will prioritise commissioning services set out in the plans. There is also little evidence that the State and Territory Departments of Health are directing their LHNs to do so. Mutuality of obligation and accountability (both of PHNs and LHNs) must be considered in implementing governance and funding reform to achieve a one system approach to integrated care.

The PHN Cooperative notes that to meet the intent of the NHRA Addendum, there needs to be a clear synergy between the LHN responsibilities and those of the PHNs. This will help ensure that the intent is achieved by embedding an equal partnership between LHNs and PHNs.

Moving towards trilateral agreements between Commonwealth, State and PHNs, reflecting the important role of PHNs as regional commissioners, system coordinators and integrators, managers and stewards of primary care and leaders in agreed system reform objectives, has been a key platform in recent papers published by the Productivity Commission and the Grattan Institute[2]. To achieve sustainable health reform, both organisations recommend an overarching Commonwealth/State (or Territory) agreement for each jurisdiction supplemented by local agreements signed by the Commonwealth, the State/Territory and the PHN. The PHN

[2] Productivity Commission 2017, Shifting the Dial: 5 Year Productivity Review, Report No. 84, Canberra. https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review.pdf

Cooperative recommends a strong indicator in the 10 Year Primary Health Care Plan implementation that requires establishment of these tripartite agreements and makes parties equally accountable.

Funding

PHNs agree funding reform is required that supports providers to tailor their care to meet the needs of their patients, delivers value based care and facilitates redirection of funding from secondary/tertiary care to primary care and prevention. The relevant actions for the implementation of funding reform require further clarity. Specifically, PHNs seek clarity regarding the nature of "*dedicated funding for primary health care"*. Detail is needed as to whether this encompasses all government spending, or solely Australian Government spending. PHNs seek detail of the methodology that will be used to determine the proportion and the allocation of this dedicated funding for primary health care. For example, the AMA wants to see an increase in Australian Government funding for general practice so that it represents at least 16 per cent of total health spending, and a subsequent mandating of this figure to ensure continued support for general practice[3]. In this context, it is important to define the funding source/s and the definition and scope of 'primary health care'. The PHN Cooperative supports the bold thinking behind this action and supports dedicated investment in primary health care. This will facilitate PHNs' ability to work in equal partnership with our State and Territory health colleagues. We recommend the establishment of an independent body to monitor and evaluate this funding and to tie PHNs and other primary health care stakeholders to a commitment to shared savings and system integration.

PHNs must be included in further discussion and development of funding reform. This is best achieved through ongoing collaboration between the Australian Government, State and Territory Governments and the PHN Cooperative. PHNs are well placed to advise where funding and governance structures and delineation of responsibilities between Governments currently magnifies the absence of a coherent and flexible system of delivering care and preventive services. Much of this is due to the way services are funded and commissioned by State/Territory Health Departments, and in turn, delivered by LHNs and equivalents. This is exacerbated by funding models which incentivise hospital-based activity at the expense of community-based services.

The PHN Cooperative strongly supports shared Commonwealth/State responsibilities to deliver pooled funding models of care, co-commissioning and other forms of payment that are predicated on strong leadership, partnerships and collaboration to support shared investment. Formal reciprocal obligations for States and Territories must be included in funding contracts/service level agreements/statements of priorities to mandate joint regional planning and co-commissioning. Resourcing and funding are required for the establishment of joint regional planning and co-commissioning functions with LHNs and PHNs in each State and Territory. Development of a regional governance agreement between funders and commissioners is therefore required in each region.

The PHN Cooperative strongly agrees with the focus of the funding reform recommendations and actions on quality improvement, with reforms needed to support leadership, data collection, sharing and analysis, improving service delivery, reporting and accountability and improving and sustaining outcomes that matter to people across care settings.

[3] Australian Medical Association. (2020). Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform. https://www.ama.com.au/articles/delivering-better-care-patients-ama-10-year-framework-primary-care-reform

Case Study

Appendix 7. Linking up and Mapping of Systems (LUMOS). Northern Sydney PHN.

Continuous Quality Improvement

PHNs nationally are maturing our approaches to undertaking data driven Quality Improvement (QI) activities with general practice in order to develop structured, systematic approaches to evaluate current processes and data, and to develop ways to improve, in order to achieve the desired outcomes. Quality Improvement is the basis of contemporary, high performing primary health care and is predicated on the value of attributing data to regional, practice and patient level outcomes. It includes team based approaches, peer review, reflective practice, best practice and data analysis. It can improve uptake of evidence-based practices for better patient outcomes, better professional development and better system performance. The QI process requires a commitment by the entire practice team to achieve sustainable improvements in quality. PHNs support practices in understanding performance at all levels and bringing systems, technology, and people together to help the practice improve in many ways. It means empowering every person within the practice to look at innovative ways to improve current practice and process.

Case Studies

Appendix 8. Using General Practice Data to Improve Quality of Care. South Eastern NSW PHN.

Appendix 9. The Heart Ambassador and Quality Improvement Program. Hunter New England and Central Coast PHN.

Appendix 10. A Breath of Fresh Air: An Integrated Approach to COPD Management. Brisbane North PHN.

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 over their own data. The Primary Health Insights program (PHI) 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. PHI will be a critical enabler to Quality Improvement in primary health care and achievement of the Quadruple Aim. The PHN Cooperative recommends an emphasis on PHI in the actions that drive Quality Improvement in primary health care and to inform future policy direction and decisions.

PHI is a fundamental building block/enabler for most (if not all) of the themes identified in the Discussion Paper. One of the critical challenges for primary health care has been its long standing inability to evidence value, benefit, scale and scope. In the face of 20 years of comprehensive hospital data, primary health care has found itself constantly unable to argue its competitive value. PHI changes this, and provides us for the first time with a comprehensive capability to collate, analyse and interpret primary health care data in a manner that allows us to argue competitive value. PHI as one of the foundations of a more informed and better

evidenced system – and at the heart of our long term capacity to rebalance the long standing resource inequity between tertiary and primary care.

Case Study

Appendix 11. Primary Health Insights (PHI). PHN Cooperative.

Respectful Relationships

Tied strongly to the recommendation covering leadership and culture change, respectful relationships based on trust are critical in enabling governance and funding transformation in collaborative commissioning arrangements that seek to jointly commission services across primary, community and acute care. These arrangements, already maturing with some PHNs and LHNs, are allowing regions to transition away from pure fee for service and activity based funding to a capacity-based model where providers are jointly funded, incentivised and accountable. Actions within the 10 Year Primary Health Care Plan that relate to governance and funding transformation should reflect the collaborative effort that already exists, clearly identifying PHN and LHN formalised arrangements as foundations for success.

Single Primary Health Care Destination - Voluntary Patient Registration

Voluntary Patient Registration (VPR) is designed to formalise and strengthen the relationship between patients and their GP to improve continuity of care and patient experience through the provision of non-face-to-face services. Consistent with advocacy from GP and consumer peak organisations, the PHN Cooperative supports the intent of VPR to enhance continuity of care. VPR is a critical enabler of all recommendations put forward by the Steering Group. PHNs will have a significant role in implementing VPR, particularly via our role in supporting general practice and building capacity and capability for GPs and the broader patient care team.

Case Study

Appendix 12. Comprehensive Primary Care. WA Primary Health Alliance (WAPHA).

The PHN Cooperative recommends the language 'single primary health care destination' in Recommendation 2 be reconsidered to better reflect the universally accepted medical home terminology. The medical home refers to a model of primary health care that is patient-centred, comprehensive, team based, coordinated and accessible, and focused on quality and safety. The AMA, in its 10 Year Framework for Primary Care Reform, recognises PHNs as "play(ing) an important role in supporting general practice during the move towards the Patient Centred Medical Home"[4].

[4] Australian Medical Association. (2020). Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform. https://www.ama.com.au/articles/delivering-better-care-patients-ama-10-year-framework-primary-care-reform

Case Study

Appendix 13. Patient Centred Medical Home initiative in NSW. South Eastern NSW PHN.

VPR is identified as a building block for reform and is the central tenet of Theme 1 (person centred health and care journey, focusing on one integrated system). The PHN Cooperative strongly supports this recommendation and the focus on the clinical governance, diagnostic and referral role of GPs for the majority of people and the adoption of a medically led and coordinated multidisciplinary team approach. Further, we support the whole of population approach to VPR. It will be useful to consider the evaluation of the Australian Government's Health Care Homes initiative to inform further development of VPR, particularly in establishing the value proposition for the person registering with a single general practice, for the nominated GP and the broader care team.

Case Studies

Appendix 14. A Collaborative Approach to Evaluate HCH Impact on Hospital Avoidance in Northern Adelaide. Adelaide PHN.

Appendix 15. Western Queensland Health Care Home Program. Western Queensland PHN.

PHNs, and our Clinical and Community advisory councils and committees are well placed to provide advice on specific local context that will enhance the successful implementation and sustainability of VPR. Members of these PHN bodies can also act as clinical and consumer champions for VPR. PHNs can provide contemporary data and evidence to pinpoint the specific regions which will require innovative approaches to VPR. PHNs can work with local stakeholders to consider models which are more likely to be successful and sustainable in specific regions experiencing barriers to access.

PHNs can also provide advice on enabling enhanced after-hours access to primary health care services through a patient's registered practice. PHNs are working closely with the Australian Government Department of Health to ensure that future iterations of the PHN After Hours program provide flexibility to target specific and unique needs at a regional level. Many PHN after hours programs focus on both the direct provision of services to support access to extended hours care whilst also seeking to address some of the local community's drivers of service demand in the out of hours period. Continuance of this dual focus is important for PHNs to leverage the strength of our capacity to respond locally to need and to support community access to vital services. The PHN Cooperative is strongly advocating for continuance of these capabilities and services and this will support successful implementation of VPR.

VPR funding should unlock access to a broader range of services for patients, which can be delivered through more innovative methods such as telehealth, as well as support preventive care. There is scope to encourage the participation of non-GP allied health professionals to these GP-led teams through the addition of MBS items for multidisciplinary case conferences. PHNs are in a strong position to provide further advice and context to inform equitable access to VPR and the viability and sustainability of VPR in the clinical and business models of general practice, particularly in regional, rural and remote Australia.

The recommendations and actions for implementation relating specifically to VPR require new ways of working and using technology to support quality improvement and multidisciplinary teamwork. The PHN Cooperative recommends that work is undertaken in developing and

implementing VPR to enable better transitions of care and better communications and inter-disciplinary understanding between healthcare professionals in primary care, acute and sub-acute care, aged care and disability. PHNs have worked to support transition of care and interdisciplinary collaboration within their regions and these initiatives can be localised, leveraged and scaled to support VPR.

Aboriginal and Torres Strait Islander Health

Quarantining funding to address Indigenous needs and disparity through community controlled primary health care arrangements will be considered in the context of the National Agreement on Closing the Gap, in particular Priority Reform 2 (Building the Aboriginal Community Controlled Sector) and Clause 55 which requires Government parties to implement measures to increase the proportion of services delivered by Aboriginal and Torres Strait Islander organisations, particularly community-controlled organisations, including by:

a) implementing funding prioritisation policies across existing programs; and
b) ensuring Aboriginal Community Controlled Organisations receive a meaningful proportion of funding for new services.

Whilst the National Agreement on Closing the Gap is not a funding agreement, agreement between the Australian Government and the National Aboriginal Community Controlled sector was made that, although funding would not be detailed in the National Agreement, governments would, at a minimum, make an announcement to commit funds to strengthening the ACCO sector in alignment with Priority Reform Two. In August 2020, the Australian Government committed $46.5m to strengthening the ACCO sector over four years on the expectation that jurisdictions would (collectively) match this investment. There is currently a complex implementation process underway. States and Territories are required to submit implementation plans to the Coalition of Peaks later this year. It is expected that PHNs will have a significant role within the Commonwealth and State/Territory implementation plans, reflective of the responsibility we all have in implementing the National Agreement on Closing the Gap.

In this context, it is important to recognise that Aboriginal people exercise choice as regards how and where they access primary health care. Supported by data, this needs to be considered in the context of the nature and quantum of quarantined funding intended to address Indigenous needs and disparity.

PHNs have sought formal advice from the Australian Government to clarify the impact of Clause 55 of the National Agreement on Closing the Gap on current funding for Aboriginal and Torres Strait Islander specific programs. PHN alignment to the National Agreement on Closing the Gap is required to build the maturity and national consistency of PHNs in delivering regional approaches with Aboriginal Community Controlled Health Organisations) ACHHOs. To support this, PHNs can demonstrate where the maturing of relationships with ACCHOs has achieved improved health outcomes for Aboriginal people and how these relationships, often in the form of formal agreements, can be further leveraged and scaled to improve continuity of care and health outcomes for Aboriginal and Torres Strait Islander people.

Case Studies

Appendix 16. Strengthening Our Spirits. Northern Territory PHN.

Appendix 17. Indigenous Dual Diagnosis. Gippsland PHN.

Appendix 18. Nukal Murra Health Support Services (ITC). Western Queensland PHN.

Structural Reform in Rural and Remote Communities

Recommendation 5 prioritises structural reform in rural and remote communities. The challenges facing rural and remote health services are widely recognised. Models and strategies for local approaches to delivering coordinated care in rural and regional Australia must be considered in the context of viable and sustainable primary health care and the broader health sector. A number of models have been pursued in Australia and internationally to address these challenges. In general, learnings from the pursuit of these models reflect the importance of:

- Engaging with the local community to reflect the principle of choice;
- Understanding that solutions will be dependent on the unique circumstances of each community;
- Working with stakeholders across the system;
- Building a shared purpose with providers, and
- Appreciating that not all changes occur instantly.

Five essential requirements for viable and sustainable primary health services in rural and remote Australia have been identified:

- Governance, management and leadership;
- Workforce organisation and supply;
- Funding;
- Linkages, and
- Infrastructure.

PHNs are uniquely positioned to consider and input to the Steering Group's recommendation to create Rural Area Community Controlled Organisations (RACCOs) and we seek further clarification as to the design and intended outcomes of these organisations. PHNs have concerns that the proposed RACCOs will not be feasible or sustainable in small rural towns, where there is highest need. PHNs have worked collaboratively with partner organisations to develop and implement integrated health group models that assure access to sustainable primary health care services in regional, rural and remote communities. PHNs understand the local circumstances where services become unsustainable. Small primary care services with few staff and variable levels of demand can easily become clinically and financially unsustainable. Most commonly this occurs in smaller rural communities. Rural settings provide particular challenges because communities often want to retain primary care services despite problems with clinical and financial sustainability. Solo practice, professional isolation, imminent retirement, family stress, on call pressure and issues with holiday, professional development and after hours coverage are all problematic.

In dispersed rural settings the main options have been to establish support agencies to assist with recruitment, training, professional development, extended hours support and to underwrite the costs of professional entry and exit. It can also mean outreach, fly in fly out and virtual models of care.

Overall, despite nearly 30 years of Australian initiatives dating back to the Coordinated Care trials, there has been only limited system wide change to better integrate the organisation of primary care services to improve the outcomes against the Quadruple Aim. As a result, organisational arrangements for primary care services have not changed much. They continue to be dominated by relatively small scale, professionally focused organisations of general practitioners, pharmacists, dentists and allied health professionals.

PHNs operating in rural and remote communities, with their local knowledge of need and supply and their involvement in mature inter-agency partnerships, are well placed to input to a systematic framework for designing and implementing new integration initiatives that contribute to structural reform in their regions. PHNs are best placed to develop and implement co-designed pilots and initiatives that work with local communities to improve access, integration and viability for local health care.

PHN Response to Theme 2: Adding Building Blocks for Future Primary Health Care – Better Outcomes and Care for All

The recommendations and actions within Theme 2 are focused on the capacity for people to make sense of information about their health and the factors that impinge on it. This is particularly important for people with chronic conditions (including mental ill health), for whom the need to consider how to best manage their condition/s is ever present. The PHN Cooperative agrees with the importance of giving people information that allows them to be participants in their care, including the capacity to self-manage. This intent is intimately connected to the development of VPR and enabling people to make informed choices about their primary health care providers and services.

In the context of patient self-efficacy and activation, the primary health care system needs to consider structural reforms and attitudinal changes of both patients and primary care clinicians that respond to this premise. Professional education and training for medical and health practitioners needs to reflect this changing model of care. For example, social prescribing is currently an area of focus for the RACGP and PHNs and we are currently considering our mutual role in supporting GPs and other primary care professionals to refer people to a range of local, non-clinical services. PHNs are undertaking co-design processes aimed at bringing together people with lived experience of chronic health conditions (or their carers) and health professionals to explore what a social prescribing model focused on primary health care could look like, suited to our local communities.

Case Study

Appendix 19. Digitally Enabled Social Prescribing. Gippsland PHN.

Digital Readiness

The PHN Cooperative strongly supports the actions to equip consumers and communities with the information and tools they need to benefit equally from digital and virtual health care. In this context, there is a role for GPs and primary health care providers to have requisite knowledge and understanding of the digital enablers that provide reliable sources of information and the tools most appropriate for individual patients.

PHNs have a key role in providing education, training and support for GPs and other primary health care professionals to enable capability uplift in response to emerging health policy measures and new clinical tools and resources. HealthPathways provides GPs with information

on how to manage and assess medical conditions and how to request timely input from specialist services. The name HealthPathways reflects the referral lines or 'pathways' which connect patients to the right care, at the right place and with the right healthcare provider. Adopted by the majority of PHNs, HealthPathways is a dynamic project, with new pathways constantly under development. The robust pathway review process ensures new evidence, technology, service redesign and feedback from users will be reflected in pathway updates.

Case Study

Appendix 20. HealthPathways. 29 PHNs.

The PHN Cooperative agrees that new models of care should be developed to accommodate digital or virtual health care. This needs to be undertaken from the ground up to ensure that we are not simply retrofitting manual processes in a digital environment and becoming frustrated that it takes more time and effort - when it should not. It should also be noted there is a financial barrier preventing adaption of technology in private general practices. This is best addressed in funding models for general practice to enable digital readiness and proficiency. Australia will become more digitally enabled with dedicated investment in supporting and providing incentives for the adoption of technology. COVID 19 has highlighted the need to provide GPs with a financial incentive to conduct virtual consultations in the form of telephone and video consultations. The PHN Cooperative would support further development and implementation of these incentives in the context of the 10 Year Plan, most particularly VPR given the intent to link VPR and telehealth.

Attachment 1.

Incorporating Telehealth into the Future of Australian Primary Health Care.

Equitable Access to Sustainable and Coordinated Care

The PHN Cooperative welcomes the acknowledgement that VPR needs to be tailored to meet the needs of disadvantaged individuals and communities. There will be learnings from Health Care Homes that will inform these tailored approaches. Participating PHNs should be consulted to inform elements of VPR that are required to address health disparities for people in rural and remote communities, Aboriginal and Torres Strait Islander people, older people, people with mental illness, CALD communities LGBTI+ communities and people with a disability.

The PHN Cooperative recommends that tailored models of VPR be co-designed with these consumers, GPs and members of the extended care team who will provide their care. It is widely acknowledged that inter-agency approaches are needed to address health disparities for disadvantaged individuals and communities. PHNs have established strong and enduring inter-agency partnerships (e.g., State Departments of Housing, Justice and Communities) within their regions. The PHN Cooperative recommends these partnerships be considered in building the foundations of VPR that is tailored to the needs of people within these disadvantaged groups and communities.

Case Study

Appendix 21. Care Navigation Across Health & Social Sectors in HNECC PHN. Hunter New England and Central Coast PHN.

PHN response to Theme 3: Leadership and Culture

The Discussion Paper identifies PHNs as leaders and champions in delivering the cultural change needed to drive primary health care reform. Within the health care ecosystems that exist in each PHN region, PHNs have created governance structures that leverage and sustain this leadership position. The PHN Cooperative welcomes the Steering Group's emphasis on leadership across the health sector to drive reform.

Ongoing investment and flexibility is needed to further develop PHN Clinical Councils and Consumer Committees. These provide input to PHN Boards on locally relevant clinical and consumer issues. Strong clinical and community leadership is essential to drive care innovation and reform and these PHN structures must mature and refine to allow for collaboration between primary health care professionals, specialist and hospital clinicians and community members. This requires a flexible approach, providing PHNs with autonomy to develop these governance structures in a way that supports our work in striving towards a one system focus.

Many PHNs have established local Communities of Practice, whereby groups of GPs and primary health care providers collaborate on priority issues to collectively develop solutions and action plans. PHNs would encourage consideration of dedicated funding to further develop Communities of Practice nationally – to champion the reform articulated in the 10 Year Plan, to support shared learning and spread ideas and innovation across the primary health care sector.

Sustained change takes time and requires authentic leadership and ongoing political commitment. It requires systems thinking, system change expertise and a culture of fortitude and support to successfully innovate and improve. Good health outcomes require the health system to be decisive, and to partner with the community to collaborate. This will require Commonwealth and State investment in the development of skills and capability in systems thinking and change, cross-sector collaboration and facilitation, research and policy, as part of systemwide frameworks for corporate and clinical leadership development. PHNs can enable primary health care stakeholders to be active participants and leaders in cross-government groups to progress key areas of reform in care coordination and integration.

There is merit in the Steering Group considering localising and scaling programs such as those delivered by the NSW Agency for Clinical Innovation which focus on continuous improvements through a range of programs. An example is the New South Wales Health Coaching Program to improve system performance and develop leadership and management capability in implementing strategic change.

It is acknowledged that demarcation between professional groups can inhibit primary health care reform. PHNs can be agents of change in their regions to build collaborative relationships between professional groups through initiatives such as WA's Health Professionals Networks, a collaborative between Rural Health West, the WA Rural Clinical School and WA Primary Health Alliance. This will, however, require time, bold leadership and the commitment of Governments and professional peak organisations to consider how different professional roles can work together to achieve the Quadruple Aim. PHNs have considered this in the development of placement of non dispensing pharmacists and geriatricians in general practices.

Case Studies

Appendix 22. Placement of Allied and Other Health Professionals in General Practice. North Western Melbourne PHN.

Appendix 23. Geriatrician in the Practice: A Person-Centred Approach to Specialist Access for Dementia. South Eastern NSW PHN.

Appendix 24. Pharmacists in General Practice. Australian Capital Territory PHN.

PHN Response to Theme 4: Primary Care Workforce Development and Innovation

Workforce is a critical enabler of the PHN Program. PHNs have developed strategic partnerships with workforce agencies, professional bodies, state, territory and local governments, primary health care service providers and local communities to determine future workforce models that address the health care needs of our regions.

In rural and remote areas, and some metropolitan PHN regions, shortage and maldistribution of primary health care professionals inhibits our ability to commission services that provide care in the greatest areas of need, improve coordination and integration of services across the continuum of care and improve primary care quality. Urgent and considerable reform is needed to address the structural and systemic issues which have devastating impacts on the health outcomes of people in rural communities. Implementing new funding and workforce models must be given immediate priority.

PHNs support the Steering Group's key recommendations within Theme 4: to develop an integrated and comprehensive workforce plan and link workforce strategies to local workforce needs. However, PHNs recommend the focus is on development of local, rather than national, comprehensive workforce plans as this work is already underway, in many cases led by PHNs to deliver local coordination and local solutions. A variety of health care and workforce models are required to meet the diverse needs of the different metropolitan, regional, rural and remote communities in Australia. Overall, the aim is to provide high quality comprehensive care, as close to the community as practical. These models should be guided by the needs of the community. Practicalities including health resources in cities and towns (physical facilities and support staff), and the availability of doctors and allied health professionals, also need to be considered. The choice of workforce model at any time should reflect a balance between meeting immediate workforce needs and long term medical workforce planning needs.

North Coast PHN has developed a comprehensive Workforce Planning Framework which can be applied to the development of integrated and comprehensive workforce plans and strategies. https://hnc.org.au/wp-content/uploads/2019/01/North-Coast-Primary-Health-Care-Workforce-Framework.pdf

Case Studies

Appendix 25. Strengthening Care for Children. North Western Melbourne PHN.

Appendix 26. A Collaboration Between Gippsland PHN and the Victorian Rural Generalist Program Regional Network. Gippsland PHN.

Appendix 27. Wagga GP After-Hours Service. Murrumbidgee PHN.

Appendix 28. The Murrumbidgee Mental Health Drug and Alcohol Alliance. Murrumbidgee PHN.

Appendix 29. Murrumbidgee Medical Succession Planning. Murrumbidgee PHN.

The PHN Cooperative supports the emphasis on Rural Generalist models in Theme 4. Rural general practitioners and Rural Generalists provide the majority of medical care for rural WA now and into the foreseeable future. Rural Generalists should be facilitated to practice their emergency medicine and advanced clinical skills where practical to ensure they are working to top of their scope and meeting the needs of their communities. This requires collaboration between GP training organisations, Rural Clinical Schools, Country Health Services and PHNs to ensure appropriate exposure to applying these advanced skills, support from specialist colleagues within the acute sector and ongoing professional development. An example of this is Western Australia's Country Medical Workforce Interagency Committee, with membership comprising WA Primary Health Alliance, WA Rural Clinical School, WA Country Health Service, Rural Health West and WA General Practice Education and Training. PHNs in many regions are working with partner organisations to further a commitment to "growing our own" health care workforce, including the establishment of well-structured and supported training pathways for rural GPs, Rural Generalists and rural specialists.

Other recommendations within Theme 4 that have strong PHN support include increasing uptake in mental health training for GPs, nurses, allied health and other primary care providers. We recognise that funding for a GP Psychiatry Diploma has been included in the current Federal Budget and PHNs will work locally with our partner GP education and training organisations to support this measure.

Acknowledging that whilst it can improve people's access to primary health care services in the short term, PHNs caution that reliance on a fly in fly out primary care workforce should be used as a last resort. There are sustainability issues with this workforce model, but conversely, in areas of persistent workforce shortage, a fly in fly out workforce increases access to the primary health care. Appropriate funding and support for telemedicine could assist the provision of services in a local area and this could be supplemented with fly in fly out workforce as required.

The focus on expanding and integrating the allied health workforce to work to top of scope is critical within a multidisciplinary team environment. PHNs have experienced the challenges of allied health workforce shortages and maldistribution in many regions and recognise that for many people, allied health professionals are the first point of contact with the primary health care system. This is challenged by a reliance on GP referral to enable MBS items for allied health professionals. In implementing the actions within the allied health workforce expansion recommendation, the challenge will be to ensure the focus is on patient needs rather than professional roles. The Steering Group should further explore the source, nature and application of funding and professional development incentives for expanding the role of the allied health workforce.

Whilst supportive of the actions within Theme 4 to enable workforce digital readiness, it is important to recognise that current MBS telehealth items are not designed to support the use of telehealth in multidisciplinary consultations. That said, PHNs continue to work actively with primary health care providers to innovate with new ways of working and use of developing technologies. PHNs continually work in the spaces where MBS funding gaps for primary health care need to be addressed and this should be recognised in funding reform considerations.

In order to expose general practice to other primary health care professionals, The PHN Cooperative recommends that, until funding models exist, PHNs should be encouraged and funded to run exemplar programs for practices to experience the inclusion of other professions, including non-traditional workforces, to support and assist patients. To complement this, PHNs would support peer run groups at practices and group consultations with peers.

PHNs have demonstrated a strong role in non-clinical and innovative models of care within general practice. An example is the Medical Assist model which assists administrative and nursing staff in primary health care in working to the top of their scope.

Case Study

Appendix 30. The Medical Practice Assist Model Comes of Age. Hunter New England and Central Coast.

Many of the workforce reforms within Theme 4 rely on new funding models and, in the rural context, an increased responsibility of State and Territory run country health services to invest in local primary health care to reduce potentially preventable hospitalisations. For example, the findings of the recent evaluation of Commonwealth funded 19(2) sites should be considered in informing future allocation of these funds and we recommend engagement of PHNs in any future planning for this funding source.

PHN Response to Theme 5: Innovation and Technology

Empowering the primary care workforce to implement and utilise digital health technologies marks one of the biggest single steps that can be taken in the move to more coordinated patient centred care and achieving the elements of the Quadruple Aim. The level of maturity required to meaningfully use digital health solutions varies significantly between primary care specialties and individual providers, including allied health and pharmacy. The capability, confidence and knowledge of individual providers, in addition to variation in the types of services provided, generates a need for tailored responses to increase integration of digital health into routine patient care. PHNs are implementing a systematic approach to training and support for primary health care providers to increase digital health capability. PHNs are well placed to support the actions within Theme 5, including supporting implementation of initiatives such as My Health Record and secure messaging which enhance both the provider's and consumer's experience.

Case Study

Appendix 31. Emerald Communities of Excellence Project. Central Queensland, Wide Bay, Sunshine Coast PHN.

Recommendation 15 is dependent on connecting the myriad of existing Commonwealth, State and locally based systems into a cohesive system for interoperable digital infrastructure across the health sector. It is essential for policy makers in the area of digital infrastructure to have a

true understanding of the scope of the existing systems, localised solutions and data repositories. This will require investment and dedicated resourcing. The PHN Cooperative suggests that a stronger recommendation is needed to ensure that the whole health system is interconnected, not just primary care. Recommendation 15 would be strengthened by the inclusion of actions related to patient provided data or input to shared care planning. This would provide an opportunity for valuable additional clinical data and support for preventive care.

It is noted that there is no mention in the actions on improving data security and privacy supported by legislation. Legislation should also support the sharing of data, via a dynamic consent mechanism to allow clinicians to access the latest information across the system. Hence, a further recommendation could be: Security and Privacy legislation to support the sharing of data via dynamic consent of the patient that is incorporated in the digital infrastructure for health care.

PHNs have taken a leadership role in the roll-out of the Australian Government's My Health Record policy. PHNs have, since inception, been focused on implementing a range of programs and supports to realise the key benefits of the My Health Record (MyHR) system. Whilst PHNs, in collaboration with our stakeholders, have achieved gains in engaging GPs, Residential Aged Care Facilities and community members with MyHR, challenges exist in the lack of conformance in allied health and specialist software which prevents meaningful interaction with the existing MyHR system. A further challenge is the experience of change fatigue within general practices which, throughout COVID-19 for example, have had limited opportunity to fully embed MyHR (and telehealth and ePrescribing) at pace. The PHN Cooperative welcomes continued investment in MyHR in the 2021/22 Federal Budget to support the next wave of MyHR. PHNs will prioritise this activity. The PHN Cooperative recommends that PHNs are well engaged with the ADHA to inform the priorities of the next wave, based on learnings from experience in leading the MyHR implementation to date.

Case Study

Appendix 32. Increasing My Health Record Usage. Gippsland PHN.

PHNs have initiated, funded, piloted and implemented technology innovations to improve primary health care and patient outcomes, including (but not limited to):

- eReferral;
- Shared Care Platforms;
- Service Capacity Platforms;
- Remote Monitoring Platforms, and
- Patient Reported Measures Platforms

PHNs are well placed to lead and test innovation in models of care, supported by digital technology. Further, PHNs have demonstrated strong engagement with GPs, Allied Health and other primary care clinicians to support telehealth information and implementation, and are well placed to continue to support further progression and implementation.

PHN Response to Theme 6: Research, Data and Continuous Improvement of Value to People, Population, Providers and the Health System

The PHN Cooperative is very supportive of the implementation of an enduring national primary healthcare data asset. PHNs have demonstrated leadership in engaging with the Australian Institute for Health and Welfare (AIHW) in considering how to gain a better understanding of what happens to patients in the health system—including their diagnoses, treatments, and outcomes—by bringing together various collections of data over time. There is enormous potential for the Data Asset to improve understanding of the nature, importance, and diversity of primary care in Australia. PHNs, working collaboratively with general practice, understand and endorse the need for primary health-care data that can inform quality improvement, planning, and population health.

As well as a broad system planning benefit, specific benefits of the National Data Asset include:

- raising the profile and political leverage of primary health care, relative to acute services
- improving the visibility of primary health service needs in rural and remote communities, and
- providing greater visibility of the wide variety of professions that operate in the primary health-care sector—for example, nurse practitioners, allied health workers, and dental health workers. It is expected that The Data Asset will enable data-driven quality improvement at the practice level.

In AIHW engagement on the development of the National Data Asset, PHNs were identified by the majority of consulted stakeholders as the preferred intermediary body in the data flow from general practices to the Data Asset. Participants emphasised that as PHNs already have established relationships with a significant number of general practices, it made sense to capitalise on existing mechanisms to collect and report the data and importantly include return-to-source feedback as part of a quality improvement cycle[5].

Similarly, PHNs have established relationships with a large range of commissioned services providers, including Allied Health and Aboriginal Community Controlled Health Organisations in many regions, and effectively utilise this for the purpose of return to source feedback.

Case Study

Appendix 33. Towards better outcomes - Data-led improvement in PHN commissioned services. Hunter New England and Central Coast PHN.

It is again pertinent, in the context of Theme 6, to reference Primary Health Insights (PHI). Data and analytics are central to the role of PHNs, informing health planning activities and providing insights to general practices on opportunities to better respond to community health needs and to achieve the Quadruple Aim. PHI brings together enabling technology and builds understanding and capacity across the PHN network in data governance and analytics. PHI commits a collaborative of 29 PHNs to the development of a single national data storage and

[5] Australian Institute of Health and Welfare. (2019). Developing a National Primary Health Care Data Asset: consultation report. Cat. no. PHC 1. Canberra: AIHW. https://www.aihw.gov.au/getmedia/023846dd-b30e-4149-a442-5dc0694aab26/aihw_phc_1.pdf.aspx

analytic solution. The Australian Government Department of Health has provided funding for this initiative.

The PHN Cooperative supports the Discussion Paper recommendations that focus on research translation. PHNs are currently engaged in State and Territory health translation agencies, such as the WA Health Translation Network, Health Translation SA and the Digital Health CRC. Hunter New England and Central Coast PHN is a founding partner of NSW Regional Health Partners (a NHMRC endorsed Translational Research Centre for Innovation in Regional Health). PHNs are well placed to lead the enablement of research findings being translated into action as quickly as possible and in a practical way, to ensure that primary health care research can positively impact the achievement of the Quadruple Aim.

PHN Response to Theme 7: Emergency Preparedness

The extraordinary circumstances of 2020 and 2021 highlighted the important role that should be held by primary health care providers and PHNs during times of crisis. Primary health care is an important part of Australia's healthcare system. While there is much goodwill and commitment from primary health care providers, they are not able to maximise existing capabilities for response, relief and recovery, without coordination, leadership and support.

Case Study

Appendix 34. Integrated COVID-19 Pathways. North Western Melbourne PHN.

Although Commonwealth and state agencies have the overall responsibility for on-the-ground disaster management during natural disasters or health emergencies, PHNs offer the opportunity to coordinate a strong primary health care response that will deliver care where and when it is needed, reducing pressure on the acute sector and ensuring an organised and effective response. It is essential that disaster management is integrated and coordinated between all key stakeholders and the role of primary care and PHNs is recognised and supported by all levels of government (local, state/territory and Commonwealth). The recommendations in the attached PHN whitepaper provide a platform for integrated emergency preparedness, response and recovery efforts in the future.

Attachment 2.

Planning for Disaster Management Guide. Nepean Blue Mountains PHN.

Attachment 3.

PHNs in Natural Disasters and Emergencies

Attachment 4.

North Western Melbourne PHN White Paper: CoVid19 Response.

PHN Response to Theme 8: Implementation is Integral to Effective Reform that Delivers on the Quadruple Aim

The PHN Cooperative is strongly supportive of the emphasis on implementation throughout the Discussion Paper, and the importance of an implementation plan that spans short, medium and long term horizons. This incremental approach reflects the scope and magnitude of many of the structural and funding reforms that are required to drive the overall intent of the 10 Year Primary Health Care 10 Year Plan. Anchored to the Quadruple Aim, and guided by the seven objectives for reform, the PHN Cooperative is confident that a robust implementation plan will lead to positive outcomes for people, for primary health care professionals and for the health system overall. Implementation must take account of the critical interdependency of all 20 proposed recommendations and their associated actions. The Recommendations deliver a package for reform that cannot be approached as a smorgasbord of exclusive selections.

The PHN Cooperative supports the establishment of an independent oversight group. We emphasise the importance of the Oversight group's independence in achieving the intent of a one system focus that delivers on the Quadruple Aim. Given the vital role of PHNs in leading the implementation of many of the actions within the 10 Year Primary Health Care Plan, we recommend that the PHN Cooperative is represented on the independent oversight group. In addition to representation from primary health care provider professional groups, we strongly recommend the engagement of the Consumers' Health Forum and the Aboriginal Community Controlled Health Sector in this group.

PHNs are well placed to contribute to the implementation plan and the monitoring and evaluation framework. We applaud the Steering Group for its commitment to co-design in these areas and the focus on equity and access for Aboriginal and Torres Strait Islander communities and people in rural and remote communities.

The PHN Cooperative welcomes the longer term focus on implementing the building blocks for reform, in particular requirement for all PHNs and LHNs to have formalised regional planning and funds pooling agreements in place, tripartite agreements between the Commonwealth, States and Territories and PHNs, increased and dedicated investment in primary health care, VPR and data collection and its use to drive continuous quality improvement.

Appendices: Case Studies

Appendix 1. A 'Health Alliance' Between Brisbane North PHN and Metro North Hospital and Health Service. Brisbane North PHN.

Identified Need

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.

Approach/Activity undertaken

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.

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.

- '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.

Appendix 2. Western Sydney Collaborative Commissioning. Western Sydney PHN (WentWest).

Identified Need

Collaborative Commissioning aims to collectively deliver 'One Western Sydney health system' which is value- based and patient-centred. The program enhances how Western Sydney works together by building on the foundations built over many years, including the admirable outcomes and momentum achieved by Western Sydney Diabetes.

In doing so, Western Sydney will be able to improve equity in health, reduce health risks, promote healthy lifestyles and respond to social determinants.

Approach/Activity undertaken

The Executive and subcommittees are led by experts in their fields, equally represented by LHD and PHN and operational and clinical roles. Consumers are at the centre of the models of care, and play a critical role in the co-design, implementation and evaluation.

Collaborative Commissioning Models to be implemented in 2021:

- Rapid Expansion of Care in the Community
- Value Based Urgent Care
- Cardiology in Community

Outcomes

- Rapid Expansion of Care in the Community model established partnerships between the LHD Integrated Community Health (ICH) team and local Patient Centred Medical Homes (PCMHs), to support the successful transfer of care of low risk COVID-19 positive patients to one of 4 general practices in our community. The process, supported by updates to HealthPathways and screening tools built into our shared care platform, has enabled vital support for ICH and our community
- Our PCMH portfolio has expanded from 7 to 23 practices, laying the foundations for transformational practices that can support our Collaborative Commissioning models of care
- Established a shared care platform across our PCMH sites, with expansion occurring in to local RASS units and the wider healthcare neighbourhood
- Central Intake Line, remote monitoring and mobile diagnostic contracts in development to help support primary care and HiTH physicians in minimising preventable hospital admissions.

Appendix 3. Sustainable Health Review. Western Australia Primary Health Alliance (WAPHA).

Identified Need

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.

Approach/Activity undertaken

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. 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.

Appendix 4. Joint Governance Agreement. South Western Sydney PHN

Identified Need

In response to in an depth joint needs assessment released by the SWSPHN and the South Western Sydney Local Health District (SWSLHD) in 2018, both parties agreed that system-wide collaboration was necessary to achieve enhanced outcomes and leverage opportunities for a region marked by rapid population growth, significant cultural diversity and widespread socioeconomic disadvantage.

Approach/Activity undertaken

In 2020 the SWSPHN and SWSLHD executed a Collaboration Agreement to explicitly address the Quadruple Aim. The Collaboration Agreement is subject to achievement of a Schedule articulating a scope of works with set milestones and KPIs. Implementation is overseen by a Joint Executive Meeting, co-chaired by the Chief Executives of both organisations. Agreed collaboration strategies include:

- Sharing of data, information and business intelligence
- Joint planning, design and evaluation of integrated health services and programs
- Synchronised workforce planning and development
- Coordinated management of health responses and recovery efforts for regional disasters and emergencies
- Mutual stakeholder engagement and partnership development
- Conjoint positioning and promotion of South Western Sydney

Outcome

Deliverables met to date include:

- *SWS Regional Mental Health & Suicide Prevention Plan to 2025* (https://www.swsphn.com.au/client_images/2227083.pdf)
- *SWS Diabetes Framework to 2026 (*https://www.swslhd.health.nsw.gov.au/pdfs/diabetesframework.pdf)
- *My Care Partners* Joint Venture Agreement (to implement a medical neighbourhood model of care)
- Joint COVID-19 action plan
- HealthPathways agreement renewal

- Co-signatories in partnership agreements with local government, state agencies, universities and industry groups in:
    - Western Sydney City's Deal Health Alliance
    - Liverpool Innovation Precinct
    - Campbelltown Health & Education Precinct
    - Fairfield Health Alliance
    - Wollondilly Health Alliance
- Co-funded models of care, including:
    - GP Drug & Alcohol Advice and Support Service
    - Antenatal shared care
    - Clinical Nurse Consultant GP Liaison Hepatitis C Initiative

Appendix 5. Joint Mental Health System Planning Governance and Redesign in Tasmania. Tasmania PHN (Primary Health Tasmania).

Approach/Activity undertaken

- Under the guidance set by Tasmanian Mental Health and Suicide Prevention Plan jointly signed by the Tasmanian Minister for Health and PHN Chair in 2020, PHT is working in partnership with Government, Mental Health Council, consumers and providers to ensure that Statewide Mental Health and Alcohol and Other Drug (AoD) Sector planning, governance and implementation is supported by 'whole of system' engagement and stakeholder involvement. Primary Health Tasmania and the Tasmanian Department of Health have jointly commissioned:
- The Mental Health Council of Tasmania to appoint a mental health service system integration support officer to work with all stakeholders to support
- The University of Queensland to undertake comprehensive service mapping of the Tasmanian mental health System using the National Mental Health System Planning Framework.
- The Mental Health Council of Tasmania to co-design and deliver youth mental health forums with the objective of developing a whole of sector response to resolving mental health service access issues identified by young people across Tasmania.
- The Alcohol Tobacco and other Drug Council of Tasmania to investigate and identify the most appropriate data sharing platform to facilitate real-time treatment services data sharing between Alcohol, Tobacco and Other Drug sector organisations and Primary Health Tasmania and the Tasmanian Department of Health.
- This work is supporting a jointly governed and highly collaborative approach to Statewide Mental Health and Alcohol and Other Drug system and service redesign.

Appendix 6. Collaboration in a Complex Health and Social Environment - Hunter, New England and Central Coast. Hunter New England and Central Coast PHN.

Identified Need

Primary Care across dispersed and unique communities requires a collaborative approach with a diverse range of stakeholders. HNECC PHN needs assessments have included a significant range of key issues that span primary and acute care, and complex social determinants of health. Many of these are poorly supported by evidence of interventions and impact.

Approach/Activity undertaken

Like many PHNs, HNECC PHN has taken a collaborative approach to addressing the issues and priorities demonstrated through needs assessments, including a range of health care and research collaborations.

The Alliance agreements between Hunter New England Central Coast (HNECC) PHN and Hunter New England Local Health District (HNELHD), and between HNECC PHN and Central Coast LHD (CCLHD) were originally established to plan and establish services while making strategic health care decision on a "whole-of-system" basis, based on needs assessments of communities. This was underpinned by an understanding of the health care needs that could not be addressed by primary care or acute services independently. A range of agreements now additionally provide targeted service oversight.

Additionally, HNECC PHN has established a grants program which has implemented over 500 grants to community and health providers.

Appendix 7. Linking up and Mapping of Systems (LUMOS). Northern Sydney PHN (Sydney North Health Network).

Identified Need

Fragmentation of data collection across primary and tertiary sectors limits understanding of needs across the health service system.

Approach/Activity undertaken

The Linking Up and Mapping of Systems is a data linkage project led by the NSW Ministry of Health in partnership with PHNs, aiming to provide a system-wide view of health needs and service gaps. The program links general practice data with admitted patient, emergency department and mortality datasets to:

- Provide a comprehensive patient journey across primary, acute and other healthcare settings
- Allow early identification of current and emerging population health issues
- Improve patient care and potentially constrain or reduce system costs
- Inform data-driven quality improvement and system re-design responses
- The program is rolled out across all NSW PHNs, with 40 practices from the Northern Sydney PHN (NSPHN) enrolled in the program.

Outcome

LUMOS provides a valuable data asset that continues to strengthen quality improvement initiatives with general practices and provide actionable insights into commissioning. The program has facilitated further collaboration between NSPHN and general practices to identify opportunities for quality improvement. Practice specific reports support the general practitioner's understanding of the range of acute care services accessed by their patients.

As the program continues to mature, data from LUMOS will also be utilised to inform:

- Identification of priority areas and emerging needs to further support targeted service planning
- Evaluation of chronic disease management programs currently implemented in partnership with general practices, other PHNs and universities.

- Development of integrated care pathways under the NSW Ministry of Health Collaborative Commissioning initiative, implemented in partnership with the Northern Sydney Local Health District.

Appendix 8. Using General Practice Data to Improve Quality of Care. South Eastern NSW PHN (Coordinare).

Identified Need

PHNs play an essential role in supporting general practices to undertake quality improvement activities such as utilising practice data to inform improved patient care. PHNs can triangulate general practice data with local knowledge and insights to provide a complete picture of which interventions are required to achieve better outcomes at each clinic.

Approach/Activity undertaken

The South Eastern NSW PHN (SENSW PHN) established the Sentinel Practices Data Sources (SPDS) project to address the accuracy, comprehensiveness and utilisation of primary care data for practices within the region. The SPDS collects data on key chronic diseases and their associated risk factors from the existing clinical databases of participating general practices. A dedicated project support team provide ongoing training on the use of practice data and the SPDS project.

Outcome

A mixed-methods approach was used to evaluate data and clinical quality improvement in 99 participating practices over 12 months. Performance was measured against 10 defined indicators, and 48 semi-structured interviews provided qualitative data. Participants reported positively on the acquisition of knowledge and skills relating to data entry, cleansing and utilising the data to drive clinical practice improvement.

The SPDS project has led to quantifiable improvements in indicators that are directly related to better quality patient care. There have been improvements in recording blood pressure for patients with hypertension or cardiovascular disease, more appropriate testing of HbA1c levels in diabetes, and improvements in recording smoking status and BMI associated with coronary heart disease or COPD. Other indicators such as recording Aboriginality or ethnicity have also improved.

Appendix 9. The Heart Ambassador and Quality Improvement Program. Hunter New England and Central Coast PHN.

Identified Need

According to the Heart Foundation's Australian Heart Maps data, the New England and North West region, which includes Tamworth, Armidale, Inverell, Moree and Gunnedah, has the state's highest rate of deaths from coronary heart disease (CHD). This region's death rate is 85.8 out of every 100,000 people, well above the state average of 64.5. The goal of the program is to increase cardiovascular disease (CVD) risk assessment/heart health checks in General Practice in the Hunter New England region.

Approach/Activity undertaken

The program was launched with the 2000 Hearts Campaign in 2019. In 2020 and 2021, the Heart Ambassador Program was exclusively implemented in the region in partnership with the

Heart Foundation. The cardiovascular working group also completed an initial local media campaign and continues to respond to media in this area. In March 2021, an event in women's heart disease was run during International Women's Week.

This has been accompanied by a quality improvement program for General Practices including data analytics and support, the introduction of cardiovascular risk and clinical benchmarking reports, record templates, a cardiovascular quality improvement toolkit (through the Heart Foundation), and the development of a Heart Health Community of Practice.

Outcome

In mid-2021, each participant in the Heart Ambassador Program presented their outcomes on their workplace quality improvement activity. The 2000 Hearts Campaign has been presented at the Australian Primary Health Care Nurses Association conference in 2020.

- The Heart Foundation was recognised by HNECCPHN as a finalist in the Primary Care Leader category of the HNECCPHN 2021 Primary Care Quality & Innovation Awards. The award is to recognise a general practice, health centre and or service provider or individual who has shown innovation and leadership in primary care.
- Initial clinical and risk measures, and practice data reports are demonstrating improvement in cardiovascular risk assessment and reporting across key clinical indicators.

The work in this area is ongoing, sustainable and scalable.

Appendix 10. A Breath of Fresh Air: An Integrated Approach to COPD Management. Brisbane North PHN.

Identified Need

Chronic Obstructive Pulmonary Disease (COPD) is a progressive long-term disease of the lungs that causes shortness of breath. In 2017, it was estimated that approximately 54,000 residents aged 40 years or older living in the North Brisbane and Moreton Bay region were likely to have COPD. As part of the Integrated Care Innovation Fund (ICIF) Brisbane North PHN (the PHN) collaborated with Metro North Hospital and Health Service (MNHHS) and Lung Foundation Australia (LFA) to deliver the project to improve the care of patients with COPD. This case study outlines the Primary Health Initiatives undertaken by the PHN utilising Quality Improvement activities with General Practice.

Activity undertaken

General practices in the region were invited to participate in the project to work towards better outcomes for patients with COPD. Practices were offered training and support from the PHN's project team in the form of:

- RACGP approved clinical audit
- General Practitioner (GP) Active Learning Module
- Practice Nurse workshop sessions or
- Queensland Health Spirometry training program

Outcome

A total of 13 practices participated in all components of the project. Eight of these practices were identified in the MNHHS hospital admissions data as the key practices to recruit. The evaluation data from the GP education demonstrated a 34.2% increase in overall confidence amongst clinicians in various aspects of management for patients living with COPD, and

increased confidence specifically in regards to the use of spirometry. In addition, 95% of participants concluded the clinical audit was entirely relevant to their general practice.

Appendix 11. Primary Health Insights (PHI). PHN Cooperative.

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.

Approach/Activity undertaken

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.

Appendix 12. Comprehensive Primary Care. WA Primary Health Alliance (WAPHA).

Identified Need

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.

Approach/Activity undertaken

Aligning to the principles of the Patient Centred Medical Home (PCMH) model, the CPC Program 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.

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.

Outcome

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.

Appendix 13. Patient Centred Medical Home initiative in NSW. South Eastern NSW PHN (Coordinare).

Identified Need

The patient centred medical home (PCMH) is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates team-based care, and commits to data-driven improvement and integration of care with services outside the primary care system. The PCMH approach is associated with improved patient experience of care, reduced staff burn out, and fewer hospitalisations compared with traditional models. However, transitioning to a PCMH model requires substantial transformational change, organisational skills, time and resourcing.

Approach/Activity undertaken

The South Eastern NSW Primary Health Network (SENSW PHN) supported 12 PCMH projects across 16 general practices, providing wide-ranging support and seed funding for innovative approaches to team based care. Each practice focused on an area they perceived needed to change to become more aligned with PCMH goals.

Outcome

An evaluation was conducted of the seven general practices that implemented PCMH projects that included analysis of practice data as well as extensive interviews with practice staff. The evaluation found that transition to a PCMH approach in general practice is potentially achievable in a relatively short time-frame however, it requires strong leadership to promote a shared vision and purpose, as well as engage practice staff and the community. Implementation of such initiatives requires dedicated time, infrastructure, training and importantly, support from an organisation such as a PHN. Participating practices highlighted the support provided by the PHN, which included training, tailored practice visits, and funding to improve infrastructure and physical space; this support enhanced the practices' capacity for transition to a PCMH model.

Appendix 14. A Collaborative Approach to Evaluate HCH Impact on Hospital Avoidance in Northern Adelaide. Adelaide PHN.

Identified Need

Adelaide PHN identified the need to connect acute and primary care and to demonstrate hospital avoidance and reduced length of stay and savings associated with HCH patients as a result of patient centred medical home approach.

Approach/Activity undertaken

Each patient was allocated an HCH alert on Oacis. The system would flag when a HCH patient presented to a Northern Adelaide Local Health Network (NALHN) service (ie ED or admitted). Patients consented to such data sharing. Involvement of LHN staff, co funded GP Liaison Unit of LHN and PHN to support project. Implementation of Inca software within Lyell McEwin and Modbury Hospitals.

Outcome

Based on 152 HCH patients:

There were significant reductions in ED presentations, number of admissions and admission days, which has in turn led to significant financial savings. The detailed data on cost savings for these 152 patients is currently being approved for distribution. These outcomes can be attributed to the HCH model, including:

- The more proactive approach to chronic disease management
- Greater interaction of nurses with patients (counselling, education etc)
- Inca- information sharing between GPs, nurses, allied health, specialists, hospitals and patients
- The increased interaction of pharmacists with patients (identifying medication discrepancies, lifestyle education etc)- pharmacy engagement in Adelaide was the best in the country.
- Clinics using the ward round concept to ensure pathology forms and observations were ready prior to patients seeing the GP (also extra opportunities for motivating and counselling patients.
- Bundle payment allowing greater engagement with allied health (eg group falls and balance classes)
- Use of telehealth (patient access to healthcare was maintained and reduced the likelihood of patients falling through the cracks).

Appendix 15. Western Queensland Health Care Home Program. Western Queensland PHN.

Identified Need

The increasing burden of chronic disease, ageing population, remoteness and rural decline, fragile provider networks, high costs, poor utilisation of digital technology, health inequity and poor alignment of funding and incentives, are significant challenges that impact on health outcomes and sustainable systems of care.

During 2017, supported by the Maranoa Accord, WQPHN consulted stakeholders across their catchment (and beyond) to consider how to commission Health Care Home (HCH) principles within the WQ context and to develop a framework for a primary health care strategy for WQ.

Approach/Activity undertaken

The WQ HCHs strategic direction for development of primary care services, and for strengthening the role of General Practice, has the aim to improve patient, provider, business sustainability and population health outcomes. The model differs from the national HCH and aligns with all jurisdictional levels of primary care services within WQ and has 3 domains and 10 foundations.

Seven practices with differing management streams tested the WQ HCH collateral including a Maturity Measure tool developed with University of Qld Mater Research Institute led by Professor Claire Jackson. This self-assessment tool is based on international and national tools, HCH principles, Bodenheimer building blocks and advice of the WQ HCH working group. This tool along with others, measures the Quadruple Aim domains for each practice involved.

Outcome

Since the early adopter program commenced, 80% of eligible WQ practices have joined and the program measures outcomes against the Quadruple Aim.

Outcome

HealthPathways has improved care pathways for patients, reduced waiting times and improved testing and referrals for a large range of medical conditions. In 2020 during the peak of COVID-19, the utilisation of HealthPathways more than doubled, with 100,000's page views across Australia.

Appendix 16. Strengthening Our Spirits. Northern Territory PHN.

Identified Need

Help prevent suicide in Aboriginal and Torres Strait Islander people inthe Northern Territory.

Approach/Activity undertaken

The *Strengthening Our Spirits* model of care is a systems-based approachto suicide prevention. It takes into account the many people, systems andprocesses that need to work together to help prevent suicide.

Strengthening Our Spirits was designed by members of the Greater Darwin region's Aboriginal and Torres Strait Islander community. It represents an Aboriginal way of knowing, and is based on the elements of fire, land, air and water.

Its guiding principles are that suicideprevention activities will be responsiveand flexible while building and developing local Aboriginal and TorresStrait Islander workforce capacity, engaging culture, elders and lived experience, and involving local design or adaptation.

Northern Territory PHN has fundedseveral innovative activities under this program, and has commissioneda local Aboriginal Community Controlled Health Organisation to guidecontracted service providers in using the Strengthening Our Spirits model in meeting the needs and priorities of local Aboriginal and Torres StraitIslander people.

Outcome

Strengthening Our Spirits has been recognised as a best practice model of co-design and suicide prevention for Aboriginal people by the Centre forBest Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

Appendix 17. Indigenous Dual Diagnosis. Gippsland PHN.

Identified Need

Gippsland PHN identified the need for an Indigenous Dual Diagnosis program to be directly commissioned within the Aboriginal Community Controlled Organisations (ACCO), ensuring Aboriginal and Torres Strait Islander peoples have access to culturally safe and culturally appropriate services.

Approach/Activity undertaken

A competitive limited procurement process was utilised, through one on one engagement with each ACCO to assist to collaboratively develop the program. Three of the five ACCO's applied and were commissioned to deliver the service. The development of the Indigenous Dual Diagnosis Program continued to evolve with each LGA identifying different needs, resulting in workforce models being customised. For example, two providers collaborated to deliver a mirrored service with a Clinician and Peer support worker.

Following the initial codesign process, collaboration continued to develop Guidelines that all providers participated in developing facilitating self-determination for each community. The Indigenous Dual Diagnosis Program steering committee was formed and developed to include not only the ACCO's providing the service but all five ACCO's. Meetings continued to collaborate with providers and surrounding ACCO's to address the needs, challenges and barriers.

Outcome

As part of the development of targets for the program a collaborative approach and process was completed. This included delaying setting of targets to ensure culturally appropriate KPIs that were meaningful and outcomes focussed. Barriers were also identified such as clients not attending appointments due to sorry business, family support issues, and processes to follow up clients were developed, working with the client for solutions to support attendance with an holistic approach to care. Based on qualitative data, commissioning ACCO's has proven to be of great value with culturally appropriate and safe services. The inclusion of family support ensures a whole person approach to care. Employment of unqualified local Aboriginal persons into Peer Worker positions, provided upskilling opportunities in the mental health and AOD sector. Over 1300 occasions of service were delivered in the 2020-21 financial period.

Appendix 18. Nukal Murra Health Support Services (ITC). Western Queensland PHN.

Identified Need

Chronic disease drives a large proportion of health need across WQ for Aboriginal and Torres Strait Islander people. The observed prevalence rates within the regions and patterns of health needs are consistent with remote regions and other similar populations as they reflect the intersection of social inequities of location, social and economic resources and the ongoing impacts of colonisation and racism.

In 2016 a review of the ITC framework in WQPHN area identified four elements of best practice:

- Emphasis on spending greatest proportion of ITC funds on supplementary services
- Co-location of care link workers who were well connected with A & TSI Communities with General Practitioners for collaborate service delivery, and
- Education of General Practitioners about ITC

Approach/Activity undertaken

In 2017, WQPHN launched an innovative commissioning framework. The NMHSS is an alliance between WQPHN, QAIHC, CWAATSICH, Goondir Services, Gidgee Healing and CACH. The goals of program are to:

- improve way chronic diseases are managed.
- deliver supplementary services to clients in need of urgent and chronic disease management for which public funding is not available,
- prioritise spending on those who are most vulnerable
- ensure access NMHSS are distributed according to population
- ensure ITC Guidelines are followed and ensure all GP's understand the program and how to access it

Outcome

A recent evaluation of the program outlined the following:

- Western Qld has third highest rate nationally for PPH for patients with at least one chronic conditions GP's suggest appropriate referral through NMHSS reduced need for hospitalisation by 50% increasing to 100% for clients with multiple chronic conditions.
- The return on investment from ITC funding that WQPHN received during the financial year 2019-2020 looking at PPH for diabetes indicated for every $1 invested in NMHSS the health system would save $3.48 in avoided hospital costs.

Appendix 19. Digitally Enabled Social Prescribing. Gippsland PHN.

Identified Need

Gippsland is diverse, however there are some common threads across all the communities including high rates of mental health disparity and access to required supports, and social isolation.

To support improve health outcomes, consideration of the social determinates of health of the Gippsland community and improved effectiveness and efficiencies within the healthcare sector need to be considered.

Approach/Activity undertaken

Gippsland PHN procured a digital platform to support healthcare professionals co-design psychosocial care plans with patients that track progress against agreed goals, referrals and patient outcomes.

To enable the effective implementation and use of such a platform a digitally enabled social prescribing model of care was developed. The model of care adopts a Social Prescribing champion approach, building the capacity of health professionals to deliver social prescribing and embed a more holistic approach to health by building on the pre-existing relationships a patient has with their primary health provider. The key elements of the model include:

- Patient identification
- Needs identification, goal setting and community prescribing
- Monitoring and review

Phase 1 of the roll out is with general practices

Phase 2 of the roll out will focus on allied health professionals

Outcome

Currently 13 Gippsland general practices have committed to implementing digitally enabled social prescribing. The project team are working with general practices to introduce and embed sustainable workflows inclusive of social prescribing. Over 500 community groups are listed within the platform, enabling digital referrals improving patient social determinants of health.

Appendix 20. HealthPathways. 29 PHNs.

Approach/Activity undertaken

HealthPathways is an online health information portal that has been implemented across the majority of PHN regions in Australia since 2012. HealthPathways is designed for GPs and other primary health clinicians and:

- Provides information on how to assess and manage medical conditions;
- How to refer patients to local specialists and services in the timeliest ways;
- And improve care pathways for patients.

During the 2020 COVID-19 pandemic, PHNs worked with Public Health Units and Public Health Services to utilise HealthPathways for Primary Care Clinicians.

HealthPathways provided daily COVID-19 updates and pathways for COVID-19 management, including initial assessment and management, practice management, referrals, telehealth, mental health support and COVID-19 outbreak and response for residential aged care facilities.

Appendix 21. Care Navigation Across Health & Social Sectors in HNECC PHN. Hunter New England and Central Coast PHN.

Identified Need

Care navigation is an emerging response to the growing complexity of healthcare service delivery, the ageing population, increased comorbidity, and to social inequalities in communities. Those with complex health and social support needs in primary care experience fragmentation and gaps in service delivery. This has been identified by communities, providers and clinicians across a range of localities and settings. Care navigation has shown some promise as a way to reduce barriers to access to care and support integration across the health and social sectors.

Approach/Activity undertaken

The Care Navigation pilot projects in the HNECC region aimed to improve outcomes for vulnerable / disadvantaged individuals in three key areas:

- Ability to navigate access to the right health, social and community services at the right time
- Ability to overcome barriers to accessing care
- Improved health literacy and self-management

Trialled in four local government areas, Tamworth, Cessnock, Taree and Armidale, and provided by two separate organisations, the pilot project used care navigators to achieve the aims of the project. The program has been evaluated by external consultants. As a result of particularly strong results from the Care Navigation pilot working with the Ezidi refugee community and local health providers in Armidale, this pilot program has now been extended. This pilot has

worked closely with a dedicated group of local general practices, the local hospital, pharmacies and social services to improve access for this community.

Outcome

The evaluation of Care Navigation has reported on a range of qualitative and quantitative measures. These were largely drawn from the following:

- Patient Activation Measures were used with a focus on changes to patient knowledge, skills and behaviours whilst incorporating health literacy concepts.
- Patient reported experience measure were used to include an open-ended question to enable clients to provide their views on their service

Interviews were conducted with service clients and carers, care navigators and service staff, and referrers from general practice health and social support services

Interim results in the Care Navigation Pilot with the Yazidi refugee community in Armidale have indicated the most improvement in patient activation and patient experience, as well as improved access to health and social services, and strong satisfaction from service providers.

Appendix 22. Placement of Allied and Other Health Professionals in General Practice. North Western Melbourne PHN.

Identified Need

In Australian general practice, prescribing occurs at a rate of 85.5 prescriptions per 100 patient encounters. Despite many benefits, medicine-related harms occur; more than 1.5 million Australians experience an adverse event from medicines each year, resulting in 400,000 general practice visits and 190,000 hospital admissions. Evidence demonstrates that integrating pharmacists into general practice can reduce medicine-related problems through medication management and coordination.

Approach/Activity undertaken

Since 2017, North Western Melbourne Primary Health Network (NWMPHN) has commissioned the Pharmaceutical Society of Australia (PSA) to integrate pharmacists into selected general practices. The pharmacists' services include:

- Providing medicines education to patients
- Identifying and resolving medicines issues
- Educating GPs and other staff about new medicines, updates to guidelines and reforms (e-prescribing, SafeScript)
- Supporting Medicare Benefits Schedule activities
- Collaborating with other care providers during transitional care to ensure medicine continuation

The outcomes from the second phase (June 2019 to October 2020) are below. This phase involved 4 pharmacists working in 4 general practices, 14 hours per week.

Outcome

Improved medicines utilisation by patients and GPs.

- 146 Home Medicines Review referrals.
- 274 hours of case finding work.

Improved patient health literacy and medicines adherence.

- 251 patient education sessions.
- 253 instances of medicines adherence issues identified.

Identification of roles for pharmacists in general practice that are accepted by GPs, patients and pharmacists.

- A survey completed by 25 general practice staff participating in the program showed that all respondents considered the pharmacists to be either extremely valuable, or very valuable in providing quality use of medicines services such as those listed above.

Appendix 23. Geriatrician in the Practice: A Person-Centred Approach to Specialist Access for Dementia. South Eastern NSW PHN (Coordinare).

Identified Need

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.

Approach/Activity undertaken

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.

Outcome

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

Appendix 24. Pharmacists in General Practice. Australian Capital Territory PHN (Capital Health Network).

Identified Need

- Lack of multidisciplinary care;
- Innovative models of care that improve access to integrated services for chronic conditions;
- Primary health care professional should be supported to participate in team-based and shared care; and
- Improved health literacy around medications for older Australians.

Approach/Activity undertaken

ACT PHN provided funding to eight general practices to each employ a part-time pharmacist (15 hours per week) for up to 18 months to work in a non-dispensing role. The practices were recruited in stages via an expression of interest to all ACT general practices. A condition of funding was that the pharmacists and the general practice would work co-operatively with CHN to monitor progress and to participate in the evaluation.

Outcome

The evaluation has demonstrated that this model has supported team-based and shared care through

- Sharing of knowledge and expertise of the pharmacist to empower the general practice team to improve the quality of their prescribing
- Providing a coordinated approach to medication management
- Contributing to 75+ Health assessment, GPMPs, TCAs and case conferences

Pharmacists also undertook a range of activities leading to a range of recommendations aimed at improving health outcomes and improving medication management. The following chart demonstrates the breakdown of recommendations. Pharmacists demonstrated an impact through:

- Reductions in medication burden
- Advising on medication interactions
- Providing health education and dosing aids to support patient self-management.
- Reconciliation of medication after ED/hospital stay

Appendix 25. Strengthening Care for Children. North Western Melbourne PHN.

Identified Need

A well trained and supported primary care workforce underpins the universal provision of equitable and comprehensive health care for children. This Strengthening Care for Children (SC4C) trial aims to determine if this can be achieved by integrating an educational relationship model between GPs and paediatricians in primary care.

Approach/Activity undertaken

The Strengthening Care for Children (SC4C) is a multi-site step wedge cluster randomised control trial with 22 GP practices and 118 GPs. The current trial is an expansion of the project that was successfully piloted with 5 general practices in the NWMPHN catchment between 2017-2019.

The SC4C model comprises three main components: weekly/fortnightly ½ day paediatrician-GP co-consulting sessions; monthly 60-minute Case Study Discussions at the GP practice; and paediatrician phone and email support for GP.

Participants include GP practices, GPs, families that choose to participate, practice managers, administrative staff, and the study paediatricians.

Outcome

Five practices took part in the pilot where 624 children were seen in GP-Paediatrician co-consultations over the 12 months of the model. This pilot aimed to test the feasibility and

acceptability of a GP-Paediatrician integrated model of care that was designed to support GPs to deliver appropriate care for children.

- Indication of reduction in referrals.
- Improved knowledge and confidence for all GPs (100%)
- Up to 30% reduction in unnecessary testing and prescribing by GPs for common conditions.
- Reduction in overall cost of care.
- With the majority of costs borne by the study funder, the model provides cost savings for state government/hospitals, federal government and cost savings for families.

Appendix 26. A Collaboration Between Gippsland PHN and the Victorian Rural Generalist Program Regional Network. Gippsland PHN.

Identified Need

The Victorian Rural Generalist Program Regional Network is tasked with analysing qualitative and quantitative population and health service information to inform regional workforce planning. Gippsland PHN was commissioned by the network to undertake a medical workforce analysis.

Approach/Activity undertaken

The purpose of the project was to identify pathways based on geography, population health need and aligned to the intent of Advance Skills Training (AST) criteria.

The Gippsland PHN Health Planning, Research and Evaluation team analysed a range of data including:

- Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool
- Australian Institute of Health and Welfare (AIHW)
- Population Level Analysis and Reporting (POLAR)
- Department of Health and Human Services
- Rural Workforce Agency Victoria (RWAV)
- Gippsland PHN Needs Assessment, Issues Papers, internal reports
- Qualitative information

Outcome

Gippsland PHN presented the key findings to the network and tabled the final report (*Meeting the medical workforce needs in Gippsland - June 2021*) at the June 2020 meeting. Based on analysis of geography, population health and available workforce data, the project recommended pathways in Anaesthetics, Obstetrics, Emergency Medicine, Adult Internal Medicine, Surgery, Mental Health, Palliative Care and Paediatrics. The report will inform planning and facilitate matching workforce training requirements with service and workforce demand at a regional and subregional level.

Appendix 27. Wagga GP After-Hours Service. Murrumbidgee PHN.

Identified Need

Wagga Base Hospital is the regional referral hospital servicing the Murrumbidgee region. Commencing in 2003, the services was originally established to address the increasing GP-type presentations to ED due to limited access to GP in-hours as a result of significant workforce

shortages. The model also facilitated shared on-call responsibilities among participating practices. Community demand for the service continues to be strong, especially in the winter months and by residents of residential aged care facilities.

Approach/Activity undertaken

The Wagga GP After-hours Service is a GP Cooperative including GPs from participating practice across the Wagga Wagga LGA. The clinic is managed by a GP Management Committee with management and administration support provided by MPHN. The clinic operates a face to face service seven days per week, 365 days per year with the hours of Monday to Friday from 7.00pm – 9.00pm, Saturdays 6.00pm – 9.00pm, and Sundays and Public Holidays 9.00am – 1.00pm and 5.00pm – 9.00pm. The service also offers an on-call service during social and unsociable hours for resident of RACFs.

Outcome

Pre-COVID, the service delivered approximately 6,000 consultations per annum. During the last 12 months, the service has introduced an option for patients to be offered telehealth appointment where clinically indicated.

Appendix 28. The Murrumbidgee Mental Health Drug and Alcohol Alliance. Murrumbidgee PHN.

Identified Need

The Alliance was established in 2016 to provide a forum through which key stakeholders from the health, community, social sectors and people with lived experience could develop a strategic approach to meeting the mental health and drug and alcohol needs and expectations of consumers for access to, and delivery of, services to the Murrumbidgee population. With the purpose to enable and enhance the recovery journey of people in the Murrumbidgee population living with mental health and/or drug and alcohol issues.

Approach/Activity undertaken

The Alliance meets monthly with activity informed by national and state strategic directions with an annual work plan identifying priority areas and projects which is informed by consumer, carer and family perspectives and identified service gaps including:

- Service based strategies to improve information exchange and the transfer of consumers' care through their recovery across member organisations
- Joint initiatives and projects
- Shared education and learning that promotes better understanding and skills sharing between services staff
- Opportunities for joint funding applications
- A communication and marketing strategy promoting services

Outcome

The overarching outcome for the Alliance is improving health outcomes for mental health and drug and alcohol consumers, families and carers.

There have been a number of activities undertaken to support this such as the development of:

- A common referral form to support the ease of referrers connecting someone to supports

- MapMyRecovery - an online service directory and hub of resources for people impacted by mental health and/or drug and alcohol issues
- Journi - a person held digital care plan, placing the person in control of their care plan

Appendix 29. Murrumbidgee Medical Succession Planning. Murrumbidgee PHN.

Identified Need

Similar to most rural and remote PHNs, Murrumbidgee PHN experienced critical medical workforce shortages in many communities across the PHN. We have a population of 242,000 with 275 General Practitioners and GP Registrars, 89 General Practices, and 3 Aboriginal Medical Services. There are 67 RACFs, and 33 public hospitals, many of those staffed by GP VMOs. Taking into account GP FTE, this represents a GP:Population ratio of 1:1,345. This does not include VMO, RACF or COVID testing and vaccination work.

At March 2021, there were 37 GP vacancies to which were being actively recruited.

Approach/Activity undertaken

The Murrumbidgee Medical Succession Planning committee was established in 2015 to identify existing and emerging workforce hotspots, include procedural hotspots, and work with practices, local hospitals and Councils to support succession planning and recruitment of adequately trained GPs and GP registrars meeting credentialing requirements to work as VMOs in rural hospitals and MPSs, and willing to do so. Partners include Murrumbidgee PHN, Murrumbidgee LHD, NSW Rural Doctors Network and the regional training provider GP Synergy.

- Early identification of potential and emerging medical workforce issues
- Shared planning to ensure rural GPs are replaced in a timely manner with minimal impact on community access to medical services
- Collaborative management of existing workforce issues
- Collaborative approach to support for existing workforce

Outcome

The model facilitates collaborative management of and support for the existing medical workforce and ensures, emerging issues are identified early and all relevant parties are engaged in recruitment. The model also assists with informing placement of GP registrars. 25 new GPs were successfully recruited to the region in the 2020-21 financial year.

Appendix 30. The Medical Practice Assist Model Comes of Age. Hunter New England and Central Coast.

Identified Need

In many rural and regional towns, General Practices report a lack of ability to recruit practice staff, issues of practice staff not working at the top of scope, and limitations in practice viability.

Approach/Activity undertaken

Medical Practice Assist staff are hybrid administrative and clinical assistant staff who undertake their clinical duties under the supervision of GPs or nurses in the practice. These are delegated duties assisting with clinical measurements and procedures, helping to coordinate care,

managing challenging patient behaviour, applying first aid, handling specimens, and maintaining medication stocks among other duties.

HNECC PHN has partnered with the University of New England (UNE) Partnerships and funded over 150 training scholarships, as well as providing support to General Practices to implement the Medical Practice Assist model.

HNECC PHN has also run the inaugural National Medical Practice Assist Conference in March 2021.

Outcome

General Practices and their staff have reported significant benefits to patient clinical care, practice models of care, practice staff workloads, practice staff satisfaction and practice income and viability. Practices benefiting from this approach have been in urban, regional and rural localities.

Appendix 31. Emerald Communities of Excellence Project. Central Queensland, Wide Bay, Sunshine Coast PHN.

Identified Need

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.

Approach/Activity undertaken

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.

Outcome

<u>Patient Experience of Care</u>

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.

Appendix 32. Increasing My Health Record Usage. Gippsland PHN.

Identified Need

The Gippsland PHN Digital Health Maturity Assessment for general practice confirmed that My Health Record was used widely however had not become embedded in most general practices.

Approach/Activity undertaken

Gippsland PHN, One Good Community General Practice (OGC GP) Program Grants encouraged general practices to develop capability to increase the utilisation and adoption of digital tools and technologies, including My Health Record.

Twenty-six (26) general practices identified My Health Record as an area for improvement. By implementing quality improvement activities general practices implemented strategies to increase the usage of My Health Record.

Some examples of activities included:

- Including digital health and My Health Record within orientation packs
- Participating in online learning for My Health Record
- Introducing competition amongst general practitioners for the most my Health Record uploads
- Developing workflows that support general practitioners to upload Shared Health Summaries

Outcome

A significant increase in the active use of My Health Record during 2020-21 has been observed, including:

- Document uploads increased by 21.27% and views by 17.88%
- Immunisation views have increased from 4 in 2020 to 1696 in 2021.

This has been attributed to the OGC GP Program Grant and the AIR immunisations recorded in My Health Record, contributing to My Health being embedded into the core business of general practice.

Appendix 33. Towards Better Outcomes - Data-led Improvement in PHN Commissioned Services. Hunter New England and Central Coast PHN.

Identified Need

Historically, service contracting in health care has concentrated on service volume, rather than the quality and outcomes for patients. The work undertaken by HNECC PHN is progressing towards an outcome-based commissioning model that focuses on the impact and the difference that commissioned service providers are achieving.

Approach/Activity undertaken

Over the last four years, HNECC PHN has worked with groups of commissioned services (including ACCHOs and Allied Health providers) to pilot patient reported measures systems and processes. This has led into a completed trial of a set of quality key performance indicators (Q-KPIs) that are now being integrated into all commissioned service contracts. These Q-KPIs capture more than session-based activity in order to additionally focus on quality outcomes

of cultural responsiveness, access to services, patient experience and patient outcomes. This data is being collected from Commissioned Service Providers from July 1, 2021.

Outcome

Using this data, service providers in HNECC PHN will receive a detailed dashboard each quarter using health intelligence data visualisation to track their performance. This will provide an opportunity to identify areas for potential improvement in patient care and outcomes. Indicators will be compared with previous quarter performances, as well as any relevant benchmarks across the program areas and support the indicators collected and assessed through the PHN Quality and Performance Framework.

Appendix 34. Integrated COVID-19 Pathways. North Western Melbourne PHN.

Identified Need

Increasing numbers of cases of COVID-19 in Victoria, and specifically the North Western Melbourne region during the second wave in 2020, put pressure on the state's healthcare system to meet the health and wellbeing needs of its citizens. Early intervention and virtual monitoring of COVID-19 positive patients, to minimise community transmission and enable timely and appropriate care transitions for deteriorating patients, was needed to improve clinical outcomes and strengthen the public health response.

Approach/Activity undertaken

NWMPHN developed and piloted the COVID-19 care pathway as an integrated model of care with primary, community and acute hospital providers to proactively support the health and social care needs of people with COVID-19. This was done in partnership with The Royal Melbourne Hospital and cohealth. Following the pilot, the care pathway was expanded to include the remaining hospitals in the network and informed the Victorian guidelines for state-wide adoption.

Outcome

- 80 percent of COVID-19 positive patients enrolled in the North Western COVID-19 Care Pathway were able to be cared for in the community by GPs. This meant patients were able to recover more comfortably in their own homes, already burdened hospitals were spared further admissions, and the risk of further transmission was greatly reduced at a time when infections were hitting record highs.
- 89% of respondents to the experience survey rated the healthcare they received as good or very good.
- More than 300 GPs and 200 practices received proactive PHN support to implement the pathway and were provided with access to secondary consult support, education and training and the HealthPathways Melbourne platform, which saw 2,633 page views during the second wave.