

PHNs and integrated care

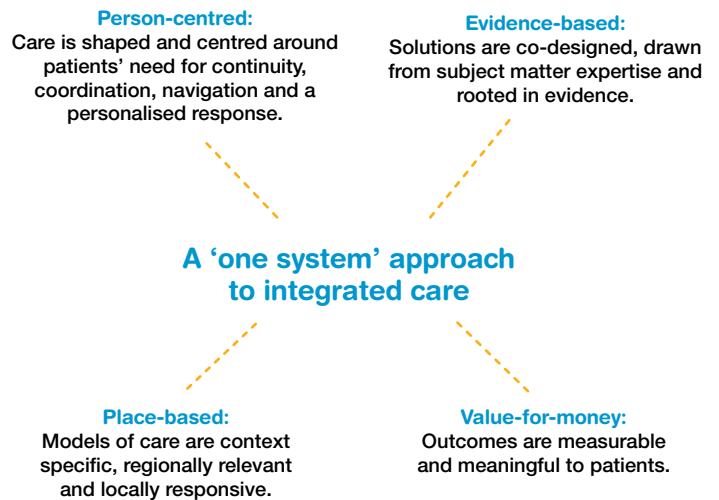
Integrated care involves the provision of seamless and effective care that reflects each person's health and social care needs. In an environment of increasing demand and tighter resource allocation, it promotes and drives efficiency and effectiveness.

PHNs recognise that person-centred care requires collaboration and integration of care across primary, community, hospital and social care sectors. As champions for better integration of services and systems, PHNs are seeking to:

- Reduce the waste caused by service delays, care duplication, and potentially preventable hospitalisations;
- Improve the safety and quality of care, through widespread adoption of evidence-based clinical pathways and decision supports; and
- Improve patients' experience of care to ensure it is timely, affordable, culturally safe, and meets their needs, closer to their homes and where possible, within their communities using primary care services.

To do this PHNs work with health system partners to integrate services and systems into a 'one system' approach.

Integrated care principles



What are PHNs?



PHNs are local independent organisations set up to improve patient care in their PHN regions and make primary healthcare more efficient and effective. There are 31 PHNs covering all of Australia.



PHNs are funded by the Australian Government and advised by GPs, other health professionals and consumers.



PHNs have formal partnership arrangements with LHNs to deliver and integrate care in their region.

PHN key functions

We use our knowledge and understanding of local health and healthcare needs to:



The 31 PHNs work collaboratively within their regions to integrate health services and systems at the local level to create better experiences for patients; gains in health outcomes; encourage better use of resources and eliminate service duplication.

A priority for PHNs is to integrate services and systems with LHNs and primary care providers for people with multiple chronic and complex conditions.

The benefits of integrated care

PHNs are uniquely placed to identify the needs and service gaps of a community. The integration of care can support addressing these gaps and the creation of a local health system that meets the needs of the community, providers and the health system as a whole.

Why and how we integrate care

What is integrated care?

Integrated care occurs when care providers work together with a shared focus on a person's needs.

Integrated care is:

- Seamless and coordinated across settings.
- Responsive to each person's continuing health needs.
- Inclusive of the individual, their carers and family expectations.
- Accessible and safe.

Why we integrate care

Evidence-based models of integrated care increase the likelihood that services are sustainable and scalable to achieve region-wide impacts.

Integrated care empowers clinicians through:

- Collaborative decision-making.
- Communities of practice.
- Streamlined workflows.
- Dedicated time for reflective practice.

Communities are empowered in the co-design and planning of services through health literacy initiatives and shared decision-making practices.

How we operate

Formal partnership agreements that support:

- Joint governance.
- Agreed priorities and outcomes.
- Collaborative commissioning.
- Unified standards, guidelines, clinical pathways and decision supports.

• Data sharing and linkage.

Joint regional needs assessments and plans that routinely apply:

- Comparative and predictive analytics.
- Patient risk stratification.
- Data sharing.

Interoperable digital platforms support:

- Real-time clinical information exchange.
- e-referrals & e-scripts.
- Secure messaging & shared care planning.

Standardised patient-reported measures are routinely monitored and reflected in service delivery and policymaking across sectors.

For the community

Integrated care enables providers across primary and acute care to collaborate to deliver the best possible care for the patient.

Integrated care enables greater continuity of care.

Integrated care supports the patient as their condition changes over time.

Those with multiple care needs can seamlessly access services and transition between sectors and care providers.

Integrated care can help ensure patients receive the right care, in the right place, at the right time.

For providers

Integrated care can improve clinician wellbeing and satisfaction and reduce burnout.

Other provider benefits include:

- Reduced costs of service delivery
- Greater operational efficiencies
- Improved timeliness and access to care

For the system as a whole

Integrated care can build a workforce that addresses population needs and goals.

The health system is at its strongest when all parts work together and achieve integrated care.

Whole-of-system integration reduces the risk of underutilisation and unnecessary gaps and overlaps in care. This in turn increases efficiency and outcomes.

Integrated care can reduce the burden on hospitals.

Integrated Care showcase

All PHNs work across these key areas to achieve integrated care in their regions.

Joint Regional Planning

We partner with Local Hospital Networks (LHNs) to develop shared comprehensive needs assessments of our regions, which inform consistent service planning.



Care Coordination

We set up networks and facilitate navigation support to improve care coordination for patients across general practices, hospitals, pharmacies, specialists and allied health services.



Data Sharing and Linkage

We work with Commonwealth and State agencies to develop systems that:

- Inform coherent regional planning.
- Enable continuity of care through tracking and mapping patient journeys between general practice and hospital services.



Clinical Pathways

We consult with expert clinicians to produce GP clinical decision support pathways for local regions.

We smooth pathways to and from local hospitals aimed at reducing avoidable admissions.

We manage HealthPathways™ to support the integration of care across multiple providers.



Digital Health

We support general practices with My Health Record set-up and implementation, as well as with other digital health innovations such as telehealth and e-referrals.

We invest in interoperable systems that enable:

- Real-time clinical information exchange.
- e-referrals and e-scripts.
- Secure messaging.
- Shared care planning.
- Virtual care and remote monitoring.
- Patient viewing portals.



Service and System Redesign

We undertake service and system redesign with a focus on:

- Innovative and evidence-based models of care.
- Improving access and continuity of care.
- Person-centred initiatives.
- Quality improvement.



Alliances and Co-Commissioning

We form alliances with key organisations to co-commission services relevant for patients with increased need of care coordination and wrap-around supports.



Case studies

Joint Regional Planning

Joint Regional Planning for integrated mental health, suicide prevention, and alcohol and other drugs service delivery

31 PHNs



All 31 PHNs have partnered with their LHNs to address the region's need for mental health, suicide, and alcohol and other drugs services and support over the next five years.

The Joint Plans are informed by relevant national, state and regional policy reform agendas for mental health and drug and alcohol and seek to implement the priorities of the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) and the National Drug Strategy within each region.

The Joint Plans will support:

- Evidence-based co-planning;
- Coordinated investment;
- And integrated service delivery to promote better outcomes for people with mental illness and/or substance misuse problems.

Results

The successful implementation of the Joint Plans over the next five years will be critical to an integrated mental health, suicide prevention, and alcohol and other drugs healthcare system and services and improved service delivery.

Data Sharing and Linkage

Lumos

10 PHNs



Growing from a pilot in 2016 with 1 PHN and 5 general practices, 10 NSW PHNs and over 258 general practices are collaborating with the NSW Ministry of Health on Lumos. This pioneering initiative links deidentified data from general practices with other health service data to provide new insights and a more comprehensive view of patient pathways.

By integrating patient data, the Lumos program is:

- Reliably informing the management, planning, evaluation and resourcing of health services;
- Driving predictive analytics and the shared understanding of risk stratification, trends and variations in care;
- And enabling cross-sector collaboration on developing innovative models of care, service re-design and quality improvement initiatives.

Results

Currently the Lumos program is mapping the health journeys of almost 2 million people (~25% of the NSW population). By June 2022, it aims to engage with 500 practices and generate insights on up to 4 million patient journeys across the NSW health system.

Case studies

Digital Health

Delivering better health care

Perth North PHN, Perth South PHN and Country WA PHN (WAPHA)



Perth North PHN, Perth South PHN and Country WA PHN (WAPHA) worked in collaboration with the Australian Digital Health Agency and Wirraka Maya Health Service Aboriginal Corporation to provide better care to over 7,000 Aboriginal people in Port Hedland, Pilbara region of WA. This population is often mobile, accessing services across the region and the Northern Territory as well as specialist services in Perth.

Through this partnership, Wirraka Maya and WAPHA worked with the National Broadband Network to improve internet connectivity to remote communities making telehealth services available to the community, reducing the need for unnecessary travel for secondary care services. They also worked to support the use of multiple digital health tools including:

- My Health Record,
- Telehealth,
- Secure messaging
- Education sessions to consumers on the use of MHR.

Results

As a result of these activities, Wirraka Maya has become one of the highest performing primary care organisations in the state, uploading the 9th highest number of Shared Health Summaries, the highest number of Event Summaries and viewing MHR information more than any other Primary Care provider in WA in 2020.

Care Coordination

Improving end-of-life outcomes for residents of RACFs

Brisbane South PHN



Brisbane South PHN and Metro South Hospital and Health Service's (MSPCS) palliative care service worked together to improve the end-of-life outcomes for residents of residential aged care facilities (RACFs).

To achieve this, Brisbane South PHN and MSPCS worked together to:

- Engage RACFs and revise policies and structures around how they work with RACFs;
- Improve the delivery of end-of-life care by focusing on Advance Care Planning, palliative care case conferencing and use of terminal case management plans;
- Support improvements in palliative care knowledge, skills and confidence in RACF nursing staff;
- Integrate end-of-life care resources into daily practice;
- And encourage sustainable end-of-life resident care through continuous quality improvement through after-death audits.

Results

The rate of residents transferred to hospital in their last week of life reduced from 41% to 25%.

Clinical Pathways

HealthPathways

29 PHNs



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.

Results

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.

Service System Re-design

Geriatric Rapid Acute Care Evaluation (GRACE)

Australian Capital Territory PHN (Capital Health Network)



In 2017, Australian Capital Territory PHN initiated the Geriatric Rapid Acute Care Evaluation (GRACE) program trial to improve the health journey and reduce presentations to one of Canberra's emergency departments from residential aged care facility (RACFs) residents.

The GRACE program is an outreach service that provides clinical support to RACFs and involves:

- Clinician visits RACFs to assess residents who are experiencing an acute health episode but are not in a clear clinical emergency;
- A support system to coordinate the management of acute health episodes in RACFs; and
- After hours services.

Results

The GRACE program created better integration and coordination of care, improved patient experience, and saw 22% decrease from baseline in ED presentations. It has since expanded across the ACT.

Case studies

Alliances and Co-Commissioning

Western Sydney Collaborative Commissioning

Western Sydney PHN (WentWest)



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.

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

Results

Example outcomes in Western Sydney Diabetes, which was a precursor to Collaborative Commissioning, is a significant mean reduction for enrolled patients in HbA1C by -0.71% (95% CI). A 1% drop in HbA1C is associated with 21% reduced risk of death, 14% reduced myocardial infarcts, 37% less microvascular complications and 43% amputations.

Six months into implementation the PCMH Program has been expanded from 7 to 23 General Practice, a COVID-19 management in primary care model is operating and we have a shared care platform rolling out across the catchment.

What we've learnt

Critical success factors

- Keeping the patient at the centre of care
- Strong, equitable relationships and alliances across the health system
- Strong governance arrangements
- Health and system intelligence including through interoperable digital platforms and shared data
- Investment and funding of enabling infrastructure
- A placed based approach that is locally responsive and regionally relevant

Where to next?

The future lies in integration across different partners in the broader service system eg social care/aged care.

Place-based resource-sharing—Pooling funds and other resources with organisations at specific locations will bring benefits of scale to collectively administering and delivering improved care services at that location.

Co-Commissioning—Joining with one or more current system partners or agencies to co-commission needed services requires a high level of trust, but will bring important benefits such as:

- highly engaged providers and consumers;
- agreed measures of success; and
- the opportunity to collect and share data that can be used to further improve the system and scale up success more broadly.

Regional planning—Extra 'buy-in' and support will be achieved by working with providers and the community to develop collectively 'owned' regional plans—for example Regional Mental Health Plans covering all levels of mental health need, from low intensity through to severe and complex.

To locate/contact your local PHN:
www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Locator

More information:
execoffice@phncooperative.org.au