AH - 1 - AH1 – Increasing After Hours Access on Weekends and Public Holidays

Activity Metadata

Applicable Schedule *
After Hours Primary Health Care

Activity Prefix *
AH

Activity Number *
1

Activity Title *
AH1 – Increasing After Hours Access on Weekends and Public Holidays

Existing, Modified or New Activity *
Existing

Activity Priorities and Description

Program Key Priority Area *
Population Health

Aim of Activity *

• Increase General Practice After Hours (AH) face-to-face service provision on the weekend including Sundays and Public Holidays in the SEMPHN catchment for LGAs of Greater Dandenong, Frankston, Casey, Kingston, Mornington Peninsula and Cardinia.
• Provide access to General Practice on weekends, particularly on Sunday, to reduce admissions to Hospital and Emergency Department (ED) presentations for Chronic Disease conditions and ‘GP Type’ presentations.

Description of Activity *

Access Activity: Increase access to General Practice on weekends and public holidays
Service elements and considerations:
• Funding for General Practice primary health care services in the unsociable AH periods as defined by DOH – weekends and public holidays
• Delivery of services – may consider suitable practices with more ‘Urgent Care’ equipment such as, X-Rays, diagnostic services, pathology in order to better cater for minor/urgent type presentations
• Links with local ED service
• Promotion of practice hours and services offered
• Workforce – upskill Nurse capabilities
• Bulk billing/private/mixed billing

Eligibility may also be based on:
• Proximity to diagnostic and pathology
• Proximity of Pharmacies
• Proximity to LHN ED

Evidence:
PwC Report and evidence from the results of SEMPHNs Round 3 and 5 AH commissioning indicate that majority of practices involved in both grants have fully or partially sustained the additional After Hours requirements beyond the funding period. Of note: One General Practice, indicated in their final report, that they dealt with more Urgent Care/Emergency Care cases on Sundays. They were motivated to work the extended AHS on the weekend particularly Sunday rather than during the week as their patient cohort started to consider them as a provider of Urgent Care. This practice had an increase in the number of walk-in’s contrary to most of the other practices in the AH Round 5 commissioning. This could be due to their position in a shopping centre thoroughfare.

Needs Assessment Priorities *

SEMPHN Needs Assessment 2019/20-2021/22

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease (Core)</td>
<td>58</td>
</tr>
<tr>
<td>After Hours (Core)</td>
<td>60</td>
</tr>
<tr>
<td>Potentially Preventable Hospitalisations PPH (Core)</td>
<td>62</td>
</tr>
<tr>
<td>Service system capacity (Core)</td>
<td>64</td>
</tr>
</tbody>
</table>

Activity Demographics

Target Population Cohort *

Patients within the SEMPHN catchment who have poorly managed complex medical needs.

Coverage *

Whole Region

No

<table>
<thead>
<tr>
<th>SA3 Name</th>
<th>SA3 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston</td>
<td>20803</td>
</tr>
<tr>
<td>Cardinia</td>
<td>21201</td>
</tr>
<tr>
<td>Casey - North</td>
<td>21202</td>
</tr>
<tr>
<td>Casey - South</td>
<td>21203</td>
</tr>
<tr>
<td>Dandenong</td>
<td>21204</td>
</tr>
<tr>
<td>Frankston</td>
<td>21401</td>
</tr>
<tr>
<td>Mornington Peninsula</td>
<td>21402</td>
</tr>
</tbody>
</table>
Activity Consultation and Collaboration

Consultation *

This activity is a result of multiple rounds of commissioning to General Practice over the life of the PHN, comprehensive research conducted by PwC and internal analysis of our previous commissioning by SEMPHNs Systems Outcomes team. GPs have been intimately involved at all points of this process and have been the recipients of the majority of commissioned funds.

Collaboration *

Continue to collaborate with:
- State and Federal funded agencies to develop a coordinated approach to PPHs
- LHNs to identify, research and explore models of care through sector engagement
- General Practices
- Community health services
- Corporate providers
- Health Insurers
- RACFs
- ACCHOs
AH - 2 - AH2 – Essential After Hours Care for Vulnerable Individuals with Chronic Conditions

**Activity Metadata**

**Applicable Schedule**
- After Hours Primary Health Care

**Activity Prefix**
- AH

**Activity Number**
- 2

**Activity Title**
- AH2 - Essential After Hours Care for Vulnerable Individuals with Chronic Conditions

**Existing, Modified or New Activity**
- Existing

**Activity Priorities and Description**

**Program Key Priority Area**
- Population Health

**Aim of Activity**

South Eastern Melbourne Primary Health Network (SEMPHN) is ranked 15 of 31 PHNs in Australia for potentially preventable hospitalisations and ranked 3 of 6 in Victoria. Chronic disease potentially preventable hospitalisations make up approximately 14% of hospital separations in the SEMPHN catchment.

The aim of this activity is to increase consumer awareness of After Hours Primary Health Care available in their community and improve health literacy on the appropriate health services to access in the After Hours period.

By implementing this activity, SEMPHN aims to address the current limitations in After Hours access for chronic disease patients participating in the Care Coordination program (refer to CF3 - Core/Flex Activity Work Plan) by ensuring After Hours care arrangements are documented in all Care Plans particularly Anticipatory Care Plans within General Practice.

This will facilitate a reduction in potentially preventable hospitalisations in the After Hours for patients with high health needs who are not accessing primary health services despite having complex or chronic health conditions.

**Description of Activity**

As part of the Care Coordination Program within General Practice, After Hours care arrangements are documented in all Care Plans. This anticipatory care planning better prepares patients for self-care through documented Action Plan arrangements. The arrangements are reviewed and discussed with the patients, carers and/or families. Unexpected patient After Hours health care needs are therefore anticipated, and appropriate actions undertaken which can have the reciprocal benefit of lowering anxiety levels for patients and families.

It is a requirement that all General Practices participating in the Care Coordination program alter all their Care Plans to include After Hours information for their patients. The After Hours information is tailored to the patient according to their
needs. The patients’ Action Plan must have sufficient information about accessing and obtaining care in the After Hours period.

General Practices must report to SEMPHN that all eligible patients have been provided with specific information about After Hours arrangements and that these arrangements have been discussed and understood.

**Needs Assessment Priorities**

SEMPHN Needs Assessment 2019/20-2021/22

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease (Core)</td>
<td>58</td>
</tr>
<tr>
<td>After Hours (Core)</td>
<td>60</td>
</tr>
<tr>
<td>Potentially Preventable Hospitalisations PPH (Core)</td>
<td>62</td>
</tr>
<tr>
<td>Service system capacity (Core)</td>
<td>64</td>
</tr>
</tbody>
</table>

**Activity Demographics**

**Target Population Cohort**

The target population cohort was derived from the Needs Assessment that identified people living with a chronic condition, a priority population group for the region.

For these reasons, patient eligibility for the Care Coordination program is targeted for:

1. Patients that have a diagnosed chronic condition and belong to one or more of the following priority groups:
   - Refugee
   - Experiencing homelessness
   - Culturally and linguistically diverse
   - Have a Mental illness
   - Identify as Aboriginal and/or Torres Strait Islander, or
2. Be diagnosed with two or more chronic conditions

**Coverage**

**Whole Region**

Yes

**Activity Consultation and Collaboration**

**Consultation**

Continue to collaborate with:

- State and Federal funded agencies to develop a coordinated approach to PPHs
- LHNs to identify, research, and explore models of care through sector engagement
- General Practices
- Community health services
- Corporate providers
- Health Insurers
- Other community services that provide social connection and health enhancing activities
Collaboration

Stakeholders:
- SEMPHN staff: Executive Leadership Team, Systems Outcomes Team, Chronic Disease Team
- Local Hospital Networks (Alfred Health, Monash Health, Peninsula Health)
- General Practices within SEMPHN
- Allied Health professionals
- Community health
- Councils
- ACCHO’s
- Relevant peak bodies
- Other clinical or non-clinical stakeholders
- Consumers and their families and/or carers
Activity Metadata

Applicable Schedule *
After Hours Primary Health Care

Activity Prefix *
AH

Activity Number *
3

Activity Title *
AH3 – Outreach Program providing Homebased Clinical Services: Chronic and Complex Conditions

Existing, Modified or New Activity *
Existing

Activity Priorities and Description

Program Key Priority Area *
Population Health

Aim of Activity *
This model is in development and will target disadvantaged groups with a particular focus on house-bound aged patients where complex interplay between patients, carers and service providers occurs both in the After Hours and at other times. We know of a large population with high health needs (especially in Greater Dandenong) who are not accessing primary health services despite complex or chronic health conditions. In addition, there is a high proportion of people aged 75 years and older who live alone (especially in Port Phillip) potentially making them vulnerable. Multiple barriers to accessing services have been identified and include:

- Poor health literacy
- Different attitudes towards health and wellbeing
- Financial barriers
- Lack of culturally appropriate services and information
- Transport barriers
- Lack of trust
- Familial relationships between Aboriginal clinic staff and clients

Description of Activity *
This activity will support vulnerable house-bound aged patients with high health needs and individuals living with chronic and complex disease through the provision of Home Based Clinical Services (HCS) provided by eligible General Practices (suitably qualified and experienced practices that have well-established care co-ordination systems in place to enhance support with the addition of Homebased Clinical Services). These services will respond to gaps in prevention, detection, ongoing management, and will support people who have difficulty accessing primary and secondary care due to a range of reasons (both clinical and non-clinical). This activity will enable increased and comprehensive management of the individual with high health needs whilst also increasing the capacity of the persons General Practice Team to remain central in their care, through increased access to primary health services, enhanced integration with the community and tertiary sector.
Individuals will be referred to the program from the hospital, or from General Practice Care Teams. Medium to long-term support will be provided to the person with activities including home visits, and phone calls. If a person is referred from hospital and does not have a current GP, a suitable practitioner and General Practice will be matched with the individual where they consent to this occurring.

The ultimate aim of this project is to support people who are disadvantaged with high health needs, particularly house-bound aged patients who do not currently access services in the primary care sector. Education, communication, and referrals will support the person, family and carers during this time. Secondary aims include reduced hospital admissions, re-admissions and length of stay. A HCS of this kind would be a new offering to residents in the South Eastern Melbourne PHN (SEMPHN) region.

Key Activities:
Home Based Clinical support delivered by General Practices that could include referral to other health professionals and community services (Nurses, Social Workers, Occupational Therapists, depending on the needs of the person, carer and family). The General Practice would conduct in-person assessments to identify the needs of the person, make referrals as required, communicate assessment and findings to other multidisciplinary care team members.

**Needs Assessment Priorities**

SEMPHN Needs Assessment 2019/20-2021/22

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease (Core)</td>
<td>58</td>
</tr>
<tr>
<td>After Hours (Core)</td>
<td>60</td>
</tr>
<tr>
<td>Potentially Preventable Hospitalisations PPH (Core)</td>
<td>62</td>
</tr>
<tr>
<td>Service system capacity (Core)</td>
<td>64</td>
</tr>
</tbody>
</table>

**Activity Demographics**

**Target Population Cohort**

This model is in development and priority access for this program will include people defined as vulnerable who are disengaged from primary health and may have been discharged from a public hospital in the SEMPHN region.

Vulnerability is measured through social determinants of health and if the individual is a house-bound aged patient.

**Coverage**

**Whole Region**

Yes

<table>
<thead>
<tr>
<th>SA3 Name</th>
<th>SA3 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port Phillip</td>
<td>20605</td>
</tr>
<tr>
<td>Stonnington – West</td>
<td>20606</td>
</tr>
<tr>
<td>Glen Eira</td>
<td>20802</td>
</tr>
<tr>
<td>Kingston</td>
<td>20803</td>
</tr>
<tr>
<td>Stonnington – East</td>
<td>20804</td>
</tr>
<tr>
<td>Dandenong</td>
<td>21204</td>
</tr>
<tr>
<td>Frankston</td>
<td>21401</td>
</tr>
<tr>
<td>Mornington Peninsula</td>
<td>21402</td>
</tr>
</tbody>
</table>
Activity Consultation and Collaboration

Consultation *

Continue to collaborate with:

• State and Federal funded agencies to develop a coordinated approach to PPHs
• LHNs to identify, research and explore models of care through sector engagement
• General Practices
• Community health services
• Corporate providers
• Health Insurers
• RACFs
• ACCHOs

Collaboration *

Stakeholders:

• SEMPHN staff: Executive Leadership Team, Systems Outcomes Team, Chronic Disease Team
• Local Hospital Networks (Alfred Health, Monash Health, Peninsula Health)
• General Practices within SEMPHN
• Allied Health professionals
• Community health
• Councils
• ACCHO’s
• Relevant peak bodies
• Other clinical or non-clinical stakeholders
• Consumers and their families and/or carers