



Australian Government

Department of Health



An Australian Government Initiative

Primary Health Networks Innovation Funding

Innovation Activity Work Plan 2016-2018

South Eastern Melbourne PHN

Revised December 2017

Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

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

In line with these objectives, the current PHN Innovation Funding stream will support PHNs to engage in innovative approaches and solutions that improve the efficiency, effectiveness and co-ordination of locally based primary health care services.

In the context of the PHN Innovation Funding under this stream, innovation includes *an idea, service, approach, model, process or product that is new, or applied in a way that is new, which improves the efficiency, effectiveness and co-ordination of locally based primary health care services.*

At a minimum, activities under the current PHN Innovation Funding stream must:

- be new or innovative;
- align with PHN Programme objectives;
- relate to the recommendations of the Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response;
- be beyond the activity expected under the Core Funding Schedule and not duplicate activity funded under other schedules (eg. After-Hours, Mental Health, Drug and Alcohol) or other funding sources; and
- link to local need (as identified via needs assessment) and/or support the application or expansion of innovative solutions across the PHN network.

Primary Health Networks can utilise 2015-16 PHN Innovation Funding to: engage expertise and work with partners to develop innovative models; implement an identified innovation(s) or expand its application; and/or undertake evaluation of local innovation.

Primary Health Networks are required to outline planned activities, milestones, expected costings and outcomes to provide the Australian Government with visibility as to the activities of each PHN.

This document, the Innovation Activity Proposal, captures these activities.

This Innovation Activity Proposal covers current Innovation Funding provided to PHNs to be expended within the period from 1 July 2016 to 30 June 2018.

Innovation Funding Activity Proposals must:

- demonstrate to the Australian Government what the PHN is going to achieve and how the PHN plans to achieve this;
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments, Local Hospital Networks and other stakeholders, as appropriate; and

- articulate a single or set of innovation activities that each PHN will undertake, as well as identifying clear and measurable evaluation criteria to review both the impacts of the innovation and its potential for expansion or transfer across the PHN network.

Primary Health Networks must also provide evidence that supports the proposed innovation activities.

The Innovation Activity Proposal template has the following parts:

1. The Innovation Funding Activity Proposal for 2016-2018, which will provide a description of planned activities funded by the current Innovation Funding Stream under the relevant provisions of the Core Funding Schedule.
2. The indicative Innovation Funding Stream Budget for 2016-2018.

It is important to note that while planning may continue following submission of the Innovation Activity Proposal, PHNs can plan but must not execute contracts for any part of the funding related to this Innovation Activity Work Proposal until it is approved by the Department.

Further information

The following may assist in the preparation of your Innovation Activity Proposal:

- Clause 3, Financial Provisions of the Standard Funding Agreement;
- Item B.5 of Schedule: Primary Health Networks Innovation Funding;
- Primary Health Networks Grant Programme Guidelines; and
- Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response (<http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-report>).

1. Planned activities funded under the Activity – Primary Health Networks Innovation Funding

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	IN 1.1 Service Mapping and Patient Journey
Description of Activity	<p>SEMPHN's innovation activity is aimed towards developing an in-depth understanding of the patient journey through the healthcare system for the around 500,000 people who are living within the catchment with one or more chronic conditions. This will support SEMPHN's work in the development and implementation of the Healthcare Home model across the region and the design of an approach of a 'to be' model of chronic disease management, focusing specifically on better service integration and the consumer experience.</p> <p>There are a number of components to this work; together they will provide SEMPHN with a deep understanding of the services currently being provided across the region and the way that clients move through the system in the management of their chronic conditions:</p> <ul style="list-style-type: none"> • Mapping of existing services for key chronic diseases identified within the Needs Assessment as leading to significant hospital activity – primary care type ED attendances, potentially preventable hospitalisations and where there is significant clinical variation within primary health care across the region (see Rationale). SEMPHN has adopted an innovative approach to service mapping in our region, applying a strict taxonomy to the mapping of services that provide long term care. This model seeks to understand and categorise the specific activities of teams that provide care, providing a deeper understanding than the program under which the service is funded, the name of the business, or advertised services. To date, SEMPHN has applied this methodology to mapping mental health, alcohol and other drugs and homelessness services. This model has yet to be applied to services for the management of chronic disease in Australia, however it has successfully been applied in parts of Europe. • Understand the patient journey through the health care system through a detailed process mapping exercise and quantitative data analysis to understand the current state, or 'as is'. This will be done in order to understand the key tension points or barriers in the system that result

	<p>in a reduction in the efficiency and effectiveness of care provided to those clients living with one or more chronic diseases</p> <ul style="list-style-type: none"> • Ethnographic and qualitative analysis of the patient journey, focusing on those key tension points where significant barriers exist, including access (such as transport, waiting times and cost barriers), integration, coordination and continuity of care (such as informational barriers and patient satisfaction), and health literacy and provider capacity, and where possible identify key vulnerable populations and how their experience varies. • On the basis of the above analysis, develop a 'to be' approach. This approach will be shared with local providers to integrate it within the existing models of care, as well as to inform the development of the Healthcare Home model to be piloted within the region. This will also support the significant activity to be undertaken by SEMPHN to support the development of models of care for chronic disease identified within SEMPHN's Annual Work Plan. • Provision of a report to the SEMPHN community using simple and innovative methods of data visualisation, iconography and infographics to be published on the SEMPHN website to help build health literacy and support developments to the patient journey.
Rationale	<ul style="list-style-type: none"> • Through its Needs Assessment, SEMPHN has identified "poor communication, lack of information sharing and coordination of care across health providers leading to fragmentation of care" as key challenges in the efficient and effective management of chronic disease • The Needs Assessment identified the following chronic conditions as leading to high rates of preventable hospitalisations and burden of disease in parts of the region: <ul style="list-style-type: none"> • Diabetes • Cardiovascular disease • Anaemia • Heart failure • COPD and asthma • Cellulitis • Kidney disease • Angina • Analysis of Potentially Preventable Hospitalisation data from the National Health Performance Authority (National Health Performance Authority 2015, Healthy Communities: Potentially preventable hospitalisations in 2013–14) identifies that SEMPHN has higher than the Australian average hospitalisation rates for <ul style="list-style-type: none"> • Iron deficiency anaemia • Asthma

	<ul style="list-style-type: none"> • Congestive heart failure • Hypertension • Through a survey of 1,500 people living within the catchment, through the Ophelia project, SEMPHN has identified areas for improvement to health literacy in the following domains: <ul style="list-style-type: none"> • Appraisal of health information • Navigating the healthcare system • Ability to find good health information
Strategic Alignment	<p>The proposed activity is closely aligned with the current public policy discourse on chronic disease management, the objectives of PHNs themselves and SEMPHN's own strategic plan.</p> <ul style="list-style-type: none"> • As mandated by the Primary Health Networks: Grant Programme Guidelines (February 2016), SEMPHN's innovation activity seeks to do the following: <ul style="list-style-type: none"> ○ better understand – in significant depth – the critical clinical and consumer pathways for people with a chronic disease and, in doing so, design more effective and efficient clinical responses for this cohort. This will be achieved through gaining a deeper and more nuanced understanding of the clinical services in the SEMPHN catchment, as well as by better understanding the critical (and often problematic) junctures in the clinical journey of consumers with chronic disease ○ empower GPs to better understand the needs of people with chronic disease as they travel through the clinical system seeking support and effective treatment • As set out in the <i>Better Outcomes for People with Complex and Chronic Conditions</i> report, fragmentation and poor integration severely limits the ability for people with chronic conditions to receive effective treatment. SEMPHN's innovation activity seeks to build a strong evidence base that will begin to unravel where the major areas of fragmentation exist and, in turn, provide the basis for evidence-based and rationale commissioning of primary health care services that can address the current limitations of the system • At the local level, SEMPHN is committed to assisting consumers and clinicians to better navigate the complex health system. Therefore, the development of a localised picture of current services and the prominent patient journeys will begin to uncover the most useful and appropriate pathways and experiences that support positive consumer outcomes • CD 1.1 in SEMPHN's Activity Workplan articulates how SEMPHN's current work is focused on addressing the significant limitations of the current primary health system in dealing with consumers with chronic disease.

Scalability	<p>As noted above, SEMPHN has already applied an approach similar to the innovation activity within the context of mental health, alcohol and other drugs and homelessness.</p> <p>Further, given the complexity and innovative nature of the activity described, SEMPHN will deliberately phase the application of the activity. SEMPHN will begin by refining the methodology within the context of a chronic disease with high prevalence in the SEMPHN catchment – such as COPD. Having done so, SEMPHN will then be able to gradually expand the approach to other chronic diseases identified as being of high priority in the PHN catchment.</p> <p>By doing so, SEMPHN will be able to not only manage the risk associated with scope creep, but will also be able to gradually and methodically expand the activity to provide a robust evidence base across the gamut of chronic diseases within the PHN's catchment.</p>
Target Population	<p>The activity is targeted at improving the patient journey for the estimated 500,000 people living with one or more chronic conditions within the SEMPHN catchment, in particular those 36,000 who end up in hospital where this could have been prevented. It will also provide clearer pathways and models of care for clinicians including GPs at over 400 practices and AHPs. The activity will also support the PHN in administering other funds committed to chronic disease and the healthcare home. The long-term aim is to reduce the impact on the hospital system by reducing potentially avoidable hospitalisations.</p>
Coverage	<p>It is intended that the mapping will cover the entire SEMPHN catchment and the patient journey will incorporate the three local hospital networks and a range of providers from across the region, with a focus on those areas with an identified need and service gaps.</p>
Anticipated Outcomes	<ul style="list-style-type: none"> • Benefits to patient or the community <ul style="list-style-type: none"> – Medium term (by June 2018) - effectiveness of diagnosis or treatment – Medium term - patient experience and health literacy – Short term (throughout activity) – improved models of care and pathways • Benefits for local health system <ul style="list-style-type: none"> – Medium term – reduced clinical variation – Long term (2019 and beyond) – reduced avoidable hospitalisations – Short term - partnership building (including better coordination and/ or integration of health care sectors) with <ul style="list-style-type: none"> ➤ Local Hospital Networks ➤ other partners/stakeholders

How will these outcomes be measured

- Potentially preventable hospitalisations for specific chronic conditions including:
 - Diabetes
 - Cardiovascular disease
 - Anaemia
 - Heart failure
 - COPD and asthma
 - Cellulitis
 - Kidney disease
 - Angina
- Improvements in health literacy and patient experience
 - Via Ophelia or other tool to be developed by the PHN to measure patient's subjective experience of care including coordination, integration and coordination of care – a targeted sample survey
- Models of care and pathways
 - Implementation and application of Map of Medicine in GP practices
 - Numbers new and updated maps
 - Numbers and proportion of practices applying the maps
- Clinical variation and gaps in “as is”
 - Data from providers and consumers on their perceptions and experiences specifically relevant to this phenomenon
 - Observational data on patient and provider experiences within the existing pathway
 - Qualitative data from providers and patients on challenges encountered moving through the existing pathway
 - Compilation of a series of case studies to illustrate observations/ experiences outlined
 - Consumers and providers invited to separate sessions to “member check” key themes which emerged from data
- Partnership building
 - Qualitative data from providers on experiences around partnership building (including better coordination and/ or integration of health care sectors) with
 - Local Hospital Networks

	<ul style="list-style-type: none"> ▪ other partners/stakeholders • Consumer consultation/feedback on proposed “to be approach” via qualitative interviews/ focus groups
Indigenous Specific	The innovation activity will not be focused specifically on the indigenous population within the PHN’s catchment. Notwithstanding this, because the activity can be scaled / modularised (as described above), it certainly lends itself to application to specific chronic diseases affecting the indigenous population in the PHN’s catchment.
Collaboration	<p>As with all of the activity that the SEMPLHN undertakes, the PHN will implement this activity in a highly collaborative manner. This will mean that the PHN will seek to engage and work collaboratively with LHNs, GPs, community health organisations and other primary care providers within the PHN’s catchment. In addition, SEMPLHN will seek to engage the Victorian Department of Health and Human Services to ensure an integrated and consistent approach with the state bureaucracy.</p> <p>The roles of the involved parties will be varied, ranging from key informant, data provider, co-collaborator and research participant. As the activity is further scoped, these roles will be more clearly defined.</p>
Timeline	<ul style="list-style-type: none"> • Service mapping – start November 2016, completion April 2017 • Patient journey – start February 2017, completion June 2017 • Qualitative analysis of patient journey – start March 2017, completion Sept 2017 • Develop ‘to be’ – start August 2017, completion February 2018 • System development and final report – start October 2017, completion June 2018

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.2)	IN 1.2 General Practice Support
Description of Activity	<p>PHN Staff will work proactively with general practice staff particularly GPs, Practice Managers and Practice Nurses, in order to support the successful implementation of the Health Care Homes trial in this region. The Health Care Homes Initiative requires significant change from practices involved. If they not provided with the appropriate levels of support there is a risk to the implementation of the program. In order to manage the change required, practices will need support with a range of activities. Without such support there is a risk to the implementation of the HCH programme.</p> <p>Specifically, SEMPHN will be working intensively with HCH practice sites to support them to implement the HCH model. This will include activities such as:</p> <ul style="list-style-type: none"> • Training staff in the use of data cleaning and extraction tools • Providing CPD in relation to chronic disease management • Support practice transition to HCH models of care • Identify and enrol patients in the HCH program • Developing business capacity to manage bundled payments for CDM
Rationale	<p>The adoption of the HETT model will require varying levels of change across the region. In order to manage the change required practices will need support with a range of activities.</p> <p>Without such support there is a risk to the implementation of the HCH programme.</p>
Strategic Alignment	<p>PHN are required to improve the co-ordination of primary health care particularly for those who are at risk of poor outcomes. The Health Care Homes initiative strives to increase the effectiveness of care co-ordination in the general practice setting. Providing general practices with support to ensure the successful implementation of the Health Care Homes trial is well aligned with the PHN programme.</p>

Scalability	<p>The SEMPHN teams will continue to develop their capacity to deliver high quality and effective general practice support through this program. One of the core aims of the teams will be to encourage practices to coach and mentor each other both within and also at times those uninvolved in the Health Care Homes pilot program.</p> <p>As practices become more capable they will require less support, and in addition as they become more confident in supporting each other, the practice communities will work together in new and innovative ways. This added capacity through practices supporting practices, will allow the PHN to scale up this general practice support across the region. Those practices that receive support early will be coached and have their systems and processes supported to develop, particularly in relation to better quality outcomes for patients and their families, and as a consequence they will then be in a position to mentor practices near them, almost a snowball effect might be seen over a period of time as practices take on those clinical leadership roles. By taking this approach the SEMPHN will not only be able to provide services over a period of time to all practices within the region. At the same time SEMPHN will be building a sustainable change in the practices culture, as well as their capacity to deliver high quality primary care.</p>
Target Population	<p>This activity is targeted at improving the chronic disease management in general practices identified as eligible under the Health Care Homes initiative.</p> <p>At this point we understand 20 practices will be enrolled in that program across our region, so the initial starting point will be working quite intensively with those 20 practices. In addition, we will be looking to other practices across our region who are interested in improving the quality of their chronic disease management and also providing them with support where possible. SEMPHN's aim is to improve the quality of primary health care across the entire region not only within the Health Care Homes trial practices.</p> <p>Ultimately the target population for this work are the patients receiving care from these practices and these are particularly patients with significant chronic illnesses who require support to better manage their care.</p>
Coverage	<p>At this stage it is not clear which parts of the PHN catchment will be best served by the Health Care Homes model, as practices have not yet been identified and approved by the Commonwealth. Once this occurs we will be able to provide the department with further information about the coverage of this activity across the region. The SEMPHN region has approximately 450 practices and we</p>

	recognise that only a small proportion of these will be involved in the trial, hence the impact across the region will be minimal.
Anticipated Outcomes	<p>The support will build the capacity of practices to:</p> <ul style="list-style-type: none"> • use the tools and resources provided by the Commonwealth for the HCH initiative • transition to new models of care • recruit and enrol patients in the HCH trial • coach and mentor each other, developing models for sharing practice expertise • become actively involved in formal and informal evaluation of the HCH models of care
How will these outcomes be measured	<p>SEMPHN uses a sophisticated database system which records all interactions with practices, the nature of these interactions, the time taken and the resources required. Our general practice support team regularly input data into this database so that we can understand where we are providing services and the kind of services most needed by our general practice community. We will be using this database to measure the amount of the support the practices need and to identify the costs associated with providing the coaching and support necessary for general practices to move into the Health Care Home service delivery model as defined by the Commonwealth.</p> <p>We would expect to see an increase in practice interaction with those practices associated with the Health Care Homes model. These interactions may occur in a variety of forms including the following;</p> <ul style="list-style-type: none"> • Practice visits by SEMPHN staff • Email and telephone exchanges with the practice support team • Attendance at practice network meetings hosted by the PHN in our local area • Increased interaction between practices (measurement to be determined) • Feedback from practices in relation to the usefulness and quality provided by the PHN in relation to their implementation of the Health Care Homes model • Subscriptions and open rates (whether people open emails we send them) for communications the PHN provides to practices across the region in relation to practice support
Indigenous Specific	<p>This activity will not be focused specifically on the Indigenous population. However we recognise that our indigenous population experience a high level of chronic disease and as a consequence improving the quality of care provided by our practices in this area, will ideally improve the quality of care provided to the first people of Australia.</p>

Collaboration	<p>As with all of the activity that the SEMPHN undertakes, the PHN will implement this activity in a highly collaborative manner. This will mean that the PHN will seek to engage and work collaboratively with LHNs, GPs, community health organisations and other primary care providers within the PHN's catchment. In addition, SEMPHN will seek to engage the Victorian Department of Health and Human Services to ensure an integrated and consistent approach with the state bureaucracy.</p> <p>The roles of the involved parties will be varied, ranging from key informant, data provider, co-collaborator and research participant. As the activity is further scoped, these roles will be more clearly defined.</p>
Timeline	<ul style="list-style-type: none"> • Supported recruitment into HCH program – start November 2016, completion December 2016 • Training – start February 2017, completion April 2017 • General Practice Support Activities - start November 2016, completion December 2018

