Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Innovation Funding

Innovation Activity Proposal 2016-2018

Nepean Blue Mountains PHN

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*.

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.

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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the Innovation Funding stream under the Schedule – Primary Health Networks Core Funding.

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	**IN 1.1** ***Intensive Support for Practices for the Health Care Home Model in NBMPHN***
Description of Activity	• NBMPHN was selected as one of ten sites to implement stage one of the Health Care Home Practice rollout. Although Practices will apply directly with the Commonwealth in our region NBMPHN plans to undertake intensive support of Practices to: 1. Build awareness of the Health Care Home Model across the region 2. Support applications from interested Practices 3. Build readiness to participate 4. Develop individual implementation models guided by change management processes, education and training, quality data capture and review, workforce mobilisation and digital health enhancements. • ***Innovation activities will be focused on the:*** 1. Development of a dedicated team to support the Health Care Home rollout, at 3 tiers of engagement, including: – co-ordination of messaging and communication for practice engagement and recruitment across the region, – direct support for establishing the Health Care Home Model inclusive of education and training, change management processes to enable transitioning to the Health Care Home Model, facilitation of data driven clinical, business and patient centred systems for performance tracking, evaluation and quality improvement, patient enrolment processes, ensuring digital enablement of cross sector communication for patient and provider,

	– facilitation of integration initiatives across health sectors including Local Health District, allied health providers, aged care services to support continuity of care and enhanced service access 2. Development and management of appropriate advisory and governance arrangements for our Health Care Home trial area, and participation in State, Commonwealth, Local Health Network/District committees as required, in order to guide resource development, table issues to contribute to the evaluation of stage one, support solutions for stage one and beyond adoption. 3. Commissioning activities to provide expertise in areas of change management, care co-ordination services, and tools to support integration of practice population data, clinical metrics and patient real time experience and outcomes.
Rationale	The key activities outlined in the above area are aligned to core recommendations tabled in the Report of the Primary Health Care Advisory Group; 'Better Outcomes For People with Chronic and Complex Health Conditions' 2015. Evidence supporting the Advisory Group recommendations have been drawn from international evidence focused on key findings by Bodenheimer *et al, '*10 building blocks for high performing primary care', *Ann Fam Med* 2014; 166-171. This paper reflects on the significance of several structural units for Health Care Home implementation including; data driven quality improvement, engaged leadership and change management processes, patient focused care, collaborative, timely, comprehensive and co-ordinated care. The report also confers with international evidence for strong system integration, driven by strong governance, shared accountabilities and IT enablers.
Strategic Alignment	In line with the PHN strategic objectives and key principles for patient centred health care homes in Australia, ***IN 1.1*** activity will be fundamental to drive the development of Health Care Homes across our region. As discussed above the rationale for this activity is strategically aligned to the Report of the Primary Health Care Advisory Group; 'Better Outcomes For People with Chronic and Complex Health Conditions' 2015, and the Roundtable report – Patient Centred Healthcare Homes in Australia: Towards Successful Implementation, July 2016. Chronic and complex conditions represent a major burden on healthcare resources in our region and our application of the above activity will support key outcomes aligned to our strategic focus.
Scalability	The innovation activity will support the development of a framework for further rollout of Health Care Home approach across the NBMPHN region during Stage One of the trial and

	beyond. IN 1.1 activities could be adapted to individual or Practice cohorts in the future.
Target Population	The target cohort for this Innovation activity focuses on the Health Care Home Stage One Practices in our region and their identified chronic and complex patients. Support population will include Practice staff inclusive of clinical and non- clinical staff, GP, AHP, Consumer Leaders, NBM LHD clinical and executive staff.
Coverage	The application of this activity will be across the entire NBMPHN region, encompassing all Health Care Home Stage One Practices in all LGA's.
Anticipated Outcomes	Anticipated outcomes include: • Awareness of Health Care Home Trial with Practices across the region and understanding of the principles supporting their implementation • Commitment of several Practices to undertake Stage One • Established and operational governance structure • Consumers enrolled report positive care experience • Increased awareness of Health Care Home principles, change management and realisation amongst PHN staff • Increased awareness of Health Care Home principles, change management and realisation amongst HCH Practices
How will these outcomes be measured	Outcomes measures/indicators will include: • Practice survey of cross section of Practices in each LGA reporting awareness and understanding parameters • Number of Practices who join the HCH Interest Network, Number of Practices who applied • Number of Practices with enrolled patients consistently claiming HCH payments • Number of education and training events held and attended by HCH Practice staff • Staff feedback at education and training sessions • HCH Practice staff feedback following training and education sessions • Minutes and Action log Governance meetings, • Attendance log of State and Commonwealth meetings/Forums
Indigenous Specific	This activity will be targeted to all chronic and complex patients across Health Care Home Stage One sites across our region.
Collaboration	This activity will be undertaken with NBM LHD and commission organisations as described in 1.1.NBM LHD will be a critical partner to support condition specific training and education and support for improved access for patients.
Timeline	• October 2016- December 2016: Intensive Support Commences: Communications and Support for tender application with Practices • Jan 17-April 17: Recruit HCH Team

	• Jan 2017 – July 2017: Practice readiness, HCH education and training, Change Management Processes commenced, Governance frameworks established and active. • Jan 2017-2019: Clinical upskilling and support activities • July 17 – 19: Monitoring and evaluation

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	**IN 1.2** ***Developing the Medical Neighbourhood and strengthening Team Based Care***
Description of Activity	NBMPHN proposes to undertake activities to ensure that the Health Care Home is framed around the supporting 'medical neighbourhood', whereby sector partners are aligned and integrated with the Health Care Home model for comprehensive and co-ordinated patient care. • **Innovation activities will be focused on :** 1. Development and management of 'Medical Neighbourhood' Advisory Committee to map appropriate partners and providers, scope communication channels and referral pathways, and new and existing integration enablers 2. Building awareness and adoption of 'neighbourhood' networks for Health Care Home Practices 3. Facilitating uptake of digital enablers for improved communication and co-ordination of services 4. Supporting development of care co-ordination services and expertise within primary care 5. Commissioning activities to provide expertise in areas of care co-ordination services, chronic disease management, and tools to support integration.
Rationale	The key activities outlined in the above area are aligned to core recommendations tabled in the Report of the Primary Health Care Advisory Group; 'Better Outcomes For People with Chronic and Complex Health Conditions' 2015. Evidence supporting the Advisory Group recommendations have been drawn from international evidence focused on key findings by Bodenheimer *et al, '*10 building blocks for high performing primary care', *Ann Fam Med* 2014; 166-171. This paper reflects on the significance of several structural units for Health Care Home implementation including; data driven quality improvement, engaged leadership and change management processes, patient focused care, collaborative, timely, comprehensive and co-ordinated care. The report also confers with international evidence for strong system integration, driven by strong governance, shared accountabilities and IT enablers.
Strategic Alignment	In line with the PHN strategic objectives and key principles for patient centred health care homes in Australia, ***IN 1.2*** activity will be fundamental to drive the development of Health Care Homes across our region. As discussed above the rationale for this

	activity is strategically aligned to the Report of the Primary Health Care Advisory Group; 'Better Outcomes For People with Chronic and Complex Health Conditions' 2015, and the Roundtable report – Patient Centred Healthcare Homes in Australia: Towards Successful Implementation, July 2016. Chronic and complex conditions represent a major burden on healthcare resources in our region and our application of the above activity will support key outcomes aligned to our strategic focus.
Scalability	The innovation activity will support the development of a framework for further rollout of Health Care Home approach across the NBMPHN region during Stage One of the trial and beyond. IN 1.2 activities could be adapted to individual/ Practice cohorts/ or regional groups in the future.
Target Population	The target cohort for this Innovation activity focuses on the Health Care Home Stage One Practices in our region and their identified chronic and complex patients. Support population will include Practice staff inclusive of clinical and non- clinical staff, GP, AHP, Consumer Leaders, NBM LHD clinical and executive staff.
Coverage	The application of this activity will be across the entire NBMPHN region, encompassing all Health Care Home Stage One Practices in all LGA's.
Anticipated Outcomes	Anticipated outcomes include: • Partnership building - better coordination and/ or integration of health care with Local Health District services, private specialists, allied health services, and NGO's. • More flexible and accessible care for patients • Improved data and information sharing between MDT and hospital services • Improved team based approaches to patient management
How will these outcomes be measured	• Number of mapped Medical Neighbourhoods and established contacts • Number of Practices, Allied Health, Specialists within the 'Medical Neighbourhood' with secure messaging • HCH Practice feedback on workforce utilisation • Number of multidisciplinary and cross sector education and training events • Clinician feedback at multidisciplinary events • Patient experience feedback reports (de-identified) on care access for HCH Practices
Indigenous Specific	This activity is targeted to all patients enrolled in the Health Care Home Stage One Practices
Collaboration	This activity will be undertaken with NBM LHD, Allied Health Leaders, Consumer representatives, and commissioned organisations as described in 1.2.NBM LHD will be a critical partner to support condition specific training and education, improved access to care, and integration initiatives.
Timeline	Critical timeframes:

	• Feb 2017 – July 2017: Recruit Health Care Home Team, Medical Neighbourhood structure developed • Feb 2017 – 19: Integration framework developed and implemented • Feb 2017- 19: Care co-ordination services framework developed, education and training • Jan 2017 – 19: Digital enablement program rolled out to Medical Neighbourhood