Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Innovation Funding

1. Innovation Activity Proposal 2016-2018
2. Indicative Budget

Brisbane South PHN

When submitting this Innovation Activity Proposal 2016-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Innovation Activity Proposal must be lodged to your Grant Officer via email to Qld_PHN@health.gov.au on or before 15 July 2016.

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).

Please contact your Grants Officer if you are having any difficulties completing this document.

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.

Definitions applied:

Short Term Outcome: change measureable in 1-2 years – patient, practice/organisational/service or sub area level

Longer Term Outcome: change measureable in 3-5+ years and may require formal evaluation/research – population, regional, system level. *NB: these in many cases will be measured through the needs assessment process or formal evaluation vs measurement per activity*

Proposed Activities	Description
Activity Title / Reference	**IN 1.1 Integrated Care Pathways**
Description of Activity	Establishing successful integrated care between acute and primary health care, as shown internationally, requires shared pathways, systems and information. Brisbane South PHN in partnership with Metro South Health (MSH) and Queensland Health are looking to implement HealthPathways – an online solution for General Practitioners and other primary health providers to access local health information, referral options, and leading practice guidelines for care treatment. This is well recognised in the *Better Outcomes for People with Complex and Chronic Conditions* report as foundational to Health Care Homes. Queensland Health - Clinical Excellence Division has recently announced that they will be funding the Health Pathways intellectual property licensing for the entire State. Needs assessment analysis and consultations across the region highlight a number of access, coordination and efficiency barriers and challenges due to decision making variation and pathway uncertainty. General Practitioners are expected to keep abreast of large volumes of new leading practice information and ever changing providers and services across their local area for their patients, within a very manual, paper based environment. Decades of local provider directories going out of date quickly, and high levels of reform driving funding and service changes, have created an untenable and fragmented health system for practitioners to navigate with their patients. Brisbane South PHN and MSH have partnered to address this problem through use of innovative pathway systems, and have identified HealthPathways (Canterbury) as best fit for the region, consistent with other parts of the state looking to tackle this issue and demonstrating success in other jurisdictions. Through jointly funding and implementing HealthPathways with Metro South Health: • pathways will be developed and agreed with local Specialists and General Practitioners that will support improved coordination of care between the services – this has been shown to improve relationships and trust, and • the regions general practitioners and other primary health providers will have up to date leading practice guidelines and information for the care of their patients which can be easily accessed through their existing systems, or web. HealthPathways has been shown (within Australian sites and New Zealand) to: • decrease demand on acute services – where care could be delivered by primary health care • improve access to acute services for those who need it most – right time, right care, right place • improve patient experience through clear information on their care journey and options • yield high general practitioner and practice nurse adoption and use – evidenced in NZ and AU environments Brisbane South PHN provides our stakeholders with a dedicated team that manages stakeholder relationships for the organisation, including general practice and other health providers in our region, such as Metro South Health. The team employs an account

	management model which offers key points of contact between Brisbane South PHN and our local healthcare community. The team's key aim is to ensure that local services and providers can effectively respond to evolving primary healthcare needs. Through relationship management, stakeholder mapping and profiling, effective and timely communication to our stakeholders and creation of linkages across sectors Brisbane South PHN has a sound knowledge of services and providers in our region and can identify opportunities for collaboration and partnership. As a key function of the organisation the External Engagement team will actively support the promotion and embedding of HealthPathways to ensure a high level of adoption.
Rationale	Supporting the rationale noted above, Health Pathways has a strong evidence base: • Gullery C, Hamilton G. Towards integrated person-centred healthcare – the Canterbury journey. *Future Hospital Journal Vol 2, No.2:*2015;111-6 • McGeoch G, McGeoch P, Shand B. Is HealthPathways effective? An online survey of hospital clinicians, general practitioners and practice nurses. http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1408/6413 • Schluter PJ, Hamilton GJ, Deely JM, et al. Impact of integrated health system changes, accelerated due to an earthquake, on emergency department attendances and acute admissions: a Bayesian change-point analysis. *BMJ Open 2016*;6:e010709. doi:10.1136/bmjopen-2015-010709 • Primary Health Care Advisory Group. *The Better Outcomes for People with Complex and Chronic Conditions report*. Department of Health, Canberra, 2015
Strategic Alignment	As highlighted above the integrated care pathways innovation activity addresses locally identified barriers and challenges (Priority area 10: eHealth – an enabler to issues noted across multiple health areas), as well as the strategic intent of the PHN programme - improving efficiency and effectiveness of medical services for patients (particularly those at risk of poor health outcomes) and improvising coordination of care to ensure patients receive the right care at the right place it the right time. It achieves this through locally developed pathways, agreed at a "system-level" across acute and primary care that are easily accessible and adopted by General Practitioners and primary health providers. This informs care treatment decisions, local alternatives and options, and over time shifts the use of expensive hospital services towards those who need it most. The *Better Outcomes for People with Complex and Chronic Conditions* report highlights the need for established Health Care Pathways between Health Care Homes, LHNs/PHNs and PHIs as a key component to better coordination and appropriate care. The report notes the benefits of local health care pathway development – defining how care is delivered, assisting with patient activation and joint direction of care, and minimising unwarranted variation from best practice. Introducing Pathways is seen as a core foundational step in supporting Health Care Homes, critical 'to providers who enrol patients with chronic and complex conditions', at a patient population level 'for those with needs that traverse community-based and hospital based services' and will support the evolution of

	the Health Care Home in the Brisbane South PHN region. Specifically the report showcases HealthPathways, which is the preferred solution by Brisbane South PHN and MSH.
Scalability	Already scalable as shown in NZ, and used in other PHN areas. By looking at a pathway solution that is consistent with other QLD sites, efficiencies can be gained reducing rework and leveraging development, as well as a level of consistency across the state.
Target Population	Approx. 1325 GPs, 7 public hospitals (6x MSH and 1x Mater), pathway development to be prioritised based on need (Whole of Region Needs Assessment) and cohort demand on hospital services (wait list/access concerns), as well as provider readiness (MSH and general practice). Patients moving between primary and acute services will be the beneficiaries.
Coverage	This will be established across the entire Brisbane South PHN region. Pathways will be prioritised based on greatest impact/value and readiness of stakeholders.
Anticipated Outcomes	**Outcomes** 1. Increased access to and timeliness of care (referrals, wait lists, hospital alternatives, potentially preventable hospitalisations) — Longer term 2. Patient Experience (including care options/choice) — Longer term 3. High levels of stakeholder satisfaction — Short term 4. Relationship Capital — Short term 5. Utilisation of pathways — Short term 6. Improved health professional knowledge — Short term
How will these outcomes be measured	A draft evaluation plan has been prepared (MSH with input by Brisbane South PHN) which is longitudinal in design. Data collection will include review of project documentation, records and registers, website analytics and hospital system and referral data. Additionally, data will be collected from participant feedback surveys, interviews, focus groups and website analytics. Sampling of participants will be both targeted and random, dependent on the measure being evaluated
Indigenous Specific	HealthPathways is inclusive of the total population; needs which are specific to Indigenous peoples will be addressed in the development of development the various pathways.
Collaboration	Metro South Health, Mater Health Service, Queensland Health – Clinical Prioritisation Criteria project. Linkages to other PHN/HHS HealthPathway sites in Qld.
Timeline	Immediate implementation Quarter 1 2016-17 with ongoing phased pathway development over the two years.

Proposed Activities	**Description**
Activity Title / Reference	**IN 1.2 Health Care Home Foundations –building General Practice's capacity for the management, support and coordination of patients with chronic and complex conditions.**
Description of Activity	The establishment and implementation of the Health Care Home model of care will involve significant change for primary care. The Health Care Home model of care will transform the way primary care treats and manages patients, profoundly affecting the business and operating models of general practice. These changes, as has been shown internationally, are significant and can be received in varying ways ranging from resistance to acceptance. Brisbane South PHN's needs assessment and 'area intelligence' indicates there will be significant challenges in the move to Health Care Homes, many of these challenges are associated with change fatigue across primary health providers as well as the diverse variation in operating models. Brisbane South PHN is uniquely placed to work with primary health providers over the next two years to address some of these challenges and build the capacity of the primary health care service system to adapt and align to the Health Care Home model of care. Brisbane South PHN already undertakes a significant amount of work which aligns with the eight parameters for PHN Health Care Home activities. However Brisbane South PHN has not undertaken any coordinated effort and work to bring together these disparate activities to form a cohesive vision of what Health Care Homes will look like in the Brisbane South context. Brisbane South PHN proposes to undertake the following activities aligned with the Framework for activities to support a Health Care Home approach in primary care. This will bring together new and existing initiatives into one overall strategic plan of integrated primary health care for the Brisbane South Region. This work will be achieved through the development of a refreshed strategic plan. This process will unify key stakeholders around shared models of coordinated and integrated care and set a new and refreshed agenda based on shared goals and strategies for how primary health care systems in the Brisbane South region will be high performing in delivering improved patient outcomes. Activities include: 1. Creating a practice wide vision with concrete goals and objectives for implementation for implementation of Health Care Home 2. Brisbane South PHN strategic realignment to positively gear the organisation for the Health Care Home initiative 3. Comprehensive general practice profiling 4. Change impact assessment

	5. Establishing and delivering practical support to general practices to facilitate their transition toward a Health Care Home **1. Creating a practice wide vision with concrete goals and objectives for implementation for implementation of Health Care Home** (Framework parameter 1) 1.1 *Supporting stakeholder information, business planning and message leadership*: providing information to general practices, doctors, hospitals, allied health professionals, community sector organisations and community pharmacies on what the Health Care Home approach will mean for them including working with them to understand and maximise individual stakeholder concepts of the Health Care Homes in a way that enables them to plan their desired future transformation in a way that is consistent with national and regionally specific priorities. **2. Brisbane South PHN strategic realignment to positively gear the organisation for the Health Care Home initiative** *(commencing Q2 – Q3 FY17):* 2.1 *Strategic Planning Refresh* – Brisbane South PHN will refresh its strategic plan to more closely align with the PHN's role as leaders in facilitating system transformation and cultural change that will occur with the Health Care Homes model. The re-development and re-alignment of the strategic plan will be completed in partnership with Metro South Health aligning Brisbane South PHN and MSH with a common vision of the health system and the role the Health Care Home will play in changing both the primary and tertiary care landscapes. 2.2 *Staff Development* - as part of the changes happening in the external environment it is paramount that the organisation's internal resources are appropriately skilled to facilitate the transformation of the primary health care service system and the organisations they work alongside day-to-day. 2.3 *Project Repositioning* - many of the projects contained within Brisbane South PHN's approved annual activity plan either currently, or with relatively minor adjustment, support the seven principles for a health care home. Brisbane South PHN will review and where appropriate re-align elements of those projects to more specifically focus on the Health Care Home model of care. This will be achieved without compromising the scope and outputs outlined in the Annual Activity Plan. Realignment of these projects (e.g. Optimal Care) within an overarching Health Care

Home program of work will remove duplication risk and will support more coordinated and targeted investment- redesigned towards building the proposed health care home model

2.4 *Knowledge transfer* to the Brisbane South PHN 'business as usual' Area Account Management team will ensure learnings, tools and evaluation findings from the intensive 18month – two year Health Care Home foundations project can be built upon for future stages of transition to the Health Care Home. Importantly this knowledge will benefit the design of future General Practice based service/model changes and will be embedded sustainably into Brisbane South PHN's approach to planning, engagement and design.

3. Comprehensive General Practice Profiling (Brisbane South PHN has over 300 general practices), involving the following steps:

3.1 *identifying the diversity in General Practice* operating / business practices involving complex patient chronic disease management

3.2 *analysis of the current Practices* to determine strategies and areas of focus for foundational activities to transition practices to Health Care Home. This profiling would be a significant change from previous service mapping. It will focus on areas such as organisational maturity, the practice's business models, approach to complex chronic disease patient management, arrangements with contractor GPs, systems for tracking patient engagement, workforce models, appointment management methods, budgeting management methods, clinical leadership traits, team based care arrangements including linked/networked allied health, pharmacy and community providers and continuity of care. (Q2FY17 – Q3FY18).

3.3 *identify those General Practices and practice models that are most suitable for a transition to a Health Care Home*

4. Change Impact Assessment

Change impact assessments and foundation plans/roadmaps will be developed from the comprehensive general practice profiling. This will focus on how best to build sustainable capacity for a transition to Health Care Home. This will include case studies from a range of practices and the implications a Health Care Home would have on their practice. Brisbane South PHN will intensively work with selected practices on how they can over the next 18 months-two years build the foundational Framework parameters that will better support their transition to a future Health Care Home model of care. (Q3FY17 – Q2FY18)

5. Establishing and delivering practical support to general practices to facilitate their transition toward a Health Care Home

As a non-pilot site Brisbane South PHN will use a 'fast follower' mentality and 'cherry pick' in adopting work undertaken by the trial sites, meaning that Brisbane South PHN can ensure the best materials inform preparedness within the Brisbane South region. It is expected that this work will occur from Q1FY17 and will work towards building capacity in primary care for the forth coming changes.

5.1 Development and implementation of General Practice capacity building support as identified through the practice plans/roadmaps. This will support sustainable capacity building in the management of complex chronic disease patients across the foundational parameters of the Health Care Home *Framework*. This may include the development of localised best practice guides and training and development programs, leveraging learning from trial sites and DoH developed resources.

5.2 *Dedicate in-field resources:* It is proposed that Brisbane South PHN invests in dedicated in-field resources to support these activities. This would be a new targeted support offering (see budget for FTE descriptions), establishing high level expertise 'on-the-ground' in complex chronic disease patient management, across all Health Care Home Framework parameters key to building capacity in General Practice for the future.

5.3 *Topics to be covered*: It is envisaged that this work would be directly relevant to the identified capacity needs of General Practices and cover topics such as:

- Developing Clinical Leadership (Framework parameter 1)
- Patients, families and their carers as partners in their care (the patient team partnership) (Framework parameter 4)
- Managing Change (Framework parameter 1)
- Working alongside Allied Health Professionals (Framework parameter 3)
- Flexible service delivery and team based care and building local team-care provider networks (Framework parameter 3)
- Using technology to better support patients and managing patient flow (Framework parameter 2)
- What bundled payments mean and how they change care (Framework parameter all)
- Expand the PHN's education to focus on supporting and educating primary care providers to proactive care coordination in partnership with MSH (Framework parameters 6 & 8)

5.4 *Data-driven improvement* using computer-based technology and Improved Access to Care (Framework parameters 2 and 7). Brisbane South PHN will make strategic investments to expand existing digital health work

	towards supporting improvements in the collection, management and use of patient data to enable better patient care (through increasing the reach of digital health programs), and technology that supports alternate access to care delivery, continuity of care and integration of shared care between HHS and General Practices 5.5 *Team-Based Care, Patient-Team Partnerships and Comprehensiveness and Care Coordination* (Framework parameters 3, 4 and 8): Brisbane South PHN will make strategic investments to supporting the development of partnerships between primary care providers and other care providers, including allied health professionals and hospital based clinicians – establishing a 'medical neighbourhood' built around the patient's preferred clinicians. This will support whole-person care provided by a team of care providers, where the patient is empowered and engaged as a partner in their care.
Rationale	Supporting the rationale noted above, Health Care Homes and the activity proposed has a strong evidence base: • Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. (2014) The 10 building blocks of high-performing primary care, Annals of Family Medicine. Mar-Apr, 12 (2) pp 166-71. • Department of Health, *Framework for activities to support a Health Care Home approach in primary care* • Royal Australia College of General Practitioners, *Vision for general practice and a sustainable healthcare system*, RACGP, Melbourne, 2015. • Primary Health Care Advisory Group. *The Better Outcomes for People with Complex and Chronic Conditions report*. Department of Health, Canberra, 2015 • Western Sydney Primary Health Network, *Transforming Primary Care: The Patient Centred Home in Western Sydney*. Sydney 2016
Strategic Alignment	The *Better Outcomes for People with Complex and Chronic Conditions* report highlights the need to establish Health Care Homes, and the role PHNs should play in this transformation. PHNs role as a facilitator of this transformation has been well acknowledged by the Department of Health and the Minister. By re-aligning strategy and operations to be more Health Care Home focused it will enable Brisbane South PHN to be aligned with the strategic intent of primary healthcare providers in the region, and the future direction of the sector as a whole. Brisbane South PHN also sees this new approach aligning better with the strategic aims of the relevant HHSs and Queensland Health – empowering primary care to keep people out of hospital wherever possible.
Scalability	The Health Care Homes Development project has been designed to be scalable and has been designed with the differences that might impact scalability in mind – e.g. different geographic or socio-economic situations.
Target Population	Approximately 1325 GPs, 344 Practices Patients with a Chronic Disease will be the direct patient beneficiaries.
Coverage	This will be established across the entire Brisbane South PHN region.

Anticipated Outcomes	**Outcomes** 1. A refreshed strategic direction which consults, prepares and unifies the primary health care sector in working toward the implementation of the Health Care Home model of care — Short term 2. Formalised agreement and related plans for a shared approach between Brisbane South PHN and MSH supporting the implementation of the Health Care Home model of care — Short term 3. Improved capacity (knowledge and operating models) of the Brisbane South primary health care sector to adopt Health Care Homes (80% of general practices will be profiled by 30 June 2018) — Longer term 4. Set of tested Health Care Home implementation tools, resources and strategies that deliver relevant support to general practices — Short term 5. Identification of Health Care Home 'ready to go' general practices in anticipation of the continued roll out of the Health Care Home model of care — Short term 6. Identification of patient cohorts who will benefit from access to care based on the Health Care Home model — Short term 7. Improved health literacy related to understanding of the Health Care Home model — Longer Term 8. Sector acceptance of the Health Care Homes initiative as a new and effective method for improved integration and coordination of care for patients with chronic and complex health conditions — Longer Term 9. Increased knowledge of and preparation for Health Care Home of Primary Care Providers — Short term
How will these outcomes be measured	A monitoring, evaluation, reporting and improvement (MERI) framework will be developed in consultation with key stakeholders, the Department and where possible with relevant other HCH trial sites. The MERI framework is essential to ensure the lessons learnt in the progressive implementation of the Health Care Homes approach in the Brisbane South PHN region are reported back in real time to improve implementation. The MERI framework will include the engagement of external, independent evaluators with experience in monitoring health sector performance. Evaluation objectives include: • The MERI will focus on process, output, outcome and cost effectiveness (including financial impact on practices) monitoring and evaluation • Success of overall practice capacity development – compared to initial baseline profile. • Assessed coverage of foundational Health Care Home Framework parameters across Brisbane South PHN region Practices, including the effectiveness of associated development activities, and the remaining change gap for transitioning to future Health Care Home models of care. • General Practice Model variations – learnings and recommendations for future application (including barriers/constraints – service, workforce, financial, business process etc)

Indigenous Specific	Health Care Homes Development is inclusive of the total population; needs which are specific to Indigenous peoples will be an integral part of the project.
Collaboration	Linkages to other PHNs, especially those Health Care Home trial sites.
Timeline	Immediate commencement with activity continuing until 30 June 2018, with transition supported as Health Care Homes are rolled out more broadly.