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phn
An Australian Government Initiative

Primary Health Networks Innovation Funding

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

North Western Melbourne 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 VicTasPHN@health.gov.au on or before 15 July 2016.

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

Introduction

This document presents the activity proposed for our innovation portfolio, which is jointly funded by the Innovation Fund and through a contribution from our Flexible Funds. Our innovation portfolio consists of a range of activities which will collectively support the implementation of the health care home model in Australia, and locally. This aligns with a long standing commitment by our organisation to the principles and intent of the health care home (patient centred medical home) model.

The health care home model itself represents an important innovation for the health system, and we have developed a suite of activities, which include both innovative and more traditional approaches, to support and embed change to improve the efficiency, effectiveness and co-ordination of locally based primary health care services.

- ✓ The health care home model represents a new and innovative approach to providing primary health care. This plan details a cohesive approach to implementing this innovation within the parameters set out by the Commonwealth.
- ✓ Supporting implementation of the health care home model aligns with the PHN Programme objectives to increase 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. The model provides a platform for delivery of a range of NWMPNH priorities, including improving care for people with chronic disease and mental health issues.
- ✓ Supporting implementation of the health care home model aligns with 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.
- ✓ The activities identified in our innovation portfolio go beyond, and clearly build upon, activities progressed through core funding and After-Hours funding.
- ✓ Supporting implementation of the health care home model aligns with locally identified priority needs, particularly with regard to improving the management of chronic disease, and improving access to care and coordination of care across settings. One of the defining features of the NWMPHN region is the complexity of the service system, and the health care home model provides an opportunity to cut through that complexity and improve the patient journey and outcomes for patients.

Overview of our approach:

1. **General practice readiness.** This involves an initial analysis of need which will be undertaken by asking practices to complete a self-assessment using a readiness tool. Based on the findings from this we will implement a multifaceted readiness strategy which incorporates:
    - Knowledge sharing and dissemination of evidence and best practice.
    - Intensive workshops focusing on readiness aspects that have been identified as highest priority.

- A round of Health Care Home grants aimed at supporting general practice to build their capacity.
- A Health Care Home Forum, to share the impacts of Health Care Home grants and to disseminate new insights and information.

2. **Complementary activity.**
   - Exploring the health care home model in the uniquely Victorian context, particularly in relation to the Victorian HealthLinks: Chronic Care initiative.
   - Establishment of the NWMPHN Health Care Home Advisory Group to engage with a broad range of stakeholders around the health care home model and to ensure that all our activities are driven by clinicians and significant stakeholders in our region.
   - Exploring research partnerships and opportunities to support research that will contribute meaningfully to our understanding of Health Care Homes in Australia.
   - Publication of *The health care home: What it means for Australian primary health care*. This activity is complete and therefore not further discussed in this proposal.

Proposal 1: General practice readiness

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	IN 1.1 General practice Health Care Home readiness self-assessment
Description of Activity	In order to understand the scope and scale of support general practices within our region will need to prepare for and begin implementing the health care home model we will undertake a general practice health care home readiness self-assessment project. This will involve: • Reviewing literature and consulting (both nationally and internationally) to determine whether there is an existing tool or one which can be adapted to suit our region. The review will involve identifying a broad range of tools, standards and critical success factors and either adopting, adapting or developing a self-assessment tool which can be then be implemented in our region. • Testing the self-assessment tool, both with our Health Care Home Advisory Group and through a small scale pilot in the region. • Implementing the self-assessment tool, with an aim to achieve 70 per cent completion within a four-month period. The self-assessment tool, along with supporting documents and reference material will be provided to practices, and our practice support team will also use visits and training events to support the roll out of the tool. Although the objective will be for practices to undertaken self-assessment, more targeted support will be provided as necessary. The findings from the self-assessment project will be used to establish a detailed understanding of the strengths and deficits within our region with regard to general practices being both ready and willing to transition to a health care home model. It is proposed that the assessment and analysis may focus on four domains of readiness (although this may change as a result of the literature review and consultation process): • Understanding of the health care home model. • Capacity building needed to implement the necessary structural changes associated with patient enrolment, different funding and billing mechanisms and reporting on costs and outcomes. • Capacity building needed to implement the necessary changes to the model of care being implemented. For example, identification of appropriate patients, care coordination and multidisciplinary approaches to care, integration with the community and tertiary sector and patient centred models of care. • Interest/willingness to make changes to implement the health care model.

Proposed Activities	Description
	The information gained through the self-assessment approach will be triangulated with our comprehensive understanding of the general practice sector within our region already, and will be tested with the Health Care Home Advisory Group.
Rationale	The readiness assessment will inform development of the readiness strategy to be implemented (see IN 1.2). We will develop a self-assessment tool with reference to the existing evidence base around appropriate tools, standards and critical success factors which have been shown to support a transition to a health care home model. Key references will include: • Better Outcomes for people with Chronic and Complex Health Conditions: Report to Government on the Findings of the Primary Health Care Advisory Group. • The Royal Australian College of General Practitioners (2015). Vision for general practice and a sustainable healthcare system. • Various publications from the Patient Centered Primary Care Collaborative. Others will be determined through the literature review and consultations.
Strategic Alignment	Supporting the implementation of the health care home model is consistent with the PHN objectives; directly reflects 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; and is consistent with locally identified priorities around improving the management of chronic disease and improving access to care and coordination of care across settings.
Scalability	We will publish the findings of our literature review, along with the self-assessment tool and supporting materials to ensure that other PHNs have access to our findings and resources.
Target Population	General practices within the NWMPHN region.
Coverage	Entire PHN region.
Anticipated Outcomes	Key outputs will be: • A report detailing the findings of the literature review and consultation process. • The self-assessment tool. • Roll out of the self-assessment tool and associate support. • An internal report detailing the findings from the self-assessment process. The outcome will be a detailed and nuanced understanding of strengths and deficits within our region with regard to general practices being both willing and ready to transition to a health care home model.
How will these outcomes be measured	The key output measures will be measured by: • Publication of the findings of the literature review and consultation process.

Proposed Activities	Description
	• Achievement of 70 per cent coverage of the self-assessment tool across the region. • Completion of the internal report detailing the findings from the self-assessment process. The key outcome will be measured through an independent evaluation to be conducted in mid-2018. Specific measures and data sources will be determined through the development of the evaluation framework.
Indigenous Specific	No.
Collaboration	It is likely that we will engage with a research institute or consulting firm to assist with the literature review and consultation process. Our key engagement structure will be the Health Care Home Advisory Group (see 2.2).
Timeline	Key activity in October 2016-March 2017, with ongoing work for the program officer over the two-year period.

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	IN 1.2 Multifaceted general practice readiness strategy
Description of Activity	Based on the findings of the self-assessment project we will design and implement a multifaceted readiness strategy which aims to boost the capacity of the general practice sector to transition to a health care home model. We understand that this will need to be a sophisticated, multi-faceted strategy that will need to be implemented over several years. We also understand that while the primary focus will be on building general practice capacity, we may also find that there is a need for a strategy to boost understanding and acceptance of a rationale for change. This change management process will be a critical part of the readiness strategy and will be further supported by complementary activities detailed in 2.1, 2.2 and 2.3. The details of the readiness strategy will be developed based on the findings of the self-assessment project, in consultation with the Advisory Group and other stakeholders. We also anticipate that the concurrent implementation of Commonwealth Health Care Home pilot may also inform our strategy. However, we do expect that the strategy will broadly involve four streams of activity: • Knowledge sharing and dissemination of evidence and best practice through development and dissemination of resources, development and publication of webinars and establishing mentoring arrangements. • Intensive workshops focusing on readiness aspects which have been identified as highest priority through the self-assessment.

Proposed Activities	Description
	• A round of Health Care Home grants aimed at supporting general practice to build their capacity. The grants will focus on building capacity in areas identified through the self-assessment project therefore it is not possible to define to scope of the grants until the self-assessment project has been completed. However, it is expected that capacity building around data quality, case finding (i.e. identifying patients with chronic and complex conditions for enhanced service provision) and (trialling, implementing and embedding) best practice models of chronic disease management would be the focus of the grants. The grants will not be used to support payment reform or alternative payment trials. We would expect that up to five grants of between $25,000 and $50,000 would be awarded. • A Health Care Home Forum, to share the impacts of Health Care Home grants and to disseminate new insights and information. The details, and relative investment in each of these streams is yet to be determined.
Rationale	We know that full and successful implementation of the health care home model in Australia will require a sustained and coordinated change agenda, which will need to be supported by government, PHNs and the primary health sector itself. Significant changes around patient enrolment and funding mechanisms will be necessary, and will be informed by the Commonwealth's Health Care Home pilot. However, the health care home model will only have the desired impacts if primary care providers are supported to adapt to new structural changes within the system, and change the way they provide care to improve patient outcomes.[1] [2]
Strategic Alignment	Supporting the implementation of the health care home model is consistent with the PHN objectives; directly reflects 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; and is consistent with locally identified priorities around improving the management of chronic disease and improving access to care and coordination of care across settings.
Scalability	While our strategy will be designed to meet the identified needs in our region, some components may be scalable to other PHNs including webinars, resources and learning materials. We will seek to negotiate with other PHNs are share scalable components and identify opportunities to achieve efficiencies across the PHN sector in doing so. The Victorian PHN Alliance already has systems and processes in place to support this approach.

[1] The Royal Australian College of General Practitioners (2015). Vision for general practice and a sustainable healthcare system.

[2] Ernst and Young (2015). A model for Australian General Practice: The Australian Person-Centered Medical Home.

Proposed Activities	Description
Target Population	General practices within the NWMPHN region.
Coverage	Entire PHN region.
Anticipated Outcomes	Key outputs will be: • The documented readiness strategy. • Implementation of the various components of the readiness strategy (including knowledge sharing and dissemination of evidence, intensive workshops, Health Care Home grants and the Health Care Home Forum). The outcome will be enhanced general practice capacity to implement the health care home model in the NWMPHN region.
How will these outcomes be measured	The key output measures will be measured by: • Finalisation of the readiness strategy. • Depending on the final components of the strategy, may include attendances at workshops, grants awarded and evaluated and delivery of the Forum. The key outcome will be measured progressively through evaluations of individual components of the strategy and through an independent evaluation to be conducted in mid-2018. Specific measures and data sources will be determined through the development of the evaluation framework.
Indigenous Specific	No, although we may tailor some components of the strategy to meet the needs of Aboriginal Community Controlled Organisations in our region if required.
Collaboration	It is likely that we will engage with a training provider to assist with the development and delivery of some components. Our key engagement structure will be the Health Care Home Advisory group (see 2.2).
Timeline	The readiness strategy will be launched in March 2017 and will continue through until June 2018. We expect that the Health Care Home Forum will be held in around November 2017.

Proposal 2: Complementary activity

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	IN 2.1 Exploring the health care home model in the uniquely Victorian context
Description of Activity	The Victorian government's *Health Links: Chronic Care* initiative aims to support public hospital funding reform and improve care for high risk patients (i.e. patients with chronic and complex conditions and who are high users of acute services). The initiative provides individual hospitals with an opportunity to use projected inpatient activity-based funding to design and deliver packages of care to eligible patients identified using a specified algorithm which takes into account age, unplanned admissions, emergency department presentations, chronic conditions, smoking status and place of residence. There are two first tranche Health Links sites in the NWMPHN region. We have been in direct discussions with one of these sites regarding how we can support their project. This provides a very real and direct opportunity to work in collaboration with a state funded initiative to change the way care is provided to high risk patients with a view to improving their outcomes, changing the way they access health care and ultimately realising cost efficiencies at an individual and systems level. To this end we will: • Work closely with the Health Links site/s to support changes to models of care for eligible patients, as relevant to the primary care setting and the primary/acute interface. • Support general practices with patients identified as eligible for Health Links to understand the implications, opportunities and their role in supporting an enhanced model of care. • Support the Health Links site/s as necessary with regard to access to data, insights and communication to support successful implementation of the approach. Each of these activities will be undertaken with strong reference to the health care home model which will therefore provide participating practices with enhanced access to capacity building relevant to health care home readiness.
Rationale	Successful implementation of the health care model in Australia is an ambitious undertaking which will require a sustained and coordinated effort to understand the implications in different settings and within different jurisdictions. While the Commonwealth Health Care Home Pilot will provide excellent insights into local considerations, we believe that complementary work is necessary to gain a full range of insights which will be needed to implement the model.
Strategic Alignment	Supporting the implementation of the health care home model is consistent with the PHN objectives; directly reflects 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; and is consistent with locally identified priorities around improving the

Proposed Activities	Description
	management of chronic disease and improving access to care and coordination of care across settings.
Scalability	This activity is not directly scalable beyond the Victorian context. We will share insights gained through this activity within the Victorian PHN Alliance.
Target Population	Health Links targets the highest risk cohorts of patients in our region, with multiple chronic diseases and high unplanned hospital admissions and presentations at emergency departments.
Coverage	Health Links sites. It is likely that the majority of this activity will occur in the western part of our region.
Anticipated Outcomes	The outcomes will be: • Enhanced collaboration between the primary and acute sector, particularly around core health care home features including risk stratification and models of care. • Enhanced implementation of local Health Links projects, leading to improved outcomes for high risk patients and cost efficiencies across the system.
How will these outcomes be measured	The key outcomes will be measured through qualitative analysis with regard to enhanced collaboration. It is anticipated that the Victorian government will undertake a formal evaluation of Health Links at both a site and state level.
Indigenous Specific	No.
Collaboration	This activity will be pursued in close collaboration with Health Links sites.
Timeline	September 2016-June 2018, or until the activity is deemed to have no further relevance.

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	IN 2.2 Convene the North Western Melbourne PHN Health Care Home Advisory Group
Description of Activity	We will convene the NWMPHN Health Care Home Advisory Group to enable us to bring together and engage with a broad range of stakeholders around health care homes and to ensure that all our activities are driven by clinicians and significant stakeholders in our region. Through the publication of our paper *The Health Care Home: What it means for Australian primary healthcare*, and publicity through our existing channels we will call for expressions of interest to participate in the Advisory Group. We will also invite key stakeholder groups such as the Royal Australian College of General Practitioners (RACGP) to nominate a representative, and will invite members of our Clinical and Community Advisory Councils to nominate themselves if they have a particular interest in this work.

Proposed Activities	Description
	Based on the expressions of interest received we will convene an initial meeting to ratify the terms of reference and set a work plan for the group. It is our intention to have very strong general practice representation on the group. At this stage we propose that the Advisory Group will meet at least four times throughout 2016-17 and 2017-18. The Advisory Group will be asked to provide guidance and input into key aspects of our proposed approach to supporting the implementation of health care homes in the region, and to also act as champions and key informants within their own networks. The Chair will act as a clinical lead for our health care home work.
Rationale	Engaging clinicians in change agendas is likely to lead to better planning and implementation, as well as enhanced buy-in from the very people who are being relied upon to change their behaviours and practices.[3] This illustrates the importance of clinicians being engaged in the health care home agenda throughout the process, and having strong buy in to the early design, implementation and evaluation of the model.
Strategic Alignment	Supporting the implementation of the health care home model is consistent with the PHN objectives; directly reflects 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; and is consistent with local identified priorities around improving the management of chronic disease and improving access to care and coordination of care across settings.
Scalability	This activity is not directly scalable.
Target Population	NA
Coverage	Entire NWM PHN region.
Anticipated Outcomes	Key outputs will be: • Establishment of the Advisory Group. • Engagement with the Advisory Group through meetings and out of session work. The outcome will be enhanced clinical input into our work, and enhanced local clinical leadership. We anticipate that clinical ownership and leadership will be domains within the formal evaluation of the general practice readiness strategy, and will seek to include specific measures and data sources in the development of the evaluation framework.
How will these outcomes be measured	The key output measures will be measured by:

[3] Clarke J & Nath V. (2014). Medical Engagement: A journey not an event. The Kings Fund.

Proposed Activities	Description
	• Successful recruitment to the Advisory Group. • At least four productive meetings of the Advisory Group. The key outcome will be measured through an independent evaluation to be conducted in mid-2018. Specific measures and data sources will be determined through the development of the evaluation framework.
Indigenous Specific	No.
Collaboration	This activity will be led and coordinated by NWMPHN, but will involve collaboration with a range of stakeholders to identify members and ensure strong general practice representation on the Advisory Group.
Timeline	The first meeting will be convened in October 2016, and the group will continue to meet throughout 2016-17 and 2017-18 or until such time as the group is no longer fit for purpose.

Proposed Activities	Description
Activity Title / Reference (eg. IN 1.1)	IN 2.3 Exploring research partnerships and opportunities to support research
Description of Activity	There is a strong interest in the Health Care Home initiative and the health care home model more generally within our region. Several organisations have approached us to discuss the implications of the model, and to discuss opportunities to work in collaboration with the PHN to contribute to the evidence base around implementation in the Australian context. Within the guidelines set by the Department of Health, we will use existing relationships and networks to support and contribute to local research projects which we believe are complementary to the Commonwealth Health Care Home pilot. Exploratory discussions have taken place with community health services around the implications of the health care home model for vulnerable and disadvantaged patient groups, and through the Inner North West Melbourne Collaborative[4] around understanding and responding to patient risk profiles.
Rationale	Successful implementation of the health care model in Australia is an ambitious undertaking which will require a sustained and coordinated effort to understand the implications in different settings and within different jurisdictions. While the Commonwealth Health Care Home pilot will provide excellent insights into local considerations, we believe that complementary work is necessary to gain to full range of insights which will be needed to implement the model.

[4] A long standing collaboration between NWMPHN, Melbourne Health, cohealth and Merri Community Health.

Proposed Activities	Description
Strategic Alignment	Supporting the implementation of the health care home model is consistent with the PHN objectives; directly reflects 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; and is consistent with local identified priorities around improving the management of chronic disease and improving access to care and coordination of care across settings.
Scalability	This activity is not directly scalable.
Target Population	Community health traditionally targets some of the most vulnerable people in our region, including those experiencing homelessness, intergenerational disadvantage and newly arrived migrants and asylum seekers. The Inner North West Melbourne Collaborative focuses on the interface between the primary and acute sectors at the local level.
Coverage	Entire NWM PHN region.
Anticipated Outcomes	While it is difficult to be specific about outcomes given the exploratory nature of this activity, it is anticipated that this work will contribute to a broader and more sophisticated understanding of the implications of implementation of the health care home model, which should in turn support a more successful scale of the pilot.
How will these outcomes be measured	The outcomes will be measured through qualitative analysis of the extent to which the PHN has contributed to and supported meaningful research projects.
Indigenous Specific	No.
Collaboration	This activity will be undertaken in close collaboration with a range of stakeholders including community health services, hospitals, other interested providers, consumer advocacy groups, research institutes and industry bodies.
Timeline	September 2016-June 2018, or until the activity is deemed to have no further relevance.