Australian Government
Department of Health

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An Australian Government Initiative

# Primary Health Networks Innovation Funding

***Western NSW PHN - 107***

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

| Proposed Activities | Description |
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| Activity Title / Reference (eg. IN 1.1) | **IN 1.1 High performing, sustainable and patient-centred primary health care in Western NSW** |
| Description of Activity | With an emphasis on the priorities identified in our needs assessment and strategic plan the innovation project aims to support primary care practices (general practice, Aboriginal Community Controlled Health Organisations [ACCHOs] and Aboriginal Medical Services [AMS]) in becoming high performing and patient-centred within a framework of financial sustainability. The project will focus on models of care to support integration of care, a priority identified in our needs assessment. Importantly, it focuses on building the financial sustainability of primary care by supporting the development of practice-based business models. Combining a focus on patient outcomes and experience, clinician experience and financial sustainability represents an innovative approach which addresses some of the key challenges of primary care.[1]<br><br>It is proposed to implement the project with estimated 20-25 voluntary practices clustered in four or five groups. Clusters will reflect the diversity of primary care in our region maximising opportunities for learning and networking across different types of practices. An evaluation framework will be developed to enable assessment of the impact of the project on clinical, experiential and financial outcomes, to facilitate shared learnings across the participating practices.<br><br>The project will be implemented over three interrelated stages:<br>**Stage 1: Understanding primary care activity and outcomes**<br>An audit of participating practices will be undertaken to better understand the processes, quality and outcomes of primary care. The data from this audit will provide a rigorous baseline for practices for assessment against their organisational clinical and business goals.<br><br>**Stage 2: Strategies to support primary care practices**<br>We will work with practices using methodologies such as those used in the productive general practice(PGP) [2] and lean methodologies[3,4] in priority areas identified by practices and reflecting those in our needs assessment. |

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| | Using the data from the audit in Stage 1, practices within clusters will identify their goals, priorities and clinical and business outcomes. The audit will also enable practices to determine key clinical and productivity data items for benchmarking within and between clusters.<br><br>These lean methods will be supported by a range of strategies aligned with the building blocks of primary care[5]. Strategies to build local and regional leaders in primary care to form a leadership community will be fundamental[6]. Opportunities will be provided for learning across practices within clusters building a culture of multidisciplinary/interdisciplinary collaborative learning[7].<br><br>Working within a business model framework is a new approach and addresses the challenge of financial sustainability faced by many practices[1]. It also aligns with the fourth of the quadruple aims[8] addressing clinician experience supporting recruitment and retention. Each practice will develop their own business model informed by the Lean and PGP methods. This plan will be monitored and reviewed over the period of project implementation with comparisons to the data at baseline from the audit. The results from the innovation projects will also guide service commissioning to ensure needs are being met.<br><br>**Stage 3: Building Sustainability and Scalability**<br>Throughout the project sustainability and scalability will be addressed. Each of the methods will systematically consider key determinants of sustainability in line with the Sustainability Model[9]. Our support of practice and regional leaders will support scalability across the region following the project completion. The development of best practice standards will support sustainability within participating practices and scalability across the region. |
| Rationale | In Australia and internationally primary care is the foundation of effective health care systems[10]. The majority of health care takes place in the primary care sector, with strong primary health care systems delivering a range of health outcomes for individuals and for populations.[11,12] These outcomes can be delivered cost-effectively by a strong primary health care system.[12,13]<br><br>The challenges of ageing populations, chronic disease, equity, and system and cost pressures have driven a range of health reforms across many developed nations.[14-17] Primary Health Networks were established in Australia in July 2015 with the objectives of 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. It is recognised that significant reform and innovation is required to achieve these objectives. |

**Stage 1 – Understanding primary care activity and outcomes**

It is widely acknowledged that data on comprehensive data on processes, quality and outcomes of care in general practice is limited.[18] In the absence of data significant system reform and improvement in outcomes for patients with chronic disease is unlikely. The recent report of the Primary Health Care Advisory group acknowledged that primary health care has not experienced the same national focus on data as other parts of the Australian health system.[19] This report also identified significant gaps in primary health care data and recognised the need for integrated data systems and reporting to support needs assessment and quality improvement processes.[19] This is particularly relevant for people with chronic conditions in general practice with evidence indicating that there is a need for considerable improvement in care management supported by data based quality improvement.[19]

Integrated clinical data is an essential foundation for gaining a better understanding of this population[20] and is considered a foundation for high performing primary care.[5] The audit framework will be developed in the context of the building blocks of high performing primary care[5], the quadruple aims[8] and Lean methods[3].

**Stage 2- Strategies to support primary care practices**

Implementing the innovation project in practice clusters provides opportunities for new models of care and specialised teams, joint training, shared learning, peer review and scale to invest in information technology.[21,22] It also supports participatory problem solving and enables the development of organisational cultures that promotes an open exchange of ideas, innovation, and system-wide incremental change.[23]

The use of evidence-based methodologies aims to support practices to put the patient, clinician and practice team at the centre of improvements within a business model. Productive General Practice (PGP)[2] developed by the NHS Institute for Innovation and Improvement supports general practices to adapt to the growing financial and clinical demands. This organisation-wide change programme, developed with general practice staff, supports general practices in promoting internal efficiencies and quality of care. Built on a foundation of understanding current processes and outcomes for patients the PGP is a practical application of LEAN based techniques that will increase the practice's capacity to achieve clinical and financial outcomes[3,4]. LEAN methods were developed in the automotive manufacturing industry, applied to various health care contexts, and have been shown to improve various efficiency and effectiveness related outcomes.[24] The proposed benchmarking process will facilitate

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| | learning opportunities and will also contribute to the development of best practice standards which can be applied across the PHN.[22]<br><br>Leadership is fundamental to transformation in health care.[5,25] The importance of engaging and supporting leaders at all levels and disciplines within practices is reflected in improved transformation outcomes associated with higher ratings of leadership.[25]<br><br>Collaboratives have demonstrated benefits for transformation in a range of clinical areas including primary care.[26] In addition to improvement in skills and knowledge, learning collaboratives have achieved outcomes related to confidence, self-efficacy, and peer-support.[23] They have also demonstrated benefits for culture in primary care supporting innovation , research and sustained practice review.[26] These outcomes are considered as foundations for sustainability.<br><br>**Stage 3 – Sustainability and Scalability**<br>Findings from a range of studies in the application of improvement methods suggest the need to focus on sustainability of transformational change,[24] however it is recognised that the sustainability of recommended practice is difficult to achieve.[9] Approaches to sustainability have identified the need to systematically consider key determinants of sustainability, provide timely data to assess progress, and prompt action to create conditions for sustained practice.[9] The sustainability model[9] developed by the NHS will guide the approach to sustainability in our program.<br><br>Our approach to developing leadership capacity across disciplines, a collaborative learning environment with shared learnings applied throughout project implementation and the development of best practice standards shared across clusters will support sustainability and scalability across the regions. |
| Strategic Alignment | The innovation project aligns with the national PHN objectives of:<br>• increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and<br>• improving coordination of care to ensure patients receive the right care in the right place at the right time<br><br>The project also aligns to the four regional goals for WNSW PHN:<br>1. Improve health outcomes through service integration<br>2. Work in partnership to improve Aboriginal health outcomes<br>3. Develop high quality programs and services<br>4. Support the development of a sustainable primary health workforce |

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| | Many GPs in our region are both in private practice as well as funded by the NSW Health as GP Visiting Medical Officers and therefore this project would also assist create consistent and more effective ways to better measure and improve performance against multiple goals including:<br>• NSW State and Commonwealth priorities<br>• Local health and service need priorities<br><br>The project combines a focus on clinical and business outcomes in the priority areas identified in our PHN's needs assessment and in our strategic plan. It will build the PHN's capacity to better understand the activity and outcomes of primary care, addressing Recommendations 12-15 of the Report of the Primary Health Care Advisory Group[19] and using these data as basis for transformation of primary care. In line with Recommendation 7 of the Report of the Primary Health Care Advisory Group,[19] projects will be implemented with an emphasis on integrated care, one of the priorities for the PHN, while achieving business sustainability for primary care practices.<br><br>Importantly the project aligns with key elements of the PHNs health needs assessment (HNA) related to 'Enhancing practice & improving quality of care.' This regional priority is consistent with the unique and significant rural and remote challenges the WNSW PHN faces regarding workforce capability, capacity and development.<br><br>The themes of 'Reframing services around a locally relevant, people & community centred health system & service improvement', 'Sustainable development of primary health care & integration between providers' and 'Improved health outcomes in priority areas' also included several general practice and ACCHO related 'place-based' opportunities relevant to this project such as:<br>• the need for greater consistency around lifestyle referrals across sites in the region,<br>• opportunities for more consistent use of health promotion resources and approaches, and<br>• PHN supported implementation of best practice models of care at a sub-regional level leveraging off of existing primary health care reform opportunities such the 'stepped care' Mental Health opportunity articulated by the Commonwealth as well as the various State funded integrated care demonstrator activities being promoted across our region.<br><br>Specifically, the project's various innovations will impact the following HNA priority areas:<br>1.1 Workforce Planning<br>1.3 Enhancing practice & improving quality of care<br>3.1 Aboriginal Health planning |

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| | 4.1 Integration and Collaboration<br>5.1 Regional planning<br>6.2 Chronic Disease management<br>7.1 Access<br><br>Similarly, the project would also align with and build on the following PHN annual work plan activity:<br><br>Core Funding Annual Plan 2016-2018<br>• NP 1.1 Regionally Integrated Allied Health Services, Early Intervention and Health Promotion<br>• NP 1.2 Western NSW Health Planning, Integration and Coordination<br>• OP 1 Workforce Support to Enhance Practice and Improve the Quality of Care<br><br>Integrated Team Care<br><br>Annual Mental Health Activity Work Plan 2016-2017<br>• Priority Area 3: Psychological therapies for rural and remote, under-serviced and /or hard to reach groups<br>• Priority Area 7: Stepped care approach |
| Scalability | The innovation project has a number of key elements that support scalability:<br>• it will apply evidence-based models to support transformation in primary care<br>• By focusing on data from the Stage 1 audit it will provide a better understanding of the activity and outcomes of primary care practices, and use these data to inform innovation strategies and assess impact<br>• It will build the capacity of leaders and other clinicians and administrators in lean methods which can be applied with practices and transferred more broadly across the region<br>• It will use benchmarking across practices to enhance performance in line with the building blocks of primary care[5], enabling the development of best practices standards which will be applicable across the region<br>Importantly it will address one of the key challenges of primary care practices, by implementing the innovation projects within a business model framework. |
| Target Population | Our region has a population of over 309,000 people, with 12% of people identifying as Aboriginal and Torres Strait Islander. Almost half (45.6%) of the PHN Aboriginal population are aged under 20 years compared to a quarter (24.7%) for the same age cohort for the non-Aboriginal population. Population projections show that the proportion of the population aged 65 years and over will rise from 18.5% in 2016 to 24.1% in 2031.<br><br>The SEIFA 2011 (Socio- Economic Indexes for Areas), the Index of Relative Socio-economic Disadvantage (IRSD) shows that more |

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| | than 80% (85.7%) of the 28 LGAs within the PHN boundaries have a SEIFA IRSD in the 50% most disadvantaged deciles nationally. More than a third of the LGASs (35.7%) are classified in 1st and 2nd deciles for the most disadvantaged nationally.<br><br>The PHN HNA identified that our region had the highest levels nationally of patients who believed they had to wait an unacceptable time to get an appointment with a GP. It is also the second lowest PHN nationally for adults who access a preferred GP in the preceding 12 months. Our region also has the second lowest average number of after-hours GP attendances compared with peer PHNs demonstrating a need to focus on primary care access.<br><br>More than half (55%) of our population has a chronic illness and we have higher rates of circulatory system health problems and diabetes compared to the national rate. There are also 1303 preventable hospital conditions due to chronic illness per 100,000 people. Conservative estimates in Australia identify that the cost of potentially preventable hospital admissions from chronic disease are $322 million per year.[18] In particular people experiencing disadvantage have worse health outcomes.[27] Aboriginal and Torres Strait Islander people experience higher rates of chronic and preventable illnesses compared with non-Indigenous Australians.[27] Evidence shows that a consistent approach to clinical care pathways for specific chronic diseases can make a real difference to outcomes and ultimately to costs of health care.[18] |
| Coverage | The WNSW PHN covers a total area of 433,379 square kilometres, over more than half (55%) of the total land mass of NSW, making it the PHN with the largest geographical coverage in NSW. With 4% of the state's population (2016 estimated resident population – ERP) this low population density presents challenges for the provision of health care. While much of the population is concentrated in a number of larger regional towns (Dubbo-41,950, Bathurst -42900, Orange - 41250) there are many smaller dispersed communities across the area. Population projections for 2013-2031 suggest that 8 of our Primary PHNs' 28 local government areas (LGAs) will have a positive population growth. In particular Bathurst, Orange and Dubbo are estimated to all reach populations close to 50,000 people by 2031. However, the remaining 21 LGAs will show negative growth (Lachlan the greatest -23.2%).<br><br>Western NSW Primary Health Network covers both Far West and Western NSW Local Health Districts across Western NSW PHN supports 332 General Practitioners that operate from over 100 GP practices in our region. |

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| | Difficulties recruiting and retaining a skilled health workforce are acknowledged in rural and remote areas which is reflected in our PHNs priorities. Addressing the fourth of the quadruple aims[8], our innovation project will target clinician experience with strategies supporting capacity building while addressing business sustainability. |
| Anticipated Outcomes | The outcomes of the innovation relate to the innovation program objectives which align to those identified in our strategic plan<br>• Reduced preventable hospital admissions<br>• Reduced health risk factors<br>• Positive patient experience<br>• Improved screening rates for cervical breast and bowel cancers<br>• Improved immunisation rates<br>• Positive clinician and stakeholder experience<br>• Increased capacity of general practice to deliver multi-disciplinary care<br>• Improved primary health care service access<br>• Improved interface between primary and secondary care |
| How will these outcomes be measured | In addition to the data identified by Stage 1 of the innovation project our outcomes will be measured through<br>• Preventable hospital admissions data<br>• Primary health care data (MBS)<br>• HealthStats NSW data<br>• Patient and Stakeholder experience surveys<br>• Number of models of integrated care<br>• Number of practices implementing integrated care<br>• Number of patients with care plans |
| Indigenous Specific | The initiative supports improved health outcomes for Aboriginal and Torres Strait Islander people. The collaboration with ACCHOs and AMS and with the support of the Aboriginal Clinical Council will ensure the initiatives are implemented to support those Aboriginal and Torres Strait Islander people with across the health system. |

<table>
<tr><td>Collaboration</td><td>We will work collaboratively with primary care practices across our region. Partnerships will be key to the implementation with support from Western and Far Western Local Health Districts and involvement of our two Clinical Councils, and Aboriginal Health Council. These partnerships will be reflected in the governance of the initiative and will be supported by a communication and engagement strategy.</td></tr>
<tr><td>Timeline</td><td>The time frames and milestones are outlined in the table below. The project will be implemented between November 2016 and March 2018
<table>
<tr><th>Key Stages and Steps</th><th>Milestones</th><th>Timeframes</th></tr>
<tr><td colspan="3">Stage 1 Understanding primary care activity and outcomes</td></tr>
<tr><td>Engagement and Visioning</td><td>• Communication and Engagement Strategy Developed<br>• Engagement and visioning workshop<br>• Agreement from 20-25 participating practices<br>• Clinical and business priorities agreed<br>• Clusters Established</td><td>November 2016 – February 2017</td></tr>
<tr><td>Audit</td><td>• Audit framework agreed<br>• Audit implementation across participating practices<br>• Audit report completed<br>• Clinical and business priorities reviewed</td><td>December 2016 – April 2017</td></tr>
<tr><td>Evaluation Framework</td><td>• Evaluation Framework developed<br>• Evaluation Framework implemented<br>• Evaluation Reports completed 6 monthly and at project completion</td><td>November 2016 – March 2018</td></tr>
<tr><td colspan="3">Stage 2: Strategies to support primary care practices</td></tr>
<tr><td>Lean and PGP workshop</td><td>• Participating practices have</td><td>May 2017</td></tr>
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| | | trained clinicians and administrators | |
| | Business model training | • Participating practices have trained clinicians and administrators | June 2017 |
| | Lean and PGP implementation | • Implementation in all participating practices relevant to cluster priorities<br>• 3 monthly cluster reviews<br>• Collaborative learning and mentoring opportunities identified and implemented | May 2017 – February 2018 |
| | Business Model Support | • Participating practices have business plans with agreed outcomes<br>• Implementation in all participating practices relevant to practice priorities<br>• 3 monthly cluster reviews | June 2017 – February 2018 |
| | Leadership Development | • Leadership training implemented<br>• Leadership opportunities provided across clusters | July 2017 – March 2018 |
| | **Stage 3: Building Sustainability and Scalability** | | |
| | Sustainability Model | • Implementation of scalability model | May 2017 – February 2018 |
| | Best Practice Standards | • Development, ratification and implementation of best practice standards | September 2017 – February 2018 |

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