Australian Government

phn WESTERN QUEENSLAND

An Australian Government Initiative

WESTERN QUEENSLAND PHN

Activity Work Plan 2016-2018:

WQPHN Integrated Care Strategy and Regional Proof of Concept Sites

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.

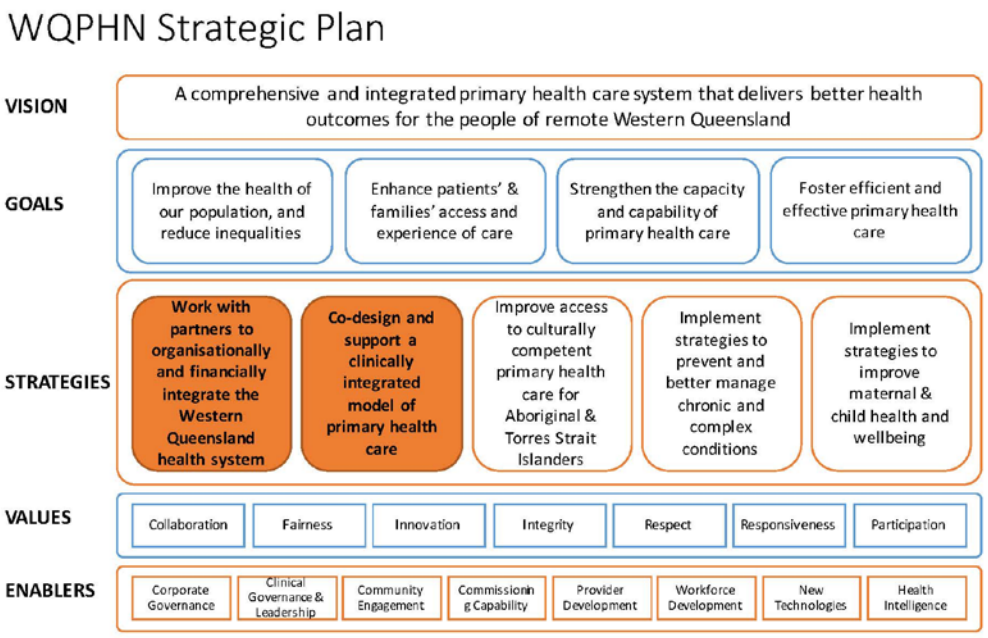
In line with these objectives, the current PHN Innovation Funding stream will support PHNs to engage in innovative approaches and solutions that improve the efficiency, effectiveness and co-ordination of locally based primary health care services.

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 (e.g. 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.

Strategic Vision



Planned activities funded under the Activity

Proposed Activities	Description
Activity Title / Reference)	**Western Queensland Integrated Care Strategy (IN WQICS)**
Description of Activity	The Innovation Funding will support the development and implementation of the Western Queensland Integrated Care Strategy over the next two years. The development of the WQICS is in line with the WQPHN Strategic Plan and will provide an implementation framework to innovate the planning and delivery of primary health care services in Western Queensland. There is presently a unique and unprecedented opportunity for collaboration to support greater primary health care performance and innovation in the WQ catchment. • The health needs of the region's population have never been greater nor in greater contrast to the rest of the Australian population, particularly in the more remote areas; • There are deeply entrenched behaviours in populations and providers which require a whole of system change to turn the curve of health inequity and disadvantage; • There is a chronic lack of systemisation within the primary health care delivery system and this will not change without strategic leadership and movement to an outcomes focus; • Unless immediate action is undertaken to support whole of government change and alignment, the ideology of universal healthcare for the regions populations commensurate with the rest of their Australian counterparts will not be progressed. On the other hand, the timing of the emergence of the WQPHN as a new Commissioning organisation and

	uncompetitive primary care partner of HHS and ACCHO organisations couldn't have been better. • The WQPHN has collaboratively developed and launched its Strategic Plan with clear intent to move to greater organisational and financial integration; re-orientation of systems to amplify locally available services, distinguishing the ACCHO sector as a crucial affiliate in WQ, and a clear purpose to redefine universally accepted models of care to optimise management and prevention of chronic conditions (including mental health) and secure vastly improved maternal and childhood indicators. • The Three HHS organisations and the WQPHN have progressed an historic Joint Protocol which provides the framework for increased governance alignment to support integrated primary health care outcomes. • A number of joint planning initiatives are well underway with co-design and ownership including the Lower Gulf Strategy in the NW in collaboration with NWHHS and Gidgee healing; the One practice model in the CWHHS, and the Joint 10 year strategic plan in the SWHHS. • The emergence of the Queensland health Integrated Care Innovation Fund provides a unique opportunity to gain leverage and greater collaboration at the PHN catchment level, with the Western Corridor project approved in 2016-17 – 2017-18. • Emerging General Practice Workforce collaboration HWQ, QAIHC and HHS's to examine new approaches to respond to the chronic lack of systemisation in General Practice across many areas of the catchment • Development of a Strategic Protocol between QAIHC and WQPHN to progress joint collaboration in relation to shared health intelligence, quality improvement and model of care development within the catchments ACCHO organisations The WQPHN Integrated Care Strategy and its Implementation Plan aim to transform existing primary care services in the region into an integrated system of care that is tailored to the needs of rural and remote communities and improves access to care and health outcomes, with a particular focus on closing the Aboriginal health gap.

	The Strategy and Plan is innovative because while individual organisations may have commenced early planning around new integrated care initiatives in recent times, the formal process of jointly developing and implementing the Strategy will provide the means to establish better connections between different health services at the local level, and closer, more creative partnerships with PHN's partners organisations, in particular Queensland Health and the three Western Queensland HHSs, QAIHC and the region's ACCHOs, private general practice and the RFDS. Key elements of the Strategy and Plan will include: • a robust overarching governance partnership to provide strategic direction and oversight of the Strategy and Plan; • joint commissioning activity that directs State and Commonwealth resources to support new local models of integrated care and monitors their outcomes; • effective clinical engagement and leadership from the region's primary care and local hospital services for the Strategy and Plan; • the development of a Health Intelligence capability to support an evidence-based approach to making decisions; • consolidating and leveraging from current integrated care initiatives being pursued by our key partner organisations; • incorporating Commonwealth, State and regional level enabler activities to support local innovative integrated care initiatives; • the establishment of proof of concept sites to develop and progress approaches to integrated care that appropriately address the coordination and provision of services, in full understanding of local factors that might impact on this integration; and

	• quality evaluation and shared learning mechanisms both locally and across the region. The development and implementation of the Strategy will run over the two years of the Innovation Funding period, 1 July 2016 - 30 June 2018. Key milestones will include: • formalisation of the joint governance partnership group to oversee the Strategy and Plan within the first 2 months; • engagement of a qualified consultant to develop the Strategy and Plan and provide strategic oversight of the roll-out within the first 3 months; • finalisation of the Strategy and Plan within the first 6 months. The plan will set out the work program for the region over the final 18 months of the Innovation Funding period; • establishment of Health Intelligence capability to support implementation and evaluation of the Strategy; • establishment of clinical leadership committee to provide expertise, advice and governance to the governance group; • development of two local proof of concept sites to trial innovative integrated models of care including the adoption of key enablers within the framework of high performing Primary Care; • program management frameworks developed for each trial site to support their progress; and • evaluation frameworks developed for each trial site and KPIs set and being captured. The Integrated strategy will adopt a modified *Building blocks of Primary Care Assessment Tool (BBPCA)* Assessment Tool to help guide the implementation and analysis / evaluation within the proof of concept sites. Specifically, the WQPHN will jointly work with respective HHS and ACCHO organisations (including QAIHC), general practice entities

	and workforce agencies, and provider networks within a nominated clinical hub (supra-region) in the CWHHS (Longreach clinical hub) and the SWHHS Charleville clinical hub (supra region) in the SWHHS.
Rationale	Over the last 12 months the WQPHN (Strategic Plan 2016-2020), Queensland Health (Integrated Care Innovation Fund) and QAIHC (Strategic Plan 2016-2019) have independently been pursuing innovative integrated care for their local populations. However the region-wide Western Queensland Integrated Strategy will provide a blueprint for a collective approach to integrated care, an injection of funding to further drive change and adoption, a stronger partnership to nurture a system-wide approach rather than discrete initiatives, a framework that sets the scene for locally lead integrated care initiatives and the identification of ongoing funding to ensure sustainability. The unique PHN Board membership provides an opportunity to strengthen organisational linkages, and leverage change and the adoption of a system of care that is based around the needs of the individual, provides the right care in the right place at the right time, and makes sure finite dollars are applied in the most effective way. Achieving the triple aim of health reform within WQPHN - better health, improved patient experience and more affordable costs – is dependent on a foundation of a comprehensive primary health care system available within local communities. It requires a vigorous effort to re-engineer primary care systems and practice to create a better connected, easier to navigate and higher quality service for the communities of western Queensland. The unique role of the PHNs as commissioning organisations, combined with the emerging roles of the Clinical Councils and Consumer Advisory Councils; create a strong value move toward greater whole-of system transformation, and an integrated care strategy is a universally accepted mechanism through which to achieve these outcomes.
Strategic Alignment	The Western Queensland Integrated Care Strategy and its Implementation Plan will be shaped by: • Key PHN 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; • Australian Government policy and drivers for integrated care in particular the Health Care Home model developed by the Primary Health Care Advisory Group; • International evidence and experience with integrated care in particular from New Zealand and the United Kingdom; and • WQPHN local health needs assessment priorities including restoring & revitalising a general practice model of care to support comprehensive primary health care, joint analysis & planning to support greater integrated service delivery, effective corporate, clinical and community leadership & engagement in the design, delivery and evaluation of primary care services, and strategic action to close the gap in Aboriginal & Torres Strait Islander health inequity. • The WQPHN Strategic Plan clearly articulates 5 strategic priorities which aim to improve the performance of the primary health care system through greater integrated care outcomes, including supporting the adoption of key system enablers which closely align with the 10 building blocks of high performing primary care. • A joint planning, health intelligence, and implementation of 'proof of concept' sites to trial in which to emphasis and trial new models of care have been identified within the FLEX, Mental health and ITC Alignment of Activity Work plans. • The Queensland Health Integrated Care Innovation Fund has been approved in at least one location in the Central West, with an emphasis on the development of a greater integrated approach in the remote western corridor communities.
Scalability	Two key differentiating characteristics of Western Queensland are its rurality and remoteness, and the relatively high proportion of the population who are Aboriginal: • Western Queensland, along with the Northern Territory, are the most remote PHNs in Australia, with around

	99% of their respective regions categorised as either Very Remote or Remote based on the ASGC-RA classification system. In terms of population density, Western Queensland is the most sparsely populated PHN in Australia with only one person for every 13 square km (Northern Territory next with 1 person per 5.5 sq km); and • Western Queensland is second only to the Northern Territory in terms of the proportion of the population who are Aboriginal (14.1% and 23.1% respectively). Given Western Queensland's distinctive demographic profile it is well placed to be a leader in remote health, along with the Northern Territory, and parts of country WA, Northern Queensland, country SA and western NSW. To this end the successful learnings from the Western Queensland Integrated Care Strategy should be able to be transferred to other remote parts of Australia. The ability to trial two specific sites through which to implement a range of activities aligned with the Health Care Home initiative will be a critical platform through which to scale innovation, provide evidence based approaches within the remote settings of Queensland and demonstrate in practice the benefit of integration.
Target Population	The Strategy's goal is an ambitious one; to transform how we deliver general practice/primary health care to improve health outcomes for patients and reduce costs from inappropriate, fragmented and episodic care. As such it will need to influence a wide array of people including administrators and managers at the regional, State and Commonwealth levels, local and visiting clinicians at the general practice/primary health care and hospital levels, mainstream and Aboriginal Community Controlled Health service providers, and patients and the general public. The development of the Strategy will provide the architecture for change management and authentic collaboration, as well as a comprehensive critique of critical enablers for adoption by services providers within local and supra-

	regional catchments. The ICP and regional proof of concept sites will specifically target better management of complex chronic conditions, especially those people most at risk of hospitalisation; but also maternal and child health development in the early years. The regional proof of concept sites have been identified as a result of consultation with the HHS and QAIHC, but more importantly include general practice and primary care capacity as highlighted through the WQPHN Practice Support activities. Sites fall within defined local clinical networks with clear relationships between hub and spoke sites and the necessary staffing establishment, basic practice systemisation and access to allied health support services to enable the reconfiguration and adoption of integrated care enablers. Key enablers include the introduction of new models of care to guide better coordination and alignment of services across provider networks to support people with complex chronic conditions.
Coverage	The Strategy and Plan will embrace the entire WQPHN region but also have two region-wide initiatives that will support and enable system-wide integration through proof of concept sites, that will develop and trial local innovative models of care and adoption of capabilities recognised as important to achieve high performing primary health care.
Anticipated Outcomes	• A coherent system of health care • Support for high performing primary care providers to deliver improved services and share experiences • An improved patient and community experience • Shared learning environment and knowledge transfer across primary and secondary care • Clear staff, stakeholder and community understanding of the case for change for integrated models of care • Rapid spread and uptake of key learnings within other regions of the catchment • Successful application of data driven health improvement using shared health intelligence and meaningful use

	of local health data to identify and better support individual patients but also to scale across whole population indicators. • Identified prioritised high risk patient Registers to support and coordinate GP-led multidisciplinary team care • Shared care planning and delivery across multidisciplinary teams led by the GP • Enhanced connectivity across multidisciplinary teams and organisations • Flexible workforce solutions for rural and remote communities • Increased Health Intelligence and formative evaluation capability enabling an evidence-based approach to prioritising outcomes, setting KPIs and making decisions • A joint commissioning capability that directs resources to support new models of integrated care and monitors delivery • Engaged Clinical leadership to better inform and drive quality improvement activities • Culturally informed clinical practice • Development and adoption of key treatment protocols to ensure coordination of care across the social, primary and secondary care settings
How will these outcomes be measured	Process measures • Reach and spread of innovation in Strategy and Plan • Effectiveness of governance groups (regional and local) • Proof of concept sites in place and effectively supported • Model of Care developed for trial sites identified health issues • Active shared commissioning is undertaken • Joint services in place • Health Intelligence capability in place • eHealth initiatives in place

	• Clinical telehealth initiatives in place • Integrated workforce initiatives in place Outcome measures • Patient satisfaction • Provider satisfaction • Establish disease Register(s) from within practice populations for medium to high risk patients cohorts • Improvements in recording e.g. Aboriginality, smoking status, alcohol assessment • Changes in delivery of GP services e.g. number of care plans, number of times patient attends their GP • Changes in delivery of closing the Aboriginal health gap services e.g. number of PIP IHI registrations, CtG prescriptions, annual health checks, GP care plans, PIP IHI outcome payments • Changes in potentially preventable hospitalisations, readmissions and ED presentations • Changes in the number of diagnostic tests e.g. pathology, radiology • Trends in key indicators e.g. HbA1C, BP
Indigenous Specific	Western Queensland Integrated Care Strategy is not Indigenous specific but one of its priorities will be engagement with ACCHO providers and targeting closing the Aboriginal health gap.
Collaboration	The Strategy and Plan will be developed and implemented collaboratively through a joint governance partnership model with the WQPHN, Queensland Health and the three Western Queensland HHSs, and QAIHC and the ACCHOs within the region. Other parties will include Health Workforce Queensland, General Medical Training, Health NGOs and allied health organisations and private providers, particularly those within the chosen trial sites of the CWHHS and NWHHS. Preliminary investigations for high level endorsement and collaboration with the Queensland Health Department (Director General) have been very positively received.
Timeline	31 October 2016 ICP Interim Governance group formalised

	Mid November 2016	Consultant engaged
	Late November 2016	High level planning meeting with QAIHC and Queensland Health
	December 2016	Health Intelligence Groups established including academic partner
	1st February 2017	Over-arching Governance Groups formalised
	31 March 2017	Strategy and Implementation Plan developed
	1 April 2017	Planning and engagement in Proof of Concept sites commences
	30 May 2017	Proof of Concept Site project plans approved and commenced
	30 June 2018	Evaluation report describing outcomes and learnings