phn SOUTH EASTERN MELBOURNE

An Australian Government Initiative

Primary Care - How are PHN's different?

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About PHN's

- What are they and what do they do?
- How to engage/contact?
- What is Commissioning?
- How are PHN's involved in Chronic Disease Management?

About PHNs

- 31 Primary Health Networks (PHNs) were established on 1 July 2015.

- PHNs were designed to:
  1. Increase efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
  2. Improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

- PHNs are assessed on the following national performance indicators:
  - Reduced potentially preventable hospitalisation;
  - Increased childhood immunisation rates;
  - Increased cancer screening rates (cervical, breast, bowel); and
  - Increased mental health treatment rates (including for children and adolescents).

What do PHN's do?

- Distribute government funding in programs designed to meet our strategic goals.
- Work with providers to support them in improving systems and processes to enable better health outcomes.

Which is my PHN?

What is Your PHN up to?

- Eastern Melbourne - www.emphn.org.au
- South Eastern Melbourne - www.semphn.org.au
- North Western Melbourne - www.nwmphn.org.au
- Murray - www.murrayphn.org.au
- Gippsland - www.gphn.org.au
- Western Victoria - www.westvicphn.org.au

About SEMPHN

- A diverse population of 1.4 million people

- 3,000km^2 area stretching along the eastern seaboard of Port Phillip Bay from Port Melbourne to Sorrento.

- Committed to making local heath care even better by:
  - improving access to existing services through better collaboration and coordination;
  - commissioning new services to better meet the needs our community; and
  - supporting clinicians to innovate and further improve services locally.

Australian Government

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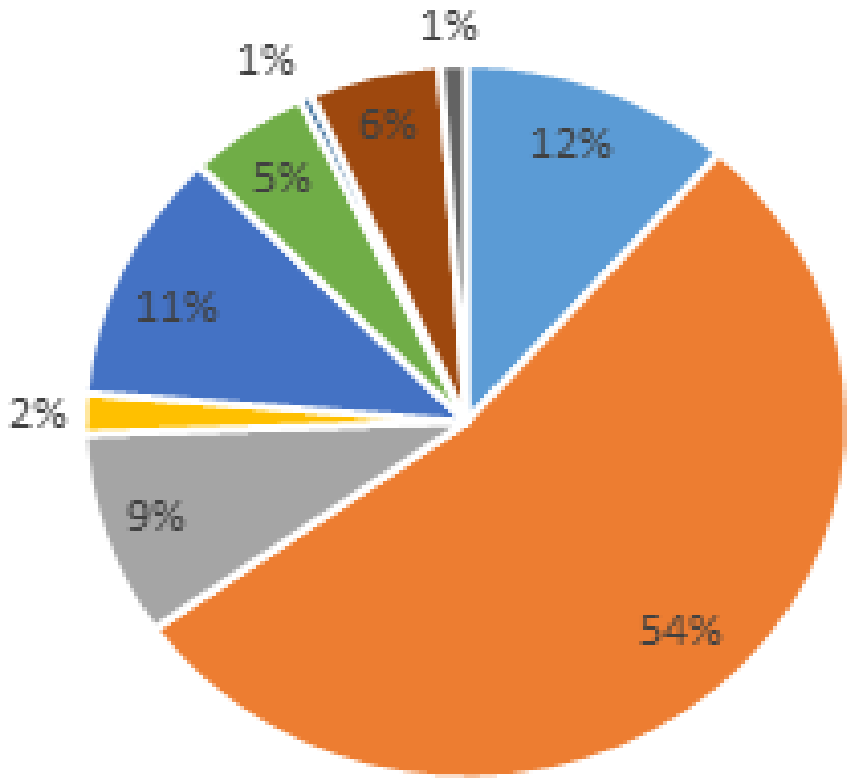
What does SEMPHN do?

- Mental Health
- AOD
- Chronic Disease
- GP’s in Schools
- Immunisation
- Cancer Screening
- Digital Health
- Integrated Team Care

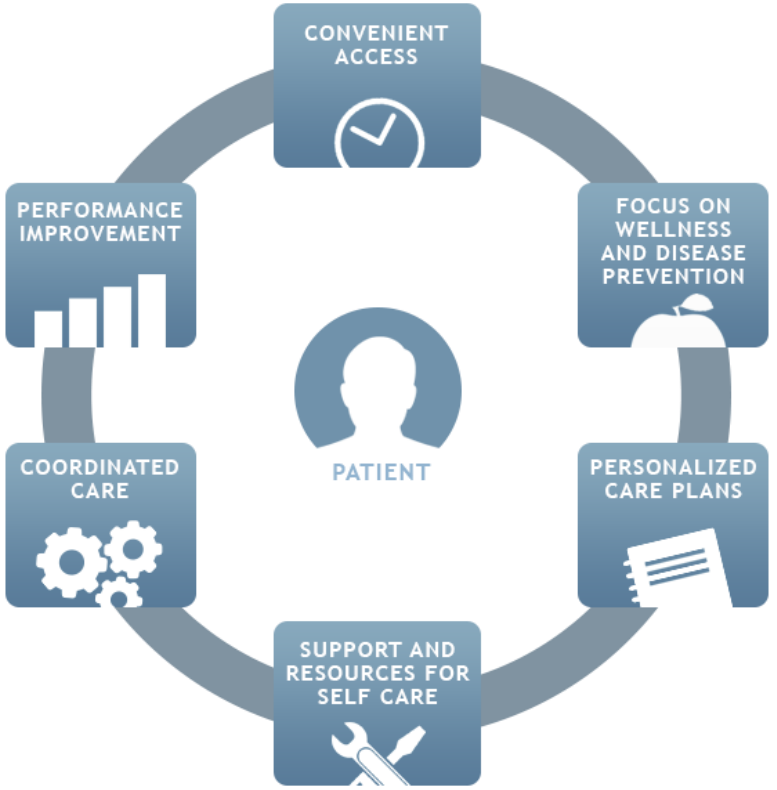
SEMPHN ALL PROGRAMS 2017-18 (Approx. $46 mill)



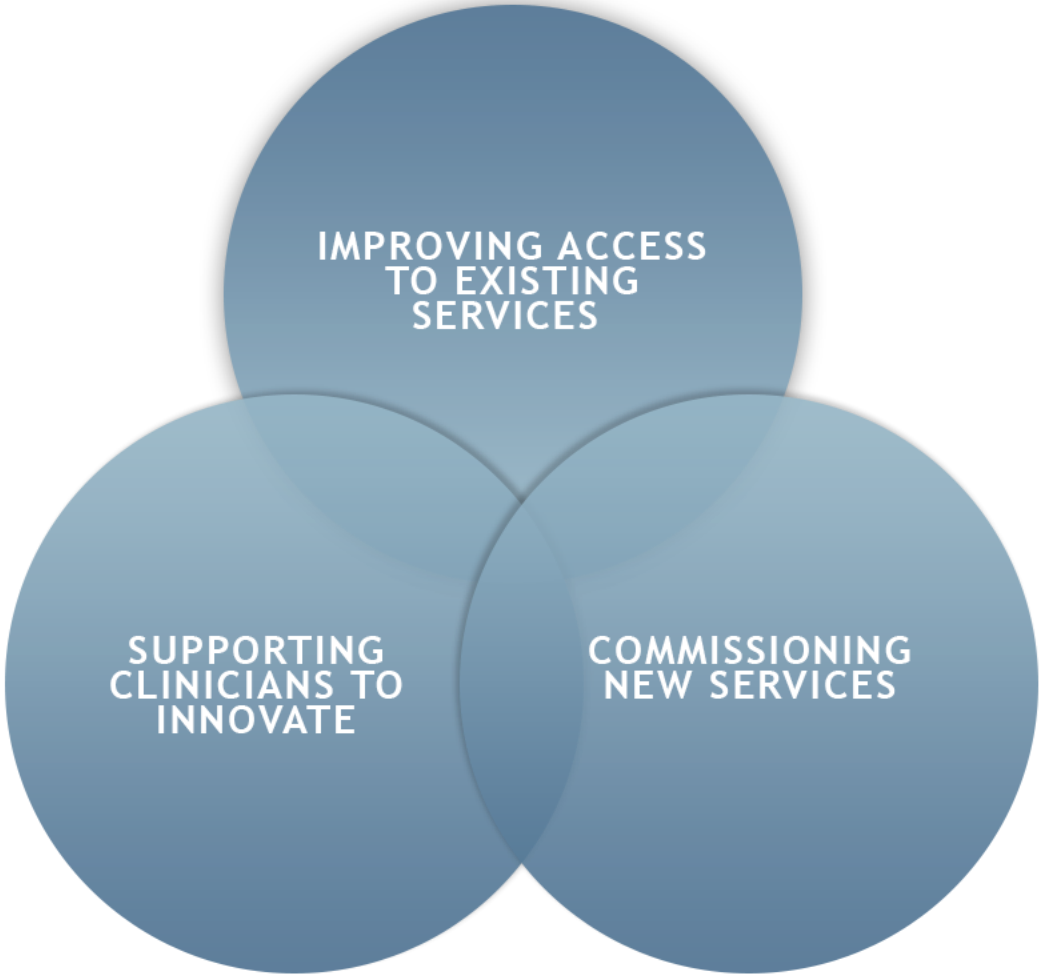
Flex Mental Health AOD ITC PIR AH Innovation SECADA SCC/AMS/A4 Pharma

Primary health is changing

Keeping patient at the centre



Our aim: even better local health care

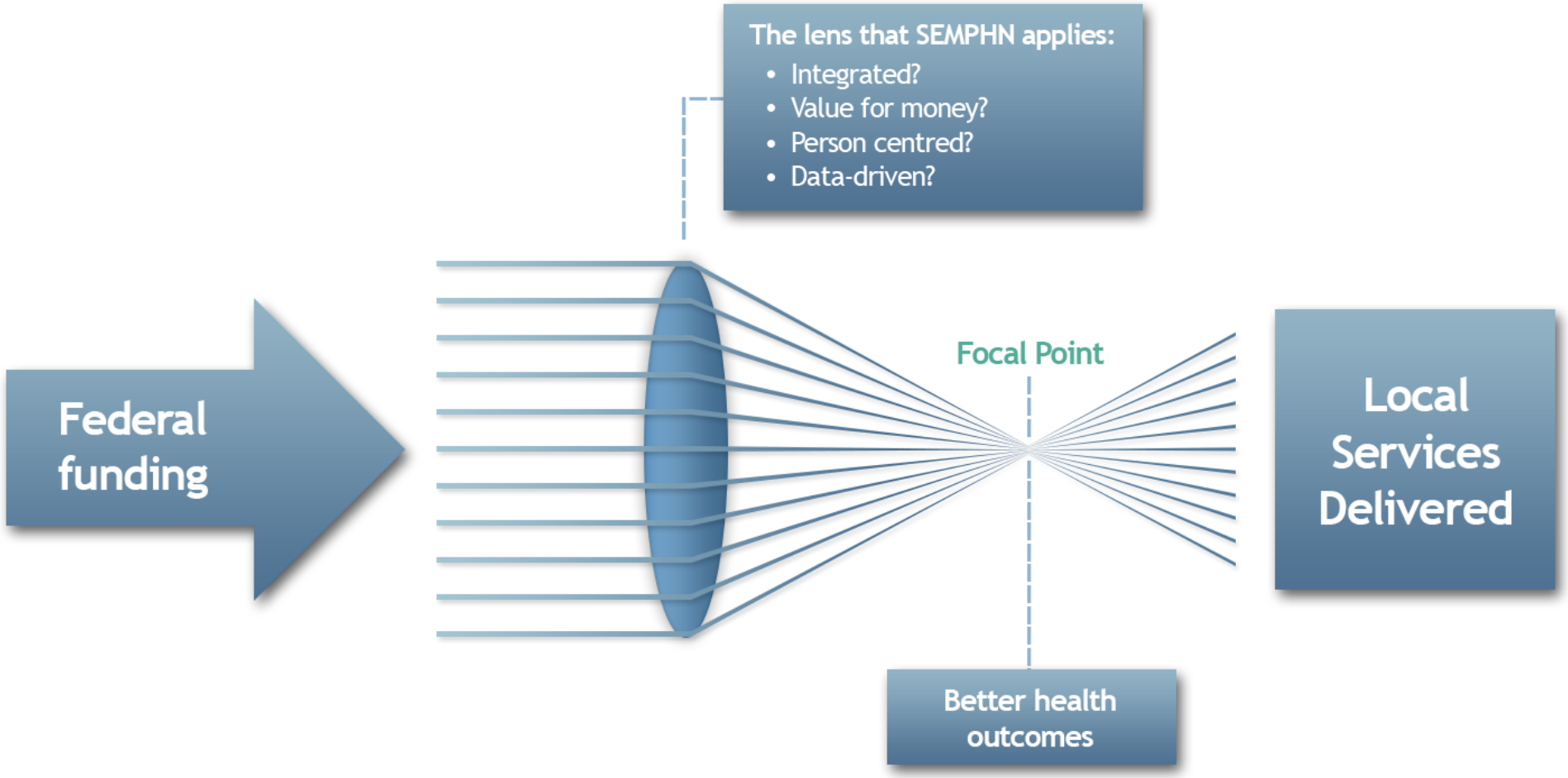


Commissioning

Commissioning is a continuous process that requires SEMPHN to be responsible for:

- Strategic planning
- Service procurement
- Monitoring and review

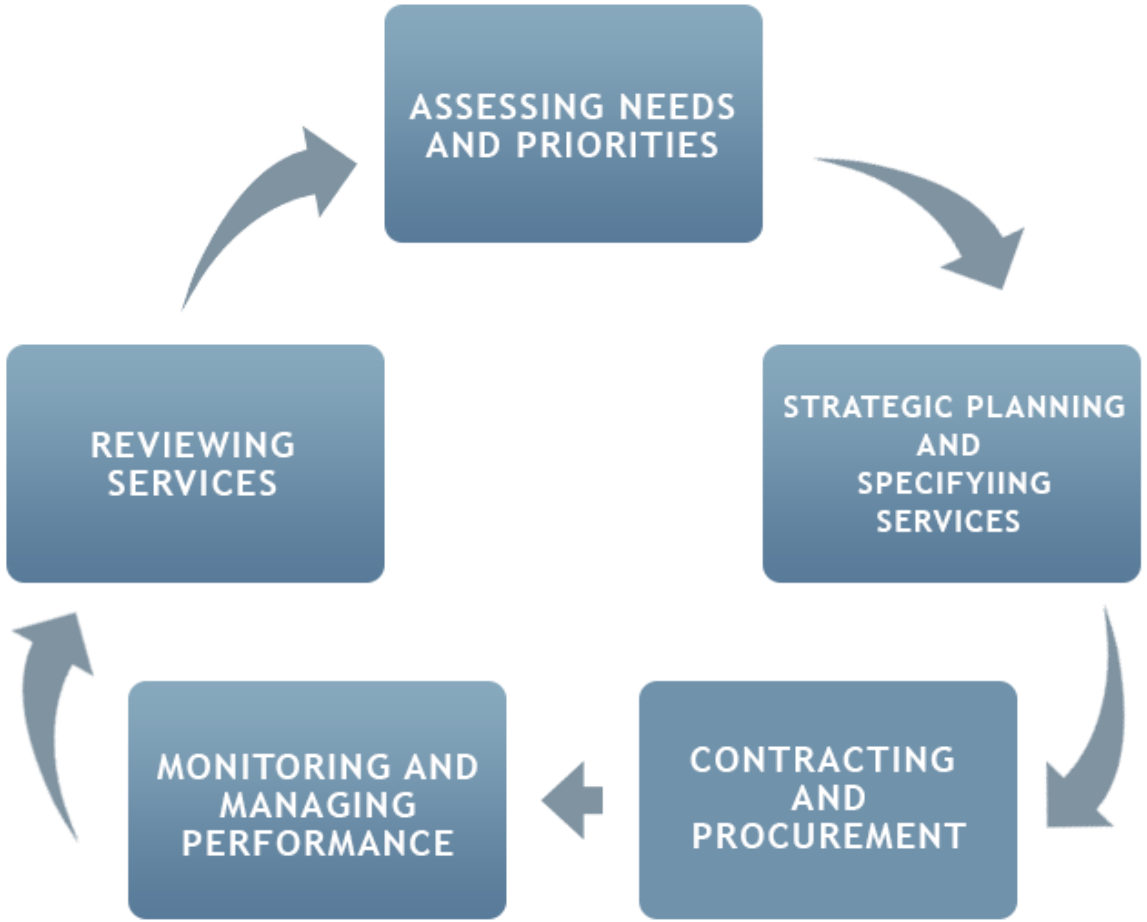
Our role in commissioning



Commissioning principles

- Consumer-driven choice
- Social model of health
- Agile and responsive
- Data-informed practice
- Open data and transparency
- Long-term sustainability

Commissioning process



What this might mean for you?

- Greater involvement with other health providers in our area
- More formal co-ordination/collaboration to design ‘bundled services’
- Better understanding of your business model/costs
- Different approach to clinical guidelines/patient record-keeping to enable collaboration and integration of services
- Investment in training and systems (digital health)

PHNs and Chronic Disease

- Activities determined by individual PHNs
- Aims and outcomes must be consistent with PHN goals
- What does SEMPHN do?

Our changing landscape

- Multi-morbidity is the new normal in CDM (Chronic Disease Management)
- CDM has steadily become a large part of general practice workload
- Current structures do not always encourage a best practice response to CDM
- Improving the quality of primary health care is of interest to every general practice…and most importantly, will benefit patients, their families and the community

Chronic Disease Management

- Improve care coordination including regular clinical contact, care plans, medication review, and self management, symptom management
- Integrated care and patient information sharing between health sectors and clear referral pathways
- Improve health literacy and patient ability to access appropriate care and support
- Target areas with high prevalence and PPH

Chronic Disease Management

- Support for General Practice to identify priority population groups and patients with poorly managed chronic conditions

- High correlation between risk factors for chronic disease and prevalence indicating a need for increased targeted preventative health initiatives for populations with high rates of associated risk

- Quantify rates of comorbidity and multi-morbidity within the catchment and patients with complex care needs

Chronic Disease – Outcomes framework for SEMPHN

Outcomes
Outcome 1: Uptake of healthy behaviours
Outcome 2: Access to chronic disease management services
Outcome 3: High quality and appropriate chronic disease management services
Outcome 4: Sector capacity to manage chronic disease and complex care

What SEMPHN is doing

- Health Care Homes
- Hospital Auspiced Community Health Service
- General Practice capacity building
- Priority Population Groups

Health Care Homes

- **Key objective:** Patient-centred care based around the patient's needs and preferences
- 23 practices in SE Melbourne
- Capitated funding depending on level of care required + fee-for service for episodes of care not related to a patient's chronic conditions
- Patients enrolled will not be able to go to any other practice for their CD care

Hospital Auspiced Community Health Services

- Support for managing patients post discharge
- New interventions for post acute services and/or community
- Acute and chronic conditions
- Reduce gaps in treatment
- Improved primary care access particularly after hours
- Improve links between hospitals and primary care providers

General Practice Capacity Building

- Defined what a practice providing “good” coordinated care looks like
- Self assessment part of application process
- Grants targeted practices which do not consider that their coordinated care processes are optimal

Priority Population Groups

- Practices which have a well developed care coordination model for patients with complex health needs
- Expand their model to specific priority population groups within the south eastern Melbourne region
- Potentially partner with organisations who can access these groups

Priority Population Groups

Specific demographic factors	• Older people (65+) • Humanitarian arrivals (refugee and asylum seekers) • Aboriginal and Torres Strait Islander people • Culturally and linguistically diverse communities • Individuals currently experiencing homelessness	• Strategies must improve the care of at least two of these groups.
Condition type	• COPD • congestive heart failure • moderate to severe diabetes • angina • asthma	• These are the most common of the chronic diseases in the region.

Reporting and Evaluation

The purpose of reporting are multifold:

- Monitoring the process and progress of commissioned activities
- Evaluation of activities to inform the commissioning cycle
- Learning lessons and sharing our successes

How else to interact with PHN's

- Practice networks
- Education and training events
- Information sessions
- Consultation forums