Australian Government

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An Australian Government Initiative

WESTERN QUEENSLAND PHN

Activity Work Plan 2018-2019:

Core Funding

General Practice Support Funding

After Hours Funding

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.

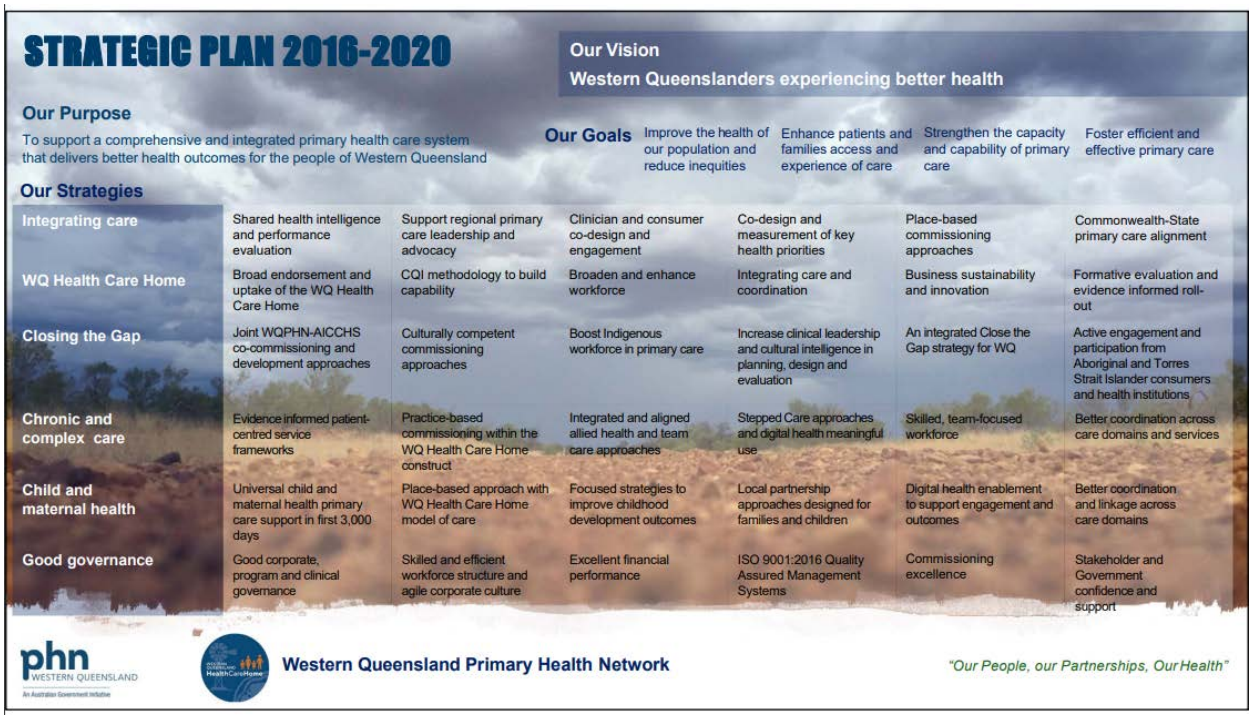
This Activity Work Plan covers the period from 1 July 2018 to 30 June 2019.

1. (a) Strategic Vision for PHN

WQPHN 5 – Year Strategic Plan was adopted in June 2016. The Plan was developed collaboratively with key stakeholders within WQ and undertook a refresh in February 2018. The Strategic Plan is a response to the system, structural, patient and health related issues portrayed in the WQPHN Health Intelligence Portal and highlighted in related Needs Assessment instruments. This strategic focus for the organisation is strengthened by 4 goals which align closely with the Commonwealths National Performance and Quality Framework, and the quadruple aim.

Integration → Health Care Home → Close the Gap → Complex and Chronic Care → Child and Maternal Health → Good Governance

http://wqphn.com.au/uploads/documents/20182505%20Strategic%20Plan_May%2018%20_FINAL_WEB.pdf



WQPHN Comprehensive Needs Assessment as at November 2017 can be located at the Web Address below;

http://wqphn.com.au/uploads/documents/20171115_WQPHN%20HNA%20Technical%20Report_FINAL.pdf

1. (b) Planned PHN activities

– Core Flexible Funding Stream 2018-19

Proposed Activities: CORE FLEX COMMISSIONING	
Activity Title / Reference	**CF 1 – Commissioned clinical services for rural and remote**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Population Health
Needs Assessment Priority Area	1) Work with Partners – Page 44 a) Support the development of a shared health intelligence capability with key partners – page 48 b) Enable effective clinical leadership and community engagement in planning and policy making – page 48 2) Co-Design – Page 49 a) Cluster PHC services to ensure a critical mass of workforce in larger towns that also support surrounding remote communities – page 48 b) Support uptake of telehealth- enabled referral pathways and practice interventions to improve access, strengthen local clinical capacity and minimise patient and clinician travel – page 50 3) Cultural Competency – page 51 a) Prescribe representation and participation of Indigenous people in all WQPHN governance forums and planning activities through engagement of the AICCHS – page 51 b) Better collaboration among relevant stakeholders to address key social determinants of health that impact on shared health priorities – page 54 4) Chronic Condition – page 55 a) Regional strategic framework developed that informs commissioning of existing and new services b) Model of care collaboratively developed with Clinical Council and Clinical Chapters – page 55

	c) Regional strategic framework developed that informs the commissioning of existing and new services - page 56 d) Implement My Health for Life, to promote enrolment of people with diagnosed diabetes in the National Diabetes Services Scheme (NDSS). – page 56 e) Plan changes to existing PHN-funded services in conjunction with partners and advocate for partner-funded services to be aligned with two frameworks and their related models of care page 57 f) Expansion of Credentialed Diabetes Educator (CDE) services – page 57 5) Child and Maternal Health – page 61 a) Regional strategic framework developed that informs the commissioning of existing and new services – page 61 b) Child and Maternal Health Services Framework collaboratively developed with Clinical Council and Clinical Chapters – page 61 c) Support and advocacy for family support and parenting programs and early learning interventions with education and early childhood sectors – page 61 d) Release of the Western Qld Child & Maternal Health Services Framework to guide new service commissioning and achieve better orientation and coordination across maternal health and 0-8years (0-3yrs, 3-5yrs and 5-8yr domains). – page 61
Aim of Activity	Undertake commissioning of targeted allied health and nursing service to better support and innovate management and prevention of chronic conditions, support healthy ageing, and improve child and maternal health outcomes in Western Queensland.
Description of Activity	Undertake place-based whole of population approaches to respond to market failure, build local capacity of allied health and nursing provider networks, improve access to services and ensure appropriate care for rural, remote and hard to reach populations in WQ. 100% of services will be commissioned including private allied health entities, Non government organisations, Aboriginal and Torres Strait Islander Health Organisations, sole trader providers, Local Government and general

practice networks.

All Commissioning activities will be evidence informed by the WQPHN Health Intelligence portal and HNA, and aligned with the eight (8) Commissioning Principles outlined in the *Commissioning for Better Health* framework (CFBH)(see http://wqphn.com.au/commissioning/commissioning-for-better-health)

Addressing needs

- Commission allied health and nursing services to support multi-disciplinary team-based approaches to care
- Provide for integrated approaches linked to the seven commissioning localities of the WQPHN catchment (place-based commissioning)
- Commission services to improve management and preventions of diabetes, child and maternal health and support health ageing support in very remote areas

Quality

- Ensure commissioned clinical services are aligned with WQPHN service frameworks and clinically integrated within the local general practice Model of Care
- Provide culturally safe and competent services
- Maintain evidence informed approach to health improvement based on the 7 commissioning localities of the WQPHN

Improving access

- Respond to market failure and promote innovative approaches to enable better service access
- Increase the % of population receiving planned and structured care for diabetes and other chronic conditions
- Increase the % of children receiving universal child health services and better coordinated care in the first 3000 days of life.

Coordinated care

- Support a place-based commissioning approach for services to promote integration, local service pathways and

	referral networks • Maintain service continuity of service provider networks and support technology enabled team based care
Target population cohort	Whole PHN Population including Aboriginal and Torres Strait Islander Peoples (Seven Commissioning Localities of WQPHN – see http://wqphn.com.au/uploads/documents/WQPHN%20CFBH%20Singles%2023%20May%2018.pdf)
Consultation - HSI Component	WQPHN primary health care partnerships support co-design and co-commissioning of WQPHN funded projects (part and wholly funded projects) including but not limited to the following avenues: 1. Maranoa Accord – Western Qld Health Services Integration Committee 2. CheckUp – WQPHN Jointing planning and commissioning Partnership Agreement 3. Health Workforce Qld partnership agreement 4. North West Tripartite Agreement –NWHHS, Gidgee Healing and WQPHN 5. WQPHN Clinical Chapters (x3) 6. Clinical Council 7. WQPHN Community Advisory Council 8. RFDS partnership agreement 9. Nukal Murra Alliance – Alliance Contract four AICCHS in WQPHN to develop co-design and co-commissioning of Indigenous services in WQPHN 10. Integrated Care and Innovation planning forums (NW, SW and CW) Consultation with the above health partners is ongoing and continuous.
Collaboration - HSI Component	Co-Design of the following programs have been facilitated:

	1. Mental Health – Mental Health Consortium 2. Child and Family Framework – Far South West CL and Lower Gulf CL Working Group 3. Diabetes Qld Partnership 4. As above in Consultation indicator
HSI Component – Other	Staff: Commissioning Coordinators provide support and information for commissioned organisations to ensure the uptake and adoption of integration, data sharing, patient centred approaches and strategies to improve practice scope and outcomes focus. Continuous quality improvement approaches guided by the quadruple aim with a focus on the WQPHN 8 commissioning principles. Contract administration, monitoring and evaluation will be provided by the WQPHN Business and Commissioning Support Unit.
Indigenous Specific	No
Duration	1 July 2018 – 30 June 2019
Coverage	Whole PHN Region
Commissioning method (if known)	Combination of ; • Preferred Provider Method (service continuity) • Select Tender (New provider entrants encouraged to accept commissioning) • Co-commissioning (Alliance partners, joint funding an co-design agreements)
Decommissioning	No decommissioning

Proposed Activities: CORE FLEX COMMISSIONING	
Activity Title	CF2 – Commissioned Practice Networks
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Select one of the following: Other (please provide details) If Other (please provide details): Practice-based Commissioning
Needs Assessment Priority Area	1) Co-Design – Page 49 a) Joint development of a sustainable practice management/small business model(s) tailored to the unique general practice circumstances of Western Qld – page 49 b) Increasing practice capacity and systemisation including: i) accreditation assistance ii) Continuous Quality Improvement (CQI) iii) uptake of eHealth technologies iv) My Health Record v) revenue maximisation vi) data quality vii) practice management systems and expertise viii) culturally informed practice ix) innovating workforce x) health intelligence – page 50 2) Cultural Competency – page 51

	a) Increased cultural knowledge and intelligence in the design, implementation and evaluation of health services for Indigenous people of Western Qld. – page 3) Chronic Condition – page 55 a) Increasing practice systematisation in chronic disease management – page 58 b) Improved whole-of-practice approaches through greater knowledge of illness burden in general practice populations – page 58 c) Better patient identification and support through practice-based interventions – page 58 d) Evidence of increased role of general practice in mental health services Delivery – page 56 e) Transition of the MHN PIP program within up to 7 selected practices targeting patients with severe and complex mental health conditions – page 60
Aim of Activity	Support a 'practice-based commissioning' approach to ensure the fragile business status and relatively underdeveloped population health emphasis of many practices are reinforced to create more comprehensive care and inform integrated and better connected clinical networks within the 7 WQPHN localities.
Description of Activity	• As outlined in the WQPHN HNA, General Practice services are provided through a combination of Private (Traditional), AICCHS, HHS and RFDS remote GP outreach. This mix of general practice business models presents significant challenges to the WQPHN. The HHS operated practices primarily address the needs of hospitals first, primary care second, the RFDS does not focus on planned care outcomes but episodic acute clinic's, and the private provider networks are extremely fragile and struggling to achieve sustainability in a shrinking population, high bulk billing rates and increasing fly in / fly out providers. Similarly the AICCHS sector is also experiencing significant workforce constraints and is benefiting through greater collaboration under the Nukal Murra Alliance Contract with the WQPHN. • The CF2 activities aim to directly respond to market failure and poor uptake of MBS GPMP and TCA and PiP through a 'practice-based commissioning' approach that aims to engage individual practices, especially the private practices, and support them through targeted

	service development opportunities linked with key population health priorities. Specifically, CF2 will support the purchasing of allied health, nursing, and Aboriginal Health worker services from practice networks where there is demonstrated need as identified in the Practice data and intelligence, and a willingness to collaborate with the WQPHN. • Priority areas include Aboriginal and Torres Strait Islander Health improvement through assisting Practices to recruit AHW support to boost enrolments, assessments and planned care; additional mental health, chronic disease nursing, and early childhood nursing to enable the practice to improve access to early intervention and planned and structured care; and specific allied health staff including aged care support and social care connectivity. • The WQPHN has developed an Outcomes-based Contract through which to commission Practice(s) who are sharing data and commitment to jointly agreed population base health improvement measures and capability KPIs. CF2 will ensure clinical leadership from local general practitioners and senior clinical leads and will be closely linked to enablers identified in the Innovation Fund WQHCH activities. • Support WQ General Practice networks to increase capability and alignment with the WQHCH Model of Care and prescribed service frameworks (chronic disease management and prevention, child and maternal health, CTG etc) to target priority population segments (as outlined under the WQPHN HNA and WQPHN Health Intelligence Portal) and support clinical leadership in the local redesign, quality improvement and workforce development and reorientation. • The Practice based Commissioning approach will overtime increase the confidence and capacity of participating Practice networks against quadruple aim outcomes. Moreover, this approach provides another alternative to fly in fly out service options through building the business capacity of local practice networks to directly commission additional services as identified in the WQPHN HNA, keeping services local, collocated with practices, contributing to practice sustainability and a more robust referral for team care outcomes.

	• Specific support provided under the HSI component will include;
	  o Primary Care Coordination, data cleaning and population planning and other practice support (Directly employed)
	  o Health intelligence (Preferred Provider - Aginic Data Visualisation support to WQPHN Qiksense Portal)
	  o refeRHealth support (Preferred Provider- for uptake of e-referral)
	  o Digital Health and PiP education and support (Directly employed)
	  o Nursing and Practice Management support, orientation and workforce support (Directly employed)
	  o Clinical and service Stakeholder engagement (Directly employed)
	
	• Provide support to rural and remote General Practice networks for accredited education and training, clinical leadership development and codesign aligned with identified population health priorities, clinical service frameworks and WQHCH Model of Care.
	
	Addressing needs
	
	• Support practice-based commissioning activities with nominated Practice networks to support better access and performance against identified whole -of-population outcome measures
	• Support practices through data sharing agreements to actively target at risk, low, medium and high risk / priority patients within their population
	• Contribute to population-based outcome measures and evidence within locality health intelligence
	Quality
	
	• Undertake quality improvement activities targeting practice and population priorities
	• Improve cultural competency of services to support chronic disease management and prevention (CDMP)
	• Support uptake and adoption of PC-PIT CQI tools

	• Provide primary care collaborative(s) for nominated practices and support clinical leadership in clinical redesign and capability development within the 7 commissioning localities of the WQPHN • Increase patient attainment of clinical targets and indicators such as completed Annual Cycles of Care • Increase patient-centred practices such as self-management and health literacy programs that lead to increased patient satisfaction where patients are assisted to better manage and maintain their own health (recorded with Patient Recorded Experience Measures) **Improving access** • Increase access to planned and structured care for patients with chronic and complex care • Respond to market failure through adopting better referral pathways, interoperability and access to NDSS, CTG and including access to Hospital and Health Service allied health and nursing services to enhance team based care. • Increase the % of population receiving planned and structured care for diabetes and other chronic conditions • Increase the % of children receiving universal child health services and better coordinated care in the first 3000 days of life. **Coordinated care** • Support a general practice leadership and integration as part of a place-based commissioning approach for services to promote integration, local service pathways and referral networks • Strengthen the capacity and scope of practice within practice clinical teams • Increased multi-disciplinary team care, via GP management plans, Team Care Arrangements • Use of risk stratification tools to identify, track and organise the care to meet the needs of patients with complex and chronic conditions

Target population cohort	General Practices within the WQPHN, including those enrolled in WQPHN sponsored quality improvement activities including the Mental Health collaborative, Diabetes Collaborative, child and maternal health activities.
Consultation - HSI Component	Practice-Based commissioning has been highlighted in the *Commissioning for Better Health* framework and is aligned with the 8 Commissioning Principles, and in particular the central role in general practice with the WQHCH Model of Care. Consultation will include; • SW, CW, NW Clinical Chapters • WQPHN Consumer Council • WQPHN Clinical Council • QPHN practice support network • WQHSIC (Maranoa Accord)
Collaboration - HSI Component	In addition to ensuring active consultation with primary care partners and forums of the role and contribution of practice based commissioning, forums established to support drive performance, uptake and innovation include; • Individual general practice engagement and business development o General Practices in WQPHN region and their staff o AICHHS o General Practitioners o Other organisations, NGOs, HHSs • Commissioned Education Provider Organisations. • Mental Health Collaborative Working group • Diabetes collaborative

	• Diabetes Queensland Diabetes Collaborative • Nukal Murra Alliance Executive Planning Group • University of Queensland Mater Research Institute PC-PIT working group
HSI Component – Other	PHC Coordinators, health intelligence and data analyst(s), and digital health staff will provide assistance to Practices commissioned to provide services linked to population health priorities and system improvement outcomes. (i.e Aboriginal health improvement, primary care collaboratives, PC-PIT and WQHCH activities within the seven (7) commissioning localities of the WQPHN. Contract administration, monitoring and evaluation will be provided by the BSCU in collaboration with PHC Coordinators.
Indigenous Specific	No, however Aboriginal Health improvement activities will feature in practice-based commissioning.
Duration	1 February 2018 – 30 June 2019 including planning phase and working group commencement. • July 2018 - Commissioning of Aboriginal Health worker(s) in general practice • August 2018 - Commencement of Mental health Collaborative • August 2018 – Commencement of the Child and Maternal Health practice-based activities in FSW CL and Lower Gulf CL. • Sept 2018 - Commencement of 5 – 7 practices under the WQHCH Model of Care • December 2018 - 2nd wave Diabetes Collaborative • March 2019 – JCU evaluation of the Mental Health Collaborative
Coverage	Whole PHN region – 9-12 practices with a combined catchment of 70% WQPHN population
Commissioning method (if known)	Enrolment and recruitment process based on; • Data Sharing Agreement • Business Plan development

	• Uptake and meaningful use of PC-PIT CQI tool and resources
Decommissioning	No Decommissioning is planned.

Proposed Activities : CORE FLEX COMMISSIONING	
Activity Title	CF3 - WQPHN Health Pathways
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Select one of the following: Digital Health If Other (please provide details):
Needs Assessment Priority Area (eg. 1, 2, 3)	Needs Assessment Priority No 4: Health Pathways, Page 57
Aim of Activity	Support the development and adoption of Local Health Pathways for WQPHN. The aim of the activity is to provide clinicians with succinct assessment and management information at the point of care, including local request and referral information. • The intended process outcome is for all parties to agree on the method and roles in progressing Health Pathways in the WQPHN catchment.
Description of Activity	The development of a localised Western Queensland Health Pathways web-based portal aims to facilitate patient care, in particular patients requiring referral or extended care. Commencement of localising Health Pathways conditions will assist shared health priorities, including diabetes, CVD and severe mental illness in the catchment area. **Addressing needs** • Clinical pathways target people with chronic and complex care **Quality**

	• Active clinical prioritisation **Improving access** • Better navigation within. Local and secondary care networks • Improved clinician and consumer information exchange **Coordinated care** • Local general practice and clinical networks aligned with secondary care and tertiary care • Digitally enabled care coordination
Target population cohort	The WQPHN Health Intelligence Portal (and practice population data) in each of the three HHS regions will reinforce the HNA which highlights poor health outcomes linked to mental illness, diabetes and child and maternal health. During 2018-19 the target population cohort will be the development of Health Pathways to target people with mental illness, chronic and complex diabetes, and children from 0 – 8 years across the whole PHN population
Consultation - HSI Component	The introduction of Health Pathways in WQ will be a collaborative process that will commission the Streamliners service to assist the adoption of customised resources and collateral designed to incorporate local clinical decision-making support and differentiate clinical prioritisation pathways within the nominated referral pathways of SW, NW and CW regions of the WQPHN catchment. • Hospital and Health Service executive to inform roadmap for 2018/19 • Hospital and Health Service medical staff who will provide input to the initiative, including Subject Matter Experts • General Practitioners as clinical writers/editors and users of the health pathways • SW, CW and NW Clinical Chapter consultation and co-design
Collaboration - HSI Component	The PHC Coordinators will provide assistance through ensuring active participation of selected general practice personnel and selected commissioned providers to assist the planning process and tailoring of

	content, resources and CPC validation and protocols.
HSI Component – Other	As above Anticipated WQPHN will contribute funds toward Coordinator role ($25,000), Hourly rate to GP for Clinical Writer and review + Streamliner Technical Writing ($25,000)
Indigenous Specific	No
Duration	Multi-year project. Commencing 1 Jul 2018 to 30 June 2019. Milestones to include: • Initiation and Scoping Meeting. 3 x HHS, WQPHN and Streamliners. • Contract with Streamliners • Streamliners commencement workshops with key stakeholders • Engagement of Lead GP clinical writers • Commencement of Coordinator role for whole catchment • Launch of Website with first group of pathways
Coverage	Whole PHN region
Commissioning method (if known)	Co-design and Co-commissioning between 3 x HHS and WQPHN.
Decommissioning	Nil

1. c) Planned PHN activities

- Core Operational Funding Stream: Health Systems Improvement 2018-19
- General Practice Support Funding 2018-19

Proposed Activities : HEALTH SYSTEM IMPROVEMENT	
Activity Title	HSI 1 – Health Intelligence
HSI/GPS Priority Area	Select one of the following: Population Health Planning If Other, please provide details:
Existing, Modified, or New Activity	Existing Activity
Aim of Activity	The aim of this activity is to: 1. provide an updated Health Needs Assessment including a General Practice Needs Assessment to guide the organisation commissioning cycle 2. provide health intelligence to WQPHN and health partners for planning needs 3. provide performance and reporting outcomes measures for co-designed and co-commissioned projects
Description of Activity	WQPHN has developed an integrated Health Intelligence capability built on a Qliksense platform with data visualisation provided through support from Healthy Futures Australia and Aginic data solutions. The Health Intelligence infrastructure includes a combination of ICT solutions to manage quantitative and qualitative data to support the commissioning role of the WQPHN and validate and align outcomes, redesign, planning and performance against the WQPHN HNA Health intelligence infrastructure includes;

	Internal 1. WQHN Qliksense commissioned services data acquisition, analysis and aggregation to support activities, performance against baseline activity 2. WQPHN Qliksense practice data portal for individual and aggregated PATCAT practice population analysis (includes web-portal access for practice networks) 3. ReferRHealth e-referral data portal to support minimum dataset analysis 4. Nukal Murra Portal to support ACCHO co-commissioning (including ITC) 5. WQPHN Health Connect portal is being utilised as an engagement mechanism to support consultation / knowledge management with WQPHNs Councils, Chapters, health partners and consumers for feedback and information flows. **External** 1) WQ Health Intelligence Portal (Qliksense) which provides data visualisation of acquired data from PHN, HHS, PHIDU, ABS and up to 8 other data sources to provide whole of population reports at LGA, Locality and HHS level. and includes 4 domains; i) Population and Social Determinants ii) Health Status iii) Population Focus Groups iv) Health System Performance The portal information will be regularly updated, further customised and expanded (data) to ensure comprehensive and accurate information. The Health System Performance domain will be a main focus to include health outcome and financial information (E.g. Medicare data) to better inform WQPHN and health partners when co-designing or co-commissioning services and programs. Regular reports to health partners including HHSs, AICHHS, Clinical and Community Advisory

	Councils, Clinical Chapters, joint programs and others will be developed and delivered quarterly with the HI portal information and the ability to print reports from the portal. **Addressing needs** • Health intelligence configured to support Place based commissioning • Consideration of critical social determinants impacting on the population health outcomes and service efficacy **Quality** • Comparative prevalence and incidence data for priority populations • Supporting evidence-based approaches **Capable Organisations** • Enabling infrastructure to support Value-based care outcomes measurement • Measurement of health system effectiveness **Improving access** • Identification of high needs populations within practice, locality and HHS regions • Identification of service gaps and duplication **Coordinated care** • Supporting greater analysis of referral pathways, stepped care approaches and team-based outcomes
Supporting the primary health care sector	This activity will provide health intelligence data to WQPHN and its Health Partners to assist with planning, co-design and co-commissioning activities to provide services and programs in priority areas identified in the Health Needs Assessment. WQPHN will be adopting the PHN Performance framework to inform the reporting and evaluation of its commissioned services and programs.
Collaboration	WQPHN will commission a consultant to provide an update of the HNA including the General Practice Needs Assessment. Updated information in the HI Portal will be included in this process. WQPHNs

	Health Connect Portal will provide the avenue for the survey component and Bang the Table will facilitate this process. WQPHN commission Aginic to provide support for the QlikSense base program and licensing for the HI portal and updating of data sources as required. WQPHNs Senior Population Health and Data Analyst regularly updates the data inside the HI portal.
Duration	1 July 2018 – 30 June 2019 Planning for the survey component of the HNA will commence in July 2018. Milestones include: 1. HNA consultant contracted – July 2018 2. Survey questions designed – July 2018 3. Survey set up in Health Connect – July 2018 4. Survey goes live – July 2018 5. Survey closed – October 2018 6. Survey results collated and triangulated with HNA data – November 2018 7. HNA completed and submitted to DoH – November 2018 8. Data regularly updated in HI portal – ongoing throughout 2018-19 9. Health Service Performance domain of HI Portal. – September 2018 10. HI portal Health Service Performance domain updated– November 2018 11. Health Partners alerted to new information availability in the HI portal through consultation activities section as above. – December 2018 12. Regular reports developed for health partners thoroughly the year and updated quarterly – September 2018, December 2018, March 2019 and June 2019

Coverage	Whole PHN Region
Expected Outcome	1. Identified Priority areas for WQPHN to focus on for commissioning activities 2. Provide Health Intelligence to Health Partners to assist with planning processes, co-design and co-commissioning activities 3. Update and refreshed HNA 4. Base performance and reporting on PHN performance framework

Proposed Activities : HEALTH SYSTEM IMPROVEMENT	
Activity Title	HSI 2 – Business, Commissioning and Support
HSI/GPS Priority Area	Select one of the following: System Integration If Other, please provide details:
Existing, Modified, or New Activity	Modified
Aim of Activity	The aim of this activity is to ensure a capable, well aligned and supported commissioning capability for the WQPHN to ensure a values-based-care approach that underpins performance, compliance, and measurement. The Business and Commissioning Support Unit will provide an integrated system improvement capability through incorporation of financial, contract management and health intelligence to ensure the WQPHN builds its commissioning capability in line with quality corporate and clinical governance, and continuous measurement and improvement. • Ensure contract fidelity and population health outcome congruence through supporting provider and practice commissioning activities • Establish a baseline status against the WQPHN eight (8) Commissioning Principles through a

	provider Capability Assessment Framework. The process will provide greater insight into commissioned provider strengths, and also to identify areas for future enhancement and capability development.
Description of Activity	The Business Commissioning and Development Unit (BCSU) will activate support for the WQPHN Commissioning Cycle (see www.wqpn.com/commisisoning) through each defined stage of planning, analysis, design, procurement, monitoring and evaluation. A key priority tor the BCSU is supporting the place-based and practice-based commissioning approaches and assessing the performance and capability against quantitative and contemporary capabilities. The Capability Assessment process is a suite of qualitative questions based on the WQPHN Commissioning Principles outlined in the *Commissioning for Better Health: A Bushman's Guide to Commissioning 2017-2020.*(CFBH) WQPHN has defined four (4) steps of maturity against each criterion from 0 (Undeveloped) through to 3 (Advanced). Providers are asked to self-assess their maturity on the Scale for each criterion with an overall Score calibrated and evaluated by WQPHN. This process has been universally applied and will assist providers familiarise themselves with the Principles, consider Scope and Orientation, and confirm Alignment within this contemporary outcomes-focussed Framework. **Quality Care** • Reduce duplication through shared health intelligence; • Incorporate PROMS in Contracts to support value based commissioning **Addressing Needs** • Better targeting of Commissioned providers to contribute to Outcomes **Capable Organisations**

	• Enhance market sustainability through commissioning approach; • Promote and support integrated and jointly commissioned approaches; • Ensure Commissioning is aligned with evidence- informed service Frameworks
Supporting the primary health care sector	The BCSU will provide reliable, timely and accurate information and advise necessary to support each stage of the commissioning cycle, in particular the procurement, monitoring and evaluation of performance against activity, outcome measures and the WQPHN CFBH 8 Principles. The Capability Assessment Framework provides a baseline to benchmark providers against WQPHN Commissioning Principles, prioritise and tailor support to commissioned providers, and also measure trends and organisational alignment, integration and system improvement.
Collaboration	The WQPHN internal Commissioning capability and structural improvement has been an area of continuous improvement with the approaches, capabilities and tools' developed through alignment with National guidance, local policy development and external collateral (service frameworks and capabilities). The development of the CFBH included broad consultation with local key stakeholders (HHS x 3; AICCHO x 4; Clinical Chapters x 3) and has recently been reviewed in line with the updated WQPHN Strategic Plan. External Consultant was engaged to guide development of the Capability Assessment Framework consistent with the Primary Health Network Program Performance and Quality Framework Version 2 May 2018 and the WQPHN eight (8) Commissioning Principles. Broad consultation with local key stakeholders (HHS x 3; AICCHO x 4; Clinical Chapters x 3) WQPHN staff participated in the PwC Commissioning workshops to inform the development process.
Duration	1 July 2018 – 30 June 2019 • The 2018-19 Commissioning commenced in May 2018 with the release of the Capability

	Assessment Matrix through Tenderlink. • Contracting and procurement June – mid July 2018 • Capability Assessment responses will be reviewed to identify improvements to be implemented with commissioned providers during the first quarter of the funding period. • Framework to be reviewed and initiated for commissioning process in second half of funding period. • Variations and potential multi-year contracts considered March 2019
Coverage	Whole PHN Region
Expected Outcome	Outcome Theme: Activities and initiatives address local needs 1. Improvement in Commissioning, Procurement and Monitoring; eg Alliance Contracting; Joint Commissioning; Prime Contractor service design and delivery 2. Stronger alignment with WQPHN commissioning principles targeting the health needs of the WQPHN community 3. Movement towards greater value-based care outcomes; eg uptake of digital technology 4. Remove areas of identified service duplication and strengthen provider markets

Proposed Activities : HEALTH SYSTEM IMPROVEMENT	
Activity Title	HSI 3 – Stakeholder Engagement and Collaboration
HSI/GPS Priority Area	Select one of the following: Other Practice Support If Other, please provide details:

Existing, Modified, or New Activity	Modified
Aim of Activity	The WQPHN will maintain effective stakeholder engagement and collaboration with Commissioned clinical providers, key stakeholder interested parties including HHS, ACCHO and local government, and ensure the CFBH 8 principles are effectively adopted across the wider primary health care sector. Promote awareness, alignment and collaboration across PHN partners and commissioned providers to leverage from place-based commissioning approaches, joint planning and evaluation activities and alignment of population health priorities and system redesign with the WQPHN HNA and service frameworks.
Description of Activity	The WQPHN will contribute to the transformation of primary care through the uptake of enablers linked to integrated care, shared health intelligence, joint planning and co-design, and supporting innovation through the influence and impact of Commissioned FLEX providers of the WQPHN. Stakeholder engagement and collaboration activities will seek to build a deeper understanding of Commissioning concepts such as value based care, the alignment and harmonisation of multi-party activity around health priorities to produce better population based outcomes. 1. Support implementation of the CFBH capability assessment outcomes 2. Provide knowledge transfer and support for WQPHN commissioned Provider networks 3. Align WQPHN commissioned Provider networks with Strategic vision, service frameworks and 4. Provide information to BCSU to meet requirements and health outcome from WQPHN strategic frameworks 5. Enhance capacity of commissioned services providers to work within the aims and objectives of Commissioning for Better Health; eg Quadruple Aim 6. Increase cultural competency of commission services providers in alignment of WQPHNs cultural integrity

	7. Ensure commissioned providers participate in clinical chapters and contribute to clinical leadership, planning and evaluation activities (within localities) and create opportunities to provide greater integration and collaboration 8. Increase intradisciplinary connectedness across private, NGO and public sectors 9. Create opportunities for allied health specific projects and research activities 10. Provide a mechanism for the distribution of local and national health sector updates 11. Increase professional development opportunities by tapping into local and external resources **Quality** • Alignment of commissioned providers with evidence-informed Service frameworks; • Cultural Competency of Provider Networks; • Universal adoption and uptake of Commissioning for Better Health; • Support local clinical leadership **Addressing Needs** • Co-design and Joint Evaluation against key health priorities; • Support for Innovative approaches that enable greater team based care **Coordinated Care** • Support uptake and adoption of Digital Technologies (Secure Messaging; My Health Record; e-referral, interoperability, shared care plans); • Facilitate and support special Interest Groups to enable partnership approaches **Improving Access** • Access to Aboriginal and Torres Strait workforce;

	• Improving Health Literacy within Team based care) and promote self-management; • Reduce siloed Service delivery and fragmentation • Promote and develop peer workforce
Supporting the primary health care sector	This activity will support the Primary Health Care sector by: 1. Providing an avenue for integration and coordination of WQPHN commissioned provider network 2. Provide education, training and information sessions for service providers 3. Provide knowledge transfer and updates needed to align services with WQPHN strategic vision and plan for transformation of Primary Health Care services and systems within WQPHN including becoming an integral component of the WQ Health Care Home and neighbour 4. Align commissioned services with WQPHN CFBH 5. Provide updates, information and data linked to the outcomes of the Quadruple Aim: i) Improved patient experience ii) Improved Patient Population Outcomes iii) Improved efficiency and lower cost of care delivery iv) Improved workforce with full scope of practice
Collaboration	WQPHN – lead WQPHN Commissioned Provider Networks WQPHN Clinical Chapters Commissioned education providers and facilitators as required WQPHN Health Partners and Alliances
Duration	1 July 2018 – 30 June 2019

	Bimonthly Clinical Chapter meetings (across each CW, SW and NW) Commissioned Service Providers Forum August 2018 Quarterly Nukal Murra Alliance meetings Bi-Annual WQHSIC meetings (Maranoa Accord)
Coverage	Whole PHN region
Expected Outcome	Outcomes of the activity will be: 1. Better coordination and integration of WQPHN Commissioned Service Providers 2. Better alignment with WQPHN strategic plan, program plans and service framework through knowledge transfer and updates provided 3. Better understanding of WQPHN direction and Health Care Home and neighbour and "fit" by commissioned services. 4. Better relationships and engagement with WQPHN Commissioning service providers 5. Improved Quadruple Aim outcomes 6. Improved cultural competency of WQPHN Commissioning service providers 7. Improved understanding of aims and objectives of Commissioning for Better Health

Proposed Activities: HEALTH SYSTEM IMPROVEMENT	
Activity Title	HSI 4 – WQ Health Care Home Support
HSI/GPS Priority Area	Select one of the following: Care Co-ordination If Other, please provide details:
Existing, Modified, or New Activity	Modified

Aim of Activity	The Practice Support team's core business aims are to: 1. adopt best practice methods to support general practice to improve the quality of care; 2. promote and improve the uptake of practice accreditation; 3. assist practices in the understanding and meaningful use of digital health systems in order to streamline the flow of relevant patient information, including across the local health provider community; and 4. develop health information management systems to inform quality improvement in health care, specifically, the collection and use of clinical data within practices. 5. commission practices to enrol into a quality improvement programs
Description of Activity	In 2018-19, the Practice Support activities will be realigned with the WQ HCH Model of care (MOC) which provides a contemporary architecture based on the Patient Centred Medical Home and Bodenheim 10 building blocks for primary care, with customisation of a framework tailored to the western Queensland context. The MOC aims to place the practice support activities within a structured continuous quality improvement program to builds the capacity of practice through support for uptake of key foundations for comprehensive primary health care. The WQ HCH model has 3 domains that provide the overarching framework for change: • Access to Care • Preventative Care • Chronic and Complex Care The foundations to secure comprehensive primary health care within the WQ HCH MOC include:

Engaged Leadership	Embedding CQI	Workforce Design
Digital Health	Infrastructure	Patient Centred
Cultural Competency	Planned and Structured Care	Annual Business Planning

A maturity matrix assessment will allow RFDS to measure where they are on the matrix and WQPHN will provide to the following *Support for Uptake* to assist the implementation of the model:

- ✓ Business and Health Intelligence
- ✓ Workforce Innovation
- ✓ Service Frameworks
- ✓ Change Management
- ✓ Primary Care Partnerships
- ✓ Connecting Care

The CQI program will be undertaken through active support through the University of Queensland PC-PIT that will assist practices to systematically work through building capabilities linked to improved performance and sustainability linked to population-based patient and system improvement indicators.

Quality

- Support (and nurture) clinical leadership within general practice networks;
- Planned and structured care for patients with chronic and complex conditions;
- Harmonisation of practice based CQI activities including collaboratives

Addressing Needs

- Active management of practice population data;
- Risk stratification of practice population

	Coordinated Care • Support uptake and adoption of Digital Technologies (Secure Messaging; My Health Record; e-referral, interoperability, shared care plans); • Increase in the # number and comprehensiveness of GPMP and team care arrangements • Increased patient partnerships in care **Improving Access** • Access to allied health services; • Better access to care (including after hours, telehealth, online appointments) • Better links to social care. Low intensity and recovery-based services
Supporting the primary health care sector	The Western Queensland Health Care Home provides a platform on which to better integrate the Western Queensland health system and break down silos of care, firmly focus on practice population outcomes, and activate patient centred approaches to care. The WQHCH MOC has been endorsed by a broad range of stakeholders (including HHS, ACCHO, RFDS and general practice networks) and provides a framework through which to collaborate, codesign with service providers, clinicians and consumers and achieve better team-based outcomes.
Collaboration	The WQ HCH MOC is fully inclusive of Practice Support functions and primary health care engagement and the team will continue to collaborate closely with all General Practices across the catchment. In addition to this, the roll-out of the PC-PIT and maturity matrix will provide the opportunity for more structured, standardised and systemised practice support aligned with the Support for Uptake areas. Collaboration will include but not be limited to 1. General Practices 2. AICCHS 3. HHSs

	4. Clinical Chapters (CW, SW and NW) 5. WQ HCH MOC Expert Advisory Group 6. University of Queensland – Mater Research Institute 7. WQHSIC 8. Partner NGOs (RFDS, HWQ, CheckUp)
Duration	1st July 2018 and ongoing
Coverage	WQPHN Catchment
Expected Outcome	Supporting the Western Queensland Health Care Home Model of Care, the following aims and outcomes are anticipated: • Improved access, responsiveness and support for patients through activated clinical triage, increased virtual consults, improved and proactive care planning for high need patients • Increased capacity in general practice teams through re-engineering clinical and business processes and ensuring all staff are working to the top of their clinical scope. • Expanded core teams including private, public and Hospital and Health Service allied health, nursing specialists, clinical pharmacists, social workers, mental health workers, all working as an interdisciplinary team. • Proactive management of whole-of-population health risk factors within the practice population • Enabling patients with more complex conditions to have more control over their self-care • Health and social care provision integrated around the individual patient and family • Maximised use of technology to support and connect care across inter-disciplinary and multi-sector domains • Creating an efficient, functional and attractive working environment to develop a sustainable

	workforce

Proposed Activities: GENERAL PRACTICE SUPPORT	
Activity Title	GPS 1 – WQPHN Data Management Program
HSI/GPS Priority Area	Select one of the following: General Practice Support If Other, please provide details:
Existing, Modified, or New Activity	Existing
Aim of Activity	The Aim of the Data Management Program is to: 1. Have 100% of PHC services that can submit data to WQPHN PATCAT with signed agreements to do so 2. 100% submission of CAT 4 Plus data collection monthly 3. Provide an incidence profile for Chronic Disease, Mental Health and other disease profiles for WQPHN regions (by Commissioning Locality) to inform planning and needs assessment 4. Provide a population profile as above 5. Attend PenCS Annual Conference
Description of Activity	WQPHN commissions PenCS to provide CAT Plus suite of tools including: • CAT 4 Plus for practices • PATCAT for WQPHN population data • PATBI for granular data • Patient Matching Data from the program is used by the PHC Coordinators and practices for:

	1. Practice Data cleansing activities 2. Population and Chronic Disease Practice Profile 3. Quality Improvement Programs 4. Accreditation 5. Identify duplicate patients 6. Chronic Disease Management 7. MBS item tracking 8. Business Modelling WQPHN provides several monthly data reports through a secure web portal to practices for: • Basic Data report • Diabetes Data • Mental Health Data An automated system has been implemented to produce these reports. Two members of the PHC team will attend the PenCS conference in November 2018.
Supporting the primary health care sector	Practices now rely on WQPHN to provide the tools to allow them to access their patient and population data to guide clinical and system decisions within each individual practice. Aggregated data is used for reporting to WQPHN Clinical and Community Advisory Councils and Clinical Chapters as well as providing data for planning and programs with health partners e.g. Lower Gulf Strategy with Gidgee Healing and NWHHS. During the recent Diabetes Collaborative program practice data was instrumental in identifying a much higher incidence rate of people living with Diabetes in WQPHN. This has led to more education particularly around performing foot and eye checks for these patients but also in commissioning more

	experienced Credentialed Diabetes Educators for the whole region.
Collaboration	9. General Practices 10. AICCHS 11. HHSs 12. PenCS 13. Aginic and Healthy Futures Australia
Duration	Continuing program – 1 July 2018 – 30 June 2019
Coverage	Whole PHN Region
Expected Outcome	Outcomes from the program are: 1. 100% Practice submitting data to WQPHN 2. Data kept in WQPHN QlikSense with reports generated for practices and aggregated for health partners 3. Population level data reports for HNA and planning 4. Attendances by 2 members of PHC team to PenCS Annual Conference

4. (a) Strategic Vision for After Hours Funding

The WQPHN vision has been directly informed by the Health Needs Assessment and provides a synchronous program agenda through which to develop system capacity, responsiveness and access to care. WQPHN AH activities and general practice engagement has been working to break down barriers across primary and acute provider systems and explore opportunities to innovate a more connected and robust after-hours framework. Targeted projects linked to identified need have helped to provide greater insights into active strategies that support comprehensive and structured care *in-hours,* minimise unnecessary demand on hospital ED services after hours, and develop a deeper understanding of the patient behaviours accessing services after hours for non-urgent interventions.

The fragile and often relatively underdeveloped state of general practice networks (especially the s19(2) HHS operated practices, combined with a number of other system, behavioural and economic factors, combine to create a degree of complexity when considering the issue of improving access (and demand) for after-hours primary health care services.

Increasing access to General Practitioner services is a foundation, as is repatriation of patients frequently using the ED for primary care, back into community. Investment in the deliberate strategies to better educate consumers and support better uptake and adoption of virtual and technologically enabled approaches is important and reinforced by recommendations flowing from the work WQPHN and MICCRH have undertaken during 2017-18.

Considering the unique needs of very remote populations in WQ is also a priority given the poor health status and relative cost on patients and services for avoidable ED and hospital presentations. Better identification of people most at risk of needing after hours support (especially frail aged, people with complex conditions, people with disabilities, people with a severe mental health condition) in remote populations is a priority for the WQPHN. Under the WQHCH MOC after hours services will be closely examined, including for these populations in the hard to reach and very remote villages of the WQPHN.

This plan will build on previous activities and expand the scope of some projects to reduce Category 4 and 5 presentations in regional centres, with an emphasis on Mt Isa Ed (which has almost 50% of all after ED presentations in WQ), increase services to RACFs in the After-Hours period and reduce unnecessary ED presentations for this vulnerable population.

Residents and families of remote and isolated RACF facilities often also experience a disconnect from appropriate and consistent general practice and specialist care services, resulting in sub-optimal care, unnecessary acuity and potentially avoidance after-hours activity. The WQPHN will continue to commission a number of RACF facilities with demonstrated need and support the uptake of systems and capabilities to improve access to GP services out of hours. These priority sites will improve both the connectivity, clinical support and a consistent General Practice after hours program of support to ensure facilities, staff and importantly residents experience better access.

A key focus area will continue to be the uptake and adoption of systems that better support sharing of clinical information around individual patient needs, such as the *myHealth record*, DAMA intelligence and better care planning for identified individuals at risk of potentially avoidable emergency support during after hours. The relative isolation, varying degrees of workforce and system capacity across the various parts of the health system in remote areas, and the health literacy of populations needs investment from the WQPHN to build the capacity within individuals, organisations and systems to better provide a robust after-hours system of care in WQ.

4. (b) Planned PHN Activities

– After Hours Primary Health Care Funding 2018-19

Proposed Activities – AFTER HOURS	
Activity Title	AH 1 - Primary Health care capacity – Supporting fragile and remotely wide-spread Primary Health Care network to support after-hours care
Existing, Modified, or New Activity	Existing
Needs Assessment Priority Area (eg. 1, 2, 3)	1. Prioritise PHC services delivered as close to people's homes as possible where it is safe and sustainable to do so – Page 45 2. Implement and evaluate WQPHN's PHC model, tailored to local needs and circumstances – page 49 3. Support business and clinical development in general practices and AICCHS – page 50 4. Increasing practice capacity and systemisation including: a. accreditation assistance b. Continuous Quality Improvement (CQI) c. uptake of eHealth technologies d. My Health Record e. revenue maximisation f. data quality g. practice management systems and expertise h. culturally informed practice i. innovating workforce j. health intelligence 5. Develop and support plan to improve access to after-hours medical services in Mount Isa with hospital ED and general practices/Gidgee Healing – page 50 6. Increasing practice systematisation in chronic disease management – page 58

	7. Improved whole-of-practice approaches through greater knowledge of illness burden in general practice populations – page 58 8. Better patient identification and support through practice-based interventions – page 58
Aim of Activity	The Primary Health Care Support team's core business aims are to: • adopt best practice methods to support general practice to improve the quality of care; • promote and improve the uptake of practice accreditation; • assist practices in the understanding and meaningful use of digital health systems in order to streamline the flow of relevant patient information, including across the local health provider community; • develop health information management systems to inform quality improvement in health care, specifically, the collection and use of clinical data within practices. • commission practices to enrol into a quality improvement programs • Build practice sustainability and greater participation in after hours • support strategies to assist repatriation of patients presenting as Category 4 and 5 patients to ED across the region to be enrolled into planned and structure care in a GP setting (preferably a WQ HCH if available). This will encourage to adoption of comprehensive Primary Health Care systems and practices instead of ad-hoc acute consultations
Description of Activity	People living in Western Queensland increasingly seek healthcare from multiple services/professionals for a variety of reasons. In the three hubs in the WQPHN region, Mt Isa, Roma and Longreach there are some After Hours services provided by General Practice and Aboriginal Community Controlled Health Services (ACCHS). To enable these services to remain viable and increase services; WQPHN will provide a support network of 4 Primary Health Care Coordinators, one in the South West, one in the Central West and two in the North-West region. This Activity aligns the second After Hours objective – improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care

	The Coordinators will provide the following activities: • Build working relationships with General Practices, ACCHSs, hospitals, pharmacies and other health professionals; • Support for s 19.2 (b) general practice activities to build capacity • Provide assistance to ensure information flows in the after-hours period e.g. access to the QHealth viewer to provide timely provision of Discharge summary information • Supply resources to General Practices, ACCHSs, HHSs, pharmacy and other health professionals to ensure there is information available to support afterhours services as needed or requested • Work with all providers to build a culture of coordination, integration and collaboration to ensure patients are provided with the appropriate service including chronic condition management and follow up after an acute presentation. • Build relationship with all After Hours services including fast track and Emergency Department GP type services to ensure pathways are present to repatriate appropriate patients to Primary Health Care services. • Provide Primary Health Care support and Quality Improvement activities to ensure all Primary Health Care services are equipped to provide quality care for all patients including those referred from After Hours services. • Provide health intelligence (including practice data) to support all services included in this plan with Population Based, ED presentation, Preventable hospitalization and other relevant data to support patient care.
Target population cohort	Whole PHN Population
Consultation	Consultation is ongoing with the following organisations through PHC Coordinators and WQPHN Exec: General Practices and their staff AICHHS including Nukal Murra Alliance (with all AICHHS in WQPHN region) HHSs (through Clinical Chapters, ICIF projects, Maranoa Accord and WQHISC) WQPHN Clinical Council and Community Advisory Councils

	Indirect consultation with General Practices clients through improvements made to practice through program introduced through this activity. Feedback from patients will be introduced through PREMs in the WQ HCH program to get direct input from patients about the services they receive.
Collaboration	Stakeholders will be: General Practice – receive services from WQPHN activities and programs and provide feedback to WQPHN AICHHS – as above HHSs – as above, collaboration and commissioned program to reduce Category 4 and 5 ED presentation and repatriate patients back to GPs to ensure patients are receiving planned and structured care in General Practice particularly in Mt Isa as a first project RFDS – as above and MOU and partnership being developed to join WQ HCH program HWQ – MOU and partnership being developed to collaborate on projects and reduce duplication of services
Indigenous Specific	No, although many Aboriginal and Torres Strait Islander peoples will be served by this activity
Duration	1 July 2018 – 30 June 2019 Key Milestones will be: 1. Ensure all PHC Coordinator positions are fully recruited including FIFO positions – 2 Coordinators including a Team Leader in the NW, and one Coordinator in the SW and CW combined. 2. Constant engagement and face to face visits with all GP type services in the WQPHN region including RFDS 3. Orientation of services to WQPHN services (where appropriate for each individual practice) which include: a) Data Management Program (with monthly Practice Data Reports) including CAT 4 Plus training and Data cleansing education and training.

	b) Collaborative Program (Mental Health Collaborative for 2018/19) c) WQ HCH Program (commencing late in 2018) d) Face to Face visits/emails/phone calls e) Education and training provided in the practice on a one on one basis or events tailored to specific requests or WQPHN/State/National priorities e.g. Immunisation programs and/of schedule changes, orientation to practice nursing/chronic disease management/nurse clinics etc. f) Discipline specific information e.g. GP, Practice Nurse, Practice Manager, Aboriginal Health Worker/Practitioner, Administration g) Accreditation information and assistance h) Continuous Quality Improvement activities including QI Incentive (3 month short QI program) i) Workforce support – incentives to attend workshops/conferences or gain an extra qualification or study to build capacity and capability within GPs j) General help and assistance as needed or requested. k) My Health Record registration, training to upload information for GP and staff etc. l) WQPHN commissioned provider and program information e.g. Mental Health stepped care or Allied Health Provider services m) Work with HHS services to ensure GP type presentations are repatriated back to GPs and enrolled into planned and structured care as needed
Coverage	Whole PHN Region
Commissioning method (if relevant)	NA – Core Business for PHNs
Decommissioning	NA

Proposed Activities -AFTER HOURS	
Activity Title	AH 2 - RACF and Palliative Care After Hours Strategy – better access to GPs in after hours and effective use of eHealth technology and systems
Existing, Modified, or New Activity	Existing and New
Needs Assessment Priority Area (eg. 1, 2, 3)	1. Improve access to after-hours GP services where gaps identified – page 50 2. Develop a sustainable model for After Hours palliative care in South West – Page 51 3. Provider access to electronic shared health summaries in AH periods – Page 51 4. Develop and support plan to improve access to GP services for RACFs - page 51 5. Develop a sustainable model for After Hours palliative care in South West - page 51
Aim of Activity	The HNA found that in general the after-hours services to most towns in the region was satisfactory. However, the HNA did identify potential gaps requiring further examination over the next 12-24 months. (a) after hours services in St George (ED and RACF) (b) after-hours services to Residential Aged Care Facilities (Laura Johnson Home, Mt Isa) . These services will meet the following aims: • Evidence of shared information platforms across RACF, General Practice and Hospital settings • Introduction and uptake of telehealth modalities within RACF settings • Decreased ED presentations for RACFs in the After Hours • Palliative Care services retained for SW residents in Roma
Description of Activity	(a) WQPHN has commissioned St George medical centre in 2016-18 to provide a largely previously unfunded service to the Warrawee RACF and after hours' support for private patients of the St George hospital. The Practice is also assisting better management of patients with severe and persistent mental health conditions including assisting patients in residential programs locally.

	This project will support greater collaboration between the ED, General Practice and RACF to adopt new protocols and innovation to provide a more sustainable framework for after-hours including VMO privileges at the hospital, training and protocol development for the RACF and new team care arrangements and connectivity. This project will be re-funded in 2018/19 with WQPHN working with the St George practice to redesign the service taking into consideration efficiencies and the use of nursing services. (b) RACFs within the WQ are dispersed across a vast geography and can experience a wide variation in the skill and capacity of staff and systems, consistency of support from General Practitioners, and a lack of clarity around escalation protocols for higher triage events in residence. This project has funded Laura Johnson RACF in Mt Isa for 2016-18. LJ has developed a range of systems, training and referral protocols including uptake and adoption of technology enabled support and improved connectivity across referral and specialist networks. Laura Johnson Aged Care Facility has been developing systems and technologies to improve care for the residents including registering for My Health Record, introducing mobile records and telehealth services. The project has also been collaborating with Mt Isa GPs and hospital to improve after hours' services for the residents at the facility. This project will be continued in 2018/19 to include improving end of life and palliative care processes in the after-hours period. This project will also collaborative with the NWHHS funded project to decrease ED category 4 and 5 presentations to Mt Isa Base Hospital with repatriation of appropriate patents to Health Care Home and RACF services.
Target population cohort	Clients of RACFs
Consultation	Community Engagement and Consultation: Laura Johnson RACF regularly consults the carers, relatives and wider community regarding the services provided at the home, the introduction of My Health Record for its clients and unnecessary presentations for RACF and particularly palliative clients. The project has a steering committee with membership from NWHHS, local GPs and other interested NGOs
Collaboration	Health Partners and Stakeholders involved in this activity will be:

	HHSs General Practices Local GPs AICCHS RACFs
Indigenous Specific	No
Duration	1 July 2018 – 30 June 2018 Continuing RACFs projects: 1. Letter advising continuation of funding – July 2018 2. Contracts developed – July 2018 3. Annual Activity Plan submitted to WQPHN – July/August 2018 4. Quarterly/Six monthly reports/budgets submitted to WQPHN – Oct 2018, Jan, Apr and July 2019. 5. Quarterly payments made on reports/budgets approval by WQPHN – Oct 2018, Jan, Apr and July 2019 6. Regular meetings with Commissioning Coordinators - Quarterly
Coverage	South and North West Regions of WQPHN
Commissioning method (if relevant)	Whole activity commissioned with some in kind contributions from RACFs, General Practice by Preferred Provider method 1. Practice based Commissioning through an agreement with St George Medical Centre to provide strategic support to the Warrawee RACF 2. Direct commissioning through the Laura Johnson RACF

	3. Practice Based Commissioning – Maranoa Medical Centre – Palliative Care Services
Decommissioning	No Expected De-Commissioning for this project

Proposed Activities – AFTER HOURS	
Activity Title	AH 3 – Support RFDS to provide comprehensive Primary Health Care to very remote WQPHN communities
Existing, Modified, or New Activity	New Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	1. Commencement of new service commissioning activities linked with implementation of the Western Qld Health Care Home (HcH) innovation fund activities. – page 44 2. Improved identification, capture, analysis, interpretation and sharing of information on the population's health and service use to inform evidence-based approaches and guide integrated outcome measures – page 48 3. Examine new approaches to respond to the chronic lack of systemisation in General Practice across many areas of the catchment – page 50
Aim of Activity	The aims of this activity is to: 1. Provide RFDS with comprehensive Primary Health Care support to enable enhanced of GP services provider to several very remote towns across WQPHN region 2. Develop MOU with RFDS for partnership/co-design approach to redesigning and aligning RFDS GP services to WQ HCH program. 3. Provide a comprehensive planned and structure care approach to RFDS clinics 4. Measure success through a Quadruple Aim lens: i) Improved patient experience ii) Improved Patient Population Outcomes

	iii) Improved efficiency and lower cost of care delivery iv) Improved workforce with full scope of practice
Description of Activity	Evidence shows that adhoc, unplanned care even within a GP type service such as RFDS services to WQPHN remote villages can lead to emergency presentations and preventable hospitals for chronic and preventable diseases. This activity will align RFDS GP services to the WQ HCH model to introduce contemporary Primary Health Care within an already established FIFO GP service. This will be facilitated through the two RFDS bases within the WQPHN region at Charleville and Mt Isa and led by the two senior medical officers at those bases. RFDS and WQPHN will develop an MOU partnership and co-design approach to bring RFDS GP clinic services in line with WQ HCH model. The RFDS will then be commissioned to deliver the model to the very remote towns they serve. The RFDS is currently the only provider of General Practice services in a number of very remote towns and villages of Western Queensland, including Thargomindah, Birdsville, Bedourie, Boulia, Windorah, Dajarra, Burketown and a number of other small communities of less than 80 people, including the opal fields of Eromanga and Yowah. Services through the GP outreach service from Charleville and Mt Isa respectively. With a collective population of more than 1,000 people, the WQPHN will collaborate with the RFDS to ensure some of Queensland's most remote populations have knowledge of and access to GP after hours services for conditions which have the potential to result in unplanned call-outs and possible hospitalisations. Within a co-commissioned approach and targeting remote populations with no access to services, the WQPHN will provide support through data sharing and health intelligence from local practice data to help identify vulnerable segments of the population and ensure better access to after hours through introduction of share care approaches in collaboration with local hospital and health service clinical teams and extended general practice services during remote visitations to local communities. Despite being a very small% of the WQPHN catchment population, the ageing profile, high Aboriginal

	population, combined with very isolated families with young children, the RFDS will be supported through adoption of WQHCH enablers to better identify priority segments of the population through whom access after-hours to online GP support, planned and structured care and access to pharmacy (via medical chests) will be extended to assist patients between visits. The active adoption of this structured approach will deliver greater equity and address service gaps through better access and tailored solutions including increased consumer awareness, improved health literacy with better linkage to local nonGP services and virtual digitally enabled services. The WQ HCH model has 3 domains that provide the overarching framework for change: 1. Access to Care 2. Preventative Care 3. Chronic and Complex Care
Target population cohort	Population in very remote villages in WQPHN region serviced by RFDS GPs
Consultation	RFDS will engage with the patient population they service to inform them of change to the model of care and gain feedback from the patients about the care they receive. Patient reported experience measures (PREMS) and Patients reported outcome measures (PROMS) will be introduced to assist the way the RFDS delivers services to patients.
Collaboration	Stakeholders include: RFDS led by Senior Medical Officer WQPHN Remote towns and villages serviced by RFDS visiting GP HHS Remote Area Nurses (including those commissioned by the WQPHN) Commissioned visiting allied health workers (including Aboriginal health Workers)

Indigenous Specific	No although many of the towns included in this activity have a high indigenous population
Duration	1 July 2018 – 30 June 2019 and ongoing Key Milestones: 1. August – Finalise Partnership Agreement 2. August – RFDS undertaken WQHCH MOC Maturity Matrix 3. September – Introduce additional GP hours to remote GP clinics 4. September – Finalise practice data in Qliksense (n=1,200 active patients) 5. September – Commence patient enrolments and establish care packages 6. December – Prepare first report of patient profiles and activity summary for at risk population 7. Ongoing – Continue to roll-out project, harmonise with GP lead multidisciplinary team care and increase GP hours to remote villages of WQ
Coverage	Very remote WQPHN towns serviced by RFDS from Charleville and Mt Isa bases
Commissioning method (if relevant)	Co-design and co-commissioning methods
Decommissioning	No decommissioning activity

Proposed Activities – AFTER HOURS	
Activity Title	AH 4 – Mt Isa After Hours and redirection project
Existing, Modified, or New Activity	Modified
Needs Assessment Priority Area (eg. 1, 2, 3)	1. Increasing practice systematization in chronic disease management – Page 58 2. Improved whole-of-practice approaches through greater knowledge of illness burden in general practice populations – Page 58

	3. Better patient identification and support through practice-based interventions – Page 58 4. Develop and support plan to improve access to after-hours medical services in Mount Isa with hospital ED and general practices/Gidgee Healing – Page 50 5. Develop and support plan to improve access to GP services for RACFs – Page 51 6. Plan, develop and implement a GP clinic in the Mount Isa Emergency Department – page 51
Aim of Activity	This activity builds on the ED Presentation Transformation program funded in 2017/18 and aims to: 1. Continue to decrease the number of GP Type presentations to the Mt Isa Base Hospital ED departments 2. Build on recommendations from MICRRHs ED Presentation Research project from 2016/17 3. Provide a consumer education program to assist with repatriation of patients back to GP type services 4. Provide GP services within the ED or other appropriate venue with the purpose of seeing Category 4 and 5 GP type presentation and introducing the patients to GPs and what to expect from GP services. 5. Develop policy in the ED regarding seeing GP type presentation and where to direct them e.g. away from the ED
Description of Activity	(a) Mt Isa has more than 50% of the total admissions within WQ and currently experience significant after-hours activity with up to 50 patients presenting daily seeking non-urgent assistance. Most of these presentations are occurring in the after-hours period with many patients Aboriginal from the Lake Nash and NT region. This strategy will support collaboration between the ACCHO and private general practices, Mt Isa Hospital and nominated social care providers to build better systems to divert ED activity and repatriate patients into general practice based programs, including consideration for better access to social services for homeless people. The funded research project led by Mount Isa Centre for Rural and Remote Health (MICRRH) to further investigate these issues has been finalised and will make recommendations to WQPHN as to working with partners on an implementation phase. The previously funded activity will commence in May 2018 and this activity

	will provide further funding for GP and Nursing services needed to meet the aims of the project. (b) Mount Isa Emergency Department is currently seeing > 60 category T4 and T5 patients a day. The preliminary findings from the MICRRH research project has found that as many as 60% of these Cat 4 and 5 could be adequately treated in a Primary Care facility by a General Practitioner supported by experienced nursing staff. Evidence shows this model is more efficient and leads to patients receiving follow up care for underlying chronic conditions that are not addressed in an acute setting such as an emergency department. When adequate chronic condition management is given in the appropriate setting preventable hospitals can be reduced. Also of concern is the number of children accessing care in the ED, many of whom are ATSI. (c) Mt Isa hospital has one of the highest preventable hospitalisation rates in Australia. Although not a primary focus of this activity, a reduction in this rate would be an advantage. Under this strategy, the WQPHN will directly commission an organisation (to be determined) to lead the implementation of a range of interventions designed to educate and repatriate up to 40% of current T4 and T5 presentation back into primary care. Informed by the MICCRH and NW Clinical Chapter work, this strategy will target more than 50% of the total after hour's presentation in the WQPHN and respond directly to hospital and ED prevention. This activity will also provide GP and Nursing services to enable a reduction of ED GP type presentations. Whilst the key focus is repatriation of current 'cycling' patients into their local general practice in Mt Isa or a GP new service, key learnings will be applied across the PHN through the Clinical Chapter networks, including shared educational resources, clinical redesign, IT interoperability and clinical information exchange (between ED and General Practice's) and evidence of cost savings.
Target population cohort	Patients who a category 4 and 5 presentations in Mt Isa ED
Consultation	Consultation has been undertaken by MICRRH to better understand why patients access the Mt Isa ED by surveys 300 patients in the ED. The results of this survey will influence the education program to

	repatriate patients back to appropriate GP services at the appropriate time and when it is appropriate to seek assistance from the ED. Further consultation will be performed with consumers and health partners as deemed necessary.
Collaboration	Stakeholders and their roles are as below: NWHHS – Mt Isa Base Hospital has one of the higher ED presentation rates in Qld, and will assist with the reductions of these and the use of resources to ensure patients receive planned and structed care at the right place at the right time by the right health team. General Practices/AICHHS – as patients are directed to GP services, GPs will need to be consulted to ensure there are enough services available to accommodate the patients. Programs such as WQ HCH will commission practices to implement new strategies to open up access and use new ways to communicate with patients to encourage patient partnerships in care NW Clinical Chapter – the chapter has played a significant role in instigating the first research project for further investigation into these issues. Therefore reporting about the progress and gaining feedback from the chapter will be important for the project to progress. MICRRH – being the commissioned organisation to provide the research to give insights on how to progress this project, MICRRH will continue to be an important partner for the project moving forward.
Indigenous Specific	No although a significant number of Category 4 and 5 presentations to Mt Isa ED are by Aboriginal and Torres Strait Islander peoples (approx. 30%) so services will need to be cultural competent.
Duration	1 July 2018 – ongoing Key Milestones: 1. Recognition this activity carries on from previous funded activities and therefore will need to progress outcomes already achieved 2. Decide which organisation will be the fund holder for this activity

	3. Develop a contract with performance and reporting guidelines and execute 4. Develop a plan with previously involved health partners 5. Develop an appropriate and culturally competent consumer education program based on research findings 6. Develop and implement GP and Nursing services in partnership with NWHHS and local GP services 7. Deliver consumer education program 8. Ensure patient pathways to embedded in the program and patients are aware of how these work 9. Assist NWHHS to develop and implement policy of how to better manage Category 4 and 5 presentations 10. Develop business model for new service to ensure sustainability after funding round is completed
Coverage	NWHHS region
Commissioning method (if relevant)	Co-design and co-commissioning model
Decommissioning	No Decommissioning intention