STRATEGIC PLAN 2016-18

phn MURRAY

An Australian Government Initiative

Contents

Chair/CEO message

The last year has been one of major transition as Murray PHN was established by the Australian Government to provide significant leadership role in the primary health care environment.

This transition brings a new model with Murray PHN now responsible for coordinating and seeking to continuously improve services that:

Deliver the highest possible quality and outcomes for patients and consumers.

Align resources to meet the population health needs of the Murray PHN catchment area.

Address health inequalities through better planning and service design that optimise the resources available.

The best future for health service system improvement and coordination of care across the Murray PHN catchment area depends on our ability to:

- match local health services to the health care needs of our communities.
- bring together health service providers, our communities, and other interested stakeholders to design, develop, and coordinate programs and services that respond effectively to local health needs, especially targeting those who are at risk of poor health.
- improve coordination through increased targeting and effective collaboration that delivers a more accessible and affordable health system in which patients receive the right care in the right place at the right time.

This strategic plan is the foundation for our work for the next three years and incorporates initial review and community consultation. On behalf of the Murray PHN Board Directors, we are pleased that you choose to be part of this exciting and innovative organisation and we welcome your contribution and effort as we all strive for better health outcomes in our community.

Fabian Reid
Chair

Matt Jones
CEO

Our vision

Better health and wellbeing for our community through better care and better systems.

When everyone in our community experiences good health and wellbeing we all enjoy a better quality of life.

When we connect with friends, family, neighbours, workmates and colleagues, we make a valuable contribution to society and we can live a life reaching our greatest potential.

To do this, the healthcare system and models of care need to support and maintain the best possible health, wellbeing, and independence for each of us.

Our values*

Our work is underpinned by our core values being…
*further work is planned with all staff to determine in scope and definition.

Our role

We will hear, understand, and address the health needs of our communities by engaging key partners to deliver targeted actions that:

- *increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes.*
- *improve the coordination of care to ensure patients receive the right care in the right place at the right time.*

Our results

We will achieve redesigned healthcare systems and redeveloped models of care across the Murray PHN catchment area through transparent planning, ongoing engagement, collaboration where and whenever possible, and resource allocation based on strong evaluation and evidence.

We will be accountable to our funding organisations, communities, and partners through good governance practice, regular and accurate reporting, quality staff expertise and by actively building a highly reputable, respected and valued organisation.

3 STRATEGIC GOALS

WE WILL

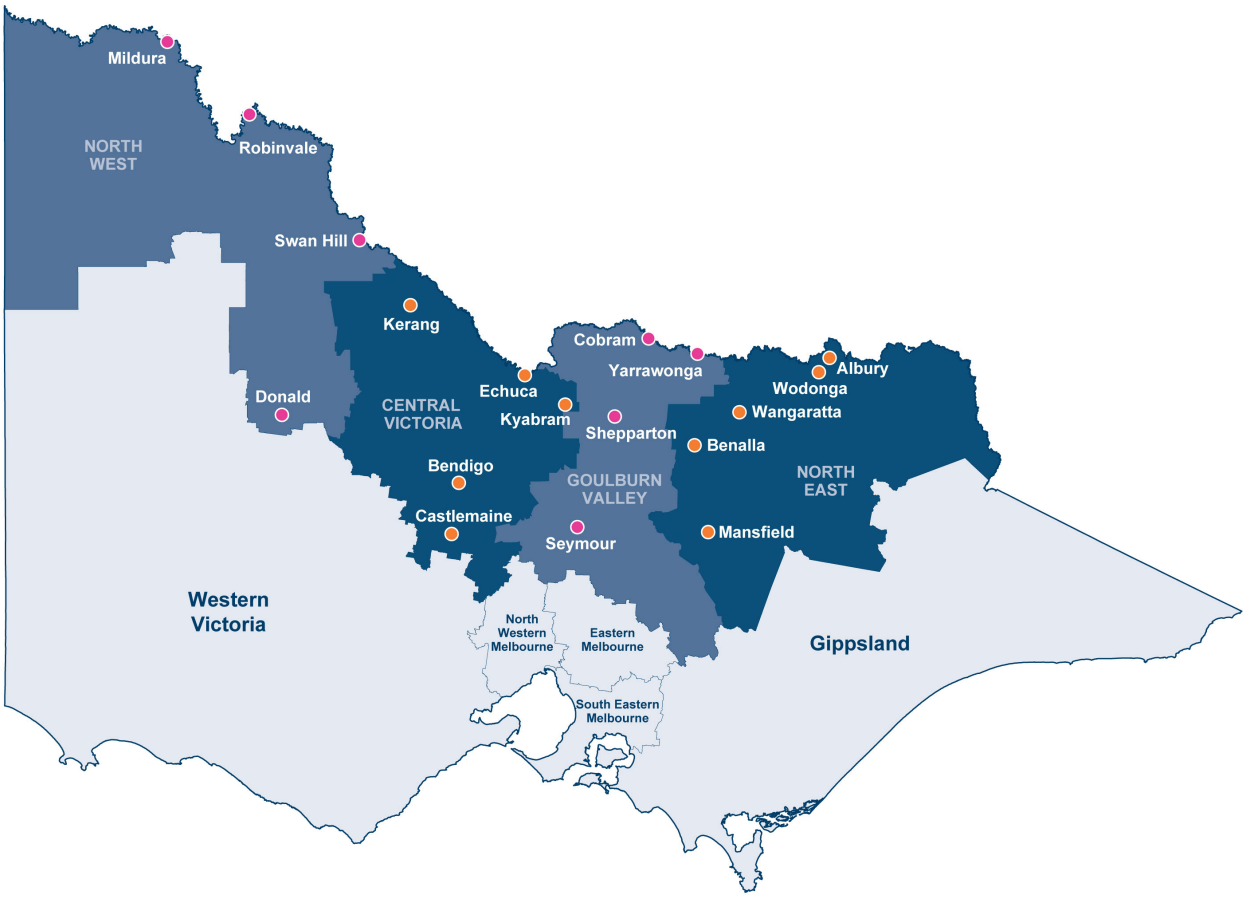
Ensure that the coordination of care is targeted and tailored to our communities and that innovation and engagement are core to our efforts in improving our healthcare systems and service delivery.

WE WILL

Address national priority areas as well as explore emerging health and healthcare issues with our communities, and work with service providers pursuing opportunities based on evidence and expertise, and being clear about how we will measure shared success.

WE WILL

Strengthen our organisational capability so that we are responsive, accountable and productive with what we know, in what we provide, and in how it contributes to improved health outcomes



Murray PHN commenced operation on 1 July 2015. Our catchment area is significant in both size and diversity. It spans northern Victoria, and includes Albury NSW.

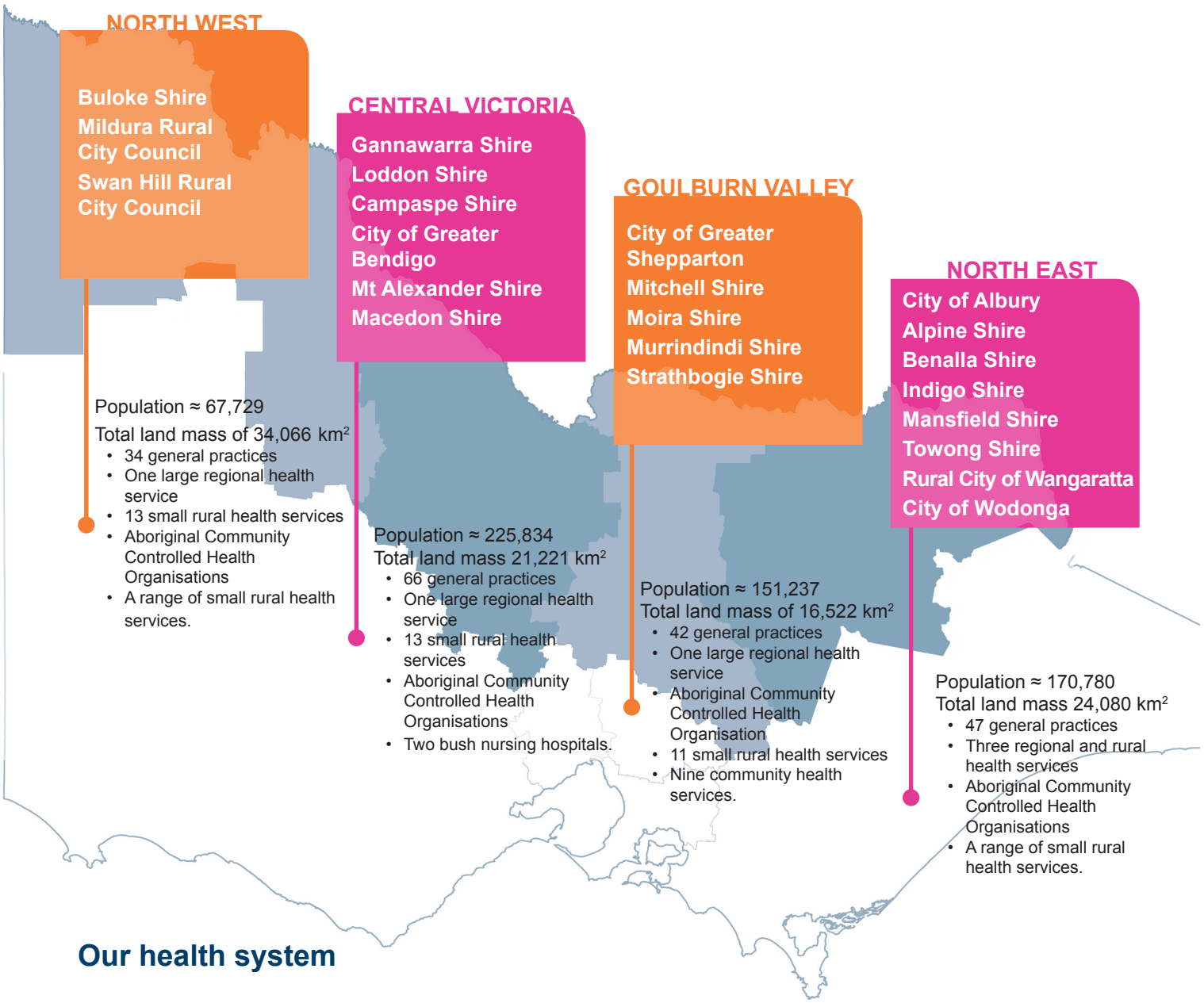
We cover an area of almost 100,000 square kilometres with health services that are accessed by more than 563,000 people.

Regional offices have been established in Albury, Bendigo, Mildura and Shepparton.

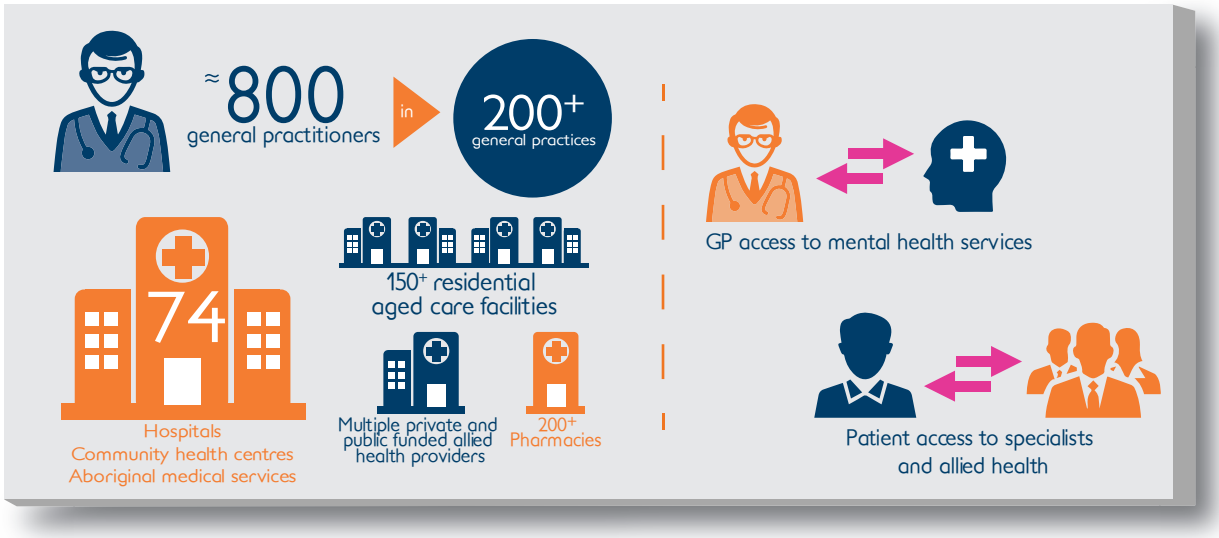
They each support health services within Central Victoria, Goulburn Valley, North East Victoria and North West Victoria.

Regional teams drive local input, build and maintain key partnerships and collaborate on local projects; as well as provide vital support with strategic planning in primary health integration and in the commissioning processes for primary health services in their regions.

Our regions



Our health system



Two important guiding principles that Murray PHN commits to are that we:

1 Add real value to the funds we distribute in the healthcare system

Murray PHN is more than a conduit of public health funding. We add value when we:

- provide a range of professional supports
- build knowledge and system infrastructure
- acknowledge that all communities have their own strengths to contribute
- lead positive engagement across communities, service providers and other stakeholders to strengthen the market
- influence and advocate for their needs with key decision makers

2 Place the patient experience of integrated and coordinated care at the heart of our work

We commit to Murray PHN's work making it easier for everyone to understand and navigate the healthcare service system and access what they need, with less duplication or waste, by:

- ensuring that for each individual to get the right care, at the right time, and in the right place, we will develop specific indicators that clearly relate to the patient journey
- providing clear care pathways for people, the opportunity to take control of their own health whilst also being communicated with and supported by the right health professionals is strengthened, and this in turn, contributes to a more cost effective healthcare system

The plan has a two year outlook through to June 2018 given that 2015/16 period has primarily sought to ensure continuity of service and establishment of the enterprise.

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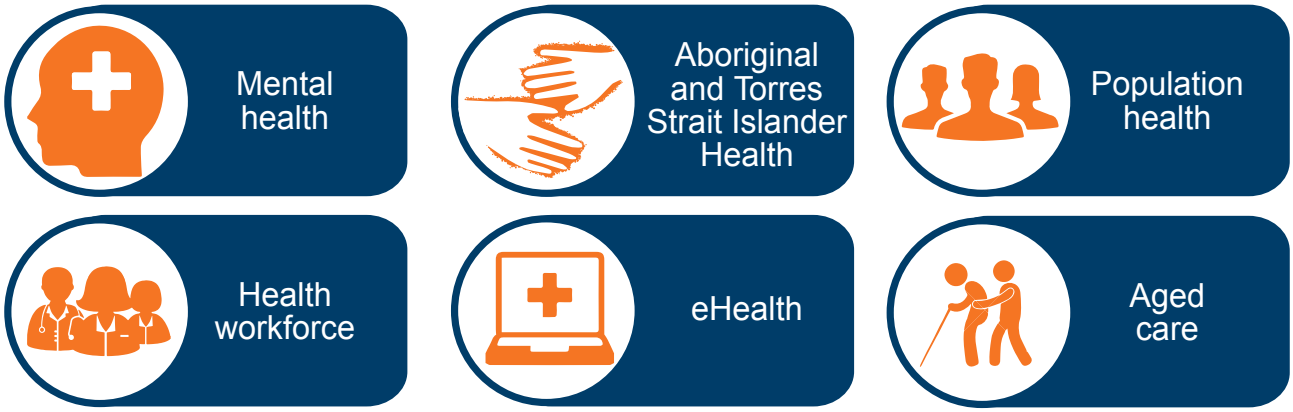
The major milestones for the immediate 2016/17 period we will deliver on are:

Needs Assessment
February-October 2016

While we are delivering on current projects and operations, the first half of 2016 will be devoted to a Needs Assessment (NA) that collects vital information from our communities to help us understand further what they need, what is working well, and where the opportunities exist for improvement.

The strategic plan aligns with the national health priorities being:



In addition to this, our performance will also be assessed on four national headline indicators:

A further four organisational performance indicators will be included that cover:

Establishment and consultation with Advisory Councils
July 2016 – June 2017

From July 2016 Murray PHN will establish Clinical and Community Advisory Councils to identify priority areas for action and to inform and improve our future health care system.

Codesign as a methodology will shape our engagement with others, and our immediate and ongoing investment in our catchment area needs assessment will establish an evidence base for the Population Health Planning Council's role and contribute to the more specific activities of the Clinical and Community Advisory Councils.

System readiness to implement commissioning strategy
July 2016 – June 2017

This timeline means that by July 2017 Murray PHN will be ready to commission new or redesigned models of care and that the healthcare services will adapt their service delivery to better respond to identified needs and appropriate care pathways.

As part of the commissioning strategy, Murray PHN will lead a range of system improvement and development activities to strengthen system readiness to embed positive change in models of care.

Alignment of our effort with national as well as local health priorities
Ongoing

In an initial phase we will continue to provide services as funded until June 2017. We have significant projects and activities underway that align with the national health priorities and our efforts will be measured accordingly beside the national performance indicators.

We will develop clear and transparent planning, monitoring, and reporting systems for efficient and effective information management and robust data governance. This will include the introduction of an embedded enterprise-wide risk management system.

Our response to identified national and local priorities

The Australian Government has identified national objectives and key priority areas for PHNs. This frames the focus of Murray PHN's efforts, however state based policy settings and program directions, local community and clinical advisory input and local government planning will also contribute to informing other drivers, influences and impacts on these priorities.

Aboriginal and Torres Strait Islander health

There are an estimated 9,900 Aboriginal and Torres Strait Islander people identified within our catchment area. This represents 1.9% of the population with a number of local government areas having significant proportions of residents identifying as Aboriginal and Torres Strait Islander People including: Greater Shepparton (3.4%); Mildura (3.6%), and Swan Hill (4.3%).

Vic Health research identified that there are four preventable chronic conditions that are the biggest direct contributors to the life expectancy gap between Aboriginal and non Aboriginal Victorians (source: Victorian Government Department of Human Services 2009). These are cardiovascular disease, diabetes, cancer and mental illness.

Our goal is to ensure that the system is responsive to the needs of our Aboriginal and Torres Strait Islander communities. As we see it, there are unacceptably high rates of:

- chronic disease
- lower life expectancy
- increased disadvantage
- variability in cultural appropriateness
- increased risk factors/chronic disease family violence
- increased complexity and chronicity
- lack of acknowledgment of the importance of culture within mainstream healthcare models.

Our role is to improve models of care through the quality and delivery of care and engagement with Aboriginal community leaders and advocates. We need to develop an Aboriginal health statement that outlines our responsibility to introduce culturally safe and aware policies and practices in healthcare settings, support uptake of appropriate models of care and work to reduce avoidable hospital admissions experienced by Aboriginal individuals, families and their communities.

Mental health

Estimates are that 20% of the Australian population (aged 18 to 85) will experience mental ill health; this equates to approximately 116,000 people across the Murray PHN catchment area. Of these, estimates indicate 1,565 people will have severe and persistent mental illness with complex needs.

During the 2014/15 financial year, 86,898 MBS item numbers associated with general practice mental health care plans were recorded across Medicare Local areas now within the Murray PHN catchment area.

A major problem in the mental health service system is that the system is in fact oriented around programs, not the needs of the individual. We will therefore engage with current providers to redesign the current systems and use our funding and flexibility to achieve this shift. This will have an impact on the mental healthcare service system, the stakeholders and with the broader health system. We will develop, implement and monitor a system that is accessible, integrated and patient centred. The outcome will be a client centred, flexible service which provides right care, right place, right time across the life course.

Aged care

There are over 95,300 people aged over 65 years residing within the Murray PHN catchment area. This represents 18% of the total catchment area population.

In some communities, particularly rural Local Government Areas such as the Shires of Gannawarra and Strathbogie, people aged over 65 years represent more than one quarter of the total Local Government Area population.

The increased number of people and proportion of the population over 65 years and over 85 years means all services need to take more account of the needs of the old and the very old. Services need to reflect consideration of:

- the significant increase in the number of older people
- the increasing incidence of age-associated disability and disease (e.g. dementia, stroke, COPD, diabetes), along with complex morbidities
- the rising expectations about the type and flexibility of care that is received
- community concerns about variability in the quality of care
- the expected relative decline in the number of informal carers
- the need for significantly more nurses and personal care workers with enhanced skills. (source: Australian Health and Hospitals Association, 2015)

Given that we understand that most people want to continue to age independently in their homes, we need to have a system that supports this. The current challenges for those requiring aged care services involve: increasingly complex care needs; a lack of access to primary care providers; increasing demand for, and sometimes, a surplus of unwanted and unnecessary treatments.

We will plan and enhance aged care packages, influence the uptake of advance care plans and strengthen access to after hours care. Over time, we expect to see reduced avoidable hospitalisations, stronger relationships/ engagement between staff in Residential Aged Care Facilities (RACF) and GPs, and an interface between the acute and residential settings where primary care services are less accessible to identified communities.\

Immunisation rates

Local government and general practice are the principal providers of childhood and adult vaccinations, with each estimated to provide close to half of all vaccinations to children. Local government provides public access to free vaccines by typically hosting immunisation sessions across its jurisdiction at regular periods. Vaccinations are free to all Medicare card holders.

Vaccines for secondary school students, Varicella (chickenpox), Human papillomavirus (HPV) and Diphtheria, tetanus and acellular pertussis (whooping cough) are delivered exclusively by Local Government. Community health services, hospitals and Aboriginal Community Controlled Health Organisations (ACCHO) play a small role in the provision of vaccines.

We know that across our catchment area immunisation rates are inconsistent. Areas where we can influence include identifying which areas are under represented, partner with local government and maternal child health services to identify and reduce barriers for target groups, and promote vaccinations to targeted groups/conditions.

This will decrease hospitalisations and reduce rates/prevalence of diseases. We will focus on identifying population groups at risk, meeting or exceeding national averages across our catchment area, and reducing avoidable hospitalisations.

Cancer screening

We must see an increase in bowel, breast and cervical cancer screening rates. Screening is important for early detection and uses less expensive interventions than those for diagnoses made at later stages of the disease. The current system for bowel cancer screening as an example is fragmented, and the target audience is less likely to access a GP to be screened.

Our role is to respond to the fragmentation and support GPs to strengthen their role in screening and early intervention. The undesired impact of inadequate screening relates directly to late diagnosis, increased interventions and associated costs and untimely responses, leading to increased mortality/morbidity rates. We will meet state-wide screening targets, strengthen procedure codes, and collect evidence from GPs regarding screening rates and practice activity.

Chronic disease systems

The prevalence and complexity of chronic disease is growing partly due to an ageing population and partly due to the fragmented systems of health professions that are required to effectively manage and coordinate chronic health conditions. Fragmentation of services, and its impact to accessing the right health service at the right time increase the risk of growing complexity and comorbidity.

The key role is to co-design chronic disease systems that support contemporary models of care. Whilst the healthcare system is centred on episodic care, more patient-centred care plans are either absent, or not actively maintained in an effective way.

There is a lack of access to allied health services and other services, and the system can generate perverse incentives for service providers.

We will seek to understand and work with models of chronic disease management that address this and reorient the service system to develop better models of care pathways using flexible funding in ways that apply an understanding of the local context and its impact to accessing health services. The work will include the implementation of health pathways, use of flexible funding to clearly impact through a reduction in hospitalisations and readmissions due to chronic disease.

Alcohol and other drug treatment (AOD)

As with most current health conditions and issues, the prevalence and impact of alcohol and drug use/misuse across our communities is significant. The healthcare system has struggled to meet the increasing demand and complexity of needs often experienced by those seeking treatment.

It involves both the primary care and acute service systems although the pathways have been fragmented. Currently there is a range of systems that impact but don't integrate effectively to meet an individual's health care needs such as primary care, justice, housing and social care. There are workforce skill and labour shortages and critical links to mental health services are often compromised.

There is a perceived problem for service providers in having a capacity to deal with the scale and the scope of complex presentations.

It is also an area of health care that specifically draws negative connotations for individuals and their families who seek treatment.

The subsequent impacts cross a range of person focussed as well as system focussed issues, such as: increased costs to community, increased family violence and individual vulnerability, Emergency Department (ED) presentations, decreased productivity, increased blood borne and sexually transmissible disease, and increased foetal alcohol syndrome.

We will measure improvement through increased access and referral to treatment services, increased culturally appropriate treatment/interventions, a reduction in ED presentations, stronger patient pathways across AOD, mental health, and primary care, and uptake of support tools such as CATPlus.

Health workforce

For our catchment area, regional health workforce data collection and analytics is limited and is more often historically reported with poor capacity to inform accurately about demand and supply issues.

The focus is often on workforce skills, clinical education and training placements and continuing professional development for general practitioners.

We will focus on strategic engagement of key players to support a locally relevant and coordinated approach to support an accessible and sustainable primary health system.

The range of strategic levers may include:

- an area based approach recruitment and retention of health professions, such as the Murray to Mountains (M2M) intern training program.
- targeted support of telehealth and other use of technology to improve remote access to health services in areas of unmet demand.
- accessible professional development for health professionals to support ongoing skilled workforce and which considers vertical and horizontal integration of disciplines, such as the WoSSP - *Whole of System Student Placement Program* (Monash University).
- vertical and horizontal integration of learning environments. For example, Monash University WoSSP program.

Potentially avoidable hospitals admissions

There are two aspects to potentially avoidable hospital admissions: managing chronic conditions in the community to avoid the need for hospitalisation, and avoiding presentations to emergency departments of hospitals.

Potentially avoidable hospital admissions are hospitalisations that could have been avoided by timely and effective provision of non-hospital or primary care services. This includes prevention activities. Potentially avoidable GP type presentations to public hospital EDs are presentations where the patient:

- was allocated a triage category of 4 or 5.
- did not arrive by ambulance or by police or correctional vehicle.
- at the end of the episode, was not admitted to the hospital, was not referred to another hospital, and did not die.

In many ways this indicator singularly points to key issues about the sustainability of the current healthcare system and the need to shift health care activity out the acute sector to primary health through early intervention of illness, particularly chronic disease and the support of a more accessible primary and community health care system to support effective health care at the right time and the right place.

Comparatively, our catchment area has recorded higher rates of preventable hospitalisations than most other Victorian PHNs during 2013/2014 in both acute and chronic categories. Vaccine preventable hospitalisations was the lowest recorded compared to other PHNs. Patterns of hospitalisations for acute, chronic and vaccine preventable conditions have shown consistent trends patterns since 2003. The capacity to address potentially avoidable hospitalisations will be a major area of focus for PHNs.

A collaborative and evidence based approach to reducing potentially avoidable hospitalisations will provide great scope to generate significant health improvements, attributable to enhanced community based care and encourage increased and early engagement of key stakeholders.
The focus will be on engaging the primary care system in conjunction with acute service providers to analyse:

- emergency and urgent care centre presentations
- avoidable admissions
- re-admission rates.

We will then identify, jointly plan and implement associated process improvements in acute and community based settings.

Population health

Population health planning aims to improve the health and wellbeing of whole populations, and to reduce inequities between specific population groups. Chronic disease has a higher prevalence within communities that are relatively disadvantaged. This is particularly evident with higher rates of health risk factors, such as physical inactivity, smoking and alcohol consumption.

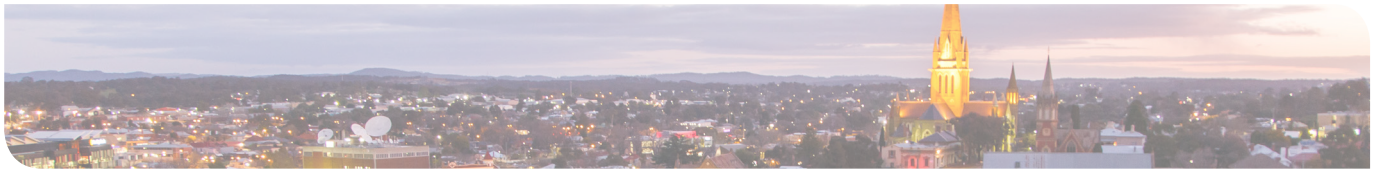
Overall, our catchment area has been relatively disadvantaged with an average SEFIA score of 970. Specific communities of significant disadvantage include parts of Mildura (482); Wodonga (556); and Benalla (552). Murray PHN is the second highest PHN in Victoria with children in low income, welfare dependent families (27.1%) and second highest PHN with 76.1% of people over 65 receiving the aged care pension, although this is similar to other regional/rural PHNs and North Western Melbourne. Across our population 1.9% in our catchment area identifies as Aboriginal or Torres Strait Islander, with up to 4.3% of the population in some LGAs such as Swan Hill.

Across our catchment area we have the highest use of GP services in comparison to most other PHNs, with higher hospital admissions and lower use of after hours GP services.

Of all 31 PHNs:

- people in the Murray PHN region identified cost as a barrier to seeking GP care more than anyone else in Australia - ranked at 9%, highest across PHNs
- 20% of people needed to see a GP, but did not in past 12 months - ranked 7th highest across PHNs
- low use of after hour GPs services with 5% of people seeing a GP after hours - ranked 6th lowest across PHNs.

In establishing our catchment area needs assessment, we will initially build a catchment area profile to inform health priorities and where identified need determines, develop discrete regional priorities. Beyond the initial assessment further analyses will be undertaken and inform an ongoing consultative strategy with clinical, community and population advisory councils, once fully operational. Adopting foresight methodology, a six stage process will guide ongoing analysis of population based health needs and service system issues to ensure that the advisory councils are provided the relevant and timely information.



eHealth

Clinical communication, virtual access to health services via telemedicine and use of eHealth platforms to quality and integrated health care are important domains of our eHealth focus.

Almost all General Practices (97%) have in place the clinical and business software systems that support safe and efficient information exchange between health services and analysis of population health needs and patterns. Whilst 72% of all General Practices were receiving ePIP payments in 2013 – 2014, only 16% were uploading clinical information to the system.

Currently 178 General practices (96% of all practices) within Murray PHN receive the ePIP.

These are the essential building blocks that will support improvements in patient care. Our role will be to support implementation and influence quality of care at scale across the catchment area; and to strengthen integration with pharmacy and allied health services.

The lack of digital or electronic medical records within Victorian public hospitals is a major structural impediment to electronic integration of systems between acute, sub acute and primary health care providers. Investment in digital innovations in health systems is a rapidly evolving market and we will keep informed about the innovation potential of this area as well as the opportunity and appetite to test innovations locally to suit our conditions.

STRATEGIC GOAL 1

We will ensure that the coordination of care is targeted and tailored to our communities and that innovation and engagement are core to our efforts in improving our healthcare systems and service delivery.

Year one objectives

- Develop and implement an engagement strategy.
- Invest in and collaborate with key partners, particularly GPs, to implement an eHealth strategy.
- Develop and embed an innovation strategy.
- Partner with stakeholders to deliver key preventative health campaigns linked to priorities.
- Develop and implement a health consumer participation strategy.

STRATEGIC GOAL 2

We will address national priority areas as well as explore emerging health and healthcare issues with our communities, and work with service providers pursuing opportunities based on evidence and expertise, and being clear about how we will measure shared success.

Year one objectives

- Establish clinical and community advisory councils.
- Establish a population health planning advisory council.
- Develop and implement a population health planning framework.
- Develop and implement a commissioning framework.
- Initiate and incentivise an avoidable hospital admission initiative.

STRATEGIC GOAL 3

We will strengthen our organisational capability so that we are responsive, accountable and productive with what we know, in what we provide, and in how it contributes to improved health outcomes.

Year one objectives

- Develop robust and accountable organisational leadership, planning and reporting frameworks.
- Develop and implement a quality and risk management framework.
- Develop and implement a communications strategy.
- Build a workforce culture and capability strategy.
- Build an integrated knowledge and information management framework.