INVESTING IN PRIMARY CARE
commissioning direction and intentions
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Executive summary

Commissioning is a major policy shift in thinking about how to build collaborative service systems in primary care. We know that change will happen when we focus simultaneously on patient experience, service system capabilities and vulnerable populations in communities of greatest need.

To this end, we provide four key messages to health providers who will partner with us:

1. Our evidence base is built on data, market analysis and community input. We have developed Murray Exchange to inform and share evidence.

2. Market analysis requires the market to work with us. Consumers will have better health care and outcomes when we can construct new and collaborative models that work to the specific capabilities and strengths from across the catchment.

3. Commissioning does not drive competition. It requires providers to work together. Service system reform will need strong, collaborative and well informed partnerships in order to address the fragmented, confusing, and at times, inaccessible primary care service system.

4. Commissioning framework is a continuous cycle of work and we are involved in system change at different stages of that cycle.

2017/18 Commissioning at a glance

Our commissioning investment will support service and system improvement in areas of identified need which include Indigenous health, diabetes, COPD / CVD, mental health and AOD.

There are two waves of investment that move us from 17/18 which builds a starting point that aligns investment with health priorities and applies models of care; through to the implementation of collaborative dialogue with the market to support full commissioning in 2018. With this comes a shift from annual funding arrangements to multi-year agreements.

For 17/18, a summary of commissioning investment is provided below.
What are we investing in?

**INDIGENOUS HEALTH**
- Care coordination, outreach and health workforce to improve the access and coordination of care for indigenous patients with chronic illness
- Initiatives that improve cultural safety and access to mainstream health services
- Improved cultural safety within mental health services
- Integrated models of care for AOD services

*Total investment directed to Indigenous Health priority: $2.52M*

**DIABETES**
- Continuation of existing contracts that provide podiatry, diabetes health education and dietetic services

*Total investment directed to Diabetes priority: $1.33M*

**COPD / CVD**
- Expansion and development of nursing and/or allied health workforce
- Investment in pulmonary and cardiac rehab clinics
- Investment in information management systems and improvements within general practice.

*Total investment directed to COPD / CVD priority: $2.94M*

**MENTAL HEALTH**
- Low Intensity Mental Health Services
- Psychological therapies for rural, remote, underserviced and/or hard-to-reach communities
- Mental health services for people with severe and complex mental illness
- Youth mental health service
- Community based suicide prevention planning

*Total investment directed Mental Health priority: $11.2M*

**AOD**
- AOD treatment services
- Transition of NGO Treatment Grant and Substance Misuse Service Delivery Grant

*Total investment directed to AOD priority: $1.58M*

We expect that there will be additional areas of investment, other than those listed above. We will update our commissioning investment details and inform the market when these are confirmed.
1. Introduction

For the 17 / 18 financial year, Murray PHN will fund more than $28M in primary health services across the catchment area. This investment will target improved health outcomes for patients and improved performance of the primary health care system.

Informed by a commissioning cycle that places population health evidence and consumer needs at the centre, our investment will be directed to services and system improvements that target diabetes, chronic pulmonary obstructive disease, mental health, indigenous health and cardiovascular disease. While this investment is significant, we acknowledge that our commissioning activity for 17/18 represents about 1% of the total health economy across Murray PHN catchment.

Through commissioning, the focus is to strengthen health system integration and collaboration between services. Our procurement does not seek to drive competition; it seeks to drive collaboration. The market therefore is required to work together to support integrated, locally relevant, evidenced based responses to health priorities.

This document provides an overview of health priorities, describes the scale of investment for priorities and outcomes the timeframes and key milestones that Murray PHN will implement its 17/18 commissioning plan. Its purpose is to frame ongoing discussion and collaboration across the primary and broader health care sector to support shared understanding of the priority issues for Murray PHN.

It is a ‘living document’ that we will refine and refresh as we move through the year and continue our ongoing dialogue with the market.

2. Health priorities at a glance

Data informs our dialogue, builds an environment for shared knowledge and underpins commissioning decisions. Murray PHN has developed the Murray Exchange (exchange.murrayphn.org.au). It is a web-based platform that provides access to data, tools and resources about population health priorities across the Murray PHN area. It has been designed to support tailored service design and system responses. We encourage all organisations participating in Murray PHN commissioning activities to access and contribute to Murray Exchange.
Chronic Obstructive Pulmonary Disease

The rate of preventable hospital admissions for COPD is significantly higher in Murray PHN than National averages (308 compared to 239 per 100,000). COPD rates of preventable admissions are more than double the National rate in the Loddon-Elmore area and high in other areas within Murray. Improving the development and review of GP action/care plans can reduce the need for hospitalisation.

Cardiovascular disease

Cardiac related admissions (including Hypertension, congestive heart failure and angina) account for approximately 26% of all ambulatory admissions within hospital services in the catchment. Hospital admissions for heart attack are higher in many parts of the catchment than the Victorian average, and very high in some areas.

50% of all LGA areas are assessed to be in the highest risk category of heart health as identified by the Victorian Heart Foundation Heart Health Maps.

Diabetes

The rates of Potentially Avoidable Hospitalisation’s for diabetes complications are highest (more than triple the Victorian rates) within the Loddon, Buleoke and Mansfield LGAs and high (more than double Vic rate) in Gannawarra, Campaspe, Swan Hill, Moira and Bendigo LGAs. (VHISS 2014-15 ACSC data).
Mental Health

Across the catchment, prevalence for the total population of 584,726 is estimated at 228,043 or 39% of the population (compared to 29.5% nationally). Of this, an estimated 96,474 people (16.5% of the total population) will seek treatment.\(^1\)

In 2014/15 the overnight hospitalisation rate for mental illness for the Murray PHN catchment was 899 per 100,000 people (5,256 people) compared to the national average of 944 per 100,000 persons.

Avoidable self-inflicted injuries and deaths across the catchment were 40.2% above the state average. Worksafe claims for mental disorders in the catchment are 27% higher than the Victorian average and the rate of ED presentations for Indigenous persons with psychiatric illness is 76% higher than non-Indigenous Australians.

Indigenous Health

In 2013, there were an estimated 14,804 Aboriginal and Torres Strait Islander persons identified to be living in the Murray PHN catchment area. This comprises 2.4% of the total population. In 2011, VicHealth released a synopsis of research examining the health state of Aboriginal and Torres Strait Islander Victorians (Aboriginal Health in Victoria - Research Summary). It identifies that:

- four preventable chronic conditions are among the biggest direct contributors to the life expectancy gap between Aboriginal and non-Aboriginal Victorians. These are cardiovascular disease, diabetes, cancer and mental illness.
- more than two-thirds of Aboriginal people living in non-remote areas suffer from at least one chronic condition and this is increasing
- mental illness is estimated to contribute 15 per cent of the burden of disease for Aboriginal Australians. This is second only to cardiovascular disease.

\(^1\) National Mental Health Service Planning framework. Commonwealth Department of Health & University of Queensland. May 2017
3. The impact of primary care upon avoidable hospital admissions

The three chronic health conditions commonly identified across the catchment as being within the top five conditions that related to avoidable hospital admissions and suitable for effective management in a primary care setting are: Diabetes and complications (Diabetes), Cardio-Vascular Disease (CVD), and Chronic Obstructive Pulmonary Disease (COPD).

At the service system level some initial cost analysis indicates that applies an average bed day figure of $4K (considered a low estimate) across all conditions, average length of stay and the estimated population rate for each condition, there is approximately $286M being expended in the catchment for these conditions alone.

General practice, primary, aged and community care are the building blocks of our primary care healthcare system. Murray PHN will invest in stronger primary health system focused on outcomes driven by practitioner, practice and system based models of care. Our investment will include opportunity for system strengthening initiatives, such as workforce capability building and quality systems.

This is a policy and commissioning shift for Murray PHN that moves from funding occasions of service to one that will emphasise outcomes through the development of a system and team based approach to the development of models of care (MoC) with clinical governance principles guiding the service. Through the development of a stronger primary health system focused on outcomes driven by team and system based models of care it is expected that there will be:

- a reduction in the potentially avoidable admissions to hospital
- a strengthening capacity of General Practice to manage and coordinate patient care relative to patient needs and local health service systems
- building capability and integration of primary health practitioners and services to invest in team based care to better contribute to coordination of chronic conditions
- building on clinical governance and models of care to drive the quadruple aims.
4. Beginning with models of care
Models of care are developed to better manage scale, both economically and population based, and
to clearly articulate pathways, practices and processes that cater for more complex care needs,
especially when managing the burden of the most prevalent chronic diseases.

With input from peak bodies, we have drawn from a range of chronic disease management and
condition specific strategy that target practitioner, practice and system level impact, including:

**National sources**, such as the National Strategic Framework for Chronic Conditions, Australian
Government, National guide to a preventive health assessment for Aboriginal and Torres Strait
Islander people (RACGP) and COPD-X plan – COPD Guidelines, Lung Foundation Australia

**State sources** including: Care for people with chronic conditions – Guide for the Community
Health Program (2016) and Community health integrated program guidelines: Department of
Health (2015)

**Regional sources** including, Hume Region Chronic Care Strategy 2012-2022: Department of
Health, Hume region and Pathways for Prediabetes, Type 1, Type 2 and Gestational Diabetes,
Department of Health and Human Services– Loddon Mallee Region (2015)

**Murray PHN Health Systems Framework**
Three pieces of work have informed the basis and shaped the development of the Murray PHN
Health Systems Planning Framework. They frame a systematic approach and include:

- World Health Organisation (WHO) Building Blocks in a Health Systems Framework
- Institute of Healthcare Innovation (IHI) Quadruple Aim
- Services for Australian Rural and Remote Health (SARRAH) Position Paper: Designing
  models of care

These have informed the Murray PHN Health Systems Planning Framework through the
integration of:

- 6 building blocks to health systems
- 4 improvement measures (quadruple aim)
- 3 tiers of model development (practitioner, practice and system)

in order to develop models of care, communicate with the market/sector and monitor change over
time in the Murray catchment.
Murray PHN Health Systems Framework

**Leadership and governance**

**Health care financing**

**Health workforce**

**Medical products, technologies**

**Information and research**

**Service delivery**

**Practitioner**
Individual patient/provider relationship, shared care arrangement; consumer focus

**Practice**
Multi-disciplinary approach involving more than one service provider and shared information management systems

**System**
Workforce, funding and clinical governance - range of service providers delivering under new forms of organisational governance

**Shaping supply**

**Managing performance**

**System reform**

- Prospective investment life
- Improved health outcome

Cost per capita - population health level data, hospital and ED utilisation rates
Population health - health status, burden of disease, other life expectancy rates etc.
Workforce health - health and wellbeing of providers - workforce sustainability
Patient experience - consumer satisfaction and community level/feedback and input

Investing in primary care
5. Commissioning: What it means to us and what 2017/18 looks like

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Two waves of investment

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2017 / 18 Commissioning activity at a glance
For 2017/2018, there is a combination of investments that are in place already for 2017/18 (for example, have been secured through direct approach to support patient care continuity or are already aligned with health priorities), as well as investment that will move through formal procurement processes. These are described in the table below.

The full scope of commissioned activity for 2017 /18 is summarised below. Further investment for the year will be released and we will update the overall investment details and inform the market following the release of details by the Commonwealth.

<table>
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Outcomes: Looking towards the long game
A focus on commissioning outcomes and making sure that performance focuses upon these outcomes is our way of making sure we have an eye to the long game. For Murray PHN it introduces the dialogue that looks at the impacts or end results of services on the patient. By doing so, we can:

- work to create the circumstances where health services look innovative solutions to deliver better outcomes for patients
- use data and evidence as a way to keep our sights upon the outcomes we want.

We understand that outcomes based commissioning is in its infancy. Our relationship with health services and development as a commissioning entity will be guided by patient-centred principles and collaboration with health services.

Patient health outcomes
The role of the PHN is to work with others to connect and improve healthcare to improve health outcomes for patients. To do this, we must understand the perspective to those using healthcare and engage them in planning and designing it, as well as provide us feedback about how it works for them.

Collaboration: The sum is greater than the parts
Key to our approach is our understanding that the sum is greater that our parts. The more that we can align health priorities with the strategic and operational priorities of health services, agencies and government, the more likely we are to more effective outcomes for consumers. Collaborating with others adds value and helps to design and deliver integrated healthcare.

7. Commissioning Guiding Principles: What you can expect
Our Commissioning Guiding Principles are our way of communicating with health services, our funding partners and the community the principles that underpin our thinking and approach to commissioning. They exist in conjunction with our organisational values of leadership, collaboration, knowledge, innovation and accountability.

1. We will develop models of care that are informed by evidence, responsive to need and community context and demonstrate progress towards improved health outcomes
2. We will ensure that consumers, carers and their families, communities and service providers are enabled to participate in service design and delivery of models of care
3. We recognise that primary care exists within a broader service system
4. We will build enduring partnerships that will invest and share accountability with us for Innovation, Quality and Systems improvement
5. We will strengthen the primary care service system to gain greater service coordination and system integration
6. We will strengthen capacity and capability of service providers to meet new and emerging market demands
7. We will embed effective evaluation to improve models of care and build our commissioning knowledge and skills
8. We will ensure decisions about resource mobilisation and distribution will be based on population health evidence, market analysis, value for money and performance
9. We will demonstrate commitment to high standards and principles of good governance
10. We will operate in accordance with high standards of probity and transparency in our procurement strategy
8. How you can engage

Connect with our regional leaders
We have established four Regional teams across the catchment, based in Mildura, Bendigo, Shepparton and Albury. They underpin our commitment to collaborate with local area health systems and communities to capture local knowledge, capability and gaps in the system.

CENTRAL VICTORIA
Regional leader: Janice Radrekusa  
E: centralvic@murrayphn.org.au  
T: 03 5441 7806  
3-5 View Point, BENDIGO, Victoria, 3550

GOULBURN VALLEY
Regional leader: Faye Hosie  
E: goulburnvalley@murrayphn.org.au  
T: 03 5831 5399  
100a High Street, Shepparton, Victoria, 3630.  
PO Box 196 SHEPPARTON, Victoria, 3632

NORTH EAST VICTORIA
Regional leader: Richard McClelland  
E: northeast@murrayphn.org.au  
T: 02 6041 0000  
594 Hovell Street Albury, NSW, 2640.  
PO Box 376, ALBURY NSW 2640.

NORTH WEST VICTORIA
Regional leader: Helen Hickson  
E: northwest@murrayphn.org.au  
T: 03 4040 4300  
Suite 1, 125 Pine Avenue, Mildura, 3500.  
PO Box 4008 MILDURA, Victoria, 3502

Register on TenderSearch
To be kept informed about procurement opportunities, you can find all opportunities through the web-based TenderSearch portal: tendersearch.com.au/murrayphn We encourage all health service providers interested in responding to Murray PHN tenders to register with TenderSearch. Registration is free and ensures that you will be notified when relevant tenders are released and receive any updated information during the tender process.

For further information
murrayphn.org.au