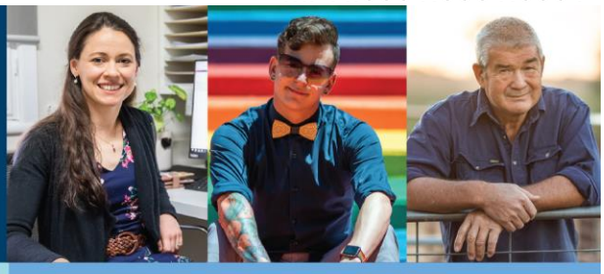

Special Commission of Inquiry into Healthcare Funding

Submission by Murrumbidgee Primary Health Network

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About Murrumbidgee Primary Health Network

Firsthealth is a not-for profit organisation which has been supporting and delivering primary health programs for 30 years. Firsthealth is federally funded to deliver the Primary Heath Network program across the Murrumbidgee region. PHNs are funded through a number of funding streams, the prescribed nature of funding can at times limit our ability to implement flexible solutions to meet local needs.

Murrumbidgee Primary Health Network (MPHN) is one of 31 local and independent PHNs established nationally to support the primary healthcare sector and improve health outcomes, particularly for people at risk of poorer health outcomes. We deliver the PHN program across approximately 126,000 square kilometres to more than 250,000 people living in our 508 communities.

With the person at the centre of care, we plan and deliver programs to ensure the needs of our individual local communities inform our approaches. We achieve this by working with our community and partners to:

- Coordinate local services and systems to improve coordination of care.
- Commission primary health services to meet population health needs with a focus on access and equity.
- Support capacity-building to ensure sustainable healthcare workforce through quality improvement, professional development and other innovative measures.

Firsthealth Limited

Firsthealth Limited, trading as Murrumbidgee Primary Health Network (MPHN), is an independent membership organisation established under the Corporations Act as a Company Limited by guarantee. Membership of MPHN consists of practices and other incorporated organisations with the prime purpose of delivering and/or supporting recognised primary healthcare services within the Murrumbidgee area.

Governance

MPHN has a skills-based Board of six (6) elected and three (3) appointed directors.

MPHN has established four Clinical Councils and a Community Advisory Committee (CAC) to assist in the identification of local needs and opportunities to improve primary healthcare across the Murrumbidgee. These committees are an important part of the MPHN governance structure. The

CAC includes representation from 33 Local Health Advisory Committees (LHACs) across the region, which are made up of community members.

The clinicians and community representatives engaged on these committees bring varied experiences and insights to assist in improved understanding of health needs and to inform service planning and delivery.

MPHN documents

Strategic Plan

2023 Annual Report

2022 Annual Report

Joint governance and planning

MPHN has strong partnerships with a range of organisations and community groups. We know the value in working together to ensure services are not duplicated, patients feel more supported, and workforce resources are utilised efficiently and effectively.

Recognising that collaboration and integration is central to delivering patient centred care, the NSW Primary Health Networks and NSW Health signed a Joint Statement in 2021 to encourage a one health system mindset. The *Joint Statement* focuses on three priority areas: focusing on care in the community; establishing regional planning processes and governance; and data and outcomes.

Locally, MPHN and the Murrumbidgee Local Health District (MLHD) have worked both informally (self-driven) and formally (mandated). In 2022 MPHN and MLHD held their first joint board meeting to discuss the challenges and future opportunities for both organisations to work together and drive system change locally. A Collaborative Agreement between both organisations was signed in November 2023 which formalised the existing partnership, aligned to the priority under the joint statement to establish regional planning processes and governance. The agreement also formalises the strong commitment between both organisations to work towards a shared vision of *one health system for the Murrumbidgee*.

It is anticipated that through joint activities, initiatives and projects the region will experience a more sustainable health system, reduce fragmentation, and provide people with a more coordinated journey through the health system that meets their needs.

The Collaborative Agreement identifies three key focus areas to guide the collaborative activity of the organisations:

1. Enhance collaboration to optimise use of the health workforce and support wellbeing of providers.
2. Identify, review and develop models of care that enhance coordination, efficiency, and patient experience.
3. Facilitate joint information, data sharing and planning to understand and improve the health and wellbeing of our communities.

The Collaborative Agreement will be monitored by the partners through agreed reporting mechanisms to the joint board. The joint board will set key performance indicators (KPIs) aligned to the focus areas to monitor progress toward the shared commitment.

The Collaborative Agreement provides an overarching governance structure to a number of local activities and projects.

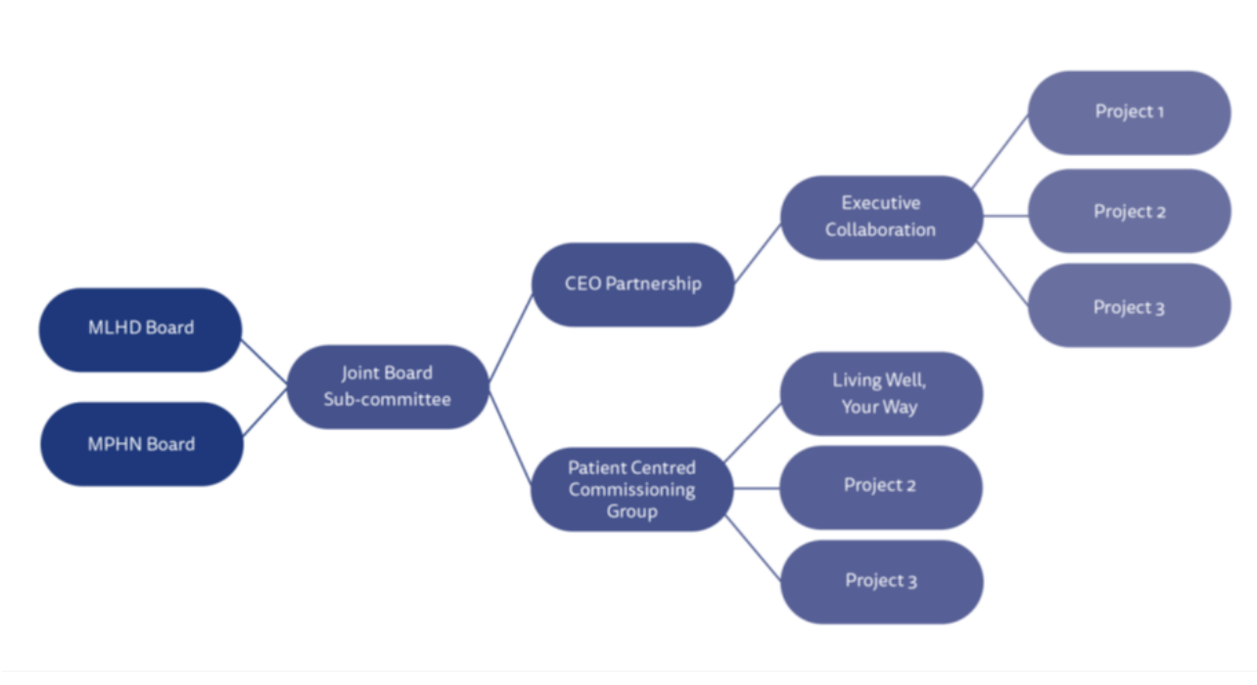
Practically, joint governance in action is demonstrated with the Patient Centre Co-Commissioning Group (PCCG). It is a formalised structure established to facilitate the delivery of the Collaborative Commissioning agreement with the Ministry of Health.

The PCCG is jointly chaired by the MLHD Chief Executive (CE) and MPHN Chief Executive Officer (CEO). It has been operating monthly since 2019 and PCCG members include:

- MLHD Director of Integrated Care and Allied Health
- Director Clinical Operations, Director Finance and Performance
- MPHN Executive Integration and Partnerships
- Senior Manager Commissioning
- Program Director Collaborative Commissioning

The PCCG initially only included oversight of Collaborative Commissioning but has since been expanded to include two other projects, Head to Health and the Statewide Diabetes Initiative. A clinical advisory group was also established including clinicians from primary care, pharmacy, and MLHD to oversee the project.

The diagram below shows the joint governance structure from the Collaborative Agreement and includes the PCCG.



Case study: The Murrumbidgee Mental Health and Drug and Alcohol Alliance

The Murrumbidgee Mental Health and Drug and Alcohol Alliance was formed in 2015 following planning work and consultations which identified the potential value of having an overarching group or governance process for mental health and drug and alcohol providers in the Murrumbidgee region.

There are 20 organisations that now form part of the Alliance including MPHN and MLHD.

The Alliance is a formal arrangement between partners in services for people with mental illness, mental health challenges including suicidality and/or drug and alcohol issues, that reflects a commitment to work together to improve mental health and drug and alcohol outcomes for the Murrumbidgee population.

The Alliance members:

- focus on consumer outcomes not organisational outcomes and place the consumer as the central focus;
- recognise the value that the wider community and social sectors contribute to addressing the needs of mental health and drug and alcohol consumers; and
- communicate and work together with each other in a collaborative, open and transparent manner that recognises the values, skills and expertise that members bring to the Alliance.

Since 2015, the Alliance has remained committed to these principles and has developed a multiagency, consumer focused, approach. Two examples of activities of the Alliance are:

- The development of MapMyRecovery – the region's free online resource and directory for local services that provide support for mental health and drug and alcohol concerns.
- The development of a Connect, Your Way – a mental health campaign to encourage people living across the Murrumbidgee to connect to services and resources and to reduce stigma around seeking support.

Case study: Local Response Group

A Local Response Group (LRG) was formed to ensure coordinated and timely supports are put in place following a suicide event or critical incident. A communications and response protocol governs and supports the work of the LRG. The LRG includes the Murrumbidgee Primary Health Network (MPHN), Murrumbidgee Local Health District (MLHD), Wellways, NSW Police and NSW Ambulance.

Individual organisations including Wellways and Murrumbidgee Local Health District provide extensive suicide prevention and aftercare clinical and non-clinical support services and community support programs.

When a suicide or critical incident event occurs in the Murrumbidgee region, a coordinated response, in accordance with the Murrumbidgee Suicide/Critical Incident Communications and Response Protocol is initiated. This enables the delivery of coordinated and timely response to suicide event and other critical incidents, and to minimise the risk of contagion following a suicide event or other critical incident.

The whole of region approach to suicide prevention and aftercare in the Murrumbidgee is unique and continues to be regarded as a leading example at both the NSW and national level.

Communications and Response Protocol

The Murrumbidgee Suicide/Critical Incident Communications and Response Protocol has two aims:

1. To ensure a coordinated and effective response to suicide events and other critical incidents.
2. To improve community capacity to minimise the risk of contagion following a suicide event and other critical incidents.

Innovative models of care

Collaborative Commissioning

What is Collaborative Commissioning?

Collaborative Commissioning is NSW Health Funded initiative aimed at 'transforming the way health care is delivered and funded through a one-system approach'.

The six guiding principles of Collaborative Commissioning are:

1. Joint responsibility between providers and organisations.
2. Strong consumer engagement, embedding accountability to the community served.
3. Local design of care pathways for improved outcomes for patients.
4. Funding reform, including flexible purchasing and provider arrangements, realignment of resources and outcome-based payments.
5. Use of data analytics, business analytics, implementation support, and digital technologies supported by Lumos.
6. Encouraging continuous learning to support improvement and innovation.

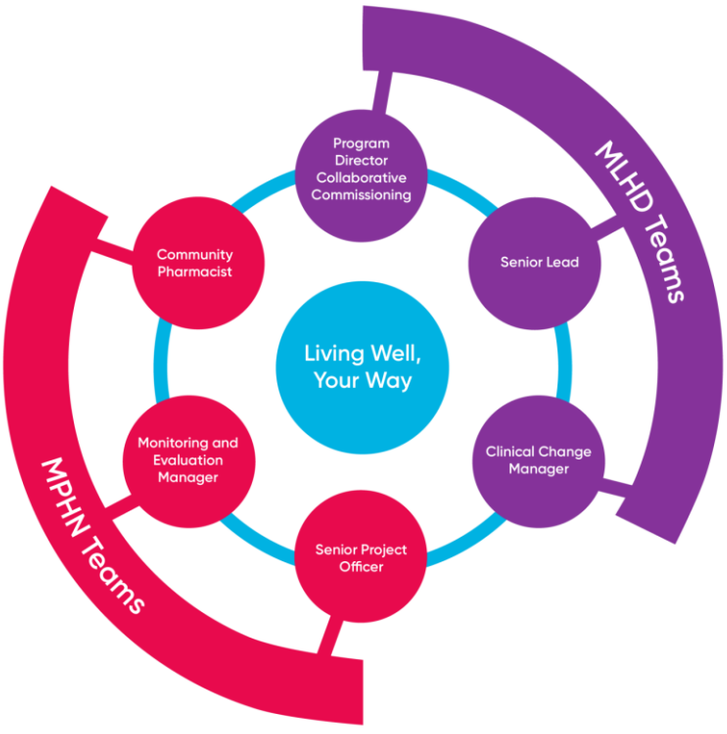
Murrumbidgee Collaborative Commissioning (MCC)

MCC is a partnership between Murrumbidgee Primary Health Network (MPHN) and Local Health District (MLHD). It has been working to improve care for people with Chronic Obstructive Pulmonary Disease and Heart Failure, since 2019.

The model of care and scope of the initiative was locally developed through co-design with more than 200 stakeholders in the region, including consumers, private specialists and allied health providers, community pharmacists, general practitioners, and local health district staff.

A shared model of implementation

Murrumbidgee Collaborative Commissioning (MCC) is unique in NSW because there is a shared project team who operationally report to both MLHD and MPHN. Staff who are employed by MLHD sit in MPHN offices, and all project information is shared through collaborative platforms such as Microsoft Teams.

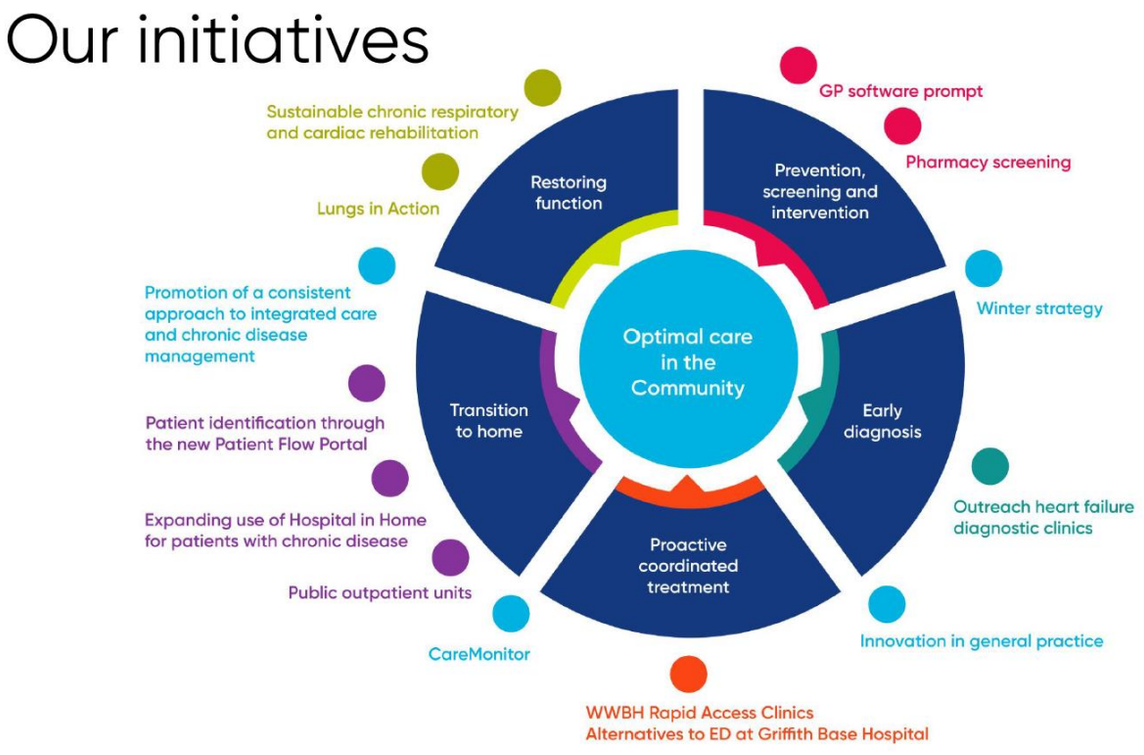


The MCC project has been named Living Well, Your Way

The Living Well, Your Way care pathway aims to:

- promotes care in the community
- build individual self-management of chronic disease
- foster collaboration between providers in private, public, state and federal funding models
- improve efficiency and effectiveness of chronic disease care

There are 13 unique projects included in the care pathway (each dot point in the wheel below). Two are outlined in more detail below.

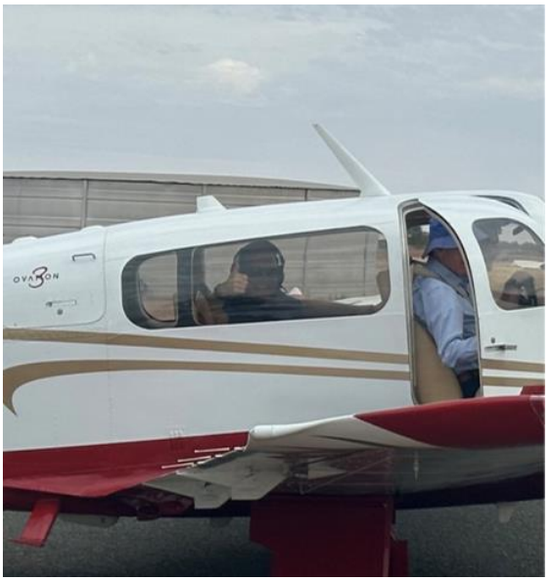


Case study 1: Outreach Heart Failure Diagnostic Clinics

The Outreach Heart Failure Diagnostic Clinics use COAG19(2) funding to support a cardiologist and sonographer from Sydney to travel to rural communities in the Murrumbidgee to perform diagnostic echocardiograms and specialist assessments in general practice. An MLHD Clinical Nurse Specialist and administrative officer are present and support the clinics. February marked the 12-month anniversary of the clinics.

Outcomes include:

- Clinics across four general practice sites including West Wyalong, Temora, Hay and Lake Cargelligo
- Clinics facilitated across two Aboriginal Medical Services- Hay and Lake Cargelligo
- Nine clinics held across Western sector
- 97 patients seen
- 34% clients of Aboriginal or Torres Strait Islander background
- 35 significant clinical findings
- 21 new diagnosis of heart failure
- 18 likely avoided hospital admissions.
- 28 referrals for either regional or tertiary for further investigations or intervention
- 22 linked with community services for ongoing support.
- One Angel Flight utilised for specialist transport home in Lake Cargelligo at no cost



Case study 2: Commissioning general practice to enhance models of care

Winter Strategy

The Living Well, Your Way Winter Strategy commissions general practice to provide holistic care to patients at risk of hospitalisation over the winter period, above usual practice. Models for MBS reimbursement are included in the initiative to help build sustainability. MPHN funding is primarily used to enhance practice nursing hours to support patients at risk.

In 2023, there were:

- 34 general practices engaged in Winter Strategy (out of 79 practices in Murrumbidgee)
- 102 visits by the MPHN Primary Care Engagement visits to enrolled practices to help them implement the program, and enhance holistic care in winter
- 8 education sessions provided, 16 practice nurses certified to provide spirometry, over 115 staff trained in chronic disease management
- 901 patients registered and receiving an enhanced level of care of winter
- Support to register with Lumos

Innovation in General Practice

The *Innovation in General Practice Program* is a Living Well, Your Way program that commissions general practice to trial a new innovation to improve care for patients with chronic disease. In November 2023, 20 general practices signed up to trial CareMonitor with 10 patients with COPD/CHF in their practice. CareMonitor is an app on patients phone that allows patients to self-monitor their condition and receive targeted health education. It is linked to a clinician dashboard

that is integrated into general practice. Two general practices signed up to use the NSW Health Outcomes and Patient Experience (HOPE) platform with 25 patients. The HOPE tool allows for the realtime collection of patient reported outcome measures and allows clinicians to address patients holistic care needs in real time.

Case study 3: Screening for chronic disease in community pharmacy

Eleven (11) pharmacies from across the Murrumbidgee have been commissioned to design and implement a screening program to identify patients at increased risk of COPD and Heart Failure through screening in Pharmacy and warm handover to the patients primary care provider. Pharmacies are located in Adelong, Deniliquin, Griffith, Leeton, Moama, Narrandera and Wagga Wagga.

Early data from the pilot has shown promising results with a number of at-risk patients being identified and referred.

As at Mid-February 2024:

Screened patients:	CHF:	17	COPD:	39
Referrals sent to GPs:	CHF:	14	COPD:	16

Pharmacists find providing the service and sending referrals professionally rewarding and are looking forward to participating in an expanded model in 2024. The options for funding pharmacies this year are still being considered, whether it is a contracted rate or a per patient funding model.

Evaluation framework

Outcomes of MCC will be measured against the quadruple aim. The primary outcomes of interest are a reduction in ED presentations and acute hospital admissions for people with COPD and CHF. Secondary outcomes include an increase in patient's confidence in self-management of their condition, quality of life and patient experience, as well access to care and diagnosis in primary care. Provider experience and ability to work to the top of their scope of practice will also be measured.

Statewide evaluation of Collaborative Commissioning is being led by The George Institute, who recently partnered with MCC to submit an ethics application locally. MCC is also commissioning an in-depth evaluation of the CareMonitor program, and is looking for partners to work with local clinicians to evaluate outreach services and the pharmacy screening program.

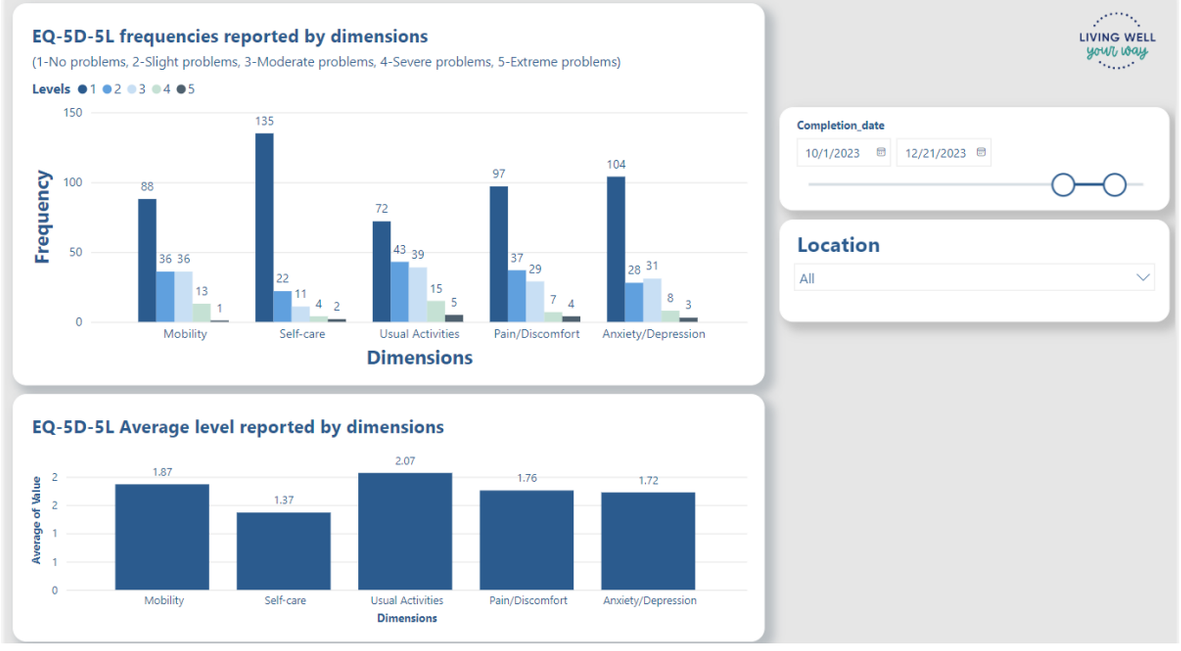
Patient experience and outcomes

As a result of Collaborative Commissioning initiatives, Murrumbidgee are leading the state in the collection and use of Patient Reported Experience Measures and Outcomes. In Murrumbidgee, six general practices are actively using the HOPE platform for patients with COPD, CHF diabetes and falls (https://aci.health.nsw.gov.au/statewide-programs/prms/hope-platform).

Murrumbidgee Collaborative Commissioning is the first project in NSW (that we are aware of) to move beyond 'how many patients collect these measures' to using HOPE outcomes data in our monitoring and reporting.

We have developed a dashboard to monitor our key outcomes of interest (see below).

This dashboard allows for shared outcomes reporting by region and service provider – a mix of outcomes from general practice, and MLHD providers. For example, the image below shows Quality of Life Measure (EQ-5D-5L) reporting frequency across the Murrumbidgee in both acute and primary settings, and then shows the aggregate data on outcomes. This tool can be used to measure pre- and post-quality of life rates on a population level across the region.



Conclusion

Collaborative Commissioning is an innovative, one health system approach that has supported the Murrumbidgee to fully diagnose the issues that affect chronic disease management in our region, and to locally design and implement a care pathway to address the challenges faced in rural areas. MCC is 18 months into implementation and already has had success in enhancing access to primary

care in rural communities. This funding is highly valued and has the potential to significantly benefit other conditions that present significant challenges on the health system in our region.

Urgent Care Services

Access to urgent care services is a key priority of both federal and state governments to help ensure patients get access to the right care at the right time. MPHN funds several services to support access to urgent care both in hours and after hours.

MPHN has received funding in 2024 from the Ministry of Health to work with local primary care stakeholders to plan and deliver an in hours, same day, urgent care collaborative model within primary care providers in the Wagga Wagga region. This program is currently in a codesign phase with eight general practices. The service will integrate with the MLHD Rapid Access Clinic and the single front door with HealthDirect.

MPHN funds the Wagga GP After Hours Service which operates outside normal surgery hours for urgent medical treatment. The service has been in operation for 20 years and uses a collaborative model with local general practices who participate on the roster. The service delivers on average 5,500 occasions of service a year.

In addition, MPHN have recently commenced a GP after hours telehealth service in the Western and Border regions of the Murrumbidgee. This service was recently utilised to provide additional support to small rural communities to address gaps in primary health service provision over the Christmas/new year holiday period when practices were closed for a short period. This approach supports local general practices by providing an alternate and time limited service upon request.

Increasing scope of practice and access to specialist care

Case study: Enhancing Paediatrics in Primary Care (EPiPC)

Boosting GP confidence in supporting specialist paediatric primary care

Background

Children in rural communities, particularly the Murrumbidgee region of NSW, experience great vulnerabilities and poorer health outcomes. This is exacerbated by the lack of access to appropriate screening, assessment and treatment services. In 2019 MPHN in collaboration with the Murrumbidgee Local Health District launched the Murrumbidgee Maternal and Child Health Strategy which provides an agreed regional approach to improving maternal and child health outcomes in the Murrumbidgee region. The Strategy identified there was a need to strengthen the existing workforce by increasing the expertise and confidence in paediatrics to try and ensure appropriate use of hospital-based resources and increase the uptake of child health screening for those requiring specialised support.

The strategy is underpinned by key strategic reviews including the NSW Ministry of Health The First 2000 Days Framework, The National Framework for Health Services for Aboriginal and Torres Strait Islander Families and the Henry Review, a review of health services for children, young people and families within the NSW Health System which made 77 recommendations for improvement including support for projects that increase the skills of GPs in managing complex behavioural problems in children and improving integration between hospital, community paediatrics and child health services.

Approach/Activity undertaken

Through a codesign process, we established the Enhancing Paediatrics in Primary Care model and includes the following components:

Community Paediatrician

- Joint funded Community Paediatrician with MPHN and MLHD; focus is to develop capability within primary care. The co-funded Community Paediatrician supports the delivery of the model, including the delivery of paediatric consultations as part of the existing MLHD paediatric team.

Primary care enhancement:

- Standardised screening, assessment, and referral tools
- Community paediatrics consultation support (email/telehealth)

- HealthPathways, including family education resources
- Continuing professional development

GPs with Special Interest:

- Five GPs engaged to develop expertise and run specific clinics to identify behavioural and developmental issues in children aged 0-7 years. GPs may engage their broader practice team including nurses to help facilitate the clinics.
- Engagement in monthly codesign meetings with the Community Paediatrician, MLHD Child and Family Health Nurse and Allied Health provider
- Enhanced training opportunities
- Supported case conferencing between GP and Community Paediatrician
- Multidisciplinary clinics including allied health and Community Paediatrician (email, telehealth, case conference) for initial assessments.
- An Expression of Interest (EOI) process was used to identify GPs with a special interest in paediatrics, with five general practices now engaged across the region, including Deniliquin, Gundagai, Hay, Leeton and Wagga Wagga. In collaboration with the Community Paediatrician, participating GPs aim to:
- Provide input into the design of the model, including the GP email support and case conferencing.
- Commence appropriate developmental screening and management at an earlier stage.
- Triage preschool/early primary school aged children who need referral for multidisciplinary assessment, paediatrician assessment or primarily GP led care at an earlier stage.
- Improve GP and family confidence in the process of early childhood development/behaviour screening/diagnosis and management at the primary health care level and beyond.

A participant of one of the CPD workshops said: *"It was such an informative and interactive workshop. I found it very useful and it provided us with excellent resources to refer to when we deal with those challenging paediatric presentations, particularly with such extensive wait lists to see a paediatrician. As a GP, I am glad we have such local expert paediatric support in the region."*

Outcomes to date

The five GPs engaged in the EPiPC program have been able to increase their skills and implementation of screening assessments through support of the Community Paediatrician (Table below). The program will be undergoing an evaluation to determine improvements to the model and to increase utilisation of the service by GPs across the region:

Location	Total # of screening assessments	Number of support emails to Community Paediatrician	Number of case conferences
Gundagai	51	1	0
Hay	47	22	3
Deniliquin	46	11	5
Wagga Wagga	227	10	2
Leeton	18	12	0
Total	389	56	10

WARATAH for Kids (Wellness and Resilience Achieved Through Allied Health) is an addition to the EPiPC model which commenced in 2023 commissioned by MPHN. The WARATAH for Kids program aims to increase the uptake of developmental and behavioural screening in general practice. A co-design process was undertaken including an extensive understanding of existing public and private allied health services. The clinic aims to screen children with developmental/behavioural concerns, refer via appropriate pathways and provide therapy on a case-by-case basis. MPHN's commissioned service provider delivers both speech pathology and occupational therapy clinics linked with the GPs with special interest across the four communities. Follow up case discussions are held between the Community Paediatrician, the GP and relevant practice nurse and/or child and family nurse, and allied health provider to determine appropriate management plans. Nine clinics have been held since April 2023 with 20 kids screened and appropriate management plans and referral provided.

Funding mechanism

Community Paediatrician (0.5FTE)	Co-funded with MLHD; $80,000pa funded by MPHN
GPs with Specialist Interest	$100,000pa funded by MPHN
WARATAH for Kids	Approx. $340,000pa funded by MPHN

Case study: General Practice Winter Strategy

Primary care initiatives to support people with chronic disease over the winter period

Identified Need

The Murrumbidgee region has some of the highest rates for potentially preventable hospitalisation, especially for people with COPD and Congestive Heart Failure.

Approach/Activity undertaken

As part of the Living Well Your Way Care pathway, the general practice Winter Strategy aim to keep people diagnosed with a chronic illness well and in the community and reduce the likelihood of hospital presentations during the winter period. This may include:

- people with a newly diagnosed chronic illness, such as Chronic Obstructive Pulmonary Disease (COPD), Asthma, Chronic Heart Failure (CHF), or Diabetes;
- people with chronic conditions who experience social isolation or are affected by the social determinants of health;
- people who are not managing their chronic illness well and are at risk of attending hospital; or
- people who are not managing their chronic illness well and are known to have attended hospital during previous winter months.

Participating general practices undertake the following activities at a minimum:

- Identify the participating practice team members and their roles and responsibilities.
- Undertake Quality Improvement data cleansing activities to identify eligible participants for the program.
- Recruit participants to the program including gaining consent.
- Provide additional clinical intervention and care to participants over the winter period.
- Implement the practice recall and reminder system for participants.
- Update the Winter Strategy 2024 Checklist for each participant for the duration of the program.
- Provide Winter Strategy 2024 Checklist data and consent to share with the Local Health District and NSW Ministry of Health for the purposes of the Living Well, Your Way program monitoring.
- Participate in the end of Program evaluation including facilitating participant evaluation engagement.

A minimum 25 patients are required to participate in the Winter Strategy program.

Outcomes

Thirty-four general practices were commissioned to participate in the LWYW Winter Strategy for 2023. Participation in the program has required the general practice team to provide additional proactive support for patients over the winter period, training in chronic disease management plans, MBS billing, and spirometry training.

Practices used funding to focus nursing time on the identification of potential patients and provide proactive care to patients living with chronic disease to improve their health over the Winter period.

Clinical and non-clinical staff education provided to assist staff to work at top of scope, improve diagnostic and testing skills, implement preventative measures, improve clinical assessments, and increase opportunities to provide patient education on what they can do to self-manage. More than 115 staff were trained.

Winter Strategy provided more opportunities for collaboration, shared and team care between general practice clinicals, administration and other health professionals which supports general practitioners workload and reduced pressure on appointment availability.

Practices engaged in proactive care to avoid exacerbations including increased immunisation, nurse check in calls, telehealth, more timely review of General Practice Management Plans, Sick Day Action Plans and Domiciliary Medication Management Review (DMMR).

There were a total number of 901 participants across 34 practices. There was an average of 26 patients per practice with a range of 19 to 39 years.

Around half the patients had COPD as their diagnosis where 43 percent had other diseases as their diagnosis with diabetes as the dominant.

In 2024, a formal evaluation of outcomes of the Winter Strategy will be undertaken against the quintuple aim. The aim is to engage in data linkage with the MLHD to measure the impact of the program on hospital usage over the winter period (pending ethics approval).

Funding mechanism

Winter Strategy program has been funded since 2019 MPHN. In the 2023 financial year, the Winter Strategy program was realigned to the Living Well Your Way Program with MoH Collaborative Commissioning funding contributing to the rollout of the program.

Case study: Diabetes Regional Education and Management Program

Increase access to specialist and multi-disciplinary diabetes care and upskill primary care workforce

Identified Need

The Murrumbidgee region has the highest prevalence of diabetes and higher rates of diabetes related hospitalisations in the State, with 10 percent of the adult population living with diabetes. Best practice diabetes care is delivered in the community by a multidisciplinary team, including

specialist care provided by an Endocrinologist and Diabetes Educator. The Murrumbidgee region has limited access to Endocrinology, with no public endocrinology services.

Approach/Activity undertaken

Through a partnership with the St Vincents Health Network Sydney, St Vincent's Curran Foundation and the Murrumbidgee Local Health District, the Diabetes Regional Education and Management Program was codesigned in 2023 and is in its early stages of implementation.

The model of care which is led by St Vincents Health Network provides a framework for undertaking diabetes management in regional and rural areas, with patients seen in their GP rooms by a multidisciplinary team from Sydney including an Endocrinologist and CNC diabetes educator. Monthly clinics are being established across the region, with the team partnering with Little Wings to enable flights to small rural communities. Case consultations are undertaken with the GP and patient, with follow-up session six months after the initial clinic provided through telehealth. The MLHD help to facilitate accommodation where available and linkage with chronic care coordination services. Educational sessions are provided for local GPs and clinicians to increase knowledge and skills in the management and treatment of diabetes.

Outcomes

This program is in its early stages of implementation, including design of outcome measures.