

CDM COMMISSIONING

Overhauling our approach – Murray PHN

Bronwyn Phillips

Health Services Lead

(Chronic Disease Management & After Hours)

PHN Commissioning Showcase

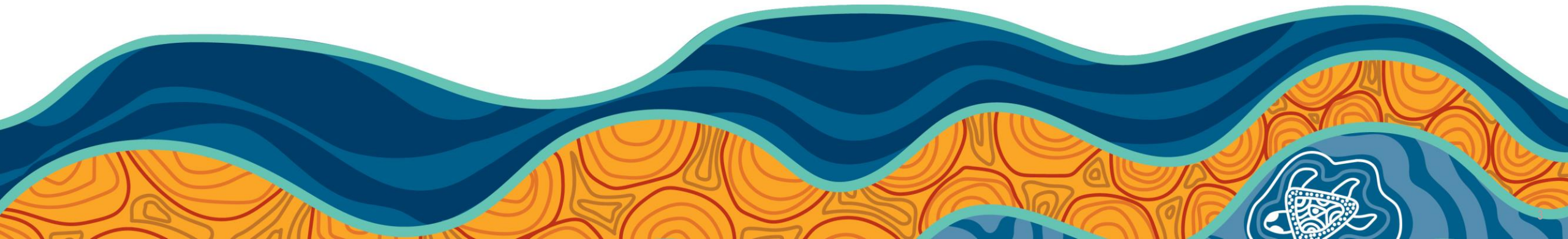
Newcastle

March 2022



Murray PHN acknowledges the Traditional Owners of the land on which we work and live.
We recognise, celebrate and respect Aboriginal and Torres Strait Islander
people as the First Australians.

We acknowledge their unique cultural and spiritual relationships to the land and waters, as
we strive for healing, equality and safety in health care. We pay our respects to elders
past, present and emerging, and extend that respect to all First Nations peoples.



Health outcomes in our region lag behind those in city and suburban areas of our state and country. We firmly believe that your rural or regional postcode should not determine your physical or mental health outcomes.

MURRAY PHN

100,000 sq km

644,000 population (approx)

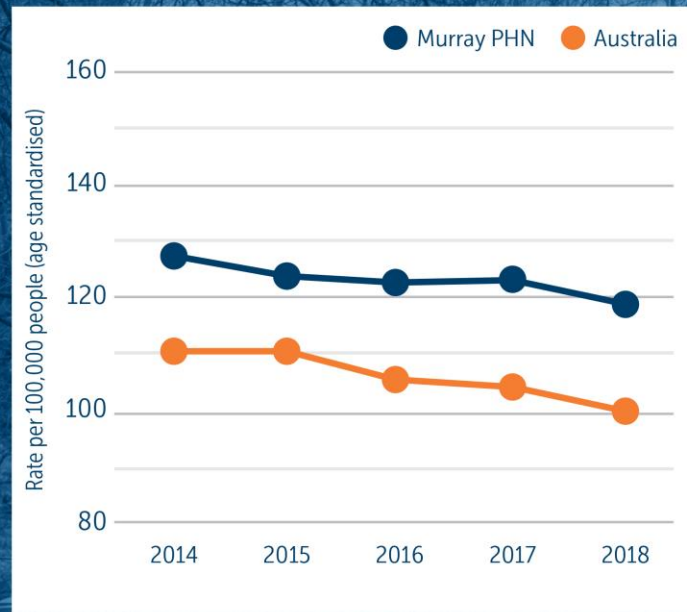
22 LGAs

A third of Victoria's First Nations People

Our work and our communities run along the Murray River and into the centre of the state, in a diverse and beautiful area covering almost 100,000 square kilometres and 22 local government areas

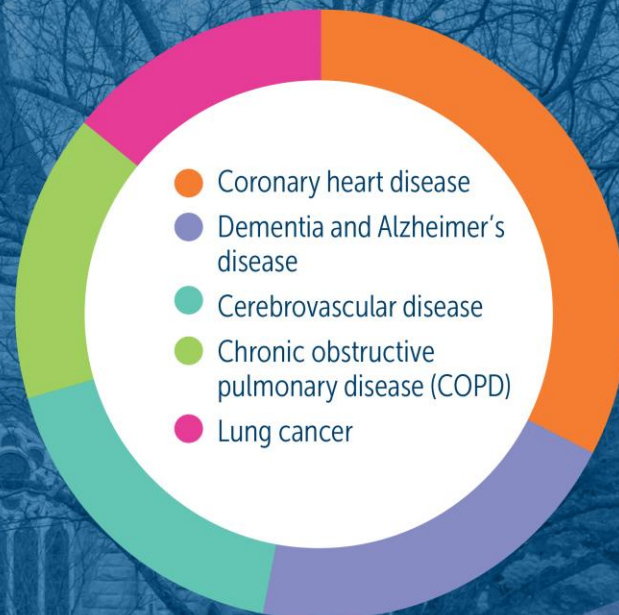
THE CHALLENGE – WHAT NEEDS EXIST?

Potentially avoidable deaths
per 100,000 people



Source: AIHW (Australian Institute of Health and Welfare) 2020. MORT (Mortality Over Regions and Time) books: Primary Health Network (PHN), 2014–2018. Canberra: AIHW.

Top 5 causes of death in the
Murray PHN region 2014-2018



Source: AIHW (Australian Institute of Health and Welfare) 2020. MORT (Mortality Over Regions and Time) books: Primary Health Network (PHN), 2014–2018. Canberra: AIHW.

- 15 of the 22 LGAs in Murray PHN have higher avoidable mortality rates for chronic conditions than Victorian averages
- Higher rates of PPH – especially for COPD, CHF and diabetes complications
- Underserved populations
- Increasing workforce 'fragility'

THE CHALLENGES – MORE SPECIFICALLY.....

Population groups in the Murray PHN region who have been identified as underserved are those who experience health inequalities, commonly through health inequity:



Rural populations



First Nations



People experiencing socioeconomic disadvantage



People experiencing, or at risk of, homelessness



Newly arrived communities (including refugees)



Older adults



People with disability



People with mental illness



People who identify as gender or sexually diverse



People who have experienced natural disasters

- Legacy arrangements and contracts
 - (previously three Medicare Locals and seven Divisions of GPs)
- Changing health needs
- Inequities in:
 - service mix
 - service frequency
 - contracted \$ rates
- Poor integration across providers
- Workforce instability
- Year to year contract uncertainty



Leadership



Collaboration



Knowledge



Innovation



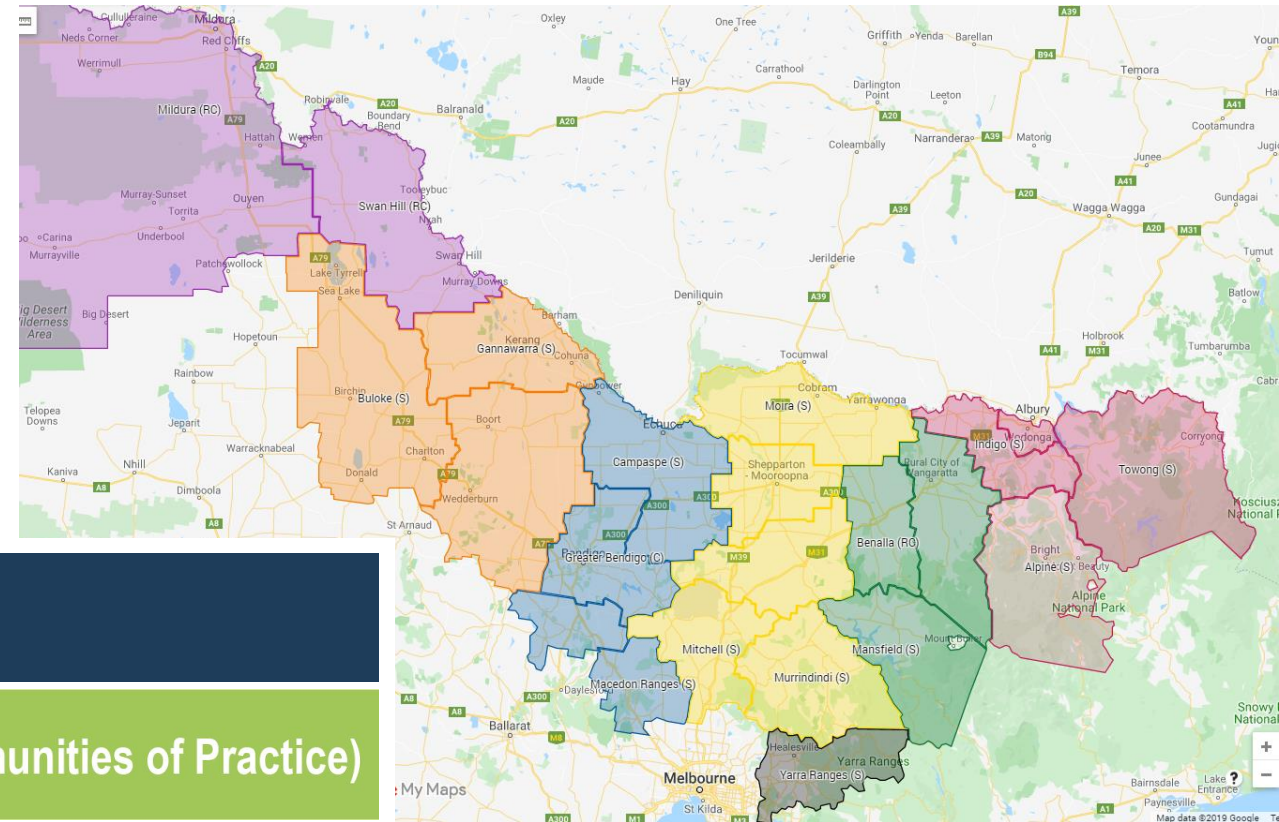
Accountability

THE APPROACH – WHAT DID WE DO?

Collaborative design

- Clear commissioning intent
- Clustered provider workshops
- Keep/ Stop/ Start/ Change
- Capacity building – planning
- Truly listened

Clustered geographies = regional integration



Direct Service Delivery (CDM Allied Health)



Building Integrated Care (skilled workforce and Communities of Practice)



Leadership



Collaboration



Knowledge



Innovation



Accountability

THE APPROACH – WHAT DID WE DO?

Unit price equity

Direct service rates based on:

- Contracted averages
- MBS rates
- DVA payments
- Insurance rebates
- Fee schedules (peak bodies)

Wrap around commissioning



Remote Patient Monitoring for chronic disease



Health System Navigators



After Hours access to primary care



Social Prescribing



Telehealth

THE APPROACH

Introduced PREMS & PROMS

- All providers
- All services
- Same tool
- Multiple collection methods
- One portal
- PHN analysis
- Shared results



Introduced Communities of Practice

- Clustered
- Lead entities
- Contracted – both ends
- Reporting
- Sustainability



THE APPROACH

Introduced Folio checklists and reporting

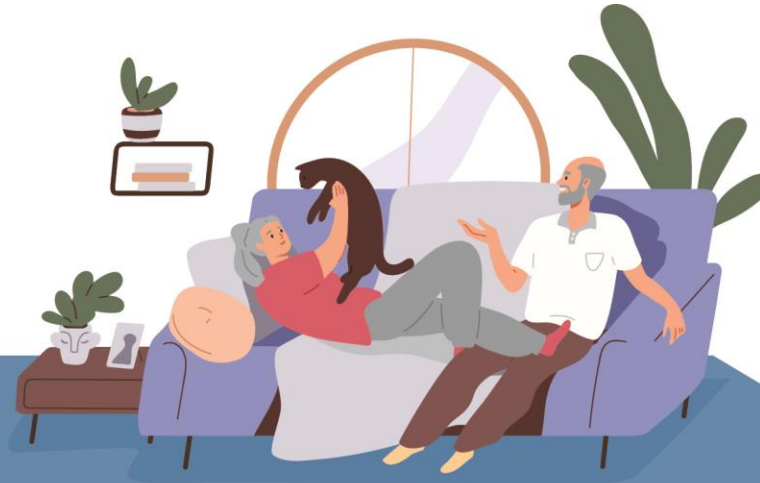
- Against targets
- Against performance indicators
- CoP reports
- Integration activities and system insights
- Applied PDSA approach to tweaking and improving reporting quality

Consistent schedules

- Same schedule for all
 - Intentional/ explicit integration expectations
 - Specific targets / service mix / geographies
 - ‘Socialised and tested’ with providers
 - Accompanied by contract management ‘cheat sheets’ specifying changes in service levels / funds/ expectations.
- = No delays in execution and no complaints



THE IMPACT



Telehealth



After Hours access to primary care



Building Integrated Care (skilled workforce and Communities of Practice)



Social Prescribing



Remote Patient Monitoring for chronic disease (people in their own homes)



Health System Navigators



Direct Service Delivery (CDM Allied Health)

A layered and integrated suite of CDM activities to address health system levels of:

- Patient
- Practitioner
- Practice
- Organisations

&

Increased ability to measure outcomes

THE LEARNINGS – FOR US AND OTHERS

1. A mix of specified elements and collaboratively designed elements equals an effective use of time / \$ / local knowledge / system knowledge
2. Longer contracts provide improved workforce stability, increased continuity of care and happier consumers
3. Communities of Practice had mixed success
4. Relational commissioning most appropriate in rural or regional context (i.e. thin market)
5. Wrap around / combined commissioning approaches
6. Reporting – importance of accuracy and consistency





phn
MURRAY

An Australian Government Initiative

www.murrayphn.org.au