Improving Chronic Conditions Management Program
Activity Work Plan

2016 – 2019
Primary Health Tasmania

An Australian Government Initiative

Background

Tasmania has had access to funding to support sustainable system re-design through the Tasmanian Health Assistance Package (THAP) for 4 years, ending at 30 June 2016. Primary Health Tasmania delivered several initiatives under this program, including social determinants and health risk factors initiatives, care coordination, Tasmanian HealthPathways and Streamlined Care Pathways (improving transfers of care between acute, primary care and aged care services. These initiatives had a focus on contributing to system re-design for the Tasmanian health service system, contributing to the prevention and management of chronic conditions.

The nature of service and system design requires time to understand how to best target effort, to build engagement with the required breadth of stakeholder required to achieve sustainable change and to implement initiatives with sufficient time to demonstrate sustainable change. This is difficult to achieve fully within the time-limited 4 years available for the funding. However, during this time much has been learned about service re-design for improve performance in the management for people living with chronic conditions and the program evaluation indicated that all elements of the initiatives undertaken demonstrated some immediate impact and the potential to achieve improved system performance over time.

With the momentum built through this work, and their consistency with the concurrent national and state health reforms, there is a significant opportunity to take these learnings to the next level and apply them in alignment to maximise the opportunities for sustainable system change and improved health outcomes for people living with chronic conditions in Tasmania.

Alignment with strategic health policy and reform

The proposed initiatives and activities listed below will ensure that the momentum and benefits achieved from the THAP funded programs can be maintained as it is our view that this work resonates strongly with current Australian Government policy reforms and announcements:

- The establishment of primary health networks (PHNs) with a key focus on improving chronic conditions management and the efficiency and effectiveness of care delivery
- Reform activity outlined in the suite of recommendations from the Primary Health Care Advisory Group (PHCAG) focused on improving the primary health system, including the specific Health Care Home initiative currently being implemented by the Australian Government in 10 regions across Australia, including Tasmania.
- The emergence of the commissioning approach, which is a specific role for PHNs and including a focus on both service delivery and service improvement
- The emergence of new approaches such as the stepped model of care outlined in the PHCAG recommendations, recent mental health and alcohol and other drug commissioning announcements, and which has potential application in focusing on other chronic conditions.

At a state level, the Tasmanian Government has developed a *One State, One Health System, Better Outcomes* White Paper outlining its intended key strategic reforms for improving the sustainability, effectiveness and efficiency of the State's public health system. This includes finalization of the transition of the state's three local hospital networks, to one network, the Tasmanian Health Service, creating significant opportunity to work with a single public health system hospital network to achieve change across the service continuum**.**

Strategic approach to improving chronic conditions management

The establishment period for THAP initially necessitated a strong focus at individual initiative level to ensure these new approaches were effectively researched and implemented. Following this period, there has been opportunity to reflect on the linkages between these initiatives and to consider the potential for next steps in developing a more integrated approach to service improvement through this work.

Of particular importance, has been the recognition of an integrated approach to an effective primary health care system, noting specifically the pillars of system integration, professional interactions and consumer engagement as key elements in improved outcomes; that:

- new services implemented in isolation will not address chronic conditions management challenges; and
- recognition and support for a service system re-design focus and associated investment is required as a critical means of addressing the current fragmentation and inefficiencies of care.

Tackling chronic conditions from multiple angles is supported by research undertaken internationally, such as the following framework developed by the United Kingdom's National Health Service (NHS).

The framework consists of three integration pillars adapted from the learnings of the NHS. Evidence suggests that integration is often difficult to achieve and the approach tends to be focused on structures and governance alone. However, this does not consider or change professional behaviours and interactions that can influence the success of developing well-functioning, integrated health care services to support the safe delivery of care. The pillars of integration proposed through this approach are:

Pillars of integration and critical success factors	
System integration	• Vertical and horizontal approach to system integration • Shared policy • Workforce innovation • e-health connectivity • Shared clinical governance
Professional provider interactions	• Integration across service boundaries to secure better outcomes for people • Reshaped and shared referral pathways • Person centred care as the preferred approach to clinical care • Evidence-based care guidelines and standards • Building workforce capacity and capability
Consumer and community engagement	• Bringing the voice of consumers to the planning, implementation and evaluation to service provision • Self-management education • Community insight into the need for change • Capacity building

This framework is well-aligned to the recommendations proposed by the PHCAG report and with programs emerging for mental health and alcohol and other drugs, focused on implementing strategic approaches to responding to these health issues through concepts such as the stepped model of care approach. Primary Health Tasmania is interested in embedding our learned service improvement approaches in support of the initiatives emerging from these national initiatives, particularly the Health Care Home initiative, providing additional resources enabling the next step to be taken in developing integrated approaches in our work across the service system.

The inter-linked nature of this work may best be demonstrated at **Figure 1**, noting alignment of potential models of care and system integration supports with the stepped model of care as it strives to respond to the changing needs of clients as they become more acute. The pillars of integration are then used as a framework for developing the proposed initiatives under this plan, summaries at **Table 1** and the subject of the remainder of this activity work plan.

Duration

This program will be funded for the period 1 July 2016 – 30 June 2019 to align with key Australian Government initiatives such as Health Care Home (HCH)and mental health and alcohol and other drugs initiatives, to allow for activities to implemented for the duration of these initiatives.

Evaluation

An evaluation of the full program will be conducted. It is believed that a number of elements of this work will provide valuable contribution to the Australian Government evaluation of the implementation of national health reform initiatives including the Department's Stage 1 Health Care Home evaluation and therefore investment in program evaluation is considered important both for Primary Health Tasmania and for the Australian Government.

Figure 1 Integrated approach to improved management of chronic conditions in a range of settings using a stepped model of care framework

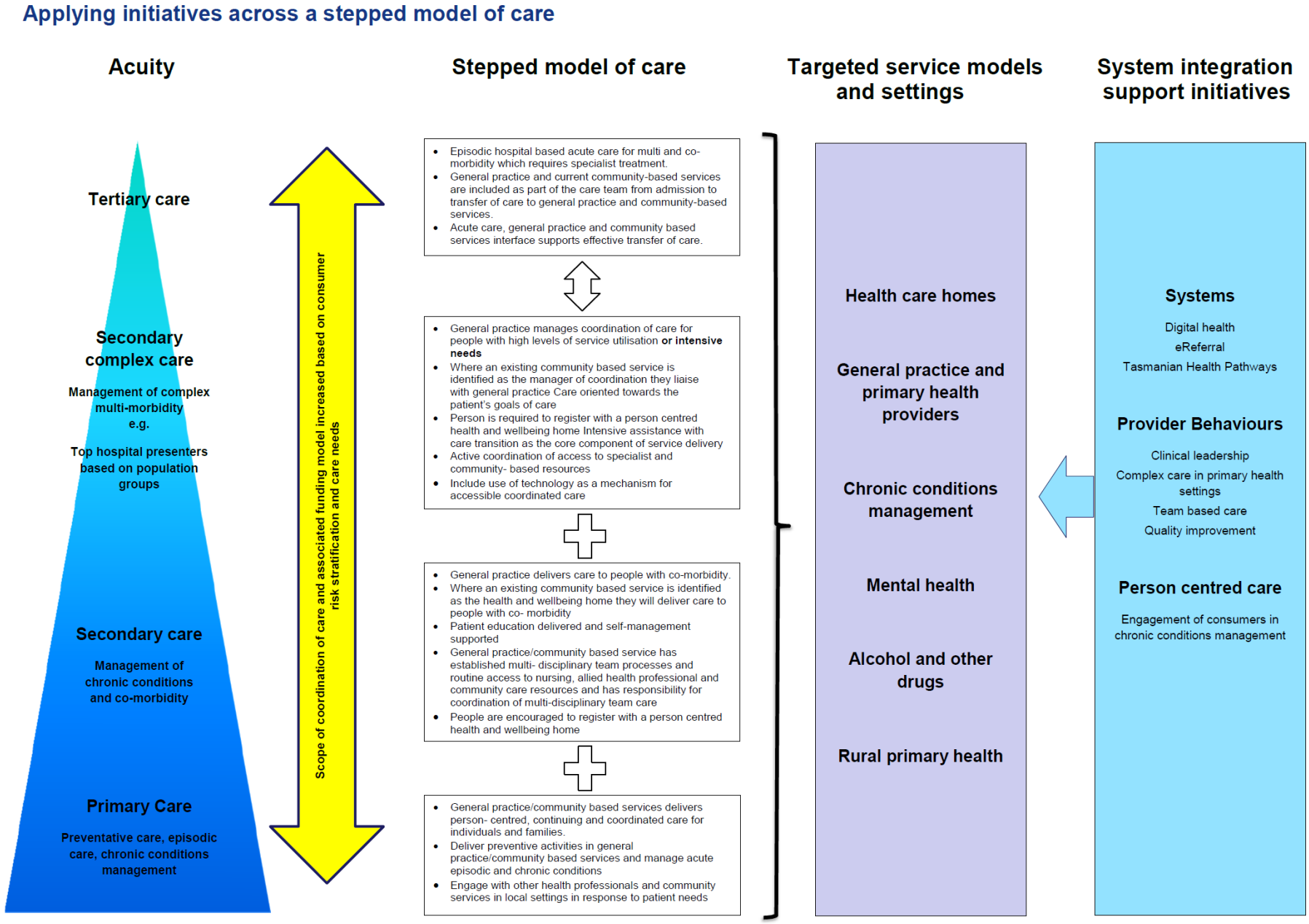

Table 1: Summary of Improving Chronic Conditions Management Program Initiatives

Pillar	Initiative	Activity
1. Systems	1.1. Digital health systems to improve capacity to share health information for complex chronic patients	1.1.a Statewide eReferral system for general practice 1.1.b Digital health resources and capability
	1.2. Health pathways supporting streamlined access to complex chronic conditions care	1.2.a Strengthening Tasmanian HealthPathways 1.2.b Building a consumer focus for Tasmanian HealthPathways (linked also to Person Centred Care activities)
2. Provider behaviours	2.1. Primary health clinical leadership in complex chronic conditions management	2.1.a Engaging general practice in national and state reforms 2.1.b Enhancing primary health leadership in regional planning
	2.2. Improving delivery of complex care in primary health settings	2.2.a Strengthening the Tasmanian Clinical Services Framework 2.2.b Delivering complex chronic conditions care in primary health settings
	2.3. Supporting the HCH initiative and general practices	2.3.a HCH support resources
	2.4. Improving team based care for people living with chronic conditions and health care home liaison	2.4.a Regional chronic conditions care collaboratives 2.4.b Team based chronic conditions care models
	2.5. Deliver care coordination services	2.5.a. Care coordination service delivery
3. Person Centred Care	3.1. Improving consumer engagement in chronic conditions management	3.1.a Improving health literacy and self-management (linked also to Tasmanian HealthPathways activities) 3.1.b Measuring patient experience of chronic conditions care
4. Project Evaluation	4.1. Evaluation framework established for each initiative as the program commences	4.1.a End-to-end program evaluation

Improving Chronic Conditions Management Activity Work Plan 2016 - 2019

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
1. Systems					
1.1. Digital health systems to improve capacity to share health information for complex chronic patients	**1.1.a. Statewide eReferral system for general practice** • System level improvement in digital health solutions and provider capabilities for improved access to care. Focused effort to improve connections between IT systems to improve timely access to and coordination of care. • In partnership with the THS, develop and deploy system capability required to support a move to eReferrals for GPs across the State. • The initiative will be implemented state-wide and enable all GP referrals, including HCH participants, to be sent electronically to the Tasmanian Health Service (THS). The system will enable ease of transition as the THS develops capabilities to receive eReferrals. • This initiative will include a focus on integration of Tasmanian HealthPathways (THP) within GP software systems to increase the targeting of referrals based on agreed health pathways. • The initiative will also include investigation of strategies for improving connectivity with primary health allied health providers.	• Improved systems enabling access to care for complex chronic conditions. • Improved digital connectivity between primary care and specialist care.	• Digital health capability identified as a key element under PHCAG Recommendation 4: *Establish effective mechanisms to support flexible team based care* • Digital health solutions identified as part of the PHCAG HCH principle No. 5: *Flexible service delivery and care teams being enabled through shared, integrated planning*, and associated HCH activities. • PHCAG HCH principles 1: *Voluntary patient enrolment* and No 5 (above) include specific focus on MyHealth Record.	Tasmanian Health Service (THS) Department of Health and Human Services (DHHS) General practice	End 30 June 2019
	1.1.b. Digital health resources and capability • Strengthen digital health expertise available from Primary Health Tasmania to assist HCH participating in implementing the new model of care. • Identify relevant digital health resources, including specific digital health formulary and focus on MyHealth Record (MHR) use by HCH practices. • Initiative will target HCH practices as well as non-HCH practices and allied health providers and community pharmacists, including education and promotion sessions	• Improved awareness and uptake of digital health solutions for improved coordination of care		General practices Digital Health Agency	End 30 June 2019

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
	with participating general practices to increase use of MHR as part of HCH model.				
1.2. Health pathways supporting streamlined access to complex chronic conditions care	**1.2.a. Strengthening Tasmanian HealthPathways (THP)** • Develop and/or review 100 additional new pathways localised as part of the continued development of the Tasmanian HealthPathways initiative. These will be targeted to ensure that HCH eligible conditions are prioritised for action.	• Improved efficiency of access to specialist services through use of agreed appropriate health pathways.	• PHCAG HCH principle No. 5 *Flexible service delivery and care teams being enabled through shared, integrated planning*, refers to care planning that spans primary health and acute care as required and enabled by digital health. • Additionally, PHCAG HCH principle No 6: *HCH is committed to care which is of high quality and is safe*, PHCAG Recommendations 5: *Enhance regional planning,* and PHCAG Recommendation 8: *Support cultural change across the health system*, refer to care being guided by evidence based patient health care pathways.	Tasmanian Health Service Clinical Working Groups General practice	End 30 June 2019
	1.2.b. Building a consumer focus for Tasmanian HealthPathways (linked also to Person Centred Care activities) • As part of its staged application, THP will be expanded to include a consumer access strategies to ensure availability of consumer information for key conditions.	• Improved consumer access to information relating to their health condition	• PHCAG Recommendation 3: *Activate patients to be engaged in their care*, includes reference to improving health literacy and enhanced access to clinically-endorsed information on health conditions and care management • PHCAG HCH principle 2: *Patients, families and their cares as partners in their care*, notes need for patients assistance to understand health information and options.	Consumer groups, eg,: Tasmania's consumer's health group, Council on the Ageing, Flourish, Carers Tasmania	End 30 June 2019

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
2. Provider behaviours					
2.1. Primary health clinical leadership in complex chronic conditions management	**2.1.a. Engaging general practice in national and state reforms** • Engage clinical leadership to enable the participation and advocacy of general practice and primary health providers including allied health and pharmacy in system national and state reform initiatives, including: – Responding to clinical consultation documents relating to general practice – Supporting implementation of HCH initiative – Supporting implementation and activities of GP champions (see below) – Contributing to regional chronic conditions collaboratives (see below) – Assisting in responding to clinical issues emerging from the implementation of new reform initiatives, including commissioning and HCH and chronic conditions care models in primary health settings. – Leading general practice engagement activities to inform Primary Health Tasmania planning and targeting of resources.	• Improved clinical leadership and general practice and primary health provider participation in national health reform initiatives.	• Recommendation 8: *Support cultural change across the health system*, refers to the importance of engaging clinical and sector leaders in implementing health reforms and the associated transition of health service delivery models.	Tasmanian Health Service – organisational reform process Primary Health Tasmania Clinical Advisory Council General practice Allied health providers	End June 2019
	2.1.b. Enhancing primary health leadership in regional planning • Using a general practice change champions model, engage general practice champions to represent general practice on key system improvement initiatives and to work with Primary Health Tasmania to target primary health systems efficiency initiatives. Priority initiatives for champions will be: – Assist in the development of the primary health tiers of the Clinical Services Framework (see below) – Represent primary health on THS health streams set up to lead state-wide sustainable service model development and delivery for health conditions – Participation in Tasmanian HealthPathways clinical	• Improved clinical leadership and general practice and primary health in local whole of system reform initiatives • Increased primary health sector profile in chronic conditions care	• PHCAG Recommendation 5: *Enhance regional planning,* notes the importance of regional governances as a lever for system integration. This includes a focus on improved links between primary health, specialist and acute care systems. • PHCAG Recommendation 8: *Support cultural change across the health system*, noted that co-design between health professionals has been demonstrated to reduce siloed	Tasmanian Health Service Primary Health Tasmania Clinical Advisory Council	End June 2019

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
	working groups. – Contributing to regional needs identification and service gap analysis.	systems and services.	approaches to health care delivery.		
2.2. Improving delivery of complex care in primary health settings	**2.2.a. Strengthening the Tasmanian Clinical Services Framework** • In partnership with DHHS incorporate primary health care into the role delineation of the tiers of care provided under the One Health System *Clinical Services Framework* (currently focuses on tiered care delivery for acute care services only). • Scoping of this work will include consideration of incorporating services beyond general practice and allied health providers, such as aged care and community services organisations, as well as state primary health services, to provide a comprehensive overview of services accessed by people.	• Tasmania's Clinical Services Framework represents a whole-of-system approach to the safe and skilled access to health care.	• As noted above, PHCAG Recommendation 5: *Enhance regional planning,* notes the importance of regional governances as a lever for system integration. This includes a focus on improved links between primary health, specialist and acute care systems. • PHCAG Recommendation 7: *Coordinate care across the health system to improve patient experience*, notes the important of enabling people to access care in the most appropriate places and acknowledges that access to care needs to include consideration of social and physical factors in chronic conditions care. • PHCAG Recommendation 8: *Support cultural change across the health system*, noted the need to support the transition of providers to new models of care.	DHHS THS General practitioners and primary health providers Community service organisations	End Sept 2017
	2.2.b. Delivering complex chronic conditions care in primary health settings • Based on the clinical services frameworks, identify priorities for improved models of care in primary health settings and utilise a collaboratives style approach to develop and implement new models in non-hospital settings, that lead to increased access to more complex care being delivered in non-hospital settings. • Work with the Health Services Innovation Tasmania to adapt the existing course in Clinical Re-Design (focused on acute care settings) for primary health settings to build sector skills in service design to support national health reform changes. • Development of new models of care will focus on engaging with HCH, general practice, allied health providers and community pharmacists to prioritise new models and to encourage participation as early adopters for implementation of these new models across the state.	• Increased models of service delivery for complex care in primary health care settings		THS Private specialist services General practice Allied health providers.	End June 2019
2.3. Supporting the HCH initiative and general	**2.3.a HCH support resources** • Establish a HCH liaison function (up to 3 FTEs) within Primary Health Tasmania to support participating general practices in establishing and implementing the HCH model.	• Effective participation in and increasing awareness of	• PHCAG HCH principle No. 5 *Flexible service delivery and care teams being enabled through shared, integrated planning*,	HCH participants General practice	As per Depart-ment of Health HCH

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
practices	These liaison roles will have a specific focus on education and ongoing support for HCH and patient enrolment into the HCH program. The roles will also assist in communicating progress on the model with other general practices not participating in the first HCH stage and consumers to continue to build interest in this initiative. • Participate in and contribute to the Regional Coordination Advisory Committee for HCH	the HCH in Tasmania.	notes the importance of team based care including HCH leadership in care coordination and expanding the health care team to specialist providers.	Allied health providers	initiative
2.4. Improving team based care for people living with chronic conditions	**2.4.a. Regional chronic conditions care collaboratives** • Engage with HCH, general practice and other primary health providers including but not limited to allied health and community pharmacists to participate in regional collaboration learning sets aimed at understanding the intention of PHCAG initiatives, (including the HCH) and to identify priorities for action to improve coordination of care. • Participating HCH practices encouraged to participate aimed at improving the efficiency of the HCH model. Based on priorities identified by the collaborative group, provide access to funding for the group to undertake projects to implement sustainable agreed actions for addressing priorities in regional areas. Collaborative projects would be implemented within a12-month period and would occur twice across the funded period.	• Improved regional collaboration in chronic conditions management • Increased general practice interest in the HCH model	• PHCAG Recommendation 4: *Establish effective mechanisms to support flexible team based care*, notes the complexity of the health and broader community services system and the need for improved team work in delivering evidence based care. • PHCAG Recommendation 5: *Enhance regional planning,* notes regional governances as an important lever for system integration and for ensuring input into local health priorities	Potential organisations include: HCH practices, general practice, aged care providers, community services and acute care services.	End June 2019
	2.4.b. Team based chronic conditions care models • Identify models and resources supporting team-based care in primary health. Familiarise general practice, allied health providers and community pharmacy with these resources and models to support their quality improvement approach in service delivery. • Activities will include access to training and resources as part of promoting orientation to and use of models in regions across the state. • This activity will be informed by the stage 1 of HCH implementation.	• Primary health care improved access to team based care models including HCH • Improved patient access to team based chronic conditions care	• PHCAG HCH principle No. 5 *Flexible service delivery and care teams being enabled through shared, integrated planning*, notes the importance of team based care including HCH leadership in care coordination and expanding the health care team to specialist providers. • PHCAG Recommendation 4: *Establish effective mechanisms to support flexible team based care*, lists innovative models, care plans and care coordination as mechanisms for improved	HCH General practice	End June 2019

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
			team care.		
2.5. Deliver coordination services	**2.5.a. Care Coordination service delivery** • Deliver care coordination services as agreed with the Department of Health from 1 July – 31 December 2016, pending announcements relating to HCH arrangements.	• THAP care coordination program effectively transitioned to HCH.	• PHCAG Recommendation 2: *Establish Health Care Homes*, the Australian Government have indicated a preference that the existing funded service model be de-commissioned to ensure this resourcing does not inadvertently impact the implementation of HCH model.	Existing providers	End Feb 2017

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration/ Partners	Duration
3. Person centred care					
3.1. Improving consumer engagement in chronic conditions management	**3.1.a. Improving health literacy and self management** (also linked to Tasmanian HealthPathways activities) • Deliver health literacy training and support for providers as part of quality and safety program for general practice focused on improved person centred care and improved opportunity for consumer self-management. • Work with University of Tasmania and partners to implement the OPHELIA model for health literacy in targeted priority communities, in support of anticipatory care approaches to improve prevention and management of chronic conditions.	• Improving health literacy skilled health professionals and environments • Improving health literacy in high needs communities	• PHCAG HCH principle 2: *Patients, families and their carers as partners in their care*, includes a focus on patient reported outcomes and patient reported experience measures. • PHC Recommendation 3: *Activate patients to be engaged in their care*, highlights the importance of health literacy in improving engagement and care planning.	University of Tasmania DHHS 26TEN HCH practices Primary health and community service providers	End June 2019
	3.1.b. Measuring patient experience of chronic conditions care • Support continuous service improvement for key elements of complex chronic conditions care support by developing and embedding mechanisms for collection and analysis of patient health outcomes and patient experience. • Test mechanisms for continuous patient feedback to inform care decision making in the complex care environment. • This work would encourage HCH practices participation.	• Improved primary health system capacity to measure and report patient health and experience outcomes.			End June 2019

	• Contribute to the establishment of a state-wide consumer engagement forum to provide strategic advice and effective mechanisms for engagement with consumers in relation to chronic conditions management.				

Initiative	Activities	Proposed Outcome	Alignment with Primary Health Care Advisory Group Recommendations	Collaboration / Partners	Duration
4. Project Evaluation					
4. Evaluation framework established for each initiative as the program commences	**4.1.a. End-to-end program evaluation** • Engage consultant to undertake program logic and evaluation measures and processes for each approved activity to ensure clear purpose and associated evaluation plan is established and implemented. • Consultant to remain involved to undertake agreed evaluation activities at each six-month interval of the approved activity. • End to end project evaluation completed for each major component to inform: – Australian Government policy – PHN evidence based initiatives most effective in supporting health reform priorities – Demonstrated system and provider behaviour changes – Demonstrated health outcomes • Participate in the Department of Health's Stage 1 HCH evaluation. • Develop targets and measures to be used for performance reporting as well as project evaluation.		• PHCAG Recommendation No 15: *Integrate evaluation throughout implementation of reforms*, is identified as critical to the success of the reforms to ensure learnings inform future actions.	HCH participants Program participants Identified consultants – engaged through procurement.	End June 2019