Sustainable Rural Healthcare HUBS

Buloke Loddon Gannawarra Sustainable Rural Healthcare Hubs (Multidisciplinary) Trial

Baseline Evaluation Report

December 2024

IMOC Round 4 – Sustainable Rural Healthcare Hubs. Grant activity ID: 4-J0EK4IH

Sustainable Rural Health Project

phn MURRAY
An Australian Government Initiative

INGLEWOOD & DISTRICTS HEALTH SERVICE

East Wimmera Health Service

Boort District Health

NDCH
NORTHERN DISTRICT COMMUNITY HEALTH

MONASH University

Acknowledgement of Country

Monash Rural Health, Northern District Community Health and project partners acknowledge this project is taking place on many unceded First Nations Countries, including the Lands of the Dja Dja Wurrung, Barapa Barapa, Wemba Wemba, Yorta Yorta, Wergeia, Wotjobaluk, Jaadwa, Jadawadjali, and Jupagalk Peoples.

We pay our respects and give thanks to the Ancestors, Elders and Young people for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuing cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us. We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations peoples.

We commit to addressing the injustices of colonisation across the region, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

The Sustainable Rural Healthcare Hubs project is funded by the Australian Government's Department of Health and Aged Care through the 'Innovative Models of Care (IMOC) Program Funding Community Supported Rural Primary Care Trials – Round 4'. The lead organisation is Northern District Community Health (NDCH) with Murray Primary Health Network (Murray PHN), Boort District Health (BDH), Inglewood & Districts Health Service (IDHS), and East Wimmera Health Service (EWHS) as consortium members. Monash Rural Health (MRH) leads the project evaluation.

The project is funded for four years from July 2023 to June 2027.

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Glossary

Integrated Health Network Alliance ('the Alliance')	A collaborative partnership between Murray PHN (Primary Health Network), Boort District Health, Inglewood & Districts Health Service, East Wimmera Health Service, and Northern District Community Health.
Healthcare consumer	A person receiving services from a healthcare provider. Used in preference to 'patient', 'client' or 'service user'.
Sustainable Healthcare Hubs ('the Hubs program')	A multidisciplinary model of healthcare for people living in the local government areas of Buloke, Loddon and Gannawarra shires.

Acronyms

AOD	Alcohol and other drugs
BDH	Boort District Health
BLG	Buloke, Loddon and Gannawarra
BSC	Buloke Shire Council
CC	Care Coordinator
CDH	Cohuna District Hospital
DBNC	Dingee Bush Nursing Centre
DFFH	Department of Families, Fairness and Housing
DoH	Department of Health
DoHAC	Department of Health and Aged Care
EWHS	East Wimmera Health Service
FTE	Full Time Equivalent
GP	General Practitioner
GSC	Gannawarra Shire Council
KDH	Kerang District Health
IDHS	Inglewood & Districts Health Service
IHN	Integrated Health Network

LGA	Local Government Area
LSC	Loddon Shire Council
MBS	Medicare Benefits Scheme
MDAS	Mallee District Aboriginal Service
MDT	Multidisciplinary Team
MRH	Monash Rural Health
MTHS	Mallee Track Health Service
Murray PHN	Murray Primary Health Network
NCLLEN	North Central Local learning and Employment Network
NDCH	Northern District Community Health
NP	Nurse Practitioner
PHU	Public Health Unit
RACH	Residential Aged Care Home
UCC	Urgent Care Centre
Western Vic PHN	Western Victoria Primary Health Network

Executive summary

The Sustainable Rural Healthcare Hubs (Multidisciplinary) Trial Baseline Evaluation Report details the planning and preparation for the implementation of the Innovative Model of Care (IMOC) multidisciplinary Hubs program in the Buloke, Loddon and Gannawarra shires to combat their similar challenges around community healthcare needs, resource use and ageing populations. The Baseline Report at Year 0 is the first of four reports tracking the implementation of the Hubs program to June 2027. It is a deliverable of the funding requirements for the grant opportunity supported by the Australian Government's Department of Health and Aged Care through the 'Innovative Models of Care (IMOC) Program Funding Community Supported Rural Primary Care Trials – Round 4'.

Data for the report were collected from interviews and focus groups with healthcare stakeholders, and population and service data. Key findings at December 2024 included:

- Partnership and governance arrangements were formalised with a Memorandum of Understanding with the IHN Alliance members.
- The four health service partners agreed to implement the trial model of care across the three adjoining shires at nine sites with another two for future consideration, increasing numbers from the six original sites proposed in the funding submission and DoHAC workplan.
- Two training days were completed for staff representing four sites (Kerang, Quambatook, Pyramid Hill and Boort).
- Three training days planned for January 2025 for staff representing three sites (Inglewood, Donald, Wycheproof). Further training days will be required for the remaining sites when they are ready to join the Hubs program (St Arnaud, Charlton, Birchip). The St Arnaud site crosses into the adjoining Western Victoria Primary Health Network catchment area and concurrent planning discussions are occurring for cross Primary Health Network collaboration.
- Blended funding models are being used for clinical services funding (analysis of which is outside the scope of the IMOC funding) which requires commissioning and contract management, service level agreements and collaborative planning, integration and reporting.
- Discussion of population needs across sites has identified priorities for team-based care and chronic condition management.
- The Hubs program model of care is expected to strengthen usual care by making team-based care more intentional and systematic.
- The model of care is expected to address consumer needs for improved care continuity and communication between providers
- Successful implementation will require developing and embedding systems for clear communication, scheduling and other organisational logistics.

The Baseline Evaluation Report describes the foundational work of the Hubs program development.

Sustainable Rural Healthcare Hubs Project Evaluation

INTRODUCTION

The Sustainable Rural Healthcare Hubs project builds on the previous work of the IHN Alliance and its collaborating research partners to identify, through co-design methodology, models of primary care that address community healthcare needs. The IHN Alliance (the 'Alliance') formed in 2019 with the intent of addressing similar healthcare challenges, including chronic rural health workforce shortages and effective resource use in a rural region with health system sustainability concerns.

It costs more to deliver primary care services in rural communities compared with metropolitan and regional centres, however rural people including those living in the BLG region are more likely to be socioeconomically disadvantaged and less able to afford the out-of-pocket costs. This makes it challenging to deliver sustainable primary care in rural regions, and this trial is exploring innovative approaches to address this and other systems barriers.

In 2022, the Alliance and Monash Rural Health commenced the Sustainable Rural Health Project, an investigation of co-designed community-focused healthcare models with input from local healthcare consumers, healthcare professionals, and those in health service leadership and managerial positions. Its May 2023 report [1] proposed three interrelated streams of work: workforce advocacy, recruitment and strengthening; integrated rural primary care services; and innovative employment models and models of care. As a result, a Nurse Practitioner Rural Outreach Model of Care was piloted, funded by the Violet Vines Marshman Centre for Rural Health Research at La Trobe Rural Health School and Murray PHN.

It delivered nurse practitioner primary care clinics in general practice settings, creating a proof-of-concept study, concluding in March 2024, that informed the current IMOC funded trial. [2]

The Sustainable Rural Healthcare Hubs multidisciplinary team (MDT) model of primary care is focused on delivering localised comprehensive healthcare for people with chronic conditions. It aims to apply and expand on the results of the Sustainable Rural Health Project and the Nurse Practitioner Rural Outreach Model of Care proof of concept trial. It will provide accessible multidisciplinary team-based care for people across their lifespan living in small rural communities (all MMM5) across the three adjoining shires who would benefit from a team-based approach. The MDT consists of shared leadership from a GP and NP, support by a Care Coordinator, with involvement from allied health and other professionals or support organisations involved in the person's care.

THE PROJECT'S AIMS

The project aims to trial a multidisciplinary team-based model of primary care (Hubs program) for rural communities in the three adjoining shires of Buloke, Loddon and Gannawarra located in Central and Northwest Victoria.

In particular, the evaluation will investigate the:

- experiences of healthcare consumers and providers with the model of care
- costs and benefits of the Hubs program, including its sustainability
- enablers and the challenges
- impact of the model of care on healthcare access equity and outcomes; and
- healthcare outcomes for consumers, the community and the health system.

THE EVALUATION

The research team evaluating the project's outcomes consists of the IHN Alliance plus members of the IMOC Action Research and Evaluation Working Group. The latter has two sub-groups focused on the intervention and the evaluation. Members of the intervention group are Dr Nerida Hyett, Trevor Adem, Donna Doyle, Dallas Coghill, and Penny Wilkinson.

The evaluation group members are Dr Pam Harvey, Kylie Shanahan, Pauline Nolan (Aboriginal Researcher), Dr Damilola Adu, Dr Kalayu Brhane Mruts, and Professor Shane Bullock. A health economist consultant in early 2025 will assist in developing a strategy over the funded years of the project to address economic and other outcome measures.

There will be four evaluation reports aligning with the project's stages. The baseline report (Year 0, this report) will review the project's stages of development and implementation across the proposed sites as of December 2024. Data will be collected on expected patient flow processes, reporting and referral mechanisms, and current Medicare Benefits Scheme (MBS) billing and practice data. Community and other services mapping will also be included. Subsequent reports will align with the remaining length of the project in Years 1, 2 and 3. These reports will include the findings from healthcare consumer and provider perspectives, and journey mapping which includes clinical file audits and patient narratives. (See Attachment 1: Data Collection Summary table.)

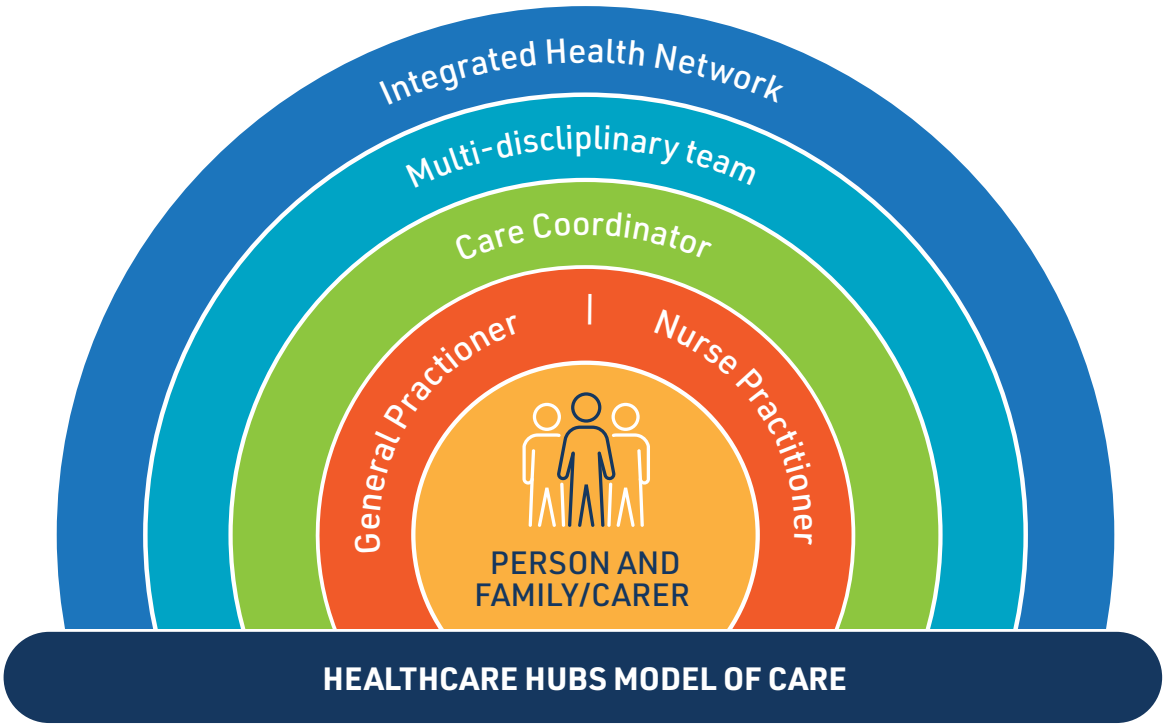
Reports will be presented to the Department of Health and Aged Care as key project deliverables and shared with the IHN Alliance and partner organisations for broader knowledge translation. Summaries will be publicly available to community members on the project website.

The Monash University Human Research Ethics Committee (project identification 42449) approved an ethics application for the project on 25 September 2024.

TIMELINE FOR REPORTS

Reporting will be based on the following project periods:

1. Baseline report: 30 June 2024 to 31 December 2024
2. Year 1 report: site commencement to 30 June 2025
3. Year 2 report: 1 July 2025 to 30 June 2026
4. Year 3 report: 1 July 2026 to 30 June 2027



Baseline Report: September–December 2024

BACKGROUND

The Hubs program setting is across the three adjoining Local Government Areas (LGAs) of Buloke, Loddon and Gannawarra in Central and Northwest Victoria. They consist mainly of small rural communities classified as Monash Modified Model (MMM) 5.[3] The overall population of the area is approximately 25,000. The LGAs have ageing communities, high rates of chronic disease, and have been impacted by a recent natural disaster (2022 floods) as well as experiencing critical health workforce shortages across all healthcare sectors.[4]

The initial proposal included nine Healthcare Hub locations serviced by four health services (Table 1). The MDT model at each site will have General Practitioner (GP) and Nurse Practitioner (NP) co-leadership, with Care Coordinator support, and other service providers and practitioners involved in team care depending on patient need and workforce availability.

Figure 1: Figure 1: Buloke, Loddon, Gannawarra LGAs.

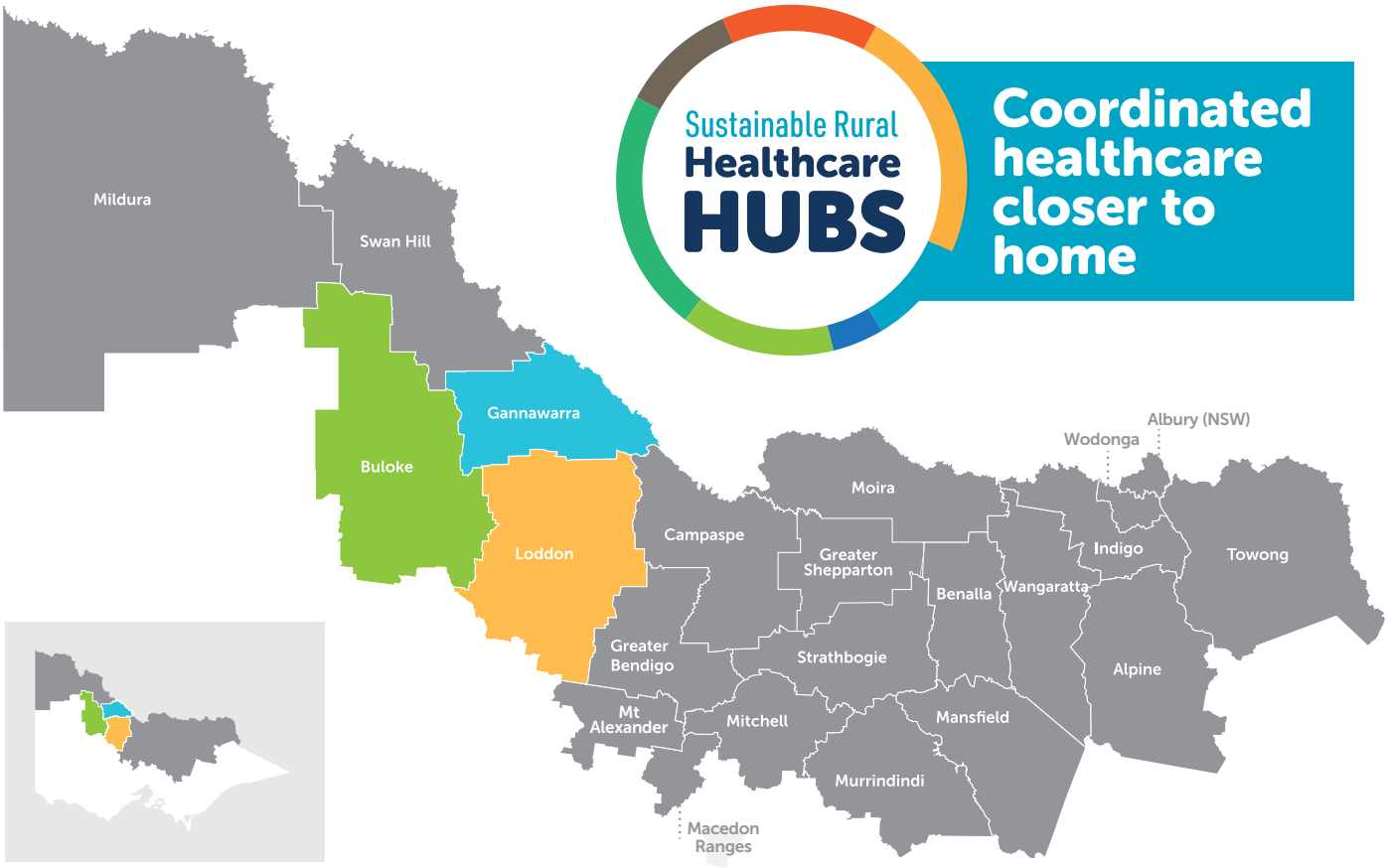


Table 1: Proposed Hub program locations and community characteristics December 2024 (ABS, 2021)

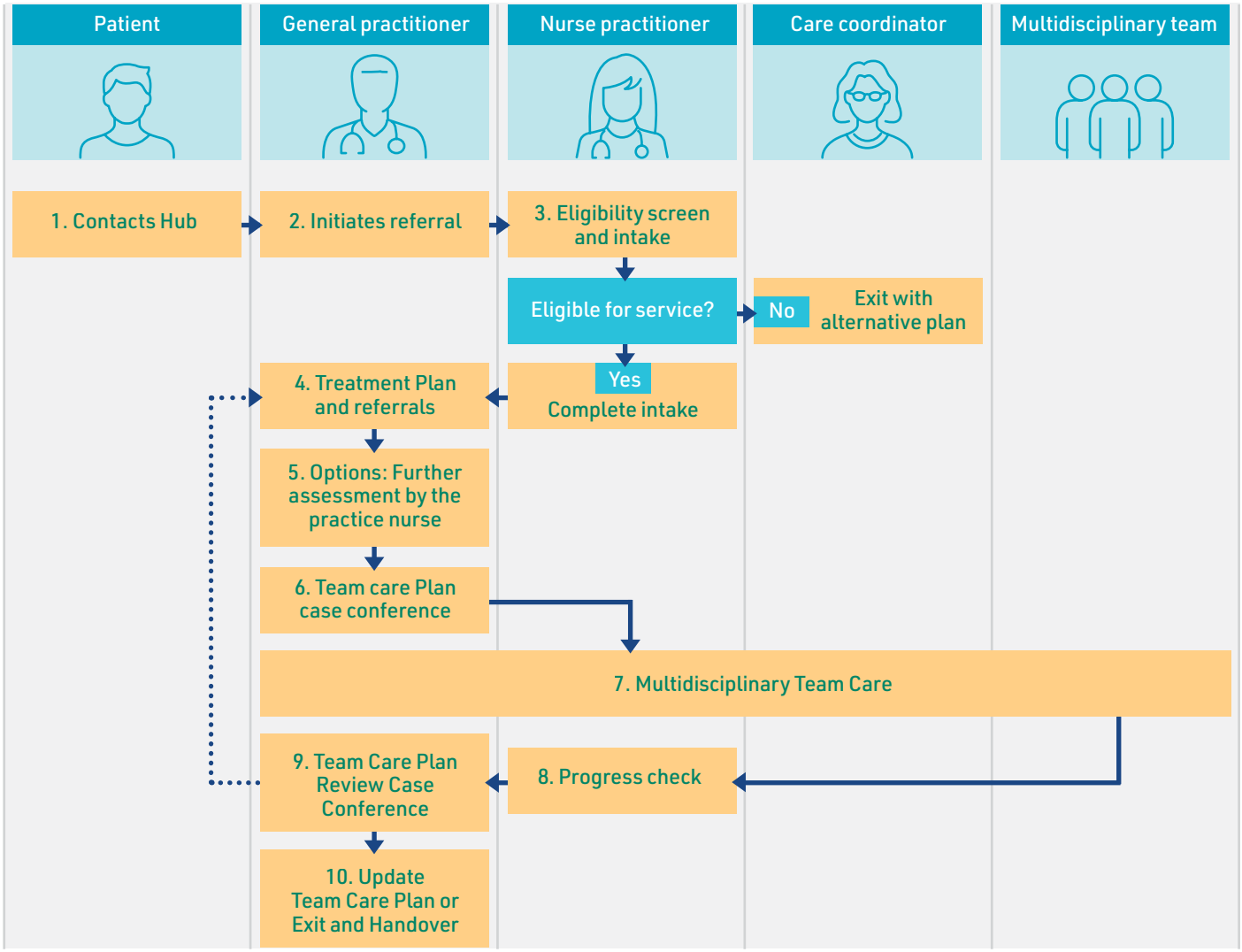
Partner Health Service	Town	GP services	Population (Suburb and Localities)	Median age	Aboriginal and/ or Torres Strait Islander People (%)	Median weekly income (household)	Top 3 chronic conditions
NDCH	Kerang	Small 2-5 GP FTE general practice and community health	3,960	51	3.9%	$1,006	Arthritis 15.7% , Asthma 12.0% Mental health 10.7%
NDCH	Quambatook	Community health site, no GP onsite	229	59	1.7%	$857	Arthritis 14.4% , Asthma 13.5% Mental health 11.8%
NDCH	Pyramid Hill	Community health site, no GP onsite	598	46	2.0%	$964	Arthritis 8.0%, Other 9.7%, Asthma 9.2%
BDH	Boort	Solo GP general practice, rural public hospital RACH and UCC	940	57	1.6%	$1,054	Arthritis 12.0% Mental health 9.4% Asthma 8.9%
IDHS	Inglewood	1.5 GP FTE general practice, rural public hospital RACH and UCC	886	55	2.6%	$844	Arthritis 18.7% Mental health 17.0% Other 11.7%
EWHS	Birchip	Solo GP general practice, rural public hospital RACH and UCC	694	49	1.2%	$1,171	Arthritis 13.1% Asthma 9.2%, Mental health 8.1%
EWHS	Charlton	Solo GP general practice, rural public hospital RACH and UCC	1,095	56	1.6%	$958	Arthritis 15.8% Mental health 9.8% Asthma 9.3%
EWHS	Donald	Small 2 GP FTE general practice, rural public hospital RACH and UCC	1,472	52	2.5%	$1,044	Arthritis 14.8%, Mental health 10.5%, Asthma 10.1%
EWHS	Wycheproof	Solo GP general practice, rural public hospital RACH and UCC	610	56	0%	$1,011	Arthritis 15.2% Mental health 12.6% Other 11.3%
EWHS	St Arnaud	Small 2 GP FTE general practice, rural public hospital RACH and UCC	2,318	52	2.3%	$920	Arthritis 14.7%, Mental health 11.9%, Other 9.2%
Victoria	-	-	-	38	1.0%	$1,759	Arthritis 8.0%, Asthma 8.4%, Mental health 8.8%

ABS (2021); RACH: Residential Aged Care Home, UCC: Urgent Care Centre

The program proposes multidisciplinary team-based care clinics in Kerang, Quambatook and Pyramid Hill, Boort, Inglewood and areas supported by East Wimmera Health Service. In-depth baseline program discussion occurred in 2024 with health services about Hub site locations.

The existing IHN Alliance partnership and preceding collaborative co-design and project activities enabled the development of key principles to inform interprofessional collaboration and shared leadership, clinical governance and collaborative planning, and clinic planning, billing and service delivery. The multidisciplinary team-based care patient flow (Figure 2) was developed to align with relevant MBS items for revenue and sustainability. As Hub locations differ in health service leadership, location and service provision, it was expected that a variation of the patient flow would be required for each site.

Figure 2: Hubs Patient Flow - generic



Suggested MBS billing items for chronic disease and aged care (Table 2) may also vary according to health consumer cohort characteristics and presentations.

Table 2: Proposed MBS item numbers

Patient flow	Relevant MBS items
1. Contact Hub (Patient)	N/A
2. Initiate referral (GP)	3 Level A GP consultation
	23 Level B GP consultation 6-20mins
3. Eligibility Screen and Intake (Nurse Practitioner)	82215 Level D Nurse Practitioner over 40mins
4. Treatment Plan and Referrals (GP)	721 GP Management Plan
	723 Team Care Arrangements (GP)
	2715 Mental Health Treatment Plan (GP)
	701, 703, 705, 707, 715 Health Assessment (GP)
5. Option: Further assessment by the Practice Nurse	N/A – included in GP claim
6. Team Care Plan Case Conference (GP)	735 GP Case Conference 15-20 mins
	739 GP Case Conference 20-40mins
	930 GP Mental Health Case Conference 15-20mins
	933 GP Mental Health Case Conference 20-40mins
	10955 Allied health/NP Case Conference attendance 15-20mins
	10957 Allied health case conference attendance 20-40mins
7. Multidisciplinary Team Care (GP, NP, CC and Multidisciplinary Team)	10950 to 10970 Individual allied health services
	81100 to 81125 group allied health services
8. Progress Check (NP)	82210 Level C Nurse Practitioner
	82215 Level D Nurse Practitioner
9. Team Care Plan Review and Case Conference (GP)	732 GPMP or TCA Review
	2712 Mental Health Care Plan Review (GP)
	735 GP Case Conference 15-20 mins
	739 GP Case Conference 20-40mins
	930 GP Mental Health Case Conference 15-20mins
	933 GP Mental Health Case Conference 20-40mins
	10957 Allied health/NP Case Conference attendance 15-20mins
	10957 Allied health case conference attendance 20-40mins
10. Continue Team Care OR Handover (NP and CC)	82210 Level C Nurse Practitioner $50.05
	82215 Level D Nurse Practitioner $73.80
	10997 Practice nurse GPMP/TCA support

AIMS

The aim of the baseline stage evaluation of the Hubs program was to investigate its development and implementation in the proposed sites. Specifically, it focused on:

- Site readiness to begin the Hub program
- Site contextualisation for patient flow processes
- Determinants identified at baseline pre-implementation stage.

METHODS

The evaluation employed a mixed methods methodology to describe each location's program readiness and context.

Qualitative data included thematic analysis of semi-structured focus groups and individual interviews with healthcare providers to determine Hub program location logistics and processes for implementation of the model of care.

Quantitative data included de-identified aggregate practice data reports supplied by Murray PHN with participating general practices' informed consent, to understand practice contexts and patient populations, and to identify current chronic disease-related workflows. Community and health service profiling through descriptive analysis of publicly available population health datasets (AIHW) was used to establish community healthcare needs (Table 1). Members of the Alliance also provided a summary of their services. Stage 0 indicates pre-NP pilot workforce, stage 1 indicates increased NP pilot workforce capacity, and Stage 3 indicates IMOC trial/ Hubs program increased capacity for multidisciplinary team care.

Program launch and training days were completed at two services covering four sites which included baseline focus groups and individual interviews of healthcare providers. Focus groups occurred at:

- Northern District Community Health (held at Kerang and including staff covering Quambatook and Pyramid Hill) on 26 September 2024 involving nursing and allied health practitioners and GP practice staff (n=8)
- Boort District Health (held at Boort) on 20 November 2024 involving nursing and allied health practitioners and GP practice staff (n=7).

Interviews were conducted with services and their respective Operational Working Group members where launches had been planned for 2025 and had not yet been completed before the preparation of the baseline report:

- Inglewood & District Health Service on 28 November 2024 involving health service leadership (n=1)
- East Wimmera Health Services (online) on 3 December involving health service leadership (n=2).

A research working group, consisting of members from NDCH, MRH and Murray PHN, held fortnightly meetings from 26 September to discuss data collection procedures and findings.

FINDINGS

The aim of the baseline stage evaluation of the Hubs program was to investigate its development and implementation in the proposed sites. Specifically, it focused on:

- Site readiness to begin the Hub program
- Site contextualisation for patient flow processes
- Determinants identified at baseline pre-implementation stage.

HEALTHCARE PROVIDER INTERVIEWS

18 healthcare provider staff participated in interviews (Table 3), some of whom worked across LGAs.

Table 3: Demographics of baseline participants

Participants		18
Gender	Women	15
	Men	3
Age range	25-34	1
	35-44	5
	45-54	6
	55-64	4
	65-74	1
	Prefer not to say	1
LGA	Buloke	1
	Loddon	10
	Gannawarra	8
	Across BLG	1
Years in BLG	Less than 1yr	1
	2-5 yrs	1
	5-10 yrs	8
	10-20yrs	1
	Greater than 20	6
	Prefer not to say	1

The discussions with healthcare providers were used to identify common themes and contextual differences between areas. The health services involved in the pilot (NDCH and BDH) had established relationships with the general practices in their area through the preceding nurse practitioner pilot, and the Hubs program was considered as the continuing relationship and expansion on this model of care. EWHS also had experience with Nurse Practitioner clinics, with a NP employed and working at the St Arnaud general practice. IDHS did not have an NP but considered the region's existing services and models of care as mostly working effectively.

Three main themes emerged from the health provider focus groups and interviews about the Hubs program development and implementation:

- enhancement of existing models of care
- provision of care continuity and efficiency; and
- model of care organisation and logistics.

Enhancing (not replacing) Existing Models of Care

The healthcare providers expressed two main views about implementing the Hubs program: the importance of creating formal processes and the ability to enhance existing care models.

The potential to formalise communication and referral pathways between healthcare services and practitioners was reported as a positive attribute of the Hubs program. The introduction of GP/NP-led case conferences and reviews as outlined in the baseline patient flow created a formality not always present in current communication about patient care which was viewed as 'ad hoc', 'informal' or 'hodge podge'. The opportunities to be created by intentional, protected and scheduled MDT case conferences were seen as beneficial, especially for the care of healthcare consumers with complex needs.

While acknowledging these potential benefits of the Hubs program, there was also a concern that its implementation may create a parallel service to already well-recognised care pathways. Considering how the Hubs program could complement existing models of care, and not replace them, was an important element for pre-implementation discussions.

There was agreement, however, that the Hubs program was an important addition to overall services by enhancing collaboration between public and private health organisations in the local context.

Provision of care continuity and efficiency

The Hubs program was seen as a mechanism for trialling improved methods for the continuity of care and workforce efficiency, such as formalising the addition of the role of the Care Coordinator in helping consumers navigate healthcare systems, improved data collection through refined referral forms conveying more explicit healthcare information, and the use of videoconferencing and technology for case conferences.

A major potential component of the Hubs program was an opportunity to improve optimisation of MBS billing items considered underused. The education and capacity building around this understanding had been a component of previous discussions about how existing resources and funding could be directed for improved healthcare outcomes.

Hubs program organisation and logistics

Much of the discussion in the focus groups and interviews concentrated on operational logistics. Creating protected time for case conferences, particularly for the GPs working in time-sensitive private business models, was a challenge, particularly with the part-time employment of other MDT members. Length of conference consultations, the time of day, number of patients to be discussed, and the preparation needed beforehand were elements carefully considered by participants. The coordination and planning of case conferences and reviews were components needing structure, especially as multiple service providers could be involved. These logistical challenges showcased the need for regular communication and solution flexibility.

Practice data

Aggregate GP practice data reports from two practices across the BLG provided a snapshot of the population currently seen in each region and MBS items used in their care. Data was provided by Murray PHN through their licence to the Practice Aggregation Tool for the Clinical Audit Tool (PAT CAT), a data repository, aggregation and reporting tool for CAT4 de-identified data extract files. For this report, population age and gender (Table 4) and MBS items recorded (Table 5) are presented. The participating general practices provided informed consent for Murray PHN to share the data with the researchers for inclusion in this report.

Table 4: Population characteristics: age and gender

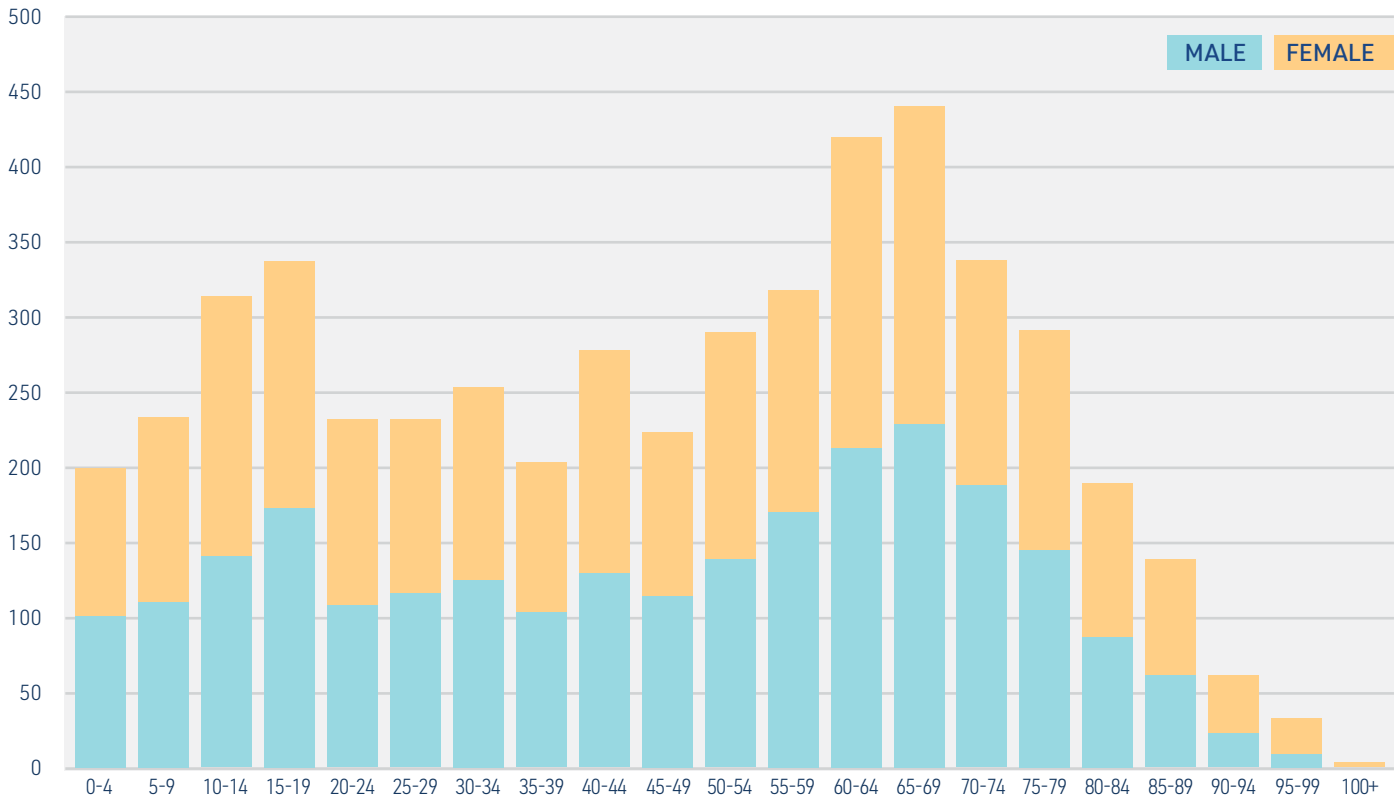
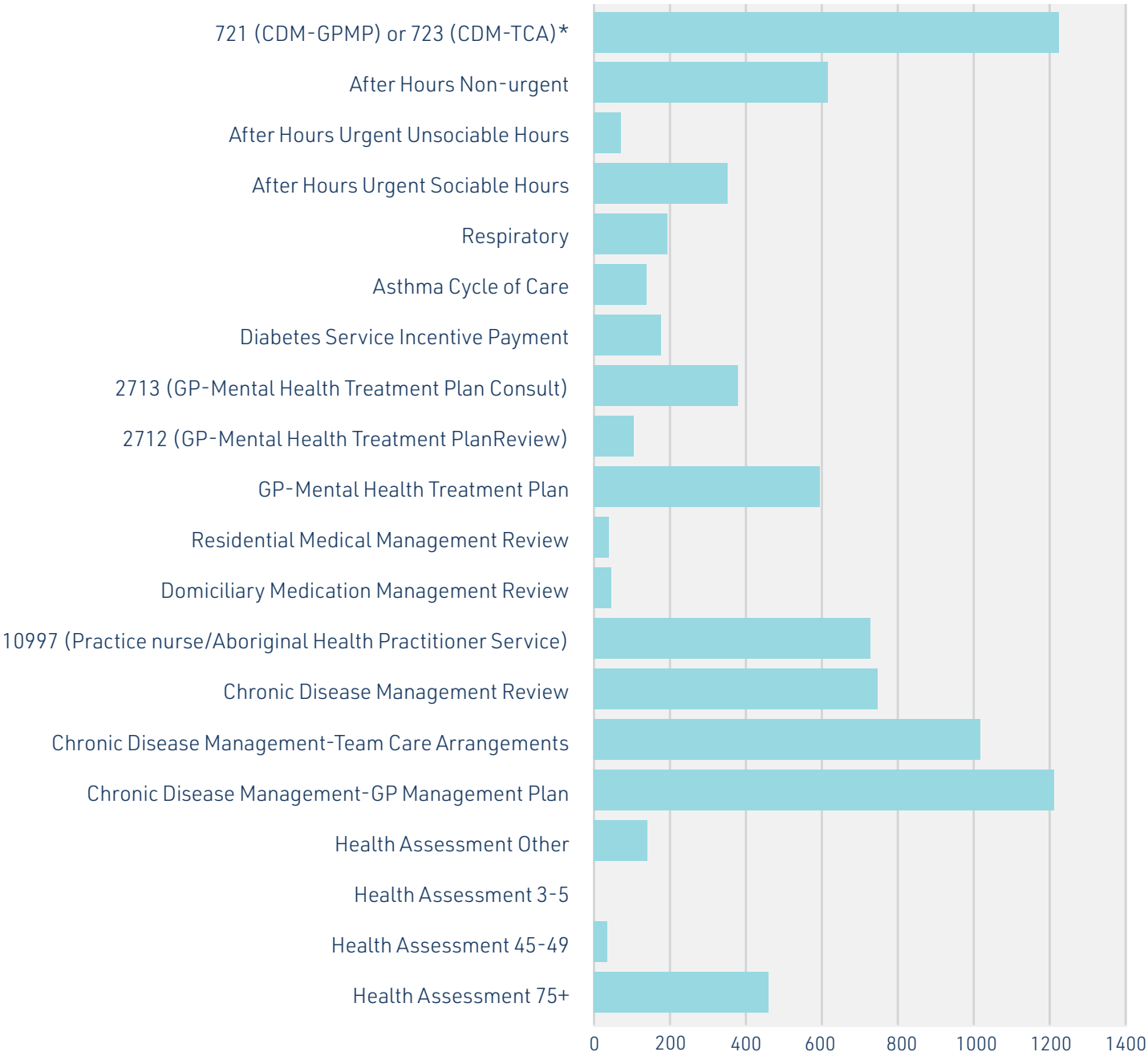


Table 5: Reported MBS items



** items have been combined for reporting*

BASELINE HUBS PROGRAM PROPOSALS

The initial discussions about the Hubs program with each healthcare service partner resulted in a program participation proposal contextualised to each region. Patient flow at each site will be based on the principles of the patient flow diagram shown previously (Figure 2).

NORTHERN DISTRICT COMMUNITY HEALTH (KERANG, PYRAMID HILL AND QUAMBATOOK)

An NP is employed at NDCH at 0.6FTE; 0.2FTE is focused on the Hubs program clientele delivering healthcare clinics one day a week over three sites. NDCH's Hubs program proposes to target consumers with chronic or mental health illnesses, using the appropriate MBS items for GP and NP consultations or case conferences (see Table 6).

Table 6: NDCH Hubs Program clinic

Clinic Location	Clinic Days	Local priorities
Kerang	Thursday (once every 3 weeks)	75+ health assessment
		Chronic Illness (adult) mgt plan
		Mental illness
Quambatook	Thursday (once every 3 weeks)	75+ health assessment
		Chronic Illness (adult) mgt plan
		Mental illness
Pyramid Hill	Thursday (once every 3 weeks)	75+ health assessment
		Chronic Illness (adult) mgt plan
		Mental illness

Other Components

Other considerations for the implementation of the Hubs program through NDCH included:

- establishment of protected and scheduled case conference times
- implementation of a Hubs program referral form using a Best Practice (practice management software) template for NP or CC to use with MDT; and
- a trial of the Hubs program for two existing patients to test the proposal before general implementation (starting December 2024).

BOORT DISTRICT HEALTH (BOORT)

An NP is employed by NDCH to provide 0.1FTE at Boort delivering healthcare clinics one day a fortnight. A portion of this time will be focused on the Hubs program clientele.

Table 7: Boort Hub Program clinic

Clinic Location	Clinic Days	Local priorities
Boort	Wednesday (once per fortnight)	Palliative Care at Home
		Chronic Illness (adult) mgt plan including pain management
		Mental illness

Other Components

Other considerations for the implementation of the Hubs program at Boort included:

- establishment of protected and scheduled case conference times; and
- design of a Hubs program referral process for NP or CC to use with MDT.
- inclusion of two Care Coordinators, one in the general practice and one in the hospital (Allied Health Assistant).

EAST WIMMERA HEALTH SERVICE (BIRCHIP, CHARLTON, DONALD, ST ARNAUD, WYCHEPROOF)

EWHS employ an NP at 0.4FTE, with NP-led clinics provided previously to a general practice in the region to cover GP leave. Recruitment is underway for a second rural generalist NP at 1.0FTE and a mental health nurse practitioner at 0.2FTE who will provide services at key sites with mental health service gaps, building mental health and AOD capacity in primary care for the workforce pool.

Discussions are underway with the general practices in the region about the provision of NP care and staff training, with planning days booked for January 2025. A focus is on a general practice without a GP service because of unexpected health practitioner leave. Further conversations about how the Hubs program could enhance current services in this region continue.

INGLEWOOD & DISTRICTS HEALTH SERVICE (INGLEWOOD)

IDHS has an established range of healthcare services across the district. The region also has one small general practice. IDHS is in early discussions regarding the benefits of the Hubs program in its service areas, and there is an in-principle agreement with a general practice to establish the trial in Inglewood beginning from January 2025.

Conclusion

The proposed Hub program initiatives were diverse in their challenges and enablers, reflective of the complexity of primary care in community health and private practice contexts within small rural towns. Stakeholders' assessment of community healthcare needs varied, emphasising the diversity of residents. The co-design methodology of the previous study enabled an in-depth understanding of needs and models of care based on community and practitioner input, and bespoke Hubs program proposal designs are expected.

The baseline data collected for this report provides a foundation for the development of the Hubs program in the BLG shires. It is anticipated that annual project reports will demonstrate the need for adaptability in program design. Critically, the health economic overlay will further provide information about the intended outcomes of the project and its social and financial sustainability.

Summary

This baseline report demonstrates the complexity and variety of healthcare in the region. Four healthcare services over nine clinic sites are involved in the Hubs program. Each partner provider is at a different stage of program implementation, and each has developed their own model of care proposal to suit the needs of their communities and the health professionals involved.

Next Steps

The Hubs program will continue to be evaluated over its development. Year 1's activities will focus on:

- incorporation of an Aboriginal and Torres Strait Islander stream with expert evaluation guidance from Pauline Nolan, Aboriginal Researcher, who will join the research team from January 2025. This will be vital for the provision of Culturally Safe care for First Nations Peoples accessing the Hubs program.
- the benefits of systemised local integration between rural public hospitals and private general practices
- collaborative opportunities provided by the Hubs program to distribute the workload associated with providing care for rural people with chronic conditions
- optimisation of healthcare funding and resources for healthcare innovation; and
- development of a health economic strategy as a health economist joins the research team from February 2025. This strategy will assist in evaluating the cost effectiveness, financial feasibility and social value of the Hubs program.
- key determinants identified in the baseline report will be addressed through project governance structures which includes the Operational Working Group (fortnightly meetings), the Project Control Group (IHN Alliance, monthly meetings), and the BLG Executive Network (bi-monthly meetings) (see Attachment 2).
- clinical staff communities of practice will be established to provide peer and program implementation support.
- planning and development of multidisciplinary workforce training pathways in the model of care will begin in collaboration with Monash Rural Health, La Trobe Rural Health School, Loddon Mallee Health Network, Bendigo Health, North Central Local Learning and Employment Network, and local TAFE providers

Acknowledgements

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RESEARCH TEAM

- Dr Pam Harvey, Chief Investigator, Monash Rural Health (co-lead)
- Dr Nerida Hyett, Murray PHN, Monash Rural Health, La Trobe University (co-lead)
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- Trevor Adem, East Wimmera Health Service
- Donna Doyle, Boort District Health
- Dallas Coghill, Inglewood & Districts Health Service
- Penny Wilkinson, Northern District Community Health
- Dr Kalayu Brhane Mruts, Murray PHN
- Dr Damilola Adu, Murray PHN

JOINING FROM YEAR 1 TO YEAR 3

- Pauline Nolan, Aboriginal Researcher
- Health economist

References

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2. Hyett, N.S., A. Hutchinson, M. Adem, T. Doyle, D., Coghill, D., O'Brien, S., Fabry, and L. Y., C., & O'Sullivan, B., *Nurse Practitioner Rural Outreach Model (NP-ROM): Final report.* 2024, Murray Primary Health Network: Dja Dja Wurrung Country (Bendigo), Australia.
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Attachment 1: Data Collection Summary Table

Data		Research question/s	Baseline 0 months	Year 1	Year 2	Year 3
Patient Experience Survey	15min survey completed hard copy or online, offered four times per year over three years.	1, 4, 5, 6		✔	✔	✔
Patient Journey Mapping	Interview and clinical file audit, once per year. Audit of patient files from target population group to extract data on diagnosis, medical history, and team-based care service provision and outcomes ("patient journeys")	1, 4, 5, 6		✔	✔	✔
Healthcare provider interviews	Semi-structured qualitative interviews (30mins), at baseline and once per year.	1, 2, 3, 4, 5, 6	✔	✔	✔	✔
Daily clinic report survey	Clinic report submitted each clinic day by the Care Coordinator through an online link.	3, 4		✔	✔	✔
Murray PHN data report	Deidentified aggregate MBS billings and practice data reports supplied by Murray PHN every six months	3, 4, 6	✔	✔	✔	✔
Community and services profile	Written mapping audit and diagrams. Descriptive analysis of public population health data identifying health needs and priorities. Public data, ethics not required.	2, 3, 4, 5, 6	✔	✔	✔	✔

Attachment 2: Hubs program Governance Structure