Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Innovation Funding

1. Innovation Activity Proposal 2016-2018

Re-Submitted Document: 14 October 2016

Northern Territory PHN

When submitting this Innovation Activity Proposal 2016-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

In line with these objectives, the current PHN Innovation Funding stream will support PHNs to engage in innovative approaches and solutions that improve the efficiency, effectiveness and co-ordination of locally based primary health care services.

In the context of the PHN Innovation Funding under this stream, innovation includes *an idea, service, approach, model, process or product that is new, or applied in a way that is new, which improves the efficiency, effectiveness and co-ordination of locally based primary health care services*.

At a minimum, activities under the current PHN Innovation Funding stream must:

- be new or innovative;
- align with PHN Programme objectives;
- relate to the recommendations of the Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response;
- be beyond the activity expected under the Core Funding Schedule and not duplicate activity funded under other schedules (eg. After-Hours, Mental Health, Drug and Alcohol) or other funding sources; and
- link to local need (as identified via needs assessment) and/or support the application or expansion of innovative solutions across the PHN network.

Primary Health Networks can utilise 2015-16 PHN Innovation Funding to: engage expertise and work with partners to develop innovative models; implement an identified innovation(s) or expand its application; and/or undertake evaluation of local innovation.

Primary Health Networks are required to outline planned activities, milestones, expected costings and outcomes to provide the Australian Government with visibility as to the activities of each PHN.

This document, the Innovation Activity Proposal, captures these activities.

This Innovation Activity Proposal covers current Innovation Funding provided to PHNs to be expended within the period from 1 July 2016 to 30 June 2018.

Innovation Funding Activity Proposals must:

- demonstrate to the Australian Government what the PHN is going to achieve and how the PHN plans to achieve this;

- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments, Local Hospital Networks and other stakeholders, as appropriate; and
- articulate a single or set of innovation activities that each PHN will undertake, as well as identifying clear and measurable evaluation criteria to review both the impacts of the innovation and its potential for expansion or transfer across the PHN network.

Primary Health Networks must also provide evidence that supports the proposed innovation activities.

The Innovation Activity Proposal template has the following parts:

1. The Innovation Funding Activity Proposal for 2016-2018, which will provide a description of planned activities funded by the current Innovation Funding Stream under the relevant provisions of the Core Funding Schedule.
2. The indicative Innovation Funding Stream Budget for 2016-2018.

It is important to note that while planning may continue following submission of the Innovation Activity Proposal, PHNs can plan but must not execute contracts for any part of the funding related to this Innovation Activity Work Proposal until it is approved by the Department.

Further information

The following may assist in the preparation of your Innovation Activity Proposal:

- Clause 3, Financial Provisions of the Standard Funding Agreement;
- Item B.5 of Schedule: Primary Health Networks Innovation Funding;
- Primary Health Networks Grant Programme Guidelines; and
- Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response (http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-report).

Please contact your Grants Officer if you are having any difficulties completing this document.

1. Planned activities funded under the Activity – Primary Health Networks Innovation Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the Innovation Funding stream under the Schedule – Primary Health Networks Core Funding.

Proposed Activities	Description
Activity Title / Reference IN1	IN1: Northern Territory Supporting Health Care Home Model Implementation Strategy
Description of Activity	**Description of the innovation activity** The Northern Territory (NT) has been identified as a Health Care Home stage one region. Northern Territory PHN (NT PHN) will lead a collaborative project to develop a strategy to enable primary health care services in the NT to be prepared to implement the Health Care Home Model of Care (Health Care Home). The proposed Strategy will build understanding by disseminating key messages, creating awareness and capacity of, and supporting health service providers to transition to a Health Care Home model, with a focus on improving health system literacy. The Strategy will include development of capability, capacity and knowledge across key areas to support integration with NT PHN's existing activities and functions, and promote learnings from the Aboriginal community controlled health services (ACCHS) sector and the comprehensive primary health care model already established in the NT. The Strategy will be developed under the guidance of a Regional Health Care Home Coordination Advisory Committee and specialised working / reference groups as required. The Strategy will be aligned to the Australian Government Department of Health's requirements for the HCH, and be suited to the NT's population demographics and health sector profile. It will support primary health care services to transition to the HCH model, regardless of their involvement in stage one of the

Proposed Activities	Description

	implementation, on the basis that this has been identified by the ACCHS sector, and the Federal Government as an effective and sustainable method to deliver primary health care.
	
	Specifically, NT PHN will support the implementation of HCH by:
	• supporting the HCH recruitment and selection process through:
	  ○ the HCH Project Coordinator and GP-lead distributing information to health services in the NT
	  ○ supporting the identification of likely sites due to their eligibility criteria
	  ○ through the HCH Project Coordinator and GP lead visiting the identified practices and informing them of the program and the EOI requirements
	• implementing education and training to selected HCHs through:
	  ○ developing a communication strategy in line with the national strategy so that practices are informed of HCH, changes to the program, troubleshooting with the participants, promoting a HCH peer community approach where lessons learnt are shared
	  ○ work with NT PHN Practice Support staff to support the selected practices through webinars, visits etc.
	  ○ arrange webinars / face to face meetings for participating sites so they can access the national training and support program that is being planned
	• supporting selected HCHs with patients consent processes by:
	  ○ informing practices of the processes
	  ○ assisting them implement the consent process
	  ○ providing nationally produced resources for the patients
	  ○ providing training on the process
	  ○ troubleshooting with the practices.
	
	As an adjunct to the implementation of HCH, NT PHN has committed to implement the clinical pathways Integration Program HealthPathways. HealthPathways originated in Canterbury, New Zealand, and which has now been implemented by 20 of the 31 Australian PHNs. In these PHNs it has been considered a valuable tool to encourage collaboration between clinicians in the health sector, adoption and adherence to localised best practice guidelines and efficiencies in the health sector

Proposed Activities	Description
	through reduced hospitalisations, improved and targeted referrals and improved patient and clinician experience. To implement HealthPathways, NT PHN will form a consortium with our Company Members and key stakeholders, the NT Government Department of Health, AMSANT and the Health Providers Alliance NT to govern and drive the program. An essential component of Health Pathways is the collaboration between participants, so a key focus of the program will be to bring together stakeholders to drive integration of services. These stakeholders will include private GPs, Specialists, Aboriginal primary health care clinicians (including those in the NT Government and community controlled sector), Hospital staff such as outpatient's services, Allied Health professionals and Pharmacists, etc. There is already a strong culture of integration of health services across parts of the NT health sector as can be seen with the long history of the development, support and usage of the Central Australian Remote Practitioners Association (CARPA) standard treatment manual for Aboriginal primary health care services, and the HealthPathways program will build on this strong collaboration for all clinicians in the NT health sector. Further, NT PHN is seeking to improve data and clinical reporting and secure sharing systems through the usage of a Shared Electronic Health Record for HCH patients. A Shared Electronic Health Record, the My eHealth Record (MeHR) has been used predominately for Aboriginal patients in the NT for over 10 years. The NT is currently transitioning to the national My Health Record, however this record does not have shared care planning capability. NT PHN has been involved in a project with the NT Department of Health and AMSANT for the last 3 years to develop an electronic shared care planning platform within the NT MeHR repository. This product is called iCare NET and is specifically for maternal health care planning at this time. In this proposed innovation project, NT PHN will continue the consortium activity work with AMSANT and the NT Department of Health and the NT MeHR technical providers Ocean Informatics, to refine the care planning capability of iCare NET so that it can be used for shared care planning by practices participating in the HCH program.

Proposed Activities	Description
	Sharing of the care plan for clinicians involved in the HCH will be an issue due to providers being spread over a wide expanse within the NT. Whilst the patients home clinic may be in a remote location, other HCH team members (specialist, allied health therapist, pharmacist etc.) may be in a major urban centre, potentially up to a 1,000 kilometres away. Further, many non-primary health care clinicians (allied health professionals, specialists, pharmacists) do not utilise a Clinical Information System that allows their consultation notes to be added into the Shared Electronic Care Plan. The IT solution through Ocean Informatics that is being proposed (based on the current model) will allow HCH team members without a conformant or any Clinical Information System, to securely access the patients consented information in the care plan, perform clinical actions based on the updated care plan and record their activities/findings/outcomes into the shared cared plan. This shared electronic care plan will also allow activity and outcome reporting. As an added incentive, this IT solution will also allow other health program activities besides HCH to be recorded on this shared care plan platform. In the NT, primary health care and acute health care activities are well recorded electronically using Clinical Information Systems. However, there are several program areas where electronic recording of data does not occur. Specifically, here, reference is made to the programs of Mental Health, Alcohol and other Drugs, private Allied Health activities, etc. NT PHN commissions organisations to deliver many of these program areas where electronic data recording and reporting has not been had the same historical emphasis as has happened in the primary health care and acute care sectors. This IT solution will provide a platform to allow these program areas to also participate in digital health by recording patient directed activities and outcomes so that data can be securely shared, reported on, and extracted for analysis of outputs and outcomes and therefore used for planning and continuous improvement of the services. Funding applied for within this Innovation submission will be used on software licence purchases where required, but mostly the technical consultancy work to develop the existing shared health plan repository into a suitable repository for the HCH purposes plus the development of appropriate care planning templates and then training for clinicians to use the shared care plans. To implement HCH and HealthPathways, NT PHN will employ the following staff

Proposed Activities	Description

	• a HCH Project Coordinator (1FTE) for 20 months from October 2016 – June 2018 to:
	  ○ develop a Change Management project plan
	  ○ coordinate the programs activities
	  ○ develop a communication strategy in line with the national strategy so that practices are informed of HCH, the EOI, changes to the program, troubleshooting with the participants, promoting a HCH peer community approach where lessons learnt are shared
	  ○ work with NT PHN Practice Support staff to support the selected practices
	  ○ identify and minimalise risks.
	• GP Lead for HCH and HealthPathways - 0.6 FTE for 18 months to:
	  ○ Lead the Clinical governance for the HCH and HealthPathways programs
	  ○ Negotiate with GPs, Specialists on implementing HCH and Health Pathways
	  ○ Provide clinical guidance and support to GPs implementing HCH and Health Pathways
	  ○ Oversee the Health Pathways Clinical Editors and their body of work to create / modify HP
	• HealthPathways Clinical Editors – 1.0 FTE (spread over 2-3 Clinical Editors) for 18 months to:
	  ○ Research HealthPathways to be implemented into NT PHN's HealthPathways program
	  ○ Lead work groups that provide guidance on what the Health Pathways should contain
	  ○ Create / modify the Health Pathways based on the specialty local advice given by the work groups
	  ○ Submit these to the Clinical Lead to be ratified and implemented into HealthPathways by the technical team.
	• Public Health Registered Nurse (0.5FTE) for 18 months to:
	  ○ Work with HealthPathways and HCH participating health services and NT PHN staff to ensure there is strong clinical governance adherence in both programs
	  ○ Collaborate with GPs, Specialist, Hospital services, the CARPA manual team to identify Health Pathways that are required or existing clinical pathways that can be included in the Health Pathways program after editing by the Clinical Editors

Proposed Activities	Description
	○ Meet with relevant specialty review committees to assess the relevance of the committees work to be developed into Health Pathways and promote these specialty review teams to be developing their outcomes into Health Pathways. Further NT PHN will allocate a Travel budget for the HCH and HealthPathways programs to be used in the following ways (given that health services are spread throughout the NT in over 100 communities and 5 major urban centres): • Travel by the HCH and HealthPathways staff to remote communities and urban centres where required to assist in the recruitment of HCH and HealthPathways health service participants • Travel to these services where necessary to provide training and support for the implementation and usage of HCH and HealthPathways • Provide support to bring clinicians and other practice staff into major urban centres for training / collaboration meetings for the HCH / HealthPathways programs where face to face meetings are required (including travel and accommodation) • Arrange webinars where possible for participates on these programs. It is envisaged that the following key areas will be addressed in this Innovation Proposal: • Health system literacy and integration • Data and clinical reporting systems • eHealth • HealthPathways • Private sector GP readiness • Workforce requirements (including Allied Health) **Briefly outline how the innovation will improve the efficiency, effectiveness and co-ordination of locally based primary health care services, and who will benefit** Development of the Strategy in collaboration with cross-sectoral stakeholders, will enable the HCH program to be successfully implemented in the NT. As recommended in the Report of the Primary Health Care Advisory Group *Better Outcomes for People with Chronic and Complex Health Conditions* and the Australian Government's response, the HCH presents significant opportunities to drive

Proposed Activities	Description
	quality improvements, leading to improved patient experience and outcomes. Further implementation of HealthPathways will increase the integration, efficiency and effectives of consistent best practice health service delivery, and therefore patient outcomes. Beneficiaries of this activity will include: • Medical practitioners, including General Practitioners and their practice staff • Aboriginal primary health care service teams including GPs, Registered Nurses and Aboriginal and Torres Strait Islander Health Practitioners • Allied health professionals, including pharmacists • Health consumers, including Aboriginal people • Professionals working in support services (i.e. housing, education) • Health and hospital services through improved referrals. **Indicate why this change is considered innovation** This activity provides an opportunity to develop an integrated approach to a range of emergent and longstanding sector issues in the NT. The NT's small population base means that changes can be effected where stakeholders are brought together, and minimise duplication. For example, the opportunity to develop a coordinated approach to health system literacy can be capitalised upon by the LHNs, ACCHS and private sector through development of a best practice approach for the NT. The development of the existing localised shared electronic care planning system, iCare Net, will allow secure sharing of a care plan for patients with chronic diseases, and ultimately for other complex conditions such as mental health, enabling a collaborative, team approach to working with individuals to improve their health outcomes through access to clinicians and support professionals who all have access to the relevant information to treat the patient consistently. Incorporation of the HealthPathways project within the broader Health Care Homes Strategy will ensure that a model is developed appropriate to NT conditions, including incorporation of the CARPA Manual learnings. Clinical Guidelines will be developed collaboratively through the HealthPathways project and the CARPA guidelines. These Guidelines will enable all NT health practitioners to deliver a more integrated health service that follows best practice. They also

Proposed Activities	Description
	promote an efficient, effective and appropriate health system with improved patient health outcomes and patient flow taking into account different pathways depending on home location (remote vs urban). **Identify the population need (e.g. burden of disease, prevalence, incidence etc.)** The NT experiences a disproportionally high burden of disease across a range of conditions, including cancer, mental illness and substance abuse. On all indicators – health status, disease profiles, quality of life and social and emotional wellbeing - Aboriginal people report worse health outcomes than the non-Aboriginal population. Access to health services is often difficult for all Territorians due to remoteness, the availability and stability of the health workforce and population demographics. **Describe current practice, including gaps in current practice, and whether the innovation replaces or enhances current practice** NT PHN enjoys a uniquely close relationship with the ACCHS sector. ACCHS and NT Government primary care services delivered in remote communities have already highly developed many of the principles of the HCH through their community based model, and this could be built on and expanded as part of the trial. A key concern for NT PHN has been how to transfer much of the expertise in multi-disciplinary primary health care developed in Aboriginal primary health care to mainstream services. This activity presents the opportunity to translate the comprehensive chronic conditions primary health care approach used in Aboriginal primary health care to mainstream General Practice services, and see further improvements in the NT wide chronic disease key indicators. The high turnover of health workforce and mobility of patients between locations and practices places patients at risk of disparate care and medical error due to lack of coordination across sites. Development of agreed pathways and common practices of care, the health care home model across the range of sites and access to an electronic shared care plan will mitigate against this.
Rationale	**Provide details (including citations) on the evidence base that supports activities in this proposal** This activity will support implementation of the HCH as outlined in the *Better Outcomes for People with Complex and Chronic Conditions* report and the Australian Government's response.

Proposed Activities	Description
Strategic Alignment	**Describe how the proposed innovation aligns to the strategic intent of the PHN Innovation Funding Stream including (<u>but not limited to)</u> linkages with:** • **the objectives of the Primary Health Networks Programme;** • **recommendations of the Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response; and** • **local need as identified via needs assessment (please identify the related Priority Title/Reference from your Activity Work plan, or provide additional evidence that links this innovation activity to an area of local need).** This activity is directly aligned to the objectives of the Primary Health Networks Programme and recommendations of the *Better Outcomes for People with Complex and Chronic Conditions* report, and the Australian Government's response through its focus on integration and support for cross-sectoral partnerships. Development of an NT-wide Strategy provides opportunities for cost savings and other efficiencies, not only for NT PHN.
Scalability	**Outline how this innovation, if successful, could be expanded within the PHN or to other PHNs** This project will directly support implementation of the HCH in the NT through development of a comprehensive Strategy to support activities and to support selected primary health care services to transition to the HCH model. This will include a range of innovative activities to support General Practice, and health system literacy which will be valuable regardless of HCH. Learnings from this project can be shared with other PHNs, including health system literacy resources developed and guidance materials. Any implementation issues experienced will contribute to the evaluation of Stage One of HCH, to be undertaken by the Department, ahead of the national roll-out. The development of an electronic shared care plan is aligned to the national Australian Digital Health Agencies goal of ensuring that digital health is a foundation of the Australian health care system. The NT has been a leader in digital health for over 10 years, strong example of this have been the MeHR, the adherence to collecting data for the NT Aboriginal Health Key Performance Indicators by the Aboriginal primary health care sector and the use of these KPIs for Continuous Quality Improvement programs and better targeting and evaluation of health service delivery.

Proposed Activities	Description
Target Population	**Outline the group or groups of people (e.g. consumers, providers, clinicians, administrators etc.) you hope to affect through this innovation, including relevant details (e.g. clinician type, patient diagnosis/characteristics etc.). Please include estimated numbers of people, if appropriate.** This activity will target the following stakeholder groups: • Medical practitioners, including General Practitioners • Aboriginal primary health care service teams including GPs, Registered Nurses and Aboriginal and Torres Strait Islander Health Practitioners • Medical specialists • Allied health professionals, including pharmacists • Health consumers, including Aboriginal people
Coverage	Entire NT PHN region by ABS Statistical areas (SA4 level) • 701 Darwin • 702 Northern Territory – Outback
Indigenous Specific	**Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?** Not specifically targeted – however the health needs of Aboriginal and Torres Strait Islander people will be a key consideration for this activity. The Aboriginal primary health care sector currently leads the way with models of comprehensive primary health care consistent with many features of the HCH. This includes leadership in ACCHSs' that involves both ACCHS management and the community to deliver more integrated, team based, patient centred and coordinated care underpinned by participation in clinical quality improvement programs. Support in the form of: (i) technical support around data reporting and continuing quality improvement and (ii) diversification of skills among primary health care team members would enable strengthening of the ACCHS sector and HCH. There is opportunity to showcase the ACCHS's models (which successfully demonstrate the hallmarks of the HCH) in the development and implementation of the HCH across the sector more broadly.

Proposed Activities	Description

Collaboration	**Outline if this activity will be jointly implemented with any other stakeholders, including other PHNs, Local Hospital Networks (or equivalent), private, public or not-for-profit organisations, and/or state and territory governments. If yes, provide details including the role of all parties.**
	This HCH activity will be jointly implemented with a range of stakeholders at a national, NT-wide and local level. A Regional Health Care Home Coordination Advisory Committee will be established to ensure the model is aligned and integrated with the regional service system.
	
	Other stakeholders to be engaged will include:
	• General practitioners and practice staff working in the private sector
	• Allied health professionals, including pharmacists
	• Consumers and consumer representatives
	• Peak bodies including:
	  ○ Pharmacy Guild of the Northern Territory
	  ○ Australian Medical Association
	  ○ Services for Australian Rural and Remote Allied Health
	• Other Rural Workforce Agencies
	• Australian Government Department of Health
	• Interstate PHNs

Proposed Activities	Description
Activity Title / Reference IN2	IN2: Health Care System Integration Response
Description of Activity	**Description of the innovation activity** Coordinate NT-wide, cross-sectorial system responses to emerging issues in primary health care, including development and implementation of pilot initiatives, with an initial focus on youth health and the impacts of Foetal Alcohol Spectrum Disorder (FASD), and lesbian, gay, bisexual, transgender, queer and/or intersex (LGBTQI) initiatives.

Proposed Activities	Description
	This activity will include NT PHN resourcing (through a contracted service) to undertake scoping, and development, design and procurement of pilot initiatives. This activity will be supported by NT PHN's existing policy officer function (staff member to commence October 2016), who will assist in scoping activities, including supporting undertaking an LGBTQI needs assessment. Commissioned activities may include: • Support for delivery of diagnostic services for FASD • Support for staff training • Preventive health initiatives for women likely to engage in risky drinking behaviours during pregnancy • Support for existing LGBTQI primary health care services Commissioned activities will integrate with NT PHN's existing commissioned services (ie. Headspace) and be culturally appropriate. **Briefly outline how the innovation will improve the efficiency, effectiveness and co-ordination of locally based primary health care services, and who will benefit:** The proposed activities will improve patient experience and outcomes by supporting delivery of initiatives in high areas of need, not currently addressed through NT PHN program funding. Commissioned activities will have a focus on capacity building and improving coordination of local primary health care services, including integration with NT PHN's existing commissioned services (ie. Headspace). Additionally, NT PHN will aim to: • Identify a funding stream to enable the activities to continue long term (i.e. accessing existing funding, identifying other funds to enable the activity to continue) • Increase the capacity of the health sector to continue the initiatives in the future through upskilling of local providers through mentorship, training, etc. Beneficiaries of this activity will include: • Health consumers, in particular youth (12-25 years) and the LGBTQI community • Medical practitioners, including General Practitioners and their practice staff

Proposed Activities	Description
	• Aboriginal primary health care service teams including GPs, Registered Nurses and Aboriginal and Torres Strait Islander Health Practitioners • Professionals working in support services (i.e. housing and education) • Health and hospital services. **Indicate why this change is considered innovation** These activities provide an opportunity to develop an integrated approach to a range of emergent and longstanding sector issues in the NT. Gaps in services in these areas have been identified in NT PHN's recent needs assessments. Through development of increased understanding of need, and the commissioning of pilot initiatives we aim to identify sustainable services that provide greater depth to the NT health sector. **Identify the population need (e.g. burden of disease, prevalence, incidence etc.)** NT PHN's recent Baseline Needs Assessment identified FASD as a health need in the NT where prevalence estimates vary and reported rates as likely to be under-estimations. Studies have found higher rates of FASD among Aboriginal people than in non-Aboriginal people. FASD has profound effects – direct and indirect - in the NT, both on individuals affected by the condition, and the broader community. This includes economic impacts (loss of productivity), reduced quality of life, reduced longevity and increased health care, educational and social services costs. A substantial portion of children in the NT's child protection and youth justice systems are believed to be affected by FASD[1]. The workforce needs access to information on alcohol and pregnancy and FASD that is culturally appropriate and acceptable, together with training in appropriate interventions during antenatal care. A recent report by the NT Legislative Assembly's Select Committee on Action to Prevent FASD[2] set out 26 recommendations for action to reduce FASD related harm in the NT. Recommendations include address alcohol management and support services, sexual health, pregnancy support, early childhood support and education services, and FASD prevention, diagnostic and support services.

[1] Northern Territory Legislative Assembly Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *The Preventable Disability*, February 2015

[2] Northern Territory Legislative Assembly Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *The Preventable Disability*, February 2015

Proposed Activities	Description
	The LGBTQI community is a very diverse group and capturing specific health needs is a complex task. NT PHN's Baseline Needs Assessment identified there was very limited data and documentation in relation to the health and wellbeing of this demographic. Limited consultation undertaken by NT PHN to date has identified the need for primary health care services that are accessible to the LGBTQI community, and where service providers are able to address the specific health needs for this population, including the treatment needs of transgender people. **Describe current practice, including gaps in current practice, and whether the innovation replaces or enhances current practice** The Select Committee's report identified a range of current practice and gaps in the identification and management of FASD in individuals affected by the condition (such as lack of training in diagnostic tools – compounded in the NT through remote service delivery context), and in screening and education of women likely to engage in risky drinking behaviours during pregnancy. Addressing the impacts of FASD requires a multi-disciplinary, multi-agency response. NT PHN does not expect that Innovation Activity Funding, or that NT PHN as a single organisation, can address this issue. NT PHN can also support this activity through our other commissioned services (particularly in mental health and alcohol and other drugs) and our functions as the NT's Rural Workforce Agency, together with our unique role as a health service system integrator in the NT. During development of NT PHN's Baseline Needs Assessment, it was identified that reliable data is not currently available on understanding the needs of the LGBTQI community, and the barriers people experience in accessing services. Community consultation has been limited and further development work is needed in this area. A Darwin-based GP has recently (June 2016) commenced a sessional LGBTI health clinic, the first of its kind in the NT, with existing NGOs also providing a range of services inclusive of this community, including the NT AIDS and Hepatitis Council, which has a specific Aboriginal Sexual Health Program.
Rationale	**Provide details (including citations) on the evidence base that supports activities in this proposal** References: • NT PHN Baseline Needs Assessment, March 2016 • Northern Territory Legislative Assembly Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *The Preventable Disability*, February 2015

Proposed Activities	Description
	• Australian Institute of Health and Welfare and Australian Institute of Family Studies, *Fetal alcohol spectrum disorders: a review of interventions for prevention and management in Indigenous communities*, 2015
Strategic Alignment	**Describe how the proposed innovation aligns to the strategic intent of the PHN Innovation Funding Stream including (<u>but not limited to)</u> linkages with:** • **the objectives of the Primary Health Networks Programme;** • **recommendations of the Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Complex and Chronic Conditions*, and the Australian Government's response; and** • **local need as identified via needs assessment (please identify the related Priority Title/Reference from your Activity Work plan, or provide additional evidence that links this innovation activity to an area of local need).** This activity is directly aligned to the objectives of the Primary Health Networks Programme and recommendations of the *Better Outcomes for People with Complex and Chronic Conditions* report. It supports the coordination of care across the health system to improve patient experience, supports cultural change across the health system and activates patients, in particular young people, to be engaged in their care. The activity supports many issues identified in NT PHN's After Hours, Baseline, and Mental Health and Suicide Prevention, and Alcohol and Other Drugs Treatment Needs Assessments.
Scalability	**Outline how this innovation, if successful, could be expanded within the PHN or to other PHNs** This activity will directly respond to issues identified in recent Needs Assessments. Many of these issues are present nationally, and any learnings and resources developed could be distributed to other PHNs.
Target Population	**Outline the group or groups of people (e.g. consumers, providers, clinicians, administrators etc.) you hope to affect through this innovation, including relevant details (e.g. clinician type, patient diagnosis/characteristics etc.). Please include estimated numbers of people, if appropriate.** This activity will target the following stakeholder groups: • Health consumers, including Aboriginal people, youth and the LGBTQI population. Medical practitioners including General Practitioners

Proposed Activities	Description
	• Aboriginal primary health care service teams including GPs, Registered Nurses and Aboriginal and Torres Strait Islander Health Practitioners • Allied health providers
Coverage	Entire NT PHN region by ABS Statistical areas (SA4 level) • 701 Darwin • 702 Northern Territory – Outback
Indigenous Specific	**Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?** Not specifically targeted – however the health needs of Aboriginal and Torres Strait Islander people will be a key consideration for this activity. Initiatives targeted at addressing FASD and health issues experienced by the LGBTQI community will provide positive changes across the NT and are targeted at both Aboriginal and non- Aboriginal people.
Collaboration	**Outline if this activity will be jointly implemented with any other stakeholders, including other PHNs, Local Hospital Networks (or equivalent), private, public or not-for-profit organisations, and/or state and territory governments. If yes, provide details including the role of all parties.** This activity will be implemented with a range of stakeholders at an NT wide and local level. Stakeholders to be engaged include: • NT PHN's Board, Clinical Councils and Community Advisory Council • NT Government Department of Health • Top End Health Service (LHN) • Central Australia Health service (LHN) • Aboriginal Medical Services Alliance of the Northern Territory • Health Providers Alliance of the Northern Territory • General Practitioners and practice staff • Allied health professionals • Consumers and consumer representatives • Rural Workforce Agencies • Australian Government Department of Health • NGOs and peak bodies including the NT AIDS and Hepatitis Council