HUNTER NEW ENGLAND AND CENTRAL COAST PHN LOGIC MODEL APPROACH

SITUATION

Ageing population

Increasing rates of chronic disease and comorbidity

High rates of mental health issues

Raising costs of healthcare

Health inequities

Fragmented health system

Inefficient use of health services

Ageing workforce

Increasing demand on workforce

PRIORITIES

Mission

Vision

Values

Mandates

Resources

Collaborators

Intended Outcomes

Who we reach

Consumers and Carers

General Practitioners

Primary Health Care Clinicians

Aboriginal Medical Services/ Aboriginal Controlled Community Health Organisations

Local Health Districts

Ambulance

Aged Care Providers

Academic Institutions

Government Organisations

Non-Government organisations

INPUTS

What we invest

Workforce (People, knowledge and time)

Financial resources (PHN Program & other funding)

Infrastructure, information technology and management systems

Data

Partners

Policy

OUTPUTS

Activities

What we do

Collate and analyse data

Undertake planning and prioritisation

Engage and consult with key stakeholders

Develop and design programs, services, models of care

Commission/ cocommission/ programs and services

Contract and performance management

Promote and support research

Facilitate collaborations and strategic partnerships

Develop Health Pathways, e-referrals, digital health initiatives

Inform and educate health consumers

Provide practice and system support

Deliver education, training and Professional development

Direct Product

What we create/achieve

Resources and reports

Planning documents and needs assessments to inform decisions

Key stakeholders involved and engaged (people bank, CAC, Clinical Councils)

Strategies and services designed and implemented to meet need

Range of local programs and services successfully commissioned/ co-commissioned, delivered and monitored

Research conducted and pilot programs completed

Partnerships, alliances, and regional networks of health providers established

Health Pathways and Digital health initiatives implemented and extended Correspondence issued;

Informed consumers

Provider and workforce support delivered, adoption of best practice, accreditation and digital health

OUTCOMES

Short Term

Program Outcomes (0-5 years)

HNECC PHN residents are better equipped to navigate the health system and participate in decision making

HNECC PHN residents benefit from the delivery of high quality health services which are: accessible, equitable, responsive, sustainable and integrated

Improved learning, awareness, knowledge, attitudes and skills of individuals and communities accessing services

Short term health outcomes are achieved for individuals and communities accessing services (effective and safe services)

HNECC PHN residents benefit from the efficient and effective utilisation of resources in the primary health system

Improved experience and satisfaction of the provider

Medium Term

System Outcomes (5-20 years)

Population Health Outcomes

The primary health system effectively protects health, prevents disease and promotes wellness

Value for investment

The primary health system obtains the maximum benefit of the resources invested

Coordination of care and system integration are improved

Efficiency of medical services are improved

Experience of Care

The primary health system provides better patient experience and achieves better care outcomes

Provider Experience

The worklife of clinicians and staff in the primary health system is improved

Long Term

Overarching Population Outcomes (20+years)

Improved Health and Wellbeing

HNECC PHN population live longer healthier lives

Increasing influence of external factors on outcome

Social conditions; Economic conditions;
Physical environment; Genetic endowment