WentWest

A SUBMISSION TO THE PRIMARY HEALTH CARE ADVISORY GROUP

BETTER OUTCOMES FOR PEOPLE WITH CHRONIC AND COMPLEX HEALTH CONDITIONS THROUGH PRIMARY CARE

A Submission to the Primary Health Care Advisory Group

Introduction and the case for change

WentWest has been supporting general practice and primary care in Greater Western Sydney for well over a decade. We recognise the importance of the continual evolution of primary healthcare delivery to improve outcomes for all people and to respond to the changing needs of our community. This is particularly important for those who use the health system the most; patients with chronic and complex health conditions.

As described in the National Primary Health Care Strategic Framework, strong primary health care results in lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality. Primary care, including general practice, needs to provide appropriate services that meet the needs of the local community; make use of the best available evidence base; make the best use of the workforce, infrastructure and technologies; and support continuous improvement in performance, safety and quality.

> *"Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong teams working, both within and across organisational boundaries"*
>
> **Source: The Primary Care Workforce Commission, UK - 2015**

Some areas of primary care are succeeding in delivering on this potential, but in others are facing challenges to do so. Fragmentation and complexity in funding arrangements, poor coordination of service planning and delivery, system inadequacies and inequities, are apparent.

In a summary of studies for Australia it was found that the overall prevalence rates for multi-morbidity (where eight or more chronic conditions were included) were approximately half of all adults aged between 45-65 years.[1]. These issue of effectively addressing this challenge is exacerbated by chronic disease management itself. Data in Figure 1 (over) demonstrates variations in the provision of effective management of chronic disease with only approximately 50% of patients receiving appropriate care.

Analysis using the Pen Clinical Audit tool in western Sydney in 174 practices indicates a similar situation. The downstream impacts of this are demonstrated in Figure 2 (over) showing a compound annual growth rate (CAGR) of hospital activity at 4.7% versus an annual population growth of 2%. Critically, the largest contributor to this is the 5% CAGR in hospital activity and associated costs for chronic disease. This is clearly unsustainable.

[1] The growing burden of multi-morbidity, K.Erny-Albrecht and E. McIntyre, PHCRIS Research Roundup, Issue 31 August 2013

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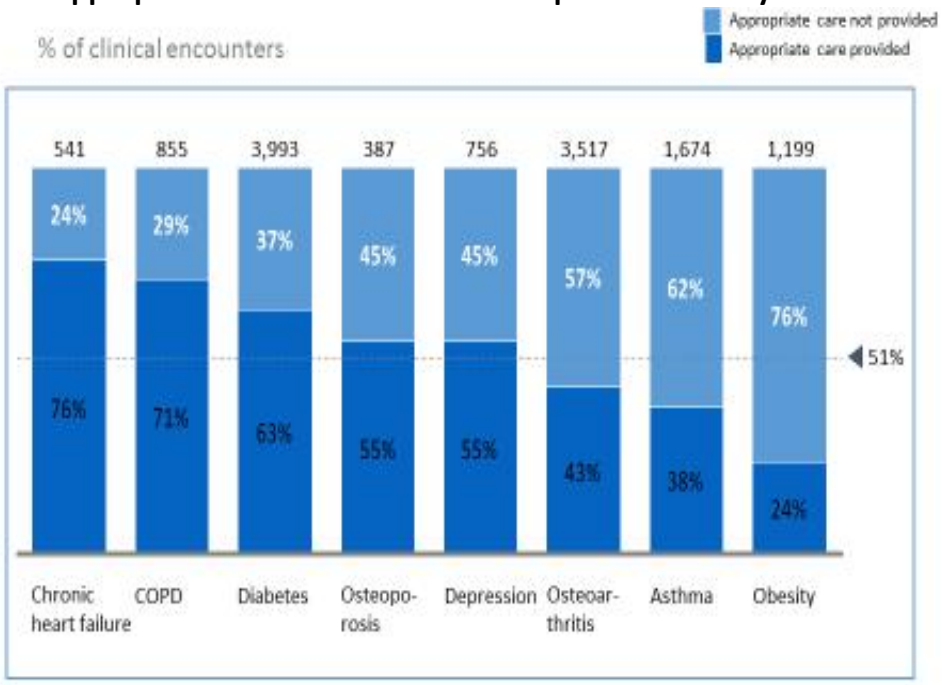
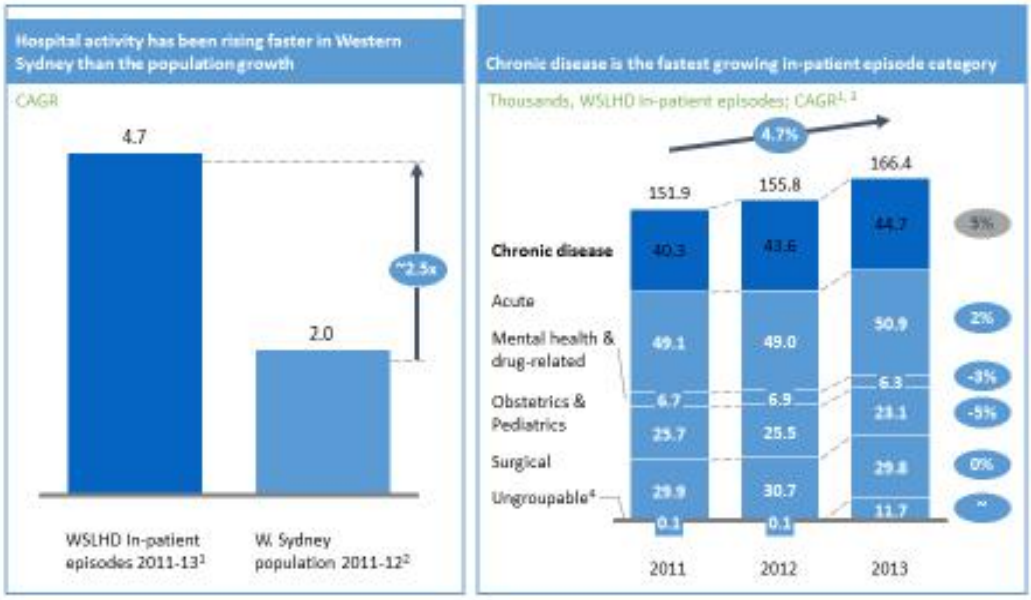
Figure 1: Appropriate care for chronic diseases provided at only -50% of the time



Source: CareTrack: assessing the appropriateness of health care delivery in Australia (MJA 2012)

Figure 2: Escalating hospital activity in western Sydney have been driven by chronic diseases



1 2013 annualised; 2 June 30, 2011 to June 30, 2012; 3 Each DRG classified into one of five categories by GP
4 Ungroupable DRGs are those that have not yet been classified - mostly from Nov, Dec 2013 episodes that were not yet coded or were still in progress

Source: Western Sydney LHD inpatient data 01/07/2010-19/12/2013, ABS Regional Population Growth, 2012

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As a precursor to this submission one-on-one in-depth consultations were undertaken with 25 General Practitioners[2] and other stakeholders via a mixture of phone and face to face meetings to gauge views about the future of general practice. The responses add a further dimension to this picture. The emerging themes from the consultations were grouped into the following five categories:

- What is working well
- Challenges and risks
- Future models of care
- Facilitating factors to enable future models
- Alternate payment models

From the above some of the key themes that emerged around the case for change:

Health System: A fragmented system that is designed to react to acute diseases, not equipped to serve emerging health problems, complex chronic diseases and an ageing population.

Integration across system: Poor communication across the various system silos; limited flexibility for GPs and hospitals to work together due to bureaucracy and funding arrangements; private hospitals not taking on the responsibility of the burden of disease.

Current funding model: Fee for service (FFS) does not serve chronic disease challenges such as continuity of care or reward quality practice; but it is useful for patients with acute care needs. FFS has the potential to be gamed creating volume not value outcomes.

Medicare/MBS: MBS item numbers associated with GP management care planning could be modified to provide a better basis for shared care arrangements particularly for chronic disease care.

WentWest Profile

Against this backdrop WentWest, operating as the Western Sydney Primary Health Network (WSPHN), is encouraged to see the creation of the Primary Health Care Advisory Group (PHCAG) to identify opportunities for health system reform, with a particular focus on the primary/acute care interface. Consideration given to potential innovation of models of care for chronic and complex patients, funding models that support service improvement, review of the roles of existing players, better recognition and integration of treatment for mental illness, would all be valuable.

[2] Undertaken independently for WentWest

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WentWest's Operating Principles have been central to our work and are closely aligned with the areas of focus for the PCAHG.

Figure 3: WentWest Operating Principles

WentWest's Operating Principles

- Support the provision of person centred, integrated and coordinated care, reflecting Medical Home Principles.
- Strengthen quality, scope, connectedness and capability in general practice and primary health care.
- Promote innovation, integration and continuous improvement to increase quality, safety and equity in all health care.
- Enhance health literacy and self care capabilities for individuals, families and communities.
- Lead the design of locally responsive and equitable services by working with local communities to build on what already exists.
- Work across sectors to influence socio-economic determination of health.
- Integrate teaching and research into health service planning, delivery and evaluation

WentWest seeks to offer a submission that will indicate how an established Primary Health Care Organisation and General Practice Training Provider can contribute to the four themes for improvement identified by the PHCAG. We offer themes and a potential innovation model for consideration, one that may potentially make further inroads into some of the challenges identified by the PHCAG.

In this submission we hope to outline how current and evolving capability within the WSPHN and its supporting partnerships indicates a possible opportunity to progress regional implementation of an innovation model at a number of levels; noting that continuing consultation with consumers, general practitioners (GP) and the broader health and human services community are all necessary precursors to successful implementation.

http://www.wentwest.com.au/primary-health-network

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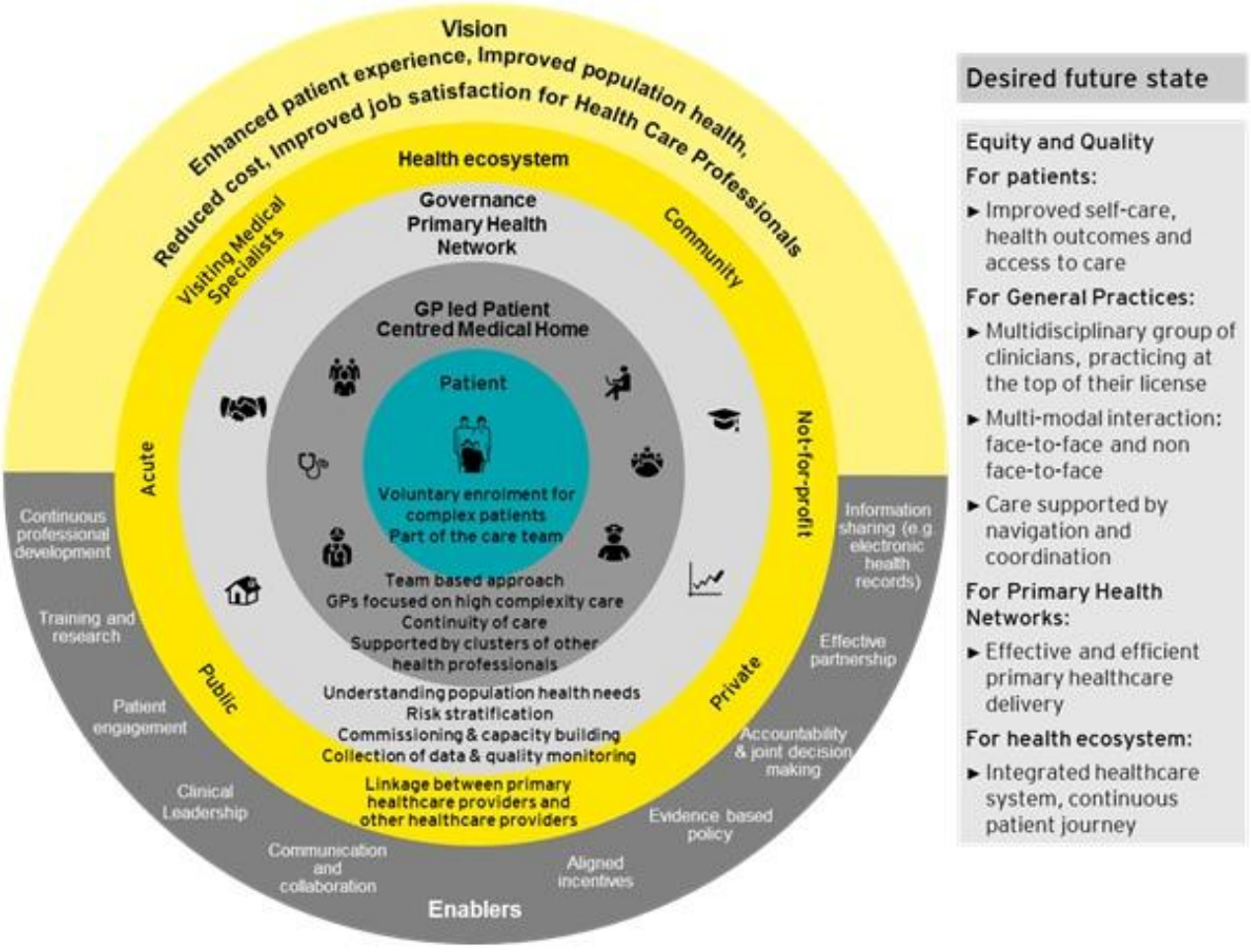
The Proposed Innovation Model

The objective of the proposed innovation model is to ensure centrality of the patient in provision of care. The GP will have the flexibility to direct funds across a multidisciplinary healthcare team and appropriate non-face to face interventions. Implementing the model will allow changing payment mechanisms to evolve to a different state that incentivises quality care and improves equity.

Figure 4: Proposed innovation model pictorial



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Features of the proposed innovation model include:

- GP practice 'opt in' via an expression of interest building in cohorts of 20-30 practices in clusters of 5-10.
- Transformation to a model anchored in the principles of the Patient Centred Medical Home (PCMH) over 12-24 months.
- Voluntary enrolment of patients with chronic conditions and complex care needs as per the Western Sydney Integrated Care Demonstrator Project (WSICP).
- The GP leading a team of health professionals and support staff to manage the patient's needs with patient engagement and using methods that are culturally appropriate.
- The PHN being responsible for funding allocation, agreeing and reporting performance metrics, outcome tracking, capacity and capability building, change management support and quality improvement.
- The PHN in collaboration with general practices establishing and commissioning cluster support roles. Cluster support roles and activities than could include mental health nurses or psychologists, care facilitators, diabetic educators, clinical pharmacists and visiting specialist case conferencing.
- Improved communication between healthcare providers at all levels (primary, secondary and tertiary) facilitates the smooth and efficient transition of patients supported by shared care planning and eHealth
- Leveraging off and incorporating partnerships with consumers and communities, and across funding and service delivery jurisdictions.

The Patient Centred Primary Care Collaborative (PCPCC) in the US has outlined elements of change required over time as part of a transformation to a PCMH. WentWest sees investment in such a transformation as critical. As the WSPHN would support the change management and transition required.

Figure 4: PCPCC PCMH transformation

Today	Future
Treating sickness/Episodic	Managing Populations
Fragmented Care	Collaborative Care
Speciality Driven	Primary Care Driven
Isolated Patient Files	Integrated Electronic Records
Utilization Management	Evidence-Based Medicine
Fee for Service	Shared Risk/Reward
Payment for Volume	Payment for Value
Adversarial Payer-Provider Relations	Cooperative Payer-Provider Relations
"Everyone For Themselves"	Joint Contracting

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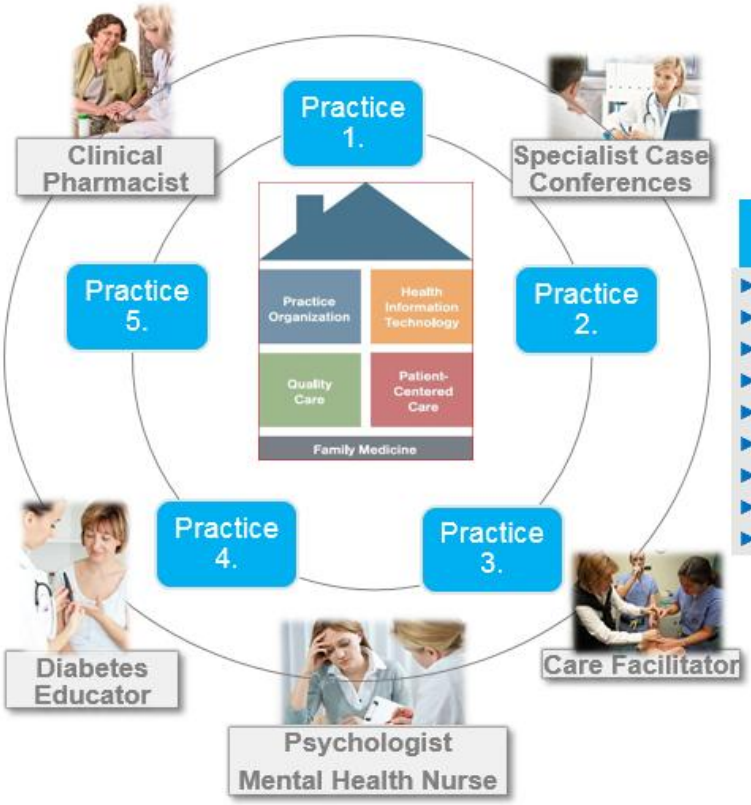
Approach to implementation

Cluster Model x 5 Practices

- 5 Participating 'opt in' practices
- Implementing 'PCMH Model'
- Focused on team based care and leverage practice nurse role
- Wrap around support roles could include:
  - Clinical pharmacist
  - Specialist 'in practice' case conferences
  - Diabetes educator
  - Care facilitator
  - Psychologist or mental health nurse

Capabilities

- Patient risk stratification
- Electronic shared care planning
- Clinical pathways
- Team care focus
- Data driven improvement
- Performance benchmarking
- Target patient cohort registration
- Patient experience tracking
- Clinical metrics dashboard
- Linked to Medical Neighborhood



Enablers (PHN provided & supported)

- PEN Clinical Audit Tool
- LinkedEHR
- HealthPathways
- Patient Dashboard
- Benchmarking software utilised by cluster
- 'Redcap' patient feedback system
- ACI Patient Proms and Prems questionnaire

This model is designed to enable the following:

- **Enhanced clinical leadership**: Allowing participating GPs and their care teams to determine what health care is most appropriate for the patient in line with patient preferences, best practice guidelines and agreed outcome targets.
- **Effective partnerships**: Participating GPs and practices leading a team of multidisciplinary healthcare providers to optimise patient care.
- **Accountability and joint decision-making**: Overseen by the GP and supported by the PHN, the ability of all members of the healthcare team and the patient to work together to determine care pathways and implement them based on evidence based best practice.
- **Patient engagement**: Providing patients with the information they require to be involved in decision-making and giving them a realistic understanding of the personal commitment required and the outcomes that can be achieved.

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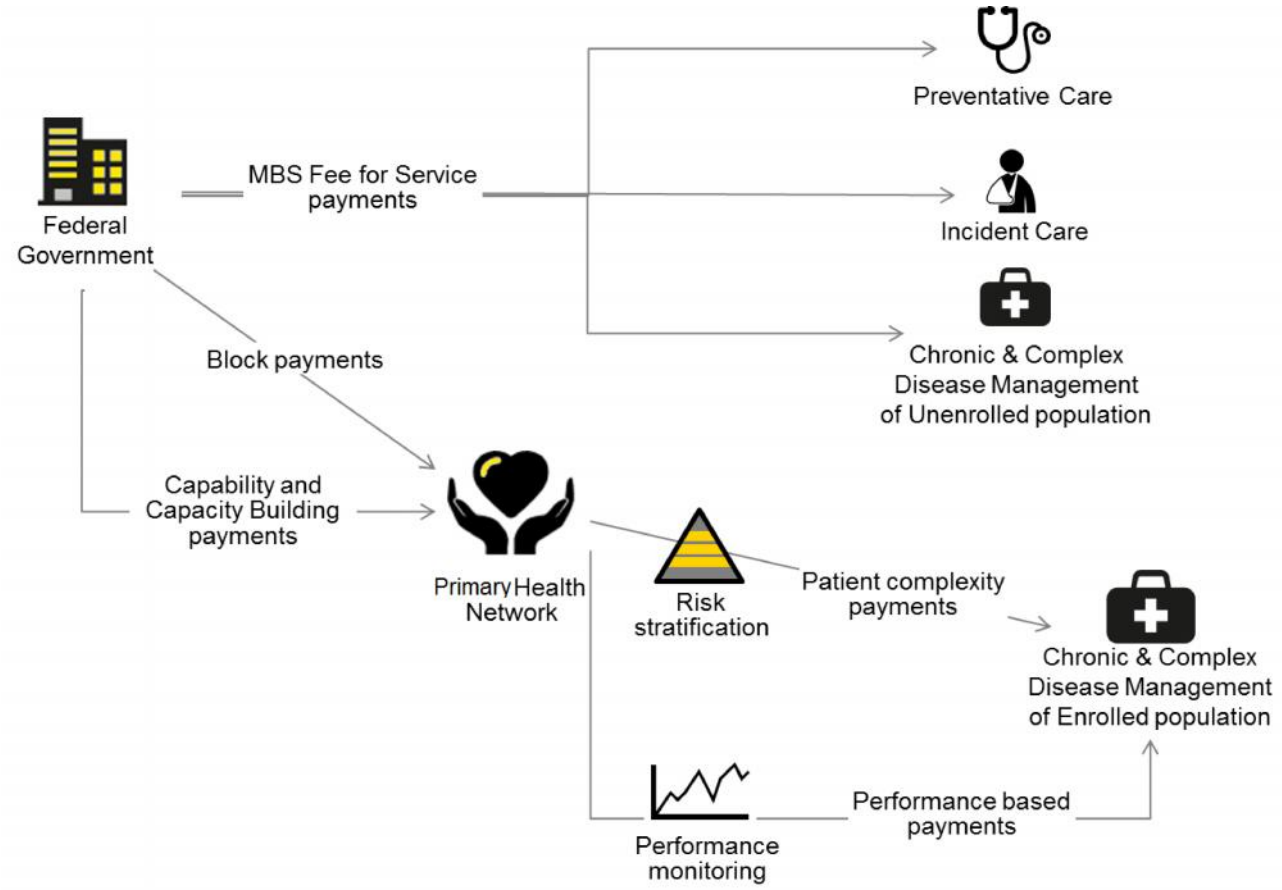
- **Aligned financial incentives with health outcomes**: Using funding and payments to align with patient and population health outcomes.

Figure 5: Potential funding flows for the innovation model



- **Continuous professional development**: Providing opportunities for sharing the results of different interventions, ensuring staff have the training and skills required to perform their responsibilities and supporting staff involvement in research projects and sharing their findings.
- **Information sharing**: To enable healthcare providers to work together, including among providers in different practices and regions, and leveraging technology. Shared care planning, electronic health records that provide multiple points of access to a patient's history and care plan.
- **Communication and collaboration**: Clear communication within the healthcare team to help establish productive and trusting relationships to support the best patient care.

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- **Supporting achievement of the Quadruple Aim and its expected benefits**: as defined below in Figure 5.

Figure 5: The "Quadruple Aim"

Team Based Care

Working effectively in teams is an emerging feature of better care for people with complex and chrionic diseases. Investing in this capability and capacity has been of central importance for WentWest, supported by investment in promolgating PCMH principles, most of which are very much consistent with good quality general practice.

The Western Sydney Diabetes Prevention and Managament Initiative which has been operating since 2013 is a good example of building primary care teams supported by, in this case, Western Sydney Local Health District (WSLHD). WentWest has has in place a formal Partnership Memorandum with WSLHD since 2012. Appendix 1 shows a recent Poster Presentation around one aspect of this initiative being case conferencing.

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Theme 1. Effective and Appropriate Patient Care

Patient home base, team based, coordinated care and patient pathways

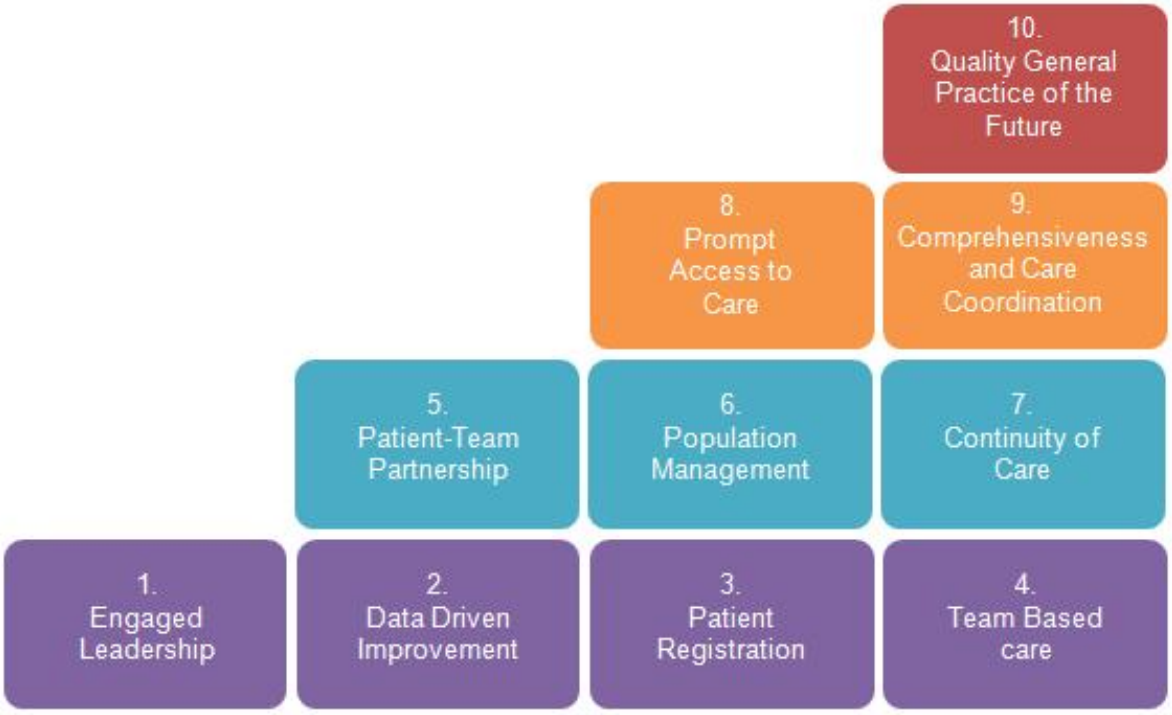
Patient Centred Medical Home Implementation

Building on its role to build capacity and capability in primary care, WentWest has extensively investigated the PCMH model, its implementation in varied contexts and the supporting evidence.

In 2014, WentWest enrolled 15 general practices through a formal EoI process to start to undertake a comprehensive and structured transformation approach towards PCMH status. At its heart this model promotes patient centred, comprehensive, coordinated, accessible, evidence-based and interdisciplinary team based care.

The implementation model has been based on 'The 10 Building Blocks of High-Performing Primary Care" which was developed based on an evaluation of the work of 23 high performing practices that had made a successful transformation to PCMH status.

Figure 6: Building blocks of high performing primary care[3]



[3] The 10 Building Blocks of High-Performing Primary Care. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. AFM 2014.

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HealthPathways

Localised pathways for patient assessment, management and referral

There are currently have over 150 pathways have been localised for western Sydney in partnership with WSLHD and SCHN with more than 2,000 unique/return users.

WSICP

The WSLHD Integrated Care Demonstrator, funded by the NSW Ministry of Health, and partnered with WentWest is trialling different methods for locally led integrated care and exploring approaches to system-wide integration. This model aims to implement a more effective approach to managing high risk patients across the primary and acute care interface leveraging off HealthOne experience and capabilities.

Figure 7: The WSICP Model

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Theme 2: Increased use of technology

Emerging technology, team based care, system integration and patient participation

Linked Electronic Health Records

A dynamic shared electronic care plan to support provider integration and efficient contribution to patient care. PCEHR compliant.

400+ GPs and Allied Health Practitioners in Western Sydney are registered to use LinkedEHR with associated relevant patient care plans uploaded with a particular focus on the WSLHD Integrated Care Demonstrator. Public and private specialists will also be able to access, view and add to patient care plans by December 2015.

Work is underway with Telstra Health will see LinkedEHR and HealthPathways integrated into the Telstra Gateway, an online person portal that will offer a wide range of support and resources based on and tailored to the content of the patient's LinkedEHR shared care plan. A pilot in diabetes in partnership with Telstra Health, WSLHD and Diabetes NSW is rapidly evolving.

Technology enabled data-driven care improvement

An electronic data extraction tool to assist providers monitor and manage patient care.

Currently there are 175 practices or 54% of all practices in western Sydney with PEN tools installed and staff trained on their usage with aggregated, de-identified data collated for population health analysis by WSPHN.

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Theme 3: Achieving Outcomes

Continuous quality improvement and improved system performance

WSPHN general practice quality improvement capability is well-evolved and would be applied in an intensified manner to support participating practices and other partners applying the ten building blocks framework outlined earlier. This includes application of formal quality improvement approaches and ongoing training and support in application of PDSA cycles. Work would also include:

- Practice data cleansing support
- Comprehensive Pen Clinical Tool support
- Provision of quarterly performance reports on agreed key metrics
- Training and support for use of HealthPathways and LinkedEHR
- Utilisation of the LinkedEHR reporting function to view changes in key outcome measures in care plans over time.

Evaluation of any work progressed is critical and the Partnership for Education, Evaluation and Research (PEER), a partnership of WentWest Western Sydney University and University of Sydney, would be utilised to ensure that a comprehensive evaluation framework was a key part of the model implementation from inception.

PEER WESTERN SYDNEY

The Partnership for Education, Evaluation and Research, together with the Universities of Sydney and Western Sydney, has overseen a number of relevant pieces of work that help inform better approaches in tackling chronic disease prevention and management, including:

- Mapping Food Environments in Australia (Food Deserts)
- Torpedo Study (cardiovascular risk management tool)
- Western Sydney Mental Health Atlas
- Evaluation Study of the Effectiveness of the SHAPE Healthy Lifestyles Program

General Practice Training

WentWest is a Royal Australian College of General Practitioners Accredited Regional Training Provider, offering vocational training for GP registrars in Western Sydney and Nepean Blue Mountains. High-quality general practice training, integrated with the broader primary health care landscape, is a critical component of the change process. The efficiency of a vertically integrated approach in this area has been realised in a number of areas and at a number of levels. General practice training and education has a role to invest in the development of a better primary health care system, ensuring that workforce needs are met, general practices are properly supported in change, and that new models of care are supported.

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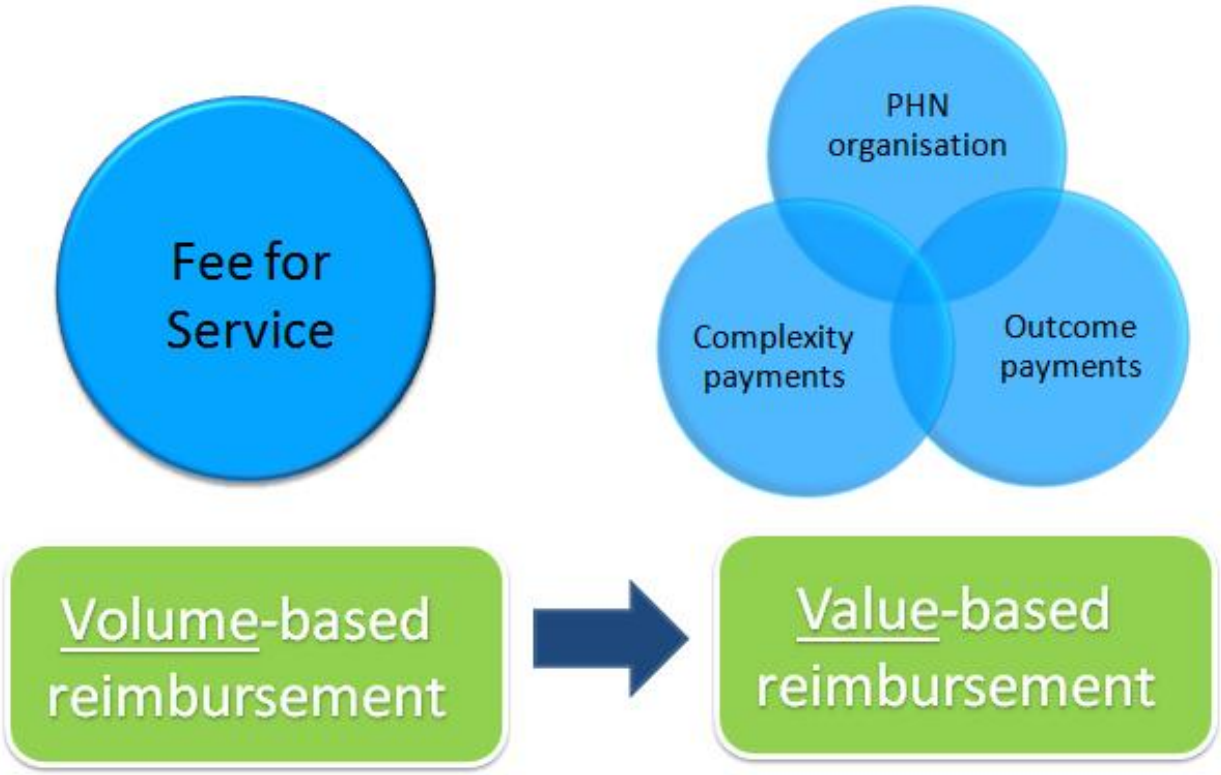
Theme 4: Payment models

Suggested Approach to Implementation

It is critical that any revised incentives and payments for participating general practices are implemented in a negotiated and appropriately phased manner so as to minimise disruption.

The goal is to support general practice and primary care to move from a volume base to a value base when considering reimbursement. Figure 8 below shows the key component that should be considered in such an evolution. The importance of ensuring that training and education, including general practice training, prepares primary care practitioners to operate effectively in this environment cannot be underestimated. Investment is required in this area as is investment in effective team work and partnering.

Figure 8: A move from quantity to quality



How to fund the proposed model of care

Fee for service
Fee-for-service payments under the MBS.

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Patient complexity payments
Following enrolment in the proposed model, the Patient Complexity Payment received by the GP will be determined by the PHN through application of a risk stratification analysis to the practice patient population. Factors to be considered in assessing the complexity payments include:

1. Cultural and linguistic diversity needs
2. Aboriginal and Torres Strait Islander status
3. Level of health literacy
4. Socioeconomic status
5. Number and severity of chronic diseases

Performance-based payments
General practices would also be eligible for performance-based payments that recognise practices for achieving targets for improvements in the quality and equity of care provided. WSPHN would assess the performance of the enrolled patients of a practice against targets related to:

- Patient-reported outcome measures and patient-reported experience measures.
- Clinical outcomes relevant to the patient's condition such as an adaptation of the Healthcare Effectiveness Data and Information Set (HEDIS)[4] or similar (Refer Appendix 1).
- Other targets as agreed such as decreased unscheduled hospital readmissions or increased equity in health measures for different population subgroups. These payments should be funded through shared saving with hospital systems.

Capability and capacity-building payments
To enable WSPHN to support general practice in the implementation of the proposed model and the change, capability and capacity-building payments would be required. These payments would allow the PHN to invest in infrastructure and training to support participating practices.

The components of funding in the innovation model outline above can be considered separately as part of the evolution to a broader value based reimbursement state.

Experience in contracting and commissioning services

WentWest has developed a commissioning framework that includes the processes of needs assessment, specification of services required, contracting of services, and review and evaluation has as of June 2015 had contracted or commissioned over 120 individual health service providers, 180 general practices with After Hours service contracts and six major NGO's.

Competency in implementing outcomes based commissioning activities is a core to PHNs. Refer to Appendix 3.

[4] A tool developed by the National Committee for Quality Assurance in the US.

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APPENDIX 1

Building general practice capacity to enhance diabetes care in the community via case conferencing:

early findings from Western Sydney Local Health District

Mani Manoharan[1,4], Sian Bramwell[1], Amanda Hor[1,2], Vidura De Silva[1], Sumathy Ravi[1], Xiaoqi Feng[1,3,4], Thomas Astell-Burt[4], Marina Fulcher[2], Mark McLean[1,4], Glen Maberly[1,4]

1. Western Sydney Local Health District 2. Western Sydney PHN
3. School of Health and Society, University of Wollongong
4. University of Western Sydney

Introduction

The magnitude of the diabetes epidemic and demand on the LHD requires the bulk of type 2 diabetes management to be undertaken in general practice. The Blacktown Hospital Outpatient Diabetes medical team (Consultant, Community AT, RMO) and Credentialled Diabetes Nurse Educator have visited general practices for case conferencing to build General Practitioners (GP) capacity to better manage diabetes.

Aims

1. Build the capacity of general practices to better manage type 2 diabetes
2. Enhance the communications and integrate diabetes care between hospital services and primary care
3. To evaluate the benefits for the GPs and impact on patients health of this service

Research and Methodology

- 500 case conferences in 90 general practices have been conducted.
- 5-10 patients were reviewed with each GP and shared management plans developed building their capacity.
- GP surveys were conducted after each case conference and follow-up biomarker assessments in 41 patients managed by 19 GPs. Statistical analysis was through multilevel linear regression.

Results

- 97% reported interactive sessions increased their confidence in managing complex patients and would recommend this program to colleagues.
- 85% of GPs reported they would be less likely to refer less complicated cases to specialist services in future.

Figure 3: GPs Confidence in managing diabetes

- The mean HbA_{1c} concentration was reduced by 0.87% (95%CI -1.31, -0.44) 3-6 months after the case conference which is highly clinically significant.
- Patients experienced an average weight reduction of 1.90kg (95%CI -4.56, 0.75).
- Reduction of systolic blood pressure -6.45mmHg (95%CI -11.48, -1.41) and diastolic blood pressure -3.93mmHg (95%CI -7.60, -0.27) were observed.
- We also noted reductions in total cholesterol -0.46, (95%CI -0.76, 0.17), triglycerides -0.32, (95%CI -0.68, 0.05), and increase in high density lipoprotein 0.09, (95%CI 0.03, 0.151).

Figure 1: Case Conference session in General Practice

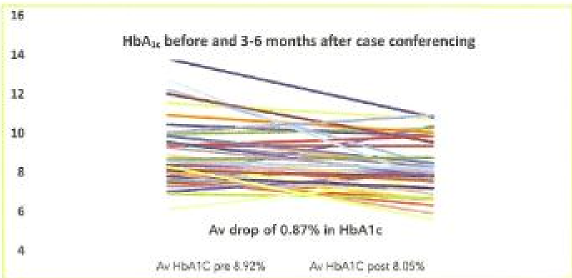


Figure 2: HbA_{1c} before and after case conference

Discussion

- These findings illustrate the effectiveness of case conferences in enhancing GPs ability to provide appropriate diabetes care in the community.
- Case conferences improve communications between general practice and hospital diabetes services.
- The evaluation has provided important insights about the acceptability, effectiveness and the impact of the program.
- Based on our experience this program is planned to expand to involve more GPs in WSLHD.

Acknowledgements

Our partner Western Sydney PHN arranged the case conferences. We thank the GPs and the patients who participated.

References

1. [illegible]
2. [illegible]
3. [illegible]

APPENDIX 2

HEDIS : Heath Effectiveness Data and Information Set adapted for WSPHN
Patient Centred Medical Home work

Effectiveness of Chronic Care – clinic only

- Children Prescribed ADHD Meds
- Drug Therapy for Musculoskeletal conditions
- Appropriate Medications For people with Asthma \
- Controlling High Blood Pressure < 130 / 80, < 140 / 80, < 140 / 90, Not Controlled

Effectiveness of Chronic Care – Diabetes Measures

- Dilated eye exam within the last 12 months
- Foot examination with the last 12 months
- Blood pressure on last visit <120/70, <130/80, <140/90, >140/90
- Hba1c within 12 months
- Hba1c >10, between 8-10, 7-8, <7
- LDL screening within 12 months
- LDL control <130, <100
- Smoking cessation

Persistent medications- Annual monitoring for patients on

- Diuretics
- ACE or ARB

Effectiveness of preventative care

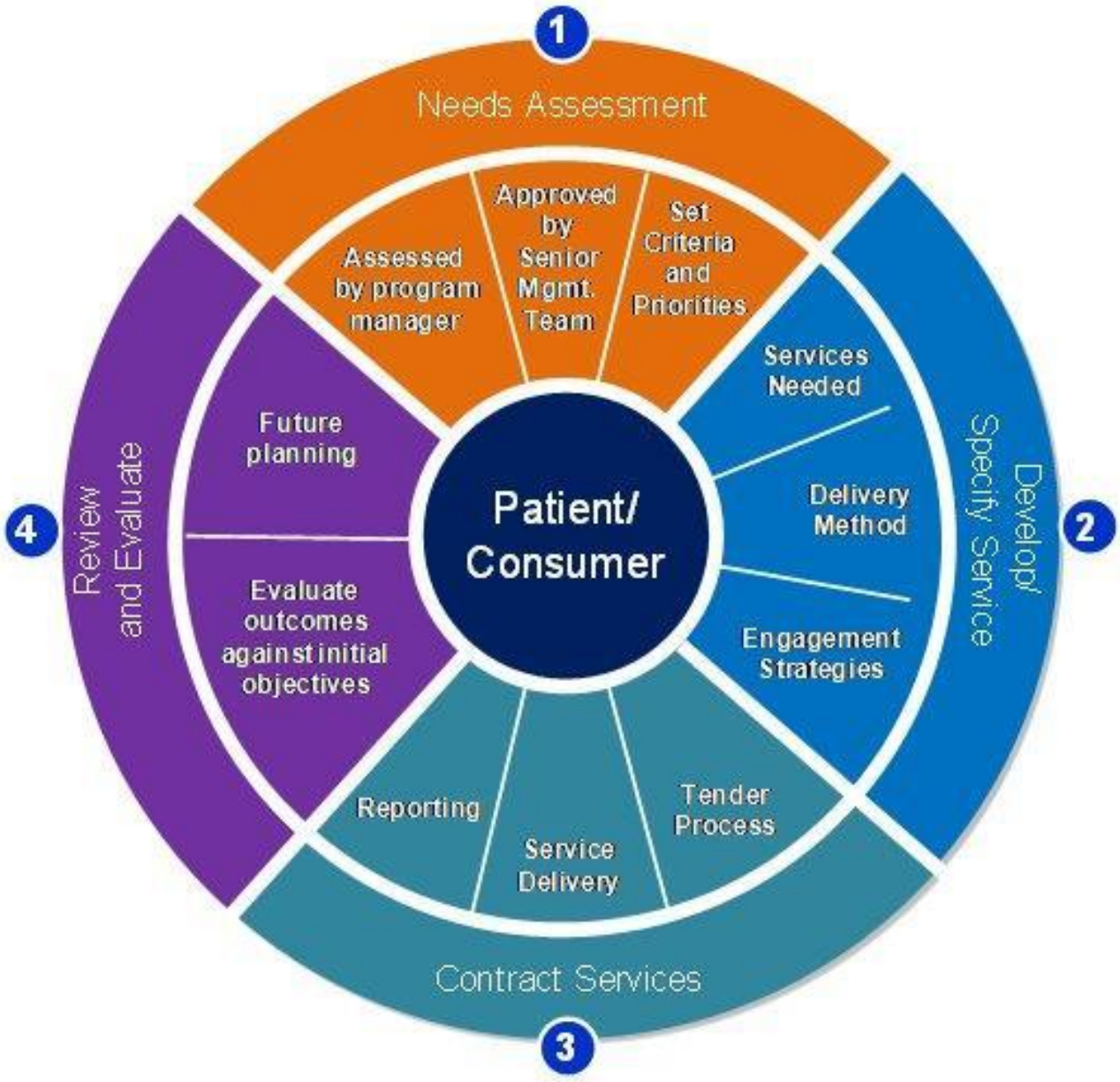
- Adult BMI
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunisations
- Colorectal cancer screening
- Child BMI

Effectiveness of preventative care in adults over 65

- TCA & GPMP Care Planning
- Home Medication Review
- Health Assessment

APPENDIX 3

WSPHN Commissioning Framework



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