COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

COORDINARE Response

Better outcomes for people with chronic and complex health conditions through primary health care

September 2015

Overall

What aspects of the current primary health care system work well for people with chronic or complex health conditions?

COORDINARE believes that for those people who are living with chronic or complex health conditions the primary health care system works well where they are able to access a local General Practice, with whom they have a strong rapport developed over a period of time, and who in turn is working closely with a team of networked health and social service providers. This coupled with the ability to easily access care as required, with limited waiting times works well. The ability for patients to have continuity of care, both with a known and trusted GP and the practice team, is highly important for chronic disease management outcomes.

This is further enhanced where the practice is aided by various system supports, including regular use and monitoring of Chronic Disease Management Plans, shared medical records, and services such as pathology, x-ray, pharmacy services that are either co-located or within easy access.

What is the most serious gap in the primary health care system currently provided to people with chronic or complex health conditions?

a) **In your area?**

COORDINARE believes that there are too many barriers created by different funding bodies that prevent the primary health system operating as part of a 'whole of health system'. Current funding models drive the existing service design and lack the flexibility to build in incentives to change/improve service design.

It is currently difficult to pool funding for people living with chronic and complex health issues from a combination of sources, public and private, and between the primary and acute care sectors. This means people receive some primary health services from the Local Health District, some by GPs and some by private allied health providers, with very little coordination between all parties.

This often results in fragmentation, duplication of tests and enormous time wasted by the patient retelling their stories, and trying to unravel the often conflicting advice, with many finding it all too hard. In many cases this then means the person living with the chronic disease may choose not to follow medical advice, making themselves more ill and not engaging with the health system again until they are in crisis.

Added to this is the lack of shared data that monitor trends and opportunities for service improvement, and the lack of a shared record that cross acute and primary health as well as across borders.

There is an ever-increasing prevalence of chronic conditions. Models of care based around GP consultations to derive practice income will result in effective medical workforce shortages. Expanding the roles of practice nurses and allied health providers, with appropriate funding mechanisms, is necessary. However, this must be implemented in a fashion that maintains the coordination and continuity roles of GPs.

b) **Nationally?**

The most serious gap nationally for people living with chronic or complex health conditions is the lack of a common agreement as to what a strong performing primary health care system should look like and function as. There is not a clear and robust nationwide system where either a GP or practice nurse is authorised and supported with the appropriate systems (funding, user friendly software, legislation) to play an active role in coordinating care, and where the patient is encouraged/supported to manage their own health and wellbeing.

What can be done to improve the primary health care system for people with chronic or complex health conditions?

a) **In your area?**
COORDINARE, the South Eastern NSW PHN can be resourced to develop a patient centered medical home and neighbourhood service delivery model in order to ensure successful and sustainable implementation across the region. It would also welcome the opportunity to facilitate and fund innovation through pooled funding.

b) **Nationally?**
Resource PHNs to develop a nationwide patient centered medical home service delivery model that is supported well by the relevant infrastructure ie. funding models, IT infrastructure, legislation and change management support to ensure successful and sustainable implementation.

Enable PHNs to facilitate and fund innovation in the treatment of chronic disease through pooled Commonwealth, State and private funding.

What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice?

There are some structural issues such as how the MBS payment system is structured that prevents this occurring, as well as industrial barriers that are put up to restrict other professionals from playing a role. Both need to be addressed. Current funding does not reward complex, highly skilled, collaborative patient-centered clinical care.

Other barriers include:

- Career progression within practices is limited as are opportunities for advanced practice roles
- Medical protectionism / pharmaceutical protectionism
- MBS billing and business models that don't support expanded practice models

Theme 1: Effective and Appropriate Patient Care

As described in Theme 1 of the Discussion Paper, a "health care home" is where patients enroll with single provider which becomes their first point of care and coordinates other services.

Do you support patient enrolment with a health care home for people with chronic or complex health conditions?

- **Yes**

Why do you say that?

Patient enrolment is one mechanism to promote continuity of care which is critical for effective management of chronic conditions

We support this on the assumption that enrolment would be linked to appropriate funding to allow quality care coordination. That said it will be important:

- that there remains some flexibility in the system for the patient to still be able to access episodic care for non-related issues.
- to ensure that patients could choose to seek care for these non-related issues in a practice they may not be enrolled in.
- to ensure that funding is not linked to individual health outcomes, as this may result in some reluctance by practices to enroll those with very complex needs because they would cost too much to manage, and may not have good health outcomes.

It should be noted that there is strong international research literature support for improved patient outcomes in a medical home model, but that appropriate funding mechanisms need to be in place to facilitate implementation, including adequate payment for non-face to face care co-ordination tasks.

Do you support team based care for people with chronic or complex health conditions?

- **Yes**

Why do you say that?

Care for those with complex conditions ideally requires input from many different providers contributing expertise across a range of specialties. The notion of 'team' implies these providers are working together in an informed and collaborative manner, which includes the patient and their carers, with shared goals and targets in a way that simplifies access for the patient. Team based care also requires non patient time allocated to case conferencing/team meetings etc which need to be acknowledged in funding models. Where team care doesn't exist, the patient is required to navigate each provider separately which results in inconvenience, duplication, conflicting care and increased cost- all contributing to poor health outcomes and system inefficiency. Shared electronic medical records are also important. There is abundant research evidence demonstrating poorer outcomes for patients with chronic illness where primary care does not fulfil this coordinating role.

What are the key aspects of effective coordinated patient care? Please number in order of importance.

2 Care coordinators

3 Patient pathways

1 Patient participation

Other

How can patient pathways be used to improve patient outcomes?

Patient outcomes are optimised when both the treating GP and the patient has an understanding of the most efficient way to refer and link into the broader primary care and acute sector. Pathways contribute to a reduction in waiting times, improved engagement in the management of their health by the patient, a reduction in the ordering of unnecessary tests inappropriate and incomplete referrals and provide practitioner support when unfamiliar practitioners begin operating in new regions - particularly important in rural areas with workforce issues.

Pathways ideally extend beyond the health system and should include at least social services.

Are there other evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic or complex health conditions?

There are a number of international models of primary care with positive results these include:

- blended payments
- paying for performance
- team based care
- shared savings
- care planning to reduce hospital stays
- incentives for quality improvements
- bundled payments for integrated care
- electronic health care focused on reduced hospitalisation rates

Any funding model needs to be carefully designed and recognise that the model with drive the behaviour of the both the practitioner and possibly the consumer. All funding models will have unintended consequences that also need to be carefully considered during the design stage. Allowing local trials to be piloted through PHN commissioning is a potential opportunity to evaluate these impacts.

There also needs to be greater use of the Personally Controlled Electronic Health Record and other ehealth tools that support more timely exchange of health information between relevant providers. Further resourcing of change management initiatives that ensure meaningful use of these tools is required.

Theme 2: Increased Use of Technology

How might the technology described in Theme 2 of the Discussion Paper improve the way patients engage in and manage their own health care?

The technology described in Theme 2 has enormous potential to improve the way patients engage and manage their own health care, however there is a need to ensure there is a tailored approach to how it is implemented and sufficient resourcing to ensure it is used in a meaningful way. Whilst the general population is adapting well to many technological changes there it will be important to ensure there are strategies in place that takes into account those who are not confident of and choose not to engage with technology, those who may not be able to afford access to smart phones etc and those in more rural and remote areas where IT services are often unreliable.

What enablers are needed to support an increased use of the technology in Theme 2 of the Discussion Paper to improve team-based care for people with chronic or complex health conditions?

Systems that are interoperable are essential. We can get apps for android and iOS for consumer use, but for reasons of commercial gain, companies continue to build medical software that won't communicate and perpetuates silos.

We also need to rethink the privacy rulings. It is consistently used as an excuse for not sharing information. It needs to be rationalised.

Incentive payments for sign up and use of - including complimentary or subsidised access to software licensing for all primary health providers.

The implementation of technology into workplaces has been exhaustively researched, but rarely are evidence-based approaches used to enhance the uptake of technology into practices. Essential new technology should be accompanied by evidence-based assistance for uptake into practice systems and processes.

How could technology better support connections between primary and hospital care?

A standard IT platform used in acute and primary settings with software systems that speak to each other. Sensible interpretation of data privacy laws that allows for appropriate data sharing for service planning. Shared access to radiology and pathology results to prevent duplication of tests and to improve patents safety.

How could technology be used to improve patient outcomes?

COORDINARE believes that technology can be used to improve patient outcomes in every way. That said, the use of technology is only one part of this issue. Practitioners are often willing to use technology however there is no business model to support this. If patients aren't seen in the practice, there is no payment - which has flow on effects for practice viability, employment, etc. For an individual patient this is not an issue but when considering the systematic use of technology it becomes unsustainable.

Government needs to quickly look at using smart phone technology for health improvement, eg monitoring health status, managing appointments, accessing and collating records etc. While this may not work for all 70 year olds with chronic and complex conditions, it is a growth area.

We also believe that further work needs to be done in trialing data linkage technology using local service utilisation data. In collaboration with Health Insurance Companies we can investigate patterns of low value health care. As the PHN matures its commissioning model, this information could be used to guide future commissioning decisions, using market levers to minimise use of low value health care.

Practice software could also be significantly improved in regard to the presentation and manipulation of patient data. For example, at present, no practice system can automatically collate the average diabetes control, cholesterol, blood pressure and body mass index of a patient over the last 12 months and compare this with the previous year. Nor can systems readily provide practices with aggregated data for their whole practice to assist with quality improvement, such as the proportion of patients with controlled diabetes. For significant improvements in patient and population health, such capabilities are essential.

Theme 3: How do we know we are achieving outcomes?

Reflecting on Theme 3 of the Discussion Paper, it is important to measure and report patient health outcomes?

- **Yes.**

Why do you say that?

Managing care of those living with chronic and complex health needs is a balance of preserving optimal function and quality of life. Attributing outcome measures to this is challenging.

How could measurement and reporting of patient health outcomes be achieved?

This is where a patient data aggregation tool in clinical software becomes useful. It is important that rewarding quality care, resourcing the capacity to improve patient outcomes and motivating clinicians is carefully balanced with ensuring practices in areas of high socioeconomic disadvantage are not penalized for taking on ‘hard patients’.

Thus measurement and reporting needs to be undertaken carefully. It needs to include process measures including cycles of care and very importantly patient measures of satisfaction.

Reporting outcomes in the context of the social determinants of health is necessary. Outcome measures should include not only targets but progress towards targets.

To what extent should health care providers be accountable for their patients “health outcomes”?

Only to the extent that they are seen to operating within their professional scope of practice and clinical guidelines. Health care providers are not responsible for the impact of the social determinants of health, individual patient choices or system and service gaps and cannot be held accountable for things beyond their control.

If providers are held accountable for outcomes and reimbursed based on outcomes there may be an emergent equity issue for the increasingly complex with expected poor outcomes - everyone wants the 'healthy' people and the positive outcome.

We believe it’s unfair to measure this on an individual patient level, but at a practice or regional level it’s a useful tool to share some accountability. If we were able to model expected outcomes, based on a set of demographics like age, socioeconomics, and then discover that a particular region/practice had poorer outcomes than expected, and these couldn’t be explained, why not make the providers a little bit accountable? PHNs are held accountable and we have even less influence than direct care givers.

That said, it is well recognized in the research literature that the social determinants of health (housing, income, overcrowding and education) have the greatest impact on patient outcomes.

These poorer outcomes result in disproportionate health care costs and health care utilization. There is currently no systematic approach to meeting this increased need geographically within health systems or modelling of the resources required to reduce high cost serious complications with lower cost intensive preventive activities in areas of high need. Rational, evidence based resourcing to areas of higher need may actually reduce overall health costs. In this context, clinician accountability concerns the extent to which consistent evidence-based care has been provided within the resources available, respecting patient autonomy mediated by the social determinants of health of the community.

What could health care providers accountability for their patients outcomes be achieved?

Please refer to the above comments

To what extent should patients be responsible for their own health outcomes?

This is challenging because responsibility should not equal victim blaming. The focus should be on empowering patients to take responsibility for their own health, while acknowledging that all decisions a patient makes will be done in a certain social and economic context.

How could patient responsibility for their own health outcomes be achieved?

The concept of Patient Activation is relevant here. A structured trial of using the Patient Activation Measure and intervening accordingly would be a clear and focused way of sharing responsibility for outcomes with the patient.

Theme 4: How do we establish suitable payment mechanisms to support a better primary health care system?

Theme 4 of the Discussion Paper discusses different payment mechanisms. How should primary health care payment models support a connected care system?

If you prefer a blended model, as described in Theme 4, select all the components that should apply.

- ☐ Capitated payments
- ☐ Salaried professionals
- ☐ Fee for service
- ☐ Pay for performance
- ☐ Other(specify)

COORDINARE believes that further developmental work needs to be undertaken with GPs to explore and test innovative funding models on a voluntary basis. This may include the development of innovative purchasing and commissioning models. It could also include cashing out some elements of the MBS for conversion to capitation and performance payments.

The first step would be to survey the local GPs to identify individuals interested in testing such models on a voluntary basis. The trial will be designed in collaboration with participants, and will be carefully evaluated.

Should primary health care payments be linked to achievement of specific goals associated with the provision of care?

- o Yes

Why do you say that?

There is good international evidence that ‘pay-for-performance’ improves some measures of patient outcomes. However, the evidence also demonstrates that there are unintended consequences and that PFP needs to be part of whole-of-system funding reform. Unintended consequences to PFP have included patients’ having reduced satisfaction in care, reduced continuity of care, exclusion of high risk or non-compliant patients and neglect of non-incentivised clinical activities. Broad measures of goals, including patient-based measures, are required. Very careful implementation is needed, paying close attention to successful international models such as Ontario, Canada, where a mix of PFP (e.g. incentivised enhanced preventive programs), fee for service and capitation funding has been demonstrated to be an effective model.

What role could Private Health Insurance have in managing or assisting in managing people with chronic or complex conditions in primary health care?

We believe that Private Health Insurance should have a role in managing and assisting in the management of chronic or complex conditions in primary health care. This could be done through the sharing of primary health care data, empowering their members to improve how they navigate the health system and manage their own health and by working with Primary Health Networks to develop more innovative models of care and pool funding where appropriate.

Do you have anything you would like to add on any of the themes raised in the Discussion Paper?

COORDINARE is committed to building a stronger and more responsive primary health care system in the region, using the imagination, determination, passion and strategic connections of its founding members and staff team. In order to deliver on some of the fundamental changes proposed considerable resourcing to support implementation will be required.

We would like to acknowledge input to this submission from our founding partners at the General Practice Academic Unit, Graduate School of Medicine, University of Wollongong, and Peoplecare.