
# WA PRIMARY HEALTH ALLIANCE SUBMISSION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH INQUIRY INTO CHRONIC DISEASE PREVENTION AND MANAGEMENT IN PRIMARY CARE

**30 January 2016**

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**Executive Summary**

The WA Primary Health Alliance (WAPHA) welcomes the Inquiry into Chronic Disease Prevention and Management in Primary Care and is pleased to present its submission in response to the Terms of Reference.

WAPHA serves a population of approximately 2.57 million people, across the entire State of Western Australia through its three Primary Health Networks (PHNs) – North Metropolitan, South Metropolitan and Country WA. WAPHA is committed to prioritising chronic disease prevention and management in its planning and commissioning activities and seeks to improve health at the primary level through efficient and long term strategies. WAPHA intends to build capacity and capability within the WA health care system to help alleviate the burden of chronic disease.

The current and projected impact of chronic health conditions in Australia needs to be urgently addressed. Effective prevention and management of chronic health conditions relies on integrating and co-ordinating services for people across the continuum of care. The focus must be from the well population through to the end of life.

The current *WA Chronic Health Conditions Framework* (1) highlights the lack of integration and linkage within the range of services for chronic disease delivered by various private, not-for-profit, and government organisations, especially in the primary care sector. This is intensified in rural and remote WA.

Primary Health Networks have been provided a unique opportunity to develop and implement commissioning models to address priorities in chronic disease prevention and management. The process of needs and outcomes based commissioning incorporates a rich set of data from a range of sources and rigorous reporting and evaluation mechanisms.

Consistently, the barriers to effective and co-ordinated service provision for people with chronic disease (from both a clinician and a patient perspective) are reported as the lack of direct engagement and communication between hospitals and community based primary health care and between the independent providers of primary health care. Successfully addressing these barriers relies on engaging and establishing effective partnerships between and across providers, sectors, consumers and purchasers of health services.

A reduction in the impact of chronic disease relies on increased and ongoing investment in primary health care and prevention and new approaches to primary care based strategies that are both evidence and outcomes based.

## 1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally.

WAPHA's vision for best practice and innovation in chronic disease prevention and management is underpinned by the Patient Centred Medical Home (PCMH) model which is well referenced in the Primary Health Care Advisory Group's *Better Outcomes* report (2). The term Patient Centred Medical Home is currently gaining significant momentum in Australia, and is often cited in State and Federal Government health policy documents – particularly in respect to the Commonwealth's current reform agenda for primary health and mental health care.

Attributes of the Patient Centred Medical Home include accountability, comprehensive and whole person care, continuity of care, team based care, patient participation, accessibility,

excellent clinical information, a system based approach to quality improvement, connections to the medical neighbourhood and education and training (3).

The primary health care sector is looking to the Patient Centred Medical Home model as a significant enabler in the management and support of people with chronic disease as close to home as possible. An example of this can be found in the NSW Chronic Disease Management Program – Connecting Care in the Community (4).

The RACGP has also identified the Patient Centred Medical Home as a key element of its *Vision for General Practice and a sustainable healthcare system (5).* Medical Home models have been associated with:

- Increased and improved access to appropriate care;
- Decreased use of inappropriate services (particularly EDs);
- Decrease in urgent care visits, inpatient admissions and hospital re-admissions;
- Increased provision of preventative services;
- Improved care experiences for patients and staff;
- Cost savings for payers;
- Better defined practice populations;
- Better relationships between GPs and patients, and
- Alignment to chronic disease management items.

WAPHA is currently bringing key stakeholders together as part of an Innovation Hub to discuss Patient Centred Medical Home model options that would be most applicable to the Western Australian primary care setting. It is intended that selected models will be trialed in chronic disease and mental health contexts within general practice.

WAPHA further acknowledges work that has been done in Australia and internationally in the area of risk stratification for chronic disease. Risk tools and models are an important part of the strategy for managing patients with chronic disease. They can be used to identify patients most at risk of future unplanned hospital admissions, and those in the later stages of disease. They can also assist in identifying people with low to moderate risk in other disease categories, or complexity, who may benefit from preventive measures. If accurate, they can direct the necessary preventive interventions efficiently and economically to prevent crises (6).

In Western Australia, a three year research pilot is currently being conducted in the Perth north metropolitan area to test a new model of care co-ordination and integrated care to support high utilisers of our public and private hospitals. The pilot has been informed by best practice models and service integration from an Australian and international perspective. The CarePoint pilot is a jointly funded collaboration between the WA Department of Health, Medibank Private, Medibank Health Solutions and HBF. The model of care involves care co-ordination, virtual system navigation, home-based services, after hours support and active liaison with clinicians in hospital and the community. It is a GP centred model with resources and supports provided in primary care teams to improve the population health management of complex and chronic disease patients. It seeks to reduce avoidable hospitalisations and to improve health indicators and experience of care for patients, their carers and families.

CarePoint has been operating for 1.5 years. The planning phase is complete and the current focus is on care delivery which includes setting up care packages, referrals and services based on individualised risk and need, and monitoring the enrolled cohort over time to ensure proactive care is provided to keep patients as well as possible, and to manage their health in the lowest acuity setting possible.

Care co-ordinators are based part time in participating practices to work with GPs and practice nurses to improve quality of care. They jointly draft care plans, conduct case reviews and clinical audits. The model has received early positive feedback from clinicians, patients and

their families. A formal evaluation of the pilot will be undertaken by the School of Public Health at the University of Western Australia in the latter part of 2017. The consortia is working closely with the North Metropolitan WA Primary Health Network.

## 2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

Financing models are required that allow for local flexibility and which meet the requirements of the community and recognise the importance of inter-sector collaboration. It is imperative that any review of the Medicare payment system in respect to Chronic Disease Management MBS items is conducted in consultation with the medical profession.

The current payment system lacks appropriate mechanisms to encourage and reward best practice and quality improvement in chronic disease prevention and management. A key factor contributing to the gap between optimal and current practice in chronic disease prevention and management in primary care has been identified as the dominance of fee-for-service funding of general practice care, encouraging reactive rather than systematic care (7).

Particular funding initiatives introduced by the Federal Government have gone some way to improving management of chronic disease by GPs and allied health providers, including:

- The enhanced primary care (EPC) programs, which include incentives for GPs to develop structured management plans for patients with chronic illnesses (GPMP) and team care arrangements (TCA) for multidisciplinary care of patients with complex needs;
- Medicare items for patients with team care arrangements to be funded for up to five occasions of service per year from private allied health services and, more recently, for group services;
- Specific funding through the Practice Incentives Program (PIP) for practice systems and completing an "annual cycle of care" for patients with diabetes and a series of planned visits for asthma education and management (originally three and recently reduced to two visits), accompanied by evidence-based management guidelines, and
- Specific funding for practice nurses through the PIP and Medicare items. (8)

Whilst these initiatives appear generally to have been worthwhile, after significant enhancement and re-working, they are too limited to produce substantial re-orientation of GP care. They have made a limited contribution towards a multidisciplinary team approach, in large part due to the availability of allied health services in the community and restrictions on the eligibility and number of services funded by Medicare. Further, waiting times for State delivered allied health services have become increasingly focused on the care of recently hospitalised patients.

The GP incentives have not been demonstrated to support chronic disease self-management, and few of the Incentives programs have effectively engaged GPs, nor have the evidence based chronic disease guidelines been effectively incorporated into practice information systems, continuing professional development and clinical audit requirements. (9)

It is appropriate that primary health care financing options involve PHNs and that this includes a new performance indicator framework that is matched to the governance mechanism. The regional needs and outcomes focus allows for the most effective delivery of services.

WAPHA advocates for models of chronic disease prevention and management in primary care which support effective team care approaches with practice nurse involvement,

patient self- management, monitoring and education. MBS incentives that recognise multi-disciplinary and trans-disciplinary approaches to chronic disease prevention and management would potentially reward general practices that innovate in team based care and could encourage the sharing of successful models.

The current format and use of GP Management Plans requires a comprehensive review in order that they are better matched to the requirements of GPs and their patients. Included in this review process should be an assessment of the associated MBS items.

Current Fee for Service arrangements are widely acknowledged to reward high volume consultations of brief duration, and these are not accepted as facilitating the delivery of high quality primary health care. Incentive programs can be effectively used to reward high quality patient care. However, these should not be standardised or made applicable across all General Practice settings. Different payment systems would be required for different types of medical services (10).

WAPHA is currently developing innovative trial models for patients with chronic and complex disease within the Patient Centred Medical Home model framework. A "naïve inquiry" process is currently underway to identify the payment related barriers that currently apply to the management of patients with chronic disease. Anecdotally, it would appear that it is the funding system barriers that limit the opportunities for General Practitioners and their practice medical staff to make best use of their time and skills in respect to specific areas of chronic disease prevention and management. Savings from the withdrawal of inappropriate MBS items that are not resulting in good patient care outcomes could be more effectively used to support payment models that are shown to result in improved patient outcomes for patients with chronic disease.

Trial models that are being explored by PHNs across Australia will result in innovation. Support and encouragement should be given to PHNs to share these models.

It is widely hoped that the current MBS review will reward General Practices and individual practitioners who clearly demonstrate that they are taking responsibility for providing comprehensive, co-ordinated and sustainable patient care for patients with chronic disease who utilise a high level of health services.

WAPHA commends the approach of the Primary Health Care Advisory Group (PHCAG) in reviewing GP compensation arrangements to consider new blended payments to achieve better balance between patient throughput and quality. Clear evidence will be required that facilitates adequate funding for such remodelled payment arrangements.

WAPHA recommends a thorough examination of the Chronic Disease Management (CDM) items that are included in the MBS. WAPHA's trial PCMH model will, in the initial inquiry phase, explore with General Practitioners, Practice Nurses and Practice Managers the care and access barriers associated with the use of these items - what works and what doesn't and the work-arounds that are currently used in General Practice to address the issues. This inquiry phase of the trial is intended to inform innovative payment structures that lead to better patient outcomes. There are acknowledged benefits of the current CDM items in that they can support a team-based multi-disciplinary approach to management of chronic disease and facilitate ongoing cycles of care - rather than episodic treatment. However, shortcomings have been identified as the deficiency of tailored responses to patient needs and the significant red tape associated with the CDM items. Under the current system, a balance is needed between generating GP Management Plans and reviewing the plans at the scheduled follow up appointments. The aim is to encourage consistent, proactive and meaningful patient review.

A renewed focus within the MBS on supporting preventative care is recommended with an ensuing expansion of the scope of the CDM items.

The Department of Veteran's Affairs' Consumer Directed Care (CDC) approach is acknowledged by medical practitioner representative organisations to be a good example of innovation in the area of providing differentiated payment structures based on patients' care needs. The AMA has recommended the introduction of a properly funded CDC style model, combined with reform of existing CDM items as a significant step forward in the approach to chronic disease management within General Practice.

## 3. Opportunities for the Primary Health Networks to co-ordinate and support chronic disease prevention and management in primary health care:

PHNs have been given a clear mandate by the Commonwealth:
*Primary Health Networks (PHNs) have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving co-ordination of care to ensure patients receive the right care in the right place at the right time.*

PHNs are subsequently well placed to co-ordinate care and improve vital links between hospital and referral based care and primary and community based care. This is done at a local level, in response to local needs. There is a clear acknowledgement by the PHNs of the importance of embedding social care needs within this context.

WAPHA is conducting a comprehensive needs assessment process aligned with our geographical PHN regions - Perth North, Perth South, Perth East and Country WA. This assessment is evidence based and will inform health services planning for WA in collaboration with the WA Area Health Services, State and Federal Governments, Clinical Councils, Clinical Commissioning Committees and Community Engagement Committees. There is a well understood imperative to reduce potentially preventable hospital admissions for the Western Australian community. This will be addressed through locally designed strategies that are aligned to local need.

WAPHA is working with State and Federal stakeholders in the development and uptake of the My Health Record (MyHR) in WA and is looking to trial strategies that encourage increased usage and acceptance within General Practice and the wider community. WAPHA recognises the significant role of the MyHR in the prevention and management of chronic disease.

WAPHA has already developed strong and enduring stakeholder relationships with WA's Area Health Services, the Federal Government, medical and allied health professionals, consumers and NGOs. The structure and governance around this engagement with PHNs is transparent, well governed and collaborative - in some cases, governed by MoUs or guiding principles.

Optimising these relationships will help to ensure that the PHN commissioning process in respect to chronic disease prevention and management is based on best practice, a clear evidence base and achieves positive population health outcomes for WA people. WAPHA will clearly identify chronic disease priorities, will analyse health and other data and will continue to engage with stakeholders to guide the needs assessment process and inform services design. It is important to share the learnings throughout the process at both State and national levels. The strong PHN communication and collaboration network that has been established nationally will facilitate meaningful exchange of information and intelligence.

WAPHA is forging strong relationships with the WA Faculty of the RACGP and with WAGPET to ensure that there remains a strong focus on the importance of General Practice in co-ordinating and supporting chronic disease prevention and management in the primary health care setting.

The opportunities for PHNs to conduct trials of primary health care models for chronic disease prevention and management are wide-ranging. These opportunities allow for the development of innovative trials within the General Practice and primary health care setting, particularly in respect to hard to reach people and those with complex health needs.

## 4. The role of private health insurance in chronic disease prevention and management:

Prior reference has been made in this submission to the CarePoint trial. The trial model explores opportunities within the context of a public / private partnership to foster innovation in the management of chronic disease. The evaluation of the trial will inform further exploration of the role of private health insurance in chronic disease prevention and management.

It is imperative that any role for private health insurance in primary care is carefully considered and clearly defined. In a recent submission to the Private Health Insurance Parliamentary Inquiry, WAPHA cautioned that any increased role of private health insurers in primary health care must not result in barriers to access, nor in any increase in costs for non-insured consumers. Additionally, there must be no negative impact on clinical independence or a shift towards managed care models.

There are unique opportunities to effectively use the PHI member data to assist the PHNs in broadening the data sets for the comprehensive needs assessments.

## 5. The role of State and Territory Governments in chronic disease prevention and management

As already highlighted earlier in this Submission, WAPHA has developed strong linkages with the Area Health Services across WA. There is a clear and mutual priority to reduce potentially preventable hospitalisations in WA and a collaborative approach has been taken.

WAPHA is cognisant of the important legislative role of the State Government in respect to regulation in public health areas including of alcohol and tobacco. WAPHA considers its role in in influencing and informing relevant policy discussions at the State level to be imperative in the prevention and management of chronic disease.

Where possible, WAPHA is prioritising co-commissioning opportunities with the State Government in a concerted effort to reduce fragmentation and duplication of services and to minimise wastage within the primary, secondary and tertiary health sectors. The imperative is to improve the patient journey and health literacy, and enhance patient access within and across systems based on their individual needs at a particular point in time.

In WA, there are significant opportunities for collaboration with the State Government by way of linkages with the Central Referral Service, eHealth arrangements for transfer of care (e.g. hospital discharge processes) and the Patient Assisted Transport Scheme.

## 6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management:

As explored previously in this Submission, the potential for innovation in trialing models in primary health care for chronic disease prevention and management is significant. The PHN trial sites facilitate collaborative approaches to this innovation and provide unique opportunities to address the health care needs of hard to reach consumers.

As WAPHA is the backbone for WA's three existing PHNs, there are opportunities for scalability of innovation across the State. In addition, WAPHA's focus on the unique needs of Country WA allows for innovation in the areas of telehealth enabled prevention and management for chronic disease and addressing the serious limitations that result from the workforce and geographic challenges that exist within the State's remote and rural communities.

Exploration of trial models such as the PCMH trial, and the subsequent investigation of optimal payment models, is expected to result in innovative approaches to facilitating improved access and patient outcomes. WAPHA utilises Innovation Hubs that involve expert consultation and exploration of particular models of care to inform model development and design.

In developing innovative approaches to chronic disease prevention and management, WAPHA has a strong focus on the influence of the social and environmental determinants of health. An integrated care PCMH model considers the linkages within the Medical Home to social care services such as housing, transport, the justice system and employment services.

The HealthPathways project that is currently being undertaken in WA and some other PHNs around Australia creates locally standardised care pathways for common chronic diseases. The web-based information portal supports primary health care professionals to plan care through primary, community and secondary health care systems. HealthPathways provides information on referrals, specialist advice, diagnostics, GP procedures, subsidies and consumer handouts and has been designed around locally agreed best practices.

The first study of HealthPathways in Australia suggests it has strengthened relationships between GPs and secondary care specialists (11). For prevention and management of chronic disease, the benefits of the HealthPathways platform stem from its process of engagement with the entire sector including specialised community groups, allied health professionals, GPs, Area Health Services' representatives and specialists.

## 7. Best practice of multidisciplinary teams in chronic disease management in primary health care and hospitals

The PCMH model facilitates a multidisciplinary team based approach and involves co-ordination and communication with the hospital sector to improve outcomes for patients with chronic disease. A central construct of the model is patient enrolment which enables a deliberate organisation of the health care activities associated with the patient within a

holistic system of wrap around care that is GP led and involves a high level of personal investment from the patient.

The PCMH model that WAPHA will trial for the patient cohort with three or more chronic diseases is an example of a best practice model that can be effectively applied to the management of patients with chronic disease. The patient is the central focus within the model and is supported by the wrap around services of the General Practice, relevant social care services and other health professionals who are involved in the collaborative and shared care approach.

To achieve best practice within the context of the PCMH model, a sustainable solution under the current MBS structure is needed. There is a range of payment structures to consider, including incentive payments and patient-centred bundled care packages.

The RACGP has stressed that the key to achieving optimal efficiency of multidisciplinary teams in chronic disease prevention and management is clear communication between team members. The College has assigned GPs a leadership role in understanding the services available in their community and the most appropriate referral processes. The College is cognisant that the various members of the multidisciplinary health care team are often located in multiple different locations and within a plethora of services. (12)

## 8. Models of chronic disease prevention and management in primary healthcare which improve outcomes for high-end frequent users of medical and health services:

Improved outcomes for high-end frequent users of medical and health services are highly dependent on:

- The identification of regional need through a comprehensive needs assessment process;
- The development of evidence based clinical guidelines and local referral pathways;
- Use of eHealth enablers to accommodate hard to reach patients with chronic disease;
- Shared clinical records and a cross-sector approach to the communication of health information via electronic means;
- Emphasis on continuity of care between all primary health care providers and specialists and hospitals;
- Sustainable General Practice – patient continuity of care;
- Timely, efficient and effective patient follow-up. Focus includes, but does not rely on face-to-face consultation. eHealth, telephone encounters, group appointments and visits with other team members are important methods of intervention;
- Data management and risk stratification to facilitate the practice's ability to stratify the needs of this patient population and design and development of team roles to match those needs;
- Strong integration of service pathways that assist patients and their GPs to navigate the numerous and differentiated services that high needs patients require;
- Recognition of the patients' role in their own health care, as well as the evidence base and the clinical and medical judgements of the clinician and team, and
- Engaged leadership, creating a practice-wide vision with concrete goals and objectives
- Prompt access to care and allowing patients to decide on priorities, and
- Due recognition of access to the related services the patient needs that primary care is unable to provide for. (13)

Two international models that have been referenced in other submissions to this Parliamentary Inquiry are the *Wagner Chronic Care Model* and *Kaiser Permanente's Pyramid Model.*

The Wagner model has been endorsed by the World Health Organisation as a framework for innovation in the management of chronic illness. The elements of the model have been demonstrated to facilitate improved outcomes for people with chronic disease and improved preventative care.

The model is:

- A framework for producing healthy communities;
- A multi-dimensional solution to a complex problem;
- Like an evidence-based guideline—a synthesis of system changes to guide quality improvement, and
- Intended to be flexible and subject to change when new evidence emerges.

The model identifies the following six major components:

1. The Community: public and private resources and policies;
2. The Health System: how health care is organized, including its payment structures;
3. Self-Management Support: education, tools, motivational techniques, patient empowerment
4. Delivery System Design: the structure of the provider organization (hospital system, clinic, doctor's office) and the organization of patient encounters;
5. Decision Support: clinicians can access and adhere to evidence-based guidelines for care, and
6. Clinical Information Systems: computerized information, medical records, decision support tools, reminders, etc.

In chronic disease care it is well established that individual patients require different levels of care and intervention, ranging from minimal/self-help approaches through to intensive case management (14). The notion of graded intensity of chronic disease care is embodied in the 'Kaiser Triangle'. This model is based on a risk stratification triangle that is used to understand the needs of different strata of the population.

Levels 2 and 3 of the Kaiser Triangle are assigned to chronic disease patients with complex needs who either frequently use hospitals (as for level 3) or infrequently use hospitals and/or are at imminent risk of hospitalisation (level 2). Level 1 contains chronic disease patients with or without complex needs who may progress to requiring hospitalisation in the medium to long term. An additional level then expands the Kaiser Triangle and targets the wider population, focusing on risk factor reduction, health promotion and primary prevention.

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