WAPHA
WA Primary Health Alliance

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PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Sustainable Health Review

WA Primary Health Alliance Submission

October 2017

WAPHA is pleased to provide our submission to the Sustainable Health Review to inform the development of an integrated and equitable health system for all Western Australians.

WAPHA is the organisation that oversights the commissioning activities of WA's three Primary Health Networks – Perth North, Perth South and Country WA. Primary Health Networks (PHNs) were established by the Australian Government in 2015 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 coordination of care to ensure patients receive the right care in the right place at the right time.

The alignment of WA's three PHNs under one organisation (WAPHA) affords a once in a generation opportunity to place primary care at the heart of the WA health system and create the mechanism for integrating services across organisations and across boundaries. WAPHA's vision is improved health equity in WA and our mission is to build a robust and responsive primary health care system through innovative and meaningful partnerships at the local and state-wide level.

More integrated care will require system-wide change. It will involve general practice, pharmacy, specialist medical practitioners, pathology, hospitals and extended care providers. At the moment, no-one is responsible for such cooperation and integration within local health systems [1]. As part of the new Commonwealth-state agreements, a specific bipartisan agreement could legitimately be struck between WAPHA and the WA Department of Health (DoH). This agreement could define funding and results targets, and commit the State and the PHNs to specific local system changes to improve patient care and reduce PPH admissions and Emergency Department presentations [2].

Ultimately, a bipartisan agreement would form the basis of an overarching localised tripartite agreement signed by the Commonwealth, the State and WAPHA, setting specific goals and creating joint accountabilities for failing to meet them.

Integrated patient care reduces demand on the State hospital system by ensuring people are only admitted when they really need to be in hospital. Primary Health Networks are ideally placed to work with Area Health Services and primary care providers to keep people healthy and at home.

The Heads of Agreement between the Commonwealth, States and Territories on public health funding recognises the shared responsibility for health between the Commonwealth and the States and Territories and positions PHNs to have jurisdictional responsibility to support general practice and primary health care.

The Agreement requires coordinated care reforms, comprising Health Care Home Stage 1 and State and Territory coordinated bilateral agreements with the Commonwealth. WAPHA understands that the DoH approach to the Bilateral had been, in the absence of additional funding, based on existing programs. Whilst WAPHA has not seen the final WA Bilateral, we are committed to working with the DoH on Health Care Homes and the coordinated care reform activities included in the Bilateral to provide a basis for a joint approach to enhanced care coordination for patients with chronic and complex conditions and reduce avoidable demand for hospital services.

Designing and delivering care that reorients resources around patients and builds partnerships across sectors including specialists, hospitals, community and primary care is exciting while posing significant challenges. At the core of integrated care is a sustainable partnership between the DoH, the Mental Health Commission, Area Health Services and WAPHA – with a shared commitment towards system reform.

WAPHA's key recommendation is the prioritisation of a Memorandum of Understanding between WAPHA and DoH (including a governance framework) to agree a staged approach over the next two years to collaborate on the identification of mutual priorities for the delivery of sustainable healthcare across the State that is: patient centred; integrated; multidisciplinary and high quality. The MoU would articulate commitments and define roles and responsibilities regarding joint planning and funding of particular activities that achieve the best possible outcomes for our community. Common aims include:

- Improved access to the most appropriate health services at the right time and in the right place;
- A focus on reducing avoidable acute hospital admissions / re-admissions and Emergency Department presentations (referencing the data in the *Lessons of Location* report);
- Facilitating a more sustainable local healthcare system characterised by innovative care pathways and joint planning;
- Improving coordination, efficiency and effectiveness between hospital and relevant community services;
- A focus on the needs of vulnerable, at-risk and high needs populations;
- Improved health literacy to enable better use of the healthcare system and support people to invest in a healthy lifestyle, and
- Better integration between general practice and WA funded health services in the planning of, and access to, services and multi-disciplinary education.

Critical to the success of a formalised relationship between the DoH and WAPHA will be a focus on clear accountabilities in the pursuit of common goals and benefits. This requires a commitment to joint planning and investment and collaboration in the design, commissioning and evaluation of services, consistent with the DoH role as System Manager.

WAPHA's submission has been informed by consultation with key partners including WA's Area Health Services, the RACGP WA, our Clinical Commissioning and Consumer Engagement Committees and Hospital Liaison GPs. This consultation has identified priority areas for consideration in this Review:

Joint Planning:

Joint planning is a key element in developing integrated care across the healthcare continuum. Studies have indicated[3] the following interventions are required to support joint planning:

- The 'new way' of working, ensures goal setting, strategic development and major decision making is jointly determined and agreed by organisations across sectors. A jointly agreed new approach is contingent upon linkage of available real time hospital and primary care data and would promote flexible, local health service delivery [4].
- Formal agreements between organisations and services have allowed them to move beyond the occasional informal partnership to a serious commitment to integrated health care and to manage deliverables, risk and process through collaborative business approaches. Examples include Integrated Care Trusts and Alliances in the UK and New Zealand respectively that are tasked with planning for geographical areas and to increase co-ordination between primary, secondary and tertiary care.
- Accountable Care Organisations in the US and Accountable Care Systems in the UK are worthy of further investigation in the WA context. They demonstrate elements of best-practice cross-sectoral partnerships in caring for distinct populations while sharing risk.
- An outcomes focussed governance model which preserves organisational autonomy of the original health institutions / systems.

Joint planning emphasises a system-wide approach alongside a focus on local priorities with a view to transforming the local health system in a way that makes integrated care sustainable. It requires a change management orientation (including alignment of culture). Joint planning for integrated services occurs across regions, settings and levels of care and includes all of the core services along the continuum of care. WAPHA is well placed to steward a collective voice for primary care to address population need through planning and collaboration.

Recommendations:

- Establish a Planning & Innovation fund to seed fund innovative integrated care initiatives at the local level, which may well become a critical part of the bigger integrated care picture over time. Initiatives in Singapore, UK, Sweden and Canada show where cross-sectoral partnerships have implemented formal meetings bringing people together from across organisations to identify system level issues and co-design solutions. In some instances they bring patients to the meetings (particularly those with chronic conditions and the elderly, who are most impacted by improvements to care integration). Partnership members hear first-hand testimony that is incorporated into their care planning. Meetings that include front line staff, stakeholder executives and patients have been evidenced to be highly impactful when undertaking system change;
- Implement a collaborative agreement between WAPHA and DoH to access MBS, PBS and hospital linked data in (almost) real time for planning and evaluation purposes. This linked data is currently held by the National Health Funding Body, and
- Convene a formal Ministerial primary healthcare stakeholder Forum to provide advice and guidance to the DoH to inform the development of integrated, patient centred care across WA.

Integrated Care Pathways Between Hospital and General Practice:

Appropriate and effective transfer of care arrangements between GPs and hospitals provide substantial benefits. When appropriate and effective transfer of care practices are put in place and followed, not only are hospital readmissions reduced and adverse events minimised, overall the patient, their families, clinicians and other health practitioners involved in providing care have a much more satisfactory and positive experience. Continuity of care is a key tenet of quality care. The key to continuity of care between GPs and hospitals is comprehensive, accurate and timely two-way communication regarding admission, treatment and patients' on-going care needs [5].

It is imperative to define shared metrics, definitions and data tracking methods across the parties that are working to achieve integrated care. This clarity and accountability has significant downstream effects when it comes to quality, standardised care delivery and waste reduction.

Recommendations:

- Prioritise appropriate funding for Hospital Liaison GPs in metropolitan, rural and regional settings to improve communication between hospital and primary health;
- Facilitate electronic referral, maximising the auto-population of relevant clinical and demographic information and decision support to ensure adequate information is incorporated, including required investigations;
- Make additional investment into integrated clinical information systems and the hardware to support them to realise the potential of electronic record sharing;
- Develop expanded state-wide processes for referral acceptance criteria to manage demand and ensure timely services for priority patients. This is in view of the success of recent ENT and Gastroenterology procedure referral projects in WA;
- Invest in care coordinators who can coordinate the hospital and community care of frequent ED attendees;
- Implement an electronic shared care planning tool (such as cdmNet or LinkedEHR) to facilitate the sharing of clinical information and collaborative care planning between relevant care providers;
- Ensure all hospitals (including public-private contracts) encourage patient uptake of MyHR and use MyHR to upload discharge summaries, ED and outpatient letters, pathology, radiology and other investigation reports by 31 December 2018, in addition to current methods of communication;
- Develop urgent care pathways that focus on individual needs of specific areas; using primary care stakeholders to facilitate local solutions and supporting a system that prioritises continuity of care;
- Invest in improving the link between Outpatients and primary care, emphasising the seamless return of the patient to the GP or primary care provider;
- Develop KPIs that purposefully reflect movement into primary care rather than increasing occasions of service in Outpatients;

- Implement discharge protocols consistent with the DoH Statewide Discharge Summary Policy and facilitate communication with GPs and patient access to general practice;
- Emphasise the importance of private hospitals engaging in the planning and documentation processes, consistent with the standards the public hospitals are striving to achieve;
- Identify and implement suitable models for hospital substitution and avoidance that have been demonstrated to prevent acute admissions for clinically suitable patients who would otherwise be admitted to hospital. These include patients being managed under chronic disease management plans or post-acute care plans, and
- Consider opportunities to provide transparent information to GPs regarding availability and wait times for outpatient appointments and elective surgery in order that GPs can work collaboratively with their patients in planning their clinical care.

Improved Health and Condition Management in Primary Care (including self-management):

Integrated care initiatives internationally and across Australia have paid insufficient attention to the relationship between physical and mental health. This aspect of integration should be a major part of our combined efforts to develop new models of care in WA. The King's Fund[6] posits that the case for seeking to support physical and mental health in a more integrated way is compelling, and is based on four related challenges:

- High rates of mental health conditions among people with long-term physical health problems;
- Poor management of 'medically unexplained symptoms', which lack an identifiable organic cause;
- Reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health, and
- Limited support for the wider psychological aspects of physical health and illness.

WAPHA is committed to enabling commissioners, service providers and public health professionals to work together to develop integrated approaches to mental and physical health. This whole of system approach will better support people within primary care who have complex conditions with underlying mental health conditions.

Access to specialist assessment and ambulatory intervention for non-admitted patients, particularly those with chronic and/or complex health care needs (including mental health) must be improved in conjunction with rationalising high cost, episodic, hospital centred care. The DoH strategic priorities are focused on a continuum of care and aim to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, and primary care through to diagnosis, treatment, rehabilitation and palliation. This requires a collective focus on delivering care in the most appropriate setting through a better relationship between primary care and the hospital system, and reconfigured and integrated hospital services to enhance a person's journey through the system [7].

Recommendations:

- Build collaborative initiatives between primary, secondary and tertiary care to focus on health promotion and disease prevention, taking into account the needs of local areas;
- Broker collaboration between PHNs and Health Networks to develop and fund statewide programs for early detection and screening;
- Link care coordination for chronic and/or complex conditions, including linkage to Comprehensive Primary Care/Health Care Homes and upskill non-medical staff to support care where appropriate;
- Invest in a multidisciplinary approach to end of life care emphasising diagnosis, prognosis and options for both malignant and chronic conditions;
- Encourage and support the use of Advance Care Planning and Advance Health Directives across sectors and create mechanisms to engage the GP in the Goals of Patient Care initiative;
- Expand the investment into HealthPathways including support for service redesign as pathways are localised and the development of a consumer-facing component;
- Consider making Pathways mandatory – especially referral criteria. This would be easier and simpler with investment in Smart e-referral forms which prompt for information and provide the right referral point;

- Increase the availability of specialists able to provide phone advice to GPs to prevent unnecessary referrals and provide a level of support to GPs to manage conditions in primary care;
- Put in place dedicated time for consultants to be available for contact by GPs for telephone and email queries, including telehealth, and
- Make clinical handover more visible and understood by patients and health services outside the tertiary hospital

Integrated ICT Systems:

Integrated ICT systems have been shown to be a clinical accelerator to improvement across the system by linking clinical processes, outcomes and financial measures. All patient records within WA Health should be fully digital and interoperable with external provider systems and allow communication with the patient.

Recommendations:

- Integrate patient records with MyHR and other sharing platforms;
- Increase secure messaging capability to the individual clinician and capture data in accordance with relevant national frameworks and standards;
- Enable patient connectivity to their records to increase engagement, improve health literacy, empower individuals to make timely decisions about their own health and reduce errors in the system, and
- Include a WAPHA GP representative on DoH ICT strategic and high level decision making committees.

In order to achieve seamless integration of digital services, a set of priority initiatives and case studies on systems integration (both governing policies and technologies) should be developed for health services, commissioning agencies and service providers.

Recommendations:

- Undertake an active research project, trial or review to achieve interoperability of DoH and general practice information systems. Linking patient details within MMex or Best Practice back to the DoH infrastructure (e.g. PSOLIS in the case of mental health) to test the process in a controlled environment;
- Conduct a general review of existing technology based approaches (e.g. Health Call Centres) to assess impact on reducing potentially preventable hospitalisations and undertake a geographical assessment of variations in levels of success to guide future interventions, and
- Undertake a review of reminder systems and their effectiveness to facilitate reduction in Did Not Attend rates. Scale effective systems across WA e.g. secure SMS, emails, automated phone call notifications.

Research and Data:

Research into integrated care, with a focus on chronic illness management, is vital to ensure a best practice, sustainable approach to integrated care across WA. High-quality WA research will be critical to understand the drivers of health expenditure and to identify and test solutions that can help contain costs while maintaining quality of care. Australia's excellent and world-leading big health data sets – including large, long-term research cohorts and routinely collected information such as hospital and Medicare data records – will be central to this effort. Establishing better models of care and services across WA will also require more sophisticated approaches to the often complex task of evaluating their impact. This will include new research methods, stronger research and policy partnerships, and more effective ways of embedding rigorous research into the roll-out of new policies and programs.

Recommendations:

- Invest in research and research translation involving primary care and specifically focusing on improved care across transitions and on sustainability;
- Re-consider moving data linkage and access to Treasury (noting that this has worked well in other jurisdictions and has previously been investigated in WA). This supports linkage of health and non-health data and addresses the time lag in accessing data, especially if data linkage is needed;

- Develop a framework for DoH and WA Health Translation Network to prioritise capacity building in WA based health service research, and
- Commence a collaborative project between WAPHA, the DoH and the private sector to assess the applicability of international models of predictive analytics that use hospital and primary care clinical and demographic data to identify patients at high risk of ED presentation and hospital admission and treating them in the community pre-emptively to prevent unplanned admissions.

As part of the integration/coordination between WAPHA, DoH and wider stakeholder groups, there may be opportunity for a **Public Benefit and Privacy Panel** that can provide robust, consistent and proportionate information governance scrutiny of requests for access to health and health related data for a variety of purposes. A Public Benefit and Privacy Panel (PBPP) for Health and Social Care can provide a governance structure for applications to use health and health related data. The panel could operate as a centre of excellence for privacy, confidentiality, and information governance expertise in relation to Health and Social Care in Western Australia, providing strategic leadership and direction in this area to data custodians, the research community, and wider stakeholder groups.

In doing so it can ensure connectivity between the many strands of relevant governance activity, and react to the changing landscape and research evidence regarding the public interest. A focus on public awareness, concern and benefit will demonstrates a commitment to the protection and promotion of privacy as a public good. Germany and the NHS in Scotland have successfully implemented PBPPs and similar models are being considered in other jurisdictions within the UK.

The Panel's three main aims:

- To provide a single, consistent, open and transparent scrutiny process allowing health and social care data to be used for a range of purposes including research;
- To ensure the right balance is struck between safeguarding the privacy of all people in Western Australia and the fiduciary duty of public bodies to make the best possible use of the health and social care data collected – it is important to note that each is in the public interest, and
- To provide leadership across a range of complex privacy and information governance issues, so that the people of Western Australia are able to gain the benefits – ultimately better health and social care – from research and wider use of data, while ensuring compliance with legal privacy obligations, managing emerging information risks, addressing public concern around privacy, and promoting the protection of privacy as in the public interest.

The Panel can provide robust, consistent and proportionate information governance scrutiny of requests for access to health and health related data for a variety of purposes.

Education and Training:

If health care providers are expected to work together and share expertise in a team it makes sense that a purpose specific approach to their education and training should prepare them for this paradigm of collaborative work. An example of effective collaboration and multi-disciplinary education between general practice and acute care can be drawn from Ribera Salud in Spain. A GP / Specialist immersion program has been developed where GPs exchange places with a Specialist in the hospital for one week per year. The feedback from these clinicians is then worked into models of care delivery. This immersion training has been evidenced to be very effective in motivating the parties to collaborate whilst educating both the GPs and Specialists on how their colleagues from other disciplines deliver care. As a result, patients benefit from improved care coordination.

There is also a need to develop initiatives to educate patients about what the health system can, and cannot, reasonably provide.

Recommendations:

- Prioritise GP education and upskilling including: HealthPathways; GP educational events and networking with health service staff; GPs upskilling in clinics; increased training and use of GPs with Special Interests (GPSIs) and hospital outreach;
- Improve clinical staff education around what GPs do, what conditions they can manage, with a view to reducing unnecessary internal referrals. Use HealthPathways as the tool for hospital staff to consult prior to internal referral that is not in line with standard disease management protocols;
- Develop cross disciplinary education pilots that may include GP Units within hospitals and GPs working in ED, clinics and inpatient settings, and
- Prioritise the development and implementation of patient education about the mechanisms that are at play within the health system to increase the capacity of patients and carers. This supports clinicians and staff within the health system to better manage patient expectations and care planning.

WAPHA appreciates the Panel's consideration of our submission. If you wish to discuss our recommendations in more detail, contact WAPHA care of [redacted]

References

1. Duckett, S; Swerissen, H and Moran, G (2017): Building Better Foundations For Primary Care. Grattan Institute
2. Interagency Performance Targets: A Case Study of New Zealand's Results Programme: 20 April 2017. Scott, R; Boyd, R. IBM Centre for the Business of Government
3. Nicholson C, Jackson C, Marley J. (2013). A Governance Model for Integrated Primary/Secondary Care for the Health reforming first world – Results of a systematic review. BMC Health Services Research, 13:528
4. http://medicalrepublic.com.au/uncovering-scandinavias-health-data-secrets/10786
5. AMA Position Statement: General Practice / Hospitals Transfer of Care Arrangements 2013
6. Bringing Together Physical and Mental Health: A New Frontier for Integrated Health, The King's Fund, March 2016
7. Better Health, Better Care, Better Value: WA Health Reform Program 2015-2020