The International reform environment

‘5 year forward view’ (UK), PHO (NZ), ACOs, PCMH (USA), LHIN (Canada), National Health and Hospital Reform Commission (Australia)

• Primary-care led reform:
• Increasing relevance, funding and accountability of the sector
• Changing governance structures to achieve this
• Strong integration with acute, private sector and social care
• Whole of system planning, funding and service delivery
• Advanced care delivery access within the community
• Linking incentives with desired structure and function
• Innovative use of ‘e’
Australia’s Commitment to Excellence: primary care quality and accountability

• 1990s: Accreditation / PIP / College QI&CPD
• 2008: National Health & Hospitals Reform Commission
• 2009: National PHC Strategy / ACQSHC / NHPA
• 2012: National ATSI Health Plan / National Strategic Framework for Rural and Remote Health / National PHC Strategic Framework
• 2015: PHC Advisory Group (15 recommendations) / growing role for PHNs / integrated clinical pathways (Health Pathways)
• 2016: COAG health reforms, PIP review, Revalidation, ADHA,
• 2017: strengthening PHN / LHN contracting and data sharing / MBS Review / Health Care Home (HCH) pilots
PHCAG’s Health Care Home

- Voluntary patient enrolment
- Patients, families partners in care
- Enhanced access to care – non F2F, a/hrs
- Patients nominate a preferred clinician, responsible for their care
- Flexible, team-based care
- High quality, safe
- Use of data to improve outcomes and performance
- Bundled payment model
2. Bilateral agreements will be signed to provide flexibility for each jurisdiction to determine the best model of care.

4. The Commonwealth will establish any necessary enabling infrastructure, governance arrangements, or systems to support a pilot of a Health Care Homes model in primary health care, consistent with the advice provided by the Primary Health Care Advisory Group, initially to include:
   a. criteria for determining patient eligibility in Commonwealth funded services;
   b. funding levels and payment mechanisms in Commonwealth funded services;
   c. establish data collection associated quality improvement processes within participating general practices;
   d. a comprehensive evaluation to determine impact on patient outcomes, hospitalisations and overall cost effectiveness of the model; and
   e. establish early implementation of a pilot of Health Care Homes in Primary Health Network (PHN) regions, to be operational by 1 July 2017.
5. The States will work with the Commonwealth in selected regions through bilateral agreements, which may include:

a. establishing elements involving joint coordinated planning and, where appropriate, collaborative commissioning of services between PHNs and Local Hospital Networks (LHNs);

b. identifying and implementing arrangements for the sharing of patient information, with patient consent, including relevant hospitalisation, MBS and PBS data;

c. educating relevant state funded health service providers to work with Health Care Homes pilots in participating regions; and

d. where feasible, implement collaborative, joint and/or pooled funding PHNs/LHN to support better coordination of care for specific patients at risk of avoidable admission.
Where is the COAG policy now?

- Trial of Health Care Home in 10 PHN Regions
- 65,000 patients with chronic conditions to be involved
- 200 general practices will transform to HCHs and trade in MBS chronic disease billings for a bundled payment model
- $21.3 million to support roll out till 30 June 2019, with $93 million in redirected MBS funding
- Practice EOI closed Dec 21, DoH practice selection to be by March 17, training to begin early 2017, HCHs operational and patients enrolled July 1 2017
- DoH independent evaluator chosen late 2016
Commonwealth Practice EOI Nov 4th 2016

- 3 Tiers of chronic disease patients enrolled
  - Tier 3 – high risk, complex, includes palliative (1%) $1,795/yr
  - Tier 2 – multi-morbid, requiring care co-ordination (9%) $1,267/yr
  - Tier 1 – multiple chronic conditions, self-managing (10%) $591/yr

- HCH Training Tender to support practice transformation using ‘10 Building Blocks’ approach
- Risk stratification tools x 2 for patient identification and patient tier categorization
- Evaluation contract – HCH to participate in qualitative and quantitative data
- One-off $10,000 for HCH non clinical participation including training, RS tool, patient enrolment, MyHR usage, enhanced in-hours access, evaluation and data collection.
... What is a ‘Health Care Home’ ???
Challenges of implementing health care home

- A systematic review of the challenges to implementation of the patient centred medical home: lessons for Australia *MJA* (2014); 201(3): S69-73

  - Requires electronic health records and exchange
  - Requires change in funding and payment models (volume to value)
  - Requires internal practice resources and infrastructure, and support with transformation and change management
  - Requires measures of performance and consistent accreditation and standards
PHC – a key partner in Big Change

- Unparallelled access to information – guidelines, pathology and radiology access, support materials, apps

- Integrated clinical pathways (Health Pathways)

- Building evidence of impact, efficiency, relationship
PHNs, practices and communities nationally will play a key role

- Practice support in quality care
- Data support and collection
- Co-commissioning
- Population-based funding esp rural / regional
- Dissemination of evidence
- Effective Networking and linkage
Building a Culture of Co-Creation in Research
Opportunities for practices - QI and transition to HCH

Tools and processes to support general practices in regional, rural and remote areas

Primary Care Practice Improvement Tool (PC-PIT) & additional resource suite
- Co-created with general practices, partners and stakeholders
- Based on 13 elements of high performing practices, identified in systematic literature review and mapped to building blocks of HCH
- Takes whole of practice approach
- Has additional complementary online resource suite selected by GPs and Practice Managers
- Is relevant to practices that have little or extensive experience of QI
- Supports practice transition to HCH model
- Now used by PHNs as part of existing QI and practice support programs
NHMRC trial of DR screening in general practice

- **5 intervention** general practices total – 3 classified as rural trialled
  DR screening over 3 years and compared with **3 matched practices**
  carrying out routine care
- GPs in the intervention practices were provided with a **camera** and
  **accredited training** to undertake the review of retinal images
- Included an evaluation of a **rural and remote outreach DR screening model**
  with visiting ophthalmology services and a **local GP reviewing retinal images**
- All **photography and screening was conducted onsite** in each
  intervention practice
- **Ophthalmic support was provided by ‘buddy ophthalmologists’ via videoconference, teleconference and/or email**
- **Clinical (screening) data and the experiences** of patients, GPs, practice nurses, Aboriginal Health Workers and other stakeholders
  were collected to assess outcomes
Summary of DR screening outcomes and evaluation

• Appropriate recorded screening evidence was 99% in intervention versus 33% in the matched practices undertaking routine care during the 3 year study period.

• Appropriate follow-up (≤ 12months, as per the NHMRC Guidelines) of mild-moderate DR was 100% in intervention practices versus a range of 0 - 53% in practices undertaking routine care during the 3 year study period.

• The rural remote outreach DR screening model increased DR screening rates in the regional area from 16 to 66% and improved local service coordination over the 3 year study period.

• DR was detected in 24.3% of rural outreach screening episodes and referred to ophthalmologist.

• Highly acceptable to patients and health professionals in rural remote areas:
  – Equitable
  – Locally appropriate
  – Multi-disciplinary
  – Sustainable

• Participating GPs and health professionals valued: positive links with buddy ophthalmologists; use of cameras to detect other pathology/conditions (e.g. hypertension); increased opportunities to use images for patient education; developing relationships with local optometry services where possible.

• Patients/community valued: decreased need for travel and a ‘one stop shop’ of diabetes management in their local area.
Opportunities for practices – successful implementation of DR screening models

- **Online DR practice training module** - a comprehensive guide for clinicians and managers to establish a functional DR screening service. The online self-test allows GPs to be confident in the accuracy of their post training image interpretation. Module is suitable for rural, urban and Aboriginal Medical Service settings.

- **Framework to guide the successful implementation of DR screening model in practice and use of new GP MBS items** – AFP (2017).
The speed bumps and challenges ahead

• 20 years on PHC still has a diverse focus, systems and culture
• Unity and focus requires local energy, commitment and vision
• Variation – good, bad and unclear
• Volume v value
• Funding models
• Workforce change
  • GPwSI,
  • medical assistants,
  • technology support,
  • patients and families as self-managers
  • care automation
Moving Care from Hospital to Community: 
navigating the bumps

4th International Health Care Reform Conference
InterContinental Sydney Double Bay
21 - 23 March 2018

Save the Date!

Save the date for the 4th International Health Care Reform Conference which will be held at Intercontinental Sydney Double Bay from 21st – 23rd March 2018.

CONFERENCE THEMES
International Innovation • Service Integration • Digital Health Capacity Building • Consumer Engagement Business/Funding Models • Change Management • Policy Enablers


For more information please contact the IHCRC Conference Secretariat Mary Sparksman and Amy Theodoros Phone: (07) 3368 2422 Email: ihcrc@yrd.com.au Website: http://ihcrc-2018.w.yrd.currinda.com