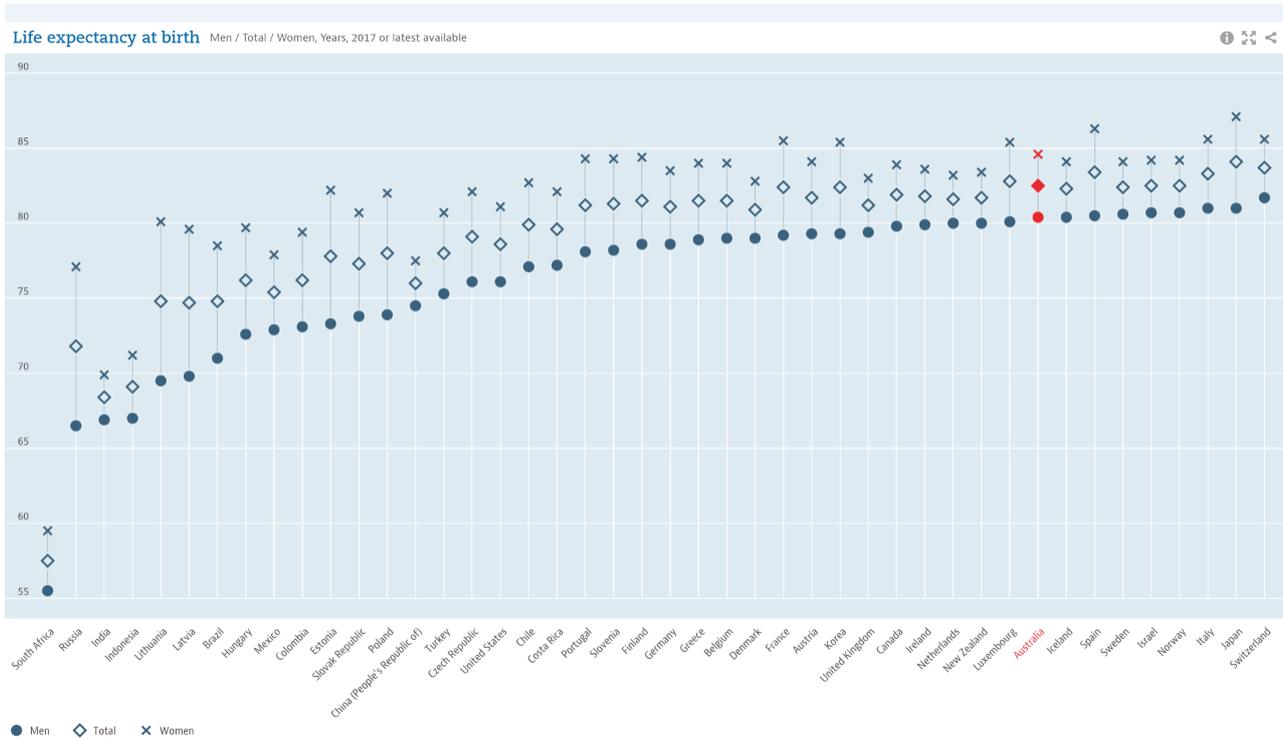


Taking integrated care forward in Australia - an Australian GP's perspective

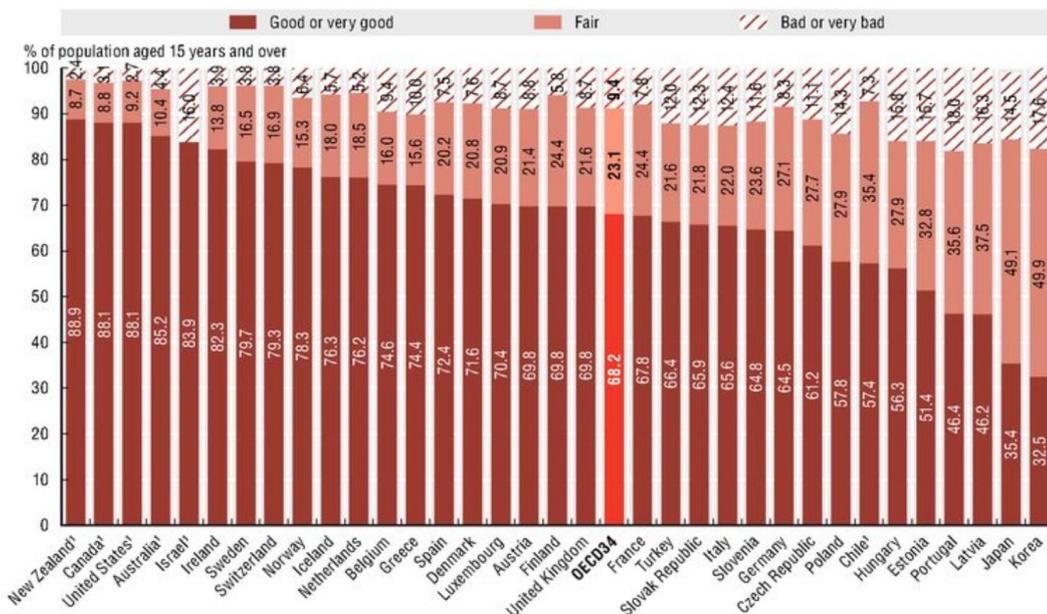
Dr Harry Pope, Inaugural IFIC Fellow 2017

Despite Australia achieving very strong health outcomes compared to our peer systems, there is a looming accessibility and affordability crisis.

The OECD data confirms that Australia ranks as achieving one of the highest life expectancy rates and it also is a high performer in the population self-assessment of their health as being "good or very good". 1.2.



3.18. Perceived health status among adults, 2015 (or nearest year)



1. Results for these countries are not directly comparable with those for other countries, due to methodological differences in the survey questionnaire resulting in an upward bias. In Israel, there is no category related to fair health.
Source: OECD Health Statistics 2017 (EU-SILC for European countries).

Life expectancy in Australia has increased mainly due to the number of reduced deaths in early life. Australians now die of chronic disease in the elderly. The over 65 health expenditure is four times higher than for younger people. Prevention and management of chronic and complex conditions in this population have increased the demand for health services. ³

Population demographics show that the healthcare demand for an ever-increasing ageing population with a substantial chronic disease and comorbidity profile will negatively impact accessibility and affordability for the whole population accessing health care.

To address this issue healthcare professionals will need to work in a more cost and quality efficient manner.

Studies in integrated care internationally have shown that the quadruple aim can be successful in obtaining positive outcomes in addressing the cost of healthcare as well as supporting quality.

The "evidence shows that integrated care not only can fix up fragmented health care but also effectively reduce hospitalisation, emergency room attendances, the average length of stay and health expenditure while improving the quality of life." ⁴

Australian general practitioners identify with the principle of integrated care and that it is to improve patient management through a seamless transition through the healthcare system for acute and chronic conditions.

The NSW Ministry of Health defines integrated care as the provision of "seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family." ⁵

Australian General Practice is often overwhelmed by the demands of acute episodic care and this can impact the accessibility, quality and provider satisfaction in health care.

The Medicare fee for service is limited to face to face consultation with the GPs and precludes alternative models of access for patients requiring episodic and/or chronic care other than in specific circumstances such as remoteness.

This demand for episodic care via the GP needs to be addressed as part of the workload reduction for Australian GPs so they can transition towards true holistic care. Team collaboration is more likely to define the outcome for the patient, but will also aim at transitioning a proportion of the workload from secondary care to primary care.

PCPs would, therefore, need to reduce their direct responsibility and clinical input into episodic care to adjust to the workload requirements that the transition of that workload from secondary to primary care would demand.

Principles of the "Delivering an integrated system of care in Western NSW program" summarises the Primary care journey below:

Support the shift of service from secondary to primary care

- Locally developed and locally led models of care

 - Review existing workforce across sectors

 - Sustainability

 - Build effective cross-sector networks and sustainable partnerships

 - Social care sector plays an integral role

NOT ALL CARE NEEDS TO BE DELIVERED FACE TO FACE BY A CLINICIAN

This journey references the networking requirements for healthcare. The Area Health, PHN, Healthcare practitioners, Allied Health practitioners, as well as social and community service organisations, need to effectively network to enhance the interoperability of these elements. A simple current directory of services for the local government areas would enhance the interoperability of these elements. This directory could be maintained by the PHN's

A comprehensive current directory is a basic requirement for a successful integrated care program. PCPs and their teams utilise their local knowledge, but new practitioners or new service providers can be missing from the database. An address book often has historical services that may have ceased to exist or have been retired and is an impediment to the implementation of holistic healthcare.

Health pathways is a tool that should be able to act as a directory of services. As the majority of chronic health conditions management follow national guidelines, then a common pathway system could be implemented with a proviso stating that the service is or is not available in that local area. The directory would then only need to be adapted with the local service provider details. This would be a more streamlined system and would be developed more rapidly and with less cost, rather than a tailored system for each Area Health.

In the UK a new Key Team Model consists of the GP, a nurse practitioner, Pharmacist, Occupational therapist and coordinator. This contrasted with the Australian system where competition exists between retail pharmacies 'performing GP work', and where tele and video consults are excluded from the National Medicare system except for very specific limited reasons, as in remote areas. These functions were fundamental to the Key Team Model and would drive IC. 5

Data-driven care

The information required to improve support for patients with chronic and complex health conditions, and overall community health, is multilayered:

- Patient-level data: clinicians and patients to manage their care via electronic health records, patient portal access, with recall and reminder systems.
- Practice-level data: where practices analyse the patient cohort, and review the care by KPIs which aid assessing adverse events, cost and resource utilisation, and project outcomes.
- Population-level data: PHNs, Area Health, Project funders – State, Federal and NGOs, identify patient cohorts on a needs basis, and monitor health outcomes and resource utilisation via the Australian Bureau of Statistics, Area Health Statistics, hospital data sets, Pen Cat, MBS and PBS.

A significant number of older Australian PCPs, often in small or solo practice, do not have the capability of software data extraction that can support the data-driven IC components. The cost of accreditation, as well as being limited in their administration support, precludes their being involved in data analysis.

The Funder-Provider divide

The Australian healthcare funding system distinguishes itself from other developed countries healthcare systems by requiring the allocation of budgets to different levels of governance and has siloed accountability. There exists National (Medicare), state or territory (hospital and community care), local government (social and environmental health) and now City deals budgets for the financing of the different healthcare components.

As these financial budgets are siloed, then healthcare is encouraged to be siloed.

If integrated care from the PCP perspective assists in a cost saving, then there is a lack of any incentivisation for the PCP to participate in that model. It appears that the effort by the PCP is recognised as goodwill. Should the PCP find that extra costs are required for the model to be implemented and progressed or that changing from episodic care to chronic care results in a decrease in income then the goodwill given by the PCP will diminish.

With the Australian Government supporting 'cost neutral' models of care and by what many participants view as the underfunding of these models, specifically the Health Care Homes trial (HCH), many PCPs are expecting the failure of that model to progress.

A true costing of the provision of those services could allay the clinicians' concerns about the negative financial impact that model is likely to have. The implementation of Richard Antonelli's analysis tool the - "Care Coordination Functions and Outcomes in the Medical Home Care Coordination Measurement Tool (CCMT)" can provide an in-depth assessment of the component costing of providing an HCH to the Clinic. 6

Of concern is the realisation that there is a substantial unmet need for yet to be detected chronic conditions. There exists up to a third of the diabetic population as - not yet diagnosed. The cost of managing those that are likely to be detected by better surveillance and data trolling of at-risk populations has yet to be fully acknowledged. This is not a reason to avoid the model rather that it further emphasises the costs that need to be considered.

Conclusions:

I have been a strong advocate for the provision of quality health through PCP upskilling. Medical specialisation and tertiary care institutions have progressed the deskilling of PCPs. I believe that the future of primary care is where PCPs will transition towards higher skill patient management roles within team care for complex chronic conditions. PCPs working at their professional highest level. ⁵ Training in Integrated care via a Continuing Professional Development (CPD) education program, as well as Medical student coursework should become an obligatory component of the professions training.

A directory of local government services should be maintained by the PHN's and available online.

A recommendation would be that a 'Key team model' that oversees the planning and care coordination but not the provision of the health care service be linked to the Medicare GP team care plan item, though this would require an increased subsidy to cover the participants.. This would have been the initial intention of the GP management plan and GP care plan Medicare items but has developed into a paper exercise for the provision of in total of five Allied Health Services.

The Productivity Commission suggested establishing regionally based prevention and chronic condition management funds to improve population health, manage chronic conditions and reduce hospital admissions. As this will have an impact on the business of General Practice, PCPs who are independent of the Area health and PHN groups but are business managers should be involved in the implementation and governance of those suggested funds. ⁷

The Australian healthcare system needs to progress towards healthcare having a focus on the quadruple aim, enhancing the patient experience, improving population health, reducing costs. and improving the work life of health care providers. ³.The new generation of HCPs value work-life balance and the triple aim can engender professional burnout without the latest identified component, practitioner satisfaction. In a fee for service system where the incentives have in the past encouraged quantity as opposed to holistic care, we need to convert to quality. Australia is searching for innovative ways of addressing the shortfalls in the current healthcare system. ⁵

When considering a new model of care, the business modelling in a General Practice and indeed the private Primary Care environment must be part of the review. Such considerations need to include a funding model which supports the implementation in private practice of any new care process.

Personal Perspective

I have practiced as a PCP for 38 years. The last 14 years have been in a corporate system. I was involved in the development of a Patient Centred Medical Home Model with Co-located team members at the Primary Health Care Fairfield Centre. This model focused on Team based care with care plan nurses at the centre of management co-ordination. The outcome was that 50 care plan nurses were attached to 70 medical centres and an expanding "Coordinating Care through Authentic Partnerships" program was implemented. ^{7,8,9}

I currently am the Clinical lead for the Our Medical Home Penrith Centre administered by Cornerstone Health. The reason for the change in corporate organisation included that as a newer entity, I can participate in and influence the early implementation of the IC program.

Team based care requires the involvement as team members of the administration managers, practice managers and research team. Data driven change can be supported by these members freeing time for the clinicians, thus "Coordinating Care through Authentic Partnerships" based upon the Principles of Team-Based Health Care of :- Shared goals, Clear roles, Mutual trust, Effective communication, Measurable processes and outcomes.⁶

Trust as mentioned above, is a cornerstone of the IC models progression. With the medicare rebate freeze, this progression is impeded by the mistrust that clinicians have developed for the current Government policy.

The International Foundation of Integrated Care Australia (IFICA) with its expanding research and knowledge base, and its networking ability, can help the bridging of those negative elements between clinicians and the financial governance structure within healthcare.

References

- 1/ OECD Health Statistics: Health status, Life expectancy at birth
- 2/ OECD Health Statistics 2017
- 3/ Mapping primary care in Australia - Grattan Institute 2018
- 4/ International Journal of Integrated Care (IJIC) 2014
- 5/ NSW STATE HEALTH PLAN TOWARDS 2021
- 6/ Antonelli, R, and Rogers, G, Coordinating Care through Authentic Partnerships with Patients and Families, in Care Coordination: The Game Changer, Lamb, G (ed), American Nurses Association, 2013
- 7/ The Australian Government Productivity Commission - Report on Government Services 2018
- 8/ My Fellowship Journey by Dr Harry Pope, IFIC website blog 30th Jan 2018
- 9/ The practicalities of implementing a Patient Centred Diabetic Medical Home – IFIC website blog 29th Oct 2016
- 10/ WICC 2017 Dublin abstract presentation and 1st Asia Pacific abstract presentation
- 9/ IJIC 2011