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**Health
Policy**



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**Serious And Continuing Illness Policy And Practice Study (SCIPPS)
Roundtable 1**

**Understanding the complexities of co-morbidity with respect to policy
and practice**

December 2011

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Policy context

The prevalence of multi-morbid chronic illness is high in Australia - estimated at 25.5% of the Australian population in 2005 and 29% of people who attended a general practitioner (GP) during that year. It is also known that the prevalence of co-morbidity increases with age. Despite this, policy initiatives at all levels of government in Australia are primarily single-illness oriented, and this is reflected in many aspects of organization, planning and delivery of health services.

The SCIPPS qualitative study, which attempted to understand the experience of living with and managing a chronic condition, found the presence of co-morbid conditions made many aspects of disease management more difficult. Co-morbidity increased the difficulty patients and carers had acting on risk factors, recognising the signs and symptoms of illness and exacerbation, and managing medications. Inconsistent advice from health care professionals when a patient had co-morbid conditions frequently resulted in compliance failures. In addition, economic hardship was exacerbated when patients had co-morbidities or multi-morbidities with the cost of illness management increasing as more illnesses were being managed.

Key findings

FUNCTIONAL LIMITATION

- > The term 'functional deficit' (both physical and cognitive) is preferable to 'chronicity' - "What can be done to develop programs of care that respond to 'increasing functional deficit' which is a result of ageing and multiple morbidities – or multiple conditions?"

FUNDING OF HEALTH SERVICES & REMUNERATION OF HEALTH CARE PROFESSIONALS

- > Funding policy impacts significantly on provision of care and communication between health care professionals and drives change.
- > The open-ended Commonwealth programs (MBS and PBS) underwrite activities in the community space, but other components key to chronic disease management in the community space, namely nursing and allied health, are not underwritten by open-ended programs. The NGO sector, which provides the non-clinical support to those with chronic disease, is also neglected.

PRIMARY CARE & CARE IN THE COMMUNITY SPACE

- > Reporting between services operating in the community space is frequently inadequate, such as between community health and general practice, and between private allied health providers and general practice.
- > There is a need for the entire primary care sector to be connected.
- > A vision for integrated primary care needs to be developed.
- > Service planning for the care and management of people with chronic disease in the community space must be strategic, and should include development of a collaborative planning model. All of the relevant government agencies and key stakeholders as well as resource maps of and demographic detail would be needed for this. Enablers would have to be identified, and there would need to be strong and consistent reinforcement strategies

until the benefits and outcomes for the individual with complex care needs are realized and become the norm.

- > The many groups providing services in the community space - community health, NGOs, private providers, public providers - need to be more accountable for service provision and resource use in this space. There are two aspects to increasing accountability in this space:
 - o Creating a governance structure for primary care (which Medicare Locals are designed to do) and
 - o Funding and Responsibility/Authority to get the space working better with what they've already got.
- > Accessing services is a problem for patients. We need to be able to demonstrate to families and individuals that primary care will help with access and navigation via an integrated primary care service.
- > The current health reforms do little to address the planning of service provision or funding difficulties faced by the community space in the care and management of individuals with chronic disease.

POPULATION PLANNING / SERVICE PLANNING

- > A single government body should be responsible for the population planning/service planning for a geographical area, such as Western Sydney. This body would be responsible for health, non-clinical support, aged care, disability, and be able to produce a population plan for chronic disease care and management in the area. A population based planning tool could be developed for out of hospital chronic disease care and management – based on the demographics of the area and the models of care proposed.
- > Service planning for the care and management of people with chronic disease in the community space must be strategic, and should include development of a collaborative planning model. All of the relevant government agencies and key stakeholders as well as resource maps of and demographic detail would be needed for this. Enablers would have to be identified, and there would need to be strong and consistent reinforcement strategies until the benefits and outcomes for the individual with complex care needs are realized and become the norm.
- > Enrolment can be a planning/coordination tool.
- > Discharge planning should be taken away from hospitals.

PERFORMANCE INDICATORS

- > The National Health Performance Authority is in the process of developing indicators for Medicare Locals and other health services.
- > Every avoidable hospital admission should be seen as a failure of community care.
- > Reducing avoidable hospital admissions should be part of chief executives' key performance agreements.

DATA & ENROLLING PATIENTS

- > GPs don't routinely collect data on functional limitations; you need data before you can understand trends and formulate policy.
- > Enrolment refers to the enrolment of patient with a particular service and happens currently in Australia (AMS and Community Controlled Services); enrolment also refers to linking the health information currently available for a particular person – MBS, PBS, general

practitioners data, hospital medical records (outpatients, inpatients, ED etc) – and generating a personally controlled electronic health record.

- > Enrolment can be a planning/coordination tool.
- > The quality of the data is only as valuable as the entry of the data.
- > The private health care industry was distressed when the Health Identifier Act – for the development of the personally controlled electronic health record – excluded access by private health insurers.
- > Those associated with the Connecting Care Program have found that patients are not concerned about enrollment, but rather the services the patient is with are (including associated clinicians).

POLY-PHARMACY

- > Poly-pharmacy is a significant problem for people with co-morbid conditions and multi-morbidity.
- > There is no mechanism for pharmacists to work in general practice currently; however, research in QLD has found that having a pharmacist working in general practice had multiple positive effects.

RURAL & REMOTE

- > The issues raised at this roundtable are amplified and more complex in rural and remote settings.

Policy considerations

- > There is an opportunity to shape the activities and outcomes of the Medicare Locals (MLs), in particular through the National Health Performance Authority.
- > There is an opportunity to influence what services relating to chronic disease care and management in the community can be funded through the activity-based funding model of hospital networks through the Independent Pricing Authority.
- > There is the need for the development of a population based planning tool for out of hospital chronic disease care and management – based on the demographics of a population and the models of care proposed.
- > There is the need for the development of a collaborative planning model for chronic disease care and management in the community.
- > There is an opportunity to influence the placement of pharmacists in general practice or an integrated primary care context.
- > The placement of most discharge planning with hospitals should be reconsidered.

Methods

The Serious and Continuing Illness Policy and Practice Study (SCIPPS) was developed jointly by the University of Sydney and the Australian National University branches of the Menzies Centre for Health Policy. The five-year study sought to examine the lived experience of people with chronic illness.

Following ethics approvals, SCIPPS gathered data from community-dwelling Australians with co-morbid chronic heart failure (CHF), complicated Type II Diabetes Mellitus (TTDM) and chronic

obstructive pulmonary disease (COPD). The 52 participants aged between 45 and 85 years of age lived in Western Sydney or in the Canberra region. Fourteen carers also participated. Eighty-seven percent of the combined group experienced co-morbidity, a figure exceeding the 70% of older Australians known to have multiple chronic conditions.

Ethics approvals were received from all institutions involved in the study.

Dissemination of research findings has occurred in part through publications that are available at:

http://www.menzieshealthpolicy.edu.au/research_scipps_publications.php

Translation of the study findings into policy has occurred in the final few months of SCIPPS in the form of Roundtable discussions. The Roundtables were by invitation only, with approximately 20 delegates in attendance at each discussion.

The three Roundtable discussions were:

- > 'Understanding the complexities of co-morbidity with respect to policy and practice' was conducted on Wednesday 16th November 2011 at the Darlington Conference Centre, the University of Sydney.
- > 'The economic impact of chronic disease on individuals and families all expenses' was conducted on Tuesday 22nd November 2011 at The Common Room, University House, the ANU, Canberra.
- > 'Health literacy for individuals and communities to support self-management' was conducted on Wednesday 30th November 2011 at The Drawing Room, University House, the ANU, Canberra.

This report records the proceedings and outcomes of the first Roundtable.

The final dissemination strategy will be a conference with the purpose of translating SCIPPS findings and the policy considerations that were raised within the three Roundtables into shaping practice and effecting policy development.

APPENDICES TO THIS DOCUMENT

Appendix A	List of delegates
Appendix B	Roundtable agenda
Appendix C	Record of Roundtable discussion

The Serious and Continuing Illnesses Policy and Practice Study (SCIPPS) was a five-year NHMRC funded program (no: 402793) conducted at The Australian National University and University of Sydney and administered by The Menzies Centre for Health Policy.

Appendix A

LIST OF DELEGATES

	Delegate	Organisation and role/ title
	Chair:	
1	Professor Stephen Leeder	Director, Menzies Centre for Health Policy, Sydney University; Director, Research Network, Western Sydney LHD; Chair, Western Sydney LHD Board; SCIPPS researcher and Chief Investigator
	Guest Speakers:	
2	Ms Louise Cowper	Network Director, Primary Care and Community Health Network, Western Sydney and Nepean Blue Mountains Local Health District
3	Dr Richard Matthews	Consultant (formerly Deputy Director General, Strategic Development, NSW Health)
	Invited Guests:	
4	Dr Evan Ackermann	RACGP (National)
5	Ms Maiy Azize	Project Officer, Consumers Health Forum of Australia
6	Ms Karen Booth	Vice President, Australian Practice Nurses Association
7	Professor Gabrielle Cooper	Professor of Pharmacy, University of Canberra
8	Dr Andrew Cottrill	Medical Director, HCF Australia
9	Ms Solange Frost	NSW Council of Social Services (for ACOSS)
10	Mr Evan Lewis	Disability and Carers Group, FaHCSIA
11	Ms Angela Littleford	Royal District Nursing Service, South Australia
12	Ms Joanne Medlin	Connecting Care Implementation Program Manager
13	Dr Anna Olson	NHMRC Post-Doctoral Fellow, Viral Hepatitis Epidemiology and Prevention Program
14	Ms Gaylene Parsell	Australian Practices Nurses Association
15	Ms Janis Paterson	Severe Chronic Disease Management Strategy, WentWest Medicare Local
16	Mr Justin Scanlan	Occupational Therapy Australia
17	Dr Annette Schmiede	Menzies Centre for Health Policy
18	Dr Tim Senior	RACGP NSW
19	Dr Matthew Gray	RACGP NSW
20	Mr Patrick Tobin	Director of Policy, Catholic Health Australia
21	Mr Robert Williams	National Health Program Manager Royal Flying Doctor Service (for National Rural Health Alliance)
	SCIPPS team members:	
22	Associate Professor Jim	Deputy Director, Menzies Centre for Health Policy (Sydney);

23	Gillespie Ms Tanisha Jowsey	SCIPPS researcher and Chief Investigator Menzies Centre for Health Policy (Canberra); SCIPPS researcher
23	Recorder: Ms Kate Corcoran	Menzies Centre for Health Policy (Sydney); SCIPPS support
24	Dr Dagmar Ceramidas	Menzies Centre for Health Policy (Canberra); SCIPPS support
	Apologies: Ms Kate Hooke Mr Michael Moore Ms Colleen Sheen Mr Chris Shipway Ms Laurann Yen	Treasurer, Health Consumers NSW Public Health Association of Australia Executive Manager, Policy, Strategy and Education, Carers Australia NSW Health Associate Director, Menzies Centre for Health Policy (Canberra); SCIPPS researcher

Appendix B

AGENDA

Menzies Centre for Health Policy

Serious and Continuing Illness Policy and Practice Study (SCIPPS)

Roundtable meeting 2: Understanding the complexities of co-morbidity with respect to policy and practice

Wednesday 16th November 2011

Agenda

Outcome: To prepare the framework of an evidence-based policy brief that will guide systems and policy reform for management and self-management of patients with multi-morbidities.

- 10:00 Welcome, Professor Stephen Leeder, Chair
- 10:15 **Speaker 1:** Professor Stephen Leeder, Director, Menzies Centre for Health Policy; SCIPPS
- 10:45 Discussion
- 11:15 Morning tea
- 11:30 **Speaker 2:** Ms Louise Cowper, Director of Community Health Services in Western Sydney
- 11:35 Discussion
- 12:30 Lunch
- 1:30 **Speaker 3:** Dr Richard Matthews, Consultant (formerly Deputy Director General, Strategic Development, NSW Health)
- 1:35 Discussion
- 2:30 Afternoon tea
- 2:45 Summary of the day
- 3:00 Close

Appendix C

RECORD OF ROUNDTABLE DISCUSSION

In attendance: 24, plus five apologies; list of Delegates at Appendix A.

Agenda: At Appendix B

Introduction and presentation – Steve Leeder

- > SCIPPS interviewed patients and carers to gain an understanding of the experience of individuals living with and managing chronic disease. The findings from this qualitative study have been used to plan this roundtable and two others (Economic Hardship, November 22 and Self-Management/Health Literacy, November 30).
- > The issue of co-morbidity is not taken up into classical policy frameworks – which are disease based; there are no chronicity clinics.
- > Five questions posed in Meeting Paper 1 to guide the day's proceedings:
 - o What can be done to develop programs of care that respond to 'chronicity' in general rather lining up with one disease or one body system?
 - o What can be done to provide the complex support needed by patients and carers to self manage in the face of co-morbidity?
 - o What financial arrangements can be proposed, by way of social policy, to alleviate the financial pressures that multiply in the presence of co-morbidity?
 - o What policy advice might we propose for local application through primary care and hospital networks?
 - o How may policies for the care of people with co morbidity be encouraged, implemented and evaluated?

Discussion

- > **The term 'chronicity' means something to the people in the room but means little to patients.** To me as a patient it's how I function in the world as my functional deficit inevitably grows that's important. I'd like to reframe Question 1 to:

What can be done to develop programs of care that respond to 'increasing functional deficit' which is a result of ageing and multiple morbidities – or multiple conditions?
- > **Some loss of function is a normal part of ageing.** How do you age healthfully? How to you age with as much functionality as you can?
- > **Functionality and external environment interact**, from having to negotiate steps to more generally the social determinants of health. Imagine having a Health Impact Assessment of the Transport Policy.
- > **We need to consider physical functionality but also cognitive functionality.** The Royal District Nursing Service, South Australia provides a lot of services (CAPAC, APAC, HACC etc) and 53% of all our nursing visits are for medications – some of which are for IV antibiotic therapies but a lot of the visits are for daily medication management for people with cognitive decline. The system currently- in terms of policy and funding model design -

assesses functional decline in a physical sense, not a cognitive sense. How are we going to provide this suite of services to cope with the increasing rates of dementia?

- > **Our clients expect we're communicating well across the pathways of care but this is not the case.** There is dysfunctionality between acute care, primary care, private providers, public providers etc, which is confusing and overwhelming for patients. The communication strategies we're using and how we share information with our colleagues and work as a team is very under-developed. Then there is how we communicate with patients and their families.
- > **The personally controlled electronic health record will improve the situation somewhat, but for communication to improve the information must be available in a timely fashion and be accurate and explained (ie in context). There is no guarantee the information input into the system will be accurate.**
- > The different sorts of remuneration do not facilitate communication between health care professionals – they frequently act as barriers. And, there are few bridges.
- > Some state health services (such as speech pathology services and audiology services) don't report to general practice as general practice is not in their reporting loop. There can be huge issues getting reports back into the primary care setting, despite making the referral.
- > **GPs don't routinely collect data on functional limitations - they routinely capture data on the presenting condition. You need data before you can formulate policy and understand trends and possible solutions.** And GPs won't share all data (advice from DOHA). Will the electronic health record facilitate the recording of this information so that other health care professionals can use the data?
- > **Clinicians are very protective of the data they collect – they're protective of clinical streams and patches.**
- > **Co-Morbidity/Multi-Morbidity – not just confined to the elderly. Trying to differentiate one approach to Co-Morbidity will be difficult; we may need a multi-faceted approach.**
- > Definitions of Co-Morbidity and Multi-Morbidity given in the following articles:
 - o Co-morbidity indexes from administrative datasets: what is measured? Shyamala G. Nadathur, AHR published online 30 Sept 2011.
 - o The prevalence of multi-morbidity in primary care and its effects on health care utilization and cost. Glynn et al. Family Practice 2011: (28), 516-523
- > The definition of co-morbidity comes from the service provider/clinician, whereas patients focus on the lived experience and what they can do and what we can help them do. Patient-centred care focuses on the goals of the patient.
- > How can we help patients self-manage? Do we accept the responsibility of ensuring a patient has the resources they need to self-manage?
- > **Funding policy can drive change.** Type of funding impacts significantly on the provision of care – activity based funding, block based funding etc. An example of this is the drive for post acute care to be episodic, such as a patient leaving an acute care facility being entitled to receiving 6 visits for wound dressing. This is not what they need, and they invariably don't recover. Previous to this drive down to episodic funding the clinic a roundtable participant works at could provide a more holistic service.
- > **Medication Reviews not always done when needed** (eg: not done on an Orthopaedic ward when a patient has gone into hospital due to a hip fracture (which was the result of a medication). Why? The DRG is not related to medication.)

- > **Models of Care for older people with chronic disease that are meaningful sit between Medicare Locals and Local Health Districts. My understanding is that hospital substitution or community-based care is not going to be funded by anyone else.** So it's going to be within the mandate of Local Health Districts to want to fund that activity and have good connection with everyone else. Western Sydney has good synergy between the LHD and the Medicare Local; this may not be the case in other jurisdictions.
- > **The health system is based on activities (ie activity based funding) rather than outcomes (ie outcomes based funding).**
- > **Episodic funding was/is being used to drive technical efficiency/allocative efficiency. It was never intended as a funding model. There are frustrations in the room about the health care system. The care system is hopelessly split and disjointed. There are lots of gap/overlap – people with varying degrees of responsibility – and limited means of communication. To solve these problems at the highest level we need to take a population approach. There needs to be a single government body that is responsible for a population (such as Western Sydney) –** whether it's health, non-clinical support, aged care, disability. This single body has to have responsibility for all of this – and this body needs to bolt it all together. Currently, we have a patchwork. Western Sydney LHD and Medicare Local having the same geographical boundary is a big step. The next step is lining up Disability and Aged Care. The next step to develop a single point of accountability and information – which is 20 years off.
- > **Submission to the Independent Pricing Authority - There may be some room to have influence on what will be block funded and what will be activity based funded, and funding of processes to lead to particular outcomes.**
- > **Enrollment of patients – occurs in the Aboriginal Medical Service and in the Community Controlled Sector.**
- > The Aboriginal Health Service sector and the Community Controlled sector (based on a cooperative model with members and broader community involvement – they elect a board and the board employs a CEO and doctors etc) could provide models of how super clinic could work.
- > **It is important to have layers of access** – some patients don't want to bother the doctor but will readily phone the nurse.

MORNING TEA

Discussion

- > **RECOMMENDATION: A submission to the Independent Pricing Authority.**
- > **There is still time to influence the measurement of performance of Medicare Locals by the National Health Performance Authority which is coming into existence currently – perhaps three months. Beyond measuring the performance of hospitals, the Performance Authority is in the process of developing indicators for Medicare Locals and other health services.**

Presentation – Louise Cowper

Learnings from HealthOne and new learnings from Connecting Care

- **Four key messages:** 1. Knowing the service arena 2. Maximizing and growing resources 3. Workforce imperatives 4. Communication and information sharing.

- **Knowing the 'arena'**

- ❖ Thinking collaboratively and planning 'outside' the patch
- ❖ Knowing all the services and how each works
- ❖ Recognising and valuing the 'virtual team'
- ❖ Understanding and respecting the contributions of each service to the complex care needs of individuals
- ❖ Building seamless connections between (PHC – GP's, Community Health, Mental Health, Drug & Alcohol, Aged Care; Community Care (NGO) services and hospital based Chronic Disease and Aged Care specialty services) takes time, reliability, respect and tenacity.

Additional comments on November 16:

We tend to bunker down in our own patch/our own service arena, but try and take the time and look beyond your immediate area or patch. Try to get to know and understand the wider service area and map it and try and understand other people's service arena, challenges and barriers – when you do this immediately solutions appear and the conversation starts to focus on solutions. Also, determine who makes up the virtual team (including those beyond your service arena). It's important to understand and respect the contribution of everyone – and try not to be precious about what we contribute and a bit suspicious of what others contribute. This changes the dynamic.

We need to build a timely and reliable seamless connection between the various components of the health sector. Getting the Primary Health Care sector connected, in our case just Community Health, Mental Health, and Drug & Alcohol – and how we can work collectively work with GPs rather than working independently and bombarding them. Getting a coordinated, consistent way of managing this takes time, trust and requires tenacity.

- **Maximising and Growing Resources**

- ❖ Mapping and promoting service availability (public and private)
 - Formula for determining/projecting the comprehensive range of services which should be in place for a particular population
 - In a locality; to maximise the multidisciplinary service response capacity
 - To establish reasonable case load management
 - To achieve service response equity e.g. minimal wait times = trust = service integrity = improved collaboration???
 - Cost benefit modeling for various care coordination models e.g. extra community based – public/private/NGO resources = improved cared coordination = better management of complex health care needs = reduced disease burden impact ??? develop an evidence base/proof of concept
 - Collaborative planning as a service sector (e.g. Families NSW Planning Model; HACC Planning Model)
 - Public & private joint planning opportunities (Medicare Local planning opportunities)

Additional comments on November 16:

There are not enough publically funded allied health workers in the Community Health sector. At the same time there is no formulation to determine the number of allied health workers required for a population based on demographics. Once we have a formulation we can make determinations and build models of care and formulate pathways, and there will be a more equitable distribution of resources.

More resource distribution planning is needed.

Regarding funding models and what needs to happen – there is good evidence about the benefits of caring for people in the community. If we do that well they won't bounce back to hospital – but there are no good tools/formula to argue for resource increases for the Community Health sector. The same could be said for the system that provides for the care and management of individuals living with chronic disease.

We need to develop a collaborative planning model - such as that developed by Families NSW – which was a very sophisticated planning model involving all NGOs and all government agencies, as well as all of the mapping and demographic detail required for decision-making. This allowed an agreement to be reached on what the service sector should look like for the population of interest.

This planning process worked because it was a whole of government directive – right from the word go. There was a governance structure that was whole of government (right down to the local level); it was reinforced at the senior level of government at both the state level and the local/regional level – and then down to the local service level. Everything cascaded up and down. All of the local service providers were empowered to be part of determining what needed to happen at the local patch – but it was reinforced by the hierarchy.

Workforce Imperatives

- ❖ Vision vs delivery (changing practice and overcoming resistance)
- ❖ Building workforce skill and understanding (working collaboratively)
- ❖ Need for 'new' style of positions and workforce configuration (e.g. GP Liaison Nurses; Clinical coordinators, Exercise physiologists plus plus)
- ❖ Projecting workforce changes and future opportunities; aging workforce (GP's); shaping the practice of the emerging workforce

Additional comments on November 16:

It's one thing to have the vision, but actual change on the ground (ie getting frontline clinicians to understand there are different ways we can do things) is a major underestimated component of this - getting new stuff (models of care etc) working on the ground takes a significant amount of time.

We need to be brave enough to consider new styles of positions eg GP Liaison Nurses working. To roll GP Liaison nurses out effectively we need 30 GP Liaison Nurses in our area.

- **Communication and Information sharing**

- ❖ Clearly established planning, communication and governance arrangements
- ❖ Systematising cross sector care coordination and information sharing arrangements
- ❖ Change management strategies to build the understanding of all stakeholders beyond their patch (identifying and nurturing 'champions')
- ❖ Marketing and Awareness Raising
 - Validation of models such as HealthOne and Connecting Care – not as 'competitors' but rather the lynch pin
 - Overcoming professional patch protection
 - Community consultation and awareness raising about changing models of care coordination

Additional comments on November 16:

Around communication and information sharing, one aspect of HealthOne that was beneficial was that it brings people together with shared governance – contributing to how we're understanding the learning of what we're doing. We've been using a reflective practice type model with HealthOne. We're all sitting around the table and looking at our systems and what works and what doesn't work – and how to change them. It becomes an owned process.

After this process it's about then systematizing this across the service. Some things have to be procedure, protocol, auditable – to ensure change continues.

Also, we need to market change to the community; we need to make the community aware that there are alternatives to how our services are arranged. We need to let them know that there are alternatives to the Emergency Department etc.

Concluding message: There needs to be a whole of system change focus; a strategic approach to service planning with identified enablers; and strong and consistent reinforcement strategies until the benefits and outcomes for the individual with complex care needs are realized and become the norm.

Additional comments on November 16:

If you require whole of system change, you need strong reinforcement strategies until the results themselves become the drivers.

Discussion

- > This morning it's clear that we as a group have found it difficult academically organizing the whole problem of multi-morbidity (what it is; what its definition is; what its impact is etc). The next step is converting that into a political problem that can be sold to a group of politicians. To address multi-morbidity we need a lot of resources – money, staff etc. We need to compete for resources – and we all know hospitals are particularly good at competing for

resources. In the end a decision that has to be made is – what can we do at this point in time with the resources we have?

- > In NSW there are bits of Wagner's Model – how then do you get that inter-agency, cross government approach required.
- > **The biggest problem we have in the ACT is that we don't have data about this population. We don't have data on the population we want to manage.** This makes it hard to get the resources that are needed for the community sector support of individuals living with chronic disease. How do we ensure that the community sector gets the resources it needs?
- > **Comments and observations about the Community space (in the context of should we be using the resources we have better) – When you look at the Community Sector there are so many groups operating in the community sector providing services – community health, massive NGO sector, private providers, public providers – and multiple funders. There are multiple providers for particular services, and a multitude of providers providing HACC funded services. WHERE IS THE EFFICIENCY IN RESOURCE ALLOCATION AROUND THAT?** There are 600 NGOs providing HACC services in NSW. Where is the efficiency in that? The Community space has to work better in terms of its structure and funding or we will have the same problems in 10 years time. **There are two aspects of addressing the problem 1. Creating a governance structure in primary care - which Medicare Locals are designed to do and 2. Funding and Responsibility/Authority to get that space working well with what we've already got. This has to be a number 1 priority for whatever happens.**
- > **A single plan for a geographical area that everybody signs in to has to be one of the goals.** Rolling out the Connecting Care program we are looking at the role of the NGO sector. Comprehensive assessments are done but how do we share this information (and not duplicate). This should be the one process. **Enrolment can be a planning/coordination tool** - if we enroll somebody and they are already well connected to the NGO sector then we know we should involve them in what's going on with the care coordination. Then how do we identify people who aren't involved and get them involved. **Some people see enrollment as competing service whereas it really isn't.**
- > **There is opposition to enrolment but enrolment does not only refer to enrolling patients with a particular general practice. Enrolment can also mean linking together the following sources of data for a particular patient (with ONE unique identifier): MBS, PBS, general practice data, hospital data – emergency, inpatients etc) – and making this data available to health care professionals as appropriate. This is what the personally controlled electronic health record is aiming to do.** It surprises me that there is so much opposition to enrolment in this sense, given people are already enrolled in a number of systems in Australia (eg: you have a credit card therefore you're enrolled and you have a credit rating; if a police officer pulls you over this afternoon you hand him your Medicare card and he'll go back to his car to bring up a raft of information about you as you are enrolled – and not just your criminal justice history). Police officers can pull up your information from their car; the majority of clinicians do not have access to the equivalent level of health information. This kind of enrolment allows for planning.
- > **If we had a commitment – on one level we do but we're not prepared to pay for it - to take the various types of health information which is held by MBS, PBS, general practitioners, hospital medical records (outpatients; inpatients, Eds etc) etc – and actually link it and link it in a way that is a personally controlled electronic health record which links to all of those things including a disability assessment if that is what you wanted in it (which is what is planned) – then we would be enrolled and this would enable the driving of reform.**
- > If patients were enrolled with a general practice this would enable the clinic to do population planning.

- > What we have at the moment is a system based on choice – where everyone goes everywhere and there are bits and pieces of information all over the place - and there is no mechanism to coordinate and integrate and share.
- > **We're finding with the Connecting Care Program that it's not patients who are concerned about enrolment and sharing information it's more the services that they're currently with that have objections (they're protective of 'their' patients). The patients are really happy for their information to be shared.** Within our LHD a patient administration system IT software that's separate to the Community Health electronic record, that's separate to the acute sector health record (in the acute component there's only some areas with full documentation). The linking within a small geography of information systems is complicated – let alone any GP information that comes in. **It's not the patients/clients who are reluctant – it's the clinicians.**
- > **Data is key. Data needs to be valued. How does our country value that data? It is data that clinicians have collected, but this data is more valuable to our society than it is to a private company.**
- > **The quality of the data is only as valuable as the entry of the data. We need to be able to share good quality data.**
- > We would all agree that data is key. **The private health insurance sector is both data rich and data poor.** We have lots of utilization data (ie use of hospitals) but we don't know who is a smoker or anything much about a person who has not been to hospital. This is a perennial problem in the private health sector trying to help people manage their own health. **The private health care industry was very distressed when the Health Identifier Act excluded access by private health insurers (ie it's illegal for us to use the single unique identifier).**
- > All of the issues raised today, when they occur in a rural/remote location, are amplified and more complex.

LUNCH

Some questions to guide discussion and thinking?

- What is actually working and working well?
- Why is it working?
- What bits can be replicated elsewhere?
- How can policy encourage widespread adoption?

Presentation – Richard Matthews

Why did reform falter/fail?

- > The principle reason reform faltered/failed is that health is a strife of interests. For reform to work you need to align the interests. There are 4 major groups of players: the Commonwealth, the States, the Clinicians, and the Consumers. There are other significant players such as Private Health Insurers, NGOs etc. But, **you can't achieve change unless you give something to the major players.**
- > **The Commonwealths interest is policy, but also it is the 'treasury'.**
- > **The actual Treasury is looking to cap uncapped programs** (MBS, PBS, Private Health Rebate, + despite activity agreements that exist between the state and 'Steven', if 'Steven' exceeds his hospital activity the 50% Commonwealth agreement is guaranteed up to GOLD)

- > **The States' problem is that there is a vertical/fiscal imbalance which leaves states going cap in hand to the commonwealth** – States collect 20% of tax revenue but provide 60% of services.
- > **Clinicians themselves are a strife of interests – the vast majority of clinicians are very dedicated to their patients but they are also making a living – there're building empires, turf and research.**
- > **Consumers don't understand the system and they have variable access to services. It should be noted that at times and in instances the system is impossible to navigate. If you're old and have multiple chronic disease, mentally ill, drug dependent, are very poor or are Aboriginal – it doesn't look joined up – but for a majority of the population the health system doesn't look too bad. I think this is part of the reason why selling reform to the community is so hard.**
- > **For reform to work it has to give something to each group.** If reform doesn't meet the needs of each of these groups – in a significant way – they won't work. Unfortunately, reform got high-jacked.
- > **EMERGENCY DEPARTMENTS have the infrastructure to respond quickly but the Community Sector does not have the infrastructure to recognise that problem early and crank up quickly to support that problem in the community. Until it gets that infrastructure the status quo will remain.**
- > Clinicians call for more beds.
- > **The open-ended Commonwealth programs underwrite community activities (doctors and pills – MBS & PBS), but other components key to chronic disease management, namely the nursing and allied health workforce, are not. The NGO sector, which provides the non-clinical support to those with chronic disease, is also neglected.**
- > INFRASTRUCTURE – human, IT, facilities are needed.
- > In the Hospital sector there are tools for resource planning by the Department. The Mental Health sector has a tool for population planning purposes – MUCKUP.
RECOMMENDATION - There needs to be a population based planning tool developed for out of hospital chronic disease care and management - based on the demographics of an area and the models of care proposed. WITHOUT SUCH A TOOL THERE IS NO WAY TO ARGUE A CASE FOR MORE RESOURCES – THE HOSPITALS WILL WIN.
- > **RECOMMENDATION - The utopia vision of integrated primary care needs to be developed; you need to have a vision that mirrors the cathedrals of the hospitals. My vision is that for every 20000 people in your geography you've got one centre with 8 – 10 GPs, allied health, nursing, pharmacy, a one-stop shop for aged care, it's got some disability services. Importantly, the populations see these centres as cathedrals the same way they see hospitals as cathedrals. It's got an IT system that allows the centre to do some population planning for its population and it works in partnership with in other integrative primary care centre in the same geography under the banner of Medicare Locals. We've got to sell this to the community as a good idea. The Reform Commission was on the money when they recommended doing this with chronic disease and kids.**
- > **The Independent Pricing Commission is key but one of its first tasks is to decide what hospital services actually are. This raises a number issues – as 50% of hospital services are to be funded by the Commonwealth, if you have a great idea that gets people out of the hospital and treats them in the community and actually replace the hospital, unless you get it included in the definition of hospital services it's going to be 100% funded by the state. Guess what will happen – the States will invest in things that are 50% funded by the Commonwealth. If you broaden the definition of hospital**

services alarm bells go off in Treasury as you are increasing funding commitments – as they will see this as cost shifting.

- > **Access to services is difficult for patients, as is navigation of the system – which at times is actually impossible to navigate. We need to be able to demonstrate to families and individuals that primary care will help with access and navigation via an Integrative Primary Care Centre.** Western Sydney is well placed to do this (with 6 HealthOnes and many GPs signed up to this system). Others try to help patients access and navigate the system – but it is so time-consuming.
- > **People who work in the Community should be camped in integrative primary health care centres.**
- > **States should get out of the business of the provision of Community Health infrastructure. Community Health centres should be absorbed into the new centres (ie integrative primary centres) or sold off and the money put into the endeavour.**
- > IT systems need to be unified - privacy advocates have to stop being hysterical.
- > In the future technology will push treatment out of hospitals into the community. Hospitals will be places you go for very intense and high tech procedures.

Discussion

- > In the future hospitals will become places where you go for ever more intense high tech activity – all else will occur in the Community.
- > **Every avoidable hospital admission should be seen as a failure of community care. Making a reduction in hospital admissions should be part of Chief Executives' key performance agreement.**
- > **Discharge Planning should be taken away from hospitals and given to the Community Sector. Hospitals are not the best placed service to do discharge planning.**
- > **Resources capacity is needed to bed down Change Management well.**
- > Australian HealthCare & Hospitals Association did a health reform simulation event. Their recommendations might be useful.
- > **Models of Care that work have people whose job it is to make the links ... to integrate ... to coordinate. Comment: It's not just one person it's a team – an Integrative Primary Care Centre might have such a person; this person would phone doctors not the other way around.**
- > There is no forcing function to cause an allied health professional or anyone else to record and document what they've done and report back to general practice. If a physiotherapist is treating someone for back-pain it should be mandatory that this is reported back to the GP.

Suggestions of successful examples of complex IT systems for the support of people with multiple chronic illnesses/ co-morbidity

- > The Northern Territory has implemented a territory wide IT system – involves Territory Health and the Community Health service – not sure if GP is up and running with that. The Aboriginal Medical Services (AMS) are involved.
- > The representative body of the Aboriginal and Community Controlled sector in QLD is doing a lot of work into quality indicators around chronic diseases in the Aboriginal Health sector in QLD.
- > Private health insurers are getting involved in remote tele-monitoring of diabetics.
- > The best examples of such IT systems are in the acute care sector eg some Ambulance officers with LED ECGs are sending results to the cardiologists on call (ie to their iPhone)

when they treat a patient who's had a heart attack – this occurs in the metropolitan area. They can be directed to either the ED or to the Cath lab.

- > I'm involved in a company that is trialing a medication dispensing system that's Wi-Fi packaged – central alert to those not taking their medication.
- > Data management in general practice – a lot of them have the Pentool that X talked about – and report to GP networks and Medicare Locals. They collect information on diabetes, CHF and COPD. The tool mines their medical software and presents reports.
- > GP Superclinics and integrated Primary health care centres are not mutually exclusive; GP Superclinics could contain an integrated Primary health care centre model of care.
- > Some AMSs provide integrated primary health care.
- > Drug and Alcohol workers provide integrated primary health care.

We're hearing about things that work, but what aspects of these systems work? Once you've identified the aspects that work you need to push it at a state/commonwealth level – to ensure scale-up of good ideas and improved integration and coordination. And, is it appropriate that things be State-based or is there a case for things to be done at a National level?

There is a set of principles on which HealthOne is built, but when each HealthOne is set up they start from scratch with all of the stake-holders sitting around the table articulating what it will be for them. Even if it ends up being the same as all of the other HealthOnes they will own it.

AFTERNOON TEA

Possible deliverables from today's discussion:

1. **A submission to the Independent Pricing Authority** – that draws attention to the types of care required for people with multiple chronic conditions – and proposing that this be taken into account when deliberations are made decisions are made about what will be funded by an activity-based funding model or through a block grant or some other form of financing? Some groups, such as those providing palliative care either in the community or hospital sector, are concerned at the prospect of Activity Based Funding.
2. **Examine various descriptors of projects and identify some of the elements of success (eg HealthOne) – based on comprehensiveness of reach, accessibility, affordability.** What has worked? Why have these elements worked? To what extent can these elements be amplified? It would be useful to examine the context around the elements that work (ie what are the pre-conditions for success).

Discussion

- > The fact that Medicare Locals are not fully developed is advantageous. There is a chance to influence this component of infrastructure. Successes need to be documented rapidly as there are some forces that do not like them.
- > At the moment in NSW the HealthOnes reside in the Local Health Districts. Where they should ultimately reside remains a question. There is a strong argument that they should reside in Medicare Locals – once they have the infrastructure and expertise to do these things.
- > Infrastructure is key. How can infrastructure be developed and used? At the moment in NSW between \$600m and \$1b is spent on health infrastructure a year – almost all of it is spent on hospitals, reluctantly we spend some on IT, and we spend the absolute minimum on integrated primary care. For instance, HealthOne in NSW received \$10m over a four year period. This thinking has to change.

- > If you look at infrastructure in NSW you have hospitals, IT, and primary care.
- > ***The National Primary Care Strategy will be an implementation plan by the end of 2012. It is important that this plan - when it is released - moves away from a narrow general practice focus and encompasses the whole area. It needs to be a roadmap document. This document is key – it is Commonwealth territory.***
- > ***Key performance indicators are needed for best care and management of people with chronic disease or multiple co-morbidities.*** It might be useful to go to the AGPN as the national peak body for Medicare Locals and try to influence the indicators they are coming up with.
- > It strikes me that there is an opportunity for Medicare Locals to become the guider of this type of planning we're talking about (ie a Medicare Local planning process).

TWO SUGGESTIONS FOR POINTS OF EASY INFLUENCE

1. There is strong evidence about poly-pharmacy (especially related to co-morbidity).
 - There is no mechanism for pharmacy to work in general practice currently, but research by a PhD student in QLD found that having a pharmacist working in general practice had multiple positive effects. HOOK: Currently the PBS costs 0.6% GDP. It is projected to increase to 2.6% of GDP in 2050.
2. Moving Discharge planning from the Hospital Sector to the Community Sector
 - There are some good models of joint discharge planning at St Vincent's Hospital
 - Some good examples in Adelaide and QLD