

**Minister for Health's
PRIMARY HEALTH ROUND TABLE**

Thursday 28th June 2018, 8:00am – 12:00pm
UWA Club, Crawley

**Improving the Coordination of Consumer Care
between Primary Care and Hospitals**

OUTCOMES REPORT

Executive Summary

The Minister, Hon Roger Cook MLA highlighted the need for change in order to seize opportunities for an outward facing health system.

The Chair of the Sustainable Health Review Panel, Ms Robyn Kruk stressed that the evidence for change is clear and the need is for practical suggestions to move forward.

From the plenary discussion on each of five implementable actions, the following **key points** emerged:

ACTIONS

Action 1: Establish appropriate and effective transfer of care arrangement between GPs and Hospitals

- There are a series of integration initiatives that require incremental change and improvement including Hospital Liaison GPs, electronic referrals, and discharge summaries;
- Investment in care coordination roles is seen as a more comprehensive reform and is strongly supported by Round Table participants;
- There is a divergence of views on how to implement care coordination:
 - one view is that care coordination naturally centres on GPs and the key is changed funding models to allow for GP time and greater support for GPs,
 - another view is that GPs are involved in care coordination but may not be the primary component in the system and a non-medical coordinator may be more appropriate in situations where community, culture or holistic factors are in play;
- Above this is the requirement to focus less on activities and more on the integrated model of care that ties the components together:
 - we need to sit together to plan the processes for our local communities,
 - we need to focus on a cooperative model for our population,
 - we have good exemplars of care coordination centres and initiatives to show what's possible,
 - we need to recognise the small numbers of high user, high risk groups but plan the system around coordination of care for the majority of health users.

Action 2: Redesign primary health care education and training pathways for all health professionals

- The key step is to broaden the experience and hence the perspectives of people working in health:
 - junior doctors in hospitals need the opportunity to do a rotation into General Practice,

- junior doctors need rotations into remote and regional health to understand broader cultural and social determinant perspectives,
 - health workers need to build their capacity to respond to people with mental illness, disability or other needs,
 - the complex needs area in hospitals, prisons and courts requires the ability to bring people into the system, not exclude them;
- System changes include:
- involving primary care in the first two years of undergraduate study for General Practice,
 - placements in primary care in the first two years after graduation,
 - opportunities for exposure of senior doctors to other systems, to maintain the broader perspective.

Action 3: Achieve seamless integration of shared patient information

- Round Table participants agreed that the My Health Record system and initiatives such as Kabisa Medical technology are step changes, will be implemented and must be supported;
- Furthermore, there is a need to bring information sharing in health in line with data collection and information sharing in other sectors such as commerce, notwithstanding the mature discussions needed around protecting the vulnerable in terms of health confidentiality;
- At the heart of this is really taking the challenge to design the health system around the patient so that the supporting systems work;
- There are exemplars such as the disability sector where agreements are in place for clinicians to look at all information around a person with disability.

Action 4: Access to hospital, MBS and PBS data to provide the opportunity for more sophisticated planning of health services

- Round Table participants confirmed the need for access to data and particularly to outcomes data to know if the patient is getting the best care;
- Collection of data at the point of care needs improvement in hospital clinics, in rural services and in allied health services;
- A minimum data set will increase standardisation, and allow more effective comparison of services.

Action 5: Establish agreements between governing bodies in WA to facilitate integration of health care

- There is strong support for agreements between governing bodies to facilitate integration of health care;
- Formalised agreements can address the issues raised so far, such as data sharing, interoperable systems, care coordination, etc;

- WAPHA is not a representative body of the Commonwealth or the State but it can be an enabler and facilitator to come up with models that the State can discuss with the Commonwealth;
- At a systems level, we need tiers of agreements:
 - a bilateral agreement between State and Commonwealth Ministers for greater flexibility in the use of funding,
 - system manager agreements to get integration within WA,
 - service provider agreements to get agreed outcomes;
- The State has the most to gain here by driving primary care in WA:
 - craft governance such that State systems can leverage on primary care,
 - partner with Primary Health Networks,
 - leverage Commonwealth funds with State funds as an investment strategy;
- There is some funding currently available to trial this approach and the best way forward is to do something fundamentally different in a select geographic area with a specific high risk group, as a first step;
- Hospitals have made fundamental change in the past 30 years, primary care integration can move down that path.

Reflection

Key Subject Matter Leads reflected that:

- People from the sector are engaging in the process to get an outcome;
- There is a very broad church of contributors that can be harnessed;
- Across the whole health system, we can only progress incremental change;
- However we can do something fundamentally different (transformational change) in a selected geographical area with a selected population and this is a great opportunity for integration between primary care and hospital settings;
- The key is for the State to work with the community and the primary care sector to get some skin in the game to leverage better Commonwealth support;
- The Primary Health Networks are a great vehicle to drive integration;
- The WA Primary Health Alliance has the authority, support and scope to act in terms of moving the potential integration forward.

Welcome to Country

Ms Ingrid Cumming performed a Welcome to Country.

Opening Address

Hon Roger Cook MLA, Deputy Premier; Minister for Health; Mental Health welcomed everyone to the Round Table:

- Innovation is needed to seize opportunities in an outward facing health system;
- Primary and Secondary health systems need to work better together;
- The current situation is strange in that primary health (as opposed to primary care) and aged care are the responsibilities of the Commonwealth, hospitals are the responsibility of the State;
- Stronger primary care is more beneficial for the patient – care, prevention and chronic disease management are the first steps in the health care system;
- There are gaps that we need to resolve as part of the patient journey through the system;
- State Government has a commitment to Putting the Patient First;
- It was pledged to hold this round table to improve the integration of primary care and hospital services;
- During the election, Labor asked what is needed in primary health, and the answer was to get the key players talking;
- 12 of the directions identified in the Sustainable Health Review Interim Report are focussed on primary care, based on significant SHR consultations;
- Evidence shows that investment in prevention is more cost effective and gives the best outcome, but accounts for only 1.4% of total expenditure in 2017;
- There are plenty of customers in every community that need us to work together effectively;
- This is a big challenge – WA is not known for fluidity and innovation in the health care system, and therefore we must come up with some changes.

Setting the Scene and Call to Action

Ms Robyn Kruk, Sustainable Health Review Panel Chair:

- The evidence for change is clear;
- The importance of building relationships is clear – nothing can be done by one organisation alone;
- Here today we have the knowledge, relationships and authority to get the practical steps undertaken;
- Ultimately, the problem will be solved if you put yourself in the position of the patient;
- In many cases, we deal with the most vulnerable people in the community; it is not acceptable for them to disappear through the gaps;
- We need to have the issues and practical steps understood and formalised.

Plenary Address #1

Prof Hal Swerissen, Visiting Fellow, Grattan Institute

- The problem:
 - health planning logic – big spikes in health care at the infant mortality stage, followed by a long period of relative health until health declines post 60 years of age,
 - the traditional system is primary health and specialist extended care. Most effort is currently concentrated here,
 - less effort is spent on preventative activities,
 - there is an increasing interest and demand for chronic disease care and End of Life care,
 - the challenge is to move the traditional system curve to the right – spiking post 80 years of age, thereby reducing costs and compressing the curve of morbidity,
 - emerging care needs have led to fragmented, unco-ordinated delivery of systems,
 - primary care is no longer just the gateway service but is now a huge system of services,
 - there is poor patient experience in the system,
 - there are unnecessary and preventable costs,
 - the same set of problems exist across all sophisticated health systems, not just in WA;
- Definitions:
 - primary care is face to face health care in the community, often focussed in General Practice,
 - it incorporates primary care data, monitoring, reporting, benchmarking; electronic patient records, etc,
 - acute care is in a hospital setting,
 - chronic and complex populations have an ongoing relationship with the health care system – they are a high cost group where integration issues are paramount. This is the population group that really matters in terms of interaction with health care system,
 - the first point of entry is often General Practice, but not always,
 - we need to find ways of creating co-ordinated, planned and monitored care (24 hr/7 day) with someone they have ongoing, engaged relationship with;
- Incremental reform is based on continuously improving current and proposed systems;
- Comprehensive reform is a transformational approach that requires major system reform in:
 - selection criteria to choose which group of people to focus on,
 - participating agencies based on contractual agreements,

- a need for funding of coordination, planning and monitoring systems,
- consideration of performance based funding transfers from institutional to community services (measure and share),
- governance models for planning, commissioning and monitoring that line up Commonwealth / State agreements,
- many elements are involved in systematic, comprehensive reform:
 - top level service pathways (eg: Diabetes Pathway), agreement between providers, service availability and service profile comprehensiveness,
 - broader system issues of service provision – patient information and data, coordination and planning, funding and incentives,
 - capital investment and service development and training,
 - organisational partnership models, regional governance / commissioning models, intergovernmental agreements;
- issues against comprehensive reform:
 - the electoral cycle and political will (this is a Commonwealth election year, therefore not a big year for reform potential),
 - service system winners and losers – who gets the advantages, who gives ground, funding transfers, etc?,
 - development costs and training – difficult if extra funds cannot be made available, looking for savings and efficiencies. More funding now to save money later is hard to sell,
 - inherent uncertainty about implementation and outcomes;
- issues against incremental reform:
 - much has been tried without success; we still have fragmentation;
- Opportunities:
 - try to line up incremental with comprehensive reform (even if high risk reform is not undertaken at the start),
 - establish regional agreements – this is easier and can be set up now,
 - establish a data model – at least measure performance to see where the problems are and bring everything together,
 - establish a joint planning, commissioning and monitoring model,
 - agree on a pathways model – such as Canterbury, NSW or other and build infrastructure that matters,
 - sort out electronic records and patient transfer as part of the incremental approach;
- More radical interventions:
 - implement basic patient co-ordination roles. Health Care Homes are not going well because they are too micro and only focus on the GP. Need to shift to a more macro focus. The NSW model is a better model for doing this,
 - trial comprehensive models in one region to start. WA is a challenge – the huge rural hinterland and Perth metro both have very different needs in terms of:

- enrolment and eligibility criteria,
- institutional primary care service models,
- organisational partnership delivery models, agreements and contracts;
- Final thoughts:
 - been in this space for 35 years and there has been no Commonwealth inclination to undertake comprehensive reform, only incremental reform. The Commonwealth answer has been to add things to the existing arrangement,
 - there is significant opportunity to reduce hospital demand by investment in primary care but this will take a while to do,
 - the States have to be active participants in transformational change, as they have the most to gain,
 - major decisions on whether to and how much to invest are required by the State in primary care integration,
 - evidence is still partial and unquantified, and still a risk. We need an architecture (hopefully this is an outcome of the Sustainable Health Review).

Plenary Address #2

Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospital Association

- Why are we here today – number one reason is that we've never cracked the governance model correctly. Time to change and transform radically or else nothing will have changed in the next 35 years;
- 2018 is the year to do something about it – 6 States / Territories have signed up to a Health Reform Agreement. There are no indications of either side of Parliament backing away from current primary health agreements;
- A sum of money (\$120m innovation funding) is available to do something different;
- One challenge in transformation is the risk of the transfer of costs from the system to the patient, resulting in out of pocket costs for the patient. For example, transferring services out of hospitals into the public space could produce a cost fall-out borne by consumers;
- AHHA is working out a 10 year strategic vision:
 - patient centred,
 - outcomes focused,
 - value based;
- Four key domains exist for transformation reform:
 - governance is the most important,
 - data critical, as a primary care data system is missing,
 - workforce is the most underdone part of the blueprint to date,
 - funding needs to be sustainable and appropriate;
- An independent national health authority is needed but unlikely to occur;

- At the least, aim for formalised agreements for consistent regional governance:
 - QLD provides two examples of regional governance agreements:
 - between primary networks (PHNs), State hospital system around Mt Isa, and Aboriginal Health – a three-part system all separately owned. Not a lot of private sector health in that area,
 - a metropolitan example is the Brisbane North Primary and Metro North Primary agreement – MOUs are in place, staffing is switched between the two areas, accountability, focus on residential age care to hospitals – better age care to alleviate need on hospitals,
 - Western Sydney – Primary Health Network, pharmacy, etc to get better diabetes care,
 - Orange – managing mental health in the district with three-way management between primary, allied health and the patient;
- Key recommendations:
 - all suppliers who receive Government funding are required to supply patient outcomes / service dimension data,
 - national data system for primary health care – inclusive of the private system,
 - patient reported experience and outcome measures – already there are projects in WA involving international consortiums, opportunity to benchmark what is happening in WA; outcomes relate back to patient-centredness,
 - regional needs assessment – often in partnership with hospital systems;
- Workforce:
 - thinking about different roles that may come up in future systems,
 - rural generalists in General Practice and allied health,
 - if expecting people to shift out of hospitals into the community to private providers, need to consider costs to the patient;
- Funding:
 - stepped approach to transformation,
 - pick a couple of regions or disease groups and apply performance funding – suggest a 25% component, based on modelling undertaken in the US,
 - are you prepared to take a risk?,
 - dedicated funds for prevention activities – need a fundamental shift to prevention. Currently about 1.9% of funding, try 2.5% for example to see what differences it makes.

Facilitated Debate

A facilitated plenary debate was conducted around five implementable actions to improve coordination of consumer care between primary care and hospitals:

- Action 1: Establish appropriate and effective **transfer of care arrangements** between GPs and hospitals.
- Action 2: Redesign primary health care **education and training pathways** for all health professionals.
- Action 3: Achieve seamless **integration of shared patient information**
- Action 4: Access to **hospital, MBS and PBS data** to provide the opportunity for more sophisticated planning of health services.
- Action 5: Establish **agreements between governing bodies** in WA to facilitate integration of health care.

Action 1: Establish appropriate and effective transfer of care arrangement between GPs and Hospitals

The pre-reading provided the following summary of input received via Citizens Space:

It is imperative to define shared metrics, definitions and data tracking methods across the parties that are working to achieve integrated care.

- *Prioritise funding and attention to:*
 - a) *enhance the scope of Hospital Liaison GPs;*
 - b) *facilitate electronic referrals and provide guidelines for referral and re-referral;*
 - c) *timely and complete discharge summaries;*
 - d) *investment in care coordination roles;*
 - e) *improve access and transparency of outpatients and improve information coming from outpatients to GPs or primary care to facilitate seamless care.*

Overall

- There are a series of integration initiatives that require incremental change and improvement including Hospital Liaison GPs, electronic referrals, and discharge summaries;
- Investment in care coordination roles is seen as a more comprehensive reform and is strongly supported by Round Table participants;
- There is a divergence of views on how to implement care coordination:
 - one view is that care coordination naturally centres on GPs and the key is changed funding models to allow for GP time and greater support for GPs,

- another view is that GPs are involved in care coordination but may not be the primary component in the system and a non-medical coordinator may be more appropriate in situations where community, culture or holistic factors are in play;
- Above this is the requirement to focus less on activities and more on the integrated model of care that ties the components together:
 - we need to sit together to plan the processes for our local communities,
 - we need to focus on a cooperative model for our population,
 - we have good exemplars of care coordination centres and initiatives to show what's possible,
 - we need to recognise the small numbers of high user, high risk groups but plan the system around coordination of care for the majority of health users.

Action 2: Redesign primary health care education and training pathways for all health professionals

The pre-reading provided the following summary of input received via Citizens Space:

Ensuring we have the right health professionals to work in the best possible primary health care teams, keeping people supported in the community and out of hospitals is critical.

- *Medical students and junior doctors being able to receive a significant part of their training in community settings;*
- *Change in the primary care workforce to utilise more health professions to improve the patient's health journey.*

Overall

- The key step is to broaden the experience and hence the perspectives of people working in health:
 - junior doctors in hospitals need the opportunity to do a rotation into General Practice,
 - junior doctors need rotations into remote and regional health to understand broader cultural and social determinant perspectives,
 - health workers need to build their capacity to respond to people with mental illness, disability or other needs,
 - the complex needs area in hospitals, prisons and courts requires the ability to bring people into the system, not exclude them;
- System changes include:
 - involving primary care in the first two years of undergraduate study for General Practice,
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Action 3: Achieve seamless integration of shared patient information

The pre-reading provided the following summary of input received via Citizens Space:

Integrated 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 shared with external provider systems and allow communication with the patient.

- *Develop a set of priority initiatives and case studies on systems integration (both governing policies and technologies) for health services, commissioning agencies and service providers;*
- *ICT systems as enablers of integration;*
- *Access to patient test results for GPs and hospitals so tests are not repeated.*

Overall

- Round Table participants agreed that the My Health Record system and initiatives such as Kabisa Medical technology are step changes, will be implemented and must be supported;
- Furthermore, there is a need to bring information sharing in health in line with data collection and information sharing in other sectors such as commerce, notwithstanding the mature discussions needed around protecting the vulnerable in terms of health confidentiality;
- At the heart of this is really taking the challenge to design the health system around the patient so that the supporting systems work;
- There are exemplars such as the disability sector where agreements are in place for clinicians to look at all information around a person with disability.

Action 4: Access to hospital, MBS and PBS data to provide the opportunity for more sophisticated planning of health services

The pre-reading provided the following summary of input received via Citizens Space:

Access to the data held by the Administrator of the National Health Funding body for hospital, MBS and PBS data and linked by the Medicare Pin needs to be released to WA to plan and commission its future services.

Overall

- Round Table participants confirmed the need for access to data and particularly to outcomes data to know if the patient is getting the best care;
- Collection of data at the point of care needs improvement in hospital clinics, in rural services and in allied health services;

- A minimum data set will increase standardisation, and allow more effective comparison of services.

Action 5: Establish agreements between governing bodies in WA to facilitate integration of health care

The pre-reading provided the following summary of input received via Citizens Space:

This would involve the Commonwealth (via WA Primary Health Alliance) and State (via WA Health) agreeing to a staged approach to collaborate on the identification of mutual priorities for the delivery of sustainable health care across WA,

- *The agreement would articulate commitments and define roles and responsibilities regarding joint planning and funding of particular activities that achieve the best possible health outcomes for members of the community.*

Overall

- There is strong support for agreements between governing bodies to facilitate integration of health care;
- Formalised agreements can address the issues raised so far, such as data sharing, interoperable systems, care coordination, etc;
- WAPHA is not a representative body of the Commonwealth or the State but it can be an enabler and facilitator to come up with models that the State can discuss with the Commonwealth;
- At a systems level, we need tiers of agreements:
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- Hospitals have made fundamental change in the past 30 years, primary care integration can move down that path.