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Quality & Safety  
in Integrated Primary/  
Secondary Care

**NHMRC CENTRE OF RESEARCH EXCELLENCE**

# **Stepping into ‘Brave New World’ – what can we learn from each other?**

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# The Australian Health Care System (an international snapshot)

- High international benchmarks in longevity, chronic disease outcomes, survival rates, access, satisfaction, cost
- Effective public / private mix
- Dual state and Commonwealth funding arrangements, their gaps, inefficiency and duplication the key problem and a strong current reform driver
- Variable access to primary care, ambulatory care due to increasing gap payments
- Strong and escalating fiscal health pressures
- Vision / funding investment mismatch

# The International reform environment

*PCT, Care Commissioning (UK), PHO (NZ), PCMH (USA), LHIN (Canada),  
National Health and Hospital Reform Commission (Aust)*

- 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'

# Recent Australian Reform

## 1. National Health and Hospitals Reform Commission

## 2. Australia's First National Primary Care Strategy

- Regional integration
- Use of new technologies
- Skilled workforce
- Infrastructure (including GP Superclinic and infrastructure grants)
- Financing and system performance

## 3. Establishment of

- 62 'Medicare Locals' – geographical catchments for primary care service coordination and performance measurement
- Local Hospital and Health Services (LHNs) – some with mapped ML borders
- National Independent Pricing Authority / National Health Performance Authority
- Australian Commission on Safety and Quality in Health Care
- National Lead Clinician Group
- Personally-Controlled Electronic Health Record (PCEHR) launched 1 July

A major national health care reform agenda strongly focused on primary care

# Early GP Reform history

- 1990: General practice poorly remunerated, low morale, decreasing training numbers
- 1992: National Health Strategy 'The Future of General Practice' ( one of 6 reform papers)
  - Modest quality payments, rural incentives, training support
  - Creation of 'Divisions of General Practice' – geographically-defined GP organisations, funded by the Commonwealth government to impact on better general practice integration with state-funded services, primary care policy development, IT, chronic disease management and population health
  - 'evolved' into Medicare Locals with GP focus no longer a central theme

# PHC Strategy Framework

- Collaboration between Local Health and Hospital Networks and Medicare Locals, to examine innovative care coordination and/or case management arrangements for people with complex chronic conditions that focus on secondary and tertiary prevention, improve health outcomes and literacy and reduce avoidable hospitalisations;
- Development and promotion of innovative ‘pathways through care’ models which support more integrated and seamless care for consumers;
- Investigation of ways to work together with primary health care providers and professional organisations to promote the development of multidisciplinary teams in which all team members are supported to fully develop their clinical skills and potential;
- Promotion of models that facilitate long term relationships between consumers and general practices to address service gaps;

# PHC Strategy Framework

- promoting discussion on funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations.
- maximising the opportunities enabled by the transformations occurring through eHealth, including the PCEHR and Secure Messaging initiatives.
- supporting the Australian Commission on Safety and Quality in Health Care to develop safety and quality standards for primary health care,
- promoting the role of consumers as key members of the health care team and empowering them to make decisions about their own health and social needs.

# What's new and exciting!

## *UQ Research:*

1. Service Integration Framework (SIF)
2. **Beacon** practice model
3. Primary Care Practice Improvement Tool (PC PIT)

## *Policy:*

4. RACGP 'Quality General Practice of the Future'
5. The Australian 'Medical Home' (AMH) – Ministerial Advisory Committee currently developing principles and characteristics with peak bodies – an evolving space post-election

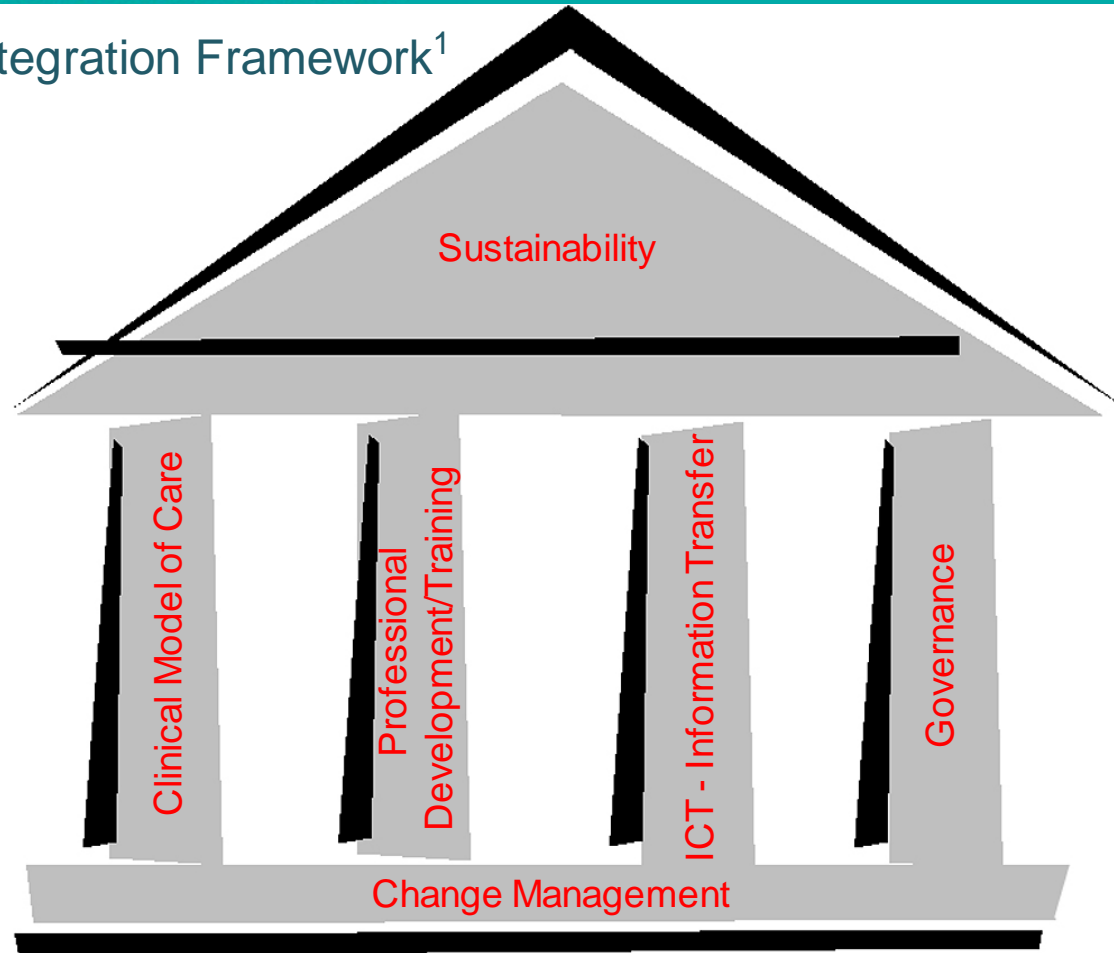


# 1. Service Integration Framework

Jackson C, Nicholson C Making integrated health care delivery happen – a framework for success' *Asia Pacific Journal of Health Management* Vol 3, Issue 2, 2008.

- Framework for creating sustainable care integration between diverse services – hospitals, GPs, NGOs, community health, residential care
- Based on literature on sustainable health service integration and 10 years of painful implementation research learning
- Utilised in all our integrated pathway, co-location, model of care and eHealth initiatives
- Critical to enabling the 'Brave New World' of linked up health players

Figure 1: Service Integration Framework<sup>1</sup>



<sup>1</sup>A (Effective change management) + B (integrated model of care + appropriate team professional development + integrated ICT to support the model of care + integrated governance arrangements) = C (A sustainable outcome).

## 2. UQ's Primary Care Amplification Model (PCAM)

- Creates a 'beacon' practice in an area which acts to support and extend the capacity of primary care in the area, and better integrate service delivery locally between general practice, specialist services and other state-funded care.
- Accomplished via the establishment of a general practice 'mustering point' for an expanded scope of practice for primary care in areas of population need, service innovation, teaching, ( undergraduate and postgraduate) and relevant local clinical research
- Pilot: *Inala Primary Care* (UQ's GP Superclinic experiment)

# The Primary Care Amplification Model (PCAM)

- Central to PCAM is the provision of the core elements of general practice and primary care – first contact, continuous, comprehensive and coordinated care provided to populations undifferentiated by gender, disease, or organ system.
- The Amplification Model features four additional key characteristics:
  - an ethos of supporting primary care both within and external to the practice
  - an expanded clinical model of care;
  - a governance approach that meets the specific needs of the community it serves;
  - and a technical and physical infrastructure to deliver the expanded scope of practice.
- It is these characteristics that enable a ‘beacon’ practice to realise its potential (Brisbane South Complex Diabetes Service)



	ICDMS (n=169)
Age (yr) mean	61.3 ± 12.8
Female (%)	50.3%
ATSIC	5.4%
Born in Australia	47%
Education ≥ Yr 12	36.7%
BMI (kg/m <sup>2</sup> ) mean	33.3 ± 7.8
Mean duration of DM	14 years
microalbuminuria	50%
Stage III kidney disease	25%
Nerve damage	32.5%
At risk foot	45.4%
Eye disease	20%
IHDx	29.6%
On insulin	49.7%

# The Brisbane South Complex Diabetes Service

- Subjects
  - Patients from surrounding 21 postcodes referred to Princess Alexandra Hospital Dept of Diabetes and Endocrinology and whose GPs consent to care via the new model
- Location
  - Managed at Inala Primary Care
- Intervention
  - DE Case manager commenced the care pathway with patients using defined screening, data collection and assessment and arranges appropriate Clinic Day review according to need – eg podiatry, doctor (all). Performs retinal photography
  - On Clinic morning, patients reviewed by the “Clinical Fellow”, an advanced-skilled GP trained via the UQ DGP’s online MMed (GP), who uses the pathway and co-consults with the specialist Endocrinologist and patient to develop an agreed management approach
  - The agreed management plan identifies clearly the actions for patient, their GP and the Service and follows the guideline as indicated
  - Variety of education opportunities for local GPs via IPC and for Qld GPs via collaboration with a number of Divisions of General Practice via CHIC

**Glycaemic control for newly referred patients with T2DM at baseline and 12 months at the Brisbane South Complex Diabetes Service (BSCDS)(n=99) and Princess Alexandra Hospital (PAH)(n=67).**

	Baseline		12 months	
	BSCDS	PAH	BSCDS	PAH
<b>HbA1c (mean ± SD)</b>	9.0±2.0	8.3±1.9	7.6±1.7	8.1±1.8
<b>% achieving HbA1c ≤ 7%</b>	14.1 (14)	28.4 (19)	45.5 (45)	32.8 (22)

Table 1.

Glycaemic control for newly referred patients with T2DM at baseline and 12 months at the Brisbane South Complex Diabetes Service (BSCDS)(n=99) and Princess Alexandra Hospital (PAH)(n=67).

## Chief Investigators

- Prof Claire Jackson
- Prof James Dunbar
- Prof Paul Batalden
- Prof Jeff Fuller
- A/Prof Julie Johnson
- Caroline Nicholson
- Dr Shelley Wilkinson

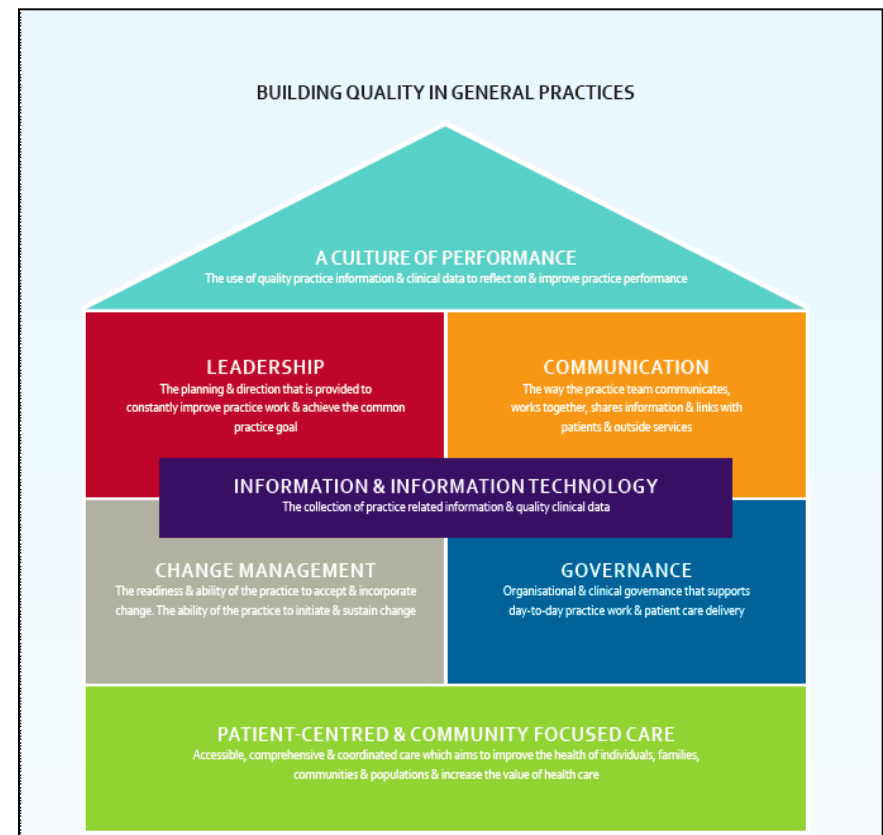




## 3. A quality improvement tool for primary care

A quality improvement tool for Primary  
Care Practices (PC-PIT):  
Seven elements

1. Patient centred & Community focused Care
2. Governance
3. Manage Change
4. Communication
5. Leadership
6. Information & Information technology
7. A Culture of Performance



# 4. *The Quality General Practice of the Future*

## Quality care for individuals, families and communities

- General practitioner led
- Accessible
- Quality clinical assessment
- Empowers patients to self care
- Provides home visit, extended hours, Hospital in the Home and Advanced Skill options for patients within the practice.

## The right services for every community

- Establishes the needs of the practice population
- Collaborates and/or coordinates delivery of services
- Monitors, evaluates and modifies models of care
- Consults with community
- Works closely with other health services



# *The Quality General Practice of the Future*

## **Education, training and research for tomorrow's workforce**

- Recruits and retains appropriately qualified and skilled team members
- Contributes to local health service workforce planning and infrastructure renewal

## **Infrastructure for integrated primary healthcare**

- Is planned and designed to meet local community needs
- Uses e-health maximally

## **Community connections and capacity building**

- Is connected to its local environment
- Establishes and maintains excellent relationship with local communities



# Barriers and Challenges for us both

1. Workforce
2. Payment reform
3. Innovative integrated models of care
4. Broader use of 'e'
5. Performance measurement

BUT

Primary care essential to high quality, affordable, accessible health care

*'How do I get to Dublin?'* the English motorist asked a local Irishman by the roadside.

*'Ah, I wouldn't start from here,'* he replied.

- Building capacity
- Measuring performance (QOF, accreditation)
- Integrated service delivery, shared accountability
- Sharing challenges, solutions, reform opportunities,
- Implementation research