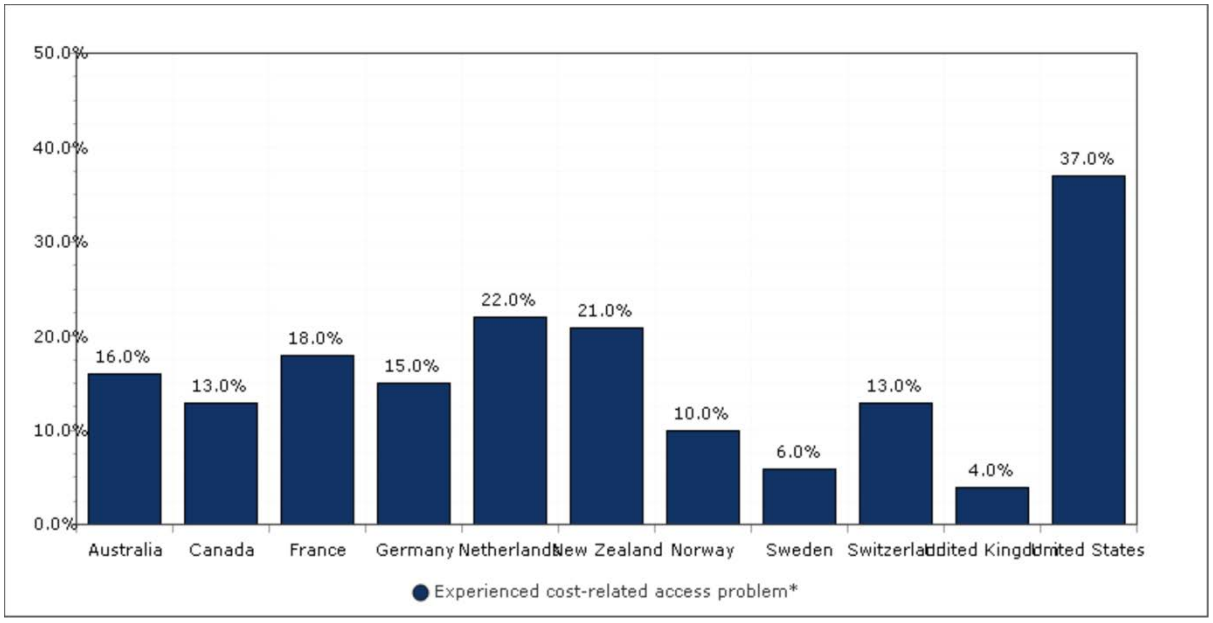
Primary Health Care Advisory Group survey questions

INTRODUCTION

1. **What aspects of the current primary health care system work well for people with chronic or complex health conditions?**

Although problems persist in underserved rural areas, universal access to general practice through Medicare and to drugs through the Pharmaceutical Benefit Scheme is a major strength of our current system which needs to be protected. Similarly there is moderate access to allied health and psychologists through Medicare and through programs run by primary healthcare organisations such as the ATAPs (Access to Allied Psychological services) program and to specialist, community health and hospital services through the state health services. This means that care is relatively affordable with 16% of consumers in Australia reporting that they did not fill a prescription, not visit a doctor with medical problem or not get recommended care due to cost – less than in the Netherlands, New Zealand and US but more than Norway, Sweden or the UK (Commonwealth Fund 2014).



(Source Commonwealth Fund Survey 2014)

2. **What is the most serious gap in the primary health care system currently provided to people with chronic or complex health conditions?**

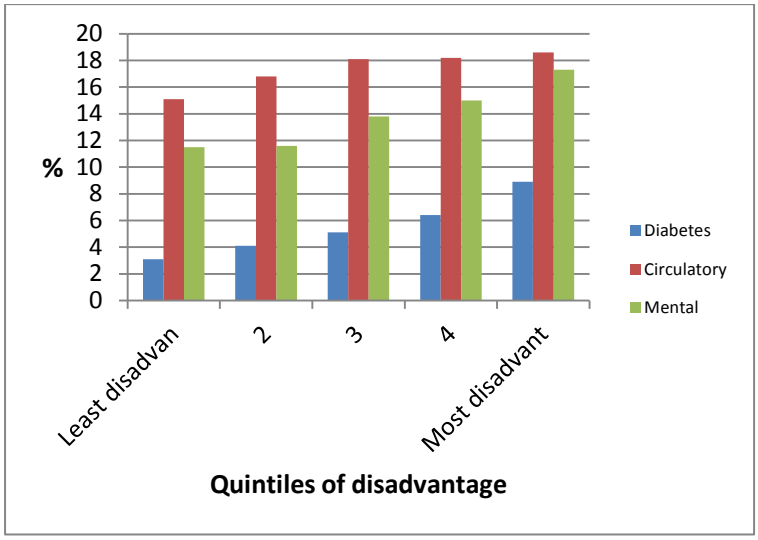
   a) **In your area?**

Canterbury LGA has a higher than average proportion of immigrants from non-English-speaking backgrounds and is the 17th most disadvantaged LGA in NSW on the ABS SEIFA Index of Relative Socio-Economic Disadvantage (Inner West Sydney Medicare Local and Sydney Local Health District 2013). They have high rates of chronic diseases such as diabetes and mental illness. However the supply and/or use of some primary health and secondary care services is not optimal. For example use of Better Access to Mental Health

and ATAPs psychologists is the lowest in the Local Health District. This is related to supply of psychologists and to lack of health literacy in the area.

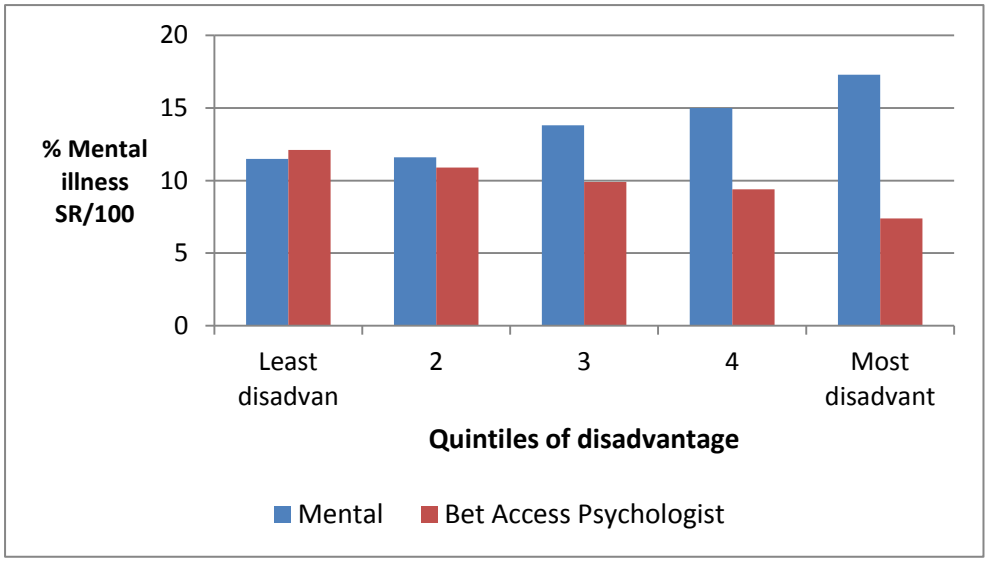
Nationally?

There are significant disparities in the prevalence of chronic conditions between different socioeconomic groups (Glover J 2004.).



Diabetes, Cardiovascular Disease and Mental Illness Prevalence by SES (Source PHIDU 2011-13)

However the distribution of PHC health professionals across high and low socioeconomic areas does not match the need – an example of the inverse care law (Wilkinson D 2000). Furthermore the use of allied health is not necessarily best matched to need. For example use of the Better Access to Mental Health items was inversely correlated with socioeconomic status.



Mental health prevalence and Better Access to Mental Health claims for psychologist by SES (Source PHIDU 2011-13)

3. **What can be done to improve the primary health care system for people with chronic or complex health conditions:**

   a) **In your area?**

This needs to be addressed by:-

- engaging the community to increase their capacity to contribute to building/strengthening access to and quality of the services

- giving priority for service development and support to PHC providers in the areas and for the population groups with the highest need including indigenous and refugee population groups

- supporting the development of strategies to improve health literacy of disadvantaged groups and tailoring service delivery to these groups especially in communication and service navigation.

   b) **Nationally?**

This gap needs to be addressed by the following:-

- Develop the primary health care (including allied health) workforce in disadvantaged areas and rural and remote communities
- Provide funding for services including allied health based on careful assessment of individual and population need rather than just demand and monitor the distribution of outcomes of this
- Support primary health care providers especially practice and community health nurses and GPs to better identify low health literacy and educate and tailor communication and care coordination to the needs of those with low health literacy

4. **What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice?**

The major barriers preventing primary health care nurses from working to their scope of practice include:-

- Other demands on their time which are specifically remunerated (eg health assessments or post-acute care) which prevent them taking on new roles in education, prevention and support for patients with low health literacy.
- Lack of training and support for new roles as part of their staff development.
- Narrowly defined funding mechanisms for their service and fee for service funding of GPs.
- Lack of career structure to support and reward expanded scope of practice
- Need for expanded research on what role enhancements deliver improved care

THEME 1, EFFECTIVE AND APPROPRIATE PATIENT CARE

As described in Theme 1 of the Discussion Paper, a 'health care home' is where patients enrol with a single provider which becomes their first point of care and coordinates other services.

5. **Do you support patient enrolment with a health care home for people with chronic or complex health conditions?** *YES*

   a) **Why do you say that?**

We support voluntary enrolment of people with chronic and complex health conditions to allow their needs to be properly assessed and an integrated package of care to be developed to address these needs. Enrolment would facilitate more active practice population management with delivery of organised and pro-active chronic disease care according to need. It would also facilitate and measurement of quality and outcomes of care provided. However to be truly voluntary, patients need to have adequate information and health literacy to be engaged in "patient centred" discussions about their health plans and services. It is also essential the "health care home" is available to patients with chronic disease and that providers are not able to "cherry pick" patients. The "health care home" also needs to be truly accountable for their patients' access to quality of care within the limits of resources available. This notion of accountability for quality care needs to be given pre-eminence over efficiency or market competition as has been demonstrated in the past in the USA and UK (Addicott R 2014).

6. **Do you support team based care for people with chronic or complex health conditions?** YES

   a) **Why do you say that?**

There is strong evidence that people with chronic conditions require a range of disciplines to be involved in helping to address their needs. This requires a team approach in which team members (including the patient) agree on a plan of care, understand and respect each others roles, and flexibly provide care and communicate effectively with the patient and each other (Harris MF, Christl et al. 2011, Chan, Jayasinghe et al. 2013). The chronic care model provides a framework for delivering this(Wagner EH 2000, Bodenheimer, Wagner et al. 2002).

7. **What are the key aspects of effective coordinated patient care?**
   Please number in order of importance (1-4)

   1. Patient participation
   2. Other: Joint funding package
   3. Care coordinators
   4. Patient pathways

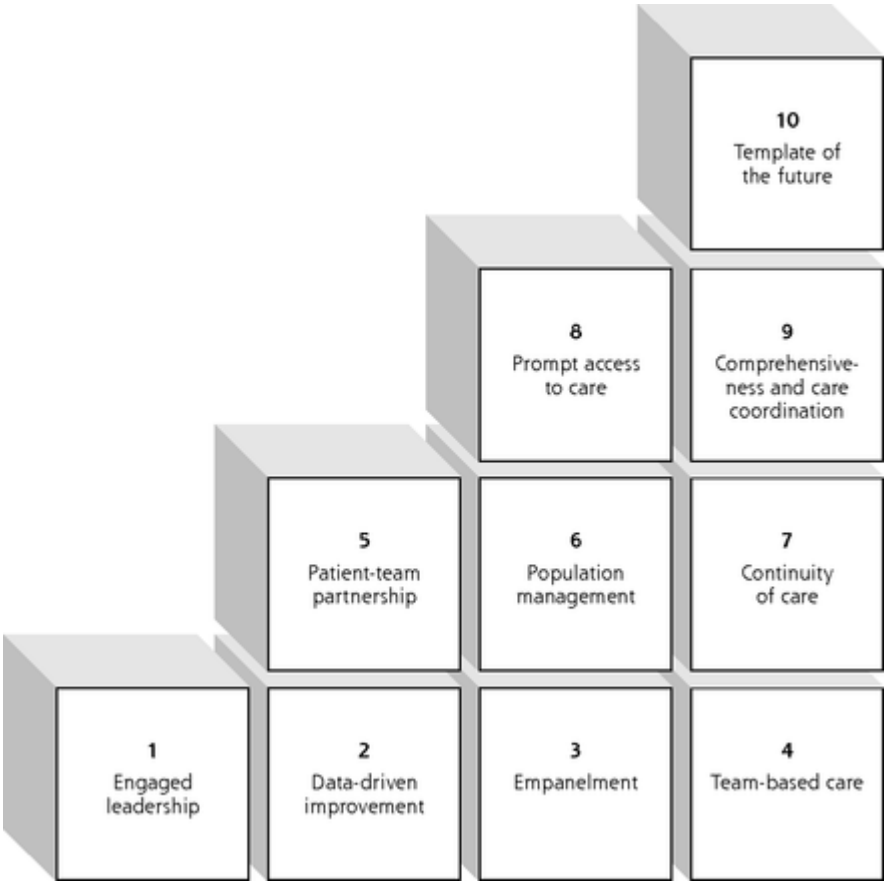
8. **How can patient pathways be used to improve patient outcomes?**

Patient pathways can make it clear to patients and all providers, the way to access to specialised, other primary health care and social services. This can act as a guide as well as specifying the requirements for this to occur.

At a system level this can provide a tool for agreeing on the appropriate steps involved in care, best practice, the roles of different providers, the resources required to facilitate it and an opportunity for "redesign" of the system to work more effectively and equitably. For the latter to occur there needs to be sufficient information to identify disparities in the use of services and the reasons behind these so that they can be addressed.

9. Are there other evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic or complex health conditions?

Other evidence based approaches include the other elements of the chronic care model: education and support for self-management; providing opportunities for teams collocate and meet to discuss patient care; using information technology to monitor quality and outcomes; engaging community organisations and programs to support care; funding to support quality of care not just service provision (Zwar, Harris et al. 2006, Nolte E 2008, Taggart, Williams et al. 2012). Bodenheimer (2014) has described 10 building blocks of high performing primary care (Bodenheimer 2014). Empanelment is analogous to enrolment – it defines the population for whose care the service is responsible.

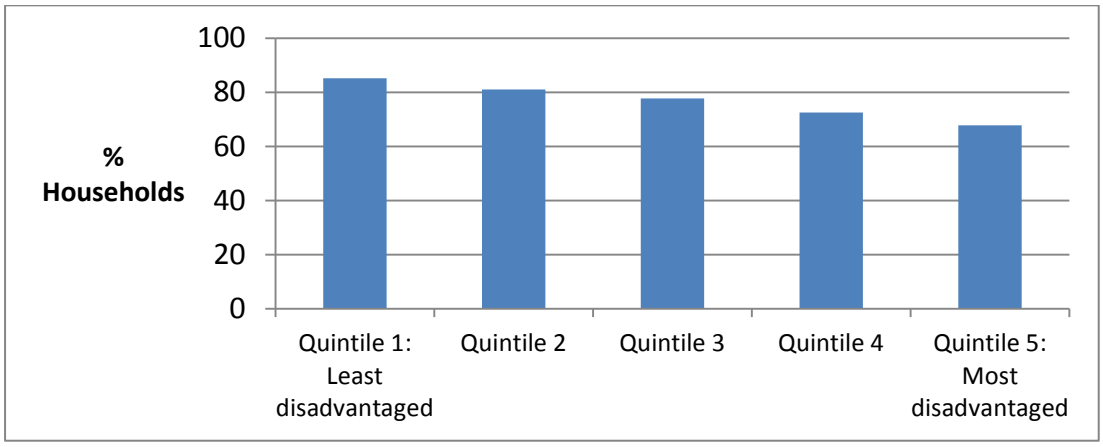


THEME 2, INCREASED USE OF TECHNOLOGY

10. How might the technology described in Theme 2 of the Discussion Paper improve the way patients engage in and manage their own health care?

Increasingly patients will be involved in contributing to their own health information system through a variety of means. This includes data home monitoring or wearable technology as well as directly into the patient held e-record and from patient reported health outcomes. This creates opportunities for a more complete and accurate health record for the management of risk factors of chronic disease such as overweight as well as chronic diseases themselves. It also creates opportunities for more support and interaction between providers and patients and between patients with similar health problems.

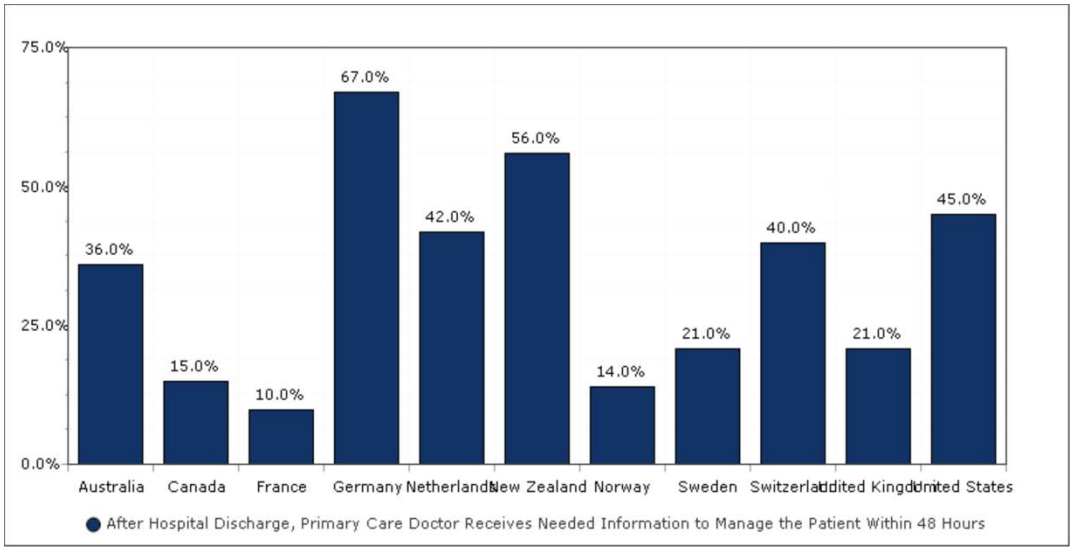
However there is a potential for low SES and low health literacy patients to be left behind and for this to flow through into the quality of their needs assessments and care plans and access to services. This is because of the proportion of households with internet access is related to socioeconomic status (PHIDU 2011-13).



Internet access by households by Socioeconomic status (Source PHIDU 2011-13)

11. What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team-based care for people with chronic or complex health conditions?

Health information systems need to be able to exchange similar information (interoperability) to allow patient care to be seamlessly conducted across multiple providers and services. At present timely communication occurs in only a third of patients discharged from hospital. This places us in lower half of countries surveyed by Commonwealth Fund (2012).



Discharge communication with primary care (source Commonwealth Fund Survey 2012)

12. How could technology better support connections between primary and hospital care?

Information systems need to be better linked together across pathways of care both from primary health care to secondary and tertiary care and back. In an additional to the patient held e-record, patient portals, which are being used in the US and NZ, provide a vehicle for patient education and engagement as well as linkage between primary and acute care (Leveille, Huang et al. 2009, Hibbard and Greene 2013). However it will require education and support for disadvantaged patients to develop health and information literacy to ensure equity of access(Weingart, Rind et al. 2006).

THEME 3, HOW DO WE KNOW WE ARE ACHIEVING OUTCOMES?

13. **Reflecting on Theme 3 of the Discussion Paper, is it important to measure and report patient health outcomes?** *YES*

a) Why do you say that?

Increasingly patients have multiple chronic conditions (Barnett K 2012). As a result single disease guidelines and quality of care measures are less useful. Patient reported outcome measures or PROMS provide a measure of the quality of care and health status that is tailored to the needs and treatment goals of patients with multiple conditions (Smith SM 2012, Harris, Dennis et al. 2013). They can also enable comparisons of providers' performances to stimulate improvements in services (Black 2013).

14. How could measurement and reporting of patient health outcomes be achieved?

These could be incorporated into the patient held e-health record and into electronic health pathways between primary, secondary and tertiary care. Current patient feedback methods used in general practice (as a requirement for accreditation) and in hospital provide only a very broad picture of patient experience. Replacing these or enhancing them with PROMS could provide information that could be directly used to improve the quality of health care for

the individual and population. However their use requires more evaluation especially by patients with low health literacy.

15. To what extent should health care providers be accountable for their patients' health outcomes?

It is critically important that health care providers are more accountable for the quality of care and health outcomes of their patients. However it should be recognised that many factors influence health outcomes and that it may be more difficult to achieve targets for health outcomes for patients from low socioeconomic backgrounds and with low health literacy. It is thus important that linking funding to quality of care and health outcomes take this into account (Scott and Harris 2012).

16. To what extent should patients be responsible for their own health outcomes?

Patients are already, in part, responsible for achieving health outcomes through self-management and adherence to treatment plans. However there is also considerable stigma associated with many chronic conditions and their risk factors (eg obesity and mental illness). Health workers may heighten this stigma. Thus it is critically important that this stigma is reduced not increased.

17. How could patient responsibility for their own health outcomes be achieved?

Patient health literacy enables patients to use health services more effectively, to communicate with providers and to self-manage (von Wagner C 2009). Any effort to increase patient responsibility must begin with a two pronged effort to both improve health literacy and to make health care more understandable and navigable for patients (Nielsen-Bohlman L 2004, DeWalt D 2010, Taggart, Williams et al. 2012).

THEME 4, HOW DO WE ESTABLISH SUITABLE PAYMENT MECHANISMS TO SUPPORT A BETTER PRIMARY HEALTH CARE SYSTEM?

18. Theme 4 of the Discussion Paper discusses different payment mechanisms. How should primary health care payment models support a connected care system? (Multiple choice)

Salaried professionals, Pay for performance, Capitated payments, Fee for service, OTHER (Other is where to apply relevant models for blended payments)

There needs to be a mixed system. Salaried professionals will continue to be important in Aboriginal Community Controlled Health Services and in state community health services. Fee for service is ill suited to the multidisciplinary care required for patients with chronic conditions. Fee for service rewards the frequency and duration of care but does not adequately reward anticipatory, long term co-ordinated care. International research suggests that patient registration and capitated payment may be a better way of funding chronic disease management and prevention because it allows more multidisciplinary approach to care and proactive care over time (Nolte E 2008). Although not cost effective, this was suggested by the results of the Diabetes Care Trial Evaluation which recommended flexible funding for registration with a health care home, payment for quality and funding for care facilitation (Health. 2015). Incentives may help providers to be more accountable for improved quality and health outcomes (McDonald, Harris et al. 2008). However incentives

should be implemented with care to ensure they do not have unintended negative consequences (Glasziou, Buchan et al. 2012).

19. **Should primary health care payments be linked to achievement of specific goals associated with the provision of care?** *Yes*

    a) **Why do you say that?**

As indicated above they may help ensure that providers are more accountable for their quality of care. However, as indicated above, this needs to ensure that providers working with low socioeconomic or vulnerable patients and the patients themselves are not disadvantaged. Pay-for-performance should only be used as part of a wider strategy for quality improvement. Schemes evolve over time and usually involve other interventions including accreditation, education, quality improvement programs, investment in information technology and data collection systems, professional support and regional structures. These are all necessary conditions for linking financial incentives to quality of care (Campbell SM 2010). Payments should be for achieving improvements rather than fixed targets as the latter are likely to increase inequities (eg improvement in screening rates rather than achievement of a fixed percentage of coverage).

20. **What role could Private Health Insurance have in managing or assisting in managing people with chronic or complex health conditions in primary health care?**

Private Health Insurance companies have an incentive to ensure their members avoid hospitalisation by preventive and proactive care. Recently Insurance companies have moved from insuring risk and providing reimbursement to directly assisting their members to manage t heir health and use particular services. Insurance companies may also be able to contribute to packages of care that help provide this and keep patients out of hospital and in the community. This may include programs to support people in the transition back to the community following hospitalisation and help reduce re-admission.

However it is important that this does not undermine the principle of fair access to care proportional to need. Patients with private insurance receive accelerated access to elective acute care and subsidies for some allied health care. They should not receive preferential access to primary care as was the case in some models explored in Queensland. This is because, in the Australian system, primary care is the gateway to other care and services including the public health system and such preferential access may lead to inequities. This is complex and may not be obvious. For example inequities are already occurring with patients previously having had private gastric banding procedures comprising the largest group requiring secondary bariatric surgery in the public hospital system.

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