Presentation by

KILDARE ROAD MEDICAL CENTRE

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KILDARE ROAD MEDICAL CENTRE (KRMC)

KRMC is a large primary care medical centre providing preventive, early intervention and comprehensive, integrated medical and allied health services in Blacktown, NSW.

PATIENT SERVICES

- 27 GPs / Registrars
- 3 onsite Specialists
- Practice Nurses
- Aboriginal Health Support Worker
- Allied Health: Dietitian, Exercise Physiologist, Physiotherapists, Podiatrist, Psychologist, Speech Pathologist
- Clinics:
  - COPD/Asthma Clinic
  - Diabetes Screening and Clinic
  - KRMC® Clean Slate Clinic (Outpatient Alcohol Detox program)
  - Skin Cancer Clinic
  - Women's Clinic
- Treatment and observation rooms with 6 beds capacity
- Radiology & Ultrasound
- Pathology collection
- Collocated Pharmacy

Key Focus Areas

- Enhancing multimorbidity, primary and integrated care in Western Sydney by focusing on risk stratification of patients; their care coordination; and preventable/avoidable hospital admissions and ED presentations.
- Delivery of culturally sensitive health services for Aboriginal people living in Western Sydney under the guidance of our Aboriginal Health Advisory Committee.
- Delivery of preventive screening, early intervention, health education programs and health promotion activities to members of the Blacktown community.

KRMC and Integrated Care Projects

- KRMC supports GP managed patient-centred, integrated care and advocates that this be appropriately funded.
- KRMC participated in two Western Sydney integrated care projects over 2012-2017:
  1. Connecting Care Program
  2. Integrated Care Program (ICP)
- Both of these programs had a principal focus on external patient management and monitoring by WSLHD and Western Sydney Primary Health Network (WentWest) personnel.
- Following these projects we were presented with the option of pursuing participation in the Health Care Home (HCH) trial.

Health Care Homes (HCH)

Following consultation with all our GPs, KRMC decided to not participate in the HCH trials.

The principal reasons were the following:

- A lack of clarity on what GPs would be contracted to do and how this would differ from long standing and proven GP Management Plans (GPMPs), Health Assessments (HAs) and Mental Health Treatment Plans (MHTPs) that could be easily enhanced through appropriate payment for care coordination/navigation by GP led primary care teams.
- Concerns the 3 tiers of capitation payments would constrain clinically responsive service provision for very complex patients with multimorbidities (including their mental health status) and, potentially, disincentives for the provision of services to chronically ill patients who are high users of services.

- Concern the HCH model could reduce the central role of GPs in delivering optimal primary care, with internal administrative processes deciding who would provide care and what type.

- Our participation in the Blacktown Hospital DaPPHne project which has been examining potentially preventable hospital admissions. This project is aiming to determine what proportion of hospital admissions for patients with a primary diagnosis of COPD, Angina, Type 2 Diabetes and CHF are *actually* preventable through primary health interventions to better understand the complex needs of these patients and the gaps in current services.

- Our preference, at this point in time, for systematically monitoring ALL of our patients using the appropriate demographic and clinical data inputs (including multimorbidity status and their previous use of services at KRMC and elsewhere) and not be focused just on a small number of patients in an extended period trial.

- Our belief that, in addition to the impact of a patient's multimorbidity status, socio-economic factors drive a higher prevalence and incidence of chronic conditions in communities and hence higher demand for GP and social care support services and programs. We were not satisfied that these factors are reflected or included in the Health Care Home trials.

The most recent national Social Health Atlas compiled by researchers at the Public Health Information Development Unit at Torrens University Australia (July 2017) reported that in Mount Druitt-north west residents died on average 19 years earlier than those living in Cherrybrook and West Pennant Hills (68 versus 87 years old), based on 2010-2014 median age at death data.

The avoidable mortality for the study was defined as mostly deaths that were potentially preventable in the Australian health system.

We do, though, have an open mind on the HCH trials and if the outcomes are superior to what can be achieved through enhanced MBS payments- we will be early adopters.

What KRMC is doing

- Instead of pursuing participation in the HCH trials, we decided to continue with the development of our own integrated care program using the hospitalisation risk advice capabilities of the Johns Hopkins ACG® System.
- The ACG® System was developed by the Johns Hopkins Bloomberg School of Public Health and has been used globally in performing risk measurement and case-mix categorization for more than 25 years.
- The NSW Government's Agency for Clinical Innovation (ACI) in its published report in 2015 on integrated care and risk stratification: http://www.aci.health.nsw.gov.au/resources/integrated-care/aci/integrated-care noted the ACG® System's validation in the UK and USA and identified it as the superior system in use globally (page 17).

The ACG® System stratifies primary care patients at risk of hospitalisation, based on their age and gender, multimorbidity status and their previous 12 months of consultations with KRMC's GPs (along with our Allied Health Professionals and Practice Nurses).

It stratifies patients into three key morbidity and hospitalisation risk groupings called Resource Utilisation Bands (RUBs): RUB 5 (Very High Risk); RUB 4 (High Risk) and RUB 3 (Moderate Risk).

ACG® System audits of all KRMC active patient records are now conducted monthly.

The ACG® System does not formally recommend to GPs the clinical services they should provide.

This is left to GPs clinical judgements and active engagement with their patients.

It does, though, cluster morbidities that patients have based on international evidence of the effects of multiple chronic conditions and this enables KRMC GPs to have information at hand on their patients who may be at risk of future hospitalisations.

The ACG® System also scales the risk of hospitalisations within each RUB through its algorithms using individual patient's gender and age data, but at this stage of our work we have simply taken all patients in the 3 key RUB categories and our GPs closely monitor their health status.

To maximise integrated care opportunities with the Western Sydney Local Health District (WSLHD), the following is carried out by KRMC GPs for all ACG® System identified patients:

- ICPC 2 Plus coding of all consultations.
- GPMPs agreed and signed off by patients (maximising their engagement with the plan and encouraging care self-management); in place for 12 months or 24 months; with cycles of reviews dependent on acuity and care management needs.
- MHTPs and HAs where appropriate and patients are eligible.

- Team Care Arrangements (TCAs) for Allied Health Care, where clinically appropriate.

- Team Care with public and private specialist consultants, when GPs identify the need for specialist advice and patient care.

- Home Medicines Reviews (HMRs) for all patients on 5 or more medications, or where otherwise clinically justified.

- Agreement with each patient on requesting our After Hours GPs Deputising Service through our centre's telephone number, only when they need urgent care and they believe a GP could deliver this instead of going to a WSLHD ED.

- Best endeavours to have patients enrol in the current Opt-in My Health Record; uploading Shared Health Summaries when GPMPs are put in place; and updating patients records when GPMPs are reviewed, or a substantive clinical event has occurred.

- Active GP monitoring of all hospitalisations and ED presentations, with reviews of unplanned events through Case Conferences with an ED Specialist Consultant, and making changes to GPMPs to reduce the risk of future presentations.

- Use of the WSLHD Rapid Access Stabilisation and Support (RASS) program and the GP Support Service for urgent specialist advice for the chronic conditions they cover.

OUTCOMES

We believe (with a high level of confidence) we are enabling our GPs to deliver patient-centred care through a ‘bottom up’ process that:

- Meets all the accepted criteria for the delivery of patient-centred primary care;
- Will provide their patients with responsiveness and flexible care and support; and
- Will lead to the more optimal use of funds allocated for both primary and secondary care for our patients.

OUTCOMES

In addition we have achieved:

- Active engagement of our GPs in large scale data analysis and the coding of clinical services.
- A further demonstration that best practice GPMPs can secure the benefits of what is described in other models as ‘patient enrolment’, with a specific GP being principally responsible for a patient’s care and their agreement with this arrangement.
- Acceptance of adverse events reviews with the involvement of other clinicians.
- Increased utilization by our GPs of the My Health Record, that will be further enhanced through universal Opt-out arrangements.
- Individual GPs’ commitment to enhance their clinical skills in multimorbidity care through their current RACGP QI & CPD triennium PLANs.

PRINCIPAL ISSUES STILL NEEDING TO BE ADDRESSED

- Adequate funding of external care coordination/navigation for Practice Nurses and/or designated administrative staff for complex care patients requiring this type of support.
- Funding for Practice Nurse home visiting for wound and other appropriate care.
- Social determinants based funding of care and support for patients, including resolving their lack of secure and affordable housing.