Hutt 2020 – A Vision for Change

A plan for developing high performing and sustainable primary care in the Hutt Valley

SUMMARY PAPER
Prepared for Hutt INC

Cosine Primary Care Network

HUTT VALLEY DHB

Te Awakairangi Health NETWORK

BUILDING A SOLUTION

Primary care sustainability is a whole system issue

1. Sustainable primary care requires high performing general practice, with effective clinical and business models.
2. Solutions must directly address the real-world barriers and issues identified by general practice in the Hutt Valley.
3. Sustainability in the longer term means that primary care must attract and retain quality staff and be attractive for clinical investors (attracting the next generation of Hutt GPs and nursing workforce).
4. High performing primary care cannot exist on its own and needs to be part of a wider sustainable community health system and whole health system in the Hutt Valley. A sustainable system would enable DHB investment in primary care, with an expectation that in return primary care would help reduce hospital acute demand.
5. Hutt INC has identified that all health initiatives must support Triple Aim outcomes, so sustainable solutions must contribute to the triple goals of improving patient experience, health outcomes, and system efficiency.
6. Sustainability in the longer term means that primary care must meet the specific health needs of the Hutt Valley community and do so in a manner that aligns with international trends in models of care, especially in the areas of chronic disease and frail elderly that strongly influence overall health system cost.

Note: this project began with a narrower definition of primary care sustainability but as the process developed so did the scope in order to achieve a solution that we believe will be viable in our highly connected health system.

Local issues for sustainable primary care

Demographics and morbidity – the Hutt Valley population is growing slowly and ageing. The exceptions are the Maori population and the Pacific population that are much more youthful. The ageing population is driving an increase in the frail elderly and long term conditions, leading to a workload of increased clinical complexity often involving social complexity.

Pressure – many GPs have identified that their clinical and business models lead to long hours, high stress and leave little time or energy to work on developing their businesses or clinical systems.

Variation - analysis of general practice has shown high levels of variation across practices in terms of size, business and ownership models, patient ratios, GP/ practice nurse ratios, and impact across issues such as ED attendances of patients. Some general practices have complained of the difficulty attracting quality staff.

Renewal – Hutt's workforce is ageing and we need to attract a new generation of GPs and nurses to general practice. Many of the current small owner-operator business models may not be attractive to new clinical investors and those seeking a career with work/life balance.

Direction – general practice is to be supported by emerging infrastructure such as POAC, Pathways, and shared patient notes but there is a lack of clarity about how new infrastructure fits together and concern over uptake. As one GP said: "Where are we going with all this".

Strengths to build from

Primary care leadership and linkages – general practice in the Hutt Valley is well connected with high interest in participating in a process of change and reform.

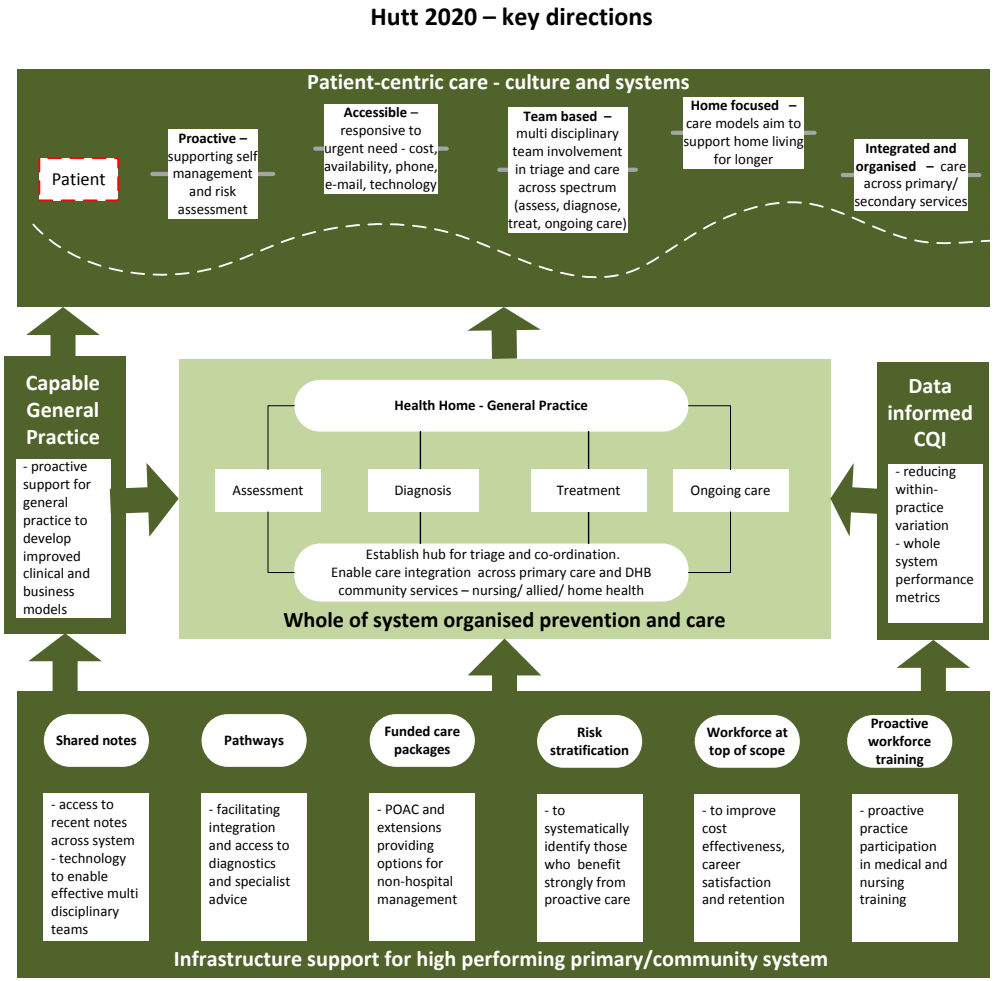
PHO and DHB leadership - Hutt now has PHO infrastructure in TeAHN with critical mass and mandate to lead change across the primary care sector. Hutt INC is a functional ALT, with good links to PHOs, DHB and SIDU. Hutt INC has a track record with joint programmes and has the strength to lead larger scale change programmes.

Flexible funding pool –Hutt Valley DHB has identified a flexible funding pool, where certain resources have been opened up to allow new ideas about how those resources can best be deployed within the health system. The pool provides an avenue for resourcing new service models.

Community service reform - Hutt Valley DHB has begun a process of reform of community health services, which opens up the opportunity for greater integration and co-ordination of primary and community services.

Fast adoption of innovations elsewhere – primary care across NZ is highly innovative, with many successful initiatives to learn from. Whilst Hutt has not been a first mover in major primary/community reform, there is opportunity to learn from others and to catch up quickly with a "fast adopter" strategy.

HUTT 2020 – KEY DIRECTIONS FOR A SUSTAINABLE SYSTEM



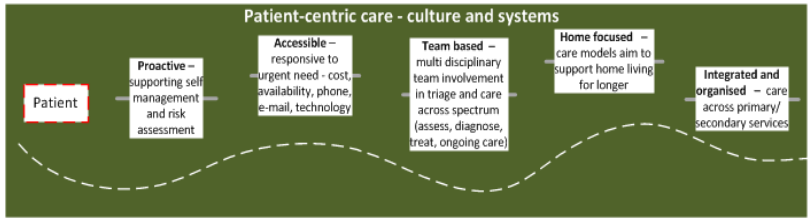
The model on this page is based on solutions developed through a co-design process with local clinicians and managers from across organisations and professional groups.

The model suggests five key (and integrated) areas of focus to build a high performing primary/community health system.

1. A common vision for a patient centric system that guides all parts of the system
2. Proactive support for developing high performing general practice clinical and business models
3. Integration of DHB community services and primary care, including developing a co-ordination hub for community services.
4. Co-ordinated development of infrastructure to support the "one system" vision – some of this infrastructure is already under development, but some requires effort in new areas.
5. Establishing a performance and evaluation framework for Hutt 2020, including a focus on reducing variation across practices and agreed 'whole system" measures.

Model components

PATIENT CENTRIC CARE – CULTURE AND SYSTEM



The aim is to provide a clear direction of travel for services, systems, skills and culture within primary care and DHB community services. The elements in the patient-centric system were identified by local clinicians and also align closely with integrated care systems. The aim is to answer the question – "where are we going". The answer is… in the Hutt Valley, we are collectively building a community health system that is:

- proactive in identifying risk and disease early and supporting self-care
- accessible for patients with urgent needs 24/7 and innovative in using technology to increase patients' access to advice and care
- team based, both within the practice and between primary and community care, ensuring patients have the right set of skills to support their needs
- home focused with the aim of supporting the patient to recover and live well in their own home
- integrated and organised to improve patient experience, clinical safety and reduce duplication

CAPABLE GENERAL PRACTICE

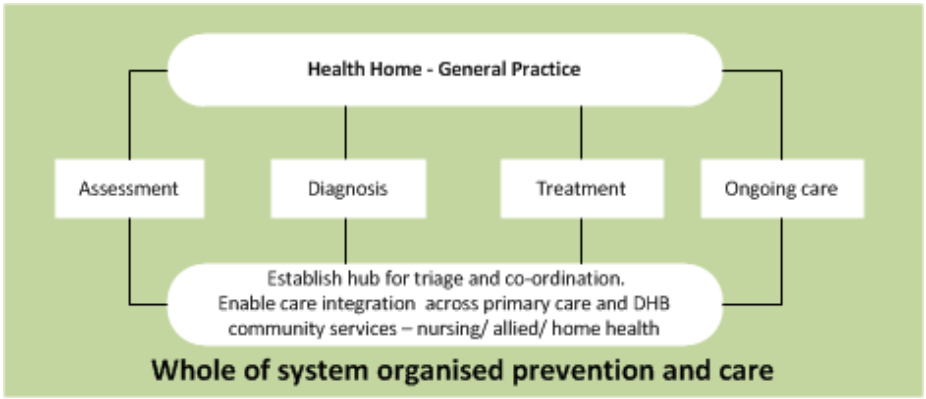
Three practical actions have been prioritised to respond to the issues raised by general practice about workload, stress and to enable a proactive focus on improving clinical and business models

1. Assisted practice self-review - (Chch model) to improve efficiency and clinical systems, supported by mentoring for strategic development of business and clinical models
2. Practice support – shared back office functions to reduce "paperwork" time overhead and allow focus on clinical work and development.
3. Establishing effective GP clusters, which would include cover, co-ordination, horizontal referrals (GPwSI and NwSI), allied health professionals, and build a locus for community integration

These immediate actions should be seen within the context of longer term directions for primary care:

- Practice consolidation (larger practices)
- Group practice models
- Effective clusters of practices

DHB COMMUNITY SERVICE AND PRIMARY CARE INTEGRATION



General Practice and DHB community services (community nursing, home health, allied health, specialist outreach services etc) are the two largest workforces in the community yet they are not strategically aligned and work together only in patches. Strategically aligning these services could be transformational for the Hutt Valley health system. There are good examples of successful primary/community integration around NZ.

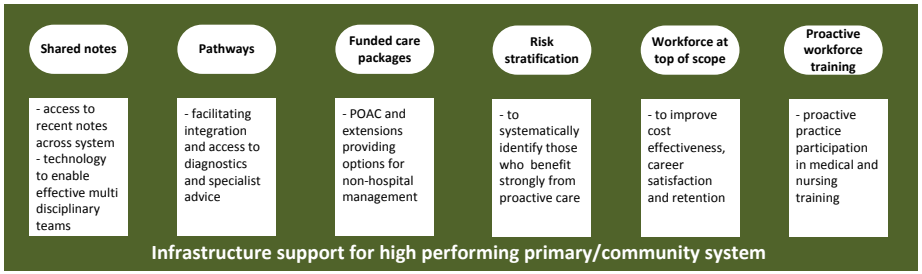
Achieving this strategic alignment will take time but as a first principle, both general practice and secondary services should be able to refer to community support systems.

Part of the integration is to establish a single triage and co-ordination hub for community services in the Hutt that over time may include Needs Assessment and Service Coordination (NASC), POAC and Community Services.

There is significant opportunity for the integrated system to improve management of patients with complex conditions in the community and to facilitate early discharge to reduce pressure on hospital bed days.

Patient experience would be enhanced through a better connected system with less duplication.

EFFECTIVE SUPPORTING INFRASTRUCTURE



SIDU and Hutt INC have made substantial progress in establishing new infrastructure including POAC, HealthPathways, Shared Care Records (Manage My Health). To enable the Hutt 2020 vision, it is proposed other areas of infrastructure require further development:

- Technology for integrated patient notes that will support shared care plans and multi-disciplinary teams
- Ensuring HealthPathways implementation facilitates primary care access to diagnostics and timely specialist advice
- Providing tools and advice to support risk stratification of practice populations

There has been strong feedback from clinical stakeholders involved in Hutt 2020 for increased investment to support primary care practitioners to work at top of scope – including support from hospital medical and nursing specialists to upskill their primary care counterparts (GPwSI, NwSI). There has also been considerable support for Hutt primary care to be more proactive in supporting PGY1, PGY2 and registrar training in primary care and supporting nursing and allied health training. One objective is to encourage a new generation of clinicians to build careers in primary care in the Hutt Valley.

DATA-INFORMED CONTINUOUS QUALITY IMPROVEMENT

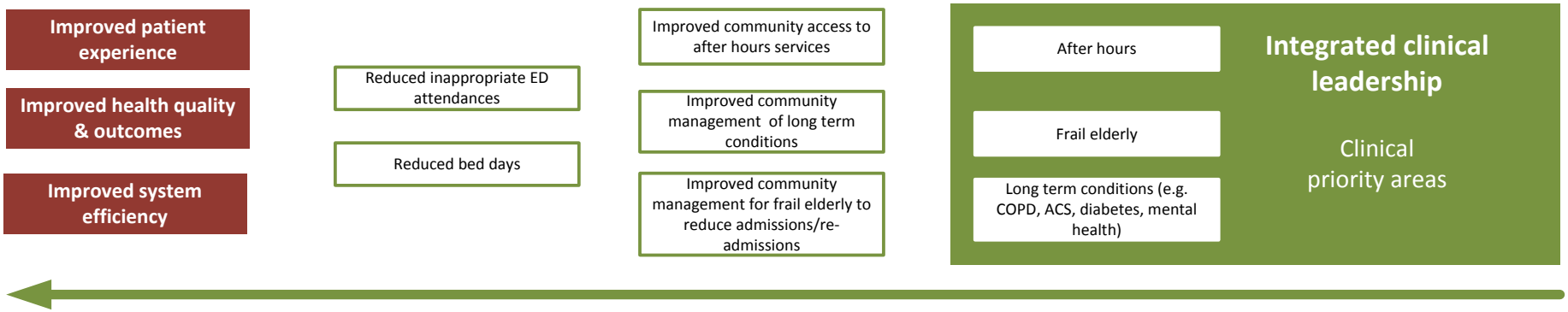
Data informed CQI

- reducing within-practice variation
- whole system performance metrics

An effective way of increasing the performance of any system is to explore and address reasons for variation. General practices involved with Hutt 2020 have supported the idea of sharing data and exploring variation, within trusted environments such as peer review and cluster groups. Variation can occur across inputs, business and clinical models and outputs. The role of the PHO should extend to providing data on variation and supporting processes to reduce variation.

Hutt 2020 should also develop a performance and evaluation framework that supports the actions outlined in this plan, tracking progress and enabling learning across organisations and professional groups. The framework should be owned by Hutt INC and become the foundation for the local elements of the Integrated Performance and Incentive Framework (IPIF). Performance within the IPIF framework will directly impact on revenue for primary care.

CLINICAL FOCUS AREAS



One of the dynamics within Hutt 2020, and an emerging trend across NZ, is for the DHB to invest in infrastructure and systems to support primary care performance. In return there is an expectation that primary care will have an increasing role in reducing the growth in acute demand. When this system operates effectively, it is a virtuous cycle that is a win - win for all parties.

To facilitate this impact on hospital bed day use, Hutt 2020 proposes that running alongside the development of the future services model (outlined previously) there is a focus on achieving specific measurable improvements in the community management in the areas of:

- After hours
- Frail elderly
- Long term conditions

Further detailed work is required across each of these areas, with the aim of developing a business case for investment in community-based services, with expected returns of bed day savings.

As part of the Hutt 2020 process, an initial analysis has been undertaken for COPD in which investment in GP-run (and specialist supported) community clinics has been modelled to deliver savings of up to 129 bed days per months in the medium term (see appendix).

IMPLEMENTATION

Hutt INC Operational Alliance

Joined-up implementation of Hutt 2020

1. Within-practice support and development initiative
2. Infrastructure support - practice uptake of initiatives (Pathways, POAC, technology etc) and primary care top-of-scope and training initiatives
3. Patient Centred Community Care design and development of new integrated service models
4. Integrated performance and improvement systems
5. Clinical priorities for acute demand management

Mix of staff seconded staff from PHOs, HVDHB, SIDU.

The concept of alliancing was developed in the construction industry, when different types of organisations (engineer, architecture, construction, safety, financial etc) would create a virtual organisation to work together as one team to deliver a project neither could achieve on their own.

A similar concept is proposed to implement Hutt 2020. We recommend the formation of an "Operational Alliance" to work as the implementation arm of Hutt INC and under Hutt INC governance. If we are to achieve a more integrated service system in the future, then we must integrate the skills and leadership that is tasked with leading change.

The Operational Alliance should be jointly resourced by PHOs, Hutt Valley DHB and SIDU as all have a stake in the outcome. The team should be located partly in a primary care setting as it is important that the focus is local and community based. Staff should be seconded from PHOs, Hutt Valley DHB and SIDU for the team, with new specialist skills recruited as necessary. There should be strong project leadership under a dedicated manager.

Five action areas are proposed that match the key areas described in this paper (see graphic this page).

To maintain momentum, there should be timely discussions to agree the resourcing of the Operation Alliance, with the aim of having a properly resourced team established by January 2015.

WHAT'S IN IT FOR ME?

Patients	General Practice	DHB	SIDU
• Better access to my GP for urgent needs • More services provided for me in the community and at my home • Faster response to access some diagnostics • Early identification of risk and disease and more proactive help for me to care for myself • My GP is able to access a team with a mix of skills to help me when I need it • I can get help in new ways – over phone and e-mail – I don't always need to go to the clinic • My care is well co-ordinated. I don't need to keep telling my story to new people. • I feel less anxious when my condition gets a bit worse. I know the community team can help. I don't need to go to hospital today.	• Support to improve practice clinical systems and back office functions- reduce stress and pressure • Support to develop longer term business plan for practice – may lead to better income and resale value of practice • Better management of pressure from urgent patient needs – spend quality time with complex/chronic patients • Opportunity to specialise as GPwSi/NwSI, increase professional scope • Able to share and learn with other practices to improve practice performance • Improved access to training • More options for management of complex patients in the community – feeling part of a team • Improved support to best utilise new tools and technology, such as HealthPathways, POAC, diagnostics etc • Improved ability to employ quality workforce	• Confidence that general practice has the skills and infrastructure to manage patients with complex needs in the community • Confidence that community systems are able to help reduce acute demand – especially in management of long term conditions and frail elderly • Able to see increasing value and outputs from the investment in DHB community-based services • Confidence that general practice is making efficient use of investment in new sector infrastructure (technology, POAC, HealthPathways) • Increased security that general practice is training and attracting a new generation of workforce to the Hutt Valley • DHB has capability to be more responsive to changing community health needs through more integrated system	• Increased focus on joined up service development and integration within the Hutt – creating local capacity better able to respond to subregional initiatives • Local leadership actively supporting uptake of sub-regional infrastructure requiring general practice response • Operational Alliance provides environment for SIDU to work more closely with local organisations – more effective implementation model • Focus on use of data and strong evaluation provides SIDU with valuable information on response to, and value of, sub-regional initiatives.

RECOMMENDATIONS

1. Endorse the Hutt 2020 plan as providing key directions for Hutt INC to achieve a sustainable and high performing primary care and community health system in the Hutt Valley.
2. Support implementation in the Hutt 2020 action areas, which include:
   - Agree to align community-based primary and DHB services in the Hutt towards a common vision of a patient-centric system that is focused on being: proactive, accessible, team based, home focused, integrated and organised
   - Agree to a programme to pro-actively support General Practice to develop more sustainable business and clinical models. Actions to include:
     - Assisted practice self-review to improve efficiency, with mentoring for development of improved clinical and business models
     - Access to outsourced/shared back office functions to increase GP time for clinical and business development
     - Establishing effective GP clusters to enable improved local co-ordination and cover, horizontal referrals for GPwSI and NwSI, inclusion of allied health professional in the team, and data sharing for quality improvement
   - Agree to systematic integration of DHB community services (including nursing and allied health) and primary care. This includes developing a single co-ordination hub for community services that is accessible to both primary and secondary referring clinicians
   - Agree to co-ordinated development of infrastructure to support the "one system" vision. Additions to the current suite of infrastructure should include:
     - Technology for integrated patient notes that will support shared care plans and multi-disciplinary teams
     - Ensuring HealthPathways implementation facilitates primary care access to diagnostics and timely specialist advice
     - Providing tools and advice to support risk stratification of practice populations
     - Providing training to support health professionals in community and primary care to operate at top of scope
     - Developing the skills and environment within primary and community services to deliver training for a new generation of medical and nursing and allied health workforce

     Supporting effective general practice uptake of new infrastructure such as HealthPathways, POAC and shared notes.
   - Establish a performance and evaluation framework for Hutt 2020, including data-informed continuous quality improvement (CQI) systems to reduce variation across practices and inform primary/community integration
3. Agree clinical priority areas for an enhanced community response to reduce hospital acute demand. The priority areas include:

- After-hours,
- Frail elderly and
- Long term conditions.

Business cases should be developed to inform investment in the community-based response for each of these three areas.

4. Establish and resource an "Operational Alliance" to lead implementation of the Hutt 2020 plan. The Operational Alliance should be seen as the implementation arm of Hutt INC. The operational alliance should be fully operational prior to January 2015, with agreed resourcing commitments from TeAHN, Cosine, Hutt Valley DHB and SIDU.
    - The alliance would include staff from PHOs, Hutt Valley DHB and SIDU working together as a team.
    - Hutt INC should provide Governance for the Operational Alliance.

5. Agree that management from Hutt Valley DHB, SIDU, Te Awakairangi Health Network and Cosine identify the resources (staffing, IS platform and funding) to implement Hutt 2020 from Q2 2014/15.

APPENDIX: HOSPITAL UTILISATION AND CHANGING MODELS OF CARE: THE EXAMPLE OF COPD

BACKGROUND ON THE MODEL

COPD provides an example of the potential for managing hospital utilisation through improved models of care. It builds on the ideas presented in this report and models the effect on bed day utilisation, of developing improved care for people with COPD.

The data for the model comes from hospital inpatient data, COPD research and discussions with respiratory physician Dr Justin Travers who checked the assumptions being used in the model.

Using prevalence estimates, the number of people aged 40+ with COPD in the Hutt Valley is around 4,000. This is based on an estimate of 6% of the adult population 40+ having COPD. Using the GOLD categories, and research on estimating the prevalence of COPD in given populations, the estimated number of people 40+ in the Hutt Valley, with COPD is:

Mild	1,000 (25%)
Moderate	2,000 (50%)
Severe	800 (20%)
Very severe	200 (5%)

What is known about best practice care is the need for a range of interventions along the disease continuum. The graphic on the following page shows the link between the disease progression and 'best-practice' interventions. The model explores the consequences of implementing this model of care for the population of the Hutt Valley.

In the model, the key interventions are the establishment of COPD clinics in the community alongside group programmes such as Pulmonary Rehabilitation. The clinics are 'specialist' clinics run by GPs with an interest, and additional training in COPD. Additional clinics would also be run by Allied Health, and other community based specialists, with skills relevant to the management of COPD. Programmes would include Pulmonary Rehabilitation and programmes such as 'self-management', targeting better control of the condition. The secondary specialist team would provide support and training to establish this new model of care.

CURRENT SITUATION

Assuming a growth in the 40+ population of around 1% per year, and no other changes, the model projects the number of annual hospital discharges for COPD to rise from around 165 to 175. Assuming a continuing decrease in average length of stay (ALOS), the number of bed days per month would drop from 706 to 670 (the model assumes that ALOS for COPD would drop from the current average of 4.2 to 3.8)[1]

A FUTURE SCENARIO

In this scenario the new model of care has been implemented. It involves the establishment of a specialist clinic, run by GPs, with support and training from secondary specialists in year one. This clinic is held once a week and is able to see 8 patients. A second clinic is established at the beginning of year two. In addition, a community-based Pulmonary Rehabilitation clinic is also established in year one. This clinic runs for 8 weeks, has an average attendance of 12 people and is run every 12 weeks. A second programme is established in year two.

[1] NB: All these assumptions are easily changed in the model so that it can be used to create projections on the basis of a wide number of assumptions.

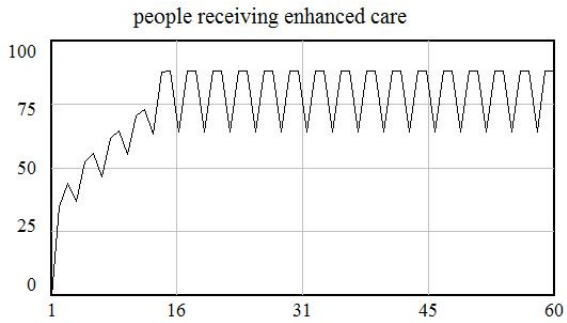
Furthermore, as patients will attend the clinics more than once, the model assumes that throughput in this new model of care involves around 30% of new patients. In terms of impact, the model assumes that each patient that goes through this programme will reduce their use of hospital services by 25%. Both of these assumptions have been checked with clinicians and, in terms of impact on hospital utilisation, sit well within the estimates that have been reported in a number of research studies. However, it takes time to make these changes, so the model assumes an 18 month lead in time, during which the impact of the changes takes time to take effect, with the full benefit only arising after 18 months.

This is a very plausible scenario that uses Hut Valley data and clinical and operational assumptions, that ensure we do not over-estimate the gains that are possible, and 'under-estimate' the time it will take to realise these gains.

RESULTS

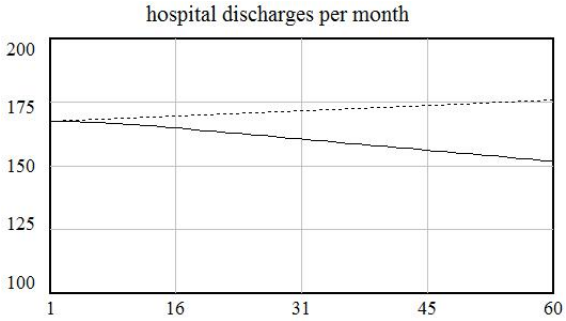
The following graphs show the result of successfully implementing this new model of care within the Hutt Valley.

A: People Receiving the Enhanced Care



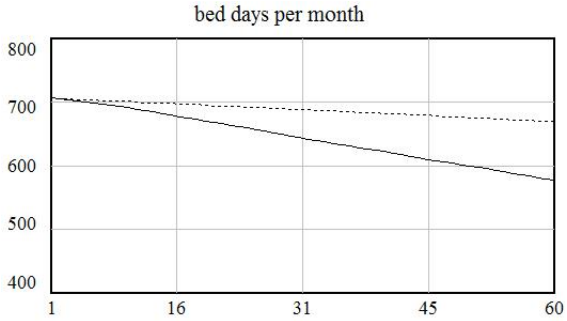
The first graph shows the number of people receiving the enhanced care rise over the first 18 months to 64 and 88 people, depending on whether or not one of the eight-week programmes is being run. Over the five-year period of the simulation this means that around 2% of the adult COPD population, or 8% of the severe and very severe COPD population would receive this new care.

B: Impact upon Discharges



The impact upon hospital discharge is a reduction from the current 167 per month, to 152 per month within five years.

C: Impact upon Bed Days



This translates into a reduction in bed days from the current 706 to 577 per month (NOTE: this also incorporates the reduction created by reducing ALOS). This is a saving of 129 bed days per month.