Annual Strategic Commissioning Planning Workshop

14 September 2018

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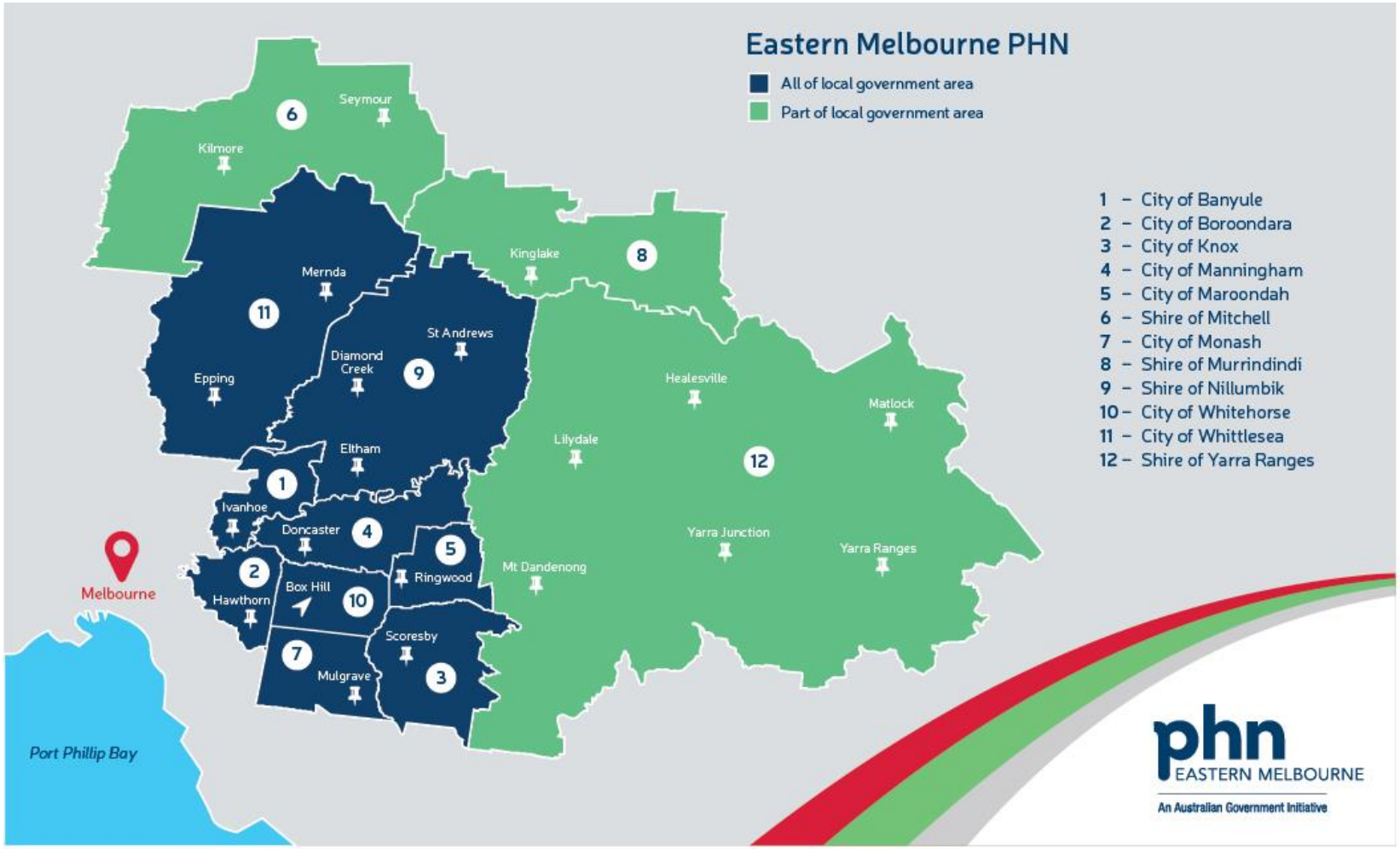
The following presentation was from Eastern Melbourne Primary Health Network's Annual Strategic Commissioning and Planning Workshop on Friday 14 September 2018. The workshop was attended by a wide range of EMPHN stakeholders to inform its priorities over the coming three years.

Agenda

8:45am	Welcome – Robin Whyte, EMPHN
8:55am	Session overview – Luke Hockley and Matt Wicking, Midnightsky
9.10am	EMPHN overview of current successes, activity and investment – Robin Whyte
10.00am	Overview of needs data, service mapping and emerging priorities – Kelly Shaw, KPHealth
10:45am	**Morning Tea**
11:15am	Opportunities in Mental Health, Anne Lyon
11:45am	Opportunities in Integrated Care, Harry Patsamanis
12:15pm	World Café – Round one. Luke Hockley and Matt Wicking, Midnightsky
12:45pm	**Lunch**
1:15pm	World Café – Round two. Luke Hockley and Matt Wicking, Midnightsky
2:45pm	Wrap up – Robin Whyte
3pm	**Close**

EMPHN Overview

Robin Whyte, EMPHN CEO


Eastern Melbourne PHN
All of local government area
Part of local government area
1 – City of Banyule
2 – City of Boroondara
3 – City of Knox
4 – City of Manningham
5 – City of Maroondah
6 – Shire of Mitchell
7 – City of Monash
8 – Shire of Murrindindi
9 – Shire of Nillumbik
10 – City of Whitehorse
11 – City of Whittlesea
12 – Shire of Yarra Ranges
Seymour
Kilmore
Kinglake
Mernda
St Andrews
Diamond Creek
Epping
Healesville
Matlock
Lilydale
Eltham
Ivanhoe
Doncaster
Ringwood
Mt Dandenong
Yarra Junction
Yarra Ranges
Box Hill
Hawthorn
Scoresby
Mulgrave
Melbourne
Port Phillip Bay
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Health Needs and Priorities

Kelly Shaw

14 September 2018

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TOPICS

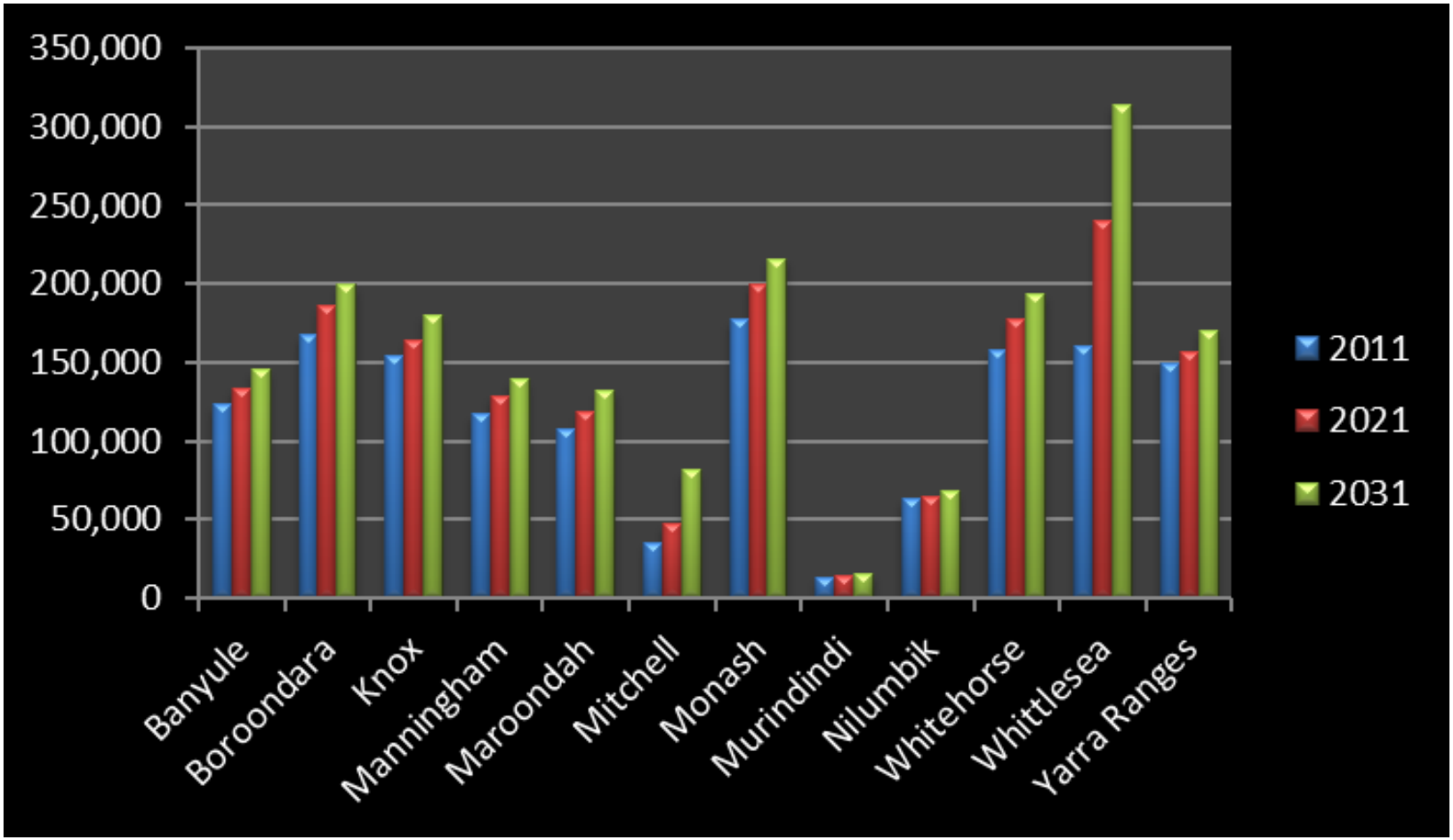
- Snapshot of the population
- Chronic disease and risk factors
- “Deeper dive”
  - Ageing
  - Mental health
  - Chronic disease
- PHN priorities

Our life expectancy is high

	EMPHN	Australia
People	84.5	82.5
Males	82.9	80.4
Females	86.0	84.6

AIHW, 2018

We have an ageing population



Number aged 65+; Increase from 14% (2011) to 20% (2031)

Victoria Environment, Land, Water and Planning 2016

experiencing a high chronic disease burden

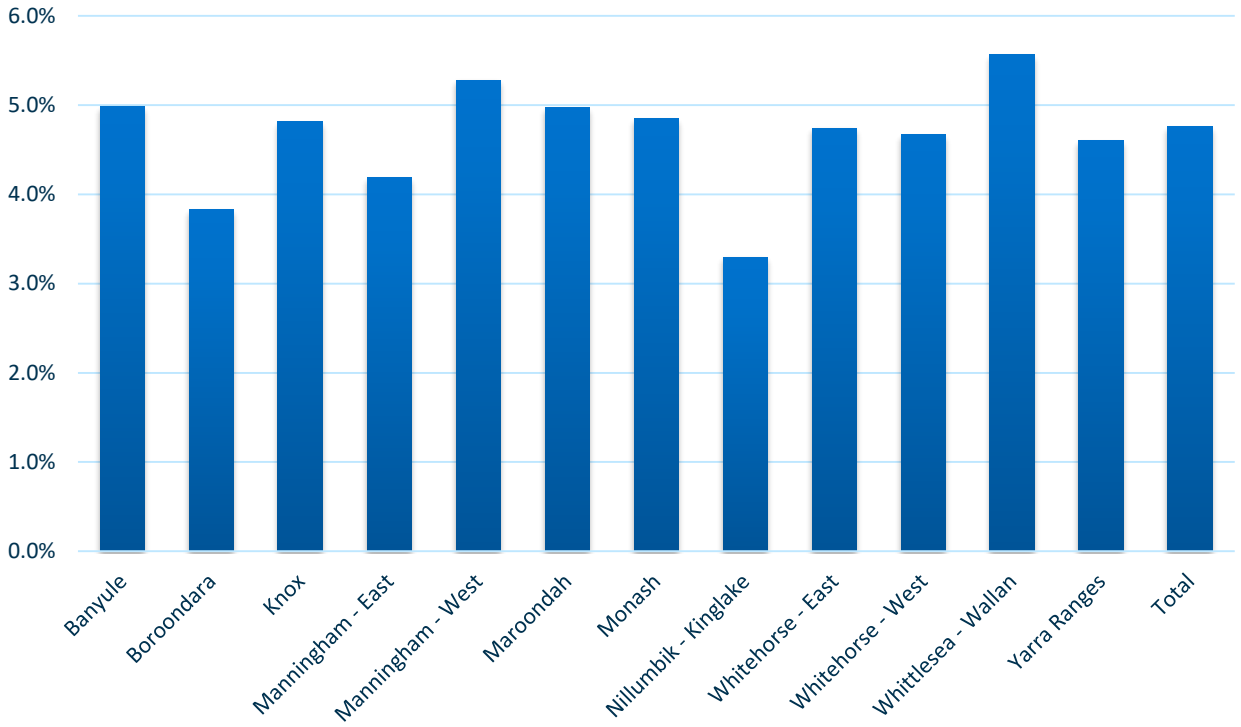
	Persons (%)	Aged 65+(%)
Total musculoskeletal/ connective tissue diseases	31.7	65.0
Total cardiovascular diseases	22.8	62.9
Asthma	11.6	10.1
Mental and behavioural problems	15.0	17.6
Diabetes mellitus	4.6	14.1
Dementia	<1	7

ABS, National Health Survey

What this means for EMPHN……

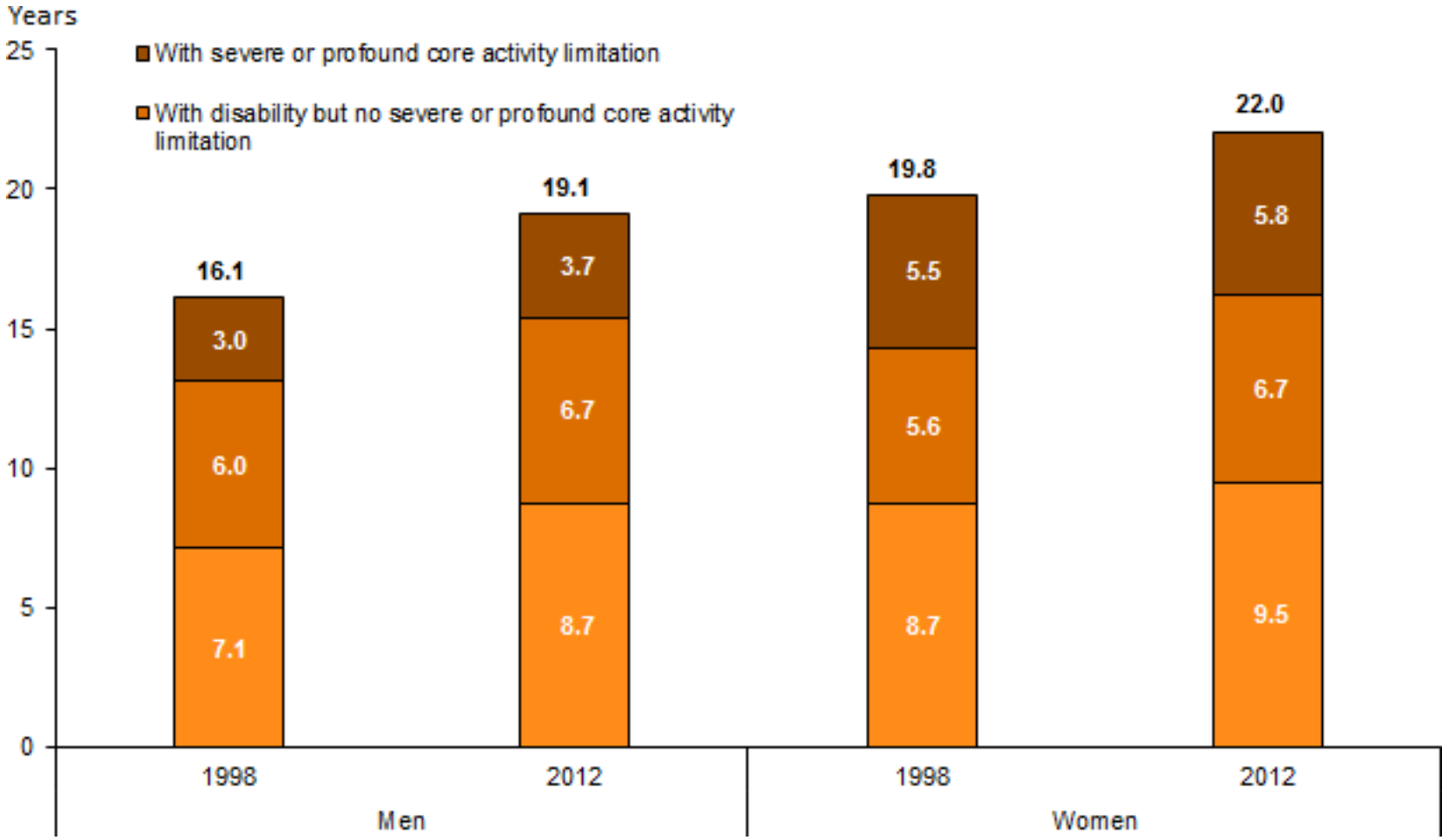
	2011	2031
OVER 65	206,132	367,063
Total musculoskeletal/ connective tissue diseases	133,986	238,591
Total cardiovascular diseases	129,657	230,883
Asthma	20,819	37,073
Mental and behavioural problems	36,279	64,603
Diabetes mellitus	29,065	51,756
Dementia	14,429	25,694

There is a significant disability burden



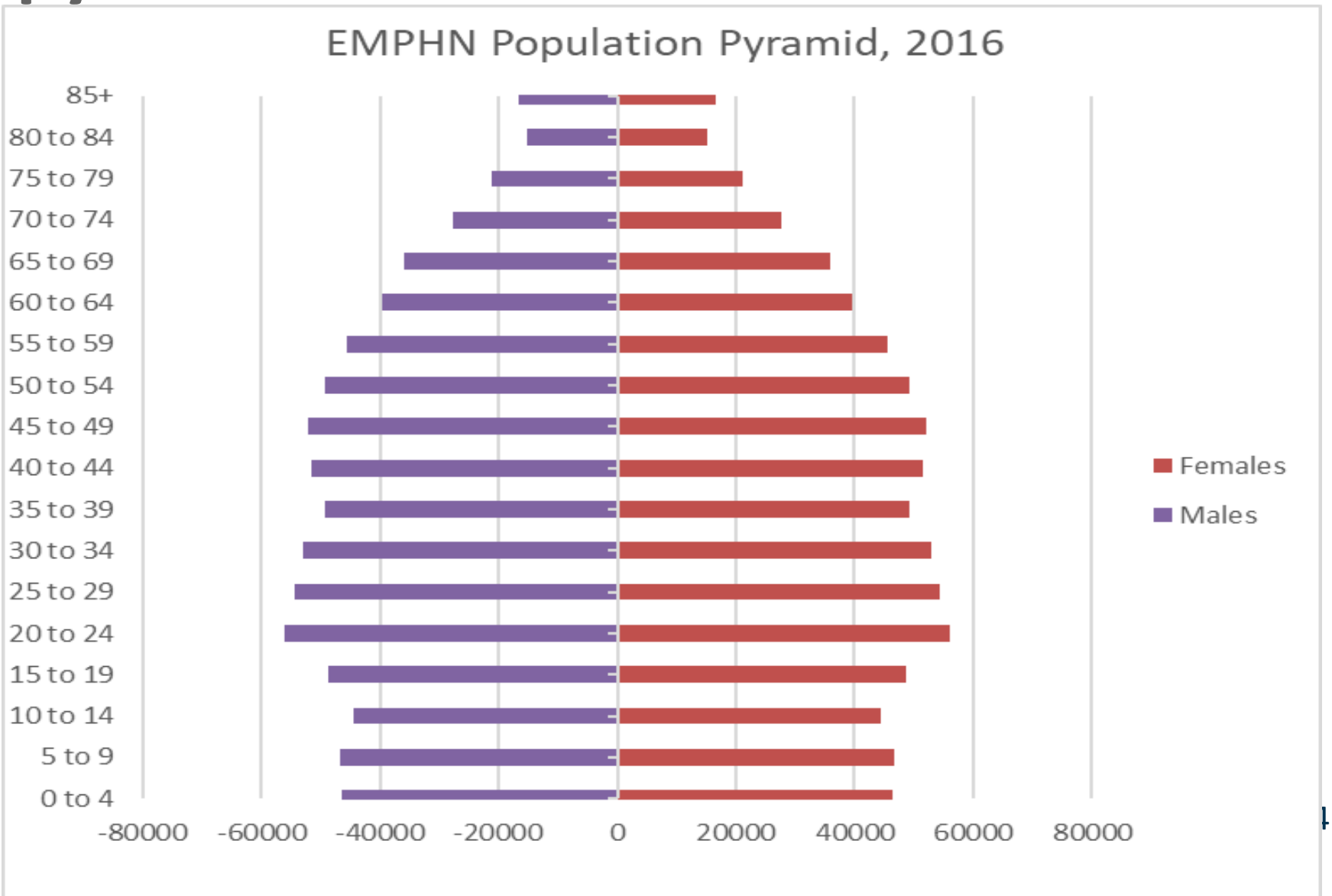
ABS, Census Table Builder, 2017

Final years are lived with disability



Australian men aged 65 and over could expect to live for another 19 years, and women another 22 years

Our population pyramid is not a pyramid



Chronic diseases

Chronic disease burden is comprised of:

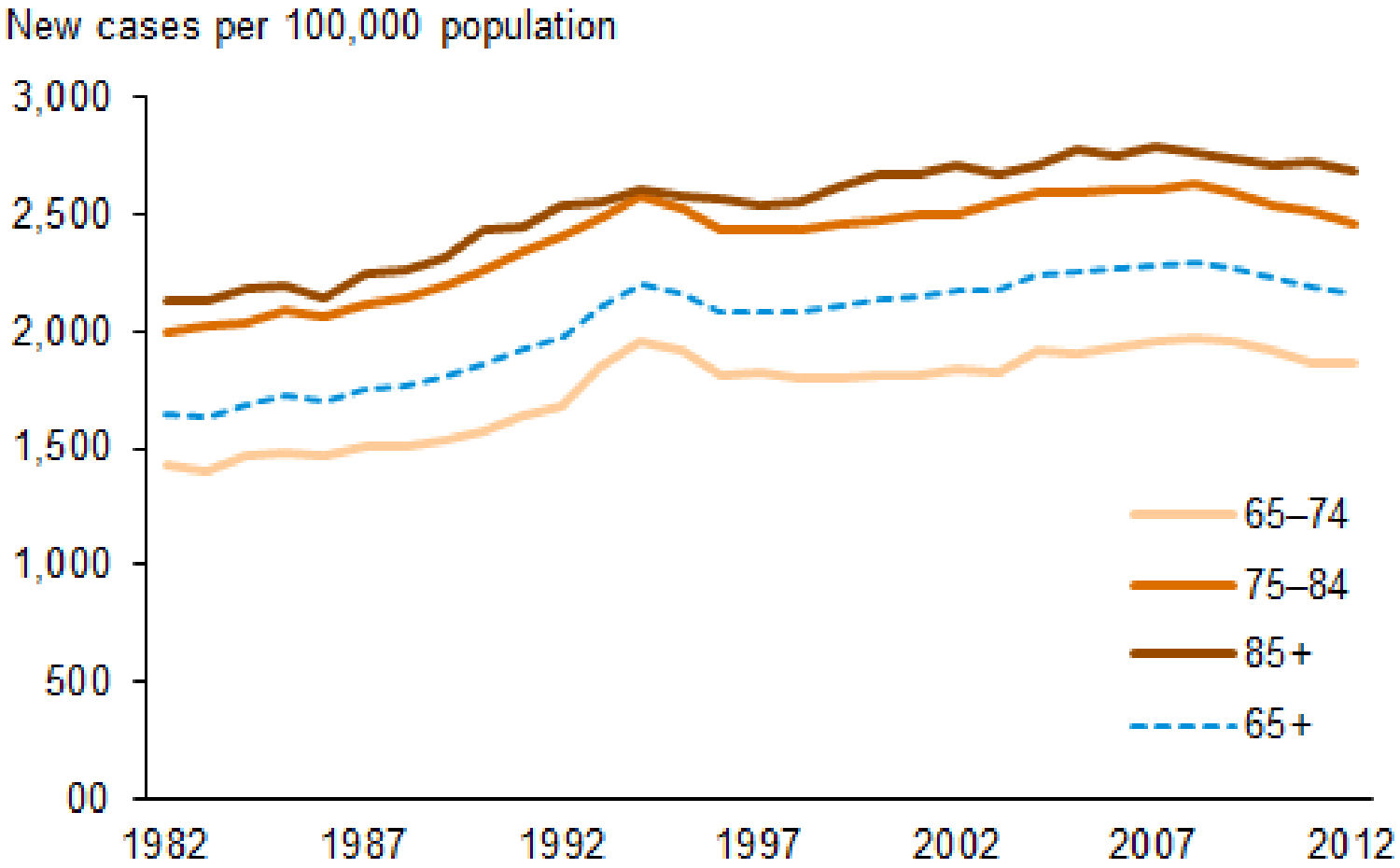
1. Arthritis
2. Asthma
3. Back pain
4. Cancer
5. Cardiovascular disease (CVD)
6. Chronic obstructive pulmonary disease (COPD)
7. Diabetes
8. Mental Health

Our main causes of death are:

Cause	Deaths	% of all causes
Cancer	7,453	16.9
Coronary heart disease	5,371	12.1
Dementia and Alzheimer disease	4,200	9.5
Cerebrovascular disease	3,213	7.3
COPD	1,688	3.8
Heart failure and complications and ill-defined heart disease	1,203	2.7
Influenza and pneumonia	1,137	2.6
Diabetes	1,130	2.6
Accidental falls	1,020	2.3
Kidney failure	819	1.9

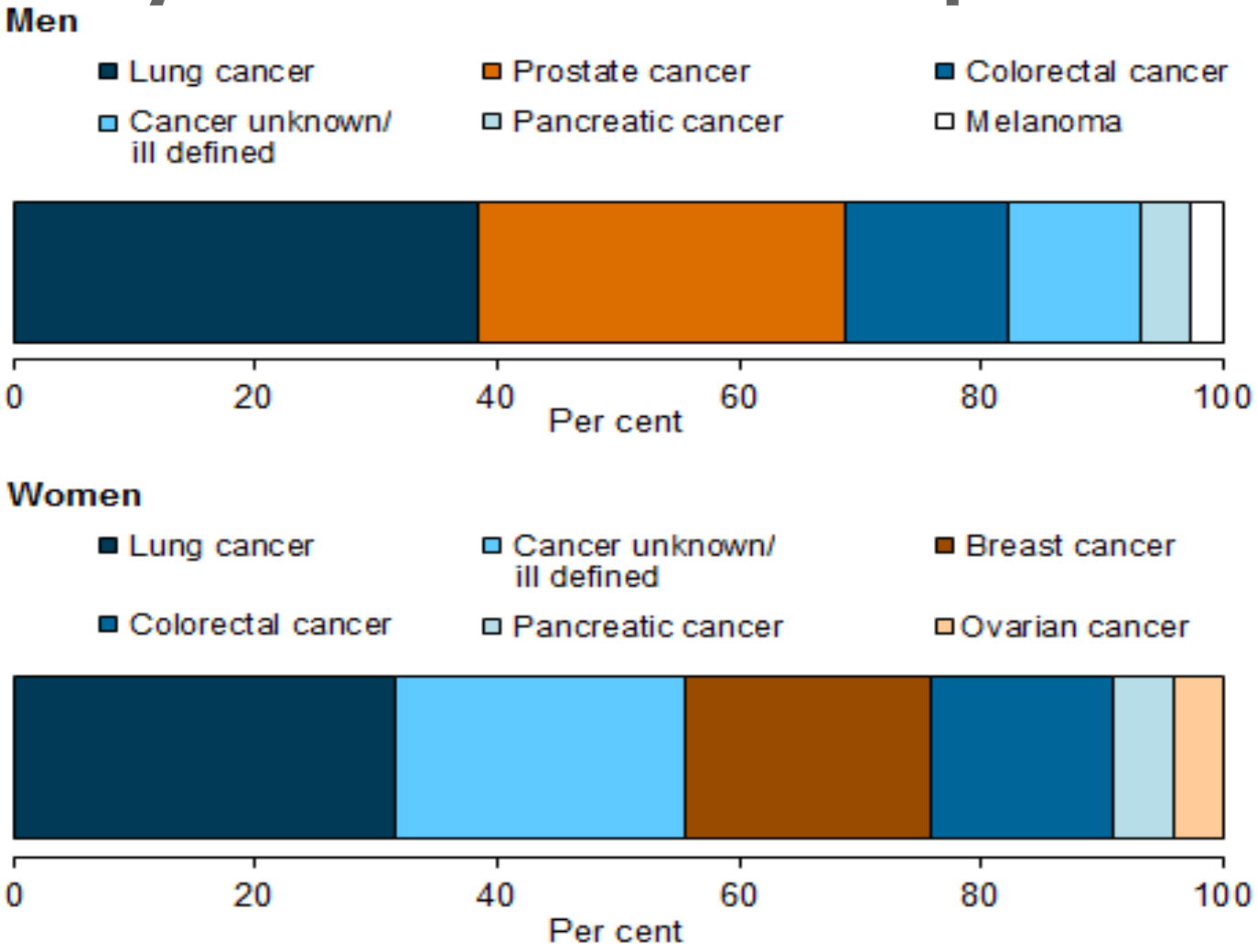
ABS, Causes of Death, EMPHN, 2012-2016

Our cancer incidence is increasing



AIHW, 2014 Australian Cancer Database

Many cancer deaths are preventable



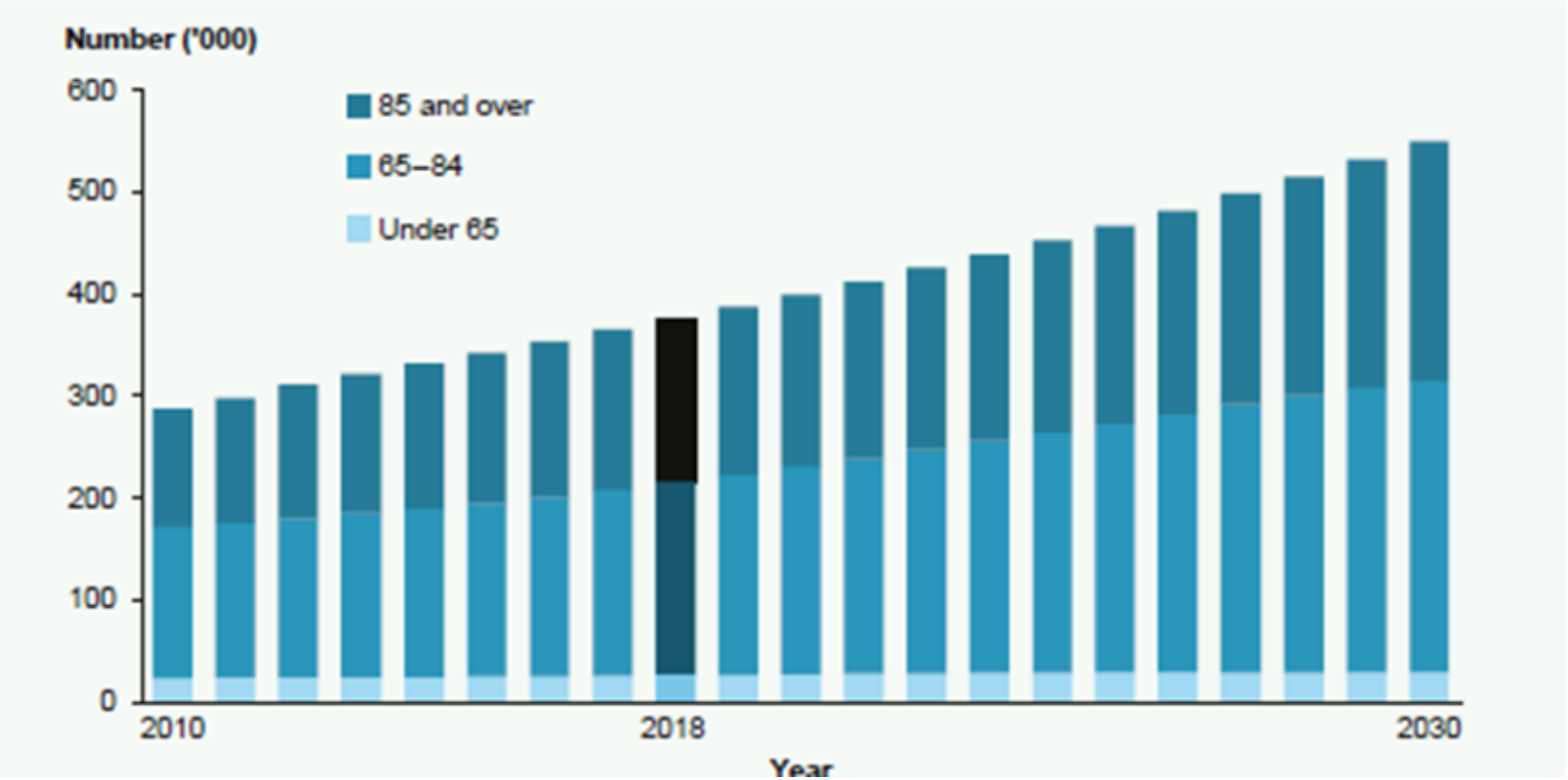
ABS, Cancer deaths, 2011-2013

EMPHN screened cancers, 2009-2013

	Rate per 100,000 people	Number of cases	Screening participation
Breast	121	4,894	55%
Cervix	4.8	182	59%
Bowel	56	4,479	43%
Lung	35	2,787	N/A
Prostate	175	6,537	N/A

AIHW, analysis of cancer screening program data, 2015-16

Dementia burden increasing rapidly



AIHW, 2012

Our EMPHN Risk Factors "Report Card"

Risk factor	Result
Daily smokers	12%
Smoking during pregnancy	7%
Smoking during pregnancy, ATSI peoples	31%
High blood pressure	32%
High cholesterol	33%
Physically inactive	52%
Excess alcohol	15%
Overweight or obese	65%
Fully immunised by 5 years	94% (1,118 kids to catch up)

ABS, National Health Survey, 2014-15

AIHW National Perinatal Data Collection, 2013-15

HEALTH RISKS ASSOCIATED WITH OBESITY

Greatly increased (RR† >>3)	Moderately increased (RR 2-3)	Mildly increased (RR 1-2)
TYPE 2 DIABETES	Coronary heart disease	Cancer
Gallbladder disease	Hypertension	
		Increased anaesthetic risk
High blood fats eg cholesterol	Osteoarthritis	
Metabolic Syndrome	Gout	Polycystic ovary syndrome
Infertility		
Sleep apnoea		

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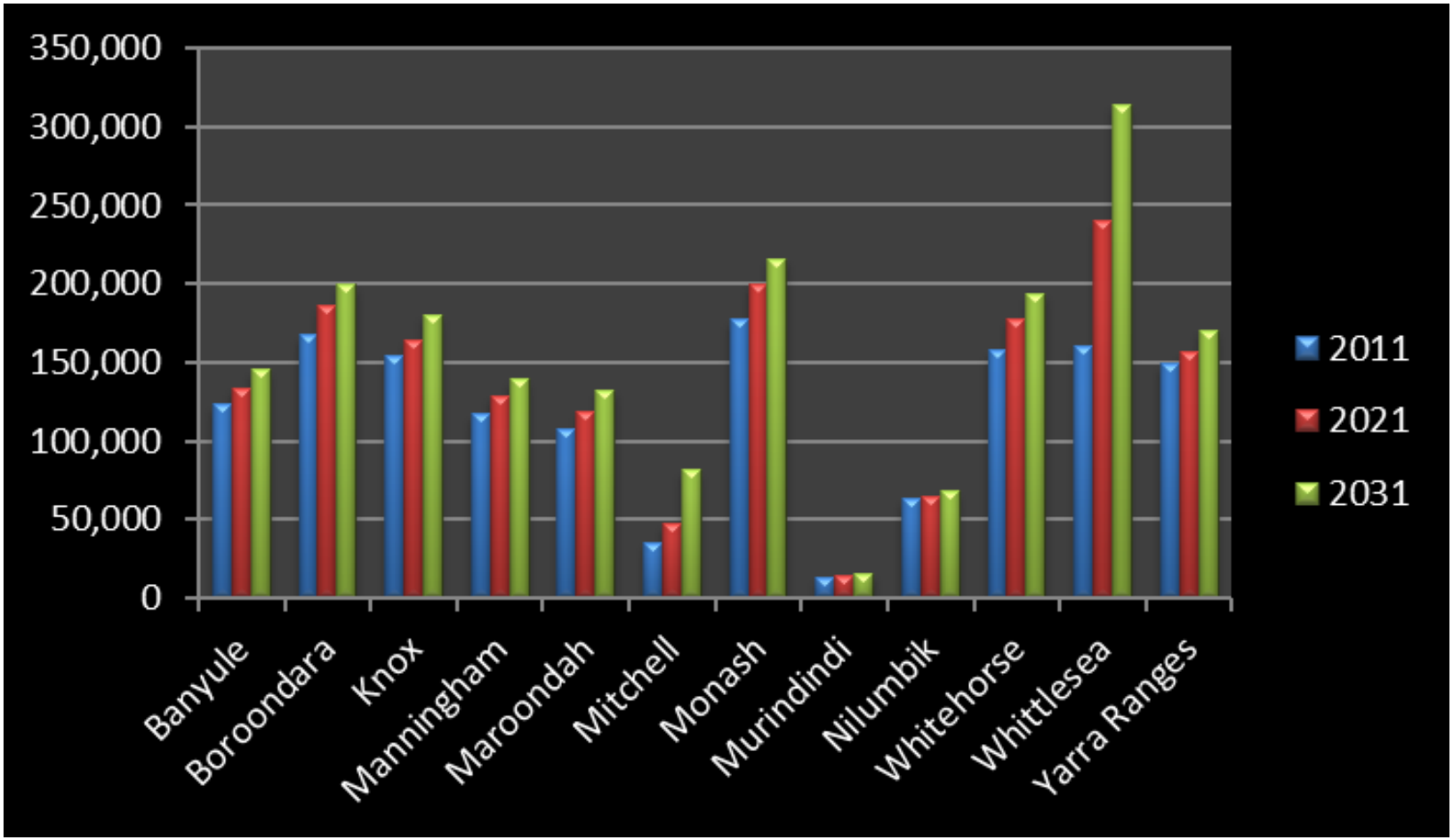
Older people – ‘a deeper dive’

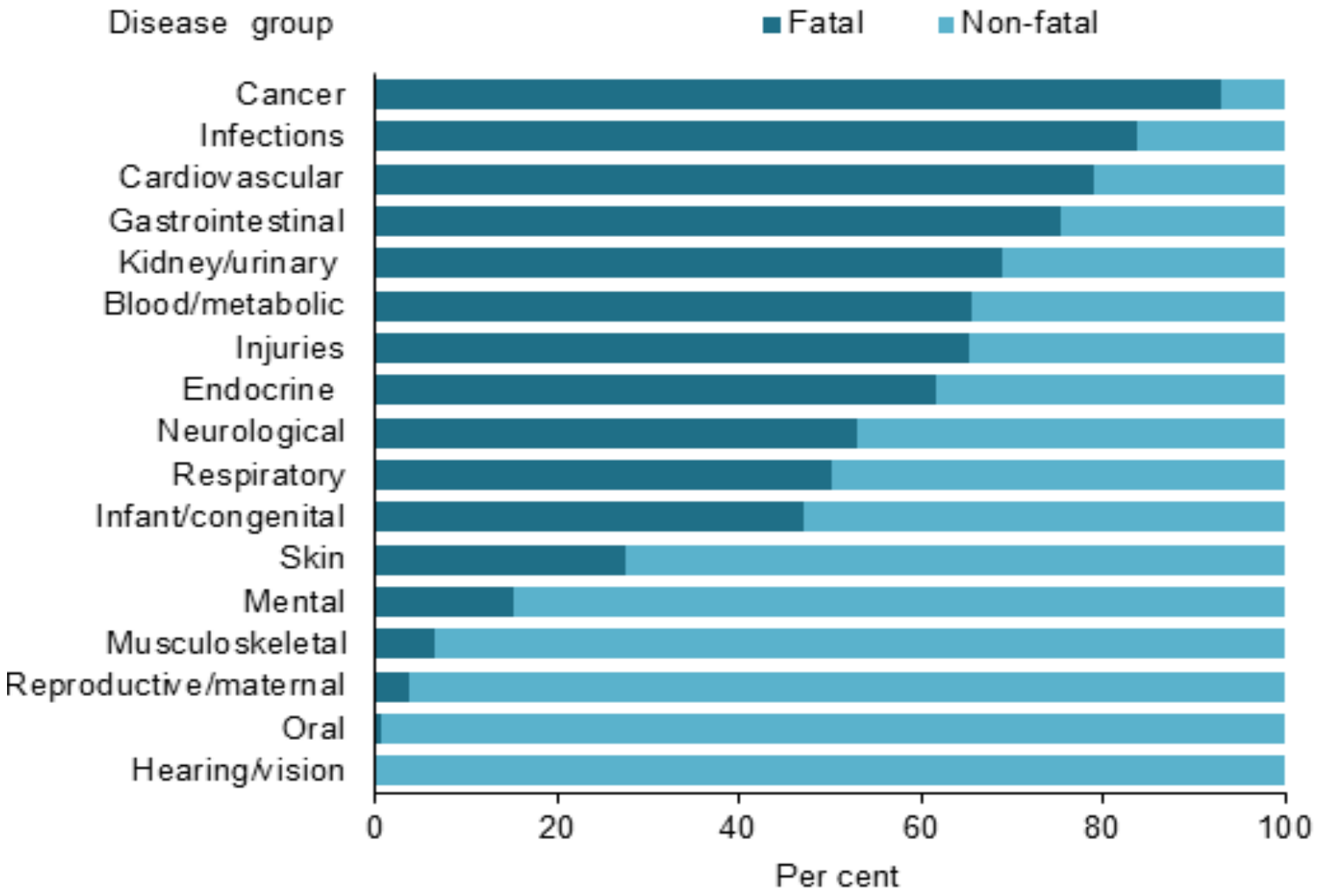
Population ageing – 65+



Increase from 14% (2011) to 20% (2031)

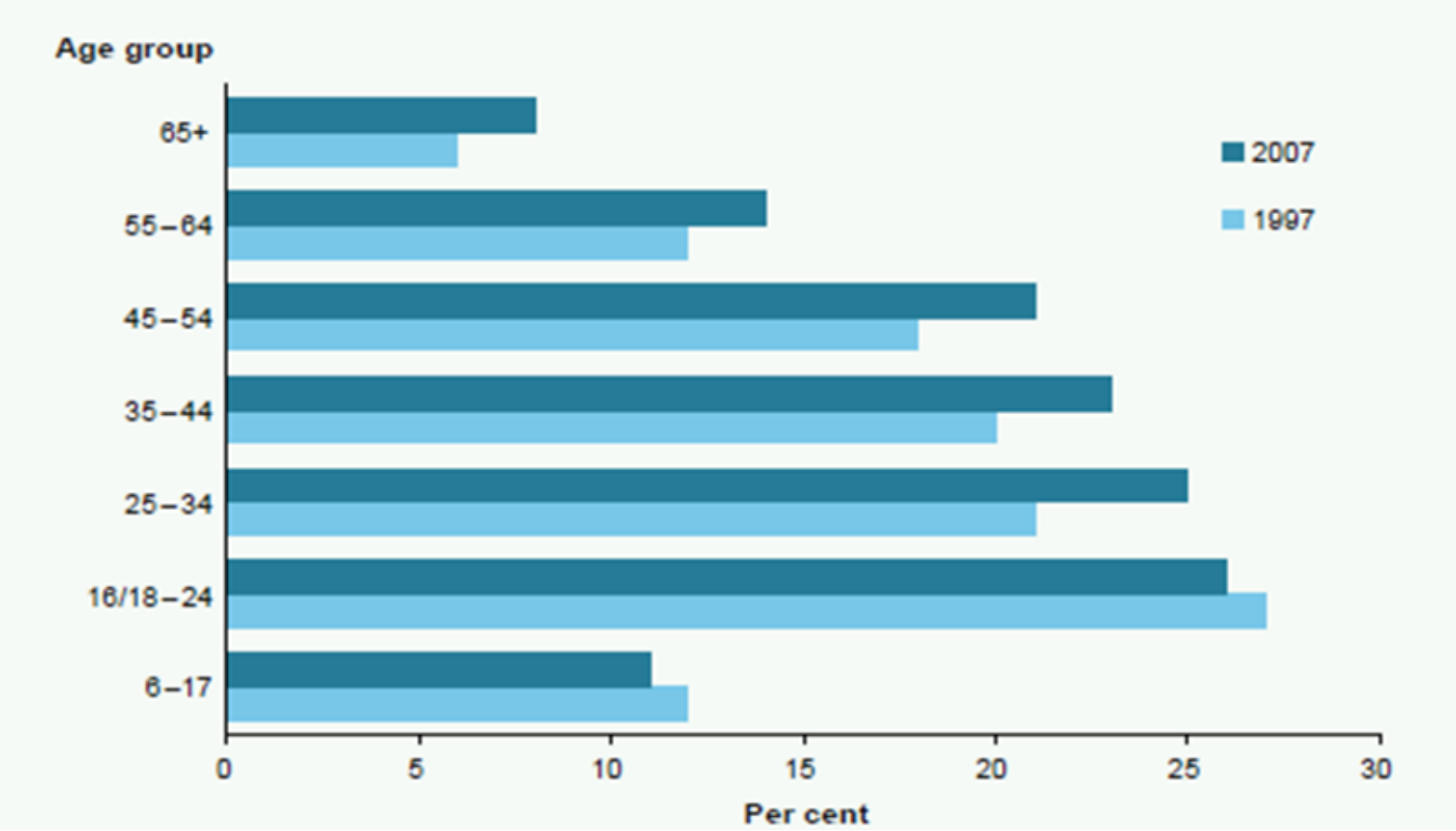
Victoria Environment, Land, Water and Planning 2016

Non-fatal disease burden contributes to disability



Australian Burden of Disease Study, Age 65+ population

Mental health disease burden is complex – older people miss out on care



Less disease burden BUT less likely to be referred for psychological treatment; DoH, 2013

And risk factors for poor mental health in older people are increasing

Disability

Chronic disease

Prior depression

Bereavement

Social isolation

Unhealthy lifestyle

Knight, B. G. & Pachana, N. A. (2015). *Psychological assessment and therapy with older adults.* Oxford, UK: Oxford University Press

Who provides mental health care?

Medicare subsidised services for mental health, 65+, 2013-14

Question?

Primary health priorities for older people?

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Mental health – a ‘deeper dive’

EMPHN mental health illness burden

Illness severity	Number of people
Mild	67,521
Moderate	54,823
Severe	46,385
TOTAL	168,729

UQ National Mental Health Service Planning Framework, 2016

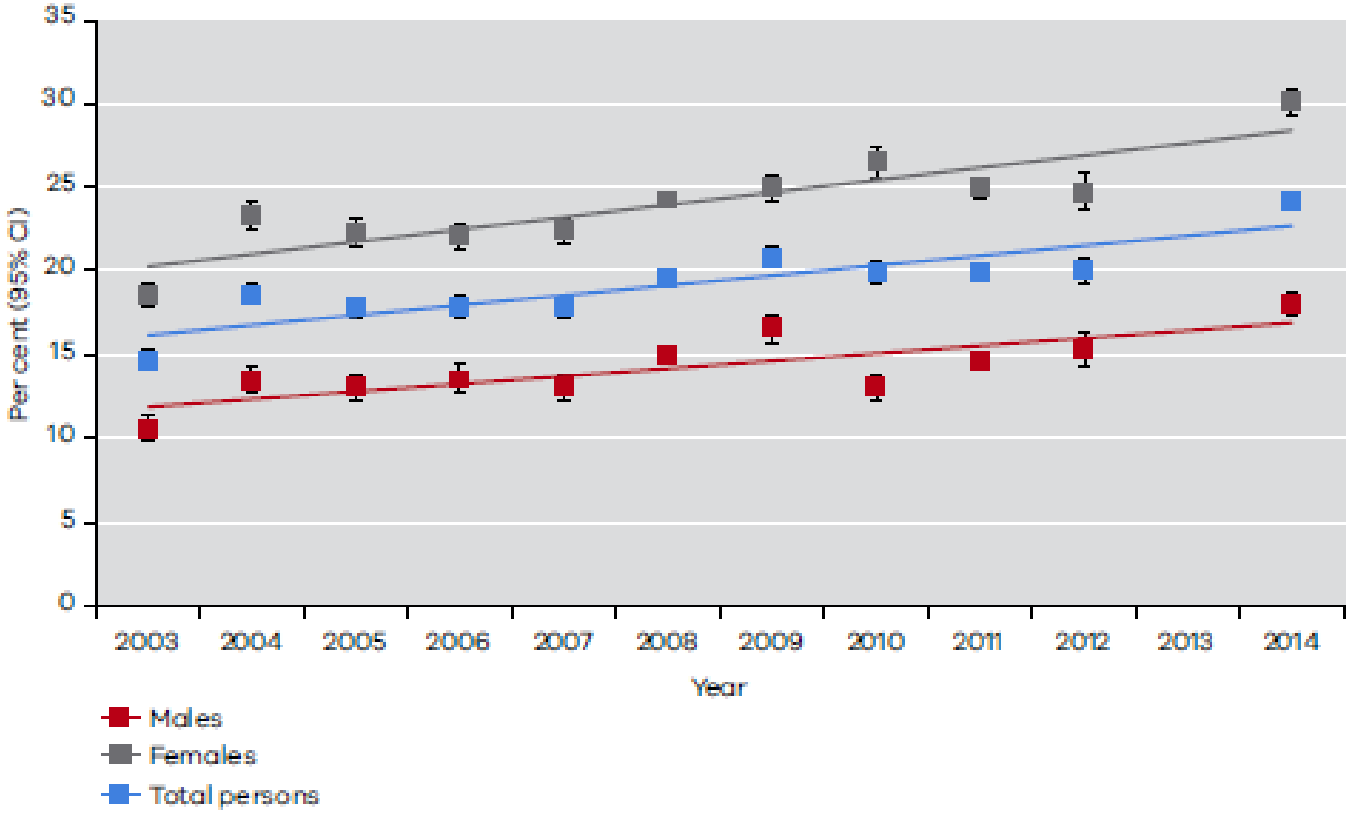
Mental health problems are highly prevalent

Indicator	Prevalence
Ever been diagnosed with anxiety or depression	24%
Experiencing high or very high psychological distress	12%
ATSI peoples with high or very high psychological distress	36%!!
Adolescents with low resilience	12%
Suicide deaths (per 100,000 people)	10

Victorian Population Health Survey results

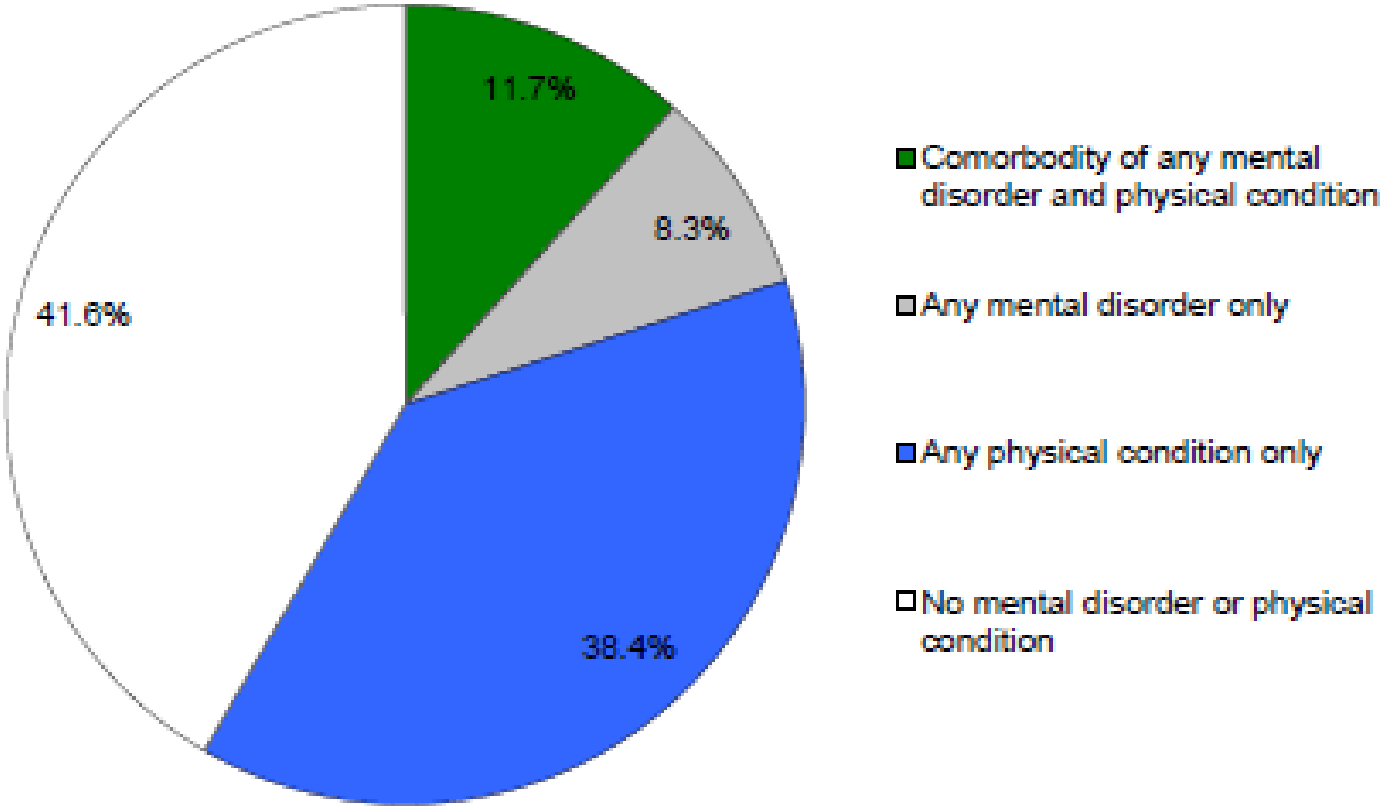
Victoria's Mental Health Services Annual Report, 2016-17

Depression / anxiety prevalence is increasing



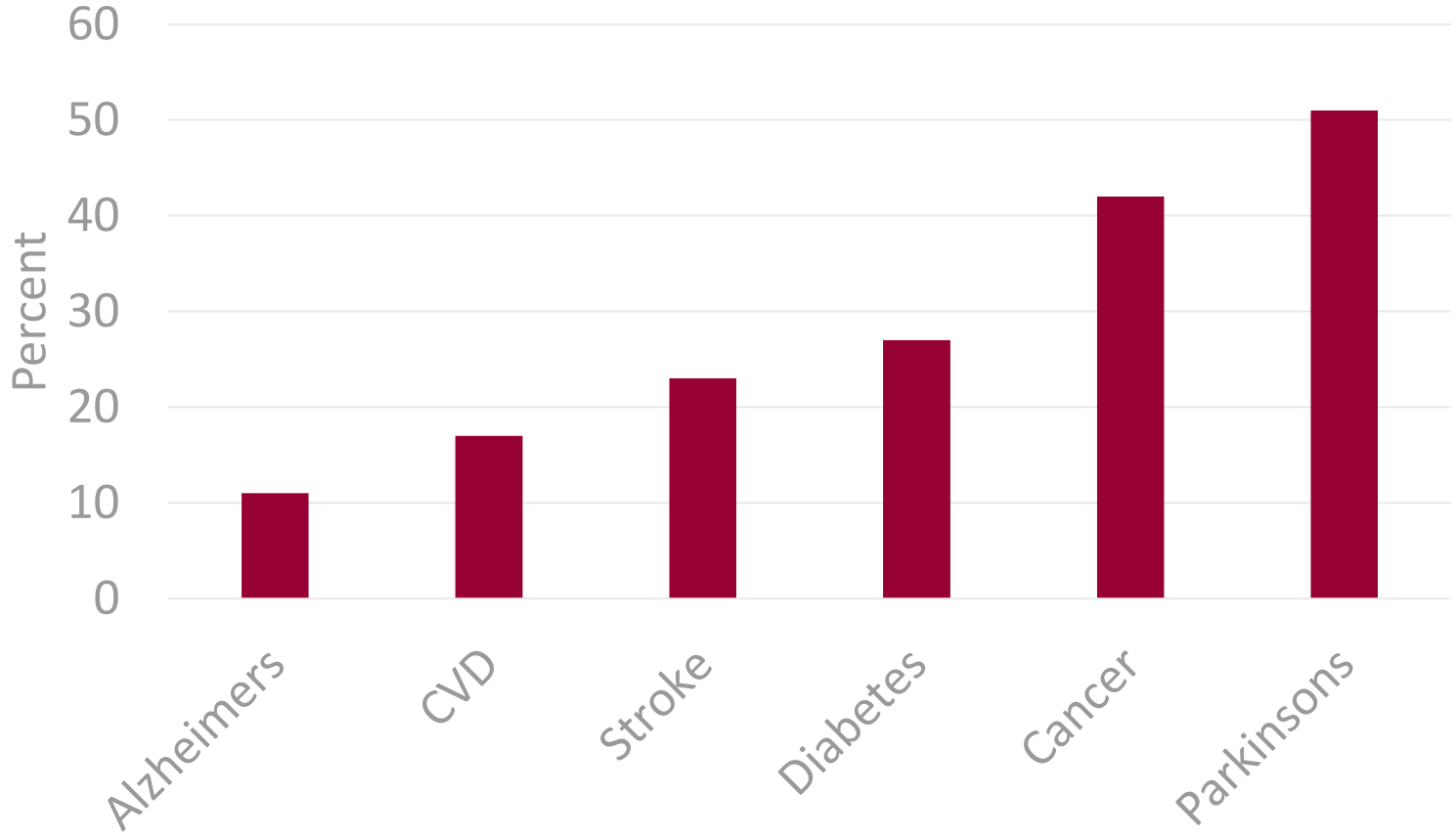
Victorian population health surveys, 2003-14. Prevalence of doctor-diagnosed depression or anxiety, Victoria

Most people with mental health problems have chronic diseases



ABS, National Survey of Health and Wellbeing, 2012 report

Mental health comorbidity differs for different chronic diseases



Prevalence of major depression in chronic disease, CDC, 2012

People with severe mental disorders die 15-20 years earlier

It is a complex relationship

Disease	Impacts
Diabetes	Depression 2-3 times more common Associated with poor glycaemic control and microvascular complications
CVD	Severe mental disorder doubles risk of ACS or stroke Mood disorder doubles risk of poor outcome after cardiac event
Chronic lung disease	1 in 3 cigarettes is smoked by a person with a mental disorder Smoking not declining in people with mental disorders People with COPD 2.5 times more likely to be depressed and depression in COPD increases exacerbations 58% with exacerbations experience anxiety
Cancer	25% of people with cancer have anxiety / depression but only 20% of these are diagnosed and treated Severe mental disorders increase cancer risk

Most prevalent with severe mental illness

27% = heart or circulatory conditions (c.f. 16%)

25% = Severe headaches/migraines (c.f. 9%)

21% = diabetes (c.f. 6%)

7% = epilepsy (c.f. 0.8%)

Question?

What are our priorities for delivering better care for people with mental health problems?

Chronic disease – a ‘deeper dive’

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Increase efficiency and effectiveness

Potentially preventable hospitalisations

	Seps	Bed days	$ (mill)
CHRONIC			
Congestive heart failure	3,858	29,139	$37.8
COPD	2,841	17,997	$23.4
Diabetes complications	2,677	15,933	$20.7
Iron deficiency anaemia	4,681	6,705	$8.7
ACUTE			
Kidney / UTI	3,658	15,900	$20.6
Cellulitis	3,023	13,450	$17.5
Gangrene	862	12,676	$16.5
Convulsions and epilepsy	1,898	5,766	$7.5

AIHW, 2015-16, Chronic disease PPHs

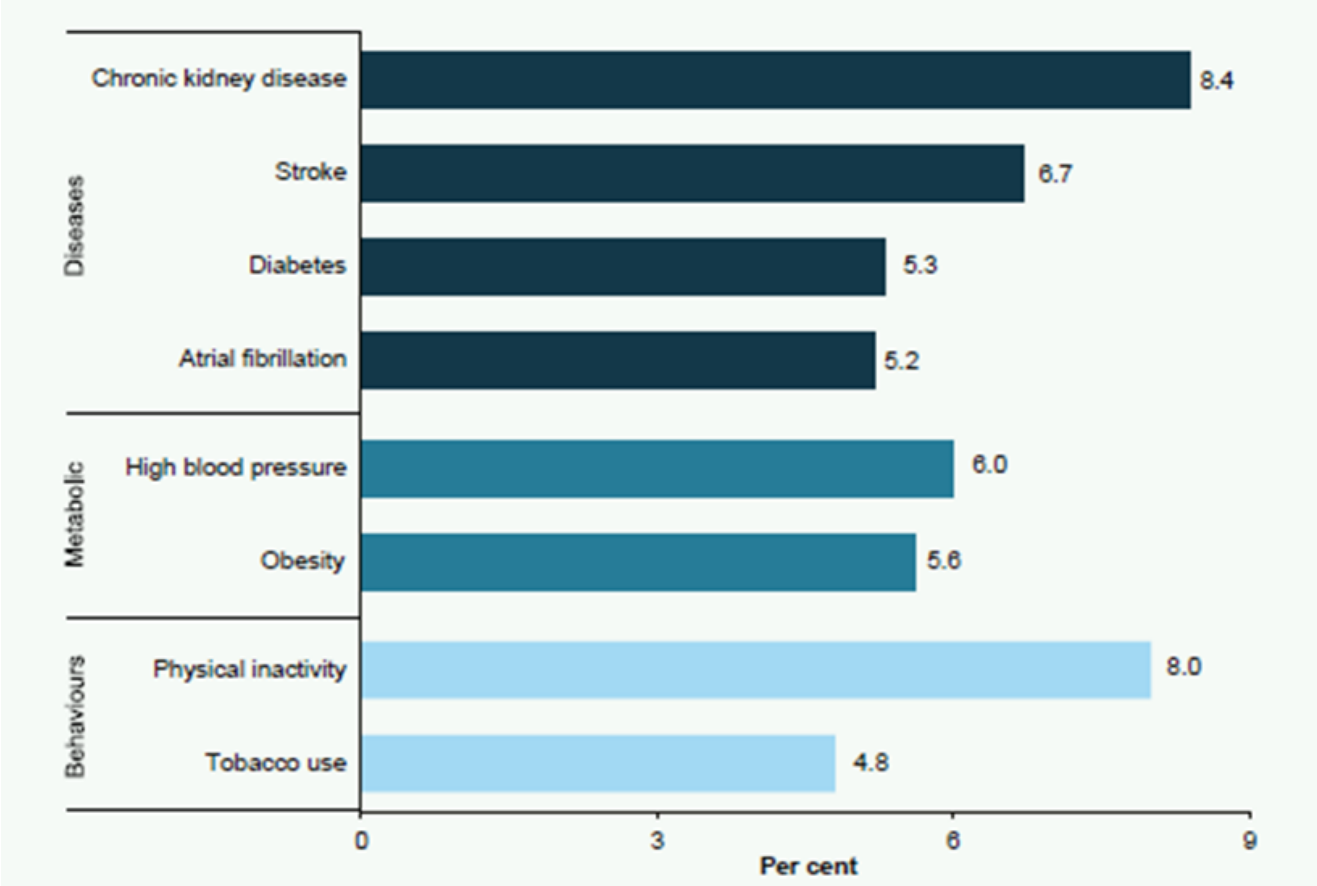
Manage chronic conditions better

Which ones? How many? (Multimorbidity)

ABS, 3 or more chronic conditions (self-reported)

Tas	44.9%
SA	42.0%
WA	39.7%
ACT	39.6%
Vic	**39.1%**
Qld	38.6%
NSW	37.4%

Upstream or downstream?



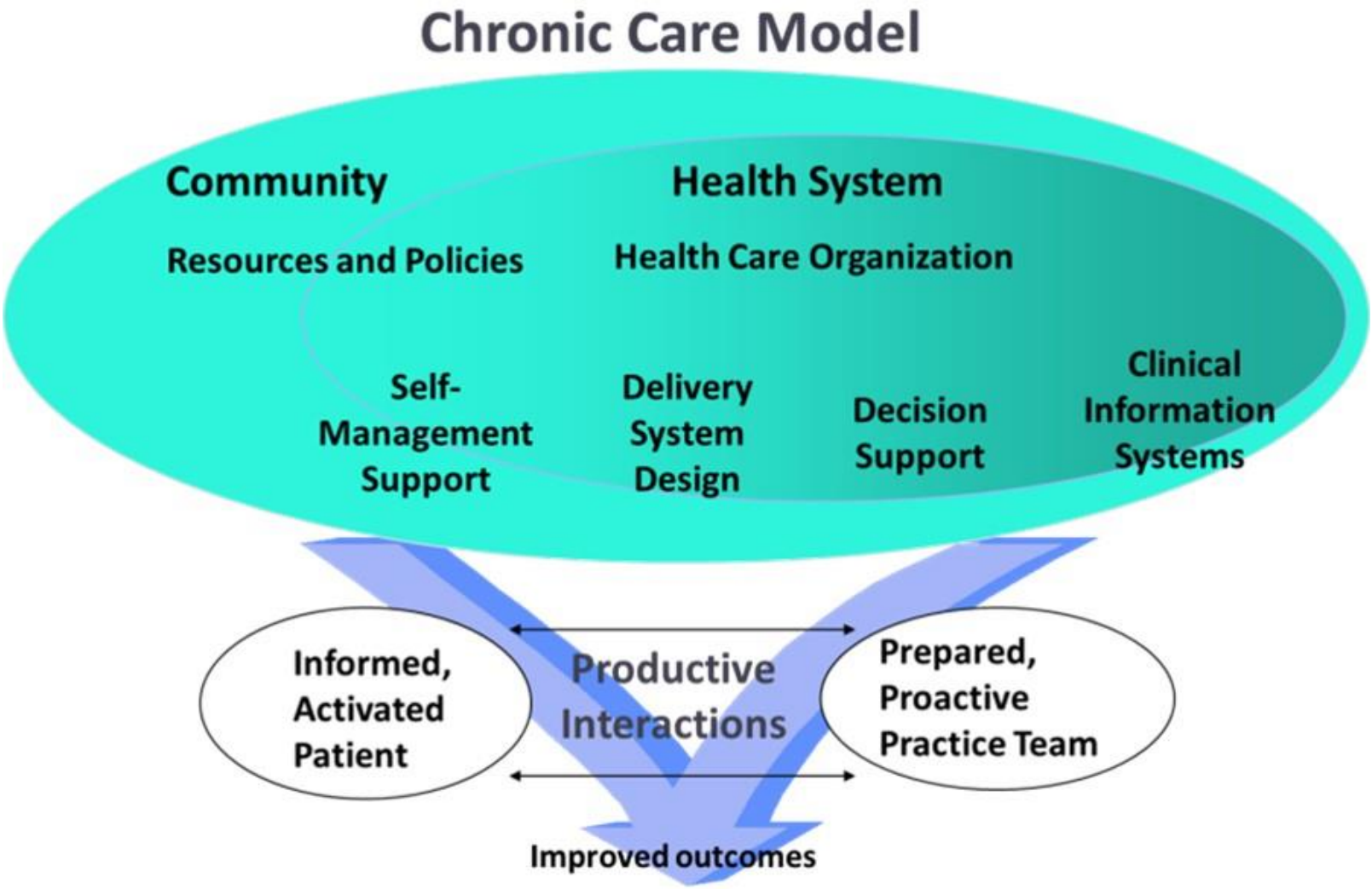
Contribution of vascular risk factors to dementia burden, AIHW, 2016

Transforming primary care

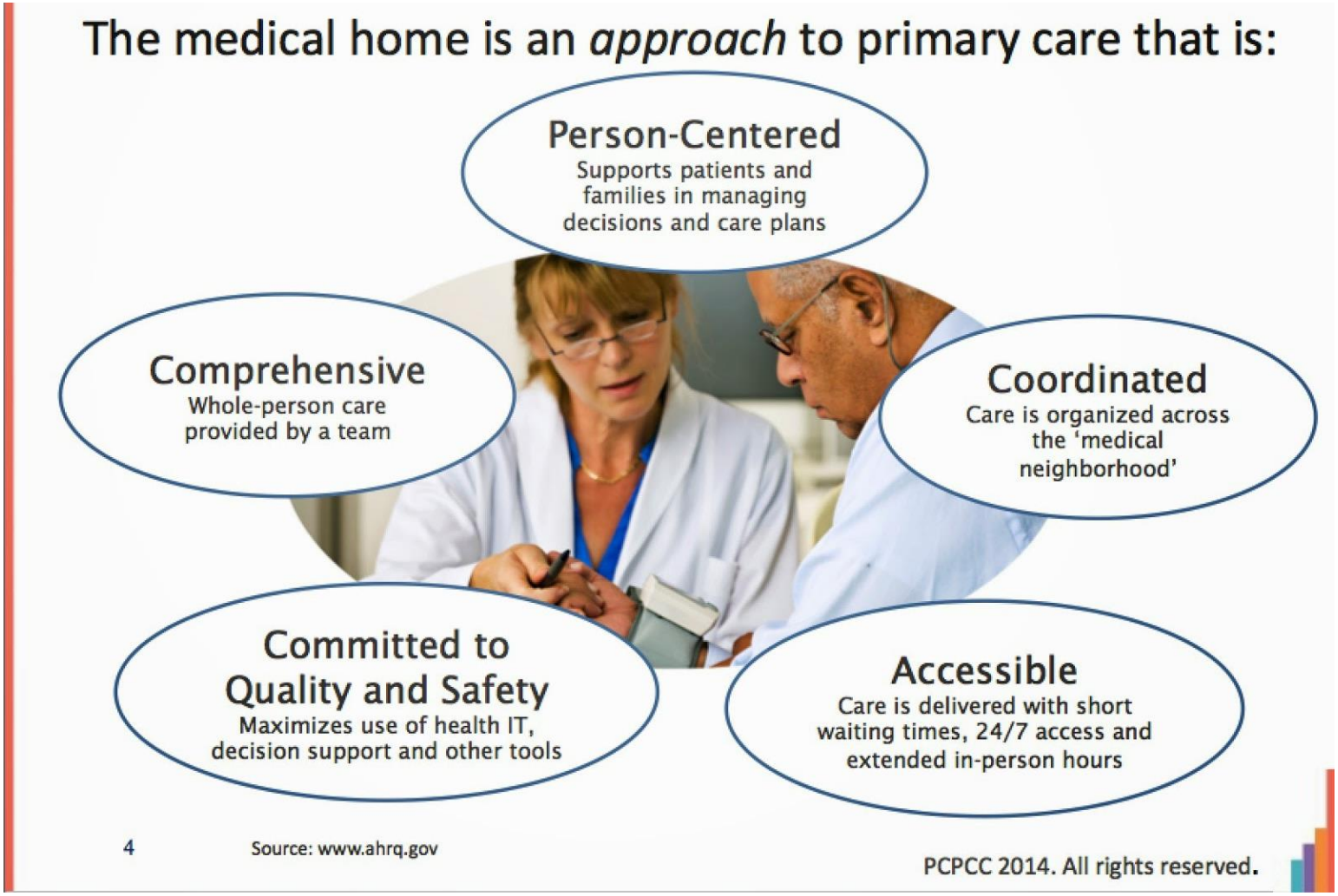
- 17% saw 3 or more health professionals for the same condition in the past 12 months
- 82% saw a GP in the past 12 months an average of 6 times
- 10% saw a GP more than 12 times in the 12 months
- 10% saw a GP after hours in the past 12 months

EMPHN, MyCommunities, accessed September 2018

How?


Chronic Care Model
Community
Health System
Resources and Policies
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved outcomes

How?


The medical home is an *approach* to primary care that is:
Person-Centered
Supports patients and families in managing decisions and care plans
Comprehensive
Whole-person care provided by a team
Coordinated
Care is organized across the 'medical neighborhood'
Committed to Quality and Safety
Maximizes use of health IT, decision support and other tools
Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours
4
Source: www.ahrq.gov
PCPCC 2014. All rights reserved.

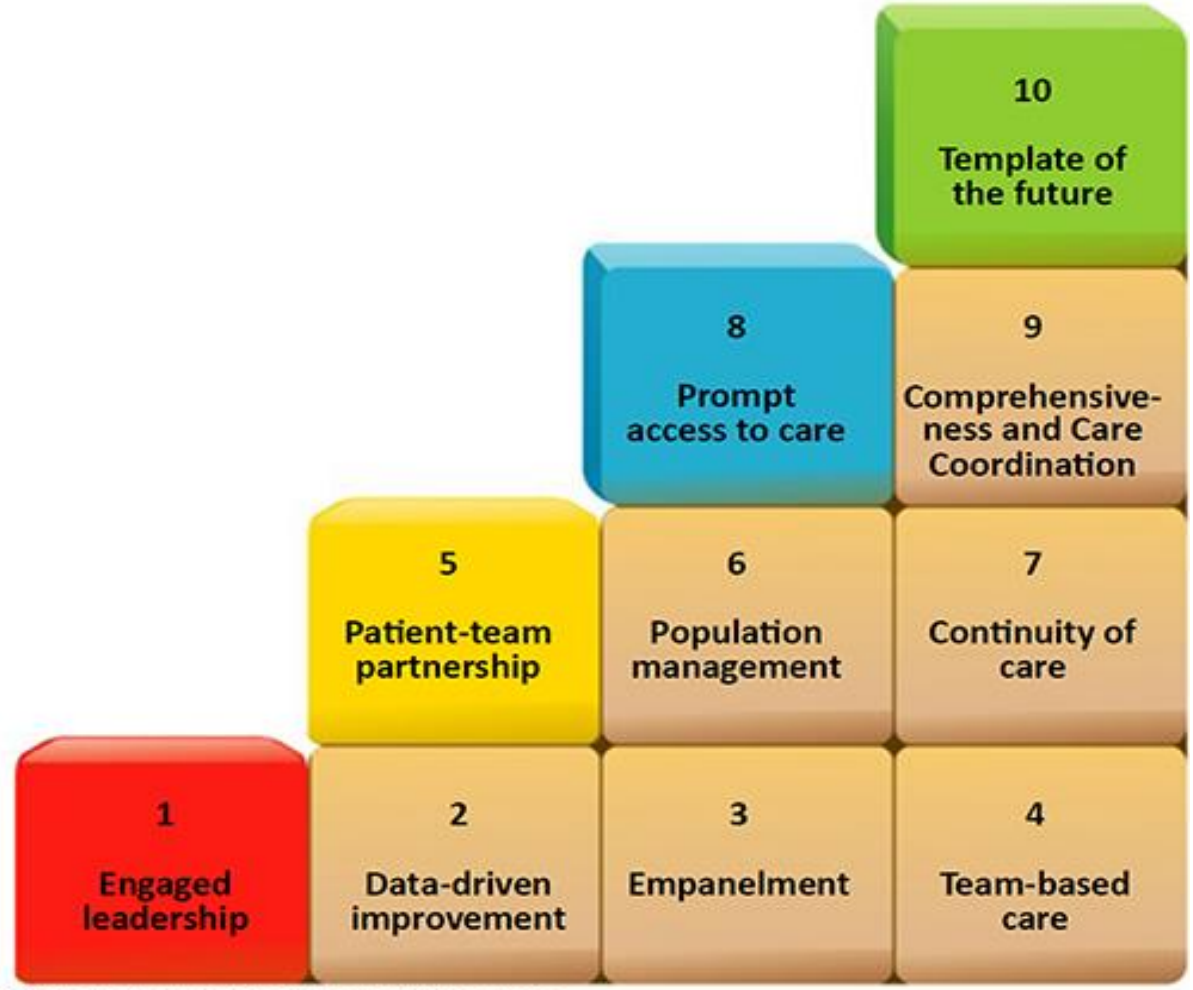
What does service delivery currently look like?

	Doctor 1	Doctor 2	Nurse
8.30-9am	Patient 1 Patient 2	Patient 14 Patient 15	Patient 2 Patient 14
9-9.30am	Patient 3	Patient 16 Patient 17	Patient 4 Patient 15
9.30-10am	Patient 4 Patient 5	Patient 18	Patient 3
10-10.30am	Patient 6 Patient 7	Patient 19 Patient 20	Patient 18 Patient 7
10.30-11am	Patient 8 Patient 9	Patient 21 Patient 22	Patient 19 Patient 20
11-11.30am	Patient 10	Patient 23 Patient 24	Patient 9
11.30-12pm	Patient 11 Patient 12	Patient 25 Patient 26	Patient 12 Patient 25
12-12.30pm	Patient 13	Patient 27	Patient 26

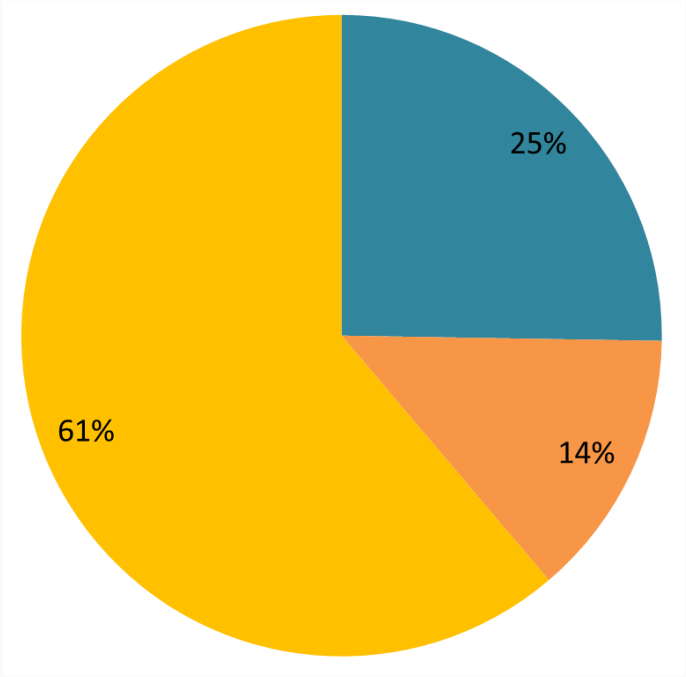
What does a transformed model look like?

Time	Primary Care Physician	Medical Assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00–8:10	←		Huddle	→	
8:10–8:30	E-visits and phone visits	Panel manage-ment	RN Care manage-ment	Acute patients	
8:30–9:00					
9:00–9:30	Complex patient				
9:30–10:00	Huddle with RN, NP	Blood pressure coaching clinic	Huddle with MD		Panel manage-ment
10:00–10:30	Coordinate with hospitalists and specialists		Care manage-ment	E-visits and phone visits	
10:30–11:00	Complex patient				

What does it look like for us?



Types of GP services delivered:

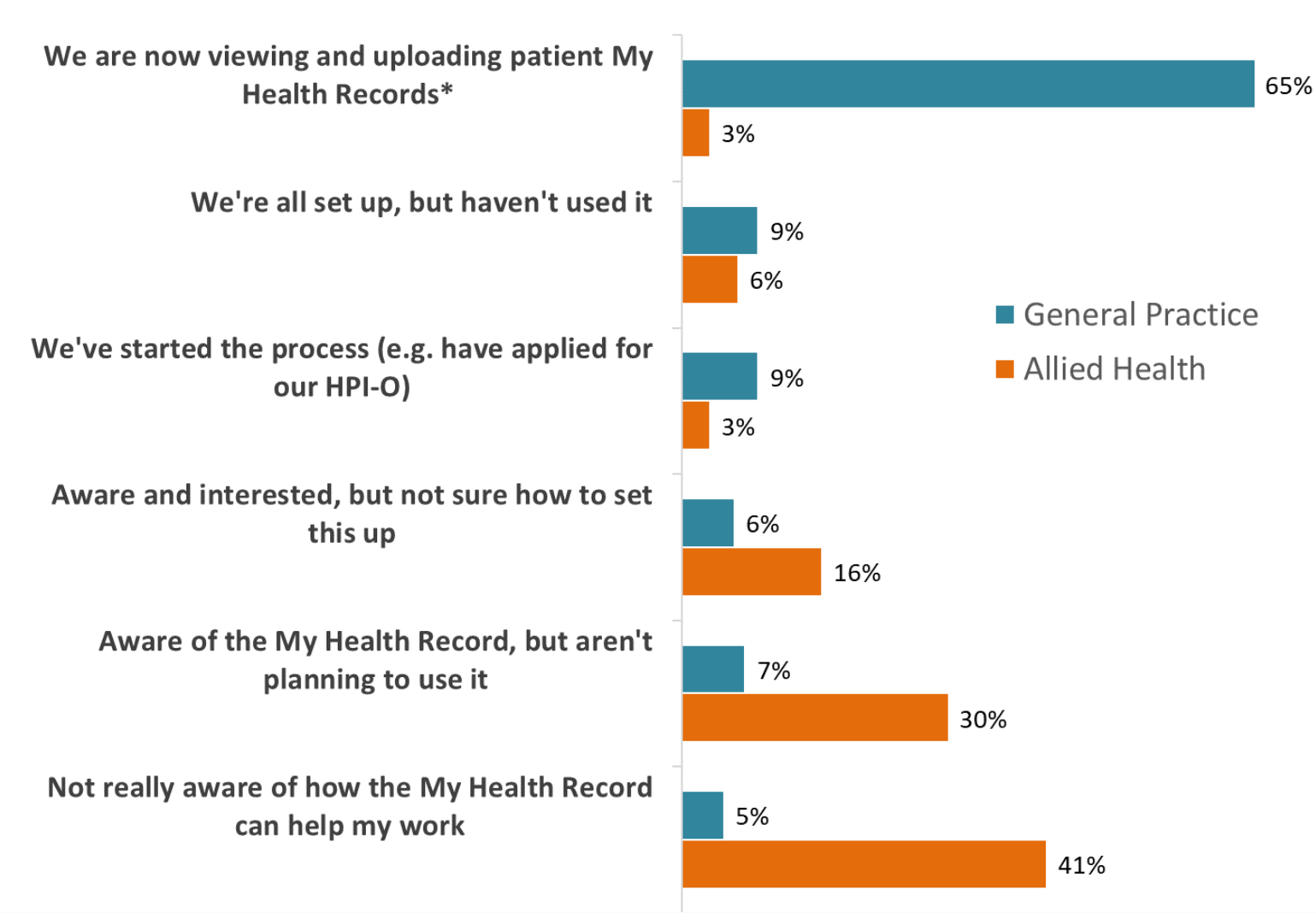


75% of General Practices operate in a co-located setting.

- 93% of practices have at least one PN
- 50% of solo GP practices have a PN

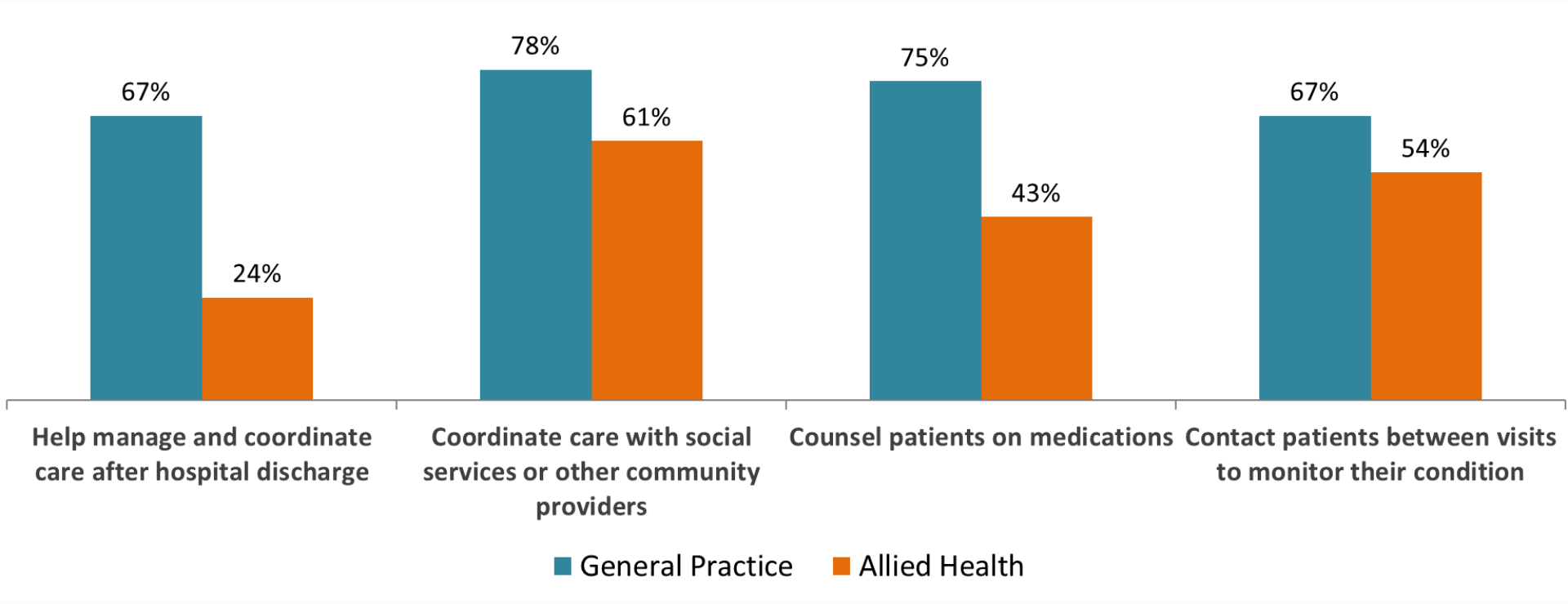
Practice eHealth Readiness:

2 out of 3 GPs are viewing & uploading but AH uptake very low



Care coordination:

Coordination with other providers reasonably common for GP; generally low for AH



Question

What are our priorities for transforming primary care?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Opportunities in mental health
Anne Lyon, EMPHN Executive Director
Mental Health and AOD

What is the opportunity?

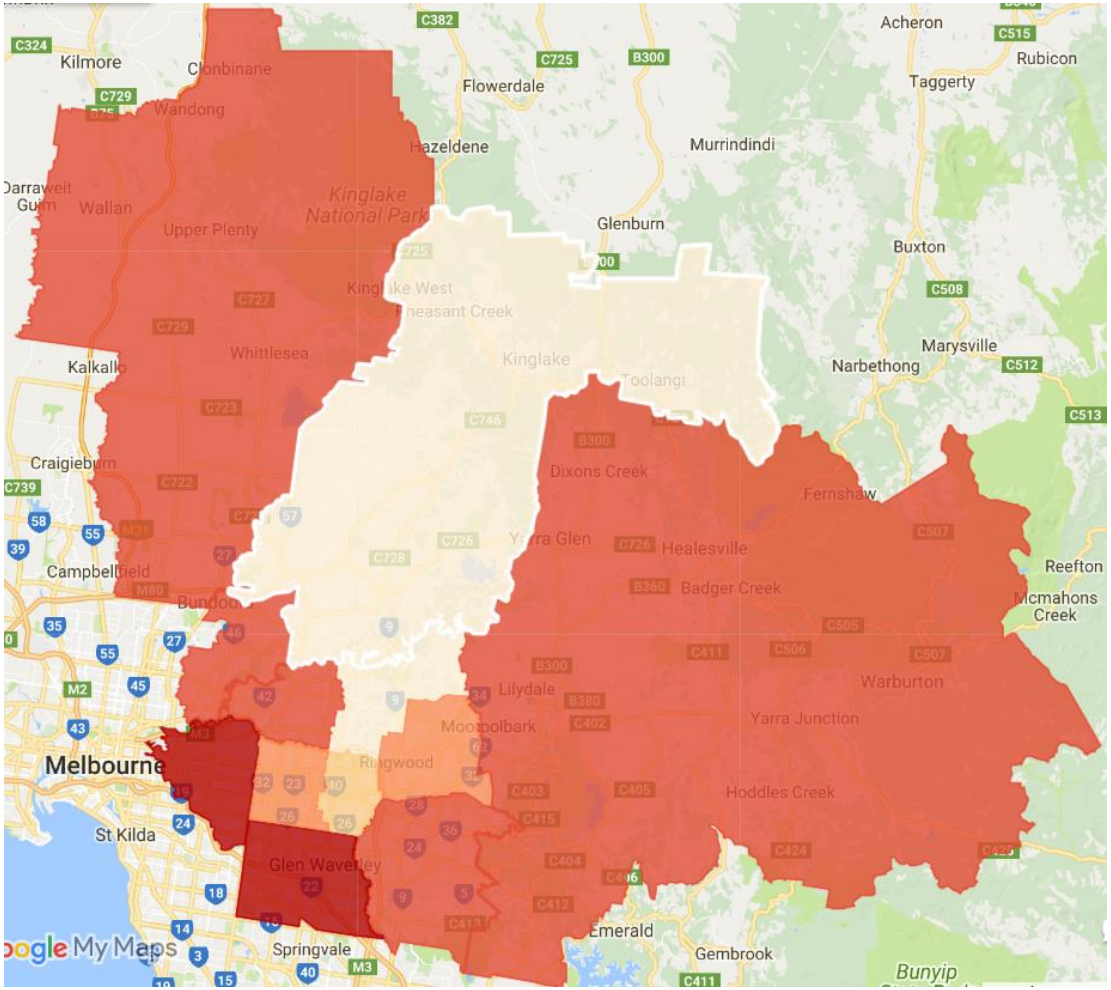
What does the data say?

- EMPHN catchment has a significant ageing population and increasing

Why is this a significant opportunity

- An emerging focus for PHNs
- Important issue to government – YES
  - Aged care policy in flux, awaiting policy and funding decisions
  - Two funding streams are noted in 2018-19 federal budget but still awaiting clarity on implementation
- Internal skills at EMPHN

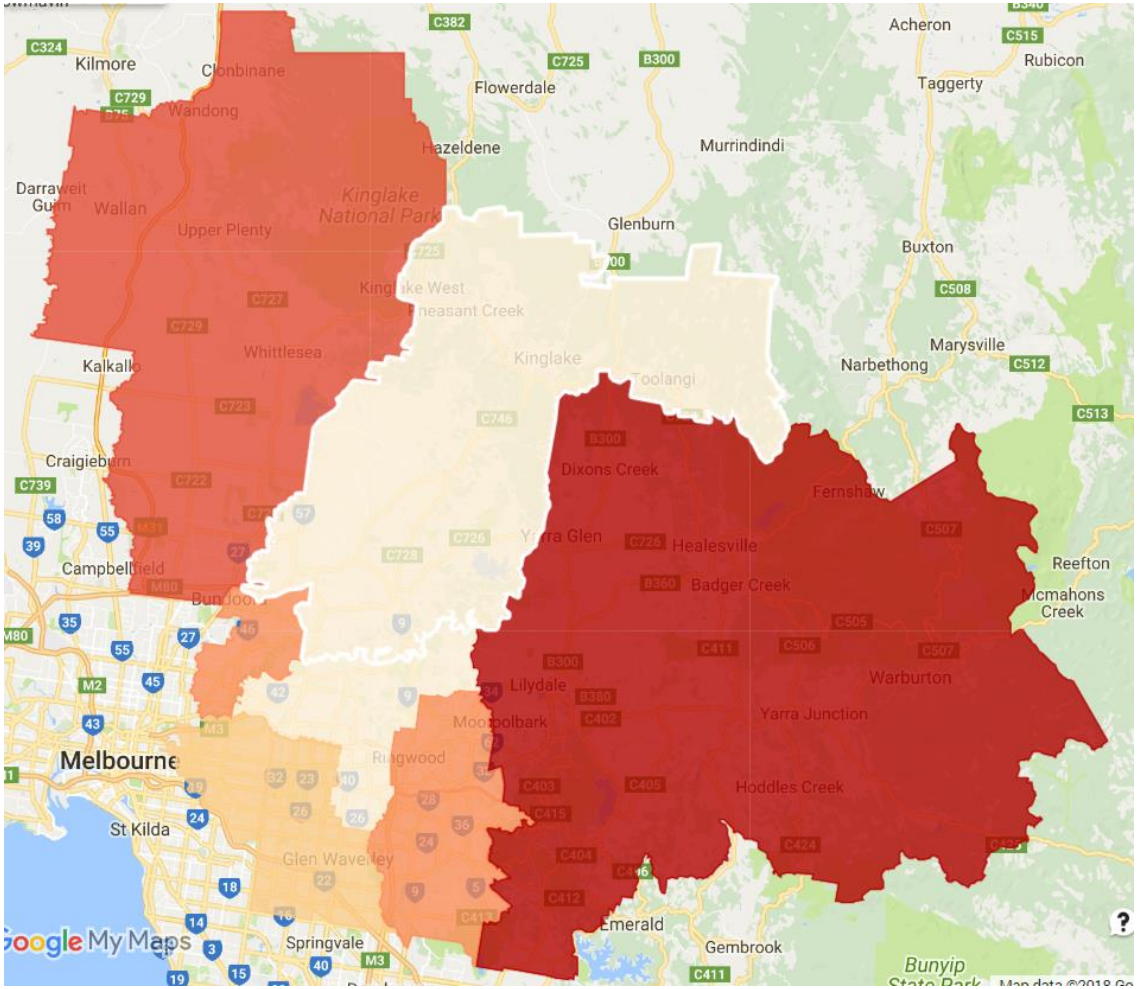
65 year old population



The 65 years + population of the EMPHN catchment is highest in the inner suburbs

ABS, 2016

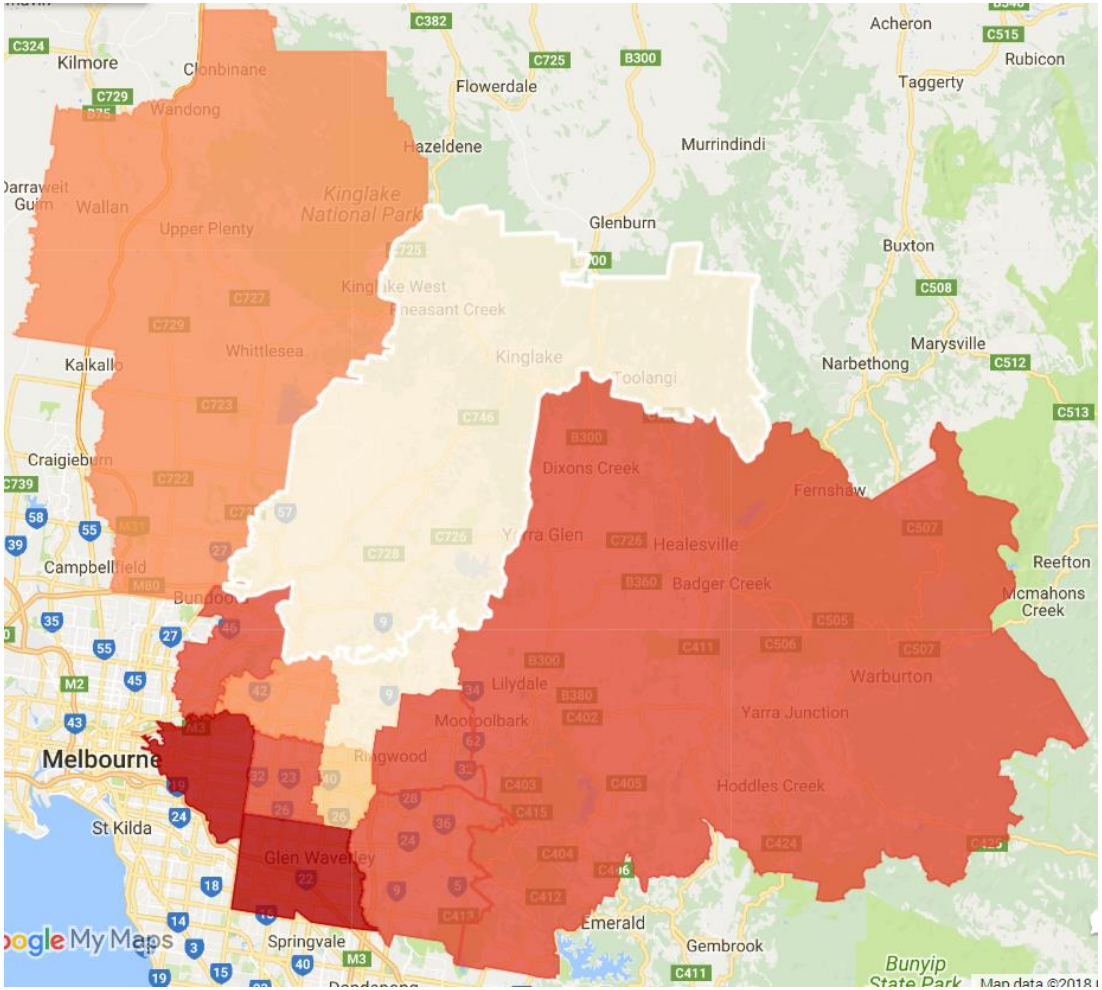
65 year old Indigenous population



The 65 year + indigenous population is highest in the outer suburbs

ABS, 2016

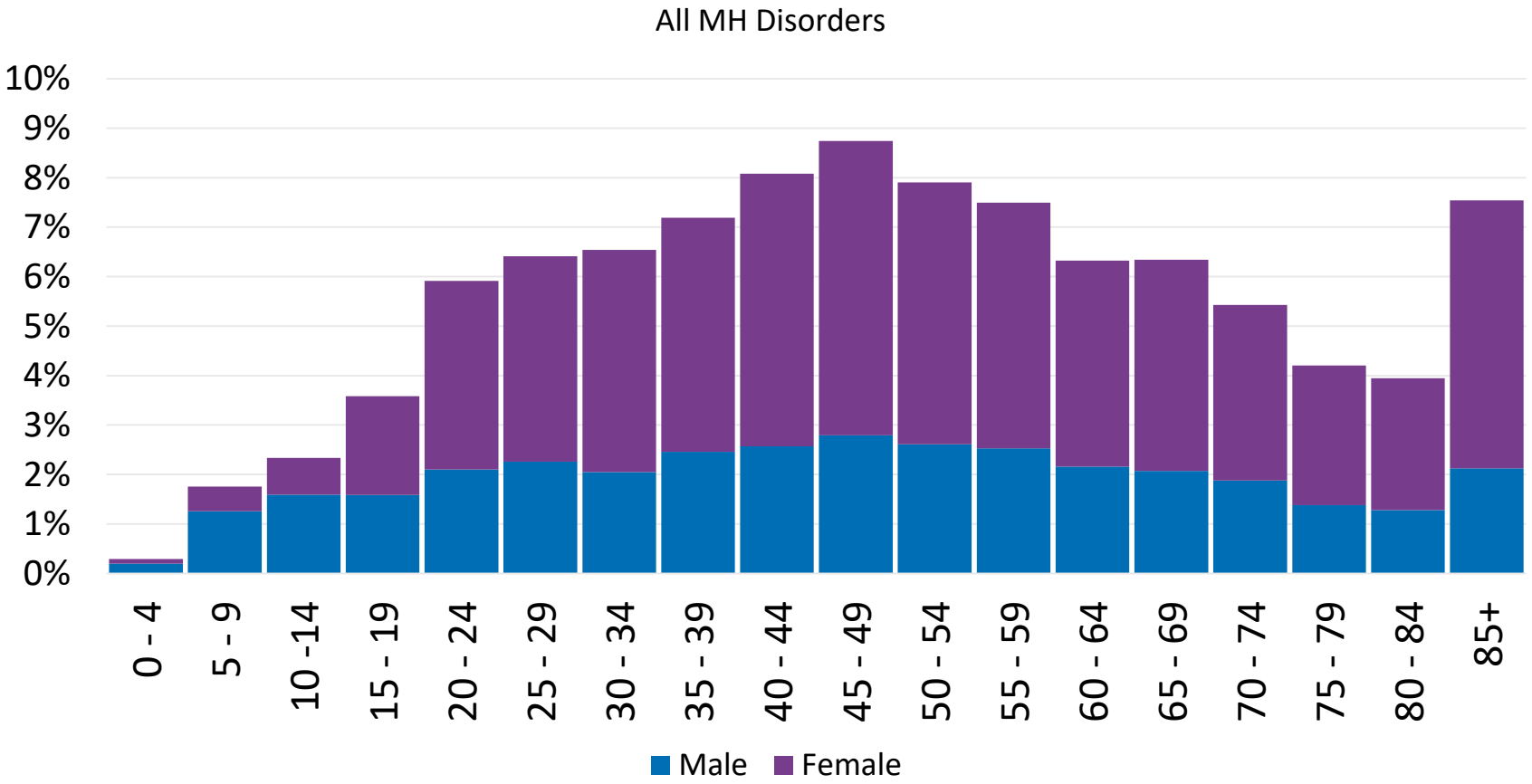
65 year old lone person households



The number of lone person households is highest in Boroondara followed by Monash.

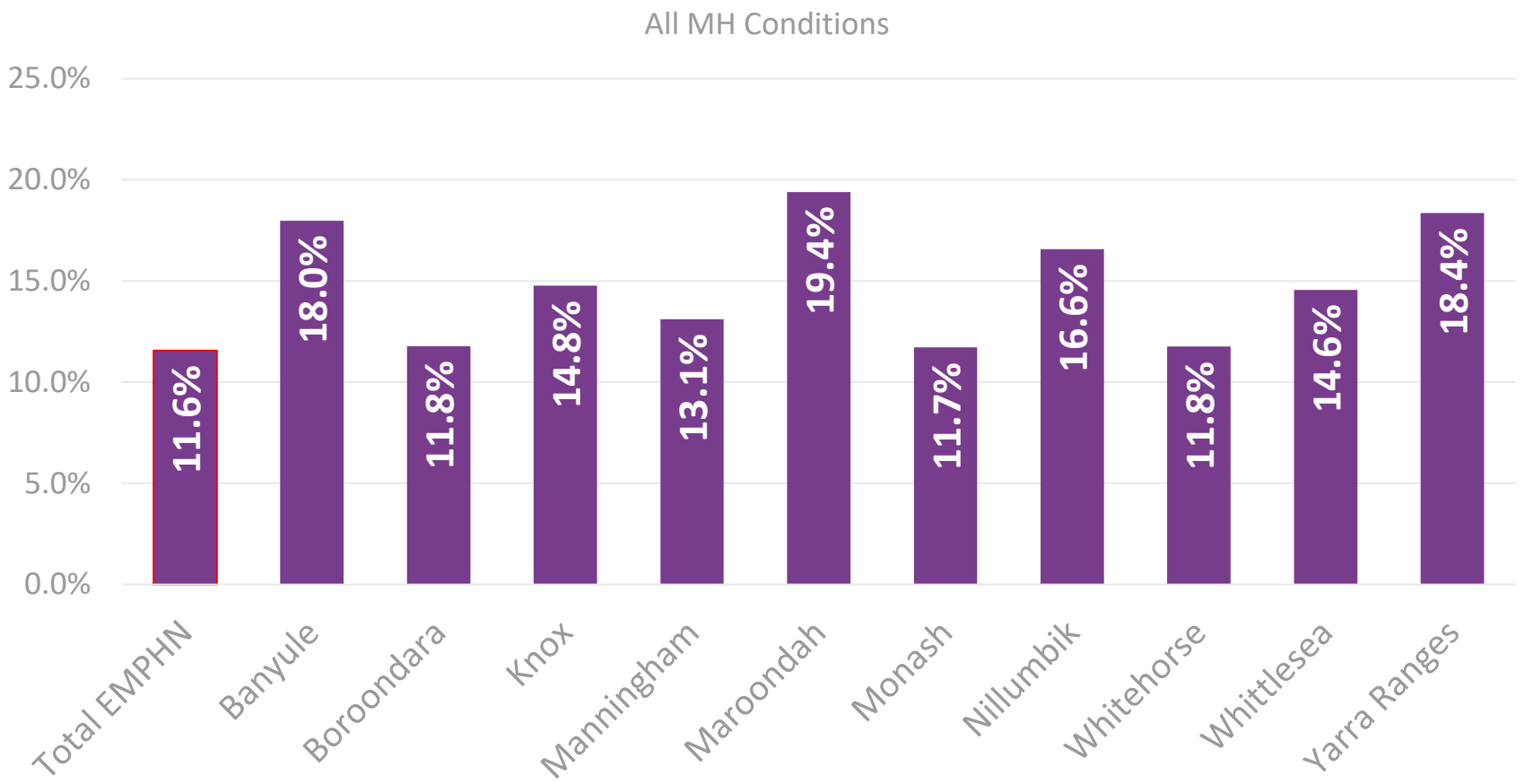
ABS, 2016

Burden of disease – mental health



POLAR, 2017

Burden of disease – mental health



POLAR, 2017

Mental health comorbidities

Chronic Disease Category	# of 65 Population	% of 65 Population
Mental Health	18,033	16.3%
AoD	395	0.4%
Cancer	2,710	2.5%
Cardiovascular	11,985	10.8%
CKD	456	0.4%
Dementia/Alzheimer's	1,130	1.0%
Diabetes	3,579	3.2%
Musculoskeletal	7,908	7.1%
Oral	115	0.1%
Respiratory	4,684	4.2%

This table represents the number of people aged over 65 years with a MH diagnosis and the rates for comorbidities. For example there are 11,985 people with a CVD diagnosis who also have a MH diagnosis (66%)

POLAR, 2018

Sample size= 18,033 (2017-18)

Where can we be most impactful?

What makes this a high impact investment?

- Maintaining people to live in the community
- Builds the capacity of general practice to support consumers and their family in managing mental health issues
- Impact on hospital admissions
- Addresses a current gap in RACFs where mental health services are either non-existent or minimal
- Potential to utilise the Mental Health Nursing workforce that is impacted by changes to mental health service delivery

What are the options?

- Review outcomes of current pilot project
- Potential to deliver mental health support to residents in RACF

What does it mean for the client?

- Improved mental health as they age (whether in community or RACFs)
- Maximising their overall health and wellbeing
- Maintain ability to continue living in the community
- Family and carers supported to manage their loved ones at home

Mental Health and Physical Health

Anne Lyon
Executive Director Mental Health & AOD

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What is the opportunity?

What does the data say?

The life expectancy for people with enduring mental health issues is 20 years less than the general population and on a par with the Aboriginal population

Why is this a significant opportunity

- ❑ An emerging area for PHNs
- ❑ Important issue to government
  - National Mental Health Commission & 5th National Mental Health Plan highlights as an issue
- ❑ Internal skills at EMPHN
  - Strong links to chronic disease management and GP Engagement work

Comorbidities related to MH

Chronic Disease Category	1	2	3	4	5
Mental Health	23,428	20,068	14,999	9,509	4,688
AoD	627	664	548	398	200
Cancer	1,252	1,133	911	549	235
Cardiovascular	5,643	5,013	3,847	2,486	1,150
CKD	182	177	118	64	37
Dementia/Alzheimer's	425	306	202	107	60
Diabetes	1,778	1,697	1,262	864	396
Musculoskeletal	4,174	4,190	3,362	2,237	1,096
Oral	58	41	38	22	<20
Respiratory	4,316	4,120	3,194	2,083	999

This table represents the number of comorbid diseases people have in relation to Mental Health conditions. It represents a component of the relationship between mental and physical health.

POLAR, 2018

Sample Size= 79,856 (2017-18)

Where can we be most impactful?

What makes this a high impact investment?

- Lower the mortality and morbidity rates for people with severe and enduring mental health issues
- Consolidation and mutual reinforcement of our strategy
- Provides the opportunity for integration of internal resources to address chronic illness

What are the options?

- Informed by models gaining traction elsewhere
- Two pronged approach
    - Community health provides a solid platform with multidisciplinary practice
    - Target multidisciplinary GP practices

What does it mean for the client?

- Integrated care that addresses whole of person needs
- Improved outcomes – physical, mental, social
- Opportunity to be well supported in the community

Opportunities in Integrated Care

Harry Patsamanis, EMPHN Executive Director Integrated Care

Transforming the Chronic Disease Model

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Pressures on the system

- Growing demand
- Ageing population with growing complexity
- Avoidable readmissions remain a growing concern
- ED presentations for category 4 and 5 remain high
- Out patient services that are inefficient and not meeting patient needs
- Fragmented care that is unable to seamlessly link health and human services for patients who need it

Patient voice

Attributes of integrated care that matter to people:

People are:

- Viewed as a whole person– valuing client, carer and their time
- Supported - psychological as much as physical
- Actively engaged and enabled to self-manage

Services are:

- In the community and close to home
- Proactive rather than reactive
- Consistent and coordinated
- Accessible, flexible, responsive and equitable

Key enablers:

- Communication, consultation and information sharing
- Education, resources and peer support that promotes clinical competence and health literacy
- Named main point of contact and continuity of care
- Social connection

What is the opportunity?

To listen to the patient voice and design a chronic disease approach that is truly patient centred

- Learn from the Stepped Care Model for mental health and bring the learnings to chronic disease management
- Identify what are the key enablers to better chronic disease management – evidence, national/international models
- Describe a set of principles, *evidence based levers* that we can use to define the elements of chronic disease models of care we want to encourage in our catchment
- Use our commissioning dollars to encourage innovation and to drive the market to implement more effective models of chronic disease management inline with our principles
- Provide opportunities to support patient self management

What we have to build on

- Learnings from Care First
- Learnings from Care Point
- Diabetes management – IDEAS and North East Model
- Role of Pharmacists in teams – general practice and Bolton Clarke
- Collaborative projects – health links, frail older people

What we have to build on (cont.)

Rising Risk

- More to gain by intervening at a rising risk rather than current high risk cohorts
- Use data tools to identify patients, understand their characteristics, design interventions that will manage risk

Where can we be most impactful?

What makes this a high impact investment?

- Moving care from hospital into community, getting primary care to work at top of practice - complex care and polypharmacy
- Assist general practice to manage greater acuity – innovation that supports this approach
- Outpatient reform agenda – aligning with DHHS objectives
    - Positioning health pathways for standard referral processes
    - E-referral as a mechanism for transmitting information
    - Primary care engagement – managing the change
- Identify rising risk cohorts in the primary care setting and intervene earlier before these patients become frequent presenters to hospital – test the interventions

What does it mean for the client?

- Better care coordination
- Accessing care in the community
- Services that respond to patient need
- Providing opportunities for self management

Meaningful Engagement of General Practice

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Insights

Insights from our stakeholder survey

- GPs are not clear about the role of PHNs
- There is a high degree of variation across our catchment in:
  - Level of interest
  - Level of engagement
  - Capacity
  - Capability
- General practice have a high degree of engagement and satisfaction with our engagement events
- General practice values the support PHNs offer for practice improvement
- General practices are capitalising on opportunities offered through our commissioning activities

Why is this a large scale opportunity?

- Market segmentation to better understand our general practices
- Purposeful engagement, targeting initiatives to achieve an outcome
- Incremental shift in how we work with general practice – commissioning for outcomes
- Directing the resources and tools that we have in place (building blocks) to the right practices depending on their readiness to engage – strategic engagement
- Shifting expectations so that we are measuring change over time rather than transactional engagement as the primary outcomes
- We need to identify GP clinical leaders (young and emerging) that we can develop and work with to drive innovation

What we already have in place

- POLAR – producing standard reports to feedback into general practices
- E-referral
- HealthPathways
- Funding innovation – Pharmacists in General Practice pilot
- Workforce education program
- Immunisation/cancer screening other DoH priority areas
- Liaison and support roles – in-house engagement expertise
- My Health Record
- QI program that will build capacity using the POLAR standardised reports
- Practice 2030 – our high achievers program

Purposeful engagement

Passive engagement:
What we want general practice to know about us
Raising awareness across all practices so they understand what EMPHN has to offer; how to access tools and resources including education and how to make contact with us when they want help

Active engagement:
Purposeful strategically driven engagement
Categories of engagement based on practice readiness and strategic positioning:
Monitor, Engage, Sustain, Grow

Where can we be most impactful?

Preparing for Patient Centred Health Care Homes models

- Tiering for outcomes
- Meaningful use of the tools we have
- A systematic approach to shifting general practice towards enhanced primary care
- Better utilisation of our staff resources

What does it mean for the client?

- An improved experience
- Better outcomes

A bold vision for general practice

Organised general practice

- Practice segmentation
- Practice portals
- Practice and clinician QI
- Patient Centred Health Care Homes models
- E-referral - GPs/hospitals/specialists
- My Health Record

What we need to do next

- Refine our approach – capacity, capability, engagement
- Service map to determine practice distribution across the catchment (equity of access)
- Strategic engagement plan identifying prioritised practices and why
- Move to more meaningful use of the tools we've developed – POLAR and HealthPathways


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Thank you