AMA

AMA POSITION STATEMENT

Local Hospital Networks and GP-led Primary Care Services Designed to Reduce Potentially Preventable Hospitalisations 2020

1. Introduction

1.1 Appropriately funded and resourced GP-led primary care can address the health needs and manage the escalating costs associated with the growing incidence of chronic and complex disease. To achieve this, greater emphasis on supporting the role of high functioning patient centred primary health care, particularly general practice, will be required from the broader health and medical community.

1.2 This position statement highlights the key issues pertaining to potentially preventable hospitalisations (PPHs) and the important role the Local Hospital Networks (LHNs)[1] could play in supporting GP-led primary care services designed to reduce PPHs.

2. Potentially preventable hospitalisations

2.1 PPHs refer to hospitalisations thought to have been avoidable if timely and adequate non-hospital care had been provided, either to prevent the condition occurring, or to prevent the hospitalisation for the condition.[2,3]

2.2 The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Rather the hospitalisation may have been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings (including by general practitioners, medical non-GP specialists, dentists, nurses and allied health professionals).

2.3 There are 22 conditions for which hospitalisation is considered potentially preventable across three broad categories: *vaccine preventable conditions; acute conditions;* and *chronic conditions*. With almost half of all PPHs due to chronic conditions, there are significant benefits from ensuring access to timely and clinically necessary health care.

3. GP-led primary care

3.1 There is an extensive body of research that demonstrates primary care delivers the best health outcomes and is the most cost effective part of the health system. Primary care is central to the delivery of high quality cost-effective health care. In countries with well-organised primary care, people live longer, are healthier and there is more equity than in systems which rely on secondary hospital care.[4]

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[1] A Local Hospital Network (LHN) is an organisation which directly manages single or small groups of public hospital services and their budgets, and is directly responsible for hospital performance. An LHN is usually defined as a business group, geographical area or community. Every Australian public hospital is part of an LHN. Some jurisdictions have their own names for LHNs. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations'.

[2] AIHW (2019) Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18 https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview

[3] ACSQHC (2017) A guide to potentially preventable hospitalisations indicator in Australia https://www.safetyandquality.gov.au/wp-content/uploads/2017/03/A-guide-to-the-potentially-preventable-hospitalisations-indicator-in-Australia.pdf

[4] Starfield, Shi and Macinko (2005) Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly* 83(3): 457-502.

3.2 The AMA supports a robust model of GP-led primary care[5] that:

- provides care equitably at the right time, at the right place, ensuring a healthier population;
- is cost-effective and community-based, minimising hospital-based care;
- acts as both an enabler and gateway to other services to ensure they are provided in a timely way but only when needed; and
- coordinates care between different health providers and different parts of the health care system, minimising fragmentation, duplication or gaps in care.

3.3 General practice, the core of primary care in Australia, has been undermined by years of underfunding while the complexity of patient consultations has increased. The AMA position is that funding for general practice must be increased to 16 per cent of the Federal health budget. This aditional funding can support a transition to models of primary care that are better supported to manage increasing incidence of chronic disease, intervene early to prevent accute hospital presentations, and coordinate care of people leaving hospital to prevent readmission where possible. LHNs have an important role to play by providing resources and infrastructure, and where appropriate, funding for out of hopsital services.

4. Key issues

4.1 There were nearly 748,000 hospitalisations in Australia in 2017-18 for the 22 conditions for which hospitalisation is considered potentially preventable.[6]

4.2 This represented 6 per cent of all hospital admissions to a public or private hospital in Australia that year. Potentially preventable hospitalisations accounted for more than 2.8 million bed days nationally – equivalent to 9 per cent of all public and private hospital bed days.

4.3 PPHs are therefore very costly, and across Australia in 2016, the costs of PPHs related to chronic disease was estimated at around $2 billion.[7]

4.4 PPHs are a system stress indicator. Addressing the root causes requires the focus to shift from funding services to funding systems and structures – or from funding treatment to funding prevention. Comprehensive GP-led primary care and innovative shared care arrangements must be supported as the population ages and the burden of chronic disease grows. The problem belongs to the community – as such the solution must involve everyone.

4.5 LHNs provide important community programs for chronic disease in communities across Australia, however these programs are hospital-centric and the involvement of GPs is at best limited and more often completely absent.

4.6 The role of the GP is increasingly important in supporting/providing long-term care for patients. An adequately funded primary care system ensures value for money by providing patients with the right care at the right time, in the community, thereby reducing costly potentially preventable hospital admissions. A challenge to the current system is that hopsital funding and primary care funding come from different sources. Investments in general practice will lead to better health outcomes and cost savings, however these saving come from different budgets. A solution to this is the incorporation of pooled funding from LHNs with targetted Federal funding

[5] See AMA Position Statement General Practice in Primary Health Care – 2016 for more details.
[6] AIHW Op Cit.
[7] Grattan Institute (2017) Building better foundations for primary care https://grattan.edu.au/wp-content/uploads/2017/04/Building-better-foundations-for-primary-care.pdf

to incentivise models of care that prevent hospitalisations. The goal is to move from a volume-based system to a value-based system.

5. The evidence

5.1 There is strong local evidence to support stronger GP-led primary care to decrease PPHs. The examples focus on proactively supporting patients to better manage their health and in managing acute and chronic conditions in a primary care setting.

Western Sydney Integrated Care Demonstrator Program

5.2 The Western Sydney Integrated Care Demonstrator Program (ICDP) is an example of a successful GP-led primary care service designed to reduce PPHs – it is a program supported by the LHN. The program received NSW Government funding to deliver system-wide approaches for integrating care at the local level.[8]

5.3 Under the ICDP, hospital clinicians in Western Sydney Local Health District work in partnership with the Primary Health Network Western Sydney and other health agencies in the primary care, not-for-profit and private sectors to develop and progress approaches to integrated care for patients with chronic conditions. The aims are to improve the care experience for patients, carers and families; advance the health of the population; achieve better use of health resources; and improve the work life of healthcare providers.

5.4 Targeted patients were enrolled into a Patient-Centred Medical Home in general practice and empowered to understand and manage their chronic disease. Care coordination and care navigation is a feature of the program – Care Facilitators located within community and primary care monitor patients and facilitate referral to health coaching, self-management strategies and non-GP specialist and other health care services.

5.5 The final evaluation of the ICDP has produced very positive outcomes: Emergency department (ED) presentations decreased by 32 per cent, potentially preventable hospitalisations decreased by 37 per cent, and ED costs decreased by 33 per cent based on National Weighted Activity Unit measures.[9]

Tasmania Community Rapid Response Service (ComRRS)

5.6 The Community Rapid Response Service (ComRRS) is a model that operates in Tasmania specifically developed to manage patients in their homes for acute problems which might otherwise have resulted in admission to hospital.[10] The team of highly skilled nurses work on referral from (and in collaboration with) GPs to manage patients. Patients referred to the service are contacted within four hours of a referral. Other healthcare professionals such as physiotherapists and occupational therapists collaborate with GPs to plan patient care.

5.7 ComRRS allows patients to receive acute care such as intravenous antibiotics to treat conditions like cellulitis, urinary tract infections, pneumonia, iron infusions, intravenous re-hydration, or indwelling catheter changes in their own home or residential aged care facility. This frees up

[8] NSW Government (2016 Better health together – Western Sydney Integrated Care Program https://www.betterhealthtogether.com.au/about-the-program/integrated-care-demonstrator-program

[9] NSW Government (2019) The New Frontier of Healthcare: Western Sydney Integrated Care Demonstrator 2014-2017 https://www.wentwest.com.au/documents/phn/programs/capacity-capability/The_New_Frontier_of_Healthcare_Western_Sydney_Integrated_Demonstrator_2014-2017.pdf

[10] Tasmanian Health Service (2019) Community Rapid Response Service (ComRRS) https://www.dhhs.tas.gov.au/ths/community_rapid_response_service_comrrs

hospital beds and saves the cost of a hospital attendance. The savings were calculated to equal over $14,000 per GP at the ten month evaluation.[11]

5.8 ComRRS is a positive model of care, however under the current arrangements GPs are not remunerated for the referral, management plan, arranging scripts and ongoing advice during the ComRRS treatment. GP remuneration would likely encourage wider use of ComRRS by GPs rather than the the quicker, less onerous option of directing patients to the hospital ED.

5.9 The strength of ComRRS is that it can only be accessed by referral from general practice and the GP maintains oversight of the management of the patient.

6. AMA position

6.1 GPs are highly skilled medical professionals at the forefront of healthcare in Australia; they are the cornerstone to succesful primary care. GPs have the expertise and the capacity to lead a truly cost-effective, community-based model of primary care that will allow Australia to transition to a system where only high acuity patients and specialised procedures are managed in hospitals.

6.2 In order to achieve this, funding and support for coordinating care between GPs and hospitals is required, as well as full utilisation of community health resources. This will also require more episodes of accute care to be provided outside of hospitals in general practices, community health centres, and in the home by GPs and other health professionals working with GPs.

6.3 The AMA is proposing a model that coordinates funding from different streams of the healthcare system and invests them in integrated GP-led primary care that supports patients to manage their health outside of hospitals and reduces readmisions. Pooled funding incorporating LHN funding for community care and additional Commonwealth funding should fund this model to reduce preventable hospitalisations. Key features include:

- Improved identification of patients who are at high risk of requiring admission to hospital.
- Improved implementation of preventative care measures.
- Improved shared coordination of patient care with clearly defined roles and responsibilities between the GP and non-GP specialist care of patients, particularly with respect to patients at high risk of admission. This must include improved access to timely secondary advice.
- Continuity of care prioritised in healthcare planning.
- Support and advice for GPs from non-GP specialists to implement best-practice, evidence-based care for patients with chronic illness and multimorbidity. This might include the provision of equipment, allied health, or psychosocial support for a patient in the community which might otherwise require admission without this support.
- Development of improved communication, care planning and delivery between GP and non-GP specialist care, particularly with regard to sharing of information about patient care-planning, current medical history, discharge planning, information regarding a patient's goals (including advance care/end of life care plans), and a better shared understanding of the psychosocial context in which a patient lives.
- Improved trust of a patient that their GP and non-GP specialist services are working together as a "team" to support and improve their health, therefore improving their engagement in their own health.
- Paying GPs to discuss and coodinate care of complex patients.

[11] Walsh and Turnock. Community Rapid Response Service (ComRRS): Working Together to care for patients in the community. *Tasmanian Health Service*. https://az659834.vo.msecnd.net/eventsairaueprod/production-acrrm-public/daefd204d2f44c198d1165fb1c1744ba

- Enhanced ability of LHNs in conjuction with PHNs to implement funded, targeted or timely interventions in collaboration with GPs e.g. to target local health priorities or implement strategies during during influenza season.
- Agreed use of improved communication modes including digital health strategies: secure messaging, My Health Record, and patient apps that support shared care arrangments, and might allow improved monitoring of patient symptoms and clinical parameters.
- Capacity building with LHNs working hand-in-hand with local general practices in service provision.

6.4 In this context, the AMA believes that with an ED visit costing around 10 times more than a visit to the GP, there is a strong argument for LHNs to contirbute funding to targeted GP-led primary care services to reduce preventable hospital admissions and re-admissions. This could be acheievd by allocating a certain percentage of their funding to support GPs and general practices to coordinate primary care services. This pooled funding will ease long-term financial pressure on the health system, as hospital-based care is more expensive than primary care delivered in the community.

6.5 A key component of this model will be widespread adoption of the patient centred medical home, which is a model of primary care that is patient-centred, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.[12] A key challenge to the medical home model is lack of adequate remuneration for GPs and other health care providers who are part of the care team, for example general practices are limited to five allied health and nursing staff under the current Workforce Incentive Program and these incentive payments are not indexed. LHNs can play an important role here by supporting practices to recruit additional staff and assisting in the coordination of out-of-hospital care. They can also support hospital staff to visit practices and patients in their homes with members of the care team.

6.6 Importantly, any model implemented would need to:

- recognise and support the usual GP or usual general practice[13] as the central coordinator of patient care with appropriate funding provided to support the coordination – ideally this would be the patient's medical home;
- adopt a collaborative approach to care, with the usual GP retaining overall responsibility for the care of the patient;
- Prioritise care in the community in healthcare planning, with a central role for GPs in program design;
- provide patients with appropriate access to care based on their clinical needs;
- preserve patient choice;
- protect clinical autonomy;
- include quality measures and cross-sector incident reporting; and
- recognise the rights of medical practitioners to set their own fees.

See also:

- AMA Position Statement General Practice in Primary Health Care - 2016
- AMA Position Statement on the Medical Home - 2015
- AMA Position Statement General Practice/hospitals transfer of care arrangements - 2018

[12] See AMA Position Statement on the Medical Home – 2015 for more details.

[13] The term "usual GP" refers to the GP who provides the majority of the patient's care. Some patients will attend the same practice but do not have a preferred individual GP in which case they will have a usual general practice. According to the AIHW, patients with a usual GP have better health outcomes.