



Primary Health Care Advisory Group consultation – response to the survey questions related to the Discussion Paper

Joint submission from the Primary Care Collaborative Clinical Trials Group (PC4), the Clinical Oncology Society of Australia (COSA) and Cancer Council Australia

The **Primary Care Collaborative Clinical Trials Group (PC4)** is a national group funded by Cancer Australia to build evidence around the role of primary care across the cancer continuum.

The **Clinical Oncology Society of Australia (COSA)** is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients.

Cancer Council is Australia's peak national non-government cancer control organisation. Its members are the eight state and territory Cancer Councils.

Contact: Paul Grogan, Cancer Council Australia paul.grogan@cancer.org.au 02 8063 4155

Link to discussion paper

<http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-discussion>

Overall

1. What aspects (*timeliness, cost and appropriateness of care*) of the current primary health care system work well for people with chronic or complex health conditions?

The Medicare Benefits Scheme provides universal access to essential health care to all Australians.

Pharmaceutical Benefits Scheme provides patient's access to a range of subsidised drugs.

These schemes provide a framework to support access to quality care to people who require medical services or therapeutic products however, there are limitations and gaps to how people use and benefit from these systems. We acknowledge that the Government is currently reviewing these schemes to improve the way they can serve the all Australians.

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

b) Nationally?

Currently the healthcare system experiences poorly integrated care between healthcare providers, especially between primary and hospital care. In terms of cancer, this occurs in terms of diagnostic pathways (or lack of them), and also in terms of communication and clarity of roles during and after cancer treatment.

This disconnection across services impacts the quality of care provided to a person affected by cancer throughout their cancer journey. In particular, areas of geographical remoteness and/or low population numbers can experience additional barriers to seamless transitions in care due to the limited medical specialists that can be accessed locally. This can delay access to essential specialist services.

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

b) Nationally?

Improved coordination of care between healthcare providers, and a greater focus on approaches to improve quality of care can support the smooth transition of people to various services throughout their cancer journey across the entire health care system.

4. What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice (*using the skills they are educated competent and authorised to perform*)?

- Underuse of practice nurses and other allied health professionals to take on some of the clinical work in primary care and allow General Practitioners to use their time to focus on areas at the top of their scope of practice;
- Poor use of existing General Practitioner information systems to manage practice populations more systematically;
- Limited incentives to focus system changes to improve quality of care;
- Poor health literacy in some people affected by cancer and subsequent compliance and adherence to prescribed treatment can be a barrier to primary care providers delivering optimal care

Theme 1, Effective and appropriate patient care

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 (patient agreeing on an ongoing basis the health provider/s of their choice) with a health care home for people with chronic or complex health conditions?

Yes

a) Why do you say that?

Unlike countries such as the United Kingdom, Canada and New Zealand, currently Australia does not have a patient registration system however, patient loyalty to a primary health care practice or individual General Practitioner may act as an informal scheme.

When assessing the individual country's international models of patient enrolment, no one system would be appropriate for replication in the Australian context. The concepts and aspects of the various models would inform an Australian patient enrolment scheme. This scheme would support formalised continuity and coordination of care to deliver comprehensive chronic disease management. A scheme requires a provision for alternative care in certain cases where a registered patient needs to access primary care at a different location.

This scheme would provide an opportunity for primary care facilities to engage in continuous improvement practises to maintain quality and assurance of the standard of care being delivered.

Implementation of an Australian patient enrolment model would be supported by the blended funding mechanism proposed below.

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

Yes

a) Why do you say that?

The role of primary care in cancer control is increasingly recognised as a vital component of cancer services in Australia. Cost-effective healthcare relies on the delivery of appropriate care by the right team at the right time. Healthcare systems with a strong primary care component have been demonstrated to be more cost-effective than those which are predominantly led by hospital specialistsⁱ. This is probably due to more efficient care when delivered and coordinated by a generalist, rather than multiple specialists, and through managing access to more expensive hospital-based care. The key elements in a conceptual model of general practice and generalism are accessibility, holistic patient-centred, team-based care, care coordination, continuity and management of complex multiple problemsⁱⁱ.

Cancer patients living longer

Australia has some of the best cancer survival outcomes in the world. A recent study published in The Lancet showed five-year survival in Australia was high for all eleven cancers, but particularly for cancers of the bowel, breast and prostateⁱⁱⁱ. This is mostly likely due to improvements in screening, early detection and treatment.

Improvements in treatment and early detection have led to marked improvements in cancer survival in Australia. Five-year survival rose from 47% to 66% between the periods of 1982-87 and 2006-10, and several cancers now have survival rates of over 90%^{iv}. With an ageing population and a median age of diagnosis of new cancer of 67 years, there is a growing number of people requiring long term follow-up and management of the consequences of a

cancer diagnosis and treatment. The escalating numbers of cancer survivors places an increasing burden on costly hospital oncology clinics, adding to the growing demand for more cancer services to be delivered in primary care^v.

Management of co-morbidities and complex case management

Cancer survivors, as part of the ageing population with increased longevity, often have several comorbidities. Many oncologists continue to monitor their patients for cancer recurrence long after the risk of recurrence has significantly diminished. This hospital-based model of follow-up focuses on detection of cancer recurrence, failing to attend to the management of other chronic comorbid conditions, many of which will ultimately cause death and morbidity in those who have survived cancer^{vi}. The multiple needs and comorbidities of these patients are more appropriately dealt with from a generalist perspective. This has become increasingly important as the number of people living with and beyond cancer continues to rise. This also supports the identification and management of possible drug interactions as the treatment of co-morbidities may require multiple therapies.

Supporting smooth transitions in care

The introduction of a General Practitioner (GP) to the oncology care team during active treatment phase could assist in smooth patient transition to follow-up care. General practice involvement in the multidisciplinary team management of a cancer case can attract Medicare billing incentives. Medicare item numbers should be reviewed to ensure the billing structure comprehensively covers and promotes GP involvement in coordinated care planning for a patient's transfer from acute to primary care. Integrated primary care in cancer management has shown to result in improved continuity of care, greater team work, proactive rather than reactive care, and improved patient support.

In addition, current research suggests that the practice nurse role in a primary care setting could improve the coordination of patient care and the ability to perform billable services where Medicare eligible services are claimable. Alongside the GP, they have the ability to manage people with chronic diseases who require time and attention in their management.

- Review the current Medicare item numbers relating to GP involvement in clinical cancer care (cancer as a chronic disease) to ensure Medicare incentives are extensive and targeted to support increased involvement of the general practitioner for pre- and post- treatment care.
- Existing Medicare Chronic Disease Management items should be applied systematically to support cancer survivorship care in the community.

Best practice care

Best practice cancer care is delivered by a multidisciplinary team. This ensures that the needs, including treatment, psychosocial and supportive care, of the person affected by cancer and their carer are addressed in a timely manner. Primary care has an important role in delivering best practice cancer care across the cancer continuum, including the provision of care during and after treatment.

As stated above, best practice cancer care is delivered by a multidisciplinary team to ensure the needs, including treatment, psychosocial and supportive care, of the person affected by

cancer and their carer are addressed in a timely manner. This team approach to care includes the GP.

Using Medicare to support team based care

The following Medicare items numbers aim to encourage GP involvement in the development of cancer treatment and follow up plans through attendance at an arranged multidisciplinary team meeting:

- Case Conferencing aims to improve the care of patients with complex and ongoing medical conditions by promoting coordinated care plans between at least three health care providers attending to the patient.
- Team Care Arrangements support the GP to deliver coordinated cancer care alongside other services to patients with ongoing chronic medical conditions. Related Medicare item numbers provide the GP with access to rebates when coordinating patient care with eligible allied health services

However, eligibility criteria can limit access to rebates. In some cases, Medicare item numbers do not comprehensively cover the range of circumstances, services required or duration of the service required, to support optimal care of the person affected by cancer.

For example, although Medicare Benefit Scheme item numbers exist to support multidisciplinary team discussion, the conditions, especially around time requirements to allow billing of this critical activity, can be prohibitive. It requires a case to be discussed for a minimum of 10 minutes to qualify for billing. However, it is usual practice now for the discussion to be shorter as considerable time is spent by doctors preparing for the case discussion. This affects all specialists and the GP involved in the delivery of multidisciplinary care to the person affected by cancer. To encourage uptake, and support the delivery of quality care, this 10 minute requirement should be changed to allow preparation time by practitioners to be included.

As noted earlier, the introduction of the GP to the oncology care team during active treatment phase could assist in smooth patient transition to follow-up care. This is a shift from traditional GP involvement in cancer care which generally occurs after treatment to address the patient's ongoing care needs.

Improved coordination and reduced burden of disease

- Keeping treatment local to the patient's place of residence through primary health care setting – reduction of burden due to travel and accommodation.
- Supports holistic approach to healthcare – treatment, allied health, support (including psychosocial) through timely referral and access to community services.

7. What are the key aspects of effective coordinated patient care? Please number in order of importance. (1 is top, 4 is least)

2. Care coordination as a recognised function

Care coordination refers to the function of organising patient care activities and sharing information among participants concerned with a patient's care to achieve safer and more effective care. For it to be effective, it needs to be recognised as a formal function than can be built into standard care for

cancer patients and performed by a designated healthcare professional involved in other aspects of the patients care (e.g. a GP or practice nurse) or, where resourcing allows, a specialised role.

2. Patient participation

Patient participation refers to shared processes in which both the patient and health professionals contribute to medical decision-making and care planning. It requires health literacy, self-management, self-awareness, collaboration and empowerment of patients in decisions regarding their health.

2. Patient pathways

Patient pathways are nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group.

1. Other: Our answer

Not one core component of care coordination supports the effective delivery of coordinated care to a person affected by cancer. A comprehensive approach to coordinated care requires action at a number of levels including the health system, health care provider and at an individual intervention level. Care coordination is the responsibility of all health professionals.

Coordinated care promotes the timely and appropriate referral to clinical and supportive services the individual person requires while facilitating the continuity of care between health professionals and settings for care delivery.

A dedicated role for the delivery of care coordination for an individual is important to work within the context of a multidisciplinary team to maximise patient outcomes and act as a liaison between the person affected by cancer and members of the multidisciplinary healthcare team, facilitating continuity of care across different settings by establishing clear referral pathways and timely communication and the identification of relevant support options.

It is critical that the individual affected by cancer is involved in the decision-making and care planning processes. This requires the communication and understanding of their options relating to clinical and supportive care which can be provided by someone involved in the coordination of their care which could be a specialist, someone in a dedicated care coordination position or another representative. This process should also involve the carer and individual's family. Health literacy is critical to supporting patient participation as it assists the person affected by cancer's ability to engage in treatment and discuss their priorities of care.

Patient pathways promote the consistency and continuity of care and provide evidence-based expectations of care delivery for a person affected by cancer. Patient pathways should support the promotion of care options available to the person affected by cancer by healthcare professionals and should always be applied in the context of the individual's care and personal needs.

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

Patient pathways are nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group.

Primary care plays a role in the delivery of optimal care pathways. Optimal care pathways assist:

- To map the patient journey, aiming to foster an understanding of the whole pathway and its distinct components to promote quality cancer care and patient experiences;
- To identify critical points along the care pathway and describe optimal diagnostic and treatment action at that point and;
- In the coordinated approach to delivery of cancer care and support communication avenues between the patient, general practitioner and specialists involved.

The national development of optimal care pathways for patient groups promotes consistency in the delivery of evidence-based cancer care across Australia. Adoption of such guidelines is required at a State and Territory Government level through the local health care system. Principles underpinning optimal care pathways for cancer care delivery include ensuring smooth transitions in diagnostic, treatment, follow-up and allied health services, the coordination of care between services, and the continuity of quality care throughout a patient's cancer journey.

Primary care has a critical role in delivering optimal care to their patient. This includes during active treatment, follow-up care and in the management of complex co-morbidities that are not addressed by a cancer specialist. Uptake of such initiatives and resources by general practice should be encouraged through Medicare item number descriptors relating to the development of patient care arrangements through primary care services. Additionally, endorsement of such guidelines from the Royal Australian College of General Practitioners as best practice would add a level of compliance of their use.

Guidances must be adaptive and maintain flexibility to ensure appropriate application to the individual patient and their situation which could consider their diagnosis, geographic location, priorities of the patient and individual goals of care.

The use and uptake of optimal care pathways could be supported by:

- *Incentivising use of evidence based clinical practice guidelines where general practice involvement is included and endorsed by Royal Australian College of General Practitioners;*
- *Promoting the coordinated uptake of optimal care pathways by State and Territory health systems where general practice involvement is included and endorsed by the Royal Australian College General Practitioners;*
- *Scoping opportunities for collation of hospital data to enable large scale audits of current and future referral pathways of patients with suspected cancer to allow calculation of conversion and detection rates and measure the impact of new*

diagnostic initiatives. This requires investment in appropriate information systems by State and Territory Governments as this data belongs to them;

- *State and Territory Governments to support the establishment of new models of follow-up involving primary care initially for breast, bowel cancer and prostate cancer. This should become the standard model of follow-up care for cancer survivors at low risk of recurrence or adverse treatment effects.*
 - Cancer follow-up care should provide clear guidance for patients, primary care and cancer care professionals about treatment and follow-up plans as well as management of treatment adverse effects and mechanisms for rapid referral and consultation to specialist advice if required. Early contact with the patient's primary care provider at the time of discharge is important.

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?

Telemedicine

- Provide patients with the opportunity to be treated close to home when appropriate. Reduce the burden of travel and accommodation time and expenses when care is delivered locally. Reduce psychosocial impact of travelling away from family to receive treatment;
- Connect regional and rural locations with larger metropolitan and tertiary hospitals to leverage knowledge and promote service improvement and quality delivery of care;
- Connect specialist care with generalist care;
- Promote continuity of care and waiting times.

Shared care models

A number of trials have assessed primary care-led and shared care for cancer follow-up, finding them to be broadly equivalent to hospital specialist care. The strongest evidence for this is among patients with earlier stage breast and bowel cancers^{vii}. A recently completed PC4 trial (The ProCare Trial)^{viii} also showed no differences in a range of outcomes for a model of shared care for prostate cancer compared with routine hospital follow-up. This also has advantages in terms of reduced travel costs for regional and rural patients. Support for greater primary care involvement by both patients and providers is increased after direct involvement in trials in which primary care is adequately supported to take on this new role. Shared care requires clear guidance for patients and primary care professionals about treatment and follow-up plans, as well as management of treatment adverse effects and mechanisms for rapid referral and consultation to specialist advice if required. Early contact with the patient's primary care provider at the time of discharge is also important to implement these models of care.

Role of Primary Health Networks

Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care

The following key objectives of Primary Health Networks aim to coordinate and support chronic disease prevention and management in primary care:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Primary Health Networks must work directly with primary health care providers, other clinical and supportive care providers and State and Territory Government hospitals to deliver the key objectives to ensure improved outcome for patients.

The Primary Health Networks should take a lead role in supporting general practices to implement evidence-based systems to raise cancer screening participation. This could include, for example, establishing recall and reminder systems and sending GP endorsement letters in advance of cancer screening invitations.

The Primary Health Networks should take a lead role and work with State and Territory Governments and Local Hospital Networks to define clear referral pathways in the public hospital system for patients with a high suspicion of cancer. This should prioritise suspected cancers where there are long waiting times for diagnostic services (e.g. bowel and gastro-oesophageal cancers) or where there are large variations in diagnostic pathways and access to multidisciplinary teams (e.g. lung cancer).

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?

Support patient empowerment, control and ability to be actively involved in decision making.

The federally funded My eHealth Record should be developed and implemented to support communication and care between healthcare providers in cancer follow-up. Further research is needed to examine the role of electronic patient held records to improve communication as part of shared care models.

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?

- Education and training for health care professionals involved in delivering a multidisciplinary approach to cancer care on how to use systems;
- Assurance of privacy and security of online systems and information for users of e-health programs for both health care providers and patients
- Technology platforms must be in place and utilised across all services involved in delivering care;
- Adoption of technology by primary health and other providers
- Associated Medicare incentive or support to increase uniform uptake and use

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

- Improve the transfer of information across services
- Support transitions in care across services
- Support follow up and on-going chronic disease care at a general practice level where appropriate
- Provide real time information to all health care providers involved in delivering the individual's care

13. How could technology be used to improve patient outcomes?

Telemedicine can reduce the barrier of geography in providing multidisciplinary quality cancer care and can support locally delivered care. For the person affected by cancer, this can improve time to treatment, reduction in burden of disease associated with travel to treatment facilities and time away from family, and support relationships between larger tertiary facilities and smaller institutions to support ongoing quality improvement in smaller institutions.

My e-Health records can be used to reduce risk of adverse events related to toxicity and drug interactions as it allows health care providers to view a transparent record of prescribed and additional therapies in use. It can also provide a comprehensive history of the individual's health over time and reduces the psychological burden of needing to recall information and repeat information to multiple health care providers.

Overall, the use of technology to support information sharing and communication can support efficient care management. As a result it is hoped that technology will support smooth transitions in care, continuity of care, community based care, and greater efficiency in referral to services and discharge plans.

Theme 3, How do we know we are achieving outcomes?

14. 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?

- Quality assurance to ensure care provided meets appropriate care standards, best supportive care and clinical management;
- The collection of data for benchmarking can demonstrate progress over time on performance of the workforce and systems to supporting improved patient outcomes;
- Provides the opportunity to identify and investigate variations in practice and outcomes, related to both the person affected by cancer and service delivery;
- Overall performance review to ensure ongoing optimal care delivery especially where advancements in treatments or services or the delivery of treatment has been identified and in addition, review of ongoing cost effectiveness of available treatments/services.

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

- Linking available datasets
- Improving the quality of data recording in general practice
- Technology to collect and report this data

Requires scoping opportunities for collation of hospital data to enable large scale audits of current and future referral pathways of patients with suspected cancer to allow calculation of conversion and detection rates and measure the impact of new diagnostic initiatives. This requires investment in appropriate information systems by State and Territory Governments as this data belongs to them.

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

- Responsibility to enable individuals to make informed decisions on their care plan in partnership with the health care provider
- Responsibility to appropriately inform individuals according to their level of health literacy
- Responsibility to provide appropriate documentation to the individual (and carer/families) regarding their treatment

17. How could health care provider accountability for their patients' health outcomes be achieved?

- My e-Health records could collect and document data on the information that has been given to the individual and shows the treatment prescribed.

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

- Be in an environment that facilitates the ability of an individual to be involved in decision making e.g. importance of education and health literacy
- Individuals must be active in seeking services to assist in health choices and then choose to accept recommended patient-centred care
- Involvement in treatment adherence based on health care practitioner recommendation

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

- Education and provision of information resources to support improved health literacy and understanding of care;
- Ensure accessibility and timeliness of appropriate services through referral pathways to support the easy reach of these services.

Theme 4, How do we establish suitable payment mechanisms to support a better primary health care system?

20. How should primary health care payment models support a connected care system?

If you prefer a blended model, as described in Theme 4, select all the components that should apply.

Capitated payments

Capitated payments or 'capitation' is a way of funding health services. Providers are paid a set amount per enrolled client or resident of an area, per time period – often monthly, quarterly or annually.

Pay for performance

Pay for performance is a way of funding health services. Providers receive payment for delivering certain types of care or achieving specific outcomes for their consumers, typically related to quality of care, access to care, patient-satisfaction measures and service provider productivity.

Salaried professionals

Salaried professionals are employed and paid independently of their productivity or their patient's outcomes. This way of funding health services is often combined with expected standards of performance for health professionals and also incentives such as 'pay for performance'.

Fee for service

Fee for service is a way of funding health services, similar to other types of retail transaction. Providers are paid a fee based on the services they provide to consumers, usually based on the time taken to deliver the service, effort or cost.

Other, please specify

Blended model – mix between fee-for-service and capitation, with a component of pay for performance for quality chronic disease care.

- Reimbursement of health care providers on the basis of expected costs for episodes of care;
- Support the appropriate use of services and support quality improvement;
- Individuals recognise a general practice as a medical home for patients.

21. 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?

- Compliance goals associated with quality and safety
- Support practices to create systems to deliver and monitor quality care

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

Medicare provides all Australians with free public hospital care and funds a range of primary care and other health services. The scheme provides universal health care to Australian residents and qualified visitors. Private health insurance is an option for Australians seeking greater incentives on some health and medical services. Although private health insurance plays a role in the Australian health system, for those who cannot afford or choose not to pay additional for private health insurance, Australia's universal health care system should adequately cover the health and medical care needs for all.

23. Do you have anything you would like to add on any of the themes raised in the Discussion Paper?

No.

References:

ⁱ Macinko J, Starfield B, Leiyu S. The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1998. *Health Services Research* 2003; 38(3): 831-65

-
- ⁱⁱ Gunn JM, Palmer VJ, Naccarella L, et al. The promise and pitfalls of generalism in achieving the Alma-Ata vision of health for all. *Medical Journal of Australia* 2008; 189(2): 110-2.
- ⁱⁱⁱ Allemani C et al. Global surveillance of cancer survival 1995–2009: analysis of individual data for 25 676 887 patients from 279 population-based registries in 67 countries (CONCORD-2). *The Lancet* , Volume 385 , Issue 9972 , 977 – 1010. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)62038-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62038-9/abstract)
- ^{iv} Australia's Health 2012. Canberra: Australian Institute of Health and Welfare, 2012.
- ^v Role Redesign Primary Care - Shared Care. Models of Cancer Treatment and Surveillance Post Treatment. Final Report. Canberra: Cancer Australia, 2010.
- ^{vi} Ganz P. Survivorship: Adult Cancer Survivors. *Primary Care Clin Office Pract* 2009; (36): 721-41.
- ^{vii} Emery JD, Shaw K, Williams B, et al. The role of primary care in early detection and follow-up of cancer. *Nature reviews Clinical oncology* 2014; 11(1): 38-48.
- ^{viii} Emery J, Doorey J, Jefford M, et al. Protocol for the ProCare Trial: a phase II randomised controlled trial of shared care for follow-up of men with prostate cancer. *BMJ open* 2014; 4(3): e004972.