Health Alliance

The Care Collective – Caboolture

Improving access to primary health care and care coordination

PHN Commissioning Showcase

Wednesday 13th September 2023

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phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

We acknowledge the traditional owners of the lands on which we meet today, and pay our respects to Elders past, present and future for they hold the memories, the traditions, the cultures and hopes of Aboriginal Australia.

The Health Alliance

A jointly-funded collaboration between Metro North Hospital and Health Service and Brisbane North Primary Health Network, formed in 2017.

Governance: A sub-committee of PHN and HHS Board including Chairs, Chief Executive, Board Directors.
Our vision: People in our region experience an integrated system of care that delivers quality health outcomes.
Our role: To work strategically and collaboratively, taking a systems approach to solving challenges that no one organisation can solve alone.

Our approach

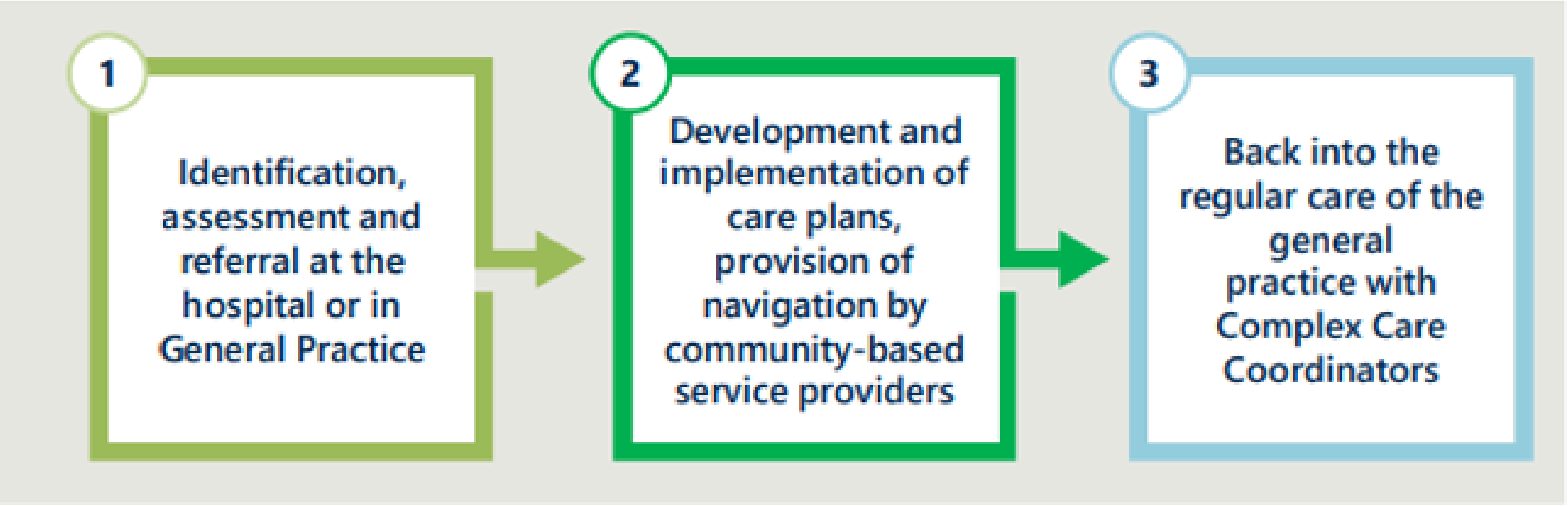
- Joint approach to governance and decision-making
- Prioritising and accelerating initiatives of strategic importance
- Providing a platform for health innovation and co-commissioning, where patient-centred ideas and models are developed, tested and evaluated
- Sharing and amplifying innovation learnings
- Exercising influence and shaping policy and funding levers to expand opportunities to change/improve practice across the health system

Care Collective – Caboolture Introduction

- The Care Collective - Caboolture was a proof-of-concept project led by the Brisbane North Health Alliance aiming to reduce demand on ED by identifying a targeted cohort of chronic and complex patients.
- It involved better identification of the cohort (via HHS and PHC) and implementing a shared care, case management model approach across the care continuum.
  - building on and enhancing existing programs and pathways managing chronic and complex conditions.
  - aims to improve patient quality of life, health literacy and health outcomes and reduce emergency department presentations and hospital admissions.
- Proof-of-concept approach should be scalable to other conditions or catchment areas including diabetes, and other patient cohorts (with amendments).

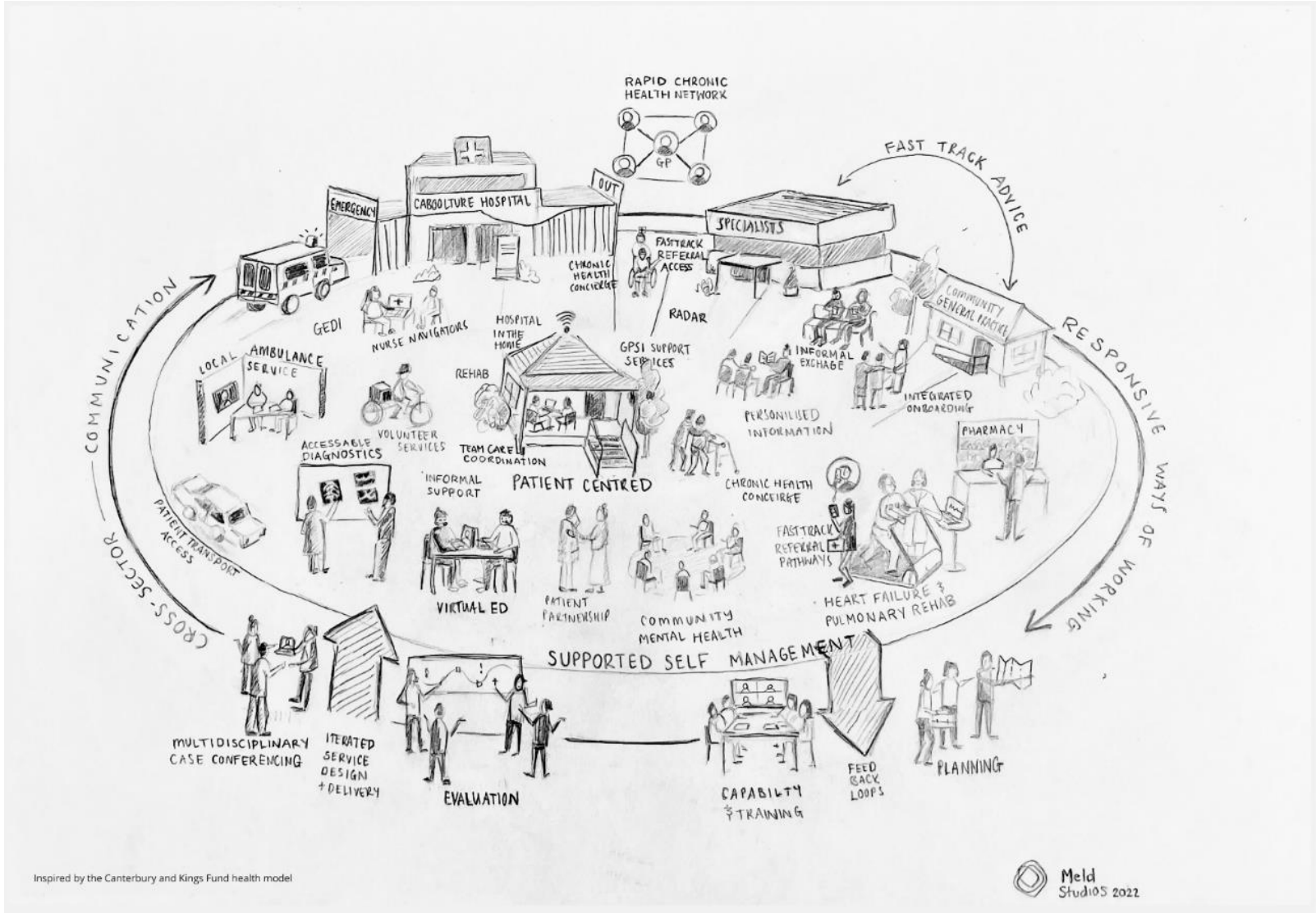
Care Collective - Caboolture model

- The model consists of Complex Care Coordination services in General Practice, as well as community-based care coordination services, and navigation services to support better health outcomes and reduce unnecessary health service use.



Co-design process

- 2021/2022
- 5 consumers participated
- Over 20 health professionals consulted
- Based on Canterbury model
- Agreement to explore the “Chronic Health Concierge” idea further with the placement of **“Complex Care Coordinators”** in general practices.



Care Collective - Implementation

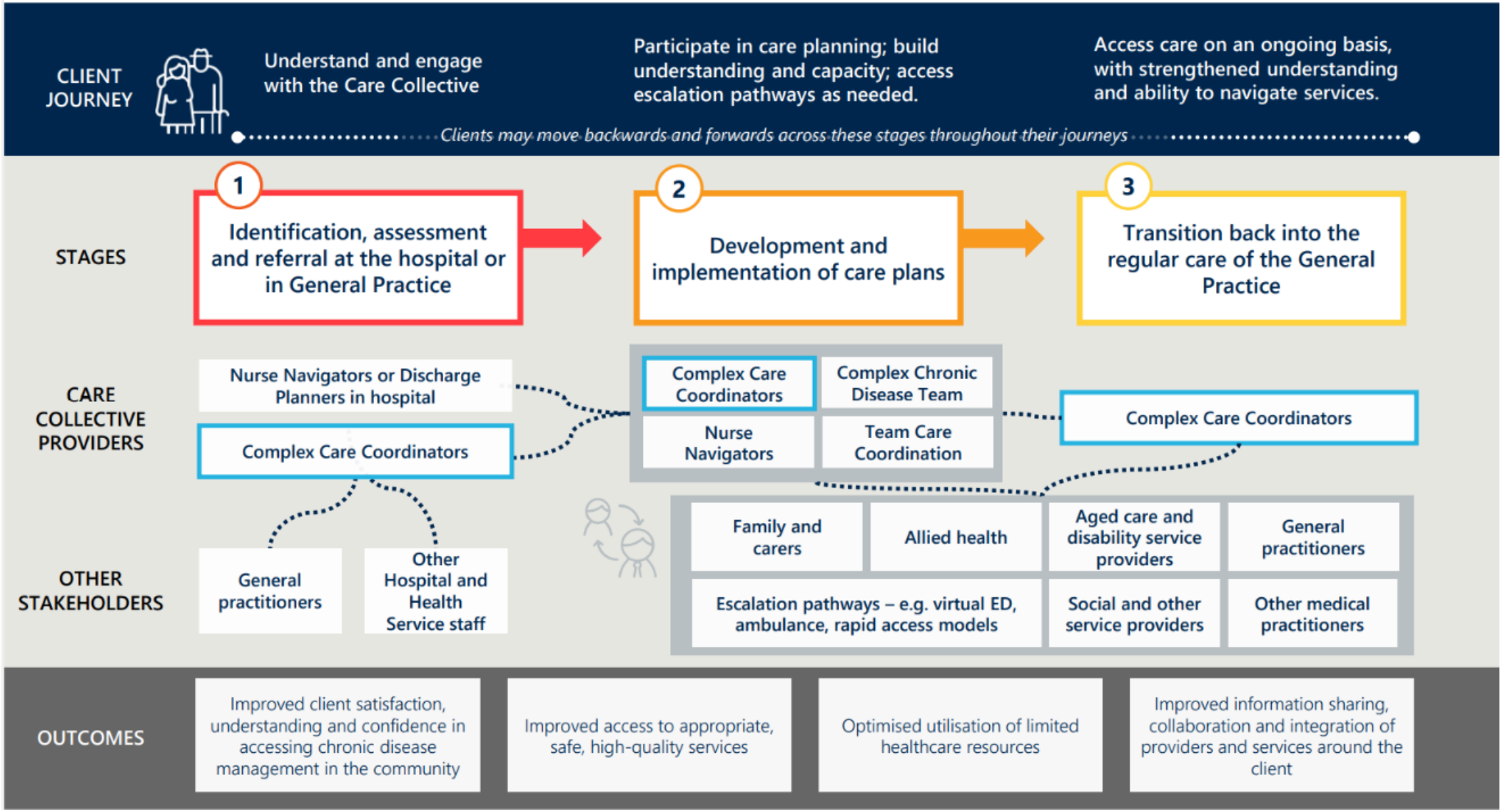
Phase 1 - building on and enhancing existing programs and pathways (July 2022-June 2023)

- Comprehensive assessment through leveraging existing Nurse Navigation and Discharge Planner resources at Caboolture Hospital.
- Data extraction at HHS level to identify frequently presenting patients and chronic disease types.
- Patients matched with existing services in community and primary care (TCC, CCDT).

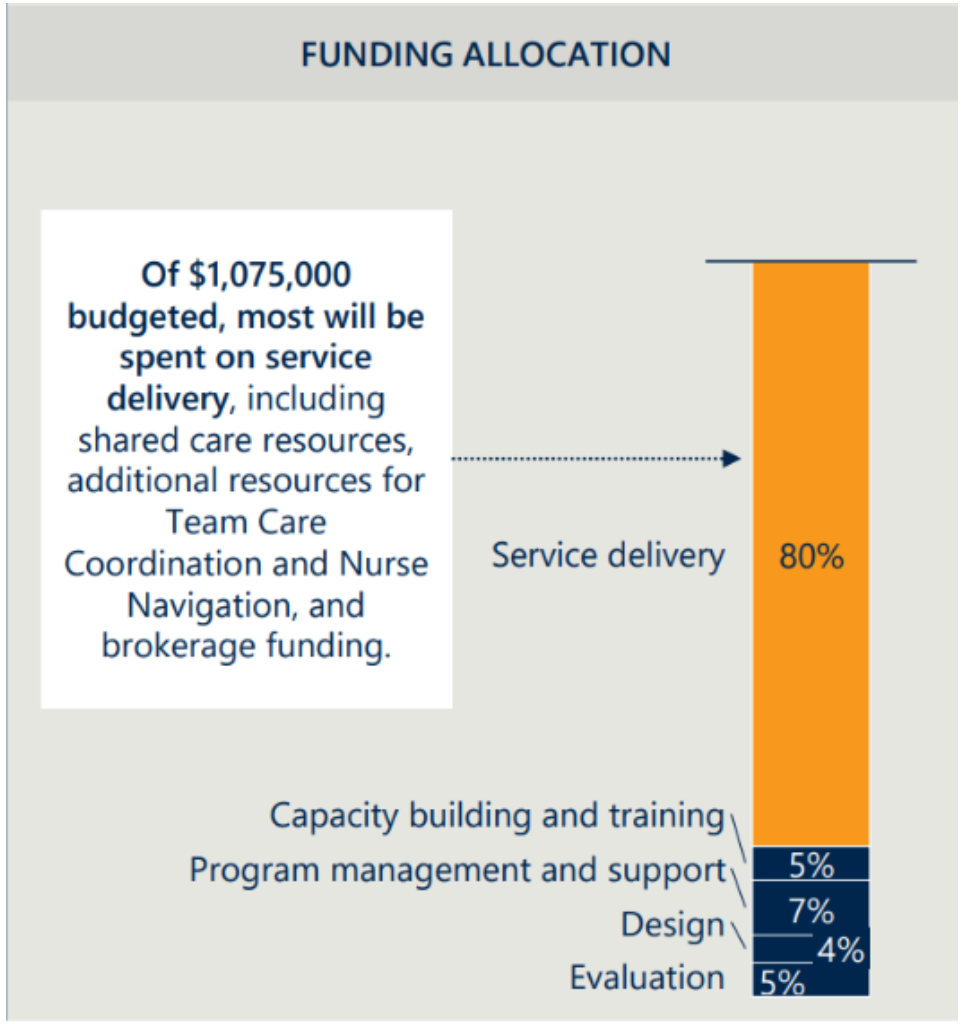
Phase 2 - improving access to proactive care coordination and condition management within General Practice (November 2022-June 2023)

- Patients managed by Complex Care Coordinators (CCCs) located in general practices utilising a suite of MBS items (care planning, case conferencing).
- Complex Care Coordinators identifying new patients collaboratively with GPs.
- Case management model used to support patients with health literacy, receive services and encourage early detection and deterioration of condition.

Care Collective Model



Funding the Care Collective



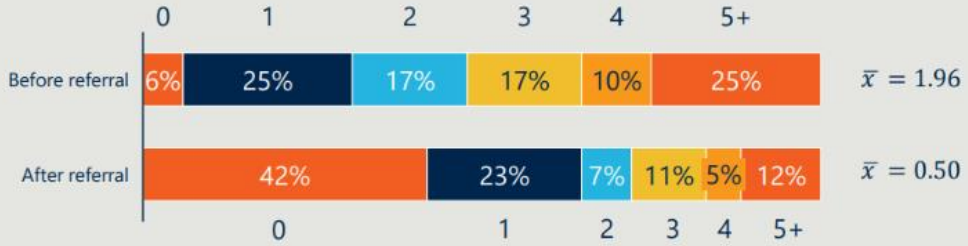
- Joint Qld Health and Commonwealth Department of Health funding requested and approved for 16-month period.
- **Total pilot budget = $1,075,000 + GST**

Final Evaluation Report - Effectiveness

EFFECTIVENESS

The Care Collective has been underway for a year, and there are indications that clients have reduced hospital service use and that the program returns more than double its funding in health system cost savings. However, the relatively small scale of the pilot program creates limitations in the significance of the analysis.

EMERGENCY DEPARTMENT PRESENTATIONS (PER MONTH)



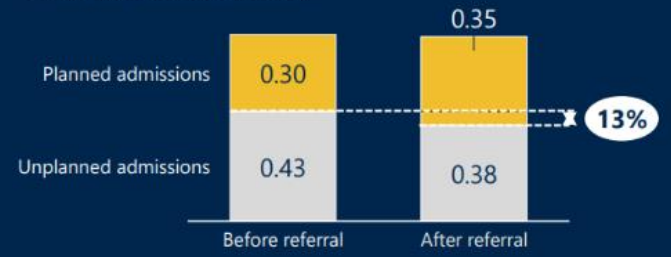
The number of emergency department presentations per month has significantly reduced after referral to the Care Collective *(p < .01)*.

On average clients had a **75% reduction in monthly ED presentation rate.[1]**

There has been a **48% decrease in the proportion of clients with greater than one ED presentation per month[1]**

INPATIENT SEPARATIONS (PER MONTH)[1]

There was a significant reduction in unplanned admissions, but overall admissions have not changed significantly after referral to the Care Collective (below).[2]



Notably, this may indicate increased engagement with planned care. Planned admissions are predominantly not related to the in-scope conditions, and are on average 23% shorter (excluding episode changes).

The data (covering the period from 3 Jan 2022 – 26 June 2023) provides an indication that the Care Collective is reducing clients' ED presentations and inpatient admissions. This is consistent with the previous evaluation, and other evaluations of Team Care Coordination and the Nurse Navigation service that found significant reductions in ED presentations, and inpatient admissions.

However, there are limitations to these findings (see overleaf).

RETURN ON INVESTMENT

Return on investment analysis is useful to understand the impacts of the Care Collective on hospital service use, and the associated cost savings to the system.

Methodological details are available overleaf.

Based on avoided ED presentations and the resulting avoided admissions, the Care Collective has returned

396% of the funding invested

in savings to the health system.

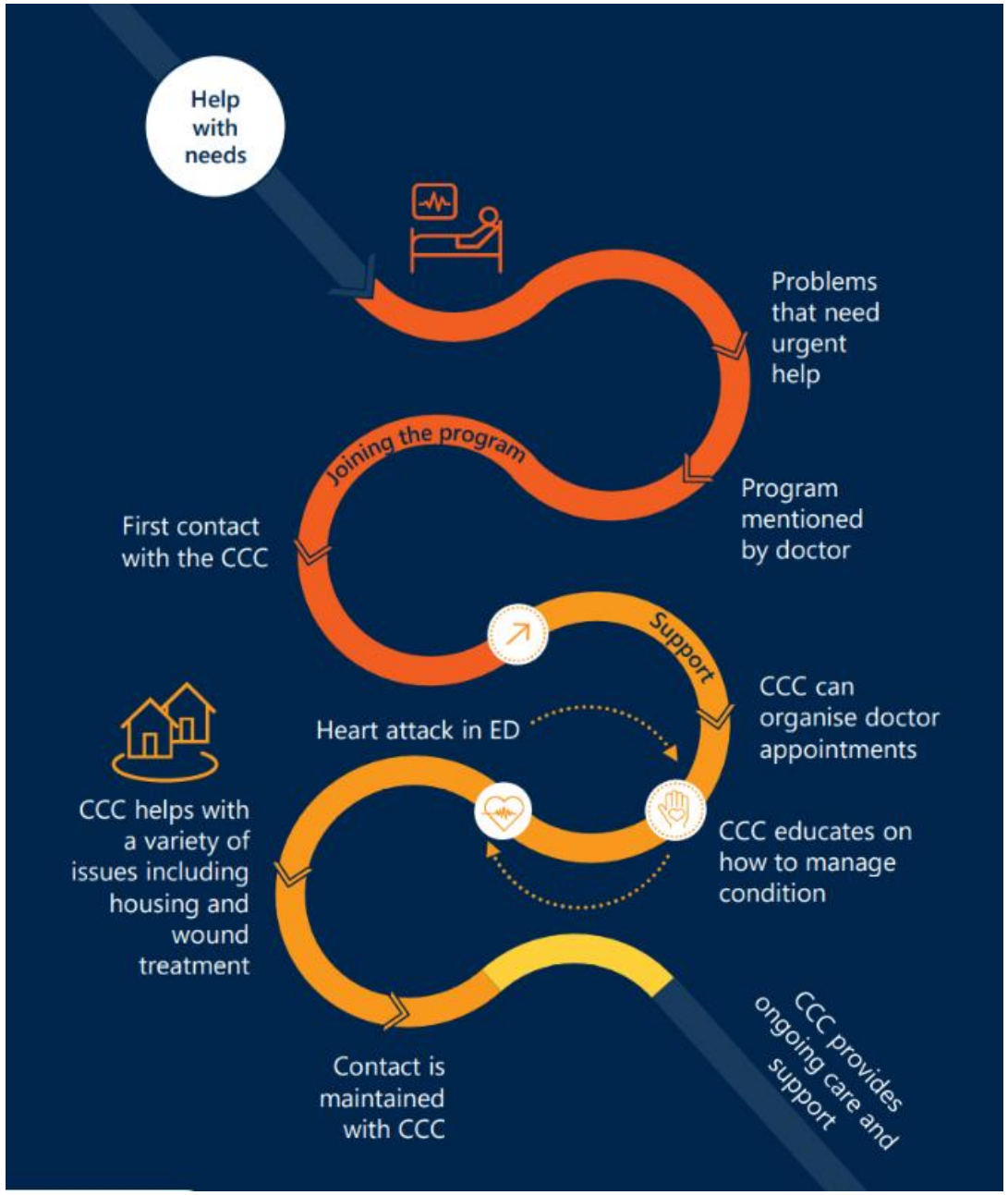
$1,971
Average saving per month per client

$311,488
Average saving per month at June 2023

Client Impact

I have things that need urgent help sometimes and I used to go to the hospital for them. I've been coming to this GP for years, and they have told me about the program. [My CCC] has been helping me with problems that need help urgently. This means I can get to see a doctor straight away. I call [my CCC] and he can always fit me in with a doctor somewhere. He is such a big help to me. **To be able to talk to someone is the best thing about the program.** My condition needs to be looked at frequently, sometimes it is good, sometimes it is bad. I can't think of anything that needs to be changed, I think it's the best thing that has ever happened to me.

– Client



Key Learnings

- Complex Care Coordinators working to full scope
- GP engagement and support for the program
- Greater flexibility needed for Complex Care Coordinators and practices
- Client's perceptions regarding “cost” of joining program.
- Telehealth – low attendance rate
- Embedding change with ED and Discharge Planning staff requires continuous communication and allowance for Tier changes

Key enablers

- Hospital and Health Service and PHN Board and Senior Executive commitment :
  - mandate for the initiative to find innovative ways around barriers
  - collaboration on data and evidence to define problem
- Strong governance – representation across the care journey
- Co-design - involvement of clinicians and consumers in co-design to provide a deep understanding of the challenges to be addressed – and design of solutions
- Data sharing agreement between Metro North Health and Brisbane North PHN
- Evaluation framework and access to data from hospital and primary care to show results and outcomes
- Direct funding to general practice – capacity to spend the time needed to understand patient needs, services available and help navigate

Project status and next steps

- 280+ clients enrolled since June 2022
- Commonwealth Primary Care Pilot Program funding received to expand Care Collective – Caboolture (up to 15 CCC's) and to establish Care Collective – Redcliffe (up to 10 CCC's)
- Flexible GP Participation Options developed – 9 practices (12 CCC's) participating (August 2023) with further practices to come on board
- Data collection requirements refined
- Case study development underway
- Working closely with Qld Health Reform Office on joint program outcomes and evaluation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