2023 PHN Commissioning Showcase

Momentum - Accelerating outcomes and equity through commissioning

A collaborative commissioning approach to health care for frail and older people in Northern Sydney

The Challenge

1. A local needs assessment identified that frail and older people were increasingly utilising ED for care that could be safely treated in the community. A clinical review of approximately 1,800 individual ED patients aged 75 years and over highlighted that approximately 30% of patients could have been safely managed in the community through existing services.

2. General Practitioner feedback demonstrated that more specialist input was required to support them to manage their complex patients in the community however this was not always accessible, and they were unfamiliar with who the Geriatricians were in the region.

3. Allocation and planning of local resources to support this patient cohort was siloed from a primary care and acute service perspective. A more formal arrangement with shared goals and a budget was required that could support a joint approach to designing and implementing an integrated model of care.

Using a population health approach

Emergency department presentations by diagnosis (Top 20)
75+ years of age, 2018/19

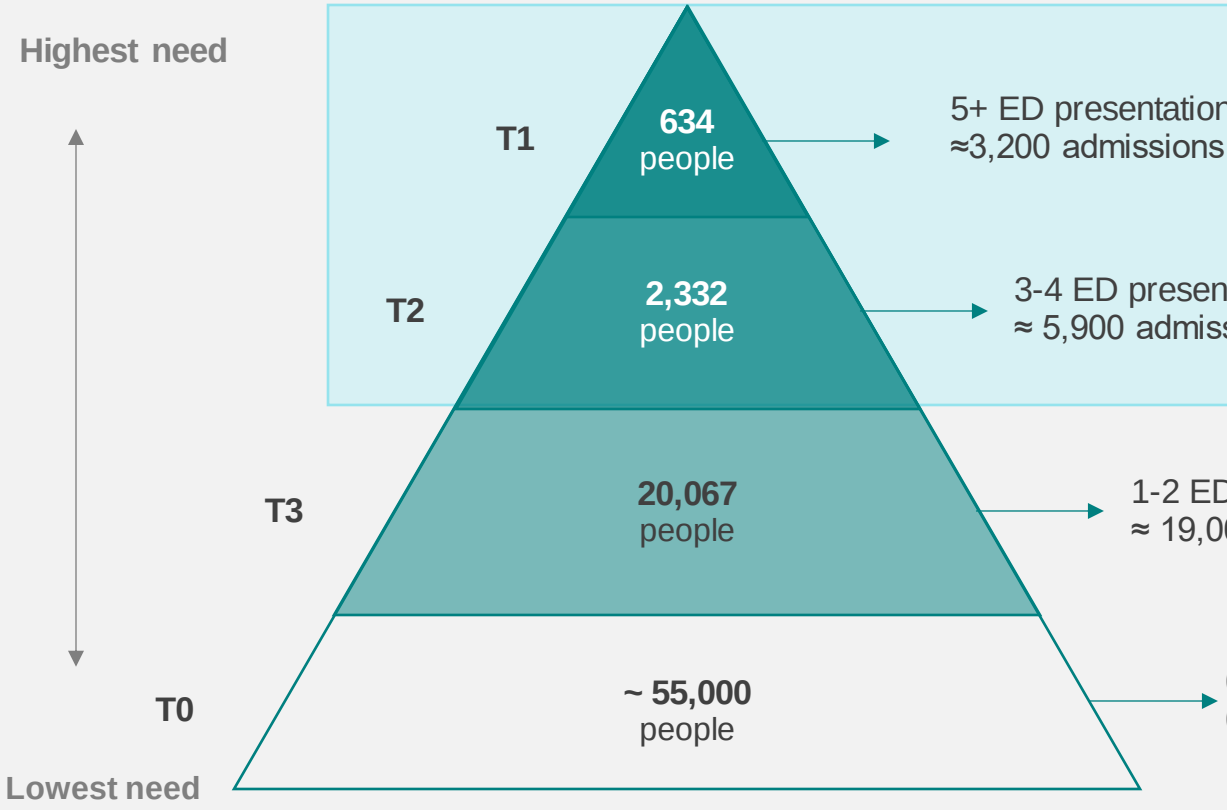
	ED diagnosis	Presentations	
1	Falls (finding)	1,615	Comm.
2	Chest pain (finding)	1,101	
3	Elderly fall (finding)	999	Comm.
4	Dyspnea (finding)	626	
5	Urinary tract infectious disease (disorder)	539	Comm.
6	Syncope (disorder)	487	
7	Abdominal pain (finding)	464	
8	Cellulitis (disorder)	351	Comm.
9	Pneumonia (disorder)	339	Comm.
10	Backache	337	Comm.
11	Cerebrovascular accident (disorder)	334	
12	Congestive heart failure (disorder)	313	Comm.
13	Systemic infection (disorder)	291	
14	Dizziness (finding)	290	Comm.
15	Constipation (disorder)	288	Comm.
16	Atrial fibrillation (disorder)	281	Comm.
17	Fracture of neck of femur (disorder)	259	
18	Community acquired pneumonia (disorder)	217	Comm.
19	Retention of urine (disorder)	212	Comm.
20	Rectal hemorrhage (disorder)	208	Comm.

! 25% of presentations with these diagnoses can be managed in the community

This equals to between 9,000 and 11,000 presentations each year in Northern Sydney.

Using a population health approach

An example of NSLHD population need (people aged 75+) in 2020/21
+- 70% ED presentations result in an admission
+- 25% of ED presentations are avoidable



	Estimated current costs (ED presentation, Ambulance transfer, admission with ALOS of 4 days		Potential savings if 25% of ED presentations are prevented	
	Per patient	**Total (p.a.)**	**Per patient**	**Total (p.a.)**
T1	$27K	$17.3M	$6.8K	$4.3M
T2	$13.9K	$32.4M	$3.5K	$8.1M
T3	$5.2K	$104.1M	$1.3K	$26.0M
T0	$0	$0	$0	$0
	$5.3K	**$153.8M**	**$1.7K**	**$38.4M**

The journey of Collaborative Commissioning

Building the relationship

- Relationship building between LHD & PHN at all levels (years).
- Developed 'Joint Executive' to oversee collaboration efforts.
- Defined a common area (strategically aligned) of focus for collaboration: Frail and older people.
- Developed initial proposal to the Ministry to proceed into Joint Development Phase.

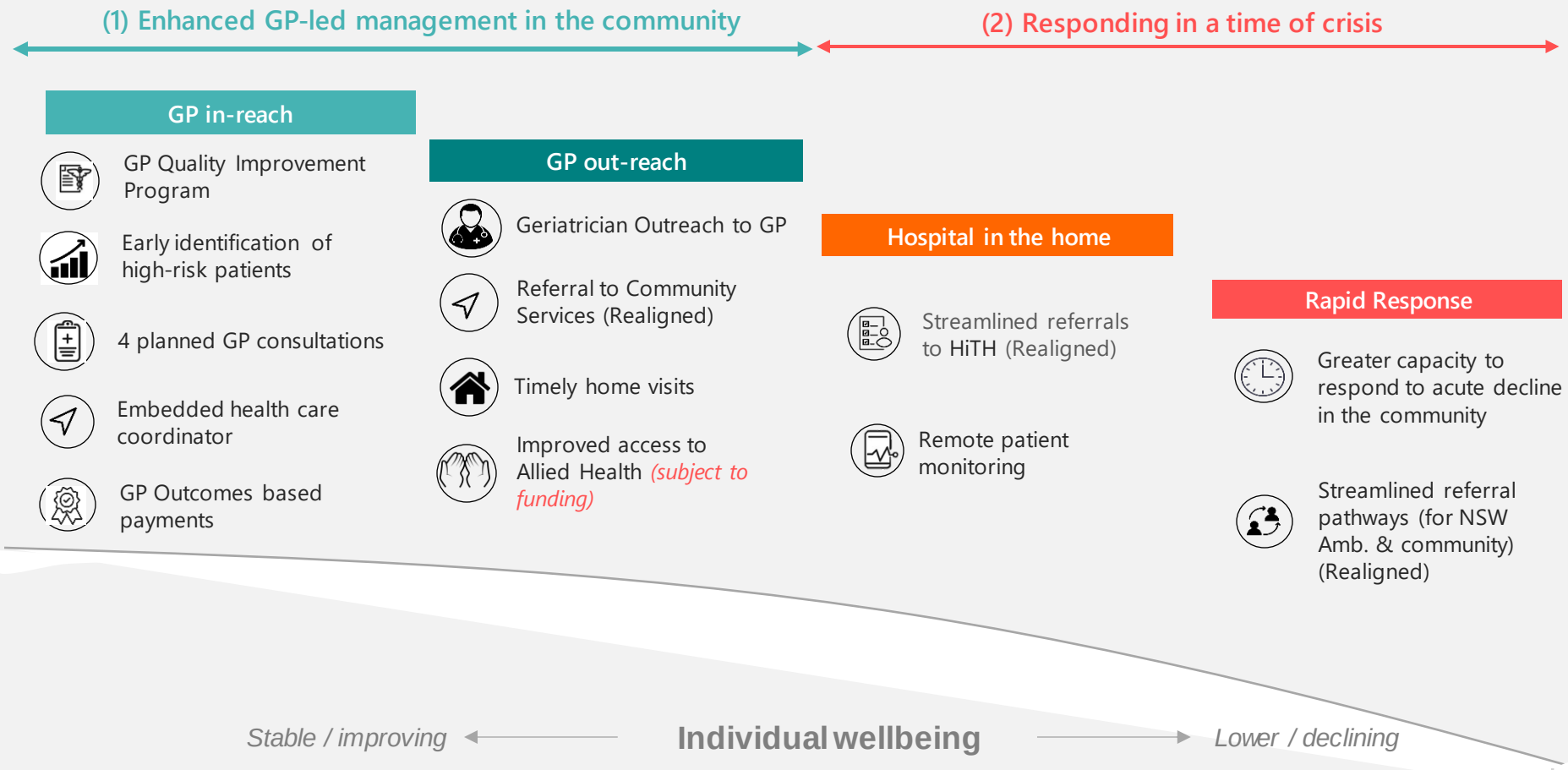
Joint Development Phase: Working together

- Wide-scale community, clinical & operational consultation
- Set up the governance
- Pathway design including detailed models of care, costing, benefits and financial feasibility modelling
- Implementation of pathway elements identified through consultation

Feasibility: Getting it done

- Implementation of pathway elements
- Commence enrolling patients in the pathway and marketing/ communications
- Collectively (i.e. PCCG) monitoring the success of the pathway (outcomes, KPIs, provider performance)
- Continued iterations to improve pathway
- Evaluation

Collaborative Commissioning pathway



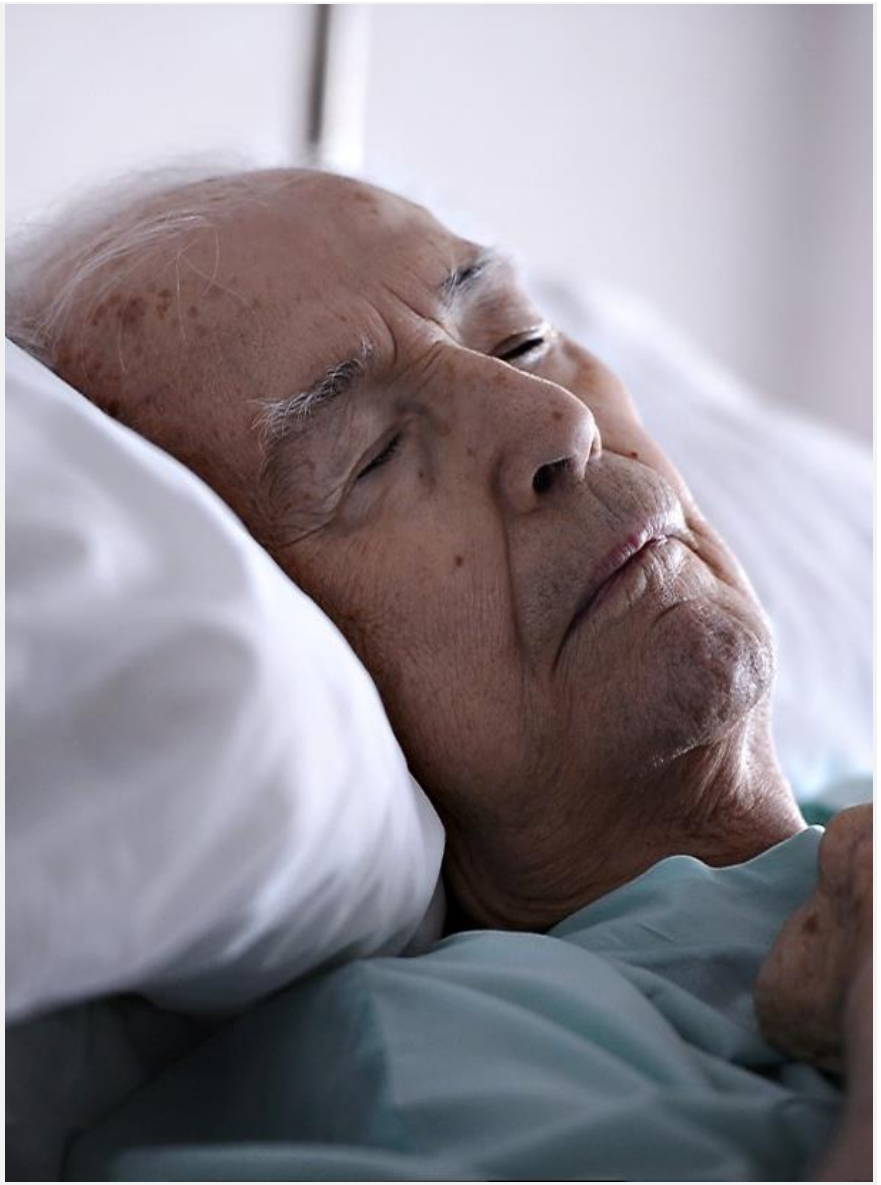
The Impact

Case study of a patient attending the Hornsby emergency department: Mr A

Name: Mr A

Age: 83 years

Location: Living at home alone in Hornsby Ku-ring-gai



What is our pathway trying to achieve?

Mr A's experience

Mr A's is not feeling well. He tries to organise an appointment with his GP but GP is only available in one week's time.

Throughout the day Mr A gradually feels worse. By the evening he is anxious and decides to phone an ambulance.

NSW Ambulance arrives for transport at 7:30pm

Mr A is taken to emergency where they find that he has a urinary tract infection.

He is discharged the same night with a script for antibiotics..

He forgets the script at the hospital.

Mr A does not take the prescribed antibiotics. Over the next two days his condition worsens. He develops a fever and delirium.

He rings for an ambulance again.

This time he is kept overnight as it is suspected that he may have developed sepsis.

Mr A is triaged and waits for over two hours before he is seen by staff

He is kept overnight as it is suspected that he may have developed sepsis.

He has a very unsettled night and in the morning tries to go to the toilet where he falls over and suffers a concussion.

Mr A is reviewed and need to stay in hospital until he is stable.

A few days later, Mr A is discharged from ward. He waits for patient transport home.

Mr A's health may never return to baseline. He goes home and instructed to see his GP.

Mr A's experience, in our pathway

Enhancing GP-led care which can proactively support Mr A

GP Care Team regularly reviews patient data to identify patients at risk of going to hospital.

Mr A has prescheduled appointments with his GP.

GP also keeps slots in their calendar for urgent appointments. Where GP is unavailable arrangements are in place to see other GPs at practice.

Embedded health worker follows up with Mr A regularly and can do home visits if required

Geriatric input to Mr A's care in the community

GP can discuss Mr A's case with Geriatrician Outreach to GP service.

Service may do a full geriatric assessment with Mr A.

If despite enhanced community care, Mr A's health rapid declines, geriatric rapid response can intervene.

Either GP, ambulance or Mr A himself can contact the geriatric rapid response team if Mr is at risk of hospitalisation.

Mr A can be treated at home and avoid ambulance trip and hospital

Key achievements

51 GPs across 24 practices enrolled

430 patients in primary care identified as high risk through RoH algorithm

Over 200 GPs have referred 670 unique patients to the Geriatrician Outreach to GP service (of which 1/3 were high risk) which has resulted in 1,000 occasions of service.

The Geriatrician Outreach to GP service won the NSLHD Quality Improvement Awards in the 'Delivering Value Based Integrated Care' category

3,700 referrals have been made to the Geriatric Rapid Response service, with 60% of those patients avoiding an ED admission.

Nearly 800 NSW Ambulance call-out events were intercepted by the Geriatric Rapid Response service resulting in 650 ED transports avoided.

Integrated Co-Co team collaboratively working across both organisations. Relationships between the partnership has led to further opportunities for innovation in other service areas.

Dashboards have been developed to better track and monitor service outcomes and activity in the Geriatric Rapid Response service, Geriatric Outreach to GP and GP Keeping Well & Independent Program

The LHD outpatient heart failure service has been identified to pilot and trial remote patient monitoring devices with the patient cohort.

The Learnings

Strong Partnership

- Authentic collaboration takes time. We have worked closely together to develop our shared vision, partnership principles and team culture to encourage a one health system mindset. It is important that other partnerships invest the time and effort to do this as trust is crucial to partnership success.

Iterative approach

- Our model of care continues to evolve as we review and evaluate our performance. We have taken an iterative approach to service implementation and remain responsive to feedback and any system opportunities that arise. Many of the outcomes and benefits that we anticipate will require more time and investment before they can be realised.

Change management

- Dedicated and continuous change management support is required from the PHN to maintain momentum and engagement with GP Practices. Variation in business models across general practice is large which makes it difficult to standardise program requirements. A tailored approach must be adopted to consider individual needs.

The Learnings

Data

- Developing and using data dashboards to drive quality outcomes with LHD hospital services. This is particularly important when redesigning and realigning existing services to meet the needs of a new program.

Dedicated planning

- Receiving seed funding during the joint development phases has enabled the partnership to spend the necessary time diagnosing the problems and designing a fit for purpose local solution.

Financials

- Allocation of funding and financial reporting across separate organisations can be complex in a partnership arrangement. New processes and systems must be in place to manage any risk.

The Learnings

Sustainability

- There is uncertainty about how the Northern Sydney Partnership will operate beyond the three-year seed funding period.
- The partnership is currently exploring how this can be continue/aligned to existing funding envelopes across both organisations.

Governance

- Utilise and leverage existing governance structures across the organisations where possible, however, it is also important to be flexible and responsive when new systems/structures are needed.

Rebbeck
205 / 275 Alfred St N
North Sydney
NSW 2060
Australia
02 9138 0668
admin@rebbeck.com
www.rebbeck.com