Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Innovation Funding

1. Innovation Activity Proposal 2016-2018
2. Indicative Budget

ACT PHN

1. Planned activities funded under the Activity – Primary Health Networks Innovation Funding

Proposed Activities	Description
Activity Title / Reference	IN 1: Comprehensive and Systematic Chronic Heart Failure Care
Description of Activity	The **objective** of this innovation is to develop and implement a comprehensive and systematic approach to the management of Chronic Heart Failure (CHF) that involves evidence-based, multi-disciplinary and patient-centred care. It will utilise the National Heart Foundation of Australia Chronic Heart Failure (CHF) Consensus Statement (2013)[1] as a framework and will be whole-of-system and whole-of-person focused. The consensus statement identifies principles and action-based recommendations required to improve current systems across the CHF care continuum spanning early identification through to end of life care. Whilst on the whole the ACT's health system is well placed to progress the majority of recommendations set out in the CHF Consensus Statement the issue remains that a comprehensive and systematic approach to CHF is not evident. Key components of our approach (based on the CHF consensus model) include: • introduction of a multi-disciplinary CHF clinical network and leadership forum to drive clinical, service and system improvement and research capability • co-design, development and piloting of a general practice focused model of comprehensive CHF care founded on established clinical guidelines and standards, collaborative team care arrangements and encompassing shared care, specialist outreach capacity and advice/support to general practice, and GP and Medical Assessment Unit clinical referral (step up) and best practice discharge (step down) protocols • establishment of a jurisdiction-wide CHF outcomes framework, CHF register and minimum data set utilising linked patient, general practice and hospital data • review of palliative care services for CHF patients in context of the developing ACT-wide model for palliative care. • a specifically tailored change and adoption implementation strategy based on best practice • whole of system multidisciplinary workforce development plan encompassing CPD opportunities.
Rationale	CHF is an increasingly prevalent clinical syndrome that limits length of life and profoundly impacts on function and quality of life. Epidemiological analysis demonstrates increasing incidence and improved survival rates of people living with CHF. Despite significant advances in CHF management clinical outcomes are poor and associated with escalating health care costs.[2] [3] We understand that: • CHF prognosis remains poorer than that for common cancers and there are significant variations in access to evidence based care for patients with CHF[4] • CHF is 1.7 times more prevalent and occurs at a younger age among Aboriginal and Torres Strait Islander peoples who are more likely to die from CHF and the rate of potential preventable hospitalisation is three time higher than other Australians[5]

	• the relative risk of developing heart disease is about 1.6 times greater for people with depression or depressive symptoms[6] • UK data shows that half of all CHF patients are diagnosed in the PHC setting and a third of all CHF patients are managed predominately by GPs.[7] • if individuals are not diagnosed in a timely manner, subsequent management is suboptimal[8] • CHF is considered one of the most frequent potentially avoidable ED (re)presentations and hospital (re)admissions. • readmissions within 30 days of discharge can be as high as 20%-27%[9] and reported rates for readmissions within 3-12 months of initial discharge between 29% and 49%[10] • the annual cost of CHF in Australia has been estimated at over $1b per year, with hospital care being the highest expenditure.[11] Prevalence rates within the ACT are estimated to be 3% of the population rising to over 23% in those aged 65 years and over. As at June 2015 there were 47,491 ACT residents aged 65 years or older[12], 10,923 of whom may be affected by CHF. In the ACT, CHF accounted for 521 potentially preventable hospitalisations (PPHs) (or 149 PPHs per 100,000 population) and constituted the second largest number of total PPH bed days (ie: 3958) in 2013-14. Crude estimates of the cost of CHF related PPHs conclude such activity cost ACT hospital services between $3.5 million and $9.5 million in 2013-14 (based on the application of the average cost per weighted separation (including depreciation) of $6872[13], or the average cost per day for admitted acute care of $2363.[14]) An emphasis on hospital based care currently exists creating an unsustainable burden on specialists and acute services. This model of care, its effectiveness and sustainability are being questioned and alternative models that involve GPs with a special interest in CHF liaising with and being upskilled by specialists within community based, multidisciplinary general practice setting are gaining prominence.[15] Evidence suggests that interventions to reduce PPHs are more effective when they adopt a person centred approach and target specific conditions, rather than taking a large-scale policy approach. [16] Multidisciplinary CHF care is differentiated by the special needs of individuals who require specific CHF evidence based treatment strategies to optimise health outcomes including symptom monitoring, a range of specific self-management strategies and titration of medications.[17] [18] The National Heart Foundation of Australia (2013) asserts that "*there is profound potential to improve CHF-related outcomes at both individual and societal levels, through improved quality of care and system change*".[19]
Strategic Alignment	This initiative will test a comprehensive (whole of person, whole of system) proof of concept for the alignment of the health system to better manage people with CHF spanning all disease phases and the continuum of care. It provides the opportunity for trialling a unique and new approach in that as a single jurisdiction PHN we have the opportunity to collaborate with the whole local health system in the ACT as well as the harness the leadership of the key peak body in this area, the National Heart Foundation (through the ACT Heart Foundation), and the Health Care Consumers' Association. It aligns with the strategic intent of both the PHN Program objectives in terms of: • Increasing Effectiveness – by enhancing system capacity and integration of CHF management across the health system, and the improving the consumer experience

	• Increasing Efficiency – through an optimised multidisciplinary workforce; and shared and coordinated care - right service, place, time, duration and a reduction in potentially avoidable CHF hospitalisations. The proposal aligns with the thrust of the recommendations of the Primary Health Care Advisory Group and the government's response as: • it is focussed on a major chronic condition the management of which often has poor linkages between the acute and primary health care systems (rec 5) • it encompasses the development and implementation of a new model of care that is based on holistic (whole-of-person) coordinated and shared care - the foundation for health care homes (rec 2, 7) • it will have a focus on patient activation and particularly self-management and shared decision making (rec 3) • it will explore utilisation of cross sectoral data linkage (including utilisation of My Health Record) for clinical information transfer between clinical teams and outcomes tracking (rec 4, 13) • it will specifically target change and adoption strategies to support system-wide change for clinicians and consumers (rec 8) • it will establish a minimum data set and outcomes framework for CHF to assist in improving quality and patient experience (rec 13, 14) • it will have a formative evaluation to assist in and monitor implementation processes (rec 15). The proposal was identified in ACT PHN's 2016 Baseline Needs Assessment as an initiative that could assist in increasing the capacity and capability of the health care system to deliver coordinated care to chronic and complex disease patients who could most benefit. Since then it has received further support from our strategic partners including ACT Health (the LHD) as it also aligns well with the service level reform program that ACT Health has recently commenced.
Scalability	Initial discussions with ACT Health have already considered the potential to replicating this whole of system approach for the development of comprehensive models of care for other chronic conditions (eg: diabetes, respiratory diseases). We plan to share our intentions, methodology and approach, tools and resources, and results across PHNs and LHNs, clinical networks and the research community. We intend to explore collaboration with NSW Agency for Clinical Innovation, which also has an interest in CHF. The evaluation will in part inform whether this approach is replicable across other jurisdictions.
Target Population	Consumers: • Estimate of 10,923 ACT residents aged 65 years and over who may be affected by CHF. Service Providers: • Primary health care service providers (general practice, pharmacists and allied health) • Specialist and hospital based providers - Canberra Hospital, (eg: Medical Assessment Unit, Medical Services Division, Chronic Disease Management Unit) and Calvary Health Care • Palliative care services (ie: Clare Holland House, community based palliative care service)

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- Health systems research provider (ie: evaluation services).

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<tr><td>Coverage</td><td>Entire PHN region</td></tr>
<tr><td>Anticipated Outcomes</td><td>

Long term outcomes (3-5 years) include:

- improved consumer experience of whole-person focused CHF care
- improved clinician experience of collaborative working
- reduced potentially preventable hospitalisations amongst “enrolled” CHF patients
- enhanced end of life care for people with CHF.

(Note: These will be measured over time through application of the jurisdiction-wide CHF outcomes framework – see below).

Project specific outcomes and key deliverables include the establishment and adoption of a:

- multi-disciplinary CHF clinical network and leadership forum
- person-focused, whole-of-system, standards driven and multi-disciplinary model of CHF care
- jurisdiction-wide CHF outcomes framework, register and minimum data set
- jurisdiction-wide CHF specific protocols for palliative care spanning all settings
- a targeted and implemented change and adoption plan
- whole-of-system multi-disciplinary workforce development plan.

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<tr><td>How will these outcomes be measured</td><td>

The following measurement framework applies to project related outcomes:

<table>
<tr><th rowspan="2">Outcome</th><th rowspan="2">Measure(s)</th><th colspan="2">Type</th><th>Source</th><th>Method</th></tr>
<tr><th>Quant</th><th>Qual</th><th colspan="2"></th></tr>
<tr><td>CHF clinical network and leadership forum</td><td>The formation of an effective CHF clinical network</td><td></td><td>●</td><td>CHF Clinical Network</td><td></td></tr>
<tr><td rowspan="4">Person-focused, whole-of-system, standards driven and multi-disciplinary model of CHF care</td><td>The adoption of an ACT-wide CHF model of care (inc. shared care pathways)</td><td>●</td><td>●</td><td>Evaluation</td><td></td></tr>
<tr><td>Enhanced general practice and care co-ordination capability</td><td>●</td><td>●</td><td>Clinicians
Gen. Practice
Evaluation</td><td>Feedback
Activity data</td></tr>
<tr><td>Increased specialist outreach and general practice supports</td><td>●</td><td>●</td><td>Protocols
Activity
Evaluation</td><td>Review of activity</td></tr>
<tr><td>Enhanced health literacy and self-management capability</td><td></td><td>●</td><td>Consumer
Evaluation</td><td>Feedback</td></tr>
<tr><td rowspan="2">Jurisdiction-wide CHF outcomes framework,</td><td>CHF outcomes framework</td><td>●</td><td></td><td>Outcomes F/w</td><td></td></tr>
<tr><td>CHF register</td><td>●</td><td></td><td>Register</td><td></td></tr>
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	register and minimum data set	CHF MDS	●		MDS	
		Quality use of data	●	●	MDS Evaluation	Perf. monitoring Research
	Jurisdiction-wide CHF palliative care protocols	CHF specific protocols for palliative care implemented	●		CHF Palliative Care Protocols	
	Targeted change and adoption plan	Change and adoption plan implemented	●	●	Evaluation	Research
	Whole of system workforce development plan	Suitably trained, resourced, distributed and optimised workforce	●	●	Workforce development activities	Workforce: - mapping CDP activity
Indigenous Specific	No					

Collaboration	The proposal will have both strategic partners and a range of collaborative agencies undertaking a range of roles as set out below:

	Clinical Network	ACT PHN	ACT Health	Calvary	HCCA	General Practice	Heart Foundation	Research Org
Lead agencies and project sponsors		●	●					
Strategic Partner				●	●		●	○
Project governance and management	●	●	●	○	○	○	○	
Co- design and development	●	●	●	○	○	○	○	○
Implementation and integration	●	○	●	●		●		○
Change management and enablement	●	○	●	●	○	●		
Marketing and communications	○	●	●	●	●	●	●	
Data collection, analysis and reporting	●	○	●	●		●		●
Monitoring, review (PDSA) and evaluation	●	●	●	●	○	●		●

Key: ● substantive involvement ○ collaboration

System-wide stewardship, leadership, capacity building and change management are critical components of this innovation. To ensure that the initiative is fully optimised, it is anticipated that:

- an ACT jurisdiction-wide multi-disciplinary clinical network will provide strategic oversight, leadership, guidance and drive to this initiative
- specific action oriented working groups will established to drive specific areas of innovation/activity.

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<tr><td>Timeline</td><td>
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<tr><th>Milestones</th><th>Start</th><th>Completion</th></tr>
<tr><td>Project initiation*</td><td>1 Aug ‘16</td><td></td></tr>
<tr><td>CHF clinical network and leadership forum</td><td>1 Sept ‘16</td><td>Ongoing</td></tr>
<tr><td>CHF model of care</td><td>1 Oct ‘16</td><td>30 June ‘17</td></tr>
<tr><td>CHF model of care - implementation</td><td>From 1 July ‘17</td><td>Ongoing</td></tr>
<tr><td>Change and adoption strategy</td><td>Jan 17</td><td>March 17</td></tr>
<tr><td>CHF outcomes framework, register and minimum data set</td><td>1 Oct ‘16</td><td>30 June ‘17</td></tr>
<tr><td>CHF outcomes framework, register and minimum data set - application</td><td>From 1 July ‘17</td><td>Ongoing</td></tr>
<tr><td>Jurisdiction wide CHF palliative care protocols</td><td>1 Oct ‘16</td><td>30 June ‘17</td></tr>
<tr><td>Jurisdiction wide CHF palliative care protocols – adoption</td><td>From 1 July ‘17</td><td>Ongoing</td></tr>
<tr><td>CHF workforce development plan</td><td>1 Oct ‘16</td><td>30 June ‘17</td></tr>
<tr><td>CHF workforce development plan - implementation</td><td>From 1 July ‘17</td><td>Ongoing</td></tr>
<tr><td>Engage research and evaluation team</td><td>1 Oct ‘16</td><td></td></tr>
<tr><td>Evaluation completed</td><td></td><td>30 June’18</td></tr>
<tr><td>Project end</td><td></td><td>30 June ‘18</td></tr>
<tr><td colspan="3">Note: *Contingent on DoH approval of Activity plan.
All the above contingent on effective clinical/consumer engagement and change and adoption strategies.</td></tr>
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<tr><td>Planned Expenditure 2016-2018 (GST exc) to match budget – Commonwealth funding</td><td>$484,992 (exc GST) (including interest)</td></tr>
<tr><td>Planned Expenditure 2016-2018 (GST exc) to match budget - funding from other sources (e.g. private organisations, state and territory governments)</td><td>N/A</td></tr>
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[1] National Heart Foundation (2013). A systematic approach to chronic heart failure care: a consensus statement. Aug 2013

[2] Goodlin S et al (2009), Palliative Care in Congestive Heart Failure. *Journal of American Journal of Cardiology*. Vol 54, No 5, 28 July 2009: 386-96.

[3] Page K et al (2014). A systematic approach to chronic heart failure care: a consensus statement. *MJA* 201(3), 4 August 2014, 146-150

[4] Teng THK et al (2012). Trends in long term cardiovascular mortality and morbidity in men and women with heart failure of ischemic versus non-ischemic aetiology in eastern Australia between 1990 and 2005. *Int J Cardiol* 2012. 158: 405-410.

[5] Woods JA et al (2012). Heart failure among Indigenous Australians: a systematic review. BMC Cardiovasc Discord 2012; 12: 99

[6] ACT Health (2016). Chief Health Officer's Report.

[7] Scott I, Jackson C (2013), *op. cit.*

[8] Goodlin S et al (2009), *op. cit.*

[9] Davies J et al (2003) Hospital Admission Risk Program (HARP); chronic heart failure working party report. Victoria Dept of Human Services, 2003.

[10] Westert GP et al (2003) An international study of hospital readmission and related utilisation in Europe and the USA. *Health policy* 2002; 61: 269-278.

[11] Krum H, Abraham WT (2009). Heart Failure. Lancet 2009; 373: 941-955.

[12] ABS (2015)

[13] Independent Hospital Pricing Authority (2016), National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2013-14 Round 18: appendix 5, IHPA

[14] Independent Hospital Pricing Authority (2016), National Hospital Cost Data Collection Australian Public Hospitals Cost Report 2013-14 Round 18, IHPA

[15] Scott I, Jackson C (2013). Chronic heart failure management in Australia – Time for general practice centred models of care? *Aust Family Physicians*; 42 (5): 343-346

[16] Katterl R, Anikeeva O, Butler C, Brown L, Smith B, Bywood P. (2012). Potentially avoidable hospitalisations in Australia: Causes for hospitalisations and primary health care interventions. *PHCRIS Policy Issue Review*. Adelaide: Primary Health Care Research & Information Service.

[17] Bodenheimer R, Wagner EH, Grimbach K (2002). Improving primary care for patients with chronic illness: the chronic care model. Part 2. *JAMA* 2002; 288: 19009-1914

[18] Glasgow et al (2002) Self-management aspects of the improving chronic illness care breakthrough series: Implementation with diabetes and heart failure teams. Ann Behav Med 2002; 24: 80-87.

[19] Page K et al (2014*, op cit*