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INNOVATIONS IN CARE FOR CHRONIC HEALTH CONDITIONS

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MR BRENNAN: Well, good afternoon everybody. I think we'll kick things off. My name is Michael Brennan. I am the Chair of the Productivity Commission. I would like to welcome you all today to our Webinar on Innovations in Chronic Health Care.

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I would like to start by acknowledging the traditional custodians of the lands on which we are variously gathered today and pay respects to elders past and present. Today we're going to have a panel of speakers talking about some reflections on our recent report

10   Innovations in Care for Chronic Health Conditions.

The structure of today is that each of our panellists is going to present for around 10 minutes and then we're going to follow that up with a facilitated Q&A session. You can use the Q&A function in Zoom to log

15   a question and to view the questions of others and you can do that throughout the conversation, throughout the presentations and then we will come to those questions at the end.

If you see a question that you really like you can also upvote that. I am

20   not sure how it works but I think you click the 'thumbs-up' or the 'upvote' button below each question and I should just remind people that the webinar is being recorded for publication in the near future.

Now, I am going to give a couple of quick reflections before I hand over

25   to Stephen King, who is one of the primary authors along with Richard Spencer of this particular report. But just to place it in some context. This was quite a different looking piece of work for the Productivity Commission, because normally we get asked by government to go and look at a particular sector or a particular issue and our job is to get

30   across the detail and sift through the evidence and ultimately to make policy recommendations to government about how they might be able to fix identified problems.

And in this instance we took a different approach. We thought it would

35   be good to go and look at what people are actually doing on the ground to solve problems themselves and tell their story, the story of those innovations and those on the ground trials and initiatives. Tell that story, try and ask what all of those innovations have in common and what sort of story can we put together about that.

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So you can think of our traditional role as being a fairly top-down one, in terms of making recommendations to government, as to what they ought to do, and this is a more bottom-up exercise in identifying and publicising some of the findings and experiences of real world

45   innovations.

Stephen is going to talk in greater detail about the various case studies but I will just give you four very high level reflections from my perspective on what I think when I look through the document. The first

is for the most part these innovations are fairly small in scale. The second is that they are, for the most part, relying on a degree of serendipity. They often rely on the extraordinary efforts of a particular individual or a group of individuals, often on a single relationship that

5 can then be leveraged into a broader collaboration. But they are, to some extent, serendipitous. And it may mean there are limitations on the ability to simply cut and paste individual innovations elsewhere. But, arguably, what we're aiming for is more of a generalised culture of innovation than particular solutions that have worked in a particular

10 place.

The third thing is when I look at several of the case studies that we talked about, they are for the most part swimming against the tide. There are some heroic efforts that have been operating to some extent

15 against the natural incentives that the system imposes. And the final thing is that they're not widely known and that says something about the diffusion or knowledge sharing mechanisms that we have across the health system and how we might be able to improve them.

20 I should say that part of the diffusion process is us. The report that we have put out and this exercise today, trying to talk about the various innovations that we have observed. The final point about what comes next. We gave our report to the CFFR, the Council on Federal Financial Relations, really just a fancy way of saying the Treasurers of

25 the Commonwealth and the States and the Territories.

When I presented that report they asked that we go away and provide them with a little bit more of a concrete road map about how some policy reforms could be contemplated that would help improve the

30 incentives for these sorts of reforms to occur on the ground. And that's what we're thinking about now. And we're going to be reporting back in coming weeks. So that remains an important next step for us.

So with that I would like to hand over to the first speaker today, and

35 that's Stephen King, who along with Richard Spencer were the Commissioners on this project and the primary author. And Stephen is going to provide us with an overview of the report before we go to our other panellists.

40 MR KING: Okay, thanks Michael. Let me just share the screen which hopefully you have now got. This slide's up. And if someone can nod their head, if they can see a Innovations in Chronic Health Care slide, that'd be great.

45 What I want to do in the next 10 minutes or so is to really give a high level, or a 'helicopter view' of what we were doing in this particular study. So as Michael mentioned for this case study on Innovations in Care for Chronic Health Conditions was finalised by the Commission around late March. It was a very different approach and we talked with

lots of people. And it seems talking with people was very much the starting point of the project. We talked to consumers, we talked to individual practitioners, we talked to service providers, we talked to government departments, hospitals, primary health networks,
5   academics.

Many of you who are listening to this webinar today I suspect were part of those conversations and can I say on behalf of the Commission, thank you, because we would not have been able to do this study
10   without the input and the willingness of so many of you to share your experiences with us.

So what's the objective here? We wanted to find out what innovation is occurring. We wanted to find out why and how it is occurring. We
15   wanted to find out what the benefits are from that innovation and we wanted to find out what the barriers are to the innovation.

So as Michael said it's a very much bottom-up, quite different to our normal top-down approach. We weren't aiming for any grand
20   recommendations for government here. Rather, we were trying to explore what was going on and why and how to assist it. So the report has 17 case studies in detail but we make reference to many, many others.

25   The first starting point, however, is Innovations in Care for Chronic Health Conditions. Why do we care about this topic? There's a bit of a paradox in health, not just in Australia but in many countries around the world. As you can see here we're living longer and Australia is doing very well in the longevity stakes. We have got the 8th highest life
30   expectancy in the world. We're certainly spending more on health and yet we actually have people living longer with ill-health compared to other developed countries. We don't do particularly well in that metric.

So we have this paradox. I would claim it's a paradox of success.
35   What has happened over the last 50 to 100 years in health care is many of the things that used to kill us – the diseases – as COVID has reminded us, the viruses, the bacteria. Many of those we now deal with. Many of the diseases that used to kill us. Both my grandparents on my father's side died in their early 60s, dropped dead of heart
40   attacks. Literally dropped dead. It doesn't happen that much nowadays because they would have had their bypasses, and they would have had the chronic disease.

What has happened in terms of health is that we have moved from a
45   situation where we rely on episodic care to a situation where we have many people with chronic health conditions who require ongoing management of those conditions. So we're talking about 38 per cent of Australians who have at least one physical chronic condition and many people who have more than one chronic condition. So the first

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challenge posed by this health paradox is how do we best move our health system from episodic care, to a system that's based on prevention and ongoing management of chronic care conditions?

5   The second thing to point out is that we have an inequitable health system. So when we start focusing on chronic conditions you will notice that those who live in poorer parts of Australia are much more likely to have worse chronic health conditions, more chronic ill-health. People who live in remote areas will have worse health. And that health

10   conditions are correlated with things such as education, income, and so on.

So those who are financially better off, those who live in cities and larger towns, those who are able to be actively engaged with their

15   health, and to self-manage their health, they're doing much better under the current system. So one of the challenges in the system is how do we enable all Australians to gain the benefits of prevention, improve management for chronic health conditions, going forward. So these two challenges; how do we change our health system and how do we

20   create more equity in our health system, really underpin the work of the Productivity Commission. They both require us to think about innovation, in our health care system and what we can do better for consumers.

25   Now, we're focusing in this report on chronic physical health care, that's a reflection that there has recently been a mental health inquiry by the Productivity Commission, slightly longer on this study, but a good read if anyone's interested in spending a fair bit of time going through it.

30   So what we've looked at here, is we've looked for innovations that can start to answer these challenges. Improve lives. How do we get the knowledge disbursed from those innovations and how do we understand the barriers, to broader innovation and adopt it.

35   So what did we find? As Michael mentioned current innovations often depend on small groups of dedicated individuals who are committed to the innovations and supported by local health service executives. And often these individuals are swimming against the tide. It's great when you find these individuals and you're going to meet a few of them in this

40   webinar but it leaves you with a bit of a problem with the current health system. We could try and clone the individuals that you're going to meet later on in this webinar – probably not the best answer.

So what we did at the Productivity Commission is we then went and did

45   a deeper dive into trying to understand more about the innovations that we see on the ground, what they are focusing on and then why aren't they being adopted when they're successful. Why aren't they being adopted more broadly.

So most of the successful innovations we looked at cover one or more of the five areas that I've got up on the screen. Let me just run through those. So the first one – self-managing chronic conditions. We have seen that when we help people to better manage their own health then there can be significant benefits for those individuals. So some of the innovations we looked at make it easier for consumers to engage and to manage their own health. These range over a broad spectrum of interventions. Reminders to consumers. Making sure that consumers are able to engage with the system in their own language. Making sure the services that the consumers need are readily accessible. Making sure the consumers have the right knowledge to be able to manage their health care.

The second area is workforce development. Many of the innovations that we came across used innovative workforce practices. For example, clinicians operating to their full range of skills, or in some cases developing new skills. Bringing non-clinicians in to assist the clinicians, helping where appropriate. For example, people without clinical management but who could work as guides within the health system, helping individuals to join the services if they need.

Sometimes individuals just check in with the consumers but in a way where they're also checking up at the same time to see how those consumers are going. Sometimes support for the consumers through lived experience, for example, through peer work.

The third factor, collaboration. One of the things that many of these innovations have in common is that they integrate care. Currently, our health system has silos but to provide managed care for those with chronic ill-health, we often need to work across primary care and hospital care. We also often have to work across health care and other services outside health and we saw that where we got this successful collaboration it was more than just groups getting together and saying, "Yes, let's work together. That sounds good." It involved real commitment. The successful collaborations had skin in the game by all the parties to that collaboration.

The fourth one. Effective data information flows. It's sort of obvious when you think about it. You know, in some ways, so many of our health professionals at the moment, it's sort of like they have one hand tied behind their back when they're trying to help their patients. They need to know who needs what, who has had what and what should I be looking out for. They're fundamental questions, but often the data and the information isn't there.

So many of the innovations that we looked at dealt with that data issue. Sometimes at an individual patient level but sometimes at a cohort or an even broader population level, to be able to help the health

professionals have the information that they need to help the consumers.

And one of the lessons from our successful innovations that underpins
issues of data is ease of use. Data works when it's easy for the
relevant clinicians to provide the data, often seamlessly in the
background, when the privacy of that data is protected, when
consumers and clinicians can be sure that the data is being used
appropriately, and then when the clinicians are getting the information
they need back in an easily accessible form. Whether that's at an
aggregate level in terms of the information or even at an individual
consumer level. It's simply an alert that comes up, on their screen,
often whilst they're talking with the consumer.

Finally, fit for purpose funding mechanisms. Many of the innovations
that we had depend on funding. Often our system funds activity so it's
not surprising that we get lots of activity but the management of
prevention it's often – and prevention of chronic ill-health – it's often
preventing or avoiding activity. So we need to change our funding. We
need to improve our funding. We need to make sure we have the right
incentives through the funding levels. So let me finish off.

There's a lot of great stuff happening. We were able to capture some of
that. The rest of this webinar you're going to hear a lot of great stuff
that is happening but what is happening out there in terms of health
care innovation is a great job. It's often tried but then defunded. It's
often never evaluated. The leaders and enablers move on. There's
often a fear of failure and even when something works and continues in
one area the information and knowledge is often not spread to allow
adoption in other areas. So if we want a health system that better
manages chronic health conditions we need to find ways to encourage,
educate experimentations, find out what works and encourage broader
adoption.

Hopefully, the Commission's case study is one part of that. And this
webinar is also one part of that getting that broader adoption. So
thanks for listening and I will pass back to Michael for the main event.

MR BRENNAN: Thank you very much, Stephen.

So let me start by introducing all of our panellists and then we will hear
from each in succession. So, firstly, we have with us Dr Kean-Seng
Lim. Those of you who had read our report, which I am sure is all of
you will remember memorably, box 3.1, which talked about
collaborative patient-centred homes in Western Sydney, and we have
Dr Kean-Seng Lim today to talk to us. He is a Mount Druitt GP. He is
also the former New South Wales President, of the AMA, and he'll talk
to us about transforming GP practices into patient-centred medical
homes.

We also have Libby Dunstan, who is the CEO of the Brisbane North PHN, and the Brisbane North PHN also has experience in implementing innovative programs in their local area and Libby is going to talk to us about sustaining innovation and the importance of collaboration.

And, finally, we're going to hear from Don Campbell and Keith Stockman. Now of Northern Health in Melbourne, formerly of Monash Health. So the Monash Watch program which of course, again, you have all read about, one of the significant case studies that we featured, funded under Health Links - another thing we talked about is now being adopted in a slightly different format as Patient Watch at Northern Health and Donald and Keith are here to talk to us a little bit about the barriers and enablers they have faced in adapting an innovation to a new environment.

So let me start by inviting Dr Lim to the stage. I think we just need to unmute you.

DR LIM: My apologies. I have just unmuted myself and thank you very much Michael, and let me first of all start by sharing my screen and hopefully you will all be able to see what I have up here. But I would like to first of all say thank you very much, Michael. Thank you to the Productivity Commission, and there is quite honestly and it's very rare I say this but there is quite honestly almost nothing in that report that I do not agree with.

So I am just going to now start by talking about things from my end of the world. So my end of the world is general practice. So I am a GP in Mount Druitt and I have been out here for about 25 years. This is our practice team. So our practice team is made up of our doctors, our practice nurses. Some of whom are on site and some are not on site. Our allied health members, dieticians, exercise physiologists. We have our pharmacists and some of this work is also supported by our primary health network and our local health district, such as the funding of a pharmacist for a practice is able to spend the equivalent of a day a week with the practice, whether they have been onsite or offsite.

And that comment that I made about onsite and offsite is actually quite pertinent as one of the challenges we are really looking at in this new world, is how we are going to better utilise our care teams. And, of course, we have our receptionists, our counsellors and are really highly skilled practised staff who do far more than reception work. So this is what our practice looks like. So we have a lot of chronic illness. So if we look at this the numbers today, are going to be slightly different because the graph is a little bit old but the proportions are remarkably similar.

We have a lot of diabetes, a lot of vascular disease, quite a lot of mental health as well. And if we look at our proportion and our practice we're sitting at roughly about 50 per cent of our practice, having one or more chronic illness; about 25 per cent having two or more; around about the
5   12 to 13 per cent having three or more and so forth.

So part of our question is how are we going to best manage this? Because while we could talk about it as our problem or a challenge, really for us, this is our job. This is what we do. And part of that is how
10 do we structure care to meet the needs of our patient population. And so some things we have had to do where I actually go right back to the start and think about the design. What do we need to do to design it?

So this is the first sort of thing. We look at the papers from the college
15 and also from around the world, looking at medical home models or models of care and how they might look. And this is, if you like, one of – this statement from the medical home implementation and shared in the US pretty much summarises our approach which is that the medical home for us is not a building or a place but it's an approach to providing
20 that comprehensive primary care facilitating partnerships between patients, clinicians and health staff I would say as well as carers. And this is where we would take a step back and say, "What is the framework we need to apply to try to realise that vision?"

25 And we look at it in terms of this type of pyramid or what we consider the PCMH, or Patient-centred Medical Home Pyramid. At the very highest level it's the quadruple aim – what we aspire to, better patient experience, better population health outcomes, sustainable costs or efficient costs and improved provider satisfaction.
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Below that we tend to look at the six key attributes, which are partly at a micro-system but also partly at a meso-system or across the whole neighbourhood and if that is the principles of patient settledness, accessibility to care, continuous care, comprehensive care as well as
35 coordinated care which is accountable. And the continuity of care was interesting because it's worth splitting that up into those key elements of continuity, which are continuity of data or information and that is, of course, good information flow, continuity of relationships.

40 And perhaps that third one which is often forgotten which is continuity of management and that should be for each patient across all sectors of health care that they traverse. And what that brings us down to then are the fundamental framework that we can use to try to realise that vision when we're talking about a micro-system level, which is our
45 practice.

And so for that we have gone back and use the Bodenheimer principles or the 10 building blocks as a framework which helps to guide our strategic plan. So if anyone wants to pause the slide and have a look at

it but that was our previous strategic plan given that we're now going into a new one this year. But what this means is it allows us to consider how we're going to do things differently, because what needs to be done in many ways doesn't change. It's actually who does it and how it is done that is actually where the innovations occur because what needs to be done, if we consider someone who has – well, at the most basic levels, high blood pressure or someone who is overweight.

What needs to be done is pretty much the same as what always needs to be done. We need to provide advice. We need to provide guidance. We need to provide support, whether it be in medications or non-pharmacological treatments, whether it be assistance from allied health or others that's what still needs to be done. Who can do it is now where it gets interesting because it doesn't all have to be done by those who traditionally have done the job. Dietary advice can be provided by doctors. It can be provided by dieticians. It can be delivered in other ways and other forums. We can start to use online resources. We can now start to expand what we do.

So we can move away from the traditional individual consultations and subsequent set of use of joint consultations and more complex cases where we have more than one health provider with a patient at the same time. Or we can flip that and have more than one patient with the provider at the same time, such as small group education sessions, or shared medical appointments. And, similarly, with shared medical appointments we can actually have multiple health providers and multiple patients to try to improve things.

Just as an interesting thing we found it takes about nine hours of intervention to meet to sustainable and sustained weight loss for a patient and that's not something you can do in your regular one-on-one individual consultations. But through the use of shared medical appointments you can actually do those nine hours of intervention which can lead to that improvement. And where we have even more complex cases there are benefits of using case conferencing where we can actually call an external team member, such as diabetic teams from the local hospital, diabetic services from the local hospitals who can reach out to patients either within our practice or now more virtually and those virtual case conferences which allows us to actually provide more complex care for more complex patients.

So this is actually moving away from the concept of considering any individual patient and my patient to our patient. So patients who attend our practice we very much like to think of this concept where the team takes on the responsibility for the practice as a whole. And that's probably one key take-home messages which is that everyone shares responsibility and so it's moving away to a whole of practice model. And that then leads us to the whole of practice population-type model.

So when we looked at our improvements and we looked at how we mapped that over time, and this is 2013 to 2017, when we're really doing most of the work on this, we started off by just taking small steps but a lot of those steps are about how we incorporated the whole

5   practice team. Initially it might be using practice staff. So receptionist, practice manager, how do we clean-up our data bases, our data, actually get some proper records in the system. But then we came to the point we needed to have proper intervention and that's where we had to really build team work with allied health, as well as external team

10   members.

And then we moved on to incorporate in pharmacies and, including regular case conferencing, regular reviews of all the data which allowed us to then to decide what was working and what was not. So here's an

15   example of our data steps and we're looking at the interventions for diabetics. But we can also look at other data sets, such as say adherence to medications, adherence to protocols and guidelines for all other conditions. Such as these become part of what guides us when we're determining the next step that we are going to take.

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And that, of course, is now where I talk about next steps because one of our challenges which quickly became clear was that in that we're all time-poor, we're all resource-poor so how do we scale this out and how do we not only engage our patients as more active members of their

25   own care team but actually activate them more so that they are better at self-management or, if you like, supported self-care. Because we are here, as our practice team to enable that. And so we're now moving to this world, where over the last three years we have been using a patient partnership, patient provider partnership platform. And this allows us to

30   share, or rather create granular management plans in our practice software which are then pushed to the patients in their application. So our patients who are using the application can then see their medications and their history but not only what it is, which is just data for the sake of data, but what it means which is actually where the utility

35   of data comes in.

So it's not just a case of saying, "You have high blood pressure and you are now taking this medication." It is "You have high blood pressure and this is a target range for your blood pressure. But in order to

40   reduce that this is the target range for your weight, target range for your exercise and we're also going to push up these preventative health screeners and our say mental health screeners which you might complete on a six-monthly basis." So we can also monitor other elements that may not be so immediately apparent.

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This allows patients to engage with us by reporting their own metrics, by reporting both outcomes as well as experience measures but also where they wish to enable their collection, their wearables and devices, so that we can now all see this information. So we can see how many

steps a day is patient is doing. We can see blood pressures, blood glucose levels, and see whatever things are reported. And the platform allows us to interact back with patients by using secure messaging direct from providers to patients. But also from provider to provider to allow us to coordinate the care as part of those six principles of improving care at that meso health care neighbourhood-type level.

So as an example, during the bushfire season, because once upon a time Coronavirus was not our biggest problem, bushfires actually were, and at that time what we were able to do was send messages out to all patients on the app on high-fire risk days and high smoke risk days, saying, "Stay inside. Do these measures. Have a look at this website and keep an eye on your breathing and do this as well and complete your symptom scores."

Patients would be able to receive that on their apps, where they would then be able to complete questionnaires in app, and they'd be informed as to whether the result was better, worse, at the same time as the practice was informed, whether our patients were deteriorating or not, which then allowed us to interact with patients whether it be through secure messaging, video calls, or through traditional phone calls from patients because many of our patients still use phones. But this allows us to expand our care further and to actually streamline the care we provide.

So this is part of our solution. So I am actually going to stop there and hand back – and I will pass it on. But what we see is that our problems which is how do we manage things at that scale and how can we do things better? And utilising our team who are both off-site and on-site and we see digital as part of our solution for that. But digital is really an enabler and, really, at the end of it, it's not about the team. It's about the people. It's about the workflows in setting up the right system. Thank you very much.

MR BRENNAN: Thank you very much, Dr Lim. And it's fascinating to reflect on how many of those five core elements that Stephen King mentioned, that presentation cut across, the data there and information sharing, the empowering of the work force and the supporting of people to manage their chronic conditions. I am going to pass over to Libby now, the CEO of Brisbane North PHN to tell us a bit about innovations in her local area.

MS DUNSTAN: Thanks Michael. So I am just going to share my screen. Bear with me. Hoping that it works. Right. I'm going to start and unless somebody tells me they can't see the screen but I think that's going well. So, again, I would also just like to take this opportunity to acknowledge the traditional custodians of the land on which we're all meeting today and pay my personal respects to elders past, present and emerging.

Like Ken Lim just said, thank you very much for the opportunity to talk a little bit about the Brisbane North PHN experience in supporting innovation in chronic care and chronic health condition management. I am not really going to spend a lot of time I think talking about individual initiatives that we have actually done in Brisbane North PHN. Probably talk a little bit more about the how and I think I was – I have been asked to focus on sustaining and building collaboration which is something near and dear to Brisbane North PHN's heart.

So for those of you that don't know Brisbane North PHN, we're one of 31 PHNs from across the country. We service about a million residents across over 4,000-square kilometre radius. So that's Brisbane's northern suburbs. It includes the Moreton Bay Regional Council as well as parts of the Somerset Regional Council. So quite a large catchment, but obviously an urban catchment.

So, as I said, what I'd like to talk a little bit about is sustaining innovation over time and some of the things that Brisbane North PHN has actually undertaken and the Commission report provides lots of fantastic examples of innovative approaches from across the country to managing chronic health conditions. So it also does a really great job talking about some of the barriers that you actually come across when you are trying to be collaborative and to be building innovation in your local areas. There's plenty of barriers but there's also plenty of really good examples of how individuals and organisations are overcoming those barriers. So that's really what I wanted to spend a bit of time on.

As I mentioned earlier sort of building and sustaining collaboration, really from our perspective as a PHN, is the cornerstone of the work that we undertake. And what I am really going to talk a little bit about now is our structured approach to collaboration at Brisbane North PHN. So how we have actually sustained that, I guess, structure and processes over time. How we have overcome some of the barriers of changes in personnel and people and how we deliver outcomes for the community that we serve.

So the example which is in the Productivity Commission report from our perspective is around the health alliance. I will just click through to there. So that's what I am going to just talk a little bit about. And so I thought I'd start by just talking about what the health alliance actually is and from our perspective, really, it's germinated in an idea from 2017 from the previous CEO here at the PHN and also at our corresponding hospital and health service. So we had a long track record of working collaboratively and in partnership and, really, the two organisations came together to form the health alliance to tackle health care problems that actually transcended the mandate of any one organisation to address on their own. So what we sort of – the vision for it was that we recognised that there were a whole lot of problems that we couldn't

solve on our own and we couldn't solve using existing approaches so we needed to think about how we would tackle those collaboratively and doing things a bit differently.

5   So what the health alliance actually does from our perspective is it creates a neutral space. The alliance isn't owned by any one particular organisation. So it's not owned by the PHN or the HHS. But it's a neutral space where we bring different parts of the sector together to identify and discuss common problems and think about what those
10   shared solutions are. So it's really for us about empowering the people working in the sector in our region and thinking about how we do a people centred system response to those big problems that we face.

So how does the health alliance work? I guess, really, fundamentally
15   what it is providing from our perspective is a formal structure and an enabler for collaboration. So some of the focus really for us has been about system coordination and integration. So the health alliance actually is the facilitator of those conversations. So, really, what the health alliance undertakes is it looks at specific health challenges. It
20   looks at how it can bring the different parts of the health sector together as equal contributors, building a shared understanding of what the problem actually is from differing perspectives, and what solutions we might be able to put in place.

25   So as part of that process and as part of sort of the codesign that we undertake, you know, the health alliance then facilitates recommendations of solutions, thinks about how we can address the problems that we have identified, what impact those solutions might have and where possible we obviously jointly commission services.
30   That's a little bit of a longer-term goal for us but at the moment we're probably doing it a bit more like co-commissioning but, in the longer term, thinking about how we would jointly commission services to address our mutually understood needs and solutions.

35   And obviously as part of any of this is really about reviewing to making sure that we're having the impact that we would like to have. So for us the health alliance, fundamentally, is about providing a shared platform to progress joint initiatives.

40   I wanted to talk a little bit about the critical success factors from the Health Alliance's perspective and you can see on this slide that outlines sort of five areas. So really the philosophy being that whilst, you know, many efforts to create change and deliver better outcomes within different parts of the health system, sort of are needed to have a real
45   impact, we need to think about change across the whole patient journey and across multiple stakeholders.

So the Health Alliance has five sort of elements to it which we think are the critical success factors to support that collaboration. So the first one

at the top there is around joint governance. So how we've actually established the Health Alliance in Brisbane North is that we have a joint Board committee that meets quarterly. So that's a formal subcommittee of the PHN and the HHS Board with equal representation and the two Chief Executives that sit across that and that really provides, I guess, the opportunity to develop and promulgate a shared vision for what this collaboration is to deliver. I guess subsequent to that we then also bring our executive leadership together. We have a monthly joint operations group. So the shared executives of the two organisations I guess then have the responsibility to implement and progress that vision.

We think, fundamentally, that the joint governance that we actually have really provides fertile ground for taking us to the next level in terms of collaboration and innovation and what we're trying to obviously overcome here is a too heavy a reliance on individuals by having some structures and processes that actually bring that collaboration together.

The second thing I just wanted to talk a little bit about is the stakeholder engagement and consultation. Again, as a PHN sort of engagement co-design, understanding the needs of our community, undertaking an annual health needs assessment, commissioning services to address those needs is fundamental from our perspective. But what we're trying to actually do is bring some of that together, you know, with our HHS colleagues. We've actually undertaken a joint annual health needs assessment.

We have a joint population health report. We have got joint plans both in mental health and the care of older people, and really starting to sort of have those fundamental pillars that drive the collaboration so that when we actually bring our stakeholders together we do that collectively wherever possible. It's not owned by any one particular organisation and we're progressing sort of shared approaches wherever possible.

The health system data, I think, has been alluded to in some of the previous presentations. And, really, I guess our vision here is for a connected health data system. We're a little bit away from that at the moment but, really, we've got some building blocks in place in terms of data sharing, joint planning, jointly identifying needs, things like that.

I guess the other thing, the fourth critical success factor from our perspective is the investment and financing element. So the health alliance is co-funded by the HHS and PHN. We're equal partners in this. So we equally invested both financially and through our own particular organisations. I think there's not always new money in the system so I think the other critical thing around sort of investment and in the opening comments, you know, new funding models and helping to support sort of innovation and collaboration is a barrier, but also an enabler sometimes. But it's not always easy to attract additional

funding. So, fundamentally, what we're looking for is how we leverage off the investment that is in the system or new announcements or things like that to enable achievement of shared goals.

5   Obviously, our eventual vision around the health alliance is for regional commissioning and so, really, we're on a continuum in that sort of capacity at the moment, thinking about we actually share commissioning approaches.

10   And then, I guess, finally just wanted to touch on the staffing arrangements. You know, the Health Alliance is jointly funded by both organisations and we have an independent staffing team that reports to both chief executives. It's a small agile team that acts, really, as a facilitator for engagement across both organisations and progression of
15   some of the key priorities that the joint boards have identified for the Health Alliance.

I am not actually going to spend a lot of time talking about the areas of focus that the Health Alliance is actually currently undertaking. I think
20   the point was really more to talk about how we're putting structures in place to sustain innovation over time. But really I put three areas of focus up on the screen just to give you a flavour of some of the work that we're actually undertaking. So the first area of focus is really the Your Care Closer initiative. And fundamental to that is really bringing
25   primary and secondary care providers together to develop and support models of care that reduce demand on hospital facilities and deliver care closer to people's home.

At the moment it has three fundamental elements so specialist advice
30   lines for general practice, better uptake of hospital in the home and GPs with special interest. The second area of focus from the Health Alliance's perspective has been around improving outcomes for children. And, really, what we've been doing there collaboratively, not only with our HHS being Metro North but with Children's Health
35   Queensland is to redesign pathways for kids that are born in the Caboolture region, which is in the northern end of our catchment.

And we have been really successful in developing a new pathway for antenatal and postnatal care, increasing continuity of midwifery care,
40   transitioning to child health, connections to the family GP. And really this is a proof of concept. There hasn't been additional funding. This is actually using the resources that were already available in a better care pathway for kids and their families.

45   And the third one just there was really around place-based shared care. So looking at, again, how we think about new models of care between acute hospitals and the primary care sector, you know, leveraging off our track record of collaboration, thinking about how we do things differently.

So the Productivity Commission report actually highlights three factors in terms of building and sustaining collaboration. That being effective leadership and governance, sort of good working relationships and shared funding. And what I have done in this slide is just to attempt to highlight from my perspective how we see the Health Alliance has built and sustained collaboration which, in turn, has provided us the platform to actually work together to solve some of those challenging problems that many of us face in addressing the growing burden of chronic disease in our local communities.

So under the effective sort of leadership and governance space – I won't read through all of that because much of it I have talked about. But, you know, fundamentally it is really having that shared vision and having some joint governance mechanisms in place.

I have a talked a little bit about good working relationships. What we have tried to do is a strength based approach, thinking about what's the strength of the PHN versus what's the strengths of the Hospital and Health Service. And, really, the funding side of things I have also talked a little bit about.

So my last slide, really, is just to talk about some of the observations and challenges that we've found in terms of building and sustaining collaborative approaches. Sustaining collaboration requires sustained effort but from our perspective we think it's fundamental and is the basis for innovation. So we've prioritised that as a role that we're keen to continue to play. But, really, I can't stress enough the importance of leadership and that enabling environment that actually enables collaboration to be part of our core business.

I think where we've had our most success is where we have responded to opportunities that happen, whether that be budget announcements or a particular political driver that might actually enable some collaborative actions. So to try and to respond to the environment as well as understanding what the needs of the local community are. I think sometimes we have to work with what we have got. It's not perfect. There's not a huge amount of new money to progress some of the innovations so we have to think about how we leverage the investment that's in the system already.

And, really, my final comment is that in a system that's focused on activity how we actually demonstrate and measure the value of collaboration is an ongoing challenge. I think I will leave it there and hand back over to the Chair if that's okay? I think you're on mute, Michael, as well.

MR BRENNAN: You're quite right. Thank you, Libby. Thanks for that presentation. Those observations at the end were very powerful.

Before I go to Don and Keith, I just want to mention again the Q&A function on Zoom. So start getting those questions flowing. You can just go in there and type out a question and we can then hit the ground running at the end of Don and Keith's presentation. I don't want to be repetitious, as you know, I mentioned earlier Don and Keith are at Northern Health. Don is the Clinical Service Director of the Staying Well Program and the Medical Division Director at the Hospital without Walls and Keith Stockman is the Director of Service Design and Innovation, Staying Well Program at the Hospital without Walls.

But as I mentioned, in particular, for our purposes critical implementers of the Monash Watch Program at Monash Health are now doing something similar at Northern Health under the banner of Patient Watch. So over to you, Don and Keith.

MR CAMPBELL: Thank you very much. I hope you will soon see my shared screen and I will just make sure that we get it to – how do we make it the big picture? Excuse me just a moment. I've just got to work out how to get the little – there it is. Got it. Thank you very much for that introduction and my co-conspirator is my colleague Keith Stockman with whom I have worked continuously over the last 10 or more years. And we have been working together on this initiative since November 2015 at Monash as Monash Watch and subsequently here as Patient Watch, a more generic name that we think will travel a bit better.

Now, I hope you can see my screen in its completeness there just to say that we want to give some thanks – executive leadership, we've heard about the importance of executive leadership. Without executive leadership you are in real strife and the leadership needs to be committed not just involved and the difference between the two is the difference between bacon and eggs. When you talk involvement, the chicken is involved. You talk commitment, the pig is committed.

I also want to name the people at the Department of Human Services. So Rosa Rocca, Denise Ferrier and Tanya Sewards, incredible support for us. Carmel Martin who is a GP based predominantly in Brisbane. We learned a lot from her and she has been intimately involved particularly in building out some of the key elements and the evaluation framework. Everything we have done has been independently, has been subject to peer review published evaluation. Narelle, and Danny Nguyen are trojans; courageous and pioneering service staff, our patients and many others who inspired us and a shout-out to the people at East Grampians who have picked up some of the elements of our model. Everything we have done has had a theoretical framework within which we have attempted to work.

So we started out as a couple of kids with a crazy dream but we wanted to move hospital outside the walls. From a Gen Med perspective we went to our then CEO, Shelly Park, and the Chief Operating Officer Siva

Sivarajah at Monash and we asked this fundamental question, "How might we help vulnerable people stay as well as possible and out of hospital?" An angel then appeared in the forms of Health Links Chronic Care that linked the capitation funding model, IHPA sanctioned, and an

5 algorithm for case finding and we asked the question, "Could we use design and systems thinking to conceive and try something different?" We had some assumptions built in as well.

The issue there was that we had some assumptions that we were

10 working – our starting point was within a fragmented system but if we just got started from where we were we could contribute over time to driving a more integrated care model. A bit like the tourist on the west coast of Ireland who goes into a pub and asks how to get to Dublin, and the drunk says to him, "If it's Dublin you're wanting to get to I wouldn't

15 be starting from here." Well, we didn't have a choice so we just had to get started.

Here's the model and that circle reads in an anti-clockwise direction but it starts with the relationship between the professional neighbour, which

20 is our telecare guide and that is a person who has no health care background. And they're checking in using a self-rated health check questionnaire with the patient and their carer and this is a – we record the information in the decision support system and when it triggers alerts based on the narrative and the events we engage the coach.

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The health coach is a person with nursing or allied health background and they're empowered – their job description is Fix It. And in order to be effective in responding they have to be both reactive and anticipatory and have access to the requisite variety of services that's needed and

30 that's a powerful set of relationships there and there's backup of course.

Their model, grossly simplified, is built on keeping an eye on vulnerable patients at home and we had these teams linked to a geographical area borrowing from the work of Jos de Blok and the Buurtzorg Community

35 Nursing Organisation in the Netherlands of self-managing teams who are coached without hierarchical management. And this virtuous cycle of risk-driven cycle time for interaction and positive user experience to build trust. The key metric really needs to be trust and getting to know this person in their environment.

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I will move on to the next slide. Now, what did we learn? We need an executive leader willing to take calculated risks and a long-term view. Clinical collaboratives matter and the department will need this clinical collaborative for the Health Links initiative. Algorithmic case finding is a

45 good thing particularly in those vulnerable cohorts that we link to funding, the finding and the focus.

We had a very strong user experience design and systems thinking capability built into this and we're really looking at complex systems

where these trained laypeople collect self-rated health information for the clinicians. It sure as heck made some of those clinicians very, very nervous. They didn't like it, they were uncomfortable, and this is built on the principle of genuine listening and encouragement and the word

5   from the Indigenous language group centred around Daly Waters in the Northern Territory – dadirri – deep listening, with quiet contemplation in order to build community – the fundamental role of that person. This is the person in the village, the neighbour with their elbows over the front gate, keeping an eye on vulnerable people close to home.

10

One of the things we learned after we had been going for a while and I've got these in the wrong order, but first up we learned that these people had features in common. They had lost purpose and connection. They were experiencing pain, somatic pain, existential

15   pain, pressure in the form of depression and anxiety and they used traditional means – pills, potions and booze – to manage their pain.

This all needed to be dealt with as a 'hamburger with the lot', otherwise you're sending them to four different services. After we got to know

20   these people what we found was that many, many of them have a prior history of abuse. What sort? Any sort. From emotional trauma and neglect, being a refugee, being tortured, being sexually abused, being physically abused. And what we really are learning our way into is a trauma informed practice model of care. The health coaches have to

25   be trusted to make high leverage commonsense decisions and micro-investments that we trust and track.

Where to from here? Build on what works using algorithms and we want to build that out and take advantage of information, not from

30   administrative data systems but to incorporate information from general practice, capitation funding. We have never been able to really make this work by the way. The capitation funding model is meant to identify a total budget. We have only got to play with very small amounts of money. The trouble with the budget is that it comes out of our gross

35   budget, and if you think about the resistance to change, for example, in the community health service you might have a hundred million dollars CAPEX. Well, if you look at that as a 5 per cent return on investment you have got 2 billion dollars invested in resistance to change. So we really need to work out how we carve out funding.

40

The monitoring systems and structured listening, that's an area for exploration. Where do you start? You start with whatever the vulnerable person wants to focus on now and this has to complement, to diagnose and treat the mechanistic medicalisation of health care. So

45   we need the medical and the social given equal prominence and maybe the social takes greater prominence.

We're looking at the impact on hospital resource use, expanding the responses to help the clients so that can be done effectively, using the

machine learning approaches and building out real alternatives to ED and wards because every road leads to the ED at the moment. We have got a leverage to digital transformation seen in other sectors and have to deepen the integration of Patient Watch with our own services and those of external partners. We want to avoid pilot, puddle and perish, and you can put something else in there if you like, and the challenge isn't going to go away and we have to be more flexible around how we pivot.

How hard is it to change environments? What's it been like moving from place A to place B? Well, the system is optimised in response to the existing constraints. So context matters. We have had to be respectful of those who are already in place doing a really good job. We don't have the luxury of saying, "Oh, these people fill in whatever you like." And I think the change journey begins with seeing possibility. You can't see what you can't describe and therefore you can't change.

Collectively we need to learn a new language together so we can describe what we see differently and we can create something new together. So I'd like to finish by thanking the Productivity Commission on behalf of Keith and myself for this opportunity.

You can't believe how grateful we are to you for the incredibly reasoned, kind and calm assessment you have made of our work and to see it in the context of the work of others. So thank you very much for this opportunity. I'll finish there. Keith wants to add a couple of words.

MR STOCKMAN: I might just add a couple of words to the end, thanks Don. One of the things that was very important to us and I suspect Narelle's line was we wanted to start designing what we were doing here from a patient experience perspective. So we learned the world of design and tried to apply that and I think that was quite a successful side of what we did. And we went out and we talked to patients and we got a sense of the different personas that we were trying to work with.

By the way, the people working with these algorithms there's usually only two or three of them in any GP practice so it sort of makes sense for a health service to be helping the GPs with these very difficult small number of patients. I will stop there because we're out of time I think.

MR BRENNAN: Well, don't let that stop you, Keith, if you've got a couple more things to say. In fact we may be able to revisit them in the Q&A. We haven't got any questions as yet but can I start by thanking all of our panellists and I am sure the questions are going to come – in fact, they are starting to come in. I am going to take the Chair's prerogative and ask the first.

Libby, you talked a bit about the advantage that comes from a history of working together, particularly where you've got an existing relationship between PHNs and the Local Hospital Network or similar. What advice would you give to PHNs in areas where they don't necessarily have that strong pre-existing relationship? How do you make a start? You talked about using the context and the importance of striking when a particular policy priority comes along or something like that. But are there other thoughts that you would have that would be advice to others?

MS DUNSTAN: Thanks Michael. Always love getting the first question but, yes I think it's a good question. I mean really, you know, when I reflect on this organisation it has been around in its various forms since back in the divisions of general practice days. So has a long history with many different people, I guess, in leadership roles – not only at the PHN but also at the – what we call the HHS in Queensland. So, you know, I think when I think about collaboration, really, you know, what I say to my team anyway, it's just about consistency. It's about doing what you say you're going to do and sort of following through. Don't promise something that you can't sort of deliver on.

But I think from taking it to that next level in terms of joint collaboratively working. You know, I think that whole thing about having a shared vision. Why are we working together? What are trying to achieve together? Why is it better to work together to achieve what we're potentially trying to achieve? And I think at the end of the day what's common between ourselves and in our case our local hospital and health service is that we are trying to deliver the best quality health care for the community that we serve. We have got a shared boundary. It's a one to one boundary between the PHN and the HHS. I'd have to say that probably makes it a lot easier than some of the other PHNs who either have multiple hospital and health services or perhaps not even shared boundaries. So I think when you've got some of those enabling factors, it's really just about persistence – I guess shared vision across both organisations and bringing it back to what matters which is making a difference to the community that we serve.

MR BRENNAN: Thanks Libby. I have got a question posed by Hannah that is, I think, relevant to all of the panellists because it goes to funding. Kean-Seng, in your presentation, as I said you'd talked about pretty much four out of the five themes that we talked about but funding was probably the last one and I did find myself asking how are you managing to use the MBS model to do all that you're doing in terms of the shared consults, the group meetings, the app and that sort of thing? And Hannah's asked the question, if a model of care requires more intensive primary services than can be adequately reimbursed with the MBS item how do you deal with that? And I think the same thing goes a bit for Don and Keith. You talked about the challenges of capitation funding but I thought I'd pose to you as a supplementary – without Health Links would you even have made a start with Monash Watch?

But I think for all panellists if you could reflect on Hannah's question about funding and the barrier that that might create?

5 DR LIM: Well, I mean I'm happy to kick off first then, Michael. I think Hannah has pretty much hit it right on the head and the problem is this one which we have in our system of the asymmetric benefit realisation which basically means if we do a better job in general practice the benefits actually do not accrue in the general practice. So if I reduce

10 hospitalisation the benefit accrues somewhere else in the system. And it's the same situation that Libby of course referred to too when she was referring to that model. So which is that partnership between LHDs and PHNs or LHNs, whichever part of Australia you're in. But is a very real issue.

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So one of the problems and there's multiple layers to Hannah's question. So the first one is what do we do with existing funding? And existing funding or what I call item-numbered directed care is a problem because item number directed care only directs you in the care which you get reimbursed for. So it's part of moving away from the concept

20 you get reimbursed for. So it's part of moving away from the concept which someone had alluded to in terms of health care homes and that it tried to move away from that concept.

However, I think the reality is that we are going to have to live with what

25 we have. That's not moving in the near future. So a part of that question then is do we have to look at funding at a meso level, rather than a micro level? And that's actually what I think we have got to do. So I think that I am going to approach my response after that sort of waffle there. From a micro and a meso level. So the micro level which

30 is at the practice level, we actually seriously don't think about the funding that where we say that the funding we get for care plans, for chronic disease management case conferences, that is the funding that we get. Then how we apply it within the practice is up to us.

35 So first of all there's of course changing the way that we think, and that's a mindset thing and I think coming back to what some of the comments were that may not be a sustainable solution. That is something which is done at a practice level and with relationships and with groups. So what is probably needed to be done is more at that

40 collaborative commissioning level which is whether it be commissioning by PHNs, but it's a regional level thing. Now that is that there probably does need to be a way. We look at how funding works. So within our practice there are examples of that. Our pharmacist is actually funded through funding which is primarily really coming from the LHD.

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The integrated care nurse who assists us with our practice, who has probably assisted us with the equivalent of point one to point two a week is also funded by the LHD. But these are additional resources that we can leverage off and that we can use. And again if this has a

benefit to the system in terms of reduced hospitalisation, reduced total cost of care and improve patient experience then we would see that to be a benefit. So I think it's about how can we more cleverly use what is existing but also we have to try to – how do you put it – try to mobilise resources from other sectors where there might be a benefit.

MR CAMPBELL: Michael, at least the contribution I'd make is really we're able to get started. The model said the funding came from this pro rata capitated funding scheme within a global budget. The global budget is both set and allocated in the year prior and there's no sense in which you can really carve out the budget at an operational level. To do that at an operational level our CEO needed to take that out of growth funding and to allocate it in that way because otherwise just setting yourself up for a massive internal fight about assets resource redistribution.

I think creating those macro level incentives and recognising the realities of asymmetric benefit realisation really requires courageous and inspired leadership and the really big one would be if that was collaborative across sectors and at the moment I can't see that there's much incentive for that. And my colleague, Keith, here has said it really depends on the uniqueness of the partnership between a PHN CEO and a health service CEO and alignment of their thinking around how they would work together. So it's very flukey and as is executive sponsorship even for us to work. You're one phone call from the Minister to the CEO away from losing your CEO for them to be taken off somewhere else and it's groundhog day. The whole system relearns how to work together. Thank you.

MR BRENNAN: Yes. Go, Libby. Yes.

MS DUNSTAN: Sorry, Michael. Yes, I think – you know – if I was just going to add to that a little bit as well I mean I think what Hannah has done is kind of nailed the big hairy question, that is, that faces – as a PHN CEO every day. That's not to say that there is not money in the system. It's just that I think as Donald was saying the macro incentives, the State-Commonwealth divide, how that funding comes to various parties really doesn't always enable it being directed perhaps to the best effect in a particular local community. So if I reflect on our learning so I think the easy part has been working together, you know, identifying shared needs, thinking about what the evidence says, how we would make an impact. The really difficult part is to change the way the system values and funds that sort of innovation to realise those benefits.

So what we have tended to do then is rather than to think well we fundamentally want to change the care of older people in our catchment is we think, 'Well what are the elements of that?' What funding do we have available? It's kind of what Kean-Seng was saying. You know?

What bits of it can we bite off? How do we incrementally do change rather than perhaps the big-bang sort of approach that that new funding might actually enable of you. So step-wise approaches, persistence and really, you know, I guess a continued discussion about how do we actually get more flexibility in the funding that is available in the system? And, you know, we obviously fundamentally believe that the vision for us – you know – with our HHS would be to regionally commission that to actually meet the needs of the population that we're serving. But it's a long way to go.

MR STOCKMAN: Michael, I might just add a little bit on Health Links if I may?

MR BRENNAN: Yes.

MR STOCKMAN: Yes. First of all it's important that to note that the HS in Victoria did that as a pilot exercise. So it was an experiment and it stimulated conversations in just about every health service in Victoria in one way or another. So I think it was a really important way of getting the conversation going about these groups of people that probably wasn't happening prior to that. It also has had an enormous number of lessons pour out of it in terms of the challenges of shifting from an activity-based model to a capitated funding model. But I think those lessons are learned and the question now is where do we go from here? And maybe blended funding models as is mentioned in your report is an interesting area to explore.

Some of the health services, initially, were concerned that they may lose money and didn't jump in. Others felt that they might do okay out of it. But I think I could say that probably we wouldn't have got off the ground financially, and maybe even driving forward and having the clinical collaborative that was sitting alongside the development of Health Links was super important. It created a network of discussion across the health services and within it.

MR BRENNAN: Yes, thanks very much for that. Applying that back into the primary health space I note Riah's asked a question, having had some experience with the Health Care Homes Program which was a genuine attempt to kind of shave some of the rougher edges off the system, in the context of managing chronic health. And the question there was basically how do you avoid reinventing the wheel? So we try things out. There's always a risk. You learn quite a lot, as you say, in relation to Health Links in the acute space. How do you avoid throwing the baby out with the bath water and making sure that we're making kind of continual improvement, rather than starting from scratch each time. What are some of the perceptions of the panel on that?

DR LIM: Well, I'm happy to start again from the primary care space, given that we are one of the Health Care Homes practices and we are

about to start going through that process. So for all the things that we get the Health Care Homes that would strike me that one of the key learnings from it is about how to work together.

5   And the funding it was actually not that big a part of it, thankfully, that's the good news about the Health Care Homes and why the impact is going to be less. But in terms of how we're going to not keep reinventing the wheel we really do need a longer term strategy for not just primary care but all of care. And, in fact, thinking of care not just in

10   terms of primary sector and acute sector but actually in terms of all of care, and I do note some of the comments in the questions as well about how we really have to think about from the first thousand days of life for all children and actually start to identify risks and identify those gaps that we have not identified in the first place.

15
And to do that that does require that more integrated system, it actually requires a more strategic approach but it requires some guidance, some teaching and some learning. So from a primary care perspective - so I'll leave others talk about the others. From a primary care

20   perspective what is needed is there does need to be some of that guidance, stopping the chopping and changing of programs which come and go. So that probably realistically is going to need to have a meso level of organisation. So, logically, that's going to be PHNs but guiding a transformation. But the transformation process is not a quick one. If

25   we look at data from the US, I mean the best I have seen is Oregon in three years. So three years to get something done in Oregon. And most other places about seven years. So we probably have got to be looking at realistic time frames.

30   There also needs to be a realisation that there has to be investment upfront in order to stimulate that change and then there needs to be guidance on that change and it does have to be as keeps coming up, that iterative approach measured at every step – but, of course, bringing everyone else along the way.

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And, of course, the last bit of that which is probably this one is and the reason I keep talking 'regional' is that benefit accrual is regional. Largely, it is regional and needs are going to be regional as well. And if we talk about how they're going to have resources to intervene, when

40   you say families at risk, a lot of that is also going to be how we mobilise regional resources. Hence my call for regional funding and that sort of regional pool funding concepts or blended funding concepts are – and I'm talking about blending at all levels – is probably one of the fundamentals to truly integrated and coordinated care.

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MS DUNSTAN: So Michael, I think Kean-Seng has answered that really well. Perhaps the only thing I'd just draw out of what he said there as well is that I think what we really need is we talked about a vision at a regional level for what we're achieving through collaboration

and working together but I think at a national level we've obviously got the 10-year primary health care plan that is under development. And really have high hopes that that will be aspirational and provide that, I guess, vision for what we're actually trying to achieve.

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Because Kean-Seng's exactly right. This sort of transformational change is not going to happen overnight. It is incremental obviously it will take time but we kind of have to have that common view point that we're working towards in order to start that journey and also to learn

10 from what has gone before us as well. So that's probably just the other bit I would highlight from what you said Kean-Seng.

MR CAMPBELL: Can I just add in? The metaphor if you like health care is a commons. It draws on the work of Elinor Ostrom who won a

15 Nobel – or the equivalent of a Nobel Prize for economics - no doubt bedside reading at the Productivity Commission – in 2009, but the concept of health care as a commons and one place that we went for inspiration very early on in our journey – a place called Rethink Health and the Principles of Collective Impact. We used that to write our report

20 recommendations for improving health services in the Latrobe Valley. But I really would emphasise it is regional, it's got to be collaborative, and it's got be integrated. So regional, integrated, collaborative health care – RICH health care – is an absolute fundamental and how do you share the governance?

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I love the word the Health Alliance draws me to Alliance Contracting and the need to bring together both health and social care. These have got to be brought together because otherwise every road leads to the ED. The ED is the sanctuary. The church was the sanctuary in the

30 Middle Ages, ED is sanctuary at the beginning of the 21st century. You come into ED with chest pain, you're going to get run through the algorithm. So we have got to build out those social services and integrate them and to target the vulnerable groups who are always at the back of the queue. Thanks a lot.

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MR BRENNAN: Yes. It's a great point and I am a big fan of Elinor Ostrom. I am going to slip in two questions. The first is specific to Kean-Seng which is how easy – how scalable is the app and the patient provider partnership that you talked about in your presentations is the

40 question from Sam, and then we will go to Lisa Woods' question which has been upvoted. So it's the people's choice. But, quickly, on the platform.

DR LIM: Okay. So I suppose my response – I'll try to cover a bit of

45 both actually because the way I see it is, well more than the way I see it – I think the reality of things is that where things happen. So the operational level of things is the micro system and the micro system is where care takes place, where interactions take place, where trust is built between providers and patients, and patients and carers and of

course where those relationships need to be built between different care, different providers in the system.

So in terms of what the app can do and what it does, firstly I am going to say is take everything I say with a huge grain of salt and be entirely sceptical of what I am going to say, because we do – and when we talk about that funding question – we're funded by the fact that we have a small equity share in the company itself. So that's why – take everything with a total grain but with a huge teaspoon of salt here.

But in terms of how it works it is a system or data integration system which means you can pull data from different systems, whether we'd be talking to Cerner, whether we'd be talking MedicalDirector, Best Practice – whatever – and it then aggregates it in a Cloud format which can then be read by other users and systems. So is it scalable? Yes, it is. It is able to be used by providers to provider securely? Yes, it can. It works very well for coordinated care. Provider to patient depends on two things. It depends on either the patient having the literacy to use the app themselves or, interestingly enough, patients' carers or patients can navigate it, being able to use it.

So is it scalable in that sense? Yes, it is, but I'll also say that I am also very wary of the digital divide and increasing inequity if we start to rely on that. So I see it as an adjunct. So oddly enough I don't see software as a solution. I see it as an enabler. The solution is actually the system, the workforce, the work flows, and those partnerships. Software can help to make it more efficient, enable it, but it is not the solution in its own right.

And so in terms of how – and I will just go to Lisa's question about how we then use that trauma and how trauma does underlie things – absolutely. I am in Mount Druitt. This is the thing we see all the time. The question is how do we then mobilise the resources and be able to apply it? Two things. One we have to identify the problem in the first place. We're not very good at doing that proactive identification.

So this is where having that sort of outreach and (indistinct) care which platforms allow us does help. We can also translate that to use the web portals and things where patients actually when they log in and answer questionnaires, then we can actually do scoring systems and it works really well with that. But then we have the next step which is how can we intervene. So while the practice is a microsystem of which intervention happens, well it's not having the resources to be able to do that intervention which is the heartbreaking part. So that's the mobilisation of resources. But thanks very much, Michael.

MR BRENNAN: Libby, do you have a view on this question about mainstreaming trauma-informed practice?

MS DUNSTAN: I think it's just a really insightful question in the sense that I know that at our recent joint forum with the Metro North HHS our keynote address was on this issue and it resonated with the clinicians and the two organisations as well. So, no, I don't have the answers in terms of mainstreaming it. I think what I would say is that from an organisation like mine as a PHN it's something that we're currently trying to think through in terms of how we actually raise partly the profile and the practical steps that we can do to actually support trauma-informed care. Because like Kean-Seng just said I think it's really fundamental to the way we deliver health care in our communities.

MR BRENNAN: Don? Keith?

MR STOCKMAN: Yes, there's so many people in the cohorts that we work with at both hospitals have got some sort of background trauma. A lot of the principles that we have built into the model and actually just talking to people through their peer contacts and so forth, actually tick quite a lot of boxes on trauma informed care, particularly if it's combined with motivational interviewing and so forth by the coaches. But I think we've got a long way to go to develop that out and figure out how to scale it and the other thing I wanted to say is that upfront investment in going sort of in the health services beyond just EMR implementations to enabling digital solutions is what we think is actually the way to amplify out the effect we're having on patients as well, and give the clinicians enough time to do the human stuff that's absolutely so critical to this. So it's a really interesting mix of things you've got to bring together.

And lastly money to fund evaluation of this stuff properly, to get it done, is some of these interventions are very hard to evaluate and we do need probably to think more about how we go about that because we get quite mixed results back from different evaluation approaches. So I'd certainly like to see more funding available to get the evaluation right because we don't want to scale things that don't work.

MR CAMPBELL: And the evaluation is critical. I point you to the ICIC, International Collaboration for Integrated Care and the European Union has done a lot of work around the evaluation tools. And you can look them up. Look for Selfie2020 but don't leave a space between the world Selfie and 2020. You'll find yourself looking at the Kardashians. So workshops to support clinicians to learn their way into trauma-informed practice I think would be very useful. Because once you have had your eyes open this stuff is absolutely everywhere, particularly, in those vulnerable groups of high users – the frequent attenders to ED, and the frequent admitters, the heartsink patients so-called – but Kean-Seng will know well. And I'm sure he supports at his practice in amazing ways.

So the really engaging and empathic practices attract these sorts of people and they will have more than their ones and twos but they're heavy users in the health system and we can do so much better.

5   MR STOCKMAN: I can't imagine how good it would be to be surrounded where we are now with practices that are all thinking like Kean's practice. That would transform our network of relationships and that's all we have to do.

10   MR BRENNAN: Stephen, I might just finish with you on Lisa's question, given your authorship or partial authorship of the Mental Health Inquiry at the PC?

MR KING: Yes, thanks Michael. So it's actually a good place to end
15   and give it a bit of a plug for our Mental Health Inquiry Report again. Whilst what we have been talking here is very much focusing on the chronic or physical health, the boundaries somewhat are artificial. We know that many people with mental health have comorbidities, physical comorbidities. Consumers don't fall into nice little boxes and one of the
20   lessons, I think, out of the experiences that our panellists shared with us today is that we have to make sure that the incentives in our system don't get caught into those same boxes. That we're able to have somebody walk in to say a GP clinic who may be presenting with certain issues.
25
So maybe diabetes, there may be another chronic physical condition, there may be indications of a mental ill-health, perhaps an anxiety attack, or perhaps just a general feeling of – you know – having trouble getting out of bed. Just not feeling well. Or it may be related to alcohol
30   and or other drugs and we know that they're all interlinked and often the basis for that is trauma, and so just to plug a couple of things from our Mental Health Inquiry, one answer to that is the prevention, early intervention, making sure that, for example, parents have the support that they need so that that early life trauma can be very possibly
35   avoided.

But the other part of the answer is exactly what we're talking about today which is making sure we have a system that allows the different parts to work together, gives them the incentive to work together. It
40   doesn't penalise them for working together and then also allows them to innovate, work out what is best for a particular group of patients, and evaluate and where it works. Where it doesn't work, don't punish people. If you don't try things – when you try things sometimes they won't work. So you're going to have failure in any system of innovation.
45   But where they work, work out that they work, and then make sure that the incentives are there to spread those good practices and I think that's sort of the underlying message, I guess, I take away from today.

MR BRENNAN: Thank you very much, Stephen, and thank you very much to our panel and to all of our participants. That's all we have time for. I'd just like to thank Kean-Seng, Libby, Don and Keith and Stephen and also Richard, the other author of our work on chronic health. I found it and no doubt others have too, a highly informative session also reassuring and affirmative to know that we have people at the front line of our health system who are so enterprising and dedicated and knowledgeable and pragmatic about getting better systems and innovating to get better outcomes for patients.

I would also just very quickly like to thank Miriam Veisman-Apter, and all of the team, at the Productivity Commission for their work, putting together our report and their ongoing work in this space, and it is an ongoing conversation and we're very pleased to be a part of it. So thank you all very much and we'll leave it there.

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