LIVING WELL
your way

Collaborative Commissioning Care Pathway Design

A care pathway to improve outcomes for people
with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF)

23 November 2021

LIVING WELL your way

Collaborative Commissioning

NSW GOVERNMENT Health Murrumbidgee Local Health District

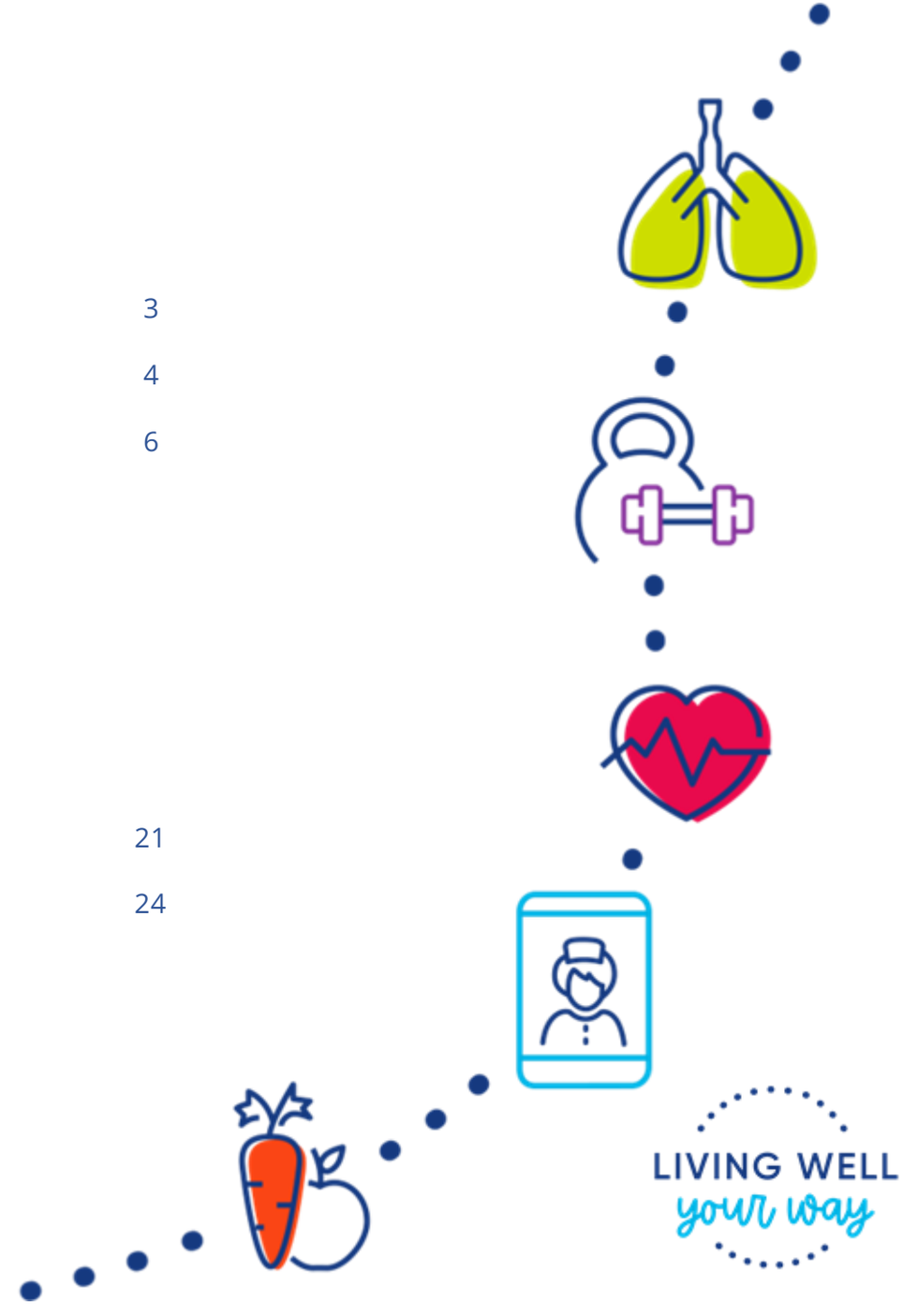
phn MURRUMBIDGEE An Australian Government Initiative

Contents

Key

Indicates there is an opportunity for an integrated digital solution

Refers to the Living Well, Your Way pathway. Stages that are being referred to will be shaded in green for clarity



Introduction and overview of the pathway

The Murrumbidgee Primary Health Network (MPHN) and Murrumbidgee Local Health District (MLHD) Collaborative Commissioning partnership was formed to develop and implement a care pathway for people with Chronic Obstructive Pulmonary Disease (COPD) and/or Congestive Heart Failure (CHF). The Living Well, Your Way Pathway ('the Pathway') outlined in this document has been developed through a process of co-design which included:

- Significant consultation with stakeholders across the region since 2019
- A virtual co-design event comprised of 12 workshops held over three days in October 2021, with overall participation equivalent to 200 people (noting that some individuals participated in more than one workshop)
- Representation from general practice, pharmacy, allied health, consumers, Aboriginal health staff and community leaders, Ministry of Health, and MLHD and MPHN staff and Executive

See Appendix A for further detail on the co-design process.

Objectives of the Pathway

The goal of the Pathway is to keep people with COPD and/or CHF healthier at home for longer. The targeted outcomes include:

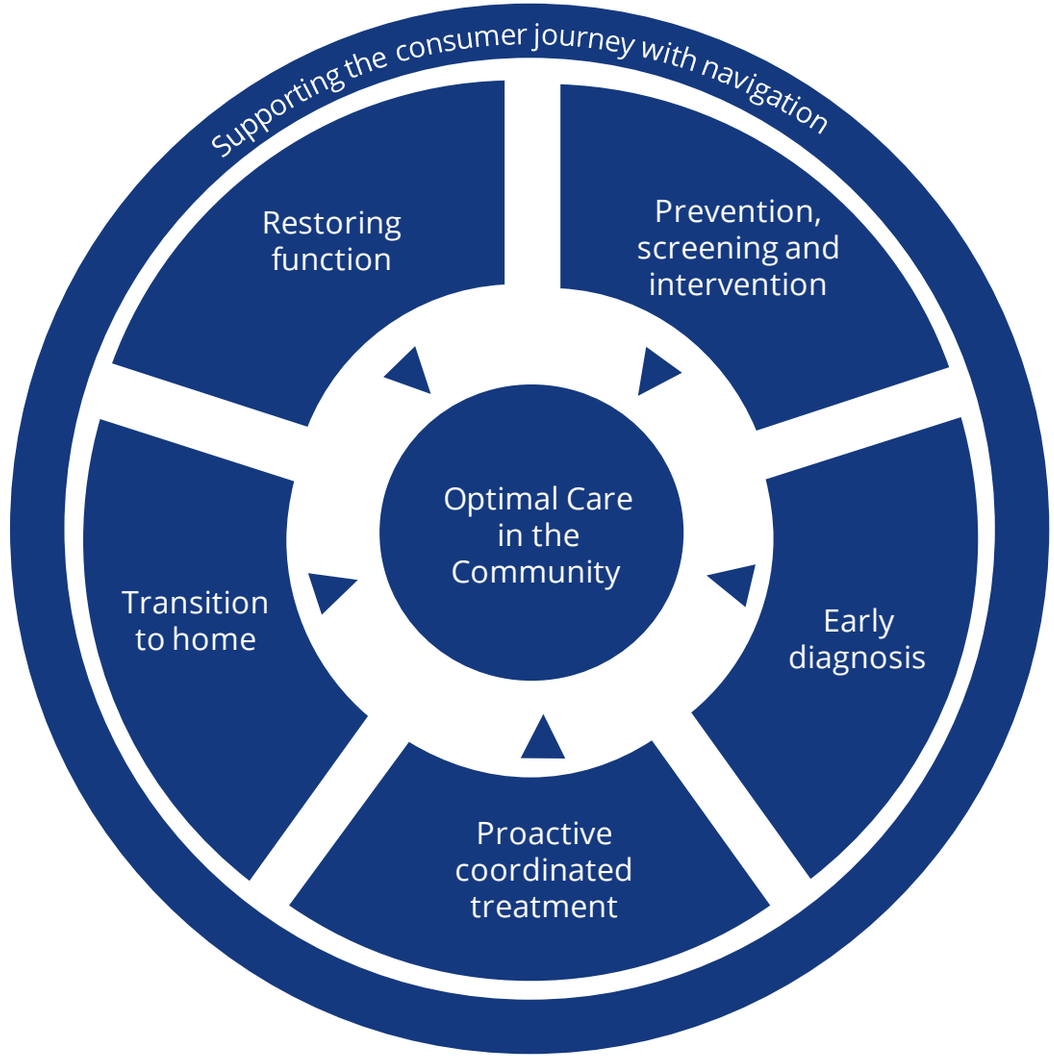
- Improved quality of life for people with COPD and CHF
- Reduced demand for hospital services for people with COPD and CHF
- Reduced avoidable mortality for people with COPD and CHF

Overview of the Pathway

The Pathway is comprised of seven key stages which encompass the whole of health care system in the Murrumbidgee region. Each stage brings together a range of capabilities to support the consumer journey through the Pathway.

Key principles underpinning the Pathway

- Consumers should always be in the community unless it is clinically unsafe to do so
- Each point of service is to ensure the consumer is linked to the next appropriate service so there is continuity through the Pathway
- An individual may enter the Pathway at any stage, however, the primary goal is for the individual to return to and remain in 'optimal care in the community'
- The long-term aim is for every consumer to have one Health and Wellbeing Plan, which integrates existing action plans and care plans, and is 'translated' into non-clinical language and connected to the consumer's personal circumstances



Recommendations

A summary of recommendations have been provided below for endorsement by the Murrumbidgee Primary Care Collaborative Group (PCCG). It is acknowledged that endorsement of these recommendations will require a detailed understanding of the associated costs and potential benefits of the interventions, which will be developed in the next step of the Joint Development Phase (JDP).

Overall pathway development
1. PCCG to confirm commitment to the conceptual design and underpinning principles of the Pathway.
2. PCCG to confirm readiness to move to the next stages of the JDP e.g. costing the Pathway.
3. Use the learnings from co-design to make recommendations to existing funding streams, models and programs that already exist in MLHD, MPHN and other providers to align with the Pathway.
Prevention, screening and intervention
4. Engage pharmacies to proactively participate in early screening through incentive schemes and capacity building, particularly in areas of high risk and known shortages of primary care capacity.
5. Formalise links between pharmacies, general practice and community based services to support active participation in targeted prevention, early screening and interventions to reduce disease risk.
6. Continue focused support to general practices to implement data-driven improvements through: a) use of risk stratification tools to identify consumers at risk for frequent hospital use b) implementation of a recall and reminder system for people at risk of chronic disease; and c) streamlined care planning.*
7. Provide support to general practices to sign up to the use of Lumos for data sharing, and encourage monitoring of consumer and system outcomes.
8. Support promotional campaigns for signs and symptoms of COPD and CHF, including in pharmacies and general practice, and through targeted health messaging.*
9. Integrate existing community groups into the Pathway to promote prevention measures, encourage increased use of social prescribing by GPs and pharmacists, and optimise health and wellbeing for consumers.

Early diagnosis
10. Support GPs and practice nurses across the region to upskill in assessment and diagnosis, so that consumers can access diagnostic tests without referral to a specialist where possible.
11. Enhance access to affordable diagnostic tests outside of inpatient care which is a critical factor in early diagnosis. Consider the cost benefit of free diagnostic tests through primary care and public outreach services.
12. Work with Aboriginal stakeholders to design and commission public multidisciplinary outreach clinics for early screening and diagnosis of high-risk populations distanced from Wagga Wagga hospital services.
Optimal care in the community
13. Encourage consumers to identify, connect and register with a regular GP or practice (in line with voluntary patient registration in the Primary Health Care 10 year plan).
14. Contract primary care to engage with the Pathway in return for increased support to strengthen business and operating models, including investment in clinical capacity to provide quality chronic disease care.
15. Review Key Performance Indicators of commissioned service providers (including allied health), to include outcome based measures in contracts, and embed workforce models to include AHAs and student workforce.
Proactive coordinated treatment
16. Further invest in Hospital Avoidance Strategies for consumers with chronic disease including the Rapid Access Clinic in Wagga Wagga, a potential Rapid Access Clinic in Griffith, and expanding hospital in the home.
17. Expand primary care services available after hours (e.g. through After Hours GP service, Nurse on-call, or alternative services).

*Starred recommendations will be partially or completely enabled by digital health solutions developed as part of the Living Well, Your Way Joint Development Phase

Recommendations

18. Realign existing community nursing and chronic respiratory network services to create a MLHD Chronic Care Service with structured clinical nursing leadership.

Transition to home

19 Establish a direct referral process into the Pathway (with 'opt-out'), which automatically flags inpatients with COPD and CHF for referral (using the Patient Flow Portal).

20. Mandate hospital in-reach activities for chronic care services in line with best practice, considering the role of community-based and inpatient services while a consumer is in hospital.

21. Establish a public multidisciplinary outpatient clinic which is consultant led and multidisciplinary including teams from hospital and primary care.*

22. Introduce a follow-up visit with the Chronic Care team within two weeks of discharge, supported by peer support workers and/or a social worker where appropriate.*

23. Review the barriers to delivering clear and timely discharge summaries to consumers and general practices, and explore digital and clinical interventions to ensure sustainable improvements in communication at discharge.*

Restoring function

24. Implement a district wide chronic cardiopulmonary program for restoring function (formally known as pulmonary rehabilitation) to include virtual allied health and nursing and support from allied health assistants.

25. In areas where the above program is not available or accessible, consider commissioning providers to deliver the service.

26. Establish stronger links to refer people to existing exercise and social groups following the completion of the clinical components of restoring function.

Supporting the consumer journey

27. Provide integrated and extended support for consumers in their health journey as a core component of the Pathway. This is not intended to be a standalone service, and should include:

a) Development and implementation of a consumer-facing digital health solution*
b) Repurpose existing health linker/navigator roles within commissioned services to support this Pathway in the primary care setting
c) Provide commissioning opportunities for general practice to participate in health linker/navigator provision
d) Implement a district wide upskilling program for all health professionals whose roles could include care navigation, and promote accountability for this.

28. Implement tools to identify and target specific points of willingness to change, encouraging incremental change as an opportunity to support consumers who may otherwise be left behind.

29. Work towards the development of a single, integrated Health and Wellbeing Plan to that incorporates consumer goals, completion of a GP management plan, and a sick day action plan.*

Enablers

30. Focus on three key areas for new digital health innovations to support the Pathway: targeted communications to support early intervention, consumer-facing digital health solutions to improve optimal care in the community, and discharge information for clinicians and consumers during the transition to home.*

31. Build workforce models, in partnership with education providers and professional bodies, that support the Pathway by enhancing recruitment and retention, offer career development and upskilling and encourage everyone to work to the top of their scope.

*Starred recommendations will be partially or completely enabled by digital health solutions developed as part of the Living Well, Your Way Joint Development Phase

Supporting the consumer journey

"I knew where I could turn to for help..."

Overview of supporting the consumer journey

The aim of supporting the consumer journey is to empower consumers to understand what they need throughout the Pathway and ensure they are able to seek and receive appropriate care at the right place and right time.

Key features include:

- A mobile application to support consumer empowerment and self-management
- One point of contact for consumers who need additional support, through dedicated care navigation roles
- Promotion of accountability for care navigation across the sector, including the idea that 'one step in the Pathway is not finished until the next step is planned'

While supporting the consumer journey takes multiple forms, it is guided by the same core principles:

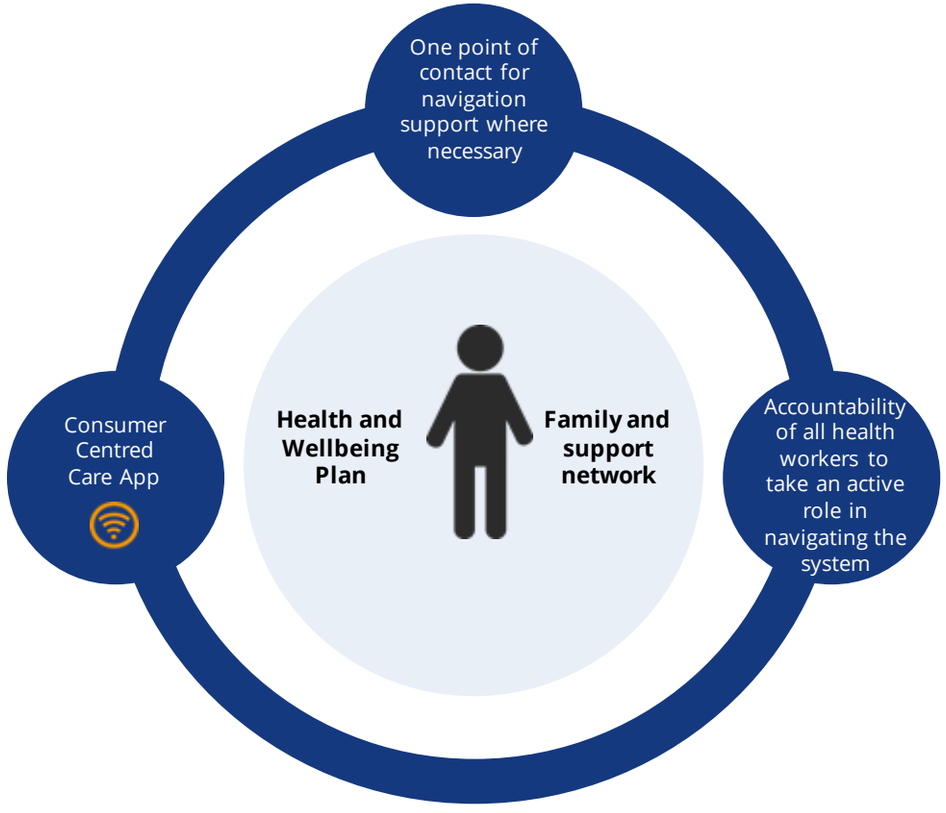
- Consumer driven: designed to empower consumers to identify their needs and the most appropriate care options, rather than telling them what they need
- Coaching approach: building capacity for self-management, by 'doing with' rather than 'doing for'
- Recognising carers and social networks: ensuring they are fully integrated into the Pathway and have the knowledge and confidence to support the consumer in their journey

Living Well, Your Way will work towards the implementation of a single, integrated Health and Wellbeing Plan to support the consumer journey. The Health and Wellbeing Plan will incorporate goals of care, actions for managing exacerbations (sick day action plans) and identified members of the care team as outlined in the GP Management Plan. The aim is for consumers to have ownership of their plan with their clinician and to clearly understand it. In some cases, this may involve support 'translating' plans into non-clinical language and assisting the consumer to apply the plan to their personal circumstances.

Motivating behaviour change, including self-management, is a critical part of supporting the consumer journey. Incorporating non-health triggers and goals in planning and coaching is an important opportunity here. Considering a consumer's readiness to change by identifying and targeting specific points of willingness to change and supporting incremental change in that area is a significant opportunity to support consumers who may not be ready for other changes.

Key learnings from the co-design process

- Social connectivity is key to behavior change, including readiness to change
- Goal setting (including non-health goals) is an important foundation of consumer empowerment
- Emphasis on holistic health care (e.g. mental and physical health) is key



Meeting the Needs of Aboriginal and Torres Strait Islander people

A number of considerations for meeting the needs of Aboriginal and Torres Strait Islander people were identified during the co-design. The 'Early Diagnosis' and 'Prevention, Screening and Intervention' stages of the Pathway emerged as particular priorities, though the challenges and opportunities outlined below will be important to address across all stages of the Pathway.

Key challenges

- Affordability of services: lack of access to bulk billed services, particularly in rural and regional areas
- Coordination between service providers: lack of communication and collaborative care leading to gaps
- Consumer health education: critical gaps in understanding disease, risk factors and management
- Access to services outside regional centres

Key opportunities

Expanding access *(see recommendations 8, 9, 10, 11, 12 & 27)*

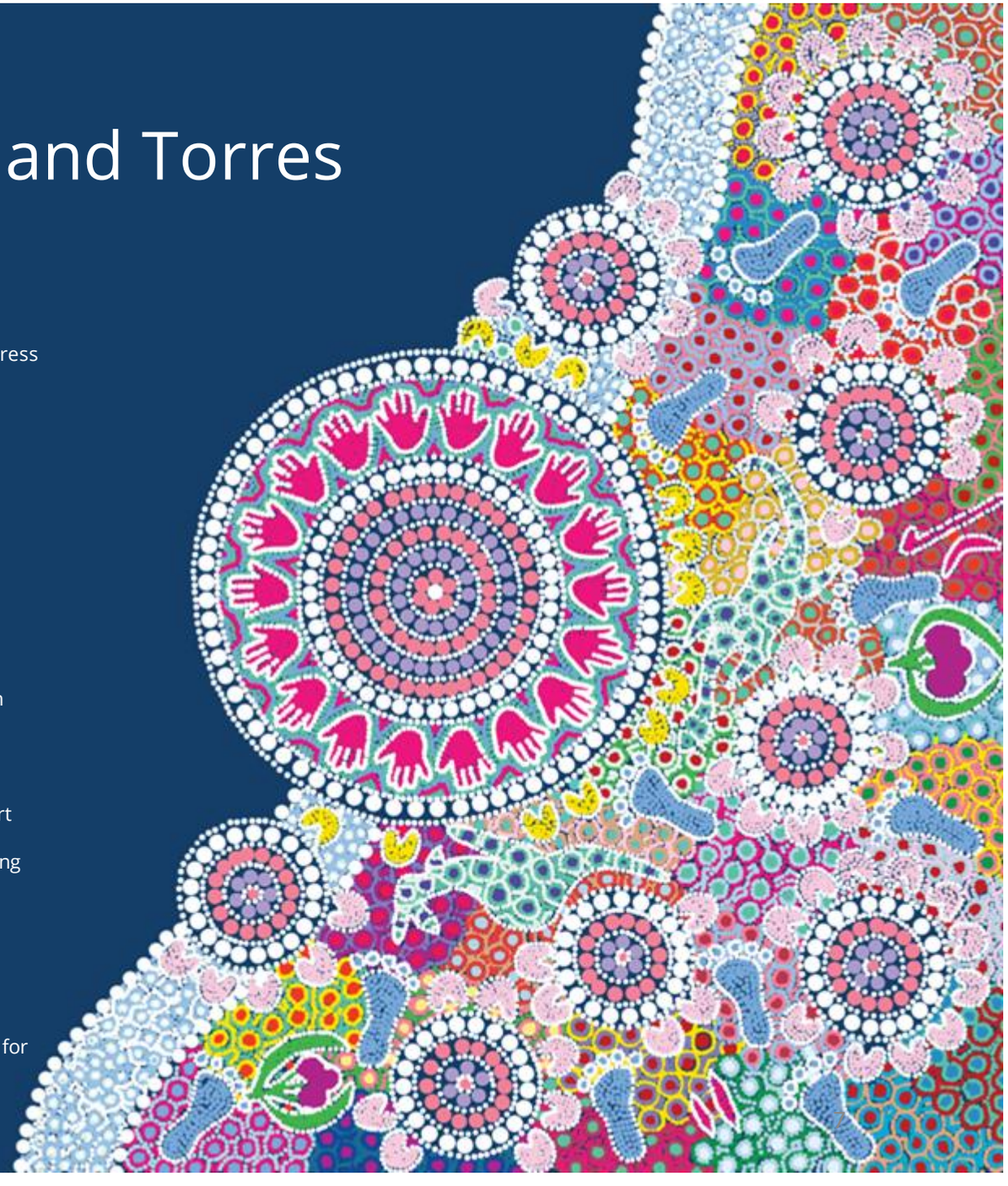
- Increasing the availability of free services across all stages of the Pathway
- Simplifying access to financial support, especially for associated services e.g. My Aged Care, NDIS
- Greater focus on community outreach, including screening for risk factors and targeted health promotion
- Integrating COPD and CHF screening into existing health checks
- Increasing awareness of services and funding available

Coordination & communication *(see recommendations 27 & 29)*

- Greater use of case conferencing, to support coordination and accountability across a consumer's support team
- Improving communication between clinicians and consumers through checking for understanding, building rapport, allowing more time for the process, and including Aboriginal Health Workers and social workers where appropriate
- Ensuring care plans avoid medical jargon and are integrated (for those with more than one condition), so they can be easily understood and implemented
- Considering kinship in Aboriginal and Torres Strait Islander culture and decision making

Consumer education *(see recommendations 22 & 27)*

- Strengthening follow-up support and education after diagnosis, recognising that this is a critical moment for education but a time when consumers may have difficulty absorbing information
- Providing education outside clinical settings and in the home where possible, to shift power to the consumer and support the inclusion of family members



Prevention, Screening and Intervention

"I started to notice that I wasn't as well as I used to be, but I didn't know what was wrong, or what I could do about it"

Overview of prevention, screening and intervention

The aim of prevention, screening and intervention is to promote individual awareness of risk factors and lifestyle change to prevent a COPD and/or CHF diagnosis. This stage also aims to provide opportunities for early screening and intervention to avoid a more severe diagnosis.

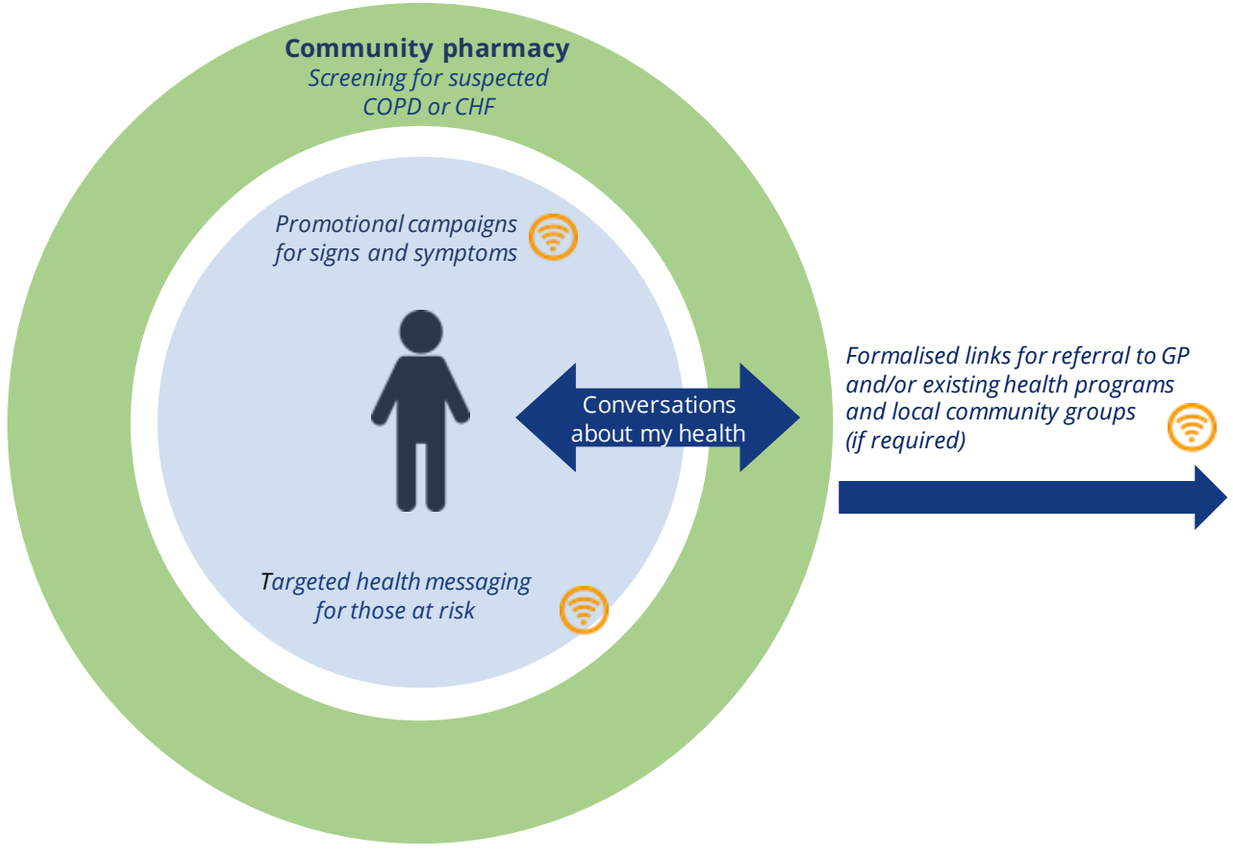
Key features include:

- Targeted health promotion
- Opportunistic screening in the community, particularly in pharmacies
- Personal lifestyle prescriptions, which is also referred to as social prescribing

The target cohort for this stage of the Pathway would be individuals in the community who are exhibiting risk factors and early symptoms for COPD or CHF, such as smoking, high blood pressure or breathlessness. Noting there is also an influence of age, genetics, comorbidities, socioeconomic, and environmental factors, prevention, screening and intervention activities would also be targeted at these 'at risk' groups.

Key learnings from co-design:

- Ensure that community pharmacists are not overburdened without sufficient resourcing and physical space to confidentially discuss an individual's health
- Importance of promotional campaigns for signs and symptoms of COPD and CHF in pharmacies, general practices and social media and use of proactive and targeted health messaging and reminders of healthy behaviours
- Find each individual's point of willingness to change and work with aspects of willingness to change



Prevention, Screening and Intervention

Key changes in roles and responsibilities

Community pharmacists:

- Be a triage point for individuals in the community by implementing condition specific screening tools, including readiness to change
- Establish formalised links with GPs, health programs and local community groups to allow for direct referral to general practice nurses for those people at risk
- Engage in social prescribing to services such as weight management programs, smoking cessation, alcohol and drug counselling
- Conduct health promotion and implement targeted health messaging, such as to mobile devices

General practice:

- Comprehensively assess consumers identified as 'at risk' by community pharmacists
- Participate in opportunistic screening by:
  - Implementing systems of recalls and reminders
  - Using risk stratification tools
  - Data sharing through Lumos
- Practice staff will populate GP Management Plans and Team Care Arrangements with consumers which will be signed off by GPs
- Participate in social prescribing, particularly for smoking cessation and weight management
- Conduct health promotion and implement targeted health messaging

Further considerations for change

Supporting community pharmacy

- Engage pharmacists through incentive schemes and capacity building to participate in the Pathway with priority for high risk localities and known shortages of primary care capacity

Communication and data sharing

- Clear communication pathways will need to be established between community pharmacists, general practices, health programs and local community groups to allow for referral pathways to be efficient and effective
- Opportunities for the use of digital pathways such as My Health Record
- Any communication solution will require adequate support and capability building
- General practice will require sustained support to participate in Lumos

PHN commitment

- Additional PHN commissioned programs will be needed to support primary care to develop capability and capacity
- PHN primary care team to support in educating pharmacies and general practice on the health programs and community groups in their areas
- PHNs will need to encourage social prescribing as well as more traditional health prescribing

Readiness to change

- Behaviour change and readiness to change is a significant aspect of prevention
- Pharmacies and GPs will need to use change readiness tools and identify the motivators for behaviour change for individual consumers. This will require working with consumers to find relevant activities to support their specific goals and aspirations

Early Diagnosis

"Then I started to feel that things were definitely not quite right..."

Overview of early diagnosis

The aim of early diagnosis is to support early and accurate diagnosis of COPD and/or CHF through support for diagnosis in primary care, access to diagnostics, and early involvement of specialists when required.

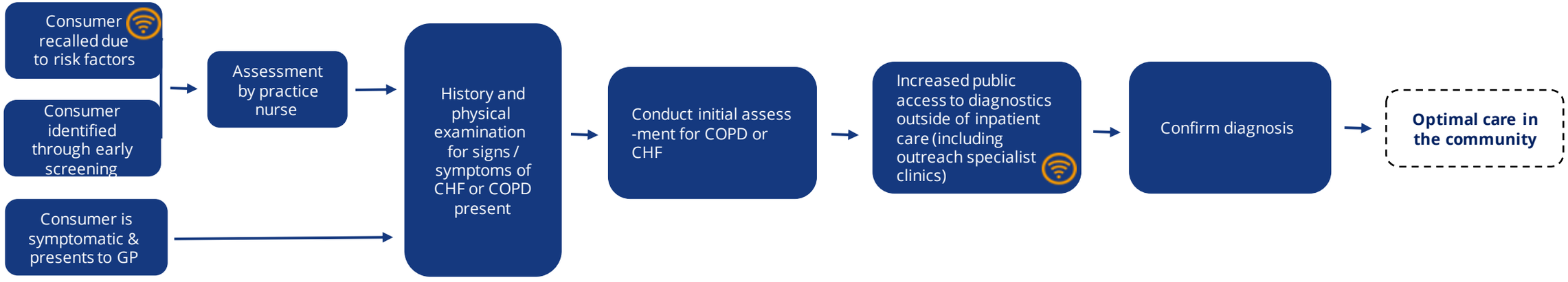
Key features include:

- Promoting early access to diagnosis in primary care, including outreach specialist clinics
- Identifying and overcoming barriers to diagnosis

The target cohort for this stage of the Pathway would be individuals who exhibit signs and symptoms of COPD or CHF and have been unwell at times, but have not yet received a diagnosis. This will include consumers identified by screening undertaken in the previous stage of the Pathway.

Key learnings from co-design:

- There is a need to increase access to affordable diagnostic services, noting inconsistent level of services across the region with limited physical access, varying degrees of cost, and lengthy waiting times
- This is a significant opportunity for general practice (nurses and GPs) to upskill and work at the 'top of scope'
- There is a long wait time to access specialists for the purpose of diagnosis, and a gap in the diagnostics tests and specialist services that can be accessed in small communities and for people with low incomes or limited transport
- Increase capacity for outreach specialist and diagnostic services



Early Diagnosis

Key changes in roles and responsibilities

GP

- Refer consumers for diagnostic tests or perform 'in house' if appropriate
- Confirm diagnosis for COPD and CHF
- Work in partnership with specialists to seek additional support or clinical expertise where required (rather than simply referring a consumer to a specialist for diagnosis)

Practice nurse

- Identify signs and symptoms of concern
- Perform initial assessment and diagnostic testing where appropriate (ie spirometry)
- Support specialist outreach clinics

Specialist

- Continue involvement in diagnosis, however, predominantly oversee diagnostic tests
- Support GPs to confirm diagnosis for complex consumer or any instance where a diagnosis is uncertain
- Perform specialist outreach clinics to support early diagnosis in high risk populations and work in partnership with local GPs

Further considerations for change

Increased accessibility

- Free diagnostic tests through primary care and public outreach services must be considered
- Explore specialist outreach clinics for high risk priority populations, particularly for Aboriginal and Torres Strait Islander people. This may involve working in partnership with local Aboriginal stakeholders to develop outreach clinics for early screening and diagnosis

Investment in building capacity and capability

- Significant investment is required to build capacity and capability of GPs and practice nurses, and to ensure the availability of appropriate clinical space, facilities and diagnostic equipment
- Support to upskill primary care clinicians will allow consumers to access diagnostic tests without referral to a specialist where possible
- GPs and practice nurses may require incentives for participation
- Commissioning and funding models are required to support service provision as described in this stage of the Pathway

Optimal Care in the Community

"I chose a GP practice that worked as a team to help me live healthier at home... "

Overview of optimal care in the community

The aim of optimal care in the community is to enable general practices to lead the delivery of holistic care in order to support consumers with chronic disease to live healthier at home for longer.

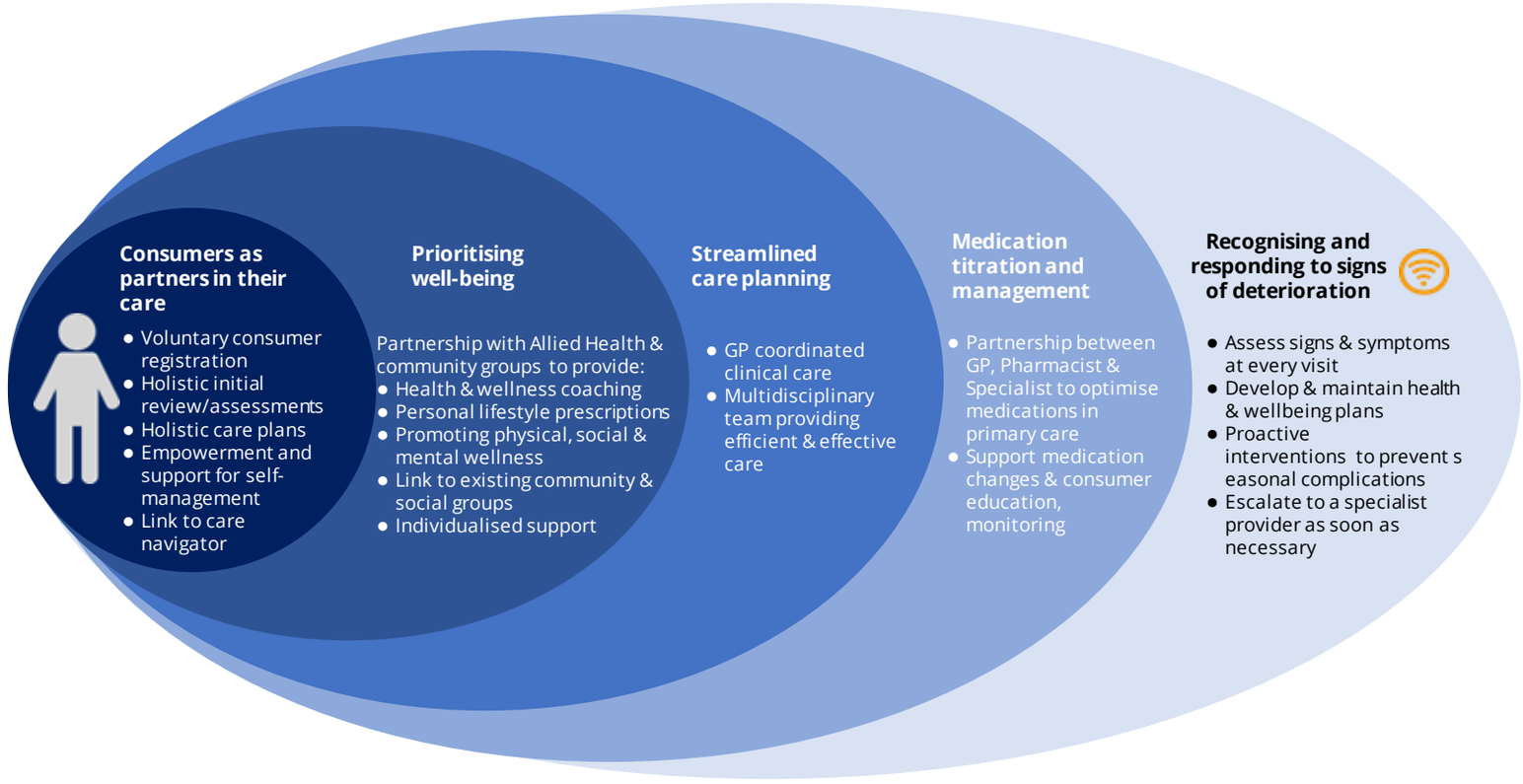
Key features include:

- Developing consumers as partners in their care
- Comprehensive preventative care
- Prioritisation of well-being
- Optimal symptom management despite life-limiting illness
- Identification of consumers who are unwell
- Promotion of the principles of palliative care

The target cohort for this stage of the Pathway would be any individual who is enrolled in the Pathway noting the intention is for all consumers to remain in the community where it is clinically safe to do so. Following any escalation into another stage of the Pathway, a consumer will ideally return to optimal care in the community for their ongoing care.

Key learnings from co-design:

- Strong partnerships between general practices and service providers will be needed to lay the foundation
- Important to frame as this stage is promoting what we are already doing more efficiently and effectively as opposed to additional work
- Provision of support to develop both business and clinical skills for general practice will be essential in gaining buy in



Optimal Care in the Community

Key changes in roles and responsibilities

GP

- Lead a multidisciplinary team comprised of allied health, pharmacy, care navigators, practice nurses or chronic care nurse to provide coordinated and comprehensive care
- Empower consumers to be partners in their own healthcare
- Sign off GP Management Plans, Team Care Arrangements and Sick Day Action Plans
- Engage in social prescribing to community based services
- Discuss consumer social and emotional wellbeing during routine appointments and address social determinants of health where possible
- Participate in education and upskilling in medication titration and management
- Take an active role in medication management for consumers with complex needs
- Assess signs and symptoms of deterioration at every visit, providing proactive interventions to prevent seasonal deteriorations
- Consider the role of palliative care in the management of any individual with a chronic disease

General practice staff

- Use streamlined systems and data to improve consumer journeys
- Enable activities such as recall systems and reminders and simplified access to care
- Optimise MBS billing items and proactive care
- Implement business models that support a holistic approach to care
- Participate in in education, upskilling and quality improvement opportunities to strengthen business and clinical practice
- Populate plans or care arrangements, identifying any goals in partnership with consumers
- Participate in education and upskilling in medication titration and management
- Conduct inhaler checks and medication review at every visit
- Screen all consumers for signs and symptoms of deterioration and triage consumers at risk for urgent GP appointments

Community pharmacists

- Be a key point of contact for consumers
- Serve as a health informant, assisting with consumer activation
- Provide consumer education in care planning, medication use, home medicines review and signs and symptoms of deterioration
- Provide referrals to escalation points such as GPs or the rapid access clinic
- Engage in social prescribing and linking consumers to social and community groups

Allied health

- Provide clinical care for consumers through disease prevention and early intervention
- Support consumers to achieve their goals outlined in care plans and gain abilities and behaviours to optimise quality of life
- Screen all consumers for deterioration and provide consumer education on signs and symptoms of deterioration
- Provide referrals to escalation points such as GPs or the Rapid Access Clinic

Further considerations for change

Investment into general practice

- Support will be required to strengthen business and operating models
- Need to increase clinical capacity to provide quality chronic disease care using a wider range of relevant MBS item numbers
- Funding for service delivery that is not claimable through MBS will need be considered

Health workforce

- Building partnerships and clear lines of communication between general practices as well as other service providers will be pivotal in the success of the Pathway
- Noting the workforce shortages across the region, workforce models will also need to be reviewed to align with range of activities of the Pathway
- PHN build into commissioning contracts with primary care providers a requirement for using student placements to grow workforce

Proactive Coordinated Treatment

"When I started to feel sick, I knew where to go to get the help I needed"

Overview of proactive coordinated treatment

The aim of this stage is to ensure consumers are provided with access to an appropriate level of care when they are experiencing symptoms of deterioration. This includes the management of exacerbations and the provision of alternatives to presenting to an emergency department.

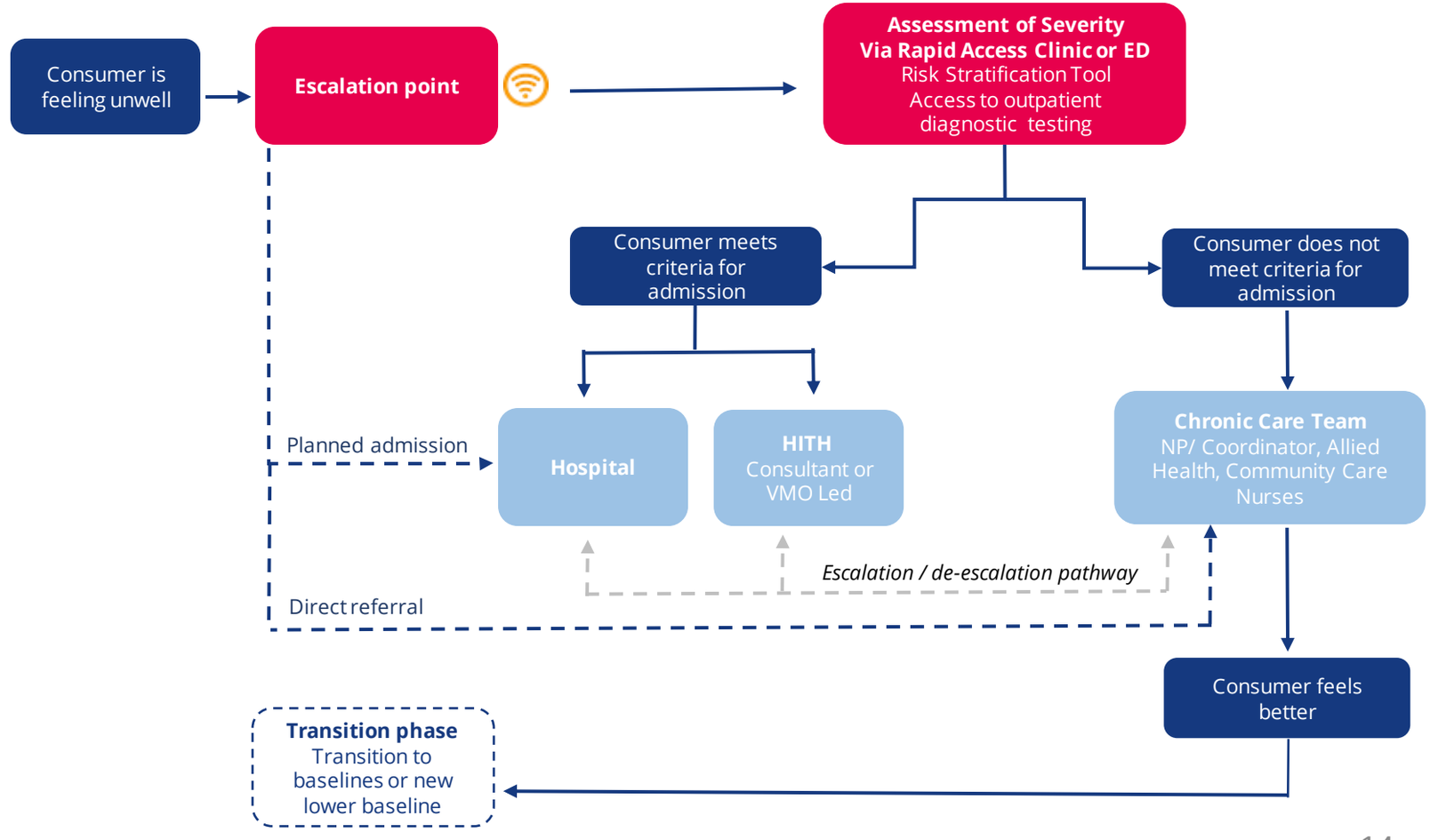
Key features include:

- Pathways for escalation in the community and alternatives to inpatient care, which may include a virtual centralised escalation point or an after hours GP
- A rapid assessment to identify needs and design a care plan to suit the individual needs
- Planned hospital admissions to support effective care when needed
- Transition to community at the earliest opportunity based on need

The target cohort for this stage of the Pathway will be consumers who already have a diagnosis and have been managing their care in 'optimal care in the community', however, have begun to feel increasingly unwell. In the current state, the consumer would likely present to the ED, however, this stage of the Pathway provides an alternative.

Key learnings from co-design:

- Requirement for an after hours service to serve as an escalation point
- At scale services required outside of Wagga Wagga through systems, process, relationships and virtual care
- There are opportunities to upskill nurses and allied health in the Rapid Access Clinic to play significant role in supporting this stage of the Pathway



Proactive Coordinated Treatment

Key changes in roles and responsibilities

Primary care services
- Be the point of escalation to prevent an ED presentation
- GPs will be the standard escalation point during business hours
- GPs will conduct risk stratification to determine if the consumer requires a planned admission, direct referral to the Chronic Care team or an assessment at the Rapid Access Clinic or ED
- Community pharmacists can serve as an escalation point after hours and refer the consumer to the Rapid Assessment Clinic or ED if required

Chronic care team
- Provide outreach care and additional level of support to consumers who are unwell in the community
- Nurse practitioner will lead the multidisciplinary team
- Service will be carried out by community care nurses, however, a practice nurse may also perform the service
- Communicate and deliver integrated team care with the GP and consultant, where required
- Conduct hospital in reach and consumer education and support for self management where a consumer has been admitted

Rapid access clinic
- An alternative to the ED for consumers with mild symptoms of deterioration
- Develop capability and models of care for chronic disease management, including a sustainable staffing model
- Access point for medical management and diagnostic testing in an outpatient setting
- Potential to serve as an after hours escalation point for consumers in the community

Specialists
- Continue to oversee inpatient and HITH management
- Act as an escalation point for the Chronic Care team where required
- Recognise the GP as a key participant in the coordination of treatment

Further considerations for change

After hours service
- Scope an after hours escalation point for this stage of the Pathway, noting the currently limited options for consumers

Expansion of Rapid access clinic
- Significant investment will be required for its expansion and sustainability to fulfil the activities of the Pathway which are beyond its current scope
- Support will be needed to build its capability in chronic disease management
- Nurses and allied health will require support to upskill to enable their ability to conduct assessments
- Currently does not include access to a complete range of diagnostic testing to support hospital avoidance
- Currently based only in Wagga Wagga and will not be sufficient for the entire region. This may require the introduction of another clinic or virtual/outreach options

Coordination of service providers
- Formalised links will be required between service providers in this stage of the Pathway to enable strong referrals, escalation and de-escalation of need
- The Chronic care team will require formal links with specialists, with the provision of digital health and administrative support

Transition to Home

"When I go home from hospital, I know I will have the tools, information and support I need to look after myself..."

Overview of transition to home

The aim of transition to home is to support people to comfortably transition from hospital to home as well as gain the skills and confidence they need to become healthy at home again.

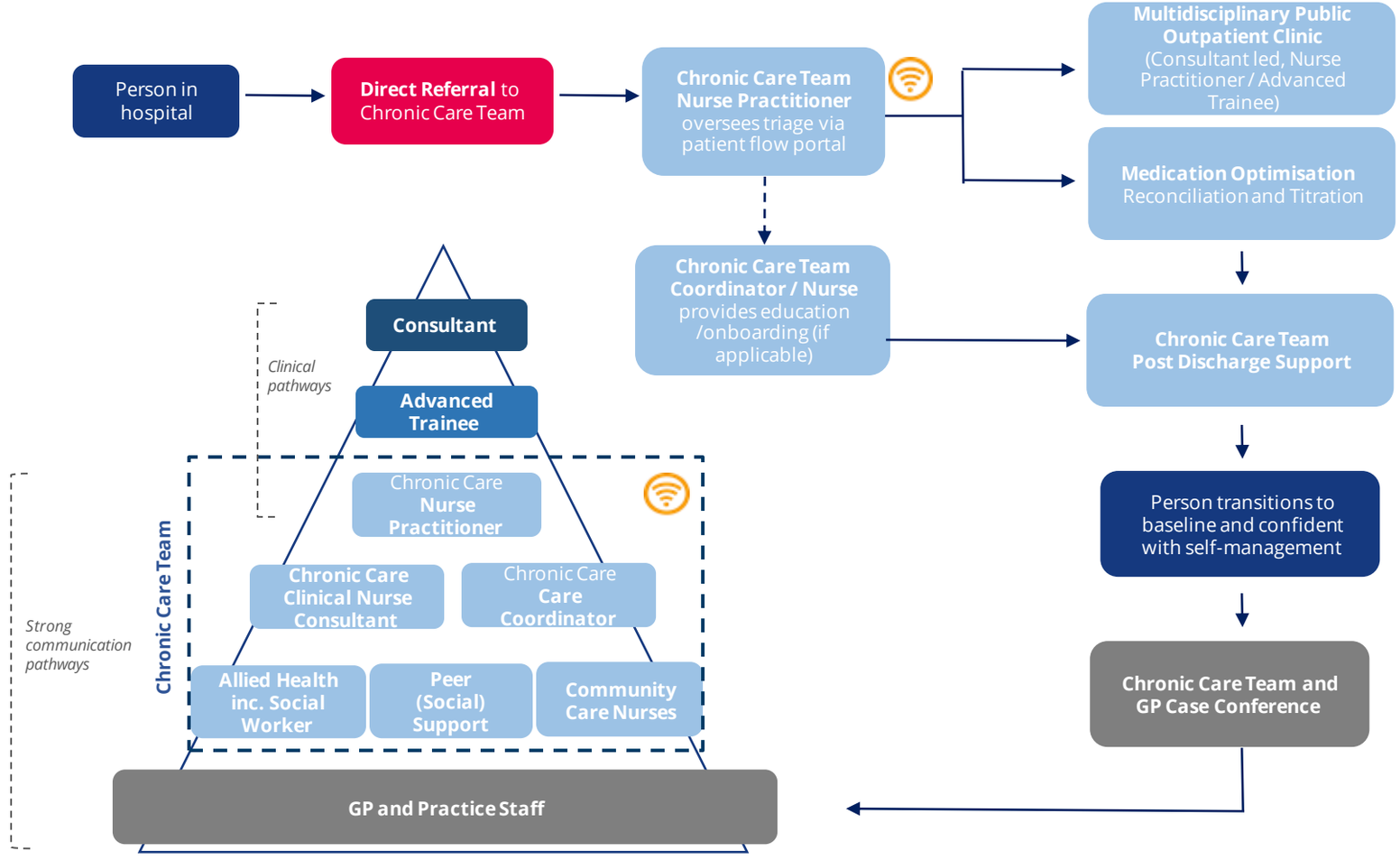
Key features include:

- A dedicated team to provide a higher level of care following discharge (linking with Leading Better Value Care)
- Hospital in-reach to ensure consumers understand what they need to do to care for themselves and are linked to services prior to discharge
- The establishment of a Multidisciplinary Public Outpatient Clinic which will be consultant led, with the support of a nurse practitioner and advanced trainee
- A focus on understanding the person's social context so the care plan can be adapted to meet the needs of the person, their carers, family and support network (inclusion of a social worker as required)

The target cohort for this stage of the Pathway would be any individual with COPD and/or CHF who has been admitted to hospital.

Key learnings from co-design:

- Consideration of the social determinants of consumers will be essential in the transition to home whereby measures should be in place to ensure consumers are appropriately supported - physically, socially and emotionally
- Consumers should be discharged to the community as soon as clinically acceptable with strong handover protocols
- Leverage community assets (e.g., partnerships with local government, use of volunteers and peer workers) to support safe and sustainable discharge



Transition to Home

Key changes in roles and responsibilities

Nurse practitioner
- Triage inpatients with COPD and/or CHF to determine their risk of readmission and deterioration at home prior to discharge
- Support access to the Multidisciplinary Public Outpatient Clinic
- Oversee care in the outpatient clinic
- Lead arrangement of post discharge support to encourage consumer empowerment and self management. This includes conducting home visits or virtual care support, developing action plans, arranging for health coaching, and coordinating rehabilitation

Care coordinator
- Support empowerment and self management by providing onboarding, health education, assessment and goal setting
- Provide post discharge support in collaboration with community care nurses
- Support access to the Multidisciplinary Public Outpatient Clinic

Allied health
- Participate in the Multidisciplinary Public Outpatient Clinic
- Conduct inreach consumer education and relevant referrals
- Respiratory physio will conduct assessment and spirometry
- Cardiac dietician will monitor fluid restriction and weight loss
- Social workers will assess the social environment the consumer will be returning to post discharge and ensure appropriate support networks and measures are in place

Hospital based staff
- Provide consumer education and support to self manage while in hospital
- Facilitate in reach chronic care management and education
- Assess and identify any transfer of care needs, in line with Leading Better Value Care principles
- Ensure timely and accurate information is provided on discharge
- Support access to the Multidisciplinary Public Outpatient Clinic

Specialists
- Oversee the transition to home model of care, including the Multidisciplinary Public Outpatient Clinic
- Advanced trainee will work in partnership with the nurse practitioner to manage care provision in the Multidisciplinary Public Outpatient Clinic
- Refer consumers to the Multidisciplinary Public Outpatient Clinic prior to discharge
- Communicate with GPs and participate in case conferences as required
- Provide upskilling, education and support, and serve as a point of escalation for nurse practitioners and advanced trainees

Peer workers
- Support consumers to navigate the transition to home, including support for mental wellbeing and connection to social networks

Community pharmacy
- Support consumers once they have been discharged through coaching medication titration, medication compliance, monitoring administration, correct inhaler use, and sick day action plans

General practice
- Formal links to the Multidisciplinary Public Outpatient Clinic
- Participate in case conferencing and work towards virtual shared clinics between GP and consultant in smaller towns
- Communicate with chronic care teams and follow up on intervention and appointments where required

Further considerations for change

- The Multidisciplinary Public Outpatient Clinic will be a new service in the region which will require exploration during the Pathway costing and benefit realisation
- A strong referral process will be pivotal to the success of transition to home
- Solutions to enable direct referrals and automatic flagging of COPD and CHF consumers in hospital would be incredibly useful to ensure timely referrals
- There will be benefit in exploring solutions for timely and clear discharge information to be provided to service providers, particularly to general practice

Restoring Function

"Now I can look after my condition, I would like to be able to do more and feel better in my day"

Overview of Restoring Function

The aim of restoring function is to expand equitable access to rehabilitation and support for physical and mental wellbeing for anyone with a COPD and/or CHF diagnosis. This stage also aims to increase consumer confidence in managing health and wellbeing, with the support of trained professionals and peers.

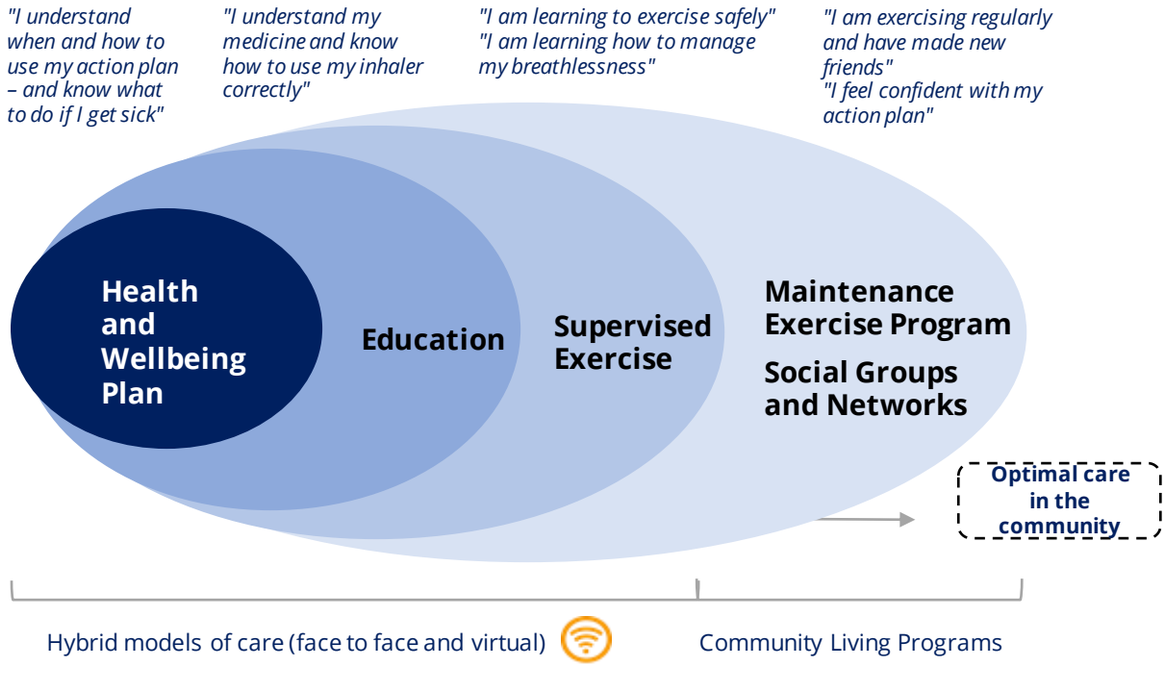
Key features include:

- A Health and Wellbeing Plan to provide holistic support that includes guidance on what to do if acute symptoms develop (sick day action plan)
- Multidisciplinary education to understand disease process and optimise medications
- Supervised physical activity to increase confidence
- Promotion of social connection and mental health through maintenance fitness and wellbeing programs

The target cohort for this stage of the Pathway will be consumers who have a diagnosis and may have experienced an exacerbation that requires additional support for their physical health and wellbeing prior to returning to optimal care in the community.

Key learnings from co-design:

- Build in flexibility for consumers to move between activities according to their individual needs to ensure the process remains consumer centred
- All activities should have a strong focus on social connection, holistic wellbeing, and fun to optimise consumer engagement and behaviour change
- Enable hybrid models of care i.e. both face to face and virtual care for all activities to expand access, particularly for consumers in rural and regional areas



Restoring Function

Key changes in roles and responsibilities

Community pharmacist

- Optimise pharmacology
- Provide education, particularly for inhaler technique and application of action plans
- Encourage consumers to participate in exercise programs and community groups
- Enhance communication with GP

Chronic care coordinator

- Assess consumers who participate in rehabilitation
- Facilitate multidisciplinary education
- Facilitate smoking cessation with nurse practitioner and GP, where necessary
- Provide education, self management support and links with local providers and social networks
- Support pharmaceutical optimisation, including inhaler technique
- Link consumers to existing exercise and social groups following completion of supervised exercise program

Physiotherapist

- Assess level of exercise tolerance and prepare exercise regime
- Improve mobilisation and activity confidence
- Provide virtual supervision to Allied Health Assistants for exercise programs, where necessary
- Link consumers to existing exercise and social groups following completion of supervised exercise program

Allied health assistant

- Coordinate the delivery of exercise programs, overseen by a physiotherapist in small communities
- Improve mobilisation/activity confidence
- Support coordinating group exercise programs
- Link consumers to existing exercise and social groups following completion of supervised exercise program

GPs, general practice staff, specialists and hospital-based staff

- Refer consumers to supervised exercise program
- Link consumers to existing exercise and social groups following completion of supervised exercise program

Further considerations for change

This stage has an emphasis on increasing equity of access across the region. This may be achieved through:

- Innovative workforce models such as multidisciplinary teams and virtual and hybrid models of care
- Supporting staff to work at the top of their scope including more effective utilisation of nurse practitioners, allied health workers and Aboriginal Health Workers
- In areas where a chronic cardiopulmonary program for restoring function is not available, commissioning additional providers to deliver the service
- Strengthening links to existing exercise and social groups
- Ensuring Health and Wellbeing Plans are written in non-clinical language, more fully understood by consumers and more widely shared (including with pharmacists, allied health, carers and other members of the consumer's support team as appropriate)

Key considerations for workforce and digital health

Every stage of the Pathway has implications for the workforce and potential scope for digital health solutions, with significant challenges and opportunities in both areas.

Workforce

Participants in the co-design identified the following opportunities as key priorities for addressing workforce challenges:

- Improving business models in general practice to support clinical models. This includes efficiency reforms supporting team-based approaches and top of scope thinking, such as:
  - Nurse led clinical models
  - Greater utilisation of Aboriginal Health Workers and allied health assistants
  - Medical practice assistants
- Leveraging student placements into primary care, including:
  - Requiring and/or incentivising commissioned providers to incorporate student placements in their models
  - Expanding partnerships with universities, targeting specific workplace learning subjects
- Exploring opportunities to more fully utilise and support volunteers, peer workers and social networks, especially in rural areas
- Collaborating on training across disciplines (e.g. pairing nursing placements with paramedic placements, and conducting joint trainings for nurses and GPs) to build trust and model ways of working together

Digital Health

There is scope to integrate digital health solutions across the Pathway, including:

- Targeted messaging for people at risk (e.g. social media marketing)
- Screening tools for use in non-traditional settings (e.g. pharmacies)
- Digital health modalities to expand the capacity and reach of clinicians
- A consumer app to support:
  - Virtual monitoring, including algorithms to flag consumers for follow-up
  - Goal setting and health coaching including gamification
  - Health navigation
  - Storage of clinical information (e.g. medication changes, discharge information)

Workshop participants identified the following risks and limitations associated with integrating digital health solutions:

- Risk of exacerbating siloed approaches and increasing complexity by creating new digital solutions for the Pathway, unless they are system wide or linked to or interoperable with existing platforms
- Digital health solutions are not one-size-fits-all, and are not appropriate for all consumers or in all contexts
- Comorbidities (e.g. osteoporosis, arthritis) and eyesight related issues can create barriers to using digital solutions
- Challenges trying to use digital health solutions can create stress and loss of confidence in using health services

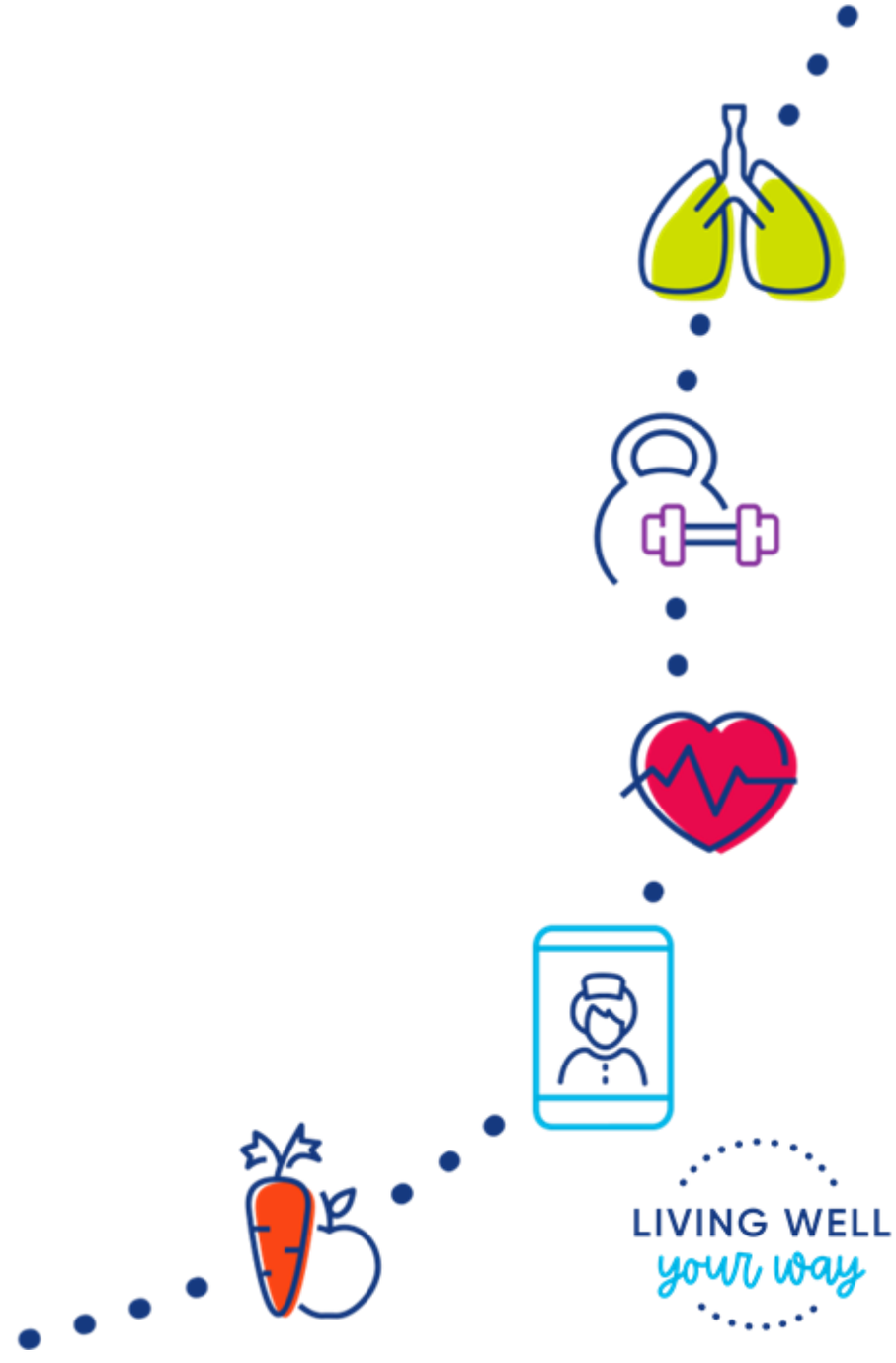
Key opportunities include:

- Exploring the cost-effectiveness of providing devices to consumers (in terms of return on investment)
- Utilising the 30 digital hubs to be established at MLHD sites in the region in early 2022, to support community access to virtual care
- Partnering with local councils, libraries and community centres to expand access to technology and technical support for digital health solutions
- Linking with the 'One Front Door' process that eHealth NSW are in the early stages of exploring. This would provide consumers with one entry point while having capacity to integrate different systems

Workshop participants also reflected on lessons learned from digital health interventions during COVID-19, and identified these success factors:

- Using familiar devices (e.g. mobile phones) where possible, rather than introducing new devices and platforms
- Ensuring adequate user testing
- Building ongoing technical support into the model, with adequate resourcing
- Providing face-to-face coaching on how to use a new device or platform
- Bringing family/support network on the journey

Appendix A - Overview of co-design process



Overview of co-design process

The Pathway co-design process included:

- A desktop review, incorporating:
  - Evidence from COPD-X Guidelines and National Heart Foundation Guidelines
  - Review of case studies of global best practice and successful models of care
  - Review of existing services in the region

- Significant individual consultation with stakeholders across the region since 2019 including general practice, community pharmacy, hospitals, community based services, allied health professionals, specialists, consumers and MLHD and MPHN staff and Executives

- A virtual co-design event, comprised of twelve workshop sessions held over three days in October 2021

  - The sessions sought to confirm the importance of the Living Well, Your Way initiative for the Murrumbidgee region and test and validate the proposed Pathway (developed based on desktop review and initial stakeholder interviews) for further development

  - Overall participation was equivalent to 200 people (noting that some individuals participated in more than one session), including representation from general practice, pharmacy, allied health, consumers and carers, Aboriginal health staff, the Lung and Heart Foundations, Ministry of Health, peak bodies, MLHD and MPHN staff and Executive. Table 1 outlines the stakeholder groups participating in each session and the workshop session topics

Extensive engagement efforts ahead of the co-design process ensured the range of stakeholders participating was as broad as possible. However, as a result of competing demands related to the COVID-19 pandemic, there was limited participation from some stakeholder groups.

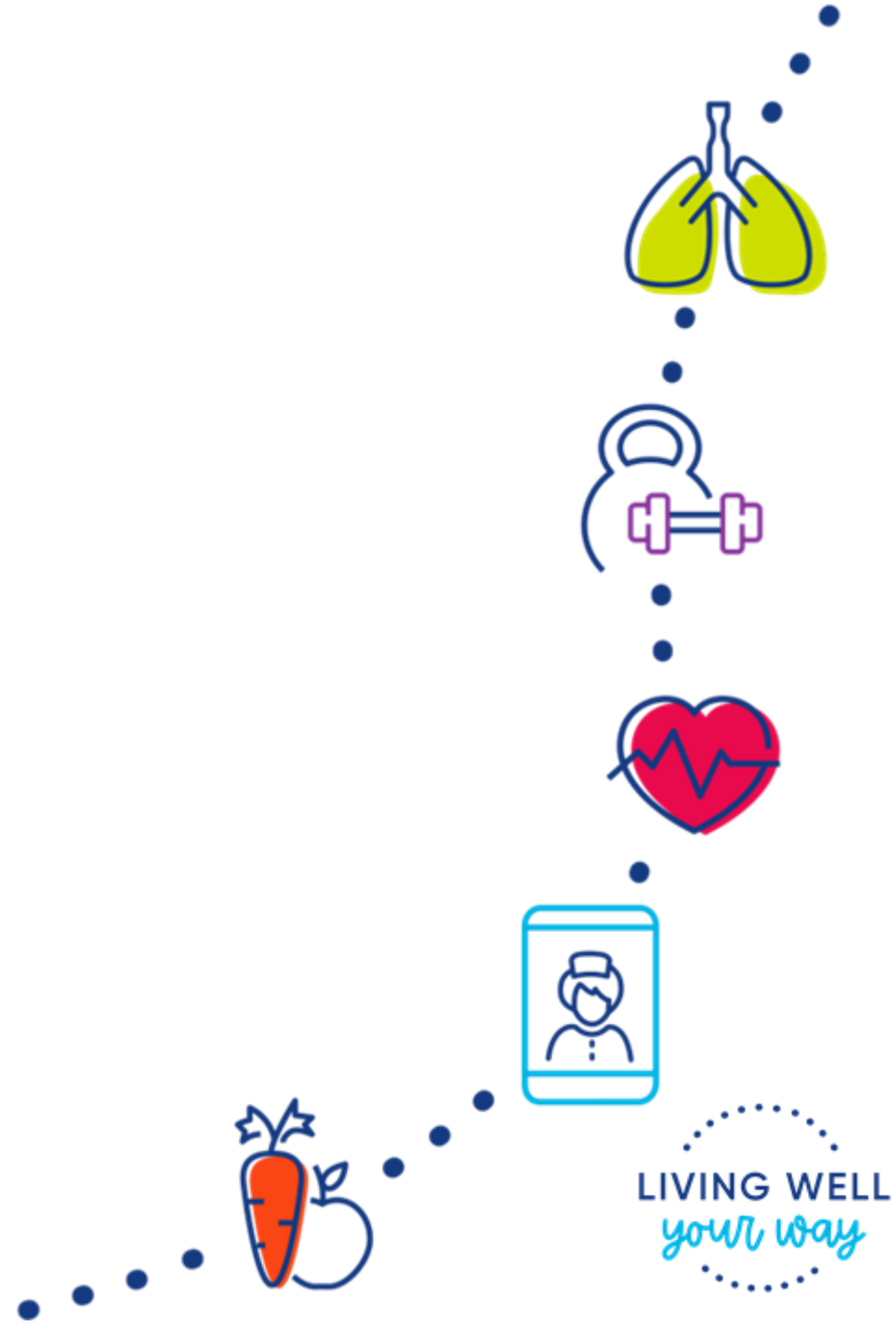
Stakeholder engagement will continue beyond the co-design sessions as the initiative progresses through the Joint Development Phase of the Murrumbidgee Collaborative Commissioning Partnership for further refinement and costing.

Table 1: Stakeholder groups participating in the co-design workshop

Stakeholder group	Workshop session											
	Prevention, screening and intervention	Consumer empowerment and self-management	Optimal Care in the Community	Early Diagnosis	Proactive Co-ordinated Treatment	Transition to home	Restoring Function	Workforce	Validating the Consumer Pathway	Aboriginal and Torres Strait Islander Health	Digital Health	Executive Session
Consumers	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
General Practitioners	✓		✓	✓			✓					
General practice staff	✓		✓	✓	✓			✓				
Pharmacy	✓		✓	✓			✓					
Allied Health	✓	✓					✓			✓		
MLHD staff	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MPHN staff	✓		✓	✓	✓	✓			✓	✓	✓	✓
NPS MedicineWise	✓		✓	✓		✓					✓	
MediCoach	✓		✓								✓	
The Heart Foundation		✓	✓	✓			✓					
The Lung Foundation							✓					
Marathon Health		✓	✓			✓	✓		✓	✓		
Other			✓		✓	✓		✓			✓	
Total attendance*	**21**	**15**	**30**	**16**	**21**	**21**	**22**	**24**	**14**	**18**	**17**	**23**

*based on number of devices connected and excludes those that joined for less than 10 minutes

Appendix B - Evidence and resources



Prevention, Screening and Intervention
Evidence, resources and current services

Evidence from COPD-X Guidelines* and National Heart Foundation Guidelines**	• For COPD, smoking cessation can slow the rate of decline in lung function, delay the onset of disability, and preserve remaining lung function • Non pharmacological prevention of heart failure includes smoking cessation, avoiding excess alcohol, weight reduction and regular physical activity • There is an influence of age, genetics, comorbidities, socioeconomic, nutritional, and environmental factors (e.g. occupation and air pollution) in developing COPD and CHF
Key statistics	• Current smokers in Murrumbidgee region: 17.1% (NSW average: 15.5%) • At risk alcohol consumption in Murrumbidgee region: 41.6% (NSW average: 32.8%) • Obesity or overweight status in Murrumbidgee region is the highest in NSW
Existing services	• GP MBS items • Ad hoc pharmacy screening • Private health initiatives, allied health and health initiatives • Inpatient opportunistic initiatives • Quit smoking hotline - 'Quitline' • Get Healthy Hotline • Weight management programs • Local Health Advisory Committee (LHAC) projects

*Yang IA, George J, McDonald CF, McDonald V, O'Brien M, Smith B, Zwar N, Dabscheck E. 2021.The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease

** National Heart Foundation of Australia and Cardiac Society of Australia Heart Failure Guidelines Working Group. 2018. National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Guidelines for the Prevention, Detection, and Management of Heart Failure in Australia 2018.*Heart, Lung and Circulation*, 27(10), pp.1123-1208.

Early Diagnosis
Evidence, resources and current services

Evidence from COPD-X Guidelines*	• Early diagnosis and treatment of exacerbations may prevent hospital admission and delay COPD progression • Requires a thorough history and examination • Perform pre and post bronchodilator spirometry to confirm COPD, which is characterised by airflow limitation that is not fully reversible • Consider COPD in patients aged 35 years and older with symptoms such as breathlessness, cough, and/or sputum production as well as all smokers or ex-smokers aged 35 years and older
Evidence from National Heart Foundation Guidelines**	• For CHF, conduct dyspnoea workup, dyspnoea defined as the subjective sensation of abnormal breathing • The history should determine the duration and severity of dyspnoea and whether there are precipitating factors e.g. exertion and emotion • Perform 12-lead ECG, oxygen saturation check, chest X-ray, echocardiography, serum biochemistry (electrolytes, renal function, and liver function) and full blood count
Existing services	• There are at least 2000 consumers on COPD medications without a diagnosis of COPD in Murrumbidgee general practices • 50% of consumers who are diagnosed with heart failure die within 5 years of diagnosis • There is no public (free) service that supports diagnosis in Murrumbidgee outside of a hospital admission • An echocardiogram in the outpatient setting costs a minimum of $200, and is only available in Wagga Wagga, Griffith and Deniliquin • Aboriginal people can get a free echocardiogram in Griffith • Spirometry may be bulk billed in general practice. • Lung function tests are performed for a fee, which may be voluntarily waived.

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** National Heart Foundation of Australia and Cardiac Society of Australia Heart Failure Guidelines Working Group. 2018. National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Guidelines for the Prevention, Detection, and Management of Heart Failure in Australia 2018.*Heart, Lung and Circulation*, 27(10), pp.1123-1208.

Optimal Care in the Community
Evidence, resources and current services

Evidence from COPD-X Guidelines*	• Clinicians should consider developing a GP Management Plan, a Team Care Arrangement and organise a home medicines review with a pharmacist • Benefit in educational and psychological support groups for self- management • Assess functional status and impact of COPD regularly. Patient should be referred to specialist respiratory services if there is diagnostic uncertainty or particular indications such as requirement for assessment for oxygen therapy • Ensure all patients with COPD receive influenza vaccine • Tailor medicines based on the patient's symptoms, exacerbation history, response to treatment, and risk of side effects • Encourage all patients to involve carers and family members in their care management e.g. attending consultations
Evidence from National Heart Foundation Guidelines**	• Referral to a multidisciplinary heart failure disease-management program for consumers with heart failure associated with high-risk features to decrease mortality and re-hospitalisation • Collaborative care using 'shared care' models between the GP, heart failure nurse, and specialist physician
Existing services	• GP Chronic Disease Management MBS item numbers • Chronic care programs • Planned Care for Better Health • Winter Strategy

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Proactive Coordinated Treatment
Evidence, resources and current services

Evidence from COPD-X Guidelines* and National Heart Foundation Guidelines**	• Educate patients and carers on how to recognise and respond to exacerbations by combining action plans with self-management education and integrated care based on shared care arrangements
	• Early diagnosis and treatment of exacerbations may prevent hospital admission and delay COPD progression
	• A COPD exacerbation is characterised by a change in the patient's baseline dyspnoea, cough, and/or sputum that is beyond normal day-to-day variations, is acute in onset, and may warrant a change in regular medication or hospital admission
	• Check inhaler technique at each visit, especially in older, frail and cognitively impaired patients
	• Avoiding re-hospitalisation by the development of collaborative care using 'shared care' models between the GP, heart failure nurse, and specialist physician
	• COPD Action Plan helps people identify when they are getting sick using the following phrases:
	  ○ I have a usual amount of breathlessness
	  ○ I am coughing a lot more and it's harder to breathe
	  ○ I have taken extra medication but it's not getting better
	  ○ My symptoms have changed a lot. I am worried

Existing services	• Planned Care for Better Health (consumers determined via algorithm) • Ambulatory services dependent upon location • GP Chronic care programs (variable across district) • Variation across district in use of Action Plans and education

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** National Heart Foundation of Australia and Cardiac Society of Australia Heart Failure Guidelines Working Group. 2018. National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Guidelines for the Prevention, Detection, and Management of Heart Failure in Australia 2018.*Heart, Lung and Circulation*, 27(10), pp.1123-1208.

Transition to Home
Evidence, resources and current services

Evidence from COPD-X Guidelines* and National Heart Foundation Guidelines**	• Combine action plans with self management education and integrated care that are based on shared care to educate patients and carers to recognise and respond to exacerbations • Patients with COPD discharged from hospital following an exacerbation should receive comprehensive follow-up led by the primary healthcare team. This should commence before the person leaves the hospital • Check adherence with non-pharmacological (e.g. smoking cessation, immunisation, exercise and oxygen) and pharmacological treatment strategies regularly, preferably at each visit. • Check inhaler technique at each visit, especially in older, frail and cognitively impaired patients • Consider a home medicines review if adherence issues are more likely e.g. multiple medicines, significant changes to medication or confusion etc. • Referral to a multidisciplinary heart failure disease-management program is recommended in patients with heart failure associated with high-risk features to decrease mortality and rehospitalisation • Patients should be followed up with a multidisciplinary telehealth program after discharge if a face-to-face multidisciplinary heart failure disease management program is not feasible • To decrease hospitalisation, nurse-led medication titration is recommended for patients with heart failure with reduced ejection fraction (HFrEF) that do not achieve maximum tolerated doses of ACE inhibitors, angiotensin II receptor blockers (ARBs), angiotensin receptor neprilysin inhibitors (ARNIs), beta blockers or mineralocorticoid receptor antagonists (MRAs)
Existing services	• Planned Care for Better Health • Referrals to chronic care programs • Cardiac support group • Regular specialist reviews • Private and community allied health • MyAgedCare • NDIS providers

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** National Heart Foundation of Australia and Cardiac Society of Australia Heart Failure Guidelines Working Group. 2018. National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Guidelines for the Prevention, Detection, and Management of Heart Failure in Australia 2018.*Heart, Lung and Circulation*, 27(10), pp.1123-1208.

Restoring Function
Evidence, resources and current services

Evidence from COPD-X Guidelines*	• Consider pulmonary rehabilitation at any time, including during the recovery phase following an exacerbation • Refer for pulmonary rehabilitation for all patients with exertional dyspnoea (symptoms) • Re-assess and consider re-referral to pulmonary rehabilitation for patients who have stopped being active • The PR Toolkit provides the requirements and steps for setting up a PR service. A guide to delivering PR via telehealth is also available • Homebase provides a framework for coordinating a PR service that is predominantly run from clients home

Evidence from National Heart Foundation Guidelines**	• Consider exercise and cardiac rehabilitation for anyone with stable heart failure, particularly those with reduced left ventricular ejection fraction
	• Living Well with Heart Failure booklet/Physical Activity Action Plan
	  ○ My fluid plan – keeps people on track with their fluid intake so they don't overload and get sick
	  ○ A list of things you can do to feel better
	  ○ My list of medicines and how I should take them
	  ○ Things to do every day
	  ○ My emergency plan
	  ○ Warning signs of a heart attack

Existing services	• Pulmonary rehabilitation • Lungs in Action maintenance exercise program

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** National Heart Foundation of Australia and Cardiac Society of Australia Heart Failure Guidelines Working Group. 2018. National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Guidelines for the Prevention, Detection, and Management of Heart Failure in Australia 2018.*Heart, Lung and Circulation*, 27(10), pp.1123-1208.

Supporting the consumer journey with navigation
Evidence, resources and current services

Evidence from COPD-X Guidelines* and National Heart Foundation Guidelines**	• Encourage patients to involve carers and family members in their management (e.g. by attending consultations) • Provide self-management support to assist patients to set and achieve realistic goals and monitor their effectiveness in the context of regular review • Commence patient and carer education about heart failure and self-management soon after diagnosis as it is a key component of non-pharmacological management of heart failure • Education and self-management should be patient centered and revised continually for life • Patient health literacy should be determined prior to commencing education to ensure resources provided are appropriate for their level of health literacy
Existing services	• GP Chronic Care Programs • Respiratory and cardiac coordinators • COPD Action Plan • Community transport (variable and dependent on location • Pharmacy • Emergency department • Planned Care for Better Health/Marathon Health • Ambulatory Care Services (including Pulmonary Rehabilitation) - dependent upon location

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