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Inquiry into Chronic Disease Prevention and Management in Primary Health Care

31 July 2015

1. Introduction

The VHA welcomes the opportunity to contribute to Standing Committee on Health's "Inquiry into Chronic Disease Prevention and Management in Primary Health Care". The VHA agrees to this submission being treated as a public document and being cited in any reports that may result from this consultation process.

2. Overarching Principles

2a. Investment in Prevention and Primary Health Care

A coordinated, responsive, sustainable and integrated prevention system is essential in reducing the prevalence of preventable chronic disease and improving the health and wellbeing of individuals and communities. Funding is an essential component required to support such a system. Research[1,2] demonstrates the significant and long-term returns on investment and cost savings of prevention activities. A 2008 study reported that for every dollar invested in proven community-based disease prevention programs, such as increasing physical activity, improving nutrition and reducing smoking levels, the return on investment over and above the cost of the program would be $5.60 within five years[3].

In Victoria, a wide range of health services offer preventative services which complement the health care provided in general practices and other primary care settings. However, Commonwealth funding for these services through programs such as Healthy Communities and Healthy Together Victoria, jointly funded under the discontinued National Partnership Agreement on Preventative Health, was ceased in the 2014-15 Commonwealth budget.

With an increasing prevalence of chronic disease, the VHA believes that greater investment in prevention and primary care is required to provide the most cost-effective care and prevent avoidable hospital admissions. The reduced Commonwealth contribution to hospital funding further highlights the need for investment in preventative and primary health care services to keep people well and in their community, and avoid reliance on more expensive hospital-based services.

1 Source: "Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities", Trust for America's Health, 2008
2 Source: "Returns on investment in public health: an epidemiological and economic analysis", Taylor R and Clements M, Department of Health and Ageing: Canberra, 2003
3 Source: "Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities", Trust for America's Health, 2008

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Recommendation:

1. The Commonwealth Government should return to partnership-based funding of preventative programs, and increase investment in preventative and primary health care measures across Australia.

2b. Changes to Medicare Funding and Rebates Impacting on General Practice and Primary Health Care

Successive Commonwealth governments have proposed a number of changes to be made to the Medicare rebate scheme. These include freezing indexation to the rebate paid to General Practitioners (GPs) until July 2018. Medicare rebates have been frozen since 1 July 2014 for a range of MBS items impacting GPs, medical specialists, allied health professionals, nurse practitioners, midwives and dental surgeons, and rebates for pathology and diagnostic imaging services have not increased in over 15 years. Prior to this, annual indexation occurred according to the Commonwealth Department of Finance's Wage Cost Index, which combines a wage index and the Consumer Price Index.

The costs of delivering healthcare services are continually increasing due to advancements in medical science leading to more people living longer with chronic disease, and surviving previously un-survivable disease and injury. Added to this is the growing (but more effective) use of increasingly expensive technologies.

Freezing Medicare rebates does not recognise the increased costs borne by health services for providing healthcare, and may force some healthcare providers to charge a co-payment in order to recoup costs. This is most likely to occur in primary care settings, which are well positioned to provide preventative and early intervention measures to address chronic disease. Even without a co-payment, it is known that up to 12% of disadvantaged populations delay GP visits for up to one year due to costs[4].

The consequences of creating a greater disincentive through co-payment for populations to attend GP appointments include further avoidance of preventative and primary care measures, and increased emergency department (ED) presentations and hospital admissions. The shift in care from GP to hospital settings effectively acts as a cost shifting mechanism to the states to fund a greater number of ED presentations. Financial modelling by a number of state governments has estimated increases of up to 27% in hospital ED presentations, which cost up to ten times as much as a typical GP presentation[5]. The end result of a co-payment is a more expensive health system, and poorer health outcomes for the population it serves. Preventative health measures and interventions can be appropriately delivered by the primary and community health care sector, and funding should be delivered in a way that incentivises this.

Recommendation:

2. The Commonwealth Government should reinstate appropriate indexation to Medicare rebates.

[4] Source: "Senate Select Committee on Health: First interim report", Commonwealth of Australia 2014, Page 29.
[5] Source: "Senate Select Committee on Health: First interim report", Commonwealth of Australia 2014, Page 30.

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3. Specific responses to the Terms of Reference

3.1 Examples of best practice in chronic disease prevention and management

Chronic disease is best addressed through prevention, with significant return on investment demonstrated as outlined above. However, chronic disease prevention needs a population health approach, through measures such as settings based health promotion, ensuring food security, encouraging active transport and improving health literacy. Furthermore, the broader social determinants of health cannot be ignored.

With this in mind, there are a number of programs that address these matters, and these are outlined below.

Healthy Together Victoria

Through the National Partnership Agreement (NPA) on Preventative Health, Victorian local governments were encouraged to partner with local organisations with the aim of promoting health in local communities. This led to the development of Healthy Together Victoria (HTV), which is seen as a gold standard, unique approach that integrates best practice approaches to obesity by creating a "prevention system" for health[6]. Local settings and community leaders are supported to map local food systems and to undertake activities that promote healthy eating and positive, healthy activity and behaviours[7]. HTV is globally recognised, and the New Zealand government has purchased a Licence Deed to replicate the program in their own settings to address obesity, under the banner "Healthy Families NZ"[8].

Across Victoria, 14 Healthy Together Communities were created as part of the Healthy Food Connect and the Victorian Healthy Eating Enterprise (VHEE). The aim was to improve the health and wellbeing of Victorians through food. To date, HTV has had a reach of 25 per cent of the Victorian population, through schools, early childhood services, and medium to large workplaces. Evaluation of HTV is ongoing, and includes a randomised comparison trial of all HTV Communities to determine effect size and effectiveness[9].

However, the cessation of the NPA on Preventative Health by the Commonwealth has resulted in uncertainty for all bodies involved in this program with varying levels of continuation of each program due to funding changes. This will affect continuation of each program and their planned evaluation activities.

[6] Swinburn & Wood 2013, Obesity Reviews. Available from: http://onlinelibrary.wiley.com/doi/10.1111/obr.12103/epdf
[7] Roberto et al 2015, Lancet. Available from: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61744-X.pdf
[8] Source: http://www.healthytogether.vic.gov.au/blog/posts/first-healthy-families-nz-community-launches
[9] Source: http://www.healthytogether.vic.gov.au/aboutus/index

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Healthy Together Wodonga: Building Local Partnerships

Wodonga, a regional city in North East Victoria, is a border town with close links to its "twin" city Albury on the New South Wales border. Located on the Murray River, the city has a population of 37,000 residents, but provides services to a greater population of 170,000 in the region. To undertake this project, the City of Wodonga (CoW) and Gateway Community Health (GCH) established a Healthy Together Wodonga (HTW) team, working in partnership to engage with other "non-traditional" partners such as the local Chamber of Commerce.

HTW targeted workplaces, early childhood and school settings to focus on health promotion through food in a settings-based approach. This was achieved through partnerships, where health and government bodies could build on each other's strengths. For example, local governments have expertise in marketing and branding, which is not a traditional skillset of a publicly funded health organisation. Furthermore, utilising broader networks across sectors allowed for greater support related to sponsorship and public appeal, and also reduced the political barriers that may occur when working with local governments.

The HTW program is focused on creating local food policy for the region. The vision for this program was "*that all residents will eat fresh, locally produced food, particularly vegetables and fruit, to make them healthy, nuture the landscape and invigorate the local economy".* Actions undertaken to date to achieve this vision include embedding healthy catering menus, coordinating healthy food forums for public attendance, and partnerships between health services, food providers and agricultural organisations such as Landcare. Relationships were developed between producers, workplaces, industry and governments working towards a common goal.

The cessation of the NPA on Preventative Health by the Commonwealth resulted in uncertainty for all bodies involved in this program. Given the intended purpose of the program and its potential to address modifiable risk factors of chronic disease, GCH and CoW have continued their own funding commitment to the HTW program through the development of a local Memorandum of Understanding (MoU) which promotes HTW until June 2017. This MoU will support a HTW coordinator, who will be employed by the CoW and will be responsible for working with GCH and act as a key contact for GCH into local government.

Evaluation of the HTW program will occur through the next Population Health Survey, from which baseline measures indicated that:

- 59.5 per cent of Wodonga residents are overweight or obese (above the state average of 49.8 per cent), and
- 23.3 per cent of females are obese (above the state average of 17.2 per cent)[a].

HTW Achievements to date[b]:

- 24 workplaces signed up, with a reach of approximately 5000 people
- 95 per cent of early childhood settings signed up
- 70 per cent or primary schools signed up
- 40 per cent of high schools signed up.

[a] Source: Wodonga Food Security Scan May 2014. Available from: http://www.wodonga.vic.gov.au/community-services/healthy-together-wodonga/images/Wodonga_Food_Security_Scan_2014.pdf
[b] Source: HTW correspondence dated 16/7/2015

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Life MAP: A Workplace and Community Health and Wellbeing Program

Life MAP (Mental and Physical health) is a long term program developed by Timboon and District Health Service (TDHS) in regional Victoria. Its aim is to improve the health and wellbeing of its workforce and the local community through:

- Encouraging daily physical activity,
- Establishing a practice of making good choices in healthy eating,
- Fostering mental wellness, and
- Promoting productive and fun participation in life, and life in the community.

As a team-based program, Life MAP is designed to work over 12 months to address the health and wellbeing of employees. More than a weight-loss program, Life MAP intends to improve mental health and stress management, creating and supporting sustainable lifestyle change within individuals and communities, and bringing people together to achieve these goals. TDHS has recognised that healthy employees are productive employees, and that a major component of lost time in the workplace is chronic disease. Chronic disease has a number of modifiable risk factors, including physical activity and nutrition. Research undertaken by TDHS has identified the benefits of workplace health and wellbeing programs, which include:

- Reduced absenteeism,
- Greater productivity,
- Reduced workplace musculoskeletal injuries,
- Better worker engagement,
- Lower staff turnover, and
- A return on investment of an estimated $5.81 for every $1 invested.

TDHS has invested $200,000 of its own funds into this program, and a full time staff member to coordinate the program. Program components include:

- Baseline blood tests,
- Provision of activity tracker (such as a FitBit),
- Participants setting exercise goals such as activity targets and strength training goals,
- Information sessions on nutrition, physical activity and health,
- Resource materials,
- Fortnightly emails and coaching sessions, and
- Access to counsellor support, physiotherapist, personal trainer, and dietitian.

Individual participants are placed into small teams of up to six people, and are encouraged to support each other within these groups by working together, creating supportive environments, and sharing their stories.

Baseline survey evaluation at TDHS demonstrated 46.8 per cent of females and 20.5 per cent of males are overweight or obese, 30 per cent never meet the Australian Guidelines for physical activity, and 85.9 per cent don't meet Australian guidelines for vegetable consumption. Since the introduction of the program, 85 per cent of participants are meeting the Guidelines for physical activity. The program will be evaluated by VicHealth and Deakin University, and is currently being negotiated to be rolled out to a Local Government, and another health service in the region.

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Recommendations:

3. Bilateral government agreements, such as National Partnership Agreements, should not be ceased unilaterally, as this creates uncertainty for funded programs and projects.
4. Health promotion activities focusing on prevention must be funded across sectors to ensure appropriate stakeholder engagement and best use of available skill sets.
5. Workplace health and wellbeing initiatives have the potential to reach significant numbers of the population and should be encouraged with regards to prevention and management of chronic disease. They must be built upon best-practice guidelines and utilise expertise available from the health sector to ensure positive outcomes.

3.2 Medicare Payment System and Chronic Disease

The Medicare payment system provides funding for a range of primary health interventions related to chronic disease. Incentives include payments to General Practitioners, General Practice Nurses and specific allied health professionals for a range of interventions, including Chronic Disease Care Plans, and Allied Health support (up to five visits).

The MBS item numbers provide rebates to eligible health professionals for managing diagnosed chronic disease for a limited range of interventions, and for a restricted number of treatment sessions. The number of sessions (up to five for allied health professions) may not be sufficient to address a consumer's health issues, and the funding provided may not cover the non-clinical care that is required to effectively manage a patient with chronic disease, such as writing referral letters and completing funding applications for services and equipment. Furthermore a number of MBS item numbers are restricted to specific professions, and limit the ability of suitably qualified clinicians to provide input to care, including general practice nurses, nurse practitioners, and allied health professionals.

Chronic disease management requires multi-disciplinary care and a team-based approach to address all contributing factors. This is poorly facilitated in the current MBS, and work could be done to encourage best-practice team-based care (where appropriate) for chronic disease.

Added to this, preventative health measures are not currently funded through the MBS, limiting a health professional's ability to implement preventative health interventions for patients with chronic disease risk factors. One example is the absence of MBS funding available for smoking cessation clinicians, even though tobacco smoking is a well-established risk factor for chronic disease, and causes the greatest burden of disease in Australia[10]. Furthermore, MBS funding is not tied to outcomes, but rather is linked to activity, which can act as a perverse incentive for managing chronic disease in particular.

The MBS could also be expanded to further promote the prevention and management of chronic disease. Preventative health measures or early intervention, introduced before a patient develops a chronic disease, would reduce the burden of disease on the healthcare system, and promote keeping people well and out of hospital. More effective utilisation of the primary health care workforce could also lead to service efficiencies, and improve the support consumers receive by broadening their exposure to health promoting messages and interventions.

To recognise the complex needs of patients with chronic disease, patient complexity must also be taken into account. There are few patients with chronic disease who would not be considered to have

[10] Source: http://www.aihw.gov.au/risk-factors-tobacco-smoking/

complex needs, and even fewer who would have a single chronic disease in isolation of others. Chronic disease is often a combination of risk factors, family history, and social determinants of health. Complexity may exist through co-morbidities such as mental illness, or through social factors such as homelessness or domestic violence.

Recommendations:

6. The Commonwealth should consider modifying the MBS to enable health professionals to undertake preventative activities with patients at risk of chronic disease, thus preventing or delaying the onset of chronic disease and avoiding the need for costlier health interventions. Funding for chronic disease prevention and management must be tied to outcomes, rather than activity, to avoid perverse incentives.
7. Appropriate access to the MBS for health professionals with demonstrated ability to address chronic disease must be supported to facilitate best-practice prevention and management of chronic disease.
8. The MBS must accurately reflect the cost of care provided to patients. As disease and illness profiles change, consideration must be given to how patient complexity can be measured and funded appropriately.

3.3 Role of Primary Health Networks in chronic disease prevention and management

The evolution of Primary Health Networks (PHNs) in Australia from Divisions of General Practice, to Medicare Locals and now to their current iteration is met with positive anticipation regarding the potential they have for enabling true regional planning with economies of scale across their geographic areas. PHNs will be tasked with improving health outcomes by integrating and coordinating health services, aiming to reduce fragmentation of healthcare.

Accordingly it is vital that PHNs are supported and funded appropriately to properly fulfil their objectives. In order to simplify the health system for consumers and providers, PHNs must be able to work with key stakeholders within and external to health to develop meaningful, strategic relationships that can be outcomes focused. With this in mind, it is important that PHNs are able to focus on this overarching role without being expected to act as service providers, which could complicate the already difficult-to-navigate sector. However there may be, for example, a role for PHNs to fulfill in funding high quality services in order to best meet the needs of their local community.

In order to deliver integrated, coordinated care, the funding of PHNs must remain flexible to ensure that local population health priorities can be met through locally appropriate interventions and programs, as well as partnerships to achieve healthy outcomes. Funding provided must also support partnerships within health and across sectors in order to embed best-practice health promotion and prevention activities into society more broadly.

Recommendation:

9. Funding of PHNs must adequately reflect the goals of these organisations. Flexibility of funding is vital to ensure that locally appropriate interventions and programs can be supported, and that collaborative, cross-sector approaches can be facilitated in order to most effectively address chronic disease prevention and management.

3.4 Role of Private Health Insurers in chronic disease

A number of trials have been undertaken by major Australian Private Health Insurers investigating the most effective and efficient methods of funding primary health care, and managing patients with chronic disease. These trials demonstrate the awareness of health insurers of the commercial incentive to prevent avoidable hospital admissions, which should indicate to publicly funded services the economic benefits of encouraging the delivery of care outside of hospital settings.

The VHA would suggest that there may be lessons from such trials with regards to the delivery of services and management of chronic disease. Where appropriate we would encourage the facilitation of meetings between private and public sector bodies to share findings and work towards common goals.

CarePoint: Victorian Department of Health and Medibank Private
The Victorian Government and Medibank Private have created a partnership to provide evidence-based, preventative care to improve health outcomes and reduce hospital admissions for 2,200 Victorians with chronic and complex conditions and a history of frequent hospitalisation[c]. Focusing on patient centred care with a preference to deliver care in the patient's own home, the program is GP led and utilises care planning, referral pathways, and shared electronic records across the acute and primary care sectors. The trial program is intended to be completed (including evaluation) by the end of 2017.

[c] Source: http://www.health.vic.gov.au/news/carepoint-update-mar15.htm

Recommendation:

10. There is an opportunity for trials between Government and Private Health Insurers to provide recommendations and guidance regarding prevention and management of chronic disease. Opportunities should be created and facilitated to develop relationships between the public and private sectors to work together towards shared goals.

3.5 Role of State and Territory Governments in chronic disease

State governments function as system operators for health care within their jurisdictions, with the exception of primary health. Funding arrangements, policy frameworks, and government identified priorities can all influence the manner in which chronic disease is addressed. Further, state governments often play a role in funding and regulation of the health sector, and therefore collect data in the form of reporting and program evaluation. Accordingly, it is vital that any mandated reporting processes and programs are fit-for-purpose and able to perform the necessary functions to fulfil the reporting requirements to regulatory and government bodies.

Data collected by state governments should be made widely available to the health sector to facilitate benchmarking, performance evaluation and population health planning. An efficient and effective health system requires continuous quality improvement, and data to inform such processes.

The structure of state government departments must continue to recognise the cross-sector nature of chronic disease management and prevention. This underscores the importance of states developing jurisdiction-wide approaches that address key issues such as chronic disease.

The key internationally recognised framework to support the role of governments in promoting health is the Helsinki Statement on Health in All Policies[11], developed at the World Health Organisation's 8th Global Conference on Health Promotion in 2013. The Health in All Policies approach calls on governments to consider all public policies across all sectors through a health framework, and to recognise the implications of decisions, seek synergies, and avoid harmful health impacts to improve population health and health equity. It emphasises the impacts of public policies on health systems, determinants of health and wellbeing. To support this approach, a Framework for Country Action has been developed[12].

Such an approach has been undertaken by the South Australian Government. Introduced in 2007 by Professor Ilona Kickbusch (the Adelaide Thinker in Residence), a number of projects have been undertaken including the promotion of active transport, encouraging active ageing through employment, and promoting uptake of digital technology[13]. Through centralised decision making, health can be promoted outside of health services, creating more effective channels to address issues such as risk factors for chronic disease, through avenues such as safe active transport, food security, and health literacy.

Recommendations:

11. Reporting to government requirements must be streamlined and be able to be completed through fit-for-purpose modalities. Additionally, centrally collected data should be made available for the health sector to encourage benchmarking, performance evaluation and population health planning.

12. State and territory governments have an important role in play in the prevention and management of chronic disease. There is an opportunity for the states to ensure a health lens is applied to policy and funding decisions. This central oversight is crucial to creating healthy environments and making healthy decisions the easy decisions, without the natural borders of departmental decision making.

3.6 Innovative models in chronic disease

Innovative models in chronic disease are increasingly making best use of the breadth of professions involved in healthcare delivery. In particular, the management of elective surgery waiting lists for patients awaiting orthopaedic surgery has highlighted the role and effectiveness of experienced physiotherapists for this patient cohort.

[11] Available from: http://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf?ua=1
[12] Available from: http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1
[13] Further information available from: http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies/health+lens+analysis+projects

Physiotherapist-led Orthopaedic Outpatient Clinics
A number of Victorian health services have implemented physiotherapist-led orthopaedic clinics to assess patients referred for joint surgery, particularly for shoulder, knee and hip procedures. The common aspects of these clinics involve an experienced, musculoskeletal physiotherapist assessing patients on surgical waiting lists to determine if conservative management is appropriate, and if such an approach can lead to effective patient and service outcomes. Published evidence has demonstrated that 63 per cent of patients on surgical waiting lists are appropriate for conservative management, and demonstrate high levels of patient and medical staff satisfaction with the service[d]. Furthermore, clinics such as these lead to improved appropriateness of patient referrals to surgery, reducing inappropriate referrals.

Models such as this demonstrate the value of the multidisciplinary team. Such approaches could be encouraged through improving links between surgical procedures and primary health and prevention services, and reduce the need for expensive surgery where conservative management is appropriate.

[d] Oldmeadow et al 2007, Medical Journal of Australia. Available from: https://www.mja.com.au/journal/2007/186/12/experienced-physiotherapists-gatekeepers-hospital-orthopaedic-outpatient-care

Recommendation:

13. A number of experienced health professionals exist who are skilled and able to provide quality care to patients with, or at risk of chronic disease. Improved links between surgical procedures and primary health and prevention services could be promoted through incentivised referral pathways, such as through the MBS.

3.7 Best practice of multi-disciplinary teams in chronic disease management in primary health care and hospitals

It is well recognised that health can be influenced by a range of social determinants of health, including but not limited to housing, employment and education. Increasingly, legal issues are being recognised as a social determinant of health, with 20 per cent of respondents to the Australian LAW survey reporting stress-related illness and 19 per cent reporting physical ill health as a result of legal problems[14]. Furthermore, individuals with legal issues most often seek advice from non-legal advisors, with almost 30 per cent seeking advice from health or welfare advisors. The survey also identified that approximately half of the respondents experienced at least one legal problem in the preceding 12 months, and that 65 per cent of legal problems are experienced by only nine per cent of people.

Health Justice Partnerships
Given the Australian LAW survey findings, a number of health services in Australia have introduced Health Justice Partnerships (HJPs). Also known as Advocacy Health Alliances, or Medical-Legal Partnerships, HJPs are a model of integrating legal services into health settings in order to address legal issues that may be influencing a patient's health status.

In Victoria HJPs have been established in a range of hospital and community health settings through partnerships with Community Legal Centres (CLCs) and pro bono services of private law firms. Legal

[14] Coumarelous et al 2012, Legal Australia-Wide Survey. Available from: http://www.lawfoundation.net.au/ljf/site/templates/LAW_AUS/$file/LAW_Survey_Australia.pdf

issues identified through HJPs include elder abuse, domestic violence, housing and tenancy issues, employment discrimination and financial issues. Through educating health professionals who spend significant amounts of time with patients with chronic disease, legal issues can be identified and appropriate assistance and advice can be provided. This is particularly relevant for matters such as domestic violence and elder abuse, where health appointments with may be the only time an individual is away from the perpetrator of abuse.

Funding for HJPs has occurred through a range of avenues, with the Victorian Legal Services Board providing several time-limited grants for the establishment and evaluation of a number of Victorian HJPs. Other HJPs have been established through partnerships with pro bono services of law firms, and through MoUs between CLCs and health services. Given the cross-sector nature of these programs and the merging of non-traditional partners, support is needed to ensure meaningful relationships can be developed more broadly to improve access to justice, and therefore health outcomes for vulnerable population groups.

Health Justice Partnerships: Loddon Campaspe Community Legal Centre and Bendigo Community Health

A HJP between the Bendigo-based Loddon Campaspe CLC and Bendigo Community Health Service (BCHS) has been operating at BCHS' Kangaroo Flat site for over 18 months. A lawyer from the CLC is located on site three days a week at BCHS, providing advice and ongoing assistance to existing clients of the health service.

The Bendigo HJP aims to operate on three levels:

- Provision of direct client services such as information, advice, casework and education,
- Institutional development with education programs for health professionals to enable early identification of legal issues and to facilitate timely referrals for assistance, and
- Facilitation of systemic change to improve population health and promote human rights.

The integrated service delivery approach of HJPs can result in both improved access to legal assistance as well as better healthcare outcomes. HJPs focus on early identification of potential legal problems by healthcare professionals with prompt legal intervention, to prevent health and legal crises from escalating, and to assist their timely resolution.

Referrals to the Bendigo HJP are made by health workers who identify that there may be an issue capable of legal resolution. During the period from January 2014 to May 2015, the HJP delivered 86 legal advices and provided 74 case work services.

The majority of the clients referred to the service present with family law and child protection issues, which is largely reflective of the client catchment and focus of BCHS, Kangaroo Flat.

A project evaluation has begun. Preliminary project evaluation data suggest that this model of service delivery is succeeding in improving the health and wellbeing of vulnerable and disadvantaged individuals[e].

[e] Source: HJP project staff correspondence dated 31/07/2015

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Recommendation:

14. Multidisciplinary care for chronic disease prevention and management must include services outside of the health sector, recognising the influence of social determinants of health. In order to achieve this funding for partnerships across sectors must include support for education and evaluation to monitor outcomes and effectiveness.

3.8 Models of chronic disease prevention and management in primary health care which improve outcomes for frequent users of medical and health services

Research demonstrates that reducing avoidable hospitalisations for patients with chronic disease is fundamental to reducing overall medical costs in this population group[15]. A number of Hospital Admission Risk Programs (HARPs) exist in Victoria, which specifically target this cohort. However, HARPs often lack medical involvement, which can limit the influence these programs can have on hospital decision makers in the historically hierarchical settings of hospitals.

Furthermore, not all patients with chronic disease are eligible for support through HARP, yet are known to be at high risk of hospitalisation and are frequent users of medical and health services. Patients with diabetes, for example, are known to be at risk of developing foot-complications that may require significant involvement with the health systems. Such known, high-risk patients require considered and effective healthcare management.

[15] Linden et al 2011, Int Journ of Person Centered Medicine. Available from: http://docs2.health.vic.gov.au/docs/doc/695F4F775DC6ACACCA257A7F00731A4C/$FILE/Alfred_Article.pdf

Disease Management Unit: Alfred Health and Inner South Community Health

The Alfred Health Network, a provider of public health services to residents of the inner southeast suburbs of Melbourne, has implemented a Disease Management Unit (DMU) through a combination of grant funding from the Victorian Government and HARP funding. Alfred Health includes two major acute health services and a subacute facility. The DMU is staffed by specialists in general medicine, nurses and pharmacists. Access to allied health staff is facilitated as required. The DMU specifically targets patients with multiple chronic diseases with high risk of acute exacerbation and therefore hospital readmission. Eighty per cent of DMU patients have at least three co-morbid chronic diseases. Patients are accepted into the program via referral from their GP, however the majority of referrals are from inpatient medical units. Upon enrollment to the program, a nurse care-coordinator visits the patient's home to undertake a comprehensive medical and psycho-social needs assessment of each patient, liaises with the patient's GP, and schedules an outpatient appointment with the DMU clinic.

DMU clinics are run in a variety of settings, including across the three campuses of Alfred Health and, through partnership with Inner South Community Health, in two community health centres. Particularly for clinics at the community health centres, GPs are encouraged to participate in team-based decision making about their patients, and the community health based GPs are able to liaise directly with specialist physicians to discuss patient care. Nurse care-coordinators also play a role in ensuring patient care is well integrated into primary care services, and that patients are effectively managing any other medical appointments they may be attending.

A direct admission pathway for DMU patients also exists to facilitate hospital admission and avoid the emergency department. Other elements of DMU clinics are the presence of a pharmacist, with the intent of better managing poly-pharmacy issues for patients and minimise harm from high-risk medications and drug interactions, as well as providing education to patients regarding self-management. Group patient education is offered to patients, covering topics such as fatigue management, energy conservation, talking to your GP and depression and anxiety. Patients are discharged from the DMU once they are considered stable, not requiring ongoing review, or are fully managed by their GP. Approximately 350 patients are managed by the DMU at any one time.

The single point of care for this complex group of patients is able to provide multidisciplinary care, avoids fragmentation and duplication (particularly for medical testing), provides a medical home for the patient, and provides an advocate for patients to help with navigating the complex health system. Furthermore, continuity of care is achieved through a consistent team of doctors looking after patients as both admitted inpatients and in the associated outpatient clinics. Through service agreements between Alfred Health and Inner South Community Health, cross sector care can be provided. Evaluation of the DMU program demonstrates significant reduction in monthly hospital admissions for DMU patients[f].

Challenges associated with the DMU program include attracting adequately skilled and interested medical staff, funding models for chronic disease, and communication between GPs and the DMU when GPs are not co-located. Funding for chronic disease management in outpatient settings can provide a perverse incentive to maximise patient throughput, rather than to optimise patient outcomes.

[f] Linden et al 2011, Int Journ of Person Centered Medicine. Available from: http://docs2.health.vic.gov.au/docs/doc/695F4F775DC6ACACCA257A7F00731A4C/$FILE/Alfred_Article.pdf

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Podiatry Diabetes Model: a Regional Collaboration Across Sectors

People with diabetes are known to be at risk of disease-related foot complications. Such complications present a significant burden to the health system, and early and appropriate prevention and management activities are cost-effective.

Bendigo, a regional Victorian city of approximately 100,000 people, is serviced by two major public health services – Bendigo Health (BH), which provides sub-acute and acute services, and Bendigo Community Health (BCH), providing community based services. Through shared regional planning BH and BCH have developed a model of care that ensures patients attending podiatry services with a diagnosis of diabetes are seen at the most appropriate location based on their level of diabetes-related foot complication as measured by a globally accepted risk tool. In delivering this model of care, patients are able to access multi-disciplinary care with access to nursing, medical rehabilitation specialists and orthotists as soon as their clinical risk score indicates a need for this. Through early intervention, health services can prevent avoidable hospital admissions and reduce the need for more costly interventions.

Evaluation of the Bendigo Podiatry Diabetes Model demonstrates that cross-sector and cross-organisation collaboration has provided effective care centred around the most appropriate services for patients[g,h].

[g] Perrin et al 2012, Australian Health Review. Available from: http://www.publish.csiro.au/paper/AH11010.htm
[h] Perrin et al 2012, Journal of Foot and Ankle Research. Available from: http://www.jfootankleres.com/content/5/1/6

Recommendation:

15. Chronic disease prevention and management requires multidisciplinary services and cross-sector relationships in order to prevent avoidable hospital admissions. Funding for such programs must reflect the goal of reducing avoidable hospital admissions, improving self-management, and enabling access to patient centred care. Activity Based Funding does not incentivise such management approaches, and therefore consideration must be given to the most appropriate and effective funding models for this population group.

SUBMISSION

4. Further information

The Victorian Healthcare Association (VHA) is the peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services, aged care facilities and Primary Health Networks. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

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