

6 August 2015

**Standing Committee on Health  
The House of Representatives  
PO Box 6021  
Parliament House  
Canberra ACT 2600**

health.reps@aph.gov.au

To whom it may concern

**Submission to the Standing Committee on Health**

Please find attached our submission to the Standing Committee on Health's Inquiry into Best Practice in Chronic Disease Prevention and Management in Primary Health Care. The five nursing organisations whose logos are included in this letter contributed to this submission and endorse its content. I am signing this letter on behalf of these nursing organisations. Please direct any future correspondence with the contributing nursing organisations through the Australian College of Nursing's (ACN) Chief Executive Office.

Chief Executive Officer  
Australian College of Nursing  
PO Box 219  
Deakin West ACT 2600  
T: 02 6283 3400 E: [tiffany.wallace@acn.edu.au](mailto:tiffany.wallace@acn.edu.au)

Please do not hesitate to contact the participating organisations for any further discussion relating to this submission through this office. We look forward to the outcomes of this inquiry.

Yours sincerely



**Kathleen McLaughlin  
Acting Chief Executive Officer  
Australian College of Nursing**



# **Submission to the Australian Parliamentary Standing Committee on Health**

*Inquiry into best practice in chronic disease prevention  
and management in primary health care*

The Australian College of Nursing (ACN), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Australian Primary Health Care Nurses Association (APNA), Maternal Child and Family Health Nurses Australia (MCAFHNA), and the Australian College of Mental Health Nurses (ACMHN) are pleased to provide this joint submission to the Australian Parliamentary Standing Committee on Health's *Inquiry into best practice in chronic disease prevention and management in primary health care*.

The signatures below represent each organisation's formal endorsement of this submission and its recommendations.



**Kathleen McLaughlin**  
Acting Chief Executive Officer  
Australian College of Nursing




**Janine Mohamed**  
Chief Executive Officer  
Congress of Aboriginal and Torres  
Strait Islander Nurses and Midwives




**Julian Grant**  
President  
Maternal, Child and Family Health  
Nurses Australia




**Kim Ryan**  
Chief Executive Officer  
Australian College of Mental Health Nurses




**Alexis Hunt**  
Chief Executive Officer  
Australian Primary Health Care Nurses  
Association



## Recommendations

### The five key nursing organisations that co-authored this submission recommend that:

1. The Australian Government considers the full breadth of primary health care services when informing its policy development and funding allocations, with a view to promoting coordination and integration amongst them. This includes, in addition to general practice, services that are funded and delivered by state, territory, and local governments, and non-government organisations.
2. The Australian Government's primary health care policy and funding allocations take into account the contribution that nurses from all settings, and at all levels of professional development, make in the provision and coordination of chronic disease prevention and management in primary health care. The Australian Government should look for, and act on, opportunities to enhance this role and contribution.
3. The Australian Government re-examines the recommendations of the World Health Organisation's Commission on the Social Determinants of Health Report '*Closing the Gap in a Generation*', as well as those of the Australian Senate Committee's *Inquiry into Australia's Response to the Report* (2012), with a view to their implementation.
4. The Australian Government re-examines the recommendations of the Report of the *National Review of Mental Health Programmes and Services* with a view to their implementation.
5. The Australian Government ensures that the chronic disease prevention and management models that it supports reflect the following essential elements:
  - Consumer-centred care
  - Multidisciplinary care
  - Care coordination by a dedicated care coordinator
  - A focus on prevention and health promotion
  - Support by eHealth technology
  - Linkage to a broader population health framework
  - Adequate and well-structured funding.

Section 2 of this submission discusses these elements in more detail.

6. The Australian Government widens the scope of its current review into Medicare to examine how Medicare/government funding can support the integration of a more comprehensive suite of services, including community-based social services, aged care, and disability services.
7. The Australian Government widens the scope of its current review into Medicare to examine and propose options for a reformed, blended primary health care funding model, including a transition plan.
8. In the interim of a wider Medicare review and reform process, the Australian Government creates access to, broadens, and increases the value of MBS items for nurses as a way of increasing access to chronic disease prevention and management in primary health care. Alternatively, nursing services in primary health care could be supported through grant or block funding.
9. In the interim of a wider Medicare review and reform process, the Australian Government creates, or modifies, MBS items to remunerate health professionals for non-face-to-face consultations, including by email and telephone.
10. In the interim of a wider Medicare review and reform process, the Australian Government funds the Aboriginal community controlled sector at a level that enables growth, and which supports the provision of comprehensive primary health care. This will enable the sector to effectively manage and prevent chronic disease in Aboriginal and Torres Strait Islander communities, as well as in other disadvantaged populations.
11. The Australian Government mandates and supports Primary Health Networks to partner with health and social care services to help address the social determinants of health, including through the coordination and integration of inter-sectoral services.
12. The Australian Government mandates and supports Primary Health Networks to promote the uptake and use of eHealth technology, by both practices and consumers, such as the electronic health record, secure messaging, telehealth, and practice and consumer supported software/technology.
13. The Australian Government requires Primary Health Networks to have nurse representation on their Clinical Committees, or any other fora relating to policy development, governance, and health service delivery.

14. The Australian Government obligates private health insurers to collaborate with other parts of the health sector to help ensure efficiency and effectiveness in the system, such as through data sharing.
15. The Australian Government works with state, territory and local governments to delineate roles and responsibilities in the funding and provision of health and social care services, with the view to better connecting services, increasing efficiency, and addressing identified service gaps.
16. The Australian Government works with state, territory and local governments, and other stakeholders, to support and promote evidence-informed care, especially as it relates to Aboriginal and Torres Strait Islander health, and the general provision of quality and safety in health frameworks.
17. The Australian Government supports the National Health Leadership Forum to work with state and territory governments to increase the Aboriginal and Torres Strait Islander health workforce.





## Contents

Contents.....	8
Our organisations.....	9
1. Introduction .....	11
2. Preventing chronic disease through addressing the social determinants of health .....	15
3. Elements of best practice chronic disease prevention and management models.....	19
4. Opportunities for the Medicare payment system to encourage and reward best practice and quality improvement in chronic disease prevention and management .....	20
5. Opportunities for Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care.....	30
6. The role of private health insurers in chronic disease prevention and management ....	33
7. The role of State and Territory Governments in chronic disease prevention and management.....	34
Appendix 1. Examples of best practice chronic disease prevention and management models .....	38
Nurse clinics .....	38
Mental Health Nurse Incentive Program .....	41
Aboriginal Community Controlled Health Services .....	45
Hospital Admission Risk Programs (HARP).....	46
Person-centred health care home .....	49
Community-based specialist nurses for the management of chronic and complex disease .....	50
Multidisciplinary team collaboratives .....	52
Shared health appointments.....	53
Integrated Chronic Disease Nurse Practitioner Model .....	55
Logan Hospital Heart Failure Program .....	56

## **Our organisations**

### **Australian College of Nursing (ACN)**

ACN is the national professional organisation for all nurse leaders. ACN is an advocate for the nursing profession, advancing the skills and expertise of nurses to provide leadership in their contribution to the policy, practice and delivery of health care. ACN is a membership organisation with members in all states and territories, health care settings and nursing specialties. ACN's membership includes many nurses in roles of influence, including senior nurses, organisational leaders, academics and researchers. ACN is also the Australian member of the International Council of Nurses headquartered in Geneva.

### **Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)**

CATSINaM was founded in 1997 and is the national peak body that represents, advocates for, and supports Aboriginal and Torres Strait Islander nurses and midwives at a national level. A key component of CATSINaM's work is to promote health services to become culturally safe working environments for Aboriginal and Torres Strait Islander nurses and midwives; and the promotion of Indigenous health through the improvement of health service delivery for Aboriginal and Torres Strait Islander peoples.

### **Australian Primary Health Care Nurses Association (APNA)**

APNA is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in consumer-centred care.

APNA's vision is a healthy Australia through best practice primary health care nursing.

APNA is bold, vibrant and future-focused. APNA reflects the views of its membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

Nurses in primary health care contribute to a healthy Australia through innovative, informed and dynamic care.

### **Australian College of Mental Health Nurses (ACMHN)**

ACMHN is the peak professional organisation representing mental health nurses, and the credentialing body for mental health nurses in Australia. Mental health nurses work in mental health across a variety of settings – acute psychiatric units in hospitals, specialist community mental health teams, primary care, general practices, emergency departments, as well as in policy, administration, management and research roles. Mental health nurses are a key component of Australia’s mental health care system. A primary objective of the ACMHN is to enhance the mental health of the community by improving service and care delivery for those affected by mental illness and disorder. The College also sets standards of practice for the profession and promotes best practice in mental health nursing.

### **Maternal, Child and Family Health Nurses Australia (MCAFHNA)**

MCAFHNA is the peak professional body in Australia for nurses working with parents of children from birth to five years of age. The Association provides a voice for Maternal, Child & Family Health Nurses (MCAFHNs), speaking out on issues that affect not just members of the Association but families with young children from 0 - 5 years of age. As such it monitors and contributes to policy development and legislation affecting child and family health at jurisdictional and national levels.

The work of MCAFHNs is embedded in the principles of primary health care under an umbrella of universal service delivery with increasing overall complexity. Health promotion and early intervention are key components of the role, with services focused heavily on child growth and development and maternal mental health. MCAFHNs work in partnership with families and a range of government and non-government health, education and care providers to achieve optimal outcomes for Australia’s children.

## 1. Introduction

Australia possesses a world-class health system that has delivered high quality, largely equitable health care to its population over many decades. It has been a major contributor to the high life expectancy and high quality of life that most Australians enjoy today.<sup>1</sup> These qualities are, however, being jeopardised by the rising rates of chronic disease, which are placing significant strain on the health system's resources and capacity. The challenges posed by chronic disease, unless addressed through timely, comprehensive, and evidence-based action, will undermine the health system's ability to adequately meet the population's needs, both now and into the future.

Australia must have a strong, well-connected and well-resourced primary health care system, where prevention and health promotion are prioritised and where the workforce is effectively developed and utilised.

Primary health care is the first level of contact with the health care system for individuals, families, and communities in most instances. It involves health promotion, illness prevention, and community development. Primary health care is based on the interconnecting principles of equity, access, empowerment, community self-determination and inter-sectoral collaboration. Finally, it incorporates an understanding of the social, economic, cultural, and political determinants of health.<sup>2</sup> The primary health care sector is the principal provider of chronic disease prevention and management in the community. It delivers prevention to people at all stages of their lives and at all stages of health including:

**Primary prevention** – which refers to actions taken to stop a disease or condition from occurring in the first place, such as immunisations, education on the dangers of smoking, addressing social issues that can impact on mental health (e.g. family relationships and violence, encouraging responsible media reporting of mental health issues, promoting school belonging), and healthy public policy (e.g. around food security, sanitation, urban design, and social services).

---

<sup>1</sup> It should be noted that Aboriginal and Torres Strait Islander peoples do not experience the same life expectancies, nor generally the same quality of life as non-Indigenous Australians, with average life expectancies being 10.6 years and 9.5 years lower for males and females, respectively. They are also at greater risk of developing chronic disease than non-Indigenous Australians.

<sup>2</sup> Keleher H. 2001. Why primary health care offers a more comprehensive approach to tackling health inequalities than primary care. *Australian Journal of Primary Health*, 7(2), pp. 57-61.

**Secondary prevention** – which refers to measures taken to reduce the impact of a disease or injury once it has occurred; examples include: early detection of cancer, dental check-ups for early treatment of dental decay, ‘developing resilience’ for people exhibiting early signs of depression/anxiety, and ‘back to work’ rehabilitation programs.

**Tertiary prevention** – which aims to soften the impact of a chronic disease or other long-term impairment following its full manifestation; examples include cardiac or stroke rehabilitation programs, support groups for people with chronic health conditions that promote ‘living well’, mental health screening for people with chronic disease, chronic disease screening for people with mental illness, and vocational rehabilitation programs that train people to undertake new jobs in accordance with their impaired abilities.

Secondary and tertiary prevention measures are integral to chronic disease management.

Primary health care encompasses a wide range of services delivered by a wide range of health and social care professionals, including nurses, numerous types of allied health provider, dentists, pharmacists, social workers and medical practitioners; all of which are equally important in the effective and efficient delivery of chronic disease prevention and management.

Chronic disease occurs in all social settings and at all stages of life. One of its major challenges is that for care to be effective it often needs to be tailored and coordinated on the basis of a person’s condition(s), their social, work and living environment, and other personal circumstances. This need for tailoring care is partly what makes the management of chronic disease so complex: it requires health professionals to consider care holistically, to span health sector boundaries and to coordinate multiple services while always considering and meeting people’s needs, values, expectations and preferences.

Nurses’ professional education provides them with the attributes and skills needed to take a holistic approach to care. It enables them to traverse the multiple layers and complexities of a health system, such as by liaising between a person’s GP, medical specialist, podiatrist, pharmacist and social worker, all while partnering with the patient in the co-production of their care.

Nurses are often referred to as the glue that holds our health system together. Nurses acquired this characterisation not only because of their vital role as care coordinators but also because the nursing workforce is large and widely distributed. There are currently more than 330,000<sup>3</sup> nurses practicing in Australia; 40,000 of which are in the primary health care sector.<sup>4</sup> They are the largest health workforce in the country and the most widely skilled as a health profession. Nurses work in a broad range of locations and settings, and attend to people at all stages of life, from maternal and child health, through school nursing, right up to aged care and end of life care where palliative care nursing may be required. They work in some of the most remote places in the country, sometimes as the only permanent/regular health professional onsite. And they care for some of the country's most vulnerable and disadvantaged populations including Aboriginal and Torres Strait Islander peoples, refugees and migrants, older Australians and those with serious mental health conditions. Their significant reach and wide-ranging skills makes the nursing profession the most efficient and effective means of delivering and coordinating chronic disease prevention and management in Australia.

To date, governments have unfortunately missed the opportunity to take full advantage of the value offered by the nursing workforce. Part of this missed opportunity stems from governments' relative inability to keep up with the evolving roles of nurses, which requires suitable policies and funding to see their potential fulfilled.

Emerging health needs, especially those presented by the wide range of chronic conditions existing in the Australian community, have continuously acted as a trigger for the development of nursing roles and responsibilities. For example, nurses act as care coordinators for people with chronic heart failure, diabetes and chronic obstructive pulmonary disease (COPD), applying prevention and management strategies that work to keep people well and out of hospital.<sup>5,6,7</sup> Other significant roles involve nurses working in

---

<sup>3</sup> Nursing and Midwifery Board of Australia. Nurse and Midwife registrant data: March 2015.

<sup>4</sup> Health Workforce Australia 2014, Australia's future health workforce-nurses detailed.

<sup>5</sup> Chan, Y-K, Stewart, S, Calderone, A, Scuffham, P, Goldstein, S, Carrington, MJ, et.al. 2012 'Exploring the potential to remain "Young@Heart": Initial findings of a multi-centre, randomised study of nurse-led, home-based intervention in a hybrid health care system', *International Journal of Cardiology*, vol. 154, pp. 52-58.

<sup>6</sup> Sutherland, D, & Hayter, M, 2009, 'Structured review: evaluating the effectiveness of nurse case managers in improving health outcomes in three major chronic diseases' *Journal of Clinical Nursing*, vol. 18, pp. 2978-2992.

<sup>7</sup> Wherry, S-A & Jones, A, 2014 'Isolated practice: Reflections of a Parkinson's nurse', *The Hive*, Summer 2014/15, pp. 18-19.

the aged care, cancer, mental health, and Aboriginal and Torres Strait health areas where chronic disease rates are highest, or in maternal, child and family health nursing where the opportunity for primary prevention is greatest. Moreover, nurses in general practice and other primary health care settings work across the full spectrum of chronic disease areas playing pivotal roles in the creation of a 'no wrong door' system that works to treat people efficiently and seamlessly.

Many of these roles have however been limited, to date, in their capacity to engender wide-scale effect due to inadequate or misaligned policy and funding support from governments. Nonetheless, there is an opportunity for government to review and reform some of its policies and funding allocations in a way that enhances the models of nursing care that are already in practice, as well as explore innovative ways of providing nursing care. By supporting nurses to work to their full scope of practice, governments have the opportunity to advance efforts in stemming the country's high and rising rates of chronic disease.

**Recommendation one**

The Australian Government consider the full breadth of primary health care services when informing its policy development and funding allocations, with a view to promoting coordination and integration amongst them. This includes, in addition to general practice, services that are funded and delivered by state, territory, and local governments, and non-government organisations.

**Recommendation two**

The Australian Government's primary health care policy and funding allocations take into account the contribution that nurses from all settings, and at all levels of professional development, make in the provision and coordination of chronic disease prevention and management in primary health care. The Australian Government should look for, and act on, opportunities to enhance this role and contribution.

## 2. Preventing chronic disease through addressing the social determinants of health

The most effective, efficient, equitable and sustainable way to address the high and rising rates of chronic disease in Australia is by addressing the social determinants of health (SDH), which are often the key contributors to the development and advancement of chronic disease.

The SDH refer to the conditions and opportunities associated with education, employment, income, housing, food security, transport, physical spaces, gender, culture, social inclusiveness, racism, connection to land, incarceration and the environment, among others.<sup>8</sup> People's health outcomes are much more strongly influenced by these conditions and opportunities than by access to health care alone. Research demonstrates, for example, that between one third and one half of the gap in life expectancy between Indigenous and non-Indigenous Australians can be explained by differences in the SDH.<sup>9</sup> Poor education and literacy is linked strongly to low income and poor health status; smoking, overweight and obesity, and other chronic disease risk factors are strongly associated with low socio-economic status; and poverty reduces access to health care services and medicines, further exacerbating already at risk populations.<sup>10,11,12</sup>

In its report *Closing the Gap in a Generation*, the World Health Organisation's Commission on the Social Determinants of Health points out that there is no biological reason why there should be significant differences in life expectancy between social groups in any given country. These differences are driven by the conditions in which people live.

This is nowhere more apparent in Australia than in the conditions and associated health outcomes that Aboriginal and Torres Strait Islander peoples experience. On all of the SDH measures, Aboriginal and Torres Strait Islander peoples suffer substantial disadvantage.

---

<sup>8</sup> Carson B, Dunbar T, Chenhall RD, Bailie R, eds. 2007. *Social determinants of Indigenous health*. Crows Nest, NSW: Allen and Unwin.

<sup>9</sup> Booth, A & Carroll, N 2005, *The health status of Indigenous and non-Indigenous Australians*, Centre for Economic Policy Research, Australian National University, Canberra; DSI Consulting Pty Ltd & Benham, D 2009, *An investigation of the effect of socio-economic factors on the Indigenous life expectancy gap*, DSI Consulting Pty Ltd.

<sup>10</sup> Marmot, M and Wilkinson, R (eds) 1999. *Social Determinants of Health*, Oxford University Press, New York.

<sup>11</sup> Marmot M. 2004. *The status syndrome: how social standing affects our health and longevity*. New York: Holt Paperbacks.

<sup>12</sup> Marmot M. 2003. *Social determinants of health: the solid facts*. Denmark: World Health Organisation



Moreover, there are many other factors that influence Aboriginal and Torres Strait Islander people's engagement with, and early presentation for, health care. These include the availability of culturally appropriate services, and access to Aboriginal or Torres Strait Islander health professionals.

Aboriginal and Torres Strait Islander people achieve better health outcomes when Aboriginal and Torres Strait Islander health professionals care for them.<sup>13</sup> The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* highlights the need for a sound primary health care system that is capable of addressing the health needs of Aboriginal and Torres Strait Islander people, particularly the high prevalence of chronic disease that many experience. The plan also identifies the opportunity for the Aboriginal Community Controlled Health Sector to provide leadership in the development of culturally competent services across the broader health sector. Well-structured placements in the Aboriginal Community Controlled Health Sector for nurses undertaking undergraduate or postgraduate education would increase the health care system's capacity to provide culturally appropriate services. Such placements would also enable Aboriginal and Torres Strait Islander people to identify nursing and midwifery as a viable career opportunity.

The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* articulates a vision whereby the Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address the social determinants of health this plan provides the necessary platform to help realise health equality by 2031. A key priority of the plan is a robust, strong, vibrant and effective community controlled health sector.

Governments have both a moral and economic imperative to address the SDH. The National Centre for Social and Economic Modelling (NATSEM), for example, reports that if the Australian Government was to implement the recommendations made in the WHO Commission's report<sup>14</sup>:

- 500,000 Australians could avoid suffering a chronic illness;

---

<sup>13</sup> Australian Government Department of Health. *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, Canberra.

<sup>14</sup> NATSEM. 2012. *The cost of inaction on the social determinants of health*. The University of Canberra.

- 170,000 extra Australians could enter the workforce, generating \$8 billion in extra savings;
- Annual savings of \$4 billion in welfare support payments could be made;
- 60,000 fewer people would need to be admitted to hospital annually, resulting in savings of \$2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of \$273 million; and
- 5.3 million fewer Pharmaceutical Benefits Scheme scripts would need to be filled each year, resulting in annual savings of \$184.5 million.

An Australian Senate Committee undertook an *Inquiry into Australia's domestic response to the World Health Organisation's Commission on the Social Determinants of Health Report 'Closing the Gap in a Generation'* in 2012. It found that Australia was not doing enough to sufficiently address the SDH. Specifically, it indicated that 'there was little evidence to support the notion that the Australian Government, through the Department of Health, was taking an adequate approach in responding to the Report's recommendations'.

The Senate Committee recommended at the completion of its Inquiry that:

- The Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context.
- The Government adopt administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities.
- The NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinants research.

Underpinning this approach to health equity and outcomes, and that to which the second recommendation refers, should be a Health in All Policies (HiAP) model of public governance – a recommendation made frequently by those who provided submissions to the Senate Committee Inquiry. The South Australian Government implemented its HiAP model in 2007, providing an example of how other Australian governments might look to design and implement their own.

In addition to governments having a fundamental role to play in addressing the SDH through public policy, clinicians can also play an important role in addressing the SDH at the level of the individual or family. Nurses in particular have an opportunity through their holistic approach to care to identify SDH-related problems affecting people they see. And through their role as care coordinators, nurses are able to offer people care that includes linking them up with services beyond the usual clinical setting such as employment and housing services. This type of care already occurs in a number of existing health service models, such as through Aboriginal Community Controlled Health services and the Mental Health Nurse Incentive Program (MHNIP), which are described in more detail in the appendix.

Specifically, these models adopt a holistic approach to care where nurses and Aboriginal and Torres Strait Islander health workers partner with their clients to identify, and subsequently link them with, the types of services that are required to address a person's comprehensive needs. This may include, for instance, referring them to, and coordinating their care between, family violence, drug and alcohol, employment, and housing services, in addition to clinical care. Nurses also contribute to addressing the SDH through their roles in schools, workplaces, and other non-clinical settings, where, among other things, they provide education, advice, support, and referral options.

While this role is well within the nursing scope of practice, currently it may often be beyond nurses' work capacity in general health care settings. MCaFHNs, for example, currently work in a range of comprehensive care settings to improve health outcomes for children and families,<sup>15</sup> prevent disease and illness, and modify the effects of chronic disease that can occur following low birth weight.<sup>16</sup> However, their scope of practice is often constrained by disparate jurisdictional/national funding priorities for primary care. Where there is clear evidence that early intervention in the form of comprehensive care, incorporating the SDH, can reduce a host of physical and psychological diseases<sup>17,18</sup> and result in the highest rates of economic return for human capital investment, there is an imperative to uniformly

---

<sup>15</sup> Fraser, S., Grant, J. and Mannix, T.G. 2014. The role and experience of Child and Family Health Nurses in developed countries: A review of the literature. *Neonatal, Paediatric and Child Health Nursing*, 17(3) pp. 2-10.

<sup>16</sup> Schmied, V., et al. 2011. *National Framework for Universal Child and Family Health Services*. Canberra, Australian health Ministers Advisory Council.

<sup>17</sup> Shonkoff, J. 2000. *From Neurons to Neighbourhoods: The Science of Early Childhood*.

<sup>18</sup> Shonkoff J. 2011. 'Building a Foundation for Prosperity on the Science of Early Childhood Development', *Pathways Winter*, pp. 10-15.

increase the capacity of MCaFHNs to undertake these roles.<sup>19</sup> For nurses to proactively address the SDHs, they require supportive government funding and policy arrangements, such as those that recognise the breadth and potential of their skills set, and which enable them to work to their full scope of practice.

#### **Recommendation three**

The Australian Government re-examine the recommendations of the World Health Organisation's Commission on the Social Determinants of Health Report '*Closing the Gap in a Generation*', as well as those of the Australian Senate Committee's *Inquiry into Australia's response to the Report (2012)*, with a view to their implementation.

#### **Recommendation four**

The Australian Government re-examine the recommendations of the Report of the *National Review of Mental Health Programmes and Services* with a view to their implementation.

### **3. Elements of best practice chronic disease prevention and management models**

The foundations for a healthy life are laid in infancy and early childhood.<sup>20</sup> This is where chronic disease prevention begins. There are numerous best practice models of chronic disease prevention and management being used in the primary health care sector, both nationally and internationally. Common among them are key elements essential to the development, implementation, support and effectiveness of any chronic disease model. A chronic disease prevention and management model must:<sup>21,22</sup>

- start early and continue throughout life
- be consumer-centred, where the consumer and their carer (where appropriate) are equal partners in the decision making about care processes and outcomes to be achieved

<sup>19</sup> Productivity Commission 2011, 'Early Childhood Development Workforce', Research Report, Melbourne.

<sup>20</sup> Mustard, F. 2008. Investing in the early years: Closing the gap between what we know and what we do. Adelaide, Department of the Premier and Cabinet.

<sup>21</sup> Morgan M. et al. 2013. The TrueBlue model of collaborative care using practice nurses as case managers for depression alongside diabetes or heart disease: a randomised trial. *BMJ Open* 3.

<sup>22</sup> Von Korff M. et al. 1997. Collaborative management of chronic illness. *The Annals of Internal Medicine*, 127(12), pp. 1097-1102.

- ensure consumer self-determination is central to the care planning process through the provision of adequate information, education, aids, and support
- be multidisciplinary in nature, where each health and social care professional is an equal partner in the health care team and works to their full scope of practice
- involve a care coordinator who has primary responsibility for connecting the consumer's services, as well as for communicating with, and supporting the consumer in a way that promotes their health and wellbeing
- promote family/carer involvement as part of the health care team wherever possible
- be supported by a funding model that recognises and fairly remunerates the work of the entire health care team, including nurses; supports team collaboration, and rewards improved health outcomes
- be supported by information and communication technology (eHealth), which promotes access, coordination, safety and quality, and cost-effectiveness
- fit within a broader population health framework which is based on prevention, health promotion, and addressing the social determinants of health.

#### **Recommendation five**

The Australian Government's funding for and/or support of chronic disease prevention and management models include the essential elements listed above.

Appendix 1 offers examples of models of chronic disease prevention and management. Some models have demonstrated their effectiveness through formal evaluation and should be considered for expansion. Other models presented in the appendix have not yet undergone formal evaluation but are showing signs of effectiveness and should therefore be supported, monitored, and evaluated for potential expansion.

#### **4. Opportunities for the Medicare payment system to encourage and reward best practice and quality improvement in chronic disease prevention and management**

There is an opportunity for Medicare to support best practice chronic disease prevention and management by structuring remuneration in a way that promotes preventative, high quality, multidisciplinary care. Quality chronic disease prevention and management is, on

most occasions, best delivered through a multidisciplinary primary health care team which will often include a GP, nurse, pharmacist, and allied health providers, such as physiotherapists, occupational therapists, dietitians, podiatrists, and social workers, among others. For these providers to work as a collaborative unit, and in so doing 'wrap' care around the consumer to ensure a seamless, efficient, and holistic care experience, all providers must have the financial and other supports needed to communicate, deliberate, plan, and evaluate together, as well as work to their full scope of practice.

The fee-for-service model currently used to fund general practice services inhibits the efficient and effective prevention and management of chronic disease for three fundamental reasons: (1) it incentivises providers to provide a high volume of services, which may not always be necessary or best practice, and which risks driving up health care costs unnecessarily;<sup>23,24</sup> (2) it does not incentivise providers to prevent illness; in fact it does the opposite: the more that people are unwell, the more that services are required, and the more that providers are able to generate revenue (that is not to say that providers neglect providing preventive care in the interests of revenue, simply that the current funding model theoretically incentivises such behaviour); and (3) it does not adequately support the coordination and integration of multidisciplinary care.

Medicare recognises the need for collaboration in the prevention and management of chronic disease in the way that it remunerates GPs under the chronic disease management (CDM) MBS items. Specifically, GPs are remunerated for preparing a GP Management Plan (GPMP) (item 721); coordinating the preparation of Team Care Arrangements (TCAs) – involving a team of at least three health professionals or care providers (item 723); reviewing a GPMP (item 732); coordinating a review of TCAs (item 732); contributing to, or reviewing, a multidisciplinary care plan that has been developed by another provider (item 729); and for organising and coordinating, or participating in, a multidisciplinary case conference (items 735, 739, 743, and 747, 750, and 758, respectively).

---

<sup>23</sup> The National Commission on Physician Payment Reform. 2013. *Report of the National Commission on Payment Reform*, accessed 19 July 2015, < [http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician\\_payment\\_report.pdf](http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf) >

<sup>24</sup> Orszag P. L. & Ellis P. 2007. Addressing rising health care costs – A view from the Congressional Budget Office. *The New England Journal of Medicine*, 357(19), pp. 1885-1887.

Non-GP health care team members, on the other hand, (e.g. privately practicing nurse practitioners, and allied health providers) are not remunerated for providing the same service, i.e. they are expected to develop, review, and contribute to consumer care plans, and to communicate and coordinate with other health care team members, for free and in their own time. This is highly inequitable and hinders coordination and collaboration between health providers, leading to sub-optimal care for consumers and to inefficiencies, gaps, duplications, and waste for the health care system.

Moreover, the current CDM MBS items lack incentive to keep people well and engaged in their health care. CDM MBS items focus on processes rather than outcomes, which creates the risk of them being merely 'tick the box' exercises with little encouragement for the health professional to oversee the plan's implementation. This may be overcome by requiring that consumers sign-off on their management plans to indicate that the plan has been explained to them and that they understand it, before the health professional is able to claim a management plan MBS item. An outcomes-based pay-for-performance measure (discussed further below) might also be introduced as an incentive for the health professional to support and encourage the consumer to implement the plan, and thus improve their health.

#### *Broad health and social care funding reform*

We support the Government's current review into the Medicare system, believing that there are opportunities to better direct funding in a way that more effectively supports and encourages best practice chronic disease prevention and management. We are concerned, however, that the review will not go far enough in investigating opportunities for reform. Specifically, we believe that work should be undertaken to map and delineate the roles and responsibilities of all relevant health and social care funders and providers, especially all tiers of government, in order to achieve long-term integration and efficiency in the health system. This would involve identifying what role Medicare has as a funding mechanism within the broader health system, what role it currently plays, and what role it should play, alongside other funding and administrative arrangements, such as those managed by state, territory, and local governments.

This issue is particularly pertinent to maternal, child and family health nurses, for instance, who are currently funded under a range of non-Medicare, state, territory and local systems. Maternal, child and family health nurses play a critical role in chronic disease prevention which will be rendered invisible if a narrow focus is applied to Medicare reform.

A narrow focus on Medicare may also miss the opportunity to identify areas for potential reform in the Aboriginal and Torres Strait Islander health sector. Currently, Aboriginal and Torres Strait Islander health services are funded through a number of different funding streams, some of which sit outside Medicare. These funding streams may not always be very well resourced, structured, coordinated, or targeted, meaning that inefficiencies, poor cost-effectiveness, and missed opportunities for population health improvements, and health workforce reform, can result. A wider review into health financing would allow governments to ensure that health funding that goes into the Aboriginal and Torres Strait Islander health sector is working to achieve the best possible outcomes for Aboriginal and Torres Strait Islander peoples.

Further, we are concerned that the Medicare review's 'three priority areas' are unduly medically focused. Any future funding reform agenda should aim to link services in a holistic manner which works to create a seamless consumer journey through both the health and social care systems, irrespective of the source of funding, or of the services needed, i.e. it should aim to create a 'no wrong door' system of health and social care services. For example, it is possible that one person with chronic disease may be required to move between a state-funded hospital, state-funded community rehabilitation service, a private general practice, a private allied health provider, a local government funded drug and alcohol program, and an NGO (grant funded) mental health service provider. Currently, the lack of communication, coordination, and collaboration between these services, driven in part by siloed funding models, creates gaps, inefficiencies, waste, duplication, poor patient experiences and poorer health outcomes. Greater delineation of roles and funding streams would allow for a process of coordination, integration, and streamlining, which would help overcome many of these issues.

Examples of joined up services, supported through one funding stream, can be seen in some state-run health and social care services, such as the Health Independence Program (HIP)



run out of Werribee Mercy Hospital in Victoria – discussed further in the appendix. The HIP has integrated six teams into one, involving 35 health professionals working collaboratively as a single team. It includes numerous types of specialist nurse, such as an emergency nurse practitioner, mental health nurse, diabetes nurse educator, respiratory nurse, cardiac nurse, and a social worker. The block funding arrangement supports the team to work collaboratively, such as by covering the time they take to case conference; it allows them to tailor the care to the consumer's needs and preferences, such as by delivering a group appointment; and it allows the consumer to receive the care they need, e.g. diabetes education from the diabetes nurse educator, and advice on and coordination of social services from the social worker, all without needing to re-tell their story multiple times, navigate a complex array of siloed services, or having to worry about which service charges a fee, and whether that fee will be affordable.

#### *A blended funding model for general practice services*

There is an opportunity to overcome some of the challenges that the current blended funding model for general practice services with its large fee-for-service component poses for the effective management of chronic disease. Australia has been employing various forms of blended funding models for more than a decade, with the practice and service incentive payment programs (PIPs and SIPs) demonstrating positive effects in some instances. One example of this is the General Practice Immunisation Incentive program (GPII) which helped lift Australia's childhood immunisation rate from approximately 50% in the late 1990s up to approximately 90% in the early 2000s.<sup>25</sup>

Australia recently experimented with a more robust form of blended funding model through its Australian Government commissioned Diabetes Care Project (DCP), which ran as a pilot from 2011-2014. The pilot tested five new components alongside existing models of care:

- an integrated information platform for GPs, allied health professionals, and patients
- continuous quality improvement processes informed by data-driven feedback
- flexible funding based on patient risk stratification - risk was determined according to the complexity of patients' health condition(s). Under flexible funding, general

---

<sup>25</sup> KPMG Consulting 2000. *Evaluation of the General Practice Immunisation Incentives scheme*. Report prepared for the Australian Government Department of Health, Canberra.

practices received annual payments quarterly. These payments funded services such as team care related activities and care delivered by health professionals other than GPs, replacing a number of general practice MBS items and allied health MBS items. This was a hybrid system with a component of population-based funding and a component of activity-based funding

- quality improvement support payments linked with a range of patient population outcomes
- funding for care facilitation, provided by dedicated Care Facilitators.

The pilot was a cluster randomised controlled trial (RCT) with two intervention groups and a control. Group one received only the first two of these care components (i.e. no funding changes), while group two received all five components. Patients in group two registered with a given general practice. The recently released DCP Evaluation Report found that group two showed a statistically significant improvement in HbA1c (blood sugar) levels – the primary clinical endpoint of the trial – of 0.2 percentage points compared to the control group. Group two also demonstrated significant improvements in blood pressure, blood lipids, waist circumference, depression, diabetes-related stress, care-plan take-up, completion of recommended ‘annual cycles of care’, and allied health and practice nurse visits. In contrast, group one did not improve on any of these metrics (with the exception of care-plan take-up). It is also worth noting that general practice nurses were found to use the patient support IT tool in these pilots five times more often than GPs, demonstrating the key role that nurses play in engaging with and coordinating the care of people with chronic disease.

The evaluation notes that, while costs were \$203 higher per person, per year, for group two compared to the control, these costs were offset by a reduction in the cost of hospitalisations – especially potentially preventable hospitalisations – of \$461 per person, i.e. a net benefit of \$258 per person, per year, from reduced hospitalisations alone. Further analysis into other cost implications, such as how the model might affect medication use, productivity, and reliance on welfare, may further demonstrate greater cost benefits – in addition to the inherent social and psychological benefits of improved health outcomes.

Importantly, the evaluation found that improved information technology and continuous quality improvement processes were not, on their own, sufficient to improve health outcomes. They required the payment reform mechanisms, 'which when combined, made a significant difference'. The evaluation recommends that 'the current chronic disease care funding model be changed to incorporate flexible funding for registration with a health care home, payment for quality, and funding for care facilitation.'<sup>26</sup>

There are numerous examples of where blended primary health care funding models have been in use over a number of years, including in New Zealand, the UK, Belgium, Ontario, Canada, and a number of managed care organisations in the US. A study on Belgium's experience, for instance, finds that the population-based component leads to a high degree of accessibility, especially for vulnerable people, no adverse risk selection, a reduction in the use of resources in secondary care, a reduced need for medication, and the quality of care is at least as good as, or better than, in the fee-for-service system.<sup>27</sup>

Under a reformed blended funding model, funds from the population-based component could be used to remunerate other health care professionals who participate in the care of the enrolled patient, such as participation in case conferencing for a private nurse practitioner, podiatrist, or dietitian. It is in the GP's interest to involve all relevant health care team members to ensure the patient receives the best possible care and improves their health, which would lead to a reduced need for additional health services, and in turn make more money available to invest in the practice and the care of its patients.

A reformed blended funding model, through its population-based component, would better support non-face-to-face communication and consultation between the health provider and consumer, such as through email and telephone. In addition to increasing efficiency through this type of consult, which reduces costs to both the health provider and consumer, it would also increase service access, and support consumers to be more engaged in their health care.

---

<sup>26</sup> Australian Government Department of Health. 2015. Evaluation Report of the Diabetes Care Project, 2015, Canberra.

<sup>27</sup> Ryssaert L. et al. 2013. An integrated comprehensive needs-based capitation system to enhance quality of primary care. *International Journal of Integrated Care 2013, EFPC Conference Supplement*.

Moving to a reformed blended funding model for general practice services, which includes a combination of population-based fixed funding, fee-for-service, and pay-for-performance, would require further engagement and discussion with all relevant stakeholders in order to determine the best model for Australia. This would include the research community, health care providers, and consumers.

### *Nurse remuneration*

There is an opportunity to improve consumer access to primary health care services and create greater efficiency in the health system by ensuring that nurse remuneration – including for general practice nurses, specialist nurses, and nurse practitioners – is commensurate with their skills and expertise, and the value they add to the health system. Evidence suggests, for example, that specialist nurses can generate significant savings for the health system as a result of lower hospital admissions and days in hospital. In the UK, for instance, where Parkinson’s disease community nurses have been a prominent feature of the primary health care sector for more than 20 years, it is estimated that over a 12 month period, *one* Parkinson’s nurse saves the health system:<sup>28</sup>

- £43,812 (\$91,237) in avoided consultant appointments
- £80,000 (\$166,529) in unplanned hospital admissions
- £147,000 (\$305,973) in days spent in hospital

This is in addition to evidence demonstrating that clinical outcomes for people either remain the same, or are improved, when being treated in a nurse clinic (by a specialist nurse or nurse practitioner) compared with usual treatment in a general practice.<sup>29,30</sup> And that in many cases, consumer satisfaction is higher due to nurses often spending more time with their clients, providing them with more information, and being more flexible in tailoring their care; responding to the client’s needs, values, and preferences.<sup>31,32</sup>

---

<sup>28</sup> Dugdale P., Ironside J. & Raines T. 2014. *Chronic Disease Management Annual Performance Report 1 July 2013-30 June 2015*. Canberra Hospital and Health Services.

<sup>29</sup> Denver E. et al. 2003. Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with Type 2 Diabetes. *Diabetes Care*, 26(8), pp. 2256-2260.

<sup>30</sup> Morcom J. et al. 2005. Establishing an Australian nurse practitioner-led colorectal cancer screening clinic. *Gastroenterology Nursing*, 28(1), pp. 33-42.

<sup>31</sup> Jarman B. et al. 2002. Effects of community based nurses specialising in Parkinson’s disease on health outcome and costs: Randomised controlled trial. *British Medical Journal*, 324:1072.

Despite the known benefits that nurses provide to both consumers and the health system, they are unduly restricted and undervalued in their arrangements with Medicare. Privately practicing nurse practitioners, who provide an effective alternative to some general practice services in the prevention and management of chronic disease,<sup>33</sup> are unable to perform Medicare eligible services unless they have a formal collaborative arrangement with a medical practitioner – a requirement that is not imposed on any other profession. Moreover, they are restricted in their access to the MBS to four time-tiered face-to-face, one-on-one consultation items; they are not remunerated for coordinating a person’s care, or for collaborating with other health care team members, such as when participating in a case conference (something that GPs are remunerated for); they are unable to refer patients to Medicare eligible allied health services; they are not remunerated for outreach clinical services (significantly restricting access for less mobile people – for example those suffering from mental health conditions which severely limit their ability to leave their home); and their Medicare rebates are not commensurate with their expertise or with other professionals at similar levels of specialisation. For example, a nurse practitioner is remunerated through Medicare for level A, B, C, and D consultations at \$8.20, \$17.85, \$33.80, and \$49.80,<sup>34</sup> respectively, whilst for the same consultation times, a GP is paid \$16.95, \$37.05, \$71.70, and \$105.55,<sup>35</sup>. General practitioners are paid more than double what a nurse practitioner receives through Medicare, despite them very often providing the same service, which requires the same level of skill and expertise.

This inequity also occurs between nurses and some allied health providers. Mental health nurse practitioners (MHNPs), for instance, are entitled to the level D (40+ min) consultation as a maximum, which is paid at \$49.80. This is despite face-to-face consultations often taking between 60-90 minutes; something that is recognised in the way that clinical psychologists are remunerated under Better Access, where 50+ min items are available. Furthermore, clinical psychologist MBS items are valued at \$84.80 (30+ min) and \$124.50 (50+ min) (\$145.65 if the consult occurs outside of a consulting room). Not only does this

---

<sup>32</sup> Kinnersley P. et al. 2000. Randomised controlled trial of nurse practitioner versus general practitioner care for patients request “same day” consultations in primary care. *British Medical Journal*, 320(7241), pp. 1043-1048.

<sup>33</sup> Kinnersley P. et al. 2000. Randomised controlled trial of nurse practitioner versus general practitioner care for patients request “same day” consultations in primary care. *British Medical Journal*, 320(7241), pp. 1043-1048.

<sup>34</sup> Factoring in the fact that NPs are only reimbursed for 85% of the MBS item, compared to GPs’ 100%.

<sup>35</sup> These remuneration figures are for a vocationally registered GP.

inequity degrade the value that MHNPs represent in the health system, it also undermines the financial viability of running a private practice.

This remuneration system is completely at odds with the Government's intent to better prevent and manage chronic disease in the community – something that unequivocally requires nurse coordinated, multidisciplinary care to be done efficiently, effectively, and sustainably. Until wider funding reform is achieved, the Australian Government should increase the number and value of nurse practitioner Medicare items to (1) increase access to chronic disease prevention and management services for consumers; (2) relieve some of the burden unnecessarily placed on medical practitioners; (3) reduce health care costs; and (4) adequately recognise the skills, expertise, and contribution that nurse practitioners make to the health system, and to the population's health outcomes. Alternatively, nurse practitioner and other nursing services in primary health care could also be supported through grants or block funding.

**Recommendation six**

The Australian Government widen the scope of its current review into Medicare to examine how Medicare/government funding can support the integration of a more comprehensive suite of services, including community-based social services, aged care, and disability services.

**Recommendation seven**

The Australian Government widen the scope of its current review into Medicare to examine and propose options for a reformed, blended primary health care funding model, including a transition plan.

**Recommendation eight**

In the interim of a wider Medicare review and reform process, the Australian Government create access to, broaden, and increase the value of MBS items for nurses as a way of increasing access to chronic disease prevention and management services in primary health care. Alternatively, nursing services in primary health care could be supported through grants or block funding.

**Recommendation nine**

In the interim of a wider Medicare review and reform process, the Australian Government create, or modify, MBS items to remunerate health professionals for non-face-to-face consultations, including by email and telephone.

**Recommendation ten**

In the interim of a wider Medicare review and reform process, the Australian Government fund the Aboriginal community controlled sector at a level that enables growth, and which supports the provision of comprehensive primary health care. This will enable the sector to effectively manage and prevent chronic disease in Aboriginal and Torres Strait Islander communities, as well as in other disadvantaged populations.

## **5. Opportunities for Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care**

Primary Health Networks (PHNs) have a fundamental role to play in commissioning and coordinating chronic disease prevention and management services. Specifically, they have a role to play in undertaking comprehensive needs assessments, building on the work of the Medicare Locals before them, and the Australian National Preventive Health Agency (ANPHA), in order to identify the health needs of their respective populations. PHNs should also have responsibility to plan, coordinate, fund, and where necessary, deliver, chronic disease prevention and management programs. Importantly, this must involve a purview that extends beyond clinical care to also address social needs, such as by partnering with local stakeholders to address issues around education, employment, food security, transport, physical spaces, and the environment. This coordination would involve working with all sectors, including Commonwealth, state and territory, and local governments, not-for-profits, and the private for-profit sector.

PHNs have a role to play in supporting both providers and consumers in the uptake and use of eHealth technology. This would include secure messaging, which allows health care providers to communicate securely with consumers and other providers, telehealth, which allows for increased access, system efficiencies and reduced health care costs, and the

electronic health record, which promotes care quality and safety, and supports consumer engagement. In addition, PHNs can assist practices in the adoption and use of continuous quality improvement tools, such as clinical decision support software, and with population health planning programs, which can assist with planning and evaluating health interventions.

To date, government has made sound investment in the design and rollout of some eHealth systems, including the electronic health record. We strongly support this initiative and encourage its continued investment and rollout. In addition, government should look to better support, engage with, and invest in, other eHealth measures. The first step would be to examine and subsequently implement a primary health care funding model that would support and encourage health professionals to use eHealth, such as remuneration for email and telephone consults, and communication and planning activities between health care team members. Much of the support for the introduction and use of eHealth systems in primary health care could be channelled through the PHNs, such as through promoting the availability and qualities of technologies to health care practices, and providing education, training, and support to health professionals regarding their use.

PHNs have a role to play in supporting continuous quality improvement (CQI), such as through funding and coordinating research, and collecting and disseminating information on best practice. PHNs can work with clinics/practices and other relevant stakeholders – e.g. the Australian Commission on Quality and Safety in Health Care, Local Hospital Networks (LHNs), and state and territory governments – to help ensure best practice implementation, measurement, and evaluation. They also have a role to play in supporting ‘grass-roots’ clinical networks, such as the Mental Health Professionals Network and other ‘hub and spoke’ specialist networks, which provide clinicians with opportunities for professional development, support and communication. Moreover, they have a role to play in supporting and coordinating local-level CQI initiatives, such as the Australian Primary Care Collaboratives (APCC), which have been demonstrating significant practice improvements in the prevention and management of chronic disease over a number of years.<sup>36</sup>

---

<sup>36</sup> APCC. Program Results. Accessed 17 July 2015, [http://www.apcc.org.au/about\\_the\\_APCC/program\\_results/](http://www.apcc.org.au/about_the_APCC/program_results/)



For PHNs to undertake their clinical responsibilities effectively, it is paramount that nurses be included in their proposed 'clinical committees'. These committees are being mandated with providing expertise and advice to PHNs on matters relating to clinical governance and service provision, yet we understand that they will be 'led by GPs', with the 'involvement of other health professionals'. This medically focussed approach to health care planning and governance is anachronistic and misaligned with the way that health care needs and best practice service provision have evolved.

Evidence demonstrates that safety and quality in health care must be addressed at a systems level rather than the level of individual health professional or individual service.<sup>37</sup> Membership of any clinical committee must therefore reflect the multidisciplinary nature of health care delivery. This approach would make it more likely that the clinical committees include the input of all health professions involved, and takes account of governance issues at an overall systems level. Further, clinical committees with strong multidisciplinary leadership may help avoid the well documented pitfall of professional groups focussing on improvements in their own care delivery, rather than working together to achieve improvements in the wider health care approach needed to effectively prevent and manage chronic disease.<sup>38</sup>

Moreover, given that much of primary health care is either delivered outside of general practice, or by a health professional other than a GP within general practice (very often the general practice nurse), and that PHNs have responsibility for *primary health care* (as opposed to merely general practice), having nurses well represented on the clinical committees, or in any other fora related to policy development, governance, and health service design, is critical. This would also involve nurses and other clinicians from settings such as community health centres, Aboriginal controlled community health services, schools, workplaces, aged care facilities, and NGO funded/delivered primary health care services.

---

<sup>37</sup> Leape, L, Berwick, DM & Bates, DW 2002, 'What practices will most improve safety? Evidence-based medicine meets patient safety', *JAMA*, 288(4) pp.501-507.

<sup>38</sup> Berwick, DM, 1996, 'A primer on leading the improvement of systems'. *BMJ*, 316, pp.619-622.

### **Recommendation eleven**

The Australian Government mandate and support Primary Health Networks to partner with health and social care services to help address the social determinants of health, including through the coordination and integration of inter-sectoral services.

### **Recommendation twelve**

The Australian Government mandate and support Primary Health Networks to promote the uptake and use of eHealth technology, by both practices and consumers, such as the electronic health record, secure messaging, telehealth, and practice and consumer support software/technology.

### **Recommendation thirteen**

The Australian Government require that Primary Health Networks have nurse representation on their Clinical Committees, or any other fora relating to policy development, governance, and health service delivery.

## **6. The role of private health insurers in chronic disease prevention and management**

Private health insurers (PHIs) have an important role to play in the provision and coordination of chronic disease prevention and management, both for their members and the broader public. For their members, PHIs are already demonstrating activity in the prevention and health promotion space, undertaking initiatives such as offering gym memberships at reduced cost, providing health counselling/coaching, health assessments, care coordination, health information and education, telehealth, and a 24 hour nurse hotline.<sup>39,40,41,42</sup> PHIs should be encouraged and supported to take this type of preventative approach to health care.

---

<sup>39</sup> Biggs A, 2013, *Chronic disease management: the role of private health insurance*, Research Paper, 2013-14, Parliamentary Library, Canberra, viewed 16 July 2015, <[http://parlinfo.aph.gov.au/parlInfo/download/library/prspub/2763103/upload\\_binary/2763103.pdf;fileType=application/pdf](http://parlinfo.aph.gov.au/parlInfo/download/library/prspub/2763103/upload_binary/2763103.pdf;fileType=application/pdf)>

<sup>40</sup> Medibank 2015, Introducing Mi Health: Looking after your health just got easier, Medibank Private Limited, viewed 16 July 2015, <<http://www.medibank.com.au/health-insurance/mi-health/>>.

<sup>41</sup> Bupa 2015, Gym memberships, Bupa Australia Pty, Queensland, viewed 16 July 2015, <<http://www.bupa.com.au/health-and-wellness/programs-and-support/living-well-programs/gym-memberships>>.

Exacerbations of chronic health conditions often require that individuals are hospitalised. PHIs should be encouraged to actively ensure a smooth transition from private hospital to the community setting for their members, and that care for any chronic condition is followed up appropriately. This involves ensuring that private hospitals have effective discharge planning services in place, which will allow members to experience a seamless transition from one care setting to another, in turn providing high quality care and helping to prevent re-hospitalisation.

In addition to providing benefits for their members, PHIs have an opportunity to provide benefits to the broader public. As a publicly subsidised industry, and given that some PHIs are playing a role in the new publicly funded PHNs, PHIs should be obligated to work with public sector bodies to ensure both efficiency and effectiveness in the system. For example, PHIs could provide de-identified population health data from their members for input into PHN comprehensive needs assessments. They could also provide evaluation results from their chronic disease interventions to feed into the chronic disease prevention and management evidence base. More generally, they should be communicating with other elements of the private and public health system (e.g. general practices) to ensure there is no duplication, inefficiency, or waste in service provision between the two sectors.

#### **Recommendation fourteen**

The Australian Government obligates private health insurers to collaborate with other parts of the health sector to help ensure efficiency and effectiveness in the system, such as through data sharing.

## **7. The role of State and Territory Governments in chronic disease prevention and management**

State and territory governments play a significant role in the funding and provision of chronic disease prevention and management services. For example, services such as state-funded community health centres, drug and alcohol, child and family health, family

---

<sup>42</sup> Bupa 2015, The Coach Program, Bupa Australia Pty, Queensland, viewed 16 July 2015, <<http://www.bupa.com.au/health-and-wellness/programs-and-support/member-support-programs/the-coach-program>>.

planning, and school prevention and health promotion initiatives are all critical to preventing and managing chronic disease in primary health care.

Moreover, state and territory governments are key in any effort to better coordinate and integrate care between the acute hospital and primary health care settings. Examples of this can be seen in the appendix below which highlights Victoria's Hospital Admission Reduction Program (HARP). HARP, which demonstrates significant success in reducing hospital presentations, admissions, and duration of stay for its chronic disease patients who are already, or at risk of becoming, high-end hospital users, focusses on education, self-management support, and service coordination (usually by a nurse). The model employs a number of the principles important to any chronic disease prevention and management model, including a multidisciplinary approach, a dedicated care coordinator, a focus on prevention and self-management, consumer and carer involvement, and a flexible funding model that supports team collaboration and a seamless care pathway. A number of models administered by the states and territories, such as HARP, provide good examples of the types of models that the Australian Government could look at supporting and expanding through appropriate health policies and funding allocations.

Importantly, the role of state and territory governments in chronic disease prevention and management must work in unison with the programs and services funded and implemented by the Australian and local governments, and other stakeholders. To assist with this, a full review into health care funding and service provision should be undertaken to delineate the roles and responsibilities of all relevant stakeholders. The current approach is contributing to the fragmented and siloed nature of health care in Australia, which is particularly experienced by, and detrimental to, those suffering from chronic disease. The determination and articulation of roles and responsibilities amongst the sector's funders and service providers would allow for reform that leads to a more efficient and cost-effective health system, where duplication, red-tape, and waste are minimised, and where the patient journey is comprehensible, seamless, and satisfactory. There is currently an opportunity through the Australian Government's review into Medicare to undertake this level of review, however, as outlined above, we are concerned that its scope is currently too narrow to include such an examination.

State and territory governments have a role to play in ensuring that health services adhere to a quality and safety framework which ensures culturally appropriate and respectful service provision for Aboriginal and Torres Strait Islander peoples – whether this be under a continuous quality improvement framework or the standards established by the Australian Commission for Safety and Quality in Health Care. Specifically, it is important to address the cultural competence of service providers so that they are able to properly respect the culture of the individuals they are seeing. This means the services delivered are underpinned by trust, mutual respect, and a holistic conception of health and wellbeing. Equally important is the employment and utilisation of the Aboriginal and Torres Strait Islander health workforce to promote, foster, and deliver culturally safe services. As Wise et al. (2013) note in their national appraisal of continuous quality improvement initiatives in Aboriginal and Torres Strait Islander primary health care: “The extent to which health care services recognise, respect, and incorporate Aboriginal and Torres Strait Islander cultural values in the design and delivery of their services is a factor that affects whether Aboriginal and Torres Strait Islanders access the service.”<sup>43</sup>

Further, these frameworks should also ensure the cultural appropriateness of care delivered to Australia’s large and diverse migrant population, generally. For primary health care to be truly effective, all levels of government need to be involved in the funding, monitoring, and evaluation, of culturally responsive services.

---

<sup>43</sup> Wise, M., Angus, S., Harris, E. & Parker, S. 2013, *National Appraisal of Continuous Quality Improvement Initiatives in Aboriginal and Torres Strait Islander Primary Health Care*, The Lowitja Institute, Melbourne.

**Recommendation fifteen**

The Australian Government work with state, territory, and local governments to delineate roles and responsibilities in the funding and provision of health and social care services, with the view to better connecting services, increasing efficiency, and addressing identified service gaps.

**Recommendation sixteen**

The Australian Government work with state, territory, and local governments, and other stakeholders, to support and promote evidence-based care, especially as it relates to Aboriginal and Torres Strait Islander health, and the general provision of quality and safety in health frameworks.

**Recommendation seventeen**

The Australian Government support the National Health Leadership Forum to work with state and territory governments to increase the Aboriginal and Torres Strait Islander health workforce.

## **Appendix 1. Examples of best practice chronic disease prevention and management models**

The chronic disease prevention and management models described below provide empirical examples of how many of the essential elements of chronic disease care identified in this submission are being implemented to drive best-practice. They also provide examples of existing models of care that can be enhanced and extended by adopting the policy recommendations in this submission. Further discussed are the funding, regulatory and other policy settings required to introduce and integrate these models on a broad scale into the primary health care system. The models are presented in two categories: (1) those that have been formally evaluated; and (2) those that are not yet formally evaluated, but are highly innovative and showing promising signs of effectiveness as indicated through informal evaluation.

### **Formally evaluated models**

#### **Nurse clinics**

There is an opportunity for government to improve the prevention and management of chronic disease by better supporting the establishment and functioning of nurse clinics. Nurse clinics are clinics where nurses lead the multidisciplinary team in providing care, they have their own caseload, and they take primary responsibility for the care of their clients. Their work involves undertaking detailed health assessments and evaluation, developing and communicating patient care plans, providing treatment, referring to other health and social care providers, coordinating care, and monitoring the patient's condition.<sup>44</sup>

#### *Benefits of nurse clinics*

A number of nurse clinics are already operating in most states and territories around Australia, with some being in operation for many years. Nurse clinics are highly valuable in terms of their ability to improve access, reduce health care costs, and reduce the workload that is often unnecessarily placed on medical practitioners. They are becoming particularly

---

<sup>44</sup> Wong F.K. & Chung L.C. 2006. Establishing a definition for a nurse-led clinic: structure, process, and outcome. *Journal of Advanced Nursing*, 53(3), pp. 358-369.

important in today's context where chronic disease, which can often be effectively prevented and managed in a nurse clinic, is at such high levels.

Nurses possess the skills to deliver comprehensive chronic disease prevention and management in the primary health care setting. They are particularly well-skilled at educating consumers about self-management, and in monitoring and providing feedback on patients' progress. Nurse-led chronic disease management, where doctors play a supportive role, is being utilised more effectively and efficiently in areas outside of Australia – especially in the UK and NZ.<sup>45</sup>

Evaluations on nurse clinics, regarding both clinical outcomes and patient satisfaction, are very positive, both in Australia and internationally. Research has shown that primary care nurses and physicians have similar patient outcomes in relation to diagnosis and management.<sup>46</sup> It has also been shown that nurses can bring additional skills and qualities to the patient care arena. Studies have demonstrated that nurses spend more time talking with their patients, are more likely to be flexible in tailoring care to suit the patients' preferences and circumstances, and are more likely to provide disease prevention counselling and health promotion education.<sup>47</sup>

Nurse clinics have been a prominent feature of the British health system for many years – much more so than in Australia. In Britain nurse clinics are often used as an alternative to general practice for the provision of chronic disease prevention and management. Evaluations on British nurse clinics have demonstrated positive patient outcomes. A study undertaken on a nurse clinic in London, for example, followed 120 outpatients who had been referred either to the nurse clinic or to their general practice, for the treatment of type 2 diabetes-related hypertension. The study found that those patients who attended the nurse clinic were three times more likely to reach their target systolic blood pressure (<140mmHg) than those who attended the general practice. It also found that within six

---

<sup>45</sup> Hoare, K,J, Mills, J, & Fancis, K, 2011. 'The role of government in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: an adapted realist review.' *Journal of Advanced Nursing* vol. 68(5), pp.963-980.

<sup>46</sup> Denver E. et al. 2003. Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with Type 2 Diabetes. *Diabetes Care*, 26(8), pp. 2256-2260.

<sup>47</sup> Morcom J. et al. 2005. Establishing an Australian nurse practitioner-led colorectal cancer screening clinic. *Gastroenterology Nursing*, 28(1), pp. 33-42.



months of the intervention, the nurse clinic group had significantly lower 10-year coronary heart disease and stroke risk.<sup>48</sup>

Moreover, in their evaluation of nurse clinics in Hong Kong, Wong and Chung (2006) examined 162 clinic sessions from across 10 clinics, which specialised in diabetes, continence, renal, and wound care. The authors measured changes in symptoms from when the patient last visited the nurse clinic using both clinical indicators and patient perceptions. They found that there were clinically validated improvements in 57.2% of continence cases, 75% of wounds, 43.2% of diabetes, and 21% of renal cases (with 64% staying the same). Patients provided an even more positive assessment of their care, self-reporting improvements in 82.4% of wound cases, 76.9% of continence, 60.7% of diabetes, and 40% of renal cases, suggesting high levels of patient satisfaction. As part of the study, the authors also interviewed 16 medical physicians who had worked closely with the nurses. The physicians reported that they valued the work of the nurses and suggested that nurse clinics be extended to other specialties.<sup>49</sup>

## **Policy enablers**

### *Funding reform*

There are a number of policy enablers that the government can implement to better support nurse clinics in Australia. One of the most significant is funding reform, which would help ensure that nurse clinics remain, or in some cases become, financially viable. The MBS items for which nurse practitioners are eligible, for instance, are inadequate to viably run a nurse clinic. While we believe that primary health care funding must form part of a broader health and social care funding review and reform process, we suggest that in the interim, the availability and value of MBS items should be expanded for nurses so that they are better able to provide treatment options for people with chronic disease. This would also reduce the need for many people to see a doctor unnecessarily, relieving some of the doctors' workload pressures, and also reducing costs to the health system.

---

<sup>48</sup> Denver E. et al. 2003. Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with Type 2 Diabetes. *Diabetes Care*, 26(8), pp. 2256-2260.

<sup>49</sup> Wong F.K.Y. & Chung L.C.Y. 2006. Establishing a definition for a nurse-led clinic: structure, process, and outcome. *Journal of Advanced Nursing*, 53(3), pp. 358-369.

This reform should consider the types of service that consumers require and determine the appropriate duration of the session (the current 40+ min item is inadequate) – there must be equity in nurse practitioner rebates in line with other health care professionals. Rebates should further remunerate nurse practitioners for outreach services to help improve access – especially for people who are less mobile such as some older Australians and the infirm. Nurse practitioner items should cover family/carer therapy, support and education. These items should further support nurse practitioners to provide care in aged care and residential care settings to ensure sufficient access for some of the most vulnerable health care consumers (and most expensive when not provided with timely preventative care); and nurse practitioners should be able to refer to allied health professionals (not just to specialists), in line with best practice chronic disease prevention and management models.

### *Regulatory reform*

To further ensure that nurse clinics are able to fulfil their potential in the health system, regulatory arrangements must acknowledge nurses' autonomous scope of practice, such as by discontinuing the restrictions that are currently imposed on their ability to practice without the supervision of medical professionals (e.g. nurses in general practice), or under a written collaboration agreement with a medical professional or health service (e.g. NPs, nurses working under the Mental Health Nurse Incentive Program). Such arrangements are not imposed on any other health professional and their imposition on nurses is unnecessary and detrimental to equitable, efficient, and effective chronic disease prevention and management.

### **Mental Health Nurse Incentive Program**

The Mental Health Nurse Incentive Program (MHNIP) represents an exemplary model for the effective management of chronic mental health conditions in the primary health care setting, especially for those who are frequent users of medical and health services. Introduced in 2007, the MHNIP provides payments to community-based general practices, private psychiatric practices, and Aboriginal Medical Services (AMS) to engage Credentialed Mental Health Nurses (CMHN) to assist in the provision of coordinated clinical care for people with severe mental health disorders.

The intent of MHNIP is to ensure that people with severe and persistent mental illness in the primary health care system receive adequate treatment, case management, outreach support and coordinated care. CMHNs work in collaboration with psychiatrists and general practitioners to provide services that are tailored to the person's needs, drawing on the CMHN's skills and experience in working with people who have complex problems. In addition to providing evidence-based mental health treatment, CMHNs:

- assess for, and coordinate the client's physical health related treatment and services (e.g. in relation to chronic disease)
- undertake mental health assessments, plan and deliver mental health care
- provide medication monitoring, management and support
- collaborate and liaise with other health professionals, government and non-government agencies, and community services to assist people to resolve problems and meet their psychosocial needs
- work collaboratively with the person and their care and support network, including their general practice, to promote a healthy lifestyle and optimal wellbeing.

These services are provided in a range of settings, such as in clinics or the person's home and are provided at little or no cost to the individual or their family.

Evaluations of the program undertaken by the Australian Department of Health<sup>50</sup>, and the Australian College of Mental Health Nurses, have found that consumers cared for under the program experience significantly improved outcomes in their clinical and personal recovery. Specifically, the program has led to:

- greater care continuity, increased follow-up, timely access to support, and increased adherence to treatment plans
- a reduction in the likelihood of unnecessary hospital admissions and readmissions - quantitative data demonstrate that overall mental health hospital admissions decreased by 13.3% for a sample of MHNIP patients in the 12 months following their involvement in the program; along with reductions in the number of emergency department presentations

---

<sup>50</sup> Australian Government Department of Health. *Evaluation of the Mental Health Nurse Incentive Program, 2012*. Australian Government Department of Health, Canberra, 2012.

- a reduction in hospital bed days for the same sample – an average reduction in total number of admission days by 58% and a reduced average length of stay, from 37.2 days to 17.7 days
- keeping people with severe mental illnesses well and connected with the community – there is evidence of increased MHNIP client employment and MHNIP has encouraged and facilitated patients’ increased involvement in social and educational activities
- increased carer support – MHNIP has had positive flow-on benefits to some carers of MHNIP patients and has had other positive impacts including improved family interactions
- cost effectiveness – the DoH (2012) cost analysis suggests that savings on hospital admissions attributable to the MHNIP could be on average \$2,600 per patient, per annum. This was approximately equivalent to the average direct subsidy levels of providing MHNIP, which ranged from an average of \$2,674 for patients in metropolitan areas to \$3,343 in non-metropolitan areas. There are also a large number of un-costed and intangible benefits associated with MHNIP including the impacts of improved health outcomes, enhanced relationships with carers and family members, and the effects on carer social security outlays
- a high level of support from medical practitioners, consumers, carers, and relevant stakeholders for the model of care – MHNIP has had a positive impact on medical practitioner workloads by increasing their time available to treat other patients and improve patient throughput.

The MHNIP is an effective collaborative model of care that is relevant to, and could easily be replicated across, other areas of the health system. It would be particularly relevant where consumers have complex needs; where treatment regimens are complicated and self-management is essential to good clinical outcome; where mental health, social and emotional needs intersect with physical health needs; where isolation and lack of engagement with the community (related to social, physical or mental health issues) contribute to poor health outcomes; where service coordination and collaboration is required for optimal care; and, where there is a significant burden on the primary health

care system. The MHNIP model of care would be particularly suitable for people with chronic disease and those in the aged care sector.

### **Policy enablers**

The *National Review of Mental Health Programmes and Services*, published November 2014, identified a number of actions that government could take to enhance the effectiveness and sustainability of the MHNIP initiative. Of these, we recommend the government:

- end the freeze on the MHNIP to ensure more equitable access to mental health services
- commit to at least maintaining the existing level of funding for the programme – when funding permits, it should grow from its allocation of \$41.7 million in 2014–15 to \$72 million a year to enable an equitable distribution of funds for the target population
- examine the cost-effectiveness of including extension of Better Access to nurses with postgraduate qualifications in mental health
- extend MHNIP eligibility to include residential aged care facilities and Multipurpose Services
- promote the uptake of the programme by Indigenous Primary Health Care Organisations including Aboriginal Community Controlled Health Services, including opportunities for MHNIP-funded nurses to be a part of the proposed mental health and social and emotional wellbeing teams
- remove the requirement for GPs to write a mental health care plan for referral to mental health nurses under MHNIP where a comparable health plan has been prepared by a specialist mental health professional
- enable individual consumers and primary health networks to contract directly with mental health nurses instead of through an 'eligible organisation' to provide greater flexibility and access to specialist mental health nursing care across multiple settings
- train general practice nurses to develop their mental health skills and provide scholarships which enable them to train to become mental health nurses
- include a mandated amount of mental health curricula content and assessed mental health competencies for undergraduate nurse preparation.

## **Aboriginal Community Controlled Health Services**

The Aboriginal Community Controlled Health Services (ACCHS) sector is a model of comprehensive primary health care providing a more holistic suite of services than those normally found in general practice. Services include illness prevention and health promotion, clinical intervention, delivery of targeted programs (such as antenatal), the facilitation of access to secondary and tertiary health services, and access to social and cultural services. Successful primary health care interventions are those that demonstrate genuine local Indigenous community engagement and which maximise participation up to, and including, full community control. Examples of effective Aboriginal and Torres Strait Islander health services include:

**Tobacco smoking cessation:** Programs that involve health professionals providing advice on how to quit smoking, complemented with pharmacotherapy, such as nicotine replacement, and quit smoking support groups.

**Alcohol and other drugs:** Programs that involve supply reduction strategies, including price controls, restrictions on trading hours, fewer alcohol outlets, dry community declarations, substitution of Opal fuel for unleaded petrol, and culturally sensitive enforcement of existing laws. Demand reduction strategies, including early intervention, provision of alternatives to drug and alcohol use, various treatment modalities, and ongoing care to reduce relapse rates. Harm reduction strategies, including provision of community patrols, sobering-up shelters, and needle and syringe exchange programs.

**Healthy lifestyle:** Programs that involve community participation and input from design through to implementation and evaluation. An evaluation of Indigenous-specific lifestyle programs, for example, demonstrates positive health effects remaining in people two years following program implementation.<sup>51</sup> Lifestyle programs involve such practices as setting clearly defined goals around weight loss and physical activity, dietary modification and weight self-management, and individual case managers or 'lifestyle coaches'.

---

<sup>51</sup> AIHW. Healthy lifestyle programs for physical activity and nutrition. Resource sheet no. 9. Produced by the Closing the Gap Clearinghouse. AIHW Cat. no. IHW 68. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.  
<<http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2012/ctgc-rs09.pdf>>

**Suicide and suicidal behaviour:** Community programs that focus on the social, emotional, cultural and spiritual underpinnings of community wellbeing. A culturally adapted intervention comprised of motivational care planning, for example, has been effective in improving wellbeing, and decreasing alcohol and cannabis dependence among Indigenous people with chronic mental illness in three remote northern Australian communities.

**Social and emotional wellbeing:** Cultural healing programs help individuals work through their own issues and exert greater control over their social and emotional wellbeing. They provide counselling to individuals, families and communities who would not otherwise access it. Culturally appropriate mental health services have been successful in engaging Indigenous young people and increasing their self-esteem, their preparedness to talk to family and friends about their own mental health issues, and their ability to identify signs of depression in others. Cultural adaptations of effective mainstream programs, such as the Triple P-Positive Parenting Program, the Resourceful Adolescent Program, and MindMatters, for example, are achieving positive outcomes for Indigenous people.<sup>52</sup>

The ACCHS sector has also assisted with tackling the physical and economic barriers to health care, such as providing services locally, providing transport to health services, having flexibility in setting appointments, providing home visitation as part of a comprehensive and multifaceted engagement strategy, increasing services that do not require a co-payment and improving access to private health insurance and private health services.

### **Hospital Admission Risk Programs (HARP)**

Hospital Admission Risk Programs (HARP) provide an example of effective multidisciplinary chronic disease prevention and management, bridging primary and acute care settings. HARP is a Victorian model that was initially developed in the late 1990s. It is based on the Kaiser Permanente Chronic Care Framework and the Wagner Chronic Care model. Its focus is on care coordination, self-management support, and specialist care. It aims to reduce avoidable hospital presentations and admissions by targeting those who are current or are at risk of becoming, frequent hospital service users.

---

<sup>52</sup> <<http://www.aihw.gov.au/closingthegap/what-works/#block->>

Following an initial 80 pilot projects being undertaken across Victoria, a formal evaluation was performed in 2004-05. The evaluation found that over a 12 month period, HARP clients experienced:<sup>53</sup>

- 35 percent fewer emergency department attendances
- 52 percent fewer emergency admissions
- 41 percent fewer days in hospital.

The reduction in hospital service use equated to approximately one less emergency department attendance, two less emergency admissions, and six less days spent in hospital for every HARP client, per year.

In 2010 HARP was extended to target older people living in rural Victoria in what was named HARP Better Care of Older People (HARP BCOP). An evaluation of this program found that HARP BCOP clients experienced:<sup>54</sup>

- 64 percent reduction in hospital separations
- 55 percent reduction in emergency department presentations
- 39 percent reduction in emergency department presentations following their exit from the HARP BCOP program.

The Royal Children's Hospital Melbourne (RCH) provides an example of how the HARP model operates with its suite of HARP multidisciplinary chronic disease prevention and management programs. These include:

#### *ACE Program*

The ACE Program is run by RCH and is available to any children who, because of their complex care needs (medical and/or psychosocial), are current, or are likely to become, frequent hospital service users.

ACE provides care coordination and 24 hour phone support for children, young people and their families, and aims to assist them in managing their child at home or assisting with presentation/admission to RCH if required. ACE employs nurse care coordinators who in

---

<sup>53</sup> Victorian Government Department of Health. *Hospital Admission Risk Program (HARP)*, accessed 1 July 2015, < <http://www.health.vic.gov.au/harp/about.htm>>.

<sup>54</sup> Ibid.



partnership with specialist treating teams, provide education to families about the care needs of the child/young person. While being based in the hospital, nurse care coordinators are on call after-hours and on weekends. Each nurse care coordinator always has access to information pertaining to the child's history, primary health care team members, contact details, and an up-to-date emergency care plan.

The Program aims to reduce avoidable hospital presentations and admissions by having experienced nurse care coordinators act as a liaison between the child's family and the rest of the health care team. The coordinator role includes developing care plans in collaboration with the health care team, educating the family/carer on how best to support self-management of the condition, responding to queries and requests for advice regarding the child's/young person's condition and treatment, and notifying the appropriate hospital team members on the child's/young person's pending arrival to hospital.

#### *Community Asthma Program*

The Community Asthma Program (CAP) aims to reduce the use of avoidable acute care services by providing primary health care in the community. The Program provides coordinated, preventative services focusing on education and self-management. It involves group education sessions provided by an Asthma Educator. In addition to providing professional advice, the group appointments are also designed to give families an opportunity to meet and network with other families who are going through the same experience.

#### *Diabetes Allied Health Service*

The Diabetes Allied Health Service (DAHT) is a multidisciplinary service that aims to reduce presentations and admissions to hospital for children who are frequent users, or are at risk of becoming frequent users, of hospital services, as a result of their diabetes. The service focuses on providing education and ongoing support around matters such as insulin pump management, sick day management, dietary education, psychosocial support, and continuous glucose monitoring. The team is multidisciplinary, involving collaboration between a diabetes nurse educator, social worker, dietitian, and medical specialists, with regular communication with the child's primary health care/general practice team.

HARP employs on a number of key elements that are important in the design and delivery of any chronic disease prevention and management model, including being multidisciplinary, consumer-centred where the consumer and their carer are engaged in the care, having a dedicated care coordinator, and having a flexible funding model that allows for team collaboration, innovation, and the ability to be flexible in tailoring the care to the consumer's needs.

### **Person-centred health care home**

The person-centred health care home (HCH), also known as the 'medical home', is a primary health care model that has gained much international attention in recent years following its initial establishment in the US in the 1970s. The HCH, in essence, encompasses five functions and attributes.<sup>55</sup>

1. **Comprehensive care** – which refers to the home meeting the holistic needs of the person, including prevention and health promotion, acute care, and chronic care.
2. **Person-centred** – which refers to the consumer and their carer(s) being equal partners in the decisions and processes that relate to their care.
3. **Coordinated care** – refers to the HCH coordinating care across all relevant health and social service elements, such as specialty care, hospitals, home health care, and community services and support.
4. **Accessible services** – refers to the HCH making it easy for consumers to engage with their care providers, irrespective of where they live, the time of day, and what reasons they may have for communicating (i.e. whether it be concerning a diabetes related exercise program, or heart medication).
5. **Quality and safety** – refers to a commitment to continuous quality improvement (CQI) through the ongoing engagement in CQI activities. It also includes publicly sharing safety and quality data and communicating improvement activities.

### **Benefits of a person-centred HCH**

A number of evaluations have been conducted on person-centred HCHs – mostly in the US where the concept originated. There are evaluation studies, for example, that suggest that

---

<sup>55</sup> Agency for Healthcare Research and Quality. Patient-centred medical home resource centre, accessed 29 June 2015, < <https://pcmh.ahrq.gov/page/defining-pcmh> >

the HCH can lead to significant cost savings and substantial improvements in consumer health outcomes. North Carolina's Medicaid management program, for instance, known as 'Community Care of North Carolina', implemented a HCH model that involved capitation payment, the requirement to use evidence-based guidelines for at least three conditions, the need to track tests and referrals, and to measure and report on clinical and service performance. It is reported that following an initial outlay of \$8.1 million US, the service saved more than \$60 million in its first year, and \$124 million and \$231 million in the following two years, respectively.<sup>56</sup>

In Erie County, New York, where a person-centred HCH model was implemented for its Medicare/Medicaid enrollees who were suffering from chronic conditions, including substance abuse, it is reported that the model saved \$1 million US per year, for every 1,000 enrollees. There was also less duplication of diagnostic testing and fewer hospital presentations and admissions.<sup>57</sup>

## **Community-based specialist nurses for the management of chronic and complex disease**

### *Movement disorder nurses*

Specialist nurses who have gained expertise and are recognised as specialists in a particular clinical area of practice, such as nurses working with people who have Parkinson's disease, offer an efficient and effective means through which improved consumer outcomes can be achieved, often at the same or lower costs to the health care system as when they are cared for by a general practitioner (GP). The UK has been employing a community-based Parkinson's nurse model in the community for more than 20 years. The role involves the nurse:

- counselling and educating patients and carers about Parkinson's disease, in their homes, at health centres, GP clinics, outpatient clinics, and on the phone
- providing information to patients and carers regarding medication, in collaboration with the GP and medical specialist

---

<sup>56</sup> Rosenthal T.C. 2007. Advancing Medical Homes: Evidence-based literature review to inform health policy, accessed 29 June 2015, < [http://www.ahcc.buffalo.edu/reports/medical\\_home\\_evidence\\_review07.pdf](http://www.ahcc.buffalo.edu/reports/medical_home_evidence_review07.pdf)>

<sup>57</sup> Rosenthal T.C., Horwitz M.E. et al. 1996. Medicaid primary care services in New York State: Partial capitation vs full capitation. *Journal of Family Practice*, 42(4), pp. 362-368.

- monitoring clinical wellbeing and response to treatment, reporting to GPs and medical specialists, where appropriate
- instigating respite and day hospital care where appropriate, seeing patients in hospital if admitted, and liaising with hospital staff once the patient is discharged
- assessing entitlements to social security benefits
- liaising with multidisciplinary primary health care teams for ongoing assessment and therapy, where necessary.

In a two year randomised controlled trial of the model, which followed almost 2,000 patients, researchers found that clinical outcomes remained the same for both those people who were cared for by a specialist nurse and those who were cared for in general practice. Importantly, they found that there was a significant improvement in patient and carer satisfaction with the nursing service compared to the general practice group, with no additional health care costs.<sup>58</sup>

Community based specialist nurses are also playing important roles in the provision of multidisciplinary primary health care in the Australian health system. As the key service provider for people with Parkinson's disease and Movement Disorders in the Australian Capital Territory, the Clinical Nurse Consultant plays a vital role in the provision of education, clinical care, and care coordination to frequent users of the acute care sector. The nurse's role is diverse and fits within a multidisciplinary framework. It involves collaboration with Geriatric and Neurological departments, Canberra Hospital, aged care facilities, university sectors, health clinics, Hospital in the Home, clinical care coordinators, research departments, Parkinson's Working Groups, allied health services, GPs, pharmacies, and the community.

Due largely to the role of the Clinical Nurse Consultant in this collaborative multidisciplinary approach, the following services have been made possible: education programs, the addition of required medicines to the hospital formulary, research projects about Exercise Physiology and Parkinson's, and the development of self-directed learning packs.

---

<sup>58</sup> Jarman B. et al. 2002. Effects of community based nurses specialising in Parkinson's disease on health outcome and costs: Randomised controlled trial. *British Medical Journal*, 324:1072.

## **Highly innovative models (without formal evaluation but demonstrating potential)**

### **Multidisciplinary team collaboratives**

Many nurses acquire specialist credentialing and/or qualifications in response to their evolving roles caring for people who live with a high chronic disease burden. Nurses may hold specialist qualifications in the delivery of health care for diabetes, cancer, aged care, mental health, renal, cardiovascular or respiratory disease, and Aboriginal and Torres Strait Islander health. Multidisciplinary team collaboratives such as the *Health Independence Programs* (HIP) in Victoria integrate specialist nurses into multidisciplinary teams that work collaboratively in preventing and managing chronic disease in the community. HIPs are based on an extended Wagner Care model,<sup>59</sup> which takes into account the social determinants of health. The HIP model is especially pertinent for people who suffer from comorbidity.

A HIP located at the Werribee Mercy Hospital in Wyndham, Victoria, for instance, has amalgamated six teams into one, consisting of 35 health professionals including specialist nurses, allied health, and social workers. The nursing team includes an emergency nurse practitioner, mental health nurse, diabetes nurse educator, respiratory nurse, and cardiac nurse. The clinic operates in the absence of an onsite medical practitioner and employs a 'no wrong door' policy, where the aim is to meet the consumer's holistic needs within one service. This type of model is especially relevant in areas of low socio-economic status where community members may often have complex issues requiring services from across the broad spectrum of providers, especially social service providers.

The model encompasses the capacity to deal with crises/acute care needs, and provides home visits and multi-provider appointments where the consumer can see several of their care providers in one appointment. To help coordinate care, ensure efficiency and best practice service delivery, clients have dedicated care coordinators, and providers meet together regularly to discuss, deliberate, and plan the client's care.

---

<sup>59</sup> Bodenheimer, T., Wagner, E.H. & Grumbach, K. 2002. Improving primary care for patients with chronic illness. *JAMA*, 288 (14) pp.1775-1779.

## **Policy enablers**

### *Funding reform*

The HIP Werribee Mercy Hospital clinic is funded by the Victorian Government, which provides block funding for its operation, including for the payment of its health professionals. This type of payment model provides health professionals with the flexibility needed to be innovative and to respond to consumer needs, such as by providing health education at home, or by providing multi-provider single client consults, which would not occur, or at least be much more difficult, under a rigid fee-for-service model. Furthermore, this payment model allows for the regular case conferencing and frequent provider interaction that occurs between the multiple providers in the health care team.

The Australian Government should examine ways of introducing a more flexible funding model than that which is currently employed under the predominantly fee-for-service model used for general practice. This can be done by implementing a reformed blended funding model, which is discussed in detail under the 'Medicare Payment System' in section 4 above.

## **Shared health appointments**

Shared health appointments (SHAs), or 'group visits', offer an innovative way to increase access, quality, and efficiency in chronic disease prevention and management. They are appointments that are carried out by a GP, practice nurse, and other (usually allied) health professionals for a group of consenting patients. Their aim is to improve access to care, make use of peer support, reduce costs and improve patient and provider satisfaction in the management of chronic disease.<sup>60</sup>

---

<sup>60</sup> Egger G et al, *Shared medical appointments - An adjunct for chronic disease management in Australia?* Australian Family Physician 43(3), March 2014

### *Potential benefits of SHAs*

In a recently published Consultation Protocol, Australia's Medical Services Advisory Committee (MSAC) identified a number of potential advantages that the implementation of SHAs for medical appointments may yield for patients, health professionals and funders:

- They are able to function as a support group, allowing patients to share their experiences and reinforce each other's determination.
- By listening to other patients, participants can learn the answers to questions they had not thought to ask.
- They are able to receive attention from different expert health practitioners (including the doctor) in the same session, which may otherwise be prohibitively expensive in a single patient appointment.
- Patients set goals in front of the group, increasing accountability and receiving support and validation from the group.
- They can reduce the waiting time for a medical appointment.
- They can make the medical appointment a more enjoyable experience for the patient.
- They reduce the need for health professionals to repeat the same information to different patients during multiple appointments.
- They allow greater specialisation within the appointment, with doctors receiving help from the multidisciplinary team and enabling better coordinated care.
- They reduce costs by allowing patients to be seen more quickly and efficiently than current practice.
- They provide more time for the doctor (and facilitator where appropriate) to contribute educational/prescriptive advice to the patient.

### *SHAs in Australia*

Shared appointments already occur in some instances in Australia, such as in the case of the allied health group sessions supported under the MBS chronic disease management items.

In terms of general practitioner involvement in SHAs, the Australian Lifestyle Medicine Association (ALMA), together with the Baker International Diabetes Institute in Melbourne,

undertook pilot SHA trials on the NSW North Coast and Western NSW as part of a grant from the Royal Australian College of General Practitioners (RACGP).<sup>61</sup> It followed a study of focus groups involving health care providers and patients with diabetes in four large regional health centres in NSW.<sup>62</sup> The results of this study were that health care provider participants appeared overwhelmingly in favour of SHAs for medical appointments, while patients were divided on the process. This study recommended that the SHA process be trialed and evaluated further before its wider introduction.<sup>63</sup>

## **Integrated Chronic Disease Nurse Practitioner Model**

The Integrated Chronic Disease Nurse Practitioner (ICDNP) Model is a new nursing model of care not replicated anywhere in Australia and which is being trialed at Logan and Beaudesert Hospitals, Queensland. In the ICDNP clinic, a renal nurse practitioner (NP), cardiac NP, and diabetes NP form a team to jointly deliver care. Joint appointments save consumers attendance at multiple outpatient clinics. The model is based on work undertaken in the BENCH study 2008,<sup>64</sup> and by Jarsmaa & Stewart (2004).<sup>65</sup> The ICDNP clinic aims to prevent avoidable hospital admissions through close follow-up both in the clinic and during home visits. This clinic's particular target group are people with two out of the three following chronic conditions – renal, cardiac, and/or diabetes – who are quite unwell and who tend to present often to health services. The NPs with the relevant expertise attend to the person together. This approach enables the NPs to collaboratively deliver integrated care, including assessment, titration of medication and teaching of self-management. The NPs partner with medical specialists and GPs which enables them to provide a channel of communication between the medical providers. GPs value this enhanced communication with medical specialists highly. Furthermore, the NPs devise and propose patient

---

<sup>61</sup> See <http://healthynorthcoast.org.au/top-stories-180/>

<sup>62</sup> Stevens J et al. *A user assessment of the potential for Shared Medical Appointments in Australia* – Australian Family Physician 43(11), November 2014.

<sup>63</sup> *Ibid*

<sup>64</sup> Driscoll, A., Worrall-Carter, L., Hare, D.L., Davidson, P.M., Reigel, B., Tonkin, A. & Stewart, S 2008. Does more equal less: development of a heart failure management complexity score (HF-IS) (BENCH study) *European Journal of Heart Failure Supplements*.

<sup>65</sup> Jarsmaa, T. & Stewart, S. 2004. 'Nurse-led management programmes in heart failure', in S. Stewart, D.K. Moser & D.R Thompson (ed.), *Caring for the heart failure patient. A text book for the health care professional*. Martin Dunitz, London.

McAlister, F.A., Stewart, S., Ferrua, S. & McMurray J.J.J.V. 2004. 'Multidisciplinary Strategies for the Management of Heart Failure Patients at high risk for admission', *Journal of the American College of Cardiology*, 44(4), pp. 810-815.



management plans for the GPs. GPs have welcomed the ICDNP clinic and highly value the NPs' contribution to the management of complex patients. The ICDNP model currently supports training of an NP candidate that integrates renal, cardiac, and diabetes care to forge a new nursing role in response to a specific population demand for care. Queensland Health and the Office of the Chief Nurse and Midwifery have assisted in funding the ICDNP model. An evaluation of the ICDNP clinic's first twelve months has recently been undertaken by Professor Anne Bonner, Queensland University of Technology.

### **Logan Hospital Heart Failure Program**

The Logan Hospital Heart Failure Program initially commenced in the hospital eight years ago but has since moved into the community setting. The team is comprised of a nurse practitioner, specialist nurses, physiotherapist, pharmacist and social worker. The model of care is based on the work of Jarsmaa & Stewart.<sup>66</sup> Some nursing staff rotate from the tertiary setting for periods into this clinic. These nurses often know people attending the clinic from hospital stays which enhances communication between hospital staff and primary care providers and enhances continuity of care. At the same time the nurses seconded from the hospital to the clinic become familiar with the ongoing management of chronic disease in the community setting, acquiring valuable primary health care skills.

---

<sup>66</sup> Jarsmaa, T. & Stewart, S. 2004. 'Nurse-led management programmes in heart failure', in S. Stewart, D.K. Moser & D.R Thompson (ed.), *Caring for the heart failure patient. A text book for the health care professional*. Martin Dunitz, London.