Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

ACRRM SUBMISSION

Inquiry into Chronic Disease Prevention and Management in Primary Health Care

July 2015

COLLEGE DETAILS

Demographic category: Organisation
Organisation name: Australian College of Rural and Remote Medicine (ACRRM)
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**The College would like its submission to be publicly available.*

About ACRRM

The College was established in 1997 and is devoted to the advancement of medical care in rural and remote communities. It progresses this through the provision of quality vocational training, professional development education programs, setting and upholding practice standards, and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM's 4000 Members/Fellows are characterised by their relative geographical isolation, broad scope of generalist practice and clinical acumen, fit for purpose use of technology and reliance on teamwork. (see Curriculum) In order to service the educational and advocacy needs of members the College continues to be innovative in the development and delivery of distance education, including the creation of collaborative e-networks and use of technology to bridge distance.

ACRRM is one of two Colleges recognized by the Australian Medical Council, providing vocational training towards Fellowship in the specialty of general practice. The ACRRM programs are specifically designed to prepare Fellows for the extended skills required to provide the highest quality care in rural and remote communities characterised by a dearth of face-to-face specialist and allied health services.

The ACRRM definition of general practice asserts a proud tradition of generalist medicine, particularly as it has applied in rural and remote communities. The importance of the generalist medical practitioner with extensive clinical and leadership abilities is increasingly recognised in Australia and internationally by communities and policy-makers. The generalist medical practitioner has a key place in a societal response to a wide range of health care challenges. These include the

complex care needs of ageing populations, increasing levels of chronic co-morbidity, the availability of increasingly expensive technological interventions and competing demands upon limited resources. General practice as defined by ACRRM is a long established tradition with a secure future in rural and remote communities as well as in the cities.

ACRRM's response to this inquiry emphasises the unique issues for Aboriginal peoples and rural and remote people with chronic conditions. These must be accommodated in the development and delivery of any strategy to redress the burden of chronic conditions.

The College welcomes this inquiry and its potential impact on strategies to redress the inequities in funding of health services for rural and remote people and improve health outcomes and efficiencies in the prevention and management of chronic conditions in rural and remote communities.

ACRRM considers that the current environment, with the establishment of Primary Health Networks (PHNs) and the range of reviews and reforms underway (e.g. chronic diseases strategic framework, diabetes strategy, mental health planning, MBS review, GP Training changes, Primary Care and eHealth reforms); presents an ideal opportunity for an integrated educational approach to support/encourage best clinical practice and improve health and service outcomes related to management of chronic disease. Models of shared care can now be made viable in rural and remote regions via meaningful use of eHealth/Telehealth arrangements, targeting a priority group - patients in underserved rural and remote regions of Australia.

Background

Average national data disguises clear health inequities for people living in rural and remote areas. Life expectancy is the key measure of the overall health of a population and, in 2009; the average mortality rate in Australia was among the lowest of all Organisations for Economic Co-operation and Development (OECD) countries[1]. If we look at the distribution, however, death rates increase with increasing remoteness. People living outside Australia's major cities have worse outcomes on leading indicators of health. In 2012, the age-standardised rate was highest in very remote areas (8.4 per 1,000 population), followed by remote (6.7), outer regional (6.4), inner regional (6.1) and major cities (5.5).[2]

Key reasons for these poor health outcomes outside of major cities are decreased access to services, including health care and increased exposure to risk factors for poor health outcomes. In remote areas, there is strong evidence that poor access to primary health care remains a critical barrier and is reflected in the high rate of potentially preventable hospitalisations Council of Australian Governments (COAG).[3]

Rural and remote Aboriginal and Torres Strait Islander populations experience health inequities compared to the rest of Australians.[4] The higher proportion of Aboriginal and Torres Strait Islander people in remote area populations contributes to the generally poorer health of people living in remote areas.[5] Aboriginal people have lower life expectancies, higher rates of chronic and preventable illnesses and a much higher likelihood of being hospitalised with a chronic disease than non-Indigenous Australians.[6]

Aboriginal and Torres Strait Islander people experience social disadvantage in relation to poor housing, overcrowding, education, income and employment in rural and remote areas leading to a negative impact on health.[7]

Additionally, very remote Aboriginal communities are influenced by environmental or geographical factors such as long distances to access services, communities being cut off due to flooding, and poorer access to healthy food sources.[8] [9] It is likely that access to health services is a significant contributor to the gap in health outcomes; many Aboriginal and Torres Strait Islander people experience problems accessing timely and appropriate health services. This may be exacerbated by a lack of culturally appropriate services (ABS, 2013b). Furthermore the quality of management in these areas that patients can expect to receive is impacted by patients' geographic distance from primary care, specialist services, and the full range of allied health engaged in multi-disciplinary management

The long distances and sparse population are major challenges for providing health services in rural and remote locations, and the case for telehealth support (including that provided by primary care provider to their isolated patients) is particularly compelling- bandwidth issues and Medical Benefits

[1] Organisation for Economic Co-operation and Development. (2013). Health at a glance 2013: OECD indicators. Paris.
[2] Australian Institute of Health and Welfare. (2014). Australia's health 2014. Australia's health 14. Cat. No. AUS 178. Canberra: AIHW.
[3] Council of Australian Governments Reform Council (2013). Healthcare 2011–12: comparing outcomes by remoteness. Supplement to the report to the Council of Australian Governments. Sydney: COAG Reform Council.
[4] Australian Institute of Health and Welfare. (2015). The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples: 2015. Cat. no. IHW 147. Canberra: AIHW.
[5] AIHW. (2014). Cat. No. AUS 178. Ibid.
[6] Australian Institute of health and Welfare (2013). Indigenous identification in hospital separations data—quality report. Cat. no. IHW 90. Canberra: AIHW.
[7] AIHW. (2015). Cat. no. IHW 147.Ibid.
[8] Harrison M, Lee A, Findlay M, Nicholls R, Leonard D & Martin C (2010). The increasing cost of healthy food. Australian and New Zealand Journal of Public Health 34:179–86.
[9] Humphreys J, Wakerman J (2008). Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform: a discussion paper. Canberra: National Health and Hospitals Reform Commission.

Scheme (MBS) telehealth item restrictions require urgent attention. Use of technology can facilitate effective models of shared care if applied with careful consideration of the rural context.

ACRRM Response to specific questions identified in the call for submission

1. Examples of best practice in chronic disease prevention and management.

The prevalence of multi-morbidity increases with deprivation [10] and is linked to lifestyles. Early life experiences in the womb, home and school are critical to health and well being.

Traditional interventions focussed on individuals and integrating care services are important, however these must be part of a broad focus on promoting health and reducing health inequities across whole populations.

Australian data from the ACE (Assessing Cost-Effectiveness in Prevention) study identified the most cost effective interventions at a population level in Australia would be:[11]

Results classified by size of health impact

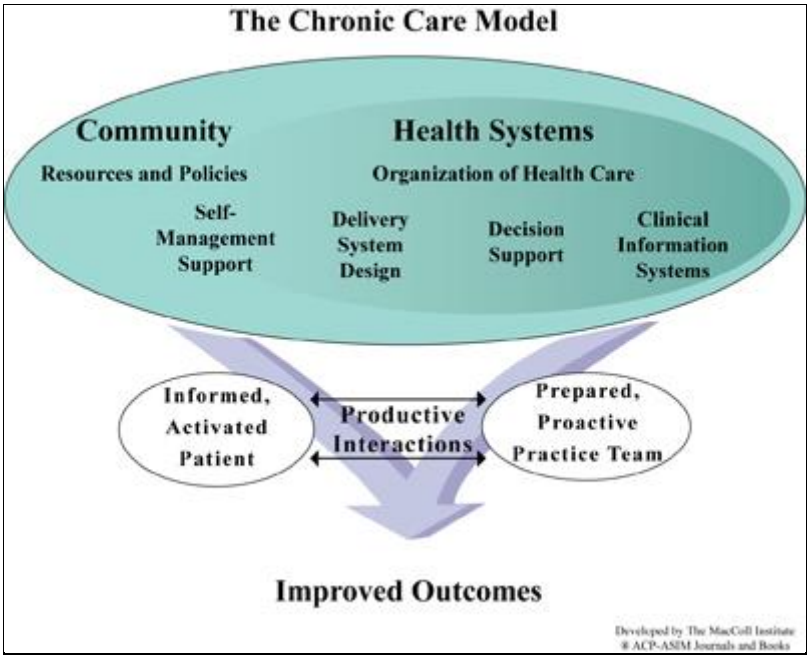
A large impact on population health (i.e. >100,000 DALYs prevented per intervention) can be achieved by a limited number of cost-effective interventions:

- Taxation of tobacco, alcohol and unhealthy foods;
- A mandatory limit on salt in just three basic food items (bread, cereals and margarine);
- Improving the efficiency of blood pressure- and cholesterol-lowering drugs using an absolute risk approach and choosing the most cost-effective generic drugs (or potentially introducing a low-cost polypill that combines three blood-pressure-lowering drugs and one cholesterol-lowering drug into one single pill);
- Gastric banding for severe obesity; and
- An intensive SunSmart campaign

Moreover, fragmentation of health care, poor coordination and communication across agencies, and a lack of continuity of care undermine the capacity of the current system to redress the burden of disease in rural and remote communities.

ACRRM recognises Wagner's model for chronic care which is and is accepted as best practice in a systems based approach, Continuous Quality Improvement (CQI) for chronic disease management programs including: [12].

[10] Barnett K, Mercer S,orbury M, Watt G, Wyke S, Guthrie B (2012). Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross-sectional study'. The Lancet, Vol 380, 9836:37-43.
[11] Vos T, Carter R, Barendregt J, Mihalopoulos C, Veerman L, Magnus A, Wallace A. (2010). Assessing cost-effectiveness in prevention: ACE–prevention September 2010 final report. University of Queensland.
[12] Coleman, K., Austin, B. T., Brach, C., & Wagner, E. H. (2009). Evidence on the Chronic Care Model in the new millennium. Health affairs, 28(1), 75-85.



In Australia, the ABCD program and the National Primary Care Collaboratives program using a strong systems approach with a focus on continuous quality improvement have proven effective. Gardner, K. L., Dowden, M., Togni, S., & Bailie, R. (2010). Farmer, L., Knight, A., & Ford, D. (2005).

Internationally, evidence in a systematic review confirms the importance of a system-wide quality improvement approaches and their association with the largest impact.[13]

In terms of equipping rural health practitioners with the skills to assist in this transformation and better advocate for change with PHNs and LHNs, ACRRM proposes the development of accredited education focussing on population health and CQI in the management of chronic conditions. ACRRM is well positioned to develop online resources to deliver in partnership with relevant jurisdictional agencies (i.e. PHNs, LHNs).

ACRRM Fellows work in many environments including Aboriginal Community Controlled Health Services (ACCHS), state and territory run rural and remote primary care clinics and hospitals, RFDS as well as private General Practice. ACRRM is best placed to work with other stakeholders to develop and design and upskill doctors in the use of CQI frameworks within these clinical settings.

For example, ACRRM is a key contributor to the "Continuous Quality Improvement in Aboriginal and Torres Strait Islander Primary Health Care project", commissioned by the Australian Department of Health, and led by the Lowitja Institute in partnership with NACCHO, and a wide range of other stakeholders.

The purpose of this National Framework is to foster commitment and a coordinated approach to CQI in primary health care for Aboriginal and Torres Strait Islander people, wherever they live and seek care.

[13] Tricco, Andrea C., et al. (2012). Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis. The Lancet 379.9833: 2252-2261.

ACRRM commends this project (and ACRRM's proposed role in education and online delivery) for consideration as a key solution which improves chronic disease management within this at risk population group in rural and remote regions.

Q1. Summary Recommendations: Best practice in chronic disease prevention and management.

1. Involve ACRRM in the development and delivery of Systems-based Continuous Quality Improvement (CQI) education

Develop standards, education and support arrangements for the rural generalist clinician engagement in CQI, which facilitates:

- Monitoring health outcomes against appropriate KPIs/guidelines re prevention and management of chronic conditions.
- Implementation of a population health approach in understanding and responding to the burden of disease within their practice population (and PHN)
- *Quality* in monitoring and auditing clinical outcomes and *Safety* in implementing care plans and treatment regimes relevant to the context
- Integration of guidelines into care planning and CQI arrangements- recognised in ACRRM CPD arrangement
- Quality Use of telehealth to improve access to care provided locally
- Meaningful use ehealth applications including;
  - Electronic shared health records- MyHealthRecord (PCEHR) ,
  - Care planning tools (CDMNet)
  - Point of Care Testing (PoCT) point of care decision support (eGuidelines)

  to coordinate and plan care across the continuum

2. Incentivise participation in CQI based activity

The College contends that up incentives are required to better equip rural GPs to;

- Understand and redress the burden of disease within their practice population (and PHN)
- Ensure that their clinical practice is in keeping with best practice
- Integrate guidelines into care planning and CQI arrangements- recognised in ACRRM CPD arrangements
- Monitor performance and outcomes within a CQI framework
- Optimise use of telehealth to improve access to care provided locally
- Use ehealth applications (including MyHealthRecord (PCEHR) to coordinate and plan care across the continuum
- routinely apply evidence based screening of patients at risk of chronic disease (e.g. type 2 diabetes, cardiovascular disease, renal disease and other chronic conditions).
- Optimise use of screening tools (e.g. AUSDRISK)
- Encourage and reward peer review activity (based on compliance with guidelines) amongst regional and local networks of clinicians (PHNs etc.)

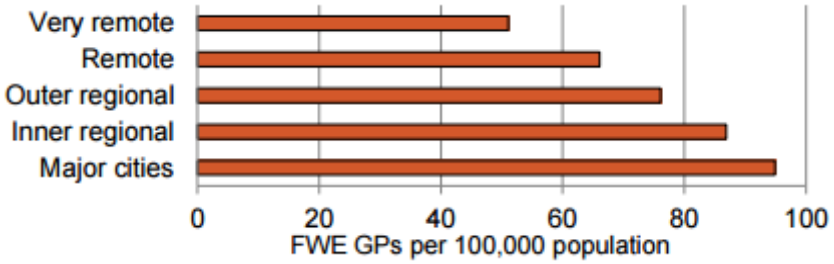
3. Education and resource development for GPs caring for Aboriginal Peoples with chronic conditions

Support ACRRM's educational and online delivery role in the Continuous Quality Improvement in Aboriginal and Torres Strait Islander Primary Health Care project to foster commitment and a coordinated approach to CQI in primary health care for Aboriginal and Torres Strait Islanders.

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

Currently the majority of Medicare payments are based around GP payments, which significantly disadvantages people living remote areas due to the misdistribution of private GP and Specialist services.

Distribution of GPs by Remoteness Area, 2010-11 (Full-Time Work Equivalent)



Source: Grattan Institute

In 2006-07, this resulted in government MBS outlays of $661 million less in rural areas than if the major cities rates had applied. MBS payments for in-hospital services in rural areas also fell short by over $150 million, bringing the total MBS shortfall in 2006-2007 to $811m[14]. This will lead to increasing health inequity unless addressed and adjustments made to take this crucial factor into account.

In very remote areas in particular, chronic disease management traditionally done by doctors is more likely to done by an inter-professional health care team, which again leads to decreased Medicare revenue.

New financing models are required so that all members of an interdisciplinary care team are adequately compensated to improving care for chronic conditions.

Rural and remote *workforce and training incentives* (linked to the new Monash Model classification), expanded access to the MBS arrangements, and changes to MBS telehealth item eligibility requirements, need to be considered to encourage suitable skilled clinicians to work and be supported in rural and remote areas.

MBS Telehealth eligibility arrangements need to be amended to enable a shared care model to be implemented in which the rural generalist doctor can provide support to the remote team; (remote area nurse, Aboriginal Health Worker etc.) at a distance. Current MBS telehealth arrangements only recognise the medical specialist at the distant end of the consultation.

[14] AIHW. Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure. Health and welfare expenditure series no. 50. Cat. no. HWE 50. Canberra: 2011.

The MBS regulations can militate against the case for funding indirect patient care, which can alter outcomes for patients with chronic and complex diseases in rural and remote communities e.g. asynchronous telehealth arrangements, remote monitoring and the role of allied health professionals, nurse and GPs at the distant end of the consultation.

The existing MBS items for online consultation have provided a platform to grow and promote the adoption of real time video enabled linkages between primary and specialist care. However opportunities to expand beyond real time video enabled specialist care are constrained by the scope of services and providers in scope for the MBS telehealth items. To harness the existing capacity within the health system and promote integrated service delivery models, which focus on continuity of care a reform agenda, targeting a broader definition of telehealth must be considered.

To better manage the growing health burden posed by the increased prevalence of chronic disease and demand on the health system we must contemplate known service delivery options that may deliver on the yet to be realised benefits represented by a range of telehealth services that are not recognised by the existing MBS telehealth funding arrangements, these include;

- Asynchronous telehealth to support wound care, ENT, ophthalmology and dermatology.
- Synchronous telehealth to support extended chronic disease management programs for example;
    - Home monitoring
    - Chronic Disease Care planning, Team based care and allied health specific services
    - Direct primary care to patient virtual visits .

Fund provision of telehealth services by rural GP to isolated/at risk patient/remote area nurse *(Currently the rural GP at the distant end of the MBS telehealth item consultation is not funded).*

- Funding for GP with patient telehealth access a public specialist. The current MBS Telehealth arrangements only fund the GP for participating and organising the consultation if the specialist is a private specialist.

ACRRM also recommends providing incentives for combined provision of telehealth services with curation of My Health Record to improve shared care, care planning and health outcomes for rural patients with chronic disease.

- Improve bandwidth and infrastructure in rural and remote regions.

There is international evidence around the effectiveness *of bundled payments*. The introduction of bundled payment for diabetes care in the Netherlands, although in the early stages, has had positive consequences, improvements in care delivery processes and in the transparency of delivered care[15]. The introduction of incentive payments for achieving improvements in outcomes from baseline may achieve even benefits.

There is a major opportunity for developing and delivering effective coordinated models of care integrating CQI, e-health and the use of electronic health records to greatly improve patient outcomes. The PCEHR /MyHealthRecord implementation trials mooted in the 2015 budget provide a catalyst for exploring such opportunities.

[15] Struijs JN, Baan CA. (2011). Integrating care through bundled payments—lessons from the Netherlands. New England Journal of Medicine, 364(11), 990-991.

Education, training, guidance, incentives and user-friendly resources are essential to improve the ability of rurally based general practitioners and primary health care teams to understand and apply guideline-based care and develop strategies improve the continuity of care for patients with chronic conditions.

It is important for incentives to reward improved outcomes not just activity, **but this needs to be done in an equitable manner that doesn't disadvantage practices with the most challenging patients and therefore should be based on improvements in outcomes compared to baseline or previous results rather than absolute outcomes against national standards that do not take context into account.**

New standards are required to incentivize quality care linked to health outcomes and CQI activity (related to clinical outcomes. not facility measures) via new accreditation and Practice Improvement Program. (Relevant to rural context)

ACRRM recommends the development of funding models and education to improve health outcomes by optimising use of ehealth solutions (including telehealth) for at risk/underserved patient groups (including those with chronic conditions)

Q2. Summary Recommendations
Opportunities for the payment to reward and encourage best practice and quality improvement in chronic disease prevention and management

- New financing models are required so that all members of the interdisciplinary care team are adequately compensated to improving care for chronic conditions
- Consider PIP SIP and other incentives for rural clinicians for optimising care and access to services by combining
  - Coordination of care planning,
  - Meaningful use of ehealth tools (e.g. MyHealthRecord, CDMNet etc
  - Monitoring outcomes (CQI) to optimise access to services and mitigate complications for patients with chronic and complex conditions.
- Introduce incentive payments for achieving improvements in outcomes from baseline indicators
- Incentivise participation in coordinated models of care integrating CQI, e-health and the use of electronic health records to greatly improve patient outcomes as part of the PCEHR /MyHealthRecord implementation trials mooted in the 2015 budget provide a catalyst for exploring such opportunities.
- MBS Telehealth eligibility arrangements need amendment to enable a shared care model to be implemented in which the rural generalist doctor can provide support to the remote team; (remote area nurse, Aboriginal Health Worker etc.) at a distance. *Current MBS telehealth arrangements only recognise the medical specialist at the distant end of the consultation*
- Explore financing models and flexible funding models for a range of effective telehealth arrangements not well suited to MBS regulations (eg sessional payments to specialists as per RHOF for TeleDerm)
- Develop and support a wider range of telehealth models (including store and forward and monitoring) which serve good clinical outcomes (reduce diabetes complications), provide up skilling and improve access to services delivered locally (e.g. ACRRM OPHTHALAssist model) based on the successful TeleDerm model operational for over 10 years

- Promote telehealth arrangements that reduce the occurrence of chronic conditions related complications' in underserved rural and remote populations (e.g. GPs and Optometrists with ophthalmologists to improve early detection of diabetic retinopathy).
- Consider immediate use of existing potential complication prevention programmes, which use the cloud- and mobile-based information technologies and services to facilitate their targeting, delivery and evaluation.
- incentivize quality care inked to health outcomes and CQI activity (related to clinical outcomes.. not facility measures) via a revised Practice Improvement Program.(relevant to rural context)
- Explore chronic disease management, linked to outcomes and a one off payment for cycle of care over a 12 month period
- Link the new Modified Monash Model (MMM) rural categories in reporting to link context with targets and outcomes
- Provide different targeted Rural and Remote Workforce and Training incentives are required redress the rural GP medical workforce maldistribution – e.g. tie training incentives to doctors training towards FACRRM (a proven of genuine rural and remote practice intent) instead of the existing incentives associated with "rural training pathway" which has not seen workforce outcomes post graduation

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;

Primary Health Networks will need to consider the rural context and workforce /scope of practice realities when developing locally tailored care pathways that reflect local service configuration and population needs. That said, they are potentially well placed play a vital role in linking together the various chronic care providers on local level to improve coordination and horizontal integration in way that is patient centred.

ACRRM and our Fellows are keen to work with PHNs to contribute to strategies to ensure programs and activities are developed so that they are effective in rural and remote communities. Care coordination is required so a patient can see a number of (visiting) specialists on the same day. Coordination is needed across the population to see the specialist and reduce 'no shows. No shows need follow up to make sure they continue to get the care they need.

ACRRM considers that the current environment, with the establishment of PHNs and the range of reviews and reforms underway – e.g. chronic diseases strategic framework, diabetes strategy mental health plan, MBS review, GP Training changes, Primary Care and eHealth reforms, presents an ideal opportunity for an integrated educational approach to support/ encourage best clinical practice and improve health and service outcomes related to management of chronic disease, within a model of shared care made viable by the eHealth arrangements, targeting a priority group—patients in underserved rural and remote regions of Australia.

The achievement of quality clinical outcomes (referenced to evidence based guidelines) is a powerful driver for most clinicians. Such clinical improvement education is the most popular within the scope of education provided by ACRRM on our online education system Rural and Remote Medical Education Online (RRMEO).

ACRRM proposes the development and delivery of accredited education (PDP and vocational training) focussing on the management of chronic conditions using models of care enabled by eHealth (My Health Record / Telehealth, POCT)

This integrated education will assist the participants (GPs Nurses practice managers) to demonstrate best practice in keeping with new clinical guidelines and eHealth meaningful use standards, and complete relevant quality Improvement activity (clinical audit, data audit, system audit) to link education with improved health outcomes and service efficiencies.

The program can be developed centrally, but delivered regionally in conjunction with the new RTOs and PHNs and eHealth implementation sites.

Q3. Summary Recommendations: Opportunities for the PHNs

PHNs engage with ACRRM to develop practicable strategies for improvement of outcomes in rural and remote communities

PHNs link the various chronic care providers on local level to improve coordination and horizontal integration in way that is patient centred.

PHNs collaborate with ACRRM in a regionally delivered, evidenced based, chronic disease focussed CQI education program promoting a model of shared care made viable by the *eHealth /telehealth* arrangements (including participation in trial sites for opt-in and opt out trials of MyHealthRecord mooted for 2016)

PHNs work with LHNs and community to develop specific population health strategies to target at risk populations

4. The role of private health insurers in chronic disease prevention and management;

There have been some effective models; for example Bellin Health in Wisconsin, and Kaiser Permanente (Curry and Ham 2010).

However, it is essential that they are held accountable for the patient experience of disease and population level health outcomes not simply a for profit model to reduced costs[16].

However, this is unlikely to be an option in rural and remote areas due to the lack of uptake of private providers in these areas. This has been found to be an issue with the roll of out of the national disability insurance scheme in remote areas. The GP needs to be central to the model of care.

Q4. Summary Recommendations: role of private health insurers

ACRRM recommends caution and careful consideration of the implications for rural and remote context which is characterised by poor rates of private insurance and scarcity of health personnel and resources and high levels of chronic disease

5. The role of State and Territory Governments in chronic disease prevention and management;

Lack of clear responsibility, blaming, duplication and cost shifting is detrimental to health outcomes for chronic conditions across Australia. Pooled funding and a collaborative approach by both State

[16] Whittington J W, Nolan K, Lewis N, Torres T. (2015). Pursuing the Triple Aim: The First 7 Years. Milbank Quarterly, 93(2), 263-300.

and Territory Governments have been effective in some MPS (multi-purpose services) and ACCHS (Aboriginal Community Controlled Health Services) and could provide a model for more effective management of chronic conditions.

There is evidence that outcomes for people living with chronic disease can be improved, and hospital attendances reduced by redesign of health care delivery across primary, secondary and acute sectors. The use of stitched up shared medical records, decision support, and clinical information systems and ubiquitous access to broad band supporting interoperable telehealth and ehealth arrangements can improve access to care and health outcomes. The participation of most states in sharing clinical data (e.g. discharge summaries) to the PCEHR/MyHealthRecord is a good start.

International insight coupled with local experience is showing that telehealth is one mechanism to improve equity of access and sustainability of a wide range of clinical services. However if telehealth is to reach its full potential it must be embedded into existing and proven models of care and must be underpinned by supporting and enabling funding and service delivery frameworks. Better alignment between the wide range of state based models and the national MBS telehealth arrangements are required.

State Health based telehealth arrangements vary widely and most do not incorporate access to primary care clinicians.

ACRRM is strongly supportive of the Queensland Health Model, which, like the National arrangements provides incentives driving adoption at both the patient (rural primary carer end) and at the distant end. The Queensland model also has a demonstrated goal of providing GP access.

ACRRM participates as member of the governance committee for this Queensland Health initiative, which is chaired by a rural GP. This engagement increases the focus on integration between primary care and hospital arrangements

Q5. Summary Recommendations: The role of State and Territory Governments

Ubiquitous engagement with primary care in the development of state based telehealth models

Improved alignment of state based telehealth and the national MBS telehealth arrangements

Pooled funding and a collaborative approach by both State and Territory Governments to support innovation in service delivery in rural and remote regions

Incentives for rural clinicians to work at the of their licence to provide comprehensive care in rural and remote hospital and GPs /VMO settings (Rural Generalist Model)

State government an LHN engagement with PHNs

6. Innovative models, which incentivize access, quality and efficiency in chronic disease prevention and management;

The scale of the rural/urban disparity stems from the distinct circumstances and nature of rural and remote communities. Effectively addressing the disparities requires an equally nuanced approach. Innovative models are required.

Not only is the incidence of chronic conditions higher in rural and remote communities; but also the

ratio of patients to medical practitioner is higher than in regional and metropolitan settings, augmenting the importance of the entire team to work to the full extent of their scope of practice to efficiently and safely provide care for their populations. This workforce reality increases the requirement for rural proofing any changes in policy or practice to ensure clinical and population health measures result in demonstrable outcomes, which improve health equity for rural people. Fit for purpose education is required to support the realities of the rural and remote clinical workforce and models of care must reflect the realities of this

Education, training, guidance, incentives and user-friendly resources will be required to improve the ability of rurally-based general practitioners and primary health care teams to know, understand and apply guideline- directed care as well as to develop strategies for management of the continuity of care for patients.

Medical education (including online modules), which provides accessible instruction on best practice in clinical management, is critical. ACRRM considers that further training must focus on the achievement of health outcomes in a model of care, which is regionally responsive and technologically enabled.

Experienced rural doctors require the focus of education and training to be shifted to facilitating the collection of data and measurement of performance in order to improve regional Continuous Quality Improvement (CQI) mechanisms. ACRRM is currently involved in scoping the development of online modules focusing on CQI in the management of chronic diseases (with case studies underway on the use of e- health).

The MBS review also provides the opportunity to examine MBS and Practice Incentives Program (PIP) arrangements for incentivising quality practice; however more flexible funding models are important. The MBS is a blunt instrument for funding indirect patient care including some asynchronous telehealth arrangements and the role of allied health professionals and primary care practitioners at the distant end of the consultation.

Care plans and e-health arrangements can support quality by sharing of essential data securely and there is evidence that tools such as CDMNet have proved effective in streamlining care arrangements and improving outcomes and reducing complications and admissions. There is a major opportunity for developing and delivering effective coordinated models of care involving e-health and use of electronic health records to greatly improve patient outcomes. The PCEHR/MyHealthRecord implementation trials mooted in the 2015 budget may provide a catalyst for exploring such opportunities. Data linkages and partnerships with PHNs and research institutions will value add to the development of CQI systems of diabetes care.

Q6. Summary Recommendations: Innovative models

Decision support and incentivising quality improvement

- ACRRM to contribute to the rationalisation of guidelines to ensure fit for purpose implementation in rural and remote communities
- ACRRM to contribute to PHNs strategies for local care pathways which are cognisant of the rural workforce configuration and scope of practice
- Integrate rationalised ratified guidelines into ACRRM's Electronic Clinical Guidelines for Rural and Remote Practitioners tool (ACRRM provides a single tool which includes an extensive range of guidelines for mobile devices)
- Make these new rationalised (NHMRC) guidelines available at point of care and integrated to the systems to streamline and improve efficiency in the creation and management of care plans
- Track and monitor guideline implementation at practice level and individual patient levels

- Incentivise CQI compliance and achievement

ACRRM strongly supports the establishment of a research agenda to focus, coordinate and translate research into clinical practice and inform population-based decisions. This research should be integrated into the monitoring and evaluation of routine health service delivery and practice, as recommended in the McKeon Report (McKeon, 2013). ACRRM is well placed to maximise this opportunity through its online learning and CPD program and networking across rural and remote Australia.

7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals

Rural health professionals, given the right education, tools, incentives and support are actually better positioned than their city counterparts to effectively coordinate the continuum of patient care and demonstrate the quality improvements required. These advantages are due to; the relationship and visibility they have with their patients and connectedness with community, the continuity of care they provide, their propensity to provide care across health care settings - including work in the local hospital and in a health promotion role for the community, and their relative willingness to use technology to bridge distance. (See www.ehealth.acrrm.org.au)

Integration of care

The continuum of care requires that care is coordinated and in rural and remote communities the providers of the care are often very distant from each other and sometimes from the patient.

Specialist care in the local rural and remote communities is available as part of visiting services, by telehealth, or not at all. The level of expertise and responsibility that local primary care doctors and team are required to have in order to effectively address this problem is much higher than in cities, where specialist level care as well as a wide range of allied health specialists, are all more readily easily accessed.
Furthermore, the interaction between the distant medical and allied specialists, and the rural primary-care doctor and team becomes even more essential and the coordinating function of the local rural practice becomes paramount.

Q7. Summary Recommendations: Multidisciplinary teams chronic disease management in primary health care and Hospitals

The role and potential collaboration benefits of eHealth tools such as PCEHR/MyHealthRecord, systematic care planning (e.g. CDMNet etc.), telehealth, Point of Care guidelines and advice has not yet been fully realised, however the opportunity and case for their implementation is most compelling in communities characterised by the dearth of face to face health services and incidence of chronic diseases such as diabetes

Work with the LHNs /PHNs to identify a range of Multidisciplinary team's chronic disease management models in primary health care and Hospitals in rural and remote regions

8. Models of chronic disease prevention and management in primary health care that improve outcomes for high end frequent users of medical and health services;

There is recent evidence to suggest that there are 5 key primary drivers to improving health outcomes for people with chronic disease and that all of the drivers need to be address concurrently to be effective[17]. These key primary drivers are:

1. Integrated data support to ensure continuity of care

2. Patient Centred Medical Home – provides integrated team-based care

3. Care coordination – across providers for all patients with chronic disease

4. Partnerships with providers – integration and redesign of incentives around improvements in health outcomes

In rural and remote areas access to specialist services is dis-proportionately less that in regional and metropolitan areas.

Metropolitan models dependant on reliance on the physical presence a wide range of specialist providers are not feasible.

Greater flexibility in the telehealth Medicare items, particularly in rural and remote communities would assist primary care providers and the allied health workforce to engage in more effective and efficient patient centred care and ongoing management of chronic conditions. Currently a general practitioner is unable to bill for patient end support when a telehealth consultation is provided by a public specialist provider and there are no items to enable billing for direct patient consultation by a general practitioner or an allied health professional.

New billing arrangements to enable general practitioners and allied health professionals to consult directly with patients and with public medical specialists where the general practitioner or allied health professional is providing patient end support will promote uptake of holistic, multidisciplinary, team based care models and improve timely access to these services for regional, rural and remote communities.

Multiple international and national trials have reported that incorporating remote monitoring in chronic disease management can significantly improve an individual's quality of life. It allows patients to maintain independence, prevent complications, and minimize cost. Remote monitoring facilitates these goals by delivering care at the right time in a location convenient to the health consumer. In addition, patients and their family members feel comfort knowing that they are being monitored and will be supported if a problem arises. Key features of remote monitoring and trend analysis of physiological parameters enable early detection of deterioration, promoting a reduction in the number of emergency department visits, hospitalisations, and length of stay.

ACRRM is committee to work in partnership with government and agencies to contribute to strategic development to ensure the fit for purpose application of these principles in rural and remote regions.

[17] Whittington J W, Nolan K, Lewis N, Torres T. (2015). Pursuing the Triple Aim: The First 7 Years. Milbank Quarterly, 93(2), 263-300.

Our key strength is the understanding is our understanding of this context (evidenced in the ACRRM Primary Curriculum) and our expertise in the development of accessible, practical education to support clinical practice and change management (see ACRRM ehealth education, strategies and networking)

Q8. Summary recommendations: Models of chronic disease prevention and management in Rural and remote primary care

- Engage ACRRM to work in partnership with government and agencies (PHNs LHNs) to contribute to strategic development to ensure the fit for purpose application of these principles in rural and remote regions. (Coordination of care, use of ehealth, telehealth, population health approach, systematic CQI)

- promote use of electronic shared health records and Integrated data support to ensure continuity of care

- Amend MBS Telehealth eligibility arrangements (see above for details)

- Develop financing models to facilitate remote monitoring

- Support education which is based on a population health approach and requires and incentivise participation in CQI arrangements