Better health, Better lifestyles, Stronger communities

Latrobe Community Health Service

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Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Background

LCHS is one of the largest stand-alone providers of community health services in Victoria with over 100 services across Gippsland. The LGA of Latrobe ranks 8th for disadvantage in Victoria. For example the incidence of type 2 diabetes has risen from 3.5% to 5.1% which is now higher than the state average of 4.8%. The diabetes admission rates ratio is 1.6 compared with 1.0 for the rest of Victoria and the ambulatory sensitive conditions are 11.9 compared with the 8.3 Victorian average and the 9.6 Gippsland average.

The LCHS health workforce includes medical, nursing and allied health practitioners providing primary care services in a regional and rural setting. Data collected as part of the minimum data set indicates that 70% of clients accessing LCHS services have a chronic disease. As a key provider of primary health care services we are well positioned to influence the health outcomes of our community.

There is significant demand for some services and despite the application of ongoing demand management strategies there are long waiting times. In some instances all we can do is see the people who come through the door. We know that particularly in lower socioeconomic rural communities this means we neglect a high proportion of the at risk population who have difficulty in accessing services and poor health literacy.

We currently provide services using multiple funding streams including a mix of private and public and including the Medicare CDM items.

Issues to consider

Issue

Multiple funding streams allow us to provide services in a responsive manner but this increases the complexity for clients who already have a poor understanding of the health system and adds to the administrative burden to those providing the service. Increased administration requirements result in less time for clinical interventions.

Recommendation
Streamline services so clients can access the right service at the right time and clinicians have less administration. This will impact positively by reducing the need for hospitalisation and prevent readmission.

Issue
The Medicare system relies on the GP as the gatekeeper, however in the rural context the shortage of GPs remains. Extended scope practitioners such as Diabetes Educators are required to comply with monitoring of approximately eight clinical indicators such as albumin levels in the Diabetes cycle of care. This often results in several requests to the GP for information and the client returning for additional visits.

Recommendation
Look at innovative models of care such as using highly trained health professionals who already have significant skills in care planning. There is an opportunity to look at the role of extended scope of practice allied health professionals or nurse practitioners to access the ability to request pathology tests specific to their area of expertise. There is also merit in looking at this suite of health professionals developing care plans including the ability to refer for funded visits.

Issue
Significant work has been done in the past by the Divisions of General Practice and more recently by Medicare Locals to educate GPs and providers. However there remains a lack of understanding of understanding of the system. The most common issue is GPs ordering more than five visits or changing care plans without notifying practitioners resulting in allied health professionals having their claims rejected.

Recommendation
Streamline services so providers and clients can more readily understand the systems and make choices about their care. Encourage client directed care.

Issue
The current payment system is based on process not evidence based outcomes.

Recommendation
Ensure the GP remains an integral part of the team but create enablers where clinicians who are specialised can assist clients to direct their care. For example a Nurse Practitioner in Dementia care currently needs to send the client back to the doctor for specific scans. These scans are often they key to early diagnosis and allow the team to develop best practice early intervention. However GPs who try to minimise tests and decline the referral can negatively impact the long term care.

Create incentives for evidence based outcomes

Issue
Chronic conditions are complex and require input from multiple service providers. Five visits are not sufficient to ensure a high level of outcomes. For example a newly diagnosed diabetic may require an assessment from a Diabetes Educator, Dietician and Podiatrist. This will use three MBS visits and leaves little for follow up.

Recommendation
Consider extending the number of visits to ten in line with psychological services. Whilst this may increase the cost of Medicare in the short term it is envisaged the longer term benefits of preventable complications and possible hospitalisation can outweigh this. This should be monitored.

Issue
Complex health systems a poor health literacy lead to poorer outcomes

Recommendation
Consider the use of a concierge model to assist clients to navigate the health system. There is emerging evidence here and overseas to support improved health outcomes the most complex and high end users of the health system.

Summary

LCHS is committed to providing services to the whole community using a variety of funding options including public, private, state and commonwealth.

We support a review in the Medicare system moving from a process based system to an evidence based system with measureable outcomes in particular improved health outcomes.

We would like the system to be consumer directed and simplified to improve access.

We support the use of innovative models of car including reviewing the roles of extended scope of practice allied health and nursing professionals.

We encourage a review of the number of allocated visits under the current model.

Kind Regards,

Rachel Strauss
Executive Director Primary Health