Terms of Reference:

The Standing Committee on Health will inquire into and report on best practice in chronic disease prevention and management in primary health care, specifically:

GPpartners is a General Practice Network covering General Practices in the Metro North Brisbane area from the Brisbane River to Caboolture. We are a member organisation with 400 GP members. GPpartners provide relevant education to GPs, offer Peer support and advocacy for GPs and General Practice. GPpartners works closely with the Australian General Practice Network and the RACGP locally. We are always looking for innovative ways to improve patient care and make working in General Practice more supported for GPs.

As a Division of General Practice GPpartners ran three Coordinated Care Trials which showed by supporting patients with chronic disease with management plans and provision of appropriate services there was a 25% reduction in hospital admissions in the intervention group. Interesting with flexible funding which averaged out about $400 per patient during the trial saved ultimately with a reduction in hospital admissions.
From the outcome of the Trial Queensland Health has continued to fund Service Coordination through the Metro North Medicare Local as it was recognised that the reduction in hospital admissions will ultimately save the State Government money. Medibank Private and DVA also provided funding for further trials to see if they could also replicate the findings. DVA continued on to provide funding for Coordinated Care for DVA patients in General Practices.

I note the evaluation of the recent “Diabetes Care Project” showed there was an added cost of $205 per patient and this was considered a negative but if you are saving a hospital admission of $800 a day then this is money well spent.

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally;

Australian Care Coordination Trials.

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

From my experience as a GP working in a practice where the practice manager and owners have had the foresight to look at patient centered care and best outcomes there needs to be a Team approach with the GP overseeing the care however using the skills and knowledge of the other health care providers whether it is the nurse who is doing the screening and recalls for patients, or the chronic disease management nurse, the nurse who does the aged care assessments, the mental health nurse, psychologist, social worker, medication review pharmacist, podiatrist, dietician, diabetic educator or receptionist. The Practice Owners have enabled this process by using Medicare funding in an innovative way to cover their costs. Unfortunately although there are other similar General Practices around the country they appear to be the exception. There needs to be some structure to assist practices to implement the team based approach. The innovation needs to come from the practice and not be imposed and using the Collaboratives Model which was funded several years ago where a General Practice would identify their own issues and provide their own solutions worked well.

It is also essential that the services are provided within a General Practice so the team is aware of each other's skills and knowledge and are able to communicate with each other easily.
Another barrier is work force. It is difficult to find nurses to work in General Practice and nurse training is very hospital orientated.

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

Primary Health Networks could provide the expertise to help general practices set up their own Collaborative to be able to look at the issues in the practice and provide their own solutions. There may need to be some funding to enable GPs and practice staff to have some time out from seeing patients. Hopefully once the value of this process is seen then it will become part of what practices do.
PHNs could provide the Business Case to general practices to show how the Team approach could be a viable way of working.
Service Coordination needs to be within the General Practice so the Chronic Disease Nurse becomes knowledgeable about local services with good communication between services. The PHN however could provide an easily searchable database of local services.

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

The private health insurers are just as keen to decrease hospital admissions and reduce their costs as the Public Hospitals. It is essential though that the GP and patient are the decision makers in the patient's care. If the Private Health Insurer's support the chronic disease plan and provide funding for services that will ultimately prevent hospital admission this will be a positive outcome for all. (Medibank Private had an agreement with IPN about identifying patients with chronic disease and health insurance and arranging for Management Plans without the knowledge of their usual GP. This goes against the whole ideology of the RACGP of the GP with the patient making decisions about their healthcare.)

5. The role of State and Territory Governments in chronic disease prevention and management;
Traditionally the States provided services to people who have difficulty accessing the Primary Care because of remoteness, financial constraints or inability because of mental health or intellectual disability.
In the practice I work in we have been fortunate to have two mental health nurses who support patients at risk of hospitalisation from their mental health issues. The national evaluation of the Mental Health Nurse Program showed a 15% reduction in hospitalisation .
Mental Health Patients have an increased incidence of Chronic Diseases because of their lifestyles and medication. Their life expectancy is the same as the Indigenous Population of Australia. It is therefore important that they attend General Practices to monitor their physical as well as mental well being.
It is important for the patients to have continuity of care and it would be better if all patients accessed a General Practice rather than the hospital system for management of their chronic disease.

Patients with chronic disease who frequently present to hospital are often there because of social or economic reasons. They are not supported in the community or are unable to afford their medications. With some flexible funding or support of a social worker or mental health nurse these patients could be better managed in the community.

It is unusual to have private social workers in the community. They are accessible through the Better Outcomes in Mental Health or Team Care Arrangements with a Chronic Disease Management Plan.

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

As part of vocational registration with the RACGP GPs need to do a quality improvement exercise. GPs could use the work on changing the way their practice functions using the Collaborative Model to meet this learning requirement.

As a GP I find great satisfaction in seeing patients receiving appropriate care and better clinical control of their chronic disease with a Team approach. It makes working as a GP easier as we do what we do best and the other team members cover their areas of competency. The funding needs to be right so it is not a barrier to patients accessing appropriate treatment.

7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals; and
Talk to the practices using chronic disease management nurses and service coordinators. The evaluations of the Team Care Coordination Trials and the Mental Health Nurse Program show reduction in hospital admissions.

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

The last Team Care Trial concentrated more on the patients with chronic complex disease with high risk of hospitalisation. The trial showed that by better holistic care in the care in the community hospital admissions were reduced.

Patients with chronic disease present frequently because they are unable to manage their condition. This can often be because of their socioeconomic circumstances and lack of financial, social or medical support. With the use of Mental Health Nurses who provided this type of support in our General Practice, I noticed a significant decrease in “crisis” presentations and generally better management of the psychiatric and medical conditions.