

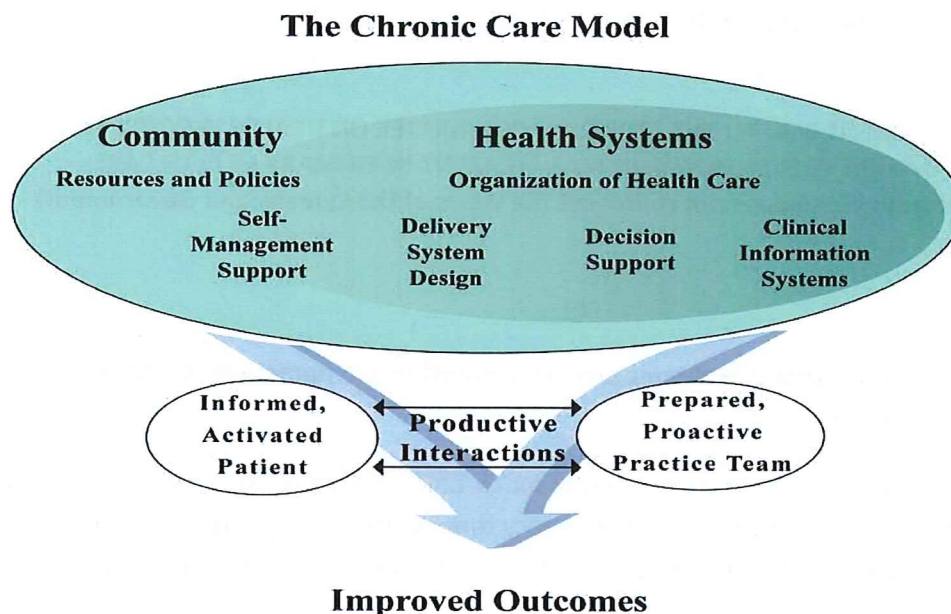
**COMMUNITY, INDIGENOUS AND SUB-ACUTE SERVICES  
METRO NORTH HOSPITAL AND HEALTH SERVICE (QUEENSLAND)**

**INDEPENDENT SUBMISSION TO THE STANDING COMMITTEE ON HEALTH INQUIRY INTO CHRONIC  
DISEASE PREVENTION AND MANAGEMENT IN PRIMARY HEALTH CARE  
(This submission does not represent the views of the Queensland Government)**

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

- A self-management education program for chronic obstructive pulmonary disease reduced hospital admissions by 40% and emergency room visits by 40%, and improved health related quality of life (reported by: Bourbeau J, et al. Arch Int Med 2003;163:585-91).
- A congestive heart failure discharge program reduced the number of hospital readmissions by 68% in the first nine months by coordinating care and educating clients and families (Group Health Centre, Sault Ste. Marie).
- By focusing on primary and ambulatory care, the Veterans Health Administration significantly decreased hospitalizations, leading to a reduction of acute operating beds from 52,000 to 19,000 over a seven year period and a drop of about 60% in the average daily inpatient population (Department of Veterans Affairs, Program Statistics April 2003).
- Kaiser Permanente adopted a series of systematic measures to address chronic disease, including a multidisciplinary steering group, physician champions, patient registries, reminders, outreach programs, and the empowerment of local clinicians. Over a ten year period it achieved:
  - heart disease mortality rate that is 30% lower than in other plans;
  - 15% decrease in death rates from congestive heart failure from 1996-2001;
  - smoking rate of 12% among plan members from northern California compared to 18% for the state as a whole (Kaiser Permanente).

- The Chronic Care Model (Wagner)



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

- Extension of nurse practitioner role in chronic disease management and enabling NP billing within the public health system
- Aligning incentives for better care so that they align with potential savings, viz targeting interventions that help high-cost, high-need patients avoid unnecessary presentation to emergency and/or admission to hospital.
- Taking a population based approach to chronic disease through aligning policies and planning to address chronic disease needs between private providers and public providers to improve access, equity and outcomes.
- Increase pharmacists in multidisciplinary teams to assist with medication reconciliations (and associated benefits to patient reducing contraindicating prescriptions, and savings through PBS from better medication management).

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

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

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

- Provide specialist multidisciplinary team comprehensive assessment and consultation to develop an action plan for short term intervention, then referring ongoing management to Primary Health Sector

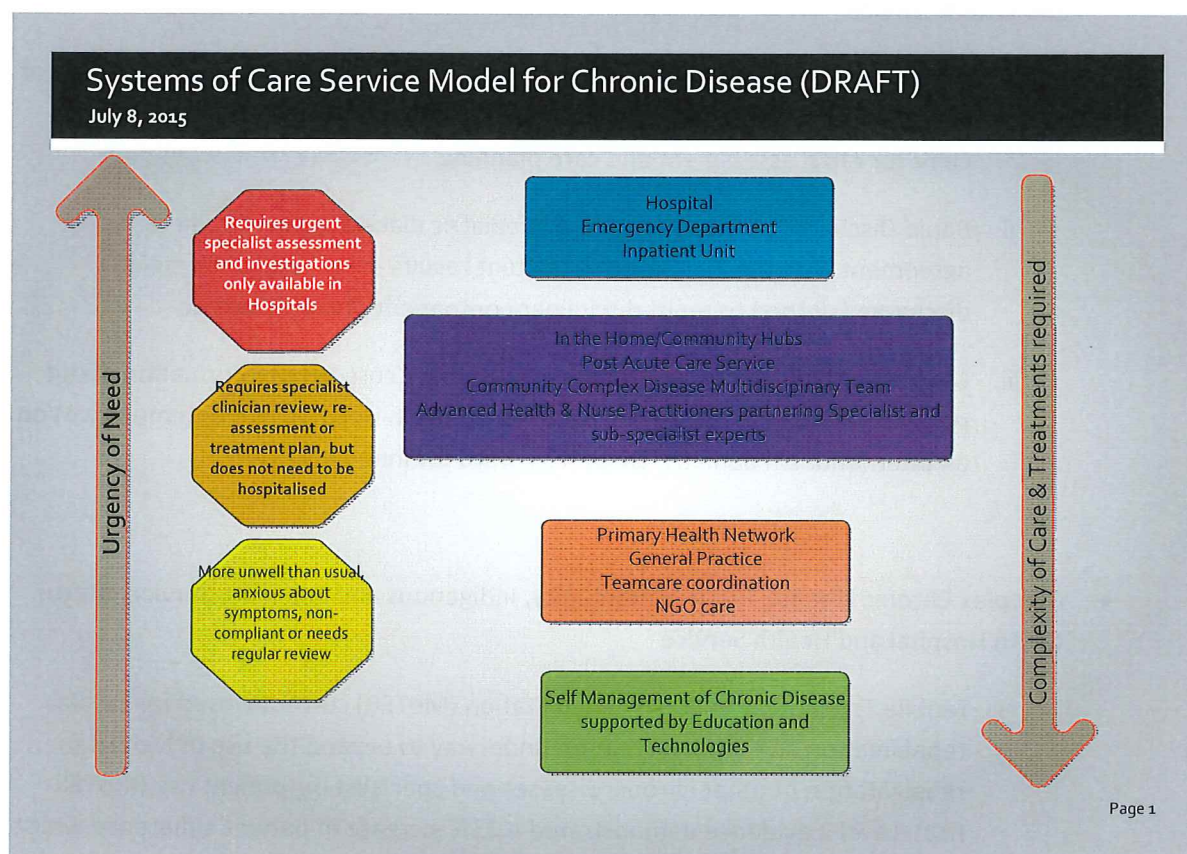
**6. *Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management***

- Diabetes Team - Community, Indigenous and Subacute Service, Metro North Hospital and Health Service
  - i. QAS diversion model where ambulances can bring patients who don't require or refuse Emergency Department attendance directly to the Nurse Practitioner clinic for rapid assessment and care planning
  - ii. Rapid Discharge pathway for acute paediatric diabetic patients where agreement with the Paediatric consultant results in immediate or rapid discharge (<24hrs) to multi-disciplinary outpatient diabetes service
  - iii. My Plan – electronic care planning tool to share core set of information about patients across service providers and locations in Hospital and Community. Won an international Paediatric Diabetes Award for Innovative care
- Complex Chronic Disease Team - Community, Indigenous and Subacute Service, Metro North Hospital and Health Service
  - i. Mobile Technology Enabled Rehabilitation (MoTER) currently used for cardiac rehabilitation and implementation underway to expand the use of MoTER for rehabilitation of other chronic diseases and specialist outpatient use (MoTER-MD) Level 2 evidence demonstrated a 33% increase in patient adherence whilst maintaining equivalent clinical outcomes to a traditional program.



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

Decisions regarding the escalation or Transfer of care between the individual/carer, primary health providers, Multidisciplinary Community/ Home based teams and Hospitals should be based on the urgency of need and complexity of care and treatments required. This is visually represented below



## 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.*

- Developing a system of care for chronic disease that recognises the critical role that the primary health setting plays in the ongoing care to help with self-management and literacy about their health condition, needs and service options, while still requiring and maintaining time limited, state funded, community based secondary specialist multi-disciplinary services and specialist acute services for escalation of exacerbations or complex clinical presentations.
- Education and self-management programs are best managed in the primary health sector
- Accessing shared assessments and care plans across all providers
- Visibility of other current/recent care providers to that patient if they suddenly become acute to access existing assessments and care arrangements and to determine if step-up is required to assist the person for that episode, and then resume or step-down to the next provider according to needs.