Assoc Prof Sharon Lawn
Director
Flinders Human Behaviour & Health Research Unit
Margaret Tobin Centre, Room 4T306
GPO Box 2100
Adelaide SA 5001

http://flinders.edu.au/medicine/sites/fhbhru

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To: Mr. Shane Armstrong
Secretary, Standing Committee on Health
House of Representatives, PO Box 6021, Parliament House, Canberra ACT 2600

Re: Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Dear Mr. Armstrong

Please consider the enclosed submission to the Standing Committee on Health for its inquiry into Chronic Disease Prevention and Management in Primary Health Care.

Brief summary of the main points:

Enhancing the person's capacity for self-management is fundamental to the effective management of chronic disease in Primary Health Care (PHC). This includes prevention of further comorbid health conditions by addressing lifestyle risk factors with assertive support in PHC.

The Flinders Program of Chronic Condition Management and Self-Management Support offers an effective person-centred care planning approach within PHC. This has been demonstrated through the outcomes of two national projects undertaken for: the Department of Veterans' Affairs (the Coordinated Veterans' Care Program) and the Department of Health and Ageing (the Flinders Closing the Gap Program).

Achieving effective chronic condition management requires PHC settings to improve communication and interprofessional practice within and across service delivery systems.

An expanded care planning role for primary health care nurses should be considered to allow them to facilitate the collaboration of multidisciplinary teams and, in doing so, reduce overlaps and fragmentation in client care.

PHC organisations need dedicated implementation support facilitators in order to implement chronic condition management and self-management support.

This submission will provide information on the following terms of reference:

1. Examples of best practice in chronic disease prevention and management
6. Innovative models that incentivise access, quality and efficiency in chronic disease prevention and management
8. Models of chronic disease prevention and management in primary health care which improve outcomes for high and frequent users of medical and health services

The Flinders Program

The Flinders Program of chronic condition management is described here as an exemplar of an approach to the effective management of chronic disease by collaborative care teams across the primary health care sector.

Fifteen years of research and clinical use in a variety of settings and countries has led to robust reinforcement of the components of the Flinders Program, the education and training options and adaptations for special populations.

The Flinders Program care planning process

From its inception in the SA HealthPlus coordinated care trial (1997-99)(Battersby et al., 2002), and subsequent research and development, the Flinders Program care planning process has five functions:

1. Generic and holistic chronic condition management: it provides a generic clinical process for assessment and planning for disease specific management. It uses a semi-structured framework, which could be applied to any chronic disease or condition and co-morbid conditions in the same person, that is patient centred and holistic i.e., incorporates the bio (disease) psychosocial aspects of a person into a plan, and is motivational.
2. Case management: The Partners in Health scale can be used as a screening tool to determine who requires full care planning and case management. The care plan itself then becomes the case management model by defining the roles of the health professionals and the client, the need for case management or coordination could be determined. (Not all people with chronic conditions need support, education or case management).
3. Self-management support: The care planning process enables assessment of the person's self-management knowledge, behaviours and barriers so as to be able to target self-management education and support to the person.
4. Systemic and organisational change: the program provides a longitudinal structure, which if followed naturally leads to the development of an integrated care plan for each patient which addresses: self-management issues; evidence based medical care; motivation and maintenance of effort; a care plan for each medical condition which is measurable and monitored and meshes with public or private practice business processes.
5. Health professional change: Use of the Flinders Program can change a health professional's understanding of their practice in delivering patient centred care. The Flinders Program provides a semi-structured method of ensuring that patients are fully engaged in the delivery of their own care. The quality of the therapeutic alliance is optimised.

Two successful PHC models that have implemented the Flinders Program into practice are described within this submission:

(1) The Coordinated Veterans Care Program
(2) The Flinders Closing the Gap Program

(1) The Coordinated Veterans' Care Program

Currently there are over 20,000 veterans across Australia enrolled on the Coordinated Veterans' Care (CVC) Program which began in 2011. Initiated by the Department of Veterans' Affairs this is a planned and coordinated health care model for eligible Gold Card holders with one or more chronic conditions, complex care needs and who are at risk of unplanned hospitalisation.

The model of health care within the CVC Program involves an ongoing partnership between a core team and is based around the development of a personalised comprehensive Care Plan. The program provides high quality coordinated care to DVA Gold Card holders with chronic and complex health conditions to help them better manage their health and avoid unnecessary hospital admissions.

The CVC Program aims to improve the health of participants by:

- providing ongoing planned and coordinated care from a GP and a nurse
- educating and empowering participants to self-manage their conditions
- encouraging the most socially isolated to participate in community activities.

The CVC Program also includes the provision of accredited learning modules and resources for health professionals leading and providing care coordination for CVC Program. Participants include general practitioners, practice nurses, community nurses and Aboriginal health practitioners. FHBHRU has been responsible for the development and maintenance of online training and education modules designed to support the CVC Program. These modules have been developed as flexible self-paced learning incorporating current evidence-based models of chronic condition care. Recent updates have included the conversion of learning modules to tablet/iPad compatible format. The learning modules developed address the following; embedding the Chronic Care Model and self-management support at a service systems level, care planning and coordination for chronic condition self-management, managing care plans for disease-specific elements, and veterans' social isolation, mental health and wellbeing. These modules are accredited and quality assured for each of the professional groups through RACGP, ACRRM, APNA and ACN.

Since September 2011 approximately 3,000 learners have enrolled in the online learning (general practitioners, practice nurses, community nurses and Aboriginal health practitioners). Additionally over 5,000 offline resource materials have been distributed. Between March 2012 and May 2014 we delivered 122 workshops nationally, working directly with 43 of the 61 Medicare Locals to promote and deliver workshops to approximately 1,500 participants.

Preliminary software integration of care planning tools with auto-populating functionality within current versions of the three most common versions of practice software, Medical Director, ZedMed and Best Practice has been achieved.

(2) The Flinders Closing the Gap Program

From May 2010 the Flinders Human Behaviour and Health Research Unit (FHBHRU), Flinders University has provided training and implementation support to primary health care services providing care to Indigenous populations across Australia in the national initiative known as the Flinders Closing the Gap Program (FCTGP). Its focus has been on training health practitioners and health workers in self-management support.

This training program has aimed to improve the self-management capabilities of Aboriginal and Torres Strait Islander people with chronic diseases and conditions across Australia so that they, together with their health workers and health practitioners, could improve their health outcomes and ultimately close the gap in life expectancy between Aboriginal and Torres Strait Islander people and the general Australian population. This work has been supported by a National Advisory Group, comprising mainly Aboriginal and Torres Strait Islander health workers and consumers from across Australia. This project has met all deliverables and exceeded expectations in each component of the work. The success of the program prompted the development and incorporation of further work known as The Living Well, Smoke Free Program.

The program of work has had three components:

1. Training

Between 2011 and June 2014, Training in the FCTGP has been provided to 825 health practitioners with 61 progressing through the process of becoming an Accredited Trainer. In addition, a suite of training materials has been created including an educational DVD, manuals, a comprehensive website and ten online learning modules.

2. Implementation

As of June 2014, 157 health services had been engaged by the FCTGP. A total of 6,866 care

plans and 59,611 occasions of service had been recorded. This achievement was the result of a systematic implementation program provided to each health service to encourage change in the management of health services.

3. Living Well, Smoke Free Program

As of June 2014, training in the Living Well, Smoke Free Program has been provided to 120 health practitioners including 90 who have already received training in the FCTGP and 30 new trainees.

Training materials such as DVDs, training manuals and posters have been developed with online education modules due for completion in mid-June 2014. Resources designed to assist health practitioners engage with their clients have also been designed and include posters, flip charts and brochures. Extensive consultation with the community and cultural advisors was sought in the development of these materials.

The FCTGP work is ongoing and has included: engagement of a further organisations in implementation over the next 3 years; further integration of the Flinders Program tools into medical software; further development of our on-line education programs; and, adding the collection of clinical outcome data to our data collection capability to demonstrate changes in health outcomes.

The Impact Of The Flinders Closing The Gap Program

The impact of the FCTGP both for clients, health practitioners and managers has been very positive. Comments collected through a series of interviews show genuine change in the way clients think about their health as well as the way practitioners work with their clients to achieve better health outcomes.

A Health worker provided the following story after introducing the My Health Story to their client, demonstrating how these care planning tools provide workers with an effective process for engaging clients in their care:

“We’ve been working with this patient, this individual, for three or four years and nothing had improved in their healthcare or anything like that. Reluctant to come in, reluctant to talk or communicate even with that person that has been talking to them and dealing with them for the last three or four years. Do that Care Plan, the next day that patient and the daughter were in here asking for Quit Smoking patches and Champix to quit smoking. They asked the health workers about diabetes, their diabetes that they’ve had for years, asking them about their Insulin, they didn’t know what diabetes was even though they’ve had it for 10, 20 years. It was instantly, the next day, because someone had started talking to her about her emotional and social issues and stuff like that, but the Flinders model, My [Health] Story, gave them a chance to bring that stuff up and to get it off their shoulders...” (Health Worker)

Another client also commented on the process of setting goals and developing a plan, demonstrating how these care planning tools engaged them more effectively in self-management of their chronic conditions:

“I think the end product, the goal and having an action plan going on, on how to change some things, I thought that was great. And I thought I came up with some ideas today that...I need to act on”. (Client)

A vitally important feature of the FCTGP was not only the provision of training to health workers but also support to implement this approach into PHC practice. This involved the development of a network of change champions that could work directly with PHC organisations and mentor each other. It has also involved support to establish more than 20 Communities of Practice across Australia to support local change managers of our partnering organisations.

Further Considerations:

Achieving effective chronic condition management requires PHC settings to improve communication and interprofessional practice within and across service delivery systems. Central to these improvements is a PHC workforce that is effective at: (1) eliciting patients' needs and preferences (asking patients) and including patients as partners in care decisions; (2) engaging and motivating patients to address self-management or chronic conditions and risk factors (behaviour change skills); and (3) working as a collaborative and coordinated 'team' across care provision (talking to each other) (Lawn & Battersby, 2009a, 2009b). The Flinders Program, as demonstrated by the CVC Program and Flinders CTG Program implementation and achievements, offers a clear model for achieving these requirements.

In order to enhance this implementation process within PHC, and General Practice in particular, an expanded care-planning role for primary health care nurses should be considered to allow them to facilitate the collaboration of multidisciplinary teams and, in doing so, reduce overlaps and fragmentation in client care. Our dedicated work in supporting multiple PHC organisations to implement collaborative chronic condition care, and our research exploring their experiences of implementation (Kowanko et al., 2012; further publications pending), have shown that they need dedicated implementation support facilitators in order to implement effective chronic condition management and self-management support.

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Submitted by:

Associate Professor Sharon Lawn
Director

On behalf of Flinders Human Behaviour and Health Research Unit
Department of Psychiatry
Margaret Tobin Centre
Flinders University
PO Box 2100, Adelaide, SA, 5001