MOSTYN STREET CLINIC

The Secretary
House of Representatives Standing Committee on Health
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5th Otober 2015

Submission to the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Dear Sir / Madam

Thank you for the invitation to the Mostyn Street Clinic to contribute a submission to your health inquiry .We are a small independent general practice of 7 practitioners in Castlemaine ,central victoria servicing (along with 2 other practices in town) the Mount Alexander Shire with a population of 17,500 . We strive to provide a high standard of care and we can report from the coal face.
We appreciate your collaborative approach .
Here follows our report.

Yours faithfully,
Dr Louisa Hope on behalf of the Mostyn Street Clinic

Key Messages:

- Chronic disease is best co-ordinated in general practice setting with a practice nurse.
- Continuity and follow up is vital and can be promoted with the concept of a medical home
- Fee for service does not reward good practice and care of complex patients and another model is required

- PCEHRs and advances in technology to facilitate communication amongst the team is needed.
- Care plans are only useful if individualized and meaningful. Accreditation could ensure a satisfactory standard is achieved.
- Reduce administrative beaurocracy and criteria and make care plans available for more patients.
- The practice nurse wage needs to be increased to attract nurses to practice nursing.
- The freeze on the rebate needs to be lifted to keep general practice sustainable.
- Bulk billing needs to continue to provide equity of care.

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

This is not our area of expertise but experience suggests that reducing social inequality and optimizing educational opportunities for all are the foundations of preventing chronic disease.
Within general practice we regularly give positive health messages to our patients with chronic disease prevention in mind. We can start by promoting good nutrition from birth (with breastfeeding) through childhood and SNAP(review smoking, nutrition, alcohol,physical activity for adolescents and adults)
Based on current evidence, the World Health Organization has suggested a number of 'best buy' policy interventions as well as individual interventions that may assist in the prevention of chronic disease. WHO suggests that these 'best buys' be implemented in primary care settings in all countries to produce rapid results in terms of lives saved,

diseases prevented and large costs avoided (WHO 2013). They include:

- protecting people from tobacco smoke and banning smoking in public places
- warning about the dangers of tobacco use
- restricting or enforcing bans on tobacco and alcohol advertising, promotion and sponsorship
- excise tax increases on tobacco and alcohol
- restricting access to retailed alcohol
- reducing salt intake and salt content of food
- replacing trans-fats in food with unsaturated fats
- promoting public awareness about diet and physical activity, including through mass media
- drug therapy and counselling to individuals who have had a heart attack or stroke and to persons with high risk of a cardiovascular event
- acetylsalicylic acid for acute myocardial infarction
- prevention of liver cancer through hepatitis B immunisation
- prevention of cervical cancer through screening, linked with timely treatment of pre-cancerous lesions. (ref 1)

We could undertake more 45 year old check and 75 year health assessments.
Health issues that seriously impact on people's health are obesity, poor diet and mental illness. Targeting these in any disease prevention model will be important.

The management of chronic disease is becoming increasingly complex and time-consuming but it is important that it is done well and general practice is the obvious location for co-ordination of care.
The Chronic Care Model (ref 2) is a well established framework with key elements being integrated and co-ordinated care, collaboration across multi-disciplinary team,

planned care with CONTINUITY,REGULAR FOLLOW-UP AND REVIEW AND SUPPORT FOR PATIENT SELF MANAGEMENT. GPs with practice nurses are ideally placed to co-ordinate care within this model and they undertake enhanced primary care and team care arrangements.
We need more practice nurses and the nursing award needs to be improved to attract nurses to this role.
The nurses provide health education that the GPs do not have time to do properly and they co-ordinate care.

Care plans can be rorted by unscrupulous practitioners and most GPs have had the experience of the patient with simple hypertension returning from a quick visit to a clinic in Queensland with a meaningless care plan. Some GPs are cynical about care plans but if they are done by a practice nurse and GP with proper care then they will be very useful. Many patients who would benefit from co-ordinated care are excluded by the criteria for enhanced primary care and team care arrangements as few need the on-going attention of 2 allied health practitioners. It is ideal for diabetics but many patients with multiple co-morbidites requiring multiple appointments but not on-going allied health input miss out .

Barriers to following best practice include :
*Complexity of communication between care team members, keeping track of who is doing what and sharing information.
*Ensuring follow-up and review when patients do not perceive it necessary (especially if they have to pay),
*Administrative and red tape requirements for Medicare.
*The paperwork is prohibitive.
*The complexity of putting together MEANINGFUL INDIVIDUALISED care plans (rather than a generic template ignored by the patient and others)
*Promoting patient self management is demanding on time and resources.(ref 3)

Castlemaine has the advantage of being a small town of 3 medical practices. We provide a high level of commitment and continuity to our patients. There is a finite number of allied health practitioners that we know well and can readily communicate with in both a hospital setting and the community health centre, CHIRP. We also use private allied health profesionals.
We can also admit patients to our local hospital and provide after hours care.

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

We support the RACGP vision for general practice and a sustainable healthcare system (ref 4) which has been proposed to help general practice meet the challenge of increasing chronic disease more akin to those in the UK and USA . The current Medicare fee for service model rewards turn over rather than the diligence and attention to detail required to care for complex patients with multiple co-morbidities which is often involves non-contact time spent on planning care and communication .

The RACGP proposal also provides incentives to establish a medical home with voluntary patient enrolment to promote continuity which is vital.

Incentives would also recognize the socio-economic, ATSI, rurality and age profile of the community to reduce health inequality. Incentives would recognize the range of services GPs provide – eg after hours in rural communities.

This would be in addition to the current fee for service model which works well for procedures etc. The model also proposes funding for practice nurse, teaching

medical students, improving co-ordination and continuity of care and IT.
Payment according to targets and outcomes might disadvantage GPs in areas of low socio-economic demographic with poor health literacy.
The Medicare payment system needs to be completely overhauled to reward to the co-ordination of chronic disease which is time-consuming.

Abandon freeze on rebate to keep general practice sustainable and attractive to new graduates and avoid over-specialisation which is a much more costly form of care that a general practitioner can often provide.

3)**Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care.**
Some GPs are cynical about the evolution of Divisions of General Practice in to Medicare Locals at the whim of politicians as it seemed to achieve little more than a lot of new logos and some education sessions. It would be hoped that Primary Health Networks will do more.
* Primary Health Networks (PHNs)have been established with the key objectives of increasing efficiency and effectiveness of medical services, particularly those at risk of poor health outcomes and improving coordination of care to ensure patients receive the right care in the right place at the right time.
* PHNs can review the local population and its health needs and establish the best way to service the local community in the most equitable way with minimal duplication of services This is very important.
* PHNs can provide momentum and education for practices, especially around the introduction of new technology for communication between different health providers and personally controlled electronic health records.(PCEHR)

which will greatly facilitate communication between providers.
* PHNs can support quality and standards in general practice.
*PHNs can promote appropriate use of health services. It is disappointing to note that 90% presentations to the Emergency Department for the 0-4 yr age group were category 4 or 5 and therefore would have been more appropriately seen in the general practice setting.(ref 5)
* PHNs can help support those at risk of poor health outcomes which general practice does not traditionally serve well, eg indigenous Australians, homeless or those with significant mental health issues.

4) **The role of private health insurers in chronic disease prevention and management.**
***** Fund gap payments for patients undertaking care plans with their GPs and promote co-ordinated care.
*Reduce premiums for patients taking responsibility for their health.
*Their telephone follow-up /coaching is effective.

5)**The role of State and Territory Governments in chronic disease prevention and management.**
* health promotion healthy diet and exercise
*fund MCHCN
* equal education opportunities for all (better education = better health)
* tax soft drinks and junk food.
* personally controlled electronic health records

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

* At general practice accreditation there will be review of at least 5 care plans developed by each practice and ensure they are completed to a satisfactory standard.
* Maintain bulk billing for vulnerable groups, especially needed for patients with chronic disease who often do not see the benefits of follow up and will not return if they have to pay.
* See RACGP vision for general practice(ref 3.)

7)**Best practice of multidisciplinary teams chronic disease management in primary health care and Hospitals**

***Better Diabetes Care in Country South SA June 2015** (ref 6) is an example of best practice.
* Clearly defined roles are essential for the different providers of primary healthcare to reduce replication.
* Maximise communication between providers
* Promote patient education and self management

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

*** HARP is designed to prevent re-admission to hospital for high end users.** They advocate for their patients with poor health literacy and promote self management. Much time can be taken up with transport to appointments as the ambulance will not transport non-urgent cases and there is only 1 volunteer driver in Castlemaine. Telehealth will hopefully serve a role here in the future.
Again communication regarding health records/medication/ treatment details is very time consuming as is communication between different health providers, despite good relationships.

HARP is very under-resourced in terms of staff required to cover a vast area. Macedon Ranges Shire needs it's own HARP service. The recent changes regarding the management of aged care packages is likely to result in increased pressure on HARP.

- Primary health providers need to develop expertise in motivational interviewing

Ref 1) Preventing and treating ill health (AIHW) www.aihw.gov.au/australias-health/2014/preventing-ill-health/

Ref 2) Aust Fam Physician. 2014 Dec;43(12):842-6. Digital technologies and chronic disease management. Georgeff M

Ref 3) Med J Aust 2008 : 188 (8 suppl):S53 Chronic Disease Management in primary care:from evidence to policy Sarah M Dennie et al.

Ref 4) RACGP vision for general practice and a sustainable health care system

Ref 5) Aust Fam Physician 2015 Aug;44(8) 584-588. Age-related variation in primary care-type presentations to emergency departments. Freed G, Gafforini S,Carson N.

Ref 6) Country South SA Medicare Local. Better Diabetes Care in Country South SA, June 2015. Adelaide: CSSAML, 2015