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***

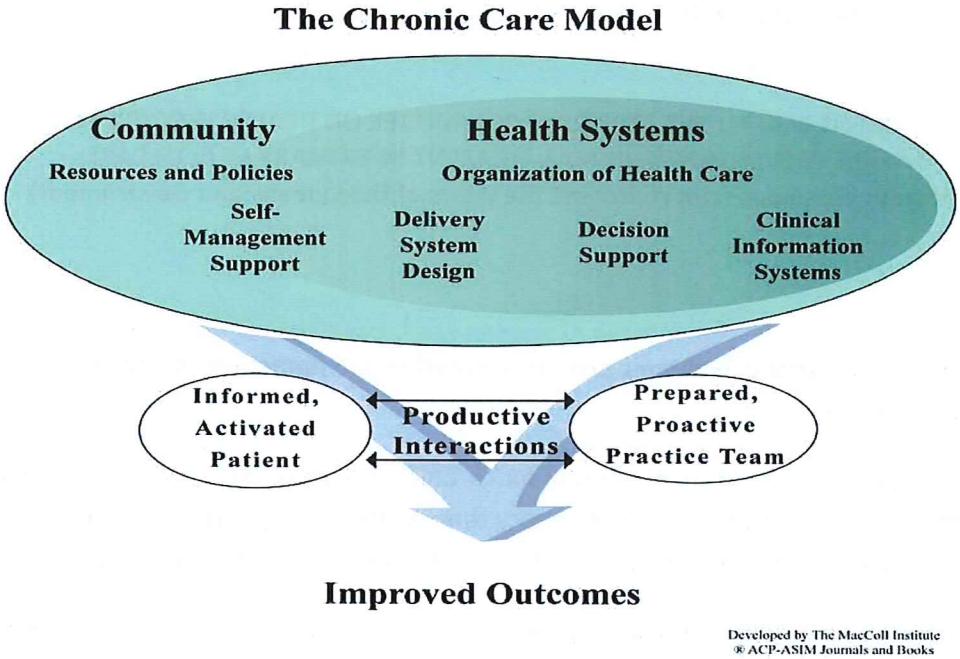
- A self-management education program for chronic obstructive pulmonary disease reduced hospital admissions by 40% and emergency room visits by 40%, and improved health related quality of life (reported by: Bourbeau J,et al. Arch Int Med 2003;163:585-91).

- 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)



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

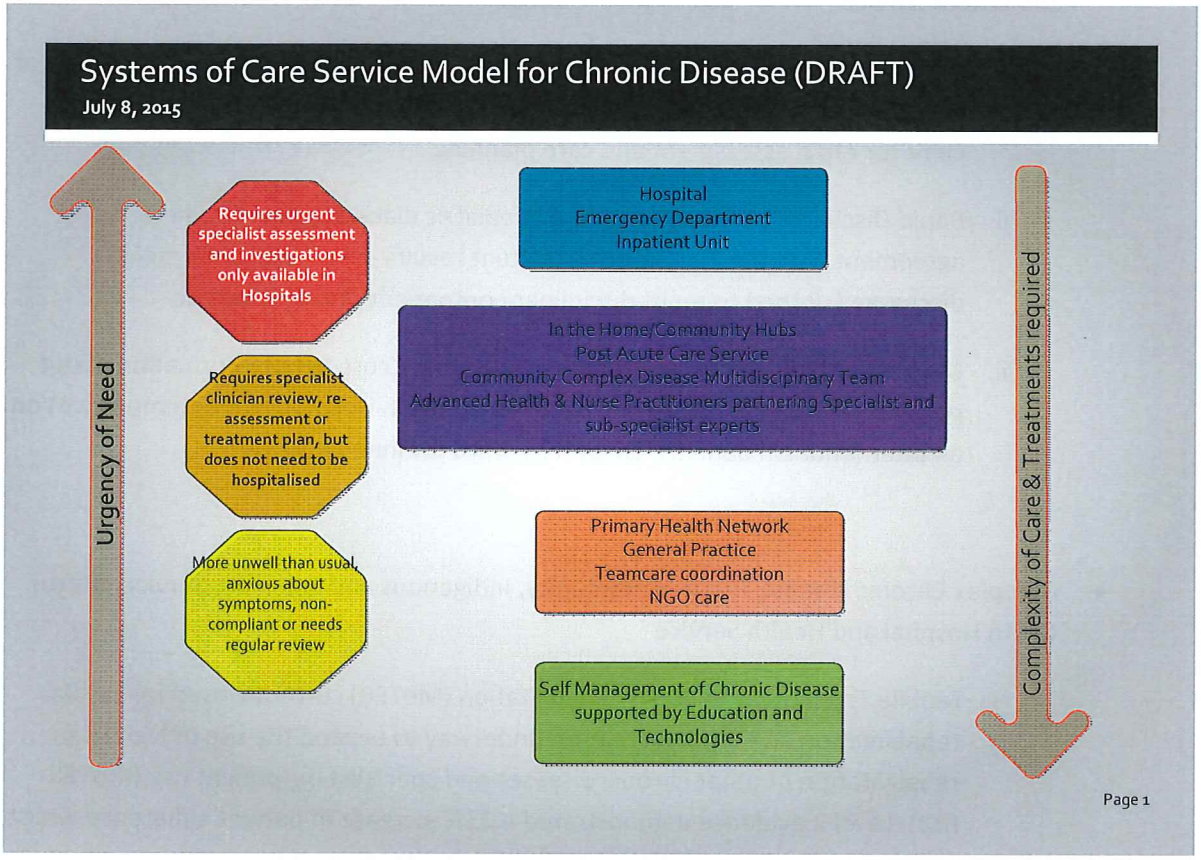
    iii. My Plan – electronic care planning tool to share core set of information about patients across service providers and locations in Hospital and Community. Won an international Paediatric Diabetes Award for Innovative care

- 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.