cohealth

Submission to the Inquiry into Best Practice Chronic Disease Prevention and Management in Primary Health Care

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Contact
Lyn Morgain
Chief Executive
cohealth
7 Chester Street
Moonee Ponds 3039
(03)9377 7170

cohealth.org.au

This submission was prepared by Stuart Beswick, Gordon Conochie, Jeremy Hearne, Catherine Joyce, Anna Vu, and Anna Wark with contributions from a large number of cohealth staff.

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Key Messages

1. A community health approach to prevention and management of chronic conditions

- Community health services are ideally placed to deliver high quality, effective prevention and management of chronic conditions.

- Community health services work across the prevention and management spectrum. Prevention activities range from population-based primary prevention, through secondary prevention (screening, early intervention and risk management), to tertiary prevention (preventing exacerbations and complications of established disease).

- Community health services have a particularly important role to play in providing services to high-needs groups, who experience difficulties accessing mainstream services and who have a great capacity to benefit. These population groups include, but are not limited to:
  - refugees and asylum seekers
  - Aboriginal and Torres Strait Islander people
  - people at risk of harm associated with drug and alcohol use
  - families and young people at risk
  - people who are, or are risk of being, homeless
  - Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex people.

- Complex needs are not just about chronic conditions or multimorbidity, but about a person's social and personal circumstances, including their housing, income, language and so forth.

- The social determinants of health are key to preventing chronic conditions. As such, population-based primary prevention approaches are needed. Community health services have a particularly important role to play in working with communities in primary prevention of chronic conditions. Such activities should:
  - Be tailored, based on understanding of specific communities, which may be defined by geography, language or other identities
  - Be developed using a co-design approach with community members
  - Focus on health literacy as a key factor in improving health behaviours and self-management.

2. Examples of best practice in chronic disease management internationally

- Key features of successful approaches to chronic disease management, as indicated by international best practice, include:
  - Integrated, coordinated care, including beyond the health sector to include social care
  - Person-centred, goal-directed care
  - Prevention-focused care

3. Examples of best practice in chronic disease prevention

- Key features of successful approaches to chronic disease prevention, as indicated by Australian and international best practice, include:
    - A community-based approach, which involves developing an understanding of specific community needs, issues and preferences, and working with them to develop interventions
    - A focus on not only individual health behaviours and choices, but also the 'upstream' determinants that influence these
    - A multi-sectoral approach which include schools, the retail sector and community organisations as well as health organisations.

4. Examples of best practice prevention and management of chronic conditions at cohealth

- cohealth services and programs include many examples of innovative and effective approaches. These include
    - Primary prevention programs tailored to specific communities and targeting health literacy
    - Innovative models of care which support access to care for marginalised groups
    - Multidisciplinary team care models which support health professionals working together in the primary care setting, and linking with specialist services/the acute sector to deliver best practice care

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

- Current items and incentives in the MBS provide some support for effective chronic disease management but they are not sufficient to support best practice approaches.

- There are particular gaps in relation to resourcing for: coordination and liaison; allied health services in line with individual needs rather cost-driven caps; and interpreters for non-medical health professional consultations.

- These gaps impact most on the client groups served by community health: those who experience disadvantage as a result of poverty, homelessness, cultural and linguistic diversity, and other factors. These groups bear the greatest burden of chronic conditions, and investment in better care for these groups has the greatest capacity to improve health status and quality of life, and to reduce avoidable health system costs.

- Community health services are a working example of how funding from different sources (grant funding from State government and MBS from the Commonwealth) can be purposefully aligned to effectively address the health needs of priority populations.

Recommendations

1. The Commonwealth Government should invest in best practice community-based primary prevention of chronic conditions that:
   - Places priority on population groups that experience higher levels of chronic disease and seeks to understand the underlying causes of this inequity
   - Is based on a good understanding of local communities and the specific underlying social and environmental factors contributing to chronic disease in these communities
   - Gives local community members the opportunity to identify these factors, as well as to design and implement solutions
   - Increases the health literacy of people in these communities
   - Works beyond the health system and identifies stakeholders that can impact on the prevalence of chronic disease
   - Is longitudinal in nature and involve rigorous evaluation.

2. Additional resources should be made available to support use of interpreters with non-medical health professional consultations.

3. Commonwealth and State/Territory Governments should pursue the development and testing of new funding models to support patients with, or at risk of developing, chronic and complex conditions. Furthermore, they should seek the involvement of community health services as key participants in these processes, given community health's readiness and capacity to implement such models.

1.0 Introduction

1.1 Overview of cohealth

cohealth is a non-for-profit registered community health service operating across the north and western metropolitan regions of Melbourne. cohealth provides integrated medical, dental, allied health, mental health and community support services, and delivers programs to promote community health and wellbeing. In excess of 110,000 people per year access cohealth services, operating from 44 sites across 14 local government areas in the north and west of Melbourne. We prioritise those who are disadvantaged or marginalised because we know that these groups experience the poorest health. These groups include people who are homeless or at risk of homelessness, Aboriginal and Torres Strait Islanders, refugees and asylum seekers and people who use illicit drugs.

cohealth was formed on 1 May 2014 as a result of the merger between Doutta Galla Community Health, North Yarra Community Health and Western Region Health Centre; three agencies with a history of working with disadvantaged population groups and delivering services that are shaped and tailored in partnership with service users and communities.

cohealth's approach is based on human rights, co-design, and a social model of health. Co-design refers to the engagement of service users in the design process, with the idea that this will ultimately lead to improvements and innovation.[1] Our co-design approach means that we work in partnership with consumers, clients, carers and the community. We create opportunities for active and meaningful participation in decisions about people's own health and health care, as well as how cohealth's services are designed and delivered. Our experience shows that people with lived experience have the expertise to inform effective developments to programs, services and systems. A co-design approach both empowers service users as well as enhancing the likelihood of successful improvements.

Within cohealth's community health approach, exists the recognition that complexity is not merely the presence of disease co-morbidity, but rather, complexity results from the challenges and experiences within a person's history and environment. Thus, it is essential for health practitioners to rise beyond their practice lens and consider the environment experienced by the community and service user.

This submission draws on cohealth's experience as a provider of prevention and management programs and services for chronic conditions. It also draws on commitment to, and experience of, being a vigorous advocate with and for people whose voice is so often absent from community and political debate.

1.2 Definition and distribution of chronic conditions

There is no single accepted definition of chronic disease. For example, under Medicare, eligibility for Chronic Disease Management items is not defined by a list of eligible conditions. Instead, it is based on the clinical judgment of the treating doctor, with the only proviso

[1] Burkett, I. (2014, October). An Introduction to Co-design. Retrieved May 15, 2015, from www.knode.com.au

being that it must be for a condition that has a duration of at least six months.[2] Chronic conditions are understood to be incurable or require prolonged treatment and care.[3] Examples of chronic conditions include diabetes, asthma and chronic obstructive pulmonary disease (COPD), cardiovascular disease, cancer, and mental health conditions.[4]

It is increasingly acknowledged that health inequity results in a higher incidence of chronic disease and that social disadvantage is a leading modifiable risk factor for poor health outcomes.[5] Therefore, chronic disease can be understood as an equity illness: ***the greatest burden of disease is experienced by the most socially disadvantaged people***. Groups that experience a higher level of disadvantage have higher prevalence of chronic disease.[6] The burden of chronic diseases is 32 per cent higher for the most disadvantaged Australians (people in the lowest 20 per cent of socio-economic status) than the most advantaged Australians (people in the highest 20 per cent of socio-economic status.[7]

Particular populations are over represented in their experience of chronic conditions. These include Aboriginal and Torres Strait Islander people,[8] asylum seekers and refugees, certain immigrant groups, and gay, lesbian, bi-sexual, transgender and intersexual people.[9] Indigenous Australians experience a significantly higher age-standardised mortality rate for all cancers combined than non-Indigenous Australians (221 people per 100,000 compared to 172 people per 100,000).[7]

It is vital to recognise the role of the social determinants of health in producing chronic conditions, and to ensure these are considered in the policy responses and interventions, as it is the within the most disadvantaged populations that the greatest potential for health gains exist.

1.3 The importance of prevention and health literacy

It is important to identify the levels of preventive interventions - primary, secondary and tertiary. According to the National Public Health Partnership:

- Primary prevention *aims to limit the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departures from good health, control exposure to risk, and promote factors that are protective of health.*

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[2] Medicare (2015). Chronic Disease Management Plan, from http://www.humanservices.gov.au/customer/services/medicare/chronic-disease-management-plan
[3] Holman H and Lorig K 2000, Patients as partners in managing chronic disease. Partnership is a prerequisite for effective and efficient health care. *British Medical Journal*, 320:526–527.
[4] Australian Institute of Health and Welfare, 2015, *Chronic Diseases*. From: http://www.aihw.gov.au/chronic-diseases/
[5] Australian Institute of Health and Welfare, 2014, *Understanding Health and Illness.* from http://www.aihw.gov.au/australias-health/2014/understanding-health-illness/
[6] Glover, J. et al, 2004, The socioeconomic gradient and chronic illness and associated risk factors in Australia, *Australia and New Zealand Health Policy*, 1(1):8.
[7] Begg, S., Vos, T., Barker, B., Stevenson, L, and Lopez, A. 2007, *The burden of disease and injury in Australia 2003*, Cat. No. PHE 82, Canberra: AIHW
[8] Willcox, S., 2014, *Chronic diseases in Australia: The case for changing course.* Melbourne: The Mitchell Institute.
[9] Wilkins, R. 2015, *The Household, Income and Labour Dynamics in Australia Survey*. Melbourne: Melbourne Institute of Applied Economic and Social Research, The University of Melbourne.

- Secondary prevention *aims to reduce progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention.*

- Tertiary prevention *aims to improve function and includes minimisation of the impact of established disease, and prevention or delay of complications and subsequent events through effective management and rehabilitation.*[10]

Primary prevention must focus on the determinants of health, including the social and environmental factors that cause individuals, communities or certain populations to be at higher risk of poor health outcomes.

cohealth has a specific interest and experience in applying community-based interventions. Such programs have the ability to bridge the divide between medical knowledge of disease prevention and the everyday lived experience; we help people apply this knowledge in their own lives. Community-based interventions go beyond just educating community members about health and lifestyle choices to ensure that community members also have the readiness to identify barriers to healthy choices, design actions to redress these barriers, make changes in their own communities and influence change on a broad level. This approach places its emphasis on the rights of communities rather than the needs of communities, and community members are resourced to articulate their right to health.[11]

In order for people be articulate about their own health and that of their family and friends, they need to be literate in terms of health; they need to have ***health literacy***. Health literacy can be understood as the ability to understand information relating to health in order to act.[12] A fuller definition is:

> *The evolving skills and competencies needed to find, comprehend, evaluate and use health information and concepts to make educated choices, reduce health risks, and improve quality of life. A health literate person is able to apply health concepts and information to novel situations. A health literate person is able to participate in ongoing public and private dialogues about health, medicine, scientific knowledge, and cultural beliefs. This dialogue, in turn, advances health literacy, individually and collectively.*[13]

It is easy for people working in health policy to underestimate the lack of knowledge that some people have regarding health. However, asking health professionals what questions they are asked by patients can indicate the depth of ignorance that persists. For example, when discussing health literacy recently, a health professional advised that a father-to-be asked how long his wife should chew in order for the food to be passed through the umbilical cord to the baby. Another patient had asked what nauseous meant. One of the participants in one of our health literacy sessions didn't think that you were "allowed" to ask questions of doctors and nurses.

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[10] National Public Health Partnership, 2006, *The Language of Prevention*. Melbourne: NPHP.
[11] Fawcett, S. et al, 1995, Using empowerment theory in collaborative partnerships for community health and development, *American Journal of Community Psychology*, 23(5):677-697.
[12] Nutbeam, D., 2000, Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century, *Health Promotion International*, 15 (3):259-267.
[13] Zarcadoolas C. et al, 2003, Elaborating a definition of health literacy: a commentary, *Journal of Health Communication,* 8:119-20.

These incidents are given to indicate the scale of effort that will be required to enable people to make healthy choices to prevent chronic diseases. Just as the incidence of chronic disease is unequal across different population groups, levels of health literacy also vary amongst population groups and in some cases these population groups are the same. For instance, lower levels of health literacy are also experienced by people living in areas with lower socioeconomic status.[14]

Chronic disease prevention programs must focus on increasing health literacy amongst population groups at higher risk of chronic disease, who are also likely to have low levels of health literacy. Prevention programs should include health education as well as the development of community members' skills and opportunities to improve their health and wellbeing in their lives and their communities. It is good that Australian states have signed onto the National Health Literacy Statement and that commitment should now be translated into action to assist prevention of chronic disease

1.4 A community health approach to prevention and management of chronic conditions

cohealth proposes that the community health approach is ideally placed for effective prevention and management of chronic conditions, due to its:

- Integrated, multidisciplinary service model
- breadth of scope from primary prevention through to disease management
- focus on the most disadvantaged populations.

A community health setting is a 'one stop shop', where service users can access a variety of health and support services from one location. This supports and facilitates multidisciplinary and integrated care. It also facilitates access to care for the service user. This is of particular importance to services users with chronic and complex medical conditions who may find it difficult to navigate fragmented health care systems. This can result in duplication of care, or missed opportunities to intervene early, resulting in poorer outcomes.[15]

Community health services are also engaged in a broad spectrum of prevention and management activities relating to chronic conditions. Numerous organisations are engaged in primary prevention, including local councils and disease-specific bodies, as well as jurisdictional and Commonwealth governments. Most health provider organisations, such as general practices and acute services, operate mainly at the level of the individual patient. While they may consider the social circumstances of the person, and adopt an early intervention or prevention focus as routine elements of care, they do not focus at the level of populations or communities. By contrast, community health organisations provide health services for both individuals and communities as their core business, making them an ideal platform for integrated approaches to prevention and management of chronic conditions.

[14] Australian Bureau of Statistics, 2006, *Health Literacy: Australia*. http://abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4233.0Main%20Features22006?opendocument&tabname=Summary&prodno=4233.0&issue=2006&num=&view=. Accessed 14 July, 2015.

[15] Goodwin, N., Sonola, L., Thiel, V., and Kodner, D. 2013, Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success. The Kings Fund: London. www.kingsfund.org.uk/publications

Furthermore, community health services such as cohealth are highly skilled and experienced in working with specific communities, which may be defined by geography (local areas), language, or other identities. cohealth's co-design approach, combined with its strong relationships with specific communities, means that we work in partnership to develop appropriate, accessible services and programs that meet the needs of individuals as well as addressing issues pertinent to the community as a collective.

Finally, community health is well placed to provide care to communities most vulnerable to experiencing chronic conditions. This is due to the community health settings' established relationship with marginalised populations experiencing social disadvantage. These population groups include, but are not limited to, refugees and asylum seekers, Aboriginal and Torres Strait Islander people, people at risk of harm associated with drug and alcohol use, families and young people at risk, older people, people experiencing mental illness and people who are, or are risk of being, homeless.

2.0 Examples of Best Practice in Chronic Disease Management Internationally

2.1 Principles of Chronic Disease Management

The Chronic Care Model (CCM), developed by Edward Wagner, is widely accepted as best practice in the management of chronic disease.[16] Embedded within the CCM is the principle that effective care requires integration of patient, provider and system level interventions. The model identifies health systems, delivery systems, decision support, clinical information systems, self management support and the community as key elements that act to promote high-quality chronic disease care (see Appendix 1). The CCM can be applied to a variety of chronic conditions, health care settings and target populations. The CCM aims to produce healthier service users, more satisfied care providers, and cost savings.

2.2 The Better Care Fund (United Kingdom)

To assist in the development of integrated health and social care, the Better Care Fund was established by the United Kingdom Government in 2013. Created through the redirection of existing resources (3.8million pounds), the Better Care Fund was established as a single pooled budget to encourage the National Health Service (NHS) and local government to work more collaboratively around people, placing wellbeing as the focus of health and support services.[17] Since then, the emphasis of the Better Care Fund has adapted to a focus on reducing hospital admissions and achieving financial savings, with a proportion of the fund now directly linked to performance in this area.[18]

The Better Health Fund has assisted case management and care-coordination to become a well embedded practice, most often delivered by multidisciplinary and community based

[16] Improving Chronic Illness Care, 2015, The Chronic Care Model, from http://www.improvingchroniccare.org/
[17] Kings Fund, 2015, Options for Integrated Commissioning. The Kings Fund: London, from www.kingsfund.org.uk/publications
[18] NHS England, 2014, *Better Care Fund: revised planning guidance*. London: NHS England, from www.england.nhs.uk/wp-content/uploads/2014/07/bcf-rev-plan-guid.pdf

health and social care teams. However, the level of success of outcomes appears dependant on the quality of care coordination realised locally. This, therefore, demonstrates the importance of care integration and coordination to be well developed within an authorising environment with systems in place to ensure its successful implementation.

2.3 The Patient Centred Medical Home (United States)

In response to the recognised need to promote care coordination for ageing populations with chronic conditions, the United States developed the Patient-Centred Medical Home (PCMH). PCMH has since received recognition and endorsement from both within the US and also worldwide for the provision of personalised, coordinated care. The PCMH is made up of four key elements: commitment to primary care; focus on service users as central to care; application of 'new model' practice; and incentives for highly coordinated care.

Users of PCMH are provided with physician or nurse practitioner led care which can be episodic or continuous, depending on what is deemed appropriate and necessary. Patient centred care acknowledges the service user as the most central person in the care team, and as a result, acts to empower service users and their families. The implementation of 'New Model' practice ensures electronic health records are utilised and supports the use of disease registers and accurate data collection. PCMH receive a care coordination fee, in addition to further income from participation in pay-for-performance programs and sharing in the savings through delivering care at below the set expenditure targets. This seeks to improve that quality of health care outcomes and cost effectiveness of care provision. Evidence suggests the PCMH has been successful in doing so, with evaluation suggesting that service user satisfaction, quality of care, access to care and care coordination is higher in PCMH than in other models of care provision. Research suggests that PCMH has resulted in fewer emergency room visits and hospitalisations at the same or lower costs of alternative models.

2.4 Accountable Care Organizations (United States)

In addition to PCMH, Accountable Care Organizations (ACO) are acknowledged as a key component of health care delivery in the US, through providing cost effective care and acting to slow the rate of increase in health care spending overtime. ACO act as an overarching 'umbrella' to PCHM and are bodies that assume responsibility for both cost and quality of care provision to a population and are consequently required to provide performance data. Most commonly, ACO's consist of at least one hospital and physician practices, but may also extend to nursing homes, health agencies or other organisations. ACO's are not identical in design and there are five models of delivery that could serve as an ACO, including integrated delivery system, multi-specialty group practices, physician hospital organisations, independent organisations and physician organisations. Evidence suggests that the more integrated designs of ACO (integrated delivery system and multispecialty group practices) provide care that is superior and at a lower cost per capita than other delivery designs.[19]

[19] Shortell, S. M.,Gillies, R & Wu F, 2010, 'United States innovations in healthcare delivery'. *Public Health Reviews,* 32(1): 190-212.

3.0 Examples of Best Practice in Chronic Disease Prevention Internationally

3.1 North Karelia Project (Finland)

Internationally, the *North Karelia Project* in Finland is seen as a clear example of best practice prevention of chronic diseases, and has taken a strong community-based approach. The project, started in 1972 as a demonstration project in one community, was then scaled-up to become a national project. Methods used in the program were varied and included working with community and health organisations, schools, media, the food industry and supermarkets. The project gained the participation of community members in identifying factors contributing to chronic diseases, and guiding project activities. Results of the project have been widespread and include:

- Massive reductions in the mortality rate from coronary heart disease (73% for men in North Karelia, 65% in all of Finland)
- Increases in life expectancy (7 years for men and 6 years for women)
- Vastly improved dietary habits, and reduced smoking rates.

Community organisation has been identified as a key to the success of this project and several recommendations for similar projects have come from this example, including:

- *Good understanding of the community ("community diagnosis"), close collaboration with various community organizations, and full participation of the people are essential elements of successful community intervention programmes.*
- *A major emphasis and strength of a community intervention programme should be attempts to change social and physical environments in the community more conductive to health and healthy lifestyles.*
- *Major community intervention programmes can be useful for a target community, but can also have broader impact as a national demonstration programme. For this, proper evaluation should be carried out and results disseminated.*[20]

3.2 EPODE (Prévenons l'Obésité des Enfants / Together Let's Prevent Childhood Obesity) (France)

Inspired by Finland's *North Karelia Project*, a program was also developed in France to reduce childhood obesity, now known as EPODE *(Prévenons l'Obésité des Enfants / Together Let's Prevent Childhood Obesity)*. The program was run in 12 towns between 1992 and 2007, and included working with schools, parents, shops, supermarkets, private businesses and health services. Activities included developing a healthy eating component to the school curriculum, identifying safe walking routes to school and distribution of breakfasts in schools.[21] The results of the initial project, known as the *Fleurbaix–Laventie Ville Sante´ (FLVS)* study, showed that over the period from 1992-2007, there were significant decreases in overweight in children, after an initial increase.[22] The *EPODE* model has now been adapted and used in

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[20] Puska, P., 2002, Successful prevention of non-communicable diseases: 25 year experiences with North Karelia Project in Finland, *Public Health Medicine*, 4(1):5-7.
[21] Whestley, H., 2007, Thin Living, *British Medical Journal*, 335: 1236-1237.
[22] Romon, M. et al, 2008, Downwards trends in the prevalence of childhood overweight in the setting of 12-year school- and community-based programmes, *Public Health Nutrition*, 12(10): 1735-1742.

a number of countries worldwide.[23] In Australia, the *Healthy Together Victoria* program[24] (funded by the Victorian and Federal Governments) was informed by the *EPODE* model and is a member of the EPODE International Network[25]. This initiative, commenced in 2011, works to improve health by reducing smoking and harmful alcohol use and encouraging healthy eating and physical activity in children's settings, workplaces and communities. This initiative is currently under evaluation with results anticipated into 2016.

3.3 Examples of Best Practice Chronic Disease Prevention within Australia

In Australia, evaluation of the *It's Your Move!* program (part of the Pacific Obesity Prevention in Communities Project) has found that this 3-year, school-based intervention was successful in reducing overweight and obesity in adolescents, key risk factors for chronic disease. The program trained school project officers and students ambassador who assisted the delivery of initiatives, such as removal of soft drinks and other unhealthy foods sold at the school, promotion of healthy foods through school canteens and the promotion of active transport to school i.e. non-use of cars. It is suggested that the success of this program was, in-part, due to the community capacity building framework that was used in its design, as it allowed flexibility for the program to be adapted to the local community setting.[26]

Similar to that program, another community-based initiative in Australia decreased the prevalence of overweight and obesity amongst 0 to 5 year olds. The *Romp and Chomp* program was conducted in Geelong (Victoria) early childhood care and educational settings from 2004 to 2008 targeting 12,000 children. There was a significantly lower intake of packaged snacks and cordial juices than that in the comparison sample and overweight incidence decreased by 2.5% in the 2 year old age group and 3.4% in the 3.5 year old group. This program also had a strong focus on community capacity building, and on the policy and environmental factors that influence overweight and obesity. Success of the program was attributed to policy and cultural changes in the educational settings as well as capacity building with teachers and care-givers, which led to the promotion of fruit, vegetables and water as opposed to packaged snacks and sweet drinks within settings.[27]

While the two examples above have been carried out in specific settings, it is also important to target specific population groups. Aboriginal and Torres Strait Islander people carry a far greater burden of chronic disease than non-Indigenous people and the largest contributors to the health gap are cardiovascular disease, diabetes, mental disorders and chronic respiratory disease.[28] For interventions to be successful with this population group, Aboriginal communities must be able to control and take ownership over them, and Aboriginal

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[23] Borys, J. et al, 2013, EPODE—A Model for Reducing the Incidence of Obesity and Weight-related Comorbidities. *Endocrinology*, 9(1):32–36.

[24] Healthy Together Victoria, 2015, About Healthy Together Victoria, from http://www.healthytogether.vic.gov.au/

[25]EPODE International Network, 2015, Healthy Together Victoria, from http://epode-international-network.com/members/programmes/2014/11/14/healthy-together-victoria

[26] Millar, L. et al, 2011, Reduction in overweight and obesity from a 3-year community-based intervention in Australia: the 'It's Your Move!' project, *Obesity Reviews*, 12 (Suppl. 2), 20-28.

[27] de Silva-Sanigorski AM et al, 2010, Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program, The *American Journal of Clinical Nutrition* 91: 831–840.

[28] Vos, T. et al, 2009, *International Journal of Epidemiology*, 38 (2): 470-477.

Community Controlled Health Organisations have an important role to play here.[29] The National Aboriginal Community Controlled Health Organisation has put forth the following set of principles for tobacco control for Aboriginal and Torres Strait Islander people:

- *Aboriginal and Torres Strait Islander tobacco control programmes should seek to maximise community control.*
- *All individuals and organisations working on programmes in Aboriginal and Torres Strait Islander tobacco control should understand and respect the social context in which Aboriginal people and Torres Strait Islanders live their lives and programmes should reflect this understanding.*
- *Tobacco control programmes for Aboriginal and Torres Strait Islander communities should be holistic in nature and consider the social determinants of health.*
- *Tobacco control programmes for Aboriginal and Torres Strait Islander communities should be as comprehensive as possible within given resources.*[30]

These principles are not just applicable to working with Aboriginal and Torres Strait Islander communities though; the same principles would apply for creating effective interventions in any community, be it geographically or culturally defined. Australia is hugely multicultural and understandings of health, illness and risk can vary across cultural and language groups, and so health promotion and education efforts need to be shaped in order to fit with particular groups' worldview.[31] When preventive programmes are co-designed with communities to consider these then their effectiveness can be increased.

In 1993, the Indigenous Looma community in remote northwest Australia began the implementation of a *Healthy Lifestyle* program, and this program shows further evidence that community-based initiatives can be an effective way to prevent chronic disease. As the community had identified a lack of knowledge relating to nutrition as well as access to nutritious foods, the program included educational sessions and exercise groups, as well as the appointment of a community member to the management of the community's one store that provided most of the food available. Program evaluation found that there were reductions in the prevalence of diet-related coronary heart disease risk factors among community members, with success being attributed to the community's ability to improve its food supply, as well as other council policies, such as smoking bans.[32] Here we can see that the strength of a community-based initiative lies in the ability to adapt a program to the specific needs, based on what has been identified by community members themselves.

Another example from a remote Indigenous community is a health and nutrition program run in 1989 and 1990 in Minjilang in the Northern Territory. This program saw lasting improvements

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[29] National Aboriginal Community Controlled Health Organisation, 2014, from http://www.naccho.org.au/

[30] Briggs, V. et al, 2003, Aboriginal and Torres Strait Islander Australians and tobacco, *Tobacco Control* ;12:ii5-ii8

[31] Vass, A. et al, 2011, Health literacy and Australian Indigenous peoples: an analysis of the role of language and worldview, *Health Promotion Journal of Australia*, 22:33-37.

[32] Rowley, K. et al, 2001, Improvements in circulating cholesterol, antioxidants, and homocysteine after dietary intervention in an Australian Aboriginal community, *American Society for Clinical Nutrition*, 74:442-448, Rowley, K. et al, 2000, 'Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian Aboriginal community, *Australian and New Zealand Journal of Public Health*, 24:136-144.

in the community's dietary intake, and success of the project is attributed to the ability of Aboriginal people to control and have ownership over the project.[33]

The above examples of initiatives that seek to prevent chronic disease show that there are important aspects that can make a significant contribution to improved health outcomes. These include the building of community capacity to identify and influence changes within settings, as well as action to redress the structural and physical environments that increase risk of chronic disease. The initiatives outlined above were all long-term in nature, and required time to be able to impact on the broader environments where risk factors occur and to see decreases in those risk factors. These successful initiatives sought to increase the capacity of community members to not only understand health information on the risk factors for chronic disease, but also apply this knowledge to impact on the determinants of health; communities were becoming more health literate.

4.0 Examples of best practice prevention and management of chronic conditions at cohealth

cohealth has demonstrated the successful prevention and management of chronic disease through care models and programs that provide innovative care to target groups experiencing chronic disease. Examples are detailed in this section.

4.1 Prevention programs

Healthy Together Health Champions

As a community health service with a strong commitment to engagement, ownership, participation and relevance to communities, cohealth is located at the interface between community and a broader public health agenda. An example of our work in this space has been our role in the *Healthy Together Victoria* as the lead agency for the *Healthy Together Health Champions* program. This program supports people to improve their health and influence the health of their families, friends and community in the places where they live, work, learn, and play. People recruited as health champions were trained and resourced to gain the confidence, knowledge and skills to lead local community action and change to support healthy lifestyles and the program was designed using an empowerment framework, engaging communities in the planning and implementation of initiatives.

Healthy Together Hume (Victoria) introduced their 'Growing Ideas Awards' that invites community members to create ideas, collect supporters, pitch their idea and decide together which ideas will be funded. Two of the very first 97 health champions in Hume started making changes with their families and workplaces. Sugary drinks are off the menu and parents who attend their playgroups now only bring healthy snacks like fruit. In Knox, Victoria, there have been 47 active health champions recruited since September 2014 and they are linked to a further 105 people, who receive support for their own activities promoting healthy living in their communities. Programmes include walking groups, community gardens and health information support for newly arrived immigrants.

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[33] Lee, A., et al, 1995, Sustainability of a successful health and nutrition program in a remote Aboriginal community. *The Medical Journal of Australia*, 162: 632-635.

Aside from community-based interventions that focus on behaviour change within communities, it is also important to focus on policy interventions that can influence the broader environments in which behaviour occurs. This can also be done using the participation and ownership of community members and one example of this is *The Parents' Jury*, an "online network of parents, grandparents and guardians, who are interested in improving the food and physical activity environments of Australian children". This network advocates for the promotion of healthy eating and physical activity in schools, improved food labelling, reductions in the marketing of junk food to children, removal of junk food from supermarket checkouts and increased resources for parents to promote healthy eating at home.[34] Some Health Champions in Whittlesea (Victoria) formed a group to advocate for better public transport in the area and road infrastructure, in addition to promoting and running walking and cycling groups. Policy formulation must include people from the target groups and consider various needs and preferences.

Connected: A Community Health Literacy Pilot Project

In 2015, cohealth has implemented *Connected: A Community Health Literacy Pilot Project*, which aimed to improve participants' health literacy by;

- building their confidence to ask questions,
- supporting them to understand the social determinants of health
- assisting participants to develop booklets themselves to share with others
- supporting facilitators to communicate in easy to understand ways

The course was designed with six members of the targeted communities to develop processes and content that would assist learning about health literacy. The course was then trialled with 80 people in six sessions and covered:

- how to ask questions and get ready to see a doctor or health worker
- taking notes during meetings with health services, and taking a person with you
- how to find good health information on the internet
- how to understand what your rights are and using your voice
- how to get involved in better health for yourself and your community

The sessions also focussed on 'Seeing the Bigger Picture' so that people understand that health is not just about health care, doctors and nurses but that there are lots of things in our environment or what we do that affects our health. This is to encourage people to take ownership for their health and for affecting their environment and behaviour. Evaluation of this project showed that it had increased participants' ownership of their own health.[35] A participant advised that whilst responsibility, control and ownership are all related, realising that the individual has ownership added another dimension to their attitude. This is crucial to helping people live healthier lives that prevent chronic disease.

Our health literacy programme was successful because it had been co-designed with members from the communities to be worked with, increasing specificity and effectiveness. There are a number of programs both in Australia and internationally that do provide

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[34] The Parents' Jury, 2013, Your Voices on Food and Activity, from https://www.parentsjury.org.au/
[35] cohealth, 2015, *Connected: A Community Health Literacy Pilot Project: Interim Report.* cohealth: Melbourne.

evidence of best-practice interventions at a community level, because of community involvement in design.

Living Well

Living Well supports people with a presenting chronic health condition (e.g. diabetes, arthritis, asthma, Hepatitis C, heart or lung disease) or people who have a presenting risk factors (e.g. smoking, being overweight, lack of healthy eating/physical exercise, high blood pressure/blood sugar) to take charge of their health and achieve their health goals. Living Well is facilitated by team of Health Coaches who provide information and support to service users in regards to healthy eating, being physically active, quitting or reducing smoking and effectively managing their condition. Living Well's Health Coaches can assist service users to begin to take action in regards to their health, maintain motivation, overcome hurdles and perceived barriers and move forward to achieve their health goals.

The Living Well Health Coach team is comprised of health professionals with clinical expertise with a variety of backgrounds and experience such as nursing, social work and occupational therapy. This team is highly skilled in Health Coaching and Motivational Interviewing and works collaboratively with the service user, GP and other health professionals involved in order to achieve the best possible health outcomes.

There exist many strengths of the Living Well program that facilitates effective engagement and support of service users in relation to their health and wellness needs. These include:

- Provision person centred care, in which the service user guides the health and wellness plan and sets goals with the support of a health coach.
- Provision of goal directed and coordinated care.
- Flexibility to work with both service users with a presenting chronic disease, and service users with a presenting risk factor.
- Support can be one on one, in a group, with significant others or carers present, or over the telephone coaching.
- A strong focus on evidence based practice, including research and evaluation, with presentations at conferences and publishing case studies.
- Recognition of the benefits of external networking and referrals when required to support service users' health and wellbeing goals.
- Quick response to service users who are identified as being in the action or contemplative phase of behaviour change.
- Option to waive service fee if this will act as a barrier to care.

As a result, the Living Well program is very effective in providing appropriate care and support to service users engaged in health related behaviour change. The flexible and responsive service is suitable for cohealth service users, often from marginalised groups, and the person-centred approach acts to improve service user self-confidence and sense of control over ones health and wellbeing.

Recommendation 1: The Commonwealth Government should invest **in best practice community-based primary prevention** of chronic conditions that:

- Places priority on population groups that experience higher levels of chronic disease and seeks to understand the underlying causes of this inequity
- Is based on a good understanding of local communities and the specific underlying social and environmental factors contributing to chronic disease in these communities
- Gives local community members the opportunity to identify these factors, as well as to design and implement solutions
- Increases the health literacy of people in these communities
- Works beyond the health system and identifies stakeholders that can impact on the prevalence of chronic disease
- Is longitudinal in nature and involve rigorous evaluation.

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

Collingwood Integrated Pharmacy

The Collingwood Integrated Pharmacy is a working and proven model of integration and good practice supporting better health outcomes for disadvantaged populations requiring complex service responses. This clinic is run from cohealth Collingwood, and employs pharmacists to work alongside GPs and other health providers within an integrated setting. The pharmacy is the only one of its type in the country, and has been in operation for over two decades since its inception in the predecessor organisation North Yarra Community Health.

The service provides low cost medication, medication review, monitoring and education in collaboration with other health providers to local community members from disadvantaged and marginalised groups. The service dispenses about 30,000 prescriptions annually.

Clients of the service are people in significantly disadvantaged circumstances, with generally low levels of health literacy and often multiple chronic diseases. Approximately 40% of clients are from non-English speaking and low English proficiency backgrounds. The use of interpreters with both GPs and pharmacists is a key feature of the model. The co-location of GPs and pharmacists means that service users access the pharmacy while interpreters are still present and available during and following the GP appointment – simply by accessing the additional minutes which are paid for as part of a minimum block of time but often go unutilised. The use of qualified interpreters in this setting promotes the right of people with diverse language backgrounds to be fully engaged in their own health care. It ensures that people actually get their prescribed medication, and that they understand what they need to know to take it safely and appropriately.

A recently completed internal review of the pharmacy model found:

1. The cohealth pharmacy provides **quality care at a reduced cost** to the Australian Government. Based on Department of Health data, the average cost of a prescription through the pharmacy is 31% lower than the average government cost

per prescription for PBS medication. Annualised, this represents a saving of just under $250k per annum;

2. The pharmacy provides efficient and effective medication management for high need and marginalised groups within the community, through preferential use of generic and cheaper brand medicines and integration within a primary health setting through:
    - simplified referrals and communication pathways across different professions (GPs, pharmacists, Alcohol and other Drugs and mental health clinicians and nurses);
    - utilisation of a common electronic record that facilitates visibility and promotes collaboration;
    - enhanced capacity to review the appropriateness of medication, and minimise the risk of over- or inappropriate medication;[36]
    - development of tailored dispensing regimes for high risk populations, those with mental health issues, substance use issues and the elderly.

3. The pharmacy supports **enhanced access for marginalised groups**. The integration of the pharmacy service into a "one-stop shop" community health service supports comprehensive care for people who experience the greatest difficulty in accessing services. As well as the language issues noted above, there are significant numbers of clients classified as "homeless or living in insecure housing" attending the clinics, as well as those with other significant risk factors like drug and alcohol dependency. These clients require tailored pharmacy practice not available in standard pharmacy setting.

The cohealth pharmacy model provides an operational example of integrated practice which is both efficient and effective in improving quality and accessibility of pharmacy services for high need populations[37].

The model is consistent with the directions promoted by the Australian Medical Association and the Pharmaceutical Society of Australia, towards developing an integrated model with pharmacists as part of the primary care team. This approach is echoed in the National Mental Health Commission's N*ational Review of Mental Health Programmes and Services*, which recommends routine pharmacist involvement in the mental health care team.[38]

The Fitzroy Model

The Fitzroy Community Health Medical Practice operates in a significantly different manner to a general medical practice, by providing a coordinated approach to the management of service users with chronic and complex conditions. The Fitzroy Model also aims to streamline

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[36] Research undertaken in 2011 by Assoc Prof Libby Roughead, Director, Quality Use of Medicines and Pharmacy Research Centre, University of South Australia
[37] Pharmaceutical Society of Australia, and Australian Medical Association, 2014, Joint Statement, from http://www.psa.org.au/media-releases/pharmacists-working-within-general-practice-the-way-ahead
[38] National Mental Health Commission, 2014, Review of Mental Health Programmes and Services, from http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx

access for service users who may otherwise miss out on appointments due to limited availability. The model is designed to:

- Enhance the work doctors are already completing
- Provide support so the treating doctors can focus more on the clinical needs of the service user and less on administrative requirements.
- Provide a coordinated approach to Care Planning to ensure all the eligible clients receive the benefits of accessing other services under General Practice Management Plans (GPMPs) and Team Care Arrangements (TCAs).
- Provide a coordinated approach to Case Conferencing including a platform for education that is provided to the client and practitioners, along with the opportunity for pre-work to be completed by the Care Coordinator or nurse, including the opportunity to refine Care Plans and enhance care.

This is achieved through the application of varied appointment models depending on the service user's specific need. There are three types of appointments applied within the Fitzroy Model:

a. Current Model: 20 minute appointments (GP, Care Coordinator or Nurse can direct service user to detailed or swift model where appropriate).
b. Detailed Model: 20, 40 or 60 minute appointments for service users with complex or chronic conditions (Alcohol and Other Drug use, diabetes, mental illness, CALD background).
c. Swift Model: 10 minute appointments appropriate for non complex/ chronic service users for specific services only (prescriptions, medical certificates, results, walk-ins).

Additionally, this is supported through the appointment of a Care Coordinator (RN or EN) to undertake initial health assessments for the care plan, schedule appointments for case conferences, work in conjunction with external support and care providers, and can operate as a third practitioner in care planning.

4.3 Multidisciplinary Team Care

Moving towards Interprofessional and Collaborative Practising Teams Project

This project was developed as a result of research and consultations undertaken by cohealth (formerly Doutta Galla) staff and service users in 2009 and 2010.[39] This research found that structures, policies and systems across the primary health care service did not support an interprofessional and collaborative approach to service delivery and support. The service user journey was often unnecessarily complex, with service users reporting experiencing poorly coordinated care. Consequently, the Moving Towards Interprofessional and Collaborative Practising Teams Project implemented the following:

i. Site based interprofessional and collaborative practicing (ICP) teams for allied health.
ii. A number of associated innovations, including the Care Coordinator role, Client Review Meetings and the introduction of a coordinated appointment system.

[39] Frizzell, J. (2015). cohealth Moving Towards Interprofessional and Collaborative Practising Teams: Evaluation Report.

iii. A range of new policies, procedures and systems to underpin the work of ICP Teams and achieve best practice chronic disease management.
iv. Extensive staff training and capacity building, to ensure staff possess confidence and competence to work in an interprofessional and collaborative team.

The project objectives were:
1. To enable staff to work in an interprofessional collaborative practice model.
2. Develop systems and tools support interprofessional collaborative practice.
3. Ensure service users experience interprofessional and collaborative practice person centred care.

This was made possible through an authorising environment for change, supported by the Board, CEO and executive manages; significant support from staff and service users; utilisation of best practice evidence to form new models; utilisation of Kotter's 8 stages of change model to facilitate the change in management process; and a dedicated project team, project plan and evaluation framework.

Project evaluation findings support that the aims and objectives of the project were achieved. In particular, the following outcomes for service users have been achieved:
- Improved access to streamlined appointments and coordinated care.
- Improved access to joint assessments and joint goal setting with an interprofessional team.
- An increase in the number of service users with a Care Plan, with self identified goals and contributions from more than one discipline.
- An improvement in the number of service users who achieve the goals set out in their Care Plan.
- Access to coordinated and person-centred team based care.
- A seamless service user journey (coordinated appointments, joint assessments, shared care planning and client review meetings.)
- Improvement in capacity to self-manage.
- Access to a Care Coordinator to assist with care coordination and building self-management capacity.
- Increased service user satisfaction.

Why Weight

In response to the recognition of the increasing numbers of service users experiencing morbid obesity yet the limited resources available to support staff, the Why Weight innovation project was established at cohealth to investigate staff and service user experiences and to explore best practice in the provision of support for people with morbid obesity. The project consisted of a literature review, which revealed the complexity of obesity for both the individual and the wider population, the many and varied factors which influence a person's' weight across the lifespan including biological factors, the built environment, physical activity, calorie intake, level of education, financial resources and government policies, and suggested a multi-disciplinary, multi component or interprofessional practice (IPP) approach is recommended to effectively address obesity. Additionally, the project saw the establishment of the Why Weight working group, made up of cohealth allied health and mental health practitioners, the group provided a platform for discussing thoughts and ideas in regards to how cohealth can enhance practice with this population. Furthermore, Why

Weight invited 9 service users with experience of obesity to be interviewed by an independent project officer, in which they were asked to share their experiences and thoughts on the services and support they received from cohealth in regards to weight management or issues related to being above their healthy weight. As a result, it was revealed that despite the challenges working with people with morbid obesity can present, service users identified many ways in which cohealth practitioners are making positive contributions:

Consequently, the Why Weight project in evidence of the continual service improvement, innovation and reflective practise required to address and support people experiencing chronic disease. The project confirmed that, as with all chronic disease, a multidisciplinary and IPP approach is required in order to create an environment to support service users and their health.

Branching Out Program

The Branching Out program is a cohealth interprofessional practice (IPP) project developed to assist people of refugee and asylum seeker background to move beyond pain. The Branching Out program works in a culturally safe way and acknowledges the impact torture, trauma and settlement experiences may have on service user's health and wellbeing. Additionally, the program recognises pain as a complex human experience and works in a collaborative and person-centred manner to assist in service users' understanding of pain and pain management strategies.

Current concepts of pain emphasise the multi-dimensional nature of the human pain experience and evidence identifies strong associations between pain and the re-experience of trauma. People experiencing pain can access a range of primary care services; however these are often not sufficient or are not delivered in an integrated manner. The Branching Out project was implemented in a community health setting to address these factors. The interprofessional practice team consists of counselling, physiotherapy, self-management support and other services as identified through service user needs. The shared experience, learning and the establishment of trust are reported as most valuable factors in enabling service users and therapists to effectively work together. Furthermore, this assists to identify factors impacting on the experience of pain and in the development of an individual service response for each person.

Collaborative Back Pain Project

This innovative pilot project was developed in partnership with the tertiary centre Melbourne Health, and the Primary Care Centres: cohealth and Merri Community Health Services. The project was developed in response to the recognition that waitlists act as an obstacle for those who would benefit from prompt surgical intervention, that waitlists are an obstacle for to people receiving appropriate treatment and full investigative work up, and that while on waitlists people develop chronic health issues due to inappropriate self management.

Funded through the Department of Health Workforce Innovation Grants, the project aimed to develop a collaborative model for improving the timely management of back pain through utilisation of Advanced Practice Physiotherapists and community health treatment models. The project consisted of triage of waitlist, Back Pain Assessment Clinic (BPAC),

Evidence based conservative care delivered at the community health centres, and three month follow up review at Assessment Clinic.

Of the 409 people on the Melbourne Health waitlist for spinal pain, 238 were contactable and were subsequently referred to the Assessment Clinic.

Of the 238 clients triaged:

- 20% discharged with no ongoing issues
- 11% required further investigation
- 4% received injection
- 49% referred for conservative management
- 4% referred on to specialist clinics
- 5% referred to pain services

As a result of the Collaborative Back Pain Project, it was concluded that providing timely and appropriate intervention for back pain acts to improve service user outcomes and reduces unnecessarily long wait times for people who could genuinely benefit from tertiary care.

HARP Diabetes Clinic

The Hospital Admission Risk Program (HARP) Diabetes Clinic provides service users at risk of hospital admissions with specialist diabetes care from within a community health setting. Follow up and support is provided by diabetes nurse educators, dietitians and podiatrists. Additional health professionals are linked in as required (i.e. Dental, Health Coaches, Physiotherapists, Occupational Therapists, Exercise Physiologist, Woman's Health Nurse and a myriad of broader services).

Through the implementation of a multidisciplinary framework, service users are commonly seen jointly where possible. Therapeutic goals are person focused and team directed. There is an emphasis on continuity of care, simple language and use of appropriate health literacy tools. Additionally, home visits are provided as required.

Receiving diabetes care within a community health setting provides many benefits for the service user. These include a sense of trust and engagement with a more flexible health care system, easier access and parking, reduced wait times for service users who may be physically frail or emotionally challenged navigating a larger formal setting. Communication is maintained with a service user's family doctor, the hospital system and other specialists as is deemed necessary.

The continuity of care proved by the HARP Diabetes Clinic team promotes safety, decreases the likelihood of hospital admissions, results in improved health and most importantly, through community engagement and a social model of care, connects services users back to their community. After discharge from the HARP Diabetes Team, the service user is subsequently linked back to the community funded diabetes educator and dietitian.

Hepatitis Clinics

The Joslin Clinic hosts a visiting Infectious Disease Specialist from Royal Melbourne Hospital - Melbourne Health who provides management and monitoring advice for service users with

Hepatitis, many of whom are refugees. The appointment system and follow up is supported by a Joslin Clinic Practice Nurse. The Melbourne Health specialist is funded through the MBS.

Many service users accessing cohealth for hepatitis support and management are from a refugee background. cohealth's approach to chronic disease screening for refugees includes specific strategies to address barriers to accessing care for this group, such as:

- Using trained interpreters
- Offering low cost, accessible services
- Promoting continuity of care and trust, supported by recall and follow up systems
- Taking the time to explain the concepts of preventative health, screening, chronic disease, and self-management
- Employing culturally competent practice and interventions

The Kensington clinic has established a hepatitis monitoring system, managed by the Practice Nurses. Additionally, an Infectious Disease Specialist from Royal Melbourne Hospital - Melbourne Health visits the clinic every fortnight to provide management and monitoring advice for services users and secondary consultation for the GP's. The Melbourne Health Specialist is funded by MBS.

A nurse-led hepatitis B clinic is being established at the Collingwood Clinic to increase screening, monitoring and referral to Collingwood GP's for management for people living with hepatitis B. The nurse will provide training to cohealth nurses and arrange training for cohealth doctors. This clinic is part of an NHMRC Translating Research Into Practice (TRIP) Postdoctoral Fellowship, and the nurse is supported by an Infectious Disease Specialist from the Victorian Infectious Disease Service of Melbourne Health.

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

Current items and incentives in the Medicare Benefit Schedule (MBS) provide some support for management of chronic conditions, but they are not sufficient to support best practice approaches as described earlier in this submission.

cohealth utilises the relevant MBS items and incentives to support its work in this area, including:

- General Practice Management Plans (GPMPs)
- Team Care Arrangements (TCAs)
- Multi-disciplinary case conferences
- Referral to allied health practitioners
- Service incentives and practice incentives for diabetes and asthma cycles of care
- Nurse Practice Incentive Payment (to support employment of a practice nurse).

These payments, while welcome additions to the standard fee for service payments under the MBS, are not sufficient to support practice management of chronic conditions, for a number of reasons.

First, GPMPs and TCAs require ***considerable administration and coordination*** work which is separate to what is done as part of direct patient contact. This includes, for example, organising three care providers to be present for meetings and reviews; organizing interpreters when required; liaising with other agencies including those outside the health sector such as Centrelink, housing agencies etc; supporting clients to access services to which they are referred (allied health etc). This is particularly the case for clients who experience compound disadvantage, for example those who are homeless or at risk of homelessness; who have substance use issues; refugee or asylum seeker status; and/or language barriers. Such clients form a high proportion of the community health client base.

Second, the number of allied health services that can be subsidised through the MBS is limited to five per year. ***Clients with chronic and complex conditions may need more than five allied health services per year*** to support effective management of their health condition/s. For example, a person with diabetes might require visits to a podiatrist, a diabetes educator, a dietitian, and an exercise physiologist or physiotherapist. It is common for people to experience mental health issues in addition to a chronic physical condition such as diabetes or heart disease.[40] The cap of five subsidised visits per year does not match with health needs for many clients. Failure to access sufficient allied health services may contribute to sub-optimal management of health condition, leading to exacerbations or complications necessitating increased Emergency Department visits and/or hospital admissions.

Finally, there is ***inadequate support for interpreter use***. While support is provided for interpreters when a client is seeing a GP, no such support is available for interactions with other health professionals including nurses and allied health professionals. cohealth is a high user of interpreter services. It is a constant struggle to support people from culturally and linguistically diverse backgrounds to access interpreters during consultations with non-medical health professionals, and often this needs to be supported from other revenue sources in order to ensure good quality of care.

These identified gaps in the current MBS funding arrangements impact most on the client groups served by community health: those who experience disadvantage as a result of poverty, homelessness, cultural and linguistic diversity, and other factors. As noted above, these groups bear the greatest burden of chronic conditions. As such, they have they highest need for care and the greatest capacity to improve health status and quality of life. This also has flow-on effects to other parts of the health system, with investment in improved care for these groups likely to reduce avoidable health system costs, by preventing exacerbations and complications of chronic conditions.

The need for Commonwealth and State/Territory Governments to work together to ensure comprehensive care for people with chronic conditions has been noted in many contexts recently, including the *Reform of the Federation Discussion Paper,*[41] and in recent comments by the Victorian Government.[42] The *Reform of the Federation Discussion Paper* includes an

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[40] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B (2007) Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet* 370:851–858

[41] Australian Government (2015). Reform of the Federation Discussion Paper 2015. From: https://federation.dpmc.gov.au/publications/discussion-paper

[42] Willingham, R. 'Too many people getting unnecessary hospital care: Premier Daniel Andrews.' *The Age* 21 July 2015. http://www.theage.com.au/victoria/too-many-people-getting-unnecessary-hospital-care-premier-daniel-andrews-20150721-gih0j7.html

option for joint Commonwealth-State/Territory funding of individualised care packages for patients with chronic and complex conditions, and a proposal to trial such a model.

There are a number of ways that funding from the two level of government might be used more effectively to deliver high quality, effective care for people with chronic and complex conditions. These include pooled funding arrangements as well as less 'structural' approaches such as the intentional alignment of different funding sources by recipient agencies. Community health services are a working example of the latter, with grant funding from State government aligned with MBS (Commonwealth) funding to effectively address the health needs of priority populations.

Some community and welfare organisations are showing increasing interest in moving into provision of primary health care as an adjunct to their social care services. Community health centres and other community organisations have established and engaged relationships with the target cohorts. These relationships, in addition to the experience community health services have in aligning multiple funding sources, make them an ideal environment for the implementation of new funding models. We would be pleased to explore further the opportunity for community health services such as ours to be involved in such trials, which would build seamlessly on our current approaches and established relationships.

> Recommendation 2: Additional resources should be made available to support use of interpreters with non-medical health professional consultations.
>
> Recommendation 3: Commonwealth and State/Territory Governments should pursue the development and testing of new funding models to support patients with, or at risk of developing, chronic and complex conditions. Furthermore, they should seek the involvement of community health services as key participants in these processes, given community health's readiness and capacity to implement such models.

cohealth
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Appendix 1
The Chronic Care Model[43]

a. The Health System: Create organisational culture and mechanisms that promote safe and high quality care.
    - Support improvement at all levels of the organisation
    - Promote effective improvement strategies aimed at system change
    - Encourage transparent management of errors and quality issues
    - Provide incentives based on the quality of care provided
    - Develop policies that support coordination of care internally and externally

b. Delivery System Design: ensure delivery of care and support is effective and efficient.
    - Clearly define roles within care team
    - Provision of clinical case-management services for complex service-users,
    - Provide consistent follow-up by care team,
    - Provide care that is culturally appropriate and that service users understand,
    - Support evidence based care.

c. Decision Support: Promote evidence-based care that is aligned with service user priorities
    - Utilise evidence-based staff education methods
    - Embed specialist expertise into primary care
    - Integrate evidence-based guidelines into daily care practice
    - Share guidelines and information with service users to support their participation and investment in their own health care.

d. Clinical Information Systems: Collect and organise service user and population data to support efficient and effective care.
    - Provide timely reminders for providers and service users
    - Support and facilitate individual service-user care planning
    - Disseminate information to service users and care providers in order to support coordination of care.
    - Monitor effectiveness of care providers and systems

e. Self-Management Support: Empower and support service users to manage their health and health care.
    - Emphasise the service user's central role in decision making and managing their health.
    - Employ evidence-based support strategies including assessment, goal-setting, action planning, problem solving and follow up.
    - Organise resources to facilitate sustainable self-management support to service users.

f. The Community: Organise community resources to meet the needs of service users.
    - Encourage service user participation in community programs
    - Establish partnerships with community organisations to support and develop interventions to address identified gaps in services.
    - Advocate for policies to improve service user care.

[43] Improving Chronic Illness Care, 2015, The Chronic Care Model, from http://www.improvingchroniccare.org/