Submission to the Primary Health Care Advisory Group Inquiry into better outcomes for people with chronic and complex health conditions through primary health care

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Key Messages and Recommendations

What is the problem? What's working well and what are the gaps?

- Current items and incentives available through Medicare provide some support for people with chronic conditions, but there is insufficient support for necessary allied health services and coordination of care.

- Complex needs are not just about multi-morbidity; they are also about a person's social and environmental circumstances, and how these can impact on their health. These circumstances include cultural and linguistic diversity, Aboriginal and Torres Strait Islander identity, homelessness, refugee or asylum seeker status, and stigma and discrimination.

- Community health services like cohealth work well for people with complex needs, who experience difficulties accessing mainstream services and who have the greatest capacity to benefit.

- The community health approach is effective in dealing with complex needs due to its integrated, multidisciplinary service model; and accessibility to the most disadvantaged populations.

  Recommendation 1: Access to allied health services for people with complex needs should be dependent on individual need rather than capped.

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

  Recommendation 3: Policy responses should be designed according to different cohorts, defined by level of risk for poor health outcomes. The system response for high risk cohorts should be high intensity, and based on best-practice approaches.

Theme 1 — Effective and Appropriate Patient Care

- Patient enrolment can benefit people with chronic and complex medical conditions. In the USA, community health centres are playing a key role as patient centred medical homes.

- The label of a "medical home" must not obscure that fact that care coordination is vital, and that a general practitioner (GP) is not necessarily best-placed to play this role.

- Key principles of effective and appropriate coordinated care, 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

- cohealth's rights-based approach recognises that empowerment is the overarching goal in person-centred care, and that having a specific health condition may not be the primary concern for an individual at a particular point in time.

- Examples of best-practice principles in action in cohealth services and programs include: Collingwood integrated pharmacy; the Fitzroy model; the Moving towards Interprofessional and Collaborative Practising Teams Project; the Why Weight project; and the Branching out program.

- Care for people with complex needs should be provided at the most local level, in community-based settings, wherever possible.

- Coordination between primary health care services and acute services needs to be improved. Primary Health Networks, and Primary Care Partnerships in Victoria, can and should play a key role in facilitating better coordination. Examples of cohealth programs provided in collaboration with acute services include the Collaborative Back Pain project; the HARP Diabetes Clinic; and Hepatitis clinics.

Theme 2 — Increased use of Technology

- New technologies such as home-based monitoring and self-testing devices have great potential to assist people to look after and improve their health.

- A key enabler of to the use of such technology is health literacy. People need to be supported to understand new technologies and the information they provide, as part of a comprehensive approach to supporting their capacity to understand their health condition/s and the factors that impact on them.

- Improved interoperability of client information systems between different providers is an important component of improved coordination of care. This needs to be placed within a broader systems approach to coordinated care, which includes care pathways and service coordination agreements.

Theme 3 — How do we know we are achieving outcomes?

- Measurement and reporting of patient health outcomes are critical for evaluating the performance of health services and health systems. Health providers need to be supported to design and implement systems capable of capturing and analysing these data.

- It is an important goal to empower people so that they are in a position to influence their health, including people with chronic health conditions. But we also need to recognise that people's health outcomes are influenced by key factors that are not their responsibility. The appropriate action for these factors is not about individual choices and behaviours or "taking responsibility", but about primary prevention to address the system-level determinants of health.

- Key features of effective primary prevention activities include:
    - Tailoring based on a good understanding of specific communities
    - Providing local community members with the opportunity to design and implement programs
    - Working beyond the health system to include key 'upstream' drivers.

- Offering support to people to assist them to influence their health conditions and the impact these have on their lives is a key element of an effective service response for people with complex needs. This support may take the form of:
    - Working with people to identify their own goals for the health and well-being
    - Providing education and support to develop specific skills (e.g., through health coaching, group-based peer support programs)
    - Ongoing, less intensive contact (e.g. telephone or web-based) to embed and maintain self-management

  Recommendation 4: Investment in improved management of established chronic disease should be complemented by investment in prevention.

Theme 4 — How do we establish suitable payment mechanisms to support a better Primary Health Care System?

- Solutions to better meet the needs of people with complex needs must not rely on Private Health Insurance companies. This will exclude the 5 out of 10 Australians who do not have Private Health Insurance, who are also more likely to be in the high risk cohorts.

- There is a role for the introduction of some form of capitation payments into the Australian primary health care financing system, to address the identified disadvantages and limitations of the current Australian system, which particularly impact on those with complex needs.

- Pooled funding from Commonwealth and State/Territory sources has the potential to significantly improve care for people with complex needs.

- Victorian community health centres are well placed to trial pooled funding models, due to: their experience in providing integrated care; experience working in partnerships with other agencies; familiarity with multiple funding sources, accessibility, and existing well-engaged relationships with high risk cohorts.

  Recommendation 5: In line with international models, Australian primary health care should incorporate some element of capitation funding.

  Recommendation 6: Commonwealth and State/Territory Governments consider Victorian community health services as a prime candidate for trialling of new pooled funding models for specific cohorts.

1.0 Introduction

1.1 Overview of cohealth

cohealth is a not-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 from 44 sites across 14 local government areas in the north and west of Melbourne. Over 100,000 people per year access cohealth services. We prioritise those who are disadvantaged or marginalised because we know that these groups experience the poorest health. This includes 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 in May 2014 through the merger of 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.

1.2 Submission development approach

This submission draws on cohealth's experience as a provider of programs and services for people with chronic conditions and/or complex needs. It also draws on our commitment to, and experience of, being a vigorous advocate with and for people whose voice is so often absent from community and political debate. It has been developed in consultation with cohealth staff and service users.

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

2.0 What is the problem? What's working well and what are the gaps?

What aspects of the primary health system work well for people with chronic and complex health conditions?
What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?

2.1 The limits of the Medicare Benefits Schedule

Current items and incentives available through Medicare provide some support for effective chronic disease management. Like many general practices, cohealth utilises the relevant MBS items and incentives to support the work of its GP clinics 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 Payments (to support employment of practice nurses).

These payments, while welcome additions to the standard fee for service payments under the MBS, do have some limitations in supporting best practice management of chronic conditions.

First, 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.[2] 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 conditions, leading to exacerbations or complications necessitating increased Emergency Department visits and/or hospital admissions.

Second, 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, even those that are subsidised through the MBS. Approximately 30% of cohealth's clients have a language other than English as their primary language. Consequently, 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.

[2] 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

In addition, there is no linkage of specific items to health outcomes. Even the existing incentive payments are mostly linked to activity measures rather than health outcomes. The question of outcomes and performance is discussed further under theme 3.

Finally, 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 multiple care providers to be present for meetings and reviews; organising 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.). The care coordinator role is discussed further under theme 1.

These identified gaps in the current MBS funding arrangements impact most on the client groups served by community health: those who have complex needs. This group is discussed further in the following section.

> *Recommendation 1: Access to subsidised allied services for people with complex needs should be dependent on individual need rather than capped.*
>
> *Recommendation 2: Additional resources should be made available to support use of interpreters with non-medical health professional consultations.*

2.2 Complex conditions versus complex needs

The phrase "chronic and complex conditions" is routinely used to describe particular groups of people who have high needs for services, and who often have more than one long-term health condition.

Complex needs, however, are not just about chronic conditions or multi-morbidity. People may have complex needs as a result of not only their health condition/s but also the challenges and experiences within their environment, circumstances and history. Complexity of need can be about a person's social and personal circumstances, including their housing, income, language and so forth. These risk factors both underlie and complicate their health conditions.

> "*A disease-by-disease approach misses opportunities to provide cohesive, scaled, whole-of-patient care.*
> *And, to the patient, this care is time intensive, repetitive, and potentially disengaging…*[3]"

Internationally, health reform is conceptualising service users by levels of risk or need rather than type or number of medical conditions. [3] There is increasing recognition that 'segmentation' of the population by level of risk can improve the effectiveness and sustainability of the health system.[4]

[3] The Advisory Board Company, 2015. The Population Health Enterprise: Building the High-Performance Care Management Network. From https://www.advisory.com/international
[4] McKinsey & Company, 2015. How can Australia improve its primary health care system to better deal with chronic disease? Background paper prepared for the Primary Health Care Advisory Group. From: http://www.health.gov.au/internet/main/publishing.nsf/Content/PrimaryHealthCareAdvisoryGroup-1

Focusing on cohorts defined by risk rather than disease type or number is a key feature of the approach taken by high-performing health organisations globally.[3]

These new reform directions are based on an understanding that ***different health system responses are required for different strata of risk.*** A 'one size fits all' fails to meet the needs of those with the highest levels of risk. It is possible to design a health system that responds differently to high risk cohorts, compared to lower-risk cohorts, without undermining the principles of universal access to care. High-risk cohorts, which represent about 5% of the total, require a response that recognises the complexity of their needs. This response includes having a dedicated care coordinator, and linking the person with all the services required to address their health and social care needs.[5] This is discussed further under theme 1.

The nexus between chronic health conditions and social factors is clearly illustrated in prevalence statistics. Chronic disease can be understood as an equity illness: ***the greatest burden of disease is experienced by the most socially disadvantaged people***.[6] The burden of chronic disease is 32% higher for the most disadvantaged Australians (people in the lowest 20% of socio-economic status) than the most advantaged Australians (people in the highest 20% 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]

Another specific group not well served by current systems is people who experience both mental health conditions and chronic physical conditions. Due to a lack of integration between different sectors of the health system, as well as the social care system, this group often has unmet needs. Users of mental health services often do not have their physical health needs met. And people with chronic physical conditions such as heart disease and diabetes are often not screened for mental health issues, despite these being common in these groups.

It is vital to recognise the role of the social determinants of health in producing chronic conditions. Social disadvantage needs to be recognised as a leading modifiable risk factor for poor health outcomes.[10] The most disadvantaged populations have the greatest potential for gains in health status and quality of life, and reduction in avoidable health system costs.

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[5] The Advisory Board Company, 2015. The Population Health Enterprise: Building the High-Performance Care Management Network. From https://www.advisory.com/international

[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.

[10] Australian Institute of Health and Welfare, 2014, *Understanding Health and Illness.* from http://www.aihw.gov.au/australias-health/2014/understanding-health-illness/

Policy responses and interventions need to be sensitive to the needs of these groups.

> *Recommendation 3: Policy responses should be designed according to different cohorts, defined by level of risk for poor health outcomes. The system response for high risk cohorts should be high intensity, and based on best-practice approaches.*

2.3 The community health approach

The community health approach is effective in dealing with complex needs due to its integrated, multidisciplinary service model; and accessibility to 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. cohealth for example, provides a wide range of health and support services including:

- medical (GP)
- nursing
- dental
- allied health
- pharmacy
- alcohol and drug
- counselling
- community mental health support.

Having one provider offer a wide range of services supports and facilitates multidisciplinary and integrated care. This is of particular importance to people with complex needs 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.[11]

A key principle of the community health approach is accessibility for local communities and priority populations. Community health organisations provide health services for both individuals and communities as their core business. 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.

Specific strategies are in place to facilitate access to services for populations experiencing social disadvantage. These include outreach and drop-in service models, as well as priority access to services.

[11] 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

3.0 Theme 1 — Effective and Appropriate Patient Care

Do you support patient enrolment with a health care home for people with chronic and complex health conditions?
What are the key aspects of effective coordinated patient care?

3.1 Patient enrolment

Patient enrolment can benefit people with chronic and complex medical conditions. The Patient-Centred Medical Home (PCMH) has become an important feature of the US health system. PCMHs are recognised both within the US and worldwide as effective providers 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.

PCMH enrolees 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 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 support the use of disease registers and accurate data collection.

PCMHs 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 set expenditure targets. Evidence suggests that service user satisfaction, quality of care, access to care and care coordination is higher in PMCHs than in other models of care provision. Research suggests that PCMHs result in fewer emergency room visits and hospitalisations at the same or lower cost than alternative models.

In the USA, community health centres have shown rapid uptake in PCMH models. In 2009, less than 1% of CHCs had recognised, certified PCMH programs, but this has now increased to 61%.[12] This dramatic increase has been driven by government policy initiatives at the federal and state levels, including new funding programs and changed payment methods. The PCMH model is a good fit with current approaches to practice in the community health sector.

It is also important to note that although the terminology refers to a "medical home", care coordination is a vital element of what is needed for people with complex needs, and furthermore, general practitioners (GPs) are not necessarily best-placed to play this role.

[12] National Association of Community Health Centers [USA]. What is Patient Centred Medical Home? At: http://www.nachc.com/Patient%20Centered%20Medical%20Home.cfm

Although a GP is a key provider in chronic disease care plans, they are not necessarily well-placed to be the coordinator of care. Often, they do not have the capacity to invest in the one-on-one relationship required for effective care management and coordination.[13]

We need a specific person to coordinate our care. Someone to go to first and who you know you can call. This shouldn't always be your GP.

The role of a care coordinator includes:

- engaging the person as an active partner in their care
- understanding their goals
- linking them in with the required services and programs to support working towards their goals.

This is a vital role for effective care regardless of the organisational structure. In many settings, nurses fill this role very effectively. The Nurse PIP provides an important support for nurses to undertake this work in Australian GP settings. Limitations of the Nurse PIP include the capping of funding at the practice level, and the lack of flexibility in the MBS structure to support work being undertaken by nurses rather than doctors. Different payment methods, such as capitation, provide more flexibility for practices to decide how their teams work. This allows practices to configure teams according to the skill mix and scope of practice that is appropriate for the needs of their patient profiles, rather than being driven by payment mechanisms. Constraints on 'who does what' which result from funding mechanisms are not in the best interests of service users, who are very accepting of different team arrangements:

The streamlining of services that occurred with the flu vaccination is an example of good practice. I used to have to go to the GP, get a prescription, go to the pharmacy and go back to the GP. Now nurses do all of it. It's much easier for me.

The coordination role routinely encompasses the need to link with services outside the health sector, in order to provide a comprehensive response to a person's health and social care needs.

In some domains (such as breast cancer as illustrated in the example here), nurse care coordinators are routine. However this is not the case across all chronic conditions or domains.

When I got breast cancer, my breast cancer nurse coordinated all my care as soon as I got a diagnosis. She was the central point and my go to person as I moved through multiple hospitals, specialists, GPs and procedures. I highly recommend this model.

Examples of care coordination at cohealth include the Fitzroy model (see section 3.3) and the HARP program (see section 3.4).

3.2 Key aspects of effective coordinated patient care

Key principles of effective and appropriate coordinated care, as indicated by international best practice, include:

[13] The Advisory Board Company, 2015. The Population Health Enterprise: Building the High-Performance Care Management Network. From https://www.advisory.com/international

- Integrated, coordinated care, including beyond the health sector to include social care;
- Person-centred, goal-directed care
- Prevention-focused care

The Chronic Care Model (CCM), developed by Edward Wagner, is widely accepted as best practice in the management of chronic disease.[14] 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. 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.

In the following sections we provide examples of cohealth's services and programs which demonstrate these principles in practice.

3.3 Examples of integrated, coordinated approaches at cohealth

Our approach to person-centred care

As noted in the introduction, co-design is one of the central principles of our approach. Our values are centred on caring about the whole person, and placing people at the centre of everything we do.[15]

Our approach is ***rights based*** and acknowledges all people have the right to respectful treatment and to access services that support good health and wellbeing.[16] This rights-based approach draws on the Victorian Charter of Human Rights,[17] and the Australian Charter of Healthcare Rights,[18] among other key documents. This rights-based framework underpins our practice in relation to, for example:

- Providing priority access to vulnerable groups
- Informing clients about their rights and responsibilities
- Maximising opportunities for people to be active partners in decisions about their own care and treatment, as well as about the services and programs we provide more broadly
- Adopting a goal-directed approach, in which we work with people to identify their goals, and work to support them in working towards these

This last point is a particularly important one for working with people with complex needs. Our approach recognises that empowerment is the overarching goal, and that within an individual's life, having a specific health condition may not be the primary concern. It is

[14] Improving Chronic Illness Care, 2015, The Chronic Care Model, from http://www.improvingchroniccare.org/
[15] cohealth, 2015, cohealth Strategic Plan 2015-18.
[16] cohealth, 2015, cohealth Human Rights and Advocacy Framework
[17] Charter of Human Rights and Responsibilities Act 2006 (Vic). No. 43 of 2006. Retrieved from http://www.humanrightscommission.vic.gov.au/index.php/the-charter
[18] Department of Health (2011) The Australian Charter of Healthcare Rights in Victoria. Retrieved from http://health.vic.gov.au/patientcharter/healthcare-rightsinVictoria/index.htm

important to keep this as the frame of reference when considering people's motivation to influence their health.

We have invested significant efforts in building the skills of our staff to use goal-directed approaches. Our mental health community support service operates using the Collaborative Recovery Model.[19] We have improved care planning as a result of the 'Moving towards Interprofessional and Collaborative Practising Teams' project described below (page 16), We are currently training our staff in Goal Directed Care Planning,[20] with over 300 staff having completed the training to date.

As noted above, we have specific strategies designed to facilitate access to services for populations experiencing social disadvantage. For example, we provide services for people who are homeless or at risk of homelessness, through a combination of welcoming, accessible sites; assertive outreach (e.g., our health providers attending housing and welfare services where homeless people spend time); and drop-in sessions where no appointment is needed. We also have priority access for marginalised groups, for example providing priority access to dental services for homeless people.

A key aspect of our person-centred, rights-based approach is a focus on health literacy. This work is described in more in section 4.1.

In the words of our Strategic Plan, we "*keep people and communities at our core*".

Collingwood Integrated Pharmacy

The Collingwood Integrated Pharmacy is a 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.

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. Aapproximately 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.

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[19] Oades LG, Deane FP, Crowe TP, Lambert G, Kavanagh D & Lloyd C. 2005. Collaborative Recovery: An integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry*, 13: 279-284.

[20] Kate Pascale & Associates. 2011. Goal Directed Care Planning Toolkit. retrieved from: http://kpassoc.com.au/resources/gdcp-resources/

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.

> *To get my script filled at the same time as seeing the doctor just makes sense. And I'm always impressed by the explanation that's provided by the pharmacists… I received more information from the cohealth pharmacist than from the hospital I'd recently visited.*

It ensures that people actually get their prescribed medication, and that they understand what they need to know to take it safely and appropriately.

An internal review of the pharmacy model found that the 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;

- Provides efficient and effective medication management for high need and marginalised groups within the community, through:
    - preferential use of generic and cheaper brand medicines
    - simplified referrals and communication pathways across different professions (GPs, pharmacists, Alcohol and other Drugs and mental health clinicians and nurses), supported by a shared electronic record;
    - enhanced capacity to review the appropriateness of medication, and minimise the risk of over- or inappropriate medication
    - development of tailored dispensing regimes for high risk populations, those with mental health issues, substance use issues and the elderly.[21]

- 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 who are 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 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 access for service users who may otherwise miss out on appointments due to limited availability.

The model is designed to:

- Provide support so that doctors can focus more on the clinical needs of the service user and less on administrative requirements

[21] Research undertaken in 2011 by Assoc Prof Libby Roughead, Director, Quality Use of Medicines and Pharmacy Research Centre, University of South Australia

- 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:

- Standard 20 minute appointments
- Detailed: 20, 40 or 60 minute appointments for service users with complex or chronic conditions (Alcohol and Other Drug use, diabetes, mental illness, CALD background)
- Swift: 10 minute appointments appropriate for non complex/ chronic service users for specific services only (prescriptions, medical certificates, results, walk-ins).

Critical to the model is a Care Coordinator, who undertakes initial health assessments for the care plan, schedules appointments for case conferences, works in conjunction with external support and care providers, and may act as a third practitioner in care planning.

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.[22] 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:

- Site based interprofessional and collaborative practicing (ICP) teams for allied health
- Introduction of a Care Coordinator role, Client Review Meetings and a coordinated appointment system
- A range of new policies, procedures and systems to underpin the work of ICP Teams and achieve best practice chronic disease management
- 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 to:

1. 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, CE and executive managers; significant support from staff and service users; utilisation of best practice evidence to form new models; utilisation of Kotter's 8 stages of change

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

model to facilitate the change in management process; and a dedicated project team, project plan and evaluation framework.

Project evaluation findings demonstrate that the aims and objectives of the project were achieved, in particular:

- Improved access to streamlined appointments and coordinated care
- Improved access to joint assessments and joint goal setting with an interprofessional team
- Increased number of service users with a Care Plan, with self identified goals and contributions from more than one discipline
- Increased 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 Project

The Why Weight project was funded under the internal Service Innovation Grants program at cohealth. It aimed to investigate staff and service user experiences and to explore best practice in the provision of support for people with morbid obesity. A literature review was completed, 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. The review indicated that a multi-disciplinary, multi component or interprofessional practice (IPP) approach is recommended to effectively address obesity.

The project engaged with a small group of service users with experience of obesity (n=9), to understand 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. Results indicated 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.

The project working group brought together allied health and mental health practitioners. 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 to address these factors. The interprofessional practice team consists of counselling, physiotherapy, self-management support and other services as required in response to identified 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.

3.4 Examples of cohealth working in partnership with the acute sector

My hospital didn't ask me if I knew about the local community health service. I needed and asked for physio but the hospital never got back to me regarding an appointment. I could have been connected with my local physio which I could have walked to. I had to push for a referral.

There are a number of ways in which the acute sector and the primary health sector can work in partnership to improve coordination of care and outcomes for people with chronic and complex conditions. These include:

- Improved referral pathways into the acute sector
- Improved communication from acute services to primary health care (PHC) services
- Outreach models where specialist care is provided in community settings instead of the hospital setting
- PHC-based management of chronic conditions, supported where required by specialist providers.

A key principle of best practice care for people with complex needs is providing care at the most local level possible, in community-based settings. Benefits of this approach include accessibility for patients (physical accessibility as well as approachability of 'human-scale' and local connectedness), and efficient and appropriate use of health system resources: the right type of care, at the right time, in the right setting. The Travis Review of capacity in the Victorian hospital system recently noted that many services which in the past needed to be delivered in a hospital setting no longer need to do so.[23] The Review further noted that future efforts to improve the system should focus on areas with large potential gains, including cohorts with complex needs, and providing care in community-based settings.

There is significant room for improvement in coordination between PHC services and acute services. Primary Health Networks (PHNs), and Primary Care Partnerships (PCPs) in Victoria,

[23] Travis D. 2015. Travis Review: Increasing the capacity of the Victorian public hospital system for better patient outcomes. Final report. From: http://www.health.vic.gov.au/travis/

can and should play a key role in facilitating better coordination. Victorian PCPs have a track record of working at the regional level to improve coordination of care. Together with PHNs, they are ideally placed to support partnerships of various forms to improve coordination of care. Partnerships between different providers are a key element of international best-practice approaches to managing the needs of high risk cohorts.[24]

An example of a partnership cohealth is involved in is the ***Inner North West Collaborative***. The Collaborative involves the Inner North West Melbourne Medicare Local (Now Melbourne Primary Care Network, the North Western Melbourne PHN), Melbourne Health, cohealth and Merri Community Health Services. A formal Collaborative Framework guides the partnership, which aims to improve patient care, pathways and outcomes in the region. Specific projects undertaken by the Collaborative include the Back Pain project described below, and a current project to improve advanced care planning.

In this section we provide examples of cohealth programs which operate in collaboration with acute services.

Collaborative Back Pain Project

This innovative pilot project was developed 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% were 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

Of particular note is that only 4% of reviewed patients were referred on to the spinal pain clinic. The project reduced the waiting time for the clinic from over 2 years to around 6 weeks, by triaging those waiting to determine the appropriate care. Timely and appropriate intervention for back pain can improve service user outcomes and reduce unnecessarily long wait times for people who could genuinely benefit from tertiary care.

[24] The Advisory Board Company, 2015. The Population Health Enterprise: Building the High-Performance Care Management Network. From https://www.advisory.com/international

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.

My HARP person works out what I need to manage my type 2 diabetes. She discusses my needs and shares her ideas. I now have access to exercise classes, allied health services, a home alarm etc. This is a very good service which could be extended to other areas.

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.

In addition, a weekly Diabetes Specialist clinic is offered at the Footscray site, as a satellite of Western Health Endocrinology. This has been running for some 8 years now and is well-subscribed and greatly appreciated by service users.

Hepatitis Clinics

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 Joslin Clinic in Footscray 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.

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 has been established at the Collingwood Clinic to increase screening, monitoring and referral to Collingwood GPs 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.

3.5 Integrated health and social care

As noted earlier, an effective response to people with complex needs often needs to incorporate not only health sector services but also social services. The UK has led developments to integrate social and health care services at the systems level. The Better Care Fund was established by the United Kingdom Government in 2013 to assist in the development of integrated health and social care. Created through the redirection of existing resources (£3.8 million), the 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.[25] Since then, the 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 domain.[26]

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 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.

[25] Kings Fund, 2015, Options for Integrated Commissioning. The Kings Fund: London, from www.kingsfund.org.uk/publications
[26] 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

4.0 Theme 2 — Increased use of Technology

How might the technology described in Theme 2 improve the way patients engage in and manage their own health care?
What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team based care for people with chronic and complex health conditions?

New technologies such as home-based monitoring and self-testing devices have great potential to assist people to look after and improve their health. However, we need to ensure that people are supported to use such devices effectively and appropriately, just as they need to be educated about other aspects of their care such as medications. This is discussed further in the section below on health literacy.

In order to ensure that new technologies are accessible and affordable, it is important that they are as low-cost as possible, and that they can integrate with common platforms such as smart phones and tablets rather than requiring separate devices.

Improved interoperability of client information systems between different providers is an important component of improved coordination of care. The My Health Record has the capacity to support better communication between services such as community health centres, private GPs and hospitals. The Inner North West Collaborative (described in the previous section) has been working to increase use of My Health Record within the participating agencies.

It is also important to note that this needs to be placed within a broader systems approach to coordinated care, which includes care pathways and service coordination agreements. As noted above, PHNs are well-placed to play a role is supporting and facilitating improved communication between different services.

Many people are supportive of sharing of records between services. They understand that this helps support effective care, and they don't like having to repeat things when information is not shared. At the same time, people want to be asked to give their consent, and they want information about electronic health records and sharing of records presented in ways they can understand.

4.1 The importance of health literacy

Health literacy is a key enabler of technology use. People need to be supported to understand new technologies and the information they provide, as part of a comprehensive approach to supporting their capacity to understand their health condition/s and the factors that impact on them.

I have two devices and get different readings from the two instruments I have. So it needs to be supervised.

Health literacy can be understood as the ability to understand information relating to health in order to act.[27] A more comprehensive definition is:

[27] 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.

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.[28]

Low health literacy is associated with poorer health outcomes, more hospitalisations and Emergency Department visits, fewer preventive health services, and more medication-related problems.[29] Furthermore, just as the incidence of chronic disease is unequal across different population groups, so are levels of health literacy. Lower levels of health literacy are experienced by people living in areas with lower socioeconomic status.[30]

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 a lack of understanding. 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. These incidents are given to indicate the scale of effort that will be required to empower people to influence their health.

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 co-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

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[28] Zarcadoolas C. et al, 2003, Elaborating a definition of health literacy: a commentary, *Journal of Health Communication,* 8:119-20.
[29] Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. 2011. Low Health Literacy and Health Outcomes: An Updated Systematic Review. *Ann Intern Med* ;155:97-107. doi:10.7326/0003-4819-155-2-201107190-00005
[30] 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.

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.[31] 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.

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

Other examples of our work in health literacy include the "Tooth out? Take care" project and the "Hepatitis See" project.

The "Tooth out? Take care" card was developed for use in our oral health services. Almost one-third of oral health service clients undergo extractions. Furthermore, a significant proportion are from culturally and linguistically diverse backgrounds (almost one third require an interpreter), and/or have low health literacy. The "Tooth Out Take Care" card is a picture based post-extraction pamphlet (see figure below) that is readily understandable regardless of literacy or language background. It was developed in partnership with consumers, and has also been translated into multiple languages.

Figure: "Tooth out? Take care" Card

[31] cohealth, 2015, *Connected: A Community Health Literacy Pilot Project: Interim Report*. cohealth: Melbourne.

The "Hepatitis See" Project produced a low literacy resource on Hepatitis C for people affected by Hepatitis C. This project was funded cy cohealth's internal Service Innovation Grants program. Service users from our harm minimisation services (needle and syringe programs [NSP]) worked in partnership with staff to create the content (including the messages and images) and test the response. A pamphlet and a poster have been developed for use at all cohealth NSP and harm minimisation sites. The resource encourages people to know they may be at risk, to get tested for Hepatitis C and to know that they can receive treatment while still using substances.

5.0 Theme 3 — How do we know we are achieving outcomes?

Reflecting on Theme 3, is it important to measure and report patient health outcomes?
To what extent should patients be responsible for their own health outcomes?

Measurement and reporting of patient health outcomes are critical for evaluating the performance of health services and health systems. As noted recently by Fitzgerald, outcomes and performance are critical aspects of an efficient, effective and high quality primary health care system.[32] Careful consideration must be given to these in any discussion of financing, in addition to discussion of provider payment methods.

We are supportive of accountability and performance reporting in the PHC sector. Any shift to outcomes-based or performance-based funding would rely on sufficient capacity within the sector to measure and analyse performance data. PHC providers vary significantly in size and in capacity in this regard. A move towards outcomes-based or performance-based funding would also require clearly defined performance indicators, in relation to efficiency, quality and other aspects.

The Victorian community health sector has experience of meeting multiple accreditation standards, which is one method of measuring performance. Accreditation standards we are required to meet include the Quality Improvement Council; DHS Standards; Home Care Standards; National Safety and Quality Health Standards; National Mental Health Standards. We also meet RACGP Standards.

The compliance and reporting standards that Victorian community health organisations already operate under are above and beyond those required for private GP clinics, which have optional accreditation.

Internationally there are a number of standards for primary health care which could be considered for application in the Australian context. Key organisations here include:

- Bureau of Primary Health Care in the USA[33]
- Canadian Institute of Health Information (see especially the Pan-Canadian Primary Health Care Indicators)[34]

[32] Fitzgerald J. (2015) Options for finance in primary care in Australia. Issues Brief No 11. Deeble Institute. From: http://ahha.asn.au/publication/issue-briefs/deeble-institute-issues-brief-no-11-options-finance-primary-care-australia
[33] Bureau of Primary Health Care. See http://bphc.hrsa.gov/index.html

- National Institute for Health and Care Excellence in the UK (see especially the Quality and Outcomes Framework for general practice)[35].

5.1 Recognising the social determinants of health

It is an important goal to empower people so that they are in a position to influence their health, including people with chronic health conditions. But we also need to recognise that people sometimes experience barriers that prevent them from doing so, such as cost, language, distance, mobility, or stigma & discrimination. In other words – and this is particularly the case for many people in this high-risk cohort – ***many of the key factors that impact on their health are not their responsibility.*** The appropriate action for these factors is not about individual choices and behaviours or "taking responsibility", but about social change to address the system-level determinants of health.

Primary prevention focuses on the social and environmental factors that cause individuals and communities to be at higher risk of poor health outcomes. These include low incomes, poor access to services (for reasons of distance, cost or acceptability), and stigma and discrimination, which may be experienced within health services,

cohealth has a specific interest and experience in applying community-based primary prevention interventions. Community-based interventions go beyond just educating community members about health and lifestyle choices. This approach is based on an empowerment model which emphasises the rights of communities rather than the needs of communities.[36]

International best practice in primary prevention, such as the North Karelia Project in Finland,[37] and Looma project in remote Australia[38] are long term in nature and focus on the broader environments where risk factors emerge. These successful initiatives increased the capacity of community members to not only understand health information on the risk factors for chronic disease, but also impact on the determinants of health.

Primary prevention activities are vital to prevent those at risk of chronic conditions from developing them. Key features of effective primary prevention activities include:

- Tailoring based on a good understanding of specific communities
- Providing local community members with the opportunity to design and implement programs
- Working beyond the health system to include key 'upstream' drivers.

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[34] Canadian Institute for Health Information. Primary health care. See https://www.cihi.ca/en/types-of-care/primary-health-care

[35] National Institute for Health and Care Excellence. Standards and Indicators. See: https://www.nice.org.uk/standards-and-indicators

[36] 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.

[37] 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.

[38] 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.

Recommendation 4: Investment in improved management of established chronic disease should be complemented by investment in prevention.

5.2 Supporting self-management

Offering support to people to assist them to influence their health conditions and the impact these have on their lives is a key element of an effective service response for people with complex needs. This support may take the form of:

- Working with people to identify their own goals for the health and well-being
- Providing education and support to develop important skills (e.g., through health coaching, group-based peer support programs)
- Ongoing, less intensive contact (e.g. telephone or web-based) to embed and maintain self-management

I met with a diabetes educator who used diagrams and clear information to inform me about my condition. Education enabled me to be active in my care; it was not about being told what to do, it was about education to help me manage my condition between appointments and at home.

Health coaching

For some time cohealth has operated the "Living Well" program, which 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 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.

The Living Well program facilitates effective engagement and support of service users in relation to their health and wellness needs. Strengths of the program include:

- Person centred care, in which the service user guides the health and wellness plan and sets goals with the support of a health coach.
- Goal directed and coordinated care.
- Flexibility to work with both people who already have a chronic disease as well as those with complex needs and risks factors for chronic disease
- 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.
- 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.

The health coaching approach 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, who are often from marginalised groups. The person-centred approach acts to improve service user self-confidence and sense of control over health and wellbeing.

We are now building on our experience of delivering targeted programs, and moving towards a model of embedding health coaching roles within multidisciplinary teams.

6.0 Theme 4 — How do we establish suitable payment mechanisms to support a better Primary Health Care System?

How should primary health care payment models support a connected care system? What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

Solutions to better meet the needs of people with chronic conditions and/or complex needs must not rely on Private Health Insurance companies. This will exclude the 5 out of 10 Australians who do not have Private Health Insurance (PHI).

Furthermore, such an approach is not consistent with the fact that the highest risk cohorts (where there is greatest capacity fro improvement in both individual health outcomes and system efficiencies) are those least likely to have PHI.

With regard to payment methods, we have already noted (under theme 3 above) that designing effective financing for primary health care goes beyond consideration of payment methods. Effective financing for primary health care must also consider the related issues of outcomes, performance, and pooled funding. This latter question is discussed below.

It is also worth noting, however, the point made in the Background Paper prepared for the Primary Health Care Advisory Group,[39] that Australia is one of the few high income countries in the world that does not include some form of capitation payment as part of its primary health care financing. All health systems include combinations of payment methods, in an attempt to balance the disadvantages and limitations of each. In Canada, several different payment methods for 'family physicians" (akin to GPs in Australia) operate in parallel. [40] The way that doctors are paid in this system depends on the type of organisation they work for. In

[39] McKinsey & Company 2015. How can Australia improve its primary health care system to better deal with chronic disease? Background Paper prepared for the Primary Health Care Advisory Group. From: http://www.health.gov.au/internet/main/publishing.nsf/Content/PrimaryHealthCareAdvisoryGroup-1

[40] HealthForceOntario. Family Practice compensation models. See: http://www.healthforceontario.ca/en/Home/Physicians/Training_%7C_Practising_Outside_Ontario/Physician_Roles/Family_Practice_Models/Family_Practice_Compensation_Models

the case of community health centres in Canada, doctors are paid in a salaried model, in the same manner as other members of the primary health care teams in their organisation, which are funded to provide care for specific identified populations.

We have already outlined some of the disadvantages of the current Australian system (heavily fee for service with minimal incentive payments), particularly for those with complex needs. As such, we see a role for the introduction of some form of capitation payments into the Australian primary health care financing system.

> *Recommendation 5: In line with international models, Australian primary health care should incorporate some element of capitation funding.*

6.1 Pooled funding

The need for Commonwealth and State/Territory Governments funding systems 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 split of funding sources works against effective coordination of care between the primary health care sector and the acute sector, and therefore effectiveness and efficiency of the system.

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 complex needs. The *Reform of the Federation Discussion Paper* discusses a number of pooled funding arrangements, including an 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.

As noted above, a partnership approach is recognised as international best practice in care for high risk cohorts.[43] A partnership approach recognises that different providers have distinct, and complementary, services to provide. It involves groups of providers entering into formal agreements to improve the comprehensiveness and continuity of care. Also as noted above, cohealth has experience of working in collaboration with acute services in a number of specific projects and areas of service delivery. It is important that accountability for the outcomes of such activities is clearly defined. These types of arrangements are geared towards operating at a regional level. As such, PHNs may be well-placed to support or facilitate such partnerships.

It is also important to note that, in practice, many health providers already receive funding from a range of sources and using a range of payment methods. As such, they are already working to use available funding in the most effective way possible to deliver services.

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[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

[43] The Advisory Board Company, 2015. The Population Health Enterprise: Building the High-Performance Care Management Network. From https://www.advisory.com/international

Victorian community health services are a working example of this, with block grants from State government (community health, HACC, mental health community support, alcohol and drug services etc.), fee for service and incentive funding from the Commonwealth via MBS funding, and other sources. Within this context, we work to draw together the required services to effectively address the health needs of the people who use of services. Formalised pooling of funds from different sources would enable us to do this much more effectively, by allowing individual needs to be the key driver of the service response.

In addition, community health centres have established and engaged relationships with high risk cohorts. As locally-based services in community settings, we focus on maximising the accessibility of our services. This includes acceptability for particularly marginalised groups who are at high risk of stigma, discrimination, or other barriers to accessing health care (for example, people who use illicit drugs, people who are homeless, refugees and asylum seekers).

Our experience in providing integrated care and in working in partnerships with other agencies, our familiarity with multiple funding sources, our accessibility, and our relationships with high risk cohorts, make community health services are an ideal environment to trial pooled 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 6: Commonwealth and State/Territory Governments consider community health services as a prime candidate for trialling of new pooled funding models for specific cohorts.*