Better outcomes for people with chronic and complex health conditions through primary health care – Primary Health Care Advisory Group Online Survey – APNA submission

3 September 2015

The Australian Primary Health Care Nurses Association (APNA) welcomes the opportunity to contribute to the Primary Health Care Advisory Group's consultation on reform of primary health care to support patients with complex and chronic illness, and the treatment of mental health conditions. We are providing this submission on behalf of our membership, Australian primary health care nurses.

APNA Submission

APNA's response to questions in the Online Survey are set out below:

1. **What aspects of the current primary health care system work well for people with chronic or complex health conditions?**

The following aspects of the current primary health care system work well for people with chronic or complex health conditions:

- The role that primary health care nurses play in the prevention and management of complex and chronic disease:
    - An example of this is nurse clinics, where nurses work in multidisciplinary teams (which may be a GP and a nurse or a larger team) providing care, have their own caseload and take primary responsibility for the care of their clients. The work of nurse in these clinics involves undertaking detailed health assessments and evaluation, developing and communicating patient care plans, providing treatment, referring to other health and social care providers, coordinating care, and monitoring the patient's condition. Nurse clinics are becoming increasingly important in today's context where the number of people with chronic and complex disease is rapidly increasing. Nurses also play a key role in preventative health activities in the communities in which they work. Nurse clinics are highly valuable in terms of their ability to improve access, reduce health care costs, and reduce the workload that is often unnecessarily placed on medical practitioners. This activity also improves patient access by freeing up the GP's time to focus on more acute presentations.

- Nurses possess the skills to deliver comprehensive chronic disease prevention and management programs in the primary health care setting. They are particularly skilled at educating consumers about self-management, and in monitoring and providing feedback on patients' progress. Internationally, nurse-led chronic disease management, where doctors play a supportive role, has been shown to result in the delivery of effective and efficient care.

- Access to Medicare-funded rebates for chronic conditions can facilitate access to care for people with chronic or complex health conditions. Problems with access to care do exist, however, depending on the availability of the services and the ability for a patient to pay a gap payment where there is no bulk-billed or state funded health service.

2. What is the most serious gap in the primary health care system currently provided to people with chronic or complex health conditions?
    a. In your area?

- No response (this is a national submission)

    b. Nationally?

Gaps include the following:

- Access to adequate clinician care is not uniform across all community settings for patients with chronic or complex health conditions.
- There is inadequate funding for care coordination for people with chronic or complex health conditions, particularly for high end users.
- Lack of adequate eHealth records contributes to care coordination difficulties. Good care coordination requires continuity of information and good information architecture, including the use of eHealth records.
- Siloed care and poor communication between services and providers contribute to difficulties tracking patient care. This can also lead to duplication of services.
- There is no current link between the My Aged Care system and the myHealth Record system; information on patients' needs and support services is not integrated.
- Patients with chronic conditions at lower risk level and complexity currently have the same level of funding for chronic disease Medicare Benefits Schedule (MBS) items via general practice as those with high risk levels for complications and comorbidities.
- Inconsistency of health funding between different state and federal health systems, as well as a lack of coordination of eligibility and entitlement rules (particularly with the level of 'safety nets') adds to the complexity of service access.
- There is a lack of awareness and recognition of the role and scope of practice of different service providers that limits the services currently provided to patients with chronic or complex health conditions.
- There is a lack of consistent record keeping and data coding that can facilitate population health activities. Properly managed data and information can be used to gauge and measure outcomes for individuals and population groups. Quality data/information is also integral to processes measuring the safety and quality of care delivered.
- There is a gap in funding for screening and early detection of chronic disease in persons aged 50-74 years. A positive example for the heath check and early intervention model is the Aboriginal and Torres

Strait Islander health checks, which are used to identify risky lifestyle behaviours and identify interventions to reduce harm.

3. What can be done to improve the primary health care system for people with chronic or complex health conditions:
    a. In your area?

- No response (this is a national submission)

    b. Nationally?

- Care for people with chronic or complex health conditions needs to be tailored and coordinated on the basis of a person's condition(s), social, work, and living environment, and other personal circumstances including carer involvement (where appropriate).
- There should be a greater focus on the full range of primary, secondary and tertiary preventative measures. There are significant advantages in preventing disease and on reducing the impact once the disease or condition has occurred.
- There should be more flexible funding options for people with chronic health conditions (thereby facilitating the delivery of the right care, at the right time, by the right provider).
- eHealth systems can be used to better track patients. There has been a slow uptake of the national eHealth system and there needs to be better education for members of the public and health professionals on the benefits and use of this system; nurses play a pivotal role in helping patients understand the benefits of a personal eHealth record.
- Steps need to be taken to ensure delivery of the right care, at the right time, by the right provider for patients with chronic or complex health conditions. This will have benefits in terms of improving cost efficiencies, improving health outcomes and liberating the doctor's time to focus on decision making and more acute care. It will also assist in making care more accessible and affordable.
- Greater use of nurse clinics can improve care for patients with chronic or complex health conditions. Nurse clinics can improve access, reduce health care costs and reduce unnecessary workloads placed on medical practitioners.
- Primary health care nurses are well established as care coordinators for people with chronic and complex health conditions, such as chronic heart failure and diabetes, applying prevention and management strategies that work to keep people well and out of hospital. Nurses, working as part of the multidisciplinary primary healthcare team, represent a skilled, efficient and effective means of delivering and coordinating chronic disease prevention and management.
- There needs to better management of data and clinical record keeping.

4. What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice?

Health professionals deliver healthcare most efficiently and effectively when they are working at the top of their scope of practice. Some barriers which may operate to prevent this include:

- Some referring providers focus on small patient care tasks rather than expanding the role of the health professionals. There is also a lack of understanding between the different health disciplines regarding the role and capabilities of the different sectors of providers; this is particularly the case with the role and scope of primary health care nurses.

- The current funding model in Australian primary health care, which is predominantly focussed on fee-for-service, operates as a barrier. For example, practice nurses are only funded for five visits per year within the Medicare Benefits Schedule (MBS) (and the patient rebate is only $12, regardless of the time taken with the patient and the complexity of the visit). This is inadequate.
- There is a lack of understanding or awareness among general practice staff of other funding sources such as the Practice Nurse Incentive Programme (PNIP) and the contribution that incentive payments can make to practices. There is also a lack of understanding of what constitutes an 'incentive' payment. In addition, the business case for utilising nursing skills in general practice is not widely or clearly understood.
- There is a clear lack of understanding about the type of work that primary health care nurses can do in terms of prevention and management of chronic and complex disease.
- Specific barriers for primary health care nurses working to their full scope of practice include access to education, costs (time etc.) associated with education and a lack of career progression/role advancement opportunities (particularly in smaller communities).

5. As described in Theme 1 of the Discussion Paper, a 'health care home' is where patients enrol with a single provider which becomes their first point of care and coordinates other services. Do you support patient enrolment with a health care home for people with chronic or complex health conditions?
    a. Yes
    b. No
    c. Prefer not to answer

    Why do you say that?

- APNA supports patient enrolment with a health care home. The definition of what a patient considers to be their healthcare home, however, will vary depending on the patient's location and type of health service available to them (e.g. a GP, a practice or a community health clinic).
- Patient enrolment facilitates the establishment of a trusted relationship between patient and their carers and the healthcare home.
- Patient enrolment can lead to better tracking and continuity of care for patients with chronic or complex health conditions (noting that all enrolled patients should have a myHealth Record).
- Patient enrolment can lead to reduced duplication of care.
- Patient enrolment can lead to improved care coordination and a more complete 'big picture' view of the patient's health.
- Patient enrolment can help to ensure the patient receives the right care delivered at the right time by the right provider.
- Patient enrolment can facilitate targeted funding to the main healthcare provider/team that both delivers and coordinates the bulk of a patient's care.
- Patient enrolment should be portable. If the patient is unhappy with the service they receive they should be able to change healthcare homes and service providers.

6. Do you support team based care for people with chronic or complex health conditions?
    a. Yes
    b. No
    c. Prefer not to answer

Why do you say that?

- Care for patients with chronic or complex health conditions is of such complexity that it is difficult for a single health discipline to cover every aspect of the patient's care efficiently and effectively. However, with a team based approach focussing on the 'bigger picture', parts of the patient's care can be shared with other health professionals; this frees up the doctor's time to focus on patients with acute conditions and improves access to healthcare for all patients.
- Multidisciplinary care can tap into the skills and expertise of different specialities to help set goals and achieve optimal outcomes for patients. Information sharing, teamwork and coordination are key features of a multidisciplinary healthcare team.
- It is important that care is patient-centred. It is also important that patients and their carers are considered to be an integral part of their healthcare team.

7. What are the key aspects of effective coordinated patient care? Please number in order of importance (from 1 to 4).

    a. *Patient participation* (refers to shared processes in which both the patient and health professionals contribute to medical decision making and care planning. It requires health literacy, self-management, self-awareness, collaboration and empowerment of patients in decisions regarding their health) – order of importance = 1

    b. *Care coordinators* (refers to a role or specific person responsible for organising patient care activities and sharing information amongst participants concerned with a patient's care to achieve safer and more effective care) – order of importance = 2

    c. *Patient pathways* (nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group) – order of importance = 3

    d. *Other.* – order of importance = 4 (e.g. efficient electronic communications between providers and linking to the myHealth Record system. Linkage to support groups and services that may not be clinical)

8. How can patient pathways be used to improve patient outcomes?

- Patient pathways can be used to optimise patient care by ensuring delivery of the right care at the right time by the right provider.
- Patient pathways can provide referring health professionals with guidelines for care, results of investigations and contact details for local health service and specialist providers.
- Having Advanced Care Directives uploaded to the myHealth Record system has the potential to reduce unnecessary intensive care unit (ICU) admissions, and to improve access to palliative care services.

9. Are there other evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic or complex health conditions?

- Nurse clinics are an efficient and effective way of improving care for patients with chronic or complex health conditions. There are a number of studies that support the effectiveness of this approach, including the following:

- Wong F.K. & Chung L.C. 2006. Establishing a definition for a nurse-led clinic: structure, process, and outcome. *Journal of Advanced Nursing*, 53(3), pp. 358-369.
- Hoare, K,J, Mills, J, & Fancis, K, 2011. 'The role of government in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: an adapted realist review.' *Journal of Advanced Nursing* vol. 68(5), pp.963-980.
- Denver E. et al. 2003. Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with Type 2 Diabetes. Diabetes Care, 26(8), pp. 2256-2260. Morcom J. et al. 2005. Establishing an Australian nurse practitioner-led colorectal cancer screening clinic. *Gastroenterology Nursing*, 28(1), pp. 33-42.

THEME 2, INCREASED USE OF TECHNOLOGY

10. How might the technology described in Theme 2 of the Discussion Paper improve the way patients engage in and manage their own health care?

- Greater use of the myHealth Record system, with patients accessing and reading their individual record, can allow patients to track and monitor their own care.
- New technologies can allow more extensive home monitoring of health conditions by patients; this will provide patients (and carers) with a greater sense of ownership and management of their condition. Primary health care nurses play an important role in supporting patients with the use of health technologies in the home; nurses understand the safety, complexity and risks associated with the introduction of these new technologies.

11. 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 or complex health conditions?

- An appropriate level of funding for technology is one of the main enablers.
- The use of cost-efficient technologies is important.
- Health literacy may be a barrier, but appropriate support (provided by primary health care nurses) for patients to use new technologies can assist with improving patient understanding of the benefits and use of technology. It can also assist patients in gaining confidence and motivation to take up new technologies.
- The ability to communicate information between healthcare providers that are part of the multidisciplinary healthcare team in an immediate manner, including an eHealth patient record, is another important enabler.

12. How could technology better support connections between primary and hospital care?

- Technology can enhance connections through the ability to communicate information between healthcare providers that are part of the multidisciplinary healthcare team in an immediate manner, including an eHealth patient record, electronic care plans, electronic discharge plans and pharmacy links.

13. How could technology be used to improve patient outcomes?

- The use of technology can provide health professionals with immediate and up to date access to relevant health information. This can enable these professionals to make appropriate, effective and efficient care planning decisions.

THEME 3, HOW DO WE KNOW WE ARE ACHIEVING OUTCOMES?

14. Reflecting on Theme 3 of the Discussion Paper, is it important to measure and report patient health outcomes?
    a. Yes
    b. No
    c. Prefer not to answer

    Why do you say that?

- Measuring and reporting patient health outcomes can allow health professionals and managers to plan and target resources appropriately for individual patients, as well as practice population groups; this can feed into needs assessment and planning for the wider community. These measures can also be used to assess and guide quality improvement activities or initiatives.
- Measuring and reporting patient health outcomes can help to ensure all patient population groups receive the right care at the right time by the right provider.
- Measuring and reporting patient health outcomes can enable health professionals to plot any improvement (or lack of improvement) in a patient's health condition since they started to receive the care. This will allow the provision of more efficient and effective patient care.
- It is important to ensure all data is recorded properly; it should be recorded and coded accurately so it can be accessed easily and used effectively to plan care and measure any improvement (or deterioration) in a patient's health status. Good data collection and analysis, however, requires sufficient funding. The current primary health care funding model, with its predominant fee-for-service focus, is problematic in that it does not specifically fund quality and safety work outside of patient consultations.
- The correct recording and coding of patient information is a critical part of good quality and safe clinical handover processes.

15. How could measurement and reporting of patient health outcomes be achieved?

- The Improvement Foundation has a well developed system for recording outcome measures – this is an excellent example of best practice in this area.
- Information on patient health outcomes could be fed back to the providers. It is not just about improving the patient's health; it is also about looking at the system as a whole. Group/pooled patient information can be fed back to individual clinicians to see how they compare to benchmarks for similar practices/care.
- New tools may need to be developed to illustrate/graphically depict changes in individual patient measures. These can be used to inform clinician decision making or as a teaching tool for patients. For example, there are already a number of commercially available tools that can download home blood glucose monitors to illustrate the measurements to patients, record whether they are inside or outside of range and plots trends in blood sugar levels.

16. To what extent should health care providers be accountable for their patients' health outcomes?

- One example of accountability relates to the treatment of diabetes. Regular measurement of HbA1c in diabetes patients can identify if blood measures are consistently high; this could trigger appropriate action such as further medication, the provision of lifestyle advice or further investigation. Healthcare

providers should be able to document what measures they have taken to address the patient's health conditions (even if the patient does not adhere to the advice or medication programme).

- Pooled patient data can be fed back to the clinician benchmarked against similar care setting/clinic/practices, so gaps can be assessed and quality improvements activities put in place.

17. How could health care provider accountability for their patients' health outcomes be achieved?

- See answer to the above question.

18. To what extent should patients be responsible for their own health outcomes?

- With the increased use of technology patients can be responsible for monitoring and recording their health data; this makes them responsible for certain aspects of their own health.
- The role of health literacy is important when considering a patient's ability to be responsible for their own health outcomes. Health literacy may be a barrier, but nurses are skilled at assessing a patient's ability to comprehend information presented to them; they can then provide support through tailored messages that can assist with improving patient understanding of their health condition(s) and treatments. This support can also assist patients in gaining confidence and motivation to take some control over their care.

19. How could patient responsibility for their own health outcomes be achieved?

- Better assessment by clinicians of individual patient and carer health literacy can help develop and enhance patient responsibility.
- Health literacy may be a barrier, but appropriate support from nurses can assist with improving patient understanding of their health condition and treatments. It can also assist patients in gaining confidence and motivation to take some control over their care. Regular support visits with the nurse can be scheduled to monitor progress and provide support.
- Including patients in care decisions can be an effective mechanism for achieving patient responsibility. Patient responsibility can also be enhanced if patients are included as an integral part of their healthcare team
- It is important to consider motivation and change management behaviours when looking at patient responsibility.
- The way in which healthcare providers target information to patients is important in establishing a patient's personal responsibility.
- Healthcare professionals have an important role to play in encouraging patients to be more accountable and responsible (where appropriate).

THEME 4, HOW DO WE ESTABLISH SUITABLE PAYMENT MECHANISMS TO SUPPORT A BETTER PRIMARY HEALTH CARE SYSTEM?

20. Theme 4 of the Discussion Paper discusses different payment mechanisms. How should primary health care payment models support a connected care system?

    If you prefer a blended model, as described in Theme 4, select all the components that should apply.

a. *Pay for performance* (a way of funding health services. Providers receive payment for delivering certain types of care or achieving specific outcomes for their consumers, typically related to quality of care, access to care, patient-satisfaction measures and service provider productivity)

b. *Salaried professionals* (Salaried professionals are employed and paid independently of their productivity or their patient's outcomes. This way of funding health services is often combined with expected standards of performance for health professionals and also incentives such as 'pay for performance')

c. *Fee for service* (a way of funding health services, similar to other types of retail transaction. Providers are paid a fee based on the service they provide to consumers, usually based on the time taken to deliver the service, effort or cost)

d. *Capitated payments* (Capitated payments or 'capitation' is a way of funding health services. Providers are paid a set amount per enrolled client or resident of an area, per time period – often monthly, quarterly or annually)

e. *Other* (SPECIFY). Other funding models

- The most effective way of supporting a connected care system is through a blended (or 'hybrid') payment model. Performance measures may form part of that model, but appropriate safeguards would need to be put in place to ensure care and enrolment was open to all, and not selectively cherry-picked by practices to ensure favourable outcome measures.
- Any new funding model needs to be sufficiently flexible to reflect the vast range of Australian health services and employment models. The funding model should be supple enough to cover the care and coordination of chronic health needs and cover breakthrough acute presentations or unrelated illnesses in the same patient.
- Consideration should be given to how services might be funded for care coordination, primarily chronic disease management service provision where the model is not a standard GP practice, and where contracted GP services are used and the patient deems the community-based clinic as their health care home.

21. What role could Private Health Insurance have in managing or assisting in managing people with chronic or complex health conditions in primary health care?

- Some private health insurers have innovative care models in place for their clients.
- Private health insurers' chronic disease management initiatives may have a role in taking some pressure off the tertiary sector; hospital services can then be redirected to people in dire need and those who are most financially disadvantaged.
- Communication is key to effective patient care and coordination. It is crucial that clinicians who are providing health care services on behalf of private health insurers share information regarding the patient's care/ treatment with the patient's GP or healthcare home in order to prevent duplication (and associated additional costs) and siloing of services.
- Private health insurers could share innovative strategies and activities, disease data collected and outcome measures with the public health system.

22. Do you have anything you would like to add on any of the themes raised in the Discussion Paper?

- Effective communication (including the use of the myHealth Record system) and clear pathways for care, delegation and management are key to improving care coordination for people with chronic or complex health conditions.
- There is lack of clarity around the scope of practice for primary health care professionals, particularly nurses. This impacts on the capability of nurses (or other health professionals) to contribute to healthcare at a higher level of professional practice.

About APNA

Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care.

APNA is bold, vibrant and future-focused. We reflect the views of our membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

Nurses in primary health care contribute to a healthy Australia through innovative, informed and dynamic care.

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