

AAGP/AGPN submission to the Standing committee on health

The Standing committee has been asked to consider

1. examples of best practice in chronic disease prevention and management, both in Australia and internationally
2. opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management
3. opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary healthcare
4. the role of private health insurers in chronic disease prevention and management
5. the role of state and territory governments in chronic disease prevention and management
6. innovative models which incentivise access, quality and efficiency in chronic disease prevention and management
7. best practice of multidisciplinary teams chronic disease management in primary healthcare and hospitals
8. models of chronic disease prevention and management in primary healthcare which improve outcomes for high-end frequent users of medical and health services.

AAGP and AGPN believes opportunities to improve Australian patient care and patient outcomes exist now.

**Recommendation 1**

**In supporting general practitioners to deal with multi-morbidity,**

**Recommendation 2**

**Making it easier for GP to arrange hospital admissions**

**Recommendation 3**

**Getting early changes by targeting specific population and disease areas**

* + **General practitioner involvement in breast cancer screening**

**Recommendation 4**

**Assisting general practice to link into the state and territory government to leverage the cost effective model of general practice**

**Recommendation 5**

**Assisting GPs to improve the efficiency of referral to the private and public sector**

* + **Using evidenced based models for referral and**
	+ **Investing in GP to improve the value of referrals**

AAGP/AGPN represent existing networks of general practitioners around Australia that first became effective in changing the primary care and general practice environment in Australia in the late 1990’s.

Despite Australian Government programs changing to a failed Medicare Local Network and now Primary Health Networks, general practitioners still find their GP networks (Division) useful and have kept their relationships working.

AAGP/AGPN represent those networks

Typical of the groups we represent are GPpartners (Brisbane)

GPpartners is a General Practice Network covering General Practices in the Metro North Brisbane area from the Brisbane River to Caboolture. We are a member organisation with 400 GP members. GPpartners provide relevant education to GPs, offer Peer support and advocacy for GPs and General Practice. GPpartners works closely with the Australian General Practice Network and the RACGP locally. We are always looking for innovative ways to improve patient care and make working in General Practice more supported for GPs

AAGP/AGPN works with approximately 6000 GP’s around Australia through existing GP networks and will be working with more networks when the PHNs settle into their roles over the coming months and years.

***Best practice in chronic disease prevention and management, both in Australia and internationally***

**Recommendation 1**

 **Supporting general practitioners to deal with multi-morbidity**,

Like the RACGP we believe the impact of multi-morbidity is significant. The American Society of Geriatrics has written about this widely since 2012 expressing it frustration with present evidence based guidelines or clinical practice guidelines (CPGs) focus on a single disease. So much so that most trials will actually exclude patients with “confounding “ conditions because of the complexity it adds.

**Multi-morbidity** Co-occurrence of 2 or more chronic conditions

**Co-morbidity** Is the presence of one or more additional disorder (or diseases) co-occurrence with a primary disease or disorder. The disorder may also be a behavioural or mental disorder

Prevalence of multimorbidity was estimated as 37.1% of surveyed patients, 29.0% of people who attended a GP in 2005, and 25.5% of the Australian population. Prevalence and complexity (number of domains present) increased with age: 83.2% of surveyed patients aged 75 years or older had multimorbidity, 58.2% had morbidity in three or more domains, and 33.4% in four or more. Prevalence of multimorbidity did not differ between the sexes. The most common morbidity combinations were arthritis/chronic back pain + vascular disease (15.0% of sample), a psychological problem + vascular disease (10.6%) and arthritis/chronic back pain + a psychological problem (10.6%). We estimate that 10.6% of people attending a GP in 2005 and 9.3% of the population have arthritis/chronic back pain + vascular disease (± other morbidity types studied), and this group accounted for about 15.2 million Medicare-claimed general practice encounters in 2005. **Helena C Britt, Christopher M Harrison, Graeme C Miller and Stephanie A Knox Med J Aus. 2008; 189 (2): 72-77**

General practitioners care for patients of all ages but probably half of adults have 3 or more disease. (Multi-morbidity) The different patterns of these conditions produce cumulative effects on each other. Multi-morbidity is associated with higher rates of adverse effects of treatment and interventions (US Association of Geriatrics)

The fact that most evidenced based clinical practice guidelines (CPGs) focus on single disease is a barrier to their application in adults with multi-morbidity. Many CPGs do not address the question of how to integrate care for individuals with multi-morbidity. Following single-disease CPGs in adults with multi-morbidity may cumulatively result in care that is impractical, irrelevant, or even harmful.

Example

A Beta-blocker (medication class) being “worlds best practice” for use in heart failure but totally contraindicated in treating a patient with asthma. What does a GP do to treat a patient with heart failure and asthma without being an easy target of criticism by some one monitoring the general practitioner or their team? The GP will also know that the patient has a mental illness and that the patient will not take the medication anyway.

General Practitioners will be criticized for not following “Evidenced Based Care” that has been developed by a specialist group.

These groups will

* Exert influence on hospitals
* Exert pressure on young training doctors,
* Advise state and territory governments about clinical practice
* Have access to research money(s) to support their models.

We note in the NSW Health Submission (sub0152) to this committee that is asserts

“That Low acuity Emergency Department presentations and access to urgent care in the after-hours may reflect suboptimal management of chronic conditions. “

The implication that the GP may have not been caring for the patients properly shows there is little understanding of chronic and complex medical problems in patients with multiple morbidities.

**The role of state and territory governments in chronic disease prevention and management**

**Recommendation 2**

**Making it easier for GP to arrange hospital admissions**

Even with the best treatment in the world patients will need to access hospital care. What is missing are tools to allow clinicians to identify problems in one sector that are recognized in other health sectors confirming agreed management. These “silos” are barriers in the Australian health system that need practical answers and need to be address urgently.

* Getting early changes by targeting specific population and disease areas

Choosing “low hanging fruit”

We suggest barriers between sectors can be broken down by initially on changing some specifically selected programs. By choosing to target programs that allow patients and their clinicians to benefit from our health system now Australian Health System will have several benefits

Benefits of targeted changes

* Help bring early benefit to the new PHN’s and their programs
* set up working relationships that will allow the different “silos” to work together

Not only is this important to improve the Australian Health System overall handover “across the silos” has been identified by the Australian Commission on Safety and Quality in Health Care as the time patients are at risk. (Clinical Handover)

<http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf>

Hospital admission may be a successful out come

Our Approach to “avoidable hospital admission” would be different to many of the existing or suggested programs that to date have seen admission to hospital as a failure of general practice and care, rather than a normal part of management.

NSW Health Submission

International models of care such as Patient-Centered Medical Home can improve access to care and health outcomes and should be considered. So too should the use of financial and non-financial incentives to reduce avoidable hospitalisations, particularly for high end frequent users of medical and health services

The inevitable outcome of living longer and living with a condition such as diabetes is that complications of age and disease will occur. If complications occur later in life it could be considered a success of management (e.g. amputation of a leg for an 80 year old instead of 60 year old patient). If catastrophic complications are avoided by hospital admission may be a success of care if a patient is admitted early and easily by a GP (e.g. Transient Ischemic Attack (TIA) rather than a stroke)

Punitive financial arrangements that see hospital admission as a failure of care or imply poor management are to be avoided.

The end result of screening programs will also lead to hospital admission. Clear examples of that are the positive screening results for bowel cancer that show a patient needs to have colonoscopy. Breast cancer detection will often mean the patient will need hospital or tertiary care such as surgery, chemotherapy and/or radiotherapy.

We are suggesting a practical step to break down the barriers/silos in our health system is to increase the role of general practitioners in admissions to hospital and the patients of a general practitioner having better access to services that are in the public or private hospitals

Example

A patient receives notification that they have a positive bowel cancer-screening test. The GP can make an appointment with a public hospital to admit the patient directly for colonoscopy. This can be done by having prior approval of a particular doctor/GP who knows the hospital system and who is conversant with the clinical guidelines needed to arrange colonoscopy. These can be special clinics in the hospital sector or GP practices who have an interest and expertise in bowel cancer

The development of shared care models in Australia run by GP networks have been seen to work well in conditions such as antenatal and pregnancy care. (GP Obstetrics Shared Care, South Australia) To make sure the hospital knows the care in the community is the same as that required for patients seen in the hospital outpatients GP’s are required to show they have kept up with the guidelines of care the hospital requires. If GP’s attend the regular updates and show compliance the hospitals accept that the GP can do the “outpatients” work in the community. If the GP identifies a problem in line with protocol and guidelines, then access for the patient to hospital is expiated because of the existing arrangements.

“Quality improvement strategies (QIS) are heterogeneous and methodological flaws in much of the evaluative literature limit validity and generalizability of results. …. Clinician/patient driven QIS appear to be more effective than manager/policy-maker driven”

**What are the most effective strategies for improving quality and safety of health care?** I. Scott <http://onlinelibrary.wiley.com/doi/10.1111/j.1445-5994.2008.01798.x/abstract?userIsAuthenticated=false&deniedAccessCustomisedMessage>=

Pre-existing guidelines and accepted protocols is a way to maintain standards, support clinician involvement, break down barriers, speed up patient access to appropriate hospital care and manage a more efficient, patient centered health system

The pathway to “evidence-informed” policy and practice involves three active stages of progression, influenced by the policy context. The three stages are (1) sourcing the evidence, (2) using the evidence, and (3) implementing the evidence.

Pathways to “Evidence-Informed” Policy and Practice: A Framework for Action

* Shelley Bowen, Anthony B WI

Published: May 31, 2005

DOI: 10.1371/journal.pmed.0020166

* General practitioner involvement in breast cancer screening

Because the AAGP/AGPN work with GP networks whose work has been with GP, their practices and the teams in their practices we believe we can ‘implement the evidence” in very practical ways and we suggest some practice opportunities exist to introduce such guidelines and quality improvement strategies in the first instance for

* Breast cancer detection and population screening for breast cancer
* Bowel cancer screening positive testing
* Joint replacement follow up
* MRI’s
* Assisting general practice to link into the state and territory government to leverage the cost effective model of general practice

**Interaction with hospitals and State based health systems**

GPs will refer their patients to the hospital because there is a wait to access services. If the GP’s are included in the process of “triaging” outpatients then a referral will be clinically appropriate and timely

Example (from UpToDate 2016)

 Abdominal aortic aneurysm (AAA) is a common and potentially life-threatening condition. Without repair, ruptured AAA is nearly uniformly fatal. Of the 50 percent of patients with ruptured AAA who reach the hospital for treatment, between 30 and 50 percent will die in the hospital

For asymptomatic patients, elective repair of the aneurysm is the most effective management to prevent rupture. However, elective aortic surgery is also associated with risks, and thus, elective AAA repair is not recommended until the risk of rupture exceeds the risks associated with repair. For asymptomatic patients, the risk of AAA rupture generally exceeds the risk associated with elective AAA repair when aneurysm diameter exceeds 5.5 cm

AAGP/AGPN believes that Australia could maintain is present expenditure on health and in particular the commonwealth can continue to support the Australian community through world’s best quality health system if it invests more money in general practice

The AMA submission to the senate inquiry in health policy, administration and expenditure quotes the figures of the cost of health including comparison to other OECD countries

* Health was 16% of the total 2014-15 Commonwealth Budget down from 18.09% in 2006-07
* Health cost were 8.9% of Australia’s GDP in 2010, stable when compared with 8.2% in 2001, and lower than the OECD average of 9.3%.

Utilisation of general practitioner services is not out of control. General Practice offers the Commonwealth a chance to get better productivity without loosing quality

Since 2007-08 the population has grown on average by 1.51% and Medicare funded GP services has grown on average by 2.47%.

GP services per capita have grown on average by 0.94%. The small increase in services per capita is despite an increase in the practising GP workforce, to the tune of 3.5%, which has occurred as a direct result of Government initiatives.

Directly supporting general Practice with population health initiatives will be a better use of the nations resources. Breast cancer screening is an example

Supporting quality of chronic disease prevention and disease management

The present system of care plans and team care arrangements can be improved to get better outcomes

* Including specific proven measure in the care plans before payment
	+ Over 70 year olds have bone density testing
	+ Over 65 have pneumococcal vaccine
	+ Palliative care and advanced care directives completed
* Population health initiative
	+ Age appropriate vaccinations on record or recorded on national data base
	+ Recorded bowel cancer screening on MyHealth
* Tighter control in linking in practices to the patients they are usually seeing
	+ Increasing ability to make sure the practice that starts seeing the patient as part of a care plan is the one the patient usually sees and the same practice will follow up the patient
* Rewarding doctor patient relationships over the long term
	+ GP’s understand patient’s clinical context through long term relationships. Sometimes the GP will also manage the other members of the family and may have 3 or 4 generations of patients at any one time.
	+ If a GP graduated2 weeks ago or 2 decades ago their support from Medicare for clinical care is the same
	+ **We suggest Medicare rebates should be higher if a GP is practicing in one practice for more than 10 years**
* Rewarding a practice if it provides broader and continuity of care
	+ GP’s may send a nurse from the practice to do a home visit. State governments will fund specific nurse home visits but neither state or commonwealth will acknowledge or support a practice who sends their own staff to review and visit a patient at home
	+ If a patient with chest pain attends a clinic they usually see the practice will not be supported to rapidly assess chest pain. A rural practice will get support to do POCT but a metropolitan practice will receive none. The States will often support separate systems (like Ambulance) to perform and monitor a patient but not the GP or their practice. A troponin in the hands of a GP is more efficient use of resources than an ambulance.

Recommendation 5

* Assisting GPs to improve the efficiency of referral to the private and public sector
	+ Using evidenced based models for referral and
	+ Investing in GP to improve the value of referrals

GP as gatekeepers

Joint replacement

* Initial referral
* Follow up

Specialist referral as appropriate

Follow up diseases

* e.g. breast cancer after surgery

General Practitioners supporting each other

PHN’s may be the new vehicle to support the people working in general practice teams. Australia government has supported non face to face payments in gen