



Best-practice examples of chronic disease management in Australia

With the introduction of Health Care Homes, practices will have greater flexibility to provide comprehensive, coordinated, patient-centred care for patients with complex and chronic conditions.

The aim of this resource is to showcase practical examples of how different clinics across Australia use a variety of patient-centred and best-practice approaches to chronic disease management.

You will find a series of practice snapshots, quotes and case studies, which help illustrate key components of Health Care Homes including:

- care coordination
- using a multidisciplinary team approach
- ensuring team members work to their full scope
- and providing enhanced patient access both within and outside opening hours.



Implementing a coordinated model of care

Robust recall and reminder system: practice with seven GPs, two nurses, three allied health professionals

“We have a lot of elderly patients who suffer from multiple conditions. We found that the best way to manage things was to create a very good recall process. We send out recalls to patients on a regular basis to make sure that the nurses are consistently creating and reviewing their chronic disease plans.

“It’s great when patients initiate this process, but most of the time, it’s largely driven by our nurses. Our nurses go through the plans, check when patients attended other services like the specialist for their osteoporosis, or check if they’ve been to see their physiotherapist or other allied health professionals.

“If other providers are involved, the nurses will call them to discuss new referrals or to check on progress or treatments.

“Our nurses are also constantly looking for new services that might be a good fit for our patients. For example, there are several social programs run by different community groups. The nurses can make the right phone calls and referrals to get isolated patients into some of those programs.”

Planning care and regular contact: practice with five GPs, two nurses, two allied health professionals

“We plan our patient contacts in advance. We print out a list of all the phone calls or contacts we will need to make with our complex patients for the next year. Then we follow that list to make sure we touch base with those patients every three to four weeks.

“For the initial consultation, the nurse will usually do a home assessment, especially if the patient is elderly. That gives us a good picture of where they’re at. It also builds a relationship with the patient. If they have a carer, we’ll liaise with them at this point as well. After that, we catch up every three weeks over the phone or we bring them into the clinic.

“When the nurse makes the routine phone call every three weeks, they’ll discuss scripts, check if things are up to date, check how they’re managing generally and if there are any issues or changes.

“We find out a lot through these calls. One patient hadn’t told anyone about a fall. That routine call led to other coordination work and discussion with their doctor to assess for injury and look at strategies to prevent further falls. We’re trying to prevent hospital admissions and we’re also trying to keep patients well in their home.

“We don’t always find out when patients have been to hospital because the discharge summaries don’t always come through. That is another reason it’s good to



touch base with the patients regularly. When the nurse rang another patient, he said: ‘I’ve been in hospital for the last 2 weeks’.”

Liaising with case managers: community health centre with three on-site GPs

“We have several clients with complex needs, including mental health. They’re sometimes more difficult to engage, less compliant and don’t cope as well.

“We also see patients who may have diabetes, heart disease, they might be elderly and have other physical ailments and most of them are not proactive about their health.

“Usually they come in when they’re in crisis or unwell and need a script. Most of them are elderly, and some of them don’t speak English, which complicates things.

“In our service, we’ve found the key for good care coordination has been engaging with caseworkers. They help patients come to regular appointments and can help to chase up their scripts. For the really pointy-end clients, you really need a caseworker to help with management.

“We also have our nurses who do a lot of the administrative and clinical legwork alongside the GPs and we have a pretty good recall system. We put a lot of effort into following up with patients and we rely on our administrative staff to help us chase up clients so they come in for their reviews and other care.”

Engaging hard-to-reach patients: Aboriginal Community Controlled Health Service

“We see some homeless Aboriginal patients who live in the bush. They have multiple health issues — they are on multiple medications, have limited health literacy, English as a second language, low-socio economic circumstances and are transient.

“They can be very time consuming. They might come into the clinic for first-aid or for immediate health issues, but they rarely come in for their check-ups or for medication for their long-term conditions.

“Instead they need to be followed up on the streets. We often find that they are not taking their medication, or not in the way it was intended.

“We have care coordinators — either a registered nurse, an Aboriginal health worker or a staff member — who can case-manage the patient’s care. The care coordinators make sure the patient gets the full level of follow-up required. We also use an electronic recall system as part of the patient notes and have regular meetings to discuss complex patients.”

Recall system to prompt reviews: GP from regional Victoria

“When I have a patient with complex or multiple conditions I always make sure we review them on a regular basis.

“In our clinic we use our recall system to keep track. For example, I have a patient who has an intellectual disability and suffers from obsessive-compulsive disorder. If



I'm referring them to another provider, between myself and my practice team, we'll coordinate the whole thing.

"Even though I will often get letters back from other services, I want to review these patients on a regular basis just to make sure that all the right care is happening, and that they are following through. If you just assume that people are following all the advice and referrals you initiate, patients can fall through the cracks.

"It's important to have a good recall system so you can proactively check that they have been to a provider and they have improved, or, if things haven't improved, you need to look at other avenues.

"With complex patients you can't rely on waiting to hear back or getting correspondence from other services before you act. If that's all you're doing, it's practically a guarantee that things will be missed and that will affect patient outcomes."



Multidisciplinary team approaches

Patients with complex and chronic conditions often require a variety of services and involvement from multiple providers across different disciplines. A team approach allows providers to collaborate, preventing duplication of services and resulting in better coordinated care.

Other benefits include:

- *stronger professional relationships*
- *improved communication across disciplines*
- *and cross-pollination of skills, where providers learn and benefit from each other's skills and expertise.*

Below are some examples of multidisciplinary team approaches.

Collaboration with external providers: practice with 15 GPs, six nurses

“We don't have allied health on the premises so we need to work closely with our preferred external providers.

“The nurses have very strong relationships with them. We know we can pick up the phone or email them and we'll hear back quickly.

“When we refer patients to external services, we give the patient the paperwork and contact details so they can get in touch with those services or providers. In the meantime, the providers are also given the patient's contact details, with the patient's consent.

“Under our system, if the allied health service hasn't heard from the patient after two weeks, then they will ring the patient to follow up. A lot of our older patients get home and forget to make appointments.

“We work with one of the dieticians and a local podiatrist. They send us a list every three months with patients we have referred, but that they either haven't heard from or haven't been able to get in touch with.

“Then we can chase it up from our end and we can add a reminder to discuss it with the patient when they come in to see the doctors.”

A practice nurse talks about collaborative care delivery with a podiatrist

“A lot of our elderly patients need services like podiatry. We recently had a patient with a lesion and it was unclear whether it was a blister or an ulcer.

“In collaboration with the podiatrist and liaising with the nursing team, we worked on a weekly wound dressing for about three months.

“We talked to each other along the way — what he thought and what we thought — until we managed to resolve the lesion together.



“We also talk to pharmacies a lot. We may have to discuss scripts, or look at starting a patient on dosette boxes. We will usually put complex patients on home medicine reviews. “

Integrating a clinical pharmacist into general practice

“The integration of a clinical pharmacist into the general practice as a team member means they actively participate in some of the most fundamental preventative interventions; identifying target patients, reviewing medication regimes, providing patient advice and options, education and reporting outcomes. Early signs are demonstrating the effectiveness of this in enhancing the general practice team.”

Case conferences: practice with seven GPs and two nurses

“With our team, either the nurse or the doctor will see the patient first and we then have a discussion about what needs to happen.

“The nurses will tend to do a lot of the administrative work to organise things and then liaise with the GP.

“Having more flexible funding means that you can do things like case conferences with multiple providers.

“We know who our tricky cases are, and this way of working with colleagues cuts through red tape and leads to better communication. Liaising with social workers for example — having that professional connection means they can help with patients transitioning from home to facility care, along with any social issues emerging from that process.

“That is priceless — just to have those professionals you can pick up the phone and call for advice.”

Multidisciplinary team meetings: community health centre with three on-site GPs

“We have team meetings fortnightly and we invite other providers like allied health to come in from different sites.

“Often we’ll discuss difficult cases during those meetings or coordinate different tasks between members of the team. Our nurses tend to do a lot of the administrative and coordination working closely with the GPs.

“With the allied health services that are in-house it’s a lot easier to have ongoing case discussions in person.

“We’ve now also added a mental health liaison worker since we found we were struggling to coordinate central intake for mental health clients.

“Now the liaison worker, along with the caseworkers, can help the client and the team work out how to get them to the pharmacy and ensure they turn up at specialists appointments.



“Having our allied health members using the same software as the GPs has made it a lot easier to work together because all the notes are now in the one place.”



Working to full scope of practice

A key advantage of the Health Care Homes is the funding flexibility, which does not restrict care delivery to a particular discipline or a specific format.

Practices can make better use of the full range of skills of different team members, including practice nurses, allied health professionals, medical practice assistants and Aboriginal health workers.

Below are some examples of different team members working to their full scope of practice.

Promoting nurse autonomy: practice with seven GPs and two nurses

“Our doctors are happy that the nurses are properly skilled in areas like wound management, immunisations and chronic disease and that they can run these services largely independently.

“Our nurses do a lot of the patient education. All our nurses are immunisation providers, so they are the ones often prompting the GPs and identifying patients for different services. They also do general observations and assessments along the way.

“They tend to take care of everything from updating family history and next of kin, to smoking and alcohol assessments. GPs may skip these areas or not have the time to cover them in detail.

“It’s often the practices themselves which shape the scope of their team members. Some practices lean towards more task-oriented, clinical nursing skills like ear syringing and immunisations.

“Our practice is very much about care coordination and chronic disease management. Our nurses are supported to develop these skills and manage their tasks and time independently around these activities.

“We’ve supported our nurses with additional training so they can provide good care coordination and so they understand behaviour change in particular, because patient knowledge does not equal change behaviour.

“For nurses working in chronic disease, it’s really helpful to understand the stages of behaviour change, so they can work alongside somebody, know where they are at, and also know how to support patients and keep them motivated while they’re going through those lifestyle changes.

“That’s a real skill that nurses can develop. It takes time and practice and a supportive environment, but it’s really worth it because we’ve seen the difference it can make to patient outcomes.”



Employing medical practice assistants

“Medical practice assistants can play a significant role in the management of patients with chronic diseases. Medical practice assistants have a formal qualification, which allows them to help both clinically and administratively.

“They can assist with non-invasive clinical procedures like height, weight, BMI and blood sugar levels. They are also trained to help with peak flow, spirometry and simple wound care.

“They can often be a first point of contact which puts them in a position to gain knowledge, trust and understanding of a patient’s issues and circumstances. This can assist the GP or nurse with planning care.”

Aboriginal Community Controlled Health Service: advanced roles for nurses and Aboriginal health workers

“Our nurses and Aboriginal health workers (AHW) do a lot of case management and palliative care. This includes using telemedicine so that the patients can remain on country if they chose to die, rather than have further treatment.

“They practice according to the Central Australian Rural Practitioners Association manual and clinical guidelines. These are the best practice clinical guidelines that registered nurses and AHWs follow to diagnose, treat, prescribe medications, order testing and refer patients.

“They also do INR management, administer thrombolytic therapy and generally manage patients with complex conditions based on the registered care plans created by the doctors.

“Our GPs oversee the medical management of patients, develop complex clinical care plans for other staff to administer, and review patients as referred by other team members when there are concerns with the management or condition of the patient. So the GPs are kind of like the conductor of the orchestra.”



Enhanced patient access

An important component of Health Care Homes is the enhanced access offered to enrolled patients both within and outside practice opening hours. Providing timely access to care and health advice can support patients with self-management at home and can help to address issues at an early stage. This prevents escalation of conditions and reduces the need for acute or emergency treatment.

Below are some examples of enhanced patient access.

Nurse triaging and after-hours action plans: practice with five GPs, two nurses, four allied health professionals

“Calls from complex patients will go directly to the nurses. They know the patients and can discuss anything that’s going on in the background.

“A nurse might decide that they need to be seen on the same day and then we’ll fit them in with both the nurses and the doctors.

“We use a locum service for after hours. If a patient is unstable and we think something might be coming up, we’ll also have an after-hours action plan in place.

“We have written plans we can use for things like asthma, angina and other common conditions and we adapt these to meet the particular needs of the patient, which can include other issues as well.”

Nurse appointments and home visits: practice with five GPs, two nurses

“We have good relationships with our complex patients. They know that they can come in anytime. They can book an appointment directly with the nurse, even if the doctors are fully booked. We also offer home visits if they need it or if they’re unable to physically come to the practice”

Priority access and same-day appointments: practice with four GPs, two nurses

“Our complex patients have priority access to same-day appointments with either the GP or practice nurse. Patient calls are immediately transferred to the nurse or doctor, but if their care provider is unavailable, a return call is made as a matter of priority.

“In some cases, a patient needs a home visit. Depending on the nature of the issue, either the GP or practice nurse make that visit.

“For after hours, we have an on-call roster internally and patients are also provided with a list of external services. They can reach for advice or for emergency situations.

“In the event the patient needs to be transferred to hospital via ambulance, the GP on-call would contact the emergency department to provide them with a clinical handover.”



Providing transport: Aboriginal Community Controlled Health Service

“We have drivers who will pick up patients and bring them to the practice. The clinic is open during office hours and patients don’t need to schedule appointments. They are seen when they come in by an available team member. Home visits are also available if required.”



Consumer case study

One in five Australians have at least two chronic health conditions. It can be difficult for these people to get the care they need because of the complex nature of their conditions. Health Care Homes will give patients, doctors and other health professionals a more coordinated way of managing these conditions over the long-term.

In this case study, 68-year-old Claire talks about being a Health Care Home patient.

“I turned 68 last month,” says Claire. “When you get to my age, the body doesn’t work like it used to. I’ve had a lot of health problems in the past, with my back, my knees and my heart. I have to take tablets every day for my blood pressure.

“I quit smoking five years ago, but I still have breathing problems that won’t ever go away.

“My son lives with me, but his work takes him interstate for weeks at a time. It can get really lonely, and I used to worry that I might be unwell and that no one would be there to help me.

“I have a good GP, but I used to go to other clinics if my doctor didn’t have any appointments.

“Then a few months ago, my GP told me that I could enrol with his practice and that they would become my Health Care Home. He explained what this meant and what would change. I really liked knowing that all my health was going to be organised and looked after in one place.

Registering for My Health Record

“The nurse told me about My Health Record, the electronic record that’s available through Medicare. She helped me to register.

“Now I now have all my health information in the one place. That way, if I have other health appointments or if I have to go to hospital, they don’t have to worry about chasing different doctors for my file. I have my online record where my doctor can keep my history up to date.”

Patient-centred care coordination and enhanced access

“The nurses now call me every four-to-six weeks or more often if I’ve been unwell.

“They’ve helped me learn more about my conditions and work out what I can do to stay well. I know that if I have questions, I can just ring them. If they think I need to talk to the doctor, they put him on the phone or book me in to see him that day.

“I haven’t had to go to other clinics because I can always get through to the nurses. Sometimes, just that phone call has been enough to reassure me.



Symptom plan

“I now have this plan for different symptoms. I feel a lot better with this plan because I know what to look out for. If I’m feeling short of breath, I know what puffer to use, how long to wait and who to call if things aren’t getting better.

“Before, if I started to feel crook, I would get really anxious and just ring an ambulance or get my neighbour to drive me to hospital.

Liaising with other health services

“I had an episode recently where I had to go to hospital because my chest was really tight and things weren’t getting better with my puffer. The hospital said they would send the notes to my doctor, but when I had my regular call with the nurse a week later, they still hadn’t received anything.

“So the nurse got on the phone and chased it up. She then booked me in with my doctor to chat about the new tablets they put me on in hospital. My doctor said I could go back to the tablets I was on before I went to hospital. It was good that he caught it. Otherwise I would have been taking more tablets than I needed to.

Nurse-led coaching sessions

“The nurses run healthy living groups on Thursday afternoons. I go and other patients who are in a similar situation also go along. We talk about goals and what we want to achieve and we support each other.

“A few of us have started a walking group where we meet a couple of times a week to chat and do gentle laps around the park

More confident

“I’m a lot less anxious and I’m more confident about what to look for and what to do if I’m unwell. It’s really inspiring me to change things with my health and be more in control.”

About Health Care Homes

In 2017, 200 general practices and Aboriginal Community Controlled Health Services in ten regions around Australia will start delivering services under stage one of Health Care Homes. To find out more about [Health Care Homes](http://www.health.gov.au/healthcarehomes), go to www.health.gov.au/healthcarehomes