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NORTHERN QUEENSLAND
An Australian Government Initiative

Chronic Conditions Strategy

November 2022

Contents

NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

Background and rationale

Northern Queensland Primary Health Network (NQPHN) is an independent, not-for-profit organisation funded by the Australian Government to commission primary health care services to help northern Queenslanders live happier, healthier, longer lives.

NQPHN invests in primary and preventative health care to help ensure North Queensland communities receive the right care, in the right place, at the right time.

NQPHN has developed this five-year Chronic Conditions Strategy (the Strategy) to support the commissioning of services that improve primary care prevention, early intervention, and management of chronic conditions. In addition to informing commissioning priorities, the strategy will also support system integration and innovation, workforce development, and primary care engagement for more effective chronic condition primary care service delivery.

The Strategy will inform priorities across the whole of NQPHN's service footprint, covering the four Hospital and Health Service regions of:

- Torres and Cape
- Cairns and Hinterland
- Townsville
- Mackay.

The Strategy prioritises communities and areas where there is greatest need for services. The strategy also prioritises vulnerable and at-risk populations including First Nations peoples, those living in rural and remote localities, older persons, and those who experience socioeconomic disadvantage.

The Strategy will primarily focus on the seven priority chronic condition categories identified in NQPHN's most recent Health Needs Assessment 2022-24:

- diabetes
- cancer
- musculoskeletal disorders (e.g. arthritis)
- cardiovascular disease (CVD)
- chronic obstructive pulmonary disease (COPD)
- dementia
- chronic kidney disease.

Whilst the above-mentioned chronic diseases are identified as the priority conditions, NQPHN's chronic condition strategy also takes into considerations other chronic conditions which causes reduction in functionality especially for people living with dementia and other debilitating chronic diseases.

The development of the Strategy aims to ensure commissioning decisions by NQPHN are evidenced-based and support the achievement of NQPHN's strategic objectives.

The Strategy will also contribute to achieving the joint priorities of the Better Health North Queensland (BHNQ) Alliance, of which NQPHN is a member.

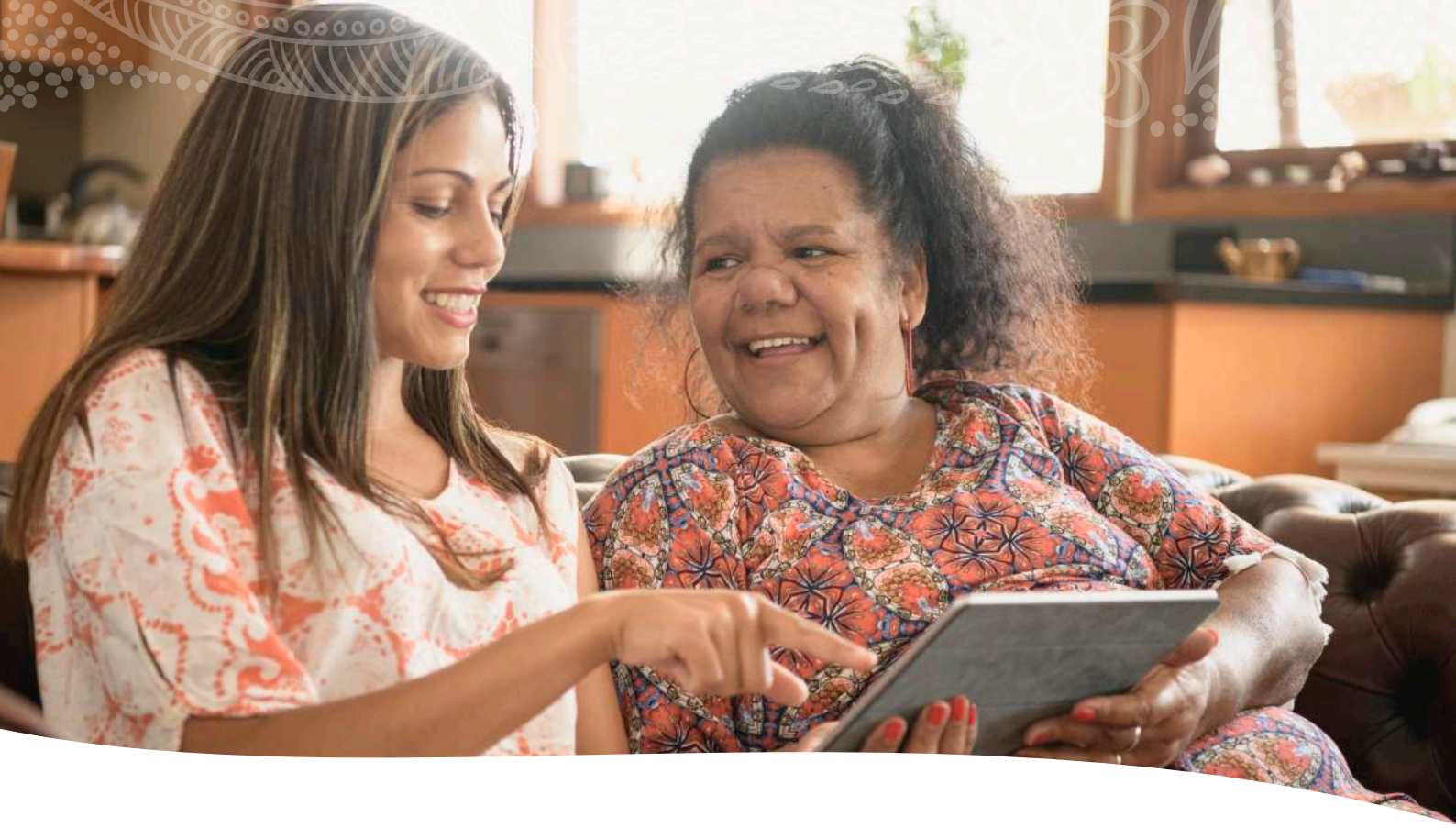
Some mental health conditions are considered chronic conditions; however, this is addressed through the mental health stepped care approach being delivered by the NQPHN Mental Health and Alcohol and Other Drugs (MHAOD) function.

People who experience chronic mental health conditions are at increased risk of other chronic health conditions. The importance of physical health management to address this risk is noted in the North Queensland Joint Regional Wellbeing Plan, where this is a specific identified priority.

Summary of need

A review of the strategic policy environment, operational environment in northern Queensland, health and service needs of the region, and learnings from existing and emerging models show that:

- The primary health care setting plays a critical role in preventing and managing chronic conditions through patient-centred and accessible care in Australia.
- Action to improve the capacity of primary health care services such as general practice, Aboriginal community-controlled health services, community pharmacy, and allied health services to meet the needs of people living with chronic conditions requires action at a national and regional level.
- National policies and strategies consistently highlight several key components to effectively prevent, detect early, and proactively manage chronic conditions, such as:
  - improving accessibility to services for people, particularly those from vulnerable or under-serviced populations
  - building health literacy of people living with chronic conditions and their families and carers, and promoting self-management
  - facilitating more integrated and coordinated care
  - utilising multidisciplinary, team-based approaches
  - building the capacity and capability of the health workforce
  - utilising technology and virtual care models.
- Primary Health Networks (PHNs) across Australia have an important role to commission services that respond to local service gaps and focus on secondary and tertiary prevention.
- Addressing chronic conditions in First Nations communities requires building the capacity of community-controlled health services while also ensuring mainstream primary care services are culturally appropriate.
- Over recent years, NQPHN has commissioned a range of programs and services to tackle chronic conditions in northern Queensland, which have focused on improving access to allied health services in rural and remote locations, delivering culturally appropriate care coordination for First Nations people living with chronic conditions, and growing the primary health care workforce in communities with known workforce gaps and challenges.
- The NQPHN region shows higher levels of need when compared with the rest of Queensland and Australia based on prevalence of chronic disease, rates of potentially preventable hospitalisations (PPHs) for chronic conditions, and relatively less access to primary healthcare services for chronic disease management.
- In other regions across Australia, most PHNs are commissioning services relating to supporting people living with chronic conditions that generally involve care coordination, improving accessibility where known service gaps exist, quality or practice improvement initiatives, or improving uptake of telehealth and other innovations.



Scope of strategy

Primordial prevention	Primary prevention	Secondary prevention	Tertiary prevention	Quaternary prevention
Addressing the social, cultural and economic determinants of health	Reducing risk factors and increasing protective factors before a disease or disorder emerges	Early detection and best practice management of a health condition to reduce deterioration and maintain quality of life	Minimising or managing functional impairment, complications and disability associated with a disease	Reducing any associated harm or impact of medical interventions or treatments

NQPHN's role is to support primary health care services to prevent and manage chronic conditions — this predominantly focuses on secondary prevention activities and is coordinated alongside other programs and services focusing on primary prevention and tertiary care.

Strategy overview

1. Vision

Northern Queenslanders live happier, healthier, longer lives through effective prevention and management of chronic conditions.

2. Goals

Goal 1: The sustainability, optimisation, and capability of the primary health care workforce is supported to better meet the needs of people with chronic conditions.

Goal 2: All people with a chronic condition access coordinated holistic and person-centred supports in the primary care setting.

Goal 3: People with or at rising risk of a chronic disease are identified early and connected with appropriate support.

Goal 4: Aboriginal and Torres Strait Islander community-controlled primary care services are supported to lead and determine priorities to 'close the gap' in chronic conditions experienced by First Nations communities.

Goal 5: Services and supports for people with chronic conditions are integrated and work together to improve outcomes at the consumer-level and system-level.

3. Principles

Health equity — activities work to eliminate disparities in outcomes between groups and overcome barriers to access and engagement.

Culturally safe — activities aim to create inclusive and welcoming environments for First Nations people, respect cultural knowledge, and eliminate institutional racism.

Sustainable — activities generate lasting and long-term changes for communities, services, and systems that aren't dependent on short-term funding.

Evidence-based — activities reflect the contemporary evidence about 'what works' in achieving outcomes for people with chronic conditions while also contributing to building the evidence base through evaluation, reporting, and learning.

Targeted — activities make the best use of available resources and build upon previous successes to focus on areas of greatest need and impact.

Collaborative — activities aim to engage with consumers, carers, clinicians, and other key stakeholders at a range of levels to work in partnership.

4. Priority population groups

The Chronic Conditions Strategy will prioritise engaging with and responding to the needs of:

- First Nations peoples
- people living in rural and remote areas of northern Queensland
- people experiencing socioeconomic disadvantage
- older people, including the general population aged 65 years and over, and First Nations people aged 50 years and over
- carers and families of people living with chronic conditions.

5. Priority areas for action

Goal 1: The sustainability and capability of the primary health care workforce is supported to better meet the needs of people with chronic conditions.

Priority areas:

- Continue to partner with organisations and health services to deliver programs that aim to build and sustain the health workforce in rural and remote northern Queensland.
- Continue to work in partnership with sector stakeholders to develop the First Nations health workforce.
- Explore opportunities to develop peer support opportunities for people with a chronic condition either through paid or volunteer arrangements to expand the reach and diversity of the current health workforce.
- Deliver a comprehensive and coordinated health workforce education and training program that is informed by local clinicians' training needs and supports the primary care workforce to work top of scope and provide evidence-based care.
- Support general practice and other primary care providers to optimise use of MBS billing arrangements to better incentivise providers to manage people with chronic conditions effectively.

Goal 2: All people with a chronic condition are able to access coordinated, holistic, and person-centred supports in the primary care setting.

Priority areas:

- Design (and re-design) programs and services together with people with lived experience of chronic conditions to ensure service delivery effectively meets people's needs and preferences, and works to overcome barriers to access.
- Promote the uptake of MBS-funded chronic disease management items and team-based care models to provide access to allied health professionals as part of a comprehensive and coordinated GP-led care plan.
- Commission primary care services to meet the needs of priority populations and/or under-serviced communities not adequately met by the current service system. These models may include:
  - dedicated roles to support care coordination and service navigation for people with chronic conditions and complex support needs
  - embedding practice nurses, allied health professionals, First Nations health workers, community pharmacists, and visiting specialists within the general practice setting
  - providing access to telehealth and other virtual models of care in areas with workforce shortages and/or service gaps.
- Promote the uptake of continuous quality improvement (CQI) activities to improve the capacity and capability of general practice and other primary care services to manage chronic conditions.
- Co-design a model of specialist advice and support that GPs can access to strengthen their capability to manage patients with chronic conditions in the primary care setting and avoid unnecessary referrals to specialist services.
- Explore the applicability of models of social prescribing for the northern Queensland context to better meet the non-clinical needs of people living with a chronic condition such as improving community connectedness and wellbeing, and reducing social isolation.

Goal 3: People with or at rising risk of a chronic disease are identified early and connected with appropriate support.

Priority areas:

- Support general practices to identify high risk or rising risk patients within their patient cohorts using practice data.
- Increase uptake of screening and assessment for chronic conditions using tools and processes that are evidence-based and appropriate for a person's needs (e.g. culture, gender, age).
- Support primary care providers to consistently connect people with a chronic condition to appropriate information, programs, and services using agreed and localised pathways.
- Empower people with chronic conditions and their carers to manage their own health through availability of health literacy initiatives, health monitoring technology, and other self-management strategies.

Goal 4: Aboriginal and Torres Strait Islander community-controlled primary care services are supported to lead and determine priorities to 'close the gap' in chronic conditions experienced by First Nations communities.

Priority areas:

- Develop service linkages to enable access to all mainstream services, in partnership with the ACCHO sector, work to improve the interface between primary health care and hospitals including through enhancement of referral pathways, improvements to the patient journey to reduce admissions and readmissions, and better information sharing including through use of shared electronic health records.
- Continue to provide funding for Aboriginal Community Controlled Health Services and mainstream general practices to deliver the Integrated Team Care (ITC) program.
- Support Aboriginal Community Controlled Health Services to undertake continuous quality improvement activities.
- Explore opportunities to expand the reach and impact of Aboriginal Community Controlled Health Services to deliver culturally appropriate models of care that focus on effective secondary and tertiary prevention of chronic conditions for First Nations people.

Goal 5: Services and supports for people with chronic conditions are integrated and work together to improve outcomes at the consumer-level and system-level.

Priority areas:

- Support the uptake and effective utilisation of health technology to improve communication and collaboration between patients and providers, and between all providers involved in a person's care team, such as telehealth, secure messaging, and information-sharing systems.
- Establish mechanisms of integration for Hospital and Health Services to coordinate and collaborate care with general practice for people with a chronic condition following a hospital admission to prevent hospital re-admission, including involvement in pre-discharge care planning, sharing of clinical information, and follow-up case conferencing.
- Improve integration between mainstream general practice and Aboriginal Community Controlled Health Services to deliver more coordinated and culturally appropriate care options to First Nations people with chronic conditions.
- Continue to develop, distribute, and update care pathways for priority chronic conditions that are agreed by both people with lived experience and clinicians, reflect national clinical guidelines, are localised to communities and meet the holistic clinical and non-clinical needs of people with chronic conditions.
- Partner through joint planning and commissioning activities to develop and deliver integrated and/or shared care models to improve the management of chronic conditions and avoid potentially preventable hospitalisations.

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