Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Feedback to the Standing Committee on Health

Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Presented to the Standing Committee on Health

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Executive Summary

The APA believes that physiotherapists, through their primary contact interventions, should be at the forefront of prevention and management of chronic disease. Physiotherapists are well-trained to educate patients on chronic disease self-management and to empower patients through providing information and techniques to improve self-care. The APA believes that Government funding should be focused on providing patient access to the most appropriate health professional.

The APA submits that:

- Medicare's Chronic Disease Management (CDM) plans which allow for five treatment sessions are inadequate to treat chronic conditions, as patients with these conditions can require ongoing treatment that supports multi-disciplinary care and patient self-management.
- The CDM program uses GPs as gate-keepers, who are expected to determine the type and the number of allied health services required for the patient with chronic condition/s. The APA believes that using GPs to ration access to primary care services from qualified and registered health care professionals provides perverse incentives that funnel people with chronic conditions to GPs, even if the GP is not the most appropriate health professional to treat the patient's condition. The APA supports a model where people with chronic conditions may choose physiotherapy treatment without the need to first visit a GP for a referral.
- The current fee for service model under Medicare is a useful model for acute and sub-acute conditions, but does not always support best practice multidisciplinary care for people with chronic conditions. To facilitate better access to health care for people with complex and chronic conditions, the APA supports funded 'packages of service', including capitated payments for particular conditions and fee for service for people with lesser healthcare needs.
- The APA supports open access to physiotherapy and maintains that patient access to funded physiotherapy sessions will not increase Medicare expenditure. In fact open access to physiotherapy is recognised by private health insurers, hospitals and state based workers compensation and motor injury schemes (compensable schemes).
- There are major patient benefits and cost-savings for Australia to be achieved through multidisciplinary teams which include physiotherapists to treat many chronic conditions like musculoskeletal conditions, diabetes, osteoarthritis and chronic pain.
- The new Primary Health Networks (PHNs) should leverage the existing capacity in the private allied health community as well as the public sector networks to implement programs focused on health promotion and chronic disease prevention and management to reduce the incidence of chronic disease in the community and prevent hospital admissions.
- Breaking down the barriers between public and private health care through better communication and funding models is vital for continuing chronic disease management in the Australian healthcare system.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Australian Physiotherapy Association

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups. The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 19,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and its current submissions are publicly available via the APA website **www.physiotherapy.asn.au**.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Background

Physiotherapy and chronic disease

Physiotherapists assist people who are at risk of developing or have a chronic disease to safely optimise their level of physical activity and manage their own care.

Physiotherapists work at public events, within hospitals and community health clinics and as first contact professionals within primary care settings like ambulatory services and private practices. They work with clients across the age spectrum from infants and children through to aged populations. This places physiotherapists in an ideal position to provide information and advice to people suffering from, or at risk of developing all forms of chronic disease.

Physical activity is recommended for the prevention or treatment of many chronic diseases.[1] Physiotherapists can prescribe and implement therapeutic exercise at an individual or group level, and lead exercise and education classes for people who have been diagnosed with or are at risk of developing chronic diseaseslike type 2 diabetes, and cardiorespiratory, vascular and musculoskeletal conditions.

The role of the physiotherapist in chronic disease management

Physiotherapists are primary contact practitioners and have the expertise to manage the care of clients at various stages of the chronic disease continuum. Physiotherapists manage people with chronic lung diseases, including asthma, through exercise prescription and cardio-pulmonary rehabilitation. People with complications from cancer surgery, like lymphoedema, are treated by physiotherapists using complex physical therapy (CPT)[2], and physiotherapists prescribe exercise therapy to improve glucose control in people with, or at risk of developing diabetes. Other examples include physiotherapy management of cardiac rehabilitation programs for people with various forms of heart disease[3] and the rehabilitation of elderly people after a stroke.[4] Physiotherapists also provide interventions, including therapeutic exercise, to reduce the risk of osteoporotic fracture, and physiotherapy is effective in helping patients manage osteoarthritis[5]

Enabling people to self-manage their condition

Person-centred health care entails the building of partnerships with people to enable them to maintain optimal function and independence. Physiotherapists work in partnership with patients to empower them to set goals, take a greater role in the management of their own condition, and to be able to source reliable information on their disease. Physiotherapists can provide education in a variety of settings, ranging from one-on -one consultations to formal group education sessions, including disease specific self-management classes. Physiotherapists are experienced in pain management techniques, and have a thorough understanding of the biopsychosocial influences that are important in long-term diseases - all factors important to enable self-care for chronic disease.

Access to a greater range of health providers has been linked to the capacity to build more effective self-management techniques and accountability in people with chronic disease. For example, there is evidence that people with heart failure enrolled in programs that feature multidisciplinary team care have shorter inpatient stays and lower rates of re-hospitalisation.

Managing the impact of co-morbidities

Co-morbidities and complications are common in chronic diseases, like type 2 diabetes and cardiovascular disease. This can complicate self-management and the provision of therapy.

Physiotherapists have the expertise, including a broad skill base and an excellent knowledge of pathology and its impact on exercise prescription, to effectively manage many aspects of care for people with chronic disease.

For example, a person with osteoarthritis of the knee in combination with impaired glucose tolerance may benefit from an exercise program to manage the risk of developing type 2 diabetes but knee pain may prevent participation in a standard program. Physiotherapists can address this barrier by initially treating the primary symptoms of the osteoarthritis, then modifying and supervising an exercise program to optimise opportunities for participation, thus improving the individual's wellbeing and quality of life.

Facilitating patient access to the most appropriate health practitioner

The APA believes that current funding models do little to support people with chronic conditions and are largely responsible for pushing those who cannot afford to pay for primary care therapies that are not funded by Medicare into the more expensive tertiary sector.

It is vital that funding mechanisms support access to appropriate primary care professionals –like physiotherapists for treatment of musculoskeletal conditions.

The APA proposes that funding be focused on providing patient access to the most appropriate health professional. To support this, the APA believes that the following measures would achieve better outcomes for people with chronic and complex health conditions.

Chronic Disease Management program

Medicare's Chronic Disease Management (CDM) program enables patients with chronic and complex conditions to access five allied health services per calendar year. This could be five physiotherapy sessions, but is more commonly used for access to a mix of allied health services, e.g. three sessions of physiotherapy and two sessions of podiatry, speech therapy or occupational therapy.

The APA does not believe that the CDM program provides the most appropriate funding method to assist patient access to allied health services. For example, some patients may be motivated to self-manage their condition and need only one or two allied health sessions, but use all five services simply because their GP management plan says they should. Other patients, particularly

patients with complex biopsychosocial issues may need significantly more than five services per year to manage their condition and avoid a preventable hospital admission.

The APA does not believe this is an effective way to provide an appropriate level of service for more complex patients, nor is it effective at reducing expenditure in healthcare. Using GPs to ration access to primary care services from qualified and registered health care professionals provides perverse incentives that funnel people with chronic conditions to GPs. People visit the GP for conditions that would be better treated by a physiotherapist in part because the GP visit is perceived as 'free' or 'low cost', when compared with allied health services that do not attract a Medicare rebate.

The APA is also concerned that the CDM program provides access to only chronic *and* complex patients. This Medicare requirement is often interpreted to mean that patients need at least 2 conditions to be complex, and a painful and debilitating conditions, like lower back pain exacerbated by excessive sitting might be considered not 'complex enough' to warrant physiotherapy intervention. This is despite the potential for physiotherapy intervention to significantly improve workforce participation and functional activities of daily living for the patient. Physiotherapy may also prevent the lower back pain patient from presenting at a hospital emergency department and/or the need for spinal surgery.

The CDM program uses GPs as gate-keepers, who are expected to determine the type and the number of allied health services required for the patient with chronic condition/s. Like physiotherapists, GPs are trained within their own scope of practice, and it is not within the scope of most GPs to make a detailed assessment of the nature and number of sessions of physiotherapy treatment required. A physiotherapist assessment of the type, duration and number of physiotherapy sessions required is standard practice within the private health insurance system, and within all state based workers compensation and motor accident insurance systems. In general, these systems work well to assist patients with both acute and chronic conditions to access the health care they need.

The APA firmly believes that physiotherapy treatment should be funded by Medicare for all people with chronic conditions, to reduce preventable hospitalisations and assist people to self-manage their condition.

The 'GP as gate-keeper' model also creates a system of unnecessary paperwork, which increases costs to Medicare, and provides a disincentive for GPs to refer under the system. It is well known that GPs want to provide clinical care for their patients, rather than complete copious paperwork. The red-tape attached to the CDM program must be reduced to allow better patient access to multidisciplinary care and its potential benefits.

A better model for allied health access in the primary care setting

Patient-centred care is important to ensure that Australia continues to have a world class public health care system and to cope with the changing needs of the healthcare consumer.

The current fee for service model under Medicare is a useful model for acute and sub-acute conditions, but does not always support best practice multidisciplinary care for people with chronic conditions. To facilitate better access for these people, the APA supports a pooled funding system focused on the consumer. This could feature agreed packages of service for people with more

complex conditions, including capitated payments for particular conditions, and more flexible access, possibly based on a fee for service, for people with lesser healthcare needs.

The APA understands and supports the role of the GP in helping people with chronic conditions to manage both their condition and their care. However, it is vital that Medicare support GPs to enable best practice, multidisciplinary care and not to inhibit them with unnecessary red tape and complex, difficult to interpret requirements that can delay access to physiotherapy intervention.

To do this, each health professional must work to the full extent of their scope of practice. Funding models should support GPs to provide the best level of care possible and the same should be true for the funding of physiotherapy services. Access to physiotherapy services should be based on patient choice and physiotherapy assessment, not only on GP assessment.

About a third of private physiotherapy patients are referred by GPs, and 1 in 10 of all referrals from a GP is to a physiotherapist, demonstrating that many people with chronic diseases will be referred by a GP. Alternatively, a large proportion of physiotherapy patients are not referred by a GP. Physiotherapists are trained to recognise red flags that indicate the need for medical intervention, and are used to referring these people to their GP for conditions that are out of their scope of practice.

The APA supports a model where people with chronic conditions may choose physiotherapy treatment without the need to first visit a GP for a referral. GPs are experts in the medical management of patients and should not be required also to be experts in the physiotherapy management of patients. Funding models must recognise the scope of health practitioners' practice and not seek to place barriers in the way of best practice multidisciplinary care for people with chronic conditions.

Funding for people with chronic conditions to access allied health services is cost-effective

Governments and bureaucrats have sometimes expressed a fear that providing access to funded physiotherapy sessions would 'open the floodgates' and increase expenditure. But open access to physiotherapy is not a new concept – physiotherapists have been primary contact professionals since the 1970's, and this is recognised by private health insurers, hospitals and compensable schemes.

Compensable schemes like the Victorian WorkSafe Authority (WorkSafe) and the Traffic Accident Commission (TAC) use physiotherapy services for injured workers and motorists extensively. These schemes use physiotherapy treatment because of its focus on restoration to function and the prevention of more invasive medical treatment like surgery where possible.

Compensable schemes stress that early intervention achieves the best health outcomes and that provision of education to patients to self-manage their condition is necessary and could reduce visits to GPs overall, as well as prevent unnecessary hospitalisations. To achieve the earliest intervention possible, WorkSafe and TAC have developed the Physiotherapy Early Intervention Framework, aimed at achieving the earliest appropriate intervention available.

WorkSafe are currently working with the APA to plan and implement a strategy to increase the number of physiotherapists writing workplace capacity certificates for patients, thereby decreasing

the need for GP consultations that may delay the implementation of early physiotherapy treatment and rehabilitation, thereby increasing the number of days on payments.

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally

Recent research from the Services for Australian Rural and Remote Allied Health's (SARRAH) shows that Australians suffering from stroke, diabetes and osteoarthritis could avoid surgery or recover more quickly if they received treatment from multidisciplinary teams that include physiotherapy.[6]

Key findings of the SARRAH report included:

- Physiotherapists, dietitians and exercise physiologists who delivered exercise and diet interventions in eight separate trials to 2,200 diabetic participants found the incidence of diabetes was reduced by 37%, compared with patients receiving standard diabetic care;
- 47% of allied health providers who treat diabetic patients (including physiotherapists, podiatrists and dietitians) nominated patient education as the most cost-effective intervention;
- A multidisciplinary team comprising a physiotherapist, occupational therapist, dietitian, orthotist, social worker and rheumatologist, who manage patients with osteoarthritis at a Sydney hospital, provided interventions so effective that 15% of patients were removed from the waiting list for joint replacement surgery;
- Physiotherapists who triaged patients on the wait list for joint replacement surgery at the Alfred Hospital in Melbourne removed so many patients from the list that the waiting period fell from 18 to 3 months; and
- Further, enhancing patient function and independence after stroke, which also leads to better mental health, was seen as the key advantage of using physiotherapists, occupational therapists and speech pathologists for stroke patients.

Physiotherapists are an integral part of many multi-disciplinary chronic disease management services. Some examples of these include:

Chronic Pain

- Hunter Integrated Pain Service (Newcastle, NSW) - patients with chronic non-cancer pain are seen in groups for an orientation session. They are then followed up with a group-based assessment where the patient co-develops their own pain management recovery plan. Physiotherapists report that this has significantly reduced wait times.
- Austin Health offers 'StepIn', a 10 hour education model taught by a psychologist, physiotherapist and pain doctor. This is the entry point program available to non-cancer patients, people with insufficient English language skills and acute complex regional pain syndrome (CRPS) or orofacial pain. Patients can proceed to 'StepUp', a program spanning 8 to 10 weeks, which is a once per week intensive style program. Patients can then upgrade to 'StepForward' which could be any of a selection of services aimed at transitioning the patient back into their community.
- The Agency for Clinical Innovation (NSW) Chronic Pain Management is a resource rich website for patients and clinicians and provides a location for the multilingual 'Brainman' pain education videos.

Chronic Diseases

- In the past year at St Vincent's Hospital in Melbourne, with the support of a DHHS grant, allied health professionals have adopted a model of care for people with chronic heart failure, ischaemic heart disease and pulmonary disease. The program supports people *exercising independently* in their local gyms to ensure they achieve long-term physical activity, which is critical to optimal physical and psychosocial health for people with chronic diseases.[7,8]
- PD Warrior Program and Dance for Parkinson's, as well as ParkinsonNET and ParkFit (based on Dutch models of health provision) - recent evidence-based models for managing Parkinson's Disease (PD) and promoting ongoing physical activity and behaviour change in people with PD.
- The Flinders Programme and Bridges Programme for stroke are used in the United Kingdom and New Zealand. The programs are backed by evidence and use a stroke self-efficacy scale as the outcome measure. The programs are also backed by international research, specifically a research paper from Japan for secondary stroke prevention, which consists of education, advice, exercise (aerobic, strengthening, home program, increasing daily PA targets) and a salt reduction focus.[9]

Musculoskeletal Conditions

- In Perth, pain*HEALTH* provides information and self-assessment for clients with musculoskeletal pain and since its launch, reported 4,027,992 hits and 258,182 visitors, averaging 309 visitors per day, with visitors from 142 countries.
- The NSW Osteoarthritis Chronic Care Program (OACCP) was developed by the Agency for Clinical Innovation (ACI) Musculoskeletal Network. The program will specifically target persons who have modifiable risk factors for OA progression,like obesity and poor muscle strength and control, and who would benefit from additional support of their self-management strategies. The OACCP team will be led by a Musculoskeletal Coordinator. The coordinator at funded pilot sites will be a physiotherapist who has extensive experience in the provision of care to people with musculoskeletal conditions and who will act as collaborative leader of the multidisciplinary team. The OACCP in NSW is now partnering with local health districts and Medicare Locals/Primary Health Networks to attempt the same models in primary care having physiotherapists as care coordinators teaching practice nurses and GPs how to identify these patients and putting them on the road to rehabilitation and recovery.[10]
- The Orthopaedic Wait List (OWL) was developed and implemented in Victoria. It aims to improve coordination of the management of people with hip or knee osteoarthritis and prioritise those people on outpatient and elective surgery waiting lists according to clinical need. Interventions include early assessment and referral of people not currently requiring surgery to appropriate conservative care, which includes physiotherapy, rheumatology, weight loss and education.[11]
- In the Queensland Orthopaedic Physiotherapy Screening Clinics (OPSC), a physiotherapist acts as case manager for people from orthopaedic surgical waiting lists. The primary aim of the program is to improve access to multidisciplinary non-operative management for those people for whom surgery is not the first option. Initial reports on the program indicate success in reducing elective joint replacement wait list numbers and wait time.[12]

There are major patient benefits and cost-savings for Australia to be achieved through multidisciplinary teams, which include physiotherapists, to treat many chronic conditions like musculoskeletal conditions, diabetes, osteoarthritis and chronic pain.

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

Physiotherapists and other appropriately qualified allied health providers could be better used to run groups and classes that help patients manage chronic disease. This is a cost-effective way of providing health services to large numbers of patients. Current provisions only allow patients who can afford private health insurance and significant out-of-pocket costs to access these group and class sessions. There are currently arrangements in place for patients of some allied health providers to access some group sessions under Medicare funding but specifically for patients with diabetes.

There is limited access to individual physiotherapy consultations through current Chronic Disease Management (CDM) Medicare items. Patients are required to have a chronic and complex condition before accessing these items. The Medicare item numbers are also inadequate to meet the needs of people with chronic diseases, with only five treatments shared between the allied health professions. These sessions are often poorly used, as doctors do not have time to complete the necessary paperwork, or may simply feel that the patient's needs are not 'complex' enough to meet Medicare requirements. Doctors also may not have the time or ability to adequately prioritise the services required. The APA submits that a greater number of sessions are required to allow for regular review and progression of exercise programs.

Physiotherapists have also found that there is little flexibility in the program, for instance if a program is written to include two physiotherapy and three podiatry visits, the patient needs to visit a GP again to change their referral plan.

Furthermore, the CDM program uses GPs as gate-keepers, who are expected to determine the type and the number of allied health services required for the patient with chronic condition/s. The APA believes that using GPs to ration access to primary care services from qualified and registered health care professionals provides perverse incentives that funnel people with chronic conditions to GPs, even if the GP is not the most appropriate health professional to treat the patient's condition. The APA supports a model where people with chronic conditions may choose physiotherapy treatment without the need to first visit a GP for a referral. A physiotherapist assessment of the type, duration and number of physiotherapy sessions required is standard practice within the private health insurance system, and within all state based workers compensation and motor accident insurance systems. In general, these systems work well to assist patients with both acute and chronic conditions to access the health care they need.

Specifically, the APA would support that services need to be delivered:

- using a variety of clinical delivery care models, including one-on-one consultations, group consultations, short through to extended consultations depending on the nature of the

service required, as well as incorporation of telehealth technology in delivery of clinical care;
- through care coordination, to ensure effectively integrated and collaborative care; and
- that Medicare funding should be stratified to the level of disease complexity.

1. **Medicare's Chronic Disease Management (CDM) plans, which allow for five treatment sessions, are inadequate to treat chronic conditions, as patients with these conditions can require ongoing treatment that supports multi-disciplinary care and patient self-management.**
2. **The community is dealing with a growing chronic disease burden and more resources are required to address the barriers to exercise, like introducing Medicare items for the patients of physiotherapists delivering group and individual sessions in treatment of a chronic disease or condition, as well as gym membership subsidies for people with chronic conditions.**

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care

The APA believes that PHNs should ensure that they correctly identify community needs, and facilitate the delivery of services that are not already provided. However, the APA submits that PHNs should avoid duplicating or operating in competition with existing services and should operate in partnership with both the public and private sector. In cases of market failure, they may need to directly provide or purchase services for the community. The APA stresses that it will be critical for the new PHNs to maintain an appropriate connection with the communities that they serve and to work effectively with local hospital networks.

The APA believes it is also very important that such networks incorporate a strong mandate for health promotion, as well as chronic disease prevention and management programs. Health promotion and programs focused on chronic disease prevention and management will save costs in the long run, with fewer people requiring treatment and stay in hospitals, saving money for public health care.

In particular, physiotherapy interventions for chronic disease prevention and management focus on exercise prescription and education, taking into account the individual clinical needs of each patient. Further, evidence shows that physiotherapy interventions which target mobility improve the quality of life for individuals with chronic conditions like multiple sclerosis, chronic heart failure and lymphedema related to breast cancer.[13,14,15]

The new Primary Health Networks (PHNs) should leverage the existing capacity in the private allied health community as well as the public sector networks to implement programs focused on health promotion and chronic disease prevention and management to reduce the incidence of chronic disease in the community and prevent hospital admissions.

4. The role of private health insurers in chronic disease prevention and management

Private health insurers (PHIs) generally refuse to fund allied health for preventative services under ancillary services, as their model is based on an episodic model of injury or illness. The APA has also recently found that the PHIs are increasingly questioning the validity of patients using their insurance product to fund ongoing care to manage their chronic condition. This is compounded by the fact that very few allied health programs have the national or at least statewide coverage needed by health insurance to meet their needs.

The Australian Government changed the law to enable PHIs to rebate allied health from the hospital fund rather than ancillary cover for management of chronic diseases. This was a huge step forward as the ancillary funds were not modelled for prevention or ongoing treatment. Hospitals could offer this type of service, but sometimes did not have the resources to do so. It made sense for primary health to provide the service and receive a rebate from the hospital fund.

Private health funds maintain that treatment provided to preserve a condition without additional functional improvement is effectively 'maintenance' treatment and cannot be funded under private health insurance. The APA acknowledges this but submits that treatments for self-management should be funded by private health insurance. As primary healthcare practitioners, physiotherapists are equipped to play an important role in disease prevention, by prescribing clinical exercises that promote physical activity, providing diabetes education and other lifestyle considerations.

Physiotherapist-supervised inpatient exercise rehabilitation has been shown to reduce physical impairment and improve functional ability and exercise capacity in individuals with Type 2 diabetes.[16] Further, there is evidence to support the efficacy of clinical treatment for chronic musculoskeletal conditions, especially chronic lower back pain, through clinical Pilates. A good quality, randomised and controlled trial conducted by Rydeard *et al* (2006) revealed that clinical Pilates-based specific exercise training resulted in a significant reduction in low back pain and disability in clients with chronic and unresolved low back pain. These results were maintained at 12 months follow-up. Clinical Pilates-based treatment was reported to be more efficacious than usual care.[17] There are many patients who cannot perform other types of exercise due to joint or spinal degenerative conditions and for them clinical Pilates in the hands of a physiotherapist is a safe, low impact form of exercise, obviating the need for expensive and invasive surgery.

Case Study

An APA physiotherapist operates a clinic in Western Australia offering a wide range of services including: rheumatology, physiotherapy, exercise physiology, dietetics, massage therapy, a dual energy x-ray absorptiometry (DXA) service for bone density and body composition and a pathology service.
The clinic runs two important programs targeting musculoskeletal pain:

1. Ankylosing Spondylitis/Spondyloarthritis (potentially >5% of patients who present with low back pain have pain that is inflammatory as opposed to a mechanical condition). Once diagnosed, the patient has a metrology assessment with a physiotherapist to get a baseline measure of function,

joint mobility (BASMI), enthesitis points, etc. Following diagnosis, the clinic runs a staged program that brings patients through physiotherapy, diet and exercise management dependent on their goals. The physiotherapist reports that the difference with this group of patients is typically that their goals will change drastically if a physiotherapist can reduce their pain levels.

2. Osteoarthritis (OA) program

This is a 9 staged program, including functional outcome measures. Diet should play an important role in many of the patient cases, as there is a volume of convincing research that weight loss reduces osteoarthritic pain. The physiotherapy practice also implements clinical benchmarks if the patient presents with a lower limb issue to measure progress against stated clinical goals.

The practice principal physiotherapist reports that the most common condition that patients present with is osteoarthritis of the spine. The physiotherapist reports that clients generally present when symptoms are aggravated and have progressed to the point that it is affecting their activities of daily living. The main models of care used in this WA clinic include:

1. Settling the acute/subacute condition by a variety of modalities including: mobilisation, soft tissue techniques, dry needling, home management and specific exercise prescription.
2. Once the initial symptoms are settled, the physiotherapist looks to progress the client onto a maintenance program of some sort. Patient care may range between three to six weekly sessions up to three to six monthly maintenance visits (one-on-one with the physiotherapist). This assists in ensuring that management and exercise are continued and function is being maintained. The goal of the clinic is to avoid further inflammatory episodes.
3. Once initial symptoms are settled, the physiotherapist would assign the patient a specific exercise program designed for the patient. Examples of exercise programs include: home program, physiotherapy gym, studio gym, hydrotherapy (group or independent), independent gym program etc. In selecting the right program for each patient, the physiotherapist considers if the program is suitable to the client's clinical condition and if the program is enjoyable and therefore a program that the client is likely to comply with. The physiotherapist reports that, in her experience, home and independent programs are less likely to be complied with.
4. The physiotherapist would provide specific advice on "looking for the signs" of flare up and seeking treatment prior to this occurring. Inevitably some people drop out of maintenance or exercise, so this advice is vital. The physiotherapist would educate the patient regarding the dangers of waiting for an acute episode before seeking treatment. Physiotherapists at the clinic encourage clients to seek treatment at "warning signs" and not once symptoms have progressed.
5. The physiotherapy clinic maintains regular contact with the client through a variety of ways, including phone calls, SMS, e-News, newsletters, birthday cards etc. The clinic's strategy is to keep in touch, so patients know that they can always return for further physiotherapy treatment if they suffer an acute attack.

As primary health care practitioners, physiotherapists are equipped to play an important role in wellness promotion and chronic disease prevention, by prescribing clinical exercises that promote physical activity, providing diabetes education and other lifestyle considerations. The APA submits that treatments for chronic disease prevention and self-management should be funded by private health insurance.

5. The role of State and Territory Governments in chronic disease prevention and management

The need to address evidence-practice and burden-service gaps and to upscale capacity in the health workforce for chronic disease management is supported by health policy, through Models of Care and whole of health frameworks.[18,19,20]

The APA submits that the best option would be for chronic disease management to be managed through primary health care in the community. Currently, there are many highly effective community based multidisciplinary care clinics across numerous sites in Australia. These clinics can offer health services targeted to meet the specific needs of that local community.

The APA submits that there is a great need to enhance multidisciplinary management services in primary care, especially in rural and remote areas, taking chronic pain self-management to the community rather than for the service to be primarily based in metropolitan hospitals.

6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management

In primary care, in relation to pain, there are examples of innovative models where best practice principles for management of chronic pain in primary health care have been implemented as outlined in a recent international review of Models of Care for musculoskeletal pain by Sperrin et al.[21]

The APA submits that public-private partnerships within the health sector must be explored more fully. Currently, Australia has two separate models of care operating independently. If health professionals are to meet the future health care demands, the public and private workforces need to be facilitated to work together. Better understanding is needed across and between the two sectors to partner together and provide care to reduce hospital waiting lists. This would improve access to care for people with chronic conditions.

Breaking down the barriers between public and private health care through better communication and funding models is vital for continuing chronic disease management in the Australian healthcare system.

7. Best practice of multidisciplinary team chronic disease management in primary health care and hospitals

Recognising that multidisciplinary teamwork fits more into the rehabilitation model than the acute care model is important. Acute care is more episodic, whereas rehabilitation is focused on delivery of ongoing care. Multidisciplinary teams work best when there is a high level of respect and trust amongst team members and each teammate is recognised for their professional and personal skills. There is a need to recognise that the medical director is not necessarily the best administrator and the APA has cited examples of physiotherapists acting in the capacity of a team

coordinator to achieve good health outcomes and prevent the need for surgery. The APA supports that all team members should have equal access to continuing education/professional development.

Some examples of good practice in multidisciplinary care include:

- The Hunter Integrated Pain Service (HIPS) functions as a multidisciplinary team, with interdisciplinary messages for outpatients. The HIPS uses every aspect of teamwork across the continuum of care in their service delivery and patients are rarely seen individually.
- At Austin Health, physiotherapists see patients in groups and also individually depending on their circumstances. Individual treatment is usually directed at preparing the patient for a group program, or for brief interventions when groups are not appropriate.
- EmpoweREHAB encourages early referral and offers combined assessment with a physiotherapist and psychologist for clients presenting with pain that has persisted for longer than 3 months. Ongoing care involves individual and further joint appointments to ensure that the client has the opportunity to work with each discipline, as well as assistance with self-management goals.

Current best practice recommendations for persistent pain suggest that Models of Care using various triage systems, including stratification, can help to make use of resources, including multidisciplinary teams more effectively.[22] Further, effective delivery of best practice for persistent complex pain may require integrated care from an interdisciplinary team with physiotherapists as key members of the team.[23,24]

The APA supports that chronic disease management is best delivered in a multidisciplinary setting, with physiotherapists as key members of the multidisciplinary team.

8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services

Multidisciplinary clinics provide the opportunity for shared understanding about disease, disciplinary roles and the development of skills transferable across chronic disease management, like motivational interviewing.

A successful example is the triage clinic led by two advanced practice physiotherapists which was formed in 2006 at the Sir Charles Gairdner Hospital in Perth. About 5-10% of patients referred to the hospital for surgical consultation for spinal pain will be assessed by the neurosurgeons as appropriate for surgery. The two physiotherapists assess non-urgent cases (Category three) from the waiting list. Two consultant neurosurgeons are available for one session each per week to review patients triaged by the physiotherapists. Since the triage clinic was formed in 2006, the waiting time of patients for an initial assessment reduced to six-nine months, compared to the previous waiting time of 18-36 months in the regular neurosurgical outpatient clinic. During 2010–2012, 60% of patients were discharged directly from the clinic without the need for a review with a surgeon.[25]

Physiotherapists are increasingly using online technologies to improve access to their services e.g. telehealth. This is especially relevant to those working with patients with persistent pain where hands on therapies are considered less appropriate and supporting self-management is the priority. Physiotherapists who are working in multidisciplinary pain practices are currently disadvantaged in terms of being able to deliver services remotely, as they are not always supported by current remuneration schemes.

Physiotherapists working in pain settings have extended knowledge and skills to adapt to transdisciplinary or interdisciplinary work settings that manage chronic disease across professions to reduce hospital admissions for surgery and support patient self-management.

Conclusion

Australia is dealing with a growing chronic disease burden and more resources are required to address the barriers to exercise, like introducing Medicare items for the patients of physiotherapists delivering group and individual sessions and introducing more than five treatment sessions under Medicare's Chronic Disease Management (CDM) program. There are major patient benefits and cost-savings for Australia to be achieved through multidisciplinary teams which include physiotherapists, including a diminished need for ongoing care and reduced hospitalisations. Physiotherapists are well-trained to educate patients on chronic disease self-management, effective goal setting and other patient-centred approaches that facilitate behaviour change. Primary Health Networks (PHNs) have an important role to play in implementing programs focused on health promotion and chronic disease prevention and management. Further, the APA submits that chronic disease prevention and self-management programs should be funded by private health funds. Breaking down the barriers between public and private health care through better communication and funding models is vital for continuing chronic disease management in the Australian healthcare system. Public and private partnerships within the health sector must be explored more fully to provide for the best utilisation of the health workforce.

Summary

- Physiotherapists are trained to educate patients on chronic disease self-management and to empower patients through providing information and techniques to improve self-care. Physiotherapists should be at the forefront of prevention and management of chronic disease.

- Government funding should focus on providing patient access to the most appropriate health professional.

- The current fee for service model under Medicare does not always support best practice multidisciplinary care for people with chronic conditions.

- Medicare's Chronic Disease Management (CDM) plans are inadequate for treating chronic conditions.

- The CDM program uses GPs as gate-keepers, but they are ill-equipped to determine the type and the number of allied health services required for the patient with chronic condition/s.

- Using GPs to ration access to primary care services through the CDM program unnecessarily funnels people with chronic conditions to GPs. Instead, people with chronic conditions should be able to choose physiotherapy treatment without the need to first visit a GP for a referral.

- Funded 'packages of service', including capitated payments for particular conditions and fee for service for people with lesser healthcare needs would improve access to healthcare for people with complex and chronic conditions.

- Open access to funded physiotherapy sessions will not increase Medicare expenditure.

- The treatment of chronic conditions by multidisciplinary teams which include physiotherapists creates patient benefits and cost-savings for the healthcare system and wider economy.

- Partnerships between private allied health providers and the new Primary Health Networks (PHNs) would grow capacity to implement health promotion and chronic disease prevention programs and so reduce the incidence of chronic disease in the community and prevent costly hospital admissions.

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