phn MURRAY

An Australian Government Initiative

# PROGRAM GUIDELINES - CHRONIC DISEASE MANAGEMENT SERVICES 2025-2026

April 2025

Leadership | Collaboration | Respect | Accountability | Innovation

# About this document

These guidelines are for commissioned chronic disease management service providers and Murray PHN staff. They are to be read in conjunction with Schedule 1 Chronic Disease Management Services 2025-2026 (the 'Schedule').

The guidelines outline the scope, eligibility, delivery and reporting requirements specific to the provision of Murray PHN funded chronic disease management services. They have been informed by best-practice, feedback and ongoing collaboration with commissioned health services. The guidelines aim to provide further detail about the requirements for delivering Murray PHN funded chronic disease management services for the 2025/6 financial year.

The Murray PHN catchment is significant in both size and diversity and covers an area of almost 100,000 square km, with a population of more than 644,000 people. While it is important to deliver care which is evidence-based and underpinned by robust clinical governance, we understand that services need to be tailored to meet the needs of our diverse communities.

This document intends to build consistency in service delivery reporting, while recognising the need for flexibility in how services are delivered. If you have any questions or would like more information, contact your nominated Murray PHN representative.

## Contents

## Service delivery-scope, qualifications and workplan

### *Scope of services*

Health professionals working in the Murray PHN Chronic Disease Management program will provide primary care-based clinical services as per their professional scope of practice to **Eligible Consumers.**

Funded services within this program include chronic disease nursing, diabetes education, dietetics, podiatry and cardiopulmonary rehabilitation.

Health professionals will provide services to consumers on an individual or, in approved cases, a group treatment basis.

- All professional services must be delivered according to best practice guidelines, as described in your program workplan. For example, Cardio-pulmonary rehabilitation programs should ensure they are delivered in line with current clinical recommendations, such as those referenced in CSANZ Position Statement or Lung Foundation Australia Introduction | Pulmonary Rehabilitation Toolkit, including reference to Safety Issues Relating to Exercise Assessment and | Pulmonary Rehabilitation Toolkit.

### *Qualifications of health professionals providing services*

To ensure a high-quality service delivery, staff engaged to deliver funded clinical services must:

- be qualified, trained and have relevant and appropriate levels of experience according to the requirements of their role, position description and discipline specific scope of practice
- have currency of registration with state or national practicing authorities and demonstrate evidence of the continuing professional development requirements for annual re-registration
- have membership with their discipline-specific professional association.

Clinical services must not be delivered by staff who do not meet the above qualification requirements without prior approval by Murray PHN.

Murray PHN will consider working with service providers to identify potential and flexible workforce models, where there is evidence that recruitment of specific workforce staff has been unsuccessful, to ensure the objectives and service functions of the program meet consumer needs.

If any clarification is required regarding qualifications, please contact your Murray PHN representative to discuss.

### *Workplan*

A **Work Plan** outlining your service delivery model must be submitted to Murray PHN for approval. Please include information specific to your unique service and avoid providing generic information. For example, describe your **Model of Care** in sufficient detail to practically explain what you are doing, why you are doing it, who will be involved and how the service will be delivered to your consumers. This could be supported by a diagrammatic representation of the model and how a consumer would travel through the service. Please also provide Murray PHN with relevant updates to your **Workplan**, such as changes in employees or service locations.

For assistance in completing your **Work Plan**, contact Murray PHN or find relevant resources on Murray PHN website, including:

- Workplan and Budget-Guide for Completion video
- Workplan Instruction document

## Consumer eligibility and referrals

### *Eligibility*

Community-based consumers with a priority chronic disease of chronic obstructive pulmonary disease (COPD), diabetes, cardiovascular disease (focus on heart failure).

Preference is given to underserviced, rural cohorts, and people who are not receiving funding for the same or similar service from a different funding source, such as:

- other Commonwealth or State funding
- Workers' compensation
- Department of Veteran Affairs
- NDIS
- My Aged Care.

If a clinical need exists, interim services may be provided while waiting for other funding sources to be approved and started.

If a health professional is providing a Murray PHN funded service to a consumer, they are not able to claim for Medicare items for the same occasion of service. Additionally, Murray PHN funding cannot be used to cover the gap between what is covered through the Medicare rebate and out-of-pocket expenses for the consumer.

Murray PHN funding cannot be used to cover the co-payment for patients with private health insurance.

Where service demand exceeds supply, a secondary level of consumer eligibility may be implemented to prioritise consumers in receipt of a Health Care Card or Pension Card. Service providers are responsible for determining consumer eligibility and managing priority access.

All services provided under the Murray PHN program are provided free-of-charge to consumers and no gap payment may be made by consumers.

The intent of the program is for services to be delivered to consumers who live in Murray PHN local government areas (LGA) and towns stated in the Schedule. In some circumstances it may be reasonable to provide services to consumers who live on the border of a neighbouring LGA who cross into the stated LGA to receive health services that are not available or accessible in their LGA.

### *Referrals and integrated care*

Consumers can be referred by a GP, other health professional or self-referral.

Service providers are responsible for promoting local access arrangements that optimise simple referral pathways and access to their chronic disease management programs.

To support an integrated care approach, it is expected that the consumer's regular GP or existing care team is notified of any referral and included in communication between health professionals, with the consumer's consent. For consumers who are not under the care of existing health professionals, this is an opportunity to help support them to re-engage with appropriate care.

Through the **My Health Record** system, authorised healthcare professionals can access timely information about their patients such as shared health summaries, discharge summaries, prescription and dispense records, pathology reports and diagnostic imaging reports. This allows them to have the most up-to-date information on their patients, which is important for clinical decision making.

To learn more about the benefits of using My Health Record in clinical practice, visit murrayphn.org.au/my-health-record

### *Consent*

The service provider must obtain informed consent from an individual and/or their legal guardian before any intervention begins and ensure that, when obtaining and documenting consent to services, it is done so in accordance with legislative requirements such as the Victorian Privacy and Data Protection Act 2014, the Victorian Public Records Act 1973 and the Victorian Health Records Act 2001.

## Service delivery - reporting

The Schedule outlines the reporting obligations for Murray PHN funded services. The following provides a guide to assist with completing some of these reports and the collection of performance data.

### *Monthly on-line performance report checklist (the 'Checklist') submitted via Folio:*

- ***Occasion of service***

*Definition: Any examination, consultation, treatment or other health service provided to a consumer, or group of consumers, on each occasion that such a service is provided.*

An **Occasion of Service** should involve the chronic disease management healthcare provider and the consumer, or a third party, such as a carer. An **Occasion of Service** may be delivered via a substitute for face-to-face contact with the consumer, such as via telephone or telehealth.

It is expected that most **Occasions of Service** involve an interaction with the consumer. For consumers with more complex needs, time spent undertaking clinical care coordination or multidisciplinary team care, without the consumer present, may be reported as an **Occasion of Service.**

An **Occasion of Service** may only be reported if it is relevant to the clinical condition of the consumer. This means that it does not include services of an administrative nature e.g. telephone contact to schedule an appointment.

- ***Individual service delivery***

Provider feedback has indicated that **Occasions of Service** duration can vary, depending on the needs of the consumer, but on average it balances out to a standard duration. The setting of service targets has taken this into account, such that all occasions of service, regardless of duration, are reported as 'one' **Occasion of Service**. If the service model and/or clinical need consistently warrants a longer than average service duration, contact your Murray PHN representative to discuss how this can be reported.

- ***Group-based programs***

Cardio-pulmonary program funding covers consumer's initial individual assessment, 6-8* weekly group exercise and education session participation, and individual reassessment prior to discharge.

- For reporting purposes, the 'Number of **Eligible Consumers commencing** a cardio-pulmonary rehabilitation program' applies to unique individuals who have been assessed as suitable for the program and have participated in at least one exercise and education session.
- For reporting purposes, the 'Number of **Eligible Consumers completing** a cardio-pulmonary rehabilitation' program applies to unique individuals who have been assessed as suitable for the program, participated in 6-8* weekly exercise and education sessions and discharged from the program.
- Individuals who have exited the program prior to completion and choose to re-enter the program at a later date may be counted as a new unique individual commencing the program if they are individually reassessed prior to restarting the program.

- If an individual re-starts the exercise and education sessions without requiring reassessment, they cannot be counted as a new unique individual commencing the program.

Any other group program proposals require Murray PHN approval prior to beginning. Contact your Murray PHN representative to discuss.

*Number of weekly group sessions may be greater than 6-8 in some circumstances, following prior discussion with Murray PHN.

- ***Cancellation and Did Not Attend (DNA)***

If a consumer cancels within 24 hours of an appointment or fails to attend a scheduled appointment, the appointment may be categorised as an **Occasion of Service** for reporting purposes, providing:

- All efforts are made to remove any access barriers contributing to the non-attendance.
- Reasonable steps are taken to fill cancellations.

Unfilled cancellations and DNAs can be reported via Folio monthly checklist for consideration when service delivery data is reviewed by Murray PHN.

Provider cancellations should be noted in the comments section of the monthly Folio checklist to provide further context to service delivery data.

- ***New Consumers***

The Checklist captures information about the number of new consumers accessing the service each month. This data is necessary to satisfy the Awareness requirement of the Outcomes and Key Results table in the Schedule, as it demonstrates an increase in the reach of the program to new consumers.

### *Travel*

Where service delivery requires a health professional to regularly travel to outreach sites, including home visits, during clinic hours, contact your Murray PHN representative to discuss individual circumstances.

### *Case Study*

The case study is an important piece of qualitative information to help demonstrate service impacts and outcomes at a patient level. It does not need to be extensive, but it should contain sufficient information to demonstrate how services have benefited consumers who may otherwise not have been able to access appropriate care. It also provides the opportunity to highlight how a multidisciplinary approach is integrated into care, as well as any local or sector challenges experienced in delivering this care. This evidence of service integration with the broader health system is important to satisfy the Integration requirement in the Outcomes and Key Results table of the Schedule.

### *Patient Experience Survey*

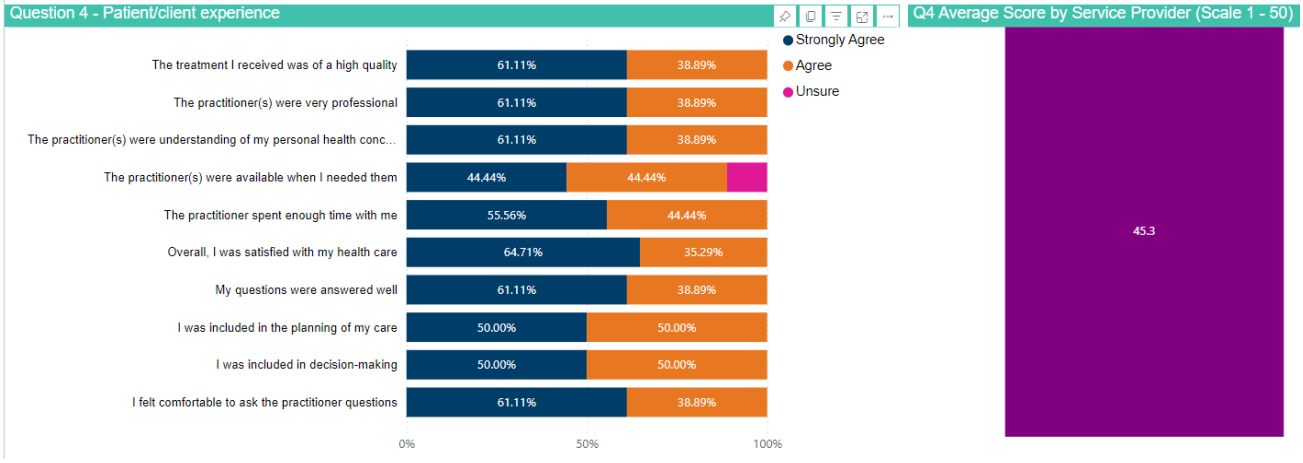
The **Patient Experience Survey** (accessible here Patient experience survey - Murray PHN https://murrayphn.org.au/patient-experience-survey/) is a modified version of the Patient Enablement and Satisfaction Survey (PESS). It aims to gather information from patients about how satisfied they are with their healthcare experience, and whether that care has enabled them to better look after their health.

All patients attending the service should be offered the survey on discharge, or at least annually if their care is ongoing. Note, the term ‘patient’ is used in this discussion as that is the term by which consumers are addressed in the survey.

A target survey response rate of 20% is now included in the Outcomes and Key results table of the Schedule. This will be calculated by dividing the number of completed surveys by the number of consumers offered the survey. It will be assumed that all new consumers (for Dietetics/Diabetes Education/Podiatry/Chronic Disease Nursing) and all consumers who completed a Cardio-pulmonary rehabilitation program, are offered a survey at least once during the year, and this figure will be used to calculate the number of consumers offered the survey.

**Patient Experience Survey** results can be viewed on your Power BI CDM Patient Experience Survey dashboard. Contact Murray PHN if you require access or would like assistance with using the dashboard.

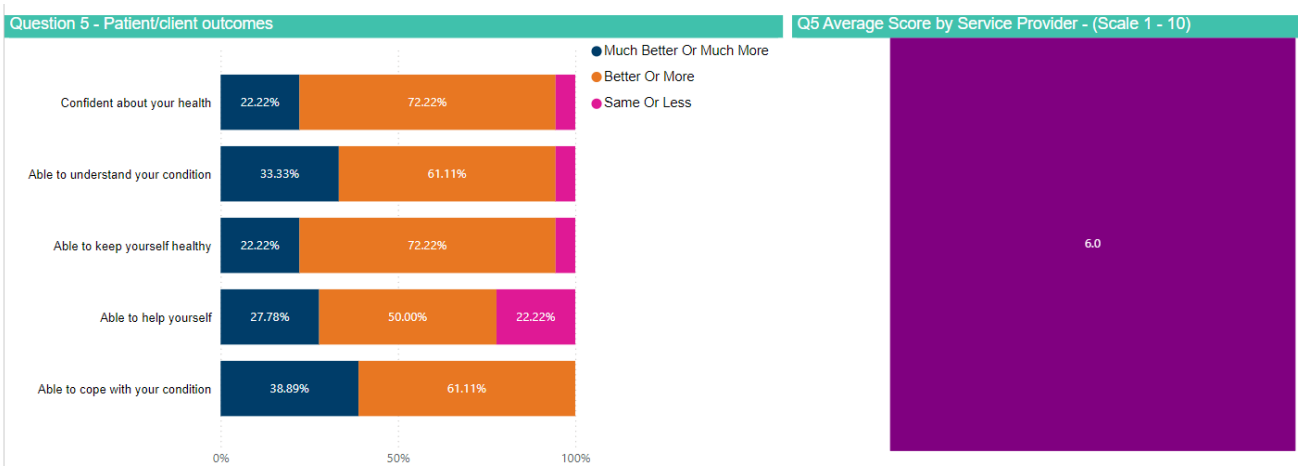
- ***Patient Satisfaction with the health service experience***




Question 4 of the **Patient Experience Survey** measures how satisfied patients were with various aspects of the health service provided to them.

- When all 10 statements in the question are rated, the patient satisfaction score ranges from 10-50.
- 10 indicates a very low level of satisfaction with their experience.
- 50 indicates a very high level of satisfaction with their experience.
- As per the Outcomes and Key Results section of your Schedule, an average satisfaction score of 40 or above is required for Question 4 of the survey. This indicates that most patients reported a positive experience (answered ‘agreed’ or ‘strongly agreed’ to each statement).
- Your average satisfaction score can be viewed in your Power BI dashboard under ‘Q4 Average Score by Service Provider’ - see above screenshot.
- The ‘Question 4- Patient/client experience’ section of your Power BI dashboard also visualises aggregate responses to each of the 10 statements, to allow for a more detailed review of the multiple factors contributing to the overall patient satisfaction score.

- ***Patient enablement***




Question 5 of the **Patient Experience Survey** measures how well their care enabled patients to understand and manage their own health.

- When all 5 statements in the question are rated, the patient enablement score ranges from 0-10.
- 0 indicates no patient enablement associated with the care provided.
- 10 indicates a positive effect on patient enablement associated with the care provided.
- As per the Outcomes and Key Results section of your Schedule, an average patient enablement score of 6 or above is required for Question 5 of the survey. This indicates that most patients reported a positive effect on enablement (answered 'better/more' or 'much better/much more' to each statement).
- Your average enablement score can be viewed in your Power BI dashboard under 'Q5 Average Score by Service Provider' - see above screenshot.

- ***Patient comments***

Patient comments and feedback may help clarify why they have scored the survey in the way that they have and can be viewed in Question 9 on your Power BI dashboard.

### *Workforce satisfaction*

Having a supported workforce is an important contributor to workforce sustainability. Provider participation, twice a year, in **Pre-** and **Post- Implementation Workforce Satisfaction Interviews** will provide an opportunity for you to provide feedback regarding program support provided by Murray PHN. The interviews will be incorporated into your scheduled verbal progress report meetings for convenience.

## References

The following resources were consulted to help inform the development of Program Guidelines – Chronic Disease Management Services 2024/5:


- Our region - Murray PHN
- Health Needs Assessment 2022-2025 (murrayphn.org.au)
- National Strategic Framework for Chronic Conditions (health.gov.au)
- Australian Institute of Health and Welfare 2012. National Health Data Dictionary. Version 16 Cat. no. HWI 119. Canberra: AIHW.
- Diabetes role statement | Dietitians Australia Dietetics - Allied Health Professions Australia (ahpa.com.au)
- Podiatry - Allied Health Professions Australia (ahpa.com.au)

- Credentialled Diabetes Educators - Allied Health Professions Australia (ahpa.com.au)
- Exercise Physiology - Allied Health Professions Australia (ahpa.com.au)
- Physiotherapy - Allied Health Professions Australia (ahpa.com.au)
- Pulmonary Rehabilitation - Lung Foundation Australia
- supervision-and-delegation-framework-for-allied-health-assistants.pdf
- Maintenance programs - Lung Foundation Australia
- What Is The Program About? | Pulmonary Rehabilitation Toolkit
- Book-Australia-and-New-Zealand-Pulmonary-Rehabilitation-Guidelines-Feb2017.pdf (lungfoundation.com.au)
- National survey of Australian cardiac rehabilitation programmes: does current exercise programming adhere to evidence-based guidelines and best practice? - PMC (nih.gov)
- What is cardiac rehab? | Heart Foundation
- Evaluation of Cardiac Rehabilitation Performance and Initial Benchmarks for Australia: An Observational Cross-State and Territory Snapshot Study (contentstack.io)
- A Clinical Guide for Assessment and Prescription of Exercise and Physical Activity in Cardiac Rehabilitation. A CSANZ Position Statement - Heart, Lung and Circulation (heartlungcirc.org)
- life-11-01236-v2.pdf
- Success in pulmonary rehabilitation in patients with chronic obstructive pulmonary disease - PMC (nih.gov)
- Information Privacy Principles – Full Text – Office of the Victorian Information Commissioner (ovic.vic.gov.au)
- PRIVACY AND DATA PROTECTION ACT 2014 (austlii.edu.au)
- Health Records Act 2001 (legislation.vic.gov.au)