

POLICY OPTIONS

The role of allied health in the management of complex conditions in a comprehensive primary care setting

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Policy context

Chronic and complex diseases require multidisciplinary care (MDC). Much of this care is delivered in the community by primary care professionals- general practitioners (GPs), nursing and allied health professionals (AHPs). Ensuring appropriate interaction, particularly between these professionals is essential to high quality care, but is not well understood. Recent advances in primary health care policy have allowed limited Medicare funding of AHPs. Recent work has highlighted difficulties faced by AHPs as a result of the limitations of the Medicare funding arrangements. As a prerequisite to reviewing the policy around funding of allied health care by Medicare, how AHPs operate in community settings needs to be clarified, as does the relationships between AHPs, GPs, and people with chronic, complex conditions.

Setting

We conducted an in-depth study of the role AHPs play in the care of complex conditions in older people, in a large urban general practice (Camp Hill Health Care – CHHC) which has developed a comprehensive MDC model of care. CHHC employs over 50 people and has about 38,000 patients. There are 15 GPs and several CHHC-based AHPs. Some of these are independent practitioners situated on the premises, and others actually work within the practice. The practice owner is a GP, and there is an Executive Officer who has comprehensive management oversight. CHHC has developed a system of review of older patients deemed to have complex medical problems. Patients are assessed in their homes by an experienced community nurse, then by the person's GP, and a GP management plan is developed and implemented. A comprehensive database of 6 years of health assessments was the basis of this research project.

Policy options

- > **This report should be distributed to all Medicare Locals with a view to assisting practices to work towards this model of care.** This report describes an effective means of organising and running general practice that facilitates the care of older patients with complex health problems. The model overcomes the hub-and-spoke model currently encouraged by the Chronic Disease Management program. The model is transferrable to smaller practices because it relies on a set of principles, not practice size.
- > **A case management approach to the care of older persons with complex care needs should be facilitated. Consideration should be made to how this can be a funded role within the general practice environment.** The support of patients by a skilled case manager meets the broad range of ongoing needs of people within complex care, and provides a conduit to appropriate AHP support. Case managers should be tertiary trained health professionals, and may require the development of specific training.

- > **Software systems that facilitate comprehensive assessment of the health needs of older patients with complex needs should be developed.** CHHC has developed purpose-designed software that facilitates comprehensive, systematic examination of the patient's health needs. This generates a database that allows for audit and subsequent quality improvement activities.
- > **Consideration should be given to facilitating the training of practice managers and practice principals in practice management and administration.** Meeting the health needs of people with complex aged care problems through primary care government initiatives requires skillful practice management that facilitates the uptake of those initiatives. This is frequently not the case, and steps must be taken to ensure general practices are managed in a way that facilitates optimal care. A national approach is required to ensure uniformly high standards of practice management and service delivery in the GP setting.
- > **We recommend changes to the Medicare funding of chronic disease management:**
 - More precise targeting of the available funding to patients with chronic and complex health care needs, especially multiple co-morbidities.
 - Increasing the number of Medicare funded services from five to ten for people within the target population.
 - Developing funding for home visits by allied health professionals for frail older people and those with limited mobility
 - To shift from flat rate reimbursement for allied health services to a payment structure that acknowledges the different tasks and time required for complex conditions and different professions.
 - A broader range of health practitioners eligible for funding under the scheme – especially pharmacists.
- > **Private health funds should be enabled to fund case management of people with complex care needs by practice- based staff.**
- > **Research should be conducted in the following areas related to the role of allied health in primary care.**
 - The development of a standardized reporting system between GPs and AHPs that is efficient and provides: 1) a minimum, condition-specific dataset on patient needs; and 2) standardised care management and follow up processes.
 - The nexus between the 75+ health report and the coming Personalised e-Health Record
 - The economic impact of general practice-based, multidisciplinary care of older people with complex health needs
 - Investigation into means by which multidisciplinary care and case management, and the management systems required to sustain it, can be systematically implemented into existing general practices.
- > **Education of the health workforce about the needs of older people with chronic care needs is a high priority.**
 - Systematic education of all health professionals on the care of older people with complex health needs take place as a routine part of undergraduate courses. This includes teaching on the breadth of the capabilities of AHPs. We recommend that a process similar to the Commonwealth- funded Palliative Care Education for Undergraduates (PCC4U) course be implemented.
 - Formal education for complex care management be a part of vocational training for general practitioners and relevant specialists

- Medicare Locals should be responsible for ongoing training and skill development of the primary health care workforce in the area of older people with complex health care needs.
- > **A health promotion campaign promoting understanding of the role of AHP in health maintenance and non-drug treatment of chronic conditions, targeting older people should be implemented.**

Key findings

Three questions were examined by the research:

- > **How do patients and health care professionals view the role and benefits of allied health in the management of complex conditions?** Patients appreciate access to AHPs at CHHC, and those operating privately within the community. They also appreciate Medicare funding some of these services. However, many older patients did not really understand the role of many AHPs, probably because many AHP interventions take time to show tangible outcomes. They often attended because their GP said they should. For GPs, AHPs provide practice knowledge and skills that 'fill gaps' in GP practice, contribute specific professional knowledge to a more comprehensive treatment approach, and provide dialogical spaces to learn about different disciplinary contributions to patient care. AHPs appreciate that Medicare funding allows some contact with patients who would otherwise get very limited AHP support.
- > **How does the role of allied health operate and interact within the comprehensive primary care setting to influence the management and outcomes of patients with complex conditions?** The community nurse was pivotal to the provision and coordination of AHP and other services. The nurse acted as a case manager, facilitating access to AHP and other services, (e.g. access to social security benefits). Having AHPs sited within the practice allowed easier and more complete communication. However, co-location was not essential to good MDC; rather it was the capacity for coordination and mechanisms for timely professional communication that matter. It was not possible to demonstrate changes in outcomes due to unexpected limitations of the database.
- > **What is the optimal funding and organisational model to support the role of allied health in the management of complex conditions within comprehensive primary care settings?** It is not necessary to have a large clinic and in-house services to develop good MDC. It does require an attitude by the practice owner and AHPs that MDC is possible and time invested to develop professional relationships. It also requires flexible and expert practice management. Medicare funding of AHPs needs to allow for more services in keeping with the complex nature of the patients, in order to maximize the impact of AHP interventions.

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