Overcoming barriers for transitioning vulnerable clients from targeted programs to mainstream primary care

Department of Health Seminar, Canberra

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Background – Rationale

- Population health data provides insight into factors that contribute to vulnerability to poor health
- Programmatic funding (particularly from state/territory jurisdictions) is often used to address this need at the level of the population group
- Services and the broader health system depend on appropriate use of limited resources
- Increasingly high demands for services resulting in waiting lists for "specialist" services and requiring some to transition to enable throughput
- Need to be able to provide appropriate levels of service – that is, transition clients between levels of care and types of service according to need
- Community Health sector in Victoria is major platform for delivery of services to “vulnerable” consumers (n=62 “integrated”, 28 stand-alone; 36 manage GP services)
- WRHC is a large inner city community health centre ($25m+), including state funding for refugee health care – this issue is central to them
- WRHC PHC response for refugees provided the case study for our research
Study Aim

- To identify potential strategies that can support smooth transitions for consumers from “specialist” or “targeted” services—which aim to be accessible, clinically and culturally appropriate, timely and affordable when consumers are most vulnerable to poor health and least able to negotiate relationships with mainstream services—to “mainstream” services that can provide effective patient-centred care over the longer term (in particular private GPs).

- Framework for exploring factors based on theories of access – recognising barriers and facilitators at all levels:
  - Consumers
  - Health professionals
  - Health services/organisations
  - Health systems
Research Questions

- How can health services support smooth transitions for clients who may require enhanced primary health care in times of high need through the health service and system?
  - How does the health service manage the type and extent of PHC service delivery over time for refugees?

- How can health providers support clients to receive different levels or kinds of care according to their need without compromising on quality?
  - How do health professionals working to deliver and support the Refugee Health Program understand the concept of “vulnerability”, and how is this reflected in their practice with refugees?

- What can consumers do to facilitate their own transitions through the primary health system, to ensure they receive care appropriate to their level of need and potential vulnerability to poor health.
  - How do refugee consumers experience and understand PH care from the time of their arrival in Australia to longer term residency?

- What aspects of the health system facilitate or inhibit making appropriate changes in the level or kind of PH care offered to consumers according their level of need at a particular time?

NOTE: There is an underlying assumption that consumers are entitled to the best quality care appropriate to their needs and the resources available. The over-riding aim is not to provide cheap “good enough” care.
Methodology

- Literature Review to develop a framework for the study and guide synthesis of findings
- Reference Group including stakeholders from WRHC
- Qualitative Data collection – one-on-one interviews
  - Consumers
    - Current or former clients of WRHC RHP (n=17; from 5 cultural/linguistic groups)
  - WRHC staff
    - Staff in management and Refugee Health Program staff (n=10)
    - WRHC general practitioners (n=6)
  - Private general practitioners (n=6 from 5 practices; email sent by ML and 27 practices approached directly by ‘phone)
  - Other practitioners in refugee health (n=2)
Project Findings – Consumers

- **Expectations**
  - Initial expectations of care were simple – around direct health care (for a few, referrals also)
  - Most (n=13) saw the PHC service as ongoing with no expected change
    - “They are good doctors – why would I stop?”

- **Choosing a principal GP**
  - Ten were using other GP services in addition to WRHC GPs
    - Mostly for “minor issues”
  - Reasons for continuing with both:
    - Interpreted reminder notices as requirement to attend – ongoing care not transferred to new GP
    - Quality of interactions
    - Thoroughness of service provided, particularly for complex needs
    - Continuity – “I don’t want to explain my story to too many people”
    - Some embarrassed to tell WRHC GP – did not feel encouraged to seek alternative provider
Engaging with a new GP

- Offered no guidance around finding an alternative GP
- Generally asked friends, family, community contacts (shared language preferred)
  - Barriers: up-front cost; trouble booking an appointment ahead - required to enable booking of interpreters.

Indications/experience of quality PHC

- Poorer quality associated with:
  - less use of interpreters
  - less time spent with client
  - more focus on presenting health issues than all issues of concern
  - less exploration and referral for complex health issues

- Higher quality associated with:
  - Continuity following initial assessment – don’t have to repeat history
  - GPs who know how to use an interpreter (not just how to book one)
  - Longer consultations, including having tests, receiving prescriptions, being referred.
Summary – Consumers

- Consumers, including “vulnerable” consumers, are entitled to select their PHC provider.
- Consumers value continuity of care – establish and maintain relationships. Personal preference and objective quality influence decisions – also personal regard for GPs.
- Transitioning from enhanced PHC to more “usual care” may be experienced/perceived as a drop in quality.
- “Health literacy” is important in determining consumer behaviour – knowledge of the health system, available appropriate services, expectations about quality and level of care.
- Changes in “vulnerability to poorer health” likely associated with:
  - Time since arrival in Australia
  - Employment status
  - Accommodation
  - English literacy level (also literacy in own language)
  - Complexity of health (physical and emotional) issues
  - Health literacy – ability to navigate service system
  - Capacity to self-manage
- Many of these factors that affect ongoing vulnerability are experienced by other consumers.
Factors that indicate quality are the same as for any consumer:

- Quality of communication with health professional – language or effective use of translators
- Ability to “connect” – empathy and care
- Perceived level of knowledge, skill and experience the GP has of physical and mental health conditions relevant to the individual
- Cost – affordability
- And, all other things being equal/acceptable, geographic proximity.

These are generic concepts – not limited to one population group.
Project Findings – Health Service Staff

- **Understanding “vulnerability”**
  - Perceived value in recognising “vulnerable” clients: general agreement that some clients need more “intensive”/“wrap-around” services
    - Complex health issues alongside other social, economic problems
    - Low levels of health literacy, including poor understanding of the health system
    - Require extensive assessment and referral for previously untreated health problems
    - Poor capacity to self-manage

- **Attributes of a good refugee PC service**
  - Recognition internally and externally that comprehensive PHC response for refugees within WRHC is high quality:
    - Health professional skills related to knowledge for health issues, use of interpreters, interpersonal skills, personal interest of GPs to spend time on acquiring cultural knowledge, willingness to spend longer time with clients
  - Triage by settlement services places complex clients with WRHC
Determining a point of transition

- Staff unclear about what is an appropriate transition point – from and to what?
- Internal policies and procedures around points of “transition” in care unclear
- Refugees seen as likely to have many characteristics indicating “vulnerability” when they arrive; however, little thought given to the duration of higher need
  - Priority access to services for refugees does not change within the service (driven by state funding & policy)
  - No documented routine ongoing processes/procedures within the service to assess need and appropriate service level for clients who are refugees
- Some staff concerned that other vulnerable consumers in the community may miss out by not being identified as a population group for priority
- GP clinic seen as very autonomous – individual practitioners determine access more than organisational policy
- GP training focussed on continuity of care for patients – not dealing with limited resources or waiting lists in system
Summary – Health Services (public and private)

- Cost of providing care to “vulnerable” consumers perceived to be higher
  - Higher “no show” rate
  - Longer consultations typically (complex needs &/or using interpreters) – and can’t or don’t always charge for them
  - Inefficient use of GP time on non-PC matters
  - Duplication of services through inadequate documentation of services already provided or poor communication between providers and “doctor shopping’ by some consumers
- Concept of “transitioning” level of PC over time not clear
  - Can be within a service and by the same health provider
- Personal preferences of individual health provider – and the effect of this on access to care – not well recognised
Project Findings – WRHC GPs

- All expressed a personal passion for “refugee health”
  - Strong level of commitment to individuals & families
  - Burn-out perceived as an issue

- Understanding “vulnerability”
  - Belief that the care required and provided is “different”
    - Recognise refugee status is likely associated with prior trauma, mental health problems, specific health issues, chronic health problems
    - Extra time required to listen to health and social issues, to explain about diagnosis and treatment, manage expectations
    - Time required for consultation may reduce as consumers access other health services and English language skills improve
- Determining a point of transition
  - No evidence of consideration of potential to encourage clients to see other GPs, even when they move to a different suburb
  - Lack of knowledge of options; no processes to support clients
  - Idea of varying intensity of service systematically by assessment (rather than by personal or professional decision/preference) not apparent

- Attributes of a good refugee PHC service
  - Whole-of-practice approach including cultural sensitivity in all staff; empathetic
  - “Welcoming” clinic – reception staff as gate keepers
  - Skilled & confident to use interpreters
  - Awareness of potential health issues for different groups
  - Awareness of how the state-funded refugee health program operates, including settlement services
  - Flexible appointments
  - Access to longer consultations
Project Findings – Private GPs

- All but 1 had long-term experience working with refugees & asylum seekers (5-10 years)
  - Most expressed a personal passion for “refugee health”; strong level of commitment to patients with refugee-like experiences; rewarding
    - Burn-out perceived as an issue

- Understanding “vulnerability”
  - Belief that the care required and provided is “different”
    - Longer consultations required for initial health checks, and ongoing care
    - Need skills and organisation to use interpreters well (and cost effectively)
    - Some reported doing case work (e.g., welfare issues) outside normal GP role, but perceived as required because of lack of options
    - Most reported referring consumers for MH support (public and private, client’s language preferred)
    - Asylum seekers seen as having further disadvantage from detention
    - Lack of literacy, cultural issues, etc. generally observed: believe GPs need special training – could include mentoring
• **Determining a point of transition**
  - Some GPs concerned about consequences of not transitioning clients from specially targeted CPHC service to more usual care
    - May create dependency
    - May block access for clients with high needs
  - No evidence of systematic transferring of clients (or records) between private and WRCH GPs, or between private GPs – “clients just disappear”
  - Several questioned the level of PC offered in detention – best time to detect important health needs and respond; less likelihood of duplication, etc.

• **Attributes of a good refugee PHC service**
  - “Culturally sensitive” staff
  - Trained GPs – in special health issues and coping with emotional demands
  - Effective use of interpreters
  - “Churning through in the minimum time” by other GPs equated with poor quality care; but also observed some over-servicing occurs
Summary – Health providers including GPs

- Personal commitment to “refugee” consumers – as a population group
  - Some preferences for providing care to refugees from particular countries and/or cultures

- Additional services provided – beyond traditional PHC
  - Through special programs like Refugee Health Nurse Program
  - By individual GPs because of their interest and commitment

- Little acknowledgement by GPs about consequences of their service delivery behaviour on access for new clients – i.e., “rationing “ available CPHC/time by need

- Little systematic thought about the nature of the change in need for care over time

- Little evidence that GPs were providing consumers with advice about alternative PHC care arrangements or actively supporting transitions

- General recognition of a lack of consistency in quality of PHC across the system
Summary of factors affecting access to appropriate primary medical care

For Individuals: **Factors that contribute to an individual’s vulnerability to poor health, immediate need and ability to navigate the health system to find appropriate care**
- Physical & mental Health
- Social & economic resources (individual & community)
- Cultural and linguistic background (and) capability with Australian culture and language
- Health literacy (knowledge, attitudes, self-management, knowledge & expectations of Australian health system)
- Personal preference, perceptions and prejudices

Within health providing organisations: (including community-managed and private GPs & others)
- Policies and procedures for supply/demand management – overall and episodic
- Number & kinds of health professionals (match of skills & qualifications to local need)
- Effective and sustainable financial model for equitable access (within available funding models)
- Safety and quality governance

Individual health providers/professionals
- Appropriate qualifications & skills
- Cultural and linguistic sensitivity (practice of person-centered care)
- Knowledge of and compliance with service policies and procedures for demand management
- Knowledge of and use of service coordination systems
- Personal preference, perceptions and prejudices

Local primary & community health system-level factors (between and across all health services/organisations)
- Systems for assessing need/demand for services across catchment ("process flow" efficiency)
- Systems for coordination and referral: e.g., service directories, sharing information, networking, training

- Commonwealth and State Health policies and funding models (can limit flexibility and choices of consumer behaviour and service system response)
- Health Workforce
- Economic environment
- Other relevant policies (will affect vulnerability of consumers)
Policy and Practice Implications

Health providers including GPs

- Should actively promote “health literacy” of consumers – knowledge about the health system, available appropriate health services, what is quality care.
- Should recognise the impact their personal preferences have on access to CPHC of different consumers – and consider how this fits with individual and community need.
- Should be clear and transparent with consumers about the level of care they provide and how this may change over time as the consumer becomes more capable of self-management and has more resources.
- Should seek training and PD about health issues relevant to different communities and availability of services (including social services) to which people can be referred.
- Should be encouraged to refer where appropriate.
- Should receive/seek cultural and linguistic competency training & other relevant training.
- Should recognise that principles of “people and family centred care” apply to all consumers.
Health Services (public and private) – management implications

- Should support development of and compliance with clear internal procedures and processes for managing “flow” and meeting demand for CPHC
- Should recognise personal preferences of staff, actively plan around them and address directly where they may be a barrier to meeting need in the community (may challenge sense of autonomy for some health professionals)
- Should have regular routine formal assessments of clients receiving CPHC and/or “special” programs
  - Tool should be applied by an experienced professional or team, not necessarily the treating GP
  - Should adopt a nuanced approach to assessing “vulnerability” and prioritising access
  - Focusing on meeting need within community not individual continuity of care
- Should be clear in communicating the nature and duration of the CPHC or special program being offered – and what the long-term options will be
System-level implications

- Prioritising access by “vulnerability” within services, by individual practitioners, and at a system/policy level needs to be nuanced to ensure appropriate allocation of resources
  - Population health planning is important, but a blunt tool for determining access and priority
  - Some characteristics are non-changing (e.g., person “is a refugee”, “is an Aboriginal or Torres Strait Islander”, “has a chronic disease”, “has an intellectual disability”) but does category membership always indicate greatest need for priority?
  - Some factors affecting vulnerability to poor health and/or need for priority access are relatively generic and may change over time: social & economic resources (at individual & community level, including accommodation, employment, access to social supports, ), cultural and linguistic background (and) capability with Australian culture and language, other mental and physical health problems, harmful behaviours
  - Specific clinical presentations require higher priority access

REMINDER: There is an underlying assumption that consumers are entitled to the timely best quality care appropriate to their needs. The over-riding aim is not to provide cheap “good enough” care.
System-level implications (continued)

- Local, statewide and national initiatives around consumer health literacy (knowledge, attitudes, self-management, knowledge & expectations of Australian health system) are important

- Idea of continuity of care (single provider or practice-level) expressed in policy (and research) has implications for access that need to be considered
  - May limit access to appropriate care at a community level

- Capacity building and system-level support around capacity to provide care to consumers tends to focus on single factors – need to generalise more
  - Individual provider training and PD for cultural competency, including working with NESB clients (not just refugees) (provided by MLs and other specialist services)
  - Importance of encouraging a multi-lingual, multicultural workforce as a means of meeting needs of CALD consumers

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However, all GPs cannot be all things to all vulnerable groups. Needs more thought at a local system level

- Most GPs make choices about “non-profitable” clients – reflecting personal special interest. How can the system make this work for consumers?
  - Registers of self-reported interest not enough – need to ensure providers have appropriate skills by an objective assessment.
  - Don’t want to incentivise practitioners to provide care without necessary skills by pushing MBS items. Further consideration of the relationship between fee-for-service, blended payments and targeted funding streams (e.g., PIP) and their impact on the choices GPs make in relation to the types of patients with whom they spend time.
  - Need to have systems to transition clients – short-term or longer (e.g., GPs who have an interest in children – “natural” transition point.) What is the system solution for this?

- Supporting assessment of match between need and GP interest/skill and facilitating transitions of care (ongoing or short-term) – not on agenda currently and raises issues related to supply and demand issues, business models in GP, personal preferences and interests of practitioners.

- Medicare Locals the obvious place to trial innovative approaches to coordinating efforts to improve access to appropriate PHC for vulnerable consumers
  - Working in collaboration with existing services and specialist programs that are designed to meet the needs of different groups

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Thank you

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