INFORMING PRIMARY CARE RESPONSES TO CHRONIC HEALTH CONDITIONS IN WESTERN AUSTRALIA

The challenge Chronic health conditions are defined by their long term nature and persistent effects. Their social and economic consequences can impact on the quality of life of people and carers. Chronic conditions are becoming increasingly common, and are a priority for action in the primary health sector.

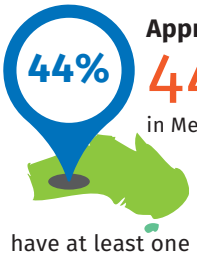
People with chronic conditions are at higher risk of developing further physical or mental health problems.

Evidence internationally suggests that to see better outcomes for people with chronic conditions we need to have:

- better co-ordinated primary care, that links effectively with hospital and other levels of health care
- a "patient centred" approach to care that supports patients and health professionals in shared decision making

Chronic conditions are the leading cause of premature death in Australia.

Half of all Australians are living with a chronic condition, with nearly 40% of Australians aged over **45 years** suffering from **two or more chronic conditions**



Approximately **44%** of people in Metropolitan Perth and over **50%** in Country WA have at least one chronic condition.

60.2% of **Aboriginal people in Western Australia have been diagnosed with at least one chronic condition**

Naïve Inquiry Study

The Naïve Inquiry is being led by WA Primary Health Alliance in collaboration with Curtin University School of Public Health, the Royal Australian College of General Practice and WA General Practice Education & Training (Part 1) and the Health Consumers' Council (WA) (Part 2). The study involved two qualitative research projects that were conducted during 2016 and 2017, as part of the larger process of developing new models of Primary Care in Western Australia. The Naïve Inquiry approach is one that aims to explore a range of stakeholder views and experiences with open questions. Details of the projects are outlined in this summary.

Emerging primary care responses in Western Australia

Comprehensive Primary Care (CPC)

Comprehensive Primary Care is the WAPHA initiative that has been co-designed and developed with GPs. CPC builds capacity and capability in general practices to manage care for people with chronic health conditions. It is a whole of practice, whole of person approach.

Health Care Homes (HCH)

Health Care Homes is a Commonwealth Government initiative. HCH are existing general practices or Aboriginal Community Controlled Health Services which will provide care which is better coordinated and more flexible, for up to 65,000 Australians with chronic and complex conditions.

My Health Record

By the end of 2018 every Australian resident will have a My Health Record, unless they actively choose to opt out. WAPHA will be increasing engagement with health professionals and community members to support expansion of use of My Health Record, including training and information for health care providers and consumers on the benefits of My Health Record.

WA Primary Health Alliance (WAPHA) is acknowledged for providing funding in its role as the operator of the Perth North, Perth South and Country WA PHNs.

Naïve Inquiry Part 1 :

From the perspectives of General Practice

The study consisted of two stages :

- **Stage 1:** Innovation Hubs
  These workshops involved short presentations and facilitated group discussions to extrapolate views on the Comprehensive Primary Care model, its applicability and development in the WA health care setting. 25 participants attended the Hubs. The outputs from the Innovation Hubs informed the content of Stage 2, both in respect to approach and focus of interviews.
- **Stage 2:** Semi structured interviews with general practice staff
  This aspect of the research involved a selection of GPs identified by WA General Practice Education & Training (WAGPET) undertaking face-to-face interviews with GPs, GP registrars, practice managers, practice nurses, and receptionists. 32 respondents from across 10 WA practices took part in the interviews.

Each stage elicited extensive information demonstrating a range of views with common themes emerging. Key brief summary information is provided below, with the full report of findings pending publication.

Innovation hubs - key themes

A number of GP practices suggest they are already providing Comprehensive Primary Care models

The need for simplicity within the Comprehensive Primary Care model – both in the funding and the model itself

Don't re-invent the wheel - lots of things already working in general practice

Need much better data about patients attending individual practices

GP practices will need to have a viable business model for this

Need for service integration and improvement

Scope to improve team based management of chronic conditions within the GP practice - not a solution to simply push more money into non-government organisations

Change the funding model, and you can change the behaviour of GPs

Make sure the Comprehensive Primary Care model is right for the WA environments – need to have guiding principles for the model, but not prescriptive

Importance of measuring outcomes

Naïve Inquiry has been a collaboration between:

Health Consumers' Council (HCCWA) an independent voice, advocating for patients in Western Australia. It offers a unique perspective on health policy and service delivery matters. HCCWA receives funding from State agencies and comments publicly on all issues affecting health. Further information available from: http://www.hconc.org.au/

Naïve Inquiry Part 1 :

From the perspectives of General Practice

Semi-structured interviews – ingredients for success	
FEATURE	**DEFINITION**
Holistic	Care that centers around the patient - may be at the expense of the business (financial model). The holistic approach takes an investment of time and a practice philosophy that's aligned.
Good systems	Having appropriate, robust systems to manage patients (including recall) and record activity. Making sure systems are used well - need to provide adequate training and support for staff.
Role clarity for team – including patient	All individuals being clear on their role, the roles of other team members and understanding how their bit adds to the whole. This also involves patient being clear around their responsibility.
Co-ordinator role	An individual that takes overall responsibility for co-ordination and relevant administrative tasks - working closely with other staff and patients.
Patient empowerment and responsibility	Patients need to take responsibility and understand their role in self-management and working with GP to achieve positive outcomes.
Valuing patients with chronic conditions	This related to putting more priority to patients with chronic disease – and providing more transparency on what this costs the system.
Continuity of care	Patients need continuity in terms of practice and GP. Patients need to access the same practice and preferably the same GP.

WA Primary Health Alliance (WAPHA) the organisation that oversees the strategic commissioning functions of the three Western Australian Primary Health Networks: Perth North, Perth South and Country WA. WAPHA's primary objective is to improve health outcomes and patient experiences through the commissioning of appropriate services where they are most needed. Further information available from: http://www.wapha.org.au/

Naïve Inquiry Part 2 :

From the perspectives of consumers with chronic health conditions

Consumer perspectives on chronic condition management within primary care were captured through a series of small group discussions with consumers from across WA. Forty six consumers participated in the study.

In the metropolitan area, groups were held in Armadale, Midland, Rockingham/Mandurah and Wanneroo. In regional WA, groups were held in Albany and Bunbury. In each region, there are relatively high levels of disadvantage and rates of chronic disease.

Focus group participants

- 76% of participants were female
- The youngest participant was 20 years old and the oldest was 75 years old; average age was 48 years old
- The most common health condition experienced was type two diabetes (48% of participants)
- Over 23% of participants listed fibromyalgia as one of their chronic conditions, with at least one participant in each group reporting this condition

It is recommended that in further developing and refining the Comprehensive Primary Care model, a variety of stakeholder engagement processes continue to be incorporated.

Consumers told us they value...

A long term relationship with a **GP** who a good listener

"Dr Google" as a source of information, used best as a way to empower **communication** with health professionals

Pharmacists, as a source of **accessible and appropriate advice** in addition to medication expertise

Allied Health and **care plan services** that are individually **tailored** and deliver therapeutic clinical care

Consumers would like to see...

Electronic **health** records **shared** between health providers and patient

Appointments and waiting

Separation for **chronic condition** patients to reduce infection risks

Flexible contact with **Primary Care** outside the clinic appointment model

Bulk billing and **no fee gaps**

Consumers told us they are concerned about...

Allied health **care plans:**

Low levels of awareness and promotion of allied health care plans

Generic education formats

Rarer conditions:

Perth vs East Coast knowledge gap

Lack of diagnostic and care pathways

The cost of care, **which can affect care choices**

People in the community who are **socially isolated** and lack support and advocacy in their health journeys

Curtin University School of Public Health teaches and conducts world-class research across three main themes in public health: health promotion and disease prevention; occupation and the environment and health systems and health economics. Further information available from: http://healthsciences.curtin.edu.au/schools-and-departments/public-health/

Naïve Inquiry Part 1 and 2 :

Bringing perspectives together

The general practice staff and health consumers we spoke to provided insights on a range of issues to be considered in further developing future models of chronic condition care management. Building on the key ingredients for success identified by general practice, the experiences of consumers help to both broaden our understanding of definitions and offer a way forward for achieving care that is truly patient centred.

Holistic

General Practice: Taking a holistic approach to care that centres around the patient - often at the expense of the business (financial model) - the holistic approach takes an investment of time and a practice philosophy that's aligned.

Consumer: Patients wish to be listened to and have appropriate time made available to them. Sometimes they need someone in the system that can "just hold their hand."

"Very early on, [GP] gave me her mobile number, and I could ring at any time. And if I was desperate, I don't even need an appointment, I just rock up. And that has been brilliant."

"I'm confident to access services... but sometimes, just to have that person on your side, because after a while it's like: I'm going to the doctor, I'm going to the specialist – they must think I'm a hypochondriac, I'm just imagining this. Just to have that support there, if you need it."

Co-ordinated team approach

General Practice: This involves multi-disciplinary skill base; good communication and relationships, a 'working closely together' co-ordinated approach.

Consumer: Sense of mismatch between service provided by GP and external allied health services – no sense of team care apparent. Limited information provided to allied health providers impacts on time available for therapy provision vs assessment.

Role clarity for the team – including the patient

General Practice: All individuals being clear on their role, the roles of other team members and understanding how their bit adds to the whole. This also involves patient being clear around their responsibility.

Consumer: Patients see lower value in team members that provide standardised information; would prefer team members deliver more individualised care.

"You've got to rely on yourself, more than anybody. Because, no one can tell you how you feel, can they? You gotta, you've got to own it yourself."

"You could have a family member that's going to support you. Or, you could be that person that has no one there for support."

Co-ordinator role

General Practice: An individual that takes overall responsibility for co-ordination and relevant admin tasks - working closely with other staff and patients.

Consumer: System is confusing and patients would like more support to navigate and just to be reassured. They worry about people who don't have a support network.

Naïve Inquiry Part 1 and 2 :

Bringing perspectives together

Patient empowerment and responsibility

General Practice: Patients need to take responsibility and understand their role in self-management and working with GP to achieve positive outcomes.

Consumer: Sometimes things have to go wrong for patients to realise their need to take responsibility. Patients feel empowered by access to other sources of information such as pharmacists, internet information and support groups.

"My doctor is willing to listen to things [information found on the internet] and do research on it if she feels it is something that, you know because GPs cannot be 100% on every single thing."

"... when you have a personal issue and you have built a relationship with a doctor [loss of access to bulk billing] can really significantly impact on your health, because – sometimes I won't even go to the doctor and worry about it."

Valuing patients with chronic conditions

General Practice: This related to putting more priority to patients with chronic disease – and providing more transparency on what this costs the system.

Consumer: Patients with chronic conditions feel that they have different needs to other patients who access GP less frequently, and would like to have different arrangements in place to meet these needs such as low-risk waiting areas/reduced waiting and flexible GP access. Bulk billing also important to facilitate regular appointments.

Good systems

General Practice: Having appropriate robust systems to manage patients (including recall) and record activity. Making sure systems are used well - need to provide adequate training and support for staff.

Consumer: Patients report a range of recall systems. Attending an appointment for a care plan and not having other issues addressed in the same appointment is a frustration.

"We've got this on-line, booking thing that's happening now with our GP... which is good, because you don't have to ring, and wait and all this sort of thing, so that's good. ....They've also created this new...special line that you can ring in for your reports, your tests, your results."

"I would have liked that to be linked to my Medicare card or something, where I could go in and I could tap it in to the system and I could see what is actually happening to me. Or, what my records are."

Continuity of care

General Practice: Patients need continuity in terms of practice and GP. Patients need to access the same practice and preferably the same GP.

Consumer: Patients have a strong preference to stay with one GP once they find one that they are happy with. They will consider following a long term GP to a new practice in preference to getting another GP from the same practice. They agree with the concept of eHealth records that can be accessed by multiple providers, preserving an ongoing central health record that they can also have access to.