Multi-disciplinary Care

Session Summary
August 2024

Background

The following definition outlines the objectives as well as some of the challenges involved in the provision of multi-disciplinary care:

Multi-disciplinary care - when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.

The Australian Government's 10 Year Primary Health Care Plan (2022 to 2032) aims to support patient-centred continuity of care through a range of recommended strategies, incentives and initiatives. The Plan proposes funding reform over time to support outcome-focused and multi-disciplinary care, and to address the challenges faced by older Australians, people in rural and remote communities, Aboriginal and Torres Strait Islander people, people with disability and other population cohorts who face barriers to accessing appropriate primary health care.

The Plan articulates incentivised programs (primarily centred on general practice) that will enable multidisciplinary care – and these have been taken forward in the form of relevant Federal Budget Measures. Measures in the 24/25 Budget ascribe a leadership role for Primary Health Networks in commissioning multi-disciplinary teams, and supporting their development, particularly in locations where people are most at risk of poor health outcomes due to lack of access to primary health care services.

In the context of multi-disciplinary care, the Government's Scope of Practice Review (Final Report due September 2024) is intended to complement the 10 Year Primary Health Care Plan recommendations and related budget measures, identifying opportunities to remove the barriers for health professionals working to their full scope of practice. It is also drawing on examples of multi-disciplinary teams where members are working to their full scope of practice to deliver best practice primary health care.

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PHN role

WAPHA will commission, or support the embedding of, multi-disciplinary care that address the prioritised health needs in our regions. A key to the success of these multi-disciplinary care measures is to build relationships and a shared understanding between general practices and allied health providers, of what multi-disciplinary care is and facilitating a team approach. WAPHA will be focused on cultivating the leadership and broad health system culture change required to enable the success of these measures.

> *"It works really well when there is a GP at the centre of the model who is a champion and a leader in that space"*
> - Panel comment

Questions posed to the panel:

1) What opportunities do you see for your organisation in supporting WAPHA's activities in commissioning and embedding primary health care multidisciplinary teams focused on WA's disadvantaged/ underserved communities?

2) What challenges do you see for your organisation in supporting WAPHA's activities in commissioning and embedding primary health care multidisciplinary teams focused on WA's disadvantaged/ underserved communities?

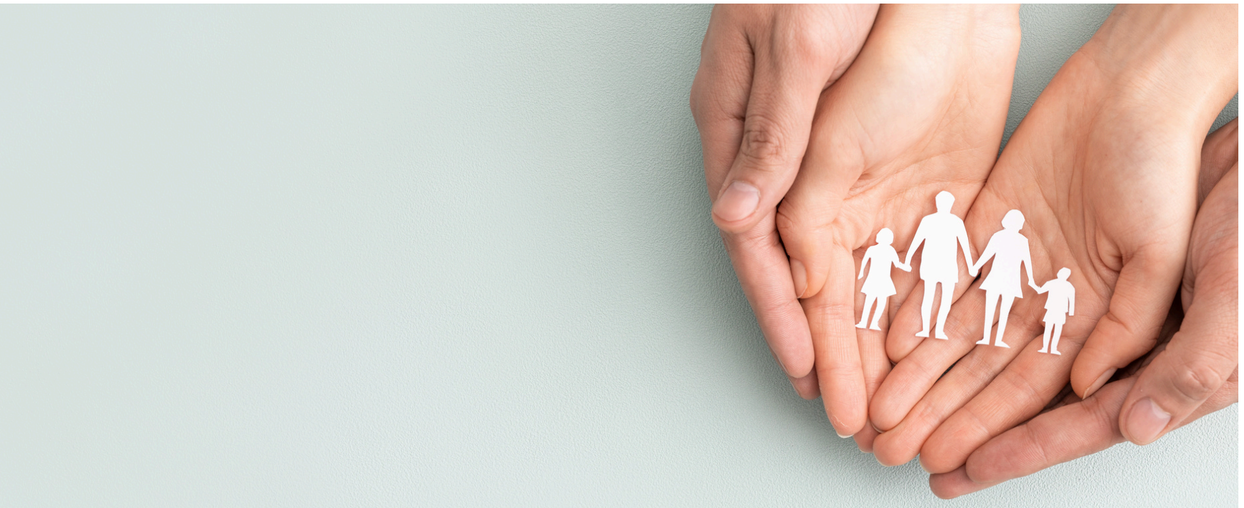
3) Can you provide examples of where multidisciplinary care is working effectively in a primary health care setting in WA or other jurisdictions?

1) What opportunities do you see for your organisation in supporting WAPHA's activities in commissioning and embedding primary health care multidisciplinary teams focused on WA's disadvantaged/underserved communities?

- Having complementary allied health professionals practising in the one clinic at the same time to deliver services and support in an effective way.
- There is potential to integrate nurses, OT's, social workers and other underutilised health professionals to bridge barriers and coordinate services.
- Integrating existing community services into multidisciplinary teams rather than creating new overlapping services.
- There are opportunities in utilising virtual care, especially in regional areas.
- Within GP practices embed peer and lived experience support to spend additional time with people who would otherwise fall outside of general consult times.
- There are lessons that can be learned from the disability sector which place the person at the centre of their care plan in a very measured and meaningful way, especially when there are multiple health practitioners contributing to the care plan.
- Develop provision for a service navigator or a care coordinator who can build the health literacy of their patients in a way that is sustainable.

Examples and ideas of health professionals working to their full scope:

- Non prescribing pharmacists working as diabetes educators.
- Mental health nurses not attracting Medicare funding. There is an opportunity to look at how funding could be applied to mental health nurses who are a great linkage between GPs and re-presentations to emergency departments.
- Utilising exercise physiologists to bridge the gap between primary care and health promotion and prevention in a more culturally appropriate way, e.g., hosting walking groups.



2) What challenges do you see for your organisation in supporting WAPHA's activities in commissioning and embedding primary health care multidisciplinary teams focused on WA's disadvantaged/underserved communities?

- The multidisciplinary team care model needs to be well organised, and the patient should be aware that they will be seeing multiple health professionals.
- The infrastructure needs to be measured, and the team needs to be heavily involved in the planning of it so it can suit their needs.
- Being aware of the burden of care that may be placed on the patient receiving care.
- Access to a GP will be critical if the GP is placed at the centre of the model, but there are challenges in finding GPs who want to work in this model.
- The fragility of sustainable and viable general practice and how we account for that to ensure that what is set up is not counterproductive.
- Where there are limited housing options available in regional areas, there is a potential to end up with a FIFO style model which raises challenges around availability of services and the social impact to the community.

"Coming out of hospital, we are finding ourselves increasingly leaning into our allied health and nursing teams, who can guide care and a suitable model."
- Panel comment

"You need infrastructure such as the clinic rooms, and for the team using it to be heavily involved in the planning of multidisciplinary care, as it needs to work to their capacity." - *Panel comment*

"It is not sustainable for dementia support specialists to travel to all regions providing face to face navigation support, so it is important to consider whether there is a multidisciplinary team on site, and where we can integrate virtual consults." - *Panel comment*

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3) Can you provide examples of where multidisciplinary teams are working effectively in a primary health care setting in WA or other jurisdictions?

- The Coordinated Endocrinology & Diabetes (CEDs) program running in Mandurah, Rockingham, and Armadale, which is a multidisciplinary chronic disease programme involving dietitians, diabetes educators, exercise physios and a specialist position.
- The Wheatbelt Health Network provides multidisciplinary primary care services including doctors, a dietician who is dually trained as the diabetic educator, a podiatrist, psychologist, physiotherapist, and exercise physiologist, all in the one building.

This allows for corridor conversations and lunchroom discussions, which assists in understanding the different disciplines and how they can connect.

- Dementia Australia is trialling a model of a dementia support specialist sitting in a memory clinic, allowing for somebody very early in their diagnosis journey, to receive help from them with navigation.
- The Street Doctor program at 360 Health runs a block funded GP service incorporating health practitioners, Aboriginal health practitioners and nurse practitioners to work effectively with a cohort that can be challenging to engage.
- Albany is trialling a model where a "link worker" accepts referrals directly from a GP, and then identifies areas for social supports and connects the person.

"There are many benefits in being able to integrate [lived experience peer workforce], but not look at it as just a cheaper or a less qualified option. I think it is an innovative option." - *Panel comment*

Overall Themes

Look to integrate Nurses, OTs, Aboriginal Health Workers, Social Workers, and other underutilised health professionals to provide tailored and coordinated care.

Developing and embedding a care navigator role to coordinate care and bridge gaps in a patient's health journey.

Being mindful of the burden of care that may be placed on the patient receiving care in a multidisciplinary team care model.