Specialist Access in the Community Co-design Project

COORDINARE–South Eastern NSW PHN

March 2022

COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

Acknowledgments

COORDINARE – South Eastern NSW PHN acknowledges the Traditional Owners of the lands and waters of the South Eastern NSW region, and pay our respects to Elders both past and present. We thank those First Nations people who have shared their cultural knowledge and experiences with the project team to improve the health of community.

We also acknowledge those consumers, health professionals and Project Steering Group members who have participated in the
co-design process - we recognise the value of the insights and expertise you have openly shared.

COORDINARE acknowledges the work of Beacon Strategies who were contracted to undertake the co-design process to develop the regional model to improve specialist access in the community.

Beacon Strategies

Contents

Introduction

This report aims to present a summary of the findings and implications emerging from the Specialist Access in the Community Co-design Project, including:

- describing the project's background and context
- outlining the co-design approach
- summarising the key findings arising from the co-design process
- outlining the proposed model of care informed by the co-design process
- providing recommendations to progress the implementation of the model

The full version of the project report, including more detailed findings emerging from the co-design process may be made available on request by COORDINARE.

Background

The Specialist Access in the Community Co-design Project aimed to co-design a sustainable, and scalable person-centred model to increase access to specialist care for the residents of South Eastern NSW.

Through its role in working with GPs, other primary and secondary health care providers, and hospitals to improve and better coordinate care across the local health system, COORDINARE has a strong rationale for improving specialist access in the community.

The health system is increasingly complex and fragmented, making it difficult for people accessing healthcare to navigate. Demand for care continues to increase, placing additional pressure on limited resources in both primary care and specialist services. GPs and specialist services play a critical role in providing ongoing care within the local community. Ensuring that this care is integrated, or seamless, is vital to people receiving the right care, in the right place, and at the right time.

Wait times for specialists can be lengthy, particularly in regional areas where considerable travel is often required increasing the difficulty of access particularly for older or vulnerable people, and the number of specialists available locally is very low.

The objective of improving the accessibility and responsiveness of specialist health services is a core aspect of integrated care, which has been a priority for a range of national, state and regional policies over recent years.

In August 2021, COORDINARE engaged Beacon Strategies to lead the Specialist Access in the Community Co-design project. The aim of the project was to co-design a sustainable, and scalable person-centred model to increase access to specialist care for the residents of South Eastern NSW.

Photographer: Emma Korhonen

Consumer experience

Implementing the model of care will contribute to improve the experience and outcomes of consumers by increasing access to specialist services in their local communities.

Current state

Mary is 73 years old and visits her local GP in Moruya to discuss concerns regarding her chronic health condition. Mary's GP refers her to the Cardiologist they routinely refer to in the public system, who is located in Canberra. Mary's GP completes the referral and faxes it to the Cardiology service. Mary waits several months before hearing that she has been allocated an appointment with the Cardiologist at 8am in a few weeks' time. Mary isn't comfortable driving the long distance to Canberra, however community transport services do not leave Moruya early enough to get Mary to Canberra by 8am. Mary asks a family member, who takes time off work, to drive her to the appointment. Mary attends the specialist appointment, which lasts 15 minutes. The Cardiologist makes changes to Mary's medication to better manage her condition.

A week later, Mary has an appointment with her GP. The GP has not received information from the specialist about Mary's change in medication, and Mary can't recall the Cardiologist's advice. After multiple attempts from Mary's GP to contact the cardiology service, the GP is faxed a brief letter summarising the Cardiologist's clinical notes and recommendations. Mary continues to see her GP and is booked in for a review appointment with the Cardiologist in Canberra in 6 months' time.

Co-design methodology

An experience-based co-design framework that involved co-creation with people from a range of perspectives contributed to a model that meets the needs and context of the region.

Adopting an experience-based co-design framework, the co-design process involved a logical series of engagements across four key phases:

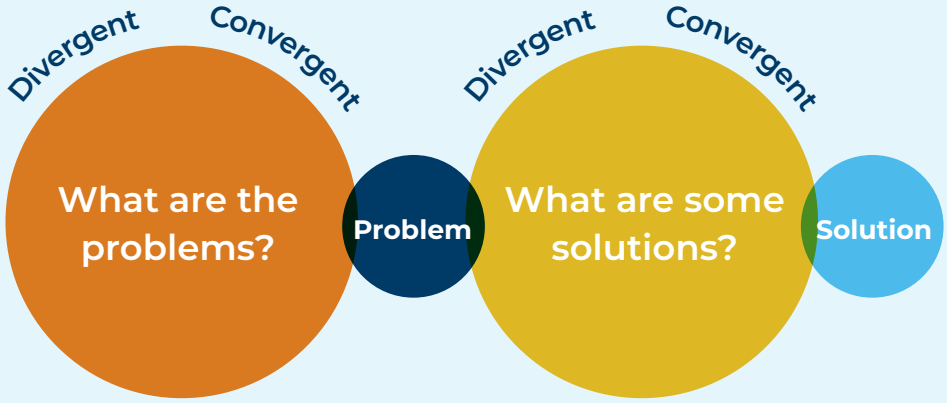
- **Discover:** understanding the needs of consumers based on reflection of previous experiences of accessing specialist care
- **Define:** developing a set of problem statements to clearly define and agree on the issues that need to be addressed
- **Develop:** identify potential solutions to respond to the defined problems
- **Test:** refine the potential solutions, gauge the level of endorsement and identify implementation considerations.

A broad range of perspectives were explored in all four phases of the co-design process, including:

- Consumers
- GPs
- non-GP specialists
- Practice Nurses
- Practice Managers
- Aboriginal Medical Services

Project governance was via a Project Steering Group comprised of Illawarra Shoalhaven and SNSW consumers, GPs, local health district managers of integrated care, aged care and Aboriginal health, and COORDINARE team members. The group met 6 times from August 2021 – March 2022.

Discover	Define	Develop	Deliver
10 focus groups **12** interviews	**5** feedback loop interviews Prioritisation survey	**2** focus groups	**3** focus groups **7** interviews



Identified issues

Insights from the co-design process informed the development of several problem statements. These problem statements related to patient empowerment and advocacy, wait times, communication and practical barriers to accessing care. Other problems identified related to workforce capability, capacity and accessibility, and the consumer experience of service.

- Patients are not **empowered** to research and make informed decisions about their referral options
- Patients experience **long waits** for an initial non-GP specialist consultation, diverting some patients to private care
- GPs are often required to advocate for their referred **patients to be prioritised** by non-GP specialist services
- Lack of communication about wait times does not support effective **ongoing patient management** in general practice
- Direct and hidden **costs** of non-GP specialist services is a barrier to accessing timely care
- Burden on patients having to travel **long distances** to access non-GP specialist services
- Insufficient information, communication and collaboration between settings results in limited **care coordination** and integration for patients
- There are limited opportunities for GPs to obtain **advice, support and education** from non-GP specialists to work top of scope and manage patients in primary care
- Patients experience **variability in quality** of person-centred care from general practice and non-GP specialist services
- There is **insufficient specialist services** to meet demand, and availability is often restricted by location and specialty
- Reliability and continuity of specialist services is impacted by **recruitment and retention** of specialists
- Limited utilisation of **nursing and allied health** led models
- Limited **resourcing** to sustain nursing and administrative support for specialist services
- Patients are not able to see their regular **GP in a timely way** due to excess demand relative to supply

"Triage is an issue when there are 200 people on the waitlist...there's not enough specialists to see all the patients and also not enough clinic space"

– Health Professional

"Not having to wait so long... three months of solid pain, very wearing... (that is the) impact that the waiting times have."

– Consumer

"(Telehealth) follow up (can take) 2 seconds – 'everything's fine' (Previously I would) travel to Canberra for hours for three or four words."

– Consumer

"Some specialists are reaching retirement age and there's no replacement for them... We're not seeing younger specialists coming along, and this is highly alarming. There's no one to come and take these roles..."

– Health Professional

"As a carer you have to be strongly advocating. It can be extraordinarily confusing. I can understand why people leave things and don't follow up."

– Consumer

"A lot of my patients could be managed by GPs with my input. Some GPs push back. Some sort of process for shared care that would be good."

– Health Professional

"People sitting quietly continue to wait. The ones without advocates, the quiet ones on the [wait] list are the ones in need... sometimes they turn up to emergency."

– Health Professional

"I get really disappointed when I go with my mum – it's a fresh slate sometimes. I have to tell the story again."

– Consumer

"I value the input between the GP and the specialist. I feel it should be an open line. The GP can't operate without the specialist and vice versa. They have to coexist"

– Consumer

Needs of First Nations people

Through engagement with First Nations communities, a set of needs to increase access to specialist services for First Nations People were identified.

Identified **barriers** to accessing specialist care for First Nations people were:

- existing Integrated Team Care (ITC) funding is not enough to support communities who experience disproportionate health issues
- long wait times for patients to access Aboriginal Community Controlled Health Organisations (ACCHOs) services and consultations
- written communication of specialist appointment times does not work well for people who are transient, resulting in non-attendance.
- First Nations people prefer to see a specialist in the local area, with access to transportation options, time, cultural beliefs regarding hospital settings, and connection to country and family impacting access to specialist services out of the area.
- consultation gap fees and lack of availability of bulk billing services is a barrier to care
- difficulties navigating the service system and limited awareness of public or bulk-billing service availability/ eligibility
- low acceptance and/or utilisation of telehealth due to patient needs and/or preferences
- turnover and lack of continuity of regular doctor
- lack of coordinated efforts of the medical community to establish relationships and partnerships to improve the health of First Nations people
- lack of consistent information and advice provided to First Nations communities
- inappropriate communication with the patient and family members, often involving medical jargon.

Identified **needs and priorities** for First Nations people to increase access to specialist services include:

- a single, holistic health care plan
- local delivery of specialist services by visiting specialists
- adequate funding for Integrated Team Care (ITC) arrangements
- patient choice in accessing ACCHOs or mainstream primary care services based on the individual's preference
- trusted and continuing relationship with treating doctors
- convenient appointment/ consultation times, particularly when travel is required
- information about services (e.g. cost, availability) and consumer education
- involvement of and connection to family supports
- follow-up and aftercare upon seeing a specialist

Artwork: Heal our COUNTRY, Artist: Rhiannon Chapman

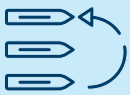
Solutions

Ten model components were developed informed by a process of collaboratively and exhaustively identifying possible solutions to the identified problems with co-design participants. Co-design participants subsequently endorsed the model as addressing the needs of consumers and health professionals to improve access to specialist care in the region.

Specialist access close to the patient's home
People living in rural areas of South Eastern NSW have access to non-GP specialist care closer to home, delivered through a mix of service modalities including outreach clinics and telehealth.

GP advice service
GPs can obtain timely advice and assistance from specialists to guide and inform care planning and treatment options for their patients, encourage appropriate and high quality referrals, and work top of scope to manage their patients effectively in the primary care setting as much as is clinically appropriate.

Referral support for general practice
General practice is supported to develop high quality referrals that include all relevant and required information for efficient triage and prioritisation by a non-GP specialist service.



Triage and prioritisation of referrals
Triage and prioritisation of referrals for public non-GP specialist services is based on consistently applied criteria, clear guidance for GPs making referrals and provides indicative timeframes for an initial consultation. This enables more appropriate and better referrals, and a mutual understanding of the process for triage and prioritisation, acknowledging existing constraints.

Shared care models
Innovative and evidence-based shared care models involving GPs, specialists and other primary care providers are routinely implemented and underpinned by integrated care, multidisciplinary teams and health professionals working to the top of their scope of practice.

Patient information and resources
Patients are provided relevant information and resources from primary care and non-GP specialist services to guide decisions about their referral and treatment options.

Non-clinical supports
Patients with complex needs have access to non-clinical supports that facilitate access to specialist care and overcome known practical barriers to access (e.g. financial, transport).

Digital health
Rollout of digital health strategies to optimise the use of information and communication technologies for service delivery, record keeping, transfer of care and interprofessional communication.

Interprofessional education and training
Primary care and non-GP specialist staff are provided education and training opportunities that support them to establish local networks, build their skills and knowledge, increase GP capacity to support patients while waiting for a non-GP specialist appointment, and optimise their respective scopes of practice.

Workforce planning and development
A whole-of-region health workforce development strategy guides longer term workforce planning and development activities that ensure continuity of specialist service delivery, build capacity to respond to demand and plans future services around emerging community needs.

Guiding principles

- Patient agency and empowerment
- Technology is optimised
- Culturally safe and appropriate
- Localised
- Sustainable

Consumer experience

A person presents to their GP reporting signs or symptoms of a health issue

Patient Information and resources

The person receives relevant information and resources by their care providers to guide decisions about their referral and treatment options, including self-management.

Non-clinical supports

The person can obtain non-clinical support that facilitates access to specialist care and overcomes known practical barriers to accessibility

Primary care setting

GP advice

The person's GP obtains timely advice and assistance from a non-GP specialist to guide and inform treatment options for their patient and determine appropriate referral pathways

Referral support

The person's GP makes a high quality referral to a specialist that includes all relevant and required information to enable efficient triage and prioritisation by a specialist service.

Shared care

Innovative and evidence-based shared care models involving GPs, non-GP specialists and other primary care providers are implemented, and underpinned by integrated care, multidisciplinary teams and health professionals working to the top of their scope practice.

Specialised care setting

Triage and prioritisation

The referral is triaged and prioritised according to consistent criteria, with clarity provided for the referring GP and referred patient and expected wait times.

Specialist services close to home

The person has access to specialist care close to their home enabled through different modalities such as outreach clinics or telehealth

System-level enablers

Digital health

Rollout of digital health strategies, optimises information-sharing and inter-professional communication

Interprofessional education and training

Primary care and non-GP specialist staff are provided education and training opportunities that support them to establish local networks, build their skills and knowledge, increase GP capacity to support patients while waiting for non-GP specialist care, and optimise their respective scopes of practice.

Workforce planning and development

A whole-of-region health workforce development strategy contributes to continuity of specialist services, builds capacity to respond to demand and plans future services around emerging community needs.

Intended outcomes

- Consumer satisfaction with care received
- Improved health literacy
- Timely access
- Decreased travel to care for patients
- More affordable care
- Improved system navigation
- Better utilisation of health workforce
- Reduced waitlists for specialist services
- Increased multidisciplinary and collaborative care
- Improved management of chronic conditions

The Quadruple Aim[1]

- Better consumer experience
- Improved patient outcomes
- Enhanced provider satisfaction
- Increased value for money

Source:[1] Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med. 2014 Nov-Dec; 12(6):573-6 doi:10.1370/afm.17.13.

Implementation of the model

To ensure effective establishment of the model across the region and acknowledging several of the components are interrelated, each of these components should be implemented.

Model horizons

Implementation considerations for the 10 model components have been grouped across three horizons that provide an indication of potential timeframes for implementation, informed by the scope and scale of work required. This is intended as a guide and will be informed by stakeholder priorities, as well as the national, state and regional policy and practice environment.

Horizon 1
1-2 years
Leveraging and building on what's already in place and developing insight for future opportunities

Horizon 2
3-5 years
Exploring and implementing new approaches for local implementation

Horizon 3
5+ years
Progressing and embedding systematic, transformative change

A set of recommendations were developed to ensure effective change management is embedded as part of the implementation process.

Endorse:

Obtain endorsement of the conceptual model, consisting of guiding principles, 10 components, priority activities/programs of work within each component, and desired outcomes

Communicate:

Develop a summary of the co-design findings and resulting model to present a compelling 'case for change' that highlights the current experiences and needs of the local health consumers and the future state model to meet these needs

Sponsorship and resourcing:

Determine executive sponsorship, governance arrangements, program management accountabilities and resourcing requirements to transition the model from development to implementation across the region

Implementation planning:

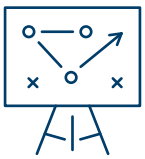
Develop a planned and structured implementation plan for the endorsed model, with a focus on governance and oversight; activity prioritisation and planning (including further co-design at activity-level); roles and responsibilities; communication and promotion; timeframes

Monitor and evaluate:

Develop a monitoring and evaluation framework to support implementation of the model, which outlines desired outcomes, evaluation priority areas, indicators, data sources/collection methods, and performance reporting mechanisms

Initial Implementation Recommendations

A set of recommendations were developed to guide initial actions for implementation of the model.



Recommendation 1: Develop consumer health literacy strategy
Develop a strategy that focuses on building health literacy and guiding decision-making around accessing specialist care. Develop patient information resources relating to accessing specialist care including how the public and private health system is structured, finding services, links to resources for self-managing common chronic conditions, assistance with telehealth and how to obtain non-clinical support (e.g. financial, transport, advocacy, carer assistance). Communication campaigns of developed resources should consider digital media as well as working with general practice and other providers to offer information resources at the point of care.

Recommendation 2: Develop shared care guidelines
Develop practical shared care guidelines, workflows and templates in collaboration with GPs, non-GP specialists and consumers for priority specialties and/or conditions. Work with a sample of GPs, non-GP specialists and consumers to develop an agreed shared care model that includes patient identification, referral, roles and responsibilities, consultation and team care arrangements, patient self-management, information-sharing and communication, escalation and review/follow-up. Shared care models should incorporate digital health opportunities such as virtual consultations and case conferencing, secure information and communication, and patient monitoring. Initially prioritise a small number of specialties and/or conditions based on need and engagement of clinicians, before progressing to other specialties and/or conditions.

Recommendation 3: Undertake service review
Undertake a service mapping and review exercise of specialist services available in local communities to identify gaps in service information available in HealthPathways. Expand existing service criteria in HealthPathways to consistently include referral information and criteria, service availability and modality e.g. telehealth, estimated waiting times, service costs and credible patient information resources. Initially focus on public LHD specialist services, followed by private non-GP specialists and GP-to-GP colleague referrals.

Recommendation 4: Scope existing advice & support mechanisms
Consult with priority LHD specialty services to identify existing advice and/or support mechanisms available, and strategically communicate their availability to raise awareness. As some specialties may already have a 'GP Advice Service' mechanism in place currently, it is recommended to scan priority specialty services to identify advice mechanisms already available to local GPs currently and how these can be accessed. Communicate and publish available information on HealthPathways. Collection of information about existing GP advice and support can be used to inform future development of GP Advice Services in each specialty.

Recommendation 5: Develop a program of interprofessional education
Develop and implement an initial program of interprofessional education and training activities for GPs and non-GP specialists in 2022-23FY. Support the development of interprofessional education and training activities with initial focus areas and priorities informed by the PHN's existing consultative mechanisms. Consideration should be given to PHN level networking forums, education/training workshops, shadowing and/or mentoring activities.

Recommendation 6: Expand digital health initiatives
Extend the roll out of digital health initiatives focused on virtual care, improving information flow and communication and supporting digital health literacy. Roll out digital health initiatives that focus on promoting better uptake of and/or consumer access to virtual care, improving information flow and communication between GPs and non-GP specialists, and supporting digital health literacy of consumers. Build on the increased acceptance of digital health modalities during the COVID-19 pandemic such as telehealth and remote collaboration, while also continuing longstanding initiatives such as secure messaging, My Health Record and e-referrals.

Recommendation 7: Provide care closer to home
Explore specialist access opportunities that improve provision of care closer to the person's home through outreach/visiting services, multidisciplinary care and/or telehealth. Draw on learnings from previous innovations such as the Geriatrician in the Practice model. COORDINARE should lead collaboration with GPs and non-GP specialist providers, including ISLHD and SNSWLHD, to progress opportunities that improve provision of care close to the person's home. This might involve improving access to specialist care through an outreach/visiting-style service, multidisciplinary care that is predominantly led by primary care clinicians, and/or telehealth-enabled models.

Consumer experience

Implementing the model of care will contribute to improve the experience and outcomes of consumers by increasing access to specialist services in their local communities.

Future state

Mary is 73 years old and visits her local GP in Moruya to discuss concerns regarding her chronic health condition. Mary's GP calls the Local Health District's Cardiology service who offer dedicated support to GPs seeking guidance on next steps. The advice service informs the GP that Mary needs her medication reviewed by a Cardiologist. The GP uses HealthPathways to identify public and private referral options for a Cardiology specialist service in Mary's community and identifies there are public and private services available, with the LHD's public cardiology service offering virtual care consultations. The GP discusses the referral options with Mary so that she can make an informed choice about where she is referred to.

Mary decides that, given the travel requirements for an in-person appointment, she would prefer a virtual consultation with the cardiologist. Mary's GP sends an electronic referral directly to the Cardiologist. Mary receives contact from the cardiology service advising that her referral has been received and expected waiting time for her appointment.

Mary schedules a virtual care appointment with the Cardiologist that she attends along with her GP from the GP's clinic. Mary, her GP and the Cardiologist develop an agreed care plan under the management of Mary's GP, with clear parameters identified for when Mary's condition would require further specialist assessment and treatment.

COORDINARE – South Eastern NSW PHN

Phone: 1300 069 002

Website: www.coordinare.org.au

Email: info@coordinare.org.au