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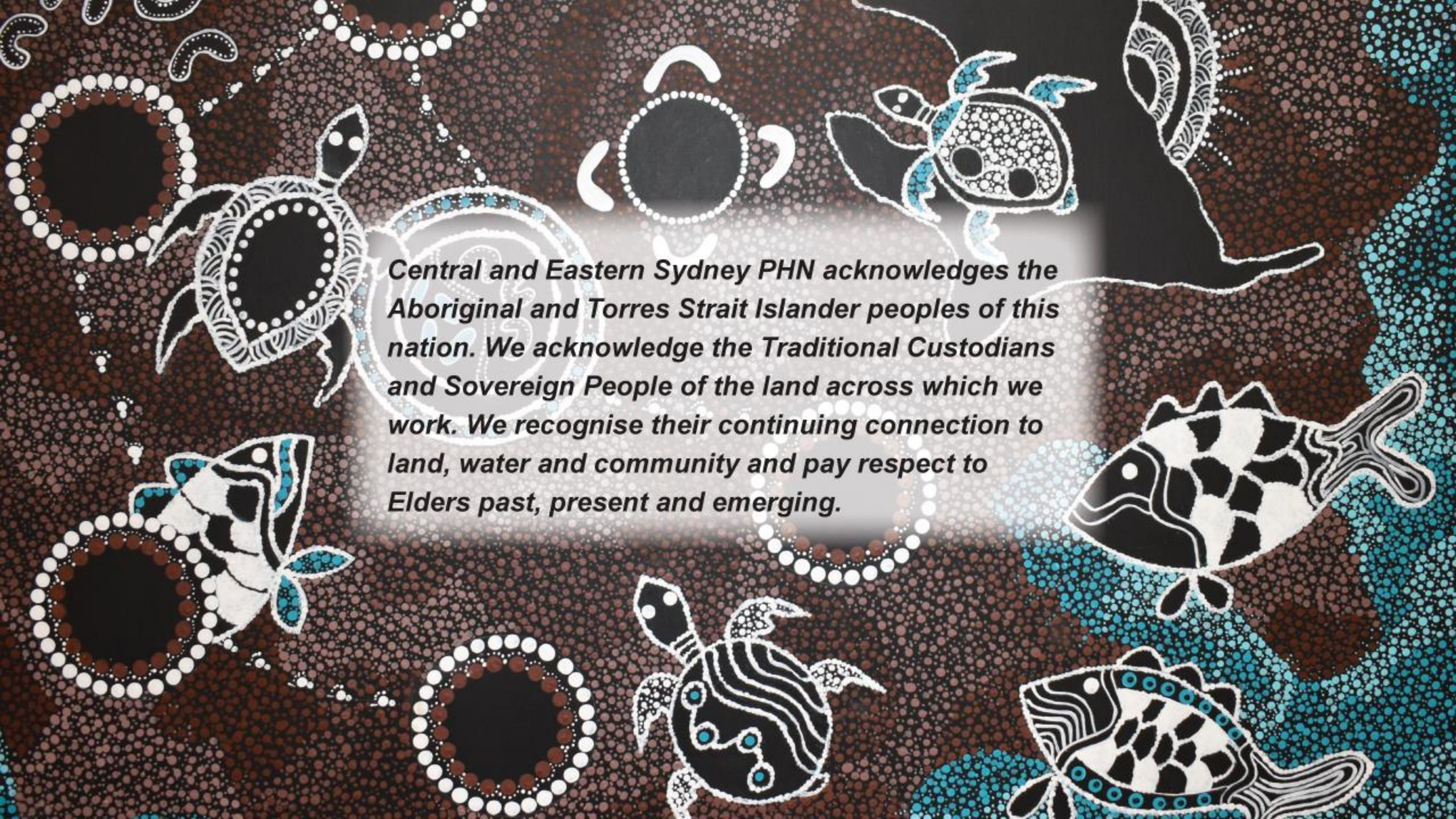
GROW
Supporting people with intellectual disability

Sunnyfield
disAbility Services

Fostering Collaboration between Primary Care and Disability sectors.

25 September 2023


Central and Eastern Sydney PHN acknowledges the Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians and Sovereign People of the land across which we work. We recognise their continuing connection to land, water and community and pay respect to Elders past, present and emerging.

Why is there a need to review how health care is provided to the person

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Higher rates of mental health conditions

A life expectancy of 54 years, 27 years less than the general population

Over 2 times the rate of hospital admissions

Higher rates of preventable health conditions

Over 2 times the rate of avoidable deaths

Longer hospital admissions resulting in higher healthcare costs

National Roadmap:
Primary Care Enhancement Program

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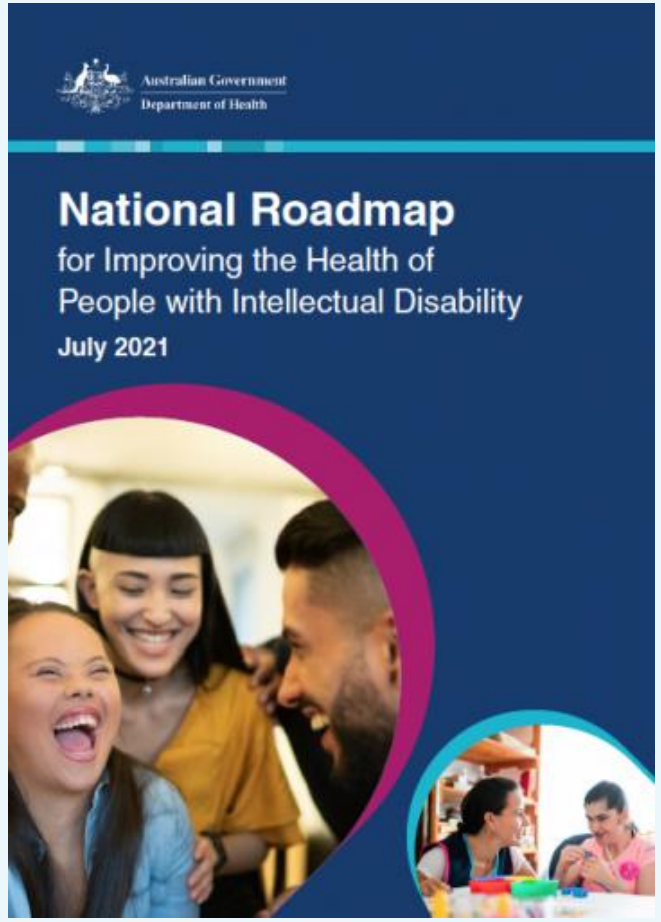
- $ Funding over 4 years (2020/21 - 2023/24)
- Four PHNs selected to pilot the development of the Primary Care Enhancement Program (PCEP)
- Council for Intellectual Disability

  Developed training and consumer resources
- Informing a potential national rollout



Differing Perspective – Primary Care Vs Disability Service Provider

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GP practices – challenges with collaboration

- Lack of health care information
- Missed appointments causing loss of income
- Increased paperwork completion
- Poor follow up of recommendations
- Insufficient time booked for appointments

Disability Service Provider – challenges with communication and access

- Lack of knowledge about how to engage with the person
- Not responding to the individuals reasonable adjustments
- Support person difficulties with health literacy
- Challenges accessing appointments
- Individual having fears and anxiety around attending health care services

Co-Design SIL provider workshops

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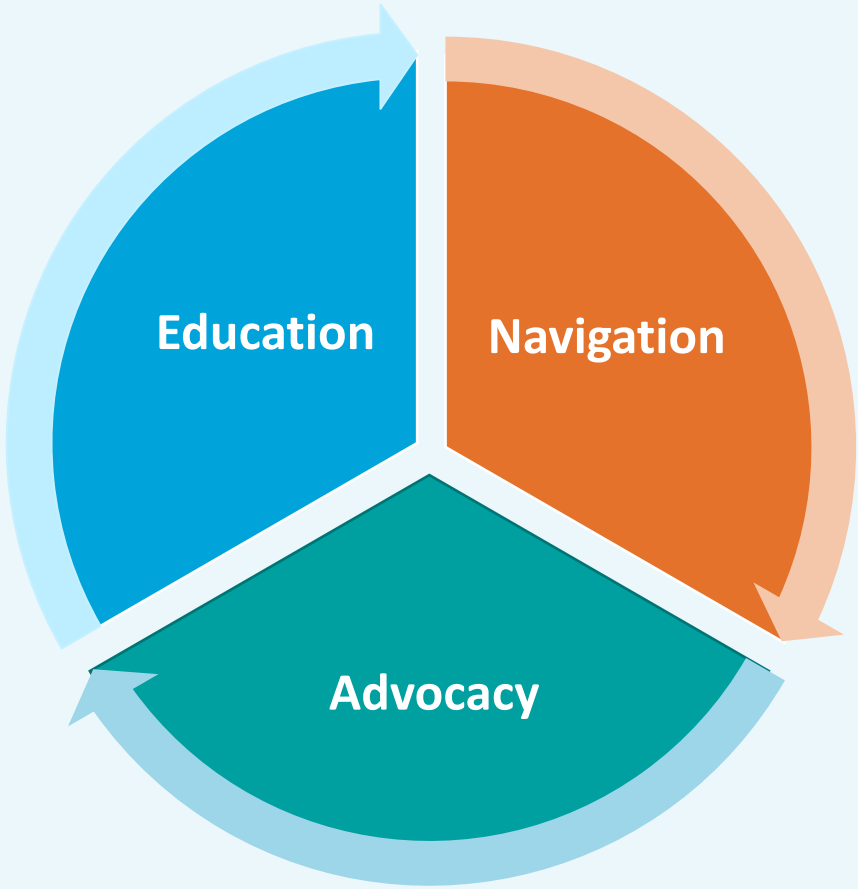
Improve primary health care for people with intellectual disability

- Improve skills of health professionals and the support workers
- Increase access to intellectual disability health resources and empower advocacy
- Promote preventative health care interventions
- Ongoing support via bi-monthly community practice

Why Annual health assessments?

- No adequate health care training being provided
- Responsible for supporting complex health needs of the individual
- Increases opportunities for collaboration for GPs and SILs to work together
- Providing a step-by-step process for each activity required to complete the annual health assessment

Principles underpinning resource development



Roles of the support team

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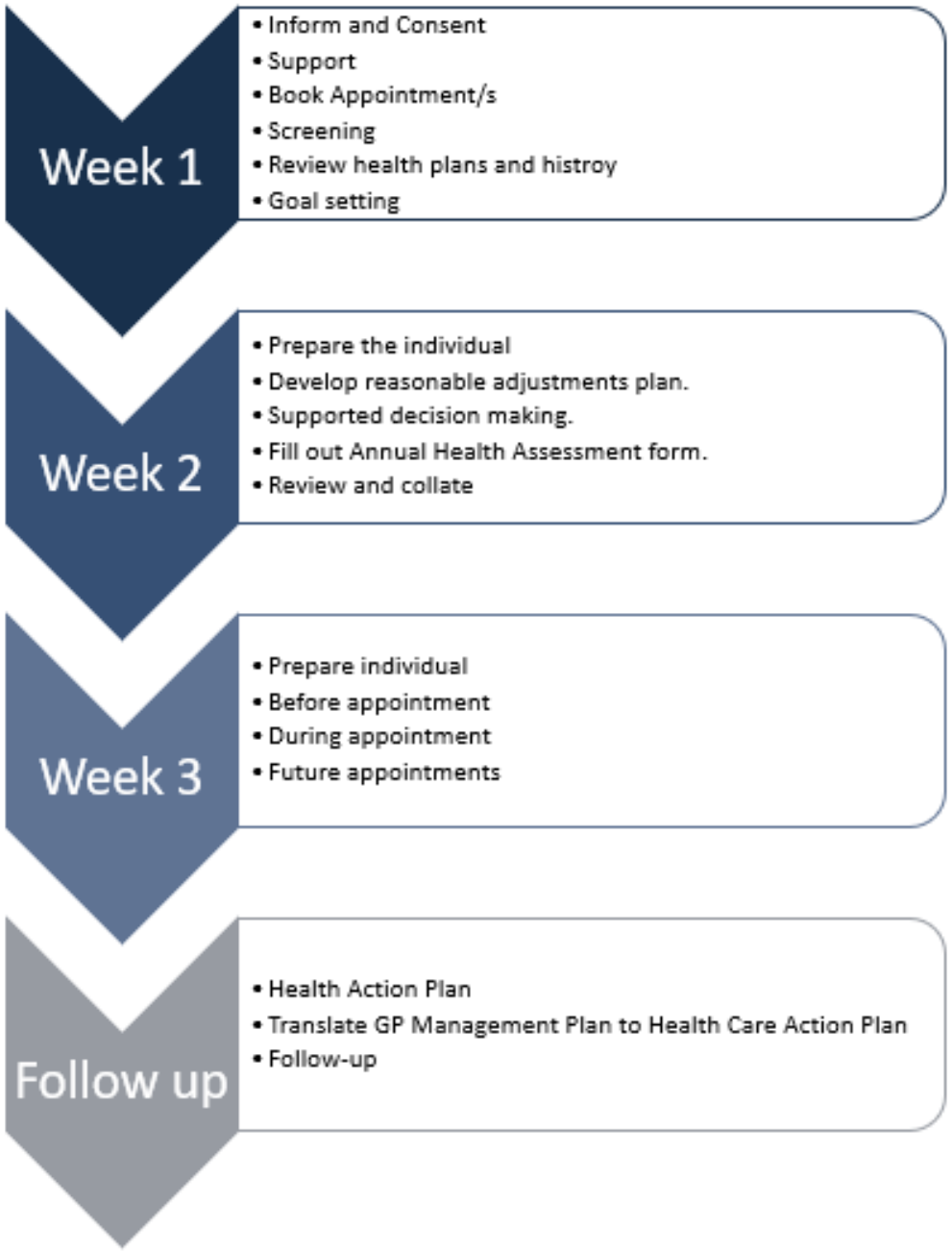
Role of Disability Support Team	• Understand the importance of knowing the person and their specific support needs. • Prepare the person for their Annual Health Assessment by supporting them to understand what the assessment is for and discussing what supports they may need throughout the process. • Inform the GP practice about the person's support needs and if reasonable adjustments are necessary for appointments. • Update the patient's health plan following the Annual Health Assessment and ensure the disability support team understands the goals and actions agreed on by the GP and the person. • Monitor the person's health, record, and report any changes to the team, the person's family/guardian and to their GP. • Know what to do in a medical emergency and seek medical help without delay.
Role of GP and GP Practice	• Understand the preventable causes of death of people living in care and take necessary action to prevent these issues. • Know the person, understand their disability and the specific health conditions related to that disability, their healthcare needs, and specific supports needs. • Make any reasonable adjustments necessary to facilitate medical appointments and interventions. • Conduct Annual Health Assessments - diagnose, prescribe, and coordinate treatment for health issues, provide guidance about medical conditions and preventative health interventions. • Refer to specialists as needed and ensure clarity around who is responsible for making appointments and following-up actions. • Understand the role of the person's support team in healthcare planning.
How GP and support team work together	• Develop a shared understanding of the person's health and support needs. • Appreciate each other's knowledge and skills, and the shared responsibility for optimising the person's health and well-being. • Support the person to participate as fully as possible during their appointment. • Seek to understand the challenges people with disability experience in the health system and work together to improve health outcomes. • Developing good relationships with all those concerned with the persons health.

Introducing the Annual Health Assessment Process



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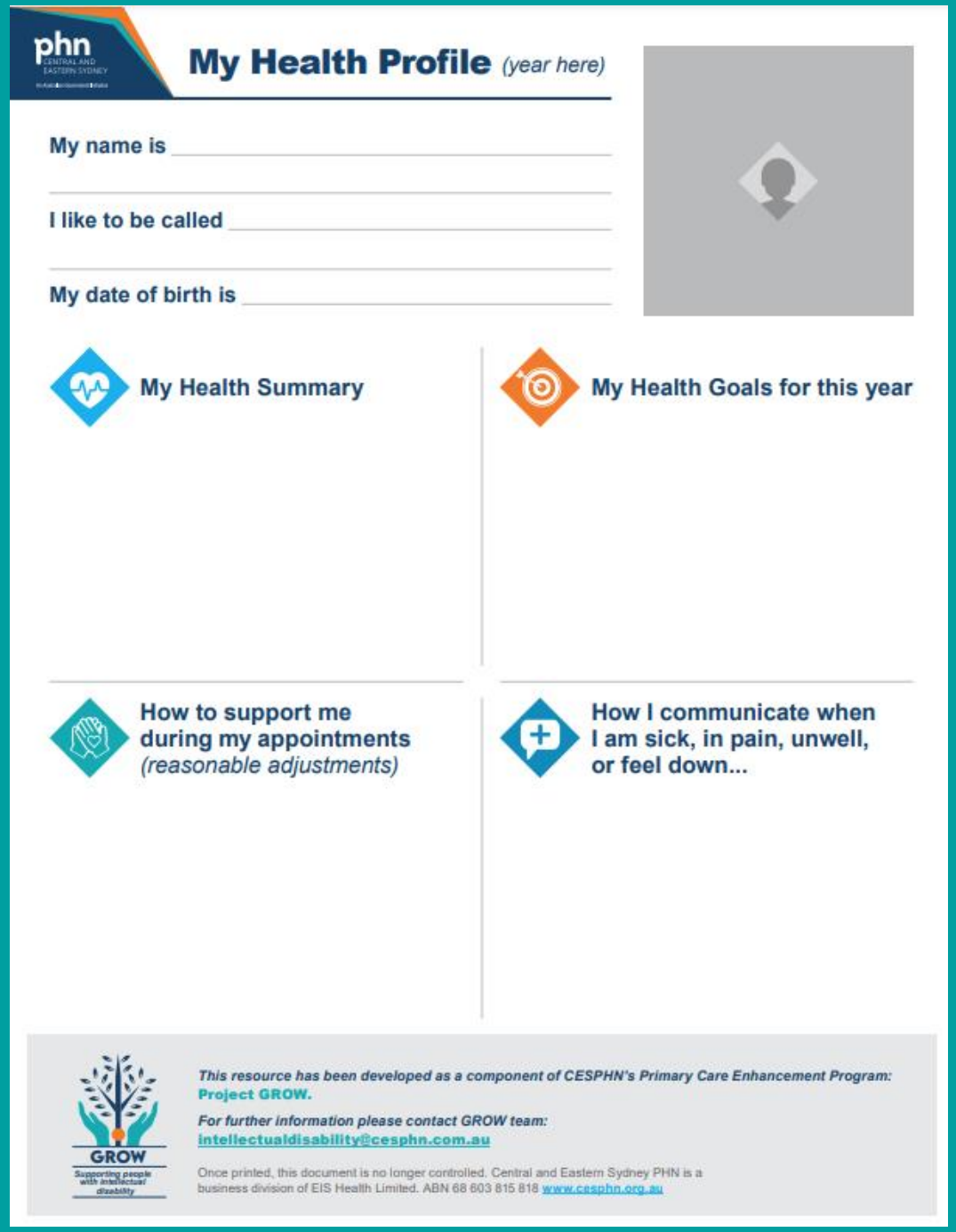

My Health Profile *(year here)*

My name is _____

I like to be called _____

My date of birth is _____

My Health Summary

My Health Goals for this year

How to support me during my appointments *(reasonable adjustments)*

How I communicate when I am sick, in pain, unwell, or feel down...

GROW
Supporting people with intellectual disability

This resource has been developed as a component of CESPHN's Primary Care Enhancement Program: **Project GROW.**

For further information please contact GROW team:
intellectualdisability@cesphn.com.au

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One Page Profile

MBS Appointment Types

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General Appointments

Appointment type	Length of time	Rationale
Standard Consultation	up to 20 mins	• For one health concern only e.g., sore throat/UTI/prescription/results. • **Not** recommended for patients with complex communication needs or complex medical problems.
Long Consultation	20 - 40 mins	• To discuss more than one health concern. • Best option for patients who have communication issues or complex medical problems.
Prolonged Consultation	>40 mins	• For very complex issues or very complex communication needs – recommend discussing with GP if this is needed before booking.
Telehealth phone-call	up to 20 mins only	Up to GPs discretion, for issues such as: • Paperwork e.g., signing of care plans/assessments – support worker can speak to the GP to explain what needs reviewing signing & can fax/email the forms to the GP to sign & they can fax/email back once signed. • Repeat prescriptions - GP can assess via phone if ongoing need/appropriate to prescribe. E-script can be sent to the patient or faxed to chemist. • Communicate results of investigations • Prior to annual health assessment or GP management plan review appointments - check whether GP requires anything to be actioned prior to the appointment.
These consultations can also be done over video call – the same length of time applies as above. The patient **MUST** be in the room when the telehealth or video call is performed & they need to give their consent for the call to take place and for the support worker to speak to the GP on their behalf (if they are unable to).		

Annual Health Assessment

Appointment type	Length of time	Rationale
Annual Health Assessment	Brief 30 mins Standard 45mins Long 45-60mins Prolonged >60mins	- Annual appointment where all the health issues are reviewed, and a plan for the year is developed. - Recommend splitting into multiple appointments as needed (according to the complexity of health issues and need for communication/reasonable adjustments). - GP can bill on the final consult for the total time spent over multiple appointments. - Should be done with the patient's usual GP. - **Face to face only**
It would be best to discuss beforehand how the GP would like you to book this in. Some GP practices may use their practice nurse to do some of the assessment.		

Health Management Plans

Appointment type	Length of time	Rationale
GP Management Plan	Generally, >20mins	• At the GP's discretion whether appropriate for the patient • The GP will review the patient's health needs and goals for the year and develops a plan with the patient to achieve these goals. • This aligns with a Health Action Plan often used by Disability Providers. • Annual appointment and should be conducted by the patient's usual GP. • Can be **face to face or video.**
Team Care Arrangement		• At the GP's discretion where appropriate for the patient and usually in conjunction with the GP Management plan. • Document will summarise the GP Management plan and is used as a referral to relevant allied health professionals.
GP Management Plan & Team Care Arrangement Review	Generally, >20mins	• Every 3-6 months (depending on complexity) • Review whether patient's goals are met or in progress and address any issues. • Recommend booking regularly and in advance to ensure health promotion & prevention is not missed. • Can be **Face to Face or by video.**
Practice Nurse Appointment		• Can be offered once a patient has a GP Management Plan/Team Care Arrangement. Discuss with GP if appropriate. • Allows up to 5 visits with the practice nurse per year. • Could be used for blood pressure/weight checks, health education etc.

Other Appointment Types

Appointment type	Length of time	Rationale
Mental Health Care Plan	>20 mins	• Plan initiated by the GP for a patient to access 10 psychology sessions with a Medicare rebate. • Initial plan gives 6 sessions. A review is then done to access the next 4 sessions. • Can be **face to face or by video.**
Mental Health Care Plan Review	>20 mins	• As above, this review is to see how the patient's mental health is going and to provide a referral for further psychology sessions. • Cannot be done until 3 months after the last plan/review. • Can be **face to face, video, or telephone call.**
Case discussion – Case Conference		• For patients with complex health needs, allows the GP to discuss care with other health professionals. • 3 health professionals need to be involved (can include SIL provider) – further information about multidisciplinary team members. • Requires patient consent & should be done by the patient's usual GP. • GP can organise this or it can be organised another health professional with the GP participating.

We’re Better together : Intellectual Disability Healthcare workshop training

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SIL provider workshop contained the following learning objectives:

- Preventative health for people with intellectual disability and roles and responsibilities of the support team
- The Annual Health Assessment (AHA) process and the Health Profile containing reasonable adjustments.
- Working collaboratively with GP’s and GP practices and understanding GP appointment types

All the sessions allowed for interactive activity and discussions with a GP advisor and a Disability Training consultant.

We're Better Together:
SIL Training Evaluation Feedback

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100% of attendees said they would recommend the training to a colleague

Feedback received on how attendees would implement the education received from the sessions

- Booking appropriate GP appointments, regular appointments to ensure continuity etc.
- Replace organisation's healthcare form with GP Management Plan for relevant clients.
- Understand client's reasonable adjustments and utilise 1-page Health Profile.
- Develop collaborative relationships with persons GP

Community of Practice (COP)

The purpose of these sessions are:

- Provide feedback on the resources and improvements that can be made
- Provide a model which supports collaboration between SIL providers
- To develop a best practice model for preventive health care
- To explore topics of interest of health care to the attendees

SIL perspective: Where to from here?

- Engage with GP practices to implement the AHA process using the resources developed
- Utilise GP Management Plans to improve GP overview of the patients ongoing health
- Ongoing education on the importance of the annual health assessment process
- Identify champions within the organisation and support them to coach other staff
- Attend the community of practice to share ideas and best practice with the different disability providers

Discussion points

- What resources have you used in GP practices to support the person with their annual health assessment.
- What are your experiences with using the GP management plan as the action plan to follow up the recommendations?
- What has been your experience in mentoring others in the team who are responsible for implementing the persons annual health assessment?

Questions

Contact details:

Jennifer Brennen – Intellectual Disability Navigator and Educator

j.brennen@cesphn.com.au

Gemma Ridley – Health Educator and Coordinator

g.ridley@sunnyfield.org.au