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Royal Australian College *of* General Practitioners

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c/ Mr Wayne Massuger
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Dear Assoc. Prof. Raven,

Re: Draft Inflammatory Bowel Disease National Action Plan 2018

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide feedback and comments on the *Draft Inflammatory Bowel Disease National Action Plan 2018* (the Plan).

The primary healthcare needs of people with inflammatory bowel disease (IBD) are significant and complex. IBD is a chronic condition that requires additional management of comorbid conditions by a multidisciplinary team.

As a patient's first point of contact and the coordinator of their care, general practitioners (GPs) are able to establish lasting and effective clinical relationships with their patients in all stages of their life. This relationship is vital for patients with complex healthcare needs such as those with IBD.

The focus on tertiary-level care does address the acute needs of people with IBD, particularly for those with more severe disease. However, most people with minor and moderate IBD will be managed in the community. The Plan's failure to recognise general practitioners in the care of patients with mild to moderate flare up of the disease is concerning.

The RACGP, therefore, recommends the plan focuses more on primary care and the role of general practice, where most of patients' healthcare is provided. This is particularly relevant to rural and regional areas, where secondary and tertiary models of chronic healthcare are least effective and available.

The RACGP provides the following comment on the draft plan.

Access to care

The plan focuses on tertiary levels of health care, emphasising the upskilling of hospital-based nurses and allied health workers; however, the plan does not adequately address issues of access. Patients require rapid, affordable access to specialist advice at the start of a flare-up of IBD. Consideration should be given not only to increasing the number of specialised practitioners, but also to the

distribution and availability of specialist services. The 'hand-back' of routine monitoring to primary care might also free up specialist resources for early intervention.

The RACGP supports a clinical help line; however, we also recommend that support is provided for telehealth services (e.g. video conferencing, online and mobile technology). Specialist outreach provided this way would improve access to care, particularly for rural and regional patients and culturally and linguistically diverse populations.

General practice–focused priorities

The RACGP welcomes the proposal to support GPs to more effectively participate in IBD management through education opportunities and clearer guidelines. Working with primary health networks (PHNs) to improve the use of systems such as HealthPathways to provide electronic clinical support would aid this.

We also believe that, as well as referral guidelines, better referral and communication pathways between GPs and specialists are required. These should ensure that communication back to referring GPs from hospital or private specialist services contains adequate information and a clear management plan.

GP management plans

Action 1B(d) proposes to "Examine MBS GPMP utilisation to allied health for IBD". It is unclear what is intended here; however, we note that the MBS Review has already examined allied health uptake and recommended changes to MBS items.

Regarding action 3(c), "Individual action plans for IBD patients", GP management plans are already individualised and include a goal-setting process between the GP and patient. It is not stated how the plans mentioned here will differ from usual GP management plans, but the RACGP would welcome discussion about how care plans can meet the needs of people with severe IBD.

Evaluation of the plan

The RACGP is concerned that the targets within many of the actions lack a focus on patient outcomes and therefore will not adequately evaluate whether the plan leads to meaningful changes for people with IBD. We recommend that evaluation of the plan includes additional measures related to patient experience of care, patient reported outcomes and clinical outcomes. We further recommend the addition of health economic evaluations and process evaluation of how this plan is implemented.

Disclosure

All authors, their affiliations, and a conflict of interest statement should be stated in this plan or available as an appendix.

Closing comments

The majority of people with IBD have multimorbidity, with chronic pain and secondary consequences of IBD being common. Greater recognition of this is needed if the Plan is to result in improved patient-centred care and outcomes.

Thank you again for the opportunity to comment. For queries on this submission, please contact Mr Stephan Groombridge, Manager, eHealth and Quality Care on 03 8699 0544 or at stephan.groombridge@racgp.org.au

Yours sincerely,

Dr Harry Nespolon
President