RACGP

# Shared Care Model between GP and non-GP specialists for complex chronic conditions

Position statement – February 2023

## 1. Position

Increasingly patients are living with multiple chronic diseases. General Practitioners (GPs), as expert generalists in the health system, provide holistic management and play a vital role in care coordination. When patients are referred for specialist care there can sometimes be a disconnect with the GP. The Shared Care Model aims to ensure that the management of co-morbidities and preventive activities remain prioritised. The Shared Care Model also allows patients to benefit from interim review between scheduled specialist visits. Shared care already happens in some settings but is not yet normalised in the management of serious or complex conditions. In this position statement specialist care is defined as care provided by non-GP specialists on referral.

**The RACGP:**

- believes all people benefit from having regular contact with a GP, especially people with complex needs who also access non-GP specialist medical care.
- supports Shared Care pathways, such as protocols between GPs and non-GP specialists, which should be established and embedded in practice to improve care for people with complex chronic conditions.
- proposes that funding for information technology (IT) infrastructure and care coordination services, to better support a system of Shared Care for complex conditions, is required.

## 2. Definition

Shared Care Model is where there is joint responsibility for planned care that is agreed between healthcare providers, the patient and any carers they would like to engage. [1] The Model provides improved quality and continuity between services by clearly delineating roles and responsibilities for the multidisciplinary team; having structured management plans; providing clear communication channels for access to prompt help; is informed by an enhanced information exchange and advice between healthcare providers and patients; and has access to unscheduled review by specialist teams when the need arises. [2-5]

The Shared Care Model presents an opportunity for people to receive the benefits of specialist intervention combined with continuity of care and management of comorbidity provided by generalists, who maintain responsibility for all aspects of the patient's health care beyond the specified chronic disease. [6] Benefits of the Shared Care Model include reductions in hospital admissions related to specific conditions which drives cost savings to the health system;[5-6] improved patient health outcomes; higher levels of follow-up care and patient adherence to treatment.[7] The model aligns with the RACGP Vision of patient centred medical homes.

Appendix A provides an example of a Shared Care arrangement between a GP and non-GP specialist for a person who has developed Schizophrenia.

# 3. Background

Traditional primary care encompasses a whole-person approach to care including preventive health, management of acute medical needs, assessment and management of chronic diseases and multimorbidity. [8-10] People who develop complex, chronic conditions are often referred to one or more non-GP specialist teams to support their care. The healthcare providers responsible for different aspects of care are often unclear to the patient at this point, so there is a risk of care fragmentation. There is a missed opportunity to share and coordinate the monitoring and management of complex conditions between the GP and non-GP specialist.

Effective and efficient long-term management of complex, chronic diseases is one of the greatest health-related challenges facing patients and health professionals.[9] In 2018-2019, the disease groups that caused the most burden on health were cancer, musculoskeletal conditions, cardiovascular diseases and mental & substance use disorders. They accounted for 35% ($47 billion) of the total national health expenditure ($133.9 billion).[11]

Evidence from Lumos [12] data in NSW demonstrates the benefits of GP access to reduce hospital readmissions and in the management of chronic diseases. The data showed that a GP visit within the first week of hospital discharge was followed by 7% fewer readmissions within 28 days, while a visit in the first four weeks was followed by 13% fewer readmissions over the following 1–3 months. Unplanned readmissions are estimated to cost Australia in the order of $1.5 billion annually. Reducing avoidable hospital readmissions supports better health outcomes, improves patient safety and leads to greater efficiency in the health system. [13]

Integration of health care using the Shared Care Model has been suggested as an effective option to efficiently coordinate and support continuity of care across different services. [14] Shared Care Models are patient centred and establish collaborative goals with the patient and health providers. Clinical handover between health providers is crucial for the success of the model. [13-15] Well-coordinated care will result in cost savings by reducing duplication of scarce health resources and reducing potentially preventable hospital admissions. [5-6]

# 4. Key Principles

### General practice at the centre of Shared Care

Shared care arrangements are not new in Australia. They are in place in aspects of healthcare where non-GP specialists and GPs need to work together and where patient or consumer engagement is recognised as essential to good healthcare and health outcomes. Some examples of existing Shared Care Models include antenatal shared care, cancer, and diabetes. [1, 6, 16,17] In these models GPs and non-GP specialists have developed tailored protocols that usually include a schedule of visits with defined roles for each provider. GPs are at the centre of these models so that patients have continuity of care across the different settings, and co-morbidities for their complex chronic conditions can be monitored and managed with non-GP specialist support. Evidence shows ongoing patient care with a local GP has higher levels of follow-up [18] and adherence to treatment such as medications [2], supports patients' independence [19-21] and reduces barriers to care in rural Australia where access to non-GPs is limited. [22] It is important that patients, GPs and other providers are both aware of Shared Care arrangements and agree to be involved.

Barriers to the Shared Care Model include poor communication and lack of clarity around healthcare provider roles in shared care [13, 15], limited opportunities for information sharing (including radiology and pathology results), a lack of current established pathways for communication or direct referrals,[13] a lack of continuous care coordination for patients and practical limitations to case conferencing in general practice.[13] Often health professionals are unclear about the capacity of other providers to perform monitoring and patient-management tasks.

### Communication and information exchange

Models of shared care have failed because of poor communication and lack of clarity around healthcare provider roles.[13, 15] Formalised agreements, such as shared care protocols, should be established to provide evidence-based, safe and efficient patient care. Shared care protocols support communication between GPs, non-GP specialists, the patient and

their carer, define roles and responsibilities and outline the frequency and nature of monitoring or follow-up. These agreed roles will differ according to the local context and capacity of each healthcare provider. There is also a need to avoid shared care protocols leading to duplication of visits and an increase in treatment burden for patients.

Greater use of secure messaging platforms and use of accessible shared care plans are required to ensure GPs and non-GP specialists have timely access to relevant patient information. [15] While My Health Record is a tool that aims to streamline sharing of patient health information, it is not a communication tool for direct communication between healthcare providers.[24] Current Medicare Benefits Schedule (MBS) arrangements also fail to adequately support direct communication between members of the healthcare team leading to an over reliance on periodic letters or waiting for MBS-funded consultation visits.

### Intercollegiate clinical practice guidelines

Interprofessional collaboration will ensure that evidence based clinical practice guidelines are free from bias and able to be implemented across different health sectors. Interprofessional collaboration is also required to develop protocols for Shared Care Models. [4] The RACGP advocates for investment in the development of intercollegiate clinical practice guidelines to actively integrate and facilitate evidence-based care between GPs and specialist services.

### Care coordination

For some people with complex care needs, successful coordination of care is supported by a trusted case manager or nurse coordinator. [2, 25] In all cases there is a need to support the work of care coordination through a combination of funding models, shared clinical records, IT infrastructure and the use of recalls and reminders. Practice nurses are well positioned to assist in these tasks but their services are currently underfunded.

Significant practical limitations exist when case conferencing between GPs and the wider healthcare team is needed. Funding and support for asynchronous case conferencing will enhance the effectiveness of shared care.

### Continuity between services

Shared care relies on continuity across health providers therefore, primary health networks (PHNs) and local health and hospital networks and districts (LHN/Ds) have a key role in supporting the structure and delivery of new Shared Care Models. Existing local care pathways (such as Health Pathways) [26] that are supported by these services need to enhance information sharing and communication across linked information platforms.

## Conclusion

This position statement outlines proposed solutions to existing barriers in Shared Care so that all people with complex chronic conditions can benefit from GPs working in coordination with non-GP specialist teams to manage their condition. It highlights the importance of shared care pathways, communication and information exchange, the need for intercollegiate clinical practice guidelines, improved care coordination and continuity between services. Health professionals alone cannot bring about sustainable change without health system improvements to support them. By establishing more appropriate funding, IT infrastructure and shared care pathways (such as protocols) for care between GPs and non-GP specialists, patients with complex, chronic conditions will achieve better health outcomes.

# 5. References


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# Appendix A

## Vision for Shared Care - example for a person who develops schizophrenia