CHAPTER 15

SUMMARY AND IMPLICATIONS FOR COMMUNITY HEALTH CARE

15.1 Summary of studies within the thesis

The series of studies in this thesis has explored the contribution of rehabilitation principles for multidisciplinary care and management plans in community health care. These studies have all been performed in the community health care sector. The goal of an integrated community health system working in a continuum of care with acute hospital services has been informed by results from these studies. Aspects of the four compartments of acute, subacute, outpatient and maintenance care are summarised in the following sections.

15.2 Acute care studies

The Macarthur Model for ambulatory services was implemented in 2000 (Chapter 4). The studies of service delivery costs and quality have demonstrated that an alternative to acute hospital care may be suitable for selected groups of patients currently admitted to hospital. This study has revealed that some diagnoses are more suitable than others for acute care in the community. These diagnoses such as tissue infections and both acute and chronic respiratory infections have also been shown to be associated with decreased costs of health care with similar or reduced adverse event indicators compared to equivalent hospital care (Chapters 6 and 7).

15.3 Medical communication

The study of methods of communication from hospital to community health care providers uncovered a range of flawed systems still in practice (Chapter 11). The use of hand-written discharge summaries should be abandoned as this study has revealed that less than one third of these summaries reach the patients' GPs. The summaries that reach the GP have information of value in less than half of the

cases. This study when completed resulted in a local introduction of an automated electronic (fax or email) notification system to GPs.

The study of video communication between medical, nursing and allied health professionals at distant sites was associated with staff satisfaction for the management of patients by a multidisciplinary team (Chapter 5). New evidence provided from this randomised controlled trial demonstrated improved communication in relation to patient care through audio and visual means when compared to audio alone.

15.4 Compartment theory and hospital care

The RCT of subacute home-based rehabilitation cases did not progress as expected, with only a small sample recruited (Chapter 8). This study when combined with a larger sample in a descriptive study has introduced new concepts about compartments of health care. The home-based rehabilitation service was designed as a substitute for subacute care. This was similar in design to the Macarthur Model which substituted for acute care. This subacute model was unsuccessful in its operation other than providing an extra period of rehabilitation in the community which may not have been necessary.

The descriptive part of this study suggested that a number of patients, who would have been transferred from an acute hospital bed to a subacute bed, were managed safely on a home-based program (Chapter 9). Those patients who were admitted to the subacute compartment of care continued to have the same treatment length of hospital stay as those not referred for home-based rehabilitation. This finding may also apply to acute care where patients may be

"trapped" into an episode of care. This implies that post-acute and post-subacute care are merely services adding to and not replacing those compartments.

15.5 Outpatient randomised controlled trial

The RCT of multidisciplinary care planning for hospital physiotherapy and occupational therapy outpatients demonstrated that more issues were considered by a multidisciplinary team than an individual therapist (Chapter 10). This realisation did not significantly influence therapists' behaviour other than demonstrating a modest increase in referrals to other health providers.

The design of this study did not engage the treating therapist directly in the care planning conference. It may be that active involvement of the therapist and the patient in planning—rather than the passive approach tested—may be more effective. A different approach was applied in the final stage of this thesis involving GP case conferencing where active involvement of the treating multidisciplinary team and patient was required.

15.6 Improved maintenance care

An observational study of patients admitted to hospital with chronic airflow limitation identified again the problems of hospital-to-GP communication (Chapter 12). GPs did not appear to be involved in acute exacerbations of their patients' chronic conditions. This study suggests that the level of hospital care offered to many of these patients could have been provided in a community setting if services had been available.

A service gap was identified for patients with chronic conditions. This was the availability of acutely responsive personal care for home support of acute and intermittent exacerbations of illness. A pilot service was designed and implemented and studied as part of this thesis (Chapter13). The study showed successful indicators for responsiveness of the service and quality of care following episodes of acute hospital care. Less than half of the clients required long-term maintenance care. This study identified a gap in the continuum of hospital-to-community care services, and the need for interim personal care for people with chronic and complex conditions.

GPs have been involved in several sections of this thesis. The home-based rehabilitation project demonstrated a willingness on the part of GPs to attend education sessions to enhance their skills in multidisciplinary care. A multifaceted education program for multidisciplinary case conferencing was designed, implemented, and studied through Health Insurance Commission data sources (Chapter 14). This education intervention resulted in a significant increase in GP case conferencing for chronic and complex patients.

15.7 Dissemination of research through the media

The development of the Macarthur Model for ambulatory services was considered an innovative shift in thinking from traditional health care in 1999. The ABC Health Report conducted interviews which were released on Radio National in September 1999 (Appendix 4). This media interest may have influenced opinion of local senior medical staff to support this research. The radio interview was soon followed by a Channel 9 network story on the program "A Current Affair". This resulted in interest from a range of health providers, and

three separate Health Districts requested consultation with their Boards or senior management to consider duplicating the service in other health areas. It is an interesting observation that health professionals appeared to be more informed by the powerful influence of the media than the release of subsequent papers in refereed journals.

The Commonwealth Department of Health and Ageing decided to promote the service for "Discharge from Hospital Care Planning by GPs", which also had a designated Medicare item number. It is likely that the successful EPC training study was responsible for the author being invited to record an educational item on an audio tape/CD sponsored by the Department of Health and Ageing to disseminate information to GPs. This CD was distributed to most GPs in Australia.

15.8 Contribution of this thesis to changes in community medicine practice

The NSW Minister for Health invited the author to attend a meeting at his offices with the Director General of Health in May 2004. The outcomes from studies within this thesis were presented. The Director General of NSW Health subsequently published an amendment to section 69 of the Health Service Act 1997 in the NSW Government Gazette October 2004 [183]. This amendment established a bed day rate for acute outreach services in NSW Public Hospitals. The Macarthur Ambulatory Care service was at the time the only Commonwealth-accredited private outreach service in NSW and thus the only beneficiary of this legislation.

The Commonwealth Department of Health and Ageing invited the author's participation as a member of their pre- and post-hospital-care Clinical Reference Group based on experience and studies in this area of practice during 2002. This work indirectly informed the Australian Health Care Agreement Reference Group on pre-and post-hospital care. This group recommended to the Australian Health Ministers' Conference among other things that there should be an expansion of existing models of care such as case management to avoid unnecessary hospital admission. It also suggested that more GPs should be involved in care planning, case conferencing, and health assessments. This may have eventuated through a new range of item numbers released in 2004 under the title "Medicare Plus", which also funds up to five allied health interventions for chronic care patients with a GP-generated care plan.

The development of new Medicare item numbers and financial incentives did not initially engage GPs in multidisciplinary care. The successful participation of GPs presented in this thesis was achieved for the home-based rehabilitation and enhanced primary care planning projects through other means. The successful approaches involved improved communication by GPs with a range of other health providers. Education of GPs about the skills and roles of other health professionals preceded the research interventions. Commitment to education and simple systems of communication was associated with a change of relationships between the various providers of care.

NSW Health extended an invitation to contribute to the Telehealth steering committee as a result of published research into medical communication contained within this thesis. During 2004, progress had been made in the funding

of four rural sites for the use of digital cameras and video conferencing to enhance chronic wound care. Much of the NSW work in relation to community nurses and allied health using Telehealth was pioneered in the MACS service established through this study[184]. It is likely that the RCT of audiovisual conferencing has encouraged investment in these new methods of remote management.

The rehabilitation team approach explored in this thesis has much to offer all compartments of health care. The challenges to the health care environment of the future are those of an ageing society with disability demanding best practice from a limited workforce of health professionals. This will require new models of community care, based on rehabilitation concepts. The traditional hospital centred systems are not able to respond to these demands, and the solutions may only be found in a more specialised and integrated community health care system.