national allergy strategy

SCOPING A SHARED CARE MODEL FOR ALLERGIC CONDITIONS

STAKEHOLDER CONSULTATION

BACKGROUND INFORMATION PAPER

MARCH 2019

INTRODUCTION

Allergic conditions include

- food, insect and drug allergies (including life threatening severe reactions called anaphylaxis),
- allergic asthma,
- allergic rhinitis (hay fever), and
- atopic dermatitis (eczema).

One in five Australians (4.1 million people) have an allergic condition, and this prevalence is increasing[1].The presentation of allergic conditions are becoming more severe and more complex. It is common for patients to have disorders affecting several systems (multi-system allergic disease). For example, a child with peanut allergy often also has eczema, rhinitis and asthma.

Every Australian with an allergic condition needs timely access to evidence-based advice and management, together with effectively coordinated healthcare and support, as close as possible to where they live. That is, *"the right care, at the right time, from the right health professional(s), in the right place."*

The National Allergy Strategy is an initiative of the Australasian Society of Clinical Immunology and Allergy (ASCIA) and Allergy & Anaphylaxis Australia (A&AA) and was developed in 2015 in consultation with 57 stakeholder groups and organisations, representing consumers, health professionals, government and industry. The National Allergy Strategy identifies gaps with existing allergy care in Australia and provides a coordinated plan to guide future actions that will improve the health and quality of life of Australians with allergic conditions and minimise the burden of allergic conditions on individuals, their carers, healthcare services and the community[2].

The National Allergy Strategy proposes that a shared care model approach may be required to improve access to care. In 2018, the National Allergy Strategy received funding from the Australian Government Department of Health to scope a shared care model for the management of allergic conditions in Australia. The proposed strategy is to scope the requirements for a shared care model for allergy to determine:

- how to improve access to care for people with allergic conditions, particularly those in rural and remote areas, and
- the allergic disease education requirements for health care professionals, particularly those in primary care.

Introducing new approaches to care or redesigning services is challenging and can only be achieved in close consultation with stakeholders and with a patient (and their carers) focused approach. Appendix A includes a list of stakeholder organisations and potential partner organisations that will be consulted with as part of this project. Appendix B outlines the purpose of an online consultation undertaken in February 2019 as the first phase of consultation for this project.

This background document explains access to care issues for people with allergic conditions in Australia, and why a shared care model is being considered. It is suggested that you read the information in this background document before participating in the consultation process.

ACCESS TO CARE FOR ALLERGIC CONDITIONS

> "Equity in access: For everyone, everywhere to access the quality health services they need, when and where they need them" – World Health Organisation (Framework on integrated people-centred health services)

People with allergic conditions need access to appropriate care by trained and knowledgeable health professionals. However, not all services are available in all areas, and an individual's right to health care may be limited by his or her geographic location and the available health services. Access to private healthcare services can require payment and may not be affordable. In some circumstances patients may need to travel or wait to receive the health care services they need[3].

Access to care for people with allergic conditions has room for improvement. The prevalence of allergic conditions in Australia is rapidly increasing. Hospital admissions for anaphylaxis have increased 4-fold in the last 20 years[4, 5]. Ten percent of Australian infants now have a proven food allergy[6]. The increasing burden of allergic disease (and new cases of childhood food allergy in particular), has led to higher demand for assessment by a clinical immunology/allergy specialist and subsequent need for review appointments and hospital based challenges to determine development of tolerance. There is a shortage of clinical immunology/allergy specialists in Australia, and an insufficient number of trainees[7]. Most specialists and specialist services are based in cities but one third of Australia's population lives outside its major cities.

The impact of this for patients is long waiting lists to access specialist care for allergic conditions. A survey by ASCIA showed the average wait for a routine food allergy appointment exceeds 6 months throughout Australia and is currently more than 12 months in some regions[7]. Delays in diagnosis and management can result in:

- unnecessary diet restrictions and impaired quality of life,
- suboptimal follow up after anaphylaxis ,
- potentially preventable hospitalisations,
- risk of serious adverse events, and
- patients seeking advice from alternative/unorthodox health practitioners[2].

As part of the stakeholder consultation, the National Allergy Strategy is seeking to better understand access to care issues from both the consumer and health care professional perspectives. How do we improve access to care for people with allergic conditions, particularly those in rural and remote areas?

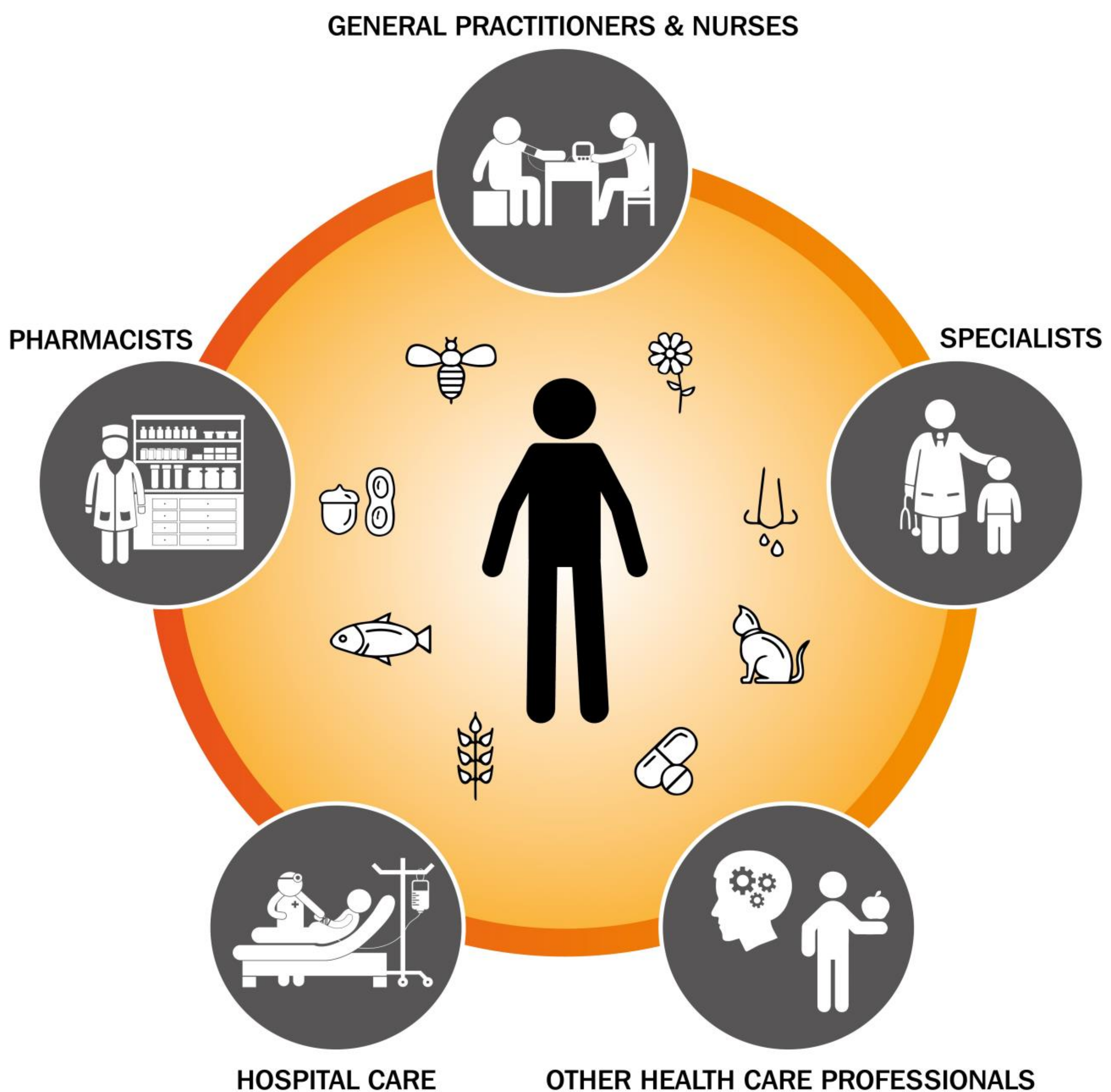
The National Allergy Strategy access to care goals [2]:

- People with allergic conditions will have timely access to best-practice and evidence-based advice and therapy, together with effectively coordinated healthcare and support, as close as possible to where they live.
- People with complex allergic diseases will have access to a multidisciplinary team of appropriately skilled health professionals (virtual or actual), both in community and in hospital settings according to need.
- Health services for people with allergic conditions will be developed and evaluated in collaboration with people with allergic conditions and/or their carers.

SHARED CARE

A shared care model is proposed to improve access to care for people with allergic conditions in Australia. For the purpose of this consultation the National Allergy Strategy simply describes a shared care model as a patient centred approach to care that uses the skills and knowledge of a range of health professionals who share joint responsibility with the patient ensuring the patient receives the right care, at the right time, from the right health professional(s), in the right place.

Figure 1. A SHARED CARE MODEL FOR ALLERGIC CONDITIONS



In the Australian context, shared care has been implemented in follow-up cancer care, antenatal care, paediatric populations, diabetes, hepatitis B and C, chronic eye disease and mental health. Shared antenatal care for example provides pregnant women with flexibility, choice and continuity of care, while enhancing the skills of GPs and promoting better communication between GPs and the antenatal clinic. An additional benefit is reduced workload for antenatal clinics[8]. For women with breast cancer, follow up care provided by a GP has been found to be a safe and effective alternative to specialist follow up with no difference in survival outcomes, breast cancer recurrences or serious clinical events[9].

Shared care models in Australia usually involve primary health care as it is the first point of contact people have with the health system. Primary health care plays an important role in the prevention, management and appropriate referral of patients with allergic conditions. There are also many other health care professionals such as pharmacists, paediatricians, physicians, nurses, dietitians and psychologists involved in the care of people with allergic conditions.

It is acknowledged that the practical arrangements of shared care will need much consideration. Key issues to be addressed include referral guidelines and the up-skilling of health care professionals to improve the local provision of care while retaining quality.

As part of the stakeholder consultation, the National Allergy Strategy is seeking to better understand whether a shared care model for patients with allergic conditions could improve access to quality care. What are the education and training requirements for relevant health care professionals, particularly those working in primary care?

The stakeholder consultation process for this project involves three phases:

- Phase 1 – Online consultation (completed February 2019)
- Phase 2 – Face to face consultation (April 2019)
- Phase 3 – Targeted consultation

APPENDIX A – STAKEHOLDERS

Allergy & Anaphylaxis Australia (A&AA)
Australian Support Network for Eosinophilic Oesophagitis (AusEE)
Australasian Society of Clinical Immunology and Allergy (ASCIA)
Australia and New Zealand Rhinologic Society (ANZRS)
Australian and New Zealand Anaesthetic Allergy Group (ANZAAG)
Australian Association for Adolescent Health (AAAH)
Australian College of Dermatologists (ACD)
Australian College of Nursing (ACN)
Australian College of Health Service Management (ACHSM)
Australian College of Rural and Remote Medicine (ACRRM)
Australasian College for Emergency Medicine (ACEM)
Australian Commission on Safety and Quality in Health Care (ACSQHC)
Australian Digital Health Agency
Australian General Practice Accreditation Limited (AGPAL)
Australian Healthcare and Hospitals Association (AHHA)
Australian Medical Association (AMA)
Australian Paediatric Society (APS)
Australian Primary Health Care Nurses Association (APNA)
Australian Private Hospitals Association (APHA)
Australian Psychological Society (APS)
Australian Resuscitation Council (ARC)
Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS)
Centre for Food & Allergy Research (CFAR)
Consumers Health Forum of Australia (CHF)
Council on the Ageing (COTA)
Council of Remote Area Nurses of Australia (CRANA)
Day Hospitals Australia
Department of Health Northern Territory
Department of Health Queensland
Department of Health South Australia
Department of Health Tasmania
Department of Health Victoria
Department of Health Western Australia
Dietitians Association of Australia (DAA)
Eczema Association of Australia (EAA)
Health Care Consumers' Association Inc
Maternal, Child and Family Health Nurses Australia (MCFHNA)
Medical Deans Australia and New Zealand
National Aboriginal Community Controlled Health Organisation (NACCHO)
National Asthma Council Australia (NAC)
National Health and Medical Research Council (NHMRC)
National Prescribing Service (NPS MedicineWise)
NSW Ministry of Health
Pharmaceutical Society of Australia (PSA)
Pharmacy Guild of Australia (PGA)
Primary Health Networks
Royal Flying Doctors Service

Rural Doctors Association of Australia (RDAA)
Society of Hospital Pharmacists of Australia (SHPA)
St John Ambulance Australia
The Australian Council on Healthcare Standards (ACHS)
The Australasian Mastocytosis Society (TAMS)
The Royal Australian College of General Practitioners (RACGP)
The Royal Australasian College of Medical Administrators (RACMA)
The Royal Australasian College of Physicians (RACP)
The Society of Hospital Pharmacists in Australia (SHPA)
The Thoracic Society of Australia & New Zealand (TSANZ)

APPENDIX B – PURPOSE OF THE ONLINE CONSULTATION

Overall goal of stakeholder consultation:
Understand issues with the current delivery of allergy care in Australia from both the consumer and health care professional perspectives, and whether shared care and/or other solutions could help address those issues.

Purpose of the online survey

1. Understand how allergy care is currently delivered, and what gaps and local variation exist in access, quality, education and training.
2. Gather as many views and perspectives as possible from health care professionals, patients/consumers, health administrators, educators and researchers about a) whether they believe there is a problem with the delivery of care for people with allergic conditions, and b) whether shared care (and education and training support to go with it), could improve access to quality care for people with allergic conditions.

How the information will be used

From the online survey we will:	With which we can…
Identify whether there is an access issue, and where the access issue is more pronounced (e.g. children vs. adults; metro vs. rural; one allergic condition vs. all allergic conditions).	Guide possible solutions to those access issues, including where shared care arrangements and/or advancing scope of practice might be more effective.
Identify what types of education and training different health professional groups, consumers, patients and their carers require.	Develop an education and training strategy that could support the implementation of shared care and/or advancing scope of practice.
Identify what decision-making support tools (including referral guidelines) are currently being used.	Support the development of national standards (to measure quality), guidelines and protocol templates that are adaptable by state/territory and could be used in shared care arrangements.
Understand the patient experience, and what patients value most when accessing and receiving care for allergic conditions.	Guide the development of a patient-centric model of care for allergic conditions; put patients at the centre when developing national standards (to measure quality), guidelines and protocols.
Gather perspectives on shared care including perceived benefits and challenges of implementing a shared care model.	Understand and further explore these perspectives, draw into a discussion document for the face to face facilitated discussions in April.

REFERENCES

1. Mullins, R. and e. al, *The economic impact of allergic disease in Australia: not to be sneezed at*. 2007: ASCIA/Access Economics
2. *National Allergy Strategy - improving the health and quality of life of Australians with allergic disease*. 2015.
3. Australian Commission on Safety and Quality in Health Care, *Australian Charter of Healthcare Rights*. 2008.
4. Mullins, R., K. Dear, and M. Tang, *Time trends in Australian hospital anaphylaxis admissions in 1998-9 to 2011-12.* J Allergy Clin Immunol, 2015. **136**(2): p. 367-75.
5. Poulos, L., et al., *Trends in hospitalizations for anaphylaxis, angioedema, and urticaria in Australia, 1993-1994 to 2004-2005.* Journal of Allergy and Clinical Immunology, 2007. **120**(4): p. 878-884.
6. Osborne, N.J., et al., *Prevalence of challenge-proven IgE-mediated food allergy using population-based sampling and predetermined challenge criteria in infants.* J Allergy Clin Immunol, 2011. **127**(3): p. 668-76.e1-2.
7. Australian Society of Clinical Immunologya and Allergy, *Immunology and Allergy Workforce Issues ASCIA Repsonse to RACP* 2012.
8. Lucas, C., et al., *Review of patient satisfaction with services provided by general practitioners in an antenatal shared care program.* Aust Fam Physician, 2015. **44**(5): p. 317-21.
9. Grunfeld, E., et al., *Randomized trial of long-term follow-up for early-stage breast cancer: a comparison of family physician versus specialist care.* J Clin Oncol, 2006. **24**(6): p. 848-55.