national allergy council

SHARED CARE MODEL PROJECT

PROJECT OVERVIEW

NOVEMBER 2022

This project overview explains access to care issues for people with allergic conditions in Australia, and why the National Allergy Council is progressing a shared care model project. It is suggested that you read the information in this document before participating in one of the working groups or the stakeholder consultation process.

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BACKGROUND

One in five Australians (4.1 million people) have an allergic condition, and this prevalence is increasing[1]. 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).

Ten percent of Australian infants now have a proven food allergy[2]. 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[3]. 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 between 6 months to 2 years. 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.

The National Allergy Council (NAC) is a partnership between the Australasian Society of Clinical Immunology and Allergy (ASCIA) and Allergy & Anaphylaxis Australia with a mission to improve the health and quality of life of Australians with allergic disease.

In 2019 the (then) National Allergy Strategy scoped a shared care model for allergy, involving three rounds of stakeholder consultation over an 18-month period. The overall goal was to:

- understand the issues regarding access to care for allergic diseases, particularly for rural and remote consumers
- develop a consensus definition of shared care (page 3)
- agree on a set of shared care principles (Appendix A), and
- formulate possible solutions to improve access to care (reduce wait times) without compromising the quality of care being received.

The scoping report proposed 15 recommendations for improving access to care in the areas of:

- education and training for health professionals
- scope of practice
- standards of care, and
- interdisciplinary teamwork and connectivity.

The NAC has been successful in securing funding from the Australian Government Department of Health (2023-2026) to progress a shared care model project with the aim of improving access to quality allergy care, particularly for people living in rural and remote areas. The term 'rural and remote' encompasses all areas outside Australia's Major cities [4].

SHARED CARE

A shared care model is described 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.

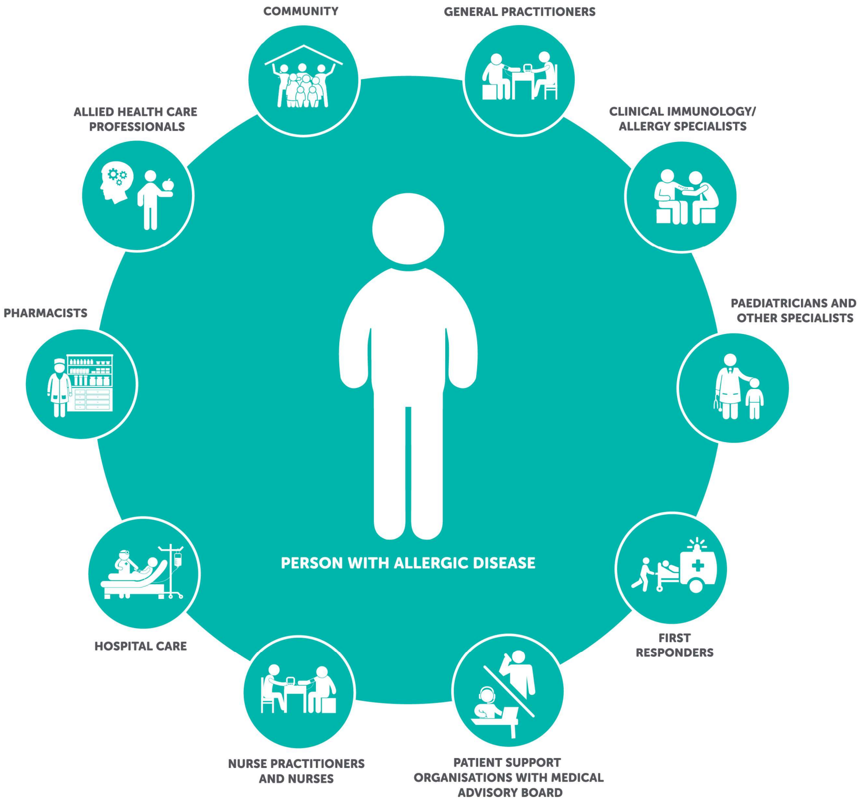
Right care - Standards of care for the diagnosis and management of allergic diseases which will help to define what quality allergy care looks like.

Right time – A multidisciplinary shared care approach and more connected healthcare for rural and remote areas and other solutions to reducing wait times so that people can access timely care.

Right health professional(s) - People with complex allergic diseases should have access to a multidisciplinary team of appropriately trained health professionals. Consumers need help to find these health professionals.

Right place – Care is delivered in the right place (virtual or actual), both in a community and hospital setting according to their needs.

Shared care model for allergic diseases



PROJECT PLAN

An overarching shared care model project working group co-chaired by Dr Katie Frith (representing ASCIA) and Ms Maria Said (AM) (representing Allergy & Anaphylaxis Australia) is being established to provide strategic oversight and direction across all components of the project and will report to the National Allergy Council Advisory Group. There will also be sub-groups tasked with progressing specific components of the Shared care model project including education and training, scope of practice and standards of care. Additional sub-groups may be established at a later stage, and according to the project needs.

Introducing new approaches to care or redesigning services is challenging and can only be achieved in close consultation with stakeholders and a consumer focused approach. In early 2023 we will engage with people to try and understand all the factors that affect access to quality allergy care in Australia. That means learning from our stakeholders and people living with allergic disease, about the current situation and understanding region-specific issues, similarities and differences. We want to use these forums to discuss local solutions that will improve access in the long term.

Information about our working groups and stakeholder consultations will be communicated via a Shared care model bulletin. To subscribe email info@nationalallergy.org.au with the subject SUBSCRIBE.

APPENDIX A – PRINCIPLES OF SHARED CARE FOR ALLERGIC DISEASES

The National Allergy Strategy brought together 50 stakeholders (consumers, health care professionals, peak medical bodies and government organisations) to agree on a set of principles that would guide a shared care model for allergic diseases. These are outlined below.

Overarching principle

Ensuring patients receive the right care, at the right time by the right health professional(s) in the right place.

Guiding principles

The guiding principles of the shared care model are that it:

1. Is patient centred

- Patients and their whole person care must be the focus for all health care professionals, addressing quality of life issues, mental health, ability to access care, optimising care for the individual and consideration of carers. This includes referral to credible patient support organisations.
- Care must be evidence-based, culturally responsive, encourage health literacy and facilitate self-management.

2. Provides safe quality care

- Provision of care must be in accordance with minimum evidence-based standards, guidelines and protocols.
- Standardised individual patient reported outcome measures and evaluation processes are used to support safe, quality care of patients.
- Provision of care adheres to shared care principles and pathways (once developed).

3. Supports interdisciplinary teamwork and care

- Consult, collaborate and communicate. All relevant health care professionals must be supported in the delivery of shared care through early involvement.
- Clearly defined referral guidelines/pathways and scope of practice are available to assist health care professionals to provide optimal care.
- All health care professionals (including specialists) must be supported through the provision of evidence-based education and resources.
- Deliver sustainable health care through education and training, outreach support and making efficient use of resources.
- Interdisciplinary teamwork is supported by incentives or remuneration.

4. Is accessible to public and private patients

- Care must be provided to the patient locally where skills and equipment can accommodate.
- The limited capacity of tertiary services is acknowledged.
- Transitioning of paediatric patients to adult care must be timely and effective.
- Addresses the affordability of appointments, tests and medications/treatments.
- Telehealth should be considered where appropriate and available.
- Is innovative and considers new ways of organising and delivering care.

5. Supports integrated care

- Care of the patient must be coordinated through timely and effective communication, and clarification of the roles and responsibilities of the care providers.
- Recognises variability in local resources and region-specific pathways.

- Information sharing between health care professionals and the patient and/or carer must have a process, be timely and meaningful and acknowledge receipt of information/follow up.
- Patient health information should ideally be shared electronically where a My Health Record exists, in addition to ongoing two-way communication between health care professionals.
- Provision of care must focus on early intervention, prevent under diagnosis, misdiagnosis and delayed diagnosis.

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. 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.
3. Australasian Society of Clinical Immunology and Allergy, *Immunology and Allergy Workforce Issues ASCIA Repsonse to RACP* 2012.
4. Australian Institute of Health and Welfare (AIHW). *Rural and remote Australians - Links and other information. https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/links-other-information* [last accessed 21 November 2022]