Access to primary care for homebound people in the Brisbane South region

A white paper

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Author	EY
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A special acknowledgement is extended to the dedicated healthcare professionals for their unwavering commitment and tireless efforts in delivering care to homebound individuals.

Brisbane South PHN acknowledge the Traditional Custodians of the land on which we live and work, and of the many different nations across the wider Brisbane South region.

We pay our respects to the Elders, past, present and emerging, as the holders of the memories, the traditions, the culture and the spiritual wellbeing of the Aboriginal and Torres Strait Islander peoples across the nation. We acknowledge any Sorry Business that may be affecting the communities as a whole.

In the spirit of reconciliation, partnership and mutual respect, we will continue to work together with Aboriginal and Torres Strait Islander peoples to shape a health system which responds to the needs and aspirations of the community.

Terminology used in this document

In this document, we only use the term “patient” to refer to a person receiving treatment for a disease or injury. When referring to people in the community involved in services related to health and wellness, the term “consumers” is used. The term “health professional” is used to denote any person involved in the delivery of health services, both clinical and non-clinical. “Primary care professional” refers to any person involved in the delivery of health services in the primary care setting only, again both clinical and non-clinical. “Primary care provider” refers to clinical professionals involved in the delivery of health services in the primary care setting, typically General Practitioners.

Limitations and extent of consultation

The contents of this white paper have been informed by targeted stakeholder engagement through a multimodal approach, in addition to a brief and focussed literature review.

Stakeholder consultation was conducted through three workshops attended by a range of primary care professionals across multiple geographies within the Brisbane South region. A total of seven individuals attended the workshops. In addition, one-on-one consultations with five internal Brisbane South PHN stakeholders were conducted to further build on findings. A brief survey was distributed to 50 external stakeholders across the Brisbane South region, both clinical and non-clinical. 15 responses were received, nine of which were fully completed and the remainder partially completed. Consumer engagement was outside the scope of this engagement.

Confidentiality and privacy

All personal and professional information gathered during the stakeholder engagement process, including but not limited to responses, feedback and quotes, have been de-identified for privacy and confidentiality reasons.

Iconography used in this document

This icon denotes survey outputs/results throughout the white paper. The outputs include quotations from free text survey responses, which are shown with a *quotation* icon.

This icon denotes workshop outputs throughout the white paper. The outputs include quotations from workshop discussion, which are shown with a *quotation* icon.

This icon denotes one-on-one consultation outputs throughout the white paper. The outputs include quotations from discussion, which are shown with a *quotation* icon.

Glossary

Acronym	Definition
AGPT	Australian General Practice Training
CALD	Culturally and Linguistically Diverse. A term often used to refer to individuals who were born overseas, have a parent born overseas or speak a number of languages.
CHSP	Commonwealth Home Support Programme. This is an Australian government initiative that supports entry-level assistance for elderly individuals within their home to encourage continuing to live independently.
DoHAC	The Australian Government Department of Health and Aged Care.
DSP	Disability Support Pension.
ED	Emergency Department.
FTE	Full time equivalent.
GP	General Practitioner.
HBPC	Home-Based Primary Care.
HCP	Home Care Package. This is an Australian government program providing care services to older individuals to encourage them to stay in their own home for as long as possible.
MBS	Medicare Benefits Schedule.
NDIS	National Disability Insurance Scheme.
NESB	Non-English-Speaking Background. Refers to individuals whose first language is not English, or individuals who grew up speaking a language other than English in the home.
NFP	Not for Profit.
NHS	National Health Service. This is England's publicly funded healthcare system.
NP	Nurse Practitioner.
QAS	Queensland Ambulance Service.
RACF	Residential Aged Care Facility.
RACGP	Royal Australian College of General Practitioners.
ROI	Return on Investment.

Term	Definition
Bedbound	Individuals who are immobile and are unable to ambulate from their bed due to severe illness, disability or frailty. These individuals usually experience weakness and require assistance activities of daily living.
Brisbane South region	This region is referred to throughout the white paper and encompasses remote to inner metropolitan suburbs. This region includes the local government areas of Brisbane, Logan, Redland and Scenic Rim. This involves 20 Level 3 Statistical Areas. Remoteness is sectioned according to the Modified Monash Model (MMM) categories (MMM 1- MMM 7). Refer to ***Appendix 6.2.1*** for a visual representation of the region.
Medicaid	State/Federal program in the United States that assists low-income adults, low-income children, pregnant women, elderly adults and individuals with disabilities with healthcare costs.
Telehealth/Telemedicine	"The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities" – World Health Organisation definition.
Urgent care clinics	Clinics (usually walk-in) that provide urgent and immediate care, like that of an emergency department, however for patients with less serious conditions. These clinics are open outside of traditional/standard operating hours.
Unmet needs	Requirements or demands of the target population not being fulfilled by current primary care services.
Usual GP	"The GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months." – Medicare Benefits Schedule definition.

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Executive summary

Ready access to primary care is a mainstay of Australia's healthcare system. General Practitioners (GPs) are usually the first point of contact for preventive care, diagnosis, treatment and coordination of services. However, people who are homebound find it difficult to access primary care in a timely manner. This can lead to inappropriate visits to emergency departments, avoidable hospitalisations, untreated health issues and a lack of preventive care.

Brisbane South PHN commissioned this white paper to investigate and articulate the opportunities for better serving the primary care needs of homebound consumers living in the Brisbane South region.

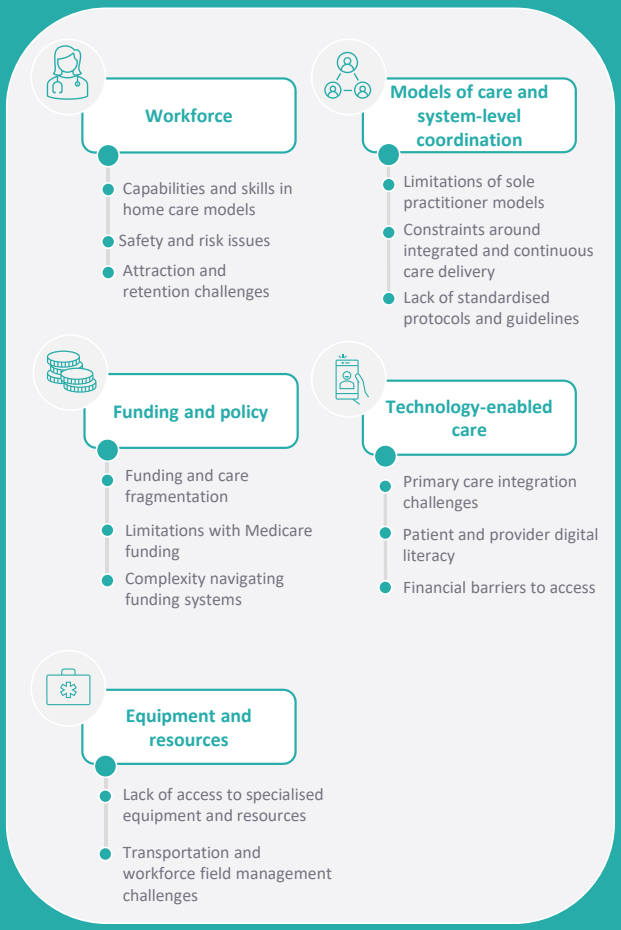
A series of workshops were held with primary care professionals across the Brisbane South area, along with one-on-one interviews and a survey of stakeholders to explore barriers and opportunities to improve access by homebound consumers to primary care in the region. Further details can be found in the Technical Addendum of this report.

Being homebound is considered to be a flexible concept falling across a continuum from being preferentially homebound to being physically confined within the home due to functional, cognitive, social and/or mental health reasons. This study identifies that limited primary care services are available to homebound individuals, including meeting the distinct needs of the diverse and multicultural communities within the Brisbane South region.

Primary care services provided to this group are highly dependent upon the goodwill of individual GPs. The lack of a systematic approach and a clear standard or model of care, along with supporting funding, has resulted in few practices and GPs providing home-based primary care services.

Health system structures, processes and procedures that create barriers to accessing primary care are a mix of funding constraints, limitations in the care model, workforce supply and skills mix, and the tools and technologies to support care delivery.

Barriers to accessing primary care



Reimagining how primary care services are delivered will significantly contribute towards meeting federal, state and Brisbane South PHN policy goals of equity of access and patient-centred care for homebound consumers, thus optimising consumers' health, wellbeing and quality of life.

Four areas of opportunity to improve access to primary care emerge from the consultations with healthcare professionals. These are built upon developing a detailed understanding of the homebound population, the scope of the problem and what is addressable through primary care. This, in turn, will inform the design and development of sustainable multidisciplinary team-based primary care models including consolidation of the system around the critical role of the GP in coordinating care and leading the team. Addressing the funding constraints that currently work against delivering primary care services to homebound consumers with sustainable solutions will support a team-based care model. And finally, uplifting access to primary care for this cohort through workforce education, skills training and technologies that support quality home-based care.

Four areas of opportunity to improve access to primary care

The target population and access need

That a baseline of demographic, health, social determinants, epidemiological and geographic information be developed to better understand the homebound population and to better address the challenges faced by these individuals, including the specific barriers faced by CALD, NESB, First Nations and disability populations.

Models of care and care coordination

That care delivery models, service blueprints and patient journey pathways be developed as guides to support local services deliver primary care to many different types of homebound consumers.

New avenues of funding and policy advocacy

That existing and future funding streams and policy levers be identified which will resolve the current financial and administrative constraints on providing primary care to homebound consumers.

Sustaining the workforce and facilitatory technology

That quality primary care service delivery is achieved through training practitioners in home-based care, who are confident in their skills base and supported in delivering care via funding, expert advice, tools, technologies and multidisciplinary team-based care models.

1. Introduction and strategic context

Many Australians live with complex, incapacitating and debilitating conditions that result in them being unable to leave home.

The term homebound is not clearly defined but can be understood as where the life-space is reduced to the home due to physical, psychosocial and systemic reasons.[1] This could be due to patient preference, a short-term or temporary medical condition or it may be permanent. Consequences can include social exclusion, health disparities, and marginalisation from health services.

The scale and scope of this problem is not well researched. Internationally, global estimates of being homebound vary between 5.6% to 7.5% of older adults.[2] Australian research estimates that Frail, Housebound and Bedridden People (FHBP) make up 2.4% of the Australian population, often living with health issues that are not recognised as disabilities but leaving them unable to leave home and receive healthcare.[3]

Brisbane South PHN commissioned this study to better understand the significant barriers faced by homebound consumers in their locality to receiving basic health and preventive care, and to understand what it would take to overcome these to improve access and health outcomes.

This white paper presents the findings from a series of workshops held with primary care professionals across the Brisbane South area, one-on-one interviews and a survey of stakeholders, which together explored barriers and opportunities to improve access to primary care in the region. In ***Section 5 Opportunities***, this paper identifies a range of opportunities arising from the research for Brisbane South PHN to consider in order to improve access to primary care for homebound individuals.

"Bedbound and unable to travel due to the severe pain and weakness this causes… we need GP visits and medical care in the home… It is distressing that she has fallen through the gaps of the healthcare system and is too unwell to access primary healthcare in Australia."
(Carer and patient advocate).

1.1. Significance of primary care services for the homebound in the Australian context

Ready access to primary care is the foundation of Australia's health system and GPs are usually the first point of contact for preventive care, diagnosis, treatment and management, coordination of comprehensive care and referrals to specialists and hospital and community health services. However, the health system is structured around having a usual GP and in-person visits, with few services providing home-based care. Virtual care and

[1] Schirghuber, J., & Schrems, B. (2021). *Homebound: A concept analysis.* Nursing forum, 56(3), 742–751. https://doi.org/10.1111/nuf.12586
[2] Lee, J., Suh, Y., & Kim, Y. (2022). *Multidimensional factors affecting homebound older adults: A systematic review.* Journal of Nursing Scholarship, 54, 169–175. https://doi.org/10.1111/jnu.12724

[3] Keough, M. (2021, April 2019). *Frail, homebound and bedridden Australians living without primary health care.* Caring Futures Institute News, Flinders University. https://blogs.flinders.edu.au/caring-futures-institute/2021/04/29/frail-homebound-and-bedridden-australians-living-without-primary-health-care/

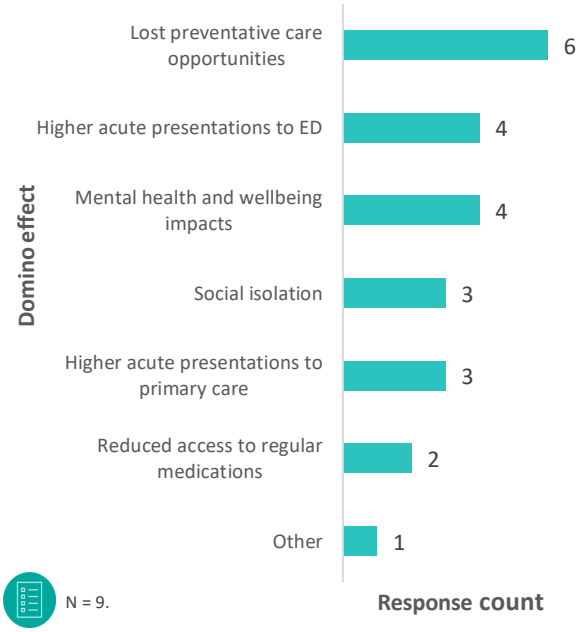
telehealth are emerging care models but not yet widely and consistently adopted or funded.

Ensuring the availability and accessibility of primary care services for homebound individuals, including those with disabilities, not only improves their health outcomes but also contributes to the overall efficiency and effectiveness of the healthcare system. Limited access to primary care commonly results in:

- Unnecessary ED visits
- Unnecessary hospitalisations
- Lack of preventive care including annual health screenings and immunisations
- Untreated health issues and higher disease burden
- Lack of care coordination, medication review, prescription management and access to other services including income support, social support and allied health

Figure 1.

Top factors identified as the domino effects from a lack of primary care services to support homebound patients



- Downstream health expenditures

Figure 1 displays the major domino effects, identified by the survey participants, resulting from primary care service inaccessibility for homebound consumers. The most frequently identified downstream effect was loss of preventative care opportunities, followed by an increase in acute presentations to the ED, and mental health and wellbeing impacts on homebound consumers.

The Federal Department of Health and Aged Care is committed to deliver systemic change through the *Strengthening Medicare Taskforce Report*, which outlines a vision for Australia's primary care system of the future. Initiatives include:

- The 2023-24 Federal budget commitment to strengthening primary care through bulk billing incentives ($3.5 billion), $358.5 million for Medicare Urgent Care Clinics to free up overstretched GPs, $143.9 million for after-hours primary care, $445.1 million for general practices to employ health professionals to provide team-based primary care and $79.4 million for GPs to augment their teams with allied health professionals commissioned by PHNs, $46.8 million to fund Medicare rebates for care provided by nurse practitioners, and MyMedicare, a voluntary patient registration scheme, which will fund GPs to provide comprehensive care to frequent hospital users ($98.9 million) and provide additional funding packages for regular patients in need of additional support.[4]
- The future vision for primary care in Australia is accessible and affordable care for all, including First Nations Australians, multicultural individuals, individuals living in rural and remote areas, individuals with a disability and

[4] Australian Government, Department of Health and Aged Care. (2023) Building a stronger Medicare. The Hon Mark Butler MP, Minister for Health and Aged Care. Stakeholder pack – Budget 2023-24. May

Australians less connected with the system. Key policy goals include:[5]

- Access to equitable, affordable and person-centred primary care
- Care provision through coordinated multidisciplinary care teams
- Use of data and digital technology to inform value-based care
- Co-design of services with users

- After-hours care continues to be an essential service for timely care access, in order to avoid unnecessary and costly use of acute services. A variety of after-hours GP services exist in most Australian states, including late-night GP clinics and medical deputising services, where doctors are employed by practices to provide after-hours services for their patients. Services provided include virtual/telehealth and home

Figure 2.

The values and approach of Brisbane South PHN to their community

[5] Australian Government, Department of Health and Aged Care. (2022, December). *Strengthening Medicare Taskforce Report*. https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en

visits, including to RACFs. The services are acute and episodic care oriented and patients are referred back to their regular GP. Examples of services operating in the Brisbane South region include 247 Home Visiting Doctors, Dial a Home Doctor, Hello Home Doctor, House Call Doctor and National Home Doctor Service (1300SICK).

1.2. The Brisbane South PHN context

Brisbane South PHN outlines its values and approach to care in the region in its Strategic Plan 2021 (***Figure 2***). Brisbane South PHN's values and approach emphasise care for all individuals in the region and strives to create a healthier and more equitable region. In particular, Brisbane South PHN is prioritising those with the greatest need, including a focus on leading change to improve homebound individuals' access to primary care.

Brisbane South PHN is developing a three-year *Brisbane South Health Access and Equity Framework* that will support the enhancement of culturally safe and inclusive practice, both internally and externally, within its spheres of influence (i.e., primary care and commissioned providers). In the spirit of partnership and collaboration, this involves joining forces with Metro South Health to take a coordinated approach to reducing health inequities in the region.

1.3. Queensland Health strategic landscape

Three key policy documents lay out Queensland Health's strategic landscape (***Figure 3***).

HEALTHQ32 outlines the vision for the future of Queensland's healthcare system. It sets the future direction for the health system and focuses on being adaptable, embedding innovative models of care and new technologies that improve patient care, and delivering services more efficiently. This includes diversifying workforce roles, embedding technologically enabled and personalised healthcare, empowering consumers, delivering equitable and accessible care closer to home and strengthening partnerships with primary care and other health and social care providers.

Key focus areas of the **Queensland Department of Health Strategic Plan (2021-25)** are to:

- **Maximise wellbeing:** Improve the health and wellbeing of Queenslanders.
- **Care in the community:** Strengthen access to care in the community and closer to home.
- **Care in hospital:** Optimise delivery of safe, appropriate and timely hospital care.

Queensland Health supports the **Australian Charter of Healthcare Rights (2019)** that describe rights that consumers, or someone they care for, can expect when receiving health care. These include *Person-centred care; Standards and accreditation; Partnering with consumers; and Building skills and consumer leadership*.

Figure 3.

Key documents setting Queensland Health's strategic landscape

1.4. Technology-enabled care landscape

Technology advancements mean that the patients of tomorrow will benefit from an array of novel therapeutic approaches and channels. These are expected to transform how patients and providers interact and give patients more control and input into their health and care than in the past.

To meet state and local Brisbane South PHN policy goals of equity of access and patient-centred care, service delivery systems will need to be redesigned to incorporate digitally enabled care models and technologies, which will go some way towards resolving many of the current barriers to accessing primary care services. This has significant implications for payment systems and for the health workforce, which will need to draw upon a very different range of skills and career pathways to operate within new technologically-enabled models of care.

2. Brisbane South's homebound

The Brisbane South PHN is home to over 1.2 million people from many different backgrounds and cultures.[6] Within this population are a cohort of individuals who require primary care services at home due to a multitude of medical and/or social factors. Demographic data relating to the true number of homebound individuals in the Brisbane South region is not available, due to:

- Variability in homebound consumer cohorts as some individuals are only temporarily homebound;
- Lack of standardised definitions or eligibility criteria to identify who is classified as a homebound individual; and
- Large cohort of patients who are homebound being unknown to the primary care system.

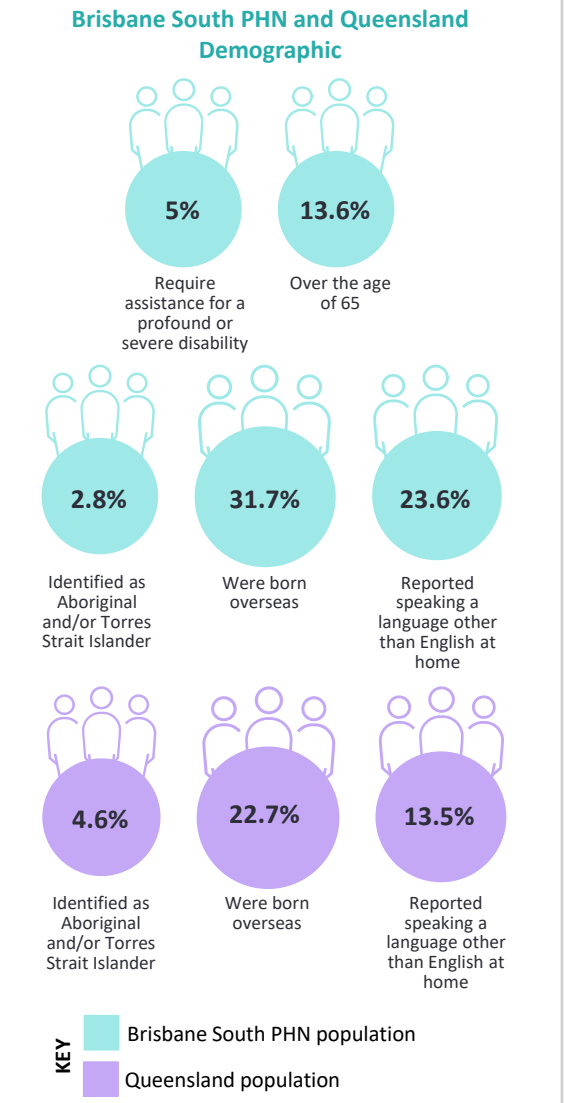
Data is available on several demographic factors related to being or becoming homebound and this can give some insight into the likely homebound consumer cohort in Brisbane South.

Figure 4 captures several of these demographic characteristics of the Brisbane South population.

The Brisbane South region is considerably more culturally diverse than the wider Queensland population, especially in relation to the significant refugee population, and large Pasifika and Māori communities. In addition, 2021 census data shows that approximately 5.6% of the Brisbane South population had a profound or severe disability, and that almost 9 in 10 people with a disability lived in the community.[6]

Figure 4.

The main demographic characteristics that contribute to the diversity of the Brisbane South population



As disability is associated with ageing, Brisbane South PHN research indicates that older people living in Brisbane South experienced higher rates of

[6] Brisbane South PHN, An Australian Government Initiative. (2022, August 8). *Our region*. https://bsphn.org.au/about/our-region/#:~:text=The%20Brisbane%20South%20PHN%20region%20covers%20a%20large,million%20people%20from%20many%20different%20backgrounds%20and%20cultures

disability, specifically an additional 1.2% of the older adult population.[7]

The workshops and consultations identified a clear need for a baseline of demographic, health, social determinants, epidemiological and geographic information to be developed to better understand the homebound population and to better address the challenges faced by these individuals, including the CALD, NESB, First Nations and disability populations.

"Growing concerns with time constraints, staffing issues, financial considerations and ensuring best practice has meant some GPs are making the difficult choice not to provide services outside their clinic rooms. There is an openness and desire to find viable and desirable ways to overcome the barriers to delivering quality, safe care in the home." (Brisbane South PHN representative).

2.1. Defining homebound

The literature provides little guidance on defining homebound. An Australian report suggested that 'Someone is homebound or housebound if leaving the house is either impossible or causes such major medical or psychological problems that the person can only go out less than once a week on average.'[8]

Internationally, approaches to defining homebound tend to be built upon some combination of how many times a person leaves the home and the presence of functional issues, both physical and cognitive.[9] In the US, the Centres for Medicare and Medicaid consider homebound to mean that a patient cannot leave home without 'considerable and taxing effort.'[10] In the NHS England, home visits by GPs have been a traditional part of the care model, including for people unable to travel to the GP because of chronic disease, palliative care and other serious debilitating conditions.[11]

Consultation with primary care providers in the Brisbane South region emphasised that being homebound is a flexible concept. The notion of being homebound is not fixed, can vary greatly from one individual to another, and can be highly dependent on patient circumstances and preferences. The consultations revealed that the state of being homebound falls across a continuum, from being preferentially homebound to being physically confined within the home or fixed homebound.

A model of the homebound continuum that was developed and validated in workshop discussions and consultations during this study is shown in ***Figure 5***. Working definitions of the key concepts along the continuum draw together ideas and experiences discussed at the workshops and consultations, as follows:

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[7] Brisbane South PHN, An Australian Government Initiative. (2022). *Brisbane South PHN. Health Needs Assessment 2021-22 to 2023-24 Report.* https://bsphn.org.au/about/key-resources-and-publications/

[8] Buchanan, R. (2018). *"Just Invisible". Medical Access Issues for Homebound/Bedridden Persons.* Not done living. https://www.notdoneliving.net/just-invisible.html

[9] Musich, S., Wang, S. S., Hawkins, K., & Yeh, C. S. (2015). *Homebound older adults: Prevalence, characteristics, health care utilization and quality of care.* Geriatric nursing (New York, N.Y.), 36(6), 445–450. https://doi.org/10.1016/j.gerinurse.2015.06.013

[10] Active Home Health, Hospice & Personal Care. (2022, April 25). *What does Medicare Mean by 'Homebound' status?* https://www.activehhh.com/home-health-blog/medicare-homebound-status/

[11] Mitchell, S., Hillman, S., Rapley, D., Gray, S. D. P., & Dale, J. (2020, June). *GP home visits: essential patient care or disposable relic?* The British journal of general practice : the journal of the Royal College of General Practitioners, 70(695), 306–307. https://doi.org/10.3399/bjgp20X710345

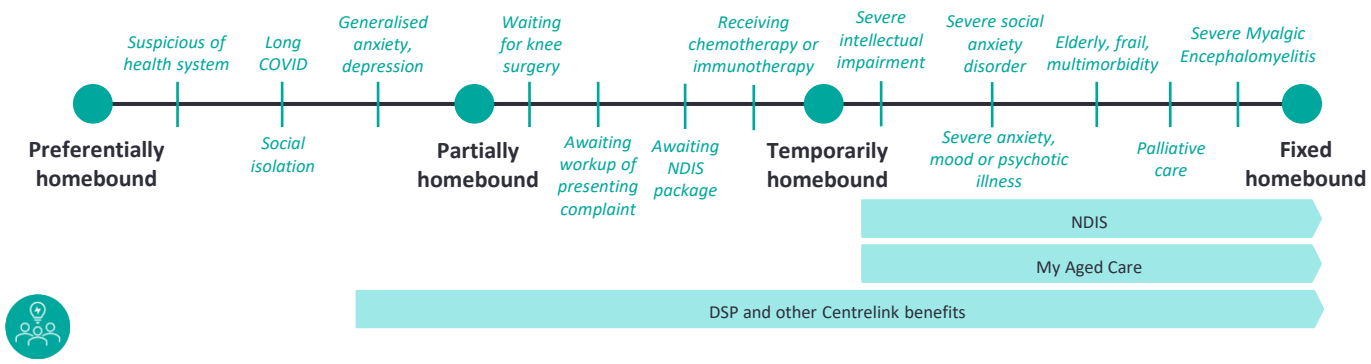
- **Preferentially homebound:** Individuals who willingly choose to remain at home most of the time due to preference or convenience.
- **Partially homebound:** Physically able to leave the house but results in a high degree of distress and trauma for the individual (physical, social and/or psychological).
- **Temporarily homebound:** Individuals who have limited mobility or ability to leave the home for a fixed span of time and are expected to regain the ability to leave home after a certain period.
- **Fixed homebound:** Physically unable to leave the home due to complex, incapacitating and/or debilitating illnesses or injuries, typically with severe functional impairment.
- ***Figure 5*** also demonstrates where on the continuum common schemes, programs or welfare supports that might be available to homebound consumers may come into effect. A broader range of social and community supports including NDIS, My Aged Care, DSP and other Centrelink benefits typically become available to those with more complex and challenging conditions. Additionally, primary care services for homebound individuals are currently directed at this end of the continuum. In contrast, preferentially or partially homebound individuals have limited access to such schemes and programs. The workshops identified that these groups of homebound consumer and patients may be experiencing issues that cannot be predominantly addressed by primary care, such as social isolation or suspiciousness of the health system.

However, the consulted primary care providers believe the GP role is critical in the preferentially and partially homebound end of the continuum as untreated issues can escalate. They concluded that primary care and social care must be connected to prevent health deterioration, and that further investigation is required around integrating social prescribing and community services into the primary care model, including funding levers and referral pathways.

Significant contributors to individuals being and remaining homebound are functional, cognitive, social and mental health factors. These need to be incorporated when developing care models for homebound consumers/patients in the community.

Figure 5.

The frontline perspective on defining homebound



2.2. Characteristics of the homebound consumer/patient cohort

Characteristics of homebound consumers/patients in Brisbane South that are most frequently encountered, through to less frequently encountered were consolidated in the workshops and survey. These are summarised in ***Table 1***, with the higher frequency characteristics encountered in the Brisbane South region depicted in the top rows under each subsection. ***Figure 6*** identifies, per survey results, the age cohorts reported to be most frequently encountered in homebound consumers

Figure 6.

Age cohorts reported by survey respondents to be most frequently encountered in homebound consumers in the Brisbane South region

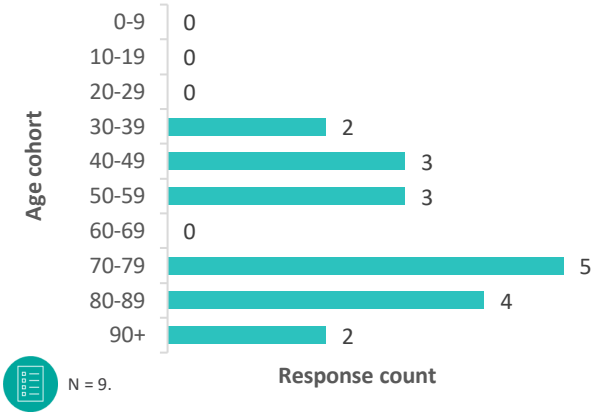


Table 1.

Frequently encountered homebound characteristics of patients in the Brisbane South region, obtained from the survey and workshops

Age profile	Schemes/ programs	Cultural needs	Reasons for being homebound	Common primary care services	Other factors
80 and over	NDIS	Aboriginal and Torres Strait Islander	Permanent disability	Prescription renewal	Access to phone/tech
66-79	My Aged Care	Culturally and Linguistically Diverse	Chronic medical condition	Chronic disease management	Social isolation
36-65	Disability Support Pension		Complex and interrelated health problems	Chronic disease care planning	Low health literacy
25-35			Mental health disorder	Palliation and end-of-life care	Location/lack of services
19-24			Mobility and sensory issues	Pain management	Low mobility
16-18			Psychosocial isolation	Regular check-up	
			Temporary illness or disability	Transitions in and out of acute settings	
			End-of-life and palliation	Exacerbations of chronic conditions	
			Geographical barriers	Mental health services	
				Vaccinations	

Identified >10 times through survey and workshops as a frequently encountered characteristic

Identified 7-10 times through survey and workshops as a frequently encountered characteristic

Identified 4-6 times through survey and workshops as a frequently encountered characteristic

Identified 0-3 times through survey and workshops as a frequently encountered characteristic

Frequency not applicable

Note. Workshop participants and survey respondents were asked to identify the top three frequently encountered characteristics under each sub-section (e.g., age profile, schemes/programs).

in the region, with the 70-79 age group most frequently reported.

2.3. Homebound patient personas

The following personas have been developed based on the key characteristics that personify homebound consumers in the Brisbane South region. The personas bring to life some of the experiences and barriers faced by homebound people across their patient journeys.

The personas illustrate how being homebound, whether by preference or due to fixed physical limitations, is a barrier to health and wellbeing, and capture specific barriers faced by those living with disability, chronic disease, in remote areas, older persons, CALD individuals and those who identify as First Nations.

Note that the persona named 'Maia' has been informed by a Brisbane South homebound consumer's lived experience of access barriers to primary care (refer to ***Appendix 6.1.1 Case Study 1*** for further information).

Max, 70
Yarrabilba (MMM 2)

Multiple complex chronic diseases, elderly with psychosocial isolation

"I can't leave my house without a lot of support since my wife passed away. She used to take me to the doctor… I would like to see my GP in-person but it's near impossible for me to get to the practice and I'm unsure where I should begin looking.

Social situation
- Family situation: widowed, 1 child (overseas)
- Occupation: retired
- Financial situation: pensioner
- Schemes/programs: My Aged Care - Home Care Package
- Care coordinator: Max and his daughter
- Allergies: nil

Medical history
- Multiple sclerosis (wheelchair bound)
- Cardiovascular disease
- Chronic respiratory disease (COPD)
- Pressure ulcers
- Severe depression and anxiety with active suicidal ideation

Community
- Max lives in Yarrabilba which has adequate community services, including medical centres
- Further support is accessible in Logan (approximately 18km away) as required, including hospital

Care consumption last 12 months
- 1 GP home visit (11 months ago)
- 1 telehealth consult with GP
- 3 ambulance transport
- 1 home visit social worker, physio and OT (post-discharge)
- 163 Meals on Wheels
- 3 hospital admissions
- 3 visits social worker, physio and OT (in hospital)
- 308 visits comprehensive My Aged Care support

Attitude towards primary care
- *"My daughter is always asking about my health. She lives overseas, so she finds it difficult to keep a track of my conditions, as do I."*

Maia, 31
Wynnum (MMM 1)

Chronic illness, permanent disability and NESB

> *I visited a GP in person two years ago. It was an extremely traumatic process, and I still haven't recovered from the experience. The GP did express concerns over my ability to access regular medical support but was unsure what advice to provide.*

Social situation
- Family situation: large extended family living locally
- Occupation: unemployed
- Financial situation: Disability Support Pension
- Schemes/programs: NDIS recipient
- Care coordinator: Maia and her mother
- Allergies: shellfish
- Non-English speaking background

Medical history
- Severe Myalgic Encephalomyelitis (ME/CFS)
- Largely bedbound
- Asthma
- Obese: BMI of 34
- Unable to travel as it causes severe pain and weakness

Community
- Maia lives in Wynnum and is relatively close to community and care services. Maia requires transport support to access these services with only some costs covered by the NDIS and her family struggles to pay for anything in addition. Travel is very detrimental to her health.
- Maia has low medical literacy and requires interpreter services in a medical environment (her NDIS plan covers this).
- Maia's mother relies on her family network to support Maia's health care and often feels burnt out.

Care consumption last 12 months
- 1 GP home visit (>1 year ago)
- 4 telehealth consults in the last year
- 2 Emergency Department visits
- 3 Social Worker home visits
- 2 OT home visits

Attitude towards primary care
- *"I am Maia's full time carer and have been trying for years to find a GP who would be willing to do regular home visits. It is very distressing that Maia has fallen through the gaps of the healthcare system." – Maia's mother*

Jemima, 16
Kooralbyn (MMM 5)

Severe and profound intellectual disability, psychosocial barriers and geographical isolation

> *I wish I could help make Jemima's experience at the doctor better… she finds the environment so distressing, disengages and will do anything not to leave the house. The GP can't provide the consistent care and support that she needs. – Jemima's mother*

Social situation
- Family situation: separated parents, one sister
- Occupation: school student (home schooled)
- Financial situation: dependent
- Schemes/programs: NDIS recipient
- Care coordinator: Jemima's mother and Children's Health Queensland paediatrician
- Allergies: Peanuts
- Aboriginal

Medical history
- Severe and profound intellectual disability
- Down Syndrome
- Autism spectrum disorder
- Complex PTSD
- Sleep disorder

Community
- Jemima goes to a day activity service once a month in Yarrabilba. She has become less interested in this activity and increasingly wants to stay at home.
- She enjoys spending time with her mother and sister.
- Jemima's paediatrician is concerned for Jemima's transition to adult health services.

Care consumption last 12 months
- 2 visits to GP in the past year
- 4 Child Safety visits
- 1 Psychologist in-home visits
- 3 Social worker in-home visits
- 7 contacts with QPS

Attitude towards primary care
- *"As soon as mum mentions I need to go to the doctor I start shutting down. I feel annoyed and my heart starts beating really quickly. I told her I'm not going to the doctors again!"*

3. Current state of access to primary care for homebound individuals

Consultation with primary care providers, both clinical and non-clinical, in the Brisbane South region highlighted the lack of a systematic approach to the provision of primary care services to homebound patients. At present, these services are predominantly delivered on an ad-hoc basis and is largely GP and practice dependent.

The offering of primary care services to this patient cohort is largely limited to those GPs with a personal motivation to support homebound care, either through home visits, virtual modalities, or both. The absence of a clear standard or model of care for this patient cohort, with supporting funding, has resulted in fewer practices and GPs providing homebound care services. Subsequently, a significant gap in regular primary care coordination and access arises for homebound individuals due to GP employment separations, especially retirement, or periods of leave.

> *"We currently have 1 GP out of 18 GPs that is happy to do home visits... He struggles to find a GP to visit these patients when he is away. (Practice manager)*

3.1. Primary care services accessible in the home

Survey and workshop outputs identified that limited primary care services are available to homebound consumers and patients in the Brisbane South region. ***Table 2*** summarises services provided and the health workforce delivering those services in Brisbane South. However, this is non-exhaustive,

Table 2.

Common primary care services provided to homebound patients in the Brisbane South region and workforce delivering these services

Home visits	Mixed home visits and virtual care	Virtual care
• Palliative care • Some chronic disease management • Immunisations • Home medicine reviews • Wound management	• Mental health care reviews and management • Post acute care services	• Prescription renewal • Referral requests • Medication reviews and management • Medical certificates
Workforce delivering services in the Brisbane South region		
GP (most common) Practice nurse Practice pharmacist Occupational therapist First Nations health worker	GP only	GP only

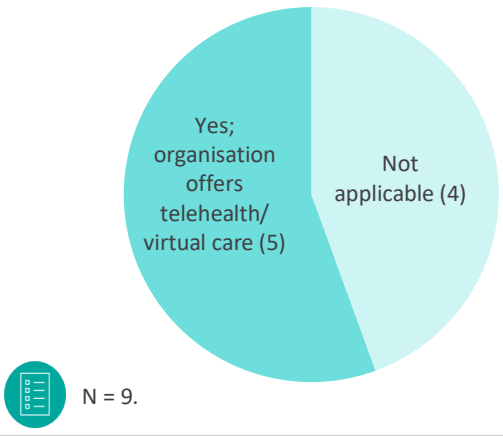
with no indication as to the sufficiency or sustainability of those services in meeting demand.

Primary care services span screening and prevention through to chronic disease management and palliative care. For homebound patients, these services are limited to the home setting and are delivered either via home visits, virtual care modalities, or a combination of both. Virtual care typically takes the form of telehealth consultation, and less commonly a video conference. The consultation modality takes patient preference and the primary care provider's judgement into account, based on clinical indication, acuity, and appropriateness. The ultimate consultation modality is determined on a case-by-case basis.

Five of nine survey respondents report that their organisation offers telehealth or virtual care in the Brisbane South region (***Figure 7***). There has been a subjectively reported decrease in utilisation of telehealth consultations across the region due to the revocation of temporary MBS rebates as of 1 July 2022, which were introduced in response to the COVID-19 pandemic.[12] The greater administrative requirements for telehealth consultations, predominantly relating to the completion of consent documentation, subsequent to these changes have resulted in a shift towards private billing of telehealth consultations, and therefore reduced accessibility for homebound patients for financial and administrative reasons.

Figure 7.

Survey respondents who stated that their organisation offers telehealth/virtual care or that it was not applicable to their organisation



3.2. Workforce delivering primary care services to homebound individuals

Across all modalities, GPs are the main health professionals who provide home visits and virtual care services to homebound patients. However, in discrete pockets across the Brisbane South region, primary care practice nurses, pharmacists, occupational therapists, and First Nations health workers also provide in-home services. Those multidisciplinary home visits, where they are offered, are typically conducted in pairs of health professionals to maximise efficiency, coordination of care and minimise risk to staff.

As shown in ***Figure 8,*** survey results indicate that home visits are performed on a varying basis by a variety of primary care professionals with GPs, nurses and pharmacists identified as professions that 'always' conduct home visits.

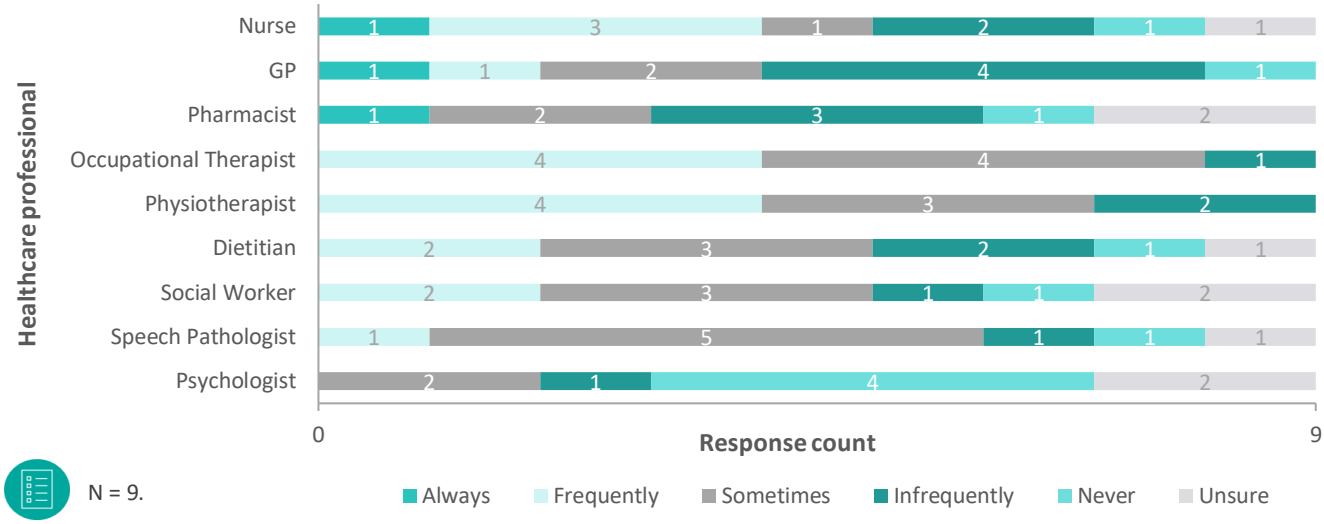
Eight out of the nine *respondents reported that occupational therapists perform home visits sometimes or frequently.*

Psychologists *were the least likely group to perform home visits.*

[12] Australian Government, Department of Health and Aged Care. (2022, July 8) *Continuing MBS Telehealth Services.* https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-telehealth-1July22

Figure 8.

Frequency of different primary and community healthcare professionals performing home visits for homebound patients in the Brisbane South region



One-on-one consultations and workshops indicated that GPs who conduct home visits in the Brisbane South region are typically male. This can be due to safety issues related to visiting a home and to funding not covering time for more than one worker. Many GPs undertake home visits in their own time, on the way to or from work, to offset the cost, time, and travel burdens. Lack of choice in providers can pose challenges to primary care service access for homebound consumers with a cultural preference for the gender of their health provider, particularly for those who identify as First Nations and/or multicultural. For instance, this is a consideration where Men's and Women's business and other cultural preferences may impact patient preference in care provider.

There is a need to consider the cultural needs of homebound consumers, particularly considering the diverse and multicultural nature of the Brisbane South region. The region comprises 31% people who were born overseas and 20% who were born in a non-English speaking country.[13] This indicates a degree of cultural diversity higher than the wider Queensland population (22.7% of people born overseas).[13] Further, within Queensland, Brisbane South is the area of highest refugee settlement and within Australia, the largest Pasifika and Māori community.[13] An estimated 46,685 people or 3.7% of the Brisbane South population reported speaking English 'not well' or 'not at all' — over double the Queensland rate of 1.8%.[13] An estimated 2.8% of the Brisbane South population identifies as Aboriginal and/or Torres Strait Islander, lower than the wider Queensland proportion of 4.6%.[13]

Figure 9 and 10 report survey results indicating that the cultural needs of homebound First Nations and multicultural people within the Brisbane South region are being met to a moderate degree.

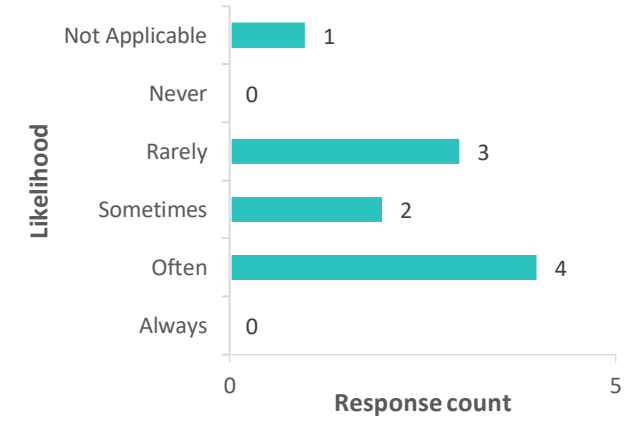
Four out of nine *survey respondents felt their service/organisation often meets the needs of First Nations peoples.*

Three out of nine *survey respondents felt their service/organisation often meets the needs of CALD consumers.*

[13] Brisbane South PHN, An Australian Government Initiative. (2022). *Brisbane South PHN. Health Needs Assessment 2021-22 to 2023-24 Report.* https://bsphn.org.au/about/key-resources-and-publications/

Figure 9.

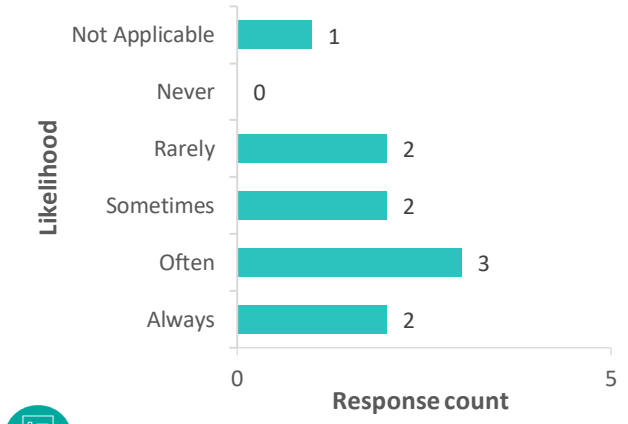
Survey participant responses to the extent to which their service or organisation is able to meet the needs of First Nations homebound consumers



N = 9.

Figure 10.

Survey participant responses to the extent to which their service or organisation is able to meet the needs of CALD homebound consumers



N = 9.

3.3. Current schemes and programs at a federal, state and local level

3.3.1. Federal

Primary care service provision is largely dependent on federal-level funding, schemes and programs. Consideration should be given to leveraging other sources of federal funding to optimise access for homebound consumers across the continuum. Where schemes and programs exist for patient cohorts who may overlap with homebound patient cohorts, analysis of synergistic funding opportunities may be conducted. One such example is Closing the Gap funding and grants, provided by governments to address the Closing the Gap targets. There are a number of programs which aim to improve the capacity of primary care services to better serve Aboriginal and Torres Strait Islander consumers, including but not limited to:

- **Practice Incentives Program (PIP) Indigenous Health Incentive (IHI)** provides uplifted access to healthcare for Aboriginal and Torres Strait Islander patients through the use of financial incentives to encourage ongoing improvements in primary care. There is a focus on promoting best practice chronic disease management through these incentives. The PIP IHI has several levels of payments including for practice sign-on, patient registration and outcomes.
- **Integrated Team Care (ITC) program** improves access to coordinated and multidisciplinary care for Aboriginal and Torres Strait Islander people with chronic health conditions and to mainstream health services, including primary care and allied health. This program funds PHNs to engage health organisations with the goal of providing support to eligible consumers to promote access to the right care when needed, establishing clear care pathways and linking healthcare across various services through teams of Aboriginal and Torres Strait Islander project officers, outreach workers and care coordinators.

Workshop participants emphasised the improved capacity to delivery of home-based services to consumers by leveraging such programs. One successful example of program synergies was raised by a practice in the Brisbane South region in relation to utilising the ITC program to support some preferentially and partially homebound individuals to attend the general practice. This was achieved by

Aboriginal and Torres Strait Islander outreach workers building strong links with patients in the community, encouraging access to healthcare and organising transport to and from primary care appointments.

3.3.2. State and local

There are state and local-level programs and schemes currently in place which may be considered for their application to homebound cohorts. Despite these not being specifically directed at the homebound population, where synergies exist, they can be used to uplift primary care access for this cohort. There is currently limited view across the local schemes and programs available and how these might be used to optimise care delivery to homebound consumers in the Brisbane South region. A synthesis of this information may improve referral to, and utilisation of, such programs by busy GPs and practice managers.

Some examples of synergistic programs currently running in the Brisbane South region, identified through one-on-one consultation, include the following:

- **State-funded Metro South dedicated Disability Nurse Navigators** help individuals with complex care needs to access community supports and navigate the various health systems and providers,[14] including continuity of care with general practice. Workshop participants shared the crucial role Disability Nurse Navigators play in promoting a seamless discharge and transition to primary care following hospital admission for eligible patients, as well as working with patients to prevent hospital admissions.
- **A model of non-dispensing pharmacists in general practice** is currently being trialled across Queensland, funded by a Medical Research Future Fund (MRFF) grant. This trial employs permanent part-time accredited pharmacists as a general practice employee, integrated into the multidisciplinary care team. Some of the benefits of this trial have been subjectively noted to improve outcomes for homebound patients, including proactive brief medication reviews to identify opportunities for deprescribing, early identification of patients at risk of medication-related harm, flagging of patients who may benefit from Home Medicine Reviews (HMR) and conducting more clinically relevant HMRs through access to the patient's health history. Each practice utilises the model of multidisciplinary coordination that works best for them, but the trial enables pharmacists to be involved in case conferences to plan care for complex primary care patients.
- **Refugee Health Connect (RHC)** is a local partnership between Brisbane South PHN, Brisbane North PHN, Mater and Metro South Health, operating as a source of support, education and resources for service providers regarding refugee health.[15] With a sizable refugee population and cultural barriers rendering some in this population group partially homebound in the Brisbane South region, there are opportunities to leverage supports to improve primary care access for this intersectional cohort.

[14] Queensland Government. (2023, July 10). *Health Equity and Access - People with disability.* https://metrosouth.health.qld.gov.au/health-equity-and-access/people-with-disability

[15] Brisbane South PHN, An Australian Government Initiative. (n.d.). *Multicultural Health.* https://bsphn.org.au/support/for-your-practice/multicultural-health/

4. Challenges and barriers across primary care access for the homebound

4.1. Challenges across the care pathway

Through multimodal consultation, clinical and non-clinical professionals within the Brisbane South region identified gaps in service access and barriers to primary care delivery for homebound consumers. Mapping of the homebound patient care pathway from first contact with primary care services, early assessment and diagnosis, through to ongoing treatment and palliative care, allowed the identification of unmet care needs and opportunities for service uplift, as demonstrated in ***Figure 11***.

The homebound patient personas introduced in ***Section 2.3*** illustrate primary care service barriers commonly experienced by this cohort. This highlights unmet care needs at a health ecosystem level by placing the homebound patient at the centre. It is important to note that the expansive definition of the 'homebound individual' results in a high degree of variation and inconsistency in the challenges identified at different points in the care journey.

"We have been unable to find a GP to do an annual home visit… We have been referred from service to service and not been able to find a solution with each institution or individual pointing to another in the system as being responsible." (Carer for homebound individual).

Figure 11.

Challenges and barriers to the access and delivery of primary care services to homebound patients, across the stages of the care pathway

Note. Patient persona challenges identified are illustrative.

The overarching challenges and barriers identified across all channels of stakeholder engagement have been distilled into five key themes, outlined in ***Figure 12*** and detailed in ***Section 4.2 to 4.6***.

Per survey results, ***Figure 13*** visualises some of the major challenges in access to and quality of primary care services delivered to homebound individuals. Among these challenges, those frequently reported (selected 5 or more times in survey responses) include funding limitations, workforce shortages, limited availability and utilisation of technology-enabled care, and lack of training/experience in delivering home-based care.

Figure 12.

Challenges and barriers in the delivery of timely, comprehensive and coordinated primary care to homebound individuals

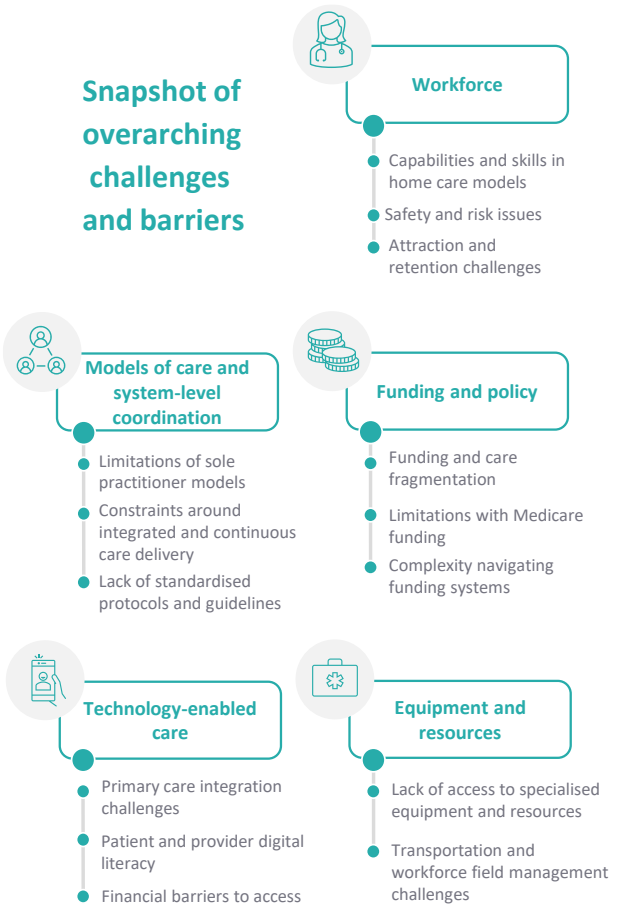
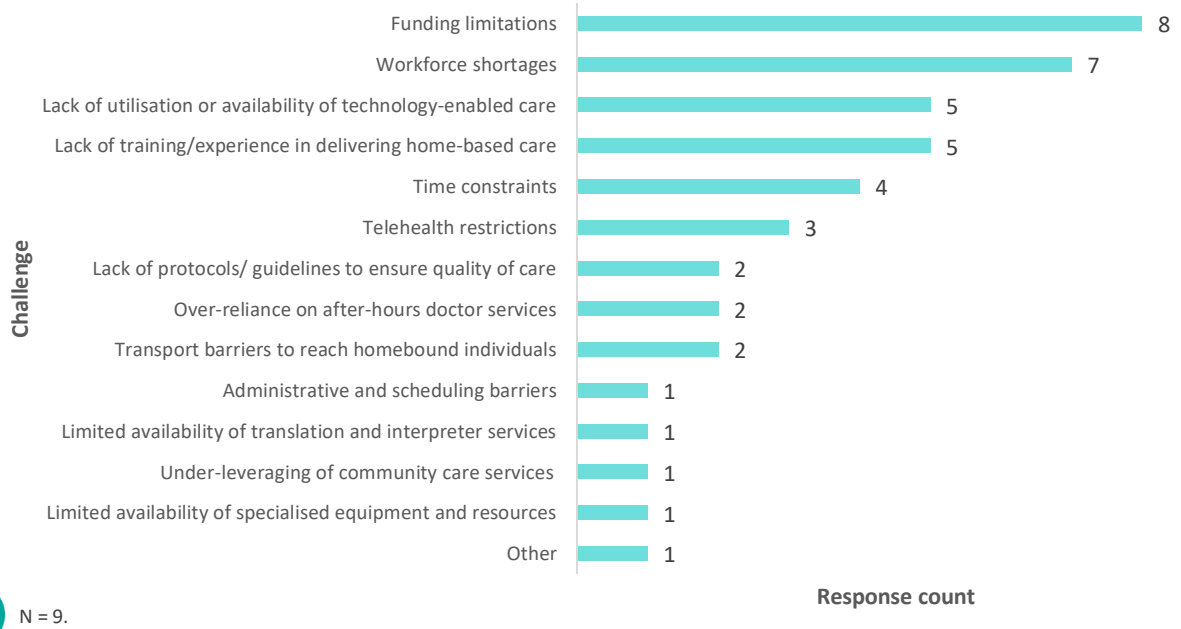


Figure 13.

Key challenges experienced in providing primary care services to homebound individuals



N = 9.

Note. Not all respondents selected their top five challenges that apply to their area of work or organisation (e.g., some respondents only chose three).

4.2. Workforce challenges in delivering primary care at home

4.2.1. Workforce expertise in delivering home-based care

The primary care workforce has limited opportunity for training specific to home-based care, both relating to home visits and virtual modalities, in the course of tertiary, post-graduate, residency and fellowship programs.

Telehealth was widely adopted over the course of the COVID-19 pandemic, becoming a core care delivery channel for homebound patients. Despite the rapid uptake of virtual care modalities, incorporation of telemedicine teaching interventions in undergraduate medical curricula has not kept pace, according to an international systematic review. The review found that there is a limited number of training opportunities to learn telemedicine in undergraduate years, and these approaches are not founded on solid evidence on their effectiveness. [1] A lack of training has been widely cited as a barrier to telehealth adoption by clinicians.[2] In its Position Statement on the use of telehealth in general practice,' The Royal Australian College of General Practitioners (RACGP) emphasises its "commitment to supporting GPs to develop the skills needed to provide telehealth services" and cautions that virtual care should be delivered by trained professionals, such as GPs with fellowship.[3] Workshop engagement identified that telehealth modalities in general practice were well-integrated into care delivery and viewed as a supplement to face-to-face consultations, which are strongly preferred, especially for the complex homebound patient cohort.

Home-Based Primary Care (HBPC) utilisation has increased in line with home care medicine in response to the COVID-19 pandemic. This mode of primary care delivery offers a viable alternative to face-to-face consultation in the practice setting, and has a demonstrable benefit in reducing ED presentations, inpatient admissions and readmissions, nursing home days and cost of care for the vulnerable homebound population. Benefits unique to home-based care have been reported, including a holistic view of the environmental and social factors affecting patient care, as well as strengthened relationships with patients and an understanding of the community- and systems-based resources that exist to support patients and families.[4]

There is a correlation between exposure to home visits in residency and an increased interest in incorporating home visits in future practice for

[1] Waseh, S., & Dicker, A. P. (2019, April 8). *Telemedicine Training in Undergraduate Medical Education: Mixed-Methods Review.* JMIR medical education, 5(1), e12515. https://doi.org/10.2196/12515.

[2] Garber, K., & Gustin, T. (2021, October 5). *Telehealth Education: Impact on Provider Experience and Adoption.* Nurse educator, 47(2), 75–80. https://doi.org/10.1097/NNE.0000000000001103.

[3] Royal Australian College of General Practitioners (RACGP). (2023, October). *The RACGP position on the use of telehealth in general practice.* https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/racgp-position-telehealth-general-practice

[4] Miller, R. K., Morgan-Gouveia, M. D., & DeCherrie, L. V. (2022, June 16). *Medical Training in Home Care Medicine: The Time is Now.* Journal of general internal medicine, 37(9), 2302–2305. https://doi.org/10.1007/s11606-022-07514-4

these practitioners. Despite this, trainees generally lack formal training in the skills needed to deliver care in the home, and those services which could be provided in the home setting.

A range of skills are required to deliver HBPC, including those relating to multidisciplinary care coordination, management of complex and multimorbid patients, management of urgent issues in the home, primary palliative care and functional and cognitive assessments.[20] Current medical training does not routinely cover home visit experiences, and if done, it is limited to a single house call or a lecture/small group discussion on the topic, limiting practical skill acquisition.[5] This sentiment was echoed in workshop discussions, with health professionals reporting a lack of home visit exposure as part of contemporary tertiary medical and nursing training, as well as medical residency and the AGPT program.

Workshop attendees raised that general practice registrars and newly trained GPs were typically unlikely to conduct home visits as a result of limited exposure in the course of their training. They reported a lack of opportunities for undertaking supervised home visits, a lack of training on how to deliver quality care in the absence of resources available in the practice setting, limited exposure to the community- and systems-based resources in place for patients in this setting, and a lack of guidance on managing home visits amongst the demands of primary practice to reduce burnout risk.

"There is a lack of skillset in upcoming GPs to conduct home visits. Home visits used to be a part of the job and expected, however, attitudes and cultures have changed. (GP).

4.2.2. Safety and risk

Stakeholder consultation revealed that safety challenges are a deterrent for primary care providers in undertaking home visits, especially for female providers. GPs performing home visits were subjectively reported to commonly be male. On consultation, primary care professionals stated that before conducting a home visit, the patient's home environment and safety concerns were routinely assessed. Often, only those patients well known to the practice and/or having a regular GP at the practice were considered suitable for a home visit, noting that these patients have typically been seen in the practice environment first.

Most primary care home visits are currently conducted by GPs, practice nurses or pharmacists attending the home on their own, with only a portion of home visits being conducted in pairs, groups or with a chaperone present. Even with pre-screening and the completion of a home visit risk assessment/safety check, this current model leaves primary healthcare professionals vulnerable to risks in the home environment. Such risks may include dangerous or uneven ground in the home, slip hazards, presence or use of weapons, animal attacks, aggression from the patient or others in the home and other personal safety risks.

A home visit risk assessment/safety screen specific to the primary care setting is not currently available to primary care practitioners and may not be a mandatory check in all practices prior to conducting a home visit. Such an assessment typically encompasses screening and identification of hazards, risk assessment, determination of controls and mitigants, final determination of safety to conduct a home visit at a given time, and an approval and review process. Such assessment allows the identification of those situations where a

[5] Miller, R. K., Morgan-Gouveia, M. D., & DeCherrie, L. V. (2022, June 16). *Medical Training in Home Care Medicine: The Time is Now.* Journal of general internal medicine, 37(9), 2302–2305. https://doi.org/10.1007/s11606-022-07514-4

home visit should not be undertaken, where the risk to employee safety is high or extreme.[6,7]

> *"Many home doctors have a driver or a chaperone which has its own medico-legal implications; claims of inappropriate patient examinations, especially after hours.*

Chaperones are an effective mitigant for risks commonly encountered in the home setting. They also serves as a source of practical support to deliver clinical services in the home, such as note-taking and other administrative functions. This protects the primary care professional conducting the home visit from reputational risks and reduces the risk of false allegations which may arise from conducting home visits alone. Home visiting doctor services often utilise a chaperone model to support and assist home visiting doctors on their after-hours shifts. According to one home visiting doctor service, a chaperone's responsibilities include accompanying doctors to patient visits in their homes, assisting with medical paperwork and online bookings.[8] Despite this, chaperoning is often not feasible with the staffing constraints of the primary care practice environment, preventing more than one primary care professional from being away from the practice at any one time.

> *"In South Australia, there have been cases of practitioners being injured during home visits. This can be a real safety concern. (GP).*

4.2.3. Sustainable pipeline, recruiting and retaining providers

GP pipeline challenges

The seventh annual *General Practice: Health of the* Nation report highlights attraction and retention of the general practice workforce as their 'topic of interest' for 2023.[9] The report identified worsening workforce issues, with supply of GPs a key concern.

Reduced interest in a career in general practice was noted amongst both medical students and working GPs, likely to affect pipeline.[24] The number of doctors entering the AGPT has fluxed since 2016, with a significant decline from 2017 to 2020, and a further decline from 2021 (1320) and 2022 (1356), to 2023 (1130).[24] On the other end, there was a noted increase in the number of GPs intending to retire or cease practicing, with almost three in 10 GPs intending to retire in the next five years.[24]

The Australian Medical Association (AMA) notes in its report, *The general practice workforce: why neglect must end,* that the demand for GP services increased by 58% between 2009 and 2019 in Australia, however, projected an undersupply of around 10,600 GP FTEs by 2031–2032.[10] This is predicated on GP training places continuing to remain unfilled, and the rate of retirement and attrition from the profession escalating. Queensland did, however, have the highest rate of GPs comparative to other states in 2020, with 122.9 for every 100,000 people.[25] It is therefore clear that community demand is expected to further outstrip the supply of GPs in the coming years.

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[6] Queensland Government. (2018). *A guide to working safely in people's homes.* Office of Industrial Relations – Workplace Health and Safety Queensland. https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0012/22233/community-working-safely-in-peoples-homes.pdf

[7] National Disability Services. (2010, January). *OHS Home Visit Checklist. Risk Management Resource, Strengthening the Sector.* https://www.nds.org.au/images/resources/resource-files/risk_management/home_visit_checklist.pdf

[8] House Call Doctor. (n.d.). *Chaperone Careers.* https://housecalldoctor.com.au/careers/chaperone-careers/

[9] Royal Australian College of General Practitioners. (2023, November). *General Practice: Health of the Nation 2023.* http://www.racgp.org.au/hotn

[10] Australian Medical Association. (2022, November). *The general practitioner workforce: why the neglect must end. AMA's plan to Modernise Medicare.* www.ama.com.au

Subsequent to the COVID-19 pandemic, GPs are often booked out long in advance, sometimes months at a time. These factors are likely to lead to high levels of primary care practitioner burnout and a reduced ability to deliver services considered to be a high time investment for low financial value to the practice, such as home visits and telehealth consultations. A key callout in the *General Practice: Health of the* Nation report was a significant decrease in GP job satisfaction over the past year, down from 70% in 2022 to 66% in 2023; with the greatest challenges in this regard identified as maintaining income and managing workload.[11] This sets the scene for the challenges experienced in recruiting and retaining GPs to deliver care to homebound individuals.

Home visits are difficult to incorporate around a tight schedule of back-to-back in-clinic and telehealth consultations, resulting in most GPs conducting house calls before or after their usual consultation hours, impinging on personal time. Health professionals engaged in consultation suggested that attitudes towards culture and professional expectations of general practice were changing, with a lower willingness by practitioners to provide services outside of standard working hours, and a greater desire for flexibility in working. Patient expectations of care quality and timeliness have increased, as raised by a GP in a one-on-one consultation. The result is less room for delays in appointments, making home visits exceedingly difficult to integrate into the primary care provider's consultation schedule.

Workshop participants discussed that the appeal of delivering home based care for GPs is limited by constraints on time, financial benefit to the practice and a lack of supports; ultimately impacting the recruitment and retention of GPs and other primary care professionals to provide home based services. Those GPs who currently provide home visits largely do so due to intrinsic motivation and an altruistic desire to provide care to this underserved cohort, often at the detriment to their personal time and at high risk of burnout. There is little impetus to support and motivate such primary care professionals to continue to provide these services through professional development, appropriate remuneration for services rendered or other means. Whilst GPs in general practice could supplement their income by conducting home visits outside of their clinic hours, this may not be practical given the existing shortages and burnout concerns raised.

> *"Often GPs have to provide this service out of hours or on weekends. The current model disincentivises and deters GPs from completing home visits.*

A core retention factor driving job satisfaction for clinicians providing HBPC is how well the HBPC program achieves its goals and values. This may include home care services successfully preventing unnecessary hospitalisation or nursing home admission, successful outreach to a fixed homebound individual, or establishing a close relationship with the patient (or caregiver).[12]

Queensland Health has committed funding to address the broader medical practitioner shortage ($5m / annum), focussing on maldistribution of the workforce in terms of geography and specialty.[13] Strengthening the primary care medical workforce is one of the focus areas of Queensland Health's

[11] Royal Australian College of General Practitioners. (2023, November). *General Practice: Health of the Nation 2023.* http://www.racgp.org.au/hotn

[12] Kim CO, Jang SN. *Home-Based Primary Care for Homebound Older Adults: Literature Review*. Ann Geriatr Med Res. 2018 Jun;22(2):62-72. doi: 10.4235/agmr.2018.22.2.62. Epub 2018 Jun 30. PMID: 32743249; PMCID: PMC7387609.

[13] Queensland Government. (2023, April 26). *Medical Practitioner Workforce Plan for Queensland. Queensland Health.* https://www.health.qld.gov.au/system-governance/strategic-direction/plans/medical-practitioner-workforce-plan-for-queensland

Medical Practitioner Workforce Plan for Queensland 10-year plan. The focus of this plan for primary care is in regard to the rural health workforce, extending limited benefit to improving access for homebound patients in the Brisbane South region. Given this patient population is relatively small in relation to the general populace, there needs to be sufficient funding and/or other incentives to appropriately attract GPs to deliver home-based care. These incentives will likely need to be additional to existing MBS reimbursements.

Primary care nursing pipeline

The primary care nursing workforce are also experiencing significant challenges in attraction and retention, with downstream impacts on the ability to optimise multidisciplinary services access for homebound consumers.

The Australian Primary Health Care Nurses Association (APNA)'s most recent Workforce Survey (2021), with over 1,000 respondents across Australia, found that more than a quarter of nurses working in the primary care setting were planning to quit in the next two to five years.[14]

The Nurse practitioner (NP) workforce is often seen as a feasible alternative to addressing GP shortages to better support health and aged care. The DoHAC Nurse practitioner workforce plan[15] seeks to improve the use of NPs to better support the growing ageing population, the burden of chronic illness and increasing complexities of care. NPs have the experience, expertise and authority to diagnose and treat people of all ages with acute or chronic health conditions. Despite this, access to NPs is very limited in the primary care setting, and a large portion of this workforce is based in regional, rural and remote areas.

4.3. Models of care and system-level care coordination

Barriers relating to current care models, care coordination and collaboration across the complex health ecosystem impacts quality care access for consumers across the homebound continuum.

4.3.1. Limitations in the current sole primary care provider model for delivering homebound care

GP-led team-based primary care is often recognised as the most effective and high performing primary care delivery model. This is because it places the patient and care continuity at the centre, enabling

[14] Gardiner, S., (2021) APNA Workforce Survey 2021. *Complex Care Takes a Back Seat.* Australian Primary Health Care Nurses Association (APNA). https://www.apna.asn.au/files/DAM/4%20News/2022/APNA%20Workforce%20Survey%202021Survey.pdf

[15] Australian Government, Department of Health and Aged Care. (2023, May 16). *Nurse Practitioner Workforce Plan.* https://www.health.gov.au/our-work/nurse-practitioner-workforce-plan

all health professionals to practice to the top of their clinical scope. In such a model, GPs have the time and capacity to focus on tasks that only they can perform, including diagnosis, treatment and overall medical management of the patient.[16] Such a coordinated and multidisciplinary approach is highly beneficial to deliver care to patients who are temporarily and fixed homebound, especially when it links into existing community supports, and secondary and tertiary care providers.

Despite momentum towards GP-led team-based primary care, the homebound state creates additional complexity which has rendered such a model difficult to implement in practice. Workshop and consultation insights revealed that currently, GPs in the Brisbane South region typically coordinate care for homebound patients alone, with siloes forming in care delivery across primary, community and secondary/tertiary care providers.

Primary care practitioners consulted reported that not many GPs are willing to engage in providing services in the home, resulting in those who do provide these services having to coordinate and deliver all aspects of care singlehandedly. Such GPs reported feeling overwhelmed by shouldering the entire primary care responsibility for a patient, including diagnosis, workup, interventions, ongoing monitoring, care planning and all related administrative functions. They reported this challenge largely arose from home-based care lacking the supports present in the practice environment, such as booking and scheduling by administrative staff; initial observations, and assessment and other well-delineated tasks such as wound care by a practice nurse. Current Medicare funding arrangements are outdated, and most have not been updated since 2012,[17] resulting in a lack of Medicare coverage for non-medical professionals being involved in care delivery, ultimately precluding a truly multidisciplinary approach to HBPC.

Other challenges noted by workshop participants pertaining to the sole-practitioner approach to HBPC, include, but are not limited to:

- When the usual GP for a temporary or fixed homebound patient goes on leave or separates from the practice, there are often no other GPs or primary care professionals to take on ongoing care.
- A greater risk of patients, carers and family overstepping care boundaries with the sole primary care provider. An example shared was that carers and families of homebound patients were more likely to call, email and seek out the GP for all extraneous care needs which would otherwise fall outside of their purview.
- GPs are just one of a number of providers home bound patients may need to access, such as pharmacy, physiotherapy, occupational therapy and dietetics. Where the GP is the sole primary care provider, these other crucial roles are either taken on by the GP or not available to the patient.
- Gaps in care available outside of standard hours, especially on weekends and evenings/nights where the usual GP may not be available. Community triage services and involvement of a broader multidisciplinary team for temporary and fixed homebound patients would reduce the strain on after-hours doctor services and EDs.

[16] Australian Medical Association. (2022, November*). The general practitioner workforce: why the neglect must end. AMA's plan to Modernise Medicare.* www.ama.com.au

[17] Australian Medical Association. (n.d.). *AMA's plan to Modernise Medicare.* https://www.ama.com.au/modernise-medicare

4.3.2. Barriers to shared, collaborative and continuous care delivery in the broader ecosystem for homebound patients

Fragmentation of care is of particular concern for homebound consumers/patients, particularly partially and fixed homebound cohorts. These patients tend to be medically and socially complex and frequently have multiple healthcare professionals involved across community, primary, secondary and tertiary health services.

Stakeholder engagement identified the following key contributors to care fragmentation for these cohorts.

After-hours doctor services

In the instance where homebound patients are regularly accessing after-hours doctor services, there is inconsistency in the provider delivering these services, and care is focussed on interim measures and interventions requiring follow-up by their usual GP. Handover between after-hours doctors and GPs is limited, with the onus on the patient to advise their primary care provider of any follow-up requirements. This poses a challenge for homebound consumers who may not have ready access to a timely GP consultation, either via home call or telehealth. Additionally, stakeholders raised concerns that the care delivered by after-hours doctors may not be in line with primary care standards as these medical professionals are often not GPs.

Community care providers

Models of community care delivery, especially NDIS and My Aged Care services, do not integrate effectively into primary care delivery for homebound patients. The challenge of community care provision running in parallel, but not intersecting, with primary care was stated as an overwhelming challenge.

Case management through community care providers often does not involve the consumer's GP in care planning, and there is a notable lack of bidirectional communication. As a result, the role of the GP in coordinating care for these patients is uncertain. Primary care providers felt out of the loop in the maintenance phase of the care pathway and reported only being involved when medical administrative requirements arose (e.g., NDIS medication and access request/review forms). The phase of care where GPs felt they had most clarity is relating to functional and Aged Care Assessment Team (ACAT) assessments, where comprehensive results are directly communicated with them. As a large proportion of partially and fixed homebound consumers have community support packages, this creates a notable gap in synchronising a holistic patient-centred care team across providers and funding channels.

> *"The NDIS model has taken the GP away from being the coordinator of the patient's care… There is no clear view of who is seeing the patient now.*

> *"The layer of communication between the GP and the community nurse is gone. Communication books are limited unless they are driven by the family. (GP).*

Acute care integration

Challenges exist in care continuity, coordination and effective shared care between primary and tertiary care providers. When patients require acute inpatient care, ED and inpatient health professionals have limited access to the patient's My Health Record. Even in circumstances wherein a consumer's My Health Record contains a chronic disease care plan uploaded by the primary care provider or identifies a registered GP, this information is not easily accessible to inpatient clinicians. As a result, duplication of investigations and interventions may occur due to a lack of visibility of what has been trialled in the primary care setting. This has been attributed to, in part, the complexity in accessing My Health Record and other digital patient records through 'the Viewer' in the inpatient setting, with some clinicians not having

access or not knowing how to navigate within the platform.

When a patient is discharged from the acute setting, GPs reported frequent delays in access to discharge summaries and their contents lacking clear follow-up requirements. Verbal handover was seldom received from inpatient to primary care providers. Post-acute and Hospital In The Home (HITH) services were often more consistent in their handover practices to primary care providers, promoting care continuity. An example in the Brisbane South region is the Metro South Disability Nurse Navigators who routinely provide support and link in with community services in the post-discharge phase for eligible patients, communicating directly with primary care providers to hand over ongoing care needs.

"The Brisbane South PHN and Metro South Health Palliative Care GP Shared Care Model is supporting GPs to share the care with tertiary services and to also attend the patient's home for visits. (Manager).

Broader community supports

Primary care providers have limited visibility of local community and non-for profit (NFP) supports available to homebound patients. There is opportunity for these agencies and eligible programs to be used to supplement primary care delivery, including social prescribing measures for preferentially and partially homebound consumers to facilitate clinic attendance. Examples of local community supports discussed include First Nations community engagement, peer support and mental health and wellbeing programs run by various NFP and private organisations, including Wesley Mission Queensland.[18] Through consultation, participants identified a particular need for community supports for patients with mental health disorders, which comprises a large proportion of all homebound consumers.

4.3.3. Lack of standardised protocols and guidelines for delivering home-based care

Delivering home-based care requires standardised protocols and guidelines to ensure consistency and quality of services for homebound patients.

Clear standards relating to eligibility criteria for different homebound patient cohorts and the models of primary care for these specific cohorts would support coordinated care delivery. Defining the homebound population has the secondary benefit of enabling development of targeted programs and initiatives at a regional level to improve access to primary care.

Guidance is required on deciding whether a patient clinically requires a home visit, or if preferentially homebound, the interventions to promote and facilitate such patients coming into the clinic. Some practices in the Brisbane South region have implemented practice guidelines to encourage face-to-face consultations where clinically appropriate, such as requiring a face-to-face consultation after three consecutive telehealth consultations and coordinating with carers to facilitate patient transport into the practice.

"It is still necessary to provide face-to-face care from time to time… [which] is underfunded and unsupported. (GP)

Stakeholder engagement highlighted the need for basic guidelines on conducting a home visit for primary care practitioners who may not have delivered care outside of the practice setting before, in the form of a 'clinician's toolkit.' Evidence-based protocols and guidelines for effective and high-quality care delivery to homebound patients do not

[18] Wesley Mission Queensland. (n.d.). *Mental Health Services, Help and Support*. https://www.wmq.org.au/mental-health

currently exist at a local, state or national level, as reported by workshop attendees. Currently, GPs perform home visits ad-hoc, typically as a service attached to their usual practice. Collaborative efforts involving healthcare professionals, policymakers, and researchers can contribute to the establishment of standardised protocols and guidelines for delivering effective HBPC.

4.4. Funding and policy

Challenges snapshot

- Fragmentation of systems-level funding (and care)
- Limitations in Medicare funding for primary care delivery in the home setting
- Complexity in navigating Medicare and reimbursements

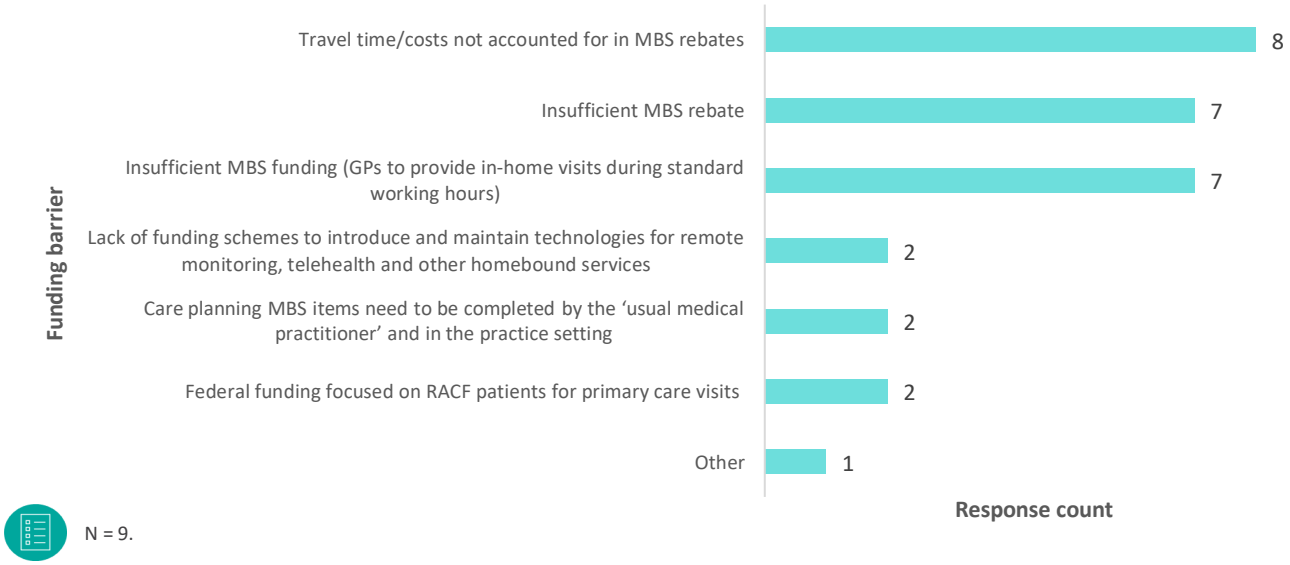
Workshop and one-on-one consultations flagged adequacy of funding as a top barrier to timely, coordinated and comprehensive primary care access for homebound patients. ***Figure 14*** depicts the high-level funding barriers, identified through the survey, relating to the provision of care to homebound consumers. The most frequently identified barrier by respondents was travel time and costs not being accounted for in existing MBS rebates for home visits.

4.4.1. Integration of funding (and care)

A notable challenge with Australia's federated system is the potential divide and lack of integration between commonwealth and state managed services i.e., between primary and hospital-based care. The fee-for-service and activity-based funding models applicable to general practice and hospitals mean that gaps in care can exist as patients transition between settings or interact with multiple providers. Homebound patients lacking adequate access to a usual GP are more susceptible to slipping between the cracks with no regular care provider to glue the multiple care interactions together.

Figure 14.

Funding barriers to provision of timely and comprehensive care to homebound consumers



Note. Not all respondents selected their top 5 barriers that applied to their area of work or organisation (e.g., some respondents only chose 3).

Most fixed homebound patients, and some temporary and partially homebound patients, will likely be receiving funding through either the NDIS or in-home aged care programs (Commonwealth Home Support Program and Home Care Packages Program). These avenues and packages of services do not fund services provided by GPs and other primary care professionals. Notably, services rendered by a GP or a primary practice pharmacist are not covered. For such homebound patients, there is fragmentation of care not only between hospital and primary care providers, but also NDIS and aged care providers.

There are currently no bundled funding arrangements in place to pool or attach funding from varied sources to an eligible consumer. This includes community support services such as NDIS and My Aged Care, and Medicare-funded primary care services. A needs-based bundled funding model would promote a cohesive and integrated approach to patient-centred care delivery, especially for fixed homebound patients with complex medical and social needs.

4.4.2. Limitations in Medicare funding for primary care delivery in the home setting

Primary care is predominantly funded through Medicare and patient co-payments. Access to some item numbers or other Medicare benefits such as MyMedicare can be inherently limited for the homebound patient cohort, especially those who are fixed homebound.

Stakeholder engagement identified limitations in Medicare applicability and coverage for homebound consumers, as summarised in ***Table 3***.

Table 3.

Challenges in Medicare applicability and coverage affecting primary care access for homebound patients

Homebound cohort not defined	Fixed and temporary homebound patients do not typically classify for MBS item exemptions or additional benefits on the basis of their homebound status. This is predominantly attributable to the difficulty in defining the homebound population, and a lack of established eligibility criteria for those sub-populations who would qualify as fixed or temporary homebound. The introduction of additional MBS items or exemptions to existing items to improve primary care accessibility requires that the criteria to classify an individual as 'homebound' be established at a national level.
Chronic disease management item inaccessibility	Some MBS items, such as those for chronic disease management, are infrequently accessible to homebound consumers. This is the consequence of these items only being available as in-person consultations and deliverable exclusively by the patient's 'usual medical practitioner.' Additionally, these consultations are often difficult to complete in the home setting, resulting in homebound patients missing out. Exemptions to the in-person requirements for these MBS items do not exist for homebound consumers.[a] Those fixed and partially homebound patients who do not have a regular primary practice or GP willing to conduct home visits, or those only accessing locum doctors through an after-hours home visiting service, may be precluded from accessing these services in the absence of a 'usual medical practitioner'. This is a significant gap limiting primary care coordination for fixed and partially homebound consumers who frequently have complex care needs, chronic disease and multimorbidity – a patient cohort that would greatly benefit from these chronic disease management MBS items.
Mental health treatment planning item inaccessibility	Some MBS items, such as those for mental health treatment planning, do not have a requirement to be completed by a 'usual medical practitioner,' however, are viewed as better performed by a patient's usual GP. The maximum benefits of GP Mental Health Treatment Plans (GPMHTP) are achieved through the GP's ongoing involvement and coordination of the patient's mental illness, serving as the point of care continuity.[b] As a result, mental health treatment planning MBS items are often less accessible to homebound consumers who do not have a 'usual medical practitioner.' Notably, however, Medicare items for GPMHTP, reviews and consultations are more accessible for homebound patients as they are available through telehealth, with an equivalent benefit amount to the aligning in-person attendance MBS items.

[a] Services Australia. (2023, November 28). *Chronic disease GP Management Plans and Team Care Arrangements*. Australian Government. https://www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements

[b] General Practice Mental Health Standards Collaboration. (n.d.). *What is a mental health care plan? Developing and reviewing a GP MHTP*. https://gpmhsc.org.au/info/detail/11920366-5b75-449e-9503-e8143478817b/why-do-mental-health-treatment-plans

Table 3. (Continued)

Challenges in Medicare applicability and coverage affecting primary care access for homebound patients

MyMedicare barriers	With the introduction of MyMedicare, a national voluntary patient registration program through Medicare, patients will achieve additional benefits that may improve access to care, such as longer MBS-funded telehealth consultations and bulk billing incentives for longer MBS telehealth consultations.[c] MyMedicare eligibility, however, relies on a patient being linked to a usual practice or GP with whom they have had at least one face-to-face consultation in the 12 months preceding, with 'established clinical relationship' requirements and exemptions applying.[d] Despite exemptions to the 'established clinical relationship' requirement existing for other patient cohorts including people who are homeless,[d] there are no exemptions for homebound consumers, restricting uplifted primary care access for this cohort. Whilst targeted MyMedicare benefits will be available to RACF patients, it does not appear these benefits will been extended to homebound patients, despite both cohorts experiencing similar limitations with access to care. Targeted benefits under the General Practice in Aged Care Incentive will come into effect from 1 August 2024, supporting regular health assessments, care plans and regular GP visits for people in RACFs.[e] Such benefits would improve primary care access if extended to eligible partial and fixed homebound consumers. New blended funding payments rolling out in 2024-2025 under the MyMedicare scheme will support better care in the community for people with complex and chronic disease who frequently attend hospitals,[e] however whether this will improve access for homebound consumers is not yet clear.
Decline in telehealth availability	The revocation of temporary MBS rebates as of 1 July 2022, which were introduced in response to the COVID-19 pandemic,[f] has resulted in a subjectively reported decrease in utilisation of telehealth consultations across the Brisbane South region. The greater administrative requirements for telehealth consultations, predominantly relating to the completion of consent documentation subsequent to these changes, have resulted in a shift towards private billing of telehealth consultations, and therefore reduced accessibility for homebound patients due to financial and administrative barriers.
Home visit items are insufficient	Despite the reimbursement for home visits being more generous than that of practice- or RACF-based reimbursements, GPs and practices delivering home-based care will be worse off once patient scheduling, travel time and costs, navigating the home environment, administrative tasks attached to home visits, necessity to deliver multiple services in one visit, and homebound patient complexity is taken into account. This risk naturally acts as a disincentive for delivering bulk billed care to this population. Notably, the MBS reimbursement is $28.55 higher for routine hours short, standard, long and prolonged consultations in the home compared to in the practice.[g] This same difference in reimbursement amount applies regardless of distance to the patient's home from the practice. Workshop participants raised that this difference is insufficient to cover the cost of home visits compared to in-practice consultations, especially in light of reduced administrative and nursing supports in the home setting. Refer to ***Appendix 6.2.2*** for a table of relevant MBS item numbers claimable for in-surgery, home, and RACF consultations.
Increased out-of-pocket costs for primary care	Bulk-billing rates are falling and limited access to bulk-billing GPs continues to see patients facing higher out-of-pocket costs, amid rising operational costs and Medicare indexation not keeping pace. To remain sustainable, practices are needing to either absorb the gap in cost to provide quality services and risk becoming unviable or pass more of the cost onto patients (with either higher out-of-pocket costs, reduced time spent with patients, or reduced bulk-billing of patients).[h] Medicare statistics revealed that 80.5% of all Medicare services were bulk billed during the recent December 2023-24 quarter, with the last time the quarterly figure dropped below that being in 2010-2011.[i] This was echoed in Cleanbill's most recent report released in early 2024, which found that the rate of bulk billing across Australia had dropped by 11.1% between April and November 2023, standing at 24.2% nationally (Queensland 17.6%).[j] The average gap fee paid was also noted to be on the rise across Australia, at $41.68 (Queensland $41.27), coming in 3.1% higher than early 2023.[j] The Commonwealth Bank's GP Insights Report 2023, based on a survey of more than 200 practices nation-wide, revealed that a further 25% of practices are considering reducing bulk billing and increasing gap fees in the coming year.[k] This disproportionately impacts access to primary care for vulnerable populations such as those homebound, and those reliant on disability or other social welfare payments as their primary source of income.
Non-inclusion of non-medical home visits	Multidisciplinary and non-medical home attendance is not encouraged through the current MBS inclusions. Non-medical home visit items are limited and reduce the home-based care offering significantly to what can be offered by medical practitioners during a home call. Nursing and allied health services in the home setting are therefore limited to private billing, minimising their utility for homebound patients for whom this is often not financially viable. Where non-medical health professionals accompany a GP on home visits, this cost tends to be worn by the practice, making this untenable on a regular basis or for multiple patients, and unsustainable in the long term.

[c] Australian Government, Department of Health and Aged Care. (2023, November 13*). Information for MyMedicare general practices and healthcare providers*. https://www.health.gov.au/our-work/mymedicare/practices-and-providers

[d] Australian Government, Department of Health and Aged Care. (2023, November 6*). Continuing MBS Telehealth - Video and Phone Services - For Medical Practitioners in General Practice*. https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Updates-April%202023

[e] Australian Government, Department of Health and Aged Care. (2023, November 13*). Information for MyMedicare general practices and healthcare providers*. https://www.health.gov.au/our-work/mymedicare/practices-and-providers

[f] Australian Government, Department of Health. (2022, April 11). *MBS Changes Factsheet. Continuing MBS Telehealth Services - GPs and Other Medical Practitioners.* https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Arrangements-Jan22

[g] Weller., A. (2023, October 3). MBS Quick Guide October 2023. *Australian Association of Practice Management*. https://www.aapm.org.au/Latest-News/Latest-News/mbs-quick-guide-october-2023

[h] Australian Medical Association. (2022, November). *The general practitioner workforce: why the neglect must end. AMA's plan to Modernise Medicare.* www.ama.com.au

[i] Royal Australian College of General Practitioners (RACGP). (2023, February 22). *RACGP: Falling bulk-billing rates a sign of things to come [Media Release]*. https://www.racgp.org.au/gp-news/media-releases/2023-media-releases/february-2023/racgp-falling-bulk-billing-rates-a-sign-of-things

[j] Orr, A. (2024, January 8). *Where you're most (and least) likely to find a bulk-billing GP*. SBS News. https://www.sbs.com.au/news/article/where-youre-most-and-least-likely-to-find-a-bulk-billing-gp/pw1etkjjq

[k] Commonwealth Bank of Australia. (2023). *Healthy practices, healthy patients. How GPs are responding to sustain Australia's primary care sector*. CommBank GP Insights. https://www.commbank.com.au/business/foresight/reports/gp-insights-report.htm

> *"Medicare rebates are completely insufficient… it literally costs a practitioner to provide home visits. (GP)*

4.4.3. Complexity in navigating Medicare and reimbursements

Even when there are MBS items that can be claimed, navigating MBS arrangements is complex and often, GPs may not be aware of the full scope of items that can be claimed and associated rules. This lack of awareness can disincentivise GPs from performing consultations outside of their standard practice. Further, where MBS items do not cover the full scope of activities relating to home-based care, these services are either not offered or only available through privately billed consultations to homebound patients.

There is an opportunity to uplift awareness and clarity of the MBS items, rules and limitations applicable to delivery of home-based care, both in-person and virtual.

4.5. Technology-enabled care delivery

Challenges snapshot

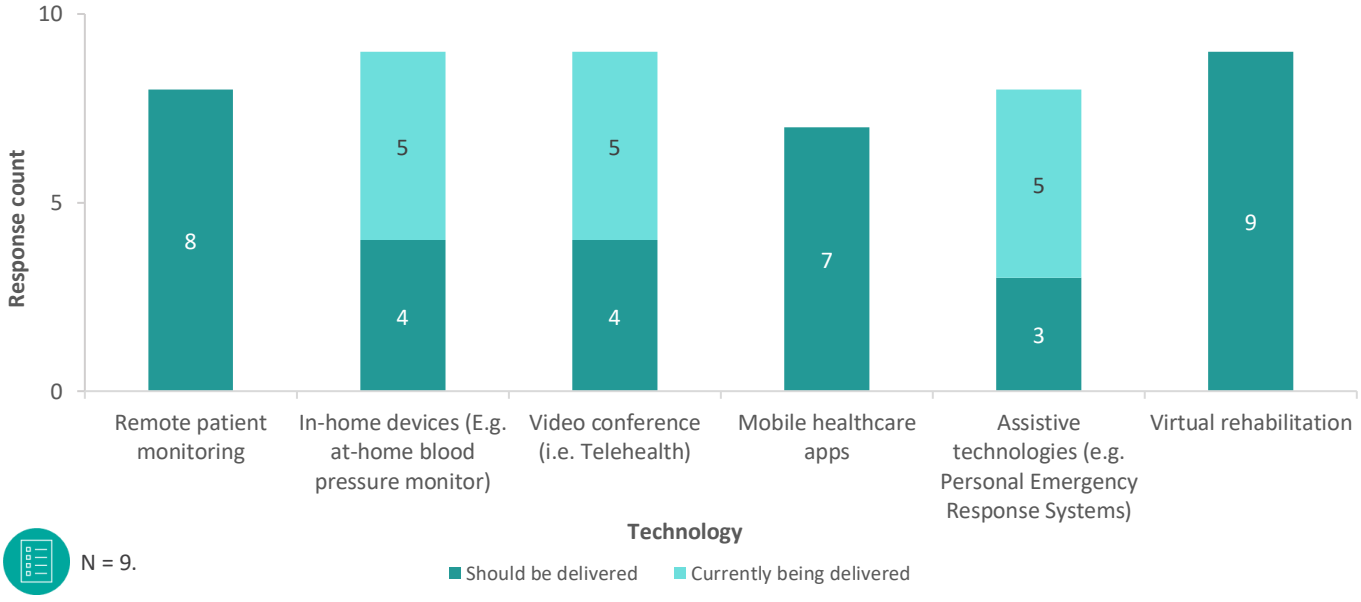
- Financial barriers to access
- Set-up and maintenance burden
- Primary care integration and patient data utilisation challenges
- Technological literacy and language barriers
- Technology infrastructure inaccessibility

Challenges identified through workshop and one-on-one consultation relating to the utilisation of existing technologies in HBPC include the following:

- Patients may be financially unable to purchase in-home devices such as at-home blood pressure monitors. Renting arrangements may

Figure 15.

Survey participant responses to types of technologies that should be used or are currently being used to provide primary care services to homebound individuals



be more accessible through community pharmacies, however, may still pose a challenge for fixed and temporarily homebound consumers.

- Remote patient monitoring requires set-up in the home, and the time investment makes this infeasible for primary care providers when conducting a home call. Ongoing maintenance of these devices, including remote ECG monitoring, needs to be conducted by the patient or carer, which can be a limiting factor.
- Mobile health care applications, including those for mental health self-monitoring and wellbeing self-reporting, can be difficult to integrate into primary care models for assessment and ongoing monitoring of disease.
- Technological literacy and language barriers can be an impact to uptake for both patients and primary care professionals.

> *"Patient cohort… may not be very confident utilising telehealth. (Nurse practitioner)*

- Primary care professionals require additional training and support to integrate these technologies into routine care delivery, creating a time and effort barrier to uptake.
- The patient data collected by home-based technologies can be extremely rich, however, primary care providers have reported a lack of guidance on how best to utilise this information to inform patient assessment and monitoring.
- Patients and primary care providers may have limitations in access to the necessary technology infrastructure, such as network connectivity and technology hardware (e.g., audio visual devices, phones, tablets and computers).

> *"We don't offer telehealth appointments regularly.. as a lot of our patients wouldn't have access to a webcam. We also don't have webcams available for all of our GPs. (Practice Manager).*

4.6. Equipment and resources

Challenges snapshot

- Specialised equipment and resources may be inaccessible for home-based care delivery
- Transportation access and workforce field management barriers to efficient and effective home visits

Challenges exist in the availability, use and funding for specialised equipment, transport and consumables required to deliver primary care services in the home.

4.6.1. Limited availability of specialised equipment and resources for home-based care

Challenges raised through workshop and one-on-one consultation include:

- The limited availability of specialised equipment and resources necessary for providing comprehensive care.
- Out of the home, patients can access a range of specialised equipment, pathology, diagnostic and treatment spaces, either on-site, in-clinic or locally. The provision of this scope of treatment is not feasible in the home.
- It is not practical for home visit GPs to carry a whole suite of consumables or drugs. The basic 'doctor's bag' is equipped only with equipment and consumables required to conduct standard assessments and deliver basic interventions. Comprehensive assessment and interventions are therefore limited in the home environment. Some equipment may be stocked at the GP's own expense.

> *In the practice, there's access to all the necessary equipment and supports like wound dressings, nursing and administrative staff. This is lacking in the home setting. (GP).*

> *Not having a properly equipped doctor's bag may be a barrier. (GP).*

4.6.2. Transportation and workforce field management for conducting home visits

Challenges raised through workshop and one-on-one consultation include the following:

- Providing home-based care can be prohibitive for providers who do not have a license or vehicle.
- There are additional cost constraints associated with performing home visits – vehicle mileage, insurance, registration – which providers or practices self-fund. Unlike community care providers (including NDIS and My Aged Care), GPs are not covered for their travel costs.
- There is a lack of workforce field management to optimise routes and create efficiency in home visits for primary care providers, reducing their practical feasibility.

5. Opportunities

Four areas of opportunity to improve access to primary care services for homebound consumers arose from the workshops, survey and consultations. These are depicted in ***Figure 16***. The overarching goal is as follows.

Homebound consumers in the Brisbane South PHN area should have access to primary care strategies, services and activities which optimise their health, wellbeing and quality of life, and that may reduce dependence on hospital services such as ED presentations and avoidable inpatient admissions.

Figure 16.

Key opportunity areas for improving access to primary care services for homebound individuals

The target population and access need

To better manage the health needs of homebound consumers in the Brisbane South PHN area requires:

- a clear definition and determination of the target population; and
- a baseline definition and understanding of the scope of the problem to be addressed and what is to be achieved.

Opportunity & key considerations
A comprehensive understanding of demand and the resources and infrastructure in the Brisbane South PHN local areas and a clearly articulated program rationale for this population will inform: i. The development of models of care including digital enablers. ii. Eligibility and funding streams. iii. Targeted workforce strategies aligned to cohort needs and models. iv. Advocacy goals and strategies. This will require: • A baseline of demographic, health and social determinants and epidemiological information. • Geographic information and area map of services and infrastructure (health, social, housing, education etc.). • Identifying the service gaps for each cohort within the homebound population. • Identifying what is addressable by primary care and the services required, articulation of program goals and ROI.

Models of care and care coordination

Primary care functions effectively when it is closely intertwined with specialist and other support services, alongside ready access to secondary and tertiary health sectors and other community-based resources. Clear care model pathways for homebound consumers that can be adapted to meet local needs and that support health professionals working as teams is fundamental to achieving good outcomes.

Opportunity & key considerations

To develop care delivery models, service blueprints and patient journey pathways as guides to help local services deliver primary care to many different types of homebound consumers. This includes articulating the roles along the care continuum to be played by the GP and the broader healthcare team and the responsibility for care coordination.

Opportunity area 1: Care model design

a) **Model design integrates leading practices used by others**. For example,
   - Adapt relevant design features of existing programs, for example triage and screening elements (among others) of the CARE-PACT aged care hospital substitutive care and demand management program.
   - Adapt relevant design features of palliative care model of multidisciplinary team, for example, program structure which is overseen by medical practitioner at the centre of care coordination.

b) **Appropriate use of technology** at the right stages of the care model. For example,
   - Hybrid care models that are a mix of in-person visits and virtual care. Virtual care/telehealth is appropriate for maintenance and management aspects of the care pathway, such as care follow-ups and script repeats, but investigations and physical examinations need to be done in-person.
   - Key design elements include supporting consumer digital literacy and capability to use telehealth and at-home monitoring devices and back-office set up, equipment and user training.

c) **Primary Care Team concept** through employing nurses, allied health, mental health clinicians, pharmacists and others within general practices alongside GPs.
   - Consider designing care pathways and workflow streaming that specify the roles played by multidisciplinary team members. This includes detailing who does what in the care continuum and where the GP skillset is best utilised, for example, care coordination, specific medical inputs, team leadership and supervision.

d) **A care model built on a core mix of services** to deliver a core bundle of services to homebound consumers. For example,
   - A core team consisting of a GP and one or more supporting clinicians who deliver a core bundle of services to homebound consumers.
   - In addition, a multidisciplinary pool of clinicians that augment the core services with a mix of discrete services (e.g., pharmacy, allied health).
   - Consider creating these additional/non-core services as a separate service layer. The PHN could play a role in facilitating provision of such services as a discrete service, for example, as a shared resource practitioner who operates across several teams/practices.

e) **Care model design features.** For example,
   - Key processes will include screening and enrolment, comprehensive assessments, multidisciplinary care meetings, care and case management, and coordinating community services and resources.
   - Consider care models that extend beyond a primarily medical focus to deal with the social determinants of health. For example, including social prescribing and mental health services.
   - Consider designing care models that cover different patient journeys and care needs. For example, consumers with long-term mental health needs or consumers temporarily homebound through receiving chemotherapy.

f) **Service quality standards and governance.** For example,
   - Service model design that aligns clinician expectations and duty of care obligations, for example, that the consumer will need to be seen in-person at a regular cadence by the GP/broader team.
   - Service model design to incorporate culturally appropriate care elements and supports (e.g., women's business, access to interpreters).

Opportunity area 2: Multidisciplinary home visits

For example,

a) **A multidisciplinary primary care team approach** to deliver care at home to homebound consumers (e.g., some combination of GP and practice nurse/ pharmacist/ allied health/Indigenous health worker).

b) **Team approach and/or chaperone approach** to avoid solo visits and support workforce safety.

Opportunity area 3: Care coordination

For example,

a) **Primary care coordinator role** as a first point of contact for consumers and community service providers.

- Establish the role of the GP as the primary coordinator of care and leader of the care delivery team.
- Design of roles to be performed by other health professionals in the care delivery journeys and pathways.

Opportunity area 4: Guidelines for homebound care delivery

For example,

a) **Home-based care model and practice guidelines** to support less experienced clinicians. For example,

- Service delivery guidelines and quality standards; FAQs of common protocols/common pitfalls; 'How-to Guides' on key topics (e.g., safety, house visit protocols, assessing the living situation).

New avenues of funding and policy advocacy

Addressing the funding constraints and opportunity costs of providers that currently work against delivering a primary care service to homebound consumers with sustainable solutions will support an effective team-based care model for homebound consumers with complex needs.

Opportunity & key considerations

To identify funding and policy levers that resolve the current financial and administrative constraints on providing primary care to homebound consumers.

Opportunity area 1: Eligibility

a) **Determining eligibility for services** including criteria and processes, covering the full range of the homebound population, from the preferentially homebound, the temporarily homebound, and the fixed homebound.

Opportunity area 2: Funding model changes

Funding model changes that support team care and enables time to be spent on complex cases. For example,

a) **Flexibility for general practices** to opt-in to new funding models to fund care for homebound consumers, that cover time for GP team leadership, a team-based care model and time to create and sustain ongoing relationships with patients.

- Options may include a flexible budget in a needs-based bundled/packaged funding attached to the patient (a 'homebound patient benefits bundle').
- Shift in practice business models built upon fee-for-service/volume driven funding to blended funding models that support team-based care alongside fee-for-service for individual visits.

b) **Funding PHNs** to support creation of partnerships between GP practices and creation of multidisciplinary networks (pools of staff) for shared resources working across multiple practices.

Opportunity area 2: Funding model changes (continued)

c) **Multidisciplinary team commissioning** through PHNs and Workforce Incentive Program – Practice Stream funding for multidisciplinary team-based models to support treatment of chronic and complex conditions.

d) **Changing models of remuneration** to pay GPs and others providing home-based care in other ways e.g., salaried positions, reimbursement to the practice to offset a salary.

e) **Examine current funding and incentives** programs for opportunities to support homebound consumers, for example General Practice in Aged Care incentive, Wrap around primary care for frequent hospital users, Chronic Disease Management items.

Opportunity area 3: Federal programs

a) **Seek specific consideration of the homebound cohort** eligibility and needs in programs with a federal focus, such as complex and chronic bundled payments.

b) **Consider a project to encourage patient registration** with a practice to promote recurring payment to cover services delivered in addition to the direct consultation, such things as travel, administration time/costs, other services consumed.

c) **Exemption for homebound consumers** from the face-to-face frequency and location requirements for access to telehealth.

Opportunity area 4: Changes to Medicare rebates

a) **GPMP, TCAs and Multidisciplinary Care Planning MBS items** to exempt in-person consultation requirement for 'eligible' homebound patients.

b) **Inclusion of non-medical professionals in home-visit items.** For example, cover home visits by multidisciplinary team members such as nurse navigator, pharmacist etc. to support a holistic care delivery model and maximise scope of targeted/bundled expertise.

c) **Increase Medicare rebate for telehealth consultations** and expand access for 'eligible' homebound consumers, including nursing, pharmacy and allied health consultations.

d) **Explore integration of medical and pharmacy services into NDIS coverage** to cover GPs for their role in care coordination and referral, and other primary care professionals for core service delivery.

e) **Cover travel expenses** and administrative tasks, insurance/liability, risk indemnity.

f) **Clear guidelines** of what the funding can and cannot be used for. Medicare rules simplification and less micromanagement of complex rules.

g) **Relaxation of funding rules** and regulatory restrictions that require excessive GP involvement that lead to double-handling and inefficiency.

Opportunity area 5: Changes in the care model

a) **Identification of what can be done virtually** that is currently required to be done in-person. For example, medication reviews, care planning.

Sustaining the workforce and facilitatory technology

To strengthen the provision of primary care services to homebound consumers by supporting GPs and other health professions to deliver the primary care needed by this population.

Opportunity & key considerations

Quality primary care service delivery requires trained practitioners confident in their skills base and supported in delivering care through access to funding, expert advice, tools and technologies and to share the workload through teams working to the top of scope.

Opportunity area 1: Sustainable workforce supports

To upskill and sustain the primary care workforce to work in the home. For example,

a) **Clinician training** pathways/curriculum to cover home-based care delivery e.g., certification or accreditation in home-based care delivery**.**
b) **New workforce roles and career pathways.** This may include exploring the opportunities for salaried health professional roles in general practices to pick up pre-GP visit screening, assessment/testing, post-visit follow-ups; and social prescribers or link workers to connect patients within their local communities.

Opportunity area 2: Technology supports

For example,

a) **Clinical information systems** that have mobile functionality, voice note taking capabilities for entry on-site and facilitate team/worker communication and information sharing in different contexts.
b) **Collaboration with local hospital.** Explore opportunities with hospitals to utilise existing expertise on digital health technology, devices and equipment; and provide the collateral support required to implement and sustain IT systems that support homebound care, and opportunities for remote home-monitoring.
c) **Health Pathways.** Consider establishing a dedicated homebound access and management care pathway.
d) **Homecare workforce management tools** to support scheduling, route mapping of consultations, real-time GPS locational information to optimise travel time, cost and worker safety.
e) **Scheduling of home care** in blocks of time e.g., 4-hour funded blocks that can be pre-scheduled.

Opportunity area 3: Accessible timely support for practitioners

For example,

a) **Helpline for practitioners** providing services to homebound patients. Similar to the CARE-PACT model, with a knowledgeable practitioner available for phone support as the first point of call for staff delivering front-line services.
b) **Establish a community of practice** for the Brisbane south region who provide services to homebound consumers – avenue to share innovative models of care delivery, lessons learned, funding opportunities etc.

6. Appendix

6.1. Case studies

6.1.1. Case study 1: Homebound consumer lived experience of access to primary care

Background

This case study is based on a consumer letter to a Member for Parliament in the Brisbane South region. The letter represents the lived experience of a homebound consumer seeking primary care.

Medical History

The consumer is a young adult female with a severe neurological condition. A complex and long-term condition, this results in chronic pain and the consumer being largely bedbound and unable to travel due to severe pain and fatigue.

Social History

The consumer is cared for by family full-time and receives NDIS funding.

Challenges

The letter outlines challenges faced in seeking ongoing primary care in the Brisbane South region. These include:

- Despite extensive inquiries in the extended local area, inability to find a GP willing to undertake home visits
- Having finally found a GP willing to conduct home visits, that GP has now retired, and the consumer is again without a GP
- Previous medical visits being traumatising, especially when attending hospital for general care (not emergency care) due to the absence of any primary care options
- Accessing other services as many health and support services have the GP act as the gateway to access, including NDIS and Centrelink
- No access to basic primary care services including immunisations, medication reviews and ongoing care plans
- After-hours/locum doctors only offering one-off appointments and referring back to the GP, resulting in short term care and inconsistent treatment
- Telehealth restrictions requiring a GP face-to-face visit in the previous 12 months
- The hospital environment is overstimulating which exacerbates the consumer's condition and risks iatrogenic harm
- Online doctors and other doctors who bill privately for telehealth with no Medicare rebate requiring in-person visits for complex cases and not offering home visits
- Pharmacists do not provide home visits for services delivered in the pharmacy (e.g., immunisations)
- Transport to a medical practice results in further damage to the consumer's health

The letter notes best practice guidelines in the UK and US for this condition routinely including GP visits and medical care at home.

Case Study 1 was used to inform Persona 2, Maia.

6.1.2. Case study 2: Mobile GP for homebound consumers (Victoria)

Service Summary[34]

Atticus Health is a privately owned social enterprise healthcare company that provides corporate health, elder care, telehealth and primary care services. In 2019, the company became a certified Benefit Corporation, and its key social project is **Mobile GP**, which is fully subsidised by profits of Atticus Health services.

[34] Gomes, F. (2019). *About Mobile GP.* https://www.mobilegp.com.au/about.html

Mobile GP was initially intended to provide medical care to patients who are unable to visit a GP clinic. Initially focused on the elderly, the service has become increasingly successful, and is now available in three local council areas in central and north-western Melbourne.[35]

The service targets people over the age of 50 (or over 35 for Aboriginal and Torres Strait Islander People) who currently have a chronic disease or are at risk of developing such. A team-based approach consists of a GP, Care Manager and Social Integrator.

The care model is built upon:

i. GP conducting an initial home visit
ii. The Care Manager and Social Integrator conduct future visits and set up additional supports, e.g., home care packages for those eligible
iii. GP monitors the patient via telehealth and supports the Care Manager and Social Integrator

Services include general health checks, ongoing management of chronic conditions, wound care, medication review, and prescription and referral for additional services.

Benefits of the service

- Bridges the gap for vulnerable Australians unable to access primary care
- Lowers hospital emergency presentations
- Consumer convenience being seen at home
- Continuity of care with the same GP, Care Manager and Social Integrator
- Comprehensive care model

6.1.3. Case study 3: Remote monitoring program for chronic disease management

Program Summary[36]

The Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment (CARE-PACT) is a demand management program to streamline the care pathway for frail elderly residents of aged care facilities. Intended to develop collaboration and further knowledge and expertise between RACFs and GPs, the service provides a centralised contact for clinical support, resources and education, and a central referral contact for acutely unwell residents to allow specialist review or consultation. Specialists, GPs and community resources are linked to ensure individuals receive appropriate care in a timely manner.

The service was developed in response to the increasing demand for RACF beds and to reduce avoidable emergency department presentations.[37]

There are 7 main components of the CARE-PACT model:

i. **Telephone triage and clinical care planning** – first point of contact to discuss/refer acutely unwell RACF residents to specialist care and post-referral follow-up
ii. **Mobile emergency team** – emergency department-equivalent assessment for residents with acute deterioration in the care facility as an alternative to transfer to the ED
iii. **Nurse navigator** – streamlines and enhances care pathway, including mediated case management for individuals with high ED presentations
iv. **Inreach Clinical Nursing Team** - ED and inpatient resource resulting in early

[35] Gomes, F. (2019). *About Mobile GP.* https://www.mobilegp.com.au/about.html

[36] The State of Queensland. (2023). *CAREPACT. Queensland Government*. https://metrosouth.health.qld.gov.au/about-us/initiatives/carepact

[37] The State of Queensland (Queensland Health). (2023). *Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment (CARE-PACT).* https://clinicalexcellence.qld.gov.au/improvement-exchange/care-pact

discharge planning, coordination and transitional communication

v. **Hospital acute care substitution** – provides inpatient hospital standard acute care substitution within RACFs to patients who meet guidelines

vi. **Clinical education and support for RACF staff** – best practice management manual for acute health concerns to provide guidance on where to refer patients, and partners with RACFs to help improve their staff skill mix

vii. **GP and Paramedic Direct Referral Line** - directly refers patients to CARE-PACT consultant

Benefits of the Program[38]

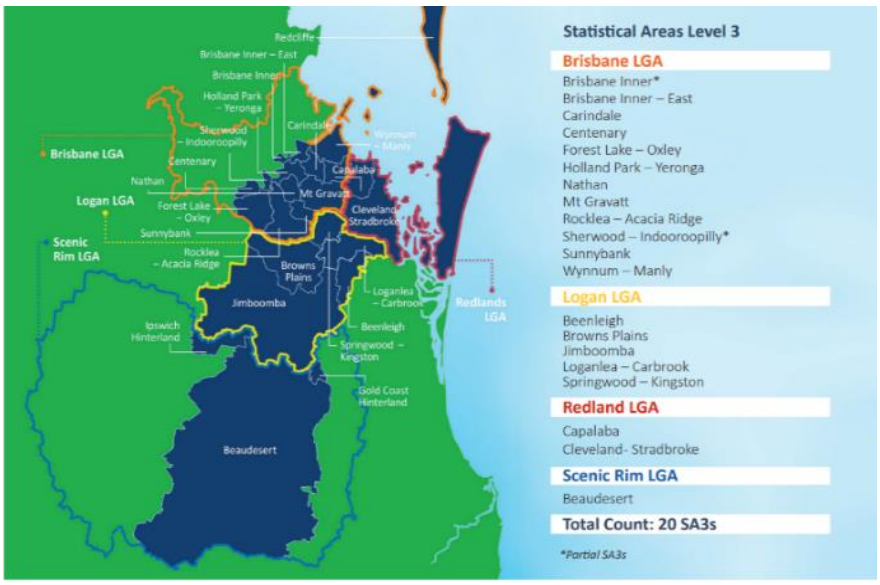
- Decreased burden on hospital resources
- Increased opportunity to increase collaboration with PHN providers and clinicians
- Improved outcomes for target cohort of community patients (and decreased hospital admissions and re-admissions)
- Calmer, more comfortable and pleasant consumer (elderly patient) experience
- Upskilling of aged care nursing staff and attending GPs so that each episode of care is an opportunity to engage with aged care staff

[38] *Burkett, E. and Scott, I. (2015). CARE-PACT: a new paradigm of care for acutely unwell residents in aged care facilities.* Australian Family Physician (Volume 44, Issue 4, April 2015). https://www.racgp.org.au/afp/2015/april/care-pact-a-new-paradigm-of-care-for-acutely-unwel

6.2. Figures, tables, graphs

6.2.1. Figure depicting the Brisbane South region[24]

The Brisbane South region encompasses four local government areas: Brisbane, Logan, Redland and Scenic Rim. Within these there is the inclusion of smaller geographical areas knows as Level 3 Statistical Areas. Eighteen Level 3 Statistical Areas are included in the Brisbane South region.



6.2.2. Comparison in item numbers claimable for in-surgery, home and RACF

MBS item numbers claimable for routine hours consultations for in-surgery, home and RACF attendances, current as at October 2023.[25]

IN THE SURGERY		
Item no		
3	$18.85	(Level A) Brief
23	$41.20	(Level B) Standard < 20 mins
36	$79.70	(Level C) Long 20-40 mins
44	$117.40	(Level D) Prolonged ≥ 40 mins
RESIDENTIAL AGED CARE FACILITY (RACF)		
90001	$60.25	Flag fall service for each visit, first patient seen only. Applies to return visits same day, except for continuation of earlier episode of care.
90020	$18.85	Brief (applicable to each patient seen)
90035	$41.20	Standard (applicable to each patient seen)
90043	$79.70	Long (applicable to each patient seen)
90051	$117.40	Prolonged (applicable to each patient seen)
HOME/INSTITUTION/HOSPITAL VISITS (EXCLUDING RACF)		
	One patient seen	
4	$47.70*	Brief
24	$70.05*	Standard
37	$108.55*	Long
47	$146.25*	Prolonged

[24] Brisbane South PHN. (2018) *phn Brisbane South, An Australian Government Initiative.* https://bsphn.org.au/wp-content/uploads/2019/07/Brisbane-South-PHN-2018-Needs-Assessment-summary-1.pdf

[25] Weller., A. (2023, October 3*). MBS Quick Guide October 2023.* Australian Association of Practice Management. https://www.aapm.org.au/Latest-News/Latest-News/mbs-quick-guide-october-2023