Increasing health assessments for people living with an intellectual disability: lessons from experience of Indigenous-specific health assessments

Transferable strategies and actions for increasing health assessments for people with an intellectual disability

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In Australia, people living with an intellectual disability comprise about 1–3% of the population and, compared with the general population, experience worse health outcomes.[1] Poorer participation in primary health care of people with an intellectual disability contributes to high levels of undetected and unmanaged health issues and premature deaths from preventable causes.[2]

A positive development to address these inequities is the roll-out of a $6.5 million Primary Care Enhancement Program over 4 years (2020–2024). The Enhancement Program will be developed through four lead Primary Health Networks (PHNs), with a view to a national rollout across all PHNs. The aim of the Enhancement Program is to increase the skills and ability of general practitioners and other health care professionals to provide effective primary health care for people with intellectual disability.[3] To achieve this aim, a key focus of the Enhancement Program is to increase the uptake of the existing Medicare Benefits Schedule (MBS) preventive health assessments to strengthen equity of primary health care access and to support the delivery of evidence-based preventive health to people with intellectual disability (Supporting Information).[3] In Australia, there is some evidence to support the use of preventive health assessments for people with an intellectual disability.[4] The evidence suggests that yearly preventive health assessments performed in the primary health care setting pick up on unmet health needs in the area of health screening, health promotion, and identification of unrecognised disease.[4] Health assessments are a mechanism to support the delivery of evidence-based preventive health care.

While people with intellectual disability might in general seem to share few characteristics with Aboriginal and Torres Strait Islander people (hereafter respectfully referred to as Indigenous), these groups have some common challenges when accessing primary health care. These include complexity of health needs, limitations on identification of being Indigenous or having an intellectual disability in clinical information systems, discrimination, clinical inertia, and communication barriers. For both groups, effective clinical practice requires attention to social determinants of health as well as specific medical needs.[5,6]

As part of a long-standing Indigenous primary health care continuous quality improvement (CQI) research collaboration, we have knowledge of the barriers to and enablers of the uptake of preventive health assessments — specifically, the MBS item 715 for Indigenous people.[7,8] As such, we have identified some positive actions that may potentially be transferrable to people living with an intellectual disability, along with strategies to inform the effective roll-out of this new program.

Reinstatement of a dedicated and adequately remunerated Medicare Benefits Schedule item

There is currently no dedicated MBS item on health assessments for people living with an intellectual disability. The 2009 Medicare review resulted in the merging of MBS items dedicated to health assessments for people with intellectual disability with four time-based MBS items (MBS 701, brief; 703, standard; 705, long; or 707, prolonged) for other target groups.[9] With the collapse of different health assessments into the single newer MBS item, the ability to identify the extent to which health assessments are being provided to different target groups, such as people living with an intellectual disability, has been lost.[9] Given this, PHNs now cannot track uptake or implementation of health assessments for people with an intellectual disability. It is impossible to extract the relevant data from administrative systems at the primary health care level or Department of Health level.

Having a dedicated Indigenous-specific health assessment (MBS item 715) has enabled research and evaluation on barriers and enablers of implementation, and data about uptake have informed subsequent policy development.[5] Reinstatement of a dedicated and adequately remunerated MBS item is vital to building the evidence base to inform health policy and the provision of health services for people with an intellectual disability through contributing to understanding of who is receiving health assessments and who is not. This will in turn enable development of targeted strategies for increasing uptake.

Increase capability in electronic clinical information systems to identify people living with an intellectual disability

The inability of existing primary health care electronic clinical information systems to systematically identify people living with an intellectual disability will limit the ability of primary health care to identify eligible patients and invite them for a health assessment. Therefore, we recommend that clinical information systems in primary health care are upgraded to enable the easy identification of people living with an intellectual disability, and that primary health care staff are appropriately trained to use these systems.

Any patient identifier established in the primary health care setting should be able to be linked to other relevant data systems. Identifying people living with intellectual disability in data systems is particularly important for piloting the new Australian National Disability Data Asset, which will bring together data from multiple sources, including primary health care, to improve the ability to measure and improve outcomes for people with disability.[10] A useful point of reference for Australian primary health care is the United Kingdom model, in which people with intellectual disability must be identified at primary health care services. This requirement is supported by a legislative framework and is part of a long term National Health Service plan for providing targeted health services.[11]

Develop electronic health assessment templates for clinical information systems

It has been observed that Indigenous health assessments do not necessarily reflect the health aspirations and goals of Indigenous people.[12] This learning can be used to ensure that health assessments for people living with intellectual disability are evidence-based, developed with input from people with intellectual disability and carers, and reviewed regularly. Electronic templates can be developed for use in common general practice clinical information systems. With appropriate ethics approval and consent, the data collected can be used for CQI and research purposes to improve implementation of health assessments and ultimately health outcomes.

Embed targets for preventive health assessments within a continuous quality improvement framework

Implementing CQI processes has been shown to be effective in improving the delivery of Indigenous-specific health assessments and evidence-based preventive health care.[8] We therefore recommend supporting CQI activities to increase the uptake of health assessments for people living with an intellectual disability. This could include a target in the Practice Incentive Program Quality Improvement program (such as, proportion of people living with an intellectual disability who have had a health assessment), or supporting primary health care to develop locally relevant CQI processes.

Develop best-practice clinical guidelines

Although prevalence studies have identified that certain medical conditions and risk factors occur more frequently in people with intellectual disability, there are currently no national clinical guidelines for the delivery of best practice primary health care for people living with an intellectual disability.[1] Furthermore, there have been recent calls for the inclusion of intellectual disability into standard clinical guidelines as a specific population that requires distinctive consideration.[13] Such guidelines would be a reference point for assessing quality of care for improvement purposes and for building the capacity of GPs and other providers, similar to the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*.[14]

Develop systems to support follow-up care at the outset

Although there has been increased uptake of Indigenous-specific health assessments, there are continuing gaps in providing appropriate follow-up care, which is essential for ensuring benefit from health assessments.[7,8,15] We recommend increasing awareness of relevant follow-up MBS items, in addition to health assessments.

Increase awareness of the availability of health assessments at the community level

Investment in the Enhancement Program appears primarily targeted at improving skills and abilities of GPs to improve the quality of care for people with intellectual disability. Yet, there is clear evidence of the value of addressing both demand- and supply-related determinants to improve access to health assessments.[5] For example, an effective strategy in increasing the uptake of Indigenous-specific health assessments has been marketing campaigns targeted at community members to increase their awareness of the importance and availability of the assessments. Therefore, we recommend a similar awareness campaign targeting community, carers and disability service providers about the availability of these health assessments for people living with intellectual disability.

Naturally, not all learning from experience of Indigenous health assessments is transferable. For example, a preference for health assessments to be conducted by a clinician of the same culture or experience may not apply. While discrimination may be a common factor affecting health and wellbeing, it will be experienced and manifest in different forms to influence health assessment implementation.

Australia lacks legislative, policy and regulatory frameworks required to support or enact improving health outcomes for people with intellectual disability. People living with disability are neglected, as a group with specific needs, in both the current draft of the 10-year National Preventive Health Strategy and Australia's Long Term National Health Plan.[16,17] Recognition in relevant frameworks would be a pivotal starting point for addressing the health needs of people living with an intellectual disability.

In conclusion, we welcome this commitment to investing in improving access to primary health care and health outcomes for people living with an intellectual disability. We believe there is a unique opportunity to reflect on, and learn from, the experience of implementing Indigenous-specific health assessments, and to apply these learnings to the campaign for increased access to health assessments for this important group.

Despite emerging evidence of the benefits of health assessments, there is a clear need to continue to evaluate their effectiveness in different contexts. Multifaceted strategies and action are required at the primary health care centre and service level, in the community, and at patient and policy levels to increase health assessments and follow-up for people living with an intellectual disability.

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References are available online.

Supporting Information

Additional Supporting Information is included with the online version of this article.

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