GP Perspective

Bridging the Gap Between General Practice & Aged Care Homes

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Medicare Plus Aged Care Initiatives

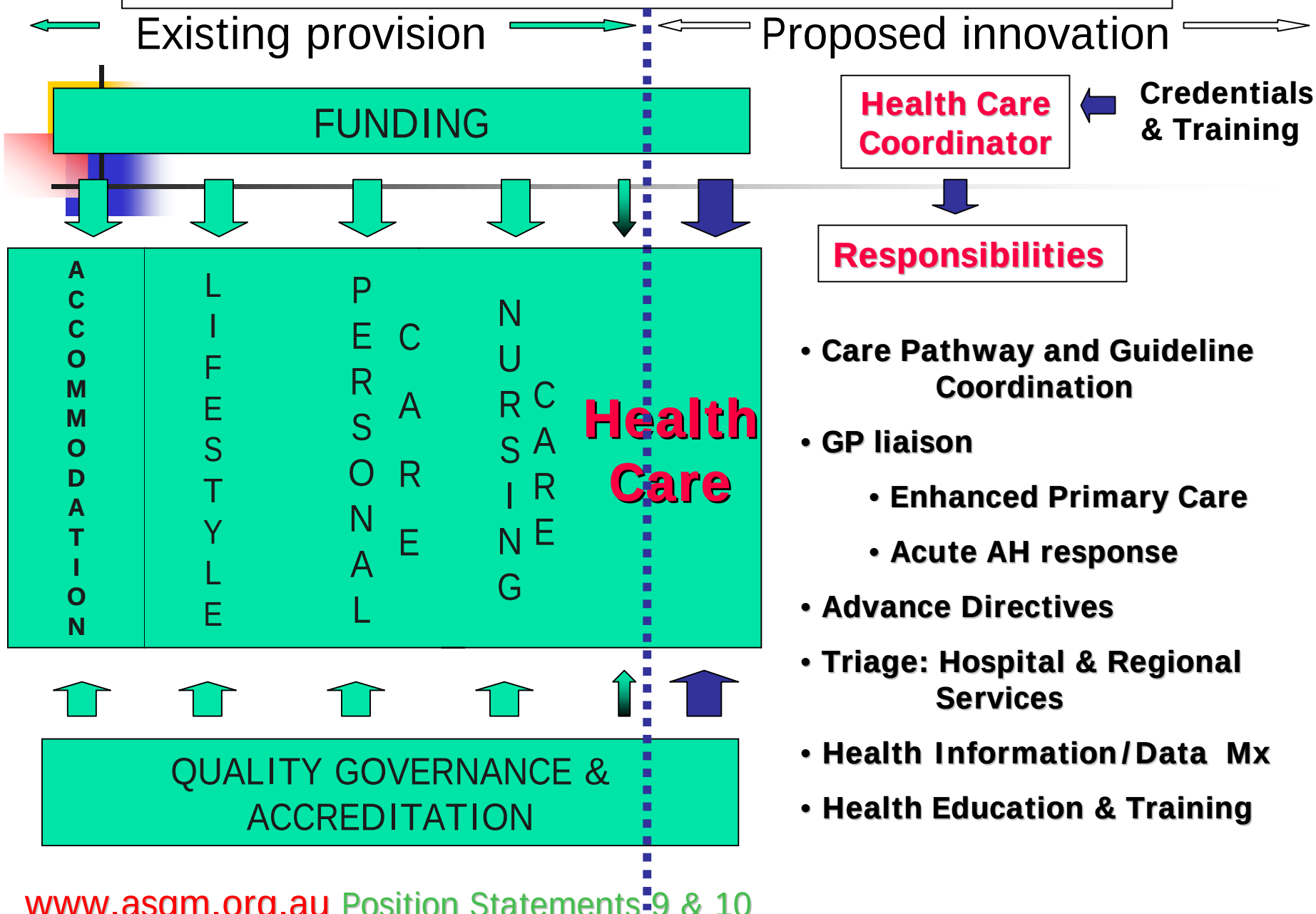
GPDV Workshop, June 2004

Medical needs of RAC population

- 6% people over 65 years of age live in ACH
  - Half over 85yrs, 72% female
- High prevalence of chronic illness & disability
  - 80% sensory loss
  - 60% dementia
  - 40-80% chronic pain
  - 50% urinary incontinence
  - 45% sleep disorder
  - 30-40% depression
  - 30% falls – 7% per year hip fracture

SOURCE: The Aged Care - Health Care Interface, NACA 2003

ASGM & NACA: Open RAC Health Service Model



- Care Pathway and Guideline Coordination
- GP liaison
  - Enhanced Primary Care
  - Acute AH response
- Advance Directives
- Triage: Hospital & Regional Services
- Health Information/Data Mx
- Health Education & Training

www.asgm.org.au Position Statements 9 & 10

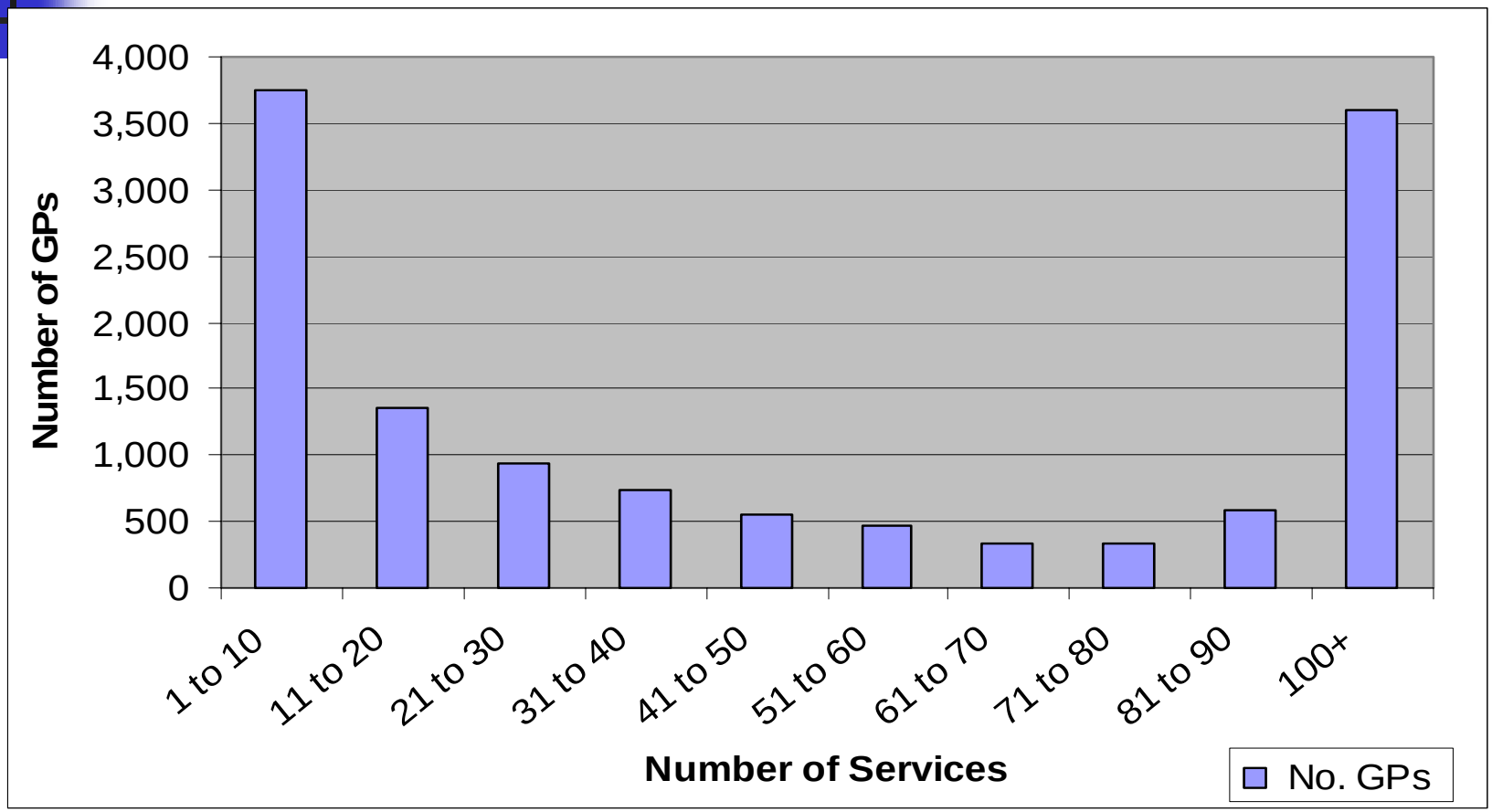
RACF and GPs in 2001/2

- 144,139 Residential Aged Care Facility beds
  - 73,664 High level (51%)
  - 70,475 Low level (49%)

- 23,195 GPs and Other Medical Practitioners
  - 12,674 GPs & OMPs claimed RACF services * (55%)

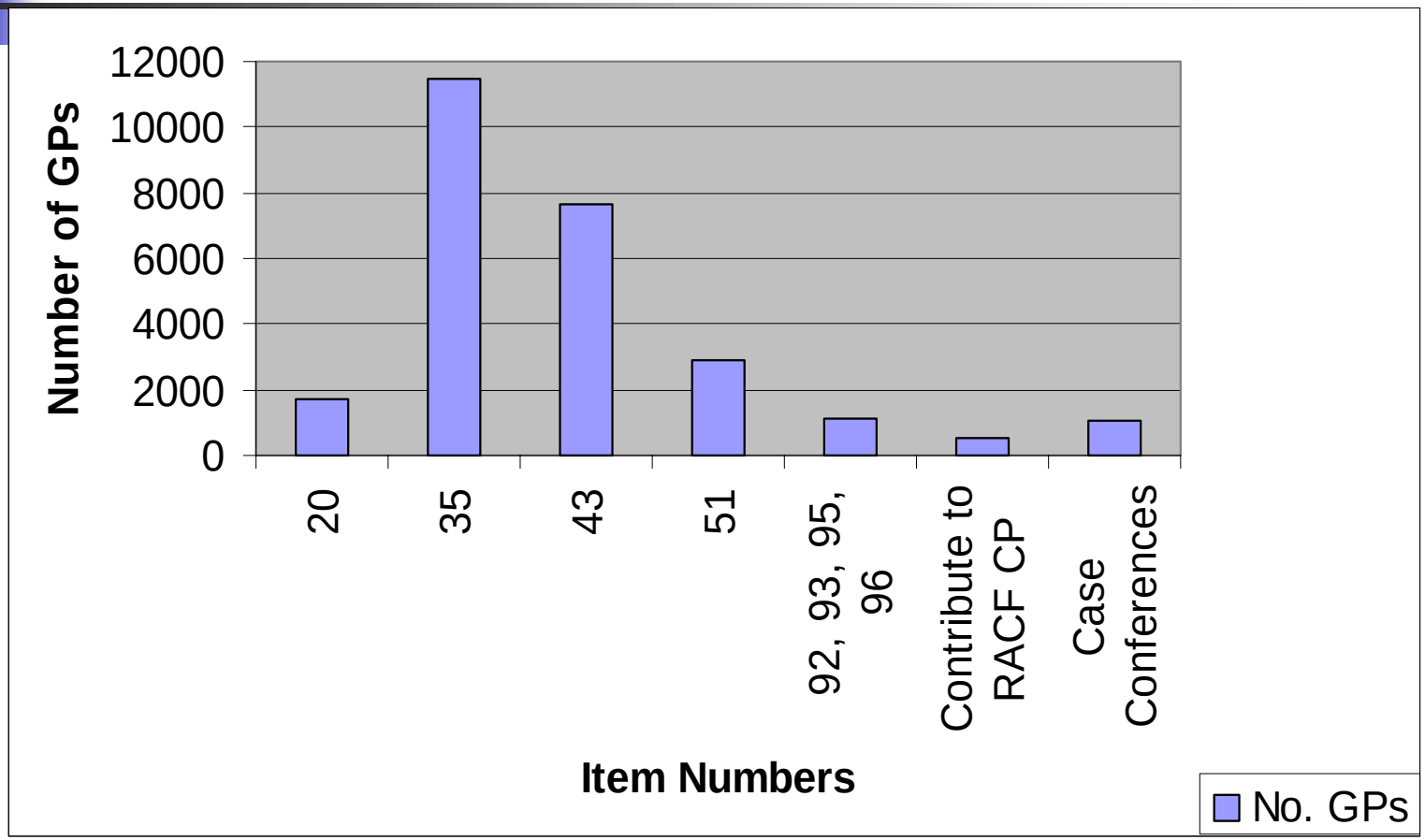
* Does not include services to residents at GP clinic or after hours

GPs providing nos. of RAC services



Source: Information Services Branch, HIC, for 2001/2

GPs providing types of RACF services



Source: Information Services Branch, HIC, for 2001/2

GP perspective

- When attending a RAC patient
- Organising care provision
  - GP clinic at RACF
  - EPC items
    - case conferences
    - contributing to a RACF resident care plan
  - Participating in RACF MAC
  - DGP support

Barriers to GP care

- Remuneration
- Time
  - away from clinic
  - travel
  - to have a life at home
- Access to trained staff, & facilities at ACH
- Resident's access to aged care services
- GP training for complex medical aged care

Medicare Plus: Aged Care Package

- Comprehensive Medical Assessment
  - Assess a resident's medical care needs for
    - care planning
    - collaboration with ACH staff, other service providers
- GP Panels
  - Improve residents' access to appropriate medical care
  - Increase GP participation in aged care quality initiatives
  - GPs and DGP work more effectively with ACHs to address local needs and issues

GP Panels: Strengths & Opportunities

- Strengths
  - Funded GP program to increase services and build partnerships
  - Builds on initial work of some DGPs
  - Links with RMMR, ACH quality activities
- Opportunities
  - Joint problem-solving
  - Links with local services & programs
  - Promote use of clinical tools

GP Panels: Weaknesses & Threats

- No corresponding funding for RAC or aged care programs to build partnerships and increase services
- Inadequate GP funding to get increased RAC services other than CMA
- Risk of inappropriate expectations
  - DGP panels are not accountable for problems in service delivery by RACF or health services
  - Some outcomes are dependent on other factors eg
    - workforce availability & training
    - residents' access to state funded services

GP Panels: Implementation issues

- DGP establishing panels
- Engaging GPs
  - GPs committed to RAC (3,600)
  - GPs doing some RAC (5,500)
  - Medical Deputising Services (core business)
- Engaging RACF staff (time to attend)
- Engaging aged care & acute service providers
- Enablers eg resources, training, champions
- Recognising constraints eg workforce, funding

Enablers - Resources

- Residential Aged Care
  - Clinical policy, eg RACGP Silver Book
  - Clinical tools
    - Eg GP and ACH kits, clinical guidelines
  - Programs
    - Eg influenza immunization, falls prevention, advance planning for end of life care, disease mx, local hospital demand management initiatives
- GP Training & Continuing Professional Development

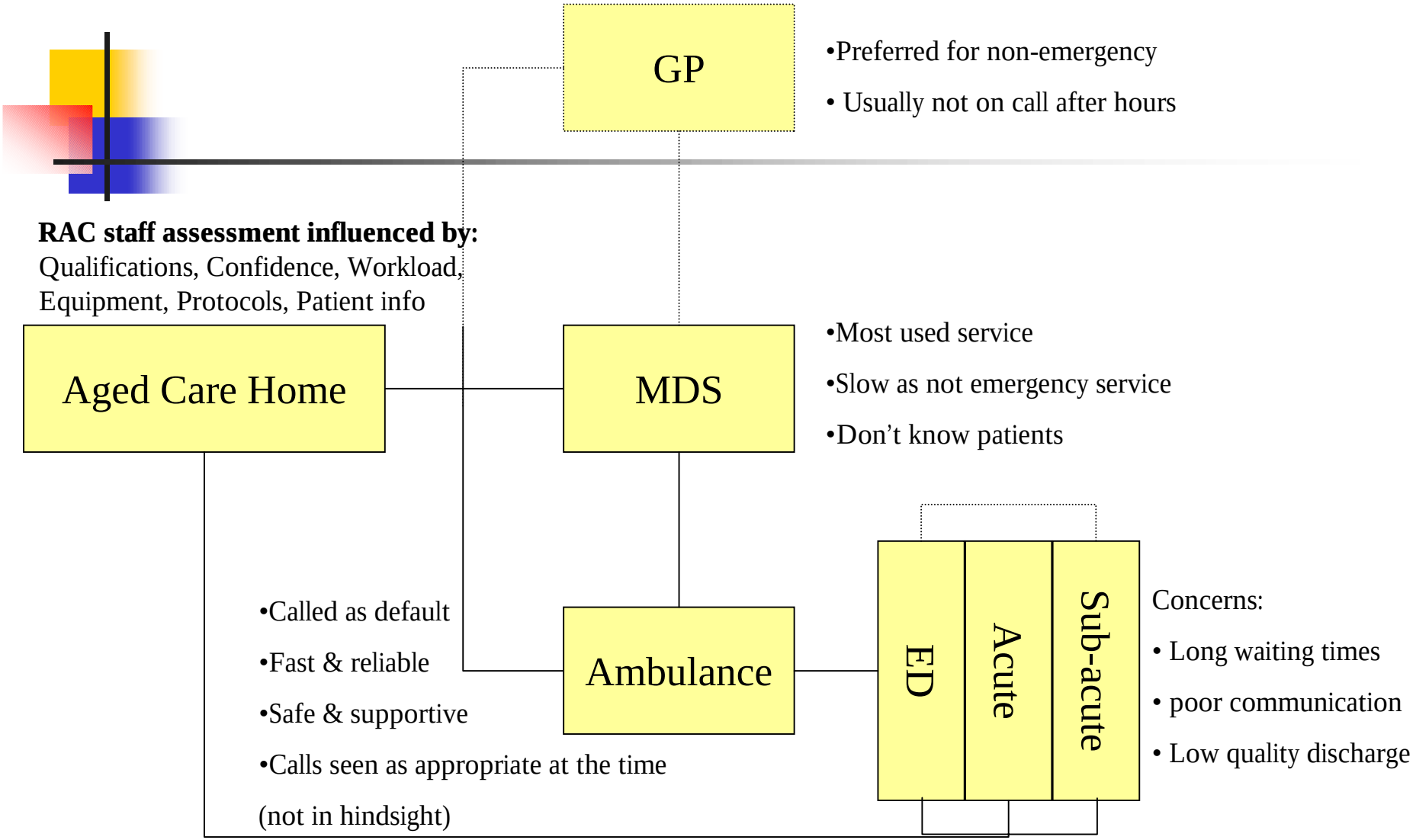
Potential benefits to ACH

- Entice GPs to attend residents and work with facility
- Upgrade and streamline documentation for medical care
- Joint problem solving
- Access to resources
  - Clinical guidelines – via VAHEC
  - CQI tools for accreditation
  - Support for staff

Experience of AHPMC Project

RAC Patient Summary & Plan

- Complies with privacy legislation
  - Resident signs consent on admission to ACH
- Completed by GP & RAC staff for all residents
- Updated by GP regularly
  - 6 monthly and within 7 days post hospital discharge
- Kept in yellow sleeve at front of resident's record
- For use of GP, RAC staff, MDS & MAS at ACH
- Travels with patient to hospital
  - with medication chart & transfer letter
- Streamlines documentation for MBS remuneration



Decision pathway & influencing factors

Experience of AHPMC Project

- Examples of models and resources available
- Building partnerships
  - Stakeholders willing
  - takes time and facilitation
- Implementing systems changes
  - Slow process of moving through stages of change
  - Need ACH and GPs to be ready at same time
  - Issues to be addressed at different levels, eg
    - National (funding, dissemination of resources)
    - State (work with chains, MDS, DHS, legislative context)
    - Local (building relationships and innovative models to suit local culture and conditions)

Working Together - national

- Medicare Plus
  - Builds a bridge from the GP base
  - Provides local capacity for GPs to work with ACH and other services
- A national RAC health strategy is needed to
  - Jointly fund initiatives in RAC, GP & aged care
  - Increase the 3 workforces
  - Provide continuing professional development
  - Address key health priorities – eg dementia
  - Provide adequate subacute and transitional care