RESIDENTIAL AGED CARE FACILITIES
ENHANCED PRIMARY CARE MBS ITEMS

PROGRESS REPORT
ANALYSIS OF RACF SURVEY RESULTS

PREPARED FOR GENERAL PRACTICE DIVISIONS OF VICTORIA

BY SHANE THOMAS AND ASSOCIATES

7 February 2001

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Outcomes of the Survey of Residential Aged Care Facilities

A quota sample of 50 RACFs were approached to participate in a survey concerning use of the RACF MBS EPC items.

41 of the 50 facilities approached agreed to participate in the survey in the targeted survey period, representing an 82 per cent response rate. 24 of the facilities were located in metropolitan areas and 17 were in rural areas. The response rate was the same for facilities from the different areas.

The facilities were asked the questions listed in Appendix 1 to this report. The areas covered included:

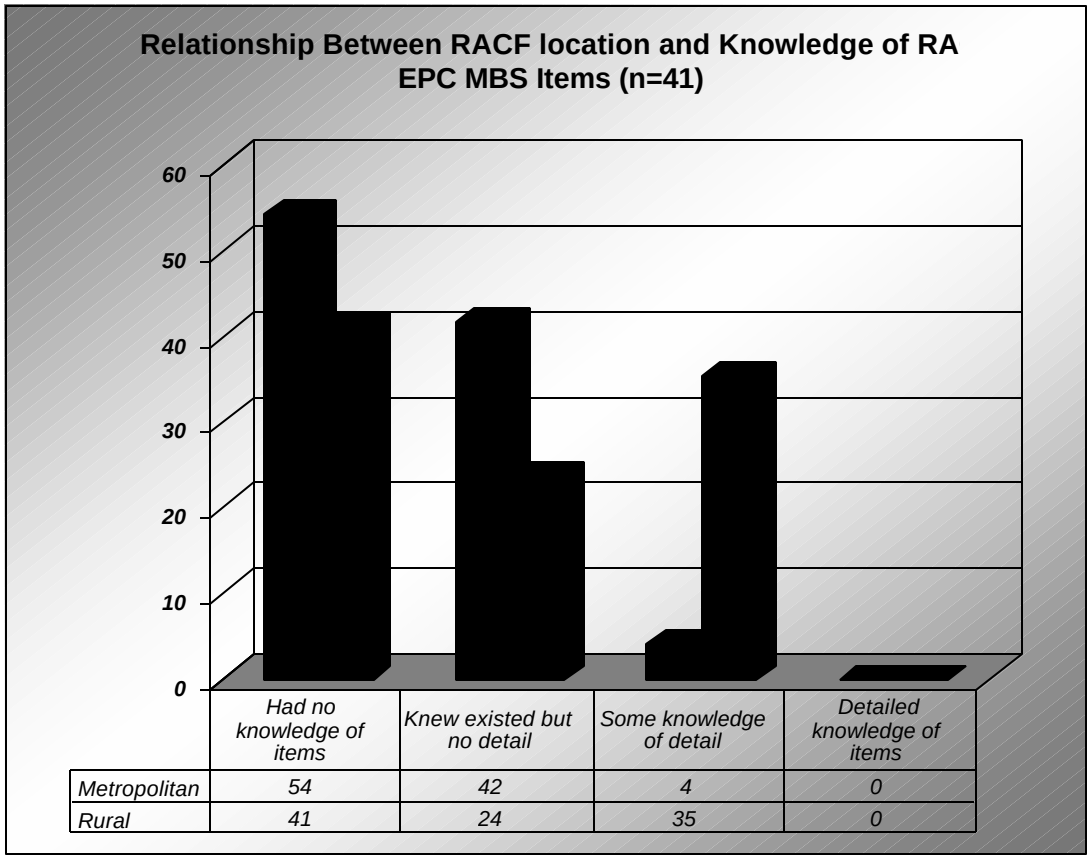
- Prior familiarity with the RACF EPC MBS items
- Current involvement in promoting the RACF EPC MBS items
- Plans to promote the RACF EPC MBS items in the future
- Suggestions concerning what could or should be done to promote the use of the Residential Aged Care EPC items to GPs
- Advantages or disadvantages to managing the care of residents if GPs were to use these Residential Aged Care EPC items (for both facilities and residents)
- Opinions of consumers and carers feel about GPs using these Residential Aged Care EPC items
- Whether the use of the Residential Aged Care items has averted an acute health episode
- Whether there is any evidence of improved health outcomes for patients when GPs use the Residential Aged Care items
- Any other comments

The results for each of these areas are now presented.

Prior familiarity with FACF EPC MBS items by location

For the sample overall, 20 (49 per cent) of the facilities claimed to have no prior knowledge of the RACF EPC MBS items. 14 (34 per cent) had prior but no knowledge of their detail and 7 (17 per cent) had some knowledge of them. None of respondents claimed to have detailed knowledge. There appears to be location differences in the degree of prior knowledge of the items.

The following chart shows the relationship between location of Residential Aged Care Facilities and their level of knowledge about the EPC Medicare Items. These data show that of the rural facilities surveyed Rural facilities reported 8 times more often that they had some knowledge of the detail of the items compared to metropolitan facilities. No rural nor metropolitan facilities claimed to have detailed knowledge of the items at the time of the survey.

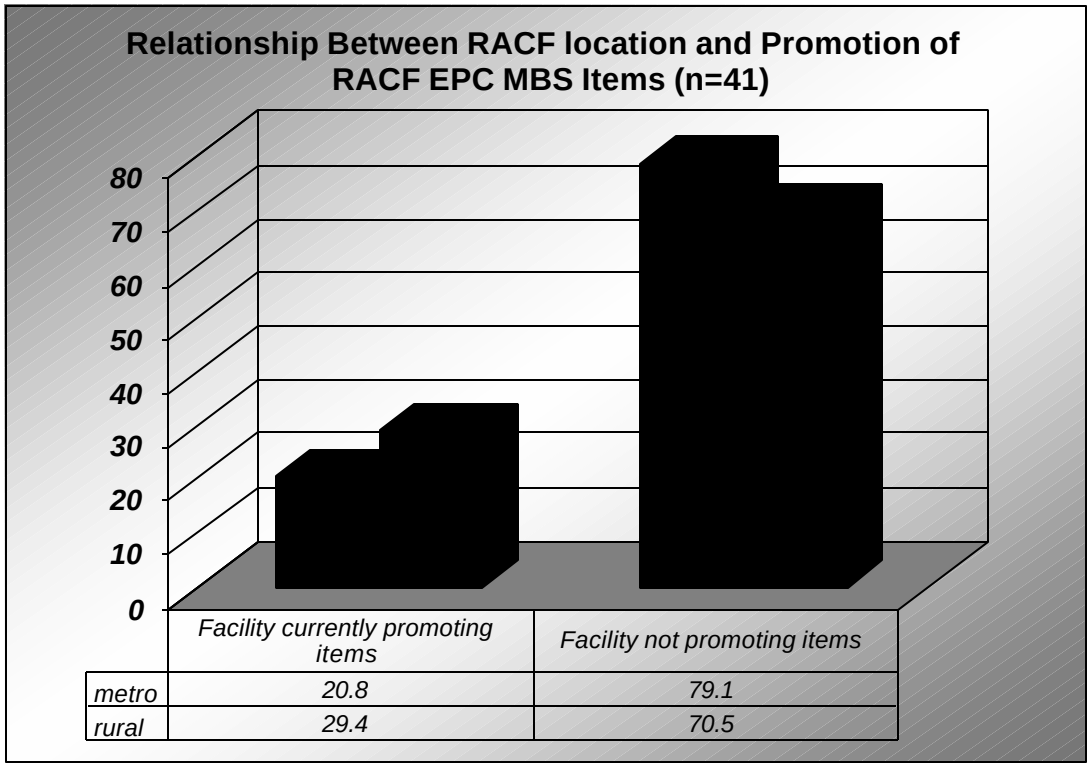


These data show that RACFs tend not to have detailed knowledge of the RACF EPC MBS items. Further, it shows that the level of knowledge is impacted by the location of the facility, with rural facilities more likely to have knowledge of the Items.

Current Involvement in promoting the use of the Residential Aged Care EPC Items to GPs who provide services to residents

31 of the 41 surveyed facilities (76 per cent) were not currently promoting the RACF EPC MBS items to GPs. Analyses were conducted to determine whether there were location differences in this rate.

The following chart shows the percentage of facilities current involvement in promoting the use of the Residential Aged Care EPC Items to GPs who provide services on residents by location. Not surprisingly, given that most of the facilities responded that they did not have prior knowledge of the items, most are not currently promoting the use of the items with GPs. A slightly higher percentage of rural facilities are promoting the use of these items but this difference did not attain statistical significance..



	Facility currently promoting items	Facility not promoting items
metro	20.8	79.1
rural	29.4	70.5

Participants were asked to report what they thought could be done to promote the use of the Residential Aged Care EPC items to GPs who provide services to their residents. The following summarises the responses:

> We would have individual discussions with the GPs. The GPs need to be less busy also.
>
> I would make contact with the GPs and arrange a meeting for discussion.
>
> I think I would approach the GPs.

I would speak to them personally.

Others reported that the Divisions should be responsible for promoting the Items with GPs and also within RACFs:

> Someone through the division or clinics needs to come and brief us on how it all works.
>
> GPs would have to be spoken to via the Division and an Advisory board.
>
> GPs would need contact via the Division. We already have a number of programs which incorporate this sort of thing. There are Community Aged Care Workers, there is discharge planning, an Aged Care Assessment Service a Community respite Centre. We are well serviced by other agencies. Why would we do it? It might be different for facilities in the metro area where people get lost in the system, but we are very well placed here.
>
> Department of Aged Care needs to contact GPs and facilities could promote them.

There were also a number of comments where more written information was requested to improve understanding for facilities, GPs and families.

> Need a pamphlet to the GPs from the Department of Aged Care.
>
> GPs need to understand the process too. They need to be interested before they adopt a new process. It needs to be GP friendly and we need more information about it too.
>
> Send them information. You could tell them at the pharmacy committee meetings.
>
> There are so many Doctors here, we would need to send out letters and try to speak to them personally as well. I certainly do not have time to promote this myself; we would need resources to do such a thing.

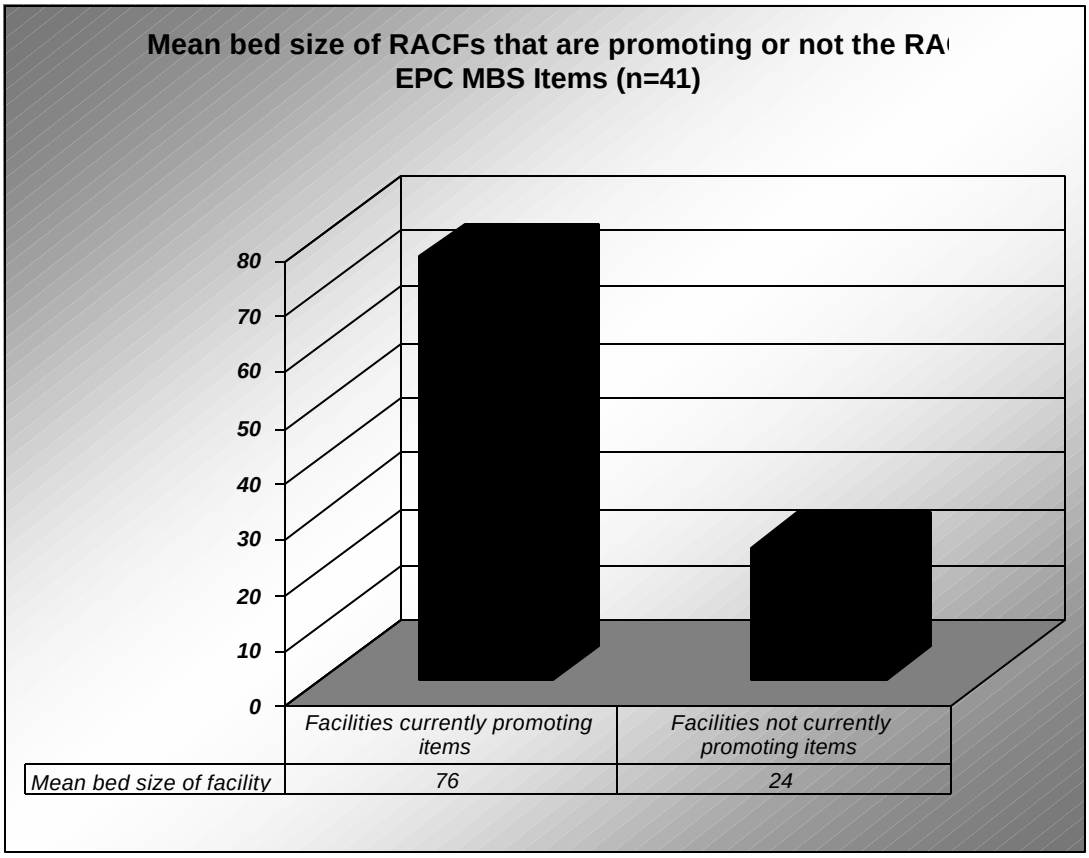
Once facility commented on how they had been promoting the items to date.

> We have been faxing GPs via the consultant pharmacist and holding meetings. I think it depends on the GP too. Some are interested and easy to speak to, others are not interested. We use the medication review as a vehicle to speak to GPs.

Mean bed size of RACFs that are promoting or not the RACF EPC Medicare Items

It was considered that there may be a difference in the rate of promotion of the items between facilities of different sizes. To examine this issue, an analysis of the bed sizes of the facilities currently promoting and not promoting the items was conducted.

The following chart shows that of the facilities promoting the use of the EPC Items with GPs, the majority are of larger bed size. This is a statistically significant difference.

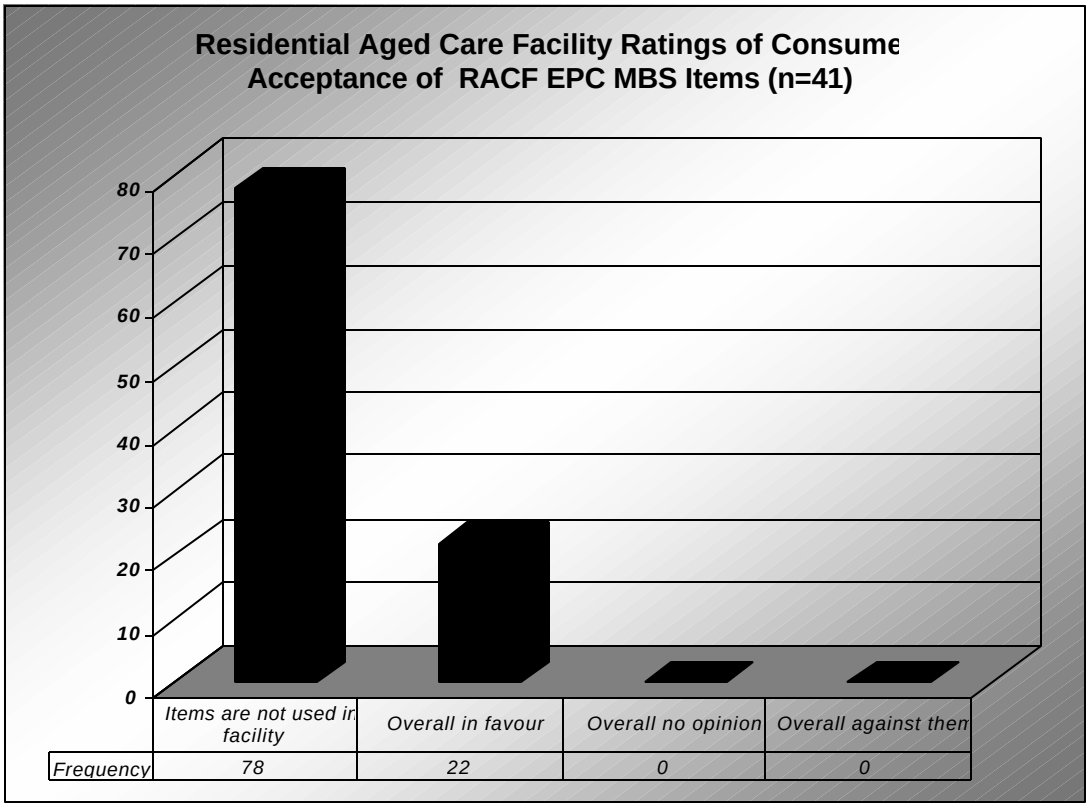


These data clearly show that larger facilities are more likely to be involved in promoting the use of the RACF EPC MBS items than smaller ones. This is important information for targeting of subsequent interventions.

Consumer and carers feelings towards GPs using the Residential Aged Care EPC items

The facilities were asked to comment on how their consumers and carers felt about the GPs using the RACF EPC MBS items. Only 9 (22 percent) of the 41 respondents were in a position to answer this question because items were in use at their facility. All of these respondents indicated they were in favour of them.

The following chart shows the frequencies of responses to this question.



These data show that when the items are in use the facilities feel that consumers and carers are in favour of them. However, there is currently a low base for their use.

Qualitative responses concerning advantaged and disadvantages for residents and facilities

Participants were asked to consider if they thought there would be advantages and disadvantages for both residents and the facility itself if GPs were to use the EPC items. It is important to consider that because many of the facilities are not currently using the items, nor do many have a detailed knowledge of them, responses to this question are perhaps more based upon initial opinion rather than upon opinion backed by experience.

Comments concerning advantages for residents:

> Many comments were made about continuity of care and holistic care for residents. Opportunity for improved communication was also often nominated as an advantage.
>
> Continuity of care and planning
>
> Increased communication between the nursing staff and the GP to create a more holistic approach to care
>
> Holistic approach. It is good for social issues as well.
>
> Much better from a safety point of view. It would lower the risk of self harm and improve quality of care. Often the GP does not see the whole picture of the patient.
>
> Comments made about advantages for residents included
>
> Better support for families and management of complex conditions, issues and provided education and resources.
>
> It is an opportunity for staff to talk about patient and the setting allows easier communication to talk about observations and changes in the patient.
>
> Better support for families and management of complex conditions, issues and provided education and resources.
>
> GP visits are often too rushed, so more time spent with recompense the family creating better care and a team approach.

Disadvantages for residents mentioned by participants included concerns about the privacy act and appropriateness of the use of the items for patients with mental illness. Concerning were also raised about the roles of GPs in patient care and patient perceptions of their own wellbeing. Cost to the resident was also questioned.

> Could promote the sickness view rather than the wellness view in terms of the aged people's perceptions

GPs might overstep the mark in terms of what they look after – boundaries between nursing staff and doctors. It would also be hard to evaluate.

Privacy issues. They must be aware that the reviews are taking place. They should be involved in the goals being set.
Privacy problems and confidentiality from the point of view of the patients.
Residents are overwhelmed by lots of people

Residents could feel that they do not want to be involved in complex care.

Patients should always know it is being carried out, especially with the privacy act. For patients with mental illness it may not always be appropriate.

As long as there is no cost to the resident.

Comments made about advantages for their facility if GPs were to use the EPC items included benefits such as better care planning and better assistance to families and staff. GPs providing an educational role for staff and families was seen as an advantage as was the ability for GPs to appreciate the roles of other allied health professionals. The Accreditation process was also mentioned a number of times as a direct advantage for facilities.

Formalising care needs. Doctors are sometimes not accountable; this would make them accountable for care.

Enhance GPs knowledge of different aspects of care, for example palliative care.

A team approach is best for everyone, including GPs and families. If GPs can spend any more time with families it puts them at ease.

Respect for GPs would increase. Opens better lines of communication and a team approach.

Better care for residents. Staff management and liaison between doctors, residents, staff and families.

For staff it is great to be able to share information and education from the GP.

It would give GPs incentive to come and diminish the problem of them not wanting to come to see residents. It is great to involve the family as when it is left up to us to explain complex things it can be difficult.

If medication costs could be reduced, this is good for us from a funding point of view. It is always good to reduce expenditure.

Accreditation process. Involving other allied health professionals is great. It is a benchmark.

Disadvantages for the facilities mentioned by participants included concerns about the time taken to promote and implement the items in an already busy schedule. Issues about funding being offered to GP but not to facilities to take part in this initiative were also raised.

> Time consuming. Administration – sending out letters. There needs to be a process.
>
> I have a concern there would be over charging, but that is not rally a concern for us.
>
> Depending on the effort of everyone. It seems a bit of a waste of time as the paper work would be too much.
>
> The time involved for staff. GPs get the benefit but what about the nursing/ caring staff. There would also be more documentation.
>
> More paper work. We are up to our eyeballs in accreditation. We don't need any more paperwork.
>
> Time staff are away from direct care.
>
> Can we bill for that time too?
>
> Takes time to implement. It may highlight complexities that can't be met.
>
> The logistics of it and that there is no funding for us.
>
> We already have plans that GPs are involved in on a basic level. The prepare work would be too much.
>
> We don't get paid at all and we are the ones doing all the background work.
>
> This sounds like overkill really. We already have plans in place. I don't think it is necessary unless it was an acute care.
>
> The reality is we need resources. We are under funded as it is. We don't always need more GP time, we need Nurse Practitioners.

Other qualitative responses

Participants were asked if they had any further comments to make about the items. Many said they found this difficult without having more knowledge about them. It is clear however that facilities do generally think that the items are a good idea if they are promoted and used properly. Alternatively, some facilities did not think that they needed to promote the items because they already have their own care plans in place that are working well. Other participants aired general concerns about higher demand for GPs and resources in their areas. Another issue raised was the potential for GPs to misuse the items.

> It is our own ignorance why we are not using them. I am very keen to see how it progresses. We need to get into the habit of using them.
>
> We need more GPs in this region (Mildura). They only have limited time and we never like to impose on them to spend extra time. The doctors need to prioritise too, they see the sickest patients first.
>
> I would be concerned that the GPs use them as a funding tool rather than for quality of care. It is about time something like this was implemented. The time involved for GPs is a barrier.
>
> I am concerned about how they would go about setting it up so as to utilise the benefits and it is not just a money spinner.
>
> I would think it would be very positive to involve the consumers and their families.
>
> It is a good idea but it is going to generate lots more paper work. Danger in taking more time away from direct care.
>
> We have had better outcomes for palliative care and terminal patients. It is a good idea to encourage GPs to be involved in care plans.
>
> We already have an assessment for residents and keep a data base of their assessment. This will make a lot more work. The ACAS team also already provide a summary statement about patients care. In other words, these needs are being met in other areas.
>
> It is different for us here in a rural setting. The GPs come and talk to us anyway if we really need them, so there may not be a real need for this sort of project in our setting. Our own primary care planning is working well.
>
> We already have our own procedures that are working very well. I think GPs only need to be more involved in palliative care for patients. The bottom line is the time factor to do all of this. It is difficult to coordinate meetings with lots of people and family. I think there is also potential for the GPs to misuse or abuse this sort of system.

We are already involved in a number of initiatives, including PCP which is a community focus, rather than a hospital focus. There needs to be more follow up with discharge rather than instigating plans. PCP is relatively new in this area and there is really no feedback about how it is working. We already have limited staff finding it hard to get through the normal workload.

We don't need it here in our facility. It would be difficult to get GPs here to do it, and why should they get paid if we don't? Our funding would suffer with the extra time it takes to do this. There is also the issue of over servicing by Drs when it is not needed.

I feel very strongly about his and I would push as hard as I can. It can happen if we all work together. We have a duty of care to complete which is hard when the GP is not involved.

Care needs to be managed daily, but bringing GPs into the facility is good. GP interest is very low in our setting; it takes proactive Unit Nurse managers with proactive GPs to make anything work.

It is a great idea to involve GPs more but the information we were sent is way too detailed and staff did not want to read it. It needs to be more simple and easier to understand. Templates would be good that we could actually use. We have liaised with a woman from the Division who has been helpful so far and we also have one GP who is wonderful and helpful.

The opportunity to improve is there. Good GPs and Nurse Practitioners are few and far between and they already have such a huge workload. GPs are too set in their way to change also.

Conclusions based on the survey of RACFs

Most of the facilities report that the RACF EPC MBS items are not in use in their facility and that they did not have detailed prior knowledge of them. As a result of this only 10 (24 per cent) of the facilities indicated that they were involved in promoting the use of the items.

The size and location of the facility appear to have an influence upon the knowledge and promotion of the use of the items. Rural facilities appear to have better knowledge of the items than do metropolitan ones, but the average size of the facility is much larger amongst those promoting the use of the items.

Overall, the uptake and knowledge of the items in RACFs is low. There is substantial opportunity for improved uptake and knowledge. The respondents had quite standard suggestions for improvements, essentially greater marketing and training amongst the facilities.

Appendix 1

Survey Tool for Residential Aged Care Facilities

34 Beaver Street Essendon Phone 03 9331-235 Fax 03 9331-3355

Thomas and Associates Pty Ltd

Dear Sir/ Madam,

RESIDENTIAL AGED CARE FACILITIES
ENHANCED PRIMARY CARE MBS ITEMS
A PROJECT CONDUCTED FOR THE GPDV

We are writing to you to seek your assistance in a short survey of Residential Aged Care Facilities.

We have been appointed by the **General Practice Divisions of Victoria (GPDV)** to investigate the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners in the Residential Aged Care Sector.

A key part of the project is to interview a range of Directors of Nursing, CEOs and Care managers in Residential Aged Care Facilities in order to better understand the uptake of these items for residents.

We shall shortly be in touch to see if you could participate in a short telephone interview in which we would like to ask you the attached questions. We anticipate it will take in the order of 10 minutes. We hope that you will be able to participate in the study.

Yours sincerely,

Professor Colette Browning
10 December, 2001

Professor Shane Thomas

RESIDENTIAL AGED CARE FACILITIES
ENHANCED PRIMARY CARE MBS ITEMS
A PROJECT CONDUCTED FOR THE GPDV

Background

Thomas and Associates have been appointed by the General Practice Divisions of Victoria (GPDV) to investigate the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners in the residential aged care sector.

The items (attached to this document for your information) were introduced in November 2000. Uptake of the items has been slower than expected and the purpose of this project is to:

- to determine the needs and issues for the residential care sector and GPs in taking up these EPC items,
- to advise on the strategies needed to address the issues

A key part of the project is to interview a range of Directors of Nursing, CEOs and Care managers in Residential Aged Care Facilities in order to better understand the barriers to and facilitators of uptake of these items for residents.

The attached questions are the basis for a short telephone interview that we would like to conduct with you.

THESE ARE THE QUESTIONS WE WANT TO ASK YOU OVER THE TELEPHONE, YOU DO NOT NEED TO COMPLETE THIS FORM

1. Please indicate your level of familiarity with the attached Residential Aged Care Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners

- ☐ Prior to seeing the attached list, I had no knowledge of them
- ☐ I knew they existed but did not know any detail of them
- ☐ I had some knowledge of the detail of them
- ☐ I had detailed knowledge of them

2. Does your facility have any <u>current</u> involvement in promoting the use of the Residential Aged Care EPC items to GPs who provide services to your residents?

☐ Yes If you answered yes, how do you currently promote them?	☐ No Why? If you answered no, do you plan to promote them <u>in the future</u>? ☐ Yes ☐ No

3. What do you think could or should be done to promote the use of the Residential Aged Care EPC items to GPs who provide services to your residents?

4. Do you think that that there are or there would be any advantages or disadvantages to managing the care of residents if GPs were to use these Residential Aged Care EPC items?

What advantages do you see for residents?	What disadvantages do you see for residents?
What advantages do you see for your facility?	What disadvantages do you see for your facility?

THESE ARE THE QUESTIONS WE WANT TO ASK YOU OVER THE TELEPHONE, YOU DO NOT NEED TO COMPLETE THIS FORM

5. How do consumers and carers feel about GPs using these Residential Aged Care EPC items?

- ☐ ? ? ? **?** ? ? ? ? ? ? ? ? ? **?** ? **?** ? ? ’? **?** ? ? **?** ? ? ?
- ☐ Overall, they are in favour of them
- ☐ Overall, they have no opinion
- ☐ Overall, they are against them

6. Has the use of the Residential Aged Care items averted an acute health episode?

- ☐ ? ? ? **?** ? ? ? ? ? ? ? ? ? **?** ? **?** ? ? ’? **?** ? ? **?** ? ? ?
- ☐ No
- ☐ Yes If yes, in how many patients? _____

7. Is there any evidence of improved health outcomes for patients when GPs use the Residential Aged Care items?

- ☐ ? ? ? **?** ? ? ? ? ? ? ? ? ? ⁇ ? **?** ? ? ’? **?** ? ? **?** ? ? ?
- ☐ No
- ☐ Yes If yes, in how many patients? _____

8. Are there any other comments you would like to make about the EPC items?

THANK YOU FOR YOUR PARTICIPATION

Excerpt from Medicare Benefits Schedule November 2000

Residential Aged Care Facilities Item Numbers

	MULTIDISCIPLINARY CARE PLANS
730	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a **CONTRIBUTION** to a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** or to a **REVIEW** of a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** prepared by the residential aged care facility (not being a payment in respect of a service to which **items 734 to 779** apply) *(See para A.21 of explanatory notes to this Category* **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
	CASE CONFERENCE – MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)
734	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $73.15 **Benefit:** 75% = $54.90 85% = $62.20
736	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
H 738	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $146.25 **Benefit:** 75% = $109.70 85% = $124.35
775	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $114.90 **Benefit:** 75% = $86.20 85% = $97.70

Appendix 2

Survey Tool for General Practitioners

34 Beaver Street Essendon Phone 03 9331-235 Fax 03 9331-3355

Thomas and Associates Pty Ltd

Dear Doctor,

RESIDENTIAL AGED CARE FACILITIES
ENHANCED PRIMARY CARE MBS ITEMS
A PROJECT CONDUCTED FOR THE GPDV

We are writing to you to seek your assistance in a survey of Residential Aged Care Facilities.

We have been appointed by the General Practice Divisions of Victoria (GPDV) to investigate the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners in the Residential Aged Care Sector.

A key part of the project is to interview General Practitioners as to their experiences in using the items.

We shall shortly been in touch to see if you could participate in a short telephone interview in which we would like to ask you the attached questions. We anticipate it will take in the order of 5 to 7 minutes. There will be a payment of $20 to compensate you for your time in the study.

We hope that you will be able to participate in the study.

Yours sincerely,

Professor Colette Browning Professor Shane Thomas

RESIDENTIAL AGED CARE FACILITIES
ENHANCED PRIMARY CARE MBS ITEMS
A PROJECT CONDUCTED FOR THE GPDV

Background

Thomas and Associates have been appointed by the General Practice Divisions of Victoria (GPDV) to investigate the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners in the residential aged care sector.

The items (attached to this document for your information) were introduced in November 2000. Uptake of the items has been slower than expected and the purpose of this project is to:

- to determine the needs and issues for the residential care sector and GPs in taking up these EPC items,
- to advise on the strategies needed to address the issues

A key part of the project is to interview General Practitioners as to their experiences in using the items.

The attached questions are the basis for a short telephone interview that we would like to conduct with you.

THESE ARE THE QUESTIONS WE WANT TO ASK YOU OVER THE TELEPHONE, YOU DO NOT NEED TO COMPLETE THIS FORM

Questions

1. Please indicate your level of familiarity with the attached Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners

- ☐ Prior to seeing the attached list, I had no knowledge of them
- ☐ I knew they existed but did not know any detail of them
- ☐ I had some knowledge of the detail of them
- ☐ I had detailed knowledge of them

2. Do you currently contribute to care planning of patients in residential care (Note whether you use the EPC items or not)?

- ☐ Yes If yes, for how many patients in a typical month?_____
- ☐ No If you answer no **go to question 5**

3. Do you currently use any of the attached EPC Residential Aged Care MBS items?

☐ Yes

If you answered yes, which ones do you use?

- ☐ Item 730
- ☐ Item 734
- ☐ Item 736
- ☐ Item 738
- ☐ Item 775
- ☐ Item 778
- ☐ Item 779

☐ No

If you answered no, why don't you use them?

Do you plan to use them <u>in the future</u>?

- ☐ Yes
- ☐ No

For how many patients in a month do you use the EPC Residential Aged Care MBS items? _____

4. Who initiated your use of the EPC Residential Aged Care MBS items?

- ☐ The practice approached the Aged Care Facility(ies)
- ☐ The Aged Care Facility(ies) approached the practice
- ☐ Both of the above

5. What are the barriers to using the EPC Residential Aged Care MBS items for patients in a residential care setting?

6. What would make it possible for GPs to use the EPC Residential Aged Care MBS items?

Excerpt from Medicare Benefits Schedule November 2000

Residential Aged Care Facilities Item Numbers

	MULTIDISCIPLINARY CARE PLANS
730	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a **CONTRIBUTION** to a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** or to a **REVIEW** of a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** prepared by the residential aged care facility (not being a payment in respect of a service to which **items 734 to 779** apply) *(See para A.21 of explanatory notes to this Category* **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
	CASE CONFERENCE – MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)
734	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $73.15 **Benefit:** 75% = $54.90 85% = $62.20
736	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
H 738	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $146.25 **Benefit:** 75% = $109.70 85% = $124.35
775	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $114.90 **Benefit:** 75% = $86.20 85% = $97.70

Appendix 3

Residential Aged Care Facilities included in Survey

Name of Residential Aged Care Facility	Location	Beds
Alexandra Nursing Home	South Caulfield	60
Allambee Nursing Home Kingston Centre	Cheltenham	35
Anna House Private Nursing Home	Moonee Ponds	30
Avoca Hostel	Avoca	10
Banksia Court Private Nursing Home	Croydon	60
Banyan Tree Aged Care Facility	St Kilda East	80
Baptist Village Baxter Hostel	Baxter	187
Bethlehem Home For The Aged (Hostel)	Golden Square	74
Boort District Hospital Nursing Home	Boort	10
Cabrini Residential Care - Ashwood	Ashwood	70
Caulfield Hospital Nursing Home	Caulfield South	90
Coppin Community Hostel	Prahran	253
Corpus Christi Community	Greenvale	84
Creswick District Nursing Home	Creswick	30
Daylesford Nursing Home	Daylesford	15
Garoopna Unitingcare-Tanderra Hostel For Olderpersons	Camberwell	39
Gillin Park Retirement Village	Warrnambool	18
Glenroy Nursing Home	Glenroy	62
Grace McKellar Centre	Geelong North	245
Greensborough Private Nurs Home	Greensborough	60
Hazeldean Nursing Home	Williamstown	40
Hume Court Hostel	Lara	59
James Barker House	Footscray	45
Judge Book Memorial Village Hostel	Eltham	79
Lionsville Lodge Hostel	Essendon	78
Lyndoch Hostel	Warrnambool	113
Mt Alexander Hostel	Castlemaine	118
Nazareth House Hostel (Ballarat)	Ballarat	96
Omeo District Hospital - Nursing Home	Omeo	10
Overton Lea Aged Care Facility	Sydenham	105
Parkville Hostel	Parkville	120
Perpetua In The Pines Residential Aged Care Service	Donvale	60
Peter James Centre Nursing Home - Northside	Burwood East	30
Princes Court Homes Hostel	Mildura	100
Riverside House	Richmond	30
San Carlo Nursing Home	South Morang	60
St Annes Nursing Home	Hawthorn	60
St Catherines Hostel	Balwyn	37
St John's Retirement Village Hostel	Wangaratta	90

St Leigh Private Nursing Home	Sandringham	60
Strzelecki House	Mirboo North	30
Sunnyside Lutheran Retirement Village	Horsham	60
Tarcoola Hostel	Shepparton	139
The Homestead Hostel	Wallington	63
Unitingcare Moorfields-Seventy Five Thames Street	Box Hill	120
Unitingcare-Yarramar Aged Care Services-Marivale Community Nursing Home	Ascot Vale	30
Villa Maria Aged Care Residence Donald Street	Prahran	32
Violet Town Memorial Bush Nursing Hostel	Violet Town	21
Wesley Central Mission-Wesley Aged Care Housing Services	Coburg	44
Wintringham Hostel	Williamstown	60

Appendix 4

Consultation question schedule for key informants

1. What are the barriers to EPC uptake?

2. What issues do you think are important?

3. Do you have any relevant documents or research?

Appendix 5

Project Reference Group Members

Title	Fname	Lname	Division Name	Delegate	ADDRESS 1	ADDRESS 2	SUBURB	STATE	POST CODE
Dr	Peteris	Darzins	National Ageing Research Institute		PO Box 31		PARKVILLE	VIC	3052
Mr	John	Brooks	CEO	John Brooks	Australian Nursing Homes and Extended Care Association – Victoria	2/1949 Malvern Road	MALVERN EAST	VIC	3145
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Ms	Mary	Barry	CEO	Pauline Bates Royal Freemasons Homes of Victoria 9510 1378	Victorian Association of Health and Extended Care	3rd Floor 450 St Kilda road	MELBOURNE	VIC	3004
Ms	Karen	Large	Assistant Director		DH&AC	PO Box 9848	MELBOURNE	VIC	3001
Ms	Annie	Lanham	Aged Care Branch		DH&AC	PO Box 9848	MELBOURNE	VIC	3001
Ms	Mary	Little	Residential Care Rights Services	Belinda Evans	Suite 4b	343 Little Collins	MELBOURNE	VIC	3000
Dr	Jane	Fyfield	Senior Medical Advisor		Department of Veteran's Affairs	GPO Box 87a	MELBOURNE	VIC	3001
Ms	Jane	Harrington	Assistant Director Aged Care		Department of Human Services	555 Collins St	MELBOURNE	VIC	3001