RESIDENTIAL AGED CARE FACILITIES ENHANCED PRIMARY CARE MBS ITEMS

Final report

PREPARED FOR GENERAL PRACTICE DIVISIONS OF VICTORIA

BY SHANE THOMAS AND ASSOCIATES

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Professor Thomas has an active range of participations in the area of aged care. He is a current co-applicant with Professor Colette Browning and Professor Hal Kendig, Dean of Health Sciences at Sydney University and a wider team of aged care researchers on two NHMRC grants. The Lincoln Gerontology Centre is a component centre of the Institute in which he is Research Director.

Colette Browning is Associate Professor in the School of Public Health at La Trobe University and a Director of Thomas and Associates. She is coordinator of the Gerontology program at the University and coordinator of the Commonwealth Corporate Public Health program. Professor Browning has published widely in the aged care area and is Director of the Health Behaviours and Outcomes of Older Australians research program, one of Australia's largest longitudinal research programs. The program has contributed over 30 papers and articles to the aged care research knowledge base.

Professor Browning recently contributed to a major review of healthy ageing research for the Commonwealth in a team of leading aged care researchers.

One page summary of report

Shane Thomas and Associates were engaged by the General Practice Divisions of Victoria to undertake a research project concerning the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners in the Residential Aged Care Facilities sector.

The Residential Aged Care Facilities (RACF) Enhanced Primary Care (EPC) Medical Benefits Schedule (MBS) Items were introduced by the Commonwealth on 1 November 2000, and were intended to focus on care planning and case conferencing in residential aged care. The lower than expected and variable uptake of these items by General Practitioners has been an area of concern.

The purpose of this project was to determine the needs and issues for the residential care sector and GPs in taking up these EPC items and to advise on the strategies needed to address the issues.

The project activities included analysis of uptake data for the relevant RACF EPC MBS items, a survey of RACFs, consultations with GPs and other key informants. The study showed:

- Highly variable uptake of the items by division. One division (North East Valley) accounted for 27 per cent of all uptake in Victoria.

- Generally low but variable levels of knowledge of the items amongst RACFs and GPs.

Analysis of successful implementation of item uptake revealed the importance of divisional involvement in facilitating partnerships between GPs and RACFs and residents and carers. The elements to successful uptake were considered to be:

- A personal and local approach drawing upon local knowledge and personal relationships
- An approach that involves all interested parties ie the GPs and RACFs and residents and carers
- A collaborative rather than top down, prescriptive approach.

Two complementary approaches for the successful engagement of Gps and RACFs are proposed, based upon successful case studies, the GP initiated approach and the RACF initiated approach. Several case studies are used to illustrate these approaches and their benefits.

The report concludes with suggestions concerning the implementation of these approaches in building better relationships between GPs and Residential Aged Care Facilities.

Background to this project

Shane Thomas and Associates were engaged by the General Practice Divisions of Victoria to undertake a research project concerning the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers (EPC MBS) for General Practitioners in the Residential Aged Care Facilities sector.

The Residential Aged Care Facilities Enhanced Primary Care Medical Benefits Schedule Items were introduced by the Commonwealth on 1 November 2000, and were intended to focus on care planning and case conferencing in residential aged care. The uptake of these items by General Practitioners has been an area of concern.

Thus the purpose of this project was

- 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.

The information to be obtained from this project is intended to facilitate the optimum use of EPC residential care items by GPs in Victoria, and as a consequence increased co-ordination of care for people in residential care facilities.

To support and advise this project GPDV convened a reference group involving key representatives of the Residential Aged Care Facilities Sector. The reference group included representatives from the following organisations:

- Victorian Association of Health & Extended Care (VAHEC)
- Australian Nursing Homes & Extended Care Association (ANHECA)
- National Ageing Research Institute (NARI)
- Residential Care Rights (consumers)
- Department of Veterans' Affairs (DVA)
- Victorian Health Association (VHA)
- DHS Aged Care
- DH&AC Aged Care
- DH&AC Primary Care
- GPDV

The Reference Group Participants List appears in Appendix 5 to this document.

The project context

The provision of services by General Practitioners in Australian Residential Aged Care Facilities is an area of active debate within health providers, commentators and policy makers.

Government expenditure on aged care in Australia comprises about 13.4% of total government expenditure and residential care accounts for 10% of the health and

welfare outlay (Kendig and Duckett (2001). Since the mid-1980s there has been an increase in community care for older people where Home and Community Care (HACC) services provide support for older people to remain in their own home. The consequences of this policy shift has meant that increasing numbers of vulnerable older people are being supported in their communities and there has been a decline in the provision of residential care (Kendig and Duckett (2001). The demand for HACC services is under pressure as HACC services are capped and waiting lists are long.

Residential aged care facilities are the care option for those who can no longer be supported in their own homes. The Residential Classification Scale provides a means of classifying residents in terms of their need for care. The residential care facility receives differential government funding based on this classification. About 63% of residents in Australia are classified as high care residents (Kendig and Duckett, 2001). There is a shortage of places in residential age care facilities particularly in Victoria and this is impacting upon the funding of acute health services.

Kendig and Duckett (2001) discuss the '…problematic interface between the aged care sector and the health sector…' (p. 36) which is '…exacerbated by changes in acute health delivery.' (p. 36). They note that the complexity of the needs of patients in hospitals has meant that there is increased demand on beds and consequent pressure to move older patients to sub-acute or residential facilities. This transition between the health and aged care sectors can be problematic for the older person and their carer. In an attempt to improve service integration, the Commonwealth introduced the Enhanced Primary Care Package (EPCP), which aims to promote a more integrated service delivery system across a range of health professionals and service providers for people with complex needs. Under the EPCP, consumers are seen as having a key role in their health care. Initiatives under the EPCP include health assessments for older people, coordinated care trials, chronic disease self-management (Sharing Health Care Initiative) and falls prevention. General practitioners are seen as integral to these coordinated approaches in primary health care.

The Australian Coordinated Care trials were an attempt to integrate the various services required by patients with complex needs by pooling various funds. Twelve Coordinated Care Trials were launched in 1996 as a joint initiative of the Federal and State governments. Under the scheme a care coordinator manages various medical and support services for individual clients with complex needs (often older people). General medical practitioners are the focus for planning and implementation of the trials. 'The primary aim of the Coordinated Care Trials is to test whether coordinating care for people with complex needs through individual care plans and the pooling of funds from existing Federal, State and joint programs will result in improved client health and wellbeing…' (Dr. Michael Wooldridge, Media release, 20 September 1996). Evaluations of the Coordinated Care Trials indicate that they have quite mixed success in achieving their objectives (Kendig and Duckett 2001).

In 1999/2000 the Commonwealth allocated $14.4 million dollars over 4 years to develop eight projects under the Sharing Health Care Initiative. Many of the projects target older people with chronic conditions including diabetes, cardiovascular disease, depression, arthritis, osteoporosis and specific groups such as people from culturally and linguistically diverse groups (e.g., Chinese, Aboriginal people). The broad aims of the projects are to improve specific self-management skills, enhance consumer

involvement in their own health care and to improve partnerships between consumers, carers and providers. A systematic evaluation strategy is in place and outcomes from the projects are expected over the next three years.

The interface between the aged care sector and the health sector is exemplified in the current project. Residents require medical services just as they would if living in the community. The provision of these services is in a context where there is a greater focus on integrated care and increasing importance of a seamless journey through the health system and in which the importance of a multidisciplinary approach to care is emphasised.

As Kendig and Duckett and many other commentators have noted, there is an increasing acuity of residents of residential aged care facilities with an associated increase in the co-morbidities of residents. Because of the ageing in place policy, residents enter as low care and become more needy and more dependent. So there is an increasing dependency of patient cohort and an increasing range of patients in any one facility.

There is considerable change and activity concerning the Enhanced Primary Care (EPC) items that is taking place at the time of writing of this report. For example, recently Australian Doctor has reported the results of a survey of Australian doctors concerning documentation requirements in which EPC items figure prominently and the Commonwealth has also announced that it is discontinuing the EPC component of its Practice Incentive Payment program with effect from November, 2002. The Royal Australian College of General Practice (RACGP) is currently conducting a major project to develop guidelines for the implementation of the Residential Aged Care Facilities (RACF) EPC MBS items and the Australian Medical Association (AMA) continues to develop policy following the release of its October 2001 major discussion paper concerning General Practice (GP) services to residents of Residential Aged Care Facilities. Further, the EPC initiatives are attracting considerable academic attention through publications in professional journals. These are important contextual factors that inform the present project and we therefore have briefly reviewed them in this section of the report.

The Australian Doctor Survey Results

The outcomes of a survey of 100 Australian General Practitioners were recently reported in the March edition of Australian Doctor. The survey was concerned with the amount of time spent in and the nature of documentation requirements for General Practitioners. Three quarters of the study sample rated that documentation required of GPs had “greatly increased” over the last three years. From the perspective of the EPC initiatives, it is interesting to note that while 73 per cent of the respondents found social security pension and disability forms to be problematic, only 10 per cent said they had a problem with enhanced primary care forms. While this statistic must be interpreted in light of the relative previous utilisation of the respective forms, it is useful to note that in a survey studying difficulties with documentation that only 10 per cent of respondents have mentioned EPC documentation. These findings would indicate that the majority of GPs do not find it to be particularly onerous.

The AMA discussion paper

The AMA Federal Council released in October 2001 a discussion paper concerning GP services to residents of Residential Aged Care Facilities. The rationale for the study reported by the paper was stated as:

> *For quite some time there have been large barriers facing General Practitioners who attend patients in Residential Aged Care Facilities. These barriers have led to a situation where fewer GPs are prepared to visit facilities, causing a critical shortage of GP services within some facilities.*
>
> *In attempting to provide quality care to patients in Residential Aged Care Facilities, disincentives such as travelling time, lack of structured patient environment and the large quantum of non face-to-face services all add to difficulties doctors experience. If standards of care are to be sustained within the facilities, new models of GP services and remuneration need to be considered and implemented.*

The paper presents statistical data tracking the decline of categories of service provision by GPs in Residential Aged Care Facilities over the period 1996 to 2000. This is supported by data in the table below presented within the Association's report. The Health Insurance Commission (HIC) statistics in the following table show the total number of services per year, for which a Medicare Benefit was claimed, for each of the Residential Aged Care Facility consultation items.

MBS Item For RACF	Year ending 31 Dec 96	Year ending 31 Dec 97	Year ending 31 Dec 98	Year ending 31 Dec 99	Year ending 31 Dec 00
20 (level A)	91,527	85,338	79,325	68,613	61,901
35 (level B)	1,374,891	1,368,966	1,385,387	1,357,275	1,347,923
43 (level C)	67,377	74,057	82,339	88,799	97,640
51 (level D)	8,203	9,246	10,519	10,719	11,837
Total	1,541,998	1,537,607	1,557,570	1,525,406	1,519,301

The definitions of the above items in the Medicare Benefits Schedule are as follows:

> Item 20
> Professional attendance at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in a residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient
>
> Item 35
> Professional attendance at a residential aged care facility (other than a professional attendance at a self- contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being

accommodation in a self-contained unit) by a general practitioner involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 43 or 51 applies an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient

Item 43
Professional attendance at residential aged care facility (other than a professional attendance at a self- contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 51 applies an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient

Item 51
Professional attendance at a residential aged care facility (other than a professional attendance at a self- contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementation of a management plan an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient

At the lower levels of complexity, ie items 20 and 35, there has been in the case of Item 20 a fairly large decline in usage and the usage of item 35 has remained static. More complex consultations, as represented by items 43 and 51, have shown reasonable growth in usage over the 5 years represented by these data. These data support and reflect the notion of increasing acuity of the medical problems of residents in aged care facilities referred to by Kendig and Duckett and other commentators.

The Association argues that despite substantial increases in the levels of dependency of residents that there has been a marked decline in Item 20 level A item provision and an overall decline in number of services over the last five years.

At the time of writing of the Association's report (October 2001), RACF EPC item uptake was running at very low levels. The Association noted:

> *However, to date, little use has been made of the items. Only 175 GPs have used the three time tiered items (15, 30 and 45 minutes) for case conferencing in Residential Aged Care Facilities from 1 November 2000 to April 2001.*

The Association's report nominated a lengthy list of barriers for GPs to visit and provide care to residents in Aged care facilities. These were:

- *The unsatisfactory levels of remuneration, especially when other competing demands on their time and expertise are better remunerated (and no way near as frustrating);*

- *The amount of time spent in travelling; the time spent waiting for nursing staff before it is possible to see a patient, and then finding the patient (or vice versa).*
- *The lack of appropriate examination facilities such as a room set aside to see patients, and basic equipment eg bright light needed for viewing wounds, performing rectal or vaginal examinations, let alone ever trying to perform any procedure.*
- *The lack of IT facilities at the facility which would improve efficiency of prescribing and administrative tasks.*
- *The large number of non-face-to-face tasks expected of GPs by the facility staff which are not covered by fee-for-service and are performed when the doctor is NOT at the Residential Aged Care Facility.*
- *The considerable unremunerated time which can be spent on issues such as: writing scripts, faxing drug and treatment orders, checking medication records and dosages; making, answering and responding to numerous urgent telephone queries from Aged Care Facility staff, arranging urgent pathology tests (eg micro-urine), arranging locums, hospitalisation, ambulances; and interviewing relatives.*
- *The increased paperwork undertaken by GPs which is required by the facility to fulfil requirements demanded by the accreditation process.*
- *The lack of consultation between staff and other health care professionals and GPs, and lack of integration of GP services in the facility system.*
- *The frequent phone calls received at the surgery subsequent to visits to Residential Aged Care Facilities, from facility staff to clarify and confirm patient/resident treatment.*
- *The lack of specialists willing to visit Residential Aged Care Facilities, which results in unrealistic and unfair expectations being placed on GPs to undertake an extended 'specialist' role. This often dissuades, especially younger GPs, from being involved in the care of patients in facilities.*

Based on their analysis, the Association recommended revisions to fees and structures so as to encourage GPs to work with and within RACFs. The most pertinent recommendation for the current report was:

> *Encourage GPs to attend Residential Aged Care Facilities by an extension of integrated models of care under the EPC initiative where GPs can:*
>
> - *Complete a Comprehensive Medical Assessment Care Plan*
> - *Review Medical Care Plans*
> - *Perform Medication Management Reviews*

Practice Incentive Payments Changes

The Commonwealth Department of Health & Ageing (DHA) introduced a Practice Incentive Payment (PIP) in November 2000 to encourage GPs to use the EPC Care Planning & Case Conferencing. Items including, but not limited to, the Residential Care Items were a component of this incentive. The PIP Care Planning Incentive is

part of the Enhanced Primary Care (EPC) Medicare items package introduced in the 1999-2000 budget. The aim of the PIP was to encourage uptake of the EPC items and improve the level of care for patients with chronic conditions and multidisciplinary needs. The PIP was made in addition to the Medicare rebates for care plans and case conferences to practice which reached particular targets.

There have been recent changes announced to the PIP relating to EPC items. The announcement on the EPC DHA website asserts that:

> *Since the announcement of the care planning incentive in February 2001 there has been a marked increase in the use of the EPC items. As the incentive has achieved its objective, the PIP incentive for care planning will no longer be available after the November 2002 PIP payment.*
>
> *PIP CPI payments will continue to be made in May, August and November 2002 to practices reaching the 10% planning coverage target. Following the cessation of the PIP CPI, EPC care plans and case conferences will continue to be remunerated through existing MBS items.*

Although the PIP appears to have achieved its aim, the main increase of activity remains solely in item number 720 which is for GPs to initiate a care plan, in a community setting (not in residential aged care). Other groups of EPC items like the Residential Aged Care, Aboriginal Health Assessments, and Hospital items remain modest.

This is an important contextual change to the EPC initiatives.

The RACGP RACF EPC Guidelines Project

The Royal Australian College of General Practitioners (RACGP) is developing Supplementary Guidelines for RACF and Carer Involvement Enhanced Primary Care Medicare Benefits Schedule items. Isobel Frean, with whom we have met and discussed this initiative is leading this development. Isobel is working on the project with the support of an RACGP Technical Reference Group. The project is scheduled for completion in July 2002. The project has identified some national best practice principles and examples and these have informed the formulation of the present project's recommendations. It is likely that the present project's results will also inform the development of the College Guidelines. The Guidelines are an important facet of their implementation.

Commonwealth inter-departmental review of documentation and procedural requirements for medical practitioners

Prior to the last Federal election, the Government committed to undertaking a review of documentation and procedural requirements of doctors. An inter departmental working group involving Health and Ageing, Treasury, Veterans' Affairs and Family and Community Services is currently developing the review's terms of reference. It is likely that EPC documentation requirements will be included in the review and this may have medium to long term impacts upon the implementation of the items.

Academic calls for EPC research

Carmel Martin writing in the April 2002 edition of Australian Family Physician notes that the EPC initiative as with other general practice initiatives is "driven by consensus and commonsense, with a lack of research to inform it". She asserts that "In such a climate there is an urgent need … for formative evaluation of new EPC initiatives".

Analysis of research and policy context and the implementation of the RACF MBS items

The context into which the RACF EPC items have been introduced is one in which there has been active change and one in which there is likely to be continued change as government seeks to improve the provision of general medical practitioner services to residents in aged care facilities.

The design of the RACF MBS initiative requires a quite specific partnership between RACFs and GPs in the provision of medical services to residents. This is enshrined in the design of the items through the requirement for the RACF to initiate the care coordination process. The notable feature of the item design is that payment for the medical care coordination input is made direct to the GP on a case by case basis whereas the "payment" for the aged care facility is made on a program basis as part of the overall grant or payment for the residents. The identifiable nature of the GP payment versus the "hidden" payment (or, as some commentators have argued, lack of payment) to the aged care facilities has created a situation where some facilities consider that they are not being adequately reimbursed for their coordination effort with GPs in the delivery of medical services to residents. This is a design issue that has frequently arisen in discussions within this project.

A second issue in the implementation of the RACF MBS items initiative is the education effort required to bring it about. Although the items inherently involve a partnership between aged care facilities and GPs in delivery of services to residents, the field education effort associated with the initiative has been strongly focussed upon GPs, with minimum focus on aged care facilities and consumers and carers. Essentially, some documentation has been provided to the facilities compared with, for the GP side of the equation, the appointment of coordinators at state and divisional level to assist GPs. This has had the expected effect as shown in the survey of RACFs where many have had no or minimal knowledge of the initiative prior to our contact. This is also an important design consideration in the implementation of the initiative. More consideration may need to be given to marketing of the initiative in the RACF context to complement the efforts already made in the GP component.

Project Activities and Methods

The following activities were undertaken within the project:

- Analysis of RACF EPC MBS item uptake
- Survey of Residential Aged Care Facilities
- Survey of General Practitioners
- Consultations with Key Informants

The methodologies employed with each activity are now described:

Analysis of RACF EPC MBS item uptake

Analysis of the RACF EPC MBS item uptake was undertaken using summary data supplied from HIC to the GPDV.

Survey of Residential Aged Care Facilities

A sample of 50 Residential Aged Care Facilities was selected from all Victorian facilities.

The sample was randomly chosen from a list of facilities ranked by bed numbers with quotas set in metropolitan, regional and rural facilities. This was to ensure a representative survey sample. The facilities surveyed are listed in Appendix 3.

Each facility was sent the letter and list of survey questions (see Appendix 1), approximately one week prior to survey. The surveys were conducted by telephone. The data were entered into Statistical Package for the Social Sciences (SPSS) and MS Word documents for subsequent analysis.

Consultations with General Practitioners

An incidental sample of General Practitioners was chosen for inclusion in the survey. Each participant was sent the letter and survey (see Appendix 2) prior to survey. The surveys were conducted by telephone. The data were entered into SPSS and MS Word documents for subsequent thematic analysis.

Consultations with Key Informants

Key Informants were interviewed using the schedule of questions in Appendix 4. The Reference Group Members were interviewed along with other Key Informants who were identified during the course of the project. The data obtained from the consultations were documented and subjected to thematic analysis.

Outcomes of the Project Activities

Analysis of RACF EPC MBS item uptake

The uptake of these items has increased steadily in Victoria since their introduction in November 2000. Nevertheless the uptake is rather small considering that there are approximately 34,000 residents in 830 facilities which all have the potential for GP involvement in care planning.

The table overleaf shows the EPC Uptake Statistics for Residential Aged Care Facilities Related MBS Items broken down by division for the period November 2000 to October 2001. The table was provided by Rosemary Fenech from GPDV based upon data provided by DHAC from HIC.

The most notable feature of these results is the very wide variations in uptake across the different geographical areas covered by the Divisions. Both regional and metropolitan divisions are represented in the high and low utilisation categories, so there is not a consistent rural/ metropolitan differential, although it is probably fair to say that the utilisation rates for most rural divisions is currently a little lower than in the metropolitan ones[1].

Analysis of the uptake data by postcode and of the numbers of practitioners within geographical areas utilising these items shows a similarly "lumpy" utilisation pattern. These data are very voluminous and there are issues concerning confidentiality with such low levels of aggregation, so we have not included the raw data in this report but GPDV hold the data should it be required.

Clearly the "Contribute to a care plan" item has achieved much higher uptake than the items concerned with "Organise a case conference" or "Participate in a case conference". This reflects the level of difficulty associated with the respective items. It is not surprising that participation in the form of contribution to a care plan is easier to achieve than actively organising a case conference or participating in one because it can be flexibly scheduled and it most closely corresponds to traditional roles for General Practitioners. Case conference organization is not a traditional GP activity, this has been traditionally done by others e.g. care or discharge coordinators at acute facilities frequently with nursing and social work backgrounds.

It is also remarkable to note the high levels of utilisation within the North East Valley Division. This Division alone accounted for over 27 per cent of the Victorian uptake of RACF EPC MBS items. This is an outstanding result for that Division. Clearly there were circumstances operating in this Division that differed from the others that we needed to understand. This is also a focus in the consultations reported later in this document.

[1] The results of the survey reported in this document actually show that the rural facilities that participated in the survey seem to have a higher knowledge of the RACF EPC MBS items than do their metropolitan counterparts, although with somewhat lower uptakes. This is seemingly a contradictory finding but is probably a sampling artefact.

In the consultations and discussions surrounding this project, it was suggested that the Coordinated Care Trial initiative may be in part responsible for the varying patterns of uptake across Victoria. That is, it was suggested that areas in which there has been a trial have higher uptake than for other areas. In particular it was suggested that the high uptake associated with North East Valley Division of General Practice may be in part attributable to their participation in one of the trials.

In considering this argument, it is useful to review the structure and roll out of the trials in Victoria. The following descriptions of the Victorian projects were obtained from the Coordinated Care Trial web-site.

> The Southern Health Care Network Coordinated Care Trial
>
> The Southern Health Care Network in Victoria has proposed a trial that aims to identify the degree to which the health outcomes for high cost acute care patients who are complex and/or chronic health care system users can benefit from the formal coordination of their total health needs. This will include clients with conditions such as mental health problems, chronic obstructive airways disease, diabetes and renal failure. It has a client intervention group of 4,000 people and is supported by the Dandenong and Sherbrooke/Pakenham Divisions of General Practice.
>
> The Peter MacCallum Cancer Institute Coordinated Care Trial
>
> The Peter MacCallum Cancer Institute in Melbourne has proposed a trial that will cover a large part of the urban Melbourne area targeting cancer patients needing a wide range of services over an extended period. The trial will include 500 clients of the Peter MacCallum Cancer Institute, selected according to a combination of treatment and diagnosis groups for which well developed care pathways exist. The trial has the support of a large number of metropolitan Divisions of General Practice.
>
> The North Eastern Health Care Network Coordinated Care Trial
>
> This trial, based in Melbourne's north east, is sponsored by the North Eastern Health Care Network and has the support of both Divisions of General Practice in the trial region, the North East Valley Division of General Practice and the Northern Division of General Practice. The trial targets individuals with diseases and disabilities typical of, but not exclusive to, old age such as dementia, stroke, Parkinson Disease, severe cardiac and respiratory conditions, arthritis and orthopaedic conditions. It is expected the trial will provide care for 800 - 1,000 people.

It is useful to first note that as outlined in the Kendig and Duckett review, it has been argued that the evaluation of the trials showed that as an overall program that the trials did not reach their intended objectives. In the North Eastern Health Care Network Trial it is useful to note that both Northern Division and North Eastern Division participated in the trial but that North East Valley's rate of RACF EPC MBS

uptake at 531 for the period November 2000 to October 2001 was almost ten times that of Northern Division's uptake of 58. If the Coordinated Care Trial (CCT) was responsible for the North East Valley uptake then one would expect a similar boost in uptake in the other participating Division. This is not supported by the data with an order of magnitude difference in actual uptake between the two divisions. If the CCT hypothesis were supported they should be much closer.

The lack of support for this possible explanation also extends to the other trial areas. In the other CCT sites, for example the Southern Health Care Network Coordinated Care Trial in which the Dandenong and Sherbrooke Pakenham Divisions were involved, these divisions have amongst the lowest uptake rates in the metropolitan area and in the state in general. While it is an intriguing hypothesis that the CCTs might have had some effect upon uptake rates there is no evidence of a positive effect in the available data. They do not support this explanation for the high rate of uptake in North East Valley Division.

It must also be remembered that while from the Commonwealth's perspective the CCTs were a significant investment in care coordination involving GPs, their effects must also be considered in the context of the many other ongoing care coordination initiatives surrounding the provision of GPs' services to the general community and older people and RACF residents. In Victoria, the jurisdiction for the present project, there has been a considerable push toward engagement with GPs from the acute sector and also from the community health sector within the Primary Care Partnership initiative. Every PCP in the state has been obliged to develop and implement a GP engagement strategy. Clearly these strategies have not translated into uniform RACF EPC MBS item uptake across the state and the Victorian Divisions. Although there was a universal requirement to produce a strategy, at least as far as the uptake of RACF EPC MBS items is concerned, they have been widely differentially effective.

There is an almost universal understanding of the desirability of GP engagement in care coordination across the health sector. Yet the ability to deliver the desired levels of engagement has proved to be a major challenge to service providers and funders.

Conclusions of the analysis of RACF EPC MBS uptake data

We consider that the following conclusions may be drawn from this analysis.

- The uptake data show very wide variations in uptake across the different geographical areas covered by the Divisions in RACF EPC MBS uptake. One Division, North East Valley accounts for one quarter of the entire uptake across the 32 divisions.

- It is not possible to explain these variations across divisions by reference to activities such as the conduct of the Coordinated Care Trials. Adjoining divisions that partnered in the trials have widely varying uptake and some divisions that participated in the trials have very low uptake levels.

- The uptake data for the various RACF EPC MBS items demonstrates that the "Contribute to a care plan" item has achieved much higher uptake than the

items concerned with "Organise a case conference" or "Participate in a case conference". This pattern of uptake probably reflects the relative difficulties associated with engaging in the activities as well as traditional roles for GPs and other professionals.

- The data suggest that General Practitioners within the North East Valley division have been highly successful in achieving high uptake of RACF EPC MBS items. The reasons for this success warrant further examination.

The findings from the analysis of RACF EPC MBS uptake data were used to inform the consultations and other data collection and analysis activities within the project.

EPC Uptake Statistics for Residential Aged Care Facilities Related MBS Items November 2000 to October 2001

Victorian Divisions	730 Contribute to a care plan	734, 736, 738 Organise a case conference	775, 778, 779 Participate in a case conference	Total
301 - Melbourne	85	10	3	**98**
302 - North East Valley	462	63	6	**531**
303 - Inner Eastern Melbourne	131	26	26	**183**
304 - Southcity GP Services	4	21	17	**38**
305 - Westgate	0	1	0	**0**
306 - Western Melbourne	30	11	1	**12**
307 - North West Melbourne	43	18	16	**77**
308 - Northern Melbourne	54	4	0	**58**
310 - Whitehorse	87	4	10	**101**
311 - Greater South Eastern	109	3	3	**115**
312 - Monash	31	65	1	**97**
313 - Central Bayside	57	2	2	**61**
314 - Knox	58	62	0	**120**
315 - Dandenong	13	4	0	**17**
316 - Mornington Peninsula	1	1	2	**4**
317 - Geelong	31	17	3	**51**
318 - Central Highlands	34	4	1	**39**
319 - North East Victorian	0	6	14	**20**
320 - Yarra Valley	42	24	3	**69**
321 - Sherbrooke and Pakenham	5	2	0	**7**
322 - South Gippsland	0	2	0	**2**
323 - Central West Gippsland	4	15	11	**30**
324 - Otway	69	14	9	**92**
325 - Ballarat and District	0	4	0	**4**
326 - Bendigo and District	0	0	0	**0**
327 - Goulburn Valley	0	5	7	**12**
328 - East Gippsland	0	0	2	**2**
329 - Border	1	5	3	**9**
330 - West Vic	11	12	0	**23**
331 - Murray Plains	0	2	0	**2**
332 - Mallee	27	3	0	**30**
	1389	**410**	**140**	**1939**

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:

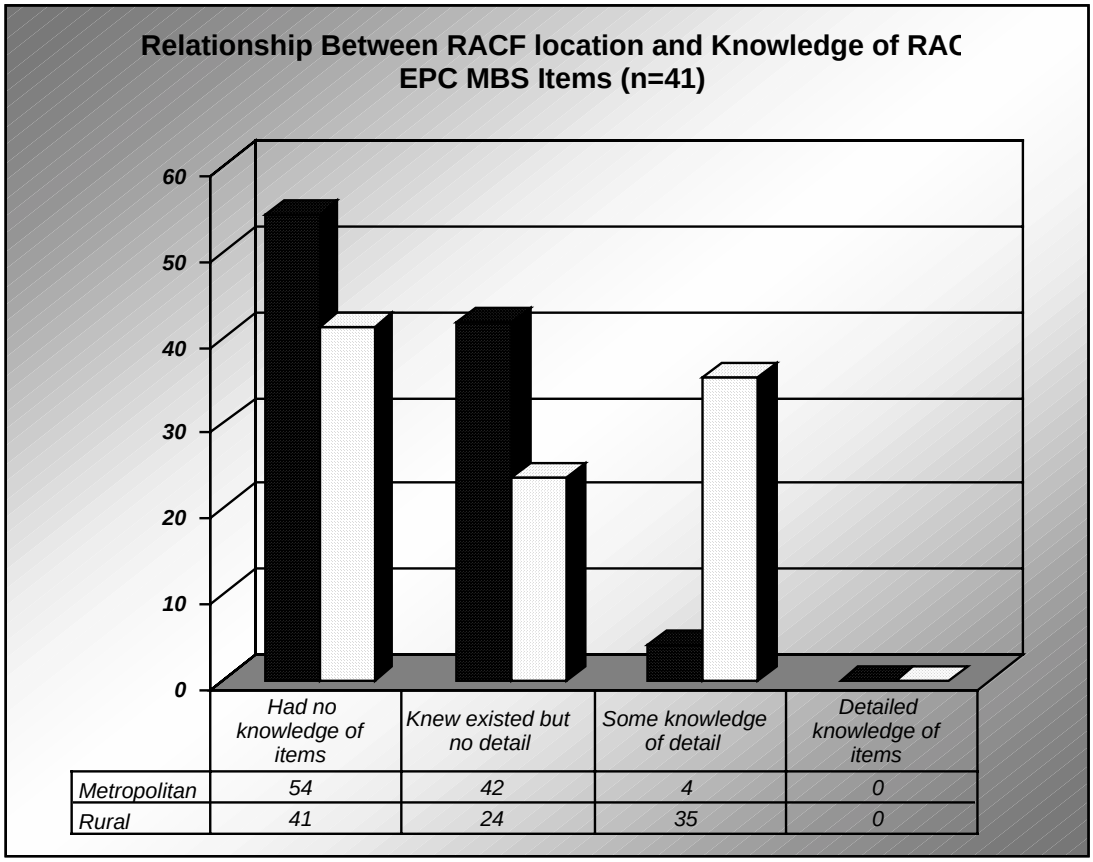
- Prior familiarity with the RACF EPC MBS items
- Current involvement in promoting the RACF EPC MBS items
- Plans to promote the RACF EPC MBS items in the future
- Suggestions concerning what could or should be done to promote the use of the Residential Aged Care EPC items to GPs
- Advantages or disadvantages 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 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. The figures in the tables are reported as percentages for ease of interpretation. They are based on a sample of 41 facilities.

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. The figures in the table are percentages of the metropolitan and rural respondents respectively so that the rates may be directly compared, based upon a sample of 41 responses. 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.

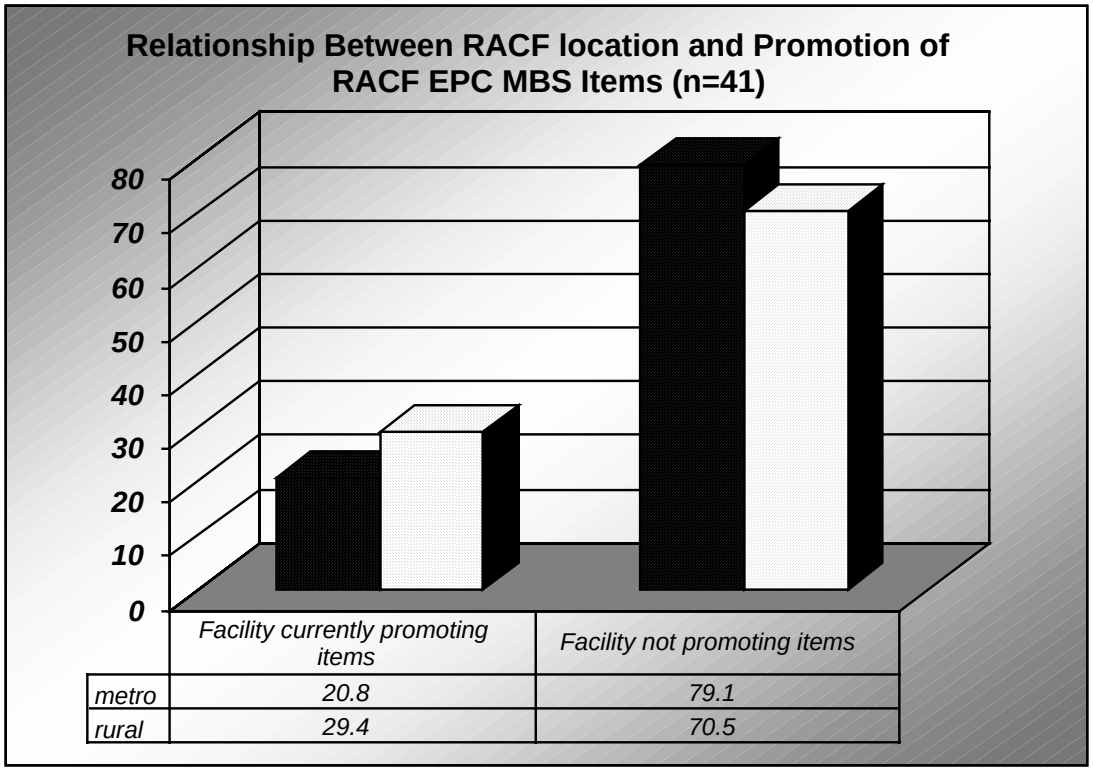


These data show that RACFs tend not to have detailed knowledge of the RACF EPC MBS items. Further, it shows that the level of knowledge is impacted by the location of the facility, with rural facilities more likely to have knowledge of the Items.

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.



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.

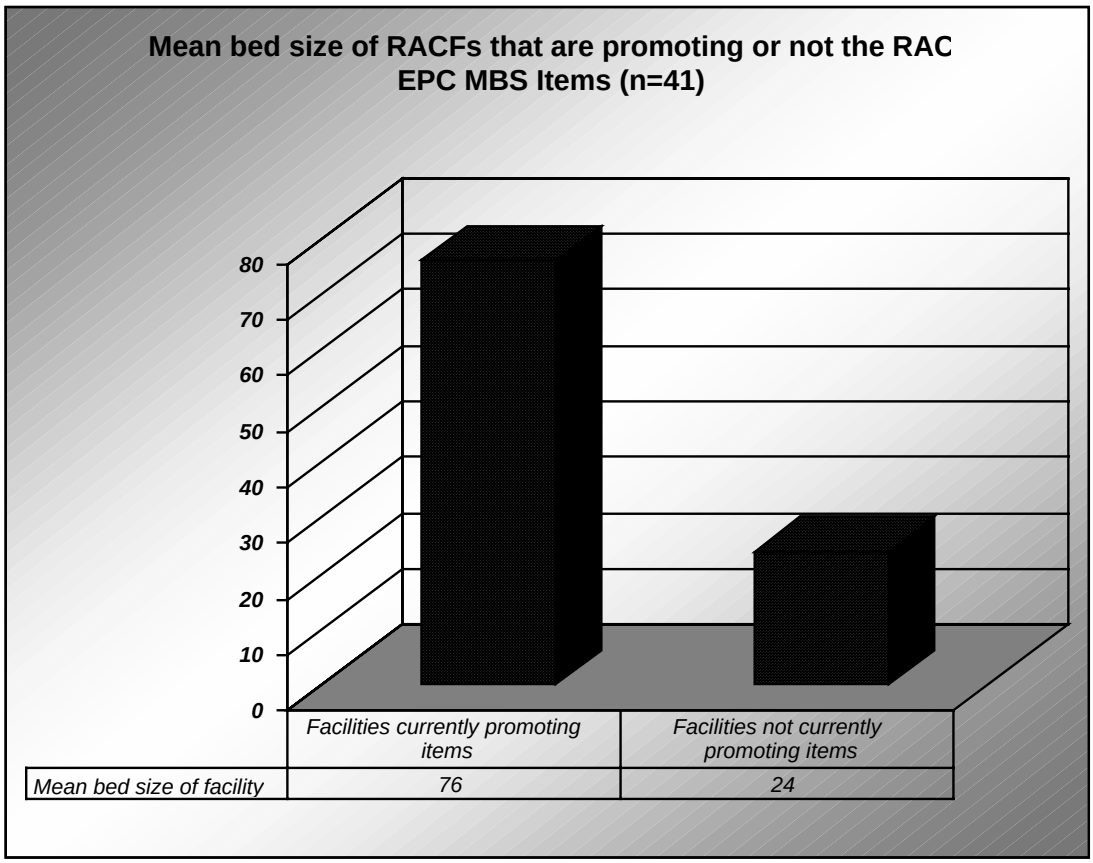
One facility commented on how they had been promoting the items to date.

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.

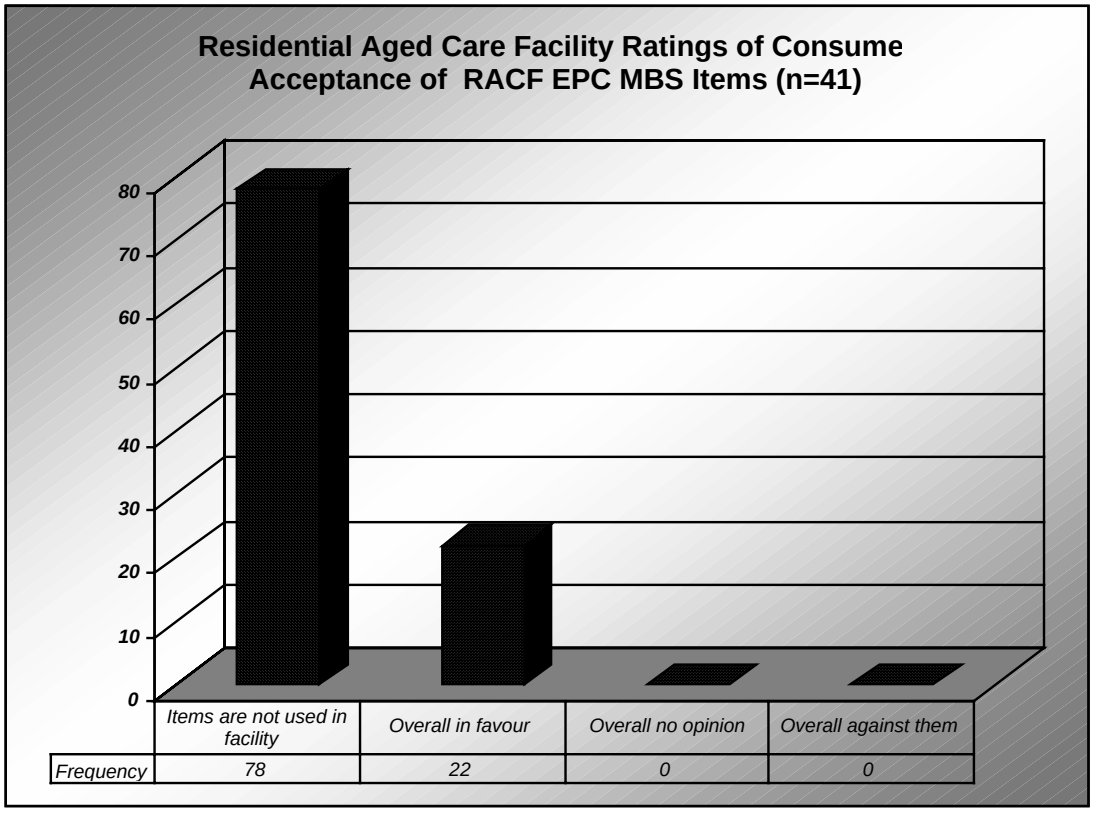


These data clearly show that larger facilities are more likely to be involved in promoting the use of the RACF EPC MBS items than smaller ones. This is important information for targeting of subsequent interventions. These results are in some respects not surprising if one takes the view that in larger facilities, there is more likely to be capacity for infrastructure to support such promotion. Smaller facilities do not have the same economies of scale and infrastructure as larger facilities. In terms of targeting, of effort of promotion of the items, apart from a potentially better ability to engage with larger facilities, there is the simple fact that larger facilities have more residents. The targeting of such facilities first means that greater efficiency of initial effort can be obtained.

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 (converted to percentages) 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 advantages 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 carers

> *Better support for families and management of complex conditions, issues and provided education and resources.*
>
> *It is an opportunity for staff to talk about the patient and the setting allows easier communication to talk about observations and changes in the patient.*
>
> *GP visits are often too rushed, so more time could be spent with 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. Concerns 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 GPs 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 really 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 preparation 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 from the RACFs

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 this 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 that participated in the survey reported 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 currently involved in promoting the use of the items. These findings are consistent with the actual uptake data reported in the previous section of this report. Although the Commonwealth is said to have written to all RACFs outlining the introduction of the items, a surprising number of respondents claimed to have not heard of nor seen the items prior to seeing them as an attachment to the survey form letter. It is worthwhile noting that the respondents were in the main, managers and DONs whom one might surmise would be likely recipients of this type of communication. We had some informal feedback from participants indicating that a useful part of the survey was them seeing the item information for the first time. The marketing of initiatives by letter would not seem to have worked well in this instance. The facilities in which the initiative has been marketed by management are the ones in which uptake has been achieved.

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. However this result is at odds with the reality of the situation as shown by uptake of the items. Rural and regional uptake is at low levels. The apparent paradox in these results may be an artefact of the sample we spoke with, for example it may have been that the rural facilities had a greater orientation to the issue or it may reflect a gap between behaviour and intention. That is, the facilities have good intentions and attitudes

towards promotion of item uptake but have not yet been able to deliver the actuality of it. Nevertheless the expression of positive intentions is promising as it does not reflect a negative disposition to change.

The issue of size of facility in uptake is an important one. Larger facilities in the survey were more likely to be marketing the use of the items to its staff. Of course, it must also be noted that larger facilities hold more prospective patients, so the targeting of larger facilities would seem to hold a double incentive. We do not know definitively why large facilities are more likely to be using the items, at least within the survey participants, but it is logical to assume that this is an infrastructure and resources issue. Smaller facilities have to spread their costs over a smaller base, so this means that infrastructure for marketing and training activities is likely to be less.

Overall, the uptake and knowledge of the items in RACFs seemed to be rather low amongst the survey participants. There is substantial opportunity for improved uptake and knowledge amongst RACFs. The respondents provided suggestions for improvements in uptake, essentially greater marketing and training amongst the facilities and a more proactive stance by GPs and divisions in engaging with the RACFs. Many of the respondents drew attention to the basic design of the initiative whereby although services are initiated by the RACFs the payments are made to the GPs providing the service. The inclusion of "payment" for the RACF involvement in this initiative in the overall operating grant, especially when compared to the case by case payment schedule effected for GPs has led to the perception by some RACFS that they have not been paid at all for their contribution to the initiative. This perception or fact is a potentially important impediment to full roll out of the items in some facilities.

In contrast with the GP side of the equation, where substantial effort and funding has been devoted to marketing and education of the initiative, there has been less effort devoted to these functions within RACFs. As would be expected, the knowledge of the initiative is far less developed in the sector. As the successful roll out of the items requires contribution of both RACFs and GPs, this is a design oversight. However, it is not a terminal oversight. It could be addressed at any time from now. The Commonwealth could resource the industry through its peak bodies and associations to promote the items and/or engage in direct promotion itself. The GP education and marketing model using what are effectively peak and coordination bodies (the state and local divisions) has seemed to work well.

Outcomes of the consultations with General Practitioners

10 Victorian Divisions were selected from the full range of the RACF EPC MBS item uptake table. They were approached by letter and a follow up phone call in order to nominate GPs who would be available to participate in a short interview with us concerning the EPC item uptake. 15 GPs participated in the interviews. Other key informants were also GPs but were asked the question set relevant to their group. Their responses are reported in the next section of the report with other key informants.

The interviews were conducted via telephone. The participants were asked the following questions:

> What are the barriers to using the EPC Residential Aged Care MBS items for patients in a residential care setting?
> What would make it possible for GPs to use the EPC Residential Aged Care MBS items?

Qualitative Responses from GPs concerning barriers to uptake

The responses from GPs centre on organisational/ logistical demands, and knowledge.

> *There is a problem with my time and the availability of staff from the facility as you need at least two other available staff to conduct. It is difficult to coordinate the other staff.*
>
> *The facilities are not asking us to do it and but when they do the times they nominate are not convenient.*
>
> *There ought not be any barriers to this. Knowledge of the item numbers by GPs is a problem as is time and availability.*
>
> *I do all the work and the remuneration is a joke considering the time and amount of work done.*
>
> *GPs have to be asked to do it by the facility, we can't initiate it and this is a problem.*
>
> *A case conference has organization problems.*
>
> *The GP is unable to initiate the care plan and some facilities are reluctant*
>
> *Conferences take too much time and travel.*
>
> *There is lack of GP involvement in the process in RACF.*
>
> *Reluctance of the facilities (due to ignorance?) is an issue.*

Time, organization at facility.

We need to educate the facility. They fear that they are being evaluated by the assessment.

Time. We need to employ another Dr to cover while involved.

The comments made by GPs in this study reflect the RACF MBS EPC uptake data. That is, while some currently undertake or would consider undertaking contribution to a care plan, they find major difficulties in organising or contributing to a case conference. Of course, these activities are not impossible as operators such as the Freemasons have demonstrated, but they are seen as very difficult by many GPs. The relativities in actual uptake for items concerning contributing to a care plan versus organising a case conference amply demonstrate the validity of the perceptions expressed above in terms of GP behaviour. Organising a case conference is much harder than contributing to a care plan. Reluctance of some facilities to initiate plans was a frequently mentioned factor by the GPs in the consultations. An effective engagement strategy needs to break down these barriers to participation

Qualitative Responses from GPs concerning facilitators to uptake

Responses concerning what could be done about facilitating uptake varied. Divisional involvement was seen as useful as was the need for better templates and training. A personal approach to RACFs was also seen as useful by GPs.

The local Division has approached the local ACFs and this has been very useful. A coordinated approach is best rather than individual GPs.

I don't know. I am too busy. It is easier to do in facilities where other staff members are around and is impossible to do in a solo surgery.

The GP had got to be really involved rather than at a token level. Face to face consulting is relevant and appropriate and the GPs get left out. There are problems with the agencies, i.e. it is too much for them (the staff). A care plan must be gone through with a GP before the plan is finalised as a way to force the issue. GPs also do all of the work and don't get any benefit. Money. Time, enthusiasm and satisfaction! The GPs need to be chased up to get involved. It is the only way.

GPs need to be welcomed by ACFs to initiate the process. Once they have done it, it is ok, but they need another party to initiate it. They need reassurance and to be walked through the process.

Money and training, hands on training. You need hand holding, I was not proficient until after 3 patients.

We need better items. There needs to be an initial item for comprehensive assessment and care plan when admitted; another review at 6-12 months and

another Medication Review item. The case conference will never be popular because it is too hard to organise.

GP to initiate plan from GP perspective. More GP involvement in process of RACF

Education for facilities and GPs. How to organise to participant?

The benefits to be explained to all (staff, patient, family and GPs). This could be done via conferences; meetings or examples on videos would be great.

The paper work needs to be simplified. Paper work too intensive especially for care plan. Some needs consent forms sent, etc.

Money is an issue.

I think the Division could coordinate training and bringing ACFs on board.

Several GPs involved in high uptake of the items were specifically approached to determine their approaches.

GPs need to understand that this is about partnership. A personal approach is best. You need to get out and about and see the management at the ACFs. Then it goes well, although early on I had some problems with appointment times.

Once you have got your templates in order, it is quite straight forward. Some GPs are initially put off by the paper work, but once you have done it a couple of times, it is much easier.

Our local division wrote to us explaining how to do it and why we should. We get so many letters from people telling us what to do!

Analysis of the responses concerning facilitators for uptake clearly identify the utility of Divisions in assisting with contacts with RACFs and perhaps also in the training of GPs in how to engage with RACFs. Several GPs also mentioned that they considered it would be useful to receive some additional training in the technical content aspects of using the items. This has already been the focus of EPC project workers within the Divisions but perhaps the engagement process could receive additional emphasis from Divisions.

The two GPs from North East Valley with whom we discussed the high uptake within the Division felt that the Division had been very helpful in getting them on board with the local RACFs. The RACFs with whom we spoke also mentioned the utility of this approach and involvement by the Division.

Outcomes of consultations with key informants

Our key informants included a wide range of people including the members of the Reference Group, officials from DHAC, DVA and from some divisions with high uptake. 18 Key informants were interviewed. They were asked the following questions:

- What are the barriers to EPC uptake and how might they be addressed?
- What issues do you think are important?
- Do you have any relevant documents or research?

The main issues nominated by the participants in the consultations were relationships, knowledge, availability and time and systems.

> *Habit is a barrier. Some doctors do not think about how they can do things differently.*
>
> *Complicated structures in the items; it's a good fee but hard to set up as all allied health practitioners need to be in one place at the same time. A big culture shift is required to achieve this.*
>
> *Lack of information and awareness within the Aged Care sector of procedures and their potential involvement is a major barrier. The changes have not been strongly marketed.*
>
> *GPs don't have, or are unwilling to make, the time available to attend case conferences. Also the aged care facility staff often feel they don't have the time. The other major barrier is scheduling as GPs often fit their visits to aged care facilities around their surgery hours. This may mean visits after 6pm. This is not a good time to try to get all the multidisciplinary staff and the families together.*
>
> *Lack of relationship between GPs and the ACFs is a big problem.*
>
> *Time constraints for GPs*
>
> *GPs do not want to go to nursing homes, it is too burdensome.*
>
> *There is not much communication between both parties.*
>
> *Too much paper work – puts GPs off.*
>
> *Some managers do not want to co-ordinate and the doctors too busy.*
>
> *Problems in the relationship between GPs and the aged care facilities. There seems to be some traditional territorial issues involved with some of the parties on both sides. Doctors sometimes feel they can't intrude even when they see*

something they don't like, eg wound management. They are more likely to talk to the family than the facility.

The attitude and practice of the facility. In facilities where the culture is to value the input of all staff ie a collaborative approach striving for quality enhancements, then the GPs are willing to engage. So if the GPs are met with in a receptive manner they are more likely to have an active role. Messages of disinterest put GPs off.

GPs are unaware that they can contribute to the care plan and claim for this. There are frequently no systems in place for the doctors to make a contribution, eg not even space for the doctor's contribution on the care plan.

GP don't realise that if they meet with a couple of the facility staff and discuss the care plan, then write up some notes in the plan they can claim for both items.

Every one is incredibly busy these days. Too much hard work for GPs going to Aged Care Facilities, lots of phone calls, paperwork, no nurses there to do rounds with them, not even doctors car parks anymore. It is much easier to sit in your surgery and let the patients come to you.

The capacity of general practices to structure their business operations in order to use the items is also a problem. Small practices especially will have difficulties structuring their work days so they can be involved in care planning.

Communication between GPs and the other care providers is an issue. Most are unaware of the role each other could play. It is also difficult to get all health professionals together for a case conference. The Allied Health professionals are often inadequately funded for their role in care planning.

Not surprisingly, the suggestions for actions to improve the uptake centred around the same themes as the barriers including the need to develop better and closer relationships between GPs and RACFs, knowledge of both GPs and RACFs, and systems designed to maximise effective use of the time of all parties. Suggestions made by informants included:

People need to be made to feel that they are a valued member of the team. This is done by development of personal relationships.

RACFs need to make sure that GPs are in the loop.

We need to understand that this involves a complex multi-factorial relationship. It needs to be managed well and not involve hierarchies or a top down approach.

We need to establish positive relationships between all of the participants.

Personal approaches supported by the Divisions are likely to lead to good outcomes. They need to invite the leading half dozen DONs in the local area over to be briefed and to get them cooperating with GPs who want to do it.

Education of the RACFs and the GPs is really important. They need to know what is required.

The consultations with key informants also led to the nomination of some important further consultations.

As previously discussed in the introduction to this document, the Royal Australian College of General Practitioners (RACGP) is developing Supplementary Guidelines for RACF and Carer Involvement Enhanced Primary Care Medicare Benefits Schedule items. Isobel Frean is leading this development with the support of an RACGP Technical Reference Group. The project is scheduled for completion in July 2002. The project has identified some national best practice principles and examples and these have informed the formulation of the present project's recommendations.

We met with Isobel to discuss best practice examples in Australia. As her project is a national one and could draw upon work in other states. The practice examples she described had at their centre:

- Facilitation of personal relationships between GPs and RACFs.

- The development of easy to implement templates and protocols to routinise the use of the items. Such initiatives include regularly scheduled meetings and well designed templates that make provision for the GP and the other health professionals in the management of patients and clients.

Another important consultation was that with the North East Valley Division of General Practice. As noted in the analysis of the uptake data, the North East Valley Division of General Practice has the highest uptake of the Victorian Divisions for the RACF EPC MBS items, representing 27 per cent of the entire volume of the RACF EPC MBS uptake. The Division has been active in the promotion of the items and has taken an effective and common sense approach to the issue. We interviewed the Executive Officer, Ken Mansbridge to study the approach. Ken described the following steps in the process:

- Personal consultations and visits were held with several General Practitioners who had established close working relationships with some of the local RACFs in order to understand the issues involved in the relationships and in the use of the EPC items.

- Based on this research, the Division sent letters to its members outlining the EPC RACF initiative and encouraging them to take it up.

- During visits to GPs and meetings with them for Divisional business this message was reinforced by divisional staff.

- The Division also visited the Directors of Nursing/ Managers of half a dozen of the key local RACFs and conducted consultations with them.

- Based on this research, the Division then wrote to all of the RACFs within the Division's catchment encouraging their participation in the use of the EPC items. The list of RACFs was obtained from local government sources.

This method of engagement is a model of elegant and effective simplicity. We consider the key elements of it to be:

- A personal and local approach drawing upon local knowledge and personal relationships
- An approach that involves both sets of interested parties
- A collaborative rather than prescriptive approach.

In formulating recommendations for the present report, we consider this approach to be very useful and pertinent. It is noted that while RACFs were sent materials from the Commonwealth outlining the EPC items, our survey of RACFs showed that most did not recall having seen the materials. A local approach involving local service providers and representatives is much more likely to engage the interest of RACF DONs and managers.

From the perspective of GPs, as the Australian Doctor survey results and the results of our consultations show, GPs are deluged with information requests and exhortations to conduct their practices in various ways. There is difficulty for GPs in sorting out which of the often-conflicting exhortations that they should follow. GPs are much more likely to value and accept advice from people whom they know to have their interests at heart. The Divisions are very well placed to influence their members directly and to understand local circumstances that impact upon them in order to provide advice that really works in the local context. It is for this reason that we consider the involvement of the GP Divisions to be pivotal in the successful implementation of the RACF EPC MBS items.

Discussions within the Project Reference Group were also very helpful indeed and we report some of the discussions as they are directly pertinent reflections concerning the project and its outcomes.

Dr Harry Hemley raised a range of issues from a GP perspective.

He noted that within RACFs there is frequently is no place on the existing Care Plan format for GPs to contribute. It is also interesting to note that in other jurisdictions a major part of facilitation of GP involvement in care plans has been provision of a place for this input. Documentation standards and protocols are important determinants of practice. If the desired practice is for GPs to contribute to the plan, then it follows that there needs to be provision for it in the standard documentation.

Dr Hemley also noted that GP engagement with patients in RACFs has reduced over the past 20 years. This assertion would seem to be supported by the AMAs position paper and also the data they have presented concerning the use of RACF MBS items.

One imagines that the introduction of the RACF EPC MBS items may in part be a response to this decline.

Dr Hemley noted that he considered the decline to have occurred because of a number of factors,:

- Lack of the proper facilities to treat people ie no treatment rooms, no sterilisation facilities,

- Staffing issues including change in DONs, agency nurses and high staff turnover

Pauline Bates from the Freemasons group supported Dr Hemley's observations concerning medical facilities by drawing attention to the seeming paradox whereby although the acuity and hence the medical needs of residents had increased in recent years, the push for a home like environment had meant that in many facilities provision for facilities for the delivery medical of services had reduced over time.

The utility of facilities directly engaging with GPs to deliver medical services to their residents was a common theme in the Reference Group discussions as were the challenges posed by interacting with such a large panel of GPs engaged in delivering services to residents of facilities. Meagan Lefebure spoke of her awareness of one 30-bed facility that has 23 GPs. This is a very complex set of inter-relationships to be negotiated by the participants from all perspectives. While RACFs may have many GPs providing medical services to their residents, equally GPs may have many RACFs with which they need to deal. Some GPs in the consultations spoke of seeing patients in 20 different facilities.

Some providers such as Bundoora Extended Care (BEC) and Freemasons have taken a proactive role in managing this complex web of relationships as indeed have some of the GPs and the Divisions

Rowan Cockerell noted that Bundoora Extended Care paid a core group of GPs for staff development education time and that they locumed for each other through a roster. The group has a strong relationship with the facility. This model has been running for 10 years, is well linked to the division, and is probably also a factor in the take-up of the EPC items in NEV. She noted that this approach required money which was hard to find but the results have been well worthwhile from her agency's perspective.

Similarly, at the Freemasons Pauline Bates noted that with a 170-bed facility there is a panel of 5 GPs for those without a local GP. The panel provides 24 hour cover which provides a high level of service to residents and this is well received by them. One of the doctors has 70 patients within the facility. Freedom of choice is maintained but also good quality coverage is provided under these circumstances.

Joan Snyder noted that where the medical care is poor there is a cost to State Health in terms of transfers to hospitals. Thus the State has a strong interest in this issue in ensuring that high quality medical care is provided to residents of RACFs.

An interesting issue that arises from these considerations and discussions is whether the relationships between RACFs and GPs surrounding he delivery of medical services in ACFs could be simplified through better coordination. The BEC and Freemasons models would seem to provide high amenity to GPs, residents and facilities. Freedom of choice is maintained and this is important for ethical and anti-competitive reasons but a high degree of amenity is provided. Divisions may also have a useful role in assisting with the establishment of protocols and training for such arrangements, especially in the context of smaller facilities where there may not be the infrastructure available in order to establish a BEC/ Freemasons approach.

Dr Petris Darzens, who is a specialist geriatrician also drew attention to the issue of provision of specialist services within RACFS. Drawing upon overseas experiences, he related several interesting case studies concerning the provision of specialist services to RACFs through cooperation between geriatricians and the facilities. He noted that the present RACF EPC MBS initiative is targeted at GPs and that there would be benefit in the development of programs to promote the appropriate use of specialist medical services in RACFS.

The Reference Group emphasised the usefulness of promoting the RACF EPC MBS initiative to RACFs through the various peak bodies and industry associations and also to residents and carers through their peak bodies. It was felt that there would be a lot to be gained through the application of some resources and encouragement from the Commonwealth in a manner similar to that conducted with GPs through state and local divisions. Reference Group members mentioned several regular meetings and conferences and other collaborative activities that could readily be utilised as a vehicle for promotion of the items. It was also noted that residents and carers would be likely to be more demanding of the use of the items if they knew of their existence and advantages. Notwithstanding concerns about the heavy demands placed upon RACFs there is strong good will amongst the sector towards initiatives that enhance the delivery of quality medical services to residents. For a modest investment of resources, this good will could be utilised in promoting the initiative.

A further clear message from the Reference Group was the need to continue to develop policy and initiatives that enhance the delivery of quality medical services to aged care facility residents. The point was made that this particular project has drawn upon issues and reflects contexts that fall outside its brief, but that this work has been necessary to do the topic justice. The Reference Group members in their discussion reinforced the need for ongoing policy and program development targeted at medical services for aged care facility residents both within the RACF EPC MBS system but also outside it.

Case studies in the use of RACF EPC MBS items

A feature of the project brief was the provision of some case studies involving the RACF MBS items with specific residents. We obtained the following case studies by interviewing two RACFs and two GPs associated with the delivery of medical services to the residents of the facilities. No identifying information was sought nor provided by the facilities nor the GPs and the case descriptions have been modified to remove any possible identifying information.

> Mrs X was an 85 year old resident of a low care medium sized 80 + bed facility in Metropolitan Melbourne. Along with cognitive problems and other predominantly musculoskeletal conditions she has mature onset diabetes. The Facility initiated medical input to the care plan because of concern about the management of her diabetes. The GP has a good relationship with the facility along with another 6 or so GPs who provide services to residents on a regular basis, but she was not previously Mrs X's GP. Mrs X was provided with a choice of GPs by the facility and chose Dr Y to see her. Her former GP practises in another area and does not visit the facility. Previously GP services were obtained by transporting Mrs X to local services on an ad hoc basis.
>
> Dr Y reviewed Mrs X condition and medication and met with other staff to contribute to her care plan and medical management. The GP said "*The nursing home called me in to attend Mrs X. They were right to call me in as she had not had a medical review for some time. I changed her medication and then met with the staff using the EPC care coordination item. This went well and she is so much better managed and monitored. Her quality of life has improved, no doubt*".
>
> The RACF manager said " *We have a group of local dedicated GPs who see our residents. Some have their own GPs... For those who do not we suggest some of the GPs with whom we have had good experiences. Dr Y is one of those. Dr Y reviewed Mrs X's medical status at the request of our staff. She reviewed Mrs X, changed her medication and made a useful contribution to the overall care plan... Mrs X is now feeling better because her condition is being better managed. Her family report significant improvement in her health and mood and they are happy about this*".

The second case study relates to a medium sized regional Victorian facility with both high and low care beds that maintains a panel of GPs for provision of medical services to residents. This is an example of service coordination between GPs and RACFs. We interviewed a GP involved in providing services and also a manager from the service.

> Dr Z stated "*We provide GP services as a kind of group locum to the nursing home residents. We operate our own private practice but we are all scheduled regularly to visit the home to see our patients. We also provide some after hours coverage via our practice. Initially we had teething issues with the*

availability of records, space to do the consults and other little niggles but these have now been fixed... Before we came on board I am sure that a lot of the residents were not getting the medical care they needed. Being in a group is good because it means that the burden does not fall on any one doctor… The EPC items have helped us financially to provide these services."

The manager stated *" The involvement of two of the local GP practices has been a real boon to us and the residents of our facility… Prior to this new set-up, it was hard… They operate effectively as a non-exclusive preferred provider set-up. People with GPs can continue to see their own GP and we encourage this... But, before when they did not have a GP it was very hard to get them services. Now that we have the groups in, we have ready access, they come regularly and we don't have to reinvent the wheel every time one of our residents need a GP... This is a great improvement... The EPC items were helpful because it meant we could be formally involved. It also makes it easier for the GPs costwise because unless you are organised there is not enough dollars in it to cover costs for them or us. This arrangement has improved the health of our residents"*

There are many positive examples of the use of RACF EPC MBS items in RACFs. The key to successful implementation is partnership between the GP and the RACF and residents and carers and organization of routine functions so that it is easy for all parties to participate in the delivery of high quality medical services to RACF residents.

Conclusions and recommendations

What has the study shown?

The purpose of this project was to determine the needs and issues for the residential care sector and GPs in taking up these EPC items and to advise on the strategies needed to address the issues.

The project activities included analysis of uptake data for the relevant RACF EPC MBS items, a survey of RACFs, and consultations with GPs and other key informants. The study has demonstrated:

- Highly variable uptake of the items by division. One division accounted for 27 per cent of the entire RACF EPC MBS item uptake in Victoria.

- Generally low but variable levels of knowledge of the items amongst RACFs and GPs.

Analysis of successful implementation of item uptake has revealed the importance of divisional involvement in facilitating partnerships between GPs and RACFs and residents and carers. The elements to successful uptake are considered to be:

- A personal and local approach drawing upon local knowledge and personal relationships
- An approach that involves all interested parties ie the GPs and RACFs and residents and carers
- A collaborative rather than top down, prescriptive approach.

In short the key to RACF MBS EPC item uptake and what it represents in effective care coordination is the quality of relationships between GPs and the RACFs. The journey to this effective relationship can be made down several different paths.

The two main paths that we have identified in this project involve initiation by GPs and the Divisions and initiation by the Residential Aged Care facilities.

The GP initiated approach

The very successful experience of the North East Valley Division has shown that effective relationships between GPs and RACFs can be strongly facilitated by the GP Divisions. The approach taken by North East Valley has delivered excellent results. The steps involved in the NEVDGP approach have been described in the body of this report. In this case the Division has been instrumental in bringing together local GPs and RACFs. Of course, individual GPs can and have done this successfully on their own, especially in smaller facilities. However, we consider that divisions can strongly facilitate this activity.

The Divisions have strong local knowledge and relationships with both GPs and local service providers. They are closely familiar with local circumstances and are seen as

honest brokers by the various participants. With appropriate resourcing, they are well equipped to deliver higher levels of uptake.

We suggest that the protocol developed by North East Valley for engagement with GPs and RACFs be further documented and developed by GPDV in association with NEVDGP and that it be disseminated amongst all divisions for consideration and implementation. The protocol will include:

- Personal consultations and visits to be held with General Practitioners who have established close working relationships with some of the local RACFs in order to understand the issues involved in the relationships and in the use of the EPC items.

- Letters from the Division to its members outlining the EPC RACF initiative and encouraging them to take it up.

- Visits to GPs by divisional staff to market the RACF EPC MBS items.

- Visits to the Directors of Nursing/ Managers of the key local RACFs by Division staff to market the RACF EPC MBS items.

- Letters to be disseminated by the Division to all of the RACFs within the Division's catchment encouraging their participation in the use of the EPC items.

The RACF initiated approach

This approach is based upon the Freemason and Bundoora Extended Care experiences in facilitating the provision of GP services to residents.

In this approach, the facility approaches GPs to participate in a panel to provide services to its residents who wish to avail themselves of the service. Freedom of choice of GP is maintained for those residents who wish to keep their own GP but those who are "unattached" to a current GP are provided with the choice of using the provided panel.

The benefits to the RACF of this model include:

- Less relationships to manage
- Level of guaranteed availability and coverage of medical services especially in the after hours context
- Ability to engage in quality enhancing activities and training with GPs and RACF staff

The benefits to GPs of this model include:

- Less relationships to manage
- Ability to engage in quality enhancing activities and training
- Better ability to influence policy and medical facilities within the RACF

- Better collegiality with other GPs

The benefits to residents of this model include:

- Maintenance of the freedom of choice
- Better access and coverage especially in after hours
- Care that is managed in a quality enhancing framework

Where to from here?

This work has identified at least two successful models of enhancing engagement between RACFs and GPs in the provision of services to residents of RACFs. These are the GP initiated approach and the RACF initiated approach. These approaches have been identified in several case examples of successful implementation.

The policy and funding settings surrounding RACFs and "ageing in place" have meant that residents of RACFs have higher medical needs than in the past. The introduction of the RACF EPC MBS items has acknowledged the need for better coordination of medical and health services to residents of these facilities.

The roll out of the RACF EPC MBS items has encountered some difficulties and challenges. Many GPs do not have the strong connections with RACFs that are required to make them a success. The patchy uptake of the items reflects the patchy nature of effective working relationships between GPs and RACFs as well as shortcomings in their marketing to GPs and RACFs. Our study has shown that many RACFs have limited knowledge of them. You cannot initiate an action you do not know about.

In the form suggested in this report the GP initiated approach and the RACF initiated approach have a common base, that of a corporate approach. We have recommended that the GP initiated approach is best coordinated by Divisions for their members or groups of GPs with sufficient corporate identity could also assume this task. It is strongly in the interests of RACFs to closely consider the Bundoora Extended Care and Freemasons approaches. This approach also has benefits for GPs and residents.

Our suggestions for future action are as follows:

Development of an engagement toolkit and dissemination of the approach and publicity of the success of the North East Valley approach to divisions by GPDV. The success of this approach deserves recognition and publicity.

Publicity of the Bundoora Extended Care and Freemasons approaches to provision of GP services in their facilities to other RACFs. These are very interesting and effective initiatives. They need to be appropriately recognised and disseminated in order that they may be adopted by others.

The Commonwealth should be approached to provide resources and input to peak bodies for RACFs and resident and carer organizations to promote the appropriate use

and good practice examples of the RACF EPC MBS items by GPs in aged care facilities.

We also suggest dissemination of our own report in a simple and accessible form.

We thank the participants for their valuable contributions to this work. We have found useful models of engagement between GPs and RACFs initiated by both groups with different but successful outcomes. Our recommended strategy is to capitalise upon these successes so that they may be reproduced in other settings.

Professor Shane Thomas
Professor Colette Browning

30 June 2002

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 current 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 in the future? ☐ 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?

- ☐ □□□□

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 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*
730	**Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
	CASE CONFERENCE – MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN) 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*
734	**Fee:** $73.15 **Benefit:** 75% = $54.90 85% = $62.20
	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*
736	**Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
	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)
H	*(See para A.22 of explanatory notes to this Category*
738	**Fee:** $146.25 **Benefit:** 75% = $109.70 85% = $124.35
	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*
775	**Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
	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*
778	**Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
	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*
779	**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	Petris	Darzins	National Ageing Research Institute		PO Box 31		PARKVILLE	VIC	3052
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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
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