Input to ADGP
September 2006

ADGP's Budget Bid for 2007

Summary

It is likely that ADGP's submission will highlight only a few areas for national funding to be allocated in 2007. Given recent developments and areas of priority for the Australian government, we nominated the following topics (in order of priority) for ADGP to consider when they decide what areas their submission will focus on.

Collaboratives – continued funding for the National Primary Care Collaboratives, and expanding the methodology for use in other programs that seek to enhance the general practice contribution to patient health in a particular area.

Cancer – we would welcome a national program supporting general practice in the prevention, diagnosis and management of cancer patients, at all stages. (ADGP is currently developing this proposal in partnership with the National Breast Cancer Centre and Cancer Council Australia.)

Team Building – work to support teams within the practice and links between practices and other health care providers (as ADGP's submission suggested last year) would be valuable.

Medication Safety/promotion of Quality Use of Medicines – joining up and expanding the different, current programs (NPS, HMR, RMMR, EDQUM and GP-Aged Care, GP-hospital work on medication management).

Indigenous Health – seek joint development with NACCHO (ADGP's MoU partner) for those aspects where general practice could make the most effective contribution to improving Aboriginal health.

Aged Care – continued funding for the current program focusing on quality improvement in the medical care of residents of aged care facilities.

45+ health check item – ensure that descriptors for MBS item numbers link with the frameworks used for Lifescripts, to build on existing systems for preventive health in general practice, and increase uptake.

Other areas from last year's ADGP bid that GPDV would be likely to support:

Funding for **Lifescripts.**

Include **obesity** as chronic condition **for EPC CDM item numbers.**

Expand **practice nurse** incentive program to <u>all</u> practices.

National Primary Care Collaboratives

- The NPCC program achieves good, measurable results and has the potential to be expanded and used as a methodology for practice improvements in other areas (ie to move beyond the current topics of heart disease, diabetes and access).
- Results are proven overseas and now in Australia in particular areas of heart disease and diabetes. Funding Collaboratives would mean implementing change now, rather than funding trials and pilots, whose later implementation is uncertain.

- Including Collaboratives in this bid is timely. Funding for the Program is due to end in 2007, and once ended, it is unlikely the program would be re-funded later. In any case, the momentum would be lost.
- Those GPs who have been involved give convincing testimonials about the effectiveness of the program; "GP champions" could be used to expand it.
- Work in partnership with the NPCC program to include consistent messages in their advocacy for further funding, and ADGP's budget bid.

Cancer

ADGP has circulated to SBOs an early draft of *A multistakeholder proposal for a national program supporting cancer care in general practice.* The proposal is being developed by ADGP, the National Breast Cancer Centre and Cancer Council Australia.

- A national program to support GPs in their work with patients with cancer would be very welcome. It would address the national health goal and target that has at times been omitted from divisions work across the country, because it lacked a specific, funded program.
- It could draw on findings from the national Palliative Care Program, including the Rural Palliative Care Program and the Program of Experience in the Palliative Approach (PEPA) clinical attachments.
- In Victoria, the state health department has a strong interest in improving cancer care. It recently developed patient management frameworks for cancer. To date, the general practice end of the care arrangements has been largely left out of the equation, because funding for general practice comes from the Commonwealth (both divisional funding and MBS subsidies to the public). As in many other areas, it is important to bring together general practice with the other state-funded providers, for better coordinated care. Divisions are in a unique position to assist. A funded, national program for divisions would allow us to progress work in an area that is a high priority for both state and commonwealth, to improve prevention and care in general practice, and to improve linkages between general practice and specialist cancer services.

ADGP's proposal refers to the National Service Improvement Framework for Cancer (NSIF) developed by the National Health Priority Action Council on behalf of AHMC. The Framework identifies 11 intervention points particularly relevant to general practice relating to:

- Early intervention
- Management and support during active treatment
- Management and support after and between periods of active treatment
- Care at end of life.

The local model suggested has six components. These components and GPDV's initial comments are as follows:

1. Governance – a local committee or reference group to guide action and stimulate community and stakeholder engagement

We would support the suggestion of a reference group at state level.

2. Coordination/establishment of multidisciplinary teams utilising existing public/private funding streams to promote collaborative care, more effective referral pathways, systems

development and networks of care, with an emphasis on ensuring all people with suspected cancers are appropriately, promptly and effectively assessed.

We would suggest re-working this point. Given that most cancer care is centred in the Acute system, set out an accompanying Cancer Primary Teams model (for *medical* care*)* that clearly articulates roles for GPs and GP nurses within primary care at the points of intervention mentioned elsewhere in the proposal:

- Early intervention
- Management and support during active treatment
- Management and support after and between periods of active treatment
- Care at end of life

3. Development of a patient held record to promote continuity of care

It may be more useful to first identify appropriate system solutions, rather than implement just one. This component could be to identify system solutions to enable effective transfer of patient information between health and community services providers to promote safety and continuity of care; and implement them. (Patient held records might be one solution but there could be others just as or more effective from a GP viewpoint.)

4. Coordination of existing programs for continuity of care e.g. screening programs, MAHS services, psyhchological support services, self-help and community support pathways

If a Cancer Primary Care Team model was developed for medical care then allied health and psychological support services may have defined roles within that model and fall within the coordination tasks of that Team. However, while there will be a division/general practice role in making connections to other community care services eg. screening services, self help programs etc, we believe it is not the division role to *coordinate* these primary community care services but rather to support the primary *medical* care that is coordinated at the practice level.

5. Education and training – targeting primary care providers such as GPs and practice nurses, but including interdisciplinary training where appropriate. Focus would be on diagnosis of symptoms and appropriate investigations and referral pathways. Promotion of structured care planning similar to the mental health 3 step process

We would support an increased emphasis on GP education and training on a broad range of issues (including pharmacy, pain management, early detection, care planning, management of co morbidities, psycho social issues, family carer health implications etc.)

6. Evaluation.

Supported.

We would suggest ranking the components in order of priority – perhaps 1, 5, 2, 3, 4, 6.

If the palliative care aspect is to be elaborated in this proposal, we would suggest referring to the Gold Standards Framework for Community Palliative Care, developed in the UK, which "offers primary health care teams an evidenced based programme with the tools and resources to help improve the planning of palliative care for their patients in the community." (http://www.goldstandardsframework.nhs.uk/)

Team Building

- We note that team building was in last year's bid, and believe work to enhance teams within the practice, and linkages that go outside the practice, remains crucial.

- We would suggest using the research findings on practice capacity by UNSW's Centre for Primary Health & Equity to support the argument.[1] (If this suggestion is taken up, we need to be aware of the particular wording used – ie the framework for practice capacity uses two different components: "team work" refers only to intrapractice teams and "linkages" refers to the team work that involves allied health and others outside the practice. Both components are needed to improve practice capacity as a whole.)

- Strengthening team work and linkages might also address problems in uptake with the team care arrangements.

Medication Safety

- We would support the development of a program involving all divisions, with at least one paid position in every division, to join together and expand existing programs relating to quality use of medicines. It would involve the current National Prescribing Service (NPS), Home Medicines Review (HMR), Residential Medication Management Review (RMMR), Enhanced Divisional Quality Use of Medicines (EDQUM) and GP/Aged Care and GP-hospital work on medication management.

23 of the 30 Victorian divisions responded to a GPDV a GPDV survey this month about their NPS and HMR programs. The survey results showed that:

- There is support for drawing the programs together. Benefits are that it reduces demands on the time of busy GPs (and is therefore more likely to get GP engagement). Practice visits can incorporate support for both programs (NPS, HMR). HMR case studies used for NPS meetings.
- Joint CPD can be used to deliver messages most effectively, reduce duplication, repetition, cost.
- Divisions are already combining the NPS and HMR programs under the umbrella of Quality Use of Medicines. It would help if this initial integrated approach were promoted and supported.
- Additionally, divisions are seeking ways to integrate HMR/QUM with other programs, e.g. Lifescripts; promotion via Practice Nurse Network; GP-hospital projects, to make both more effective, and seek support from SBOs and others in doing this.

- In the list of activities used to promote HMR, the emphasis on practice visits/support systems is striking, and has implications for strengthening the approach of practice support that is likely to be argued for elsewhere in the budget bid.[2]

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[1] The Centre for Primary Health & Equity have well-presented new information sheets summarising the findings from the Practice Capacity Research Project. (See http://www.cgpis.unsw.edu.au/files/Practice%20capacity%20research%20summary%20TEAM%2020060614.pdf (Teamwork) http://www.cgpis.unsw.edu.au/files/Practice%20capacity%20research%20summary%20OVERVIEW%20FINAL%2020060424.pdf; http://www.cgpis.unsw.edu.au/files/Practice%20capacity%20research%20summary%20PATIENTS%20FINAL%2020060424.pdf (Patient's point of view);

[2] Practice visits were the most common activity reported (by 19 divisions or 86% of respondents), followed by CPD and academic detailing by 16 divisions (73%). 10 divisions (45%) reported activities on practice support systems.

Indigenous health

- At the state level, GPDV's MoU partner is the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). Our MoU commits us to support the principle of community control. This principle does not only govern *how* we work with VACCHO, and how divisions work with their local Aboriginal Community Controlled Health Service (ACCHS), but governs *what* we work towards – ie we work on areas that are a priority for ACCHSs. We believe that ADGP's budget bid should reflect the priorities of its MoU partner, NACCHO, in the same way.

- We believe it is likely that support to ACCHSs to obtain general practice accreditation and advocacy for Aboriginal Health Workers to access MBS items currently available to practice nurses would be two areas to include (as they were in ADGP's bid last year).

- NACCHO will be making a submission and we would encourage ADGP to work with NACCHO to ensure that ADGP's complements and is entirely consistent with, NACCHO's.

Aged Care

GPDV has consulted with key member stakeholders regarding the future of the ACGPPI in three forums: GPDV board meeting 11th August, Rural CEOs network 25th August and the Aged Care Program Officers at a network meeting on the 31st August at which Debbie Bampton, Principle Advisor ADGP was involved.

All groups recognised the value of the program particularly the role of relationship building between sectors which should be built on in the future for further development. Other key recommendations include:

- Support for clearer outcomes across the board, less local variability with deliverables such as consistent IT linking back to general practice.
- Support for GPs to complete cycle of care for residents including role for care coordinator and incentives such as SIPs.
- Stronger support for GPs through Aged Care standards also recommended.
- Emphasis of the program should be on building on communications between aged care homes, pharmacy, allied health, GPs & geriatricians to improve the quality of medical care to residents.

45+ health check item

- The are precedents for allocating divisions funding to support uptake of new MBS items. We know that funded division support increases uptake at the practice level.

- The most likely way to ensure good uptake of the well person's health check is to link it to the frameworks used for Lifescripts. This approach would build on the systems that practices are already familiar with, and that divisions have already promoted (to a limited extent, due to funding constraints). It would also reinforce the Lifescripts framework. Given the competing demands on general practice, the introduction of a new MBS item with descriptors that use new frameworks would be less likely to achieve good rates of uptake.