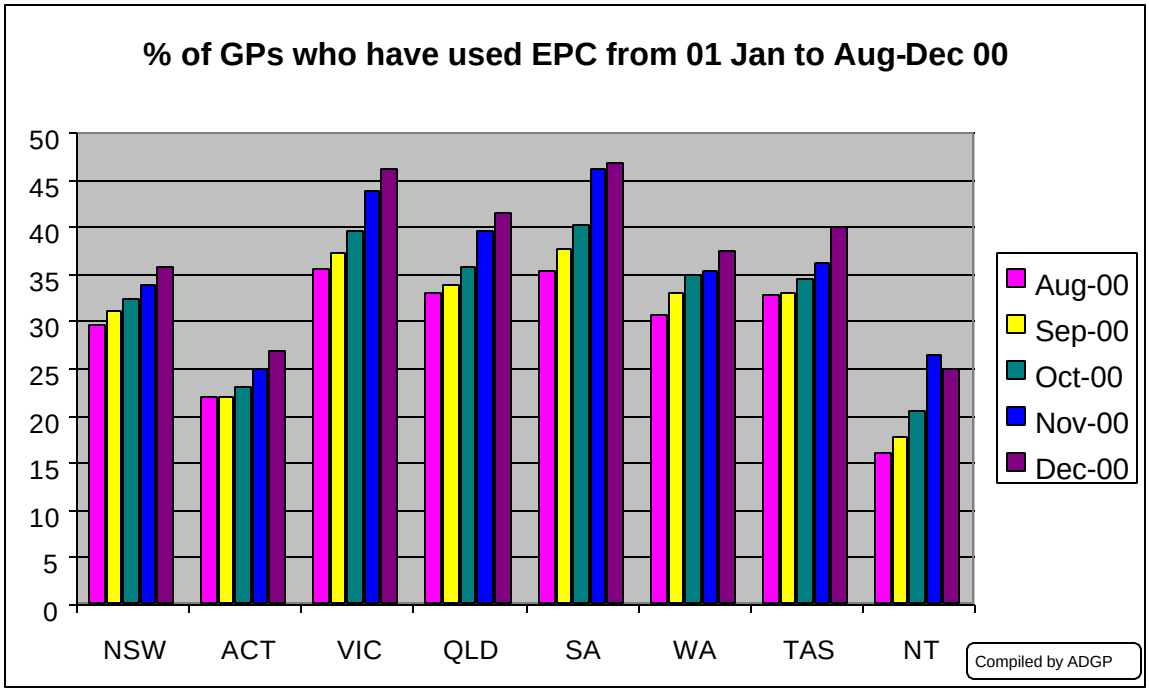
GP Education Support and Community Linkages Program

Quarterly SBO Report

1st October to 31st December 2000

Contents

Interest in the item numbers has remains high in Victoria, with over 46% of GPs having used an EPC item since the 1st of January 2000, which is equal to South Australia. GPDV believes that this may be an initial indicator that the "train the trainer" model has been a success, by a champion GP leading educational activities locally.



1. Workshops

Young People and EPC Workshop 22nd November 2001

GPDV offered a combined Youth Health and EPC network workshop in this quarter. There were 40 participants at this workshop with 27 Victorian divisions represented, 1 Tasmanian division, RACGP, DH&AC & the National Coordinator from ADGP. Key speakers at this workshop were Dr Leanne Rowe from Geelong Division, who explored how the EPC Care Planning and Case Conferencing items can be used in caring for adolescence. Leanne is preparing a paper on this topic, which GPDV is providing consultancy support. Dr Lena Sanci from the Centre for Adolescent Health, spoke about who will benefit from EPC. In the afternoon the networks separated, so to have a program specific focus. The EPC network received an update regarding the November 2001 MBS, a presentation from Bob Currie on the financial benefits to the practice in employing a practice nurse, and information from Fiona McCormack regarding the EPC clinical audit. The workshop was well received by participants and described as relevant, high quality and touched on some key integration areas in their work.

The GPDV EPC Web Page became live this quarter. The web page has been developed as a resource for project workers and GP trainers in Victorian divisions of general practice. The web page will be built on over time for the purpose of collating relevant information, storing links to other relevant web sites and to share the diverse work currently being undertaken by divisions.

GPDV EPC program manages the EPC network address for Victorian Divisions. Divisions are encouraged to use this address to connect with program workers in other divisions around working in a particularly area.

3. VACGP Sub Committee

The VACGP sub committee met on the 21st of November. This was a very informative meeting focusing on emerging models, DHS GP engagement strategy consultation, and issues for state evaluation. See Attachment 1 for minutes.

4. Activities undertaken by EPC Coordinator

Extensive support was provided to divisions in this period. The coordinator undertook 13 site visits to Divisions including; Monash, West Vic, NorthEast Vic, Border, East Gippsland, South Gippsland and Melbourne. Also a regional meeting was convened including Northern Melbourne, NorthWest Melbourne, and Melbourne divisions. Direct support was provided to educational activities in Westgate, Whitehorse, Goulburn Valley and assistance to Mallee Division in preparing visiting Melbourne GP trainer for training in Mallee in the first quarter of 2001.

The Coordinator participated in the National EPC Coordinators meeting in Canberra on the 15th and 16th of November and the Hospital at Home Seminar on the 8th of December.

The coordinator continued her commitment to networking with key stakeholders and met during this period with DH&AC state office, DHS GP Branch with Adele Hamlyn Primary Care Consultant, Helen Efthimou from the Health Insurance Commission, Fiona McCormack from the RACGP, Physiotherapists Association, and Bob Burgell DHS consultant.

EPC presentations were provided to the Social Workers in Community Health Network, and Anglicare Aged Care Services.

5. Educational Activities Undertaken by divisions

Victorian divisions have reached 864 GP members in this period, a slight increase from 852 GPs in the previous quarter. 80 educational activities were offered to all GPs and further 26 educational activities were undertaken in the practice by academic detailing. This was fairly consistent with the previous quarter although there appears to be a slight increase in academic detailing offered. This seems to be because Melbourne division undertook 21 sessions.

214 Practice Nurses and 146 Practice Managers participated in EPC education in this quarter. This compares with 84 and 93 respectively in the previous quarter. In particular 41 practice nurses from Whitehorse Division, and 47 nurses from Central Bayside division participated in EPC training in this quarter. Regarding Practice Manager participation, 27 practice managers from South City GP services, 29 from Greater South Eastern, 28 from Mallee and 19 Practice Managers from Knox division participated in EPC training in this period.

401 allied and other health providers received EPC education from divisions in this quarter. Even though divisions are aware that it is the primary responsibility of DHS to provide education to their funded sector there is awareness that one contribution to uptake, particularly for the multidisciplinary items, is the awareness and understanding of the items by DHS funded organisations. Divisions have been impatient in waiting for DHS and have significantly increased the targeting of education to allied and other health providers. This is an increase of over 100% participation from the previous quarter, when 178 allied and other health providers participated in EPC education. See Attachment 2.

6. Development of Community Linkages

Divisions have reported a continued commitment to the development of Community Linkages around the promotion and use of the EPC MBS Items. Since the start of the program in April 2000 clear trends are emerging, about which organisations are the key players who are clearly the Hospital sector, Primary Care Partnerships, RDNS and Community Health Centres.

Hospital Sector

Since the previous report 6 more divisions have reported contact with hospitals around the use of the items. In this period 24 divisions reported liaising in some capacity with Hospitals. 20 divisions reported that they had face to face meetings, 15 divisions provided an RACGP kit and 9 divisions reported providing an information session.

Divisions are requesting information regarding successful protocol development with hospitals. Without vigorous evaluation of emerging projects it would be irresponsible to promote such developing projects. Divisions are aware of the demonstration projects, which are being negotiated

and have requested a speedy release of these projects.

GPDV has prepared an Information Sheet on the use of the EPC Items within the Hospital Sector. This sheet is on the GPDV EPC Web page as a resource for divisions. See Attachment 4.

Primary Care Partnerships

Division's role in the Primary Care Partnerships is clearly emerging as an important area for EPC Items to be incorporated at a strategic local level. The Department of Human Service has been keen to ensure division involvement in the development of the GP engagement guide for the PCPs. The EPC coordinator has played an ongoing consultancy role for DHS in providing useful consultation around how the items can assist with local engagement.

RDNS

21 divisions have reported having face to face meetings with RDNS and 25 divisions have reported some contact regarding EPC. It appears that 7 divisions have either developed or are in the process of developing local arrangements regarding subcontracting arrangements for Health Assessments.

Community Health Centres

The introduction of the EPC items particularly the multidisciplinary items do effect Community Health Centres. We have anecdotal evidence that the impact of increase in referral and demand which CHC have at times been unable to meet and in one instance reports of closed waiting lists. This issue is explored further in item 8 Local barriers.

7. Local barriers

Preparedness of GP to allocate time to using the EPC items. Clearly the involvement of nurses in assisting GPs to undertake Health Assessments has been a significant enabler and probably one of the major reasons why there has been a high uptake of the Health Assessment Items. For GPs in a solo practice without a practice nurse this is even a bigger issue. The division has a key role to engage local nursing services to assist GPs, in particular solo's in the use of the items.

An argument may be to promote the financial benefits of employing a practice nurse. We have had anecdotal feedback that Solo GPs may not want to employ a nurse. Also divisions report that GPs state that financial benefits alone are not enough of a motivator. GPs on the whole want to see evidence that a Health Assessment will benefit their patient. At this stage divisions have not got evidence of benefits to give to their members.

The uncertainty of how a third party can assist with Care Planning and Case Conferencing in the manner it is clearly stated for Health Assessments is perceived as a barrier to uptake. We are aware

proposed follow up is to research and investigate the role of subcontracting elements of the multidisciplinary items. In regard to Care Planning and case conferencing we are still unclear of when it is appropriate for GPs to have a multidisciplinary approach to care. Divisions have reported that some GPs find the necessity of working with other health providers daunting. GPDV supports the initial proposal of Monash Division to undertake research into appropriate sub contracting arrangements for Care Planning and Case Conferencing.

Logistical issues pertaining to low uptake remain, the GPs unpreparedness to allocate time particularly for Care Planning and Case Conferences for reasons already discussed, the number of "hoops" that need to be jumped to be able to claim, and absence of translated materials. Regarding Case Conferencing GPs report that they are too logistically difficult to organise.

The reluctance of allied health providers to get involved remains a significant barrier. This may be due to DHS funded services not being able to include non direct service in their statistics under the "output based funding" system. Also, as discussed through this report, the delay in an allied health education strategy has caused significant difficulty for GPs. The introduction of these items has created a significant change to the way GPs practice. The change process needs to be dealt with in the allied health sector in response to the new way GPs will work. This may be addressed though the GP engagement strategy of the PCP. DHS & DH&AC may need to support this cultural change by implementing funding changes. This may be in funding Community Health for care planning and case conferencing activity involving GPs. Also service agreements and tenders for new services could accommodate engagement of GPs. An example of this may be policy development for Aged Care Assessments teams and clear direction from the Commonwealth in how a GP Health Assessment can compliment the Assessment undertaken by ACAS. Also it could be written into Community Aged Care Package tender specifications for organisations to demonstrate how they can engage GPs in their Care Planning activities, the same could be said for the Residential Aged Care Facilities Sector.

The last barrier that I would like to note is the lack of capacity of the practice to support GPs use of the items. Clearly the skills required for Health Assessments are significantly different to Care Planning and Case Conferencing items. Divisions report that the multidisciplinary items are daunting and unfamiliar to the practice predominantly because they are non-clinical and require negotiation with service providers. On the whole GPs are unfamiliar with what other service providers can offer their patients. GPs also report that they are frustrated with referral processes and that service providers are not available when they are eg. Lunch time and after hours. This issue will be explored in the Information Management Workshop on the 4th of May 2001. Mary Matthews will discuss the role of the practice nurse, Helen Yaacoub from Whitehorse Division will present her experience of working for the practice to undertake care planning, and Jonathon Pietsch from Central Bayside Division will

Border division and Sandra Beirs from North East Vic to present their work for the Upper Hume PCP in tracking over 75s through the service system. The project will research the benefits and barriers to access for the GP, patient and service provider.

8. Local enablers

The list of barriers provided by divisions clearly outweighed the enablers, yet key themes that have emerged around nursing support, infrastructure change within the practice, clear protocols and intensive developmental work with one agency, and general integration of EPC into division business.

Divisions reported that where they have an MOU with RDNS, bush nursing, have a team of nurses employed by the divisions or provide training to Practice Nurses, that the uptake of Health Assessment items has been increased. The development of the role of the "nurse", (could be a social worker, case manager etc) with skills to undertake Care Planning and Case Conferencing within the practice is endorsed.

Divisions reported that significant change is required within the practice to be able to take on Care Planning and Case Conferencing activities. There needs to be a significant commitment by the practice to change and divisions are playing a key role in promotion. As discussed earlier there has been consistent representation by Practice Managers in EPC educational activities in this reporting period.

Divisions have reported that integrating EPC into CME activities has been an enabling strategy. In the training skills workshops in the following quarter GP trainers reported that educational activities that have been most successful and engaging have been the ones that were integrated. An example of this may be to look at the Care Planning Items for diabetes management. This is clearly a logical fit and was well received by participants.

A division reported that developing a resource with examples of goals, problems and management steps has been an enabler in supporting academic detailing within the division. This concept would be worth building on, yet requires validation and expert input before being promoted as an approach. Packages of Case Studies, sample care plans and resources on disease areas would further support the education program.

9. What divisions said they want GPDV to address

Primary Care Partnerships (Department of Human Service Initiative)

Although this issue was explored at length in the Community Linkages section 4, the issue of GPDV guidance for the promotion of EPC items in PCPs is noted as an area which needs further development.

DHS funded sector.

Translated Materials

The issue of the provision of translated materials is often raised by divisions particularly in the Western Metropolitan areas, where the population of older people who do not have English as a first language. In the Brimbank area for example, the population of over 75s who are from culturally and diverse backgrounds exceed 60% of the population. Clearly an absence from the release of the EPC items has been a strategy for promotion of the items for non- English speakers. Although the items are generally geared for people with chronic illness the predominant target population is the aged. As there is clear evidence that as people age their understanding of English deteriorates, there is an even greater need.

The other interesting issue identified by divisions is around EPC education for GPs from non-English speaking background. Divisions report that the items and rules associated are generally complicated and difficult to distil into clear and simple language. This issue is exacerbated when the GP does not speak English as a first language.

Eyre Care Software

Although acknowledgment was given that GPDV was not in control of the release of the Eyre Care Software a request was made regarding the speedy delivery of training once available. Regular updates regarding the training has been provided by ADGP and communicated regularly though the EPC update to divisions. The launch of the software is scheduled for the IM in Primary Care workshop on the 4th of May 2001.

Networking Opportunities

Divisions have requested local area network meetings around EPC to coordinate local activities and initiatives around EPC. GPDV is convening a local network meeting for NorthWest Melbourne, Melbourne and Northern Divisions. Divisions have reported that they valued the opportunity to network, share ideas and coordinated work with organisations they have in common such as hospitals. Further development of Regional Network Meetings in other areas will be facilitated in 2001.

EPC Frequently Asked Questions

A division has asked GPDV to circulate responses to queries. This will be undertaken through the monthly EPC update. Infrastructure support is still required from Medicare Branch in investing resources into the development of an EPC Q&A website. Extensive time continues to be wasted by GP trainers and division staff and GPDV in researching answers to EPC questions. The items and rules in using the items clearly remain a barrier to uptake and a burden for trainers. By not having a

ensure that accurate information is provided to members.

10. Divisions comments on GPDV support

In the standard quarterly activity report for this quarter, we asked divisions to comment on GPDV support, what is useful, what is not and what is still needed.

What is useful?

- Regular dissemination of uptake statistics is reported as very helpful,
- Monthly Updates,
- EPC email network address,
- Visit and support given by program coordinator,
- provision of clearing house of good ideas,
- support provided by coordinator for presentation to other health providers,
- Networking opportunities is reported as the most useful role for GPDV, including EPC e-mail address,
- GPDVs role in providing up to date information has been very successful
- Excellent support with training days and collation of resources, statistical analysis of EPC item usage with comparative data.
- Useful GP training events
- One to one support by coordinator - personal and timely
- "It is great knowing that if a question arises out of our knowledge and understanding GPDV will help. This allows us to provide great service to our members".

What is not?

There were no responses from divisions regarding what GPDV has provided that has not been useful.

What is still needed?

Divisions requested;

- Further opportunities for participating in training skills workshops, as there is an attrition of trainers. A series of workshops have been offered in the first quarter 2001.
- A summary of what is working in EPC educational activities
- Regional Interdivisional EPC network meetings
- Sample of Care plans for disease states
- dissemination of information on initiatives Divisions have found effective in promoting uptake of items

- Problem solving sessions, or quarterly consultations with GPDV
- Quick response to queries
- A Statewide forum for managers/CEO of allied health and private health professionals, to discussion and identify, the barriers to participating in the new items and to explore the experiences to date.
- More discharge planning/ care planning advice

11. GPDV Plan 2001

GPDV is committed to establishing an operational plan for the delivery of the EPC GPSCL program. The plan will be determined by how we decided to utilise unspent funds resulting from a delay in the implementation of National and therefore State Evaluation. Please see attachment 5 Proposal for use of EPC unspent evaluation funds 2001. We are keen to meet with you to discuss this proposal.

ATTACHMENT 1

VACGP Subcommittee on GP Education & Training for EPC

Tuesday 21 November 2000 at 4 pm
GPDV, 3rd Floor, 458 Swanston Street, Carlton

~ Minutes ~

Chairperson: Bill Newton

Present:

Bill Newton (GPDV) CEO
Rosemary Fenech (GPDV)
Andrew Kallaur (DH&AC)
Pier de Carlo (VHA)
Dr John Stanton (DHS)
Fiona McCormack (RACGP)
Catherine Elvins (VHA)
Dr Peter Waxman (Central Bayside Division)
Dr Rob Currie (North East Valley Division)
Jeannine Jacobson (DHS)

In attendance:

Graham Clark (GPDV)

1. DH&AC

Andrew Kallaur spoke about the roleout of MAHS to 14 divisions. Requirements of the division's submissions are for the positions to assist the uptake of the MBS items. Divisions are required to consult with local agencies. Shortage of allied health resources in rural and regional areas is anticipated as an issue for divisions to address. Divisions are also exploring models of employment that is whether to subcontract or provide services directly from the division.

2. DHS Program

John Stanton tabled a confidential draft document about Primary Care Partnerships for comment before February/March of next year. John would like all comments to be emailed to him at John.Stanton@dhs.vic.gov by Friday 15 December.

3. GPDV Program

Rosemary Fenech briefed the meeting on changes to the MBS items

- 7 new items have been introduced around GPs role in Aged Care Facilities.
- Health assessment items are unavailable in Aged Care Facilities.
- GPs have access to item numbers to contribute to a care plan and to organise or participate in a case conference.

4. Emerging Models in Divisions

- Dr Rob Currie spoke about a model developed by NE Valley division with the Austin Hospital. Dr Jenny Oliaris is employed as GP liaison and is working on developing protocols around aged care and psychiatric patients.
- East Gippsland Division has developed the mental health program whereby the divisions are

- Dr Peter Waxman briefed the meeting on EPC work undertaken by Central Bayside division including a care planning index to help practices determine how to take the next step in care planning.
- Discussion also around the model developed by Central Bayside and Como Private Hospital. This model is possibly being extended to Brighton Rehabilitation Hospital.

5. Communication

The sub committee supported the need to have a Victorian Divisions EPC newsletter for stakeholders.

Dr Peter Waxman spoke about presenting EPC at the Case Management Society and its annual conference.

Dr John Stanton suggested an EPC forum for stakeholders next year. The sub committee thought this was a good idea and that the forum should be a combined DHS/GPDV initiative with a strong focus on Primary Care Partnerships. Dr Stanton suggested VHA and DHS to co-sponsor the forum. Dr John Stanton, Catherine Elvins, Robyn Dowling (nominated in her absence) and Rosemary Fenech will discuss this matter further prior to the next meeting.

6. Evaluation

Bill Newton asked the committee to look at aspects of the program, which the State evaluation could focus these included:

- Barriers to uptake of the case conferencing and care planning items.
- Community participation
- Quality of care plans
- Patient satisfaction

7. Future Directions

Dr Peter Waxman suggested that we meet more often. Bill Newton suggested focussing on links with RDNS, MAVs, etc.

8. Next Meeting

Next date To be determined

ATTACHMENT 2

ducational Activities undertaken by Victorian divisions

ctober 2000 to December 2000

	North West Melbourne	Western Melbourne	Dandenong	Mornington	Melbourne	Northern Melbourne	Whitehorse	Geelong	North East Valley	Central Highlands	North East Victoria	South City GP Services	Otway	Greater South East	Inner Eastern Melbourne	Knox	West Vic	Central Bayside	Goulburn Valley	Westgate	Monash	Central West Gippsland	Mallee	Ballarat	East Gippsland	Border	Murray Plains	South Gippsland	Yarra Valley	Bendigo	Sherbrooke/Pakenham	TOTAL
vision Number	307	306	315	316	301	308	310	317	302	318	319	304	324	311	303	314	330	313	327	305	312	323	332	325	328	329	331	322	320	326	321	
embership	312	280	248	205	NA	312	309	160	379	91	110	257	107	162	287	163	62	255	54	58	163	96	55	92	59	84	92	51	140	82	50	47
gible Membership	406	221	260	220	NA	188	340	210	234	152	110	331	110	187	340	260	63	487	85	150	125	96	58	92	67	79	47	52	145	86	55	52
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rcentage of Practices presented	12%	8%	22%	35%	10%	15%	90%	80%	36%	50%	93%	NA	100%	28%	54%	57%	83%	38%	25%	13%	52%	20%	89%	32%	-	45%	33%	90%	80%	83%	47%	
mber of educational tivities	2	3	2	1	21 AD	1	4 + AD	4	2	3	4	5	5	2	2+AD	2 + AD	4+ 5 AD	3	1+ AD	2	3	1	2	6	3	3	2	3	6	AD	2	80 + A
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GP Participants	25	30	6	5	26	29	76	65	6	13	16	46	67	56	27	92	22	17	20	11	38	-	36	31	?	-	4	26	62	26	6	86
Practice Nurses	0		2	-	6	0	41	5	0	18	22	0	0	27	-	19	10	47	1	-	-	0	0	-	-	-	4	9	0	0	3	21
Practice Managers	0		2	-	3	0	4	3	-	1	0	27	0	29	2	19	4	5	-	-	-	0	28	-	-	-	2	3	11	0	3	14
mber of allied and other alth provider participants	-	3	19	-	-	0	43	28	10	2	29	0	-	0	7	70	2	0	50	3	2	16	6	12	56	30	0	4	7	0	2	40
pe of Educational tivity Undertaken:																																
Presentation	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	
Small Group Discussion			✓	✓			✓	✓	✓	✓	✓	✓				✓	✓	✓	✓		✓	✓	✓	✓		✓		✓	✓		✓	
Case Study	✓	✓	✓	✓		✓				✓	✓		✓	✓	✓		✓			✓	✓			✓			✓		✓		✓	
Practice Staff Training	✓	✓						✓	✓	✓	✓									✓				✓				✓	✓		✓	
Academic Detailing					✓		✓	✓	✓				✓		✓	✓	✓		✓				✓	✓						✓		
Case Conference												✓																				

	North West Melbourne	Western Melbourne	Dandenong	Mornington	Melbourne	Northern Melbourne	Whitehorse	Geelong	North East Valley	Central Highlands	North East Victoria	South City GP Services	Otway	Greater South East	Inner Eastern Melbourne	Knox	West Vic	Central Bayside	Goulburn	Westgate	Monash	Central West Gippsland	Mallee	Ballarat	East Gippsland	Border	Murray Plains	South Gippsland	Yarra Valley	Bendigo	Sherbrooke/Pakenham	TOTAL
vision Number	*307*	*306*	*315*	*316*	*301*	*308*	*310*	*317*	*302*	*318*	*319*	*304*	*324*	*311*	*303*	*314*	*330*	*313*	*327*	*305*	*312*	*323*	*332*	*325*	*328*	*329*	*331*	*322*	*320*	*326*	*321*	
ocus of Training:																																
All Items	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Health Assessments				✓									✓					✓										✓				
Care Planning						✓																						✓				
Case Conferencing						✓																										
this part of the Division's ogram area?																																
EPC Items	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
GP Hospital					✓				✓		✓								✓										✓			
Diabetes					✓						✓					✓													✓			
Mental Health					✓						✓	✓																	✓		✓	
CVD									✓		✓					✓												✓	✓			
Practice Support					✓			✓								✓													✓		✓	
Aged Care					✓							✓				✓												✓	✓		✓	
Consumer Liaison																																
Information Technology									✓		✓																		✓			
Pharmacy					✓																											
Quality Use of Medicines																	✓															
Drug and Alcohol																✓	✓															

ATTACHMENT 3

EPC Community Linkages	Aboriginal Health Services	Aged Care Assessment Team	Community Health Centres	Consumer Groups	Coordinated Care Trials	Local Government	Mental Health Providers	Linkages Services	Self Help Groups	Hospitals	Pharmacy	Primary Care Partnership	RDNS/Local Nursing	Victorian Survivors of Torture Foundation	Bush Nurses	Centre for Developmental Disability	Nari	Other Services
elp Desk	6	6	7	6	1	2	8	5	1	9	2	9	8	3	0	3	3	1
ace to face meetings	5	10	17	12	4	8	12	10	2	20	5	15	21	3	1	3	3	5
formation Sessions	4	10	14	7	1	5	9	8	1	9	2	4	14	3	1	0	4	3
volvement in CME activities	0	5	6	2	0	2	3	1	0	4	2	2	8	0	0	0	2	3
evelopment of Protocols	0	2	2	0	0	1	4	1	0	7	2	0	7	0	1	0	0	2
ssemination of RACGP Kit ***available please attach list)***	5	8	15	3	2	10	14	8	1	15	6	13	15	0	0	0	0	4
ther	0	1	1	0	0	1	2	0	0	0	0	0	1	0	0	0	0	1
COLUMN TOTALS	20	42	62	30	8	29	52	33	5	64	19	43	74	9	3	6	12	1
umber of Divisions	10	15	21	15	5	15	21	14	4	24	9	21	25	3	1	3	4	8

ATTACHMENT 4

Medicare Benefits Schedule items
Relating to discharge from public hospitals
Information sheet
GPDV, February 2001

Case Conference

A case conference entails all service providers involved in the care of a patient being present at the same time. This presence may be face to face, by video link, or by phone. The purpose of a case conference is immediate problem solving by identifying patient needs, desired outcomes, and tasks for each team member.

For a GP to be able to claim a rebate in relation to case conferences the following circumstances must apply:

The patient has a chronic illness or complex care needs . They can be of any age.
The GP and a minimum of 2 other service providers are involved in the discussion. An informal carer is not counted towards the minimum of 3 service providers.
Patient consent to the GPs involvement must be gained; the day, time and participants recorded; the decisions recorded; and copies distributed to all, including the patient.

In relation to discharge GP's can initiate a discharge case conference for private patients only. However GPs can contribute to a discharge case conference for private and public patients.

A Case Conference cannot be claimed on the same day as a Care Plan.

Case Conference Rebates

Contribution to hospital discharge case conference		Schedule Fee	Rebate
768	15 to 30 minutes	$ 52.20	$44.40
771	30 to 45 minutes	$ 83.55	$71.05
773	> 45 minutes	$114.90	$97.70

Multidisciplinary Care Plans

A Care Plan is a shared vision for the individual (patient), GP and service providers to work together towards achieving the best possible health and well being outcomes for the individual. It is geared to longer term planning than a case conference.

A care plan may be compiled by one service provider making contact with other relevant service providers sequentially. The contact may be by phone, FAX, email, or written form.

For a GP to be able to claim a rebate in relation to care plans the following circumstances must apply:

The patient has a chronic illness or complex care needs . They can be of any age.
The GP and a minimum of 2 other service providers are involved in the careplan . Informal carers are not counted towards the minimum of 3 service providers.

Patient consent to the GP's involvement must be gained; the day, time and participants recorded; the decisions recorded; and copies distributed to all, including the patient. The patient needs to be included in the preparation of the plan.

In relation to discharge GP's can initiate a discharge care plan for private patients only. However GPs can contribute to a discharge care plan for private and public patients

The careplan needs to include an assessment of needs; services/ treatments needed; community supports needed; management goals; arrangements for giving treatments/services; and review arrangements.

Care Plan Rebates

Item		S fee	Rebate
722	Discharge care plan preparation	$188.05	$159.85
724	Review of a careplan	$ 94.05	$ 79.95
728	Contribution to discharge careplan	$ 37.90	$32.25

These services are designed to support the discharge services provided by the hospital but are separate and distinct services focused on the post-hospital care of the patient, and should be provided by the patient's usual GP.

Usual GP

This term has been defined as the doctor/practice who has provided the majority of services over the previous 12 months (and /or is likely to provide the majority of services in the next 12 months). When another doctor provides an EPC MBS service, a copy of the case conference/careplan report should be sent to the patient's 'usual' doctor (subject to the patient's agreement).

Patient Consent

"*The MBS items may only be claimed if the patient gives consent to the care plan or case conference and to the sharing of information with the other providers involved. Consent may be given orally or in writing and must be recorded in the patient's notes.*

Informed consent can only be given if the patient understands the care planning or case conference process; has been made aware that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and has been given an opportunity to specify what medical and personal information he or she wants to be conveyed or withheld from the other members of the care planning or case conferencing team. Informed consent also requires that the patient be aware of the costs he or she will incur for the preparation of the care plan or case conference." (p55 RACGP: 2000)

Private Patients

The EPC discharge items items 722, 746, 749 and 757 are available in respect of services provided to private in-patients only. These relate to care plans or case conferences which must be prepared or organised by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner). These services are professional services provided to the patient in conjunction with in-hospital treatment, and therefore will be rebated at 75% of the MBS fee. GPs providing these EPC discharge services must be acting in a fully private capacity. These Medicare items are not available for services provided by GPs who are employed under contract or VMO arrangements to provide public hospital services to admitted public patients.

MBS items available for consultant physicians

From November 2000 new discharge case conferencing items are available for consultant physicians. Items 813 and 815, participation in a discharge case conference, are available to private and public patients, are out of hospital services and should be rebated at the 85% rate. Items 809 and 811, organisation and co-ordination of a discharge case conference, are available to private patients only, are in-hospital services, and will be rebated at 75% of the MBS fee.

For a consultant physician to be able to claim a rebate in relation to case conferences similar circumstances must apply to those outlined for GPs. However case conferencing items for consultant physicians require the involvement of an additional 3 care providers. The case conference participation needs to be for a minimum of 30 minutes, and the rebates are substantially higher than for GPs.

For more detailed information See Medicare Benefits Schedule book, 1 November 2000.

ATTACHMENT 5

GPDV

PROPOSAL FOR USE OF EPC UNSPENT EVALUATION FUNDS 2001

Draft

Proposal 1
Consultancy Support to Divisions to evaluate "emerging models"

Divisions are asking for a dissemination of ideas. ADGP has recently collated emerging models in divisions yet there is little evidence base for whether these models have useful outcomes to consumers, GPS and other stakeholders.

In particular this has been raised in regard the need for an evaluation of the use of EPC items for mental health case conferencing and care planning.

As you know, divisions are trialling this at present, and our best models appear to be in Otway, East Gippsland and possibly Melbourne for a metropolitan division. It would be extremely useful to have some thorough evaluation of these models a bit later this year with a focus on patient outcomes, GP perceived benefits, allied health providers perceived benefits, practice costs, division costs, etc.

It would be useful, also, to compare the outcomes for EPC using mental health with other disease-based uptake, ie diabetes and asthma, to see where cross sector multidisciplinary care works well and where facilitated team work using EPC is perhaps forcing the issue or not so useful. Some good evaluations will assist us and others consider the potential changes to general practice in terms of the role of nurse practitioners, costs, practice systems, etc.

Proposal
Consultancy support to divisions, to evaluate models of implementing EPC activities. This will create evidence base to effective implementation of EPC models. This can either be in a consultancy or direct capacity.

Proposal 2
Follow up on work to be done at the National Conference in Canberra in May 2001.

This may include a 6-month position to support and provide training VACCHO affiliates to use the EPC items.

Proposal 3
Residential Aged Care Facilities

The November 2000 MBS released 7 additional EPC items around the use of a specific care planning item and case conferencing items for GPs who have patients in Residential Aged Care Facilities. The GPSCL agreements with divisions did neither anticipate nor include the divisions working in these areas. DH&AC in WA have created a position within the department to work in the RACF sector to encourage uptake of these items.

Project worker position to work with the Residential Aged Care Facility Sector in the promotion of the new (2001) RACF item numbers.

Proposal 4

Training Resources

In February/March 2001 GPDV provided divisions with follow up training skills workshops for EPC GP Trainers. This included both the "GP expert" in the divisor and the division EPC program workers. A volume of ideas and recommendations came out of these sessions, which could be followed up to provide useful resources to divisions.

- Tool kit of warm up activities
- Training resources for allied health sector