Introduction

General Practice Divisions Victoria (GPDV) is seeking applications from qualified persons or organisations to undertake a research project around the introduction of Enhanced Primary Care Medicare Benefits Schedule Item Numbers for General Practitioners in the residential aged care sector. *See Attachment 1 Excerpt from Medicare Benefits Schedule.*

GPDV will employ a consultant

- 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 key outcome that is expected from this project is to achieve 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.

General Practice Divisions Victoria will use some of the funding provided under the Enhanced Primary Care Program to implement a project to examine, with the Residential Aged Care Facilities sector, ways to promote the use of the seven Residential Aged Care Medicare Benefits Schedule Item Numbers and to overcome barriers to their use.

To support and advise this project GPDV has convened a reference group involving key representatives of the Residential Aged Care Facilities Sector. The reference group includes 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)
- DHS Aged Care
- DH&AC Aged Care
- DH&AC Primary Care
- GPDV

The group met for the first time on September 11 2001 to discuss the project and contribute suggestions for this brief for tender by consultants. The reference group endorsed the feasibility of undertaking the project in the current climate despite the difficulties. *See attachment 2 Reference Group Participants List.*

Rationale

The residential care MBS items were not part of the original package of EPC items nor the training provided to GPs. Therefore they have received very little attention to date. These items provide an opportunity for Divisions to work more closely with the aged care sector, and to identify how GPs, Divisions, and residential aged care facilities can work more effectively together.

The uptake of these items has increased steadily in Victoria since their introduction in November 2000. Nevertheless the uptake is negligible considering that there are 34,098 residents of 830 facilities which all have the potential for GP involvement in care planning.

EPC Uptake Statistics for Items relating to Residential Aged Care Facilities Cumulative Uptake	Contribute to a care plan	Organise a case conference	Participate in a case conference	**RACF MBS Items**
Item Numbers -	730	734, 736, 738	775, 778, 779	**Total**
November 2000 - 31st January 2001	31	30	11	**72**
November 2000 - 28th February 2001	83	52	24	**159**
November 2000 - 30th March 2001	99	82	34	**215**
November 2000 - 30th April 2001	130	110	43	**283**
November 2000- 31st May 2001	223	137	54	**414**
November 2000- 30th June 2001	281	157	77	**515**
November 2000- 31st July 2001	475	218	84	**777**

This project is structured in three main components, each component dealing with the uptake of the residential aged care facility Enhanced Primary Care MBS Item numbers.

Component One - Consultation with the sector

This section is an extensive consultation with a range of Residential Aged Care Facilities representing the sector. We want to explore what are the perceived barriers that have inhibited GPs from using the EPC Items in residential care.

- Are the barriers about structures, relationships or attitude?
- Why are facilities reluctant to promote the use of these items to GPs who service their residents?
- Is it the facility's role to promote the use of these items?

Component Two - Consultation with GPs

This section explores the knowledge & attitude of GPs in using the EPC items in a residential care setting. To date a very small number of the EPC residential care items have been claimed by GPs. Anecdotal evidence suggests that GPs already undertake Care Planning and Case Conferencing within aged care facilities.

- What are the reasons for the poor uptake of these items?

Component Three - Assessment of systematic model within facilities

Some GPs have developed ways to use the EPC Items in the Residential Care setting. It would be valuable for GPDV to have these models of use documented and assessed to determine the perceived benefits to the consumers of the different models.

Main Components of this Project

1. Consultation with the sector

The consultant will select a range of facilities to undertake semi-structured interviews to explore the barriers from the facilities' perspective to General Practice use of these items.

It is expected that a range of facilities will be consulted for this project. The consultant will need to choose a range of High and Low Care Facilities in rural and urban settings, not for profit, for profit, specific needs facilities and "ageing in place" facilities. Variations on the use of the items in this range of facilities will need to be explored as a key factor in this research. In undertaking this research the consultant will interview the Manager/CEO and the DON or Care Manager in each facility. We expect that some facilities may not be aware of the EPC items.

Key research questions for this component include the following;
- Does the facility know about the items?
- How does the facility promote the use of the EPC items to GPs who service its residents?
- Does the facility perceive that there would be any benefits to managing the care of residents if GPs were to use these items?
- What strategies could be employed to encourage the use of the EPC items?
- Are there different issues in different settings?

2. Consultation with GPs
Rationale
The consultant will select a group of GPs who are currently servicing residents of Aged Care Facilities to undertake semi-structured interviews to explore difficulties from their perspective in using these items. To date a very small number of the EPC residential care items have been claimed by GPs.

We want the consultant to explore the knowledge & attitude of GPs in use of the EPC items in a residential care setting. Anecdotal evidence suggests that GPs already undertake Care Planning and Case Conferencing within aged care facilities but do not claim the work under the EPC Items.

Key research questions for this component include the following;
- Do residential care facilities invite GPs to contribute to their care planning process?
- How do GPs contribute to care planning of patients in residential care?
- What are the barriers to using the EPC items for patients in a residential care setting?
- What would make it possible for GPs to use the items?

3. Assessment of systematic model within facilities
Rationale
There are some instances, of GPs who are systematically using the EPC items in aged care facilities. We are interested in the consultant investigating this area to identify models of use, which can be circulated to GPs through the Divisions of General Practice.

This component will include interviewing the facility manager & DON, the GP and consumers. To limit the breadth of this inquiry we are interested in documented evidence of

perceived benefits to residents, of the various models, from the consumer/carer, GP and facility perspective.

Key questions for this component include the following;

- What effect has the use of the items had on the relationship between the GP & the facility?
- How do consumers and carers feel about GPs using these items?
- Has the use of the items averted an acute health episode?
- Is there any evidence of improved health outcomes for patients when GPs use these items?
- What are the perceived benefits to the consumer, GP & facility?

Expressions of Interest

GPDV seeks expressions of interest from suitably qualified persons or organisations to undertake the research detailed in this brief.

The tenderer is required to;

- Detail the organisation's experience in undertaking research and evaluation in the Residential Aged Care Sector.
- The name/s and relevant experience of individuals who will be undertaking the project.
- Detail the methodology that will be undertaken.
- Submit a budget of all anticipated costs in undertaking this work (including cost of interviewing GPs). The budget for this project is in the region of $35,000.
- Submission is required to be no longer than 2 pages.

Timeframe

- Applications for tender close at 5pm on Wednesday October 31st 2001.
- Selected tenderers will be interviewed in early November.
- GPDV requires the successful consultant to meet with the expert reference group on Tuesday 27 November 2001.
- An interim report to be submitted by the 30th of January 2002.
- Final report to be submitted by the 30th of March 2002.

Attachment 1

ENHANCED PRIMARY CARE IN

AGED CARE HOMES

Enhanced Primary Care (EPC) services are now available to care recipients throughout all aged care homes under the Medicare Benefits Schedule

In November 1999, the Commonwealth introduced into the Medicare Benefits Schedule (MBS) the Enhanced Primary Care (EPC) items for health assessments for older Australians and for care planning and case conferencing for patients with chronic conditions and multi- disciplinary care needs. Following a review of the items, in consultation with the profession and other key stakeholders, several changes to the items have been made.

As a result, from 1 November 2000, new items for case conferencing and contributing to care planning have been made available for all residents of aged care homes.

The EPC MBS items provide a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between care recipients' needs and services.

The aim of these new EPC MBS items is to deliver improved health for residents through better integration and linkages between general practitioners, aged care home providers, other primary health providers and patients and their families. The items will enable GPs to participate more fully in the delivery of quality care in aged care home services.

Care Planning

Care planning is an essential component in the overall care of residents, especially when they first enter aged care homes. The new EPC item for care planning enables GPs to **contribute to a multidisciplinary care plan** where the patient has a chronic medical condition and multidisciplinary care needs. The GP's involvement in care planning for a care recipient in an aged care home must be at the request of the home in question. The contribution made by the GP should be documented in the multidisciplinary care plan maintained by the home, and recorded in the resident's medical record. GPs may contribute to a patient's care plan up to 4 times in any one year. GPs are not able to **organise** a multidisciplinary care plan for care recipients in aged care homes, as care plans are already required to be prepared by the facility.

Case conferencing

GPs are also now able to **organise and coordinate, or participate in, case conferences** for care recipients in residential aged care services. These items, similar to those practiced in the community setting, are available to residents with a chronic condition and multiple care needs. The items are time-tiered, ranging from case conferences lasting at least 15 minutes to conferences lasting at least 45 minutes. The GP must give a record of the conference (or a record of his/her participation in the conference) to the aged care home, place a copy in the resident's medical records and offer a copy to the resident.

Health assessments

The EPC MBS items for health assessments are designed for use in the community setting and are not available for care recipients in aged care homes.

Making use of the new EPC MBS items

The new EPC items can be utilised in aged care homes in many ways, including:

- The care-planning item can allow a facility to utilise the expertise of the resident's GP when developing a new resident's individual care plan. The benefits of involving GPs in care planning include obtaining and assessing residents' medical history and identifying appropriate medical interventions.
- Case conferencing can allow GPs more time to assess a resident's care needs, taking into consideration social and emotional factors that may be impacting on their condition. Within an aged care home setting, case conferencing could include a GP, the Director of Nursing (DON) and an accredited pharmacist, specialist, physiotherapist or social worker.
- Case conferencing can also be used to encourage discussions between GPs, consultant pharmacists and facility staff following medication management reviews.
- The EPC items can be utilised when an aged care home is undertaking the yearly Resident Classification Scale (RCS) review on behalf of a resident. The service can involve the resident's GP and other health professionals when reviewing the care needs of the resident.

New Case conferencing items for consultant physicians

A related change, also with effect from 1 November, is the introduction of case conferencing items for consultant physicians, including case conferencing in aged care homes.

Eight new MBS items have been introduced for consultant physicians, allowing them to *organise and coordinate*, or *participate in*, case conferences in the community, on discharge from hospital or in the aged care home setting. While these items are separate to the EPC package, they do take into account appropriate linkages with the EPC items.

These items for consultant physicians have been developed to further establish and coordinate the management of the care needs of eligible patients. They also facilitate more coordination and interaction between GPs and consultant physicians as they work together as members of multidisciplinary case conference teams.

The Department of Health and Aged Care is committed to facilitating delivery of the highest quality EPC services to as many eligible people as possible. Issues arising in the operation of the EPC MBS items for all recipients of the service including those in aged care homes will be monitored and evaluated to assist with developing a continuous improvement in the quality of service.

More Information?

For more information please contact the Medicare inquiry line on **13 20 11**, or visit the Department of Health and Aged Care EPC website:

http://www.health.gov.au/hsdd/primcare/enhancpr/enhancpr.htm

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

Attachment 2
GPDV Residential Aged Care
Reference Group-participants List

Title	Fname	Lname	Division Name	Delegate	ADDRESS 1	ADDRESS 2	SUBURB	STATE	POSTCODE
Dr	Peteris	Darzins	National Ageing Research Institute		PO Box 31		PARKVILLE	VIC	3052
Mr	John	Brooks	CEO	John Brooks	Australian Nursing Homes and Extended Care Association – Victoria	2/1949 Malvern Road	MALVERN EAST	VIC	3145
Ms	Jane	Gilchrist	Project Worker	Rowan Cockerall Manager Bundoora Extended Care Residential Care Facility 9261 3100	The Victorian Healthcare Association Limited	PO Box 3145	SOUTH MELBOURNE	VIC	3205
Ms	Mary	Barry	CEO	Pauline Bates Royal Freemasons Homes of Victoria 9510 1378	Victorian Association of Health and Extended Care	3rd Floor 450 St Kilda road	MELBOURNE	VIC	3004
Ms	Karen	Large	Assistant Director		DH&AC	PO Box 9848	MELBOURNE	VIC	3001
Ms	Annie	Lanham	Aged Care Branch		DH&AC	PO Box 9848	MELBOURNE	VIC	3001
Ms	Mary	Little	Residential Care Rights Services	Belinda Evans	Suite 4b	343 Little Collins	MELBOURNE	VIC	3000
Dr	Jane	Fyfield	Senior Medical Advisor		Department of Veteran's Affairs	GPO Box 87a	MELBOURNE	VIC	3001
Ms	Jane	Harrington	Assistant Director Aged Care		Department of Human Services	555 Collins St	MELBOURNE	VIC	3001