Submission
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Integrated Service Model for the provision of HIV Services in Victoria: Response to Consultation Paper

GPDV is the peak organisation for divisions of general practice in Victoria. Our role is to improve health outcomes through enhancing general practice service delivery. To achieve our aims we assist Victorian divisions to build the capacity of general practice at the local level (through education, system development and strengthening workforce) and to enhance service integration between general practice and other parts of the health system.

In recent years our work has included a focus on some health areas that involve low prevalence but high need. It can be difficult to respond adequately in general practice to these areas (especially in rural areas) unless the right systems and processes are in place. Our work particularly in the areas of Hepatitis C and palliative care has given us an insight into ways to maximise the capacity of general practice to provide a satisfactory response to such need.

The consultation paper clearly maps the relevant service system and the needs of people living with HIV or AIDs (PLWHA) and defines the principles of service integration in such a way that GPs are recognised and included as integral to the system. GPDV supports the principles outlined on page 5 of the paper. We also recognise that there are particular challenges for GP participation in an integrated service system for HIV and we offer some suggestions that fit within the proposed framework developed in the consultation paper.

The paper makes clear that

(a) all HIV patients must access GP services with utilisation rate ranging from 3 times per year for blood tests for Level 1 PLWHA to weekly or fortnightly for Level 4.
(b) there are approximately 4,000 PLWHA in Victoria with approximately 360 living outside the metropolitan area.
(c) 30% have been diagnosed with depression
(d) 24% of men and 52% of women living with HIV or AIDs were born outside Australia.
(e) Level 2 people visit a specialist once or twice a year.
(f) Level 3 have intense periods of service use with multiple service providers
(g) Level 4 have consistent high use of multiple services.

These statistics suggest the need for general practice capacity to understand HIV as an illness; to understand the medical needs of PLWHA; to understand the various psychosocial needs of PLWHA; to refer appropriately and to communicate regularly with relevant service providers. While acknowledging that there are several GP clinics that specialise in HIV care, this response focuses on the need to ensure that all GPs (and, where relevant, practice nurses) have the capacity to provide appropriate care for PLWHA and that service systems can accommodate the different levels of GP engagement in care for PLWHA.

Barriers & opportunities

The barriers to and opportunities for effective inclusion of GPs as part of an integrated service system can be considered under the broad categories of GP capacity, relationships and systems for coordination.

Capacity

HIV is a high-intensity, low-prevalence illness. GPs are not generally well educated in HIV medicine and there are disincentives for them to focus on HIV as part of their Continuing Professional Development to maintain vocational registration. The model of HIV education proposed by the

GPDV, Alfred, ASHM partnership is to offer HIV education to general practice at three levels. Firstly, there will be an introductory level of HIV education offered through divisions of general practice. Then an intermediate level HIV education would be offered as a package with viral hepatitis and STI education. This would be aimed at practitioners who have an interest in HIV management. The third level of education is aimed at practitioners with a special interest in HIV, either in becoming an s100 prescriber or in participating in shared care.

Some GPs in rural areas find the continuing medical education requirements to maintain their status as HIV s100 prescribers are disproportionate to the number of patients they are treating with HIV. A further disincentive for GPs in rural areas to become HIV s100 prescribers is that they become the referral point within a region for all HIV patients and their primary care needs. This can often be a burden for GPs who already have a heavy workload.

It is vital that rural GPs qualify as s100 providers as there are no other options for the several hundred people living with HIV in rural areas. GPDV is developing a study to foster new approaches to supporting the capacity of low caseload GPs to provide HIV care including the s100 prescribing.

It may also be worth looking at financial incentives for some rural GPs to become the main primary care provider for HIV patients.

Systems for continuity

The paper refers to the Victorian Statewide Referral Form as a possible device for communication from GPs to state-funded services. This tool tends to focus on referral to a particular service system and may not be suited as a system for communication when patients need to access multiple service providers.

The MBS provides a framework for chronic disease management that enables the GP to be reimbursed for developing a GP management plan (Item 721) and to be reimbursed for developing Team Care Arrangements (Item 723) for patients with chronic conditions. At this stage, these items are not often used with PLWHA and there is scope to support GPs to recognise HIV as a chronic condition and to make use of the items as an incentive to provide systematic coordinated care for PLWHA. As of July 2007 there is also an item number (10997) for the provision of monitoring and support to people with a chronic disease by a practice nurse or registered Aboriginal Health Worker on behalf of a GP.

Relationships

Access to secondary consultation

Case coordination is more effective when GPs and other service providers have the opportunity to meet each other and to understand each others' frames of reference. Supporting case-based education with health professionals from the relevant disciplines is one way to solve the capacity and relationship barriers at the same time. In palliative care, programs of clinical placements with specialists for GPs and nurses have assisted in improving the education base of a significant number of primary care providers and at the same time have enabled GPs to develop professional relationships with specialists thus facilitating communication for secondary consultation.

If these forms of co-education are not available it is still important to ensure that every primary care practice is connected to a secondary consultation service. This implies that due publicity be given to available services and that gaps, especially for isolated rural GPs, are identified.

Negotiating case management

Case management can be a difficult area because of the wide range of roles that GPs play in HIV care. The paper notes that high caseload GPs tend to be involved in case management. We support the requirement for explicit negotiation early in the diagnosis for the service team to negotiate who will

provide case coordination and who will provide primary care. This needs to be explicitly renegotiated once PLWHA reach level 3 because at this level there are more options for co-ordination. It would be easy for each health professional to assume that someone else was coordinating care and/or providing general primary medical care unless these roles are formally negotiated.

Participating in case conferences

When GPs participate in multidisciplinary care they are often criticised for not attending case conference meetings when invited. The reality is that the logistics of case conferencing are very difficult for GPs especially for those with a low caseload in the relevant area. Two examples from palliative care illustrate ways to approach this problem. Mornington Peninsula Division of General Practice has a system of case discussions by teleconference set up to include general practitioners. The case discussions are organised by the palliative care providers, GPs are given advance notice by fax and invited to participate. At a pre-arranged time the GP receives a call and the palliative care team members focus only on the matters relevant to the GP, so the discussion will often take no more than a few minutes. Sometimes two or three of a GPs' patients may be discussed at the one teleconference. Following the discussion the palliative care service forwards the relevant paperwork to enable the GP to claim the MBS Case Discussion Item Number.

The GP Association of Geelong is piloting a system in which a GP with a special interest and expertise is reimbursed for attending the case conference meeting with the specialist and other service providers. The GP participates using both specialist knowledge and a primary care perspective, then following the meeting relays the relevant information to the appropriate GP colleagues.

It would be well worth considering these and other innovative approaches to including low caseload GPs in an integrated service system.

Finally, DHS has released for comment a DHS-wide GP Position Statement which will formally confirm the recognition by the DHS senior executive of the central importance of general practice to the state's health system. This statement will:

- enhance the productive collaboration between the private primary health care sector and the state-funded health and human services sector, with both its primary and tertiary health care elements
- establish a framework for this collaboration to occur.

In conclusion, GPDV supports the directions of the consultation paper for a more comprehensive and integrated service system for HIV but would like to see greater attention given to the capacity of low caseload, especially rural GPs, to provide adequate care for PLWHA wherever they are in Victoria.

GPDV
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