



AMA

GP SERVICES TO RESIDENTIAL AGED CARE

JOINT PROPOSAL BY

THE AUSTRALIAN MEDICAL ASSOCIATION

AND

**THE ROYAL AUSTRALIAN COLLEGE OF GENERAL
PRACTITIONERS**

27 SEPTEMBER 2006

EXECUTIVE SUMMARY

Residents of aged care facilities are amongst the sickest and frailest of Australians, and have higher needs for general practice than their counterparts of the same age and sex living in the community.

There are numerous barriers faced by General Practitioners (GPs) who care for patients in residential aged care facilities (RACFs). 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.

MBS items for attendance of patients in RACFs do not reflect innovations that exist in other areas of the MBS that have been demonstrated to contribute to high quality team based care. These include the capacity of general practitioners to delegate some tasks to their general practice nurses and other clinical staff; and the ability for patients to claim a rebate for a range of clinically relevant services, some of which are done by the GP in the absence of the patient.

The AMA and the RACGP strongly encourage the federal government to begin modelling Medical Benefit Schedule (MBS) item numbers to improve access to medical services in aged care facilities by extending the improvements in the MBS into residential aged care.

Both AMA and RACGP are of the view that proposals on the attendance items outlined in this paper, particularly the capacity to delegate clinical tasks to a general practice nurse, are applicable to the whole of the MBS. However, given the significant profile of aged care and the opportunity this model provides to increase the level of medical services and quality of care to residents in residential aged care, it offers a real opportunity for the Government to implement an innovative proposal.

The proposed model of care outlined in this document seeks to address the major challenges faced by GPs who care for residents of aged care facilities:

- The disjointed nature of care for patients, created by workforce and infrastructure issues in RACFs;
- The necessity to undertake clinically relevant tasks for patients (e.g. discuss falls, writing prescriptions, discuss issues with relatives and RACF staff and hospital staff), while not in attendance at the RACF. (Most GPs receive a list of prescriptions needed by the pharmacist for packing every fortnight as well as requests from nursing staff.);
- The opportunity cost of attending a RACF, compared with caring for patients at the general practice.

INTRODUCTION

The growing size of the aged population in Australia demands that policy makers, health professionals and aged care providers consider the opportunities available to ensure that older Australians receive the best care possible regardless of the location at which the care is provided.

There is a significant range of barriers facing General Practitioners (GPs) who care for patients in residential aged care facilities (RACFs). 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.

The AMA and RACGP have been collaborating in the development of a model, which will assist in alleviating this shortage, and thus improving the reliability of providing high quality care to residents of aged care facilities.

In attempting to provide quality care to patients in RACFs, disincentives such as travelling time, lack of structured patient environment and the large proportion of non face-to-face services provided all add to the difficulties doctors experience. Significant lost opportunity costs related to the fee structure for RACF attendances, combined with increased in-surgery patient demand and overall workload contribute to a wide range of disincentives to attend patients in RACFs. If standards of care are to be improved and sustained within RACFs, new models of GP care delivery and remuneration need to be considered and implemented.

This paper discusses the issues surrounding the provision of medical services to residents in aged care facilities, and draws on relevant research to support those statements. It then proposes a new model of care to provide primary care medical services in RACFs that improve the quality of health care and health outcomes for those residents.

ISSUES AND EVIDENCE

Residents of aged care facilities comprise a substantial amount of general practice work:

- Approximately 90% of older people (over 65) attend a GP at least once a yearⁱ;
- Those visits account for 25% of all general practice consultationsⁱⁱ.

Residents of aged care facilities are sicker and frailer than most patients:

- Older people in residential care are the sickest and frailest of people with severe or profound disability in Australiaⁱⁱⁱ;
- Nursing home residents are associated with higher workload for GPs than other patients of the same age and sex living in the community^{iv v vi};
- Consultations with patients aged over 65 are significantly longer (15.4 mins) than those of patients who are less than 65 (14.9 mins)^{vii viii};
- There are significantly more deaths in the nursing home residents, than in the balance of a GP's practice population^{ix};

- General practice care costs for a population of residents of nursing homes who died during a study were unrelated to age, but significantly related to proximity of death. The study supports the contention of others that health care costs are more directly related to proximity of death than age^x.

The particular issues associated with the way residential aged care operates creates challenges for GPs:

- It is common for RACFs to employ a large proportion of casual or agency staff, resulting in little time or commitment to build up cooperative relationships, and/or to facilitate team spirit^{xi};
- 84% of GPs reported that they were sometimes called out unnecessarily, citing lack of knowledge due to staff turnover, and use of agency staff as two of the reasons for this^{xii};
- GPs felt that as a result of the higher turnover of RACF staff, they often worked with nurses who were inexperienced, under-skilled and unfamiliar with the patients. This caused a range of outcomes, including:
 - unnecessary phone calls to GPs, including ‘panic’ calls;
 - unnecessary admission to hospitals;
 - poorer working relationships;
 - poorer communication;
 - poor understanding of the role of and demands on GPs;
 - poorer standards of care for RACF patients;
 - difficulty establishing ongoing processes, and;
 - GPs’ difficulty in accessing information about their patients.^{xiii}
- Nurses felt that GPs could spend more time talking with family members of clients, and with nurses themselves, in order to transfer valuable information about the patient’s care^{xiv};
- Nursing home patients had more face-to-face general practice contacts in normal surgery hours, telephone calls, and out-of-hours visits. A British study reports that the mean workload cost per month of a nursing home patient (assuming one patient was seen per visit) was estimated to be £18.21 (£10.49 higher than the cost of controls)^{xv};
- GPs reported that when they attend a patient they often have difficulty locating relevant background information, locating staff to accompany them and discuss the patient’s care, and difficulty in linking with patients’ relatives. GPs reported that sometimes they allocate time to see one patient at a RACF, and on arrival are asked to attend to two or three other patients or asked to do administrative work related to compliance rather than clinical care. One GP said he often received phone calls from several different RACF nursing staff about one patient, and felt that one call from the charge nurse would be more appropriate^{xvi};
- Increased patient contact and drug use (over 13 times the practice mean) amongst patients in residential aged care increases practice administration.^{xvii}

There is a rapidly approaching workforce problem:

- GP age played a significant role in practice style. Older GPs provided more attendances at residential aged-care facilities^{xviii};

- One explanation may be that older physicians tend to treat older patients, which may reflect a natural tendency for physicians to age in step with their patients^{xix};
- Currently, recent graduates are less likely to work in these environments. As older physicians retire, there is the potential that older patients requiring care in these settings will be left unserved^{xx};
- The average age of the nursing workforce in aged care facilities is now 58.

The workforce problem will be aggravated if there are incentives to not visit residents of aged care facilities.

- GPs have expressed concern that phone calls from RACFs, additional paperwork required by accreditation standards for RACFs and other tasks were not reimbursed, creating a substantial disincentive to their participation in the care of residents of aged care facilities^{xxi};
- GPs said they were substantially better off, both financially and in work load, seeing patients in their surgeries than in RACFs, when travel time, administration, consultations (including by phone), and other activities are taken into account^{xxii};
- GPs who focussed on the positive side of their work at RACFs often cited altruistic motives, saying they would be better paid and have an easier workload if they saw patients in their surgeries instead^{xxiii}.
- The existing GP MBS structure and fee level for visits to RACFs does not encourage GP attendance.

Calculation of disincentive*:

- Available time: 2.5 hours
- In surgery patients seen: 9 (less than BEACH data suggests)
- In surgery bulk-billed fees generated: \$283.05 (non-VR: \$189)
- Residential aged care patients seen: 4 (based on 15.4 min cons plus non-face-to-face time);
- RACF bulk-billed fees generated: \$147.80 (non-VR: \$81.50)

***This calculation does not include the lost income created by the likelihood of generating co-pays at the practice and continuing to bulk bill residents in aged care facilities, and does not account for unpaid clinically relevant services provided once the GP has returned to the practice**

THE PROPOSED MODEL OF CARE

The model of care needs to address the major challenges faced by GPs who care for residents of aged care facilities.

In summary, those challenges are three:

- The disjointed nature of care for patients, created by workforce and infrastructure issues in RACFs;
- The necessity to undertake clinically relevant tasks for patients (e.g. discuss falls, writing prescriptions, discuss issues with relatives and RACF staff and hospital staff), while not in attendance at the RACF. (Most GPs receive a list

- of prescriptions needed by the pharmacist for packing every fortnight as well as requests from nursing staff.);
- The opportunity cost of attending a RACF, compared with caring for patients at the general practice.

The RACGP and AMA share the view that taking lessons learned from other innovations in the MBS, and bringing them together in the residential aged care environment will create a substantial improvement.

Longitudinal General Practice Team Model

Both the AMA and the RACGP support a model of care that allows the doctor to delegate tasks related to the care of residents of aged care facilities to the general practice nurse (or, on occasion, other team members with clinical training). Claims that there is a resistance in the medical profession to incorporate nurses into models of care are not supported in the evidence^{xxiv} including in the uptake of federal government incentives to support general practice nurses. General practitioners support and desire appropriate expansion of the role of nurses within team based model of care. Support for a structured approach to the expansion of the practice nurse role in the care of patients in aged care facilities reflects this fact.

The proposed model of care is likely to have an immediate impact. The Federal Government already supports a model of care that allows delegation of clinical tasks to the practice nurse through a variety of GP MBS items. The role of a general practice nurse in assisting a general practitioner at the RACF, and coordinating communication with the RACF following this will make an immediate impact on the challenges created by the workforce and infrastructure arrangements of RACFs.

The substantial lost opportunity costs, linked to the significant proportion of non face to face time both at the facility and on return to surgery leads the AMA and RACGP to the view that structuring the MBS in a manner that incorporates the delegated delivery of some care is not only efficient from both a cost and care perspective but will contribute to improved health care outcomes, and efficiency in the use of time by GPs, which will allow them to devote time to other clinical tasks.

While this proposal considers GP visits to RACFs as the initial starting point, the principle is likely to be transferable to home visits for older patients and to geriatrician visits.

Given the shortage of undergraduate training places and lack of opportunities for clinical training, there is also potential to link the provision of increased medical services in residential aged care to the idea of a 'teaching nursing home'.

It has many advantages over a Nurse Practitioner model:

- The vicarious liability for general practice staff plays a key role in ensuring that tasks undertaken by a general practice nurse will be part of the overall management plan of the GP, decreasing any risk of fragmentation of care, or poor quality;

- The independent nurse practitioner model is inefficient and over-utilises investigative resources^{xxv};
- It does not make sense from an economical perspective in the primary care environment. Nurse practitioners are paid much more than a registered nurse: almost as much as a junior doctor;
- The model cannot be implemented quickly and represents a band aid only solution to the broader issues of improved health outcomes for residents, quality of care and increased medical services in residential aged care;
- There are very few nurse practitioners to date. With current pressures on nursing numbers, the numbers of registered nurses prepared to undergo training to become a nurse practitioner is small;
- Nurse practitioners are often taken up in areas such as oncology and emergency departments (not rural care which is what they were originally designed for) and not into aged care.

The second component of the model is to ensure that clinically relevant tasks undertaken by the GP in anticipation of the attendance at the RACF are ‘captured’ as part of the overall work undertaken for the patient. This approach of acknowledging that a range of tasks for a patient might need to be done, but not at the same moment, is seen in the health check items and care planning items within the MBS. It has particular relevance to maintaining responsive care for residents of aged care facilities whose condition is likely to change quickly, and for whom a visit from the GP may not be needed to address issues such as ensuring sufficient information is available to staff at the RACF, family members or hospital staff.

POSSIBLE STRUCTURE OF REPLACEMENT MBS ITEMS: AGREED PRINCIPLES

The AMA and the RACGP have been working together to develop ideas on aged care that involve an overhaul of the MBS aged care items (residential aged care visits) to extend the reach of medical services into residential aged care by increasing GP attendances.

The core objective is to structure the MBS in a manner that will:

- Improve the continuity and responsiveness of care for residents of aged care facilities;
- Encourage more GPs to provide services to patients in RACFs;
- Promote team care arrangements acceptable to GPs through use of the practice nurse or other appropriate staff at the GPs discretion.

These objectives are separated into principles applying to revised MBS Attendance items and those relating to Visit Payments as follows:

Attendance Items

Develop a new (replacement) set of MBS GP aged care attendance items including those associated with after hours attendance in RACFs.

A Per-Patient Fee. The new item structure should include per patient rebates tiered for complexity. They would be content-based, and reflect the time banding of the

other GP attendance items in the MBS. Importantly this would limit the highly unsatisfactory sliding scale fee under the current items which clearly act as a disincentive to not only provide service to RACFs but to also limit number of services per visit.

Permit Delegation of Tasks At the GP's Discretion. The new items would permit the delegation of tasks to the GP's general practice nurse, and on occasion, other staff with clinical training. This is consistent with AMA policy that supports the right of a GP to determine tasks that might be appropriately undertaken by their practice nurse and in that context promotes team based care. Further it will contribute to the efficiency of GP attendances at RACFs. The RACGP and AMA would be happy to discuss any perceived need to restrict the ability to delegate to general practice nurses only.

Must Incorporate some GP Face to Face Contact. Current thinking is that the descriptor would include a requirement that the GP to see the patient before an item can be billed. This principle aims at ensuring the continuity of the personal relationship with the GP, and their continuing responsibility for overall care.

The longitudinal nature of aged care is recognised by a structure that allows non face-to-face tasks undertaken prior to a face-to-face visit to be incorporated into the fee charged at the (next) face-to-face visit. The object of this principle was to develop a means to ensure recognition of the non face-to-face time subsequent to a face-to-face attendance. It was agreed that non face to face time could possibly be incorporated into the billing for the subsequent face to face item. Using existing consultation items as an example, the GP may have spent only 15 minutes with a patient. The patient is billed for that attendance. However, subsequent to that attendance the practice nurse and/or the GP spends 30 minutes or more on other clinically relevant but non face to face tasks (e.g. changing prescriptions to address changes in the patient's needs, or having discussions about the care of the patient with relatives or hospital staff). These activities would be recorded in the patient's health record, and those recorded tasks would be incorporated into the fee charged at the next face-to-face attendance. This is the most complex issue within the model, and the AMA and RACGP are keen to work through the detail with the relevant parties.

Alternatives to billing such as an ongoing payment for each episode of care, and a per-visit payment for the GPN visits might also be considered.

Access to the items to be limited to the person's "usual GP" or practice In order to ensure that continuity of comprehensive general practice care occurs, access to the proposed items would be limited to the person's "usual GP or practice". Other arrangements may cause fragmentation of care.

The patient rebate would be linked to the bulk-billing incentive A very high proportion of visits to residents in aged care facilities are bulk-billed. In order to maintain this contribution by GPs, the AMA and RACGP strongly recommend that any replacement items continue to attract the bulk-billing incentive.

‘Visit’ Payments

A ‘visit’ payment would be tied to the rebate for the patient, to assist in addressing the costs (including opportunity costs) of travel time, and be based on a “standard” time of travel. The current RACF items include a loading for travel. The proposal is that this be removed and a separate per visit payment be established. This payment would be made each time a GP attends a patient or patients at an RACF. Discussion needs to occur around what might be an acceptable standard time of travel and whether this might be tiered. It is likely that there is a (very) common travel time but it is acknowledge that here are exceptions (in rural areas, and for urban GPs who agree to care for a patient who relocates across the city).

The ‘visit’ payment would be made to the GP (not the practice). The visit payment would be a GP payment and be paid in a similar way as the current bulk billing incentive payments. An item number could be added to one patient’s bill. This would trigger a Medicare payment directly to the doctor. It would not affect the patient on whose bill it is included in any way.

The visit payment only to GPs and linked to face-to-face requirement. The visit payment should not be claimed for a general practice nurse visiting an RACF on his/her own.

There is acknowledgement in all quarters that more work needs to be undertaken in developing the detail, identifying any pitfalls and finding solutions to some of the more difficult elements. It is proposed that the AMA, RACGP and the Government work together to further develop this model of care and proposal.

Augmenting the longitudinal general practice team model, there are other initiatives that the RACGP and AMA consider worth exploring. These are outlined below.

GP Adviser Model

Consideration should be given to extending the GP adviser model for RACFs. This is currently being trialled in Victoria via the Aged Care Panels project.

Innovative Panels Aged Care Modelling Process

The AMA recommends that an Innovative Panels Aged Care Modelling Process be established as an alternative to the Aged Care Panels process that has not proven its effectiveness to date. This project would value add to the system and drive systems change through consideration of different models of care, and by exploring the most effective way to engage medical services in residential aged care settings, including how to engage specialist support.

CONCLUSION

The AMA and the RACGP strongly encourage the federal government to begin modelling MBS item numbers to improve access to medical services in aged care facilities through the GP practice nurse model.

The RACGP and AMA are certain that the introduction of items that reflect the principles outlined will make a rapid and meaningful difference to the provision of care for residents of aged care facilities.

The informal consultation undertaken by RACGP with other peak agencies in the residential aged care sector confirms this, as well as their support for the concepts outlined.

Importantly both AMA and RACGP are of the view that proposals on the attendance items outlined, particularly the capacity to use a general practice nurse, are applicable to the whole of the MBS. However, given the significant profile of aged care and the opportunity this model provides to provide improved services to residential aged care, it offers a real opportunity for the Government to test an innovative proposal.

References

- ⁱ O'Halloran J, Britt H, Valenti L, Harrison C, Pan Y, Knox S. Older Patients Attending General Practice in Australia 2000-02. General practice series No. 12. Australian Institute of Health and Welfare. Canberra. 2003.
- ⁱⁱ O'Halloran J, Britt H, Valenti L, Harrison C, Pan Y, Knox S. Older Patients Attending General Practice in Australia 2000-02. General practice series No. 12. Australian Institute of Health and Welfare. Canberra. 2003.
- ⁱⁱⁱ Flicker, L., (2002), 'Clinical issues in aged care: Managing the interface between acute, subacute, community and residential care', *Australian Health Review*, 25(5), 136-139
- ^{iv} Groom I, Avery AJ, Boot D, O'Neill C, Thornhill K, Brown K, Jones R. The impact of nursing home patients on general practitioners' workload. *Brit J Gen Prac* 2000; 20(455):473-76.
- ^v Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{vi} Pell J, Williams S. Do nursing home residents make greater demands on GPs? A prospective comparative study. *Brit J Gen Prac* July 1999;49:527-30.
- ^{vii} BEACH Older persons
- ^{viii} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{ix} Pell J, Williams S. Do nursing home residents make greater demands on GPs? A prospective comparative study. *Brit J Gen Prac* July 1999;49:527-30.
- ^x O'Neill C, Groom L, Avery AJ, Boot D, Thornhill K. Age and proximity to death as predictors of GP care costs: results from a study of nursing home patients. *Health Economics* 2000; 9(8), 733-738.
- ^{xi} Chou S, Boldy DP, Lee AH. Staff satisfaction and its components in residential aged care. *Int J for Qual in Health Care* 2002;14(3):207-17.
- ^{xii} Pell J, Williams S. Do nursing home residents make greater demands on GPs? A prospective comparative study. *Brit J Gen Prac* July 1999;49:527-30.
- ^{xiii} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{xiv} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{xv} Groom I, Avery AJ, Boot D, O'Neill C, Thornhill K, Brown K, Jones R. The impact of nursing home patients on general practitioners' workload. *Brit J Gen Prac* 2000; 20(455):473-76.
- ^{xvi} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{xvii} Craig-McFeely PM, Sedgwick JR, Holden S. Nursing home residents: demands on GPs. *Brit J Gen Prac* October 1999;49:836-7.
- ^{xviii} Charles J, Britt H, Valenti L. The independent effect of age of general practitioner on clinical practice. *MJA* 2006;185:105-9.
- ^{xix} Chan BTB. The declining comprehensiveness of primary care. *CMAJ* 2002;166(4):429-34.
- ^{xx} Chan BTB. The declining comprehensiveness of primary care. *CMAJ* 2002;166(4):429-34.
- ^{xxi} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{xxii} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{xxiii} Siggins Miller Consultants, School of Population Health University of Queensland. A report to the Brisbane North Division of General Practice – The Residential Care Project. December 2002. unpublished.
- ^{xxiv} ^{xxiv} Watts I, Foley E, Hutchinson R, et al. General Practice Nursing in Australia. Joint project by the RACGP and the RCNA, RACGP 2004; Melbourne.

^{xxv} Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. *The Cochrane Database of Systematic Reviews* 2004, Issue 4. Art. No.: CD001271. DOI: 10.1002/14651858.CD001271.pub2.