Submission
July 2010

Productivity Commission Inquiry into Aged Care

General Practice Victoria (GPV) is the State-Based Organisation (SBO) for Victorian divisions of general practice, which are also known as general practice networks. GPV works at the state level to support Victorian divisions of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities. Divisions provide the organisational interface between government and other stakeholders and general practice because they provide broad representation of general practice, have an effective role in GP education for systems and practice change, and have a role in the coordination and provisions of vital services.

This submission is in response to the Productivity Commission Inquiry into Aged Care, and the issues raised in the Commission's discussion paper and terms of reference and is based on GPV's past and current work with the Victorian general practice network.

As part of this work, GPV and the Victorian general practice network have delivered several Commonwealth funded programs aimed at improving the interface between general practice and aged care facilities (Aged Care GP Panels Initiative – ACGPPI) and to improve access to care for residents (Aged Care Access Initiative – ACAI). Several Victorian General Practice Networks are also involved in the Rural Palliative Care Program[i] and the Evidence Based Practice in Residential Aged Care (EBPRAC) grants[ii]. Through this experience, several areas are identified for improvement and some recommendations are suggested to improve the delivery of services to the aged care sector.

In particular, GPV focuses its response on systems and protocols to support general practice in providing the best care for older people. These include accessibility of other services, development of standard care processes, education and training and sharing of information.

Support for general practice to work with residents in aged care facilities

Adequate physical space for GPs (and other health professionals) to consult.

Through the ACGPPI, divisions identified barriers and enablers for the provision of general practice services in residential aged care. Access to a private space for consulting with residents and discussion of patient management with the care team was identified as one of the main barriers to good GP care for residents.

Nursing homes usually have no area allocated for patient review, performing medical procedures, team meetings, confidential discussion, etc. Through the ACGPPI, divisions attempted to negotiate for and set up areas where GPs had access to a private space equipped with a computer, printer and examination couch. The room also doubled as a treatment area for the various allied health practitioners visiting the facility. Access to a computer and printer allowed the GP to access clinical notes, references and decision support and to print and sign prescriptions.

A dedicated GP space facilitated better organisation of the GP's time, better communication with the nursing staff and better patient review. It also meant that the facility staff knew

when the GP was scheduled to visit, were able to arrange appointments for residents and discuss management with the GP.

Recommendation: Residential aged care facilities should have dedicated space for clinical review and treatment that is adequately equipped to provide privacy, access to computers for record keeping and access to information.

GP workforce and new facilities

Understandably, there are set ratios for the provision of places per population for both residential and community aged care packages. Provision of residential places is becoming increasingly expensive in inner and mid suburban suburbs, and there has recently been an increase in the number of places provided in the Melbourne outer suburbs (where land is usually available and considered less expensive). GPV has learned through the local general practice networks that have been approached by aged care facilities to recruit GPs, that these developments have been built without due consideration of availability of services in the area (pharmacy, nursing, medical and allied health) to provide services to residents. The current aged care application process (ACAR)[iii], asks providers to explain how the selection of the proposed site of a residential care facility is "accessible to older people and their families and to medical and other local support services" (ACAR section B15.1, page 73). The application should include evidence that the applicant has already negotiated with services to provide care to residents.

Recommendation: Availability and provision of staff and services in residential care facilities should be a necessary requirement for any new facility that is developed.

Remuneration for the work that is done

Older people with multiple problems require additional input from the GP. However, under the current MBS structure there is a disincentive for GPs to see patients in a residential care facility.

For example, if a GP visits a facility and has a short consultation with 6 residents, he/she is paid a total consultation fee of $59.45 (MBS item 20, not including any bulk billing rebate). In the GP's usual consulting rooms, 6 short consultations will earn $94.20 (6 x MBS item 3 at $15.70 per patient, not including any bulk billing rebate). A full description of rebates for work in residential care facilities is available in the MBS online[iv]

Care of residents in an aged care facility is complex; residents are old, frail and have multiple problems (63% have a diagnosis of some form of dementia, 30% have a circulatory disease, 17% have a musculoskeletal/connective tissue disorder and 8% have an endocrine/nutritional/metabolism disorder[v]). The current MBS rebates for GP work in RACFs do not reflect the time needed or complexity of care required.

Recommendation: The MBS item description for consultation at a residential care facility is changed to allow the claiming to be based on an amount per individual resident consultation and the level of remuneration reflects the complexity of the work.

Quality and review activities

Under the Aged Care GP Panels Initiative (ACGGPI) from 2004/5 to 2007/8, GPs, nursing staff and allied health professionals were remunerated for quality and education activities. These activities were frequently multidisciplinary and promoted understanding and team work between health care professionals.

These included: GP participation in Medication Advisory Committees (MACs) that are a contractual requirement of the residential facilities. In many cases, MACs were supported by divisions of general practice and MACs were frequently organised regionally. This meant the care and systems could be standardised in a particular area (as professionals often work in a number of different facilities).

Education for staff was also provided through the ACGPPI. This enabled personal care staff to receive additional training relevant to clinical care of residents, and the development and implementation of specific protocols for resident care.

Since the ACGPPI funding was withdrawn, there is no provision to support health professionals to work together on quality activities to improve systems and therefore the care of residents. Delivering programs across local areas contributed to the care and safety of residents. For example, Central Victorian General Practice Network developed 'geographical zoning[vi]' which gave residents and facilities a process for accessing GP care for existing and new residents, and enabled GPs to provide care for more residents in fewer facilities. Other Victorian Divisions have developed agreements and protocols for GPs, other health professionals and care staff working in aged care facilities. (For example, Peninsula General Practice Network[vii] and North East Valley Division of General Practice[viii] both developed local protocols for management of residents' health conditions.)

Local solutions and activities supporting medical care of residents could be delivered through the proposed Medicare Locals; roles for Medicare Locals are outlined in both the COAG National Health and Hospitals Network Agreement (2010)[ix] and the NHHN "Red Book"[x]

Recommendation: That general practitioners and other health professionals are supported (by funding and human resources) for their involvement in safety/quality activities and interdisciplinary education/training. This role could be managed by the current general practice networks/divisions or the proposed Medicare Locals (primary health care organisations).

Medication management

As mentioned above, regional Medication Advisory Committees have been successfully supported by the divisions of general practice. MACs served to standardise medication systems across a local area, and therefore assist practitioners who work across multiple aged care facilities.

Medication management and continuity across the various healthcare sectors should be mandatory. When a person is transferred between a residential care facility and hospital, a new medication chart must be written before that person receives his/her medications. This causes delays, particularly in the residential care facility where the GP must be called in to write the chart. A pilot project (MedGap[xi]) was recently completed by Austin Health, Northern Health, Monash University and North East Valley Division of General Practice. The project evaluated the use of a standardised medication chart generated by the hospital for use in a facility for up to 7 days (to give the facility and the GP time to review the patient). The project team found that the use of an interim drug chart improved continuity of care, reduced medication administration errors and reduced the need for a locum service doctor to visit a facility to write out a new medication chart, thus reducing health costs for the resident.

Recommendation: Implement a common medication chart and protocol for managing medications as a resident moves between the various health care sectors. This chart would ideally be implemented as part of a broader e-prescribing system.

Electronic Health Record and Prescribing

To facilitate continuity of care and reduce duplication, access to a resident's records should be readily available to all treating health professionals. The electronic health record should be available across a range of services (including hospitals) to read and update the information. Information about prescribing is an important aspect of an older person's care and should be a part of the record. Electronic prescribing reduces the need to transcribe medication orders and reduces the risk of medication errors.

NEHTA is developing standards and guidelines that contribute to the development and implementation of an electronic health record.

Recommendation: That electronic prescribing and a shared electronic health record are implemented in aged care facilities. This should be supported by specific resourcing to address the particular needs around gaining consent, which, in many cases, cannot be given directly by the resident. The shared electronic health record should also serve as a point of storage for advance care planning documents (ie Medical Enduring Power of Attorney, Refusal of Treatment certificates, statements of wishes) as this will enable them to be accessed at any time, from any place including hospital Emergency Departments.

The role of the practice nurse

The role of the practice nurse is currently critical to support general practitioners to provide appropriate acute, preventative and coordinated care for patients. Many practice nurses currently provide assistance with (among other things) development of care plans, patient health assessments, immunisation, acute triage/assessment, asthma/diabetes/wound management and general patient education. The current situation with residential care funding does not generally provide residents with access to the services provided by general practice/primary care nurses. The practice nurse is in the unique position of having a direct working relationship with the GP and the ability to establish a nurse-nurse relationship with the nursing staff in the residential care facility. The role of the practice nurse should be expanded to support and assist the GP to provide care for residents. The practice nurse might assist with care coordination, health assessment and care planning with the staff in the facility. Funding for this could be provided through the MBS.

Recommendation: That the role and scope of practice of general practice nurses is expanded to include their involvement in the care of residents in nursing homes

Access to allied health professionals to support resident independence and restorative care

Access to allied health support is determined in legislation, through the Aged Care Quality of Care principles 1997[xii] under Part 5, Schedule 1, parts 2 and 3, Care and Services. This sets out the minimum level of care that contractually should be provided for each resident and includes access to and delivery of allied health services for residents. Facilities have a varied interpretation of these guidelines and this affects the level of allied health support available for residents. Residents in high care have little or no access to other funded services because they are already entitled to allied health services under the funding arrangements between the Commonwealth and the residential care provider.

Residents in aged care facilities should be able to access care when it is needed. This may mean that clinical services (provided by allied health professionals) need to be 'unbundled' from the funding allocations that aged care service providers already receive. Currently the divisions of general practice provide additional allied health services to residents under the

Aged Care Access Initiative (ACAI)[xiii]. These services are above those that should already be provided by the facilities. General Practice Victoria manages the ACAI program in Victoria.

Recommendation: Funding for clinical allied health services should be funded separately (and unbundled) from provision of services by the aged care facilities. The funds for these services could be held and brokered by a "trusted advisor" such as a Division of General Practice or a Medicare Local (PHCO). This would reduce the repetition of clinical governance requirements that exists currently, such as the checking of professional indemnity and police checks.

While Martin and King (2008)[xiv] estimate that allied health make up about 7.4% of the aged care workforce, the majority are diversional therapists and recreation officers. The specialised input into the care and management of residents from allied health professionals (occupational therapists, speech pathologists, dietitians, podiatrists and physiotherapists) is an important factor in preventing / delaying functional decline. Residents should have access to quality allied health interventions to improve, or at least maintain independence and mobility for as long as possible and allied health professionals should be remunerated to provide quality review activities and education for nursing home processes and staff (as was provided under the ACGPPI funding).

Recommendation: Consider remuneration for allied health professional involvement in quality review and education for staff in aged care facilities.

Residents are already entitled to an annual assessment / review from a GP (MBS item 701/703/705/707)[xv] and to an annual medication review (MBS Item 903). Extending annual reviews to allied health professionals would support GPs to develop care plans and develop programs to delay functional decline and maximise resident independence

Recommendation: Consider an expanded range of assessments and allied health services to complement the care from GPs, pharmacists and the facilities.

<u>In-reach and access to acute care support</u>

In Victoria, the state Department of Health has introduced the Residential Care In-Reach program[xvi]. This program is run by acute hospitals and provides support for nursing home staff to care for sick residents in the nursing home, to support GPs in their care of residents and avoid a trip to the hospital emergency department. The service runs out of hours and has been very positively received by nursing homes, GPs and hospitals. It is not currently available to all nursing homes. Results from this type of program have also been published in an international health services journal[xvii].

Recommendation: That Residential In-reach services are available to all residential care facilities, high and low care. These services could also be extended to a greater part of the out of hours time periods, and could perhaps coordinate with an expanded after hours GP service to provide greater coverage.

<u>Access to palliative care and support</u>

In residential aged care facilities there is a need for improved access to specialist palliative care consultative teams.

GPs currently report that there is limited access to consultative palliative care teams or additional support for residents in facilities. This may be due to the increasing demand for care in the community and the perception that residents already receive support in their facilities. However, not all facilities have access to 24-hour Division 1 and 2 nursing support, particularly low level care facilities with ageing in place. Support for residents to stay in their 'home' during the palliative care phase and for the facility nursing staff and the GP might be provided through better resourced community palliative care teams or through an expanded residential in-reach service.

Recommendation: That residents in aged care facilities have access to specialist palliative care consultation and staff in facilities are supported to manage the resident in the facility. The funds for these services could be held and brokered by a "trusted advisor" such as a Division of General Practice or a PHCO. This would reduce the repetition of clinical governance requirements that exists currently, such as the checking of professional indemnity and police checks.

Education, Information and support to manage end stage chronic disease

It is well known that the prevalence of chronic disease is rising and that the burden of care of people with chronic illness will increase with age. The chronic disease trajectory is unpredictable, and health professionals would benefit from support to manage people with worsening disease. Health professionals will need assistance to recognise the need for and implement the palliative approach, and later, palliative care.

Recommendation: Develop education programs dealing with worsening chronic disease and support for health professionals to manage this growing demand. Palliative care services should have the capacity to expand their services to include more work with advanced chronic disease.

End of life care planning and Advance care planning

Universal systems to support end of life care and advance care planning in both residential and community care programs will provide families, carers and health professionals with information about an individual's preferences for future management of illness. Because the general population is mobile and health professionals practice in a range of settings, a standard format for care planning needs to be transportable across a range of disciplines and services. Provision of electronic information would allow greater access to these vital details for a greater number of health professionals working with a person.

Recommendation: Introduce a standard method for advance care planning and end of life care planning that is accessible to all members of the health care team. Information about patient preferences for care should be available to all treating team members. The shared electronic health record should be the "home" for this documentation

Through the EBPRAC and ACGPPI programs, several Victorian General Practice Networks have worked with GPs, hospitals, local palliative care services and aged care facilities to implement standard pathways for the care of the dying person. Two pathways that have been trialled are the Brisbane South Palliative Care Project[xviii] and the Liverpool Pathway for the Care of the Dying[xix]. Use of these pathways has led to better patient outcomes. Clinical care staff are supported to implement the care pathways. These care pathways are also designed so that services can collect data about the program for quality improvement and can benchmark their service against others.

Recommendation: That consideration is given to the introduction of standard care pathways for care of the dying patient and support for clinicians and services is provided to implement these programs.

Dental Care

Dental care for residents needs to be provided in the residential aged care facility, and needs to cover routine assessment and care planning, provision of expert oral hygiene training to carers, and timely accessible emergency care. Currently there is limited access to mobile dental services; private dental practitioners do not generally have the specialist mobile equipment for procedures to be undertaken at the facility, and in the Victorian jurisdiction oral hygienists are not yet able to provide services independently of dentists. It is expected that the proportion of the aged population retaining their natural teeth will increase over the coming years, and this will increase the incidence of dental pathology and resulting medical complications. Some work has already been progressed through the EBPRAC program. Improved access to dental care, and support to continue the training of nursing home staff to manage residents' oral hygiene, needs consideration.

Recommendation: Support for improved oral hygiene and for dental care should be increased, with specific funding to provide access to mobile services enabling better access to routine and emergency dental care for residents. Training for nursing home staff in oral hygiene should be regularly provided.

Access to a range of primary care services and providers to support patient management in the community

Access to services such as nursing, home support and allied health for older people in the community is currently available through a range of funding sources. GPs often need to consider which funded program might be the most relevant for a patient. This is time consuming for the GP and causes delays for the patient. A 'one-stop-shop' for access to community support services would be very valuable for both health professionals and patients. Currently several Victorian divisions of general practice operate a single entry point for services that relate to a particular program area. This means that GPs can refer into a service and the division fits the referred patient into the appropriate service (E.g. Dandenong Casey General Practice Association Diabetes Coordination and Assessment Service[xx] and Goulburn Valley Division of General Practice Navigating Life Program[xxi]). The proposed Medicare Locals (PHCOs) might be the most appropriate organisation to manage single entry point to services in the local region.

Recommendation: Implement a single entry point for services.

Access to preventative and early restorative services (e.g. physiotherapy and occupational therapy for decreasing mobility from arthritis) for community based older people would delay decline and the need for acute care and residential care services. The HACC active service model is an example where particular services are available to suit an individual's rather than a program's needs.

Recommendation: Older people should have access to a range of services, including restorative and preventative, according to their needs. Flexible service delivery models would facilitate this.

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