Have home visits been overlooked?

Synopsis

This summary is accompanied by a detailed position paper and explanation of the vital role of medical deputising within the umbrella of the primary health care in Australia. The information has been prepared by Melbourne Medical Deputising Service (MMDS).

Medical deputising is an effective and efficient model of more than 30 years standing in the provision of after-hours primary medical care. MMDS in particular, certainly ticks all the boxes in regard to key issues for government in its 2010 report Investing in the National Health and Hospital Network: reduce hospital waiting times; improve access to GP services; ensure necessary workforce; improve access to health services for older Australians - everything MMDS does (and has done for 35 years) meets/contributes to these objectives and all without any additional government investment.

MMDS supports increased access to after-hours care for all Australians; however, the current policy initiative runs the risk of adding another layer of bureaucracy to the health system, unnecessarily duplicating existing services, crushing the current providers, removing them from the primary care equation and replacing them with a more costly and less accessible service.

What are the options for patients to access necessary primary medical care after hours when they are sick and unable to get to a GP clinic?

- home visit arranged by their GP through a medical deputising service
- take themselves to a hospital emergency department or be transferred by ambulance – as is the case for patients in aged care facilities
- do nothing, wait for the next available appointment with their GP, deteriorate until the situation requires time off work, loss of wages etc

Who is reliant upon a home visit to be able to access urgent primary medical care?

- Anyone who is too sick to wait until the GP is next available, particularly
- the aged including those in residential aged care facilities (RACFs)
- Those who are disabled, visually impaired, single parents, financially disadvantaged, chronically ill and those who live alone.
- Essentially, those in our community who are the most vulnerable.

How significant is the need for home visits?

In 2009, 110,000 home visits were provided through MMDS on behalf of the GPs of 650 general practices in Melbourne. Of this number: **55,065 were to patients in RACFs** and **16,811 were to patients 65 + years** and living in their own homes. In the first 24 weeks of 2010 MMDS has facilitated an average of **1,100 visits per week to RACF** patients in need or urgent primary care.

Efficient allocation of resources

$55m is the cost to government of the PIP which underpins the provision of after-hours care at general practice level. Of this amount, $9m is used by general practice to cover the provision of after-hours via a medical deputising service. Based on the 850,000 home visits nationally, the cost to government of after-hours primary care via a medical deputising service is approximately $10.50 per patient

Please contact Josie Adams of MMDS on 03 9429 5677 or 0409 184 255 to discuss how we can retain medical deputising as an integral part of Australian primary medical care and the community benefits it already provides and which are in line with the government's health reform intentions.

For further information about medical deputising or the services provided by MMDS please visit www.mmds.com.au.

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Introduction

From 2011 Medicare Locals will replace the Divisions of General Practice and will add after-hours urgent medical care to their responsibilities. How these services are to be provided is not yet clear from the Government's budget papers:

'*In 2010-11, the Department will work to establish a telephone-based GP medical advice and diagnostic service as an add-on to healthdirect Australia, a 24-hour, nurse-based telephone health triage, advice and information service operated by the National Health Call Centre Network (the Network). From 1 July 2011, anyone needing to see a GP at night or on the weekend, when their usual GP practice is closed, will be able to contact their local GP practice and have the call referred as necessary to the Network. A nurse in the first instance, and then a GP if required, will assess the patient's needs. If needed, the GP will arrange for the caller to be seen as soon as possible by a local primary health care provider.'*

This paper seeks to provide a community perspective as to how the proposed changes to the provision of after hours medical care may affect service provision to those who need in home care; essentially those most vulnerable in our community

- The aged living at home, alone and those in aged care facilities
- Disabled, visually impaired, single parents, financially disadvantaged, chronically ill.
- Those unable to go anywhere due to lack of transport, too ill to travel, worried about their safety at night, no money for taxi or no access to a clinic if there is one open late.

And secondly to demonstrate the role played by Australia's medical deputising services in the after hours care segment of primary care. For more than 30 years the provision of after hours medical care has been delegated by Australian GPs to the medical deputising services (MDS). These services work primarily in the capital cities and some large regional centres. The MDS are a mix of for profit and not for profit companies.

The MDS provide care in a market where access is regulated by Government to the after hours period and effectively price controlled through MBS item numbers. Some services charge the patient a small co-contribution; most provide no gap for pensioners, health care card holders and Veterans.

While we would support an increase in access to after hours care for all Australians the current policy initiative runs the risk of crushing the current providers and replacing them with a more costly and less accessible service.

Community perspective: caring for the vulnerable is an important community priority

MDS provide an essential service for some of the most vulnerable in our community, including the frail and elderly who live at home alone; those in aged care facilities, the disabled who live in DHS community residential units (CRU) and those who act on their behalf.

Residents in aged care facilities are totally dependent on others for all their needs. These members of our community are unable to visit their own GP and increasingly rely on deputising doctors to provide primary medical care in their home environment, the aged care facility.

In 2009 MMDS facilitated more than **55,065 home visits to patients in RACFs** and **16,811 to patients 65 + years** living in their own homes on behalf of their regular GP. (see attached graph)

Many calls came from carers, priests, police, meals on wheels volunteers; RDNS, neighbours and friends who were unable take the patient to a GP during surgery hours.

Here are some examples of situations we encounter daily:

Imagine you're one of the thousands of unsung older Australians – a carer at home looking after someone who is wheelchair bound and totally dependant upon you for all their needs. You've both developed diarrhoea and vomiting – it's not possible in these circumstances to get to your doctor and your doctor is unable make a home visit. Who do you call?

Your mother, surrounded by family passes away. Her usual GP is not available to make a home visit to formally verify death at night. The deputising service will make it a priority and offer comfort to the family.

Single mother of three young children has one child distressed pulling its ear with a high fever. She has no Panadol at home and is reluctant to take the child out in the cold which would also mean taking her other children with her. There is no family car. GP care at home is needed to provide a diagnosis, care instructions and reassurance.

An elderly lady home alone requires a daily Penicillin injection and review – GP has constraints at the clinic which prevent daily home visits. When her own GP can't come, this elderly lady relies on a deputising doctor to attend.

Elderly parent with IDD child has concerns that his gastro bug is not resolving. Worn out by providing 24 hour care and unable to take her son to a doctor's clinic the nurse on call service suggests seeing a doctor within 4 hours after triaging the symptoms and the situation. An MDS doctor is requested to attend.

Nursing home patient Mrs A was seen by the local GP and left in acute urinary retention and pain because of a blocked in dwelling catheter. The GP did not change the catheter telling staff 'I haven't done one in twenty years'. Neither did the GP or staff flush the old catheter to remove the blockage. When the deputising doctor attended the poor lady was in intense discomfort and sitting in her own faeces. The deputising doctor was asked to help clean and change the patient if he wanted her ready for a catheter change since there was only one staff member on duty. Mrs A weighed 100kg, was post CVA, on PEG feeding and had a fractured hip.

Meals on Wheels volunteer visits an elderly gentleman who has no next of kin. The volunteer is the only contact this man has during the day. His condition has deteriorated and he is now dizzy and cannot eat; not life threatening but needs to see a doctor. The elderly gentleman is very fearful of going to hospital due to a previous bad experience but agrees that ambulance to hospital is the only available option. The GP cannot leave the clinic and recommends calling the deputising service. Without the deputising service this is a no win situation - fearful and distressing for the elderly patient, inappropriate ambulance transfer and presentation at hospital emergency department.

Many residents in aged care facilities are sent to hospital during the afterhours period as staff at the facility are too busy or not skilled enough to cope with a resident who is

unwell. They call an ambulance and send the patient to ED thinking it is the best for the patient. The patient is quite traumatised, waiting for hours on a trolley, busy nursing staff struggle with toileting, keeping the patient comfortable and hydrated. Many times the patient is admitted for a chronic complex problem he has had for years or possibly sent back to the RACF much worse for the experience.

Systemic Perspective:

Demand:

Demand for after hours home care rose at approximately 10% per annum during the period 2005-2009. (Source: Medicare) This increased national demand is also reflected in the Victorian figures despite the introduction of the Nurse on Call service four years ago. **Nurse on call has had no impact in reducing demand** in fact it has been said that it merely adds another layer:
The patient, seeking advice, possibly confirming something they read on the internet, "the worried well," ringing because it is available.

- It has been estimated that >$70 is the cost per call of providing the Nurse on Call service and this is before any medical care is initiated
- If the patient is advised to see a GP within 4 hours the patient then calls an MDS for a home visit, or the next alternative is to go to the ED,

Why duplicate services thus adding to the cost of delivering appropriate and timely medical care?

In 2009 there were 7.2 million attendances for urgent, non emergency after hour's medical services nationally:

After hours models –market size 2009	**No of visits**
At home attendances	850,000
Practice Based services (Normal GP surgeries with extended opening hours – generally until around 10pm/11pm on a weekday, and for a few hours on a Saturday afternoon / Sunday)	5,000,000
Hospital ED presentations	1,300,000
Telephone triage	50,000
Total	7.2 million visits

Based on a comparison of rebates one could assume that practise based services (whether GP or Super Clinics) open in the after hours period would be the cheapest method of treating patients. However in practice these clinics generally require large additional grants and ongoing funding to be sustainable.

Also they serve a different set of consumer needs and as such do not replace the demand for urgent after hour's home visits.

Government is of course keen to reduce the number of patients who seek after hour's non emergency care in the EDs of major hospitals. Care in this environment is relatively expensive, is a drain on emergency resources and reduces staff time and focus for emergency cases. This can compromise patient safety.

The H1N1 epidemic in the winter of 2009 placed enormous strain on the Victorian health system. Flu clinics, ED's and General practice were turning patients away. At

the coal face of this Pandemic was the Melbourne Medical Deputising Service (MMDS). Patients were voluntarily quarantined at home, they were unwell, anxious and parents were concerned about their children. MMDS doctors were able to provide patients with reassurance, explanation and symptomatic care. In one 24 hour period there were 858 requests for a home visit. Our doctors had protective clothing, Tamiflu and throat swabs.

Workforce Issues:

Workforce considerations are also important and will continue to be as GPs are no longer willing or able to provide the afterhours service themselves. Where an MDS is in operation the service is well supported by the local GPs and overall 60% of Australian GPs delegate the provision of after hours services to an MDS and use part of their PIP payments to fund the annual subscription.

The MABEL Survey, funded by the National Health and Medical Research Council (NHMRC) for five years until 2011, and has been endorsed by key medical Colleges and organisations. The latest report shows:

- Around 50% of doctors would like to reduce their working hours.
- Around a quarter of all doctors are very or moderately dissatisfied with their hours of work.
- The first wave of the study's data collection completed in 2008 found that nearly 12% of the GP workforce was expected to retire within five years (*MO, 1 May 2009*).
- Intentions to quit are largely driven by those over 55 years old who expect to retire, and thus reflects the loss to the workforce of the 'baby boomer' generation

GPs say:

- *We use the MDS locum service to save ourselves from having to do it. It is terrific for us as it really reduces our load (GP)*
- *MDS providers are really beneficial to us and our patients, and the service we receive is of very high quality (GP)*
- *We signed up for an MDS provider years ago, long before accreditation enforced it. We just don't want to do after hours home visits ourselves (GP)*
- *I don't want to be called at all hours of the night. Its a lifestyle decision (GP)*

And from government:

- *MDS services have helped us address burn out issues with GPs (Govt. Official, DOHA)*

And from MMDS files:

- *GPs are able to recruit and retain doctors to work in their practices because they do not require them to work after hours.*
- *GPs have been able to delay their own retirement because they do not have to commit to working on an after hours roster in addition to surgery consulting hours, some retired GPs now work with MMDS for the flexible hours.*
- *Imagine an 85 year old trying to tell a phone consult GP service about her pulse or lung sounds? Complete bollocks if you ask me. One hopes they will refer to MMDS in the end anyway. (MMDS deputising doctor)*

From the Government's perspective:

New Initiatives announced in after hours medical services

In the 2010 Budget the Government announced funding of $140 million in 2010/11 and $417 million over five years to establish a nationwide network of Primary Health Care Organisations to be known as Medicare Locals.

The Budget papers describe the following actions and timetable:

2010-11

- PIP payments to cease on 1 July 2011. (GPs use a proportion of the PIP incentive (A/H Tier 1) to pay the annual subscription to engage the MDS).
- National Call Centre opens 1 July 2011.
- The Government has already signed contracts for a National Health Call Centre Network which will provide nurse advice and the delivery of telephone based GP medical advice and diagnostic services if necessary.
- All General Practices will be instructed to divert their phones to the National Call Centre at the end of the working day and on weekends and public holidays.
- The first Medicare Local will commence in mid 2011, no numbers released, (consultation period precedes)
- DoHA will develop new funding arrangements for after hours primary care services to be provided through Medicare Locals by 2013-14

So, stop PIP funding and divert calls to National Call Centre July **2011** and new funding arrangement for after hours primary care will be provided by Medicare Locals **2013-14. In the interim who will provide the afterhours home visits to the most vulnerable in the community?**

July 2012

- Improved Access to primary health care services for Older Australians Initiative

RACGP Response:

In their response to the Budget the RACGP noted:

"The strengthening of primary health care services, at a regional level, is welcomed, including the direct investment in patients' health at a local level.
Both general practitioners and their patients value continuity of care after hours. In rural communities this can be particularly important where the GP is also responsible for the procedural care of a patient.
However, the RACGP also notes that there appears to be a shifting of resources regarding after hours care, and will clarify funding proposals with the Government. Any new programs should build on existing and proven programs within general practice."

The Demand for after hours care:

After hours care has always been a part of the provision of holistic patient care

GPs traditionally provided in home and institutional care for their patients. This model of care is now considered impractical as the demands on general practitioners have increased during the day.
In 2009 60% of GPs subscribed to an MDS to provide their after hours patient care.

There are key reasons for this:

1. Regulation
Practices seeking accreditation under the RACGP standards must provide their patients with access to after hour's care including home visits. There are financial incentives (PIP) which compensate the practice. GPs can choose to provide the service themselves or use an MDS. (Arrangements with a local hospital have proved problematic.)

2. Workforce Issues
GPs seek to attain work/life balance and adopt safe working hours. It is no longer seen as 'part of the job' to provide on call or home visiting. Only 24% of practices claim to provide all after hours care and it may be that some of this is still delegated to an MDS. Some practices make it cost prohibitive for a patient to access their own doctor after hours.

3. Personal safety
Another critical barrier for GPs doing their own home visits especially after hours. An MDS has policies, processes and proven systems in place to protect their workforce.

4. Availability of a local MDS
Where a local MDS provider is available GPs tend to subscribe. Thus GPs providing their own after hours cover tend to be rural or regionally based.

5. GPs providing no formal program of after hour's access.
Only unaccredited practices fall within this category. Their patients would tend to use an ED or another practice which has extended hours if they have transport.

GPs use a proportion of the PIP incentive (A/H Tier 1) to pay the annual subscription to engage the MDS. If PIP payments cease under the new plan GPs will not fund the fees from practice income and MDS services will become unviable.

We suggest that the Government at least consider providing direct funding to accredited MDS for GP subscription fees or at least bridging funding in the interim, this will ensure continuity of care for the aged and infirmed. MMDS can supply accurate, clean data on EFT GPs using the service who qualify for the Teir 1 PIP. (other data could be available on request eg: number of visits.)

Who needs after hours care?

The demand for after hour's medical care will continue to rise due to the change in demographics of the population and the change in the general practice landscape. The elderly, both those in aged care facilities and those at home now represent between 21% and 45% of all calls made by deputising services.
At the other end of the spectrum the 0-14 year age group accounts for 14-36% of calls.
Neither of these groups are similarly represented in practice based after hours attendances reflecting the difficulties in access due to age/frailty, family circumstances etc.

Why do patients/carers seek after hours care?

For some patients acute symptoms present during the day but have to wait until the after hours period if they are unable to attend a GP clinic due to:

- An appointment not being available in the short term; this is the common reason we hear on a daily basis when the patient requests a home visit
- Access issues such as
  - No car or convenient public transport
  - Other children making journey difficult
  - Visually, physically or intellectually impaired
  - Frail/elderly and no carer available to escort
  - Residents of aged care facilities

Many seek after hours care for problems that arise during the after hours period. Patients who book with an MDS are seen during the same after hour's period.
MDS triage calls and are able to prevent inappropriate use of emergency resources. Emergencies are referred to ambulance services or hospital. Non acute care is handled by the MDS.

Care is sought for, but is not limited to, the following conditions:

For older people:

- Falls/lacerations
- Urinary tract infections
- Chest infections
- Gastric outbreaks
- Changing catheters
- Adverse drug reactions
- Agitation
- Unexplained general malaise

For the 0-14 year olds:

- Fever
- Pain
- Gastro
- Rashes
- Anxious parents

Across all age groups

- Pain and discomfort associated with anxiety
- Abdominal
- Neurological
- Ears
- Migraine

Service provision for 'urgent' After Hours Medical Services[1] currently comprises a number of different models.

Model	**National attendances per annum 2009**	**% share**
After Hours visits to homes or aged care facilities by MDS	≈0.6m[2]	9%
GP Roster	≈0.25m[2]	4%

Practice based Services	≈5.0m^2	64%
Hospital ED	≈1.5m	23%
Telephone triage	SMALL	SMALL

Note 1 After hours is defined as: 6pm-8am weekdays; after 12pm Saturdays and all day Sunday and PHs.
Note 2 Taken from Medicare MBS data from AIHW, Medicare (MBS Code Data) excludes TAS, ACT and NT data

MDS provide continuity of care that is integrated with the care provided by the patient's own GP

MDS are contracted by GP practices to care for their patients when the clinic is closed and they are unavailable.

Deputising services, such as MMDS, provide urgent (not emergency) medical care for the entire out of surgery hour's period to the patients of GP clients who need a home visit. A written report of each after hour's consultation is downloaded electronically into any clinical software the GP uses. The report goes to the patients history file one hour after the report is confirmed. Many GPs flag in advance with MMDS particular concerns relating to the care of individual patients so that the deputising doctor can be fully informed before attending the patient. The MMDS secure website allows doctors to log in and search by patient name to read reports from other deputising doctors who have seen a patient. When they are on the road they can use their PDAs to check the last time a patient was seen and why if this is a return visit. MMDS has contact numbers for all GP clients in case the deputising doctor needs further information regarding the patient. MMDS regularly receives pathology reports for GPs after the surgery closes and is able to pass these on to the GP at home.

Continuity of care cannot satisfactorily be provided by telephone triage or phone advice from a nurse or even a GP. A nurse on call service has not decreased the demand for home visits in fact they have increased. (**See attached graph**.) When patients are triaged either by Nurse on Call or the ambulance service, as needing care within 4 hours but who do not need to go to hospital they refer to MMDS. If the care is life threatening an ambulance would be recommended to the patient.

RACF staff after hours are very often agency staff who are not familiar with the patient's history and would not be content to administer treatment to a resident even on advice from another nurse. For them the priority is to transfer the patient to hospital.

All calls referred to Ambulance Victoria (AV) from Nurse on Call are triaged again. Where a home visit is deemed appropriate by AV the patient is referred electronically to MMDS, a doctor attends the home and a report is sent to the GP and AV to ensure continuity of care for the patient and as 'best practice' for the purposes of QA and audit. This is a significant saving to the State health budget.

The way forward

The current health reforms run the risk of destroying the current, proven model of after hours care and replacing it with a model that puts additional barriers and expense to the provision of care. The time frames stated do not to take account of either work force issues or supporting infrastructure or a plan to provide for patients at home after hours.

It would seem obvious that establishing Medicare Locals prior to ceasing PIP funding for after hours would be the way to go. Extended GP services for after hours care

and facilitation by Medicare Locals could be 3-4 years away, grant funding has to be applied for and allocated along with too many other details to mention.

All resources should go to improving health care in rural areas, more ambulances, medical advice lines and super clinics in the interim.

The model as proposed will decimate the current infrastructure and investment of the MDS sector without providing effective, reliable replacement services. This will not decrease the strain on emergency resources or result in better health outcomes for the patients.

Consultation with the industry may highlight ways in which the funding could be allocated to extend/ improve the service to patients.

MMDS is keen to participate in this debate and is happy to provide expert briefings to inform the community and parliamentary response.

Please contact

Julian Adams on 03 9429 5677 or 0408 145 190
Melbourne Medical Deputising Service (MMDS)

Attached: Q&A about medical deputising services and after hours care

Medical deputising services – Frequently asked questions

Q: What is a medical deputising service?
A: A Medical Deputising Service is an organisation which directly arranges for medical practitioners to provide after hours medical services to patients of its client GP practices during the absence of, and at the request of, the Principals of those practices. A Medical Deputising Service is a means whereby a Practice Principal may externally contract the after hours components of both continuous access to care and continuity of care to practice patients.

Q: How long has MMDS been operating?

A: MMDS has been providing continuous service 365 days of the year for more than 30 years.

Q: Is there an industry body?
A: NAMDS is the peak body representing after-hours medical deputising services in Australia.
Please note that MMDS is not currently a member but facilitates and provides high standards of after-hours primary medical care. MMDS has been integral in developing and negotiating definitions and standards for medical deputising in Australia with Government, the Royal Australian College of General Practitioners and accreditation bodies to the betterment of patients, subscribing GPs and members. MMDS has a strong reputation with all stakeholders for the quality of the service provided.

Q: What sort of self regulation or other regulation is in place?

A: Accreditation by the RACGP Standards for Accreditation of General Practices.

Q: What is the definition of 'after hours' in the context of medical deputising?

A: Medical deputising provides service for up to 118 hours or 70% of the week providing a clinical continuum to patients. This service provision is embedded in the accreditation requirements of general practice. The RACGP Standards require cover for the total out of surgery hour's period, which is whenever the GP is not available.

Q: Who is the client?

A: All GPs who work in a general practice registered with the deputising service. In Melbourne and Geelong, MMDS provides cover for 3000 GPs or 50% of the total number of practices.

Q: Who uses Melbourne Medical Deputising Service?

A: The patients who need after hours care are typically:

Residents of aged care facilities – this is a particularly important sector as many GPs no longer visit aged care facilities due to the pressures/demands on their time. For instance in the last month at the request of staff in aged care facilities MMDS visited more than 4000 patients.

Families with young children, if they present to the ED they may well face long delays before seeing a doctor, then arriving home in the middle of the night and possibly face loss of wages the next day if unable to go to work due to loss of sleep and stress.

Those with acute but not life threatening conditions that arise after hours.

Q: How does Melbourne Medical Deputising Service interface with the patient's own doctor?

A: MMDS works in partnership with the patients regular GP, between the two providers 24 hour access to care is available. MMDS establishes if the patient is a client of a GP registered with the service, first time callers are not refused but are advised to ring their own GP the next day to find out how to contact him/her after hours.
In accepting the call and arranging for the doctor to visit the call is triaged according to patient need and the GP practice's instructions are checked to ascertain if there are any standing instructions regarding the patient or under what circumstances the GP may want to be contacted.
After the consultation the attending deputising doctor types a comprehensive clinical note which is electronically downloaded via a secure network to the patient's GP before the following day so that the patient's clinical record can be updated and any follow-up can be provided. This ensures continuity of care, the GP has a complete copy of the patient record and remains the primary carer.

Q: What is the cost to the patient of a visit from an MMDS deputising doctor?

A: A pensioners, veterans and health care card holders are bulk billed. Private patients are charged a fee for the consultation and can claim 75% rebate from Medicare:

- Before 11pm $160. The Medicare rebate is: $120.30
- After 11pm $190. The Medicare rebate is: 141.75

If private patients are unable to pay they are bulk billed.

Q: What are the key issues currently faced by this sector?

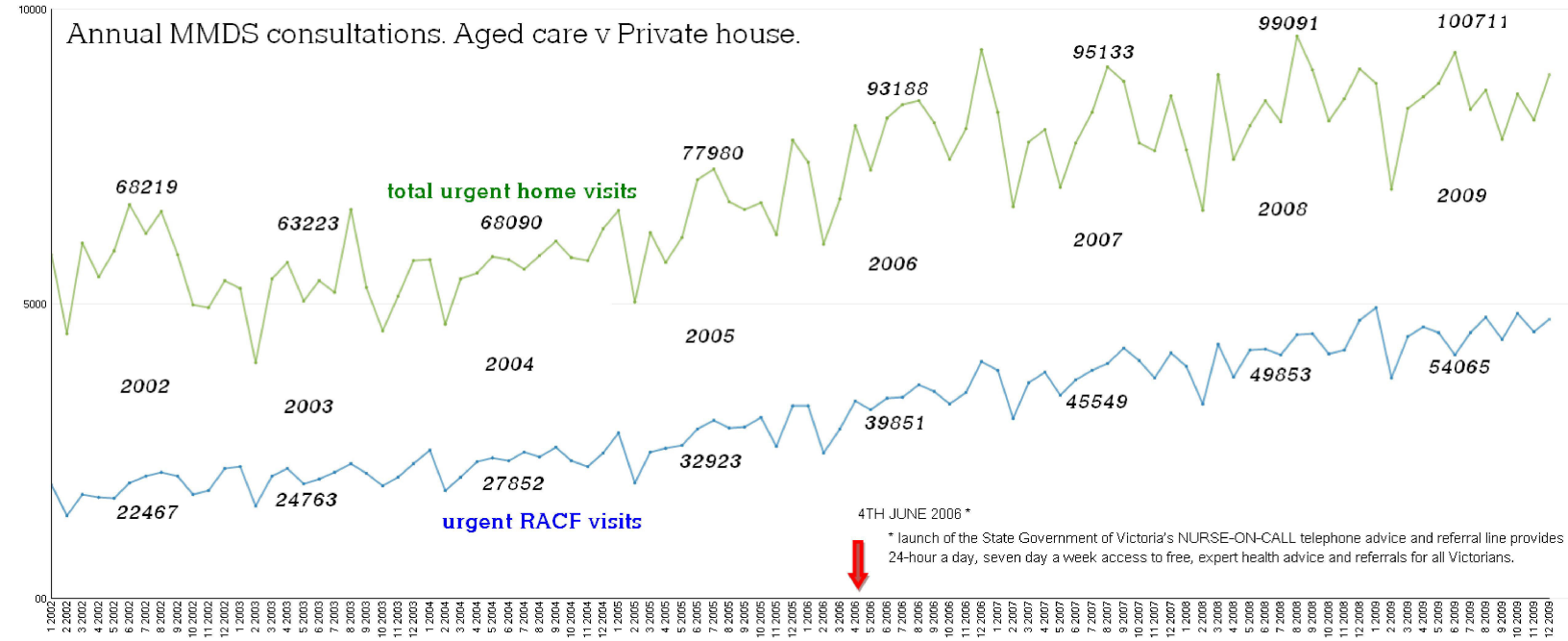
A: The metrics of service provision are patient demand (number of calls) / workforce (the staffing of the service with suitably qualified VR doctors) / geographic spread/ MBS item numbers/ fees applicable to the service required.

These metrics translate (eventually) into the income for the doctor providing the service. The reward must be commensurate with the level of skill, experience and effort required. At MMDS the doctors are paid on a fee for service basis by the patient or direct from Medicare.

The Government has been slow to respond to the particular problems of the aged care sector which is underserved by local GPs due to the pressures on their clinic time. A dedicated set of MDS MBS item numbers available for calls at any time would vastly improve capacity to service this important and vulnerable population.

For further information about medical deputising or the services provided by MMDS please visit www.mmds.com.au or contact Julian Adams of MMDS on 03 9429 5677 or 0408 145 190

MMDS
16 June 2010



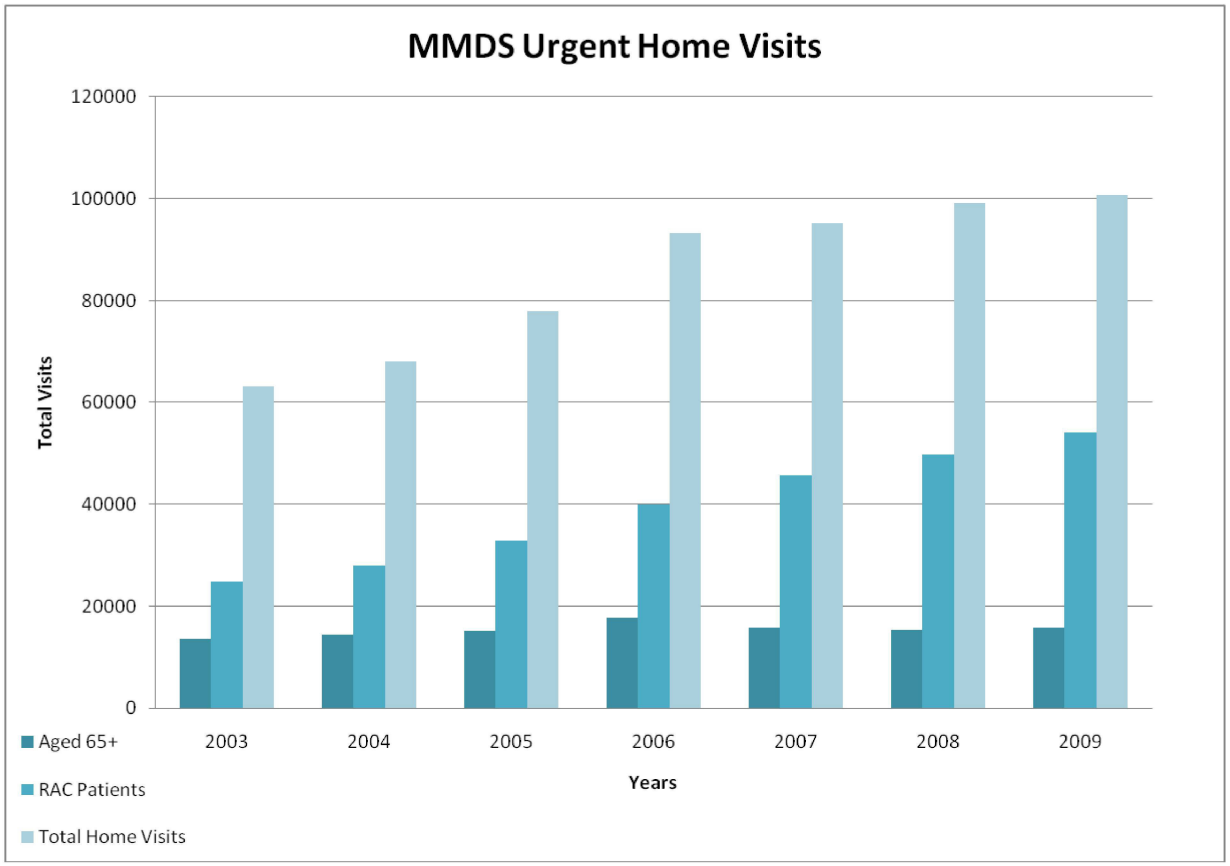
MELBOURNE MEDICAL DEPUTISING SERVICE

In detail:

MMDS facilitated urgent medical attention in the home to over 77,600 patients aged over 65years old.

Provided in the first 24 weeks of 2010 an average of:

- **1932.96 urgent consultations in the domiciliary environment.**
- **an average of 1123.5 were to residents of aged care facilities.**



With the increase of patients in aged care facilities requiring urgent medical attention after hours it is an interesting contrast to elderly patients over the age of 65 actually decreasing.