Melbourne Medical Deputising Service (MMDS)

Submission

Productivity Commission Inquiry into Caring for Older Australians

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1 Introduction

This submission comprises an Executive Summary and the following documents:

- *Have home visits been over-looked?* MMDS Position Paper, June 2010[1]
- *MMDS proposal to improve access to timely and appropriate primary medical care for the aged*, May 2010[2] (submitted to the Minister for Ageing).

In particular, the Executive Summary draws on the components of these documents which relate specifically to access to primary medical care services for older Australians.

2 Executive Summary

2.1 Overview of Melbourne Medical Deputising Service (MMDS)

MMDS provides urgent primary medical care during the entire out of surgery hours period through the provision of home visits to patients of subscribing general practitioners (GPs). It has been in operation for over 30 years; is fully accredited by the Royal College of GPs; and approved by the Department of Health and Ageing as an accredited provider in respect of medical practitioner workforce programs[3] and featured prominently in the 2010 Telstra Business Awards[4].

At any one time MMDS manages a pool of 75 - 80 VMOs (**Visiting Medical Officers** who provide primary medical care to patients after hours on behalf of the patient's principal GPs).

More detailed information is available in the 'Medical Deputising Services – frequently asked questions' section of the MMDS Position Paper and on our website www.mmds.com.au.

2.2 Number of home visits after hours in 2009

In 2009 MMDS doctors attended 110,000 home visits – of this number, 55,065 were to patients in residential aged facilities (RACFs) and 16,811 were to patients over the age of 65 and living independently in their own home. Accordingly, MMDS has valuable knowledge and is well-placed to comment on the access required by older Australians to primary medical care.

Residents in residential aged care facilities (RACFs) are totally dependent on others for all their needs. They are unable to visit their own GP and increasingly rely on VMOs (arranged through a medical deputising service) to provide primary medical care in their home environment; the aged care facility. As illustrated by the attached MMDS graph (RACF Home Visits Growth 2001-2009) there has been a steady increase in the need for home visits to patients in RACFs.

The community's goal for older Australians to retain their independence, live at home and stay out of residential care for longer is beneficial all round and must not be undermined by a lack of home care services[5] As MMDS statistics attest (refer graph Number of Home Visits After Hours), many

[1] MMDS operates only Victoria, however, the Position Paper refers to medical deputising across Australia.
[2] MMDS aged care proposal is provided as separate, confidential material, not for publication on the Productivity Commission website.
[3] The Approved Medical Deputising Service (AMDS) Program was established by government to improve after hours VMO workforce
[4] MMDS won the 2010 Panasonic Medium Business Award; the 2010 Sensis Social Responsibility Award; and the 2010 Victorian Business of the Year Award
[5] Australian Healthcare & Hospitals Association, Friday, 2nd May 2008

older Victorians living in their own home rely on MMDS because they are unable to attend a clinic when they need medical care. Reasons for this vary, for example, they may not drive or may be too unwell to leave the house (a bout of gastro is not always conducive to travel) or their usual GP may be closed. Also, it's not unusual for older carers to be reluctant to leave the house because their spouse has dementia or is disabled and there isn't another carer available.

MMDS has worked closely with general practitioners for over 30 years and the support it provides enables GPs to coordinate and manage the care of their patients on a 24 hour basis.

2.3 What prevents home visits during the in-hours period

MMDS provides home visits only during the after-hours period (after the GP clinic is closed on weekdays, weekends and public holidays). As things stand, medical deputising services do not provide home visiting services during the 'in-hours' period. They could (provided it was requested by the patient's GP) but the Medicare rebate is not sufficient for a VMO who, rather than travelling from his nearby clinic is battling today's traffic congestion and paying high prices for petrol to provide domiciliary care.

As mandated by Medicare, the after-hours period commences at 6.00 pm Mon-Fri and requires that the booking for an after-hours visit is made no more than 2 hours prior. This means that a resident in an aged care facility who becomes ill early in the day (and whose GP, for many good reasons, is unable to do a home visit) will have to wait until the after-hours period for medical attention (the exception is an emergency ambulance transfer to hospital which is not always appropriate.[6])

Other contributing factors relate to increasing in-clinic workloads and GP workforce shortages. A GP whose waiting room is overflowing may see 6 patients an hour. Even one home visit a day will impact heavily on a GP's capacity to meet the medical care needs of their patient constituency[7]. This can be a dilemma for GPs and one that prevents in-hours home visits (and may unwittingly force patients in residential aged care facilities (and others) into the after-hours period).

2.4 Changing Patterns – fewer GPs do home visits

As the ageing population increases so does the need for home visits and increasingly home visits are being delivered by medical deputising services rather than local GPs. Medicare item numbers do not differentiate between services delivered by GPs and services delivered by medical deputising services. As a result, the significance of medical deputising within the umbrella of primary medical care in Australia (particularly in regard to older Australians) tends to be invisible. This means that while Medicare can identify the number of after-hours services provided it cannot ascertain whether or not the medical practitioner was a GP or VMO. This inhibits meaningful and accurate analysis of

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"The term 'ageing-in-place' implies that an older person is provided with the option of staying in their (own) home and out of a care institution. However, to enable the older person to "age in place" services must be available to meet their needs and to assist them to live independently, so as to avoid or prevent a costly, often traumatic and inappropriate move to a more dependent facility," Dr Barbara Horner, Director, Centre for Research on Ageing, Curtin University, Perth (0409 457 550)

[6] Many residents in aged care facilities are sent to hospital during the after-hours 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.

[7] Six patients in-clinic per hour compare with 2 patients per hour which is the average for a VMO doing home visits.

the primary medical care needs of older Australians and clouds the effect of government initiatives aimed at encouraging GPs to do aged care visits.

GPs shortages, increasing in-clinic workloads (many clinics are closing their books to new patients), lifestyle choices about work/life balance are but a few of the issues related to the reduction in home visits by GPs. As a result, older Australians who are house-bound or in residential care and unable to get to a clinic but need medical care be it acute, follow up or routine are currently being forced into the after-hours period through no fault of their own.

As expressed by a number of aged care associations[8] it is frustrating that the many submissions put before government seem to go unheeded or get stalled in the decision-making process. MMDS has raised petitions, wholeheartedly supported by GPs and aged facilities and has made repeated attempts to engage policy makers to consider simple, limited intervention solutions – but to no avail.

The simple and efficient solution (underpinned by resources and infrastructure already in place) that MMDS offers could be implemented as soon as tomorrow and would immediately improve access to primary medical care for older Australians.

2.5 Who pays for primary medical care services at home

The clinical components of home visits facilitated by a medical deputising service are covered by the Medicare system of universal access to medical care:

- Patients in RACFs, pensioners and health care card holders are bulk-billed;
- VMOs are paid fee for service by Medicare.

MMDS is a propriety limited company and it bears the full cost of the administration and management of the provision of home visits (including recruitment of medical practitioner workforce, their induction and training for the practice of after-hours home visiting practice and their continuing professional development).

The government bears no cost whatsoever for the administration, management and service delivery costs related to the provision of primary medical care services provided via a medical deputising service.

Notwithstanding that MMDS provides the full range of general practice services[9] (albeit after hours) and is fully accredited in line with the Royal Australian College of General Practitioners (RACGP) Standards for General Practices, it is not (nor are other medical deputising services) included in the Practice Incentives Program (PIP)[10] This means that even though individual VMOs do **no fewer than 720[11] visits** to patients in residential aged care facilities in a year, they are not eligible to receive

[8] Campaign for Older Australians Forum – Radio National broadcast 15 August 2010

[9] With the exception of immunisation and Pap smears

[10] PIP is a part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by general practitioners (GPs) and the practice, such as patient payments and Medicare rebates. For a practice to be eligible to receive any of the above incentives they must either be accredited, or working towards accreditation for the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practices.*

[11] This number relates only to VMOs who work part-time – the number is greater in regard to full-time VMOs

Aged Care Access Incentive payments[12]. Whereas in-clinic GPs who do 200 visits a year receive a $5,000.00 incentive payment.[13]

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[14]

2.6 Consultation Invitation

MMDS has been an advocate for improving aged care services for many years and would be very pleased to be involved in further consultation. In addition, MMDS would be happy to provide an opportunity for the Productivity Commission to view its comprehensive statistical data regarding aged care. Notwithstanding that MMDS is the largest service of its kind in Australia, its data can be seen as microcosm of the role medical deputising across Australia plays in the delivery of primary medical care for older Australians.

3 Recommendations

3.1 Improve Government Policy

Establish a policy which allows the community to benefit from the medical deputising service framework which is already in place and is able to provide immediate improvements to primary medical services for older Australians. (MMDS has proven experience in the provision of domiciliary care after hours and has the capacity to expand its current service to include in-hours visits to the aged, in RACFs or in their own homes).

3.2 Define Medicare Items Numbers to Appropriately Remunerate VMOs

Appropriately remunerate VMOs working in medical deputising and structure workforce programs to facilitate recruitment. (With appropriate in-hours remuneration for its clinical workforce, MMDS would be able to attract doctors to work during the day. Clinic GPs may see 6 patients an hour with the comfort and support of clinic infrastructure and staff; whereas VMOs doing home visits during the day will average only 2 patients per hour, supply all medical consumables for the patient and operate without clinical services support. In addition, traffic congestion during the day can be exasperating and certainly more expensive in terms of fuel consumption, while parking is a nightmare.)

3.3 Include Medical Deputising in PIP

This will ensure parity for VMOs and assist in retaining necessary workforce levels to provide after - hours and in-hours visits to patients in residential aged care facilities.

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[12] Department of Health and Ageing:*…GP Aged Care Access Incentive (ACAI) aims to encourage GPs to provide increased and continuing services in Commonwealth-funded Residential Aged Care Facilities (RACFs) and recognises some of the difficulties faced in providing care in these facilities*

[13] Tier 1 payment of $1500 … by providing at least 60 eligible MBS services in RACFs in 2010-11; Tier 2 payment of $3500… by providing at least 140 eligible MBS services in RACFs in 2010-11.

[14] MMDS position paper, June 2010

3.4 Benefits of Recommendations

Implementation of these recommendations would:

- Immediately improve the level of medical care available for residents in aged care and the level of support for the elderly who want to continue to live independently in their own home.
- Redistribute domiciliary visits so they are attended in a timely and appropriate manner (reduce the need to wait until after hours without increasing the volume of calls).
- Better utilise available workforce both within MMDS and RACFs more efficiently.
- Decrease numbers of residents in RACFs being sent to public hospitals by ambulance when being seen promptly by a VMO is a more satisfactory outcome not only for the patient but for all stakeholders.
- Improve health outcomes for older Australians - providing aged care residents with medical care in a timely manner, that is, having them seen by a general practitioner when they first become unwell would result in better health outcomes.
- The MMDS model in particular, aligns with 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 more than 30 years) meets/contributes to these government objectives and all without any additional government financial investment.
- In addition, it aligns with a patient-centred approach (key recommendation of the 2020 Summit - health services must be patient-centred).
- Enhance the platform already established by MMDS to get GPs re-engaged with aged care.

4 Case studies

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 may be the only available option. The GP cannot leave the clinic but recommends calling the deputising service. Without the deputising service this would have been a no-win situation - fearful and distressing for the elderly patient, inappropriate ambulance transfer and presentation at hospital emergency department.

Elderly lady home alone requires daily injection for chronic illness – GP has constraints at the clinic which prevent daily home visits. When her own GP can't come and see her, this elderly lady relies on a VMO to come and see her after hours. Patient in aged care facility needs catheter changed, pathology test and possible treatment for infection. The patient's usual GP is in surgery for the afternoon and unable to attend. As a result, the patient will just sit there in pain with blockage until 4.00 pm when staff can arrange a VMO to visit after hours. Nursing staff could send the patient to hospital via ambulance but that's not a good solution. Hospital emergency departments are just that, emergency departments, they are not geared for the management of elderly and chronically ill patients who need regular turning, toileting and fluids – imagine, also, how distressing it must be for this type of patient long wait on a trolley in unfamiliar surroundings.

5 Conclusion

MMDS operations are underpinned by purpose built ICT (Information and Communication Technology). This is a leading edge resource with the capacity to provide fully customized services for our clients. All aspects of data collection from patient booking through to uploading the VMO's clinical report into the GP client's practice software are completely transparent and auditable.

As part of managing over 1.2 million patient records in a secure environment, MMDS has accumulated substantial and valuable primary health care intelligence and data. Its management information systems have been developed to provide maximum flexibility and the capacity to quickly produce reports within numerous chosen parameters.

MMDS has been an advocate for improving aged care services[15] for many years and would be very pleased to be involved in further consultation. In addition, MMDS would be happy to provide an opportunity for the Productivity Commission to view its comprehensive statistical data regarding aged care. Notwithstanding that MMDS is the largest service of its kind in Australia, its data can be seen as a microcosm of the role medical deputising across Australia plays in the delivery of primary medical care for older Australians.

The MMDS model has worked well for some 30 years, has made a considerable contribution regarding the needs of the aged, containing inappropriate ambulance transfers and emergency department presentations and, above all, has provided timely and appropriate medical care for patients. Medical deputising has the capacity to collaborate/integrate with all sectors of the health care industry to improve access to primary medical care.

For further information, please contact Josie Adams, MMDS Director and Chief Executive Officer on 03 9429 5677.

[15] Josie Adams, MMDS Director and CEO - standards and advocacy roles include:

- AGPAL Surveyor of general practice standards as set by the Royal Australian College of General Practitioners
- RACGP Accredited QA & CPD Provider
- Vice President, National Association of Medical Deputising Services (NAMDS) 2002-2004, 2007-2008.
- RABSQA Assessor for Aged Care Standards and Accreditation

In addition, Josie works closely with Divisions of General Practice and by invitation has participated in a number of GP Division projects:

- Steering Committee of the General Practice Division Victoria (GPDV*) After-Hours Guidelines Project 2003*
- Member of the Project Advisory Committee of the North West Melbourne Division of GP which developed **a comprehensive residential aged care tool kit for use by facility staff, GPs, other health service providers and Divisions of GP**
- Member of the Advisory Committee of the ***Good Death in Residential Aged Care*** **project**, North East Valley Division of General Practice (NEVDGP), 2009
- Provides IN-REACH aged care support services to Barwon Health.