

## **Getting GPs into Residential Aged Care: Time for a rethink on remuneration model?**

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There is some evidence and a common perception that General Practitioners (GP) are increasingly reluctant to provide care in residential aged care facilities (RACFs). While there is no readily available evidence for how or whether this differs in rural areas, given the continuing challenges of attracting and retaining GPs it is likely that the issues in this paper impact rural communities equally, if not more than urban communities.

This paper was developed following an evaluation of a pilot of GP video conferencing into RACFs which highlighted a number of factors impacting on the provision of GP care in RACFs more generally (the Better Health Care Connections (BHCC) evaluation).<sup>1</sup>

Delivery of GP care in RACFs is provided in various ways. Often there are one or several general practices/GPs that provide care to a facility, scheduling time to visit the facility to review residents on a regular basis e.g. one afternoon a week or fortnight, as well as provide on-call to the facility. Some residents in the facility may continue to see their own GP who provided care prior to entering residential care (i.e. visit the patient at the facility), or the resident sees the GP in their practice (dependent on mobility). Other models include RACFs partnering with particular GPs and GPs with special interest in Residential Aged Care. There is limited evidence for which of these models is most effective and in what circumstances.<sup>2</sup>

GPs provide care to residents of aged care facilities under specific Medicare Benefits Schedule (MBS) items. Recent changes to these items include an additional call out payment and changes to the way fees are applied to attendance involving multiple consultations.<sup>3</sup> In addition the Practice Incentives Program (PIP) GP Aged Care Access Incentive (ACAI) aims to encourage GPs to provide increased and continuing services in RACFs. This tiered incentive payment remunerates the GP where a required number of eligible MBS services in RACFs within a financial year are provided. The Tier 1 payment of \$1500 is paid if a GP provides at least 60 eligible services and the Tier 2 payment of \$3500 is paid if a GP provides at least 140 eligible services. The maximum payment is \$5,000 per year.

### **Trends in GP service provision**

While studies have identified difficulties in access to GP care as a factor contributing to transfers of residents to hospital, data indicate that GP service provision to RACFs has been increasing in the last decade.

A study analysing trends in general practice services in RACFs for the period 2005-2014 found an increase in the permanent resident population of 13.3%, and an increase in the overall number of general practice consultations per year. In 2013-2014 there were 3.4 million GP consultations compared with 1.9 million in 2005-2006.<sup>4</sup> In addition, the rate of standard GP consultations per resident increased by 4 per resident per year and the rate of after-hours consultations increased by 2 per resident per year. While there were significant increases in all GP service rates, these were a shift toward after-hours consultations, and standard (short) consultations. Collaborative GP services i.e. contribution to care plans and Residential Medication Management Review, were accessed by only

50% of the RACF population.<sup>5</sup> An earlier study analysing GP services to RACF in the period 1998-99 to 2010-2011 found the mix of services had changed, where the delivery of comprehensive care and/or length consultations delivered in RACFs had stagnated, while short consultations increased.<sup>6</sup> As suggested by Taylor et al, these findings are counterintuitive given the increasing levels of dependency among RACF residents over that period. Suggested explanations for these findings include weaknesses in the ACAI for which short consultations count equally with longer ones in calculating bonus payments to GPs and an increasing reliance in RACFs on less qualified staff. A lack of qualified nursing staff may have contributed to diminished capacity in some RACFs to deal with minor medical issues and increased reliance on GPs.

The low numbers of nurses rostered to work in a facility and ability to attend to complex needs of residents has been suggested as a contributing factor in the increased rates of after-hours GP services in RACFs.<sup>7</sup> A significant and important component of the after-hours GP service delivery system are medical deputising services. Deputising services arrange after hours services to patients of a GP practice during their absence in the after-hours period. Deputising services are required to operate and provide uninterrupted access to care, for the whole of the after-hours period (6pm – 8am Weekdays, from noon Saturday, all day Sunday and public holidays).<sup>8</sup> They differ from ordinary general practice in that medical deputising doctors are not required to have college fellowship and there is minimal continuity of care in comparison to services provided by a person's usual GP. With the high rates of dementia in RACFs, residents may be unable to give reliable histories and deputising service doctors are unlikely to have the time or capacity to trawl through RACF notes.<sup>7</sup> A review of bookings for one such service in Melbourne between 2008-2012 found that 81% were for residents of RACFs. Most of these calls resulted in a GP visiting the RACF with 3% resulting in a transfer to hospital.<sup>9</sup>

It should be noted that most of the increase in service since 2005 occurred after 2009-10, possibly reflecting the implementation of the Aged Care Access Initiative (ACAI) which provides incentives for GPs to provide services in RACFs. The change in the definition of after hours, from after 8pm to after 6pm may also have contributed to the increase in after-hours services as many GPs see RACF patients outside normal clinic hours, either on the way to or way home from their normal practice.

Accurate data on the proportion of GPs who regularly visit RACFs is not readily available. However, the 2017 Australian Medical Association (AMA) Aged Care Survey Report<sup>10</sup> indicates the number of GPs servicing RACFs is likely to decrease in the short term. The survey found approximately 64% of respondents indicated they do undertake such visits. Of these 36% said they intend to either only visit their current patients but not new patients, decrease the number of visits or stop visiting RACFs altogether in the next two years. Only 11% of the total survey respondents suggested they would increase visits to RACFs in the next two years.

### **Factors affecting GP service delivery in RACFs**

Previous studies have highlighted a number of factors impact on the willingness and capacity of GPs to provide services in RACFs.<sup>10 11</sup>

- Inadequate remuneration for the time and work involved. Visiting RACFs during normal clinic hours can be problematic and relatively fewer patients can be seen at the RACF in comparison to the clinic. In addition, each consultation at an RACF attracts a diminishing fee, unlike those

undertaken in the practice setting. The complexity of residents' health needs also means that RACF consultations are often more time consuming.

- Medical Benefits Schedule regulations limit the extent to which payments can be amortised across GPs in a group practice in order to be eligible for incentive payments. This can result in fewer GPs from a practice attending RACFs rather than all GPs sharing this clinical activity.
- RACFs also often place high out of hours demands on GPs. Many GPs visit RACFs on the way to or home from their clinics. Those that do visit RACFs are often required to cover leave and absences of colleagues, compounding their out of hours workloads.
- Unremunerated work including updating RACF clinical notes in addition to medical records, consultation with RACF staff and discussions with family members. Travel to and from RACFs is also unremunerated.

Other areas of difficulty include:

- Poor information transfer between RACFs and hospitals and time required for updating medication prescriptions
- Cumbersome communication methods with external providers, including GPs, has also been reported to be a challenge for RACF staff<sup>12</sup>
- The lack of interoperability between systems used by RACFs and GPs results in multiple records and time consuming information processes.

These factors were reinforced during interviews with GPs as part of the video conferencing pilot evaluation. In recent evidence to the Aged Care Royal Commission, the president of the Australian Medical Association (AMA) also highlighted lack of equipment, facilities and appropriate staff members to work with as other significant obstacles to the provision of high quality GP care in RACFs.

Further, the current arrangements challenge the capacity of the system to allow for the provision of high quality coordinated multidisciplinary care.

In the BHCC evaluation many of the GPs indicated that as the RACF has a multidisciplinary plan they tend to write up specific orders and include these in the plan (and may bill for a contribution to a care plan, MBS Item 731).<sup>1</sup> As a result, care planning in residential aged care was identified as being RACF led, not GP-led. This is supported by a recent study that showed that while the volume of GP services to RACFs increased between 2005 and 2014, and the number of GP services per resident increased, there was a much smaller increase in collaborative GP services (i.e. Contribution to care plan, Item 713, and Residential Medication Management Review, Item 903), with less than 50% of the residential aged care population having received these services.<sup>13</sup>

Furthermore, GPs indicated that the RACF Multidisciplinary plans were not as useful as a GP Management plan or Team Care Arrangement for planning and reviewing care on a scheduled basis.<sup>1</sup> This aligns with a review of the ACFI, that found while the instrument is used to assess care need to inform funding levels for individuals, it is disconnected to care planning and care provision for the individual, some of the assessment tools prescribed in the ACFI do not align with contemporary evidence to optimise resident health and wellbeing and are not used to inform care plans.<sup>14</sup>

From the GP perspective care planning and care delivery in RACFs is piecemeal and ad hoc, occurring outside their usual care planning and review processes where care planning is facilitated by the

practice nurse and underpinned by: patient register and recall; GP Management Plan or Team Care Arrangement; and access to clinical records. The BHCC evaluation found that while GPs attend RACFs on a scheduled and/or as needs basis, the residents to be seen by the GP are usually identified by the RACF staff, and it not usually a planned review process.<sup>1</sup>

Under the ACFI, RACFs are paid according to the level of need for a resident, receiving higher amount of funding for residents with high care needs. As such, if an RACF supports the re-ablement of a resident the amount of funding for the resident decreases, hence the funding mechanism does not reward wellness.

It is a requirement under the Australian Aged Care Standards Agency that an RACF develops a multidisciplinary care plan for each resident to inform resource allocation. Hence the RACFs consider there is a care plan in place and some see the development of GP management plan as duplicative or a “money grab” by the GP. As a result, RACF staff can be resistant to working with the GP or practice nurse to provide information to inform the development of Comprehensive Medical Assessments and care plans for residents. Conversely, a number of GPs raised concerns about the amount of time senior RACF nursing staff seem to spend “on paperwork” i.e. completing and/or revising ACFI and supporting documentation required for payment. These issues contributed to the activity in some trial sites to run information sessions for GPs and RACFs on funding models and importance of documentation such as Comprehensive Medical Assessments and updating documentation as the health needs of a resident change.<sup>1</sup>

### **Health Care Homes**

The establishment of Health Care Homes was a core recommendation of the Primary Health Care Advisory Group which was established by the Health Minister in 2015 to develop options to improve care and health outcomes for people with complex and chronic conditions

On 31 March 2016 the Government announced its plan to introduce a Health Care Home model to improve care for patients with chronic and complex conditions. Under this model, eligible patients will voluntarily enrol with a participating general practice or Aboriginal Community Controlled Health Service, known as their Health Care Home. This practice will provide a patient with a ‘home base’ for the ongoing coordination, management and support of their conditions. The Trial has now been extended to 30 June 2021.

Health Care Homes or medical homes is a funding model intended to resolve fragmented primary and acute care services for people with chronic conditions.

‘The model emphasises a patient having an ongoing relationship with a particular doctor (who leads a multidisciplinary practice team) and primary care that is comprehensive, coordinated and accessible, with a focus on safety and quality. The definition is explicitly doctor-centric in that it nominates the physician as team leader and as the main focus of relationship-based continuity of care’.<sup>15</sup>

Under the Health Care Home trial in Australia, Health Care Homes in the selected trial sites will be paid an upfront payment by the Government (about \$10k) plus a regular bundled payment to provide care related to a patient’s chronic and complex condition. This will enable Health Care Homes to be flexible and innovative in how they deliver care to enrolled patients. The intention of the model is to

allow doctors and their teams to focus on delivering quality improvements to patient care when they need it, no matter how often it is needed, without the rigid constraints of Medicare's current fee-for-service model. Health Care Homes will be rolled out and evaluated in selected regions from October 2017.<sup>16</sup>

The national Coordinated Care Trials in the 1990s and 2000s showed that system reform is necessary to achieve the goals of integrated multidisciplinary care for people with chronic conditions, including new systems for patient enrolment, strategies to drive improvements in delivery system design, clinical information systems including electronic health records, self-management support, and technologies to link general practice to other health and social care providers. This places emphasis on a shift from reactive primary care to more planned and proactive care.

### **A new approach**

In the current Health Care Home trial, residents of aged care facilities are not identified as a target group. However, considering the nature of GP care required for people living in residential aged care, a similar approach may be warranted.

As identified, under the current system a myriad of activities undertaken by GPs in providing care to residents of RACFs are unremunerated. The incentives in place to compensate for these tasks do not appear to be sufficient to attract more GPs to provide care in RACFs. One option would be to create direct item numbers or direct remuneration for each of these tasks, for example, telephone consultations with RACF staff, pathology requests and script renewals that occur outside the usual patient consultation. It could also be argued that further compensation should be provided for the necessary duplication of documentation, travel time and participation in RACF led multidisciplinary care planning.

However, this would likely result in an overly cumbersome system, with a commensurate increase in administrative requirements. Alternatively, a bundled payment approach could address many of the common concerns of GPs and the factors identified as reasons for them reducing visits to RACFs.

The Health Care Home model recognises the benefits of coordination and management of peoples' needs and allows for GPs to focus on responding to the needs of their patients, however often that is needed. In the context of RACFs this would legitimately include consultation with RACF with or without direct input from residents.

Remunerating GP practices using bundled payments could take account of the considerable "extra" tasks routinely undertaken by GPs but not currently recognised in the fee for service model. It is suggested that, like the Health Care Home model, this be done at a practice, rather than individual GP level.

A remuneration model supporting practices to provide care could have a number of other benefits including:

- enabling practices to share their aged care workload
- utilising practice nurses and other practice staff more effectively
- providing continuity of care during periods of leave.

The doctor centric Health Care Home model could be adapted for the residential aged care setting to improve and streamline care planning and coordination processes with a greater emphasis on collaboration between RACF staff and GPs. It would also provide opportunity for innovation in the delivery of care allowing for greater flexibility within the system.

A bundled payment could be made to a GP practice to provide care to a resident for a defined period of time, taking into consideration the frailty of the population and the average length of stay.

Some issues, including improving the interoperability of systems between general practice and RACFs require a national approach to support both GPs and RACF staff in improving resident care.

While this concept would require considerable work to arrive at an appropriate fee structure, the problems in the current system suggest that piecemeal adding of further fee for service based payments is unlikely to either increase access to GPs for RACF residents or improve their care.

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