

Models of general practitioner services in residential aged care facilities



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Background

Provision of timely and high-quality general practitioner (GP) services to patients in residential aged care facilities (RACFs) is essential for this group of patients as they have high medical needs.

Objective

The aim of this article is to describe different models for general practice care for patients in RACFs.

Discussion

Models for general practice services include the Continuity Model, where GPs follow long-term patients; the RACF Panel model, where GPs provide care to several patients in nearby RACFs; the GPs with Special Interest in Residential Aged Care (GPwSI RAC) model, where GPs provide regularly scheduled services to larger groups of patients; the Longitudinal General Practice Team (LGPT) model, where GPs provide team-based care; and RACF-based models of care, where GPs partner with RACFs. Hospital-based models of care have also been developed to provide in-reach services to patients in RACFs during episodes of acute illness. There is limited evidence for which of these models is most effective. Developing and testing different models of general practice care should be a priority.

Keywords

homes for the aged; primary healthcare; delivery of healthcare

Provision of timely and high-quality general practitioner (GP) services in Australian residential aged care facilities (RACFs) is essential for this expanding population of at least 170,000 people,¹ who have substantial health needs.^{2,3} There is growing evidence that the current methods of delivering GP services to this population are not optimal, and there are high and rising rates of acute care services use⁴ and concerns about the quality of services provided.⁵ People in RACFs aged 65 years and above account for nearly 9% of hospital admissions,⁶ despite representing only 4% of this age group.⁷

GPs provide most primary care services on-site in RACFs. However, a survey by Catholic Health Australia (CHA) in 2010 of 90 affiliated RACFs indicated that only half of these facilities provide visiting rooms for GPs.⁸ A recent Bettering the Evaluation and Care of Health (BEACH) survey,⁹ conducted in 2012–13, indicated that 53% of GP participants provided care in an RACF in the previous month. This proportion increased by a small amount over the past decade (personal communication, Dr Helena Britt, University of Sydney). However, estimates provided by the Australian Medical Association (AMA) suggest that those who are regularly engaged in residential aged care are considerably fewer at only 21% of GPs.¹⁰ Reasons given by GPs for this low participation rate include inadequate remuneration and increased time required to care for this population.³ The Medicare Benefits Scheme (MBS) funds general practice services at the same level as in the GP's surgery (with an additional call-out fee for travel time). This payment fails to sufficiently account for the high levels of non-contact time,¹¹ including communicating with RACF staff, and makes involvement of other general practice staff such as practice nurses difficult to fund.

On average, GPs provide 17.1 separate MBS services annually when caring for an RACF patient for 1 year.¹² Despite this number of services, RACF staff indicate that improved access could result

in better care. The CHA survey noted that 54% of homes were struggling with accessing GPs but were able to cope, whereas an additional 15% of respondents reported that the difficulty they experienced in accessing GPs sometimes compromised patient care.⁸ Additionally, 57% reported GP access problems occasionally resulted in transfer to the hospital, and an additional 18% reported that hospital transfers occurred fairly frequently or regularly.

Optimal delivery of general practice services is best accomplished through planned organisation of clinical services, which are sometimes referred to as models of care. A range of general practice models can be identified. It should be noted that these models of care are not mutually exclusive; nor are all models of care included in this discussion.

The continuity model

Many GPs continue to provide care for their long-term patients after they move to an RACF. This continuity model is viewed by the RACGP as the preferred model and that it is 'always best' for elderly patients to continue to see their regular GP.¹³

However, the proportion of patients cared for in the continuity model is likely to be lower than is typically assumed. In the previously described CHA survey,⁸ respondents at 43% of these facilities indicated that most residents ($\geq 70\%$) need to have alternative arrangements made for general practice care at admission.

Additionally, after entry to these facilities, 55% of homes surveyed reported that most residents ($\geq 70\%$) had changed within a few months to a GP who has existing patients residing in the home. Lack of continuity of GPs was much greater in the major cities, where only 17% of RACFs reported that most residents ($\geq 70\%$) continued to receive general practice services from their prior GP. BUPA Aged Care, which operates many RACFs across Australia, states that only 30% of GPs in their facilities continue to provide care to their patients following admission.¹⁴

Disadvantages of changing GPs include loss of the long-term relationship and lack of information regarding prior healthcare. However, this may be mitigated by a fresh assessment by a different GP and potentially increased access to healthcare if the new GP is near the RACF. Evidence from the UK suggests having larger numbers of RACF patients at a facility results in more regular visiting by GPs.¹⁵ Not all GPs are interested in gaining the special knowledge and expanded skills required for RACF care, such as managing difficult behaviours in dementia or working in a setting where access to diagnostic tests, specialists or equipment is delayed. Additionally, capacity of RACFs to support in-facility services such as palliative care varies widely and knowledge of the skill mix of staff in each facility can contribute to better care.

RAC panel model

Some GPs accept new patients in nearby aged care facilities or see all of the RACF patients for their practice, allowing them to

continuously provide care to a number of RACF patients referred to as a panel. Having a sufficiently sized panel allows GP access to the Aged Care Access Incentive (ACAI).¹⁶ This practice incentive payment (PIP) is currently worth up to \$5000 annually for GPs who provide more than 140 occasions of RACF-identifiable services. On the basis of reported annual rates of general practice services,¹² this would require an individual GP panel of 8–12 residents to obtain the full incentive. The additional compensation paid to an individual GP substantially increases funding for a panel of this size; however, once 140 eligible annual services are provided, there is no additional incentive payment. GPs need to be attached to a PIP-eligible (accredited) practice to receive the ACAI.

GPs with special interest in residential aged care (GPwSI RAC)

Some GPs regularly provide scheduled care in RACFs. These GPs tend to cluster their patients in a few facilities where they have established a relationship with RACF administration and staff and have substantial panel sizes. In the UK, these practitioners are referred to as GPs with Special Interest (GPwSI) and there are methods for accreditation, including for older adults.¹⁷ These GPwSI are typically very committed to providing aged care, despite the low compensation, and also appreciate the flexibility of working hours. As with many areas of specialisation in general practice, there are concerns raised regarding losses of generalist skills,¹⁸ particularly for those who solely provide care in this setting. However, GPwSI RAC are likely to be few in number but could account for care of a substantial number of RACF patients.

Longitudinal general practice team (LGPT) model

Currently there are few incentives for nurses to engage in the support of GPs in their work in RACFs. However, practice nurses have the capacity to enhance and substitute for GPs in this setting. The Australian Medical Association (AMA) and the RACGP wrote a position paper in 2006,¹⁹ which promoted a LGPT model that allows the doctor to delegate tasks related to the care of residents of aged care facilities to the general practice nurse (or, on occasion, other team members with clinical training) rather than to staff employed in the RACF. This paper also advocated for changes in MBS payments to facilitate this model.

Nurse practitioners can also provide RACF primary care services in a team-based model.²⁰ However, evidence for this model of care is sparse and a recent systematic review using specified quality criteria was able to identify only two nurse practitioner studies from the USA that met the criteria. These papers were published at least a decade ago.²⁰ The two studies found some improvements in care, including higher family satisfaction and greater attainment of resident-specific goals. The MBS allows for payments for nurse practitioner services in RACFs if engaged in collaborative practice with a medical provider. However, the payments for these services

are considerably less than those paid to GPs (eg 57% of a GP standard consultation in 2014) without a supplemental call-out fee. This funding may not cover the costs of provision of these services by nurse practitioners. This low rate of reimbursement will be a substantial barrier to developing integrated GP–nurse practitioner models funded solely from MBS payments.

In a recent position statement, the AMA supports appropriate expansion of the role of nurses within a team-based model of care in RACFs but states that ‘all healthcare provided to older Australians must be coordinated by a medical practitioner familiar with the patient, who provides continuity of, and takes ultimate responsibility for, that care.’²¹ The AMA also notes that ‘nurse practitioners can only provide care within their scope of practice. Residents will still require access to medical practitioners to provide comprehensive medical care.’²¹ The Southern Adelaide, Fleurieu, Kangaroo Island Medicare Local has developed an LGPT model using GPWSIs, a practice nurse and a nurse practitioner trainee (*Table 1*).

RACF-based models of care

Some RACFs have established relationships with specific GPs to take most patients in a facility who lack a GP willing to provide ongoing care. Many of these GPs also provide input into clinical governance. There is a long history of aged care facilities in the USA partnering with primary care doctors as the US federal government mandates that a doctor be involved in RACF governance as part of their accreditation standards. These US RACF medical directors take responsibility for overall clinical care carried out at the facility. They apply their clinical and administrative skills to guide the facility in providing care, help the facility develop and manage quality and safety initiatives, including risk management, and provide information to facility

Table 1. An example of a longitudinal general practice team (LGPT) model – REACH Aged Care

The Southern Adelaide, Fleurieu and Kangaroo Island (SAFKI) Medicare Local developed the REACH Aged Care in the South Program to support GPs and RACFs in their region.

REACH services included:

- urgent assessment when a patient’s usual GP was unavailable during regular hours
- interim coverage for GPs who were on vacation or ill
- provision of ongoing medical services to RACF patients whose GP was no longer willing to provide care in the RACF.²⁶

This program also worked with facilities to assist with their clinical governance. REACH became a major provider for ongoing care for residents using a GP–nurse team and there was high satisfaction with the services.

Training for nurse practitioners was also provided.

The program was initiated with funding from SA Health but closed in 2014 because of changes to government funding and subsequent changes to the REACH business model.²⁷

staff and medical practitioners to aid understanding and provision of high-quality care.²² This work is compensated by the facility.

The AMA has released position statements^{21,23} on the medical care of older adults that are consistent with this approach. These statements recommend that all staff employed in RACFs should be appropriately trained and be involved in continuing educational programs. Regular discussion of patient care issues between the patient’s GP and other providers of care is also recommended. The document states that quality assurance procedures should also be established to facilitate monitoring by medical practitioners of the clinical services provided to residents and recommends retainer arrangements between RACFs and medical practitioners to support this.

Recently BUPA Aged Care has begun employing GPs to work in its facilities in line with this approach (*Table 2*).

Hospital-based in-reach services

People living in RACFs have high rates of transfer to hospital. A number of programs have been developed to reduce the rate of acute care service use, which are funded by the Australian states and territories that provide these services. These models of care include:

- the State of Victoria In-Reach Services,²⁴ which provide a range of medical and nursing services to RACFs to reduce emergency department demand
- programs using paramedics²⁵ who visit RACFs to deal with acute problems such as minor suturing or replacing percutaneous endoscopic gastrostomy tubes
- Silverchain’s Home Hospital program, which provides hospital level services (eg intravenous antibiotics) in community settings including RACFs.²⁶

These programs show promising results in reduction of acute care services use but often do not address ongoing care issues (eg lack of GP access or quality-of-care issues). These models return the patients to general practice care after a period of

Table 2. An example of a RACF-based model of care – BUPA Integrated Health Care model

BUPA Aged Care has developed the Integrated Health Care (IHC) model for its RACFs where it employs vocationally registered GPs with a strong interest in geriatric medicine in the aged care setting.²⁷ GPs provide individual services in on-site consulting rooms, which include the capacity to perform simple procedures. GPs are provided with training as required.

The IHC GP also works with a specialist nurse on-site in providing clinical oversight for clinical care in the facility including the ability to provide leadership and training to nurses to deliver more complex medical care.

The IHC model has been implemented in 20 aged care homes²⁸ and BUPA intends to roll out the model across all of its facilities.

This program is currently being evaluated by the University of Tasmania.

high need and do not add to the capability within the general practice.

Conclusion

Several models of general practice care for RACFs are in use in Australia. More comprehensive models such as team or facility-based models have the potential to provide responsive and integrated services but are limited by low rates of reimbursement through the MBS. Historically, the development and evaluation of new models in this sector has relied on supplemental funding from a range of government or private sources and, indeed, the sustainability of models currently in operation is likely to require ongoing subsidy. Those models of care, which promote improvements in general practice services within RACFs, as well as effective involvement of GPs in clinical governance, should be supported. More rigorous evaluations of initiatives in this area would strengthen the case for increased public funding of these models, which is well overdue. The new Primary Health Care Networks (PHNs) would be well placed to support initiatives in this sector.

Key points

- Several different models for general practice services in RACF exist but all are limited by low levels of reimbursement.
- The GP panel model provides access to the Aged Care Access Incentive (ACAI), which provides a payment to GPs who maintain a panel of RACF patients and provide a sufficient number of eligible services.
- New models of RACFs are developing that provide the opportunity for GPs to contribute to clinical governance and quality improvement.

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