

Enhanced Primary Care A rural perspective

Philippa Lewis, Angela White, Gary Misan, Peter Harvey, Jerome Connolly, Joe Noone

Philippa Lewis, is a fifth year medical student, Adelaide University, South Australia.

Angela White, is a fifth year medical student, Adelaide University, South Australia.

Gary Misan, PhD, BPharm, is Associate Professor and Head, South Australian Centre for Rural and Remote Health, Whyalla, South Australia.

Peter Harvey, PhD, BEd, is Manager, Sharing Health Care SA Project, Spencer Gulf Rural Health School, South Australian Centre for Rural and Remote Health, Whyalla, South Australia.

Jerome Connolly, MBCHB, is a general practitioner, Whyalla Clinic, South Australia.

Joe Noone, BHS (Hon), is a research associate, South Australian Centre for Rural and Remote Health, Whyalla, South Australia.

BACKGROUND The Enhanced Primary Care (EPC) program is designed to promote better management of and improved health outcomes for people with chronic illness. Specific Medicare item numbers provide government funding to encourage general practitioners to take up health assessments, care plans and case conferences.

AIM We investigated elements of the EPC program from a rural general practice perspective.

METHOD Questionnaires summarising experience of EPC for patients and health care providers, undertaken over four weeks at three rural general practices, and observation.

RESULTS The EPC program assisted the management and coordination of care for patients with multidisciplinary care needs. General practitioners were generally positive about the EPC program. The main barrier was the extra time required. The main concern of allied health workers was the lack of appropriate remuneration for their participation. Patients were positive in their responses, but many appeared to lack the motivation and self management skills to take full advantage of the program.

DISCUSSION Strategies seeking to increase the uptake of EPC items need to address efficiency and accessibility, and funding for participating health professionals.

The Enhanced Primary Care (EPC) program, announced in the May 1999 Federal Budget, consists of a range of innovations designed to encourage health care providers to better assist and care for people with chronic illnesses and complex care needs. It emerged from the early outcomes of coordinated care trials¹⁻³ with a focus on preventive and multidisciplinary care, and encourages patients to have a more active role in their management. It also consists of Medicare rebates for annual health assessments for the aged, and for general practitioner involvement in care planning and case

conferencing. It is based on a preventive care model.⁴⁻⁷

Aims

We investigated some aspects of the EPC program from a rural health vantage point.

EPC item numbers

Aged Health Assessments can be provided for any patient over the age of 75 years, or any Aboriginal or Torres Strait Islander patient over the age of 55 years.

Care Plans may be prepared for any patient with a chronic and complex medical condition and who requires mul-

tidisciplinary care from at least two other health care providers.

Case Conferences may be provided for any patient who has a chronic medical condition and who requires multidisciplinary care from at least two other health care providers. In contrast to care plans, the patient and health care team meet together to discuss key health care issues and to develop care management goals.

The Practice Incentives Program

The Practice Incentives Program (PIP) is part of a payment system for GPs. It is designed to promote the aspects of

general practice that are associated with quality health care, such as the provision of after hours services and student teaching, by compensating GPs who take time to look after the continuing health care needs of their patients rather than relying on many quick consultations for income alone. A 'rural loading' is paid to practices in rural and remote locations.

PIP payments support the uptake of case conferencing and care planning in addition to the individual Medical Benefits Schedule (MBS) item numbers. Payment is made to medical practices that meet a specified coverage rate based on the number of patients aged over 65 years as a rough estimate of the numbers of patients with complex care needs attending the practice.

Methods

We collected data over four weeks in two general practices in Whyalla and one in Port Lincoln, South Australia; designated practices A, B and C throughout the following report. We:

- talked to relevant health professionals,
- examined relevant documents
- observed EPC consultations in different rural general practices, and
- administered questionnaires to patients and health care providers using a 5-point scale.

Results

Recruitment and recall of patients

We observed two methods for GPs recruiting patients for EPC:

- searching their patient records electronically to identify eligible people, and
- opportunistically with patients attending routinely.

Health assessments

Two health assessments were observed at two practices. The practice nurse collected most of the information. Assessment of patients' clinical condi-

tions and medications was more thorough than psychological and social function.

In the third practice, health assessments were completed at home which allowed for a direct assessment, especially of factors predisposing to falls.

Care plans

We observed 16 care plans. The assessments of patients' problems and care needs were comprehensive with clear management plans. Involvement of other health care providers varied from minimal to active contribution to the plan's development. So also was the degree to which patients defined program aims, which varied in the extent to which they were clearly set out, the input of the health care providers, and the emphasis on medical or lifestyle issues.

Patient and health care provider questionnaires

Patients reported better matching of health care services to need, improved quality of health care and improvements in their own knowledge of their condition and its management following introduction of the EPC program. Whether the EPC had improved their relationships with their doctor and other health care providers was unclear.

Some suggested improvements were home care plans or health assessments conducted for those with mobility difficulties.

Health care providers surveyed were involved with the EPC program. These included four GPs, three practice nurses, a diabetes nurse, diabetic educators, a service coordinator, a dietician and a podiatrist.

The GPs were generally positive about the EPC program: integration of health care services had improved, although IT support needed further development.

Allied health practitioner responses were more variable. Although most were positive about the EPC program, it was not clear that it had constructive impact

on their practice.

Perhaps there was better communication between medical and nonmedical workers. However, some commented on the lack of funding to allied health workers, and perceived doctors over dominated decisions in care plans.

Discussion

These findings should be interpreted cautiously; the samples were not representative, and were small. General practitioners and allied health practitioners who participated were probably biased toward being positive about the program.


Similarly, the responding patients were skewed toward those with long term and continuing involvement with the program, and not those who had dropped out.

These initial findings suggest a subjective improvement from the use of the EPC program on the health care coordination of the elderly and those with chronic conditions. Possible improvements to the process may include encouraging GPs to set aside one or more designated sessions a week for EPC activities, developing more effective information technology support systems for documenting and accessing patient records, and the provision of adequate remuneration for all health providers involved.

Conflict of interest: none declared.

References

1. Podger A. Reforming the Australian health care system: a government perspective. *Health Aff* 1999; 18:111-113.
2. Commonwealth of Australia. The Australian Coordinated Care Trials: Interim national evaluation - summary. Canberra: Commonwealth Department of Health and Aged Care, 1999.
3. Harvey P W. PhD thesis: Coordinated care and change leadership: inside the change process [PhD]. Perth: University of Western Australia, 2001.
4. Telford R D, Reid R A, Vickery D M, Fries J F. Optimising health status and cost outcomes through population health improvement. Brisbane: Healthtrac Australia, 2000.

- 
5. Lorig K, Stewart A, Ritter P, Gonzales V, Laurent D, Lynch J. Outcome measures for health education and other health care interventions. California: SAGE Publications Inc, 1996.
 6. Fries J, Koop C, Beadle C, et al. Reducing health care costs by reducing the need and demand for medical services. *N Engl J Med* 1993; 329(5):321–325.
 7. Fries J F, Koop C, Sokolov J, E B C, Wright D. Beyond health promotion: reducing need and demand for medical care. *Health Aff* 1998; 17:70–84.
 8. Eyre Peninsula Division of General Practice, Pfizer. Eyre Care. In: <http://www.eyrecare.com>; 2002
 9. Scott C. Public and private roles in health care systems. Philadelphia: Open University Press, 2001.
 10. Royal Australian College of General Practitioners. Chronic condition self management guidelines for GPs. In: <http://www.racgp.org.au/folder.asp?id=229>; 2002
 11. Battersby M, et al. The partners in health handbook: a guide to help you become an active partner in the management of your health. Adelaide: Flinders University of South Australia Coordinated Care Training Unit, 2000; 25.

AFP

Correspondence

Dr Peter Harvey

Email: peter.harvey@unisa.edu.au