RACGP
Royal Australian College of General Practitioners

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31 January 2023

Hon Mark Butler MP
National Dementia Action Plan
MDP 765
GPO Box 9848
Canberra ACT 2601

Via email: dementiaplan@health.gov.au

Dear Minister Butler,

RE: National Dementia Action Plan

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to review and provide comment on the National Dementia Action Plan.

Dementia accounts for approximately 1.6% of general practice encounters,[1] and is the second leading cause of death in people aged 75 years and older.[2] New prevalence estimates for dementia reveal that 3.4% of patients aged 65 years or older had a new record of dementia,[1] making this an increasingly common and important condition for general practitioners (GPs) to consider. Guidance on dementia is provided by the RACGP in a number of key resources:

- RACGP Aged care clinical guide (Silver book) (in particular Part A- Dementia, Behavioural and psychological symptoms of dementia and Short-term pharmacotherapy management of severe BPSD)
- RACGP Guidelines for preventive activities in general practice and,
- National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people.

We acknowledge and appreciate the hard work that has gone into updating the National Dementia Action Plan (the Action Plan). The RACGP supports all the objectives included in the Action Plan and we provide the following comments for your consideration.

1. Overall comments

The RACGP recommends that the following changes be applied to the Action Plan:

- transparency about funding to support implementation of the Action Plan.
- explicit actions, targets, KPIs, responsibilities and transparent population targets should be stated for all focus areas and actions.

2. Objective 1: Tackling stigma and discrimination

The RACGP recommends the following be included in objective 1.

2.1 Dementia awareness training (page 18)

GPs are often the first contact for people experiencing early signs of dementia. It is important that GPs are trained to properly recognise early signs of dementia so that they can refer people to a specialist for diagnosis when it is appropriate. The RACGP recommends training for GPs on identifying, managing and communicating with patients and their families about dementia should be freely available.

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2.2 Challenges (page 19)

With increasing availability of genetic tests and alternative therapies, there is a need to ensure people with dementia are protected from unnecessary costs and harms associated with non-evidenced genetic screening or complementary and alternative medicine therapies. The RACGP recommends that a statement is included within the Action Plan about protecting people from unnecessary costs and harms.

2.3 Focus area 1.2 Creating inclusive communities and environments for people living with dementia, their carers and families (page 21)

We recommend including the following as a dot point in Focus area 1.2: Working with personal insurance companies to identify where inappropriate loadings/exclusions inhibit people from seeking a diagnosis for dementia.

3. Objective 2: Minimising risk, delaying onset and progression

The RACGP recommends strengthening the actions supporting this objective.

3.1 Focus area 2.1 Risk factors for dementia are well understood (page 27)

Traumatic brain injury is listed as one of the Lancet Commission's 12 potentially modifiable risk factors for dementia. It emphasises the importance of engaging in sports activities in a safe way and wearing protective gear where head injury is possible. The RACGP recommends the following preventive action be included:

- reduce recurrent head trauma from sports by changing sporting codes to improve safety and prevent head injuries.

3.2 How can we measure our performance (page 28)

The RACGP recommends the funding of annual multifactorial preventative health appointments with general practice be included as a strengthened preventive action for the prevention of risk factors for dementia.

4. Objective 3: Improving dementia diagnosis and post-diagnostic care and support

4.1 Diagnosis (page 32)

4.1.1 Barriers to communication about signs and symptoms

The RACGP recommends communication between GPs and other health providers is added to the Action Plan. A lack of communication is a potential challenge to timely diagnosis. State and local services can work together to resolve gaps in communication.

For example, hospitals need to detail any displayed signs of delirium and dementia during admission within discharge summary notes to GPs. Likewise, GPs should mention observations of impaired cognition within referrals to hospital. Any loss of information can delay diagnosis and impair treatment.

Communication between allied health providers should also be considered. Education for allied health providers, who often have high patient contact time, on the signs and symptoms of dementia should be made available. Allied health providers should be encouraged to flag concerns with a person's GP who can then escalate diagnosis via screening and referral to specialist services.

4.2 Limited GP capacity and capability to recognise the signs and symptoms of dementia (page 33)

The articles cited on page 33 describes negative patient experiences of GP care and that the potential solution as the use of GP time-tiered Medicare funding arrangements. This statement is incorrect, as Medicare Benefits

Scheme rebates are inadequate to support long consults. Concerns about funding for general practice are detailed within the RACGP General Practice Crisis Summit White paper. This statement should be removed from the Action Plan.

4.3 Focus area 3.2: Quality and timely diagnostic services (page 36)

Increasing capacity of memory clinics is an important focus area. The RACGP notes that due to fear/stigma, many patients are hesitant to be referred to a memory clinic. We recommend that an outreach model via pop-up clinics at medical centres or home visits may be a way to reduce fear and stigma. However, these models would need to be appropriately funded to be successful.

5. Objective 4: Improving treatment, coordination and support along the dementia journey

5.1 Barriers to multidisciplinary team care

Care of people with dementia is often fragmented across the health and social care system, therefore there is an opportunity to improve patient management across a multidisciplinary care team. Barriers to multidisciplinary care include:

- poor communication and lack of clarity around healthcare provider roles
- limited opportunities for information sharing (including radiology and pathology results)
- a lack of current established pathways for communication or direct referrals and
- lack of continuous care coordination for patients.

An example of a communication gap impacting patient care is when people with dementia enter residential aged care facilities (RACF). Prior to admission to a RACF patients are often referred by GPs to undergo an aged care assessment with an aged care assessment team (eg ACAT or ACAS in Victoria) who determine a person's eligibility for government-funded services. A person's GP does not receive a copy of the ACAT or ACAS and is not informed of the type of aged care services being provided or whether they have been wait listed for packages (or not). People with dementia are often unable to comprehend this complex system and unable to explain to the GP what has occurred.

The use of secure messaging platforms and use of accessible shared care plans are required to ensure GPs and non-GP specialists have timely access to relevant patient information.[3]

For some people with complex care needs, successful coordination of care is supported by a trusted case manager or nurse coordinator. In all cases there is a need to support the work of care coordination through a combination of funding models, shared clinical records, IT infrastructure and the use of recalls and reminders.

Supporting and promoting better integration between the services provided to elderly people must be a priority as it will ensure the health and medical sector is better equipped to deliver care to these patients. The RACGP recommends that the above barriers to care and potential solutions be included within Objective 4 of the Action Plan.

6. Objective 5: Supporting people caring for those living with dementia

The RACGP agrees that responsive access to respite care is important to carers. The RACGP recommends access to emergency respite care could be made easier by implementing a registry of available emergency respite facilities that can be booked using an online booking system. The booking system would allow time poor

carers to gain a broader view of available places for emergency respite in their local area without needing to ring facilities directly.

7. Objective 6: Building dementia capability in the workforce

7.1 Focus area 6.1: A skilled, dementia aware health and aged care workforce (page 59)

The RACGP agrees that the aged care workforce needs to invest in the knowledge, skills and capability to support patients with dementia. Elderly people with dementia account for more than half of all residents in residential aged care facilities (RACF), therefore, staff employed by RACFs need better education and training in many core areas of aged care, including dementia.

Additional resources should be made available to RACF staff and GPs who support patients with dementia in RACF and the community setting. These resources must ensure patients with dementia can continue to be treated within their RACF or usual residential setting (where possible). Appropriately trained professionals must be readily available to patients in these settings, to support RACF staff and the patient's usual GP, to assist the patient, and manage the symptoms of dementia.

Implementation of the Action Plan should recognise that GPs face significant barriers in providing care to residents in RACF, including a lack of recognition of their role as a patient's nominated GP and inadequate clinical, administrative, and financial support.

There is a suggestion of creating micro-credentialing in dementia care with enhanced access to MBS for a subset of GP or nurse practitioners in the third dot point of action 6.1: "Exploring the opportunities for semi-specialist GPs or nurse practitioners to focus on dementia care, with extra training and to access to MBS remuneration". The RACGP does not support micro-credentialing as professionals should work within their scope of practice and seek relevant education to match the need of their patient populations. Credentialling of GPs will create more barriers for patients to access appropriate dementia care. For example, the additional time and capacity needed to complete courses, especially for the rural GP workforce, is often not available. The RACGP recommends that a better approach would be to make on-demand resources and appropriate remuneration available for all GPs.

7.2 How can we measure our performance? (Page 61)

The RACGP seeks clarification over the two proposed performance measurements listed under the longer-term examples:

"• Create XXX dementia practice leaders.

• Establish XXX communities of practice/learning networks."

8. Objective 7: Improving dementia data and maximising the impact of dementia research and innovation

The RACGP has published a position statement that recommends the Federal Government's aged care and digital reform agendas prioritise the need for healthcare settings to seamlessly share clinical information in real time, creating a 'single source of truth' medical record that is accessible to all clinicians involved in an older person's care, ie dementia care. [3]

9. Additional comments

GP education is often detailed as a solution to many of the objectives and a way to measure performance within the Action Plan. What is not taken into consideration is the full context of what GPs encounter, such as time poor consultations to complete assessments, patient resistance to undergoing tests or screening processes, long waits

for specialist advice and patient fear of referral to aged care facilities – although these are all mentioned separately within the document the true impact on GPs is not truly realised.

There is also frequent mention of GP Management Plans (or what is often referred to as chronic disease management plans) as solutions to care, but no real understanding of the potential for these to provide a regular review and to include action points about social care and shared with other support services in the care team ie allied health.

10. Conclusion

The prevalence of dementia is predicted to increase in the number of patients aged 65 years or older in Australia, GPs play an important role in recognising, assessing, diagnosing, and managing dementia. However, an integrated health system is required to support and improve diagnosis and care between services.

The RACGP appreciates the opportunity to engage in this important consultation. For any enquiries regarding this letter, please contact Stephan Groombridge, National Manager, Practice Management, Standards & Quality Care on 03 8699 0544 or stephan.groombridge@racgp.org.au.

Yours sincerely

Dr Nicole Higgins
President

References

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3. Royal Australian College of General Practitioners. RACGP position statement: Seamless exchange of information between aged care and general practice RACGP; 2022 [cited 23 January 2023]. Available from: https://www.racgp.org.au/advocacy/position-statements/clinical-and-practice-management/seamless-exchange-of-information.