Aged care model

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Dr Troye Wallett's new aged care organisation may help provide greater incentives for GPs to visit residential aged care facilities.

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The importance of high-quality healthcare for residents in aged care is growing as the number of older Australians increases. Figures from the Australian Bureau of Statistics (ABS) predict the number of Australians aged 65 or older will increase rapidly in the coming decades, in terms of both numbers and proportions of the total population. According to the ABS, the age group is projected to increase from 3.2 million in 2012 to up to 5.8 million in 2031, and up to 11.1 million in 2061.[1]

According to the Australian Institute of Health and Welfare (AIHW), an estimated 200,000 Australians live in residential aged care facilities (RACFs),[2] where the main source of care provided to residents is staff members, such as nurses.

Many believe, however, that GPs can play a larger role in visiting and treating these residents.

'The idea of GPs going into RACFs is to improve the health of aged care residents and, working as a medical professional, engage the facilities at every level, especially the clinical nurses that run the facilities,' Dr Troye Wallett, a South Australian GP who services six RACFs, told *Good Practice.*

Troye Wallett's GenWise model sees its GPs receive much greater remunerations for visiting residential aged care facilities.

'One of the most important roles of GPs in RACFs is that they are there to support the nursing staff in dealing with the medicine side of aged care.'

This idea of GPs playing a significant role in treating older Australians was a major part of Wallett's thinking when he started GenWise, an aged care organisation that consists of GPs who work solely in RACFs. With three full-time GPs and a nurse practitioner, GenWise has no physical location, but rather sees its healthcare professionals spend their time visiting patients in different RACFs.

'We have looked at how to streamline everything and decided that we needed to set our system up differently to how general practice is now,' Wallett explained. 'We don't have a building, we don't have any overheads and we are able to pass on the billings to our GPs, who don't own practices. It makes the remuneration, in that way, adequate.'

Primary care for people in RACFs usually involves the management of chronic diseases, rehabilitation, preventive care, end-of-life care and others.

'As GPs, we are there to work on preventive care of things because, if you look at it, it can severely impact an elderly person and have further health complications in them,' Wallett explained.

'Another aspect that is often not mentioned about GPs visiting aged care facilities is that it has to do with rapport-building and comfort for the patients. It is about letting them understand that they can get hold of me 24/7 and that their health is not going to be lost. [That] is really important as well.'

Heather Letcher, site coordinator of the Warrina Homes RACF in South Australia, believes while GPs do a great job many are unable to treat older Australians, who need a greater level of care, within the structure of the clinical setting.

'We had a couple of residents who used to go down to the local GPs, but it just proved to be an absolute nightmare,' she said. 'They would sometimes forget to take their med charts, the GPs then wouldn't fill in the med charts. But, more importantly, the staff at the RACFs have no conversation with the doctors at all and there is this great divide between the outside GPs and the staff.'

According to Wallett, one of the most important roles GPs play in RACFs is working to stop or slow the symptoms of certain conditions. He believes this is more achievable when a visiting GP is able spend more time with older patients and get a clearer understanding of the issues.

'The prevention of their conditions from deteriorating is probably the biggest benefits that patients in RACFs will get from a visiting GP like myself,' he said. 'We are able to help them because decreasing their hospital admissions by tackling the issues before they become a problem is one of our goals.'

For Letcher, having a GP who is regularly on-hand and who can build a rapport with residents is one of the keys to good health.

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'The experience of the residents at the facility has always been very positive and great with [Wallett] because they know that he is going to be there every week and they know that if they are sick or need him, that he will be there,' she said.

'They are reassured and they are quite happy swapping doctors because they know [Wallett] sits down with all the residents and talks to them and if he decides to make any changes, he suggests it to them, talks about it and he is guided by what they want as well as good practice.'

GPs in RACFs also have a responsibility to develop an advance care plan and ensure any final patient wishes are respectfully and sensitively carried out.

'The other thing that we know, because we know our patients so well, is their wishes should anything happen to them,' Wallett said. 'I know that I am not going to send a patient to hospital who has expressed wishes not to go and, often, I have chatted with their families and I know what is going on and I can tailor the information for them.

'That is really beneficial because it gives the patient and their families a chance to know what each other want.'

Overcoming barriers

As someone who has worked in the industry for more than 30 years, Letcher has found GPs often perceive the level of reimbursement for their services in RACFs to be much lower than for routine clinical work in their surgeries. >>

200,000

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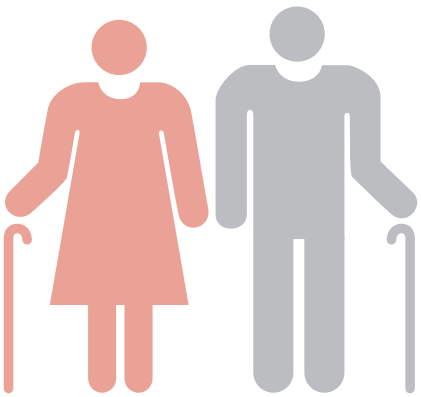

5.8 million

Australians aged 65 or older in 2031[1]

11.1 million

Australians aged 65 or older in 2061[1]

>> 'One of the biggest barriers that you will see is the money for GPs because the fees for visiting people in a RACF aren't great. And if you calculate it, you can probably see three or four people in your surgery in the same time that it took you to get here and get back,' Letcher explained. 'Most GPs are booked solidly and, for example, if we have someone who is really sick, they can't just drop their surgery and come [to the RACF].'

The main source of remuneration currently comes from GPs using MBS item numbers, which look at the length and complexity of the consultation, and for specific services such as a comprehensive medical assessments or residential medication management.

'I agree with the fact that GPs get very little remuneration for the time that they spend in RACFs,' Wallett said. 'The traditional general practice setting is such that, unless it is set up properly, it doesn't pay a GP to go see an RACF.'

GenWise differs from a normal general practice in that the doctors work independently to visit their RACFs, with only minimal costs incurred.

'From a generalised point of view, we have looked at the system and are working well within the system to make sure that our GPs are getting well remunerated for the work that they do,' Wallett said.

'Our model is basically a virtual kind of practice, where we have [practice software system] Zedmed on the computer network of the server and we do billings for the doctors on the system. Our receptionist then sends that off to Medicare and we are able to give the GPs about 85% of the billings back to the doctor, which makes the remuneration part of it a little bit easier.'

The Practice Incentives Program (PIP) GP Aged Care Access Incentive (ACAI) encourages GPs to continue their work in RACFs and provides additional payment based on a two-tiered system. Eligible GPs who provide at least 60 MBS services in RACFs in a financial year are entitled to a payment of $1500, while those who provide at least 140 MBS services in RACFs are entitled to $3500.[3]

GenWise not only encourages more doctors to work in RACFs, it makes sure they are well remunerated and well supported.

'Because everything is done virtually, we are not bound by where we are and if a doctor in Melbourne wants to take on what we do, they can contact us and we can show him how we do it,' Wallett explained. 'The message that I would give all doctors is to look at your aged care patients, dedicate some time to them and take some time off in the afternoon, for example, and go and see them.'

Time constraints

The limited time available in a busy general practice is another reason often cited as a barrier to GPs visiting RACFs.

'We were having trouble getting GPs to come out and treat our residents because most GPs don't really have the time to look after the elderly and that is a real shame,' Letcher said. '[Wallett] came to us and offered a service, which is really excellent. He comes every week and he is interested in his patients. He spends time with the residents but, also importantly, he spends time with their relatives and the staff at the RACF.'

General practice services in RACFs are generally provided by GPs who dedicate one or more session of their week to caring for the elderly.

'A lot of GPs are working long hours and they feel that they need to see the patients they are seeing [regularly],' Wallett said.

'To ask GPs to cut down on a session in their practice to go out to RACFs will just put more time pressure and pressure from patients to see more of them.'

Wallett also believes the availability of resources is an area that needs to be better managed in order to encourage more GPs to treat in RACFs more regularly.

'Often, when GPs walk into the RACFs the processes that are available are often not really streamlined because they either have to double-take notes or double-write notes,' he explained. 'You have cases where the notes are on the RACF system but not in their own system in the practice.'

References

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