



Making dollars and sense in general practice

Complete Primary Care

Australian Divisions of General Practice

Complete Primary Care...

...is not a new program but a new approach using existing programs such as EPC and HMR, already endorsed by the Commonwealth and all national GP groups, to enhance quality patient outcomes, general practice sustainability, and GP job-satisfaction.



GP environment

- Under pressure
- Suspicious of Government
- Low morale
- Low job satisfaction
- Lack of entrepreneurial culture
- High value on autonomy



General practice characteristics

- Diverse individual and practice styles
- Wide variation in use of IM/IT
- Individualistic
- Conservative culture
- Resistant to change



Change Environment

- Ageing population
- Chronic conditions
- Health budget pressures
- Consumer awareness/advocacy
- Workforce shortages
- Litigation/Indemnity
- Evidence Based Medicine
 - Consumer education and self-management
- *New targeted Medicare payments*



Targeted MBS Payments

Enhanced Primary Care

- Care Plans, Health Assessments, Home Medicine Reviews etc

Service Incentive Payments

- Asthma 3 Step, Diabetes Cycle, Mental Health 3 Step etc

Practice Incentive Payments

- Immunisation, Diabetes, IM/IT, PNs etc

Payments for process not just time



Common Themes?

- Consumer centred
- Multi-disciplinary
 - Continuity of care
 - Communication and collaboration
- Longitudinal, reviews, planning
- Management
- Consumer Education
- Evidence Based



GP adoption of change

- EPC: 1999
 - Roughly 10% GPs driving 80% activity
 - Issues around quality
- HMRs: 2001
 - Around 6% GPs
- SIPs and PIPs
 - Immunisation success
 - Mental Health in WA: 25% of GPs



The shape of general practice

- ✓ ✓ **Episodic and Acute Care**
(major and minor)
- ✓ **Population Health**
(eg paps and immunisation)
- ? **Chronic Disease Management**
(up to 80% of GP workload)
7 out of 10 consults



Problems in implementation

- GP resistance
 - Red Tape & remuneration
 - Clinical Interference
 - Change fatigue
 - Philosophy of practice
- Change management
 - Inconsistent resources and requirements
 - Short-term support/facilitation
 - Lack of overall vision and framework
- Practice Capacity



Covey's Time Matrix

Urgent and Important

"Driven Time"

Important but not Urgent

"Quality Time"

- Relationships
- Communication
- Management
- Planning and review

Urgent but not important

"Stolen Time"

Not important or urgent

"Wasted Time"



The MBS primary care puzzle?



Comments?



Other Benefits

Patient

- Loyalty and continuity of care
- Education and self management
- No waiting times – all pre-arranged appointments
- Bulk-billed

Health system

- No new changes or programs to introduce
- Optimising GP use of current solutions (items)
- Shifting costs from expensive tertiary to cheaper primary care
- Reducing demand on PBS/health care system



Other Benefits

GP and practice

- Adds intervention tools to the GP 'toolkit'
- Remunerated for best practice
- Not working in isolation /GP morale
- Confirms GP confidence in patient management
- Reduces 'demand chaos' into structured care
- Reduced red tape – less frustration
- GP directed not patient/problem directed consultations
- Long term management rather than short term solutions
- Indemnity risk reduced (records and collaboration)



Saving Lives *Saves* Money

■ PBS Savings		
■ 11 less drugs	=	\$3,779 pa
■ Prevent insulin dependence	=	\$1,970 pa (PBS)
■ Tertiary Savings		
■ Asthma Hospitalisation 1/12	=	\$1,169 (2001 ABS)
■ Heart attack	=	\$5,000 (1994 AIHW)
■ Stroke	=	\$25,000 (1994 AIHW)
■ Delay dialysis by 5 years	=	\$234,000 (est)
■ MBS		
■ Reduced specialist visits	=	\$1,020 pa (est)
■ Reduced episodic GP visits	=	\$125 pa (est)
■ Social		
■ Carer Allowance (partner)	=	\$87.70 p/fn (Centrelink)
■ Carer Payment (single)	=	\$452.80 p/fn (Centrelink)
■ Sickness benefit (partnered)	=	\$9,029.80 pa (Centrelink)



CPC represents win/win/win/win

- Patient
 - Preventative health care
- GP/practice
 - Remuneration and job-satisfaction
- Other health providers
 - Information and collaboration
- Government (Federal and State)
 - Reduced health system demand and costs



CPC impossible without...

- GP knowledge & trust of items
 - Philosophy of practice
- Practice nurse
- IM/IT (paperless practice)
- Access to other health providers
- Structured care – multiple intervention
- CPC active templates



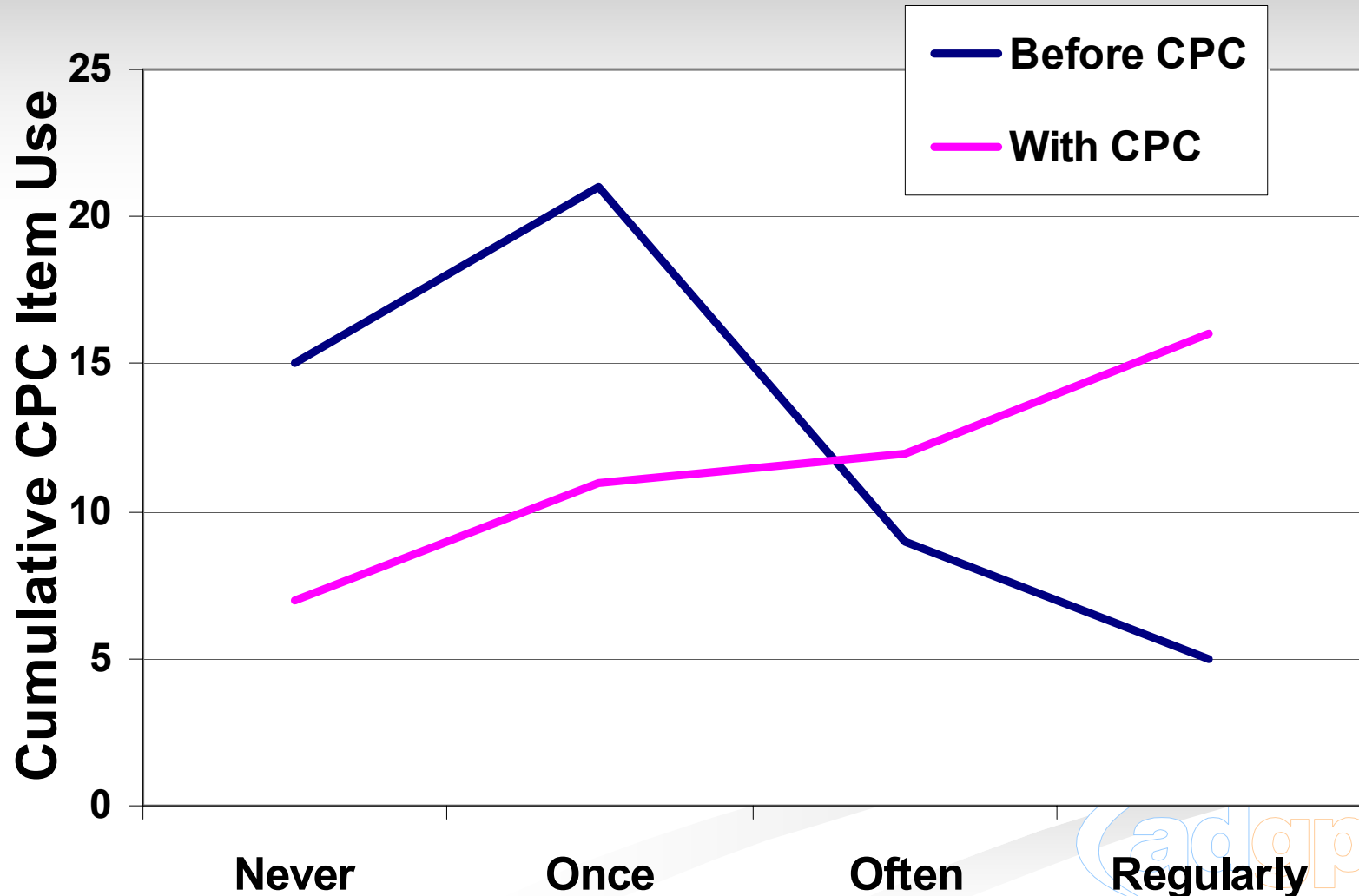
Border Division (Albury) pilot

Unfunded minimal dissemination of templates and basic model: 9 GPs

- Bulk-bill the CPC MBS items 85%
- CPC has reduced red-tape 57%
- Templates are efficient to use 85%
- Positive effect on patient care 71%
- Recommend to other GPs 85%



CPC Item Use: Border Division



Without CPC approach?

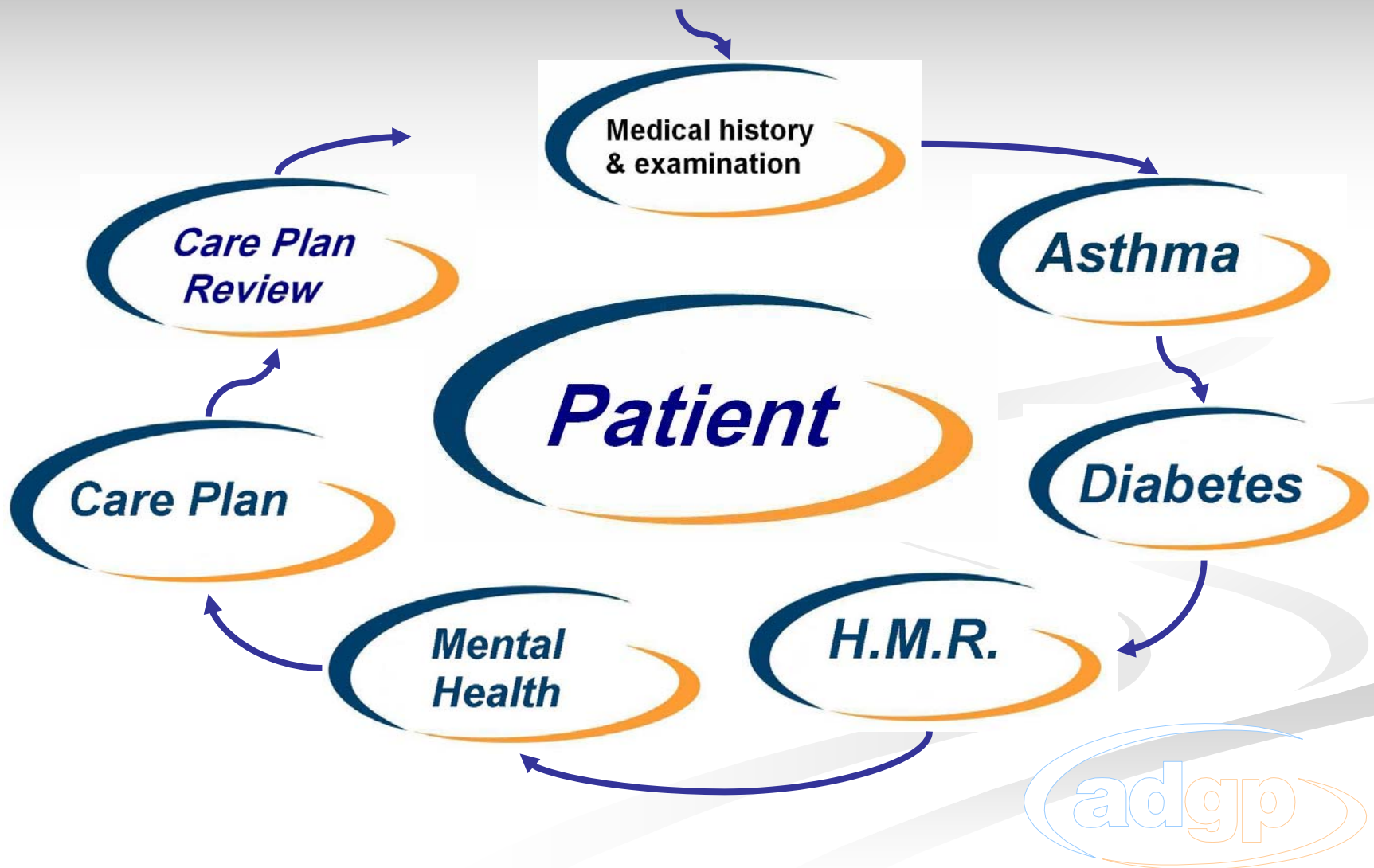
- Harder for GP to structure care
 - Complex patients become burdensome
 - GP must structure pt care themselves as opposed to CPC use of Items to provide basic decision 'support'
- No remuneration for
 - Involving other health professionals
 - Delivering longitudinal preventative care
 - Implementing evidence based care
 - Applying QUM principles
 - Maintaining electronic patient record



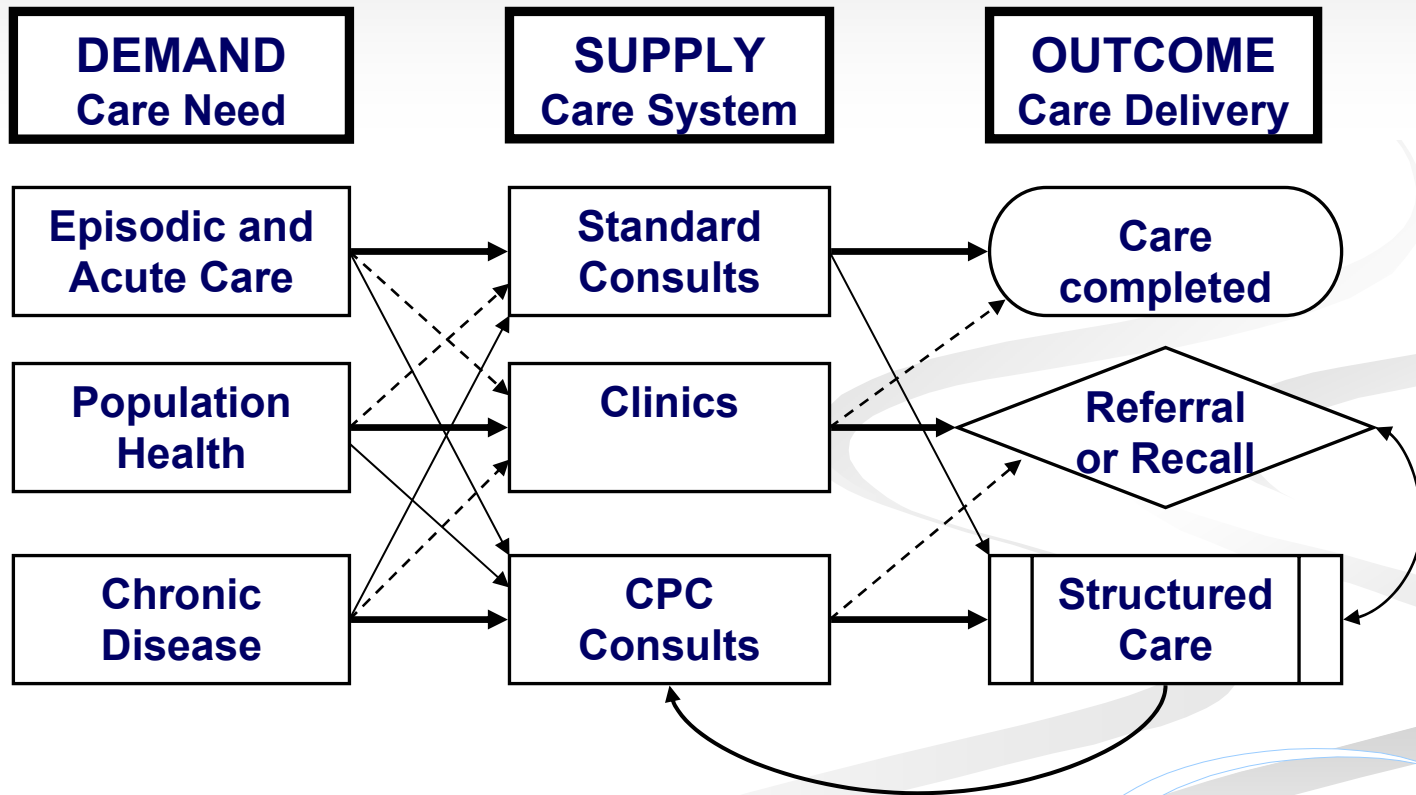
Completing the Primary Care puzzle?



“Bill” - GP led Complete Primary Care



A “complete” framework?



ADGP currently consulting...

- Intellectual property owners of CPC templates
- Members of the Divisions Network on
 - CPC as a resource to general practice
 - Next steps in developing CPC
- The Commonwealth regarding:
 - A study grant to write up CPC experiences to date
 - A demonstration project to roll out CPC in a limited number of practices and Divisions
- Stakeholders re inclusion of CPC templates onto medical software programs



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