WA GP ADVISORY PANEL

MEETING COMMUNIQUE

WEDNESDAY 24 AUGUST &
TUESDAY 20 SEPTEMBER 2022

RACGP
Royal Australian College *of* General Practitioners

RURAL HEALTH WEST

WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

PANEL UPDATE

Impact of Panel to date

The WA GP Advisory Panel pilot has strengthened the voice of general practice in the planning, design and policy setting for primary healthcare and the lead agencies remain committed to ensuring that discussion is translated into tangible action.

Discussions at previous WA GP Advisory Panel meetings have:

- shaped the development of WAPHA's See Your GP – Keep your health on track campaign, providing GPs and practice staff with the necessary communication tools to remind patients of the importance of looking after their health, and to understand why their care may be delivered a little differently within the COVID-19 context, as well as promoting the benefits of telehealth (where clinically appropriate), e-prescribing, and COVID-19 and influenza vaccinations;
- informed submissions and representations from the Panel Lead Agencies to the State Independent Governance Review of the WA Health Services Act and enabled a primary care voice into that review; and
- been translated into actions for the three lead agencies to support GP wellness and self-care

TOPIC ONE

Labor government election commitments

GP URGENT CARE

The Australian government has committed to trial bulk-billed Medicare urgent care clinics nationally over the next four years across 50 clinics. In order to support engagement with the Commonwealth in developing the Urgent Care policy, members were asked to reflect on the key lessons to be learned from the WA GP Urgent care pilot and also what elements are needed to make the proposed national Urgent Care expansion successful.

Key discussion points from Panel members included:

REMUNERATION

Many practices are not equipped to do urgent care or don't have the skills in these areas due to poor bulk billing remuneration. This was a significant barrier to the success of the WA pilot. One-off grants won't be sustainable as there needs to be ongoing funding to make GP led Urgent Care viable.

The remuneration of GPs needs to change from fee-for-service to a salaried model to make the expansion viable, particularly for after-hours work.

Having Nurse Practitioners in urgent care clinics operating in a similar capacity to the fast-track program at hospitals may reduce the cost burden as they'll be on a salaried arrangement.

Bulk billing is not a viable model and may lead to patients not booking appointments for things like scripts or chronic disease management - and opting to go to Emergency Departments or stand alone urgent care centres instead.

CHANGES TO THE PROPOSED MODEL

Medicare urgent care clinics may best be co-located with emergency departments for triaging and security.

Medicare urgent care clinics should be funded through the public health system (either state or federally funded) and the model would be that patients would attend the emergency department and be triaged either to the emergency pathway or the Medicare urgent care pathway.

Given the Medicare Urgent Care Clinics is an election commitment which was made without adequate consultation, in practice the best way forward may be to have clinics run by the State in cooperation with the Commonwealth to avoid damage to the reputation of general practice.

The model could replicate elements from the Scottish model:

- employing salaried staff
- utilising existing space next to, or close to, emergency departments
- several doctors on a shift with a nurse practitioner
- no walk-in appointments, all appointments are booked in and triaged with people attempting to come in for script refills etc. advised that it can wait until their regular GP is open

Important to consider:

- supporting urgent care appointments in existing general practices, particularly during peak demand times from 8am-8pm
- Updated skills training (similar to the sessions RACGP led during the WA GP Urgent Care pilot) which will be essential to ensure the success of Medicare Urgent Care
- a clear business case presented to encourage GP involvement in the commitment and to ensure private practices can cover all the extra associated costs

OTHER COMMENTS FROM CHAT

"Medicare has been defunded over such a long period that this will not work as a bulk billing model."

"I would love to see a system where we better utilise allied health care. I've been fortunate the last 18 months having a great optometrist across the road where I can get patients seen the same day but lots of people are unaware that an optometrist is probably better than a GP for eyes."

"There is also a potential risk around who sees the urgent care patients. There is a risk that a practice could allocate these urgent care patients to registrars, who then don't learn about chronic diseases and continuity of care during their training and can only bulk bill less lucrative item numbers so they end up worse off financially."

"Good option would be to have a consultant GP who is supervising nurse practitioners and RMOs in a co-located state funded GP clinic which allows training for our RMOs as pre-vocational GP registrars."

"Where are they proposing finding all the GPs to staff this? We can't find GPs to do regular hours and GP work, especially in the country."

Within this commitment, grants of $25 000 - $50 000 per general practice will be available for upgrades aimed at improving care and the ability to see patients. To assist us in our engagement on the implementation of the grants, we sought feedback on:

- **What should the parameters be for these grants (if any)?**
- **What would be most useful to implement for your practice?**

Key discussion points from Panel members included:

- Grants given to individual practices leads to siloes – horizontal networking is needed to work out what can benefit general practice as a whole. Individual practice grants won't bring about change and transformation in general practice.
- Grants should be made available for practice staff CPD or specialist training for GPs.
- Additional nursing staff to run clinics would be useful to enhance services. Nursing Assistant positions would also be useful to free up clinical nurse to undertake care planning and more complex tasks.
- Criteria should be as broad as possible to accommodate individual practice needs.
- Grant funding needs to be structured and it would be helpful if the grant funding could be retrospective to help with the cost burden of existing spend within practices where this has achieved the desired aims of the grant.
- With the impending CPD changes the grants should be applicable for admin work such as review and improvement of practice systems and quality audits.
- The grant applications need to be simple enough to complete to ensure that all practices can get a fair share of the funds, particularly smaller practices that have less resources. Support via WAPHA to assist these practices to complete applications would be appreciated if possible. It's also important to make sure reporting on the grants is clear and practices are able to demonstrate that the grants have achieved the intended outcomes.
- It needs to be clear exactly what the grants are designed to achieve before the criteria can be determined clearly.
- What's needed is more people doing more services that are more financially rewarding which seems to have been precluded from existing grant parameters.
- Criteria should be added to the grants so that funds can't go towards ongoing services that already exist or routine GP care
- Funds should be directed towards adequately funding practice nurses, dieticians/diabetes educators etc. so GPs can focus solely on what's in their scope of practice.

- The application process should be robust and clearly based on the needs of patients at a practice (for example, paying for a spirometry machine because the practice has X number of patients with asthma and COPD).

- Rather than an individual practice grant application system it would be useful if WAPHA could provide key equipment and services for all practices - such as a comprehensive IT package/system support or a package of skills training/CPD.

- Criteria should be added to the grants so that funds can't go towards ongoing services that already exist or routine GP care

- Funds should be directed towards adequately funding practice nurses, dieticians/diabetes educators etc. so GPs can focus solely on what's in their scope of practice.

COMMENTS FROM CHAT

"I agree that money being used towards CPD is important, especially with the changes to CPD requirements."

"CPD funding is vitally important. If courses are undertaken during the week then fee-for-service model means you pay for the course but lose income through not seeing patients. Eg RHW REACT+ course is $2500 across two days. Not financially a good trade-off for those that only do limited sessions in ED."

"The other thing that could be considered is measuring and improving ventilation not just PPE."

"Grants should also be available to provide afterhours on call allowance for GPs who cover RACFs."

"Requests made via grant applications should be publicised (anonymously) so others can benefit from the choices made by other surgeries."

"I think we need to be clear what a small one-off grant can do and is intended for, versus what needs structural change (e.g. MBS reform, improved WIP, better remuneration for aged care visits etc.) and needs larger ongoing funding via other mechanisms..."

"Grants might need to be linked to the PDSA process. This also forms part of the QI component from practice accreditation and CPD for practitioners (GP and PN)"

"Seconded - this grant alone won't fix primary healthcare so won't relieve tertiary overload"

"I think the important thing is that we do not give government any signal that the token amount on offer will change anything significantly, or any excuse for them to claim it is fixing general practice. Notwithstanding we are going to try to ensure it benefits GPs to the extent it can."

"There is a second piece [of work] here for WAPHA helping facilitate this discussion with GPs and practices and providing examples to GPs to help achieve the most efficient and long lasting use of these funds."

"Another idea instead of one-off grants is investigating the opportunity for WAPHA to have stewardship of grant funds to provide a range of services/training to practices. For example, there was a dermatoscope course and program which provided GPs with a free dermatoscope upon completion which greatly improved [patient] outcomes."

PROCESS IMPROVEMENT INITIATIVES

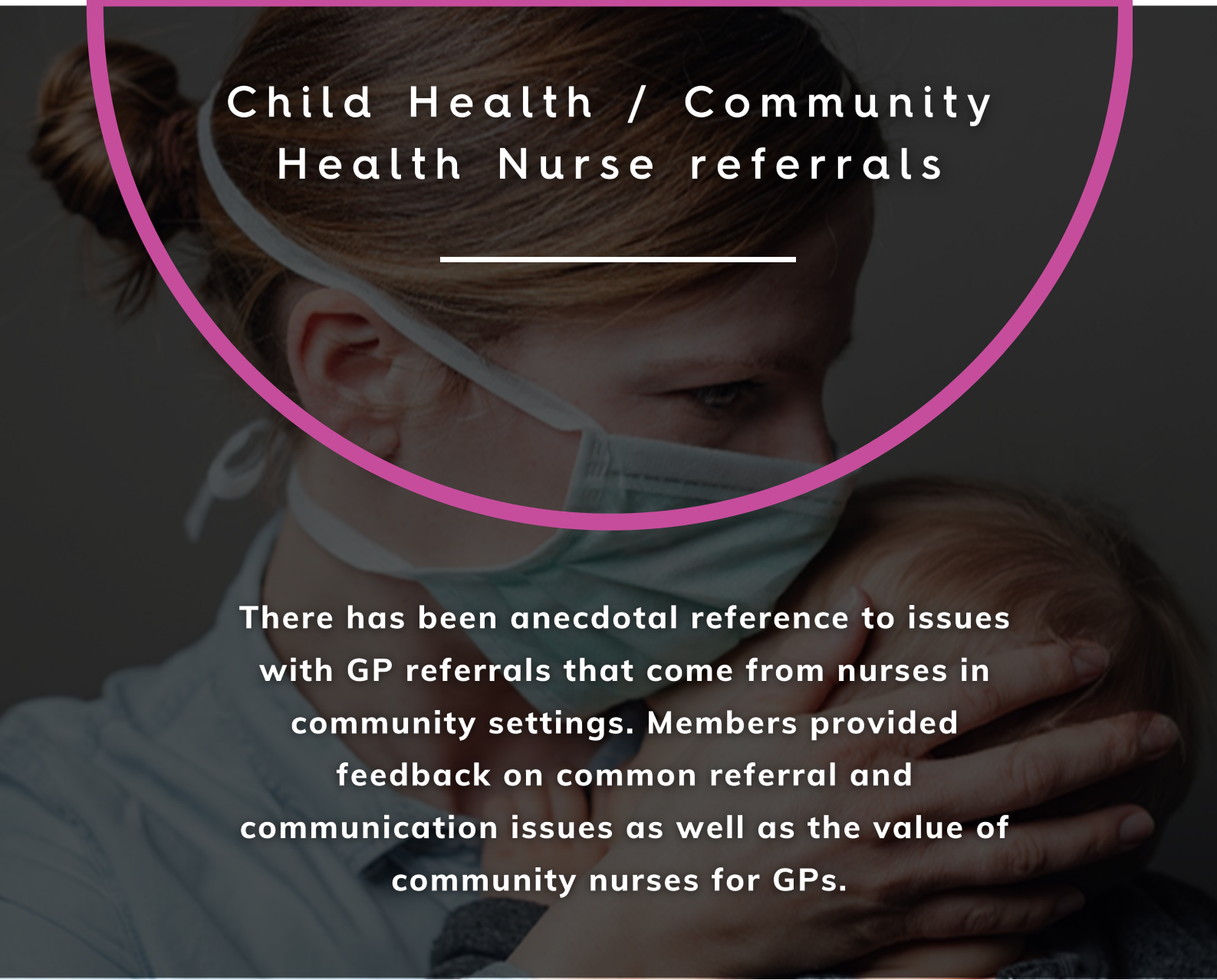
In the spirit of collaboration and learning, one member shared some initiatives implemented at their practice to improve processes around chronic disease and complex patient management and preventative care, including:

- assigning a data field for every patient parameter including biochemistry, hematology, cardiology, respiratory, your radiology/referral letters etc. to turn the patient record into a database and link these parameters to a reminder cycle so each practitioner knows exactly what patient needs or is due for each time they visit. This also facilitates a team care review that nurses and GPs contribute to.
- creating over 3500 auto text entries covering acronyms and dosage as well as chronic disease management goals, chronic disease management, tasks, history, performance, symptom list etc. to add detailed plain-English information to a patients consult record
- incorporating clinical guidelines and NPS guidelines into our order forms including MRI listings for item numbers. This reduces the risk of ordering a noncompliant MRI or other procedure as the items that it applies to are annotated in the limitations in the forms.

Further information on assessing and implementing these processes in other practices will be shared with members in due course.

TOPIC TWO

Child Health / Community Health Nurse referrals



There has been anecdotal reference to issues with GP referrals that come from nurses in community settings. Members provided feedback on common referral and communication issues as well as the value of community nurses for GPs.

Comments from members included:

Concerns have been raised about some of the advice that community health nurses have given in the past which is outdated and sometimes deviates from current practice.

More understanding about the education and training community nurses receive would be beneficial.

Promotion at GP events of the role of community nurses and value for GPs would be useful to help foster good communication and mutual respect.

Direct communication is critical and can be facilitated by a standard form that the GP gives to the patient to send back to the nurse. However, this doesn't seem to be standard practice everywhere. Use of this form should be standard practice.

Some community nurses can over-refer or refer for issues that aren't serious. However, sometimes things will be missed by a GP that the nurse will pick up.

Fostering a good relationship between GPs and community health nurses (CHN) is more difficult today due to siloing and separation of roles.

A good CHN is an invaluable resource for patients and, in some cases, easier to access than a GP.

Colleagues advised that they feel CHNs under refer pathology and try and manage too much independently within the community, rather than referring to a GP.

To increase collaboration and improve communication, all general practices should be made aware of who the CHNs for their area are.

CHNs are really valuable especially when working with an integrated and collaborative team as in the case of an AMS.

OTHER COMMENTS FROM CHAT

With regards to CHN and school nurses I would recommend that there is a standard proforma letter that is sent back. If there is concern about growth, would need to feed back the longitudinal growth data rather than just a one-off weight. Knowing your nurses can be very helpful to build trust. Unfortunately at the moment most CHNs aren't seeing patients face to face due to COVID-19 so there is a lot of referrals because they can't see the child.

A common communication channel for all allied health may help (same as specialists). I understand that allied health currently can't use Healthlink.

Community child nurses are great for screening for a number of issues, however there is indeed a problem of inappropriate referrals of normal kids, as well as extremely outdated advice about breastfeeding, sleep, baby wearing etc.

My experience [is that] high school nurses can be very helpful with the most common adolescent school problems - i.e., mental health support to keep teenagers "at school" when having mental health acute presentations.

TOPIC THREE

Feedback on funding and training

Rural Health West, WAPHA and RACGP WA are planning their individual and collective General Practice training offerings for 2023. The ensuing discussion focused on the skills/knowledge gaps in the general practice workforce that the lead agencies can address through training and education opportunities.

Input into 2023 General Practice Training

These suggestions will be used to inform future training and education opportunities:

TRAINING FOR GP REGISTRARS

in the use of clinical software which is vastly underutilised.

BRINGING BACK THE PROCEDURE LOGBOOK

to record skills GP Registrars need to achieve competency and incorporating that into training.

PROGRAMS OR INITIATIVES

to help practices organise chronic disease management (connecting practices with a consulting pharmacist, extracting records of patients who need medication reviews etc.)

EDUCATION TO HELP WITH TRANSITION

from working in a hospital environment to a general practice, covering off on Medicare, establishing GPs and building relationships with both patients and colleagues and other specialists.

TRAINING IN PRACTICAL SKILLS FOR EARLY CAREER GPS

that have been impacted by the pandemic (cervical screening, biopsies etc.) or who go straight into GP training and miss out on certain skills.

Training and education suggestions continued

COMPREHENSIVE education on Medicare billing.

ENSURING THAT KEY regional education on topics such as rheumatic heart disease, rheumatic fever, STI management etc. isn't lost in the move to national training.

OTHER COMMENTS FROM CHAT

"Training on procedures/practical skills is important (3 of 7 registrars in the last 12 months told me they had never ever done a pap smear and 5 had never done any kind of biopsy)."

"The problem with education about billing is that there is not a single body which can give reliable advice."

"MBS & PBS are poorly understood by many doctors. I have learnt so much since finishing GP training."