Australian General Practice Network

Healthy ageing: time for action

Draft Submission to the 2012-2013 Federal Budget

THE AUSTRALIAN
GENERAL PRACTICE
NETWORK

Delivering local health solutions through general practice

AGPN represents a network of 106 general practice networks as well as eight state based entities. More than 90 percent of general practitioners (GPs) and an increasing number of practice nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development and delivery, eHealth, data management, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an integrated, high quality health system by delivering local health solutions through general practice.

AGPN) is supporting the Federal Government's primary health care reforms through the transition of its members (the Divisions of General Practice and General Practice Networks) to Australia's new primary health care organisations, Medicare Locals.

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Summary of recommendations

The aged care system is on the cusp of undergoing major reform. Acknowledging that the many challenges confronting the aged care system will continue to erode the quality of care older Australians receive until they are tackled, the Government has flagged aged care reform as a second term priority. The series of Intergenerational Reports also remind us of the growth in the number of 'baby boomers' as a proportion of the overall population and the cost burden their health and aged care needs will represent for the system. Meaningful reform in aged care must include a focus on enhancing how the primary health care system works for older Australians. We need to move beyond the current system which too frequently delivers fragmented care, poor access, and is focused on addressing acute presentations rather than preventing disease, immobility and complications. Not only does our current system fail to optimise health and wellbeing for older people, but it is unsustainable, too frequently leading to preventable hospitalisation or escalation of care needs.

AGPN recognises the imperative for the Government to deliver a fiscally responsible budget, and the limitation on new health funds likely to be available. We recommend a focus of new health initiatives on driving improvement in access to, and the quality of, health care, for older Australians.

The introduction of the new regional infrastructure of Medicare Locals (MLs) to drive better coordination and address service gaps in primary health care provides the opportunity to provide older Australians with a health care system that:

- ensures timely access to comprehensive, well-coordinated primary health care
- promotes their health, wellbeing and independence
- enables a "good death"
- provides timely diagnosis and effective management of dementia.

AGPN recommends that the Commonwealth, through the Federal Budget, seizes the opportunity to deliver real improvement in health care for older Australians, through the following investments in the ML network. These five initiatives address key areas where prudent spending is necessary to ensure that older Australians have access to the health care they need to maximise their independence, quality of life, and the quality of their death. They constitute what AGPN believes is the most effective possible use of funds already earmarked through the 2010 federal budget to support better access to primary health care for older Australians, and critical areas demanding additional dedicated funding. Further, they accord with the Productivity Commission's recent recommendations regarding the need to deliver better coordinated care for older Australians within a wellness framework.

- $55 million over three years to deliver better access to quality primary health care for residents of aged care facilities through an initiative that provides local solutions to address identified local care gaps and drive quality improvement in primary care in these settings[1].
- $56.8 million over three years to establish a new evidence-based care coordination program to support older Australians with complex conditions and chronic care needs to access the care they need to maximise their health and wellbeing. This initiative will support an estimated 40,000 eligible older Australians through provision of a dedicated care coordination service.
- $22.8 million over 4 years to support the national roll-out, through the Medicare Local network, of high quality, evidence-based programs such as the Heart Foundation's *Heartmoves* initiative, to support greater physical activity amongst older Australians living in the community and in residential facilities, and thereby prevent the onset of disease, exacerbation of existing conditions, and help maintain functionality and wellbeing. This measure would build on a workforce already trained and credentialed by general practice networks in the delivery of lifestyle modification programs under the COAG Type 2 Diabetes Prevention Program.
- $3.9 million over 3 years to establish a best practice program to deliver a best practice end of life care approach in Australia so that all Australians can access quality generalist palliative care in the primary care setting.
- $2.7 million over 3 years to enhance the timely diagnosis and effective management of dementia through primary care, through the development and delivery of education and training for primary health care professionals, and mapping and networking of local services to maximise the benefit of resources available to promote the safety and wellbeing of people living with dementia.

[1] As discussed in the body of the submission, this dedication of funding is AGPN's recommendation of how to most effectively target funds allocated through the 2010-11 federal budget for Medicare Locals to improve access to primary health care for aged care recipients.

About the Australian General Practice Network

AGPN is the national organisation representing a 106 general practice networks (GPNs) and eight state-based organisations (SBOs). AGPN and its members are collectively known as the Network. AGPN coordinates and disseminates general practice and other primary health care programs through the Network, including those with a focus on:

- Chronic disease management
- National primary mental health care initiatives
- Indigenous health
- Immunisation
- eHealth and information management
- Prevention and lifestyle modification
- Nursing in general practice
- Rural palliative care
- Quality use of medicines

GPNs represent the community-based infrastructure which enables general practice to provide services to patients in the community and in their homes. GPNs:

- deliver local health solutions through general practice to ensure all Australians have access to high quality primary health care
- increasingly deliver services directly to patients – particularly through allied health and nursing
- are in tune with their local communities. They understand their communities' health needs and socio-demographics as well as how these two interact - which makes them a solid foundation for strengthening Australia's primary health care system
- are involved in a range of activities including
    - health promotion
    - early intervention and prevention strategies
    - health service development and delivery
    - medical education
    - workforce development and support
    - eHealth and other strategies to connect care.

The Network is unmatched in its locally based support services which penetrate the vast array of communities across Australia – it is the only national, state and regional/local infrastructure of its type.

The Network is currently in transition, providing the foundation for the establishment of the new national network of Medicare Locals (MLs.) MLs are regionally-based primary health care organisations, responsible for:

- supporting greater coordination of primary health care services across their region
- identifying and addressing local service gaps and areas of need
- driving quality improvement in primary health care.

The Government has announced that initial focal areas for MLs will include mental health care, after hours services and care for older Australians.

The first tranche of 19 MLs have been established, with the full national network of 62 MLs expected to be operational by 1 July 2012.

The Commonwealth Government has made clear its intention that AGPN will evolve to become the national body for the network of MLs. It is expected that AGPN will have transitioned to this new role by early 2012 and, as the ML national body, will be providing leadership to support MLs in driving change management at a regional level and driving high quality performance through MLs.

Background and context

The challenges facing aged care in Australia are numerous. They include significant increases in the number of older people; an increasing incidence of age-related disability and disease, especially dementia; rising expectations about the type and flexibility of care that is received; community concerns about variability in the quality of care; a relative decline in the number of informal carers and a need for significantly more nurses and personal care workers with enhanced skills. These challenges will continue to erode the quality of care older Australians receive until they are tackled.

The series of Intergenerational Reports also remind us of the growth in the number of 'baby boomers' as a proportion of the overall population and the cost burden their health and aged care needs will represent for the system.

A range of specific issues also present significant challenges for older Australians in accessing primary health care services. For older Australians ageing in the community, the care they receive can be patchy, incomplete and delayed, as a result of a fragmented system that is difficult to navigate. Furthermore, care is often reactive and curative, without a systematic approach to prevention. As a result older Australians can receive suboptimal care, leading to preventable hospitalisations and premature entry to aged care facilities. For those living in residential aged care facilities (RACFs) there is often limited and insufficient access to the team of primary health care professionals required to best manage their care and a limited focus on primary and secondary prevention. The result can be an unnecessary or hastened deterioration in health, poorly managed pain, and preventable hospitalisations. These are not only often highly distressing for the older person but also significantly impact on their care needs, frequently resulting in more intensive and costly care than that which could have been provided earlier in the primary health care setting.

Encouragingly, the Government has acknowledged the necessity of reform to the aged care system and clearly flagged aged care reform as a second term priority. Government action to date has centred on a request to the Productivity Commission to undertake an inquiry into aged care and advise on necessary reforms. The resulting report, *Caring for Older Australians,* outlines wide-ranging recommendations designed to create a fairer, more responsive and sustainable system. This includes clear recommendations around:

- improving access to quality primary health care
- increasing the focus on prevention, health promotion and restoration for elderly Australians

- quality and better co-ordination of a fragmented system
- increased patient choice, including through advanced care directives and planning and end of life care
- improved care for residents of aged care facilities.

Concurrent Government health reform has included the establishment of Medicare Locals (MLs), regional primary health care organisations with key roles in identifying, linking, coordinating and developing services to fill priority gaps in primary health care services to increase access to, and quality of, care.

The Government has been clear that an early role for MLs will be to support better access for older Australians to primary health care. The 2010 Federal Budget announced the Government's intention to provide MLs with a flexible funding pool to target gaps in access to primary health care services for aged care recipients (both those living in the community and in residential facilities) from 2012-13. It is understood that $55 million will be dedicated over three years to this initiative.

The forerunner Aged Care Access Initiative (ACAI) commenced in 2008 and focused solely on addressing the issue of poor access to primary health care services for residents in care facilities. The ACAI is comprised of two components: an incentive payment to GPs administered through the Practice Incentive (PIP), Program and an allied health component which is due to cease at the end of the 2011-12 financial year. The allied health component supports payment for clinical care by providers to residents of aged care facilities where these services are not otherwise funded by the Commonwealth. It is managed by the Network's SBOs who can purchase allied health services directly or, as is done in most cases, through contractual arrangements with GPNs in their jurisdictions. Whilst the program is working effectively to support better access to allied health services and offering increasingly sophisticated solutions to address local service gaps, current funding levels are insufficient to address all areas of need.

Budget priorities: Healthy aging – a time for action

Addressing the Government's second term priority of reforming aged care and providing older Australians with better access to quality care, demands system wide reform that includes a focus on enhancing how the primary health care system works for older Australians.

Timely access to comprehensive, well-coordinated primary health care, and to a health system focused on evidence-based prevention, is a promise that we should be able to make to all Australians. Delivering on this promise for older Australians requires initiatives that are specifically tailored to address the specific care need of older Australians, which are often more complex than for younger generations, and which overcome the barriers to realising this promise traditionally associated with RACFs. It further demands a focus that extends to the end-of-life and works to promote comfort for those who are dying. It must also address the reality of a

growing number of Australians ageing with dementia – a number which will only increase as our population continues to age.

AGPN's budget submission outlines a pragmatic approach to taking the first steps in realising a healthy ageing agenda that:

- ensures timely access to quality and comprehensive primary health care for older Australians
- proactively and effectively promotes the health, wellbeing and independence of older Australians
- supports Australians for who death in the near future may be expected, to experience a 'good death' that accords with their care preferences
- seeks to offer early diagnosis of dementia and ensure effective early intervention to delay the onset of the disease and support patients and families in planning for the future.

It highlights four key areas where prudent spending is necessary to ensure that older Australians have access to the health care they need to maximise their independence, and the quality of their life, and of their death. The submission suggests the most effective possible use of funds already earmarked to support better access to primary health care for older Australians, and critical areas demanding additional dedicated funding.

The initiatives proposed below are derived from the Network's extensive experience in coordinating programs that support better access to coordinated primary health care and are based on best evidence. They are aligned with the core building blocks of reform and key areas of change highlighted in the National Primary Health Care Strategy:

- 1. Access to primary health care: new and enhanced services
- 2. Integration for better connected care
- 3. Prevention: promoting healthy, productive communities
- 4. Quality and safety in the primary health care setting

The submission also aligns with the Productivity Commission's recommendations for aged care reform. Central tenets of the Productivity Commission's reports are a wellness framework and the need for better coordinated care. It is in these two areas where a significant down-payment can be made in aged care reform through a healthy ageing agenda implemented through MLs, building on their central role in addressing regional population health needs in partnership with others.

Providing timely access to comprehensive, well-coordinated care

In the 2010-11 budget announcements, the Commonwealth committed $99 million to support better access to primary health care services (GP and allied health services) for aged care recipients in the community and living in RACFs. Through the Aged Care Access Initiative Allied Health Component program

guidelines for 2011-12, the Commonwealth noted that $55 million of this would be provided as a flexible funding pool to Medicare Locals over three years from 2012-13 to support better access to primary health care services for aged care recipients living in the community and in residential aged care facilities.

AGPN is pleased the Commonwealth has acknowledged the necessity of dedicated funding to address primary care access issues for older Australians. However, we advise that due to workforce shortages, the limitations of current subsidisation and remuneration arrangements for GPs and other primary health care professionals to provide services in RACFs, and the chronic and complex needs of many aged care recipients that require relatively high intensity multi-disciplinary team care, this funding is insufficient to enable MLs to effectively meet the needs of aged care recipients in the community as well as in RACFs.

Through the following two proposals we outline two initiatives that would meet the stated objectives of this measure, whilst directing funds where they are most needed to support better access to comprehensive and coordinated care for older Australians. We recommend that the funding dedicated through the 2010-11 budgetary announcements are used to focus on supporting better access for residents in RACFs *only*. Additional investment and models of care are necessary to ensure effective programs can support access to well-coordinated care for older Australians in the community. This can be most effectively utilised if it is targeted at ensuring well-coordinated care for older Australians living in the community with chronic and complex care needs.

Better Access to Aged Care Initiative

$55 million over three years to deliver better access to quality primary health care for residents of aged care facilities through an initiative that provides local solutions to address identified local care gaps and drive quality improvement in primary care in these settings.

Access to primary health care services for residents of RACFs, both during and after hours, is unequal and poorly distributed. There is substantial anecdotal evidence to attest that some RACFs are unable to regularly access timely and affordable GP and PHC services for their residents. Research undertaken by Catholic Health Australia (CHA) in 2010 on the interactions between Catholic aged care facilities and general practice found that whilst close to one third of 90 survey respondents reported no difficulty in accessing GPs to attend their residents, over half reported it was an "ongoing struggle" to access services, and 15% reported the difficulty they experienced in accessing GPs sometimes compromised patient care.[2]

Poor access to PHC services in RACFs leads to suboptimal care and can negatively impact a resident's wellbeing, physical functionality, mental health, palliation or recovery from a major health event. Limited access to primary care can lead to avoidable hospitalisations, which can leave patients confused and distressed, as well as incurring unnecessary costs to the system. Indeed,

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[2] Catholic Health Australia (2010). Survey of access to general practice services in residential aged care. Canberra. Australia.

of the survey respondents noted above, 57% reported that limitations in access to GP services occasionally resulted in transfers to emergency departments and 18% reported that such transfers occurred fairly frequently or regularly.

MLs have been mandated with responsibility for population health planning and coordinating primary health care services across their region. Building on this role, as well as on MLs' well established networks with local GPs and primary health care providers, they are ideally placed to coordinate access to primary health care services for RACFs in their region.

Through the Better Access in Aged Care (BAAC) initiative, MLs would broker GP and allied health professional access for RACFs and drive quality improvement in primary health care in these settings, through the use of flexibly tailored funds to address identified care gaps and identify and implement systems improvements to overcome barriers to service provision. The BAAC initiative will fund MLs to:

- undertake a needs assessment to identify priority care gaps for residents of aged care facilities
- develop services, or extend existing services, to address identified care gaps and coordinate access to enhanced primary health care services in RACFs. Through the BAAC initiative MLs will provide locally-relevant solutions to address both episodic care needs and ongoing preventative health needs. Services supported may include individual access to GP, nurse or allied health services, and individual or group access to prevention and health promotion services and programs. While the emphasis is on systems improvements, the measure could include additional incentives or conditions for providers to reduce access block depending on local circumstances and funding guidelines (eg. clinical room fit outs). Service delivery models may potentially include rostering programs, 'in-reach' care models, and greater use of practice nurses and nurse practitioners in the context of coordinated models of care. For example, a ML may work with local general practices to determine a GP-service provision model for residents in RACFs that enables GPs to provide required services. The current MBS payments for GP services provided in RACFs is inadequate and is detrimental to practice income opportunities – which, as private businesses must remain viable in order to provide services to the community. This major barrier to the provision of GP care in RACFS could be overcome through the type of approach outlined above available through MLs.
- introduce targeted initiatives to drive quality improvement in primary health care for older Australians in residential aged care facilities, for example supporting greater interdisciplinary collaboration in designing service delivery models for residents in facilities or education for RACF staff to support greater identification of residents needs for primary mental health care support.

In implementing the BAAC initiative, MLs would leverage existing relationships between themselves, RACFs and primary health care providers,

established through the implementation of the allied health component of the ACAI program, and build on the increasingly sophisticated service models employed through this ceasing program which are delivering locally-relevant solutions to address identified care needs. This would ensure the initiative maximises outcomes for residents in aged care facilities from its early days of implementation.

Connected Care for Healthier Ageing Program

$56.8 million over three years to establish an evidence-based care coordination program to support older Australians with complex conditions and chronic care needs to access the care they need to maximise their health and wellbeing. This initiative will support an estimated 40,000 eligible older Australians through provision of a dedicated care coordination service.

As longevity has increased, so has the number of people ageing with chronic conditions, multiple morbidities, and complex care needs. Yet the care needs of these older Australians can often remain unmet as they struggle to navigate the complex, and often fragmented, system of health and social care services. Lack of service coordination and fragmentation of care can have a detrimental effect on health outcomes, lead to poorly managed chronic conditions, reduced wellbeing, and preventable hospitalisation. Conversely, well-coordinated care can promote health and wellbeing; there is good evidence that a dedicated coordination role has a positive impact on patient outcomes and leads to lower service utilisation.

In its recent report on aged care in Australia the Productivity Commission emphasised the problem of poorly coordinated services and fragmented care for older Australians and the need to support older Australians with care coordination services. They proposed establishing regional 'gateway agencies' which would assess the aged care needs of older Australians in their jurisdiction and, for those requiring it, provide care coordination support through a dedicated care coordinator role. The Government has not yet responded to the Productivity Commission's recommendations and it is unclear whether this recommendation will come to fruition. However, the need for care coordination support for older Australians, to ensure they can access the care they need, seems to be well established and broadly agreed.

MLs are already in a prime position to provide better coordinated primary health care services for older Australians with complex care needs through implementation of a regionally-based service coordination program to ensure more connected care for older Australians. MLs could lay this foundation and then work closely with regional gateway agencies, when, and if, they are established, on their ongoing implementation.

The Connected Care for Healthier Ageing Program (CCHA) is a regionally-based care coordination program aimed at delivering better connected primary health care services, better chronic disease management and self-management support, and brokered access to social care services, for

Australians 65 years or older with chronic conditions and complex care needs. By supporting timely access to comprehensive care, implementation of the CCHA will reduce preventable hospitalisation and institutionalisation and promote health and wellbeing while also reducing the number of avoidable and cost-intensive hospital admissions.

The CCHA program is based on a proven approach to delivering care coordination services for Australians with chronic conditions and complex care needs. It is modelled on and extends the Department of Veterans' Affairs' *Coordinated Veterans Care* program which itself is based on coordinated care programs implemented by Network Members in urban Brisbane. These programs have been proven to enhance health outcomes, increase community-connectedness and reduce hospital admissions.

The CCHA would provide planned and coordinated access to a range of community based health and social services for eligible older Australians who have one or more chronic conditions, complex care needs and are at risk of hospitalisation. For eligible older Australians, the CCHA would provide:

- a personalised care plan developed by the GP and nurse. (This could be financed via an update to the existing over 75 MBS health check, including a downwards revision (to 65 years) of the age cohort it applies to, or a new practice incentive to enrol and develop a care plan for older Australians. Remuneration to practices/providers for the development of this plan is not included in the funding requirement for project implementation noted above.)
- dedicated coordination support from a health professional trained in best practice chronic disease management, who will oversight the implementation of the plan, provide home visits, assist in self-management strategies and coordinate and monitor various aspects of care. In most instances this role will be performed by a nurse. Where capacity exists this role may be performed by a practice nurse employed through a general practice/primary health care service who receives funding through the ML to support them in providing this level of care coordination to eligible patients. Where workforce limitations mean this model is not viable the ML may directly employ a nurse to work with local practices/ services to provide care coordination for eligible patients
- practical support, such as with transportation costs and arrangements, though flexible funds held by their ML, to access services necessary to ensure the implementation of their care plan
- support to access allied health care to supplement MBS funded services, through funds held by their ML, to support effective chronic condition management in accordance with their care plan.

In all cases, the service coordination would be integrally connected and linked back to the patient's usual general practice as the principal primary care setting in the community.

Following an initial 'start-up year' in which the program is established across the ML network, it is expected that the program would support an estimated 18,600

older Australians with complex care needs each year to manage their chronic conditions through better coordination of services to meet their care requirements. Based on the experience of similar programs it is expected that most patients will not require coordination support for longer than a 12 month period (though changing health and social care needs may mean they require support again at a later period.)

Promoting health, wellbeing and independence

"Live Well" 65+

$22.8 million over 4 years to support the national roll-out of high quality, evidence-based programs such as the National Heart Foundation's *Heartmoves* initiative, to support greater physical activity amongst older Australians living in the community and in residential facilities, and thereby prevent the onset of disease, exacerbation of existing conditions, and help maintain functionality and wellbeing.

Most older Australians do not participate in the level of physical activity required to benefit their health. Amongst Australians over 75 years of age, for example, around three-quarters do not meet the recommended guidelines for physical activity. Participation in physical activity is often particularly low amongst those living in residential facilities.

Yet physical inactivity and sedentary behaviour can increase the risk of developing disease, loss of mobility and acute exacerbations of chronic conditions. Conversely there is good evidence that physical activity can promote continued health and mobility as people age, and the more effective management of existing conditions. There is also a growing body of evidence to support the antidepressant effect of exercise and its role in improving emotional, cognitive and social functioning of older people. More particularly, evidence suggests:

- some age related physiological changes can be reversed by increasing levels of physical activity
- physical activity can have a protective effect against, and decrease risk factors for, many common chronic conditions
- physical activity plays a key role in better self-management of existing chronic conditions, including diabetes, arthritis and depression
- physical activity can support the better management of chronic pain
- activity that improves balance, flexibility and strength can help prevent falls and help retain functionality amongst older people
- there is an antidepressant effect for exercise in older people
- positive mood is more common in physically active older people compared to their sedentary counterparts
- physical activity can reduce the risk of cognitive impairment and dementia

- physical activity programs enhance social networks and social connectedness – a major contributor to good mental and physical health in ageing Australians
- physical activity can improve sleep quality and help prevent falls associated with poor sleep.[3]

Despite the potential benefit of an active lifestyle it is difficult to persuade older Australians to become more physically active and to sustain this. Evidence suggests that the effect of education or counselling interventions is limited. However, well-designed interventions, particularly group-based activities, that support older people in undertaking an exercise program, can be effective in increasing levels of activity.

Yet access to gyms and general exercise programs is often difficult as people age. Standard programs can be expensive and particularly out-of-reach for pensioners' pockets. They are often full of young, fit people and offer programs that are too vigorous for many older people. There are limited programs that are designed for the particular health and prevention needs of older people. These factors further prohibit participation by older Australians who may need to re-engage with exercise.

"Live Well" 65+ offers an approach to promote healthy levels of physical activity amongst older Australians across the country through the national roll-out of a physical activity program/ programs for older people shown to be effective in promoting health, including through a reduction in falls and by increasing functional mobility and quality of life. The "Live Well" program will:

- identify high quality, well-evidenced interventions/programs centred on promoting healthy physical activity amongst older Australians, of the calibre of the Heart Foundation's *Heart Moves* program
- support MLs through the provision of flexible funds to implement one or more of these programs to meet the needs of older Australians in their region, thus providing access to evidence-based physical activity programs for older Australians across the country. MLs will be required to demonstrate improved health outcomes, particularly greater participation in physical activity and a reduction in sedentary behaviours
- utilise and build on an existing allied and primary health care workforce based in general practice networks and MLs who are already trained and credentialed in the delivery of structured lifestyle modification programs under the COAG Type 2 Diabetes Prevention Program.

[3] Taylor et al. 2004. 'Physical activity and older adults: a review of health benefits and the effectiveness of interventions.' *Journal of Sports Sciences*, 22; 703-725.

Making 'a good death' a reality for more older Australians

The Australian Primary Palliative Care Framework

$3.9 million over 3 years to establish a best practice program to deliver a best practice end of life care approach in Australia so that all Australians can access quality generalist palliative care in the primary care setting.

Most of the last year of a person's life is spent at home, and most health care is provided by a person's GP and general practice team. Whilst around 75% of those people whose death can be predicted are dying of non-malignant conditions, specialist palliative care services have tended to be provided, primarily, to people with malignant diseases.[4] Most of this 75% are cared for at home and in an *ad hoc* way by their GPs, and sometimes by disease based specialists. Most would benefit from access to systematic palliative and end of life care.

Providing high-quality care at the end of life is among the most complex challenges in general practice.[5] Patient symptoms may be severe, disease trajectories difficult to predict, family issues complex, and the GP's and nurse's own beliefs and fears about death and dying challenging.[6] There are also a number of structural and resource barriers including lack of time, remuneration, training, knowledge and resources, and experience in palliative approaches.[7]

Yet there is evidence that the proactive involvement of GPs enables more terminally ill patients to die at home and that this is the preference of patients and their carers.[8] There is also widespread agreement that a sustainable health care system needs to be built around primary care, with the primary medical responsibility being borne by general practice and the primary care team, supplemented by specialist teams on the basis of complexity of need.[9] It is imperative therefore that primary care teams are well equipped to provide care to people as they approach the end of their life. This demands the ability to recognise patient and carer needs as patients approach the end of life and the capacity to provide appropriate, well-coordinated care.

The first step in doing so is identifying those people likely to die in the foreseeable future so that appropriate care planning can be put in place. This requires the systematic identification of such patients within a practice population and the development of effective management plans for this population. Access

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[4] Murray, S & Sheikh, A 2008, 'Care for all at the end of life'. *BMJ*, vol. 336, pp. 958.

[5] Mitchell, GK et al. 2008, 'Do case conferences between general practitioners and specialist palliative care services improve quality of life? A randomized controlled trial'. *Palliative Medicine,* vol. 22, pp. 19.

[6] National EOL Framework Forum. *Health System Reform and Care at the End of Life: A Guidance Document.* Palliative Care Australia, 2010 pp. 35

[7] Rhee, JJO et al. 2008, 'Attitudes and barriers to involvement in palliative care by Australian urban general practitioners'. *Journal of Palliative Medicine,* vol. 11, pp. 980–5.

[8] *ibid*.

[9] National EOL Framework Forum, p. 70

to mental or allied health support and/or referral to specialist services would also be included as part of the plans.

No national system to achieve this exists in Australia. To rectify this we need to build the capacity and competence of integrated primary and community care services to provide needs-based end of life care.

An exemplar model for this process - the Gold Standards Framework (GSF) - has been developed in the United Kingdom. The GSF is focused on helping people live well until the end of life. It provides a systematic evidence based approach to optimising care delivered by generalist providers for all patients nearing the end of life. The GSF:

- educates and promotes understanding and confidence in generalists (GPs, PHC nurses and others) regarding quality end of life care delivery
- enables practices to implement organisational system change so that appropriate end of life care is delivered
- provides a system of care for all those with any end stage condition
- supports improved pre-planning care in the final year or so of life, to provide better quality proactive rather than reactive care
- provides a context for health professionals and patients to discuss the potential benefits of advance care directives
- enables care to be provided closer to home –so decreasing more costly hospital admissions and deaths
- is patient-led and focussed on meeting the needs of patients, families and carers
- can be applied across boundaries and in all settings - care homes, hospitals, hospices etc

Differences between the UK and Australian health systems mean that the GSF needs to be adapted to suit the Australian context. There are already many building blocks, at a national, state and jurisdictional level, for such a system in Australia. An Australian Primary Palliative Care Framework would complement and build on existing models, activity and infrastructure, rather than duplicate it.

The establishing network of MLs provides a key foundation for the implementation of such a framework in Australia. Charged with developing and implementing primary health care services to meet the needs of their communities and performing a key role in ensuring access to appropriate primary health care for their ageing populations, they are ideally placed to work with general practice and other primary health care providers in their regions to roll out the framework.

Developing, refining and rolling out an Australian Primary Palliative Care Framework would help fulfil a number of the Australian Government's health reform objectives, and has been identified as a key priority by Palliative Care Australia (PCA) and AGPN.

To establish an effective Australian Primary Palliative Care Framework (the Framework), AGPN would coordinate:

- the development of the Framework by a panel of experts in the delivery of palliative care services in primary care settings. The Framework would be developed based on a review of the GSF and other international examples and key initiatives that have been developed in Australia. The process of developing the Framework would include an environmental scan to identify existing initiatives at national, state and territory level, to ensure the Framework complements and builds on what is already available.
- a pilot program trialling the Framework in up to 6 Medicare Locals with demonstrated capacity to implement the pilot. The pilot would be designed to ensure the workability of the Framework in a range of settings and circumstances and to develop an understanding of what is universally replicable and sustainable throughout the primary health care system.
- the first stage of a national roll-out of the program through the Medicare Local network. Estimated uptake would see 70% of Medicare Locals employing targeted approaches to support the uptake of the Framework by general practices and primary health care practices in their jurisdiction.

Helping to tackle dementia – an increasing reality of our ageing population

Dementia: Early diagnosis, better management

$2.7 million over 3 years to enhance the timely diagnosis and effective management of dementia through primary care, through the development and delivery of education and training for primary health care professionals, and mapping and networking of local services to maximise the benefit of resources available to promote the safety and wellbeing of people living with dementia.

Over a quarter of a million Australians are currently living with dementia. As our population ages this figure will rise and it is projected that by 2050, almost one million Australians will be living with dementia. Dementia will continue to be more frequently encountered in general practice, underpinning the need for timely diagnosis and effective management through the primary care system. Yet delayed diagnosis is common, resulting in lost opportunities for earlier medical and social interventions to support those suffering with dementia and their families. In addition to this delay, the capacity of primary care teams to support patients in managing their dementia is inconsistent and often limited.

In Australia, symptoms of dementia are noticed by families, on average, more than 3 years before a firm diagnosis is made. Yet there is sound evidence that addressing modifiable risk factors can help delay the progression of dementia, and that early diagnosis provides opportunity for planning for future care that accords with the individual’s wishes and preferences.

There is a range of factors relevant to delays in diagnosis:

- The insidious and inconsistent nature of early stage dementia poses particular challenges for diagnosis in brief primary care consultations where the GP or other health professional may not observe symptoms.

- Clinical assessment can be difficult, requiring the GP's clinical judgment, and information from the patient and their families, along with the use of screening tests and, in some cases, referrals to specialists.

- Assessment processes often do not fit neatly within the brief consultation periods that can be claimed through the MBS.

- Most general practice teams have had very limited education and skills development relevant to the diagnosis and management of dementia, and can have difficulty recognising and responding to the symptoms of dementia. Further they may be reluctant to make a difficult diagnosis, particularly if they are unaware of the potential benefits of early diagnosis and feel there is no clear benefit from such diagnosis.

The capacity of primary care teams to support patients and their families in managing dementia effectively is also inconsistent and, too commonly, limited.

- GPs and practice teams are often unaware of the relevant RACGP guidelines for managing dementia in general practice

- Though often best placed to perform a service coordination role, practice teams are often are not aware of the availability, or the positive impact of, local support services, and do not work within clearly established care pathways.

- There are not clearly established pathways for specialist referral that are relevant to the local context where specialist availability may be limited.

Education and training for General Practitioners (GPs) and primary health care teams to employ best-practice approaches to diagnosis, assessment and management of dementia in primary care settings is sorely needed, and local primary care and specialist services must be supported to ensure they are well integrated, working in accordance with agreed, evidence-based care pathways. Further, local health services must be networked with local social care services to ensure that patients can access services beneficial to their health and wellbeing.

The Dementia: early diagnosis, better management (EDBM) Project would address these needs by:

- Developing an accredited training package directed at enhancing the skill and confidence of primary health care professionals to work as part of a team to diagnose dementia and deliver care in accordance with best practice. The package would promote an approach to diagnosis, assessment and management that accords with relevant Royal Australian College for General Practitioner (RACGP) guidelines and provide guidance of how to effectively use existing Medicare Benefit Schedule items in implementing a best practice approach. It would involve an interactive,

structured learning format. Modules will be developed in a ready-to-use manner for experienced medical educators, negating the need for a more costly train-the-trainer rollout model.

- Supporting Medicare Locals across the country to map and network services at a regional level to facilitate better integrated care and maximal benefit for the person with dementia and their family from available health and social services, and to work with primary care professionals and specialists to confirm referral pathways that accord with best practice.

- Supporting the national roll out of the accredited training package in a face-to-face delivery mode, through the Medicare Local network. This approach will ensure that that the outcome of local service mapping is incorporated into the workshops to enhance primary health care professionals understanding of locally available services for people with dementia and their carers, and opportunities to link patients in with these services.

- Converting the training package to an online delivery platform and facilitating its uptake by primary health care professionals through a well targeted communications program.

  AGPN's experience in coordinating the development of accredited education and training packages for primary health care professionals indicates that whilst face-to-face delivery modes are most effective in supporting interdisciplinary learning and networking, the option of an alternate online delivery mechanism, when accompanied by an effective marketing campaign, enhances the reach of the education package and supports greater uptake amongst health professionals, including those in rural and remote areas.

The EDBM project would be coordinated by AGPN, working in partnership with Alzheimers' Australia, the ML network, and key clinical and academic experts. AGPN believes that the outcomes of the EDBM project would be maximized if a simultaneous social marketing campaign raising awareness of early symptoms of dementia was undertaken.