

Melbourne Medical Deputising Service (MMDS)

Response to the Australian Government Productivity Commission

Draft Report January 2011

Caring for Older Australians

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1 Introduction

Aged care is indeed an important component of Australia's health system and as such it could be argued that the Draft Report is somewhat limited in that it does not provide details of the type and number of medical services provided to older Australians. This response argues that access to timely and appropriate medical care is an essential component in the quality of life and well-being for older Australians and that the demand for and provision of primary medical care services needs to be examined closely in order to assess the level and effect of unmet demand on the well-being of older Australians.

While the Draft Report explains some of the reasons why GPs do not or rarely visit patients in residential aged care facilities or provide home visits for older patients who are living independently at home, it does not shed any light on who does attend and treat these patients. Rather than in-clinic GPs, it is in fact, after-hours visiting medical officers (VMOs) who attend to these patients on behalf of the patient's usual GP; **the greater proportion of all primary medical care visits to patients in residential aged care are carried out by VMOs**¹. It is well-recognised that as the number of older Australians rises there will be an increase in chronic and complex illnesses and across the board the demand for aged care services will increase. In addition, the recognition of primary medical care as an essential support service will assist the desire of the *majority of older Australians who want to receive care and age in place in their own homes*² and further will ensure that the elderly and frail in residential aged care who are totally dependent upon others for their well being ...

The Draft Report indicates general agreement that there should be greater access to primary medical care for older Australians but offers little in the way design and practical application of programs.

¹ Analysis of Medicare statistics linking individual provider numbers to aged care item numbers would provide specific details in this regard.

² Productivity Commission, *Caring for Older Australians*, Draft Report, January 2011, p. 51

This response from Melbourne Medical Deputising Service (MMDS) refers specifically to the experience in Victoria and includes a proposal that illustrates solutions for particular areas identified in the Productivity Commission's Summary of draft proposals³, specifically the areas are:

1.1 Care and Support

- End of life care (VMOs working with MMDS are regularly involved in the establishment of palliative care regimen and are often the first person to speak to relatives in this regard, MMDS collaborates with care providers in this regard and was integrally involved in the development of *End of Life Pathway* education for GPs under the auspices of the North East Valley Division of General Practice.)
- Improving the interface between aged care and health (the information in the proposal included in this response provides detail about the level of VMO experience regarding the provision of primary medical care for patients in residential aged care and MMDS collaboration with other providers aimed at coordinating services and avoiding unnecessary transfers to hospital.)

1.2 Workforce issues

- There isn't (but ought to be) a draft proposal regarding the need to establish mechanisms and incentives achieve medical practitioner workforce levels that will support improved access to primary medical care. (The proposal included in this response provides detailed information about possible remedies to medical practitioner workforce shortages.)

1.3 Policy research and evaluation

- Improving data collection and access, eg: Chapter 11 outlines some of the obstacles which prevent timely and appropriate access to medical care in residential settings, however, what is missing is information about:

³ Ibid pp LVIII-LXV

- the amount of primary care needed by elderly Australians living at home or in residential aged care
- Who attends to their primary medical care needs
- How many ambulance transfers to hospital would have been more appropriately managed by a doctor's visit
- Among others, The National Ageing Research Institute noted *We don't know what models of community care are most acceptable, effective, cost efficient, and feasible in an Australian context.*⁴

The MMDS proposal included in the response provides the opportunity to *'trial and pilot programs to build evidence'*⁵

2 Overview of Melbourne Medical Deputising Service (MMDS)

MMDS provides urgent primary medical care during the entire out of surgery hours period through the provision of home visits to patients of subscribing general practitioners (GPs). It has been in operation since 1979; is fully accredited by the Royal College of GPs; and approved by the Department of Health and Ageing as an accredited provider in respect of medical practitioner workforce programs⁶ and featured prominently in the 2010 Telstra Business Awards⁷.

At any one time MMDS manages a pool of 75 - 80 VMOs (**Visiting Medical Officers**) who provide primary medical care to patients after hours on behalf of the patient's principal GPs).

3 Number of aged care visits provided by after-hours VMOs

In the past year MMDS doctors attended 110,000 home visits – of this number > 55,000 were to patients in residential aged facilities (RACFs) and 16,811 were to patients over the age of 65 and living independently in their own home. Accordingly, MMDS has valuable knowledge and is well-placed to comment on the access required by older Australians to primary medical care.

Residents in residential aged care facilities (RACFs) are totally dependent on others for all their needs. They are unable to visit their own GP and increasingly rely on VMOs

⁴ Productivity Commission Draft Report *Caring for Older Australians*, January 2011 p. 437 The National Ageing Research Institute submission 260 p. 2

⁵ Ibid p. 441-443

⁶ The Approved Medical Deputising Service (AMDS) Program was established by government to improve after hours VMO workforce

⁷ MMDS won the 2010 Panasonic Medium Business Award; the 2010 Sensis Social Responsibility Award; and the 2010 Victorian Business of the Year Award

(arranged through a medical deputising service) to provide primary medical care in their home environment; the aged care facility. MMDS stats indicate a steadily increasing need for home visits to patients in RACFs.

The community's goal for older Australians to retain their independence, live at home and stay out of residential care for longer is beneficial all round and must not be undermined by a lack of home care services⁸. As MMDS statistics attest (refer graph Number of Home Visits After Hours), many older Victorians living in their own home rely on MMDS because they are unable to attend a clinic when they need medical care. Reasons for this vary, for example, they may not drive or may be too unwell to leave the house (a bout of gastro is not always conducive to travel) or their usual GP may be closed. Also, it's not unusual for older carers to be reluctant to leave the house because their spouse has dementia or is disabled and there isn't another carer available.

MMDS has worked closely with general practitioners for over 30 years and the support it provides enables GPs to coordinate and manage the care of their patients on a 24 hour basis.

4 What prevents aged care visits during the in-hours period

MMDS provides home visits only during the after-hours period (after the GP clinic is closed on weekdays, weekends and public holidays). As things stand, medical deputising services do not provide home visiting services during the 'in-hours' period. They could provide this service (provided it was requested by the patient's GP) but the Medicare rebate is not sufficient for a VMO who, rather than travelling from his nearby clinic is battling today's traffic congestion and paying high prices for petrol to provide domiciliary care.

As mandated by Medicare, the after-hours period commences at 6.00 pm Mon-Fri and requires that the booking for an after-hours visit is made no more than 2 hours prior. This means that a resident in an aged care facility who becomes ill early in the day (and whose GP, for many good reasons, is unable to do a home visit) will have to wait until the after-hours period for medical attention (the exception is an emergency ambulance transfer to hospital which is not always appropriate.⁹)

Other contributing factors relate to increasing in-clinic workloads and GP workforce shortages. A GP whose waiting room is overflowing may see 6 patients an hour. Even

⁸ Australian Healthcare & Hospitals Association, Friday, 2nd May 2008

"The term 'ageing-in-place' implies that an older person is provided with the option of staying in their (own) home and out of a care institution. However, to enable the older person to "age in place" services must be available to meet their needs and to assist them to live independently, so as to avoid or prevent a costly, often traumatic and inappropriate move to a more dependent facility," Dr Barbara Horner, Director, Centre for Research on Ageing, Curtin University, Perth (0409 457 550)

⁹ Many residents in aged care facilities are sent to hospital during the after-hours period as staff at the facility are too busy or not skilled enough to cope with a resident who is unwell. They call an ambulance and send the patient to ED thinking it is the best for the patient. The patient is quite traumatised, waiting for hours on a trolley, busy nursing staff struggle with toileting, keeping the patient comfortable and hydrated. Many times the patient is admitted for a chronic complex problem he has had for years or possibly sent back to the RACF much worse for the experience.

one home visit a day will impact heavily on a GP's capacity to meet the medical care needs of their patient constituency¹⁰. This can be a dilemma for GPs and one that prevents in-hours home visits (and may unwittingly force patients in residential aged care facilities (and others) into the after-hours period).

5 Changing Patterns – fewer GPs visiting patient at home or in residential aged care

As the ageing population increases so does the need for home visits and increasingly home visits are being delivered by medical deputising services rather than local GPs. Medicare item numbers do not differentiate between services delivered by GPs and services delivered by medical deputising services. As a result, the significance of medical deputising within the umbrella of primary medical care in Australia (particularly in regard to older Australians) tends to be invisible. This means that while Medicare can identify the number of after-hours services provided it cannot ascertain whether or not the medical practitioner was a GP or VMO. This inhibits meaningful and accurate analysis of the primary medical care needs of older Australians and clouds the effect of government initiatives aimed at encouraging GPs to do aged care visits.

GPs shortages, increasing in-clinic workloads (many clinics are closing their books to new patients), lifestyle choices about work/life balance are but a few of the issues related to the reduction in home visits by GPs. As a result, older Australians who are house-bound or in residential care and unable to get to a clinic but need medical care be it acute, follow up or routine are currently being forced into the after-hours period through no fault of their own.

6 Who pays for primary medical care services at home or in residential aged care

The clinical components of home visits facilitated by a medical deputising service are covered by the Medicare system of universal access to medical care:

- Patients in RACFs, pensioners and health care card holders are bulk-billed;
- VMOs are paid fee for service by Medicare.

MMDS is a propriety limited company and it bears the full cost of the administration and management of the provision of home visits (including recruitment of medical practitioner workforce, their induction and training for the practice of after-hours home visiting practice and their continuing professional development).

The government bears no cost whatsoever for the administration, management and service delivery costs related to the provision of primary medical care services provided via a medical deputising service.

¹⁰ Six patients in-clinic per hour compare with 2 patients per hour which is the average for a VMO doing home visits.

Notwithstanding that MMDS provides the full range of general practice services¹¹ (albeit after hours) and is fully accredited in line with the Royal Australian College of General Practitioners (RACGP) Standards for General Practices, it is not (nor are other medical deputising services) included in the Practice Incentives Program (PIP)¹² This means that even though individual VMOs working with MMDS do **no fewer than 720**¹³ visits to patients in residential aged care facilities in a year, they are not eligible to receive *Aged Care Access Incentive payments*¹⁴. Whereas individual in-clinic GPs who do 200 visits a year receive a \$5,000.00 incentive payment.¹⁵

7 Summary of Benefits of the MMDS pilot project

- Immediately improve the level of medical care available for residents in aged care and the level of support for the elderly who want to continue to live independently in their own home.
- Redistribute domiciliary visits so they are attended in a timely and appropriate manner (reduce the need to wait until after hours without increasing the volume of calls).
- Utilise available workforce both within MMDS and RACFs more efficiently.
- Decrease numbers of residents in RACFs being sent to public hospitals by ambulance when being seen promptly by a VMO is a more satisfactory outcome not only for the patient but for all stakeholders.
- Improve health outcomes for older Australians - providing aged care residents with medical care in a timely manner, that is, having them seen by a medical practitioner when they first become unwell would result in better health outcomes.
- The MMDS model in particular, aligns with key issues for government in its 2010 report *Investing in the National Health and Hospital Network*: reduce hospital waiting times; improve access to GP services; ensure necessary workforce; improve access to health services for older Australians - everything MMDS does (and has done for more than 30 years) meets/contributes to these government objectives and all without any additional government financial investment.
- In addition, it aligns with a patient-centred approach (key recommendation of the 2020 Summit - health services must be patient-centred).

¹¹ With the exception of immunisation and Pap smears

¹² PIP is a part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by general practitioners (GPs) and the practice, such as patient payments and Medicare rebates. For a practice to be eligible to receive any of the above incentives they must either be accredited, or working towards accreditation for the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practices*.

¹³ This number relates only to VMOs who work part-time – the number is greater in regard to full-time VMOs

¹⁴ Department of Health and Ageing: *GP Aged Care Access Incentive (ACAI) aims to encourage GPs to provide increased and continuing services in Commonwealth-funded Residential Aged Care Facilities (RACFs) and recognises some of the difficulties faced in providing care in these facilities*

¹⁵ Tier 1 payment of \$1500 ... by providing at least 60 eligible MBS services in RACFs in 2010-11; Tier 2 payment of \$3500... by providing at least 140 eligible MBS services in RACFs in 2010-11.

- Enhance the platform already established by MMDS to get GPs re-engaged with aged care.

8 MMDS pilot project to improve access to timely and appropriate primary medical care for the aged

8.1 Objective

To provide medical care, within a proposed budget, to ensure elderly citizens have 24-hour access to appropriate, timely and affordable primary medical care in their own home, be it a residential aged care facility or independent living.

8.2 Summary

Melbourne Medical Deputising Service (MMDS) provides urgent primary medical care via home visits to patients of subscribing general practitioners (GPs) for the entire out of surgery hour's period. In the past year MMDS provided 55,352 consultations for patients in RACF's after hours. This number is increasing annually.

8.2.1 Current Situation

As a result of pressures from a diverse range of factors, a resident in an aged care facility who becomes ill during the day may wait until the after-hours period for medical attention.

8.2.2 The Case for Change

Successful change is based on the understanding that:

- We need to develop service delivery models that are able to respond more appropriately to the health care needs of the community.
- The need for health services to an ageing population with chronic, complex conditions will increase in the future.
- Re-shaping the delivery of health services will utilise available resources more efficiently.
- Treating patients in their own homes will ensure the timely, cost efficient, appropriate and equitable delivery of service.

8.3 Proposal outline

- MMDS proposes to implement a pilot project through which it will extend its current service to include in-hours visits to residents in RACFs and to the elderly who live independently in their own homes. The pilot project is budgeted to provide a total of 16,000 patient attendances over a year.¹⁶
- This would:
 - Immediately improve the level of medical care available for residents in aged care and the level of support for the elderly who want to continue to live independently in their own home.

¹⁶ In the past year, 55,352 of the 110,000 patient attendances at home by MMDS during the after-hours period were to patients in RACFs

- Redistribute domiciliary visits so they are attended in a more timely and appropriate manner.
- Better utilise available workforce both within MMDS and RACFs more efficiently.
- Decrease numbers of residents in RACFs being sent to public hospitals by ambulance when being seen by a general practitioner promptly is a more satisfactory outcome.
- Impact on service delivery to the community during Pandemic outbreaks.
- Enable Government and MMDS to trial this initiative to evaluate
 - patient satisfaction,
 - improvement in health outcomes for patients,
 - a reduction in inappropriate transfer of residents in RACFs to emergency departments due to prompt medical intervention
 - cost savings.
- Provide potential to roll out this initiative to other medical deputising services in Australia which might include a Medicare amendment.

8.3.1 Applicant Details

Melbourne Medical Deputising Service Pty Ltd (MMDS)
Suite 59, 57 Plummer Street, Port Melbourne, Vic 3207
Tel: 03 9429 5677 Fax: 03 9427 1014
Email: josie.adams@mmds.com.au
Website: www.mmds.com.au

Championed by:

Ms Josie Adams Director and CEO, MMDS

- FAIM
- Background in nursing.
- >30 years experience in the after-hours arena with medical deputising service.
- Past Vice President National Association of Medical Deputising Services, NAMDS,
- AGPAL surveyor
- Registered with RABSQA International as a quality assessor for Aged Care Standards and Accreditation Agency,
- RACGP QA & CPD Accredited provider.
- 2008 Finalist Telstra Business Women of the Year

Dr Nicholas Demediuk, Medical Director, MMDS.

- MB BS (Melb), FRACGP, DRANZCOG and BEd (La Trobe).
- Medical Director of MMDS for more than 6 years and oversees all aspects of clinical governance, has hands-on involvement in clinical induction and the evaluation of new doctors and initiates and participates in all clinical continuous quality improvement mechanisms
- Chairman of the Planning Committee for the MMDS QA & CPD Program and is the managing mentor (one of six) of the MMDS Mentor Meetings (Case Study) Program
- GP who manages his own practice (AGPAL accredited and a VMA Registrar Training Practice)
- Works part-time as a Forensic Medical Officer with the Victorian Institute of Forensic Medicine and a Medical Officer with the Custodial Medicine Unit of the Victoria Police
- Chair of the Dandenong Casey General Practice Association
- Other professional appointments include: Professional Services Review Panel ; Victorian WorkCover Authority Panel; member of the AVANT Core Medical Experts Committee; RACGP Victorian Faculty: Board Member and Chair of the Professional Standards Committee and he is a national body representative on various Commonwealth Pathology Committees and Australian Standards Infection Control Committees including national infection control guidelines and sterilisation
- AGPAL as a surveyor and educator
- Publications include the RACGP Infection Control Standards for office based practices, 4th edition, September 2006; the Dandenong District Division of General Practice Policy and Procedure Manual 2003; the Practice Safety and Security Manual 2008 for Dandenong Casey General Practice Association and contributor to the RACGP Pandemic Planning Guide 2009.

8.3.2 Project Team Capabilities

Project Team		
Name	Role	Specialist skills
Patricia Coles	Project Manager	BA (Hons) Econ and Politics, Corporate Affairs Associate Melbourne Medical Deputising Service, Quality Improvement, Accreditation, Policies and Procedures, Recruitment, Compliance and Continuing Professional Development co-ordinator.
Josephine Adams	Director and CEO	FAIM, Executive Director, Melbourne Medical Deputising Service. Australian General Practice Accreditation Limited surveyor, background nursing, 30 years experience in Medical Deputising Service, author Melbourne Medical Deputising Service Policy and Procedures Manual, finalist Telstra Business Woman of the year 2008, Vice President National Association of Medical Deputising Services 2004-2005, 2007-2008.
Julian Adams	Director, Operations and Business Development	GAICD, Director Melbourne Medical Deputising Service. Operations manager, business development and GP liaison. 16 years experience in medical deputising.
Adam Wilson	Director, Operations and Information Communication Technology development	GAICD, Director Melbourne Medical Deputising Service. Operations manager, strategic development of information and communications technology.
Steven Long	IT Programmer	Programmer works on site full time.
Carol Cheung	Chief Finance Officer	Carol Cheong, Certified Practising Accountant Bachelor of Economics and Accountancy (University of Sydney) Finance Manager
Dr Nicholas Demediuk	Clinical Governance	MB BS FRACGP, Dip RACOG BEd Melbourne Medical Deputising Service Medical Director, clinical governance, peer review, mentor, Quality Assurance & Continuing Professional Development principal.
Selected medical practitioners from the MMDS clinical workforce pool	Visiting Medical Officer	Qualified medical practitioners with unconditional Australian medical registration trained and experienced in the provision of primary medical care in domiciliary settings (residential aged care facilities or private home environments)

8.3.3 Capability Overview

The necessary infrastructure, service delivery experience and flexibility already exist within MMDS and a pilot project could be implemented without delay and within the attached budget by seamlessly extending the service model already in place.

1. MMDS is accredited according to the current RACGP Standards for General Practice 3rd Edition 3 (revised).
2. Full clinical governance from two medical directors both Vocationally Registered, are accessible to VMOs, management and GP clients by phone 24 hours a day, 7 days a week.
3. Key personnel are fully qualified and attend continuous education.
4. MMDS has a strong reputation with the RACGP, Divisions GP and Vic DH.
5. MMDS is a preferred alternative service provider for Ambulance Victoria and has worked in partnership with them since 2002.
6. RACGP QA&CPD accredited provider.
7. MMDS runs a robust QA&CPD program that meets all Commonwealth/AMDS and RACGP guidelines.
8. Josie Adams CEO has > 30 years experience in after-hours medical services.
9. MMDS has been providing home visits to patients after hours in the Metropolitan area for >30 years.
10. Melbourne Medical Deputising Service provides comprehensive after-hours medical care via home visits to patients of 3000 general practitioners comprising 650 separate general practices. This represents approximately 65% of all General Practitioners in the Greater Melbourne and Geelong area.
11. ICT Infrastructure and business model capable of delivering the proposed service
12. Flexibility to adapt quickly to changing needs
13. Sophisticated reporting and data analysis capacity
14. Secure electronic downloading of medical reports that meet all Privacy guidelines, to both principal GPs and aged care facilities.
15. Excellent management skills and experience.
16. Fully qualified clinical workforce, recruited from the Australian Health System with Full Medical Registration and Medical Defence.

8.3.4 Why the need for change

The need for primary medical care in a domiciliary setting has steadily increased over recent years. It will continue to do so, particularly in regard to services for the aged, because of insurmountable issues that include but are not limited to, an ageing and rapidly increasing population; shortage of suitably trained aged care staff; workforce shortage in general practice; increase in demand for general practice in-clinic services; increase in complex chronic medical problems; GPs recognition of the importance of a healthy work/life balance; and cultural changes to a 24-hour society.

MMDS has been a consistent advocate for improvement in the level of care available for residents in RACFs. Our proposal has the full support of RACFs, MMDS GP clients, Divisions of General Practice and other stakeholders, capitalises on existing resources and does not conflict or compete with GPs who will continue to be the patient's primary

care manager. Josie Adams (CEO) has consulted with Divisions on projects such as: *Improving care to residents in RACFs; A good death in RACF; Transfer to hospital envelope; and MedGap*

Patients requesting medical care who are unable to attend a clinic due to their condition, house bound or institutionalised patients, disabled, elderly, or are just unable to get a prompt appointment in line with their problem be it acute, follow up or routine are currently being forced into the after-hours period through no fault of their own.

MMDS doctors work after hours – according to Medicare after-hours (Mon-Fri) commences at 6.00 pm - with the booking made not more than 2 hours prior. Accordingly, RACF staff wait until 4.00 pm before calling the after-hours service. This means that a resident in an aged care facility who becomes ill during the day (and whose GP is unable to do a home visit) will have to wait until the after-hours period for medical attention (the exception is an emergency ambulance transfer to hospital which is not always appropriate.)

Providing aged care residents with medical care in a timely manner, that is, having them seen by a general practitioner when they first become unwell would result in better health outcomes for them and would mean urgent after-hours calls could be attended promptly.

With appropriate in-hours remuneration for its clinical workforce, MMDS would be able to attract doctors to work during the day. Clinic GPs may see 6 patients an hour with the comfort and support of clinic infrastructure and staff; whereas VMOs doing home visits during the day will average only 2 patients per hour, supply all medical consumables for the patient and operate without clinical services support. In addition, traffic congestion during the day can be exasperating and certainly more expensive in terms of fuel consumption, while parking is a nightmare.

MMDS has proven experience in domiciliary care and the capacity to expand its current service to include in-hours visits to the aged, in RACFs or in their own homes. A pilot project would assist policy development and provide the foundations for a seamless roll out to other medical deputising services in all States. In addition, it will provide meaningful information about current and future aged-care primary health needs, for the benefit of all health sectors in the community.

8.3.5 Implementation Plan

The pilot (and any future strategy) would capitalise on the existing MMDS workforce as well as the MMDS ICT infrastructure. Vocationally registered doctors from the current MMDS clinical team (and interested others) would be utilised to provide medical services during the day, on behalf of and at the request of general practitioners, to their aged care patients either in RACF's, Hostels or independent living arrangements.

General information and promotion would encourage carers and patients to 'always ring your doctor first' – this ensures that all services are initiated by the patient (not by MMDS

or the attending doctor) and that the patient's GP reserves the right to attend if he/she is available.

MMDS has a well established promotional, communications program which will focus on our target market and include an educative and consultative approach to engage both the general practice community, RACF management and its VMO team.

Continuity of care for all patients is guaranteed through the provision of a comprehensive clinical report of the patient consultation to the patient's regular doctor.

MMDS ICT has the capacity to record special management instructions from the patient's regular doctor for the VMO prior to the consultation.

The MMDS infrastructure would underpin the 'new' service in the same way it now provides domiciliary care to patients during the entire after-hours period. MMDS has the capacity to implement a pilot project or a 'new service' without delay.

The project manager will coordinate a face-to-face meeting with all stakeholders, including both Public and Private Hospitals and Ambulance Victoria to establish and build on relationships. Plus a meeting with the Directors of Nursing (DON) from all residential aged care facilities (or those chosen for a trial) to consult with them about residents needs when it comes to medical care during the in-hours period. The project team will continue to meet with all stakeholders when ever requested or as needed.

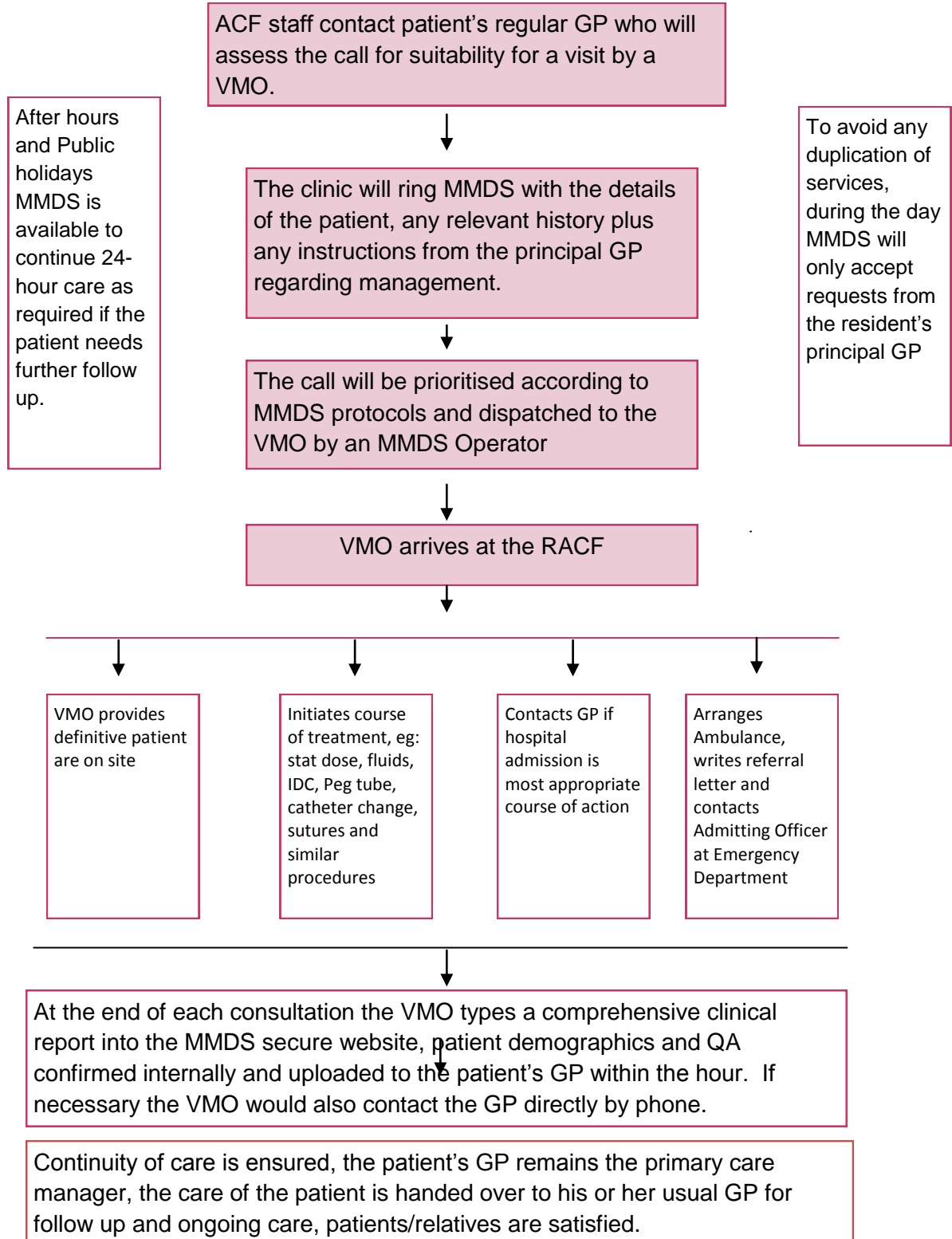
We will enhance our P&P Manual to make sure that all internal staff are trained to make the correct decisions when booking in-hours calls for patients in RACFs or who live independently at home.

MMDS CFO will track all budget items and report on all financial aspects of the proposal and arrange a full audit.

MMDS will adapt its ICT to keep the in-hours service separate from the after-hours service for accurate data and evaluation.

The project manger will report to the Commonwealth on time in line with guidelines.

8.3.6 Flow chart for proposed pilot for non-emergency in-hours primary care



8.3.7 Risk Management.

Melbourne Medical Deputising Service is fully accredited by the Royal Australian College of General Practitioners Standards for General Practice 3rd edition revised. Current accreditation period is to 14 March 2014.

Melbourne Medical Deputising Service Information Communication Technology (ICT) provides clean, accurate data on all activities provided by the service. With an onsite software programmer and systems maintenance and support group all disaster recovery situations are well documented and tested.

All patient health information is encrypted before uploading (in line with Commonwealth and State health records and privacy legislation) and there is off site backup and tested restoration. All telephone conversations inbound and outbound are recorded for quality assurance.

Melbourne Medical Deputising Service has a strong reputation for ensuring the safety of all our doctors. Calls are carefully vetted following mandatory guidelines; there are systems and protocols in place to track each doctor during the shift which are well tested.

MMDS provides all new doctors with a comprehensive induction session and continuing professional development and monthly mentor sessions to ensure patient safety. These sessions are mandatory for all doctors.

The Medical directors are on call 24/7 to assist with unexpected clinical situations. There is a network available for all doctors to contact for advice if necessary, including the patients regular GP.

All MMDS key personnel have longevity in the health services industry, are qualified and attend regular continuing professional development courses.

There are proven processes in place at MMDS to ensure continuous quality assurance.

Abides by all legislation, regulations and guidelines, State and Commonwealth health records and privacy. Complete audit trail and transparency provided through ICT system.

8.3.8 Stakeholder Support

Written expressions of support received from representatives of:

- Our entire GP client base (3000)
- 560 Residential Aged Care Facilities
- Royal Australian College of General Practitioners
- GP Divisions
- Public Hospital Department of Emergency Medicine
- Ambulance Victoria
- Victorian Infectious Diseases Research Laboratory

- Vic DH
- Testimonials from clients, patients, relatives, aged care who have used the service - available on request.

8.3.9 Evaluation

MMDS ICT will enable a thorough audit of the proposed service in a totally transparent manner.

A complete data analysis of all consultations using any criteria requested by the Commonwealth can be delivered. For example:

- Most common conditions (using ICPC – international codes for primary care)
- Time of visit
- Reason for visit
- Age of patient
- Where they were seen
- Transfer to hospital
- Number of visits, hour/day/week/month
- Cancelled calls – reason for cancellation
- Who booked the call
- De-identified for confidentiality
- Graph, raw data, comprehensive spread sheet.

MMDS capability in this regard as previously demonstrated, eg:

During the H1N1 flu 2009 when MMDS data was an integral part of the VIDRL and WHO flu surveillance¹⁷. Minister Roxon thanked MMDS at the Australian Influenza Symposium 2009¹⁸.

MMDS was also able to provide the Health Department Victoria with data to assist with future planning following the Heat Wave in Victoria 2009.

Audit and data analysis through MMDS purpose built software will include but not be limited to:

- Numbers of home visits to ACF patients and elderly citizens during the day and after hours
- Distribution of resources to equal needs of ACF patients and elderly citizens during the day and after hours.
- Track calls which result in transfer from RACF to hospital after assessment by the VMO and provide reason behind disposition to hospital.
- Monitor response times both in-hours and after-hours.

¹⁷ Victorian Infectious Diseases Reference Laboratory and World Health Organisation

¹⁸ (Address by the Hon Nicola Roxon MP - Minister for Health and Ageing, introduced by Ms Mary Murnane, Deputy Secretary Dep. of Health & Ageing)

- Analysis of
 - Patient/relative satisfaction surveys
 - GP satisfaction surveys
 - ACF satisfaction surveys

8.3.10 Budget

Pilot project will cover 16,000 patient attendances during the in-hours period over a 50 week period. Budget with assumptions is on the next page.

March 2011 MMDS Response to Productivity Commission *Caring for Older Australians* Draft Report January 2011

Budget Item	Estimated Total (Year 1 = 50 weeks)	Assumptions
VMOs	1,760,000.00	4 doctors working 8 hours shifts Total of 32 hours GP coverage per day.
		Total number of hours per week 160
		Estimated 2 patient attendances per hour per doctor
		320 patient attendances per week = 16,000 patient visits over pilot period
		Hourly rate for each doctor \$220.00 Cost per week: \$35,200.00 (50 weeks)
Financial Tracking, Reporting and separate audit process	62,400.00	Finance personnel = 16 hours per week @ \$75.00, \$1,200.00 per week (52 weeks inc.s post-pilot acquittal)
Operational Management: in-hours	95,000.00	1 full-time person, 38 hours per @ \$50.00 per hour , \$1,900.00 per week (50 weeks)
Project Manager: in-hours GP and ACF liaison	85,500.00	1 full-time Project Manager, 38 hours per week @ 45.00 per hour, \$1,710.00 per week (50 weeks)
	10,750.00	Vehicle expenses (own vehicle) approx 43 cents per km, 500 km per week = \$215.00 per week. (50 weeks)
Maintain workforce levels across in-hours and after-hours	50,000.00	Recruitment, induction, training and CQI for both clinical and non-clinical personnel
Control Room Operators	134,000.00	2.5 full-time Operators, 38 hour week @ hourly rate \$228.21, (includes on-costs) \$1,072.00 per week. \$53,600.00 per Operator (50 weeks)
Consultation, promotional and advertising costs	25,000.00	Consultation process costs, education material for ACFs and GP clients, in-hours brochures/promotional material; printing and distribution costs
ICT modification	1,980.00	Minimal development of ICT to distinguish day service from after-hours service to ensure transparency with audit for Commonwealth. Modify programming total of 11 hrs @ \$180.00 per hour
Communications	12,090.00	Ph: \$10,000.00; Fx: \$840.00 plus additional internet line 1,250.00 usage and rental.
Funding Total	2,236,720.00	†
*Potential to reduce/offset funding total	-1,213,600.00	2 patient attendances per hr @ 75.85 (Medicare item 35/1 for RACF in-hours visit) = 151.70 per hr. (NB: in-hours private home visit Medicare item 24/1 = 57.05)
		160 hrs p week @ 151.70 = 24,272.00 p wk over 50 weeks = 1,213,600.00
Total	1,023,120.00	In this funding scenario, Ageing is topping up the doctor cost of patient attendance by @34.15 each rather than funding the full cost of doctors.

8.4 Case studies

Meals on Wheels volunteer visits an elderly gentleman who has no next of kin. The volunteer is the only contact this man has during the day. His condition has deteriorated and he is now dizzy and cannot eat; not life threatening but needs to see a doctor. The elderly gentleman is very fearful of going to hospital due to a previous bad experience but agrees that ambulance to hospital may be the only available option. The GP cannot leave the clinic but recommends calling the deputising service. Without the deputising service this would have been a no-win situation - fearful and distressing for the elderly patient, inappropriate ambulance transfer and presentation at hospital emergency department.

Elderly lady home alone requires daily injection for chronic illness – GP has constraints at the clinic which prevent daily home visits. When her own GP can't come and see her, this elderly lady relies on a VMO to come and see her after hours. Patient in aged care facility needs catheter changed, pathology test and possible treatment for infection. The patient's usual GP is in surgery for the afternoon and unable to attend. As a result, the patient will just sit there in pain with blockage until 4.00 pm when staff can arrange a VMO to visit after hours. Nursing staff could send the patient to hospital via ambulance but that's not a good solution. Hospital emergency departments are just that, emergency departments, they are not geared for the management of elderly and chronically ill patients who need regular turning, toileting and fluids – imagine, also, how distressing it must be for this patient a long wait on a trolley in unfamiliar surroundings.

9 Conclusion

In practice, older Australians tend to be disadvantaged when it comes to access timely and appropriate medical care and as consumers, particularly those in residential aged care, may be vulnerable and in need of others to speak and act on their behalf. MMDS believes that the system regarding access to primary medical care for older Australians is failing badly and that it is incumbent upon government to intervene to correct this situation. In addition, MMDS believes that the matter of primary medical services needed and used by older Australians should be closely examined in the context of an inquiry into aged care.

As expressed by a number of aged care associations¹⁹ it is frustrating that the many submissions put before government seem to go unheeded or get stalled in the decision-making process. MMDS urges the Productivity Commission to recommend to government that it trial the simple and efficient solution (underpinned by resources and infrastructure already in place) that MMDS offers – it could be implemented without any delay and would immediately improve access to primary medical care for older Australians.

For further information, please contact Josie Adams, MMDS Director and Chief Executive Officer on 03 9429 5677.

¹⁹ Campaign for Older Australians Forum – Radio National broadcast 15 August 2010