NAMDS National Association for Medical Deputising Services (Australia)

# Medicare Local GP Link model for funding Australian GP managed after-hours care.

## Preamble

The Medicare Local GP Link Payment Model is created by the National Association of Deputising Services (Australia) (NAMDS) to assist the Australian Medical Local Alliance (AMLA) and the 61 Medicare Locals (MLs) in Australia in their implementation of the Governments after-hours reform policies.

The model is supported by all members of NAMDS. Its purpose is to facilitate a:

- seamless patient journey;
- universal patient access;
- ease of accessibility to face-to-face medical care, including home visits where clinically warranted,
- National access to nurse and medical advice via HealthDirect and support of the PCEHR.

The model can be applied wherever medical deputising services exist in Australia (roughly 85% of the national population). Note that where Medical Deputising Services do not exist, NAMDS contends that direct funding of GPs to provide 24/7 patient care must be maintained by Medicare Locals (MLs).

The model establishes the central role of:

(A) Medicare Locals in supporting the 24/7 patient care access to primary medical care in Australia.

(B) The continued authority, accountability and authority of General Practitioners in coordinating 24/7 primary healthcare in Australia.

(D) Maintenance and enhancement of essential continuity of care principles, including accessibility to genuinely available face-to-face medical care 24/7, nurse and medical triage, home nursing, palliative care and extended hours pharmacy.

(E) Development of linkages to HealthDirect and PCEHR compliance for patient reporting by after-hours service providers.

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## Medicare Local GP link Payment Model (MLGPL) for after-hours care in Australia

- MLs get PIP money ($57 million PA) and General Practice after-hours Grant funds ($47 Million PA) from DoHA or around $4.50 per head of population.
- It is accepted that part of the General Practice After Hours (GPAH) grant money may be deployed by MLs to resolve gap and service quality issues while the AH PIP money is used to continue to support existing well-functioning after-hours service providers through the Medicare Local Payments (MLGPL) and GP services to the community.
- Under the MLGPL model, MLs will fund GPs and their stipulated contracted and accredited after-hours care providers:

1. Accredited Medical Deputising Services are funded directly by the ML based upon the number of their contracted FTE GPs. In return the MDS **must provide universal access to after-hours face-to-face medical care including home visits where clinically warranted.**

    - Funding is $2000 per FTE GP contracted per annum (the same that presently applies to PIP Tier 1)
    - MDS tenders need to be called for a minimum of 3 years so that existing services can have some certainty in their ongoing service delivery models
    - Certainty will also allow for capital investments to meet ML local service improvement goals.
    - Prospective service providers must be able to prove to the ML their capacity to provide the level and scope of the after-hours services required: including evidence of capability, a history of effective and efficient service provision to the defined ML community, maintenance of the service to both the RACGP standards and the Commonwealth definition of a Medical Deputising Service, workforce availability, the integrity of their IT and software systems linking after-hours patient reports back to their regular day-time GP and evidence of sufficient capital and expertise to operate the service for the period of the tender.

2. GPs are to be funded $2000 per FTE GP per annum by the ML where their practice undertakes a minimum of 15 hours of **extended after-hours medical practice** in addition to having a contract in place with an accredited MDS providing “out of hours” and “after-hours” coverage during the whole of the defined after-hours period and when practices are closed at other times.

3. GPs are funded $6000 per FTE GP per annum by the ML for providing **24/7 after-hours care within the practice during the whole of the defined after-hours period** (as occurs presently within sub-regional, remote and rural practice). For practices in RA Areas 1, this payment is subject to audit and can only be claimed in arrears after providing documented evidence to the ML of

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after-hours care services being provided directly to patients by each claimant GP within the practice during both the social and unsocial hours.

## Key benefits of the model:

- The MLGPL model maintains the key continuity link of General Practice as the central coordinator of 24/7 care in Australia.
- The model retains the critical link between GPs/patients and their chosen after-hours care providers for ongoing continuity of care. Linkages also need to be provided to 24/7 nurse triage services, after hours doctors' advisory services, mental health services, nurse at home services, palliative care services and extended hours and after hours pharmacy services.
- The model removes cost barriers and barriers to accreditation for GP practices facilitating their connection to accredited after-hours care providers. Under this model a practice does not face any out of pocket expenses for contracted after-hours care support. This therefore increases 24/7 continuity of care through maintaining and/or establishing new links to after hour care by including GP practices not currently covered.
- Maintains equivalent level of funding to existing after-hours care providers and GPs who provide extended after-hours care or who provide genuine access to all after-hours care 24/7.
- After-hours care providers are incentivised to seek out GP practices to connect appropriately and establish the full continuity linkages.
- After-hours providers are only able to provide services to practises when they are appropriately accredited against both the RACGP standards and the Commonwealth approved definition of a Medical Deputising Service. Additionally, the ML is able to liaise with local primary care providers, ascertain desired service quality improvement initiatives and then encourage improved services via the tendering process, thus improving after-hours service access and quality.
- All patient have access to after-hours care.
- Where a patient either does not have a regular GP or that GP has elected not to provide after-hours cover (and is thus not accredited) the patient report can be transmitted to the patients PCEHR (subject to patient consent)

## The MLGPL model maintains the key continuity link of General Practice as the key coordinator of 24/7 care in Australia.

1 MLs become the fund-holder and fund distributor to General Practices for AHPMC (instead of it being funded via the PIP and DoHA).

2 The general practice (and any accredited after-hours provider they choose) remains the after-hours service provider to patients.

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3 The Medicare Local sets the after-hours standards for providers allowing them to access ongoing funding and carries out an audit function to ensure accreditation compliance, provision of genuine access to care for patients during the whole of the defined after-hours period and carrying out other matters as mandated by the ML to meet local needs.

4 The MLGPL preserves all the good aspects of the Australian GP managed primary health care system and avoids all the risks associated with GP abandonment of 24/7 care responsibility.

5 The MLGPL will maintain GP practise commitment to extended hours general practice.

6 The MLGPL payment model establishes Medicare Locals as organisations that support and compliment General Practice, confirms General Practice as the primary coordinator of 24/7 patient care and provides a platform for the provision of universally accessible after-hours care to patients.

7 MLs and AMLA would then carry out additional audit and standards work to ensure:

- Universally accessible after-hours care access for the community
- Service providers meeting RACGP/ACCRM standards
- High standards of AH providers (in accordance with RACGP standards and Commonwealth approved MDS definitions)
- Coordination with HealthDirect
- Linkages to Ambulance services
- PCEHR compliance, including the posting of after-hours patient reports to the patients PCEHR (subject to patient consent)
- In accordance with ML local requirements, improved access for ACF/Frail-aged and house-bound patient care.
- Other matters as determined by the ML that relate to local requirements and identified gaps

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