RACGP

Royal Australian College *of* General Practitioners

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Our Healthcare Future- Consultation Responses

The Tasmania Faculty of the RACGP thanks the Tasmanian State Government for the opportunity to respond to the *Our Healthcare Future* consultation questions. Our basic points are as follows:

- Future Healthcare investment – we see the need for the Government to pivot away from bricks and mortar investments to people, systems, communication and IT system investment. This will ensure that primary health care remains sustainable and adaptive. We would like to see the Government partner further with General Practice as a way of preventing illness and keeping people in their communities and out of the hospital system.

- General Practice is patient centred, provides whole of life, coordinated and efficient health care. The infrastructure and work force teams for General Practice already are in place and so we would ask the Government to leverage off the existing services to improve patient access and coordinate patient health care – providing the right care in the right place, at the right time.

- We would ask that funding be redirected away from the Urgent Care Centre model by offering grants to existing General Practices to enable them to extend their scope and extend their operating hours. The staffing and infrastructure is already in place in General Practices and this will provide an opportunity to leverage existing local provider relationships.

- We would request a grant to fund 'Community Nurse Coordinators' within General Practices to coordinate the right care in the right place, at the right time. This would help patients with poor health literacy or complex conditions to navigate their local health pathways – e.g. referral to social worker, community nurse, mental health services, and physiotherapy. The Community Nurse Coordinator could also coordinate discharge planning with GP follow-up including relevant discharge information. There is no current funding stream for a Community Nurse Coordinator and so we would suggest that rather than funding specialist physicians to become embedded into General Practice, that this money be used to fund Community Nurse Coordinators, which will improve the patient experience.

Reform Initiative 1 – Consultation Questions and Responses

1. Q. How can we target better our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?

   A. More funding needs to go to primary healthcare – most healthcare is delivered outside of the hospitals, in GP rooms, so more funding is required to improve these services with preventative care to care for patients in their homes and therefore keep patients out of hospitals. Funding for chronic disease management, better IT communication between the hospitals and general practice, and out of hours funding would all help to keep patients in the community and reduce the load on the hospital system

   Current investment in hospital beds is more heavily weighted to the south of the state however Launceston is known to have a greater number of ED presentations than Hobart and ongoing issues

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with bed block so if beds are a part of the spend, then more beds are needed in the north.

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2. Q. How can we shift the focus from hospital- based care to better community care in the community?

A. The ComRRS model works very well in the north to keep people at home rather than in the ED. General Practice and nursing homes can refer to the ComRRS program and this is a great support to general practice allowing patients who might normally be admitted to hospital, to be managed in their own homes.

ED presentations tend to peak between 5pm and 10pm and then drop off after about 11pm, so if General Practice was funded to work longer hours (say to 9pm) and then be on call after hours, this would prevent many admissions to the ED. We would suggest that this is run as a pilot model – rather than putting funding into Urgent Care Centres.

Better funding for consulting medicine and chronic disease management for GPs in the community would further support this as previously highlighted.

We do not support the concept of embedding specialist physicians into General Practice for several reasons:

There are very few general medicine physicians any more and so finding these to work in General Practice will be very difficult.
The GPs are able to do virtually everything a specialist physician can do and so having an embedded physician would be of no additional benefit – other than provide easy access to a second opinion.

We believe that it would be better to have easier access to specialists who can take a quick call from the GP and provide an answer simply and quickly.

We propose a smoother transition process between inpatient care and outpatient GP care that includes GPs as part of the discharge planning.

3. Q. How can we facilitate increased access to primary healthcare in particular:
   a. After hours and on weekends
   b. in rural and regional areas
   c. for low-income and vulnerable clients
   d. for extended treatment options (e.g. urgent care or non-emergency care)

A. Grant funding for out of hours work – when working out of normal business hours, the costs to general practice increase exponentially. Although there are MBS item numbers for out of hours work, the costs to the practice of providing nursing cover and administrative support are way higher than during

business hours – making it financially non-viable. A grant to cover this additional cost would allow general practice to operate outside of normal hours and would help to reduce admissions to the ED. This may also allow GPs to bulk bill or have a reduced gap for low income and vulnerable clients. We believe that running a pilot model of after-hours care by GPs that is funded to do so, will provide clear evidence of whether this is better done as an after-hours model from a GP who has existing relationships to their patients, rather than an urgent care centre.

4. Q. The UCC Feasibility Report 2019 identifies UCCs as a feasible service model for Tasmania. Are there other barriers and opportunities for implementing a model of urgent care in Tasmania not identified in the studies?

   A. The issue with the UCCs will be finding staff to work there. We believe that it would be better to provide grant funding to general practice to run their own walk- in, out of hour's clinics. The local GPs already have relationships with their patients and with local providers and other specialists and so, the management of the patients in a familiar environment with their own doctors would be of much more benefit and prevent further segmentation of care. The government is proposing that there would be a saving of $100 million by increasing community based care but we believe the modelling for this requires further work and it may well be more successful and likely cost-effective to provide grant funding to general practices that are keen to run an out of hours walk-in clinic with practice nurses and administrative support.

5. Q, How can we make better use of telehealth so people can receive care closer to home, and what are the barriers preventing the use of telehealth?

   A. Telehealth should be provided by the patient's usual general practice and not corporate telehealth-providers who may be based in other states. This ensures that the relationship between the patient and their GP remains strong and the GP is able to provide optimal care for their patients. This would ensure that Telehealth would support usual patient care and not surpass the important need for face to face consultation as needed.

   Barriers are minimal – telehealth can be done either by just phone or by video call and most mobile phones are able to do video calls. Obviously if the GP has a telehealth consultation with a patient and is concerned, they will request the patient come in to the practice for a face-to-face consultation.

6. How can we make better use of our District Hospitals to enable maximum utilisation of beds in these facilities as a step-down from public hospitals and a step-up from the community to improve patient flow in acute hospitals and care in the community?

   A. Most district hospitals have a limited number of beds and they are medically managed by a local general practice with on-call VMOs. Many of the rural general practices are using locums to provide continuous cover of the district hospital and provide general practice cover. Increasing the number of patients in the hospital will take GPs away from their daily practices and once a patient has been admitted to the hospital, the GP is no longer able to bill Medicare for any services provided – e.g. daily ward rounds. Improving the funding model for the GPs providing care in the district hospitals would be of benefit.

   Most district hospitals also run with a very low nursing ratio and this would need to change also if there was to be any increase in patient numbers.

If District Hospitals were to be used as Rehabilitation Hospitals between full hospitalisation and home care, then the model of the hospitals would need to change and the staffing model would also need to change and to include allied health and facilities required by Allied Health teams – e.g. gyms, hydrotherapy pools etc and nurses trained in rehabilitation medicine. Careful handover and discharge planning from bigger centres to these Rehabilitation Hospitals would need to take place.

7. Q. How can we improve integration across all parts of our health care system and its key interfaces (e.g. primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?

   A. With improved IT systems to allow a more rapid, free flow of information both from the hospital system to primary health, aged care etc. (e.g. on discharge), and from primary health, aged care etc. in to the hospital (e.g. for admissions/ transfers). IT systems would need to be designed and developed by an external IT company to provide agile, cost effective solutions. A new IT system is required – not just patches to the existing system, which is not functioning.

8. Q. How can we strengthen the interface between hospital services and aged care to improve community healthcare for older Australians?

   A. By improving the IT systems in the hospital to allow GPs to dial in to the THS to look up their patients' records and quickly know the medications the patient is now on and the care provided during the patient admission – this would save many hours where the GP needs to phone the hospital and chase up results and avoid possible re-admissions where GPs are unable to find the information they need and feel that the safest option for the patient is to be hospitalised

9. Q. How can we make the best use of co-located private hospitals to avoid public hospital presentations and admissions (by privately insured patients)?

   A. Co-located private hospitals require a functioning Emergency Department in order to triage +/- admit private patients. In the North of the State, previous experiences with ED in Calvary have been unsuccessful due to a lack of appropriately trained Emergency Specialists willing to provide 24-hour cover, as well as a lack of patient numbers to ensure financial viability. To encourage the use of these facilities by privately insured patients, an agreement between the State and Private hospital providers, as well as insurers, would need to occur to ensure adequate recruitment and retention of doctors, as well as improving current infrastructure and equipment to extend available services. It is likely that the State would be required to contribute financially to ensure a functional Emergency Department with ongoing costs of patient admission to be borne by the Insurer/ Patient.

10. Q. How can we build health literacy, self- management and preventative health approaches in to the day-to-day practices of our health services across the whole of the health system?

    A. State Government to fund a linking person to plug patients in to the various services available in the community. A nurse to run this coordinating role and be aware of all the services available – e.g. for psych patients. Health literacy needs to start with young children and the school is an obvious starting point for learning about health, eating well, exercise, not to smoke, be sun smart etc.
    Ultimately, consulting medicine needs to be better renumerated so that GPs can take the time to incorporate all of these aspects in to patient care. Unfortunately due to the poor renumeration of items

23 and 36 and subsequent time pressures around consultations, these aspects run the risk of being missed or not explored thoroughly despite GPs being the best place people to provide this advice/education.

11. Q. How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute, community, primary and private?

    A. Look at the model of health literacy training provided to schoolchildren in NSW and QLD – Life Education with Healthy Harold. This bus travels to every school through each year of education and provides interactive education around health issues such as healthy eating, exercise, smoking, alcohol etc. The children all look forward to their Healthy Harold visit each year. Healthy Harold is a big giraffe and mascot for the program. www.lifeeducation.org.au

12. Q. How to we provide clear pathways into our health system so that patients are accessing the most appropriate care for them?

    A. Keep General Practice as the centre point of the health system. The GP can refer patients on to other specialties; allied health, hospital services, pathology etc. and the GP will be able to coordinate the total care of the patients.

Reform Initiative 2 – Consultation responses

1. Q. How can we best target our digital investment to improve the timely sharing of patient information across key health interfaces?

   A. Have a new system designed and developed by an external IT company. Should allow GPs to be able to log in to the THS system to access patient information about their patients who have been discharged or who are being admitted. To access discharge summaries.
   The new system should allow seamless communication across the hospital system – all departments. So the physio dept. should be able to see the patient notes online as should the specialist clinics etc.

2. Q. What digitisation opportunities should be prioritised in a Health ICT Plan 2020-2030 and why?

   A. Communication into and out of the hospital for improved communication with General Practice. The reason for this is to end avoidable admissions where a greater understanding of patient medication, condition, tests undertaken (with results) and treatment while an inpatient could allow the GPs to provide continued care and to avoid doubling up on tests and possible medication errors.

3. Q. What information should be prioritised for addition to the My Health Record to assist clinicians in treating patients across various health settings (e.g. GP rooms, Hospital in the home, Hospital Specialist Outpatients)?

A. Updated medications list; recent tests and results, as well as correspondence from other treating doctors and allied health staff.
List of planned outpatient appointments, referrals in the system and estimates of wait list times based on triage category

4. Q. What are the opportunities to develop a digital interface between hospitals and other care providers (such as GP, aged care and the private system) to improve the timely sharing of patient information?

   A. The private sector (e.g. GP practices, private hospitals, private rooms and nursing homes) are already using software that allows encrypted communication between parties for sharing of patient information, referral letters etc. (e.g. Healthlink). There remains space and the opportunity for the public sector to liaise with the private sector in adopting platforms that already exist, or alternatively develop new technologies that could be integrated within current systems in order to improve communication between hospitals and the private sector.

5. What information would help to improve your experience as a patient or consumer interfacing with public hospital or health services in Tasmania?

   A. To know what medications and what doses you are on following discharge. To know what your test results were and to understand what treatment you received in hospital and why – and to know that this information has been shared with your GP. To understand what appointments have been made for you for follow up and why these are important to attend.

6. Q. What technology would best help you to deliver improved patient outcomes?

   A. Software that allows secure access by the GP to a patients' digital hospital record.

7. Q. How can we use technology to empower patients with their own self-care?

   A. Using smart devices which record health status such as Weight, HR, BP, food diaries (and more as these develop) to allow this information to be sent directly to the GP if it is outside normal ranges. Most primary care facilities already engage in recall and reminder systems to improve regular patient engagement with the healthcare sector (and thereby improve their self-care).

8. Q. What is the key paper or manual administrative process that would provide the most benefit to digitise/ bring online?

   A. The hospital discharge summary.

Reform 3a – Consultation responses:

1. Q. What are the major priorities that should be considered in the development of a 20-year infrastructure strategy to ensure the right care is provided in the right place at the right time?

   A. Health planning and clinical governance has traditionally come from those involved in the public hospital system. By providing an equal voice for representatives in health provision across all sectors , across the entire state, including primary and community care, as well as in the private sector, the focus is likely to shift back to preventative health care and building on existing primary care capacity, thereby reducing future costs of healthcare delivered in the tertiary sector and reducing the strain on hospitals.

2. Q. How should the Government ensure we achieve the right balance of infrastructure investment across the range of care settings including acute, subacute and care delivered in the community?

   A. Health service planning and delivery requires a community voice, with representatives drown from all demographics and geographical areas. The establishment of a state-wide consumer group would afford the opportunity for communities to adequately be represented in present ideas and recommendations to at state-wide Clinical senate.

3. Q. How do we ensure current facilities continue to be invested in appropriately so they continue to be fit-for-purpose, including during the COVID-19 pandemic?

   A. Ongoing grants to support clinics to allow clinics to continue to upgrade their infection control infrastructure and PPE.

   Continue to liaise with hospital staff to improve patient flow through the Emergency Department. This may require funding additional clinical coordination positions to ensure that after triage and initial treatment, patients can be directed on to an appropriate area in a timely fashion, preventing ramping of ambulances etc. This may mean more investment in funding Acute Medical Units, more funding for existing wards, or increasing the funding and scope of services such as ComRRS, whereby patients may be referred directly to their service from Emergency so they can continue the rest of their treatment at home (e.g. with IV antibiotics etc.).

4. What are the key factors that should be considered in the development of modern health facilities in a community setting – e.g. location, proximity to other community services?

   A. Consultation with local private businesses (i.e. General Practices) to inform the needs analysis of each area. Many appropriate community health facilities already exist, though access to their services is limited by a lack of available clinicians (e.g. physiotherapists) to keep the majority of care provision in the community.

5. Q. How do we integrate our capital investment planning with the private sector to help complement and /or supplement the public system?

   A. Grants to General Practice to help develop clinics to allow for more segregation of infectious and non-

infectious patients.
Ensure adequate supplies of PPE available to all health workers at all times.
IT systems that allow GPs to log on to THS and access their patient discharge summaries, med charts etc. – at any time of the day or weekend.

Reform Initiative 3b – Consultation responses:

1. Q. How should the Health Workforce 2040 strategy be further refined to guide and inform the development of a strong and sustainable professional workforce that is aligned to meeting the future health needs of Tasmanians?

   A. We feel that all hospital doctors should be required to do a term in General Practice to increase the understanding of general practice and to create a more understanding and collaborative workforce.

2. How do we work with the private sector and primary care, as well as other levels of government, to ensure our combined workforce serves the future needs of our community?

   A. Ensure that general practice is financially sustainable. Increase Medicare rebates. Govt grants to general practices wishing to take on evenings to help take the burden off our hospitals.

3. Q. What steps can be taken to improve the State's ability to attract and retain health professionals in regional areas, particularly in the North-West?

   A. Saunders Street Medical Clinic in Wynyard has just won the RACGP National Practice of the Year and is a shining example of how to attract and retain health professionals in the north-west. The practice is innovative and designed to look like a trendy café where people feel welcome and comfortable. The staff link in with local school children from year 9 onwards to bring them in to the clinic to learn about what jobs are available in general practice – medicine, nursing, physiotherapy, exercise physiology, admin work etc. Then the clinic takes on medical students, then registrars – so builds a workforce pipeline. This practice also takes genuine care of their workforce. The clinic closes for an hour each day and the team sit at a big table and have lunch together – great opportunity to debrief, ask for help, discuss concerns and to relax and enjoy collegial time. Patients often come to the clinic to sit by the fire and read a book – even when they don't' have an appointment – so it has become a vital hub in the community. Ongoing education is an important part of the clinic.
   We need to introduce the concept to school aged children and help them achieve the marks at school to enter the training at university. Why be a rural GP? Work/ life balance, great opportunities for life outside of work, experience some of Tasmania's most pristine areas.
   We need general practices to take medical students and give them a great experience - particularly in rural areas.
   We need to give registrars interesting work, excellent supervisors and to show them the lifestyle benefits of rural general practice.
   Wellbeing of our workforce is vital – making sure doctors can take holidays, debrief from stressful situations, are supported by their co-workers.

4. Q. What innovations or changes are needed to our health workforce to more closely align our professional health teams with the future needs of Tasmanians?

   A. increased focus on preventative medicine – population is ageing and overweight, unwell and has multiple co-morbidities.
   An understanding that the Tasmanian population is the oldest, sickest, obese and least health literate in Australia.

5. Q. How do we support health professionals to work to their full scope of practice?

   A. Opportunities for post-graduate learning.
   Support around Doctor care and Medical Board legislation that supports Doctors seeking help when not well.

6. Q. How do we support Tasmanians to access the education and training they need to be part of the State's future workforce?

   A. Encouraging school students to take on STEM subjects;
   Early exposure to what a life as a Doctor, Nurse, Physio, Optometrist, OT etc. could look like to stimulate interest in the health career pathways;
   Consider running post graduate Masters degrees in allied health – Physiotherapy, Occupational Therapy, so that we are not losing these students to mainland universities as we do not teach these courses in Tasmania.
   Ensure that junior doctors are treated well in the public health system during their intern and RMO years – anecdotally we hear concerning stories about young doctors being overworked, treated terribly by their co-workers and this needs to change urgently.

Reform Initiative 3c – Consultation responses:

1) Q. How could a Statewide Clinical Senate assist in providing advice to guide health planning in Tasmania?

   A. Health planning and clinical governance has traditionally come from those involved in the public hospital system. By providing an equal voice to representatives in health provision across all sectors across the entire state, including primary and community care, as well as the private sector, the focus is likely to shift back to preventative health care and building on existing primary care capacity, thereby reducing future costs of healthcare delivered in the tertiary sector and reducing the strain on hospitals.

2) Q. How can we better engage meaningfully and effectively with consumers and other key stakeholders in health service planning, delivery and quality improvement?

   A. Health service planning and delivery requires a community voice, with representatives drawn from all demographics and geographical areas. The establishment of a state- wide consumer group would afford the opportunity for communities to be adequately represented in presenting ideas and recommendations to a

state- wide Clinical Senate.

3) How can we strengthen and optimise consumer engagement and participation at all levels of healthcare including:
   a) Personal: participation and engagement in a person's own care

   b) Local: participation and engagement in service improvement at a local level

   c) Policy and service system; participation and engagement in planning, developing, reviewing, evaluating and reforming services at a system level?
   A a) Much of this has been covered in responses 11 and 12 in Reform Initiative 1. Consumers are already more engaged with their healthcare through access to information previously out of reach, through sites as the Better Healthcare Channel and the Royal Children's Hospital patient information. Similar Tasmanian sites for consumers exist, though they are fragmented and difficult to navigate.
   b) As mentioned above, encouraging a forum to allow a consumer voice though adequate representation will allow feedback and improvement at a local level.
   c) Again this may be best served by the establishment of a state-wide consumer group to feedback to a state-wide Clinical group.

4) Q. Are there particular models of consumer engagement and participation that we should consider?

   A. As well as a state- wide consumer group, open forums (online or in-person), collation and publication of considered feedback from consumer groups regarding existing services, and regular meetings between clinicians, policy makers and consumers to strategise implementation of proposed improvements would see improved engagement between all three groups and improvement in service provision.

5) Q. How can we improve opportunities for consumers to feed back on their healthcare including following discharge from care?

   A. GPs will generally see the patients following hospital discharge and this is a good time to discuss the admission, treatment and how they plan to improve their health going forward and develop ongoing health care goals. A feedback loop to hospital care would be useful as they often miss out on relevant assessment of their care.

6) Q. How do we strengthen education and training for health professionals and health policy makers and planners in relation to the importance of consumer engagement and participation across all levels of health care?

   A. Most health professionals in the private sector already realise the importance of consumer engagement and participation in health care, and use feedback from consumers to build on and strengthen existing

services, or alternatively develop new models to improve services. This enhances consumer satisfaction, improves profitability, promotes efficiency and improves overall health outcomes by fostering effective relationships between clinician and consumer, making the patient a partner in their own healthcare. Though much more difficult to achieve in larger public health services, there remains the opportunity for public health professions and policy makers to improve engagement with consumers (e.g. having dedicated personnel to collate patient feedback, ideas for improvement etc. and present to relevant parties), which will improve health outcomes.

7) Q. What format would be best to engage our future health leaders?

A. Given the need to encourage future health leaders to engage with colleagues from around the State, web-based meetings and forums would allow the highest number of participatns to ensure adequate representation from all stakeholders.