Uptake of health assessments, care plans and case conferences by general practitioners through the Enhanced Primary Care program between November 1999 and October 2001

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Abstract

We aimed to describe the uptake of the Enhanced Primary Care (EPC) item numbers listed on the Medicare Benefits Schedule for health assessment (HA), care plan (CP) and case conference (CC) between November 1999 (when these items first became available) and October 2001. We used data provided by the Commonwealth Department of Health and Ageing. General practitioners rendered 371,409 EPC services in all. Most services were HA (225,353; 61%), most of the remainder were CP (134,688; 36%), and CC comprised the rest (11,368; 3%). The number of HA done increased steadily and has stabilised at around 13,000 HA per month. Most CP done (80%) were in the community and with the GP preparing the plan. From a slow start, the number of CP done increased rapidly in 2001 to about 15,000 per month. There has been a slow and steady increase in the number of CC done each month, reaching 8-900 per month. Uptake of the EPC item numbers in the first two years of their availability has been rapid and has reached substantial levels, especially for HA and CP. The uptake of CC has been slower.

The Enhanced Primary Care package

The Enhanced Primary Care (EPC) package was launched by the Federal Government in the 1999 budget. The aim of the EPC package is to improve the health and the quality of life of older Australians, of people with chronic conditions, and of those with multidisciplinary care needs (Commonwealth Department of Health and Aged Care, 1999). The EPC package comprises a range of initiatives including additional coordinated care trials, chronic disease self-management demonstration projects, establishment of Carelink, and the introduction of new EPC items on the Medicare Benefits Schedule (MBS).

The EPC MBS items allow general practitioners (GPs) to undertake or participate in activities that support the broad aims of the EPC package. Specifically these activities comprise health assessments for older people, care planning for patients with chronic, complex and on-going care needs, and also multi-disciplinary case conferencing (Commonwealth Department of Health and Aged Care, 1999).

The EPC MBS items were introduced in November 1999 and initially comprised 21 new items. To support their introduction and to promote their uptake, a broad program of GP Education, Support and Community Linkage was undertaken, primarily through Divisions of General Practice (Commonwealth Department of Health and Aged Care, 1999). Amendments were made to the MBS items in November 2000 to expand access to residents of aged care facilities (www.health.gov.au/epc/index.htm).

We are conducting a national evaluation of the uptake of the EPC MBS items under contract to the Commonwealth Department of Health and Ageing (DoHA). As part of this evaluation we are analysing in detail patterns of EPC MBS item uptake in the first two years of the program. Here we report on trends in uptake of items for health assessment (HA), care plans (CP) and case conferences (CC), between November 1999 and October 2001.

Methods

Data source

The General Practice Branch of DoHA provided us with de-identified unit record data relating to each EPC service rendered between 1 November 1999 and 31 October 2001, and claimed through the Health Insurance Commission (HIC) prior to 31 December 2001. Data were provided under the strict confidentiality provisions of paragraph 130(3)(a) of the Health Insurance Act. Services funded throughthe DVA system were not included as we were unable to access the relevant data.

It is usual to allow a three- or four-month lag between a MBS service being provided and the data being processed by the HIC to allow for the time taken for patients to make a claim for reimbursement through a Medicare Office. However most (96%) EPC items are billed directly to HIC by the provider ("bulk-billed") and the lag in these instances is significantly reduced. The average lag between service occurring and being processed for all bulk-billed services was 16.5 days during 2000/01 (Health Insurance Commission, 2001a, Health Insurance Commission, 2001b). As such our data set is expected to be complete.

Date of service data was used in these analyses and hence our results differ slightly from most other reports based on HIC data. In particular, the monthly numbers of services that we report will not tally with those on the HIC web site, or with reports that Divisions of General practice have on EPC activity. The HIC traditionally uses "date of processing" data because it is a lot easier. The advantages of using date of service data (as we did) are (1) it is more interesting to know exactly when the service occurred and (2) this approach avoids some artefact patterns that can appear when using date of processing data. For example there are often troughs in April due to the number of public holidays and school holidays.

EPC services, patient and practitioner details

EPC services included item numbers in the November 2000 Medicare Benefit Schedule (MBS) groups A14 Health Assessments (items 700 to 706), and A15 Multidisciplinary Care Plans and Case Conferences (items 720 to 815). We excluded items relating to services by consultant physicians (items 800 to 815).

Each patient, doctor and practice (for those GPs registered with the Practice Incentives Program [PIP] during the period of study) associated with an EPC service was given a scrambled identifier by DoHA. Each record contained information on the age and gender of the patient. Provider information for each record included age, gender, the year of basic qualification, postcode of practice location, Division of General Practice, and number of non-referred attendances (NRAs) in 12 months to 30 June 2001.

Results

In the first two years of the availability of the EPC MBS items, GPs rendered a total of 371,409 EPC services (Table 1). Most of these EPC services were health assessments (225,353; 61%), most of the remainder were care plans (134,688; 36%), and case conferences comprised the balance (11,368; 3%).

Health assessments

Of the 225,353 health assessments done in the first two years of the program, 99% (223,420) were for non-Indigenous people. Overall, most (129,749; 58%) were done in the GP's rooms. For Indigenous people, a higher proportion (64%) was done in rooms (Table 1).

The monthly number of health assessments done increased progressively from about 4000 in the first month of availability to about 7000 six months later, and stabilized at around 13,000 per month between the middle and the end of 2001 (Table 2, Figure 1).

Whereas in the early months of the EPC program about twice as many health assessments were done in the GP's rooms as were done at home, by mid-2001 only slightly more were done in rooms (Table 2, Figure 1).

Care plans

Of the 134,688 care plans done in the first two years of the program most (107,181; 80%) were done in the community and with the general practitioner preparing the care plan (Table 1). Most of the rest (20,371; 15%) were review of a care plan.

The monthly number of care plans done was a few hundred in the first few months of the EPC program, gradually increasing to 1000 to 2000 per month by the end of 2000 (Table 3, Figure 2). In early 2001 the monthly number of care plans done increased more rapidly to 4-6000 per month and reached around 15,000 per month in late 2001 (Figure 3). This rapid increase followed the introduction of a special payment as part of PIP to encourage uptake of care plans and case conferences.

Case conferences

Of the 11,368 case conferences done in the first two years of the EPC program most have been based in the community with the GP in organise and participate roles, for different consultation durations (Tables 1, 4 and 5). Prior to the introduction of the residential aged care MBS items in November 2000, 2-300 case conferences (of all types) were done per month. This increased to about 6-700 per month (excluding residential aged care) and to about 8-900 per month (including residential aged care) in mid to late 2001.

Discussion

These data demonstrate the rapid uptake in the number of health assessments, care plans and - to a lesser extent - case conferences in the first two years of the Enhanced Primary Care program, implemented in November 1999. Health assessments were taken up most quickly and reached high and stable monthly levels first. Care plan numbers reached even higher monthly levels, but only after the introduction of special PIP payments to encourage their uptake, and that of case conferences. Numbers of case conferences remained lower, increasing more after the introduction of case conferences to support care of residents of aged care facilities.

It is perhaps expected that health assessments of non-Indigenous people aged 75 years and above, and Indigenous people aged 55 years and above, were taken up first and at higher levels. Health assessments require only the GP to be involved, in comparison with care plans and case conferences that both require at least another two health workers to be involved. Furthermore, health assessments can be done by a nurse on behalf of, and under the supervision of the GP. Care plans and case conferences require the direct involvement of the GP, and cannot be substituted by a nurse or other practitioner.

Health assessments were initially done in much larger number in the GP's rooms than in the patient's home. This may reflect the ease of conducting an assessment in the consulting rooms (the patient coming to the GP), and perhaps the opportunistic assessment of older people who attend their GP for other reasons. It is of interest that in the second year, almost equal numbers of heath assessments were done in rooms and at the patient's home. This perhaps reflects the time it has taken some medical practices to recruit and train practice nurses to conduct health assessments at home; the delay in reaching patients who are more home-bound and less likely to attend the GP's rooms for a consultation; and an ability to get the practice and business systems in place to conduct assessments at home and in rooms. Aspects of GP's views about the implementation of the EPC items have previously been identified (Blakeman et al 2001), and follow up of GPs in this evaluation indicated the need for organizational and service developments across medical practices, Divisions of General Practice and associated health services (Blakeman et al 2002).

While the value of routine health assessments for older people is still being debated it seems that this intervention does confer some benefit. A recent systematic review of 15 randomized controlled trials of home visiting that offered health promotion and preventive care to older people showed that home visits reduced mortality and admission to nursing homes, but not to hospital (Elkan et al 2001). In contrast an earlier review demonstrated no effect of the intervention (Van Haastregt 2000). The difference has been attributed to different methodologies in the two reviews. It has been noted that "... the challenge now is to tease out which components of the intervention are effective and which populations are most likely to benefit" (Eggar 2001).

It is notable that only 1% of all health assessments were done among Indigenous people, whereas Indigenous people make up more than 2% of the population and have a significantly lower health status. On the face of it this suggests that Indigenous people may have been disadvantaged in terms of health assessment uptake. However, it has been suggested that many eligible Indigenous people have already had case conferences and care plans done, through (for example) Aboriginal Medical Services, outside the EPC program, and hence perhaps are not perceived to need a HA. It will be important to monitor this closely to ensure that Indigenous people - and their medical service providers, who potentially have much to gain from the EPC program, are not unduly disadvantaged.

As noted above care plans and case conferences require the involvement of at least two more health workers, in addition to the GP. It is of interest that the number of care plans only increased substantially after DoHA provided an extra incentive payment, through PIP for practices that met a target number of services (Commonwealth Department of Health and Aged Care 2001). Following the clear success of this incentive, these PIP payments have now been withdrawn. It will be interesting to see whether the number of care plans done continues at present levels, now that systems and processes to do care plans seem to have been established at least in some practices. Clearly, linking specific targets to financial incentives can have the desired effect. The modest numbers of case conferences done to date suggests that widespread, systematic, adoption of this new, multidisciplinary approach to care has not yet been widely adopted. It is important to note that the EPC item numbers were established as a way of driving integration and partnership between primary care providers, for the benefit of patients.

It seems inevitable and reasonable that the easier to adopt EPC items (health assessments) were indeed taken up first and most quickly. Furthermore, additional incentives to conduct care plans and case conferences have clearly had an impact. There is also evidence that when an area of clear need is identified (such as CC for residents of aged care facilities) EPC uptake ensues. However, the fundamental changes that are needed to fully implement the EPC program in general practice must not be underestimated, and in many ways the changes that have occurred to date indicate some success. Further analysis is underway to describe and understand more fully the patterns of EPC item uptake.

Acknowledgements

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Table 1. Number (%) of enhanced primary care services rendered (item numbers 700-706; 720-730; 734-779) between November 1999 and October 2001.

Item number	Enhanced primary care service	Number	Percent
700	HA -Consulting rooms	128,514	34.6
702	HA -Elsewhere	94,906	25.6
704	HA -Consulting rooms ATSI	1,235	0.3
706	HA -Elsewhere ATSI	698	0.2
720	CP - Community preparation	107,181	28.9
722	CP - Discharge preparation	1,151	0.3
724	CP - Other review	20,371	5.5
726	CP - Community attendance	1,175	0.3
728	CP - Discharge attendance	625	0.2
730	CP - Residential attendance	4,185	1.1
734	CC - Residential organise 15-30 min	954	0.3
736	CC - Residential organise 30-45 min	487	0.1
738	CC - Residential organise 45+ min	469	0.1
740	CC - Community organise 15-30 min	1,870	0.5
742	CC - Community organise 30-45 min	1,311	0.4
744	CC - Community organise 45+ min	2,035	0.5
746	CC - Discharge organise 15-30 min	65	0.0
749	CC - Discharge organise 30-45 min	151	0.0
757	CC - Discharge organise 45+ min	188	0.1
759	CC - Community participate 15-30 min	1,097	0.3
762	CC - Community participate 30-45 min	613	0.2
765	CC - Community participate 45+ min	1,240	0.3
768	CC - Discharge participate 15-30 min	116	0.0
771	CC - Discharge participate 30-45 min	69	0.0
773	CC - Discharge participate 45+ min	76	0.0
775	CC - Residential participate 15-30 min	259	0.1
778	CC - Residential participate 30-45 min	198	0.1
779	CC - Residential participate 45+ min	170	0.0
TOTAL		**371,409**	**100.0**

HA - health assessment; CP - care plan; CC - case conference

Table 2. Monthly and cumulative health assessments completed between November 1999 and October 2001

	Health assessment items							
	Monthly services				Cumulative services			
	In rooms	Elsewhere	ATSI (in rooms)	ATSI (elsewhere)	In rooms	Elsewhere	ATSI (in rooms)	ATSI (elsewhere)
Month/year								
Nov-99	2,670	1,451	27	12	2,670	1,451	27	12
Dec-99	3,958	1,694	35	21	6,628	3,145	62	33
Jan-00	3,923	1,605	23	16	10,551	4,750	85	49
Feb-00	5,980	2,889	45	13	16,531	7,639	130	62
Mar-00	7,515	3,541	78	50	24,046	11,180	208	112
Apr-00	4,467	2,566	48	16	28,513	13,746	256	128
May-00	5,313	3,457	45	16	33,826	17,203	301	144
Jun-00	4,661	3,552	35	16	38,487	20,755	336	160
Jul-00	4,431	3,376	38	19	42,918	24,131	374	179
Aug-00	4,936	3,903	50	42	47,854	28,034	424	221
Sep-00	3,505	3,096	41	14	51,359	31,130	465	235
Oct-00	3,800	3,500	33	39	55,159	34,630	498	274
Nov-00	4,310	3,715	55	19	59,469	38,345	553	293
Dec-00	3,666	2,989	43	18	63,135	41,334	596	311
Jan-01	3,995	2,830	39	19	67,130	44,164	635	330
Feb-01	5,308	4,168	45	50	72,438	48,332	680	380
Mar-01	7,145	4,994	53	51	79,583	53,326	733	431
Apr-01	6,162	4,029	60	26	85,745	57,355	793	457
May-01	7,712	6,157	68	49	93,457	63,512	861	506
Jun-01	7,042	6,103	74	50	100,499	69,615	935	556
Jul-01	7,592	6,285	74	40	108,091	75,900	1,009	596
Aug-01	7,493	6,863	72	39	115,584	82,763	1,081	635
Sep-01	6,328	6,114	72	20	121,912	88,877	1,153	655
Oct-01	6,602	6,029	82	43	128,514	94,906	1,235	698

ATSI - Aboriginal or Torres Strait Islander

Figure 1. Cumulative and monthly health assessments done in rooms and at home (non-Indigenous)

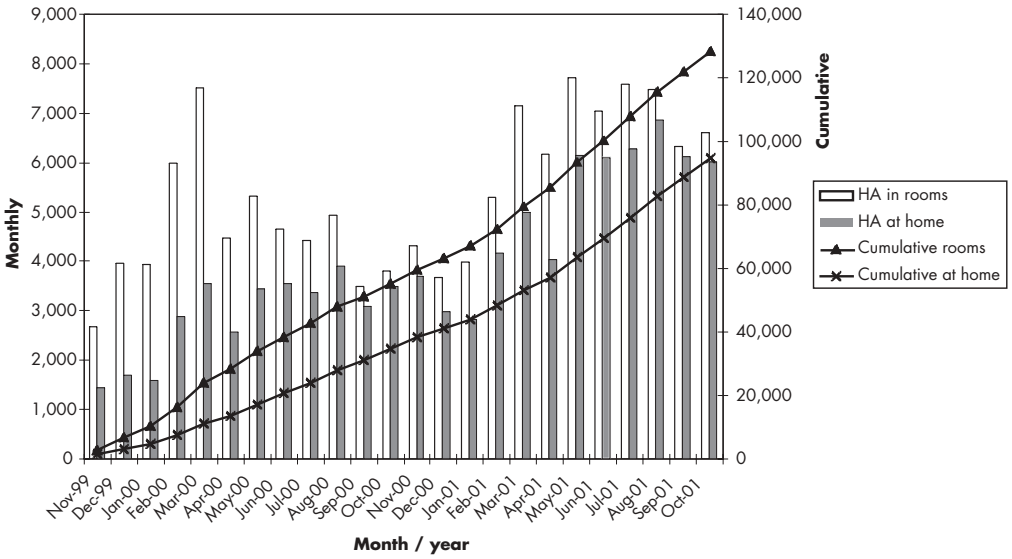

Figure 2. Cumulative and monthly care plans

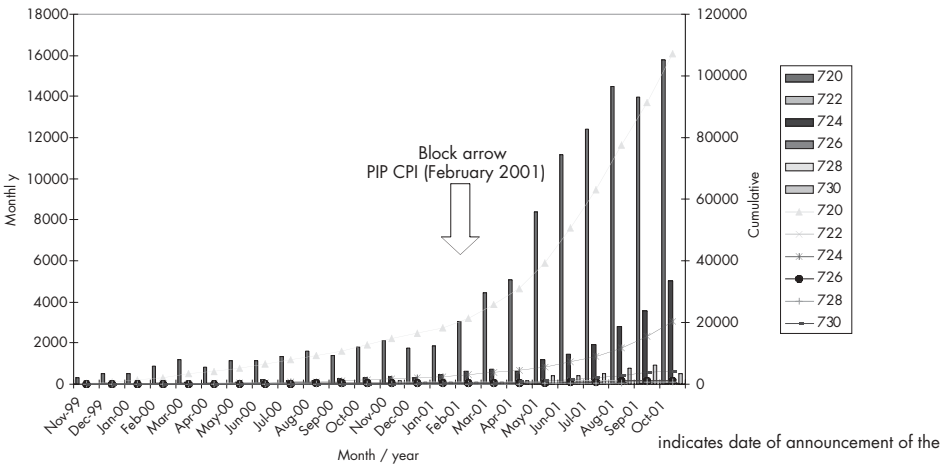

Table 3. Monthly and cumulative number of care plans completed between November 1999 and October 2001

	Care plan items											
	Monthly services						Cumulative services					
Month/year	720	722	724	726	728	730	720	722	724	726	728	730
Nov-99	291	24	11	42	0	0	291	24	11	42	0	0
Dec-99	516	28	4	22	1	0	807	52	15	64	1	0
Jan-00	494	21	5	8	7	0	1301	73	20	72	8	0
Feb-00	905	31	15	14	3	0	2206	104	35	86	11	0
Mar-00	1,194	46	86	14	6	0	3400	150	121	100	17	0
Apr-00	807	44	48	12	0	0	4207	194	169	112	17	0
May-00	1,135	28	104	15	3	0	5342	222	273	127	20	0
Jun-00	1,145	57	188	15	9	0	6487	279	461	142	29	0
Jul-00	1,366	55	176	23	15	0	7853	334	637	165	44	0
Aug-00	1,609	62	173	19	10	0	9462	396	810	184	54	0
Sep-00	1,400	38	243	7	2	0	10862	434	1053	191	56	0
Oct-00	1,829	47	295	11	1	0	12691	481	1348	202	57	0
Nov-00	2,108	44	373	15	5	134	14799	525	1721	217	62	134
Dec-00	1,777	30	329	20	7	93	16576	555	2050	237	69	227
Jan-01	1,837	30	488	42	15	85	18413	585	2538	279	84	312
Feb-01	3,038	54	595	35	20	100	21451	639	3133	314	104	412
Mar-01	4,468	50	722	59	26	94	25919	689	3855	373	130	506
Apr-01	5,058	38	620	42	35	149	30977	727	4475	415	165	655
May-01	8,398	73	1,198	82	74	400	39375	800	5673	497	239	1055
Jun-01	11,182	79	1,428	117	74	414	50557	879	7101	614	313	1469
Jul-01	12,439	82	1,914	117	85	514	62996	961	9015	731	398	1983
Aug-01	14,461	58	2,774	139	79	756	77457	1019	11789	870	477	2739
Sep-01	13,961	61	3,583	202	78	950	91418	1080	15372	1072	555	3689
Oct-01	15,763	71	4,999	103	70	496	107181	1151	20371	1175	625	4185

Block arrow indicates date of announcement of the PIP CPI (February 2001)

Table 4. Monthly number of case conferences completed between November 1999 and October 2001

	Care Conference items (monthly)																	
	organise									participate								
	Residential			Community			Discharge			Community			Discharge			Residential		
Month/year	734	736	738	740	742	744	746	749	757	759	762	765	768	771	773	775	778	779
Nov-99	0	0	0	38	31	54	0	9	5	29	19	45	4	1	0	0	0	0
Dec-99	0	0	0	35	37	37	1	4	4	17	15	48	0	1	1	0	0	0
Jan-00	0	0	0	37	27	39	0	11	4	9	18	28	2	1	1	0	0	0
Feb-00	0	0	0	32	37	74	0	12	11	34	25	51	2	1	2	0	0	0
Mar-00	0	0	0	67	47	84	0	18	10	39	23	64	1	2	1	0	0	0
Apr-00	0	0	0	41	31	65	1	5	6	21	19	44	1	1	3	0	0	0
May-00	0	0	0	59	37	71	7	16	6	48	36	61	1	4	2	0	0	0
Jun-00	0	0	0	51	41	80	5	20	5	38	14	51	2	0	6	0	0	0
Jul-00	0	0	0	31	34	60	1	6	7	22	20	54	0	2	2	0	0	0
Aug-00	0	0	0	41	45	94	0	7	2	41	35	52	3	1	2	0	0	0
Sep-00	0	0	0	59	39	80	0	1	7	37	21	41	2	0	2	0	0	0
Oct-00	0	0	0	51	48	97	1	0	6	32	23	53	0	3	2	0	0	0
Nov-00	37	28	18	80	48	89	6	2	7	58	25	49	0	5	7	17	6	13
Dec-00	17	17	13	56	50	52	0	2	4	30	15	32	2	4	2	9	5	7
Jan-01	45	26	13	47	22	53	1	7	5	31	18	31	1	4	2	16	4	4
Feb-01	40	29	25	64	60	116	1	4	1	60	18	40	4	3	2	10	9	18
Mar-01	29	42	40	83	61	104	5	6	10	58	34	67	8	3	7	36	17	13
Apr-01	26	25	31	94	62	79	4	3	4	39	16	51	9	4	1	14	12	17
May-01	49	49	57	149	104	124	5	6	10	70	39	67	14	5	7	24	26	16
Jun-01	110	83	48	125	85	115	5	4	10	77	42	60	15	6	6	23	14	19
Jul-01	126	56	51	154	97	108	8	1	13	70	36	61	14	5	4	36	27	19
Aug-01	149	59	83	181	105	146	4	2	20	85	39	65	9	5	2	25	27	14
Sep-01	194	44	35	159	87	109	5	3	19	75	22	48	7	3	6	41	28	12
Oct-01	132	29	55	136	76	105	5	2	12	77	41	77	15	5	6	8	23	18

Table 5. Cumulative number of case conferences completed between November 1999 and October 2001

	Care Conference items (cumulative)																	
	organise									participate								
	Residential			Community			Discharge			Community			Discharge			Residential		
Month/year	734	736	738	740	742	744	746	749	757	759	762	765	768	771	773	775	778	779
Nov-99	0	0	0	38	31	54	0	9	5	29	19	45	4	1	0	0	0	0
Dec-99	0	0	0	73	68	91	1	13	9	46	34	93	4	2	1	0	0	0
Jan-00	0	0	0	110	95	130	1	24	13	55	52	121	6	3	2	0	0	0
Feb-00	0	0	0	142	132	204	1	36	24	89	77	172	8	4	4	0	0	0
Mar-00	0	0	0	209	179	288	1	54	34	128	100	236	9	6	5	0	0	0
Apr-00	0	0	0	250	210	353	2	59	40	149	119	280	10	7	8	0	0	0
May-00	0	0	0	309	247	424	9	75	46	197	155	341	11	11	10	0	0	0
Jun-00	0	0	0	360	288	504	14	95	51	235	169	392	13	11	16	0	0	0
Jul-00	0	0	0	391	322	564	15	101	58	257	189	446	13	13	18	0	0	0
Aug-00	0	0	0	432	367	658	15	108	60	298	224	498	16	14	20	0	0	0
Sep-00	0	0	0	491	406	738	15	109	67	335	245	539	18	14	22	0	0	0
Oct-00	0	0	0	542	454	835	16	109	73	367	268	592	18	17	24	0	0	0
Nov-00	37	28	18	622	502	924	22	111	80	425	293	641	18	22	31	17	6	13
Dec-00	54	45	31	678	552	976	22	113	84	455	308	673	20	26	33	26	11	20
Jan-01	99	71	44	725	574	1029	23	120	89	486	326	704	21	30	35	42	15	24
Feb-01	139	100	69	789	634	1145	24	124	90	546	344	744	25	33	37	52	24	42
Mar-01	168	142	109	872	695	1249	29	130	100	604	378	811	33	36	44	88	41	55
Apr-01	194	167	140	966	757	1328	33	133	104	643	394	862	42	40	45	102	53	72
May-01	243	216	197	1115	861	1452	38	139	114	713	433	929	56	45	52	126	79	88
Jun-01	353	299	245	1240	946	1567	43	143	124	790	475	989	71	51	58	149	93	107
Jul-01	479	355	296	1394	1043	1675	51	144	137	860	511	1050	85	56	62	185	120	126
Aug-01	628	414	379	1575	1148	1821	55	146	157	945	550	1115	94	61	64	210	147	140
Sep-01	822	458	414	1734	1235	1930	60	149	176	1020	572	1163	101	64	70	251	175	152
Oct-01	954	487	469	1870	1311	2035	65	151	188	1097	613	1240	116	69	76	259	198	170