ACP subsidy for general practice

What: Offering an ACP subsidy to general practice teams

Why/rationale: To support ACP conversations and creation of plans in primary care for selected patient groups, such as:

- those who meet the 'surprise question' criteria
- the frail elderly, those with metastatic malignancy, or end-stage heart, respiratory, renal, or hepatic failure
- patients with progressive cognitive impairment, motor neurone disease, or other progressive neurological disease where judgement is expected to become impaired within a few years
- patients with severe psychiatric disease or cognitive disability who meet the surprise question criteria, and for whom ACP is appropriate (eg, high suicide risk or severe addiction, in aged residential care, a rest home or hospital-level care).

Who: Canterbury DHB

Benefits/value added:

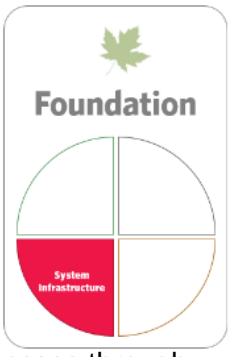
- Subsidy allows general practice teams to spend time supporting a patient through the ACP process and logging their plan on their electronic record.
- The subsidy can be applied for by any member of the practice team with a professional registration and the knowledge to adequately inform and support the patient through the ACP process. This encourages innovative approaches to ACP implementation in many practices.
- Increases staff willingness to invest time and give ACP a go.
- The subsidy criteria allow the ACP team to set and maintain minimal standards for advance care plan quality. If a plan doesn't meet the standard it will not be published (to Health Connect South) and the subsidy will not be paid.

Risks/challenges:

- Some practices may treat advance care plan creation as a revenue-generating venture. Having clearly outlined minimal standards for plan quality helps to mitigate the risk.
- One payment is available per patient. There is no payment available for an update to an existing plan.
- Other areas of the health community outside of general practice may not support a patient with the ACP process because there is no financial incentive.

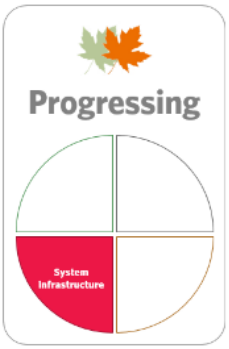
Steps: How this looked on the ground

Foundation



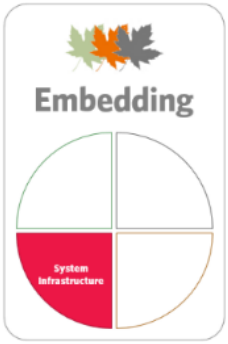
1. The Canterbury initiative instigated discussions with planning and funding to subsidise ACP in general practice. Subsidy criteria were established and a one-off payment of $172.50 (GST inclusive) was set as the payment. There was an initial capped of 500 subsidy payments per year.
2. Subsidy exception payment criteria were defined.
3. The ACP subsidy was added to the existing schedule of practice payments, allowing for use of established application and payment processes through the Pegasus subsidy portal. There were also links into established systems for payments to non-Pegasus practices.
4. A HealthPathways page was created, outlining the criteria and processes for applying for an ACP subsidy (see example).
5. ACP and the subsidy was socialised with practice teams through practice visits and GP educations sessions. (See example – Funding and services poster)
6. Groups supporting practices (eg, Pegasus practice liaison teams) were educated about ACP and the subsidy so they could reinforce ACP messaging on practice visits and encourage practices to contact the DHB if issues arose or support was required.

Progressing



1. Established administration processes for following up outstanding ACP subsidy claims, ie, claims made when no plan is submitted. A report is generated every three months and practices who have claimed but not submitted a plan are followed up and offered support to complete the process. This prevents plans from being missed and helps ACP facilitators develop relationships with practice teams.
2. Part of the subsidy criteria is that the practice loads the advance care plan onto Health Connect South/HealthOne (the electronic patient record). ACP processes were adapted to allow practices without the time or capacity to load a plan to submit the plan to ACP administrators for loading. They are invoiced $50 per plan for this service. Most fund this from the ACP subsidy.
3. Secured a presentation slot at the 2016 GP education sessions. The main messages included:
    - ACP is a practice initiative. Creation of an advance care plan does not need to be GP-led. The subsidy criteria support this.
    - Tips to avoid the main pitfalls experienced with ACP sharing/subsidy claims.

Embedding



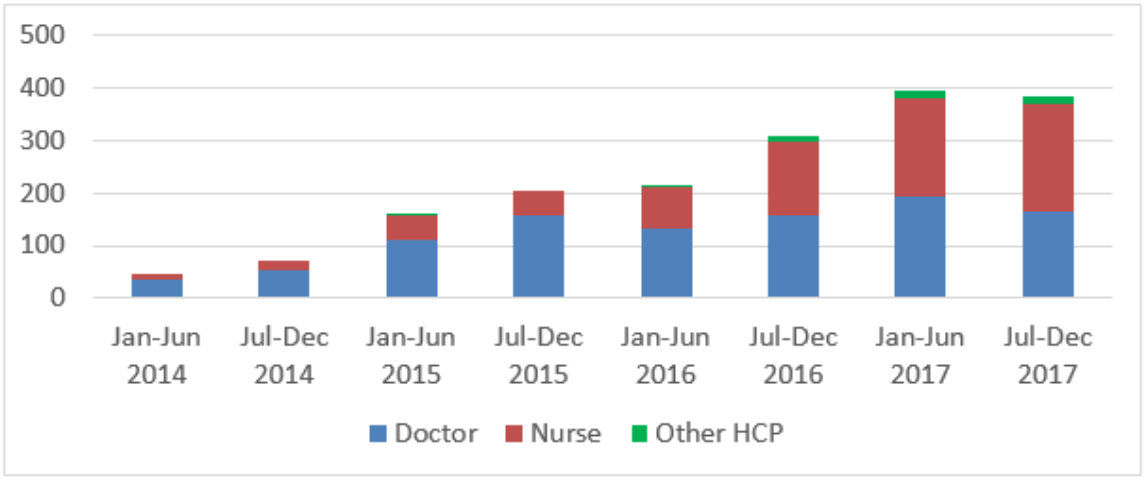
1. Extended annual ACP subsidy claim cap.
2. There have been innovative approaches emerging in general practice relating to the use of the ACP subsidy to support the creation of advance care plans. Examples include:
   - practice nurse-led ACP clinics
   - designated nursing full-time equivalent to support home visits involving ACP discussions and plan creation
   - a level 2 trained self-employed occupational therapist adding ACP support and plan creation to services offered during home visits. She invoices practices for a portion of the ACP subsidy.

Impact:

By the end of 2017, 1,775 advance care plans had been published. Eighty percent of these were generated by general practice.

An increasing multidisciplinary approach is being seen in advance care plan creation. Much of this is practice nurse-driven.

Advance care plan creation by discipline



Future opportunities:

The DHB has recently extended the ACP subsidy to cover medical care guidance (MCG) creation. It is negotiating with planning and funding for aged residential care facilities to be eligible to apply for the subsidy when they have led the ACP/MCG process.

Similar examples from others:

ACP funding for general practice

Things to consider:

- Not all advance care plans created in general practice meet the subsidy criteria. The DHB has found around two out of every three GP-created plans have a corresponding subsidy claim.
- For budgeting and planning purposes Canterbury GP subsidies are capped at 500 payments per year. The DHB reached 500 subsidy claims in 2017. Planning and funding extended the cap and the allocation has been increased for 2018.