

## Case conferences in general practice: time for a rethink?

*Current requirements for case conferences make them unworkable*

IN 1999, THE COMMONWEALTH GOVERNMENT introduced the Enhanced Primary Care (EPC) package, aimed at improving preventive healthcare and coordination of care, particularly for elderly people.<sup>1</sup> This package comprised a number of elements, including the introduction of new items on the Medical Benefits Schedule (MBS) to enable general practitioners to conduct health assessments (annual assessments of medical health and physical, psychological and social function in elderly patients), care plans (plans to coordinate the care of patients with chronic disease requiring care from multiple providers) and case conferences (see Box 1). Case conferencing was designed to enable GPs to shift from episodic care to providing longer-term care in collaboration with a wider healthcare team. It involves GPs organising or participating in a conference with two or more other healthcare providers. It may be conducted in person or by telephone or videoconferencing. The patient's consent must be obtained, and patients and carers may also be involved.

The case conference is a tool for coordinating care across a multidisciplinary team.<sup>2</sup> It is used by team members to identify and discuss the care needs and goals of patients with chronic or complex conditions and to assign interventions to particular members of the team.<sup>3</sup> Although there is little evidence as yet of their impact on health outcomes, the value of case conferences is that they help ensure that problems are properly identified, care is not duplicated, and errors in communication (which all too often result in adverse events<sup>4</sup>) are minimised. Case conferences can also serve as a vehicle for education and an opportunity for healthcare providers to get to know each other, thereby building up capacity and strengthening the team approach.<sup>5</sup>

Those who stand to benefit most from the case-conference approach include patients who

- have complex problems for which the GP has difficulty finding solutions (eg, patients with stroke or other physical or intellectual disabilities);<sup>6</sup>
- are coping with complex psychosocial problems, such as child abuse;<sup>7</sup>
- have cognitive problems that make them unable to coordinate their own care among providers;
- require case management across multiple services (eg, those with mental health problems);
- are managed by telemedicine or by visiting teams in rural areas;<sup>8,9</sup> and
- need coordination of care after being discharged from hospital.

There has now been considerable uptake of the health assessments and care-planning items by GPs. However, uptake of the case-conferencing items has been particularly slow, representing less than 3% of total EPC items claimed (see Box 2). In February 2002, there were 577 case

### 1: Requirements for case conferences under the Enhanced Primary Care program\*

#### *Which patients are eligible?*

- Patients with one or more chronic conditions and multidisciplinary care needs

#### *How often can a case conference be held?*

- No more than five times a year, or once for each hospital admission

#### *Participants*

- General practitioner and at least two other formal care providers

#### *What is involved?*

- Provision of relevant patient history and identification of problems and management issues
- Setting (or review) of goals and management strategy
- Evaluation of progress
- Allocation of tasks to team members

#### *Paperwork required*

- List of participants and times the conference commenced and concluded
- Documentation of problems, goals, and strategies discussed
- Summary of outcomes (provided to all participants)

#### *Obligations to patient*

- Patient must provide informed consent and receive a copy of the summary.

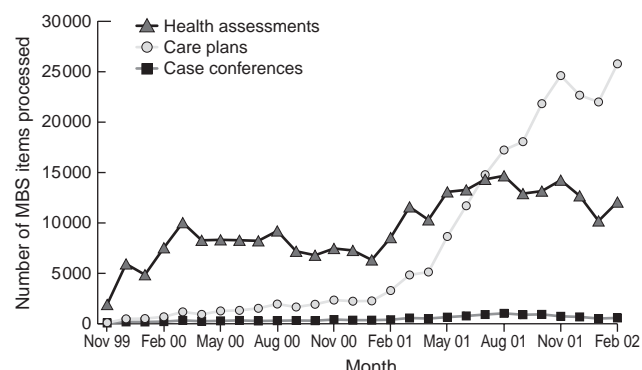
\*Medical Benefits Schedule book. 1 Nov 1999. Sections A.20, A.21, A.22 (Items 700-773). Canberra: Commonwealth Department of Health and Aged Care, 1999: 32-35. Available at: <<http://www.health.gov.au/pubs/mbs>>. Accessed 13 June 2002.

conferences in the whole of Australia, compared with 25 787 care plans for the same period.

What are the reasons for this? Mitchell et al (*page 95*)<sup>10</sup> detail some of the difficulties GPs experience in fulfilling the requirements for case conferencing. The main problems are logistical ones. The procedures to be followed (including prior patient consent) when initiating case conferences are complex. Even when teleconferencing is used, it is difficult to synchronise times when all participants are available. A single case conference is not enough to build the knowledge and trust required among participants with differing agendas and service orientations, making commitment to participation and joint decision-making difficult.

Healthcare workers other than GPs may initiate case conferences. However, the EPC has been a somewhat one-sided development. GPs and private physicians are remunerated for their roles (new physician MBS items were introduced in May 2002), but community and allied health professionals are not. Nor are non-government organisations such as Home and Community Care services or community-controlled Aboriginal health services. Many State-funded health services (such as those for aged or palliative care) are understaffed and find it difficult to

## 2: Claims for enhanced primary care items, by month\*



\*Australian Health Insurance Commission. MBS item statistics reports. Available at <[http://www.hic.gov.au/statistics/dyn\\_mbs/forms/mbs\\_tab4.shtml](http://www.hic.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml)>. MBS=Medical Benefits Schedule.

engage GPs in their existing case conferences because of conflicting demands on their time.

In contrast to case conferences, health assessments require action only by the GP, and much of the work can be done by other healthcare professionals, such as a practice nurse working with the GP. Thus, GPs have been quick to make use of health assessments. The uptake of care-planning items has been slower, but started to take off in the first half of 2001. This was due to various factors: the establishment of education and training programs, the provision of practice support from Divisions of General Practice, and the offer of extra incentives through the Practice Incentives Program. Given the extra organisational complexity of case conferences and the lack of specific support systems to date, it is hardly surprising that uptake by GPs has been low.

Continuing with the existing items, using a targeted approach to identify patients who will benefit most (eg, patients with complex psychological or social problems), may be appropriate. However, we should also consider whether the current case-conferencing items are what is really needed. Consultation-liaison (in which a specialist provider provides consultation support to the GP) and case management approaches have been shown to be effective in primary care.<sup>11,12</sup> Two separate phone discussions to develop a care plan with two other providers may achieve many of the same objectives as a single case conference. While this may not represent a full "multidisciplinary" approach as envisaged in the EPC package, it does at least work. Such a model should be considered for an EPC rebate as an alternative to the current requirements, which are clearly too difficult.

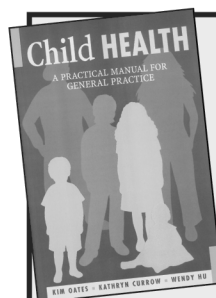
On a more fundamental level, perhaps we first need to devote more time to developing primary care teams within practices and between GPs and local community-based and allied health services.<sup>13</sup> Case conferencing not only facilitates integration between health service providers, it depends on it.<sup>14</sup> The difficulties in implementing case conferencing may simply be a demonstration of the lack of effective

multidisciplinary education and team building within much of Australian primary care.

**Mark F Harris**

Professor, School of Public Health and Community Medicine  
University of New South Wales, Sydney, NSW  
m.f.harris@unsw.edu.au

1. Primary care initiatives: enhanced primary care package. Canberra: Commonwealth Department of Health and Aged Care, 1999.
2. Wagner EH. The role of patient care teams in chronic disease management. *BMJ* 2000; 320: 569-572.
3. Taplin S, Galvin M, Payne T, et al. Putting population-based care into practice: real option or rhetoric? *J Am Board Fam Pract* 1998; 11: 116-126.
4. Wilson RM, Harrison B, Gibberd RW, Hamilton JD. An analysis of the causes of adverse events from the Quality in Australian Health Care Study. *Med J Aust* 1999; 170: 411-415.
5. Harris M, Blakeman T. Enhanced primary care items: their use in diabetes management. *Aust Fam Physician* 2001; 30: 1134-1140.
6. Lennox NG, Diggins JN, Ugoni AM. The general practice care of people with intellectual disability: barriers and solutions. *J Intellect Disabil Res* 1997; 41: 380-390.
7. An ethical debate: child protection: medical responsibilities. *BMJ* 1996; 313: 671-672.
8. Dossetor DR, Nunn KP, Fairley M, Eggleton D. A child and adolescent psychiatric outreach service for rural New South Wales: a telemedicine pilot study. *J Paediatr Child Health* 1999; 35: 525-529.
9. Alsop M, Harris MF, Powell-Davies G, et al. Piloting case conferencing between GPs and mental health services: phase II of the Northern Queensland Rural Division of General Practice Mental Health Program. *Aust J Primary Health - Interchange* 2000; 6(2): 78-85.
10. Mitchell GK, de Jong I, Del Mar CB, et al. General practitioner attitudes to case conferences: How can we increase participation and effectiveness? *Med J Aust* 2002; 177: 95-97.
11. Harmon K, Carr VJ, Lewin TJ. Comparison of integrated and consultation-liaison models for providing mental health care in general practice in New South Wales. *J Adv Nurs* 2000; 32: 1459-1466.
12. Marshall M, Lockwood A, Gath D. Social services case-management for long-term mental disorders: a randomised controlled trial. *Lancet* 1995; 345: 409-412.
13. Discussion paper from the NSW Allied Health Alliance on issues surrounding the implementation of the enhanced primary care (EPC) package. Sydney: Allied Health Alliance Inc, 2000.
14. Appleby NJ, Dunt D, Southern DM, Young D. General practice integration in Australia. Primary health services provider and consumer perceptions of barriers and solutions. *Aust Fam Physician* 1999; 28: 858-863. □



## Child HEALTH

*A concise, accessible and practical desktop manual for General Practice, only \$77.00\**

This major Australian book deals with the main childhood and adolescent clinical problems commonly seen in general practice. Taking a problem-based approach, the contributors recognise the realities of general practice and place the child within the context of their family and community. Its focus is on the key features of diagnosis, management and essential practice pitfalls (eg, *Traps to Avoid* and *When to Refer*). A carefully developed and authoritative text that recognises the central role of the GP in child health.

\*AMA members receive a 10% discount, plus \$7.65 P&H • \*Price includes GST

For further information contact AMPCo: Ph 02 9562 6666  
Fax 02 9562 6662 • Email: [sales@ampco.com.au](mailto:sales@ampco.com.au)  
[www.mja.com.au/public/bookroom/](http://www.mja.com.au/public/bookroom/)