Building partnerships and better understanding between Aged Care providers and Medicare Locals

On 29 November 2013, GP Practice NSW and the Aged and Community Services Association NSW and ACT held a joint workshop with the following objectives:

- Develop mutual understanding between Medicare Locals and Aged Care Providers
- Facilitate the building of strategic relationships between MLs and ACPs
- Facilitate practical opportunities for ML/ACP engagement and service coordination at regional and local level

The workshop was designed to establish a common awareness of the current operating environment and the existing shared objectives and strategies. The day was planned to be interactive with a focus on exploring barriers to achieving the objectives and coming up with solutions. A good outcome for the day was to have a prioritised list of barriers and solutions. This was achieved and the product for the day is set out in this document.

The Barriers given priority were:

1. Lack of Medical handover; and consistent minimum data set on a person and/or their medications at time of transfer of care
2. Regional programs not available State-wide
3. Lack of knowledge of what programs are out there
4. Transfer of Advanced Care plans to different facilities or arms of care; and staff knowledge of community based palliative care
5. Overuse or inappropriate use of GPs

The top solutions, in priority order, were:

1. Electronic Record Sharing and Electronic Health records, eg PCEHR
2. Implement an outreach of Aged Services in Emergency Teams (ASET) so nurses from ED go out into the RACFs and an older person's home
3. Agreed frameworks / role delineation particularly around when a person's condition is deteriorating
4. Collaborative state-based group with representation from Aged Care, Medicare Locals, Ministry of Health, DSS, NGOs to work on Statewide approach, not just regional
5. Create a single, central portal for information about what programs exist

Our 4 Top Shared Objectives with known Existing Strategies

1. Improved Access between aged people in their homes or RACF and GPs and Allied health workers.

Strategies/projects

1.1 GP (and other health professionals) Office in an RACF
1.2 GP employed by RACF (e.g. Bupa)
1.3 Telehealth
1.4 E-health
1.5 Linked health records
1.6 After hours GP services
1.7 Mobile services e.g. X-ray and Pathology

2. Avoiding Unnecessary Hospitalisation

Strategies/projects

2.1 GRACE / Flying Squad
2.2 Paramedics extended care
2.3 Transition care (Uniting Church of Australia)
2.4 Remote wound care support (Concord)
2.5 Hospital in the home/ Acute Post-Acute Care (APAC)
2.6 Inreach program (Kogarah)
2.7 Palliative care unit (Hammond)
2.8 Falls Prevention programs
2.9 Healthy Pathways Project (Hunter)
2.10 Chronic Disease management program
2.11 Complex care projects
2.12 Authorised Care Plans – Ambulance
2.12 Mobile X-ray
2.13 T.R.A.C.S – Teaching and Research Aged Care Services

3. Smooth transfer of care/ discharge from acute

Strategies/projects

3.1 Secure messaging to a single provider
3.2 Transfer of Care approach (ACI recent publication)
3.3 Medication regime
3.4 ACAT process
3.5 Yellow envelope
3.6 ISBAR training (Introduction, Situation, Background, Assessment and Recommendation)
3.7 AARCS - Acute to Aged Related Services & Co-ordinated discharge planning
3.8 ASET – Aged Services in Emergency Teams (ASET)

4. Choice and quality end of life care

Strategies/projects

4.1 Recording End of Life wishes
4.2 Advanced care plans and directives
4.3 Palliative care in the home
4.4 My wishes website – Alzheimer's Aust.
4.5 Speaking for Myself (with Legal Aid)
4.6 Capacity toolkit Attorney General; Guardianship Tribunal
4.7 Clinical handover RACF – 'yellow envelops'
4.8 Amber
4.9 PEPA Program of Experience in the Palliative Approach

Barriers to meeting the objectives

1. Improved Access between aged people in their homes or RACF and GPs and Allied health workers

Barriers:

1.1 Overuse or inappropriate use of GPs (*10 votes)
1.2 RACF staff risk adverse related to current legislation
1.3 Lack of compensation for Telehealth GP service provision (*8 votes)
1.4 Lack of referral to Telehealth (*1 vote)
1.5 Lack of home visits particularly in rural and remote (*3 votes)
1.6 GP after hours limitations to rural and remote areas RACFs (*1 vote)
1.7 Community transport Options(*5 votes)
1.8 Lack of processes for acute care referral processes post hospital(*2 votes)
1.9 Need for Service Integration (*3 votes)
1.10 Not enough GPs and other services(*1 votes)
1.11 Lack of geriatric specialty (*1 vote)
1.12 Lack of compatible software between GP and RACF(*1 vote)
1.13 Lack of physical space and privacy in older aged care homes (*1 vote)
1.14 Episodic fee for service pay structure
1.15 GPs' lack of enthusiasm to engage in aged care
1.16 Contested turf between practices
1.17 Lack of security of e-health
1.18 Resident right to retain their GP or choose GPs rather than use the clinic GP
1.19 Lack of systematic Approach to engaging GPs
1.20 Promotion of MBS item in RACFs
1.21 Philosophy of Care – aged care is enable and support, health is cure care and treat

Solutions included:

1.22 More use of Aged Care Clinical Nurse Consultant & Nurse Practitioners
1.23 Need GP registrars to work in RACFs

2. Avoiding Unnecessary Hospitalisation

Barriers:

2.1 Regionally based programs, no State-wide approach (*22 votes)
2.2 Lack of knowledge of what is out there, the ability to access it and how to navigate it. (*15 votes)
2.3 Limitations imposed by interagency non acceptance of existing End of Life / advanced care plans (*5 votes)
2.4 Risk of failure to acknowledge that aged care and acute care fulfil different roles. Addressed via integrated care (*2 votes)
2.5 Fear of responsibility/cost shifting or abuse of availability of services. Addressed by clear (not complex) framework (*2 votes)
2.6 Research that focusses on changing aged care but doesn't also identify its existing strengths (*2 votes)
2.7 Funding limitations re dedicated funding streams (*1 vote)
2.8 Funding is pilot only, not ongoing even is evaluated as successful. Seed funded projects should be ongoing if successful
2.9 Timeframes for submission, implementation and evaluation too tight, e.g. delayed advice, doesn't correlate to extension of program i.e. 12 month program, find out 2 months into timeline, only 10 months to do it (*1 vote)
2.10 Availability of rapid diagnostic procedures (*1 vote)
2.11 No consistent outreach service to RACFs to minimise unnecessary admissions (*1)
2.12 Terms of government limiting longevity of planning
2.13 Terms of governance for agencies can limit voice for older people
2.14 Philosophy of Care – aged care is enable and support, health is cure, care and treat
2.15 Communication ASET type as in Emergency Department
2.16 Funding for Sub-acute care in RACF or patient's house/community

Solutions included:

2.17 T.R.A.C.S – Teaching and Research Aged Care Services
2.18 Support carers and families
2.19 Promote Aged Services in Emergency Teams (ASET) in EDs
2.20 Information on Service Delivery Options important
2.21 Need for Health System Reform to allow workforce redesign
2.22 Single point if access to services (telephone)
2.23 HealthOne/ CCSS (Aboriginal Care Co-ordination)
2.24 Staff training to deal with emergency situations e.g. falls, minor wounds
2.25 Standardise method of practice for GRACE, Flying Squad etc. across state
2.26 IWSML after hours nurses practitioner model in RACFs
2.27 Flying Squad like Sutherland

3. Smooth transfer of care/ discharge from acute

***Barriers*:**

3.1 Inconsistent minimum data sets and medication changes (*22 votes)
3.2 Inconsistent connection to Primary Care/ medical handover (*10 votes)
3.3 Ineffective Home care/package waitlists (*8 votes)
3.4 Lack of e-health Integration/ e-health record uptake in RACF (*3 votes)
3.5 Some hospitals/LHD unable to interact meaningfully with PCEHR (*3 votes)
3.6 Paper based systems (*2 votes)
3.7 Medication management between facilities & discharge notes (*3 votes)
3.8 Delays in medication orders/ changes on discharge (*1 vote)
3.9 Return to RACF or home without medications (*1 vote)
3.10 Confusion over discharge planning process/ patchy inconsistent (*2 votes)
3.11 Private hospital – lack of timely discharge and advice (specialist letter only) (*2 votes)
3.12 Lack of clear communication between local providers (*1 vote)
3.13 Failure to identify and address home carer stress
3.14 Philosophy of Care – aged care is enable and support, health is cure care and treat
3.15 No 48 hour follow up
3.16 Dementia / delirium

4. Choice and quality end of life care

***Barriers*:**

4.1 Transferring of Advanced Care Plan (ACP) from one place to another, e.g. home, RACF and hospital (*13 votes)
4.2 Staff knowledge/experience in dealing with community palliative care (*8 votes)
4.3 Resourcing / funding for community based palliative care (*5 votes)
4.4 Lack of standardisation (*4 votes)
4.5 Interpretation of information in the Advanced Care Plan (*3 votes)
4.6 Lack of confidence in Advanced Care Plan (ACP) discussions among GPs, families, carers, staff (*3 votes)
4.7 Services unavailable in rural and remote (*3 votes)
4.8 Legal risks for providers when relatives disagree with patient choices (*2 votes)
4.9 Legality
4.10 Recognition of the ACP in hospital vs GP clinic vs community
4.11 Use right terminology on ambucare bundles
4.12 Support for carers missing in terms of End of Life resources
4.13 Risk of assuming all residential care is high end and failing to plan for difficult behavioural care that also needs residential care (*2 votes)
4.14 Philosophy of Care – aged care is about enabling & support, health is about cure and treat

Choice and quality end of life care *(cont)*

***Solutions included*:**

4.15 Standardise the Advanced Care Plan (ACP) and its use
4.16 Use the yellow envelops
4.17 Acknowledge role of carers and families
4.18 Require ACP to be embedded doctor's training
4.19 Staff education on End of Life Planning throughout the year
4.20 Employ specialist nurses to only do ACP
4.21 GP and allied health compensation for case conferencing

Most Important Barriers – in priority order

1. Lack of Medical handover; and consistent minimum data set on a person and/or their medications at time of transfer of care
2. Regional programs not available State-wide
3. Lack of knowledge of what programs are out there
4. Transfer of Advanced Care plans to different facilities or arms of care; and staff knowledge of community based palliative care
5. Overuse or inappropriate use of GPs

Possible solutions for each of these Barriers

1. **Lack of Medical handover; and consistent minimum data set on a person and/or their medications at time of transfer of care**
   - 1.1 Implement an outreach of Aged Services in Emergency Teams (ASET) so nurses from ED go out into the RACFs and person's home (*15 votes)
   - 1.2 State standardisation of forms (*7 votes)
     - 1.2.1 Yellow envelops
     - 1.2.2 Standard template (*1 vote)
     - 1.2.3 Increase use of ISBAR (*2 votes)
     - 1.2.4 E-Health (*6 votes)
     - 1.2.5 "Blue book" used for school students to be similar for people in their own homes
   - 1.3 All residents in RACF or community to have eHealth Record (*7 votes)
   - 1.4 Identify dementia at top of handover forms / communication. ACP etc (*1 vote)
   - 1.5 Training to support consistency in documentation and ISBAR/ assessment/medications (*3 votes)

Note re 1.3 and other e-health solutions: ACSA has been lobbying for E-health for a while. For interest see: http://www.agedcare.org.au/news/2013-news/aciitc-review-of-the-pcehr/view

For issues 2 and 3 the following is relevant. It was thought that the reason there is too little sharing of the information and regional vs State approach is that we are motivated by the need for ownership; there is a lack of recognition that we are one system; pilot funding made available but not recurrent; poor evaluations so good programs not seen and bad ones may continue; inadequate mapping of what is already out there; different names being used for the same program so we don't recognise it.

2. **Regional programs not available State-wide** (Barbara, Andrew Coe, Natalie Cook, Sandra Vincent, Janice Petersen, Jenny Fares)
   - 2.1 Collaborative state-based group with representation from Aged Care, Medicare Locals, Ministry of Health, DSS, NGOs (*13 votes)
   - 2.2 Collate common projects (*6 votes)
   - 2.3 Commonality of names and vision (*4 votes)
   - 2.4 Collaborative group to do evaluations and share information so we know what is working and what is not. (*2 votes)
   - 2.5 Address funding constraints and motivations for silos (*2 votes)
   - 2.6 Pooling of resources and funding (*2 votes)
   - 2.7 Mapping/ gap analysis by funder
   - 2.8 Deliver solutions in stages and communicate with stakeholders on the strategic approach
   - 2.9 Consider actuary/ risk assessment/ governance/ inter-agency.
   - 2.10 Take Whole of Government approach

3. **Lack of knowledge of what programs are out there** (Bryan, Regina, Ray, Dennis)
   - 3.1 Create a single, central portal for information (*11 votes)
   - 3.2 Key contact points / central number (*2 votes)
   - 3.3 Use a co-ordinated across Medicare Locals (*2 votes)
   - 3.4 Healthy pathways project might be part of puzzle (*1 vote)
   - 3.5 Medicare Locals to work with GPs to get them to use Telehealth
   - 3.6 Use each other's forums and conferences
   - 3.7 Broadening focus outside the silo
   - 3.8 Agreed contact points in ML and LHD as information channel
   - 3.9 Use language that clients, residents and other providers understand

Note in relation to 3.6:

- ACS and the Agency of Clinical Innovation holding "Better health Connections" conference on 20 February 2014
- Medicare Local / GP Practice NSW event planned for end March 2014

6. **Overuse or inappropriate use of GPs**
   (Mark, Darren, Jenny)
   - 6.1 Electronic Record Sharing (*12 votes)
   - 6.2 Agreed frameworks / role delineation particularly around when a person's condition is deteriorating (*10 votes)
   - 6.3 "Between the Flags" to identify when to call GP {ISBAR?} (*6 votes)
   - 6.4 Medicare Locals to work with GPs to get them to use Telehealth (*6 votes)
   - 6.5 Health Pathways Project (*5 votes)
   - 6.6 Nurse Practitioner models (*2 votes)
   - 6.7 Clinical Nurse Consultant in Palliative care &/or ACP/ end of life planning

7. **Transfer of Advanced Care plans to different facilities or arms of care; and staff knowledge of community based palliative care** (Cynthia, Anne, Margaret, Suhasini)

7.1 Electronic health records, eg PCEHR (*13 votes)

7.2 Better paper records as interim – eg yellow envelopes (*6 votes)

7.3 T.R.A.C.S – Teaching and Research Aged Care Services to upskill, increase knowledge of ACP/ palliative care, professional development. (*10 votes)

7.4 State-wide campaign to raise community awareness of ACP and palliative care (*3 votes) (see note below for a good start)

7.5 PEPA: promote to medical & nursing schools as per 5.4 above (*3 votes)

7.6 Ongoing education for staff/ health professionals and community

7.7 Consistent messaging around ACP and palliative care

7.8 Using triggers from 75+ assessment, CMA to follow up on ACP with patient

7.9 Capacity Australia toolkit

7.10 Service mapping for palliative care

Get it in Black and White campaign – might be a start to 5.4

The NSW Ageing Strategy aims to help our ageing population to live healthy, active and socially connected lives. A highlight of the strategy is My life, my decisions aimed at delivering community education activities to raise awareness and increase the number of people completing Wills, Powers of Attorney and Enduring Guardianships.

The Get it in Black and White Campaign there has been developed in joint partnership between the Office for Ageing and NSW Trustee and Guardian. The aim of the campaign is designed to start conversations and promote action around the importance of pre-planning by encouraging people to prepare these legal instruments.

The call to action is the re-designed Planning Ahead tools website, which provides easy access to information, resources and referrals, designed for the general public, service providers, and legal and health professionals. For more information on Planning Ahead visit www.planningaheadtools.com.au

Aged Care Representatives		
First Name	**Last Name**	**Organisation**
Karen	Best	Calvary Aged Care
Mark	Sewell	Warrigal Care
Ray	Harris	Cowra Retirement Village
Anne Maree	Hodgson	Catholic Healthcare
Wendy	Rocks	Lutheran Aged Care
Jim	Butterworth	Imlay District Nursing Home Ltd
Nicole	Schleicher	benevolent
Joanne	Toohey	benevolent
Mary	McConochie	Anglicare
David	Goodhew	Anglicare
Dennis	Marks	Bundaleer
Jenny	Symons	Banksia Villages Ltd.
Phil	Walsh	Adelene Retirement Village
Illana	Halliday	Aged & Community Services
Medicare Locals and other health Representatives		
Michelle	Shiel	NSW Ambulance
Graeme	Malone	NSW Ambulance
Rene	Pennock	South Western Sydney Medicare Local
Darren	Hunter	Inner Western Sydney Medicare Local
Suhasini	Sumithra	Inner Western Sydney Medicare Local
Donna	Sedgman	Western Sydney Medicare Local
Sandra	Vincent	Western Sydney Medicare Local
Cynthia	Stanton	North Sydney Medicare Local
Shona	Dutton	Eastern Sydney Medicare Local
Elizabeth	Lovell	Sydney North Shore & Beaches Medicare Local
Linden	Harper	South East Sydney Medicare Local
Richard	Nankervis	Central Coast Medicare Local
Vahid	Saberi	North Coast Medicare Local
Graeme	Kershaw	New England Medicare Local
Kerrie	Graham	Nepean Blue Mountains Medicare Local
Jenny	Beange	Western NSW Medicare Local
Bryan	McLoughlin	Hunter Medicare Local
Andrew	Coe	South East Sydney Medicare Local
Lewis	Kaplan	GP NSW
Regina	Osten	Agency for Clinical Innovation
Natalie	Cook	AML Alliance