ACI Clinical Innovation Program

Specialised geriatric outreach to residential aged care

Acknowledgements

This document reflects the work of clinical leaders, management and supportive organisations in the development and implementation of innovative models of care. The Agency for Clinical Innovation (ACI) takes this opportunity to thank all creative and visionary leaders in NSW who are working toward the implementation of evidence based services to achieve the best outcomes for their clients and communities.

This document highlights the work of Southcare Geriatric Flying Squad in developing a specialised aged healthcare outreach model to residential aged care – a service redesign project that has been successful in decreasing both hospital presentations and admissions in older people, improving consumer experiences of care and producing significant avoided costs for local health services. The document also highlights some of the successes of four similar models across the state.

In particular, the ACI takes this opportunity to thank the following organisations and their staff for giving their time and efforts in the preparation of this document, and sharing their ideas with the rest of the State.

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NSW ACI Clinical Innovation Program

The NSW Agency for Clinical Innovation (ACI) is a leader in the design and implementation of innovation in healthcare. The ACI's Clinical Innovation Program supports clinical innovation in the NSW health system, with a focus on accelerating implementation of ACI Models of Care/Guidelines and supporting the spread of local innovations.

In the context of the ACI Clinical Innovation Program, innovation means finding a better way to do something[1], or "the intentional introduction and application within a role, group, or organisation, of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, or wider society"[2].

Across NSW, clinicians, managers, consumers and carers are designing and delivering new, efficient and effective ways to deliver services, achieving positive change for consumers, carers, communities and clinicians. The ACI Clinical Innovation Program outlines new models of care that have been developed by teams of local healthcare providers in NSW; clinical innovators who identified a need for change and addressed the need by designing and implementing new models of care. These models are not clinical practice guidelines, but instead models based on "real life" examples of local practices, developed and implemented to improve experiences and outcomes for consumers and communities. These models of care are available to providers across the state to read, consider, and identify local opportunities for change for and improvement.

The ACI Clinical Innovation Program has a methodology for identifying, prioritising and working to spread innovations, as outlined below:
1. Identification of local innovations occurs via the NSW Health Innovation Award Finalists and Centre for Healthcare Redesign school.
2. Innovations are evaluated and examined for sustainability, reviewed to ensure the model is a priority for the ACI and its Networks/Taskforces/Institutes, and provides the best outcomes for patients, staff and the health system. ACI Clinical Networks also identify leading initiatives which are adding significant knowledge and value to their field.
3. The identified innovation and other leading initiatives, are drawn together to develop a model which effectively addresses the identified need, problem or opportunity. The model is examined to ensure it meets the needs of metropolitan, regional and rural services.
4. The resultant model is documented to support replication across NSW.
5. Implementation planning is the next stage in the process, with support for implementation of the innovation.

Purpose of this document

This document has been developed to highlight some of the innovative work of NSW Local Health Districts and their partnering organisations, to improve the health and wellbeing of older people. The document outlines central elements of various services across the state which aim to prevent deterioration, reduce hospital presentations and admissions and improve the health of older people living in residential aged care facilities (RACF), by providing timely access to specialist aged healthcare. It describes the innovative work of South Eastern

Sydney Local Health District in developing and implementing the Southcare Geriatric Flying Squad, together with the work of the Nepean Blue Mountains, Mid North Coast, Northern Sydney and Hunter New England Local Health Districts. This document describes the enablers of the service design and provides some cues for local organisational partnerships in improving local systems.

Throughout the document, examples are provided to illustrate how elements of the model are implemented. Additionally, the document is followed by appendices outlining the four initiatives visited as part of the model development.

It is acknowledged that there may be many examples of similar services already in place across NSW which are not included in this document. This document aims to share experiences, illustrate commonalities across services and describe some points of difference. It is hoped that by reading this document, Local Health Districts, together with local partners, may identify opportunities for improvement; learn about alternatives to existing service models; and be able to implement local changes to improve the experience and outcomes for older people living in residential care.

Endorsement

This document has been endorsed by the co-chairs of the Aged Health Network.

"The Aged Health Network endorses the Specialised Geriatric Outreach to Residential Aged Care which is consistent with the vision of the ACI Building Partnerships Framework: *that older persons, their carers and families, as partners in their care, have access to appropriate, high quality, evidence based healthcare that is provided in a timely, equitable and coordinated manners and delivered safely as close to home as possible*. This model of care demonstrates how local services can effectively work together to deliver person-centred health care".

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Specialised geriatric outreach to residential aged care

Specialised geriatric outreach to residential aged care aims to maintain the health and independence of older people living in residential care. Specialist geriatric outreach services provide rapid access to medical and nursing care for older people experiencing rapid decline, in the RACF. This document focusses on those older people whose homes are within residential aged care facilities. This is an effective strategy for keeping older people well in their homes, reducing avoidable hospital presentations and/or admissions, supporting the older person's choice for treatment in his/her home and reducing healthcare costs.

Service elements central to the success of specialist geriatric outreach to RACFs, are summarised below.

Proactive & timely care
Ability to provide rapid response
Clear point of contact

Coordination & continuity of care
Working together across service, organisational and sectoral boundaries
Coordinating care for the older person

Identification & risk stratification
Use of decision support tool to identify risk
Local care pathways for different risk levels

Capability building
Across individuals, units and organisations
Workforce development initiatives

Comprehensive geriatric assessment
Interdisciplinary process

Partnerships
From networking to integration
Partnerships across the breadth of care

A number of geriatric outreach models are already in place in NSW, and have had significant and positive impacts on the lives and health of older people and the aged care and healthcare systems.

Benefits of the model in one LHD
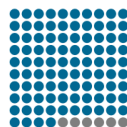
94%
of older people able to stay in their own homes, who would otherwise have gone to hospital

$1M
costs avoided per annum

370 presentations avoided

1,350 bed days avoided

Specialist geriatric outreach to RACFs is reliant of strong service relationships and a partnership approach. Key facilitators/enablers to the development, implementation and sustainability of the model are illustrated below.

What supports achievements of specialist geriatric outreach?

PERSON CENTRED APPROACH GOVERNANCE TOOLS EQUIPMENT & SERVICE ACCESS FLEXIBLE DELIVERY OPTIONS RELATIONSHIPS MONITORING & EVALUATION

The value of specialised geriatric outreach: Edith, 89 years

Edith lives in a RACF and has multiple comorbidities, including anxiety. Over a six month period in 2011, Edith presented to the Emergency Department (ED) on 18 occasions. During this period, both the hostel and ambulance worked to prevent further presentations.

After having presented to the Emergency Department six times in January 2012, the specialist geriatric outreach team became involved with Edith. Over the next 12 months the specialist geriatric outreach service provided 30 occasions of service to Edith, including home visits, telephone calls, emails and regular catheter changes. Edith presented to ED just four times for the remainder of 2012.

Edith's presentations to the Emergency Department Aug 2011- Dec 2012

Specialist geriatric outreach services commence
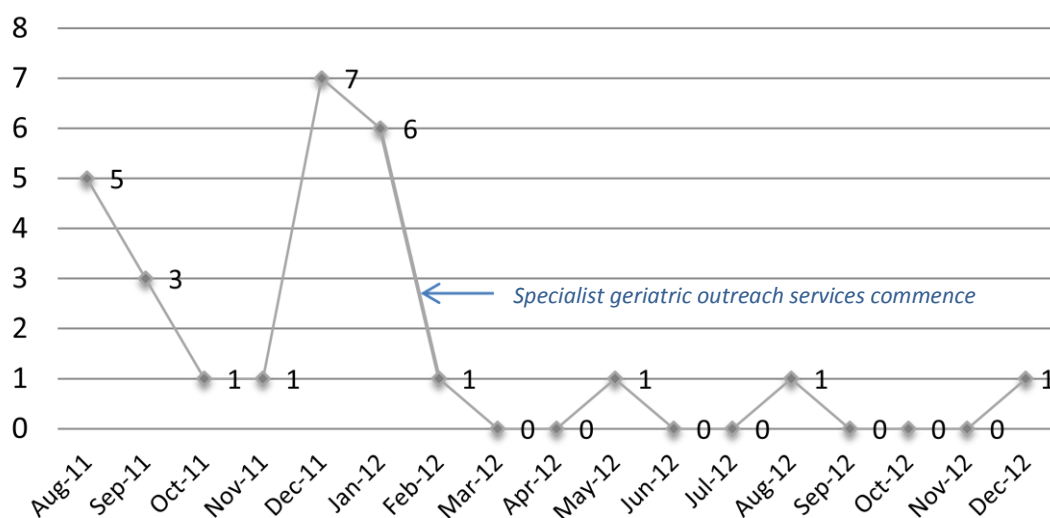
Case for change

The Australian population distribution is shifting. In 2010, 13.5% of the Australian population was aged 65 years and over compared to 12.4% in 2000[3]. In NSW, this is expected to increase to 24% by 2050[4]. The impacts of an ageing population on health and support services are significant. Older people are now living longer with more complex health care needs and multimorbidities, and will require more complex care and support, with numerous social and health care providers involved.

In Australia, there were 169,000 people living in residential aged care at 30th June 2011, with 77% of these residents over 80 years, and 57% of residents over 85 years of age[5]. NSW had 63,923 residential aged care places in 2011. This group of older people have higher health and care needs, often with multiple medical comorbidities, with one quarter of all residents having at least one hospital encounter over the course of one year[5]. Eight per cent of all hospital admissions across Australia in 2012 were for permanent residents of residential aged care[6], with the main health conditions requiring admission including respiratory and circulatory conditions, and injury due to a fall.

There are numerous causes of unnecessary or avoidable hospital admission for older people, ranging from individual patient factors to system failures, including limited access to primary care, underskilled workforces and poor continuity of care across and between care providers[7,8]. Likewise, there are numerous factors that contribute to the decision to hospitalise older people living in residential aged care, including:
- Patient and family preferences

- Availability of a trained workforce in the residential care setting
- Caseload, complexity and acuity of the older person in the residential aged care setting
- Advance care plans and end of life planning
- Access to diagnostic and pharmacy services in residential aged care
- Funding and regulatory frameworks
- Primary care availability
- Emergency Department demand and local service arrangements

It is well recognised that hospitalisation of older people is associated with risks, including falls, delirium, infections and functional decline[9,10,11]. Additionally, transitions from hospital back to the home environment (whether this be a RACF or in the community) are fraught with difficulties, including polypharmacy and medication risks. There is a need for work across organisational boundaries to prevent unnecessary or preventable hospital admissions for older people living in RACFs, and to smooth the transitions from home to hospital and hospital to home through better coordinated and integrated care.

Opportunities for improvement

Appropriate care for older people may be able to be delivered outside a hospital environment, in many cases. Evidence suggests as many as 70% of hospitalisations may be avoided with well-targeted interventions[12]. Reducing avoidable admissions has a direct impact on reducing hospital burden and health care related expenditure. Additionally, there is anecdotal evidence that at times older people are being transferred from their homes to hospital in their final stages of dying, when residential aged care staff perceive they are unable to manage the person's end-of-life symptoms. Over one third of permanent residential care residents will die within one year of moving to residential care. End of life, and advance care planning policies and practices are essential in this environment, and may reduce unnecessary hospitalisations and treatment towards the person's end of life when the focus should be on comfort care and symptom management[13].

There are a number of examples, locally and internationally, of service models that focus on preventing unnecessary hospitalisation of older people, and keeping older people healthy in their homes.

The evaluation of the Geriatric Flying Squad (GFS - Southcare, SouthEastern Sydney LHD) determined that the GFS is an efficient service model, avoiding approximately $1M per annum, 1,350 bed days and nearly 370 presentations to hospital. GFS has prevented 747 hospital presentations over the 20 month period prior to April 2014, with residents able to receive care at home. Importantly, there is strong partner support for GFS, with 100% of engaged general practitioners satisfied that referrals and care was appropriate, and 100% of patients and families satisfied with the care and communication provided by the GFS.

The INTERACT (US) model is a program based on quality improvement methods and involves primary care providing outreach into residential aged care. The program has resulted in significant, positive outcomes on the experience of older people, their health outcomes, and reducing costs to the health system[14]. Evercare's model[15] (US) is characterised by Nurse Practitioners providing outreach primary care services into residential aged care facilities, in conjunction with the resident's general practitioner, as well as working together with the residential aged care staff to build capability. Evercare has been associated with significant reductions in hospitalisations (up to 50% fewer hospitalisations in a comparative study), and reported savings of $103,000 in hospital costs, per Nurse Practitioner. Caplan et al (2012)[16] conducted a meta-analysis of 61 papers comparing Hospital in the Home (HITH) to inpatient care, and found HITH was associated with a reduction in mortality, readmission rates and costs, and improved patient and carer satisfaction.

The ARCHUS program in New Zealand[17] did not show the same positive outcomes, however researchers questioned the results due to lack of measurement of hospital presentations (the study focussed on

admissions), and their existing relationships with residential aged care facilities (perhaps reducing their baseline hospitalisation rates). Similarly, a UK study[18] found that presentations may initially increase due to a 'case finding' element of the intervention. It did not find a reduction in hospital presentations, but did find a reduction in length of stay. An Australian program which focussed on advanced care planning and HITH initially saw an increase in hospital presentations for residents, however over a three year period hospital admissions reduced by a third[19].

A specialist geriatric outreach service is an effective strategy for reducing avoidable presentations and/or admissions, keeping older people well in their homes, supporting the older person's choice for treatment in his/her home and reducing healthcare costs.

The model of care: Specialised aged healthcare outreach to residential aged care

Key elements

The model of care outlined below is a blend of models visited across the state. It does not represent any one of the models visited, but instead is a composite of the various models in practice.

Proactive & timely care
Ability to provide rapid response
Clear point of contact

Coordination & continuity of care
Working together across service, organisational and sectoral boundaries
Coordinating care for the older person

Identification & risk stratification
Use of decision support tool to identify risk
Local care pathways for different risk levels

Capability building
Across individuals, units and organisations
Workforce development initiatives

Comprehensive geriatric assessment
Interdisciplinary process

Partnerships
From networking to integration
Partnerships across the breadth of care

Proactive & timely care

What it is

Central to this model is the timeliness or responsiveness of the service, in particular in cases where residents would previously have been taken to the emergency department. Timeliness and responsiveness hinge upon an available team, ready to provide a rapid response service, and a clear point of contact for RACF staff to access support. With continuity of care central to this model, it is essential that it is built around general practice as the central care provider for the older person. Access models therefore need to prioritise effective working relationships and communication protocols with general practice.

Preventing spread of infectious disease in residential aged care

When the specialist geriatric outreach team were contacted about a resident's vomiting and diarrhoea, they asked the residential aged care staff to keep the resident on site and were at the home within two hours. The resident underwent a comprehensive geriatric assessment. Viral gastroenteritis was suspected and the resident placed on parenteral fluids, with residential aged care staff trained in administering this treatment. Additionally, measures were put in place that reduced the opportunity for the spread of gastroenteritis within the facility, and no other resident or staff member became unwell. The residential aged care staff commented on how different their experience had been from previous years, when gastroenteritis would spread throughout the facility,

Evidence base

Timely hospital substitution models of care have been found to reduce health system costs, improve hospital efficiency, reduce costs to patients and carers and improve the workforce participation of carers[20,21]. Home hospital services have also been associated with high patient and carer satisfaction. The involvement of ambulance services in integrated care pathways have also been found to be effective in preventing avoidable hospitalisations for older people[21]. Given the risks associated with hospital admissions and any period of reduced function and deterioration it is essential this group of patients has timely access to care.

Enablers/supportive structures

In developing a specialist geriatric outreach service, there are four main considerations:

- **Availability / hours of service**

  Some specialist geriatric outreach services are contactable during business hours only, others work across extended hours. Levels of service availability may best be determined by interrogating Emergency Department and admission data, specifically looking at those times when patients are most frequently presenting or admitted from a RACF. Additionally, talking with local residential aged care providers and general practice about usage patterns and standard escalation procedures will provide useful information about when a service needs to be available and contactable.

  Whilst initial contact often occurs between the RACF and the specialist geriatric outreach service, there is a need to ensure that communication with general practice occurs. The role of ambulance services also needs to be considered. Importantly, financial considerations will need to contribute to decision making around the hours of service and team members. Appendix A provides some more detailed information about different models and staffing configurations for some of the specialist geriatric outreach services in NSW.

- **Establishing a clear point of contact**

  A clear point of contact enables RACF staff to immediately make contact with the Specialist Geriatric Outreach team members. It is beneficial for medical staff or senior nurses to be the point of contact, to enable immediate risk stratification over the telephone and provide clinical care advice in the short term prior to arriving on site at the RACF. Also important, particularly to general practice, is the ability to accept faxed or electronic referrals. In this instance, staff of the specialist geriatric outreach team need to be regularly checking for referrals and responding in a timely manner.

  Hours of service vary significantly across the state, according to local needs and service availability. Local models are developed taking into account local needs and service demand, together with service availability. Sustainability considerations are important when designing a service of this type, and its operating hours. In some instances, the specialist geriatric outreach Nurse Practitioner answers the phone after hours, in others the specialist geriatric outreach service's telephone number is redirected to an after hours point of contact when the specialist service is not available. After hours calls may be redirected to the ACE Clinical Nurse Consultant, or Geriatrician on-call depending on the model of care which has been implemented at a particular site. In other services, particularly rurally, the number may redirect to a general ward or emergency department, or a local after-hours general practice, where a senior nurse responds to the call and assists the RACF staff decide which is the most appropriate location for care.

Specialist geriatric outreach services require a referral from a general practitioner. This is managed in many services by the RACF staff attempting to make contact with the resident's general practitioner to discuss a potential referral prior to calling the specialist service. Additionally, with a referral from general practice, Geriatricians' services are able to recoup some costs of the service via Medicare item numbers. Incentives for telehealth consultations provide further support to Geriatricians wanting to provide care to older people in RACFs.

- **Collaboratively developing a decision support tool that enables RACF staff to make appropriate decisions about who to contact at different points in time**

  Key to timely access is the ability of RACF staff to make appropriate decisions regarding the level of presenting risk to a resident, and the best course of action to achieve the best outcome for the resident. The decision support tool may provide three main pathways; to consulting general practice, to consulting the specialist geriatric outreach service, and/or calling the ambulance. A local specialist outreach service needs to ensure all relevant service providers are involved in development of the decision support tool(s), to ensure the RACF staff have the skills to use the tool appropriately. Tools may benefit from refinement over time, as the use of the tool reveals if it is being used appropriately, working effectively and resulting in the right outcome for the patient.

- **Ensuring a skilled team is able and prepared to intervene when needed**

  A point of contact is only of use when it enables access to a service that is available and appropriately responsive. Models across the state vary significantly in terms of philosophy, approach and staffing. Whilst access to comprehensive geriatric assessment and capability building are central elements of specialised geriatric outreach models in NSW, there are differences in focus of the various models across the state, which is also reflected in staffing configurations. This is illustrated on a continuum below.

Continuum of specialised geriatric outreach models in NSW

Capability model	**Medical intervention model**
Focussing on capability of RACF staff to care for older people	*Focussing on acute medical management of deterioration*
General Practitioner / Nurse Practitioner / Clinical Nurse Consultant	Geriatrician / Nurse Practitioner
Hospital nursing staff (may be ED staff, aged care medicine staff or general ward nursing staff)	Clinical Nurse Consultant
Practice Nurse, General Practice	Access to medical equipment and diagnostics (eg. mobile xray, pathology services)
Most likely to be rurally/regionally based due to limited access to specialist practitioners	Most likely to be metropolitan based due to access to specialist practitioners

The following *Local service design* section of this document may provide some assistance in developing a local service model based on approach and target population. Appendix A provides some more detailed information about different models and staffing configurations. Strong clinical governance arrangements for these models are crucial, and outlined within the section titled *Making it happen (pg. 21)*.

Specialist geriatric outreach services have been developed with an aim to improve rapid access to specialist care for older people living in a RACF. As such, timeframes from referral to comprehensive assessment are tight, within 1 hour to same-day response times across the four initiatives visited for the development of this model (during service hours). Importantly, timely access includes the process of

initial referral, information gathering by the service from the RACF when more clinical information is required and communication with general practice.

▲ Identification & risk stratification

What it is

Identification of resident needs and appropriate classification according to risk is key to obtaining the right service at the right time for older people. Decision support tools form one component of the care pathway for residents and assist RACF staff in identifying deterioration, making relevant observations and gathering clinical information as relevant, and determining the appropriate course of action. Once a referral is made to the specialist geriatric outreach service, the team communicates with the RACF staff and general practice, making judgements based on clinical information and determining an appropriate action (and response time).

Decision support tools in residential aged care

Through a partnership with the Medicare Local and NSW Ambulance, one LHD has been able to successfully design and implement a set of clinical pathways for management of older people living in residential aged care. The pathways include an initial decision matrix determining if an ambulance should be called. Once this decision is made, decision support tools outlining care processes (eg. use of ISBAR in handover) for the appropriate care of the older resident, with clear escalation points are able to be put in place.

Use of the clinical pathways and tools is supported by ongoing education and training, local networking opportunities with local service providers, and continued review of the tools by the specialist geriatric outreach team.

Evidence base

Decision support tools and clinical pathways have been found to be supportive of clinical practice that is reflective of the evidence base, particularly in situations where staff may have less training, or in complex workplaces[22]. Clinical pathways and protocols are key to building a shared understanding of the service system, they are used to understand and make decisions regarding the management and care of older people, and central to the achievement of effective, integrated care[23].

Enablers/supportive structures

Identification and risk stratification models and tools need to be developed collaboratively. Working together across providers (RACFs, GPs, LHD, Ambulance) to determine locally appropriate care pathways and develop tools to support clinical practice and decision making is essential. Additionally, specialist geriatric outreach services have a role in supporting the staff of RACFs to develop and maintain knowledge and skill in using decision support tools.

Comprehensive geriatric assessment

What it is

Defined by the Australian Society for Geriatric Medicine as an "interdisciplinary process used to quantify an older individual's medical, psychosocial and functional capabilities"[24], comprehensive geriatric assessment is the core of the specialist outreach service. This process encapsulates diagnosis, problem identification and goal setting. It also includes the development of a comprehensive management plan, together with other involved care providers[25].

Evidence base

The multiple comorbidities often experienced by older people in RACFs result in complex presentations and healthcare needs which require access to a range of integrated services, including specialist geriatric care. The Australian Society for Geriatric Medicine asserts that comprehensive geriatric assessment supports care decisions for older people, reduces hospital readmissions, enables older people to maintain cognitive and physical function and reduces mortality[26].

Forming a relationship between specialist geriatric services and RACFs also enhances outcomes for residents by impacting positively on quality standards, staff training and skills and supporting older people to stay well in their homes[27].

Enablers/supportive structures

Comprehensive geriatric assessment needs to be undertaken by a team member with specialist clinical knowledge and skills in geriatrics. In this context, team members need to be a dedicated resource to ensure that comprehensive geriatric assessment occurs in a timely manner and rapid assessment is available where appropriate.

Some services across the state have specialist Geriatricians on staff, some have Nurse Practitioners, and some are using telehealth consultations to access specialist assessment. Telehealth consultations are outlined in more detail in the *Making it happen* section of this document *(pg. 21)*.

Some specialist geriatric outreach services are billing via Medicare to support the costs of the service making it more financially sustainable. More information on Medicare billing and item numbers is included in *Making it happen (pg. 21)*.

Coordination & continuity of care

What it is

Good communication across primary care, residential aged care and specialist services is essential when providing outreach services to support older people living in RACFs. Care coordination involves working across service, organisational and sectoral boundaries to maximise outcomes for older people.

Due to the complex relationships involved in the care of an older person living in a RACF, protocols and processes for communication across these boundaries are central to development of a strong model of care.

In the context of the specialist geriatric outreach service, general practice remains the primary provider of medical care for the resident, with the RACF staff responsible for the day to day care and support of the resident. For this reason clinical decision making needs to be especially collaborative in this environment, involving the resident, carers and providers.

Communication processes for referral to specialist geriatric outreach services, and communication and feedback loops are illustrated in the diagram below.

Communication & referral pathways
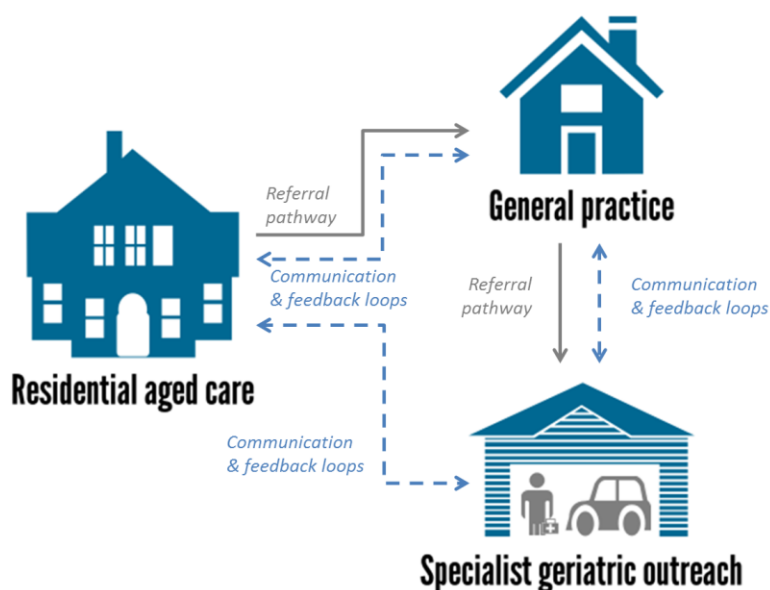
Evidence base

Coordinated care is essential for older people, who may experience an adverse event if care is not well-coordinated. This is particularly true when older people are experiencing transitions of care, from home to hospital, hospital to home, and in particular for those older people with multiple comorbidities and reduced capacity to engage in their own care and care decisions[28]. Evidence is available on the risks associated with poor transitions of care, particularly in relation to rapid readmission and/or medication error and adverse events[29]. To achieve effective change, coordinated care needs to be reflected in local pathways and clinical protocols, with a focus on care transitions and how these will be managed[30].

Enablers/supportive structures

Protocols and processes for communication across professional, service and organisational boundaries are key to coordinated care for older people living in RACFs. These should be developed in conjunction with the relevant providers and organisational partners. Communication across boundaries is not only a requirement of person-centred care and positive outcomes, but is also a foundation for inter-professional and cross-organisational relationships and trust.

Additionally, it is important to consider means of care coordination and communication. Whilst in some instances practitioners and providers may be able to meet face to face, in other instances communication may occur via e-referrals and electronic information sharing, telephone contact, telehealth (together with residents and their carers) and mailed correspondence. Local partnerships will be able to determine which means of communication will work best at a local level, with flexibility built in for individual variation.

Capability building

What it is

Effective capability building comes from a strengths-based approach and takes place across a number of areas, including individual skills, organisational policy and systems and supportive networks and environments[31]. In this context, capability building refers to the *collaborative work* by partnering agencies to improve care by sharing knowledge and skills, and building organisational and cross-organisational systems of care.

Levels of capability building/development

Level	Components of capability building/development	Examples
Individual	Engaging in education and training on a specific clinical issue or aspect of care, supported practice, clinical competency development	Web-based self-directed learning modules Supervised practice, for example, IV therapies
Organisational	Embedding processes, protocols, systems, policies and tools to support care Engaging in process redesign work Developing local quality reports and actions arising from reports	Development of local dementia practices and policies Development of decision tools to identify a deteriorating resident, and supporting care pathways
Sector, or partnership level	Focussing on local supportive practices and environments across organisational boundaries Development of care pathways across organisational boundaries	Regional RACF Director of Nursing forums (with LHD DoNs) Shared Continuing Professional Development programs Staff rotations through RACF & aged care wards

> Working collaboratively to build capacity
>
> A LHD identified a residential aged care facility (RACF) whose residents were frequently presenting to the emergency department. The LHD reviewed patient information at the hospital and determined that most of these residents were not admitted, indicating that their needs may have been able to have been met in the community. The LHD approached the RACF to determine if they were interested in engaging with the LHD to improve how care was delivered for the older people living in their facility. Together they identified challenges at the individual, facility, and care system levels, generated some possible opportunities for improvement and developed a plan for action. Together the LHD, RACF, Medicare Local, general practice representatives and Ambulance developed a training package for personal care staff, accompanied by decision support tools, and ongoing contact with the specialist geriatric outreach team. The LHD saw a reduction in ED presentations, an increase in specialist geriatric outreach contacts and a reduction in length of stay in hospitals for older people, with the RACF more skilled, prepared and better supported to care for residents.

Evidence base

It is well-recognised that those with the most direct contact with older people have the least training and support to work with older people[32]. There is an increasing trend toward the employment of less skilled workers in residential aged care, combined with a decrease in employment of Registered and Enrolled Nurses[33]. An improved system of care for older people is reliant on the transfer of knowledge, skills, and systems for supporting carers (paid and unpaid)[34]. The residential aged care workforce in Australia experiences skills shortages[35] requiring organisations to have strong succession planning and recruitment processes, and processes to ensure staff attain and maintain clinical competencies appropriate to the setting and local service arrangements[36,37,38].

Enablers/supportive structures

Capability building is built on partnerships working, sharing strengths and varying knowledge and skill bases across units and organisations in an environment where skills transfer is encouraged. It requires clinicians and managers who are capable of teaching and transferring skills. A strengths-based approach acknowledges the skills, knowledge and experiences of the partner organisations, and enables sharing across organisational boundaries. Leadership is essential, with organisational leaders in the position to approve initiatives such as opening access to education programs and libraries, designing and approving rotation programs, and working effectively on high-level partnerships.

Partnerships

What it is

Partnerships involve two or more organisations committing to work together, develop shared goals and taking collaborative action to achieve shared goals. Partnerships are built on the premise that by sharing skill sets, building capability, reducing duplication and communicating, more can be achieved together than alone. There are various levels of partnerships, which are illustrated in the diagram below.

Integrated partnership working: Separate identities of the partners or agencies no longer as significant as the outcome

Collaborative practice: Longer term and more deliberate efforts of organisations and groups to: undertake shared planning; take joint responsibility, with equal commitment for activities; and shared vision of the outcomes, with high level trust and power sharing based on knowledge and expertise

Partners move up and down these levels and relationships intensify as there is movement from one level to the next

Coordination: Time-limited activities with some joint responsibility and shared outcomes that requires only enough trust to give and receive help from one another

Cooporation: Exchange of information; altering activities for a common purpose; joint working but marginal to organisational goals

Communication: Joint working but marginal to organisational goals. Frequent interactions and sharing of information as it applies to users whose needs cross boundaries; a nominated person is responsible for liaison

Networking: A loose arrangement of contact (or encounter) for the purposes of information sharing; divergent organisational goals and perceived rivalry

Isolation: Agencies are separate from others with little or no communciation

From *Building Partnerships2014*[39]

Partnerships are formed to serve a common purpose; in this context, establishing and maintaining local partnerships supports local agencies to improve the older person's experience and quality of care. These partnerships aim to improve the health of older people, minimise preventable hospitalisations and reduce costs to the health system. Partnerships should bring benefits to the partnership as a whole, but additionally provide benefits to its individual members.

Evidence base

Integration of care for older people is key to improving health outcomes, experiences of care and quality of life[40]. Partnership arrangements support achievement of integrated care by bringing services and organisations together to think about the system of care from the older person's perspective, with the aim of removing barriers to integrated care[41].

There are numerous tools that enable assessment of the quality of a partnership and the level of engagement by its members[42]. These tools provide insights into what constitutes effective partnerships, such as clearly understood and shared goals, commitment to take action toward achievement of goals, effective processes of the partnership. Like any quality measure, the findings from these tools can be used to further improve the functioning and experiences of the partnership.

Enablers/supportive structures

Developing a successful partnership requires time and effort to be invested in building relationships, trust, and successes in areas that are meaningful to all members of the partnership. Open communication, time allocated to the building and maintenance of partnerships and strong leadership are all central to the development of positive and effective partnerships. Additionally, a partnership requires clarity around what it aims to achieve and how partnering organisations will work together, who will be involved and the expectation of the partnership[43].

Local service design

Local service design will be largely influenced by decisions regarding the planned service approach and target population. Determination of a local target population is central to the development of a service's design and a localised model of care for older people living in a RACF. For example, those services which aim to prevent deterioration of older people in RACFs are configured differently from those which focus more strongly on preventing hospital presentations.

The diagram below illustrates the typical end-of-life trajectory of an older person[44]. This trajectory may be used to consider and make decisions regarding the local geriatric outreach service's focus, for example focussing on prevention of decline and deterioration, or focussing on treatment and/or management of deterioration, or end-of-life care.

Typical end-of-life trajectory of an older person
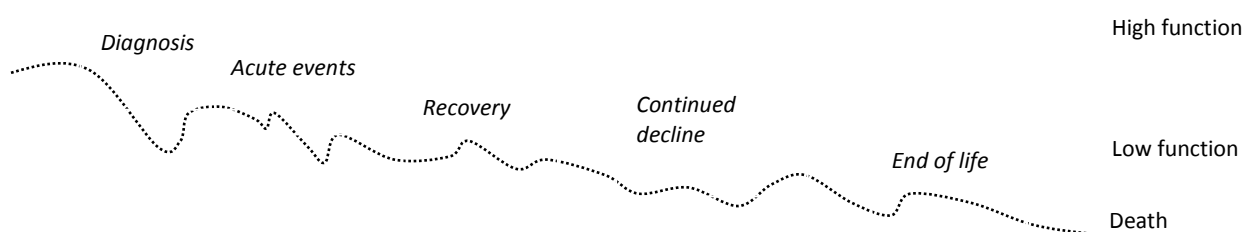
Decisions regarding the focus of the service model, service target population, and intervention types and locations will impact significantly on how the local service is designed and implemented. The table following illustrates the differences in outreach specialised aged healthcare service target populations across NSW, and how these decisions impact on service design.

Strategic focus and design		Focus areas to achieve the focus			
Service target population	Service focus	Capability building focus	Approach: individual or service level interventions	Individual resident monitoring / review	Coordinating care
Older person at risk of deterioration	Capability building	Ability of RACF staff to identify deterioration early, and to commence a care pathway. Capability building would also occur across areas likely to benefit a number of residents (eg. dementia, falls).	Service level interventions to reduce or minimise risk of deterioration, eg. environmental adaptations. RACF ability to identify individual deterioration. Residents may be identified as at risk of deterioration due to predetermined risk factors or identified through a previous hospital contact.	Undertaken by the RACF staff, with care pathways implemented if deterioration begins to occur.	The Specialist Geriatric Outreach Service may facilitate communication / support the relationship between RACF and general practice, and support development of a process for regular medical review of residents.
Older person experiencing rapid deterioration/decline	Timely access to comprehensive specialist assessment	Ability of RACF staff to identify deterioration in an older person. Ability of RACF to use local decision support tools to determine which service to contact: general practice, specialist outreach team or ambulance. Ability of RACF staff to screen resident and provide meaningful clinical data to specialist outreach service. Ability to provide clinical interventions within the RACF, enabling the older person to receive care in their own home (i.e. RACF).	Individual clinical interventions, with support for staff to implement clinical interventions within the RACF as appropriate. Service level interventions focus on care strategies, such as handover and communication processes, clinical care (including new equipment). Once a resident is identified as experiencing deterioration/decline, RACF staff can begin to implement local care pathways and use local decision support tools that have been designed together with local providers (eg. general practice, specialist geriatric outreach service, ambulance service).	Specialist outreach service would work together with general practice to ensure monitoring /review for the period of acute deterioration.	Specialist Geriatric Outreach service would work with general practice to share information about the older person and collaborate on care decisions. The role of care coordination remains with the general practitioner. Where appropriate, Specialist Geriatric Outreach would facilitate rapid access to emergency care, whether this is provided by the Service, ambulance for care in the RACF, transfer to ED or direct hospital admission. Specialist Geriatric Outreach would facilitate direct hospital admission as appropriate and maintain communication with general practitioner.
Older person requiring immediate, emergency care	Rapid access to comprehensive specialist assessment and care. May involve ambulance if older person's condition is life threatening.	Ability of RACF to identify rapid deterioration and utilise local decision tools to determine who is appropriate to contact. Ability of RACF to make appropriate decisions in context of advance care directives and local service agreements.	Focussing on individual clinical interventions (may be provided by ambulance or in hospital), with support for staff to implement clinical interventions within the RACF as appropriate.	Specialist outreach service would communicate with general practice and monitor/review for the period of acute deterioration, and may provide follow up visit(s). Treatment plan may facilitate a change in focus to a palliative approach, depending on the client's response to active treatment trial.	Specialist Geriatric Outreach would facilitate direct hospital admission as appropriate and maintain communication with general practitioner.

Making it happen

Adapting to local context

In adapting the geriatric specialist outreach service model to the local area, there is a need to assess the local context through asking a series of questions. These may include:

- What is the demand for services? How many RACFs are in the area?
- What is the current demand on ED for older patients? Are there patterns in reasons for presentation?
- Identify resources available to allocate to a service. Are there funds available? If yes, how many? What staffing could be employed within available resources?
- Which RACFs would be best to work with?
    - Review emergency department data and identify facilities with most preventable or unnecessary presentations to the emergency department
    - Gauge interest with senior staff/management in doing work in this space
    - Examine skill mix at the RACFs
- Which services or organisations may need to be involved in this process/partnership?
- Identify target patients – those experiencing acute decline, or those at risk of decline?
- What are the barriers that need to be overcome? What is the problem that needs to be solved?
- How could the service be delivered?
- What might be the local solutions?

These questions may reveal the beginnings of local solutions, and can then be discussed with partnering organisations and care pathways developed and implemented accordingly.

Process

Initial work in this area may involve reviewing hospital data and medical records to identify unnecessary presentations or admissions, reviewing resident stories, and mapping resident journeys when deterioration occurs to identify current practices. This process reveals information about the service in its current form and provides some prompts in terms of where action is needed. This initial body of work may be completed in conjunction with, or independent of other local service providers.

A partnership of agencies working together is required to develop effective models of geriatric specialist outreach. Local partnerships may prefer to complete a review of current practices together, or may wish to accept work completed by one of the agencies, to enable the partnership to focus on goals and developing actions for change. Capability improvement is a central element of this model, and features strongly within the process planning.

In any partnership, it is essential to check in on the health of the partnership itself (separate from the its work), to ensure organisations are getting good value from time expended, and seeing real clinical change and impacts for residents, as a result of the change.

Facilitators/enablers
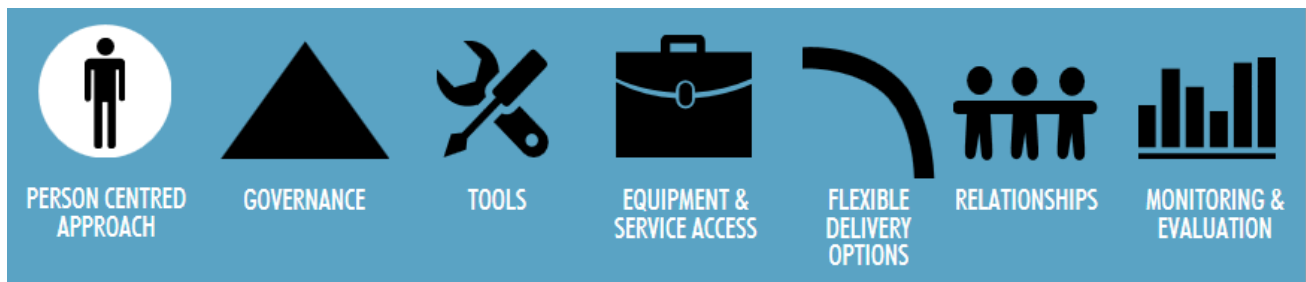
Person centred approach

Applying a person centred approach keeps integration and holistic care central to any redesign or change for improvement project. This model is focussed on equity of access to appropriate and high quality care for older people living in RACFs. A person centred approach also assists partnerships of organisations see where potential "cross-overs" or handover points in care may occur. Mapping residents' experiences of care can assist in highlighting areas for improvement and areas of care that are working well.This approach also helps maintain the focus on the older person and planning effective care, as opposed to focussing on artificial organisational boundaries.

Governance

Whether organisations develop a truly integrated model of care, or an integrated partnership way of working, strong clinical governance structures are required for specialist geriatric outreach. There are numerous configurations for specialist geriatric outreach service models across the state, with examples of some of these outlined at Appendix A. It is essential that it remains clear who is primarily responsible for the resident's medical and social care at points in time, and there are clear and available contacts for advice and consultation as required.

For example, where the specialist geriatric outreach involves a Geriatrician, Nurse Practitioner and Clinical Nurse Consultant, there need to be clear protocols for consulting more senior or specialist staff as required, and processes and contacts for communication and consultation for extended hour services. In some services in NSW, a Nurse Practitioner is responsible for the assessment of the older person during extended hours, with medical consultation available via the Geriatrician on call, or emergency department physicians.

Tools

A number of tools are used in specialist geriatric outreach services. This section focusses on those tools that facilitate communication, decision support, intervention planning & care coordination, advance care planning.

Information systems aim to improve ease of practice, reduce duplication and ensure appropriate transfer of information that supports care. This may be more challenging when information needs to be shared across service and organisational boundaries. In the case of specialist geriatric outreach, at least three services will be communicating about one resident's care at any point in time, each with different information systems; general practice, residential aged care, and the Local Health District-based specialist geriatric outreach team. There are numerous solutions to this challenge, with notes being scanned from one information system into another, with paper-based correspondence in the post, and in some cases, double entry into both the residential aged care file and LHD medical record, with additional documentation going to the general practitioner. Many sites agree on the value of having detailed notes on the LHD medical record, as these may

then assist in the instance that a resident presents to hospital. The challenge remains to determine the most efficient means of maintaining information systems across organisational boundaries.

There is clear policy support for use of advance care directives to support patient centred end of life care. Specialist geriatric outreach services note that use of advance care plans support the management and care of the resident in the RACF and reduces the need for invasive interventions.

Decision support tools and care pathways are key to the success of specialist geriatric outreach. These tools assist in the consistency and standardisation of care processes, supporting staff in RACFs to make decisions and identifying appropriate contacts with relevant services.

Equipment & access to services

For a mobile service, such as specialist geriatric outreach, ready access to equipment and services is key. Equipment includes specific clinical equipment (eg. pulse oximeters, bladder scanners, pharmaceutical stock) and equipment such as a car and mobile telephone. It is important to note that equipment lists will be dependent on locally agreed care pathways and models of care, outlining which interventions may be managed within the RACF and which need to be managed in a hospital environment. In some cases, RACFs have achieved a level of competence and confidence with particular equipment, and have purchased their own equipment for use with residents. In addition to equipment, some specialist geriatric outreach services have established relationships with service providers who can provide rapid access to assessment or interventions, for example, pathology services and mobile imaging.

Equipment to support telehealth is also growing in its usage and importance. The Agency for Clinical Innovation is doing significant work regarding telehealth and has resources available to support local work in this space (http://www.aci.health.nsw.gov.au/resources/telehealth).

Flexible delivery options

Geriatricians are not in every health service in NSW. Hence, there is a need to think flexibly and creatively about how specialist geriatric outreach might best be provided in a local area. Alternative models to face to face care can also be considered where there are greater travel distances or times between service locations. Some specialist outreach services are delivered by nursing staff, supported via specialist consultations (over the telephone or via telehealth) as required.

Telehealth is a growing means of service delivery for specialist geriatric outreach. Telehealth delivered by consulting physicians is now supported by Medicare item numbers which provide funds for telehealth consultations in addition to the usual specialist consultation item numbers.

Relationships

Positive working relationships with partnering organisations are central to the success of specialist geriatric outreach models. The complexities of service relationships for older people are illustrated below. Services that supported the development of this document all stressed the importance of strong relationships between and within the Local Health District, RACFs, general practice and NSW Ambulance.

Specialist Health Care designed for Older People Services Diagram

Health care delivered in Aged Care sector
Contact Centre support and outreach
Hospital in the Nursing Home
SMHSOP – RACF special care units
MPS

Transition between hospital and Aged Care sector
AARCS
TACP

Hospital Care
Acute Care
 - ASET
 - MAU
 - AARCS
 - ACAT
 - Inpatient units
 - Delirium/ dementia units
 - Dementia services
 - Consultation liaison
Subacute care
 - Inpatient beds
 - Consultation liaison
 - Shared care
  - Orthopaedics
  - Neurology
  - Oncology
  - Urology

Transition between hospital and primary care
HITH or post-acute care
ComPacks
TACP
HASI

Aged and Community Care sector

Primary Care

Older person and family

Hospital care

Integrated Primary Health Care

Specialist health care in the community

Transition between health care in community and Aged Care sector
AARCS
ACAT

Specialist health care in the community
Intake
ACAT
Clinics
Day Hospital and outpatient therapy
Home-based therapy
Community Dementia services
Community Nursing
Allied Health

Integrated Primary Health Care
HealthOne NSW
Connecting Care

NSW Ministry of Health[45]

Monitoring & evaluation

Monitoring and evaluation should be considered and planned from commencement of delivering a service which has the aim of reducing unnecessary presentations to hospital. Systems for monitoring the number of patient referrals, contacts, the types of referrals, interventions and the outcome, all provide important information about the services being delivered and the outcomes achieved. A number of services around the state are using Excel spreadsheets to enter data about the specialist geriatric outreach service, which are then able to be searched or used to run reports on this data to extract key information about the service. This data is particularly helpful to describe a service, prove its value including ROI, and in addition supports early publication of service processes, demand and results.

Sustainability

Medicare item numbers are used by services across the state to recoup costs, particularly by Geriatricians. This adds an additional administrative component to the management of the program, which can be significant. However, these financial rewards may contribute to development of the service, particularly when they are also combined with incentivised flexible delivery options such as telehealth.

Sustainability planning is also related to an available and suitable workforce. Workforce considerations are larger than the funding arrangements for positions, and include issues such as professional support (when staff are working independently, across a number of sites) and team association, actively protecting staff from burnout and protecting hours away from work. Some services across the state have specialist staff responding to mobile calls 24 hours a day, 7 days a week. From a workforce perspective, this is not sustainable. Areas need to inspect closely the level of demand for services, invest heavily in capability

building with residential aged care, and develop out of hours options that support RACFs but also protect the wellbeing of specialist staff and the longevity of these programs.

Self-assessment tool

This tool may be used by local organisations engaging in local service improvement for specialist geriatric outreach. The tool provides agencies with areas to target for improvement, and supports agencies to identify their current level of achievement and track progress over time. It allows organisations to self-rate across three levels of care – basic, advanced, innovative.

The self-assessment tool can be used by services to make judgements about their current services, by noting whether features are *met*, *partially met*, *not met*, or *not applicable* in their services. Services then need to determine if this level/type of service is appropriate for their organisation and develop a plan of action for improvement, where improvement is warranted. It may be revisited following improvement efforts. This model of care document provides agencies with support in identifying opportunities for improvement and opportunities for action.

	Met	Partially met	Not met	Not applicable
Specialist geriatric outreach The organisation has a strong commitment to improving care for older people.				
The specialist geriatric outreach service is one of a suite of local initiatives that are working to improve experiences and outcomes of care for older people				
The Local Health District (LHD) has engaged in a process together with local partners in care for older people, to determine local specialist geriatric outreach needs				
The LHD has a process to translate local service needs into local service plans/models, together with partner organisations				
Service models include appropriate clinical governance mechanisms, taking into the account the complexities of working in complex acute care outside a healthcare environment				
The LHD has a process in place for monitoring, reviewing and evaluating the specialist geriatric outreach service, in terms of reach, process and outcomes.				
The impact of the specialist geriatric outreach service, including clinical care components, timeliness, continuity of care, costs of care, capability building approaches and partnership activities are measured, recorded and used for service monitoring and evaluation				
Proactive & timely care				
The service has a single point of contact that is known to the RACFs				
The point of contact is staffed by team members who have the relevant skills to support RACF staff's decision making during the initial phone contact				
The point of contact is staffed by senior, specialist team members who have the relevant skills to respond to the needs of the RACF during the initial phone contact, and can provide advice on interim care				
There are clear expectations regarding appropriate service access times, and these are met by the specialist geriatric outreach service and other partners				
An arrangement for after-hours support is in place				
The RACF accesses the specialist geriatric outreach service appropriately				
Identification & risk stratification				

RACF staff are supported to develop skills in identifying deterioration of residents				
Decision support tools are documented and available at the RACF to support decision making around accessing care for older people				
Evidence informed care pathways are documented and available within the RACF to provide support for staff caring for residents in the RACF				
RACF staff are supported to develop skills in clinical handover and use of decision support tools (and clinical pathways where these exist) to support transitions of care for residents				
Comprehensive client assessment				
Comprehensive client assessment is undertaken by Geriatrician, or authorised team member and includes diagnostic investigations as appropriate				
Comprehensive client assessment includes formal geriatric assessment				
Assessment occurs in clinic (where resident is able to travel), RACF or via telehealth				
Assessment findings are documented and communicated to the older person and/or carer/person responsible, the RACF staff, general practitioner and other involved providers, with consent				
Specialist secondary consultations are offered to general practitioners via telehealth when reviewing their patients at RACFs				
Coordination & continuity of care				
The specialist geriatric outreach service has a documented process for communication with general practice				
Local service partners have agreed on processes and protocols for referrals and communication. Means of communication may include face to face discussions, e-referrals, electronic information sharing, telephone contact, telehealth and written correspondence.				
General practice is recognised as the centre of the resident's care, and care decisions take place in collaboration with the resident's general practitioner				
Capability building				
Varying skills across the partnership are identified and mapped to determine the strengths and offerings of the different partners				
The partnership members work together to identify local areas of need				
Partnership members work together to develop appropriate plans to build capability across the individual, organisational and partnership levels				
Partnership members share or pool existing resources for capability building[A]				
Partnerships				
There is a shared understanding of the aims of the specialist geriatric outreach service				
Partners share a commitment to the goals and work of specialist geriatric outreach. This may be documented in the way of an MoU or is understood through discussions on service establishment and development				
Partners are willing to share resources, skillsets, knowledge, influence and power to achieve the aims of the specialist geriatric outreach				

[A] For example, LHDs may open access to grand rounds to local general practice, or nursing continuing professional development to RNs from residential aged care. Likewise, residential aged care staff may be able to offer education for aged care ward staff on environmental modifications to support people with dementia. Partnerships may also wish to pool funds to purchase in specialist training/workshops or evaluation support.

Regular meetings are attended by local partners, and are used to identify further needs, refine the model of care, address any challenges (present or future) and to celebrate successes				
Changes to the model of care, service delivery and/or service tools are developed and refined in conjunction with local partner organisations				
Some roles work across traditional organisational boundaries in the partnership				

Appendices

Appendix A : Specialist geriatric outreach to residential care, service profiles

The Geriatric Flying Squad, Southcare, SESLHD

Context	The Geriatric Flying Squad forms one part of Southcare at SESLHD.
Aim(s)	Provide rapid assessment and management into RACFs for acutely deteriorated patientsImprove quality of aged care services through timely and effective interventions Reduce avoidable emergency department presentations and hospital admissions of residents living in aged care facilities Reduce risk for potential adverse outcomes relating to hospitalisation of the frail older person Improve end of life care Reduce impact of unnecessary transfers on ambulance service
Eligibility	Any resident from a RACF with acute deterioration where a hospital transfer is being considered.
Service features	7 days a week, extended hour services Point of contact is Geriatrician or Nurse Practitioner (on mobile) Between 40-60 referrals/month The Geriatric Flying Squad provides an outreach service to 26 aged care facilities with approximately 2,600 older people residing in these facilities Relationships with local public and private hospitals for direct admissions Medicare billing by geriatrician for some client episodes
Team member(s)	1 Geriatrician 2 Transitional Nurse Practitioner 1 Clinical Nurse Consultant (role is primarily capability building with RACF staff)
After hours	Nurse Practitioner/Transitional Nurse Practitioner to 1930hrs Mon-Fri, to 1830hrs on weekends. . Communicates with Geriatrician on call where appropriate.
Key relationships	RACFs, local general practitioners, ambulance, Southcare (for specialist community nursing)
Achievements	Timeliness: Comprehensive assessment in the older person's home at the RACF within 2-4 hours of referral. Expedited ward admission where necessary. Choice in place of treatment: Assessment occurs in at the person's home in the aged care facility if this is their choice. Diagnostics: Utilisation of point of care technology (iSTAT, bladder scanner, coaguchek, auditory Doppler) and local mobile pathology and radiology services. Capability building: Care pathways implemented for simple treatable conditions, including chest and urinary tract infections. RACFS able to manage residents with increasing acuity and clinical care needs (eg, IV therapies). Person centred care: Advance care planning and end of life services in place in RACF. Preventing hospitalisation attendances and admissions: 94% of clients seen by GFS from November 2011 to June 2014 (N=980) were managed in the facilities. Clients receive average direct visits of 2.07 and an additional 3.3 indirect interventions during their acute phase of illness. Costs avoided: $1M per annum, through avoidance of 370 presentations and 1,350 bed days. Stakeholders' satisfaction: GP's, RACF nursing staff and clients' families reported 80-100% satisfaction with the overall service provided by GFS.
Challenges	Months before service started receiving referrals. Relationships with general practice take time. High staffing turnover at RACFs means capability to manage residents can change over time. Turnover also impacts on referrals. Administrative demands associated with maintaining databases and establishing Medicare billing.
Future	Looking at opportunities in telehealth Expansion of the Geriatrician hours for GFS Administrative support for GFS

Virtual Aged Care Services (VACS), NBMLHD

Context	VACS sits within Geriatric Medicine (Aged Care) at NBMLHD, and has relationships with acute services, subacute services, community programs, primary care and residential aged care
Aim(s)	Reduce unnecessary hospital presentations and admissions for older people Facilitate early discharge from hospital (reducing length of stay) Streamline older patients' entry points to hospital Two pilot sites (RACFs) to trial telehealth strategies for delivery of VACS
Eligibility	Minimum of two criteria: • Presence of acute/subacute condition requiring hospitalisation if not reviewed by VACS • Medication adjustment required • Educational needs • Functional decline, or improving resident quality of life • Referral to other services
Service features	24 hour access, 7 days per week Response time of 24-48 hours 20-50 referrals to VACS per month (average is 50) Point of contact is Career Medical Officer (after hours managed by Aged Care Specialist at Nepean), who supports risk stratification and referrals to appropriate service(s), e.g. VACS, HITH, ACE CNC, ED MAU. Care coordination: collaborative care plan development with involved providers. Provides post-discharge support, ensuring discharge plan is enacted, managing polypharmacy issues and transitions of care from home to hospital to home. Strong links with specialist clinics. Capability building: access to LHD education for RACF staff, webinars for general practice, education focussing on care of individual residents Targets both hospital access and exit blocks Telehealth strategies improve resource utilisation
Team member(s)	0.2 FTE Geriatrician 1.0 Career Medical Officer (CMO) 1.0 FTE Physiotherapist Advanced Aged Care Trainee Access to allied health (speech pathology, social work, occupational therapy, dietician) Telehealth Nurse Manager has had a key role in preparing and training RACF staff to use telehealth equipment

Key relationships	Residential aged care (especially DoNs) Ambulance (Extended Care Paramedics) Medicare Local General practice	Aged Care Assessment Team (ACAT) ACE Clinical Nurse Consultants HITH

Achievements	Local evaluation suggests presentations reduced by 60%, unplanned admissions reduced to approximately 10% and two day reduction in LOS for older people. Strong links with Extended Care Paramedics, with clear agreements around roles, formalised pathways and pharmaceutical guidelines. Working together to provide training, education and support to RACF staff Changing behaviour of staff within RACs to be more proactive around deterioration Establishing telehealth sites (and trained staff members – RNs, ENs & AINs) in two RACFs, to provide secondary consultations for general practice
Challenges	RACF workforce issues pose ongoing difficulties
Future	Strengthen links with community/social care Continue partnership with Ambulance, with focus on palliative care and end of life in 2015

Aged Rapid Response Team (ARRT), NSLHD

Context	ARRT offers an outreach service to RACFs in the Lane Cove, Mosman, North Sydney, Ryde, Hunters Hill and Willoughby local government areas and collaborates with APAC and ASET
Aim(s)	The ARRT service aims to provide person-centred health care with the best possible outcomes for residents of aged care facilities and older persons residing in their own homes, by providing medical and nursing care at home for older people experiencing acute functional and/or medical decline; developing management plans for residents as an alternative to hospitalisation, or to expedite hospital discharge; offering telephone advice, on site rapid clinical assessments, advice, and management of a wide variety of conditions; collaborating closely with APAC, ACAT, the Aged Care department, Northern Sydney Home Nursing Service and other services in the area; acting as a link between ED/AAU and RACFs; providing educational assistance for RNs working in RACFs.
Eligibility	Frail older person living in their own home or in a RACF at risk of deterioration, who would otherwise require hospitalisation Flexible referral and admission criteria
Service features	Rapid access medical and nursing community visits to older people living in the community, and in RACFs Telephone service for advice regarding resident care Approx 90 referrals/month Mon-Fri service. Callers on weekends are advised to contact Geriatrician on-call, to call APAC, or messages can be left for review the following Monday for non-urgent cases. Care coordination: comprehensive geriatric assessment followed by collaborative care planning, service linkages in consultation with the GP. In-hospital visits to expedite discharge or smooth transition home. Capability building: opening LHD training to RACF staff, rotations program, collaborative development of training programs for RACF staff, on-site education of RACF staff Use of decision support tools by RACF staff (APAC flipchart, accessed here: https://www.nsml.com.au/for-health-professionals/resource-centre/aged-care-resources/aged-care/ryde-apac-sick-patient-flip-chart_20130829131144.pdf
Team member(s)	1 FTE Geriatrician 1 FTE Advanced Trainee (jointly funded by APAC and Aged Care) 2 FTE Clinical Nurse Consultants
Key relationships	RACFs Medicare Local and general practices Internal LHD relationships: including APAC, ASET, ACAT, Chronic and Complex Care Internal LHD relationship: RNSH Pathology Northern Sydney Home Nursing Service Specialist Mental Health Services for Older People Mobile radiography services Palliative care services LHD Specialist Clinics
Achievements	Timely access to specialist care at home Preventing unnecessary hospital presentations/admissions Development of education for Registered Nurses (RNs) in RACFs Working closely with general practice around advance care planning
Challenges	Workforce issues in residential aged care Duplication of records in LHD & RACFs (information technology is supportive in this case) Ongoing funding for this service model
Future	Increasing initial assessment by nurses Increasing access to allied health Greater partnership with Medicare Locals Establish long-term funding

Aged Care Nurse Practitioner (ACNP): Outreach Rapid Acute Care Service for Older Community & RACF residents, Coffs Harbour Health Campus (CHHC), MNCLHD

Context	The Acute Aged Care Nurse Practitioner role is based within the Emergency Department of Coffs Harbour Health Campus
Aim(s)	To prevent unnecessary presentations from RACs to the Coffs Harbour Health Campus ED, and inappropriate admissions to CHHC. To facilitate appropriate ED access Provide a single point of contact for outreach rapid acute care service to GPs, RACFs, CAPACs and Aged Care Assessment Service teams Provide timely follow-up after discharge from the ED
Eligibility	Any RACF resident consenting to assessment by ACNP Any person over 70 years living in the community Any Aboriginal or Torres Strait Islander over 50 years living in the community
Service features	Mon-Fri service, after hours RACs are advised to contact ED Face to face, telephone contact and telehealth delivery Point of contact is Nurse Practitioner on mobile MoU with RACs regarding expectations of collaborative practice Capability building: training RACF staff in clinical management of residents and handover
Team member(s)	1 FTE Aged Care Nurse Practitioner Supported by ED Specialists and Geriatrician, Coffs Harbour Health Campus
Key relationships	RACFs General practice Coffs Harbour Health Campus ED, ASET & ACAT
Achievements	Local evaluation suggests ACNP is preventing 90 presentations/month Strong positive relationships with RACs Improved relationships with local general practice New Geriatrician and Nurse Practitioner working to review every RACF resident in Coffs Harbour over next 12 months
Challenges	Difficulties with sustainability, as model is built on availability of one person. Issues exist around succession planning and leave replacement. Working on a new "frontier" (ie. Nurse Practitioner in residential care) can be met with some resistance Workforce challenges in residential aged care
Future	Work on sustainability, potential to start succession planning, and to provide leave cover Measuring and quantifying the value of the model

Aged Care in Emergency (ACE), John Hunter Hospital, HNELHD

Note: the ACE program at John Hunter Hospital is a different service model from the other specialist geriatric outreach models highlighted within this document. However, it shares a significant focus on capability building with residential aged care. As a result, this service has been highlighted. This table reads differently from other service examples.

Context	The ACE service has a strong focus on capability building with residential aged care. It currently covers 90/126 RACFs across a large geographic area, working in partnership with Hunter Medicare Local and NSW Ambulance as well as Armidale, Belmont, Calvary Mater, John Hunter, Maitland, Manning, Tamworth and Tomaree EDs
Aim(s)	To support staff in RACFs to facilitate residents' acute care needs being met within the facility and avoiding an ED presentation Reducing the need for residents of RACFs to present to an ED for acute care, or where ED presentation is required, to proactively manage the visit Enhanced integration of a range of services for older people
Service features	Respect for knowledge and skills of RACF staff Collaborative relationships with RACFs, GPs, Hunter Medicare Local, NSW Ambulance and ED Partner EDs linked with RACF supports development of personal working relationships and trust for appropriate decision making about best location for care Evidenced based algorithms for common health problems experienced by residents, so RACF staff can better manage the acute symptoms in the facility Education and empowerment of RACF staff, including cert III and IV workers, including Clinical Handover, Deteriorating Patient along with algorithms A 24 hours a day, 7 days a week telephone consultation service for RACF staff to access clinical guidance, supported by Medicare Local out of hours and ED in business hours Establishment of clear patient goals' of care prior to transferring to an ED Proactive case management within the ED A change management team to implement and support all the above elements
Team member(s)	ACE CNC position funded by Medicare Local, supported by MOU between LHD & Medicare Local Builds on and links with existing services, eg. ASET, HITH, specialist CNCs, ED, NSW Ambulance Medicare Local call centre, nurse educators and management team
Key relationships	Internal HNE Health service providers, including: ACE, ASET, HITH, CNCs, ED External partners: Hunter Medicare Local and its GP after hours service, general practices, RACFs and NSW Ambulance
Achievements	Roll out to large geographic area General practice and ED report better quality handover from RACF staff. Train the trainer model enables greater reach and broader impact of training across facilities. Changes in RACF practices with reduced transfers to hospital, reduced hospital admissions Addition of unique RACF identifier into demographic content in Hospital Information System facilitates communication with RACF (discharge summaries sent out to both GP and identified RACF) and identifies RACF residents as a group within the overall hospital population for service planning Good quality data can also be utilised by RACFs, not just by LHDs
Challenges	Partnering with many residential aged care providers brings the challenges of complex national and state policies and procedures within which each RACF must work High staff turnover in RACF Uncertain future of Medicare Local Staffing, equipment and training of staff to proactively manage unwell and dying residents at home.
Future	Development of appropriate chronic disease care pathways so that care escalation can be proactive when required Linking with telehealth opportunities Use of Model of Care in rural and remote communities including Multi-Purpose Services Use of Model of Care for Older People living in the community Use of Model of Care for People with Disability

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