phn COOPERATIVE

An Australian Government Initiative

SUPPORTING HEALTHY AGEING
THE ROLE OF THE PHNs

CASE STUDIES

This document is supplementary to the paper titled 'Supporting Healthy Ageing: The role of PHNs'. It provides a range of examples of from across the network of 31 PHNs to demonstrate their specific expertise and experience in developing regional and place-based approaches to enhance the health of older people and improve the coordination and integration of primary health care, acute and aged care services.

We acknowledge the traditional custodians of country throughout Australia and recognise their continuing connection to land, waters and community. We pay our respects to them and their cultures; and to Elders both past and present.

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Brisbane North and Brisbane South PHNs: Supporting patients to access aged care services: A national resource for general practitioners, specialist and health professionals

Identified need

To increase General Practitioner (GP) and Specialist knowledge of the aged care system and improve their capacity to refer patients to aged care services.

Approach/activity undertaken

The Brisbane North and Brisbane South PHNs, identified a joint interest in developing a resource to support the interface between medical and health professionals in primary and acute care and the aged care sector.

The aged care system is complex and can be difficult for health professionals to navigate which acts as a barrier to referring patients for support. While valuable information for medical and health professionals is available on the My Aged Care website, it doesn't convey a complete overview of the aged care system and the range of government funded support programs.

Outcome

The aim of the resource is to enhance access to community and residential support services to support the health, wellbeing and independence of people as they age.

The key outcome was the development of a national, easy reference tool that provided an overview of the aged care system and the key program streams, as well as key information about how to make referrals and includes information about where to get further information.

By substituting and localising the PHN logo on the front cover, the resource can be used and distributed by PHNs nationally.

This initiative provided staff from the Brisbane North and Brisbane South PHNs with an opportunity to build relationships through working collaboratively, which will support future joint activities.

Other information

- web article on Brisbane North PHN website: https://brisbanenorthphn.org.au/news/new-national-resource-explains-aged-care-referral-options
- link to resource on Brisbane North PHN website: https://d1jydvs1x4rbvt.cloudfront.net/downloads/Practice-support/BNPHN_BSPHN_Aged_Care_System_Resource_For_GPs_Mar2021_DIGITAL.pdf?mtime=20210705111929&focal=none

Central Queensland Wide Bay Sunshine Coast PHN: Wide Bay Falls Collaborative – Fraser Coast Pilot

Identified need

Central Queensland Wide Bay Sunshine Coast PHN in consultation with Queensland Ambulance Service (QAS), Hervey Bay Neighbourhood Centre (HBNC) and the Wide Bay Hospital and Health Service (WBHHS), identified falls as a potentially preventable population health issue and health system burden. Falls prevention was an existing priority for Central Queensland Wide Bay Sunshine Coast PHN based on needs assessment data and the Hanlon Method for prioritising health needs. The *Wide Bay Falls Collaborative* (Collaborative) commenced between these parties with the aim to reduce both the personal and system burden related to falls amongst older people residing in their homes within the community.

Approach/activity undertaken

Through the Collaborative the Fraser Coast Falls Prevention Service referral pathway has now been developed and implemented. Referrals are made to the WBHHS Integrated Care team for assessment and care coordination by a Nurse Navigator. Recommendations may include occupational therapy assessments or referral into a strength and balance exercise programs as a falls' prevention activity. Within the integrated model the complex referrals remain with the WBHHS for management and non-complex referrals will flow to the PHNs contracted in home falls assessment service.

Central Queensland Wide Bay Sunshine Coast PHN ran a tender to find an appropriate community nursing provider for the in-home falls assessment. The Community Nursing In-Home Falls Assessment program was co-designed by the PHN in collaboration with WBHHS, QAS, consumer groups and service providers to integrate with the overall Fraser Coast Falls Prevention Service referral pathway.

The PHN has also contracted a provider to deliver the Active at Home strength and balance program within client's homes and the Hervey Bay Neighbourhood Centre to complement this model. The commissioning of this component has involved a partnership with Brisbane North PHN as the owners of the Active at Home program. The Central Queensland Wide Bay Sunshine Coast PHN has proposed the continued customisation of the program to extend the reach to older people living independently within their community and who do not receive in-home care services by incorporating aspects into the services of GP practices.

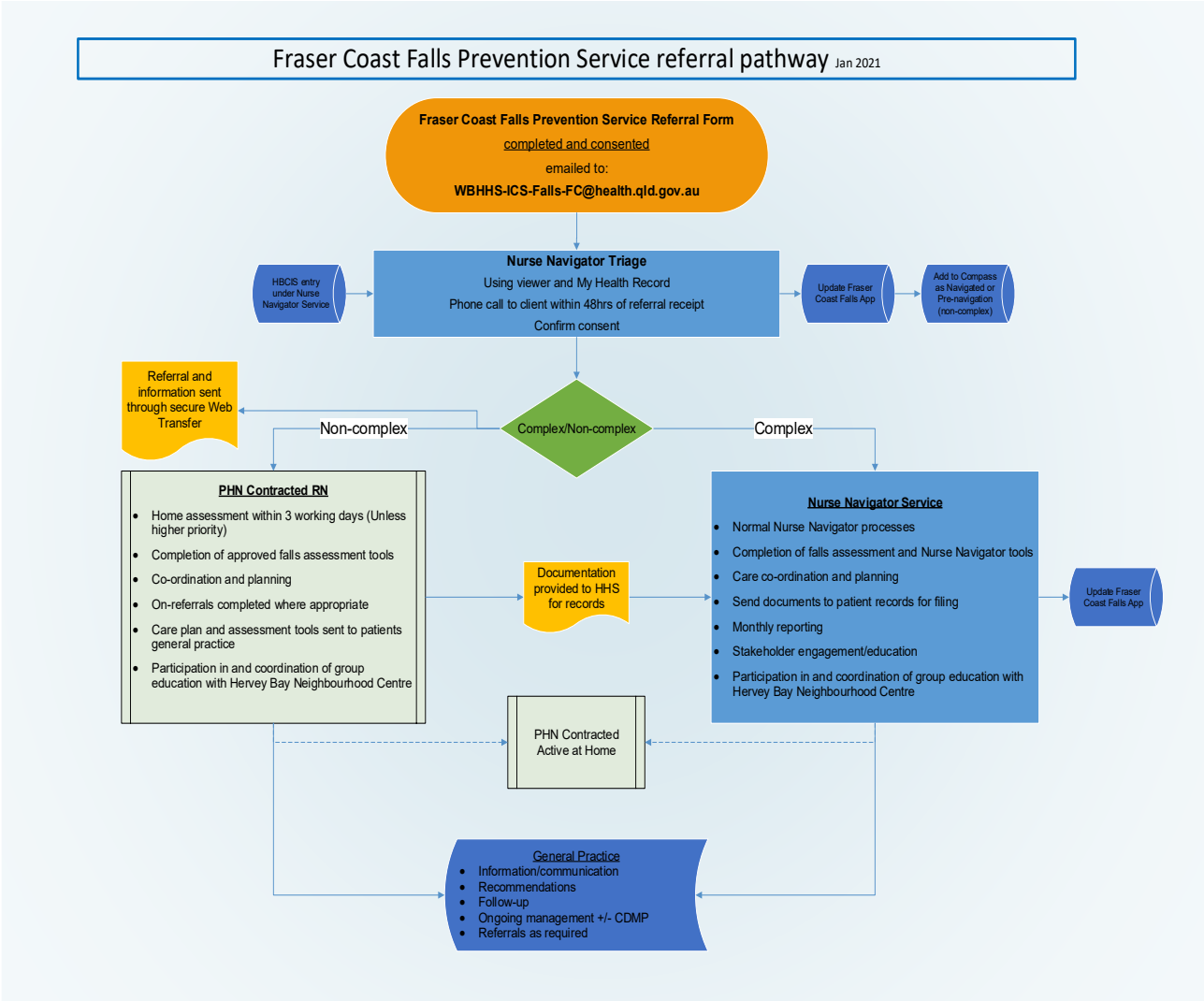
Outcome

As the referral pathway is newly established and the Community Nursing In-Home Falls Assessment program was commissioned in mid 2021, evaluation data has not yet been gathered. Data sets incorporated into the evaluation will include:

- referral data
- falls related ED admission data
- QAS fall related emergency call outs
- falls notifications to GPs
- Patient Reported Experience Measures (PREM's)
- Patient Reported Outcome Measures (PROM's)

Other information

Referral pathway flowchart:



Western Queensland PHN: Community Empowerment through Community Services Facilitator Project

Identified need

After a series of community consultations and a review of services, it became apparent that there is an absence of a central connection point that can assist the aged and/or disabled population to navigate their way through the health and support services system. Issues gaining access and being able to optimise the benefits of the care and support services was widely reported. This was especially so for the ageing population in the WQPHN region.

Approach/activity undertaken

WQPHN has embarked on a community focused project with the introduction of designated Community Services Facilitators who provide an ongoing interpersonal relationship with the target population i.e., vulnerable individuals aged >65 years and those disabled <65 years in the Far South West sub-region). The Community Service Facilitators will encourage the development of health service and system literacy through building connections with relevant service providers and promote sources of reputable information. The Community Services Facilitator will also play a role in forming relationships with key stakeholders to provide quality seamless services from multiple providers.

Outcome

The Community Services Facilitator Project is still in its implementation phase however, preliminary findings have indicated that 57 per cent of the clients who have already engaged with their local Community Service Facilitator are over 65. All were seeking assistance with healthcare pathways.

Other information

- The Community Service Facilitator Project aligns with the WQ Health Care Home Neighbourhood strategy which aims to maximise population health outcomes, enhance patient experience, optimise health provider experience and improve efficiency and sustainability.

Brisbane North PHN: Regional Assessment Service consortium to improve access to aged care services

Identified need

Access to services is fundamental to better health for older Australians and the driver for the Brisbane North PHN to hold a Regional Assessment Service (RAS) contract for the Commonwealth Department of Health.

The Australian aged care system is complex and can be confusing to navigate, resulting in access barriers. These barriers can be amplified for First Nations people and people from diverse backgrounds.

Approach/activity undertaken

The Brisbane North PHN is the independent lead for a high performing Regional Assessment Service in a collaborative commissioning model. The consortium specialist providers conduct over 4,000 aged care assessments every year.

Brisbane North PHN plays an integral backbone role in leading and supporting the delivery of high quality and equitable assessment. The Consortium focuses on the navigation and access barriers faced by people with diverse needs such as First Nations and CALD people, those at risk of homelessness, experiencing cognitive decline or other spiritual, sexual or socio-economic and geographic disadvantage.

The partnership approach is underpinned by shared performance data, client-centred decision making, a cultural shift to a wellness and reablement paradigm and capacity building and connectivity across the health and aged care sectors.

Outcome

The Brisbane North PHN has successfully delivered the Regional Assessment Service since its inception in 2015 – providing over 27,170 in-home assessments with older Australians.

Having an active role in the gateway to funded aged care services provides a depth of information on the experience of consumers, providers and health professionals that enables an advocacy role for regional and national service and system improvement.

WA Primary Health Alliance – Perth South PHN: Aged Care Liaison and Transition Nurse (ACTaLN)

Identified need

Local analysis from 2017 indicated that older persons from Rockingham a readmitted to hospital at a rate two times higher than the national average. It was identified that following discharge, vulnerable older people aged 80 and over were not connected back well with general practice and older people and their families were unclear about next steps in their care.

Approach/activity undertaken

The Aged Care Transition and Liaison Nurse project was funded by WAPHA from 2017 – 2021 at Rockingham General Hospital (RGH). The service improves healthcare experiences and outcomes for older people with complex needs through improved service integration and flow of individual information and support across traditional hospital, community and primary health care service programs. This service was co-funded by the WA Primary Health Alliance and the South Metropolitan Health Service (SMHS).

The ACTaLN Nurse completes a holistic comprehensive home-based assessment and together with the patient/family/carer determines what interventions are required to maintain their persons independence and improve quality of life. This ensures that discharge and care plans are clearly articulated and followed – GP appointments made, community services enacted, and education provided patients. The nurse also works with GPs and specialists to develop shared care plans as appropriate.

Outcome

This service has demonstrated:

- a contribution to reduction in readmission rates for patients aged 80+ (20-15%)
- proof of concept and is now integrated to become a permanent service in the hospital for all older people who are at risk of readmission.

For the 969 patients referred to the program:

- 94 per cent were reviewed by a GP since discharge
- 97 per cent received a medication review
- 100 per cent found discharge care plan helpful
- 98 per cent Strongly agreed or agreed the care they received helped them manage their condition better.

Patient Quote

“Makes me feel more comfortable having someone to discuss health at home with me after discharge”

Other information

This service has received the following awards:

- 2019 WA Health Excellence awards Improving the Healthcare Experience and Outcomes for Older People – Finalist
- 2021 South Metropolitan Health Service excellence in Strengthening Partnerships – Winner
- 2021 WA Nursing and Midwifery excellence Awards, ACTaLN Nurse Deb Jones – Winner (Excellence in Primary, Public and Community Care and the prestigious WA nurse of the year)

Links

- https://www.rkpg.health.wa.gov.au/About-us/News-and-Events/New-program-links-the-elderly-with-primary-health-services
- https://rkpg.health.wa.gov.au/About-us/News-and-Events/Partnership-supporting-elderly-patients-commended
- https://www.mediastatements.wa.gov.au/Pages/McGowan/2021/05/Rockingham-aged-care-nurse-wins-2020-Nurse-of-the-Year.aspx
- https://m.facebook.com/SouthMetropolitanHealthService/videos/590035975271922/?_se_imp=0Hc2Ujc2jyDofjHgq
- https://smhs.health.wa.gov.au/About-Us/SMHS-Excellence-Awards/Excellence-in-strengthening-partnerships
- https://smhs.health.wa.gov.au/About-Us/SMHS-Excellence-Awards/Excellence-in-strengthening-partnerships

Northern Sydney PHN: Hospital Discharge Program

Identified need

Local patient journey modelling identified limitations and delays with care transfer for patient discharged from hospital, particularly in the afterhours period.

Approach/activity undertaken

NSPHN commissioned a hospital discharge follow-up service, designed to reduce the likelihood of re-admission to hospital after discharge, including the after-hours period. The program also provides short term care coordination for people identified at risk of hospitalisation within the primary care setting.

The key features of the service model include:

- providing a seamless transfer of care from hospital to home
- development of strong relationships with relevant community health, primary health, and tertiary health professionals to facilitate smooth transition of care
- assisting people and their carers to access the right service, in the right place, at the right time
- facilitating access to services and put into place supports for people in the afterhours period including on weekends when mainstream services are more difficult to establish or access
- reducing re-admission to hospital or deterioration during the after-hours period

Outcome

The program has had sustainable uptake since service commencement, with low rate of unplanned hospital re-admissions and improved patient outcomes. 230 clients engaged with the program in the 2020 calendar year, with an average unplanned hospital readmission rate of 2.6%. 76.4% of clients engaging in the program demonstrated an improvement across all domains of the Personal Wellbeing Index. Commissioned services have also developed effective partnerships and linkages with a range of local services including My Aged Care, Commonwealth Home Support services, social work services to optimise client outcomes.

Key outcomes and corresponding metrics include:

Outcome: Improved health outcomes for clients and increased efficiency within the health system.

- Metric: Rate of unplanned hospital readmissions.
- Result: Average unplanned hospital readmission rate of 2%.

Outcome: Improved outcomes for clients accessing the program.

- Metric: Improved patients reported outcomes demonstrated through the Personal Wellbeing Index at service commencement and discharge.
- Result: 76.4% of clients engaged demonstrated an improvement across all domains of the Personal Wellbeing Index.

Outcome: Increased coordination and linkages to adequately address client needs.

- Metric: Partnerships and linkages established with key services across the region.
- Result: Partnerships have been established with a range of local services including My Aged Care, Commonwealth Home Support services and allied health services.

Northern Sydney PHN: Health Navigators

Identified need

The project is focussed on the frail older person, which was chosen after undertaking a joint process between NSLHD and SNHN that considered the needs of the community and current Commonwealth, State and Local policy priorities.

Health and social providers within the Northern Sydney region identified service gaps and barriers, to support frail older people. This included no navigation or support lines for themselves that were timely and easily accessible. In the meantime, due to COVID-19, services were also changing access and delivery scope rapidly. A concierge service was prioritised to deliver as the first component of Collaborative Commissioning.

Approach/activity undertaken

NSLHD and SNHN consulted and co-designed with a group of health professionals and aged care providers (Concierge advisory group) to develop a proposed concierge model. The model included the target cohort eligibility, service delivery mode, aims, scope and proposed outcomes.

An Expression of Interest (EOI) was developed and released through Tenderlink to gain a more detailed understanding of the current market capability and to develop a short list of potential and preferred delivery partners.

Outcome

NSLHD and SNHN commissioned a delivery partner. The delivery component of the service was co-designed though workshops in partnership with the delivery partner. The concierge service 'Health Navigators' was implemented in February 2021.

Health Navigators have received a number of phone calls from health providers and continue to provide information, navigation support and sometimes care coordination in order to support frail older people.

Other information

- https://sydneynorthhealthnetwork.org.au/programs/northern-sydney-health-navigators/

29 PHNs: HealthPathways

Approach/activity undertaken

HealthPathways is an online health information portal that has been implemented across the majority of PHN regions in Australia since 2012. HealthPathways is designed for GPs and other primary health clinicians and:

- provides information on how to assess and manage medical conditions;
- how to refer patients to local specialists and services in the timeliest ways;
- and improve care pathways for patients.

During the 2020 COVID-19 pandemic, PHNs worked with Public Health Units and Public Health Services to utilise HealthPathways for Primary Care Clinicians.

Outcome

HealthPathways provided daily COVID-19 updates and pathways for COVID-19 management, including initial assessment and management, practice management, referrals, telehealth, mental health support and COVID-19 outbreak and response for residential aged care facilities.

Hunter New England and Central Coast PHN: Aged Care Emergency Program (ACE)

Identified need

Since 2015, The PHN along with many stakeholders have progressed an integrated approach to enhance quality care for older people living in residential aged care facilities (RACFs).

Initially piloted to prevent avoidable transfers from RACF's to a single emergency department bringing together emergency physicians, GPs, nurses and RACF staff into a community of practice (CoP), the Aged Care Emergency (ACE) program has become a strong, multi-agency network that provides a mechanism for:

- implementing change in practice;
- advocating for improved policy;
- conducting translational research into the interface between residential aged care and the healthcare system.

The CoP has used a variety of methods to investigate and respond to issues that impact on residents in RACFs' experience of quality, integrated care, including responding to urgent issues and improved clinical handover.

Stakeholders include

- 185 RACFs across The PHN footprint
- NSW Ambulance
- University of Newcastle
- Hunter Medical Research Institute
- Hunter Primary Care
- Resident's GP

Outcome

- residents are 20% less likely to be transferred and 21% less likely to be admitted to hospital (A stepped-wedge non-randomised cluster trial with 11 steps – ref 5)
- model of care changes for residents with acute conditions; including piloting telehealth to best serve the wishes of the individual
- education for stakeholder staff
- progressive scaling up of initiatives across all RACFs and partnering hospitals
- cost benefit – compared annualised net costs of the ACE program with usual care saving A$921 214, (ref 4)
- network and existing infrastructure to optimise preparedness for COVID-19 in RACFs and RACF staff vaccine rollout
- peer reviewed publications.

Patient/provider/stakeholder quotes

The below quotes/comments come directly from our ACE service annual satisfaction surveys or our compliments and complaints register:

"I would like to give a positive feedback and a huge thanks to XXX (GP Access After Hours RN) and the service tonight for the quick response, guidance and follow up on the patient care situation came across for one of my patients. This is a great service and I am sure the patient, family and myself are thankful for your great support when needed it most"

"I thank you all for the wonderful job you are doing and the care you show for the aged care sector. The updates you have been doing during COVID have been outstanding so thankyou"

"I had a GP come to me (care manager) and say, -I don't know what you have been doing but I am getting a much better handover from staff these days about residents. I told him ACE had done some ISBAR 4 aged care education recently"

Other information

1. Stokoe A, Hullick C, Higgins I, Hewitt J, Armitage D, O'Dea I. Caring for acutely unwell older residents in residential aged-care facilities: Perspectives of staff and general practitioners. Australas J Ageing 2016;35:127-32.
2. Hullick C, Conway J, Higgins I, et al. Emergency department transfers and hospital admissions from residential aged care facilities: a controlled pre-post design study. BMC Geriatr 2016;16:102.
3. Conway J, Dilworth S, Hullick C, Hewitt J, Turner C, Higgins I. A multi-organisation aged care emergency service for acute care management of older residents in aged care facilities. Aust Health Rev 2015;39:514-6.
4. Ling R, Searles A, Hewitt J, et al. Cost analysis of an integrated aged care program for residential aged care facilities. Aust Health Rev 2019;43:261-7.
5. Hullick CJ, Hall AE, Conway JF, et al. Reducing Hospital Transfers from Aged Care Facilities: A Large-Scale Stepped Wedge Evaluation. J Am Geriatr Soc 2021;69:201-9.
6. Conway J, Higgins I, Hullick C, Hewitt J, Dilworth S. Nurse-led ED support for residential aged care facility staff: an evaluation study. Int Emerg Nurs 2015;23:190-6.

HNE Aged Care Emergency Guidelines (healthpathways.org.au)

- Username – aged
- Password – care

Hunter New England and Central Coast PHN: Capacity Tracker

Identified need

- Need for increased visibility of links between general practices (GP) and residential aged care facilities (RACF), so that if a GP closes or is unavailable, it is faster and easier to identify which residents in aged care are no longer receiving primary care.
- View GP and RACF on maps so PHN users can see facilities and providers in close proximity and the potential level of support available from each one.
- Enable GP and RACF to raise alerts and PHN to monitor status of COVID-19 cases, vaccinations, PPE supplies, bed capacity, staffing and operations for GPs and RACF during the COVID-19 pandemic, bushfires and flood events.

Approach/activity undertaken

All GP, RACF and Aboriginal Medical Services known to the PHN at the time of implementation were pre-loaded into Capacity Tracker to simplify the registration process.

A cross-PHN team liaised with Aged Care Emergency contacts and key stakeholders to roll out Capacity Tracker to RACF, in the Hunter New England (HNE) region where the PHN was relatively unknown.

The team achieved registrations through individual contact, explanation, repeated efforts, provision of ongoing support and in-person walkthroughs and demonstrations.

In response to COVID, and to meet the needs of the Australian market, new additions and functions have since been developed and implemented in Capacity Tracker, including a PPE request form, automated alerts function and vaccination module.

Outcome

Across the HNECC PHN footprint, 83% of RACFs are now registered, and Capacity Tracker is regularly used to communicate to the PHN about:

- operational and workforce concerns/issues
- PPE shortages and requests
- vaccination operations, status and concerns/issues

Five (5) other Australian PHNs are now utilising the platform. Additional functionality including linking Pharmacies and Allied Health clinicians who work in RACFs is under development.

Other information

- Capacity Tracker for RACFs and General Practice
- Capacity Tracker – a tool to improve emergency response in aged care
- Capacity Tracker – Registering Residential Aged Care Facilities
- Capacity Tracker – PHN webpage

Hunter New England and Central Coast PHN: Enhancing Primary Care in Aged Care Strategy

Identified need

- HNECC PHN has an above average proportion of older people living in the community, at home and in RACFs.
- Access to primary care is a challenge, particularly in rural areas and for vulnerable communities.
- Both local LHDs, local GPs and RACFs were seeking coordination and oversight of the preparedness for outbreak planning for RACFs.
- HNECC PHN is ideally situated to provide the coordination and to bring this work together with our other COVID-19 response and vaccination work.
- HNECC PHN has a history of funding and coordinating various programs to support access to Primary Care for RACF residents.
- HNECC PHN also funds a number of innovative programs designed to increase the Mental Health and wellbeing of older people.

Approach/activity undertaken

Through the funding of a range of programs aimed at increasing access to primary care for older people, particularly those living in Residential Aged Care, HNECC has identified the need for an integrated and strategic response. The increasing challenges of workforce availability, capability building and limited funding are a national problem for RACFs.

HNECC has made submissions to the Aged Care Royal Commission and is preparing to respond to the recommendations, many of which align with work already under way.

Through Health Pathways and Patient Info sites, we are assisting older people to navigate to services that address their health needs.

We have also piloted Care Navigator positions which connect older people with GPs and other service providers, in response to the needs identified by the community in a range of programs.

Outcome

HNECC PHN is seen as a key partner in the planning and delivery of programs aimed at enabling older people to maintain their health.

Our partnerships with the local LHDs, with the GPs, RACFs and other service providers across the region have enabled us to respond to the older people in our community.

Nepean Blue Mountains PHN: Improving Social Connections for Older People

Identified need

Older people without adequate social connections have an increased risk of poorer mental health and well-being which negatively impacts on their physical health and use of health services.

The Social Connections pilot project is aimed at reducing isolation and loneliness through the implementation of a compassionate community approach in the Hawkesbury region.

Approach/activity undertaken

Asset Based Community Development co-designed approach working with the community focusing on priority areas including: *Identifying the Unidentified; Networking and Community Awareness; and Improving Transport and Volunteering.*

Governance structure established with a Steering Committee and Working Groups involving Health, Local Government, Aged Services, Aboriginal Services, Emergency Services, Community and Transport Services, Local Government and Consumer Representatives.

Multilayered support available through Practice Nurses who are trained **Health Connectors** based in general practice providing specialist support for older people seeking social connections; **Community Connector Points** at local touch points in the community such as the hospital, neighbourhood centres and libraries for people to access when seeking assistance in navigating the online directory and local community supports; **Community Connectors** who are everyday people trained to point people in the right direction if seeking social connections.

The development of the MyHealthConnector online directory to find a local lifestyle service or support is an important resource and tool used by and for the community.

Outcome

Currently in evaluation with Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

Patient/provider/stakeholder quotes

Bob* is an Aboriginal man who was interested in doing something in the community. The Health Connector put him in touch with an organisation and he now speaks to children and teaches them about Aboriginal Culture.

Iris* was caring for her husband and presented to the GP surgery in a crisis state. The Health Connector was able to speak to a service and suggest respite care for her husband. This was positively received.

Maria* was looking for some informal friendships. The Health Connector connected her with another patient at the Practice. These ladies had vaguely known each other through church but now continue to socialise together as friends.

*Fictional names used

Other information

- www.myhealthconnector.com.au
- https://www.nbmphn.com.au/Health-Professionals/Services/Older-Persons-Health/Social-Connectedness-Project

Tasmania PHN: Increasing the safety and quality of care transfers between residential aged care and acute settings

Identified need

The process of people transitioning across health care boundaries, transfers, is often characterised by, fragmentation, poor information sharing and minimal or non-existent collaboration between services, presenting a significant challenge for the system and for the person. The handover of clinical information between care providers as patients enter and leave hospital or other parts of the health system is essential for the continuity of quality care. The timeliness of this exchange is particularly important where the community setting is a Residential Aged Care Facility (RACF)

Approach/activity undertaken

Primary Health Tasmania developed the Shared Transfers of Care learning platform, the Emergency Decision Guidelines and the Yellow Envelope to increase the safety and quality of aged care resident transition between residential and acute settings. The focus of this work was building and supporting health professional capability across the Tasmanian primary and acute sectors to support patient transfer between care settings with timely, clear, and appropriate communication and supporting health information.

Shared Transfers of Care (SToC) learning platform

Primary Health Tasmania's Shared Transfer of Care eLearning course is a free online course. It is designed to support staff in the health and community services sector working with people who are being discharged, referred, or transferred to other services.

The platform has recently been revised to reflect current best practice and simplify information to make it easier to consume by time poor health professionals with course content structured in to nine (9) modules with seven (7) key learning objective (LO) areas. On completion of the course, participants will have increased knowledge and skills in

- LO 1: Person-Centred Care
- LO 2: Accountability in the transfer of care process
- LO 3: Effective shared communication between service providers and consumers
- LO 4: Effective shared documentation between health care providers, and between providers and consumers
- LO 5: Enablers and barriers to shared transfers of care
- LO 6: Effectively coordinating care
- LO 7: Applying the Shared Transfer of Care Sharing Points in practice

To complement the SToC learning platform two resources were developed to support communication and information transfer in resident care transfer between residential aged care and acute settings. These resources have been embedded in curriculum for various health professions in Tasmania (e.g. with medical students)

The Yellow Envelope

The Yellow Envelope was implemented in 2011 following collaborative work between Primary Health Tasmania (PHT), Aged and Community Services Australia (ACSA) and the Tasmania Health Service (THS). The intent of the envelope is to provide relevant documentation that must be compiled prior to transfer and then accompany the person during transport between facilities, on admission and discharge.

The Emergency Decision Guidelines

The Emergency Decision Guidelines (EDGs) were developed in 2011 and are a step-by-step guide to identifying, assessing, and managing acutely unwell and deteriorating residents in an aged care facility.

The guidelines are designed to be accessed and used at the point of care, content is grouped by clinical symptoms – e.g. pain, confusion, breathing problems. Each section has advice on what to do now, what to do within 12 hours, and what to do while waiting for help. There is a checklist to support a phone call to a GP, hospital or ambulance service to discuss the best course of action when a resident is acutely unwell and deteriorating.

In early 2017 PHT received feedback from a number of RACFs that there was variation in the use of the yellow envelope and in response PHT worked with a range of stakeholders including the Tasmanian Health Services, aged care peak bodies and local GPs and aged care staff to review and update the resources, design a training video and implement a training program to increase awareness and meaningful use of these resources.

PHT has committed to maintaining stocks of the resources which residential aged care facilities can order as needed.

Outcome

Feedback provided by staff in residential aged care facilities support the fact that improved levels of information sharing improve transfers of care. In the evaluation of the training program to promote transfers of care, the yellow envelope, the emergency decision guidelines and the ISOBAR principles over 90% of attendees felt that their levels of self-perceived knowledge and skills had increased. PHT is continuing to provide the training to increase the levels of knowledge within the sector and to encourage the use of the yellow envelope on discharge from the hospital.

Other information

- https://www.sharedtransferofcare.com.au/

Central Queensland Wide Bay Sunshine Coast PHN: Compassionate Communities

Identified need

Central Queensland Wide Bay Sunshine Coast PHNs needs assessment identified high rates of palliative care admissions especially in Wide Bay and on the Sunshine Coast. Greater availability and access to at home and community palliative care, enhancing workforce skills and capacity in the area of palliative care and enhancing integration of palliative care services were also identified as areas of need. These needs were presented to the PHN's Palliative Care Interagency Steering Committee, and it was determined that in addition to focussing on upskilling the clinical workforce in best practice palliative care approaches, a model to skill and empower community members to play an active role in providing connection for individuals at end of life would be a benefit to our communities and to individuals within them.

Approach/activity undertaken

Central Queensland Wide Bay Sunshine Coast PHN partnered with The Groundswell Project to deliver a Compassionate Communities model across the PHN which included 9 train the trainer sessions for community members across the PHN region. These train the trainer sessions activated everyday citizens to draw upon their knowledge of services and local resources and groups to create a movement to connect people to wrap around supports locally at end of life.

With the extension of the Greater Choice for at Home Palliative Care program, Central Queensland Wide Bay Sunshine Coast PHN continues the implementation of the model moving forward providing support to the newly trained lead connectors in the community and end of life care. Outcomes and impact from this work is discussed with PHNs partners through existing Palliative Care Interagency steering committee and integrated with the acute care system via the WBHHS end of life committee to enhance and complement existing clinical supports at end of life.

Outcome

The interest in and uptake of the initiative throughout the community was overwhelming. Through the nine (99 community based train the trainer sessions held there are now 150 volunteer lead connectors trained in the Central Queensland Wide Bay Sunshine Coast PHN region as a result of this initiative. As a result, people living within regional communities at end of life, have access to new community designed, owned and led opportunities to be seen, heard and involved in conversations and support that meet their needs and respects their right to dignity and at end of life.

Stakeholder quotes

"I felt the training is the missing link in Palliative Care! Awesome content. Thank you!" – **Birtinya Lead Connector**

"I am excited to roll this initiative out in our community! I will definitely organise a talking café outside my work!" – **Gympie Lead Connector**

"I love to learn new things! This training ticked all the boxes for me. Thank you. I want to know more about creating a death café group!" – **Hervey Bay Lead Connector**

A community of practice has been established among the local lead connectors, facilitated through the PHN to provide the community volunteers with the opportunity to collaborate, reflect, innovate and learn. The community of practice group is leading a regionwide series of localised ***dying to know day*** initiatives across their communities involving people at end of life and their supports.

Other information

- Participant feedback from one of the 2021, nine (9) lead connector train the trainer workshops:

Brisbane North PHN: Commissioning Aged Care (CHSP) services to enhance access for vulnerable people

Identified need

In 2013, Brisbane North PHN seized a local opportunity and successfully tendered for a Commonwealth Home Support Programme (CHSP) grant through the Department of Health, Ageing and Aged Care Branch.

The key driver for securing CHSP funding was the opportunity to target services for vulnerable people by commissioning aged care providers with specialist expertise. It also provided an opportunity to enhance our sector engagement within aged care.

Approach/activity undertaken

To address the requirements of the CHSP program and augment capacity to collaborate with the aged care sector, the Brisbane North PHN apply this funding using a Lead Partner Consortium-Commissioning approach. This enables the Brisbane North PHN to *'lead from within'*; using the mechanisms of commissioning services and mobilising relationships to enhance local service provision, provide sector support and influence the system through the aged care reform process.

Called healthy@home, the consortium comprises 18 members, including the Brisbane North PHN as the lead/backbone organisation and a diverse group of service providers offering specialist and culturally diverse services, as well as consumer and carer advocacy representatives, peak bodies, and the local hospital and health service.

Outcome

The healthy@home culture combines data monitoring and transparency, group accountability and healthy competition to build high performance. This has supported the consortium to consistently exceed funded outputs and KPIs. In 2020/21, healthy@home collectively:

- delivered 191,010 service sessions to older Australians living in the community. This represents 107% output performance against funded activities; and
- provided clinical and social-care services to 7,713 people, including 1,142 (14.8%) Aboriginal and Torres Strait Islander people and 1,236 (16%) people born outside of Australia.

Healthy@home's governance structure supports regular communication, strong and trusting relationships and a community of practice among consortium members to enhance service quality. By virtue of working more closely together, consortium members share information on topics such as service models, workforce and clinical practice.

A further value add is the provision of sector support and development, creating opportunities for stakeholder engagement and professional development. The Consortium has funded innovative pilots such as Active at Home and projects such as the Centre-based Respite Project to support service and sector improvements.

Provider quote

"They [PHN] are really solid and really committed. They come at it from a values perspective. Of course dollars matter, but I don't feel that is front and centre. Commitment to regional improvement is a very genuine motivator – not just holding you to the contract because they have the power but instead holding you to account about the outcomes. The PHN is not just telling [partner organisations] but has an openness to hear from community."

Other information

- Healthy@home website: https://healthyathome.org.au/

Western Queensland PHN: Planning and Commissioning for Healthy Ageing in the Community and Residential Aged Care

Identified need

WQPHN has commissioned services in the region with a healthy ageing focus since the inception of the PHN model. The region is entirely rural and remote which requires a high level of collaboration across a very large area.

Approach/activity undertaken

The healthy ageing services vary from community to community however the key enablers included place-based program delivery that suits the community's needs as well as flexibility to provide solutions to gaps in services. Community consultation and service mapping have been conducted through similar processes and have involved LGA's, HHS's, ACCHOS', community groups and individuals as well as current or potential service providers including RACF's and other organisations providing services under a Community Care or Allied Health service function. All key stakeholders have been involved in providing training and support to clients which has resulted in improved e-health literacy and greater willingness to uptake telehealth service delivery options.

Having a diverse range of people delivering these services meant that during lockdowns associated with the pandemic these providers and groups were still able to have contact with their clients via telehealth. Due to the normalising of telehealth service delivery during the COVID-19 pandemic, it is presumed that some communities will experience greater access to services in a more timely manner.

Outcome

There is now a greater willingness from the ageing population in our regions to access a service via a telehealth medium.

North Western Melbourne PHN: The Stepped Care For Older Adults Project

Identified need

Whilst mental health problems are serious conditions at any age, they are particularly complex in older adults (Aged 65 or over/50 + for Aboriginal and Torres Strait Islander people) due to the increase in comorbidities such as physical illness, disability and self-neglect, suicidal ideation, and mortality. They also tend to follow a more chronic course and display higher relapse rates than mental health problems in earlier life.[1] Reviews of current research[2] and an analysis of the NWMPHN 2018 health needs assessment It was estimated that 10-15% of older Australians living in the NWMPHN community were experiencing anxiety or depression and approximately 10% experience loneliness.

Approach/activity undertaken

In response to the evidenced need, in early 2019 North Western Melbourne Primary Health Network (NWMPHN) tendered for a pilot program to innovate a new approach to supporting the mental health needs of older adults based on a stepped care approach

The 'Stepped Care: Wellness and Mind Care for Older Adults' (SCOA) service commenced in late October 2019. The model was embedded within a biopsychosocial framework which supported taking a holistic approach to service provision for older adults living in a community setting. The model included a multidisciplinary team and close connection to in home aged care services to mitigate the lack of established referral pathways, to ensure continuity of services for older adults and recognising that these carers/ service providers were likely to identify behavioural changes but with no clear referral option for support.

Outcome

In summary, findings from the SCOA pilot found there was a positive impact on reducing clients' psychological distress and improvement on their relationships and social connectedness. The Kessler Psychological Distress Scale (K10) and the Campaign to End Loneliness Measurement Tool were administered at commencement of service and upon discharge. Statistical analysis for both client samples indicated that clients receiving services/ interventions from SCOA showed a reduction in their levels of psychological distress and there was a positive impact on how clients' felt about their relationships and social connections.

Other information

- In late 2020, with the observable adverse impacts of the COVID-19 pandemic on the mental health, wellbeing, and social connectivity of older Australians[3], the pilot program was extended and expanded to continue to meet the growing mental health needs of the community. https://nwmphn.org.au/news/new-mental-and-physical-wellbeing-service-for-older-adults-at-merri-health-now-accepting-referrals/

1 De Mendonça Lima, C.A. and G. Ivbijaro Mental health and wellbeing of older people: Opportunities and challenges. Mental Health in Family Medicine, 2013. 10, 125-127.
2 Polacsek, M. and B. Brijnath. Mental health of older adults: A National Ageing Research Institute position paper. 2019; Available from: www.nari.net.au.
3 Department of Health and Human Services (2015). Mental health and wellbeing of older people. 10-year mental health plan technical paper. https://www.mhvic.org.au/10_year_plan_for_mental_health

South Eastern NSW PHN: Joint planning to implement mental health services in bushfire-affected areas

Identified need

South Eastern NSW was severely impacted by the 2019/2020 "Black Summer" bushfires. The South Eastern NSW Primary Health Network (SENSW PHN), the Illawarra Shoalhaven Local Health District, and the Southern NSW Local Health District, had previously established joint governance and planning arrangements under the *South Eastern NSW Regional Mental Health and Suicide Prevention Plan 2018-2023*.

Approach/activity undertaken

The PHN and two LHDs built on these established, formalised relationships, to maximise resources and deliver a coordinated regional mental health disaster response regarding the bushfires, which was also delivered in alignment with the NSW State Disaster Recovery Plan. Using a community development approach, this included a range of strategies to provide immediate, medium and long term mental health and community support services for bushfire-affected communities.

Outcome

Through these arrangements and in partnership with communities, local councils, the National Bushfire Recovery Agency and the National Mental Health Commission, tailored trauma counselling and emotional wellbeing support services were commissioned for bushfire-affected individuals and families. The PHN and two LHDs then worked together to strategically align state and Commonwealth funded bushfire recovery funding to ensure streamlined access to services (which were commissioned by the PHN), to limit risk of duplication and to promote a united health system for consumers. Part of the joint support and community recovery approach included a **co-branded communications campaign** to encourage help seeking behaviour and was a positive example of sharing resources in order to act swiftly to provide resources on the ground.

The existing collaborations established under the Joint Statement and the joint Regional Mental Health and Suicide Prevention Plan, allowed our three organisations to quickly build on our existing base, and create a broader and deeper collaborations across the region, allowing us to deliver services that lead to more resilient communities.

Hunter New England and Central Coast PHN: Safer Smarter Homes for people living with dementia

Identified need

The HNECC PHN completed a focus group at the end of 2020 to determine existing and potential system response in the community to manage the impact of COVID-19 on mental health and isolation of older populations.

In late 2020 the PHN was also investigating the value of remote patient monitoring in primary health care and the opportunity to pilot technology developed by CSIRO for those living with dementia arose.

Approach/activity undertaken

The PHN engaged and facilitated group meetings with the technology licence holder, a local dementia provider, clinician, and consumer voices to scope the pilot.

Outcome

The pilot program Safer Smarter Homes (SSH) for older Australians living with dementia or early dementia in the community was commissioned in July 2021.

The program has a case management and service navigation approach support with the aim of the program to support people to live safely in their homes longer through:

a. enabling clinicians to access objective individual patient data (Activity Daily Living (ADL) wellbeing scores) to understand and assess any changes in ADLs

b. increase meaningful activities and engagement strategies to support wellbeing, connection with others and cognitive ability.

The evaluation will use the Quadruple AIM approach. It has a focus on the value to the patient and primary care clinicians experience to monitor, assess and amend care plans based on the data the technology provides.

The completion date of the pilot is June 2022.

Other information

- Technology overview: HSC Care – HSC TECHNOLOGY GROUP (hsctg.com.au)

Hunter New England and Central Coast PHN: Mobile Aged Care X-Ray Service (MACX)

Identified need

- reduced access to services for older people
- transport limitations
- high proportion of non-urgent emergency department presentations
- health needs of an ageing population

Approach/activity undertaken

The Mobile Aged Care X-Ray (MACX) service is a partnership between HNECC PHN and Central Coast Local Health District (CCLHD). The initiative provides mobile X-Ray services to Residential Aged Care Facility (RACF) residents who experience difficulty accessing outpatient X-Ray services in the community. The underlying healthcare model is to provide X-Ray services to Residential Aged Care Facility residents to:

- improve patient journey through unnecessary transport and removal of residents from their homes
- prevent avoidable emergency department presentations for non-urgent (Category 4 & 5) residential aged care facility (RACF) residents
- where possible, prevent unnecessary utilisation of NSW Ambulance and Patient Transfer resources
- provide a responsive and effective service

Outcome

The five (5) day a week service provides on average approximately 80 x-rays per month onsite at RACFs within the Central Coast region. Since July 2018 (service inception) until March 2021, the MACX has undertaken 2622 x-rays onsite at RACFs, avoiding the need for transporting residents to private and/or public imaging facilities. Service responsiveness is measured by monitoring *exam* and *report* turn around time (see Table).

Measure	KPI	Target	Actual (Most Recent reporting quarter)
exam turn around time (The time taken from the request being received by referring GP, until the X-Ray is completed)	Within 48 hrs	90%	86%
report turn around time (The time from the X-Ray being taken until the report is approved by the Radiologist and sent to the referring GP)	Within 24 hrs	90%	77%

Data provided by CCLHD shows non-urgent emergency department presentations for patients aged 65+ over a 4-year period. Breakdown provided. The MACX service commenced in July 2018.

Table: Age group emergency presentations for non-urgent x-ray

Count of ed_visit_identifier				
Row labels	65 to 74	75 to 84	85+	Grand total
2016/2017	1883	2162	1879	**5924**
2017/2018	2223	2458	2083	**6764**
2018/2019	2165	2255	1922	**6342**
2019/2020	2117	2256	1944	**6317**
Grand total	**8388**	**9131**	**7828**	**25347**

Hunter New England and Central Coast PHN: Mental Health, Wellbeing and Healthy Ageing

Identified need

Appropriate Mental Health Services for Older Australians

Approach/activity undertaken

In response to increased funding for Mental Health Services for Older Australians (including COVID specific funds), HNECC developed an innovative strategy to engage the sector, build capacity and commission services within a stepped care framework. Acknowledging the existing psychological services available, the workforce challenges across the region and the unique needs of an ageing cohort, HNECC have commissioned a range of evidence informed services that maximise the available workforce and provide suitable services for older people. A collaborative co-design was undertaken including stakeholders such as RACFS, council, community pharmacy, consumers and carers. HNECC has commissioned a number of pilot programs, such as Animal Assisted Therapy, Music Therapy and physical exercise interventions to support early prevention and early intervention.

Outcome

HNECC is commissioning a robust external evaluation to measure the impact and outcomes of the services commissioned – including traditional psychological interventions delivered by allied health professionals. It is anticipated that this evaluation will provide guidance on effective interventions to best guide future commissioning and will further enhance research into best practice solutions for increasing wellbeing and addressing mental health issues for older people.

Nepean Blue Mountains PHN: Access to Psychological Therapies in Residential Aged Care Facilities

Identified need

Residential Aged Care Facilities (RACF) provide a range of support for older people when they are unable to live independently, and care can no longer be provided at home. However, mental health services are not routinely available to older people living in RACFs. The Australian Institute of Health and Welfare reports that the mental health of older people in RACF is significantly worse than their counterparts in the community. The prevalence of anxiety and depression usually declines with age, but this is not the case for people living in RACF. Around half of older people entering RACF in Australia have symptoms of depression. Planning for our ageing population should prioritise proactive support for the mental health of older people, and when mental health issues arise, there is evidence to show that the right care, including psychosocial treatments, can improve conditions like anxiety and depression in older people.[4]

Approach/activity undertaken

The Wisemind Program involves mental health professionals delivering evidence-based psychological therapies to residents identified as being at risk or having mild to moderate mental health needs. The mental health professionals (mental health nurses and psychologists) also provide guidance to staff of each RACF to build their capacity to assist with better identification and referral of these residents.

Access to this service requires a diagnosis of a mental illness, or an assessment of being 'at risk' of mental illness. It offers evidence based, person-centred short-term support. Referrals are made to the service by either the resident's GP or registered nurse based at the participating RACF. The service is intended to complement and integrate with, rather than substitute existing services, e.g. for dementia and severe and complex psychiatric problems.

Outcome

COVID demands initially impacted in further expanding the program. However, the provider initiated an education and awareness program to assist RACF in identifying residents with clear referral pathways for appropriate services based on individual needs. Promotion of this service has increased RACF involvement and whilst telehealth is offered, residents are receiving face to face support with providers complying with RACF specific requirements.

Patient/provider/stakeholder quotes (optional)

Feedback from participating RACF: 'This has been such a beneficial program for several of our residents, resulting in a noticeable improvement in their mood and wellbeing.'

4 Beyond Blue submission to the Royal Commission into Aged Care Quality and Safety, 26 September 2019

Northern Sydney PHN: Rapid Care for Frail and Older People

Identified need

People living in Northern Sydney have the highest life expectancy of any region in Australia of 86.3 years of age, which has risen by almost five years over the last 20 years. This is a substantial and positive achievement and one that is expected to continue as our healthcare system continues to develop and innovate.

People aged 75 and over utilise health services at much higher rates than other people, and as their population grows they will place increased pressure on acute, aged, community and primary care. Those aged 75 consult with GPs at more than twice the rate (9.1 – 14.7 services per person) compared to all other ages (5.9 services per person). Those aged 75 are also three times more likely to present at an emergency department and be admitted. This is due to the significantly higher rates of chronic disease present in this cohort – academic literature shows that people are living longer, but sicker and requiring more healthcare.4 As this population continues to grows, the demand for health care will also grow quickly.

A program of work for frail older persons has commenced between the NSLHD and SNHN which is focusing on the development of a comprehensive pathway for frail older people to maximise the health and social outcomes of our older people. This partnership is supported by the Ministry of health particularly under the umbrella of 'Collaborative Commissioning'. Working across the health system provides us with the insights necessary to tailor our services and approach as one system. Providing holistic, integrated care that can be consistently supported throughout the primary, acute, and secondary system.

Approach/activity undertaken

The NSLHD and SNHN are in the process of developing a new pathway for urgent care for frail and older people in Northern Sydney.

As part of the development of the pathway, new elements have been identified as areas that would assist in improving current service delivery and building on current systems but aligning it to our intended outcome which is more suitable care, that is centred around the needs of our frail and older people.

The partnership is seeking to advance care in these key areas:

1. **Support GPs to better manage complex patients.** This includes giving GPs additional clinical support and enabling them to have greater input into patients who higher needs.
2. **Better target services at those who are most at risk of an unplanned presentation.** Currently there are a limited ways of targeting resources at patients who are at risk of an unplanned presentation and greater targeting would enable proactive management of these patients and targeting solutions at the right groups.
3. **Help our community better utilise services, particularly our emergency services.** Providing patients with greater assistance to make decisions regarding what care to seek at what time to improve their experience and the utilisation of emergency services.

Outcome

There will be a series of outcomes used for different purposes: some outcomes measured will be used for outcomes-based commissioning and funding arrangements, while others will be used for performance monitoring and evaluation. Initial set of outcomes and measures are aligned to the Quadruple Aim domains that we intend to use for a combination of outcomes-based contracting, monitoring and evaluation.

The broad areas or outcomes are outlined below:

Domain/outcome	Indicator
Better management of frail older persons in urgent care	Frailty screening rate in people aged over 75
	Patients with frailty in a centralised register
	Reduced rate of emergency department presentations (against projected rate)
More proactive identification and management of high-risk patients	Patients identified as high risk are referred to Concierge
	Proportion of high-risk patients with specialist GP support
	Number of patients aged over 75 with an avoidable diagnoses referred to ED with a GP
	Number of patients aged over 75 with an avoidable diagnoses who saw a GP within the last month
Better patient experience and satisfaction of care	Proportion of consumers that felt: ☐ Providers listened to their concerns ☐ Staff were professional and friendly ☐ Their needs were met ☐ They were empowered to be involved in and make decisions about their care ☐ Services were safe and high quality
Better patient health outcomes	To be confirmed with GPs, using the International Consortium for Health Outcomes Measurement (ICHOM) Standard Set for Older persons
Better value for money	Reduced (whole of system) cost per patient / increase level of service per patient
More appropriate use of emergency services	Reduction in per capita ambulance transports to emergency departments with avoidable diagnoses
	Reduction in per capita rate of emergency department presentations for target avoidable conditions
Staff satisfaction	Staff satisfaction survey – staff that felt, for example: ☐ They were supported to undertake their duties ☐ They are recognised for the value they bring ☐ Are heard and listened to ☐ The service is high quality and safe ☐ Consider cross sector communication to be successful
Increased clinical capacity & capability	Number of clinicians engaged in frailty assessments
	Number of high risk patients being managed in the community by our Geriatricians

Western NSW PHN: General Practice Support

Identified need

PHNs work closely with General Practitioners (GPs) and other health professionals to build health workforce capacity and design and support quality care initiatives. (PIP QI)

Approach/activity undertaken

WNSW PHN supports quality Improvement within the General Practice to ensure accurate data reporting, to understand those patients that may benefit from preventative treatments and enabling regular access to care for our ageing population.

Implementing continuous quality improvement activities into General Practice supports them in their role of managing their patients' health and at the same time provides information relating to their Practices ageing population needs to assist in care decision making, referral pathways and support that may be required for carers and families.

- WNSWPHN works with Practices to implement Quality Improvement projects relating to ageing population health needs and areas for better preventative care in Clinical software and the Primary Health Information Platform. Documented and socialised to staff for QI PIP purposes and to improve patients access to care and health outcomes.
- The Practice Support and Improvement (PSI) Teams functions are listed below:
    1. Work with the Practices clinical team to facilitate their understanding of the MBS billing schedule and how GPMP, TCA, Medication reviews and referral pathways apply to the ageing population particularly at risk, living with a Chronic Disease and on multiple medications.
    2. Assist GPs to connect the patient's information from General Practice to MHR or appropriate secure messaging method to enable patient centred shared care with their health team (Pharmacy, Aged Care facility, Allied Health, Specialist etc).
    3. In collaboration with RDN, GP Synergy, RVT reviews workforce capacity at General Practice including GP workforce, registrar capacity, Nursing and Medical assistant staff using training and scholarship programs.
    4. Work together with the RDN, HIU, local councils and healthcare providers in several LGAs to compile a community Health Profile. Identifying needs for the community including; the ageing population to enable health providers and local council to lobby for improved access to transport, more aged care beds, connectively and services required for identified patient cohorts.
    5. Support the General Practices clinical team to ensure correct templates and referral information in the clinical software are used to support referral pathways.
    6. Assist General Practice in accessing correct local services to link their aging population to the right care.

Outcome

LUMOS data is utilised to provide patient journey information through primary and acute care; assisting to identify opportunities for improving patient outcomes and experiences. Reducing preventable hospitalisations and looking at health literacy and carer support services required and available to the patient and families.

Other information

- Quality improvement with WNSW PHN https://www.wnswphn.org.au/support/support-for-health-professionals/quality-health-information-program
- Patient centred care our PHN support practices with https://www.wnswphn.org.au/uploads/documents/corporate%20documents/00604%20CC%20PCMH%20self-assessment%20tool-WNSWPHN.pdf
- Templates our PHN has available (more on request) https://www.wnswphn.org.au/resources/gp-referral-templates
- Specialist referral information our PHN has available https://www.wnswphn.org.au/resources/medical-specialist-services/dubbo

Gold Coast PHN: Use of Primary Sense™ point of care prompts to reduce hospitalisations in the elderly

Identified need

High complexity patients 65 years and over are identified as making up 58% of the most highly complex patients: how to intervene at the point of care to try and reduce unnecessary hospitalisations.

Aim

To understand the effect of Primary Sense™ point of care prompts for influenza vaccinations and care plans on avoidable hospitalisations for high complexity patients 65 years and over.

Approach/activity undertaken

Primary Sense™ incorporates the Johns Hopkins ACG® tool which uses routine clinical data from the GP's record to calculate complexity scores for each visiting patient from 0 to 5, with 5 being the most complex. It also generates a predicted hospital risk score for the next 12 months.

Primary Sense™ reports target high risk groups, including the most complex patients (score 4 and 5) which are mainly downloaded by managers and nurses. However, it was deemed important to get the key information to the treating GP at the point of care as a prompt for missing interventions. Prompts that target high risk groups, including the most complex patients, trigger when the GP opens the patient's record were introduced in January 2021.

Outcome

Primary Sense™ has identified 18,704[5] high complexity patients 65 years and older that have visiting during the 18 month period of 1 January 2020 to 30 June 2021. To enable comparison two timeframes are being used: 1 January 2020 to 30 June 2020 and 1 January 2021 to 30 June 2021.

Results

15,791 high complexity patients[6] have visited during 1 January to 30 June 2021, and nearly half (7,122 patients) saw a GP with the Primary Sense desktop app which provides, amongst other suggested interventions, the influenza vaccination and care plan prompts.

Influenza vaccinations – high complexity patients

- 9,995 patients have had an influenza vaccination between January to June 2021.
- GPs received the prompt for 2,882 patients during their consultation.
- 1,568 patients got influenza vaccinations on the day of prompt.
- 1,046 of the patients had other visit reasons documented on the day, indicating the consult was probably designated for those reasons.
- A further 2,119 patients are still not vaccinated who will trigger a prompt if they visit their GP.
- 6,986 of the patients have had at least one COVID-19 vaccination recorded by the practice.[7]
- For the same period last year, 8,722 of the patients had the influenza vaccination indicating this year's rates are very good given current COVID-19 vaccination program.

5 noting 933 have deceased during the data analysis period
6 High complexity patients are those with a score 4 or 5
7 Noting vaccinations can occur elsewhere and are not transcribed into the GP's system

Care plans – high complexity patients

- 3,758 patients have had a care plan done between January to June 2021.
- GPs received the prompt for 2,992 patients during their consultation
- 717 patients got a care plan done on the day of prompt (this figure typically doubles when 2 weeks is allowed for MBS billing)
- A further 5,014 patients without a care plan will trigger a prompt for a care plan if they visit their GP
- In the same period last year, 3,603 high complexity patients had a care plan done.

Effect of the prompts:

- 77 per cent (n=1,046) patients got the vaccination added to their consult when prompted while in the same period last year without prompts, only 51 per cent (n=2,275) of patients had influenza vaccination added to their consult.
- 83 per cent of patients have care plan added to their other conditions documented during the consult when prompted while in the same period last year, only 76 per cent had care plan as part of their consult (other conditions documented).

These results indicate the GP adds the intervention to the consult when prompted.

Next steps

Assessing the impact of prompted interventions on hospital avoidance is challenging. Between January to December 2020, 4,942 complex patients had one or more discharge summary. So far this year (from 1 January 2021 to 30 June 2021), 3,242 have already had a discharge summary (1,037 had a >80 per cent hospital risk score in the next 12 months[8]). With 6 more months left of this year the number of discharge summaries received is likely to exceed last year's; probably due to increasing age and complexity over the two year timeframe. However, hospitalisations may decrease as people avoid hospitals during COVID-19 outbreaks. The relationship between ever increasing complexity in this age group, hospitalisation rates and prompted interventions requires ongoing monitoring to assess the longer-term impacts, especially during a pandemic. Further validation of this approach of prompting for care in this cohort and results is needed.

Other information

- https://www.primarysense.com.au/

8 Noting planned vs unplanned admission not known, and not all discharge summaries get received

Sydney North PHN: Dementia Quality Improvement Initiative

Identified need

It is estimated that over 12,000 people in Northern Sydney are living with dementia and this figure will continue to grow as the population ages. The Northern Sydney Dementia Collaborative was established in 2014 with an objective to integrate care for older people with complex health needs. Nowhere is this more needed than in people with dementia. There are a range of services available in Northern Sydney for people with dementia and their carers. However, information about these services and how to access them is not well understood by the people who need them the most or by health professionals. A range of in initiatives were developed by the Collaborative including a General Practice Quality Improvement program.

Approach/activity undertaken

Sydney North Health Network, the Improvement Foundation and a local expert reference panel collaborated to develop quality indicators to support improvement in dementia care in general practice nationally, including detection, timely diagnosis and management.

The Dementia Quality Improvement Program (DQIP) commenced in Feb 2018, the program provides support to participating practices to analyse current dementia care management utilising the specified indicators. Practices are participating in education and peer support programs to develop individualised improvement plans to support implementation of evidence-based best practice care.

Outcome

The program aim was to improve identification of patients with a Dementia diagnosis. The first Wave consisted of five practices who were tasked with providing data to a set of indicators for a 12 month period. The indicators were:

1. Dementia Register (Patients with a diagnosis of dementia)
2. Dementia – Health Assessments (Over 75 Health Assessment)
3. Dementia – Reducing Cardiovascular Disease Risk
4. Dementia – MyHealth Record Currency (Health Summary Uploaded)
5. Dementia – Carer Identified (Person most responsible and support provided)
6. Dementia – Domiciliary Medication Management Review (including anticholinergic load and use of anti-psychotic medication)
7. Dementia – High Risk of Dementia (Identify patients)

Outcomes from collection of data using indicators and ability to collect the data from the extraction tool, included were data not included in the indicators.

After taking a baseline of patients with a diagnosis of Dementia recorded in the software and archiving deceased patient or patients no longer attending practices, the below results show outcomes.

January 2018	December 2018
150	115

MBS Item numbers – indicators 2 and 6 including CDM item numbers

	January	December
HC 75+	59.3%	70.4%
721 (CDM-GPMP)	46.7%	60.0%
723 (CDM-TCA)	43.3%	59.1%
732 (CDM Review)	24.0%	34.8%
900 (DMMR)	8.7%	13.9%
903 (RMMR)	32.7%	33.0%

My Health Record and uploaded Shared Health Summaries

	Jan-18	Dec-18
Total Population	150	115
My Health Record	9	22
SHS Upload	5	11

CVD – BP Recorded – reduced outcome due to data cleansing

	Jan-18	Dec-18
Total Population	150	115
<= 130/80	36	29
> 140/90	35	23
> 130/80 and <= 140/90	22	25
Recorded	93	77

CVD – Cholesterol Recorded

	Jan-18	Dec-18
Total Population	2,630	2,837
< 4.0	15.4%	16.1%
>= 4.0 and <= 5.5	37.4%	37.9%
> 5.5 and <= 6.5	13.8%	13.5%
> 6.5 and <= 7.5	5.1%	5.1%
> 7.5	2.0%	2.2%
Recorded	73.7%	74.8%

Overall, all indicators and outcomes increased. Some indicators did reduce but due to the decrease in overall patient numbers, there was actually an increase. Those indicators where numbers did increase, this was actually higher, again due to data cleansing.

Northern Sydney PHN: Wellbeing Check – a primary care screening tool to detect, prevent and treat mental health issues for older people

Identified need

One in twenty older Australians have a current mental health disorder, with studies indicating under-detection and lower treatment rates for mental health disorders among people aged 65 years and over[9]. The burden of undetected and undertreated mental health disorders is likely to grow with an ageing population nationally and within the Northern Sydney PHN region. Routine screening in primary care was identified as an opportunity to identify risk factors for poor mental health early to facilitate early intervention.

Approach/activity undertaken

Northern Sydney PHN has partnered with Macquarie University to develop a primary care screening tool, *Wellbeing Check*, to detect common mental health disorders, including depression, anxiety, and substance abuse, in people aged 65 years and over. The project aims to facilitate early detection of risk factors for poor mental health to enable early intervention.

The screening tool will be co-designed with consumers, clinicians and Northern Sydney PHN staff and rolled out across general practices in the Northern Sydney PHN region to evaluate the clinical and cost effectiveness of the screening tool.

Outcome

The project is currently in its initial stages of development, with key intended outcomes summarised below:

- successful integration of the screening tool into primary care in the Northern Sydney PHN region
- increased detection of mental health disorders and risk for mental disorders among people aged 65 years and over
- increased access and referrals to evidence-based interventions
- increased monitoring of wellbeing across later life

9 Sunderland et al 2015, Lifetime and current prevalence of common DSM-IV mental disorders, their demographic correlates, and association with service utilisation and disability in older Australian adults, Australian and New Zealand Journal of Psychiatry, vol 49, issue 2, pp 145-155; Wuthrick V & Frei J 2015, Barriers to treatment for older adults seeking psychological therapy, International Psychogeriatrics, vol 27, issue 7, pp 1227-36.

Nepean Blue Mountains PHN: Winter Strategy to reduce avoidable hospital admissions for our most vulnerable including older people

Identified need

The Winter Strategy aims to support general practice (GP) and residential aged care facilities (RACF) in improving the management of their patients and residents during the winter months to reduce avoidable hospital admissions.

- The GP program focuses on patients with chronic conditions by implementing important preventative care measures to minimise their risk of hospitalisation. Patients are encouraged to be equal partners with their care team to better manage their chronic conditions and stay as well as possible.
- The RACF program focuses on improved immunisation rates for older people being significantly at risk of poor outcomes in relation to influenza and pneumonia. To reduce the risk of influenza outbreaks in RACF immunisation plays a critical role in implementing a vaccination program.

Approach/activity undertaken

The GP program involves practices successfully implementing this quality improvement initiative through the Collaborative Methodology. Identified patients were recruited to ensure the following proactive clinic care activities were undertaken and/or reviewed and appropriate data uploaded: GP Management Plans (GPMPs) and/or Team Care Arrangements; Sick Day Action Plans (SDAPs), influenza and pneumococcal vaccinations; Domiciliary Medication Management Review (DMMR); MyHealthRecord shared health summary.

The RACF program is supported by: Immunisation scholarship for the RACF registered nurse within the RACF to complete an online immunisation for health professional's course; medical vaccination fridge to ensure cold chain is adhered; local General Practitioner support and consent provided by residential GPs; Public Health Unit Nurse Manager

Outcome

Patient surveys were completed with 72 of the 74 patients reporting that they were provided with Sick Day Action Plans and more than half of all patients, 48 in total (65%), stated that they had subsequently used these action plans.

Patient/provider/stakeholder quotes

Testimonial from participating GP "...The aims of the program were really well defined and we found it easy to identify patients that were at high risk of hospital admission or major sickness though out the winter months...One of the most beneficial additions for patients has been the opportunity to complete individualised 'Sick Day Action Plans'. These have included; Cardiac / Chest Pain Action Plans, Asthma Actions Plans, Keep Me Safe (Mental Health) Action plans and NSW Ambulance Authorised Care Plans..."

Tasmania PHN: Resources to support prescribers to reduce medications for chronic and complex patients in Tasmania

Identified Need

- In Australia, 1 in 4 older persons living in the community have been hospitalised for medication-related problems over a five year period.
- Inappropriate prescribing and polypharmacy is a significant contributing factor in significant factor in reported adverse drug events (ADE)
- ADEs account for more than 10 per cent of all direct cost for prescribing drugs and healthcare use among affected individuals.

Approach/Activity undertaken

Deprescribing has been described as the systematic process of identifying and discontinuing potentially inappropriate drugs with the aim of minimising polypharmacy and improving patient outcomes.

Primary Health Tasmania in partnership with Consultant Pharmacy Services (CPS) has produced a suite of evidence-based guides for deprescribing. These resources have complemented by fact sheets to guide health professionals when considering polypharmacy can be found in the Resource section of the PHT Website and include:

- deprescribing general information
- quick reference guide
- deprescribing vitamin D and calcium
- deprescribing sulphonylureas
- deprescribing statins
- deprescribing proton pump inhibitors
- deprescribing opioids
- deprescribing NSAIDS
- deprescribing glaucoma eye drops
- deprescribing cholinesterase inhibitors
- deprescribing bisphosphonates
- deprescribing bezodiazephines
- deprescribing antipsychotics
- deprescribing antiplatlet agents
- deprescribing antihypertensive agents
- deprescribing allopurinol.

Primary Health Tasmania also created two consumer resources for practice to use with patients. These include:

- Rethinking Your Medication consumer card
- Rethinking Your Medication brochure.

Outcome

The deprescribing resources developed are consistently on of the top five (5) most frequently accessed resources from Primary Health Tasmania since 2017 having been accessed 24,129. This shows a high and sustained level of interest from Tasmanian prescribers to improve quality and safety of patient care.

Other information

- https://www.primaryhealthtas.com.au/resources/deprescribing-resources/

Western NSW PHN: CPD Program Core Delivery

Identified need

The WNSW PHN conducts an annual learning needs assessment to inform and direct CPD activities. Care of Older Persons is consistently ranked in the top 10 identified priority learning needs by health professionals in our region.

Approach/activity undertaken

The WNSW PHN partners with local, state-wide and national partners to deliver CPD sessions to provide practitioners with updated, evidence-based and relevant education. Key external education partners include Western NSW Local Health District, Program of Experience in the palliative Approach (PEPA) and Hammond Care.

The COVID Pandemic meant that CPD delivery was moved online. Due to the broad reach that webinars provide, this element of the CPD program is continuing (in conjunction with face-to-face sessions when possible) to enable even greater access to ongoing learning opportunities for health practitioners in rural and remote areas.

The WNSW PHN CPD team are also launching PODCASTS in coming months, featuring a 4-part series focussing on End of Life Care.

The WNSW PHN is committed to being responsive to ongoing learning needs and evolving community needs when planning and delivery the CPD Program. Examples of this are coordinating infection control and immunisation training for Aged Care Nurses.

Outcome

Each CPD session is evaluated to enable the Education Team to maintain a responsive approach to meeting changing health practitioners' needs and to inform ongoing quality improvement processes. This approach enables the Education Team to plan and customise education sessions to meet what practitioners have identified as key topics and issues in this space and ensures the WNSWPHN stays responsive to local needs.

Other information

- PODCASTS will be on our website in coming months.

Brisbane North PHN: Clinical Pathway and Communication Project

Identified need

Nursing staff in residential aged care facilities (RACFs) are often the first to identify deteriorating health in residents. This project was based on findings from a large-scale stepped wedge evaluation that found that training and support of aged care staff in early recognition and management of acute common conditions as well as improved transitional care communication resulted in reduced hospital admissions.

Approach/activity undertaken

A nurse practitioner was engaged to deliver clinical pathway training and coaching based on five state-wide clinical pathways for RACFs during 2019-2021. The aim of the project was to increase the knowledge and skills of RACF nursing staff in identifying and managing acute clinical conditions on selected clinical pathways. It also focused on developing better links and communication between RACF nursing staff, other healthcare providers and the Metro North HHSs Residential Aged care District Assessment and Referral service (RADAR).

The clinical coaching aspect was included to ensure that nursing staff were able to embed their learnings into real world practical examples. De-identified cases of residents at their facility pertaining to the clinical pathways were discussed for by the nurse practitioner as well as their peers.

Outcome

Despite the impact of COVID on the project, staff from 47 facilities (55 per cent) in the region participated. High proportions of nursing staff who participated indicated that they would recommend the training and coaching to colleagues (84 per cent); a vast majority (86 per cent) scored 100 per cent accuracy on the knowledge-based review questions and reported increased knowledge and confident in the use of clinical pathways. Due to limitations in obtaining patient data from the HHS, the project was unable to determine the impact on reducing hospital admissions.

South Eastern NSW PHN: Geriatrician in the Practice

Identified need

The Shoalhaven region has an ageing population and a high prevalence of dementia; and insufficient geriatricians available to provide a timely service to patients. This has resulted in long waiting lists for local hospital clinics. Dementia is a serious chronic condition that requires expert clinical assessment, diagnosis and management.

Approach/activity undertaken

The Geriatrician in the Practice (GIP) program is based on the Physician in the Practice Clinic model, developed in Toowoomba and resulted in significant improvement of diabetes management and reduced hospital admissions. The aim of the GIP program is to improve patient care, upskill GPs and practice nurses in diagnosing and managing their own patients with dementia, while also reducing the waiting lists for hospital outreach clinics – as they will ultimately only be required to see the more complex patients. Overall, the GIP program aims to improve care coordination, communication and linkages between specialists at Shoalhaven hospital and local general practices, while involving people who may have dementia and their carers in the care and management of their condition.

Outcome

This model has successfully provided dementia screening to over 662 patients in general practices and one Aboriginal Medical Service in the Shoalhaven region. The GIP program strengthens the capacity of primary care through upskilling the primary care providers, during the shared care arrangements and also by the provision of an ongoing consultation and liaison service with the geriatrician.

Brisbane North PHN: Chronic Wound Training and Clinical Support for RACF and community clinicians

Identified need

Within Australia, more than 460,000 people suffer from chronic wounds costing the healthcare system approximately $3 billion a year according to the Chronic Wounds Problem in Australia: A Call to Action paper. Based on these statistics, there are an estimated 18,000 people in the Brisbane North region living with a chronic wound.

Fragmented care between care providers can often lead to people with wounds not receiving the right care, which can contribute to poor outcomes and potential avoidable emergency department presentations. In the Brisbane North region, there was no effective process or framework to respond to the increasing demands of clients presenting with wound issues.

Approach/activity undertaken

After consultations with the Brisbane North PHN Chronic Wounds Governance Group – that includes stakeholders from the acute, primary care and community health settings – the following activities were undertaken by Wound Innovations over a three year period:

- delivery of a series of face-to-face and online workshops in chronic wound management for staff of RACFs and community service providers
- provision clinical placement position at Wound Innovations for each RACF and participating community service provider in year 1 of the project
- provision of bedside and telehealth consultations in RACFs and in-home consultations during community service provider visits that included onsite coaching for RACF and community service provider staff in years 2 and 3 of the project.

Outcome

The project achieved significant outcomes that enhanced care providers skills and improved wound healing for people living with chronic wounds.

- 452 RACF and community nursing staff received wounds training
- 94 per cent of clinical staff who attended the training agreed or strongly agreed the sessions were relevant to their clinical practice
- The average wound knowledge score (from a pre and post, written wounds knowledge assessment) for clinical staff improved from 61 per cent to 81.2 per cent
- 790 specialist wound consultations face to face or via telehealth for 191 patient referrals across 30 RACFs and 10 community care providers were delivered
- Of the 85.4 per cent patients with healable wounds, 31.7 per cent were healed and discharged with an average time to healing of 15 weeks according to patient case data.

Other information

- Chronic Wounds Problem in Australia: A Call to Action paper

Nepean Blue Mountains PHN: The Advance Project: Initiating Advance Care Planning, Palliative & Supportive Care in General Practice

Identified need

NBMPHN commissioned a needs assessment and report delivered by Synergia to increase our understanding of end of life care needs in the region: the level of uptake of Advance Care Planning and their use in current service provision and to develop a pathway model that could support future planning and commissioning of End of Life services for the region. As a result of this consultation process and the market analysis conducted, five key recommendations were made, one of which was the 'Use of Advance Care Plans'.

The report identified a number of drivers affecting the use of Advance Care Plans (ACP) in our region which include: lack of communication and cooperation across agencies thereby resulting in inconsistent design and use of ACPs; Advance Care Plans are often provided to the patient by someone not skilled or experienced enough to discuss the issues that the document may raise for the patient and/or their carers.

Approach/activity undertaken

To support general practice in initiating advance care planning conversations and assessing patient's and carers palliative and supportive care needs, NBMPHN worked with HammondCare to deliver The Advance Project workshop: Initiating Advance Care Planning, Palliative and Supportive Care in General Practice.

The Advance Project provided access to free, evidence-based training package and suite of resources. The Advance Project was specifically designed to support GPs, nurses and practice managers to work as a team to initiate conversations about advance care planning and to assess patients' and carers' palliative and supportive care needs.

Participants from the Advance Project workshops considered that appropriate and timely use of ACPs would ensure that people would have their wishes and preferences for end-of-life recorded and respected, potentially improving the dying experience for patients and their families and carers.

Outcome

In total, 103 participants completed the Advance Project training, including GPs, practice nurses, Practice Managers, and other nurses with the following overall learning outcomes:

- Increasing the capacity and confidence of GPs, nurses and practice managers to initiate advance care planning conversations and assess patients' and carers' palliative and supportive care needs.
- Identifying and assessing the needs of patients, and their carers, who might be at risk of deteriorating and dying.
- Overall, enable primary health professionals to work as a team to implement the Advance Project™ resources in clinical practice.

Other information

- https://www.nbmphn.com.au/Health-Professionals/Services/Older-Persons-Health/Advance-Care-Planning

Tasmania PHN: Commissioning for quality improvement – working collaboratively to improve the quality of diabetes management in residential aged care

Identified need

Diabetes is a high priority health need in Tasmania, with approximately 5 per cent of Tasmanians with type 2 diabetes. Diabetes is the cause of a large burden of morbidity, avoidable mortality and potentially preventable hospital admissions. Additionally, the prevalence of diabetes rises dramatically as people age and Tasmania has the fastest ageing population in Australia with 1 in 5 Tasmanians being aged 65+ years. Over a quarter of Tasmanians living in residential aged care facilities (RACFs) have diabetes.

The residents from RACFs with diabetes contributes to a considerable number of emergency department (ED) presentations and inpatient hospital admissions. Therefore, improving the management of diabetes in place is better for the residents and broader Tasmanian health system.

Approach/activity undertaken

The aim of the project is to improve the management of residents in RACF who have diabetes. The project commenced in 2016-17 and has followed a staged implementation approach based on learnings and outcomes.

Phase 1: Diabetes Tasmania developed the Diabetes Management in Aged Care handbook. This process involved engaging with RACFs and initial review of the RACF policies and procedures related to the management of diabetes.

Phase 2: Based on the phase 1 findings and recommendations, PHT commissioned Diabetes Tasmania to further strengthen the capacity and capability of RACFs. Facilities with higher hospital presentations were prioritised and strategies included:

- review and modification of existing policies and procedures
- an increase in the availability of in-reach support to residents of RACFs
- the provision of training using Six Minute Intensive Training or SMITs

SMITS were developed in response to challenges associated with long training sessions.

The use of short sharp training allowed increased numbers of staff accessing training in a concise and easy to understand format that may be incorporated into situations such as shift handover.

Phase 3: PHT commissioned Diabetes Tasmania to continue phase two work with additional facilities as well as developing online SMIT training resources to improve access to and sustainability of training resources.

Phase 4: Phase 3 identified issues related to the management of diabetes in RACFs with residents often being classified as being 'too complex' to manage. PHT commissioned Diabetes Tasmania to undertake a review of patients to determine what made the residents 'complex'.

Phase 5: Based on phase 4 findings, PHT have commissioned Diabetes Tasmania to provide targeted support for complex residents to receive early input from a Diabetes Educator as well as continuing the training program and support to the RACF staff.

Outcome

Phase 1: indicated that there was a need to increase the levels of skills and knowledge of staff working in RACFs to improve the management of diabetes as well as the need to review and modify if required the policies and procedures that are in place.

Phase 2: the project targeted 20 RACFs. Outcomes achieved:

- a reduction in diabetes-related hospital admissions of 53% (2015-16 to 2017-18)

- a reduction in emergency department presentations of 29 per cent (2015-16 to 2017-18)
- increased screening for diabetes on admission improved significantly with 80 per cent of facilities reporting at follow-up that they screened residents (compared with only 15 per cent at baseline).
- increased Hypoglycaemia management planning to also improved significantly 70 per cent of residents comparative to the 10 per cent baseline
- 193 staff received face to face training

Phase 3: Outcomes achieved:

- 65 per cent reduction in diabetes related hospital admissions – a further 12 per cent reduction from the previous period
- 38 per cent reduction in emergency department presentations – a further 9 per cent reduction compared to the previous period (2015-16 to 2018-19).
- a further 313 RACF staff received training
- the specific focus around complex patients identified that 43 per cent of the participating RACFs had reported adverse events related to diabetes

Phase 4: reviewed complex patients and identified key areas for improvement such as:

- workforce education
- key elements of policy and procedures required to embed change
- early access to specialist skill and knowledge may improve outcomes

Phase 5: evaluation identified that prompt access to specialist skills and knowledge improved the outcomes of residents with diabetes in residential aged care facilities.

The use of funding to commission for service improvement rather than service delivery has been very effective in improving the management of residents in RACFs with Diabetes. PHT continues to work with Diabetes Tasmania with a view to be able to integrate the delivery of services to ensure that residents in RACF are effectively managed and their health outcomes are improved.

Other information

The SMIT resources (videos and training materials) have now been adopted by Diabetes Australia and are now being disseminated and implemented nationally.

Western NSW PHN: Shared Health and Advance care Record for End of life choices (SHARE)

Identified need

The SHARE (**S**hared **H**ealth and **A**dvance Care **R**ecord for **E**nd of life choices) project built on system change achieved through a Decision Assist Linkages project led by Far West Local Health District (FWLHD) Specialist Palliative Care Team (SPCT) in partnership with Residential Aged Care Facilities (RACFs). The Far West Palliative Approach Framework (FWPAF) was developed to build capacity and improve provision of comprehensive, consistent, patient-centred, needs-based, high-quality palliative and end-of-life care (PEoLC) for all, irrespective of diagnosis, care location or care provider. The paper based FWPAF suite of clinical and educational tools and resources achieved sustained improvements in advanced care planning, care coordination and quality of PEoLC in line with patient wishes in RACFs and Multi-Purpose Service (MPS) facilities, as well as reduction in unnecessary hospital admissions. When translated into all care settings, including community, primary health, General Practice and hospital services, it will provide a shared framework to provide genuine choice that enables the right care, at the right time, in the right place.

Approach/activity undertaken

The SHARE Work Group was established at the commencement of the project to provide an overarching governance structure for the project; with members representative of the FWLHD, WNSWLHD and WNSW PHN.

Implementation of the SHARE project was undertaken:

- **Stage 1a** (April to October 2018) A business analyst contractor engaged to undertake the business analysis required for the FWPAF to be developed into an ePAF for implementation in community and primary health care settings across our region.
- **Stage 1b** (February to May 2019) An information and Communication Technology (ICT) contractor was engaged to develop a Web Resource Centre housed on the WNSW PHN web page containing the framework, model of care and resource required by generalist clinicians to implement a palliative approach to End of Life (EoL) care.
- **Stage 1c** (July 2019 to June 2020) A shared locality record housed in a Regional Electronic Health Record (REHR). An ICT company was engaged to run an approach to market for a REHR solution to connect MyHR, GPs, LHDs and RACFs providing a shared care platform evaluated against the ePAF requirements already documented in stage 1a of the Business Analysis. South West Sydney PHNs Integrated Realtime Active Data (iRAD) project was identified as meeting 67% of SHARE projects requirements for a shared locality record.
- **Stage 2** (May 2019 to June 2021) WNSW PHN employed palliative approach linkage officers (PALOs) to implement the ePAF into 5 RACFS, 2 MPS facilities in WNSW LHD and all RACFs and MPS facilities, except one, in the FW LHD. With a 12-month extension of funding 2 more RACFs were added to the existing pilot sites. In January 2021 an EOI was sent to all RACFs in the region and a 'Rapid Rollout' of the ePAF commenced into interested facilities. The framework has been implemented into a further 18 RACFs.

Outcome

The WNSW PHN Data Team developed a Power BI data dashboard that allows WNSW PHN and the two LHDs involved in the project to monitor clinical care through evidence-based outcome indicators which will inform continuous improvement of services across all care sectors.

The data fields included are listed below:

Advanced care planning

1. advanced care directive or plan

2. resuscitation plan
3. preferred place of care
4. person responsible
5. ambulance palliative care plan
6. preferred place of death

Coordination of care

1. MDT case conference discussion
2. specialist palliative care referral

Planning for last days of life

1. anticipatory medications
2. expected home death form

Web resource centre

1. page hits and views
2. access by location
3. access by non health care persons
4. access by health care staff
5. access by facility type eg. hospital, RACF, community, other

Other information

- The WNSW PHN electronic Palliative Approach Framework (ePAF) was launched in May 2019 and is located on our website www.wnswphn.org.au/epaf
- Please follow the link: https://www.wnswphn.org.au/epaf-healthcare-professionals/epaf-webinars-healthcare-professionals to a webinar with information in the use of the ePAF.

Country WA PHN: Tackling the Barriers to Aged Care and Advance Care Planning

Identified need

The integration of healthy ageing principles and end of life planning between the local community, acute hospital and general practice to planning transitions of care and provision of appropriate pathways of care and promote healthy ageing for older people in the Great Southern Region of Country WA PHN.

Approach/activity undertaken

The Aged Care network (ACN), which included General Practice, WA Country Health, Local Government Authority, District Health Advisory Committee, Residential Aged Care consumer groups and specialist services within Palliative and aged care, completed an environmental scan of community assets to improve healthy ageing, advanced care planning and end of life. Work has included:

- Collaboratively co-designing and developing tailored Goals of Care (GoC) for advanced care planning in Residential Aged Care (RAC) and the development of a COVID 19 Emergency response plan for RAC led by a Geriatrician with a collaboration of General Practitioners.
- Development of a ACN Governance structure and nine key priority working groups to which are currently active and include expanding the use of digital health and improving the hospital admissions and discharge process for older people.
- Development of ageism awareness modules by co-design with state health agencies, consumers and carers their to raise the awareness of healthy ageing within our community. The modules aim is to promote positive change in how we think and talk about ageing and older people and what it means to be an older version of ourselves. These modules are available on the learning management system within WA country health, TRACS and for downloading on the WAPHA webpage.

The ACN is increasing the effectiveness of engagement and relations across the health and wider community system and enabling the development of robust local pathways and tailored solutions to support older people. This network has benefited from the assets discovered within the Greater Choice for at Home Palliative Care project.

Other information

Aged care network workshops

Health Professional Ageism Online Learning Module

Murrumbidgee PHN: My Health Record Connected Towns

Identified need

My Health Record provides healthcare organisations and consumers with the opportunity to share and view health information when, where and when it is needed. Having regional/rural towns fully connected to My Health Record provides the community with a connected health system and assists with consumer's community of care.

Approach/activity undertaken

The MPHN Digital Health Officer selected potential towns that were eligible (eg had conformant software) and worked with the General Practice, Pharmacy and Aged Care Facility in those towns to register and connect them to My Health Record. The Digital Health Officer also liaised with the local hospital or MPS to ensure My Health Record was operational and that their staff knew how to access and use it. Staff at each facility were educated about My Health Record and trained to use the system. Some of the benefits experienced are listed below:

Benefits

- **General practice**: Access to hospital discharge summaries and pharmacy dispense reports
- **Pharmacy**: Access to information not previously readily accessible (eg allergy status, health conditions)
- **Aged care**: Access to information (health conditions, medications etc) as needed
- **Hospital**: GP VMO has access to the above, including information uploaded at the General Practice

Outcome

The towns of Berrigan, Finley and Culcairn are fully connected with high numbers of community residents having their own My Health Record. The result of fully connecting a town goes towards demonstrating how interconnected healthcare in a community can help achieve positive health outcomes. As My Health Record grows over time, it is becoming increasingly valuable to health professionals and the community.

Gippsland PHN: Remote Patient Monitoring

Identified need

Gippsland experiences high rates of preventable hospitalisation, and avoidable presentations to emergency departments and high rates of people with chronic health conditions.

Approach/activity undertaken

Gippsland PHN are undertaking the implementation of digitally enabled remote patient monitoring.

The software platform, Lifeguard, connects health professionals to patients. The software includes a mobile app for patients, a web portal and mobile app for health professionals, and infrastructure to connect these together.

The model of care developed by Gippsland PHN, supports patients with chronic health conditions to undertake regular home-based monitoring and have access to comprehensive clinical decision making and care coordination within or close to their home, when clinically safe to do so.

Vital signs, PROMs and other elements related to specific conditions are routinely recorded through an app on a smart device and uploaded in real time to a central location. Each patient can have individual parameters set in consultation with their care team (based on a clinically developed monitoring templates), who will monitor their entries. If a participant records data outside of their defined thresholds, this will alert via the platform and action can be taken, including contacting the patient via telehealth, arranging an appointment with the General Practice or directing the patient to urgent care services.

Outcome

Since commencement in February 2021, 16 health services are implementing this innovative model of care. In the most rural area of Gippsland, seven (7) health services including general practices, community health services and bush nursing centres are implementing remote patient monitoring. They will benefit from more efficient use of resources by identifying patients who are at risk of deterioration, reduction in travel and staying connected to patients through the software.

Australian Capital Territory PHN (Capital Health Network): Pharmacists in General Practice

Identified need

- Lack of multidisciplinary care;
- Innovative models of care that improve access to integrated services for chronic conditions;
- Primary health care professional should be supported to participate in team-based and shared care; and
- Improved health literacy around medications for older Australians.

Approach/activity undertaken

ACT PHN provided funding to eight general practices to each employ a part-time pharmacist (15 hours per week) for up to 18 months to work in a non-dispensing role. The practices were recruited in stages via an expression of interest to all ACT general practices. A condition of funding was that the pharmacists and the general practice would work co-operatively with CHN to monitor progress and to participate in the evaluation.

Outcome

The evaluation has demonstrated that this model has supported team-based and shared care through

- sharing of knowledge and expertise of the pharmacist to empower the general practice team to improve the quality of their prescribing
- providing a coordinated approach to medication management
- contributing to 75+ Health assessment, GPMPs, TCAs and case conferences

Pharmacists also undertook a range of activities leading to a range of recommendations aimed at improving health outcomes and improving medication management. The following chart demonstrates the breakdown of recommendations. Pharmacists demonstrated an impact through:

- reductions in medication burden
- advising on medication interactions
- providing health education and dosing aids to support patient self-management
- reconciliation of medication after ED/hospital stay

Hunter New England and Central Coast PHN: Aged Care Rural Telehealth Project

Identified need

General Practitioners (GPs) in regional New England areas of NSW are reporting difficulties with long distances needing to be travelled to review their patients in Residential Aged Care Facilities (RACFs).

Approach/activity undertaken

This project will work to assist GPs to provide clinical care to RACF residents via a video telehealth-based platform. Work will involve training and education of both GP's and RACF staff on the identified telehealth platform and for RACF staff on recognising the deteriorating patient and ISBAR4AC clinical handover.

A multi-stakeholder steering committee has been convened to assist in clinical governance and delivery of services.

The HNECCPHN facilitated stakeholder engagement, education, and establishment of IT in RACFs and GP sites.

Case example: A GP from Tenterfield visiting RACF in Emmaville fortnightly involves over three hours of travel for the GP and the Practice nurse/administrator.

This GP will now hold weekly video telehealth consults and visit face to face once a month. This increases the clinical coverage of the RACF residents.

Video telehealth will be utilised for urgent clinical situations, reducing the need for hospital presentations.

This pilot program is being implemented in 2021-2022.

Other information

- Telehealth – Resources – Primary Health Network (thephn.com.au)
- https://hneccphn.imgix.net/assets/src/uploads/images/Telehealth-practice-workflows-guide.pdf

Hunter New England and Central Coast PHN: New England Dementia Partnership

Identified need

Dementia is the second leading cause of death of Australians. In 2021, there are an estimated 472,000 Australians living with dementia (source: Dementia Australia).

However, only 50 per cent of mild dementia cases in Australia are diagnosed with the average delay between observing dementia symptoms and diagnosis more than three years. Timely diagnosis starts with a timely comprehensive assessment.

Approach/activity undertaken

The New England Dementia Partnership (NEDP) was established in 2003 to improve dementia assessment, management, and care across the New England Northwest region of NSW.

Partners include Healthwise, Hunter New England Local Health District, HNECCPHN, Home Nursing Group, NEEST, Dementia Support Australia.

NEDP began with mapping the patient journey from memory concern through to end of life care to identify where there were delays in assessment.

A range of agreed validated, comprehensive assessment tools were collated to recognise and quantify cognition, function, mood, and carer burden. Next the NEDP organised access to training in administration and interpretation of the tools.

A Clinician's Handbook for Dementia was produced in hardcopy, and now available on the HNECCPHN Website.

A Clinical Case Discussion for effective multidisciplinary dementia care guideline was also produced.

A standardised referral pathway was included in the Hunter & New England Health Pathways. (Link below)

A dementia specific forum is held biannually, attracting sought after specialist guest speakers from around Australia, including A/Prof Lyn Goldberg from UTAS, and Professor Sue Kurrle from University of Sydney, well known for her role in the ABCs Old Persons Home for 4-Year-olds.

Other information

- Clinicians Handbook – https://hneccphn.imgix.net/assets/src/uploads/resources/nedp-dementia-care-information-booklet-dec-2016.pdf
- Clinical Case Discussion – https://hneccphn.imgix.net/assets/src/uploads/resources/nedp-clinical-case-discussion-framework-feb-2017.pdf
- Community HealthPathways – https://hne.communityhealthpathways.org/_

Nepean Blue Mountains PHN: After Hours care provided via telehealth to Residential Aged Care Facilities

Identified need

There has long been an identified need for medical care for residents of RACFs in the After Hours period. When residents at RACFs are unable to access medical care at their facility, they are often transferred to local hospital emergency departments by ambulance. The negative outcomes associated with inappropriate use of emergency medical services include increased mortality, delay of services, increased length of hospital stay, poor patient satisfaction and privacy, frustration among staff and increased costs.[10] [11] [12] This need was confirmed via consultation with local RACFs.

Approach/activity undertaken

NBMPHN commissioned a service provider to deliver telehealth consultations into six RACFs during the after hours period.

GPs remained the first point of contact for their patient's care. Contact with the service provider only occurred if the resident's GP was not available and a GP referral to the service was in place.

The service provider worked with each facility to install, set up and train the staff on the use of the service providers app. Other enablers for this activity included: NBMPHN provided a device (iPad) to each facility; sufficient administrative capacity within the RACFs to organise referral documentation; engagement with GPs; facility access to wifi or cellular data; a primary contact at each RACF to lead the implementation and ongoing appropriate service use. As the service was delivered by specialists, referral to the service enabled the use of Medicare items to fund the consultation.

Outcome

Use of this service (209 calls over a 12 month period) has helped to care for the resident within the facility (174 instances), avoiding unnecessary ambulance transfer to a hospital emergency department (55 instances). This outcome was measured by asking RACF staff whether they would have normally called an ambulance if the service was not available.

Patient/provider/stakeholder quotes

Has relieved my burden in answering calls. So, I get fewer calls from them now than other facilities (GP).[13]

When they go to hospital, particularly if they remain in ED all day, they come back distraught. They come back upset. It's an unsettling experience for them. And it's not necessary when you've got something like this (RACF staff)[14]

Other information

- https://www.nbmphn.com.au/Health-Professionals/Services/After-Hours-Medical-Services

10 National Association of Medical Deputising Services 2016, *Analysis of after hours primary care pathways*, prepared by Deloitte Access Economics, Sydney
11 Sun, B.C., Hsia, R.Y., Weiss, R.E., Zingmond, D., Liang, L., Han, W., McCreath, H. & Asch, S.M. 2013, "Effect of emergency department crowding on outcomes of admitted patients", Annals of emergency medicine, vol. 61, no. 6, pp. 605-611.e6
12 Yarmohammadian, M., Rezaei, F., Haghshenas, A. & Tavakoli, N. 2017, "Overcrowding in emergency departments: A review of strategies to decrease future challenges", Journal of Research in Medical Sciences, vol. 22, no. 1, pp. 23-23
13 Trankle, S. A., & Reath, J. (2021). Evaluation of the Nepean Blue Mountains After Hours Telehealth Service in Residential Aged Care Facilities (Draft, unpublished). Campbelltown: University of Western Sydney University.
14 Trankle, S. A., & Reath, J. (2021). Evaluation of the Nepean Blue Mountains After Hours Telehealth Service in Residential Aged Care Facilities (Draft, unpublished). Campbelltown: University of Western Sydney University.

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