PHCRIS RESEARCH ROUNDup

PHC and integration with aged care services: Challenges and approaches in Australia

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ISSN 1839-6348

Issue 42
April 2015

Lynsey Brown, PHCRIS
Jenny Davis, Benetas/ Monash University

Recent Australian health reforms highlight the role of effective primary health care (PHC) in providing coordinated, person-centred care and keeping individuals out of hospital.[1] In the context of an ageing population and rising rates of chronic and complex conditions, there is growing demand for health services. Collaboration is needed across all service providers who support older people, including integrating PHC with aged care services. This *RESEARCH ROUNDup* highlights current challenges and approaches to such integration in Australia.

Policies, partners and funding approaches

In the current dynamic policy context, significant changes are underway as part of the Living Longer, Living Better reforms.[2] This policy is shifting responsibilities between governments, expanding the community sector, changing eligibility for residential care and has established an information hub for available services ('My Aged Care' website).[3] One substantial reform relates to funding arrangements. The Commonwealth Home Support Programme, to be rolled out in July 2015, focuses on keeping individuals well in their own home, and improving home support services.[4] Using a consumer-directed care approach, individuals receive an individualised budget and play a key role in coordinating their own care.[5]

The Commonwealth Department of Social Services is responsible for aged care, whereas health is under the Department of Health's portfolio. Thus, a core challenge for supporting older Australians relates to the intersectoral nature of such collaboration, requiring connections across PHC, aged care, acute care and community sectors. Further, integration is needed across the care continuum including health promotion, prevention, chronic disease management, rehabilitation, transition to residential aged care facilities (RACFs), and palliative care.[6] Therefore, potential partners in integration include PHC professionals, community/residential aged care providers, aged care assessment teams, geriatric specialists, ambulance officers, and allied health practitioners. Figure 1 illustrates key stakeholders involved in integrating care in a RACF setting.[7]

The different stakeholders are funded and governed quite separately. Currently the Commonwealth Government funds residential aged care and PHC. State Governments fund hospitals and have regulatory/administrative roles in Commonwealth aged care packages. The community sector, which includes allied health, home help, transport, and respite, is funded jointly by Commonwealth and State/Territory Governments.[8] Navigating across sectors is a fundamental challenge for integration.

Medicare Benefits Schedule (MBS) items fund the majority of PHC provided in aged care. These include fee-for-service arrangements for case conferences, medication reviews and comprehensive assessments in both residential and community settings. In many ways general practitioners (GPs) act as gatekeepers to care for older Australians. However, while MBS funds GP visits to RACFs, research shows reticence among some GPs due to perceptions of poor remuneration.[9,10]

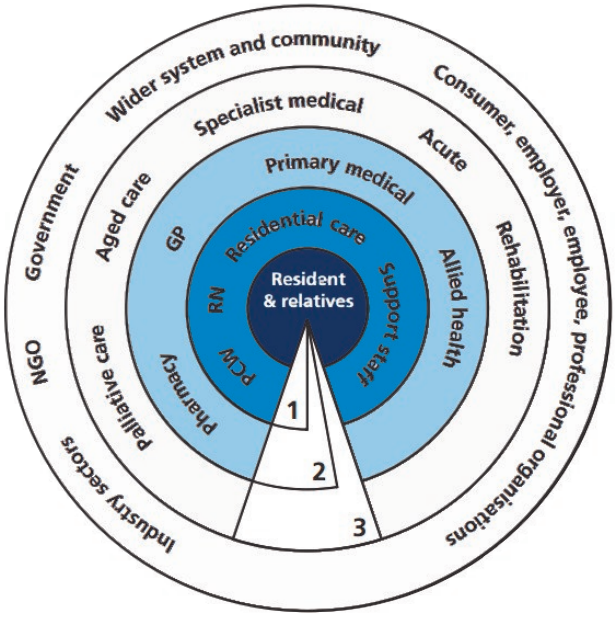

Figure 1 Key stakeholders in integrating PHC and residential aged care

Infrastructure

Effective integrated care requires an appropriately trained **workforce**. Consistent evidence indicates that predominantly older, male GPs work in RACFs.[11] Existing health practitioner shortages, exacerbated in rural/remote settings (where increasing numbers of older people reside), are often related to work/life balance but also limited access to training. Some education models providing geriatric training have succeeded in addressing this knowledge gap.[10] There are two sides to this challenge: the need for more PHC professionals trained in geriatric care, and for more community providers (e.g. nurses and personal care attendants) to be trained in chronic disease management or related aspects of care. In terms of person-centred care, some older people express reluctance towards advanced practitioner roles,[12] preferring to see their GP for certain needs. This highlights the need to engage older people, carers and families in designing integrated care solutions.[13]

There has been much discourse on **after hours** PHC and aged care; if PHC services are not available, aged care services recommend transfer to hospital. Arendts et al.[14] describe the value of an on-call assessment team that could be dispatched to RACFs around the clock, thereby reducing the need for hospital

transfers. This highlights a shift away from hospital-based care towards more community or **home-based care**. However, limited information is available regarding current integrated care models for older people in community settings.

The current environment has seen a shift from single practitioner models towards multidisciplinary teams working to improve efficiency and care coordination. In many cases, this involves **co-location** where appropriate PHC consulting spaces are set up in community aged care settings or RACFs (or via telehealth models). Maddocks[15] proposed a community hub model in which aged care, social support, preventive care, dementia care and palliative care was provided in a RACF, including a PHC practice on site. Similarly, in the AgedCare+GP model,[16] GPs from a local practice are rostered on a weekly sessional clinic in a RACF, funded by MBS items for aged care planning. Residents have the choice of seeing: their own GP, the in-house GP for acute events only, or only the in-house GP. Evaluation of this model found an almost 70% reduction in hospital transfers. SA Health's Health Service Framework for Older People[6] includes similar models of specialised interdisciplinary older people's health care in settings which include RACFs, homes, GP Plus Clinics, and hospital services. Additional models are currently being developed as part of the *Hume Region Integrated Aged Care Plan* and *TLC Community Healthcare Hubs*.

Communication

Communication is essential to successfully integrating care.[17] This relies not only on face-to-face discussions, but also effective mechanisms for timely sharing of records, discharge summaries and referrals. Without efficient information infrastructure, fragmented services prevail, with poor information transfer, incomplete cross-sector communication, duplication and risks to patient safety.

eHealth systems (currently a work in progress[18]) are proposed as tools to share records across multiple providers. However, their effectiveness and efficiency depends on software compatibility across systems. A South Australian trial evaluated an electronic data linking system which connected a local hospital and community care provider.[19] The system included shared records, email alerts informing community staff about admissions/ discharges and notifications to hospital staff when a patient was a client of the care provider. Results demonstrated reduced labour costs, admission times and demand for hospital beds, and improvements in organisational communication, quality of discharge plans, and staff's perceptions of being informed.

Mechanisms to improve communication across providers also include **shared guidelines**. The RACGP Silver Book is one example.[7] This resource promotes high quality medical care in RACFs, with an emphasis on "implementing systematic care involving residents, their GPs, RACF staff, families and other carers". The Silver Book complements the 'Best Practice Guide for Collaborative Care Between GPs and RACFs'[20] which aligns with Living Longer, Living Better reforms. **Advanced care directives**, typically coordinated by GPs, also reflect a form of shared guidelines for integrating palliative care, aged care, PHC, and the wishes of older people in both community and residential care settings.[21]

Conclusion

Core challenges to integration between PHC and aged care services relate to improving collaboration across aged care, community, secondary care and PHC sectors, and across Commonwealth and State/Territory Government portfolios. Successful models rely on effective communication, shared records, education, co-location and collaboration. There are gaps in available research addressing integrated care for older people living at home. An increasing focus on consumer-directed care and positive ageing highlights greater need for coordinating health care and preventive services with older people at the centre of all processes.

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