PS179

Sustainable Primary Healthcare to Residential Aged Care Facility Clients

(Townsville Local Government Area)

A Sustainable Model of GP-Led Primary Health Care Services within Residential Aged Care Facilities (RACFs) **with** Implementation Recommendations

Executive Sponsor: Stephen Eaton, Chief Operating Officer, Townsville Hospital and Health Service

Prepared by	Role	Credentials
Dr Toni Weller	Project Lead	GP Liaison Officer
Dr Jane Dutson	Project Lead	FIT Clinical Lead
Dr Chris Stelmaschuk	Project Officer	GP – Special Interest in Aged Care
Helen Hatchard	Project Officer	FIT NPC
Bethany Roche	Project Officer	FIT NPC
Tahnee Pedersen	Administration Officer	AO Health Pathways

Abbreviations

AH	Allied Health
CAC	Consumer Advisory Council
CDM	Chronic Disease Management
CMA	Comprehensive Medical Assessment
CNC	Clinical Nurse Consultant
CPD	Continued Professional Development
EBA	Enterprise Bargaining Agreement
ED	Emergency Department
EN	Enrolled Nurse
ENRMC	Electronic National Residential Medication Chart
FIT	Frailty Intervention Team
GP	General Practitioner
HITH	Hospital In the Home
HIU	Health Improvement Unit
ieMR	integrated electronic Medical Record
JCU	James Cook University
MDT	Multi-Disciplinary Team
NFP	Not for Profit
NP	Nurse Practitioner
NPC	Nurse Practitioner Candidate
NPS	Nurse Practitioner Service
NQPHN	North Queensland Primary Health Network
PCC	Primary Care Company
PCW	Personal Care Worker
QH	Queensland Health
RAC	Residential Aged Care
RACF	Residential Aged Care Facility
RACS	Residential Aged Care Solution
RN	Registered Nurse
THHS	Townsville Hospital and Health Service
TLGA	Townsville Local Government Area
TUH	Townsville University Hospital

Table of Contents

Overview

The following report and model of care recommendation has been determined based on the quality improvement project PS179 – Sustainable Primary Healthcare to Residential Aged Care Clients, funded by the NQPHN and tendered by the THHS.

The project team was comprised of

- Dr Toni Weller, THHS GP Liaison Officer
- Dr Jane Dutson, THHS Emergency Physician and Frailty Intervention Team Clinical lead
- Dr Chris Stelmaschuk, GP and Practice Principal of North Shore Medical Centre with special interest in Aged Care
- Bethany Roche, Nurse Practitioner Candidate – Frailty Intervention Team
- Helen Hatchard, Nurse Practitioner Candidate – Frailty Intervention Team
- Tahnee Pedersen, Administration Support – Health Pathways

The purpose of this report is to recommend a local systemic solution to the recent and projected ongoing General Practitioner workforce crisis in Residential Aged Care in the Local Government Area of Townsville. (1) The aim of the project was to develop a sustainable, GP-led Primary Health model of care that caters to the needs of RAC residents, can develop with the demographic growth over the next 15 years and aligns with the projected need for change identified by the Royal Commission into Aged Care Quality and Safety. Following a literature review completed by TUH clinical redesign unit, the project team explored local experiences of primary health care in residential aged care across all stakeholder groups. This was achieved through broad survey distribution followed by smaller individual stakeholder co-design workshops. Please see: Residential Aged Care Solution (RACS) Sustainable Primary Health Care to Residential Aged Care Facility Clients - Quality Improvement Research Report for a more detailed analysis of the method and results.

Key drivers for change from stakeholder engagement and literature review were:

- Respect and dignity in care delivery and communication with the consumer
- Timely access to care
- Enable consumer choice
- Improved interdisciplinary communication
- Improved work efficiency and remuneration
- Improve access and communication between treating practitioners and RACFs
- Enablement of digital technology to help support practitioners access to information and improve medication safety and prescribing
- Reduce, if not replace, after-hours workload

This report will outline key recommendations with a focus on three core areas of healthcare delivery:

1. Nurse Practitioner Service
2. Primary Care Component
3. Residential Aged Care Facility Collaboration

This model aim is to provide:

- Patient and relationship centred care
- Timely access to services
- A collaborative GP-led approach to caring for Aged Care residents
- Co-ordinated and planned care
- Flexible staffing models
- Cost efficiency

The collaborative design of the identified healthcare service streams, developed with interconnecting multidisciplinary relationships (2) with THHS and private allied health services, the model delivers person and relationship centred services strongly aligning with:

- The Principles of Primary Healthcare
- The Aged Care Quality Standards
- The National Safety and Quality Health Service Standards
- The Nursing and Midwifery Board of Australia – Nurse Practitioner Standards of Practice

Following this model, the RACS project team recommend the following steps as a pivotal point of action to lead service delivery change:

- Development of the NPS stream
- Development of the Consumer Advisory Council
- Development of the Residential Aged Care Solution Steering Committee

1. Description of service

The recommended model will provide care to residents of RACFs through a multi-stream, GP-led, relationship centred design. It is designed to support current GPs active in the TLGA RACF workforce as well as entice GPs not currently providing aged care services, including the future generation, into this clinical area of service delivery to improve access to primary healthcare for this underserviced and frail demographic. GPs will be supported by a Nurse Practitioner service and bolstered RACF systems to provide their specialist care in an efficient manner. The model ensures job satisfaction, balanced working conditions and fair financial remuneration for GPs.

The primary goal of the RACS model is to build stability and sustainability in the provision of care for residents of RACFs. The multi-disciplinary design provides care across the care continuum: preventative, acute, and post-acute phases, and into end-of-life and palliative care. (3)

The proposed model is new and innovative, involving a strong collaboration between primary care (federally and privately funded), public tertiary care (state funded) and Residential Aged Care Facilities. (2,4,5)

The two proposed service streams combined with the RACF collaboration will create a model with diversity of care delivery, shared-care responsibility, and build a community network for workforce growth and development in the region.

In a rapid sequence of events leading to a drastic transition to the final phase of life, this model may empower residents and their families to choose their preference of GP where possible, delivers timely access to quality healthcare, and dignifies individual's lives.

2. Key Vision:

The key vision of the RACS model is to provide:

- Respectful and dignified person-centred care
- Patient choice
- Collaborative, GP-led care to Aged Care residents
- Co-ordinated and planned care
- Timely access to care
- Cost efficiency

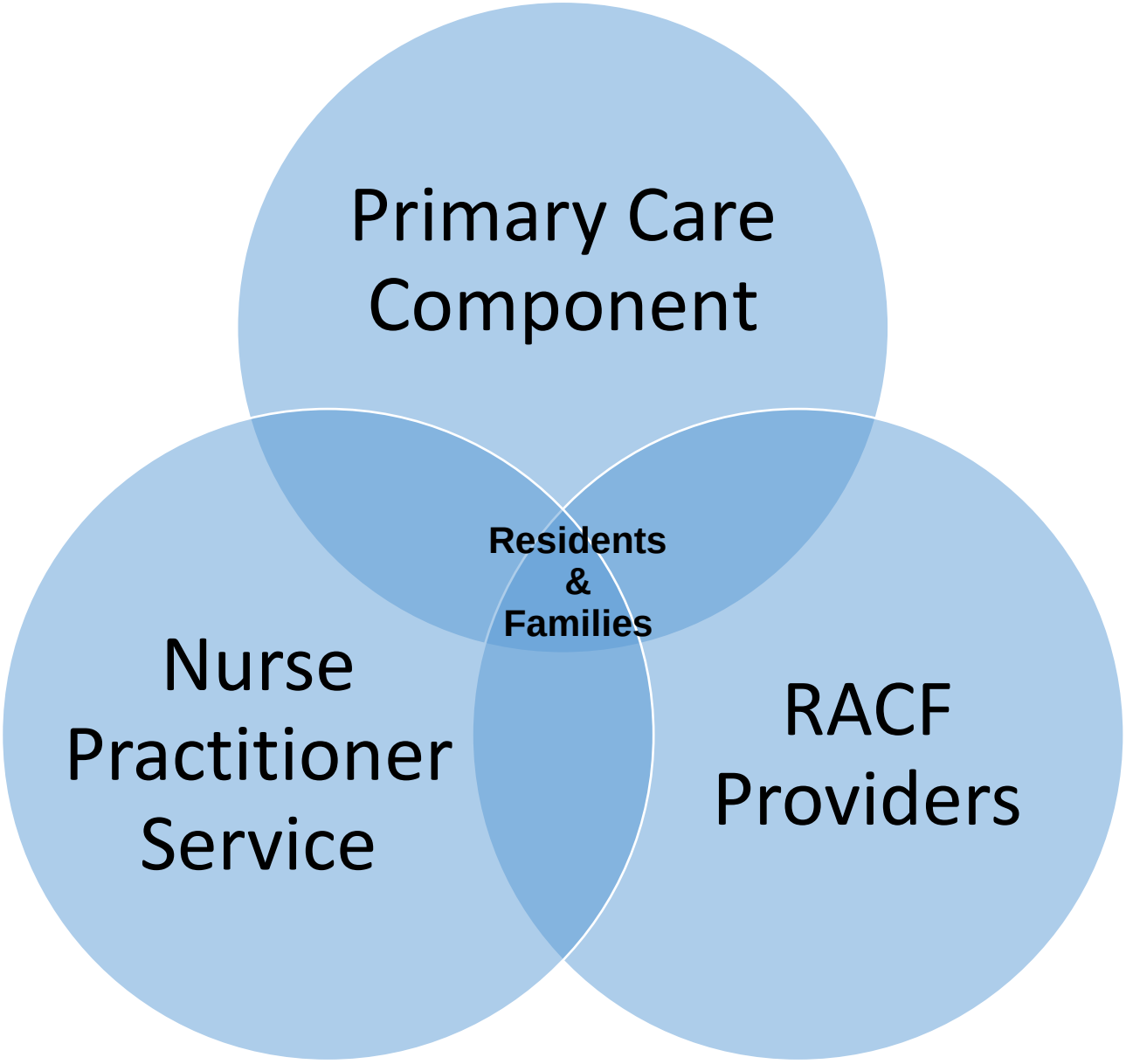
3. Key Functions:

The key functions of the RACS model are to:

- Improve frontline access to residents for preventative and acute healthcare
- Build a shared-care model, that supports the current GP workforce and encourages the future generation of GPs to the specialty, through improved job satisfaction and adequate financial remuneration.
- Enable GPs to provide planned chronic disease management, co-ordinated by an RAC special interest RN, and streamline care processes for work efficiency
- Provide RACFs with a structured Nurse Practitioner-led acute ward rounds, with the aim to prevent unnecessary transfer to TUH ED (which has a risk of subsequent iatrogenic complications) and reduce the occurrence of deterioration through early intervention. (4)
- Demonstrate the satisfaction gained from working with this frail demographic through training and education to the current workforce, GPs in training, junior medical officers, undergraduates and TAFE diploma and certificate students.

4. Service Streams:

To meet the scope of work, the RACS project team have determined that to build a sustainable GP-led model to meet the needs of residents and other stakeholders, two core clinical streams (Nurse Practitioner Service and the Primary Care Component) combined with RAC Facility contribution is required:



4.1 Stream 1: Nurse Practitioner Service

Purpose: To provide scheduled care rounds for acute needs that bridges the gap between GP care reviews and ED in-reach services; work collaboratively with the FIT NP service for post-acute transition of care; support and facilitated transitions from hospital inpatient care; and provide direct support to GPs (when requested) for co-management and review of patients where they may not require FIT/ED services. (4)

The NPS aims to provide:

- Residents with prompt, holistic care that links and bridges the specialties of preventative, acute and geriatric scopes
- Ease of access to families to communicate healthcare concerns.
- RACF clinical staff with advanced nursing expertise, empowering staff to recognise deterioration and provide early intervention (6)

- GPs with advanced nursing care support and streamlined communication that reduces the GP administrative burden, allowing them to provide their specialist care efficiently.
- Strengthened preventative and acute care planning to reduce the after-hours need for GP contact and transfer to TUH ED
- Training and education to all healthcare streams (medical, nursing, AH, support services)

4.2 Stream 2: Primary Care Component

Purpose: To develop a collaborative GP-led clinical, teaching and learning primary care entity that embodies a corporate culture with a focus on workforce wellbeing and flexibility; that fits the demographic of the broader GP workforce; positively translating into the care provided to patients. (7)
The core elements required to attract and engage GPs include:

- A well remunerated flexible working arrangement, preferably with the option to work as an employee or sole trader
- Nil or reduced after hours and on-call burden
- Reassurance of medical coverage for patients if GPs are taking leave
- Inter-practice networking and collaboration (which could potentially be expanded in community emergency response situations).
- Opportunity to follow community patients through their final stages of life.
- Opportunity to provide palliative care and other end of life services.
- Close links and access to specialist services – Frailty Intervention, Geriatric, Palliative, Persistent Pain, Older Persons Mental Health
- Access to shared clinical records (including cloud and/or remote access).
- Administrative and IT support
- PCC employed RN support to primary care delivery including to co-ordinate reviews and plans with RACFs

4.3 Residential Aged Care Facility Contribution

Purpose: to optimise the clinical environment for care providers and patients, empower confidence in RACF clinical staff care delivery and communication of care needs, and to strengthen the RACF infrastructure for clinicians to deliver efficient and best evidenced based care. (8)
The RACS project recommends each RACF:

- Ensures an appropriate clinical space be allocated for GPs and the NPS as required for care unable to be attended within the resident's bed space, such as full privacy, hygiene station, and adjustable bed for minor procedures or comprehensive assessments
- Ensures allocation of a private space for multidisciplinary team meetings, confidential handover, and documentation
- Collaborate with PCC/NP to ensure Facility RN is available during on-site visits/ward rounds
- Make available a private space that can be booked for family discussions
- Provide high speed Wi-Fi throughout the entire facility
- Provide practitioners on-site and remote access to facility electronic medical records
- Transition to the ENRMC

5. Principles of care

The principles of care determined by the RACS project are transferable and need to be integrative across all streams. These principles have been based on the principles of Primary Healthcare; the Aged Care Quality Standards; the National Safety and Quality Health Service Standards; and the Nursing and Midwifery Board of Australia – Nurse Practitioner Standards of Practice. (9–11)

5.1 Access

5.1.1 NPS Stream:

- Regular acute care rounds at each RACF to allow earlier identification of deteriorating patients and a safety net review for patients who have had an after-hours call out or presentation to an ED service.
- Provide direct support at the request of GPs, to bridge the gap between GP availability and FIT/ED presentation
- Patients receive the right care in the right setting
- Patients receive streamlined access to TUH specialty services, including escalation pathways to the Frailty Intervention Team and Hospital in the Home.

5.1.2 PCC Stream:

- Regular preventative care rounds at RACF(s) to allow well-coordinated management health needs, earlier identification and treatment of patients with changing clinical needs, including the documentation of clinical management plans. May also see their acute care needs patients in these rounds.
- Residents receive regular CDM care rounds, approximately 1-3 monthly depending on the patient's needs, including a comprehensive medical assessment (CMA) performed by the PCC RN and GP.
- Creates opportunity for residents to request their community GP continue their care with transition to the RACF. Where this is not possible: to have a consistent personal GP leading their care needs.
- Provides a consistent, engaged governing GP service for NPS and RACF staff to collaborate and communicate with, regarding the resident’s health needs

5.2 Resident and Relationship Centred

5.2.1 NPS Stream:

- Frontline service designed to deliver high quality acute and subacute clinical care in the RACF setting
- Specialist nursing care with advanced practice regulations, delivering dignified and holistic care that interconnects the MDT with a focus on the importance of the GP-patient relationship
- Focus on delivering care in the right setting to prevent complications and meet the wishes of the individual

5.2.2 PCC Stream:

- Promotes the GP-patient relationship, by providing a co-ordinated, supported and satisfying GP work environment
- GP time is focussed on patient care and family consultation, with administrative tasks re-distributed to administration and clinical support provided by nursing staff

- GPs are enabled to provide care that meets the wishes of the patient and their family, through collaborative planned care

5.3 Multidisciplinary

5.3.1 NPS Stream:

- Interconnection with THHS, Pharmacy, GPs, AH, NQPHN, RACFs and consumers.
- Work collaboratively with FIT NP service for post-acute transition of care reviews
- Collaborate with private providers to expand on services provided in RACFs, for example, dental care, optometry.

5.3.2 PCC Stream:

- GP-led care supported by the MDT of nurses, pharmacists, AH and RACFs
- Direct referral access to THHS HITH and FIT (other specialist services by extension)
- Higher quality working relationships with relevant secondary care services

5.4 Co-ordinated and planned care

5.4.1 NPS Stream:

The NPS co-ordinated and planned care will provide scheduled morning needs rounds to RACFs, weekly for smaller facilities and 2-3 times per week for the larger facilities. RACFs can plan for these rounds in advance ensuring resident with a clinical change can have their care needs met in a safe, time and efficient manner. The NPS will also be available to bridge any acute care gap that does not fit the scope of TUH FIT/ED, where the GP is not immediately available. (4)

5.4.2 PCC Stream:

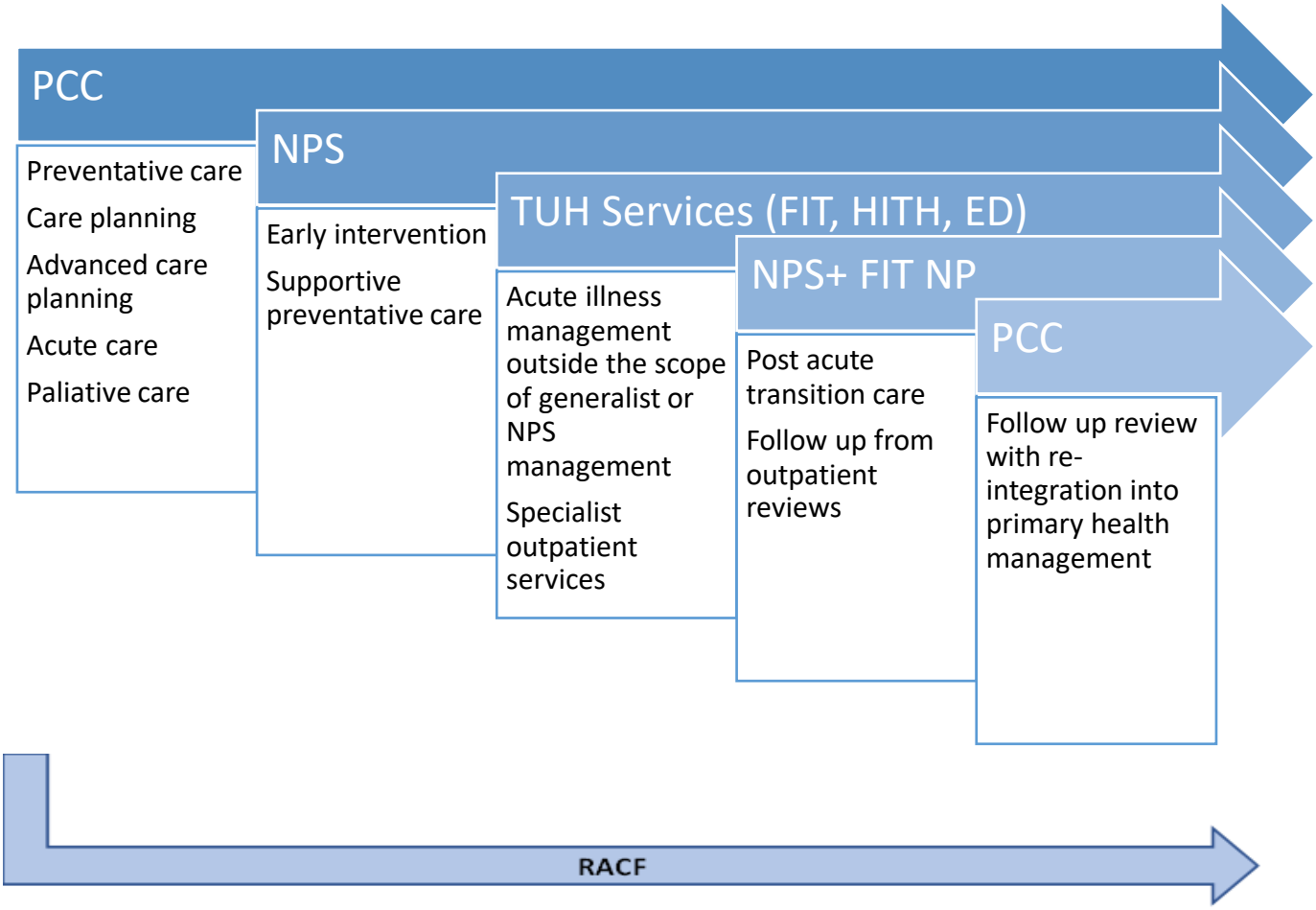
Through the PCC administrative and nursing staff, GP planned care rounds will be communicated to consumers and/or family members, the NPS, and RACF staff in advance and within PCC hours. (12) This will create:

- Opportunity for consumers to prepare for their review and plan what they wish to discuss with their GP
- Opportunity for family members to either be present (with the resident's consent) or request items to be raised with the GP
- RACF staff prepared and available to facilitate rounds to provide recent history and receive handover from the GP, thus becoming more active and enabled participants in the medical care of their residents
- Efficiency of care delivery for GPs

The expectation is that every effort is made by the GP to begin a scheduled care round on time. The value of RACF nursing staff being part of the patient's care team is vital where family members are unable to attend or wait (e.g. where there is an unavoidable delay), especially for residents that have cognitive impairment.

5.5 Collaboration and Continuity of Care

Patient Journey across the Care Continuum



6. Operational Framework

6.1 NPS Stream:

The RACS team recommend the Nurse Practitioner Service be embedded in THHS as a separate employer to the PCC as they are providing transition care between hospital services and primary care or in home acute care services. In our collaborative care model, this high-level nursing service directly bridges the needs gap between TUH ED and FIT service and PCC by performing the following:

- Regular acute care rounds at each RACFs to allow earlier identification of unwell patients, including reviews of patients who have had an afterhours deputised GP call.
- Collaborate reviews with the FIT NPC service, of patients discharged from hospital within 48 hours of arrival back at the RACF, day 7-10 and again day 21-25.
- Direct support, where requested by the GP, for co-management or review of deteriorating patients where they may not require FIT/ED services.

A key responsibility of this service will be effective and timely communication with the regular primary care teams regarding patient care. (13) A core aspect of this role will be to facilitate respectful long-term working relationships between the NPS, PCC, RACF and FIT service providers.
The NPS suggested hours of operation are Monday to Friday 8am to 4pm. Effective care planning combined with high levels of staff should support greater translation of informal education as well as preparedness for care delivery after hours.
As these NPs are offering acute and transition care services with bridging preventative care, they are better placed within the acute service for the following reasons:

- Access to Queensland Health medical records
- Direct support from FIT telephone triage line, TUH acute care staff specialists and inpatient services to optimise streamlined care.

- Consistent employment conditions and vicarious liability provided.
- Pre-established EBA accounts for time allocation for data collection, interpretation and education development and delivery.
- Access to federally funded weighted average units (WAU) remuneration since the service is provided by a Hospital and Health Service (NP rebates are very low and limited from Medicare and not available for CNCs).

A qualified NP has a master's degree in his/her area of clinical interest and can prescribe. Most importantly they understand the need to offer high quality handover and communication to the patient's regular general practice care team when a patient has had an ED or other specialty intervention including inpatient care. (14)

The gap in the TLGA Geriatric NP workforce is noted, therefore as an interim measure the NPS can be delivered by NPCs or CNCs. These nurses are also highly skilled and have a minimum of 5 years in aged care and acute or critical care settings. They have a high ability to work independently and interdependently and act as a facilitator for change within the RACF.

With the support, clinical variety, training experience and clear career progression pathway provided by this model of care, we anticipate growth and retention of the full NP workforce over time.

6.2 PCC Stream:

The Operational Vision is a collaborative GP-Led clinical, teaching and learning entity.

GPs are given the opportunity to lead a corporate culture that focuses on wellbeing and flexibility to fit the demographic of the broader GP workforce. This will increase the likelihood of full recruitment and retention of a high-quality GP workforce, as the goal is to attract doctors that are currently not engaged in providing Residential Aged Care services in addition to the retention of those already providing care for our elderly population. Furthermore, GPs will have the opportunity to work full time or part time, as either an employee or a sole trader.

The model is designed for GPs to maintain provision of care for their own patients within the PCC.

The RACS Project team consider that there are risks and benefits for various PCC company structures and believe the most ideal arrangement would be the formation of a NFP Charity: consider membership limited by guarantee. The exact structure of a newly developed company would require legal and financial advice, which is outside the scope of this project; however, we suggest membership be available to all current employees and GP contractors (rather than corporations) with an independent skills-based board to provide corporate governance.

The structure of a NFP has the potential for added benefits such as salary sacrificing and attracting donations or philanthropic funding outside of Medicare. Prioritising the mission statement, corporate culture and values that place patient experience and team-wellbeing as highly as good corporate governance will be paramount throughout the development phase. The lack of these compassionate human factors in the existing system is a direct contributor to the poorer outcomes and care experiences of residents as well as the lack of a high quality, sustainable workforce.

It is recommended that the PCC be operational Monday to Friday 8am-6pm, and 8am-1pm Saturdays with administration support available for these hours: GPs may only be "on-site" at RACFs for a portion of this. Our research suggests, a preventative care ward round of approximately 12-16 patients take a GP on average 3-4 hours to complete. There is no clinical need for the GP to remain onsite after the round and to do so would not be financially viable for the GP and PCC organisation. GP's may choose to remain accessible by phone or telehealth for the remainder of in hours: this will be at the discretion of the individual GP. Appropriate processes are to be in place by PCC to manage non-acute care calls within working hours for all patient care. This is to include knowing which GPs remain available, and their preferred method of contact, the ability to securely send an asynchronous message to non-available GPs, which GPs are away and who is providing cover for their patient cohort. The RN assists with triaging clinical calls and referring to an acute service where appropriate.

Whilst current providers of GP services to residents in RACFs felt out of hours calls were not a barrier to them (some express a preference to be notified out of hours for all medical care queries regarding patients under their care) after hours calls remain one of the leading reasons cited by GPs as to why they do not offer services to RACF residents as part of their regular practice and a frequent reason GPs who were previously providing aged care services left.
The project survey identified that many GPs prefer a deputising service after hours: rather than sharing on-call service between themselves.
Well structured, preventative care will not only improve the baseline health of residents but decrease out of hours service needs for primary care. For example, if a resident has individualised, comprehensive management plans for exacerbations of known conditions and end of life care these can be initiated and followed out of hours, meaning deputising services and EDs will have less inappropriate calls for non-acute care. (12)
Furthermore, promoting set, reasonable, and transparent working hours will prompt improved organisation by key stakeholders.

The project team recommend the PCC host and facilitate continual quality improvement programs and learning for employees including (but not limited to):

- Morbidity and mortality meetings quarterly
- Case studies and journal/research club.
- Annual review of governance health pathways by all GPs
- Basic life support annually for all clinical staff
- Cultural competency training
- Regular professional colleague interdisciplinary meetings with secondary service providers relevant to patient care needs e.g., gerontology, older persons mental health, palliative care providers.

7. Culturally Appropriate Care

The Royal Commission into Aged Care Quality and Safety identified First Nations people commonly requiring earlier access to aged care services, however due to largely systemic distrust in institutions, daily barriers are faced in accessing culturally safe, consistent, and quality of care that translates across all healthcare domains. (16) The Commission has expressed that to deliver culturally safe and inclusive care, healthcare providers need to build trust within First Nations patients. The Commission advocates that this be achieved through continuity of care, where residents receive consistent care through the same providers. (16,17)
The RACS team believe that through the principle of relationship centred care as well as a focus on continuity of care, all service streams will deliver consistent, culturally safe and sensitive care.
First Nations leaders will be invited to join the steering committee to ensure inclusivity, equity, empowerment and self-determination.

The RACS team have identified that at this time specific intervention into care delivery to First Nations residents may longer term be detrimental to establishing trusting relationships without the appropriate consultation and cultural consideration with First Nations key stakeholders.

8. Clinical governance framework

8.1 NPS Stream:

Although Nurse Practitioners (through their education) have advanced recognition on their practices with the ability to work autonomously, the RACS team acknowledge the RACGP recommendation that NPs should not work as sole providers in Primary Healthcare. Additionally, the team respects consumer requests for a continued care GP-patient relationships within Townsville. This was also a significant consideration when recommending the NPS be provided by THHS as an acute, subacute and transition care service. Governance of a patient's primary healthcare will remain with their treating GP. NPs will also benefit from THHS governance structures and vicarious liability. Further collaboration with the THHS Executive and Legal department will be required to establish appropriate reporting lines and clinical escalation pathways.

8.2 PCC Stream:

The development of a clinical governance framework will require cross-collaboration of stakeholders and legal consultation. Ideally, formulation of a clinical governance committee as part of the entity structure of the organisation would provide the framework and oversight for issues arising with clinical governance. Due to each RACF being their own entity with potential unique clinical issues or concerns, each individual RACF would require their own clinical governance oversight involving the practitioners attending those respective RACFs. These meetings ideally would be every three months.

9. Governing Bodies

9.1 Consumer Advisory Council

To support the integrity and validity of the PCC, the project team recommends the development of a Consumer Advisory Council, consisting of residential aged care consumers and family members from the RACFS that receive PCC services., reporting to the PCC board. We suggest the Consumer Advisory Council be a compulsory component of the structure and constitution of the PCC, representative of the residential cohort and convened quarterly.
The CAC can be stood up early during implementation to inform model of care suitability and changes as required.

9.2 Residential Aged Care Solution Steering Committee

Given the 3-arm proposal for the implementation (below), and the complexities involved in establishing a separate entity for the GP led primary care healthcare service, it is recommended that the NQPHN establish the RACS Steering Committee. This committee should consist of key stakeholders committed to providing care to RAC patients. The committee is designed to oversee the initial implementations of service streams and the RAC provider contribution as well as subsequent quarterly reviews of performance of the system, including setting and monitoring outcome measures.

10. Training and Education Framework

10.1 NPS Stream:

The final component of the NPS will be a co-ordinated training and education program, developed through the needs expressed by RACFs. All education will be developed for participants to self-apply CPD hours to meet registration requirements. Additionally, the regular presence of advanced practice nurses delivering care within RACFs will provide consistent informal learning opportunities for RAC staff.
Modes of education delivery may include:

- RACF in-service (individual topics)
- Combined education evenings (2.5 hours). Short topic presentations developed on a theme, with the inclusion of guest speakers
- Full day workshops, also theme based with specialist guest speakers

Longer-term planning would include collaboration with the JCU School of Nursing, TAFE QLD, QH HIU and RACF Organisations for sustainability in a structured transition program across all care fields within RAC. Future considerations can also be made to nursing and student rotations within the service to support local workforce growth.

10.2 PCC Stream:

The RACS team recommend the PCC be accredited as a GP training provider. As an accredited provider, the PCC can create opportunities for rotations for GP registrars, medical students, and possibly interns and Resident Medical Officers (RMOs) to strengthen Townsville's strategy to grow our own GP workforce with special interest in residential aged care. Positive experiences through exposure to a supportive and collaborative working culture, will encourage junior doctors and training GPs to consider a career that involves providing services to RACF residents.
Further consideration may also be paid to shared medical student rotations through the NPS.

11. Software

11.1 NPS Stream:

The aim of the NPS integration into THHS also adds value to this service as it can utilise the pre-existing software in place by Queensland Health – ieMR. The use of ieMR by the NPS supports the increased cross-collaboration between the public system and primary healthcare providers through access to accurate hospital intervention documentation that the NPS can ensure is transferable across the care continuum. Furthermore, NPS providers being able to access RACF and PCC software will allow streamlined transition of information and documentation from system to system.

11.2 PCC Stream:

The PCC will be built on the foundations of a virtual office, providing cloud-based medical record and administrative software with privacy protocols available for all staff to work from home, or other environments, which include the delivery of clinical and confidential services and accessing consumer information.
The physical space required will be a small base with hot desk style workstations which may be used as needed by employees, a private room available on a casual-as required basis for practitioners to provide telehealth, and a secure area to store equipment and supplies.
Provision of physical patient consulting space is not required and therefore decreases unnecessary operating costs. Clinical employees are to be provided with an iPad, or similar, to deliver telehealth

services. Appropriate software licensing, such as Dragon (or similar) may be covered by the practice, and usage will be available to all clinical staff who wish to use the verbal dictation option for documenting. The cloud based and remotely accessed clinical and administration software utilised by PCC will require integration with GP smart referrals for public health referrals and a system, such as Medical Objects or HealthLink, to send private referrals and other correspondence. Secure messaging functionality between team providers (i.e., RACF, Nurse Practitioner Service, TUH) is also necessary. Secure email enablement is a contingency only where these secure interinstitutional communication systems are unavailable. THHS iEMR read-only access for the PCC would allow streamlined transition of information to treating primary care physicians and help improve overall care particularly on patient discharge from TUH.

12. Measure for Outcomes:

12.1 NPS Stream:

Outcomes to measure for service effectiveness include:

- Patient and family satisfaction post engagement
- Total TUH ED presentations per month by participating RACFs
- Rate of 7- and 28-day re-presentation
- THHS total bed days
- GP satisfaction
- RACF satisfaction

The RACS team suggests monthly quantitative data collection, and three-monthly qualitative reviews. Feedback forms can be offered post engagement with cognitively intact patients or family members.

12.2 PCC Stream:

Corporate feedback avenues should be developed for patients and families to be able to provide feedback in real time. Other measurements for outcomes include:

- Patient and family satisfaction
- GP satisfaction
- RACF satisfaction
- Pre and post survey evaluation of the company
- Rate of deputised after-hours service utilisation

13. Residential Aged Care Facility Contribution

Aligning with the principles of care delivered by the PCC and NPS, RACFs and consumers will receive:

- Facilitated, unobstructed access to the NPS
- Improved access to GP support and care
- Opportunity for consumers to transition to residential aged care with ongoing provision of care by their community GP, where the GP opts in
- Access to clear, tiered pathways to appropriately manage and, where needed, escalate clinical concerns regarding residents
- Timely responses from NPS and PCC, strengthening the RACF staff - resident relationship
- RACF care staff are empowered to provide higher levels of clinical care and, due to a greater level of knowledge, more appropriately advocate for the needs of residents and family members
- Less unnecessary or inappropriate referrals to Emergency services

The RACS team recognise that operational frameworks are determined by individual RAC Organisations, however the following recommendations are made for each RACFs consideration:

- Digital enablement to ENRMC charting system is a priority and necessary requirement for the success of the service implementation. As a core requirement, extensive discussions would be required for an exemption to be granted.
- Physical environment optimisation:
  - Private room or area for history, examination and discussions with residents.
  - Where residents are in shared room/ward, a full privacy curtain and a sink for proper hand hygiene is a minimum requirement.
  - Small room with adjustable bed and good lighting to allow minor procedures to be performed on site or where full examination (e.g., skin check) is required for a patient normally resident in a shared space.
  - A private room on site for multidisciplinary team meetings, confidential handover between teams, note writing/dictation.
  - Private space that can be booked for family conferences when required.
- Nursing and care staff ratios consistent with that recommended by the Royal Commission. (15)
- A nursing staff member, familiar with patient histories and recent health needs, be available to handover clinically as required to the primary care team before they run scheduled care rounds. Staff member must also be available after or during the round (depending upon GP/patient wishes) for handover.
- A nursing staff member, familiar with patient histories and recent health needs, to handover clinically to the NP service prior to the acute needs round. Staff member must also be available after or during the round (depending upon NP/patient wishes) for handover. (2)
- Mandatory meeting (quarterly for larger RACFS and biannually for smaller) with senior and nursing management to review and discuss concerns with a practice clinician from PCC. RACF to pay for the PCC clinician time. Agenda to include administrative, governance and clinical (learning themes from the PCC morbidity and mortality meetings or other QI processes) reviews and discussions. NPS are invited and included in these meetings at their discretion.
- Commitment to decrease variability in processes wherever possible between RACFs in the Townsville LGA that affect the provision of primary care and in reach medical services.
- On-site and remote access to information systems and medical charts available for clinical staff working as part of PCC.
- On-site and remote access to information systems and medical charts available for NP/CNC within the NPS
- Implementations of the Electronic medication charting (ENMRC) - This recommendation is the most desired aspect of RACF care for all GPs currently attending and not attending RACFs. Roll-out of these systems may still be in early phases however feedback is overwhelmingly positive from all stakeholders including prescribers, pharmacists and facilities.
- High speed Wi-Fi enabled in all areas of the facility
- Digital Telehealth devices available and enabled for use, with staff available to assist residents to use the technology if required during a consultation

Lastly, aligning with the NPS structured education and training for RAC nurses and care staff, the RACS team recommend a percentage of financial contribution be delegated to the structured educational program tailored to RACF staff. It would be beneficial for an NQPHN steering committee to assist in the formation and governance progress of such a program. Financial commitment by TLGA RACFs would also facilitate protected staff participation.

14. Future considerations

14.1 NPS Stream:

Depending on the uptake and demand of the NPS, the RACS team suggest further collaboration with JCU School of Nursing for consideration of developing:

- Residential Aged Care nurse transition program
- Residential Aged Care Specialty Post Graduate Degree
- Master of Nurse Practitioner

These programs have the potential to lead Aged Care Nursing development in North Queensland.
The RACS team also propose the consideration to further explore the option of a reverse placement opportunity to RAC nurses into the NPS. Exploration of the following fundamentals would assist on informing its potential:

- Backfill for RAC staffing
- Funded position (i.e. scholarship placement)

14.2 PCC Stream:

Consideration has been paid to the GPs already providing care; existing sole trader GPs providing care will be welcome to join PCC and other incorporated service providers are to be consulted and, where possible by negotiation, share resources and collaborate.
If they do not wish to use PCC as their service agent or be part of the new model of care, it is extremely important that there is no intentional or unintentional undermining of the service they do provide. An important implementation aspect will be co-design of how to introduce this collaborative model of care with existing providers and maintaining transparency and engagement with these stakeholders. Furthermore, a relatively new current GP provider in our region is employed by Access Aged Care, with telehealth private specialist care as part of the model who currently manages the primary care of several hundred RACF residents.

After the initial setup and trial of PCC with proven viability, expanded PCC services should include:

1. Social workers with mental health training with a complimentary psychology service to address the high mental health burden in the older population)
2. Non-dispensing pharmacist.
   Valuable resource to prevent and manage medication dangers/complications when prescribing in the elderly population and can champion appropriate deprescribing. Non prescribing pharmacists can also be involved in Chronic Disease Management planning including formulation of CMAs and care plans. They are currently eligible for Workforce Incentive Payments (WIPs). Will need to consider and negotiate if this pharmacist would also perform RMMRs.
3. VMO geriatrician to improve wholistic and multidisciplinary care for complex meetings, planning and improve remuneration for all practitioners involved. This scope of practice would be further developed between the GP services and Geriatrician.
4. Preventative in reach allied health to extend and compliment the current Commonwealth funded services (18)

14.3 Scalability

Although the Townsville region has unique challenges surrounding the provision of care for RAC residents, the core barriers to GP-led care have been similarly raised throughout literature over the last decade. (8,18,19) The commonality in these barriers supports the opportunity for this model to be trialled in other regions of Australia, and potentially internationally.

15. Complimentary services to consider:

Comprehensive linked allied Health Services such as OT, physiotherapy, speech, dental, optometry, podiatry – all have a recognised need within the RACF, but currently hold a limited niche or poor funding to facilitate meeting their specialist need. (18)

Patient transport service to support residents to attend appointments outside of the RACF. These appointments may include imaging, skin procedures, iron infusions, primary or secondary care specialist appointments. Such a service should also include the option of a safety escort.
Currently these appointments need to be arranged by family, using taxi or RACF transport which can be difficult due to patient mobility factors. Alternatively, for those requiring increased supportive transport, the Queensland Ambulance Service is the only option with safety escorts provided at a cost to the resident.
If specialised transport is required, it may be unaffordable for the patient, thus creating an unintended barrier to care. Having a dedicated transport service may alleviate these issues and result in timelier planned care, preventing future damaging acute care need.

16. Risk Considerations

Risk Description	Likelihood	Consequence	Mitigation
Alienation of GPs currently working in the field. This could occur through the implementation of either the NPS or PCC, or both.	Possible	Major	The core principles of the NPS are based on the philosophy of relationship-centered care, with the priority to foster the GP-patient relationship GP is to opt-in for the chronic disease management support or primary care components
Lack of appropriate NP recruitment due to workforce shortage	Likely	Moderate	Service can be delivered by supervised NPC and/or CNC with a clinical governance change
Alienation of nurses working within RACF by the introduction of the NPS	Possible	Moderate	Defined scope of patients to be reviewed. RACF staff as a valid referrer – internal RACF clinical escalation pathways to link with NPS
Perception by RACF's, GPs and Hospital services that the NPS is an inferior service to the existing GP model ("GP Lite")	Possible	Minor	Defined scope for the NPS with clear communication of how the service fits into the overall system. Consistent communication, delivery and experience for consumers and stakeholders. Feedback – both 1:1 and at a corporate level.
Conflict arising between organisations or individuals	Almost certain	Variable	Toolkit design – early recognition of likely points of contention. Explicit expectation management, dispute resolution, head of agreement contracts, clear escalation pathways within both the NPS and PCC.
Demand is greater than NPS capacity	Possible	Moderate	Have clear early documented and known priorities and processes for times of NP workforce absence or shortage. Clear scope of service.
Lack of GP recruitment due to workforce shortages	Likely	Major	As this is the current issue, the model is designed to provide a more positive experience for GPs allowing more to enter this sector. Much of this relies on RACF being able to deliver on their suggested contribution. Education through the NPS model, creating positive environments and work experience will foster a supported healthcare network.

RACF reliance on NPS	Likely	Moderate	Defined scope with adherence by the NPS. Encourage empowerment of RACF staff through NP delivered education and training.
Significant financial and vocational challenges within RACF organisations and their structures resulting in inability to deliver suggested contributions	Almost certain	Moderate	Establishing strong lines of communication and relationship building between RACF, attending NP and PCC services Empowerment of staff through training and education Power of advocacy from a large supportive primary care collaboration
Legislative changes	Possible	Variable	Monitor and seek advice as this occurs.
RACF declining access of a service stream to the facility	Possible	Major	Build on and integrate with existing relationships and positive service delivery (e.g. with FIT team). Open discussion and exploration of potential and real barriers. Mediation where required.

Implementation Considerations

Workflow process

Phase 1

Consumer Advisory Council

The collaborative model is based on person and relationship centred care; therefore, the RACS project team advise the priority for the NQPHN is to lead the establishment of the Consumer Advisory Council. Recruitment should target individuals who wish to contribute valuable insight, guidance and feedback throughout the implementation and evaluation phases. This council can then transition into the governance structure of the PCC, once that body is established.

Residential Aged Care Solution Steering Committee

Given the 3-arm proposal for the implementation (below), and the complexities involved in establishing a NFP as a separate healthcare service, it is recommended that the NQPHN establish the RACS Steering Committee. This committee should consist of key stakeholders committed to providing care to RAC patients and work with the Consumer Advisory Council. The committee is designed to oversee the initial implementations of each service stream and subsequent quarterly reviews of performance of the system including monitoring outcome measures.

TLGA RACF Engagement

Round table discussions and presentation of the model including all 3 components, benefits to and expectations of RACF participation.

TLGA Broad General Practice Engagement

Round table discussions and presentation of the model including all 3 components, benefits to and expectations of GP and GP practice participation.

THHS Engagement

Round table discussions and presentation of the model including all 3 components, benefits to and expectations of integrating THHS services.

Nurse Practitioner Service Introduction

Simultaneously, the immediate establishment of the NPS is required to demonstrate its supportive purpose to GPs and develop a foundation for the PCC. As previously identified the Geriatric NP workforce within Townsville is limited and therefore will take time to grow a service staffed fully with NPs. Role description development and national recruitment will open the opportunity to recruit an experienced Geriatric NP to lead future workforce growth in the region.

The RACS team have pre-emptively presented the NPS plan to the THHS Medical Service Group and Chief Operating Officer, and with their approval submitted a formal application to the QH HIU Connected Community Pathways funding program. This application was successful, recruitment and service design has begun, and service delivery is on target to commence in the first half of 2023.

NQPHN was a collaborative partner in the bid and development of this service and as such the new Residential Aged Care – Nurse Practitioner Service (RAC-NPS) is designed to link in with the PCC and RACF contribution components of this model if they are implemented.

Primary Care Component

Following the establishment of the steering committee:
The RACS project team identify the importance of not disengaging current GPs in the RAC field, therefore ongoing engagement and co-design throughout the implementation phase is paramount.
The RACS team suggest NQPHN consider taking the lead to develop a RACS steering committee to advise on the following:

- Potential funding sources
    - These may include sources such as:
        - Medicare/MBS
        - Federal and State Government initiatives
        - PHN
        - Research Grants
        - RACFs
        - Patient contribution
        - University
        - Other Private/Philanthropic Funding
- Clinical Governance Pathways
- PCC structure clinical support roles: Administration, Registered Nurse
- Outcome measures, data collection and management

The RACS team recognise that funding and finalising the best structure/governance for the PCC is the greatest barrier to service implementation.

Phase 2:

Residential Aged Care Education Network

Development of the RAC Educational Network will formulate a basis for Education planning. It is proposed that formal education plans align with the respective discipline's annual registration, for instance; nursing educational plan begins June 2023, whereas the medical begins January 2023.

Phase 3:

Outcome Evaluation

The first reporting period for measurement of outcomes. This data can now lead the formal meetings with the CAC and RACS steering committee, and drive any organisational change required.

Operational phases:

1st Phase

NPS principles of care to be integrated into the current Northshore GP-Arcare model. This was trialled from August 2022 until November 2022 using the FIT NPC on Primary Care placement.

2nd Phase

Consideration for roll out of the NPS principles of care to Parklands (QH RACF). Parklands is a facility recognised to have a high level of experienced nurses with improved ratios over private facilities. Engagement with the two GPs in this facility is required as the success of the PCC in this facility will be dependent upon whether these GPs would consider working alongside or joining the PCC.

****The aim of operational phases 1 and 2 is to trial the functionality of the NPS in RACFs with stable yet two differing models of GP care.*

3rd Phase

Consideration to be made to approach a private GP practice within the TLGA that has expressed interest in residential aged care, however not currently providing regular care to this demographic, with proven record as a teaching practice. The aim is to recruit this practice to join/participate in the PCC. This can lead discussions about onboarding practice owners, sole traders and employee GPs as well as “sharing” registrars i.e., GP registrars that work primarily in a mainstream practice but may care for some patients of the practice/supervisor under this model.

Reference List

1. The Townsville Hospital and Health Service. Health Service Plan: Background Paper. 2018.
2. Meade C, Ward B, Cronin H. Implementation of a team model for RACF care by a general practice. Australian Family Physician. 2016;45(4):218–22.
3. Dwyer JM, Duckett SJ. Restructuring primary health care in Australia. Med J Aust. 2016;205(10):435–6.
4. Carter HE, Lee XJ, Dwyer T, O'Neill B, Jeffrey D, Doran CM, et al. The effectiveness and cost effectiveness of a hospital avoidance program in a residential aged care facility: a prospective cohort study and modelled decision analysis. BMC Geriatrics. 2020;20(1):1–10.
5. Dwyer T, Craswell A, Rossi D, Holzberger D. Evaluation of an aged care nurse practitioner service: Quality of care within a residential aged care facility hospital avoidance service. BMC Health Services Research. 2017 Jan 13;17(1).
6. Mundy L, Hewson K. Thinking outside the system: The integrated care experience in Queensland, Australia. Australian Journal of Primary Health. 2019;(Goodwin 2016):303–9.
7. Haunch K, Thompson C, Arthur A, Edwards P, Goodman C, Hanratty B, et al. Understanding the staff behaviours that promote quality for older people living in long term care facilities: A realist review. International Journal of Nursing Studies [Internet]. 2021;117:103905. Available from: https://doi.org/10.1016/j.ijnurstu.2021.103905
8. Reed RL. Models of general practitioner services in residential aged care facilities. Aust Fam Physician. 2015;44(4):176–9.
9. Australian Government. Aged Care Quality Standards [Internet]. Aged Care Safety Commission. 2021. Available from: https://www.agedcarequality.gov.au/providers/standards
10. Nursing and Midwifery Board of Australia (NMBA). Nurse Practitioner Standards of Practice [Internet]. 2022. Available from: https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/nurse-practitioner-standards-of-practice.aspx#:~:text=In Australia%2C the educational requirement for endorsement of,a variety of health systems to maximise outcom
11. Public Health Association of Australia. Public Health Association of Australia : Policy-at-a-glance – Primary Health Care Policy. 2011;(September 2011):1–6. Available from: http://www.phaa.net.au/documents/111204_Primary Health Care Policy FINAL-with cover sheet.pdf
12. An ICT solution for medical care to residents in residential aged care faci...: EBSCOhost [Internet]. [cited 2022 Jul 11]. Available from: https://web.s.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=5&sid=69a2e4f7-de25-43f4-af3b-c7a92f8ccd42%40redis
13. Martin RS, Hayes Phd BJ, Hutchinson Phd A, Tacey M, Yates Phd P, Lim WK. Introducing Goals of Patient Care in Residential Aged Care Facilities to Decrease Hospitalization: A Cluster Randomized Controlled Trial. [cited 2022 Jul 11]; Available from: https://doi.org/10.1016/j.jamda.2019.06.017
14. Marsden E, Craswell A, Taylor A, Coates K, Crilly J, Broadbent M, et al. Nurse-led multidisciplinary initiatives to improve outcomes and reduce hospital admissions for older adults: The Care coordination through Emergency Department, Residential Aged Care and Primary Health Collaboration project. Australasian Journal on Ageing. 2018;37(2):135–9.
15. Royal Commission into Aged Care Safety and Quality. Recommendations [Internet]. 2021. Available from: https://agedcare.royalcommission.gov.au
16. Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect. Volume 2: The current system. Vol. 3, Final Report: Care, Dignity and Respect. 2021. 1–447 p.
17. Deravin LM, Anderson J, Mahara N. Cultural safety for First Nations people in aged care. Contemporary Nurse. 2021;57(5):308–11.
18. Maddocks I. The Community Hub: A proposal to change the role of Residential Aged Care Facilities (RACFs). Family Medicine and Community Health. 2014;2(4):20–5.
19. Kistler CE, Zimmerman S, Ward KT, Reed D, Golin C, Lewis CL. Health of Older Adults in Assisted Living and Implications for Preventive Care. The Gerontologist cite as: Gerontologist [Internet]. 2017 [cited 2022 Jul 11];57(5):949–54. Available from: https://academic.oup.com/gerontologist/article/57/5/949/2632052