Department of Health

Evaluation of the Better Health Care Connections:
Aged Care Multidisciplinary Coordination and Advisory Service Program

FINAL REPORT

March 2018
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACAI</td>
<td>Aged Care Access Incentive</td>
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<td>ACAT</td>
<td>Aged Care Assessment Team</td>
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<td>ACC</td>
<td>Aged Care Coordinator</td>
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<td>ACFI</td>
<td>Aged Care Funding Instrument</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>ARCHUS</td>
<td>Aged Residential Care Healthcare Utilisation Study</td>
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<td>BHCC</td>
<td>Better Health Care Connections</td>
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<tr>
<td>CMA</td>
<td>Comprehensive Medical Assessment</td>
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<td>CSAPHN</td>
<td>Country South Australia Primary Health Network</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EN</td>
<td>Enrolled Nurse</td>
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<td>GCPHN</td>
<td>Gold Coast Primary Health Network</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HNECC PHN</td>
<td>Hunter New England Central Coast Primary Health Network</td>
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<tr>
<td>ISBAR</td>
<td>Identification, Situation, Background, Assessment and Recommendation</td>
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<tr>
<td>KBC</td>
<td>Kristine Battye Consulting Pty Ltd, trading as KBC Australia</td>
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<td>LHN</td>
<td>Local Health Network</td>
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<td>LLLLB</td>
<td>Living Longer Living Better</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>MDC</td>
<td>Multidisciplinary care</td>
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<td>ML</td>
<td>Medicare Local</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>NQPHN</td>
<td>North Queensland Primary Health Network</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>NWMPHN</td>
<td>North West Melbourne Primary Health Network</td>
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<td>PHN</td>
<td>Primary Health Network</td>
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<td>PI</td>
<td>Performance Indicator</td>
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<tr>
<td>RACF</td>
<td>Residential Aged Care Facility</td>
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<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SEMPHN</td>
<td>South East Melbourne Primary Health Network</td>
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<td>WAPHA</td>
<td>Western Australia Primary Health Alliance</td>
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<td>WNSWPHN</td>
<td>Western NSW Primary Health Network</td>
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**GLOSSARY**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Better Health Care Connections Program/the Program</td>
<td>When the term Better Health Care Connections Program or the Program is used, it refers to both elements of the Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program collectively i.e. the Multidisciplinary Care Coordination and Advisory trial and the GP video consultation pilot.</td>
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<tr>
<td>Element 1</td>
<td>Multidisciplinary Care Coordination and Advisory Service trial. This is also referred to as the Trial</td>
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<td>Element 2</td>
<td>GP video consultation pilot  This is also referred to as the Pilot</td>
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<td>Medicare Local Phase</td>
<td>The period from 2013 to end June 2015 when Medicare Locals were contracted to manage the Program.</td>
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<td>Non-participating Residential Aged Care Facilities</td>
<td>Residential aged care facilities that were engaged by the Aged Care Coordinators for some activities under Element 1 but did not participate in the GP video consultation pilot</td>
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<tr>
<td>Participating Residential Aged Care Facilities</td>
<td>Residential aged care facilities that participated in the GP video consultation pilot.</td>
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<tr>
<td>Primary Health Networks Phase</td>
<td>The period from July 2015 to end June 2017 when Primary Health Networks were contracted to manage the Program</td>
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<td>Program Site</td>
<td>Refers to the nine sites in which the Program operated</td>
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<td>Site Manager</td>
<td>Refers to people responsible for the implementation of the Program in each of the funded organisations</td>
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EXECUTIVE SUMMARY

The Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program (the Program) was a component of the Better Health Connections measure announced in the 2012-13 Federal Budget. The aim of the measure was to improve linkages between the aged care sector and the wider health system to improve access to health care and prevent hospitalisations for older Australians.

The Program commenced in June 2013 under the direction of the Australian Government, Department of Health and Ageing. This initiative had two elements:

- Element 1: Trial an Aged Care Multidisciplinary Care Coordination and Advisory Service with the support of dedicated Aged Care Coordinator(s) (ACC) to improve health outcomes for aged care recipients in both residential and community settings.
- Element 2: Pilot General Practitioner (GP) video consultations for residents in aged care facilities.

The objectives of the Program were to:

- promote expansion of in-reach health services to RACFs
- promote development of regional or locally based visiting multidisciplinary teams
- develop better links between the health system and aged care sector (community and residential care)
- promote multidisciplinary care (MDC) for aged care recipients
- create links that assist specialists, GPs and allied health professionals and aged care providers to deliver MDC, and inform allied health professionals about the availability of relevant MBS items (if available), incentives and resources.

Eight Medicare Locals and one aged care provider were funded as program sites. Following the change in policy settings resulting in the cessation of funding to Medicare Locals (MLs) in June 2015 and the establishment of Primary Health Networks (PHNs), these entities were contracted to manage the Program in eight sites. Sites were situated in metropolitan, regional, rural and remote locations. The Program ran over four years commencing in 2013 and ceasing at the end of June 2017.

Evaluation of the Program

In March 2017 KBC Australia was commissioned to conduct an evaluation of the Program. The objectives of the evaluation were to:

- assess the implementation of the program
- assess the appropriateness, effectiveness and efficiency of Aged Care Coordinators and GP video consultation from the perspectives of aged care recipients, service providers, and the health and aged care systems
- identify the barriers and enablers for trial implementation and achieving outcomes, and
- identify lessons for improving access to, and delivering, multidisciplinary health care for aged care recipients.
A mixed methodology was adopted and included: development of an evaluation plan and retrospective program logic informed by an environmental scan and available program documentation; analysis of performance reports from sites across the four years and analysis of a supplementary data report requested by the evaluators; site visits to interview key participants supplemented with telephone interviews (finalised prior to cessation of program funding); development of site reports incorporating analysis of administrative and service data and thematic analysis of qualitative data; workshop with the project team to synthesise the quantitative, qualitative and secondary data to form evaluative judgements and make conclusions. The outcomes from the workshop formed the basis for the final report. Ethics approval for the evaluation was obtained through Bellberry Ltd.

The evaluation was limited by the lack of consistency of data reported by Trial sites to support a robust assessment of Element 1, the Multidisciplinary Care Coordination and Advisory Service. As a result, achievements of the role of the ACC with respect to Element 1 are reported on a descriptive basis. Limited activity occurred in the community aged care setting and hence the findings of evaluation are predominantly focused on the residential care setting. Baseline measures relevant to outcomes relating to acute events, emergency admissions and hospitalisation were not established at the commencement of the Program precluding an assessment of impact of the Program on these parameters.

**Implementation of the Program**

All sites employed or contracted an ACC responsible for activities relating to both Element 1 and Element 2.

**Element 1: Multidisciplinary Care Coordination and Advisory Service**

The work undertaken by the coordinator to implement the Multidisciplinary Care Coordination and Advisory Service differed according to local conditions and interpretation of the contract requirements and Program Manual.

Key activities undertaken included:

- networking with aged care services and local health sector
- undertaking needs assessment and service mapping to develop understanding of the local and regional service system and identifying opportunities to address service or system gaps
- developing knowledge of the complexity of the aged care system in order to target service enhancements that aligned with organisational and legislative requirements
- developing or contributing to development of health pathways relevant to aged care
- building capacity within the local general practice and residential aged care sector to support care planning and care coordination, and knowledge of clinical care of older people.

**Key Findings**

The provision of MDC to residents of aged care facilities was enhanced to a *limited* extent as a result of the Trial. Several underpinning assumptions of the Trial were incongruent with the way MDC planning, resourcing, and delivery currently occurs in residential aged care. As such, RACF management did not perceive a significant role for the ACC in sourcing or establishing
multidisciplinary teams as RACFs are funded under the Aged Care Funding Instrument (ACFI) to provide maintenance therapy or more intensive therapy to enable residents to reach a level of independence at which maintenance therapy meets their needs.

ACCs tended to operate as service navigators to source allied health, medical specialist and specialist nursing services to meet service gaps specifically in the RACFs participating in the GP video consultation Pilot.

The establishment of Aged Care Advisory Groups or Project Steering Committees (in some sites), were useful mechanisms to build relationships at a local level between the aged care sector, the Local Health Network (LHN) and other providers and GPs.

**Barriers** to service enhancement, care coordination and improvements to health outcomes for aged care residents included:

- Limited opportunity to use MBS items for allied health service provision in RACFs due to the complexity of residential aged care funding mechanisms, lability of residents’ care needs and limitations of MBS Item 731 allowing for only 5 allied health services per year
- The absence of additional funding for allied health services through the Trial limited capacity of sites to source additional allied health services beyond those available for therapy maintenance
- The ACFI, the predominant funding mechanism for residential aged care, resources RACFs to meet residents’ care needs, including allied health services at a maintenance level, but does not extend to resourcing to support specific wellness and re-ablement services
- Policy and logistical issues limited access of residential aged care recipients to public allied health and medical specialist services
- Differences in the approach to care planning by RACFs and general practice challenges the role GPs can play in leading clinical care planning. Multidisciplinary care planning in RACFs occurs under the ACFI and informs resourcing for individual residents. This is separate to practice based systems GPs use to support clinical care planning for people with complex and/or chronic health issues
- There was a lack of shared understanding of funding arrangements and documentation required to support care planning by both RACFs and GPs and this hindered collaborative care planning processes.

**Summary**

While sites undertook a wide range of activities to progress Element 1 of the Program, there is little evidence of systemic or sustained change as a result of these activities. The evaluation highlighted a number of key areas for consideration in the development of future policy and programs aimed at improving care coordination and the provision of MDC in the residential aged care sector. Improved planning and program design, including the early development of a robust monitoring and evaluation framework, would likely have enhanced the implementation of this component of the Program.
Element 2: Pilot of GP Video Consultation

All sites established GP video consultation to some extent including recruitment of RACFs and GPs, development of protocols and training to support implementation of video consultations, and establishment of processes for GP payment.

Key Findings

Overall a total of 5,029 GP video consultations were conducted across all nine sites over four years. This represents approximately 14% of the aspirational target of 36,000 consultations (based on targets in individual site Grant Agreements). Varying factors contributed to the delivery of video consultations at a site level and at a facility level. These are outlined below and explored in detail in the report.

The cessation of funding to MLs and establishment of PHNs in June 2015 (in eight of the nine sites) disrupted implementation of the Pilot and required engagement of new RACFs and GPs in the majority of sites.

The model of GP service provision to RACFs impacted on adoption of video consultation. The sites where uptake was higher tended to be locations where participating GPs had a concentration of patients residing in the participating RACFs and hence video consultation became more embedded in the model of care at the facility.

Video consultations were considered by GPs and RACF staff to be appropriate for a wide range of health conditions, although there was variation between individual GPs in terms of which patients they deemed to be suitable.

Perceived benefits of video consultations included:

- improved timeliness of care
- greater flexibility for families to participate in decision making about residents’ care
- reduced travel time for GPs
- improved access by GPs to clinical information
- improved capacity for RACFs to promptly implement changes in clinical care
- improved continuity of care.

Enablers to implementation included:

- having a dedicated resource to establish the video consultation model at each site was essential to adoption and ongoing utilisation
- identifying “champions” at both RACFs and in GP practices for driving the change necessary to implement the Pilot
- staged implementation at a RACF level to familiarise participants with the technology and application
- reliable connectivity, IT support, user-friendly platform, previous experience with technology at both facilities and GP practices
- RACF readiness to support innovative models, supportive management, stable workforce and ability to integrate video consultation into the model of care.
• GP interest in innovation, practice management support, confidence in skills and knowledge of RACF nurses and payments to GPs.

Barriers to implementation included:

• technology problems including poor internet connection and inadequate technology infrastructure
• staffing capacity, turnover and familiarity with technology in RACFs
• logistics and organisational issues such as all parties being ready for video consultation at scheduled time.

Summary

The Pilot demonstrated GP video consultation can be a component of primary care for residents of aged care facilities. However, a number of systemic challenges remain before this approach could be more widely adopted. These include the robustness and reliability of the available technology and the need for ongoing support and training to develop and implement the chosen model. The evaluation highlighted a number of issues related to the wider context of GP service provision in RACFs that remain a barrier for improving and increasing GP care. The potential role GP video consultations could play in the provision of primary health care to residents of RACFs is directly linked to and dependent on resolution of these systemic issues.

Lessons Learned

The findings of the evaluation and lessons learned predominantly relate to residential aged care as limited Program activity was directed toward community aged care. The lessons learned are drawn from the findings of the evaluation including analysis of reports, interviews and review of relevant literature. These lessons are presented with a view to informing future policy and program development.

Improving timely access to GP care for residents of aged care facilities

GP Video Consultation

The pilot demonstrated that GP video consultations have the potential to work as a component of primary health care for people living in RACFs. A number of strategies could be implemented to ensure readiness for wider adoption and sustainability.

• Reliable connectivity is required but is not currently universally available, as demonstrated by the problems experienced across all pilot sites. Both GPs and RACFs require appropriate quality and capability of equipment as well as strong and reliable internet access.
• The workforce needs to be trained and skilled to work effectively with telehealth. Ongoing commitment to training in skills and knowledge for use of telehealth technology is needed within the RACF context where there is a high rate of staff turnover.
• Commitment to the change in practices by GPs and RACFs to make video consultations a normal and sustainable part of care for residents is required. The logistics of organising and implementing a video consultation session need to be seen as a legitimate responsibility and priority for staff.
• A dedicated role or resource is required for the establishment of systems and processes to support video consultation between general practices and RACFs. This role needs to be sustained for a period of time to assist to embed video consultation into the model of care.

• The evaluation showed that there are costs associated with GP video consultations for both GPs and RACFs. Adequate remuneration for both parties, and nurse staffing capacity in RACFs are essential considerations in wider implementation of this model.

**Promoting provision of GP care to RACFs**

Improving access to primary health care for residents of aged care facilities was a key driver of the Program. The use of video consultation to reduce time constraints for the GP to visit the RACF, and remuneration for the video consult under a fee for service model was tested as an approach to improve access to GP care. While the GP video consultation could be an adjunct to primary care, the findings of the evaluation support other studies that highlight the challenges for GPs in providing care in residential aged care settings i.e. the volume of time and unremunerated work to provide care to residents in RACFs. Cumbersome communication between GPs and RACFs, and lack of interoperability of systems between general practice and RACFs results in duplication of effort by the GP in transferring notes between the RACF records and general practice management system. The fee for service model does not remunerate GPs for these time consuming aspects of providing care in RACFs.

The model of remuneration for GPs providing quality care to residents of aged care facilities needs to consider differences in scope and nature to that provided in the community, and the utility of a fee for service model when much of the activity does not directly involve the resident.

**Care planning and coordination**

The Trial demonstrated that there was not an identified or obvious role for the ACC as an external resource, in care planning and coordination at a resident level. This was the case in both the PHN Trial sites and Feros Care. Holistic MDC planning is currently undertaken by nurses employed by the RACF under the ACFI, and opportunities for GPs to play a lead role in clinical care planning were limited.

Acknowledging the current ACFI process for clinical care planning purposes, and the increasing average age and complexity of health care needs of residents of aged care facilities, strategies are needed to better support and enable GPs and practices to systemise an annual cycle of care for RACF residents in line with the Royal Australian College of General Practitioners (RACGP) Silver Book guidelines and relevant clinical care guidelines.

• Improving the interoperability of general practice and RACF systems would enable the GP to have access to the resident’s clinical record, medications, recent pathology and investigation reports, and capacity for real-time pathology requests and scripts, hence streamlining care and addressing issues of duplication of effort.

• Care planning and coordination activities in residential aged care are best undertaken by health providers directly involved in the individual’s care. Facilitating processes to use general practice-based care planning supports including practice nurses, access to clinical records, patient register and recall systems, and team care planning arrangements, in
collaboration with RACFs are required. PHNs have a direct role in general practice support and can leverage these functions to support GPs and RACFs to develop locally relevant approaches.

**Promoting access to MDC**

The Program evaluation has highlighted the complexity of the legislative and funding environment of the residential aged care system, and variation in LHN and state government policies and programs in relation to service provision into RACFs.

Future programs to promote access to MDC in RACFs need to consider:

- ACFI funding mechanism and the type of services required to be provided by RACFs to meet accreditation requirements
- the regulations under which the MBS can be applied for individual residents based on their ACFI assessment
- limitations of the utility of the MBS to support re-ablement of residents, where eligible, as only five allied health services can be accessed in a calendar year, and the quantum of remuneration for an allied health service as an appropriate incentive for a provider as a one-off or ad hoc clinical encounter
- LHN and state government policies in relation to service delivery into RACFs.

**Opportunities to build links between the aged care and health care sectors.**

The evaluation of the Program provided evidence that there is a lack of understanding of funding models, service availability and delivery mechanisms between the primary health care providers, aged care services, and the broader health system. Trial managers identified the complexity of the aged care sector at a local level where it is populated with multiple small and diverse providers as well as larger not for profit and for profit corporate entities, presented challenges for engagement.

Activities undertaken under the Program to establish Aged Care Advisory Groups, undertake service mapping and needs analysis, and develop clinical pathways, were useful mechanisms for participating PHNs to engage providers and develop local intelligence of the aged care service system. This intelligence can inform their work as systems innovators, change agents and commissioners to improve the connections and interface between the aged care sector and other parts of the health system.

Linkage between the aged care and the health sectors could be improved by greater understanding of respective funding mechanisms, business models and service models.

**Overall program design**

The Program tasked Program sites to increase access to MDC. However, this did not fit well with the responsibility of residential aged care providers to fund necessary allied health services to meet individual residents’ needs. Similarly, the Program contracts and Program Manual refer to the expectation that the Trial would facilitate GP-led MDC for aged care services. While this may have been relevant for the community aged care sector, it did not align well in the residential setting.
Program design could be strengthened by bringing together industry knowledge from the aged care sector and general practice to co-design the program to ensure it is grounded in evidence and context and there is congruency between program objectives and the complexities of the existing processes, routines and funding mechanisms.

Program design needs to include development of a robust program logic informed by evidence and industry knowledge to support development of clear objectives, alignment of key activities and outputs linked with outcomes and PIs. These could be documented in a program manual and considered in development of a monitoring and evaluation framework prior to trial commencement. Engaging evaluators in this early work as a basis for a formative evaluation provides the opportunity to re-orient aspects of the program and/or data collection mechanisms for a more robust program and evaluation.
1 INTRODUCTION AND BACKGROUND

The Australian Government, Department of Health (DOH) commissioned KBC Australia to undertake the evaluation of The Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program*. The Program was announced in the 2012-2013 Federal Budget as a component of the Living Longer Living Better (LLLB) Aged Care Reform package.

1.1 Policy Context

The LLLB Aged Care Reforms were developed in response to, and informed by the Productivity Commission’s Caring for Older Australians report, 2011.¹ The Productivity Commission’s Report found that over 1 million older Australians receive aged care services, and while the range and quality of services had improved over past decades, further developments were needed particularly as it is estimated that over 3.5 million Australians are expected to use age care services each year by 2050. The report identified weaknesses in the Aged Care system that included:

- difficulties in navigation
- limited services and limited consumer choice
- variable quality of services.

The Productivity Commission proposed an integrated package of reforms to address the weaknesses of the system and deliver higher quality care, many of which were adopted in the LLLB Aged Care Reform package, legislated in June 2013. The key elements funded through the five year package included:²

- helping people to stay at home through an integrated Home Support program
- increasing carers access to respite and other support
- better residential aged care
- strengthening the aged care workforce and development and implementation of an Aged Care Workforce Strategy
- support consumers and research
- ensuring better health connections through:
  - investing in specialist palliative care and advance care planning advisory services to build better links between aged care and palliative care services
  - expanding palliative care training for staff in residential aged care and Home care package services
  - commissioning projects with a focus on prevention of hospitalisation for older people and improve access to complex health care.

* Please refer to Glossary for explanation of terms used in this Report in relation to naming of the Program

1.2 Better Health Care Connections

The Better Health Care Connections (BHCC) measure was developed in response to the increasing number of people needing aged care and the increasing complexity of their care needs.

Almost 400,000 Australians receive services through residential aged care, Home Care or Transition Care. At June 2015, nearly 173,000 people resided in permanent aged care facilities, 4,992 were in residential respite services and 59,500 were receiving a home care package.3

The pattern of use of aged care services changes with age. At June 2015, of those people aged 70 years and over receiving an aged care service, 32% were cared for in their home and 7% in a residential care setting. These proportions increase for people aged 85 years and over, where care in the residential setting is nearly tripled.4 Furthermore, the complexity of health needs of residents in aged care is increasing with older residents having one or more chronic conditions. About a quarter of people residing in aged care facilities are rated as needing a high level of care in activities of daily living, behaviour and complex health care. Over 50% of residents with an ACFI assessment have dementia.5

A key aim of the BHCC measure was to improve access and linkages between the aged care sector and the wider health system to prevent hospitalisations for older Australians and improve access to complex health care. Several programs were funded under the BHCC measure including The Better Health Care Connections Aged Care Multidisciplinary Care Coordination and Advisory Service Program, which is the focus of this evaluation.

1.3 BHCC: Aged Care Multidisciplinary Care Coordination and Advisory Service Program

The Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program (the Program) commenced in June 2013 under the direction of the Australian Government, Department of Health and Ageing. This initiative was to provide support for MDC for aged care recipients encompassing GPs, nurses, allied health and relevant medical specialists, in both residential and community settings and to test video consultation to improve access to GPs for residents in aged care homes.6 The underpinning rationale was that better access to GP care and more effective linkages between aged care services and health services would reduce exacerbation of acute events, reduce presentations to hospital emergency departments (EDs) and reduce avoidable hospital admissions. At that time eight Medicare Locals (MLs) and one aged care service provider were funded to manage the Program.

Aim of the Program

The aim of the Program was to improve the quality of health care for aged care recipients in both community and residential aged care settings.

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3 AIHW Older Australians at a glance. (2017) Web Report
5 AIHW Older Australians at a glance. (2017) Web Report
The **two elements** of the Program were:

- Element 1: Trial an Aged Care Multidisciplinary Care Coordination and Advisory Service with the support of dedicated ACCs to improve health outcomes for aged care recipients in both residential and community settings.
- Element 2: Pilot GP video consultations for residents in aged care facilities.

The **objectives** of the Program were to:

- promote the expanded use of in-reach health services to Residential Aged Care Facilities (RACFs)
- promote the development of regionally or locally based visiting multidisciplinary health care teams
- develop better links with the health system in both the community and residential settings
- promote MDC for aged care recipients
- create linkages that assist specialists, GPs, allied health professionals and aged care providers to deliver MDC and inform allied health professionals about the availability of relevant Medicare Benefit Schedule (MBS) items (if available), incentives and local resources.

The **intended Program outcomes** (as set out in the Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program Manual) included:

- decline in acute events, emergency admissions and hospitalisation
- decline in premature entries into residential aged care facilities
- improved health outcomes including re-ablement, improved functional ability and increased independence for aged care recipients
- enhanced client satisfaction and more seamless and continuous care provision
- reduced duplication of effort by health and aged care providers through enhanced coordination
- better uptake of innovative practices in aged and health care, such as the use of video consultation
- better management of workforce shortages.

The sites were situated in metropolitan, regional, rural and remote locations across New South Wales (NSW), Queensland, Victoria, Western Australia and South Australia. Funding for the program ceased on 30 June 2017.

### 1.4 Program Logic

KBC Australia developed a Program Logic for the Program in order to contextualise the evaluation. The evaluators developed a **retrospective** Program Logic drawing on information provided in the Program Manual, and with advice from the Department, prior to developing the Evaluation Framework.
The Program Logic is a depiction of the relationship between the resources allocated to the program, activities and intended outcomes (Appendix 1). It is useful in understanding the intent of a Program, and to inform the propositions to be tested in the evaluation. The Program Logic outlined the key drivers, resources, outputs and intended outcomes of the program.

**Funding Inputs to the Program**

Nine sites were involved in the Program. Each site was funded to trial an Aged Care Multidisciplinary Care Coordination and Advisory Service, including employing an ACC with resourcing of $145,000 per annum for 4 years. The ACCs were responsible for implementation of both elements of the Program, reporting and participation in the evaluation.

The GP video consultation component of the program included funding of $10,000 per annum per facility to approximately 30 RACFs. This funding was provided to RACFs to: support and enable residents to participate in videoconferencing; report on activities; and participate in the evaluation.

A total of $24,000 per annum was allocated to each RACF for payment of GP claims for video consultations with aged care residents. Clinical service payments were structured in a similar way to Medical Benefit Scheme (MBS) items with respect to time and complexity of the consultation.

The MBS and ACFI were existing resources available to support multidisciplinary services for aged care recipients (as they would be available to any aged care recipient in Australia). State funded services could also be utilised dependent on local availability.

**Context in which the Program occurred**

During implementation of the Program there was significant change in the governance and management of the program. Over this period management of the program was transitioned from the Department of Health and Ageing to the Department of Social Services and then to the Department of Health. At a site level, policy settings changed resulting in cessation of funding of MLs in June 2015 and establishment of PHNs. The new PHNs that had coverage of the localities in which the Program was operating were contracted to manage the Program for 2015-16 and 2016-17. Feros Care was contracted for the full duration of the Program. There was also extensive reform in the aged care sector during the period.

**1.5 Purpose of the Evaluation and Audience**

The purpose of the evaluation is to inform government policy aimed at:

- improving health outcomes by enhancing access to appropriate multidisciplinary health services for older people living in the community and RACFs
- improving linkages between health services and RACFs so that residents receive the same level of service as older people residing in the community and have improved health outcomes
- improving linkages between health services and community based aged care services so that older people residing in the community have improved health outcomes.
1.6 Key Evaluation Questions

Seven key evaluation questions were developed in consultation with the Department. Sub-questions were developed to assess appropriateness, effectiveness and efficiency of the program. The key evaluation questions were:

- To what extent did implementation of the program align with the program manual and contracts with the Trial Managers?
- What difference did the Multidisciplinary Aged Care Coordination and Advisory Service make to the provision of allied health and other specialist services in RACFs and the community?
- What difference has the Multidisciplinary Aged Care Coordination and Advisory Service made to care coordination for aged care recipients in RACFs and the community?
- What difference did GP video consultation make to the provision of GP care in RACFs?
- To what extent has the Aged Care Coordination and Advisory Service improved health outcomes for aged care recipients in the community?
- To what extent has the Aged Care Coordination and Advisory Service improved health outcomes for residents of aged care facilities?
- What are the lessons learned for future policy development in delivering multidisciplinary care to aged care recipients?

1.7 Roadmap to the Report

The report sets out:

- the approach to the evaluation and methodology
- Key Findings with separate Chapters reporting on:
  - Implementation of the Program
  - Element 1: Multidisciplinary Care Coordination and Advisory Service
  - Element 2: GP Video Consultation Pilot
- Lessons Learned
- References
- Appendices.
2 EVALUATION APPROACH AND METHODOLOGY

2.1 Rationale for the Approach

A mixed methods approach was adopted for the evaluation of the Program. The aged care coordination and advisory service and GP video consultations were the key elements of the Program to be investigated at each site. Each site was required to collect administrative and service data for reporting purposes, and to inform the evaluation. Qualitative methods were chosen to develop a detailed understanding of factors influencing the delivery and uptake of the interventions from the perspective of the target population and other stakeholders.

2.2 Objectives of the Evaluation

The objectives of the evaluation as outlined in the Request for Quote were to:

- assess the implementation of the program
- assess the appropriateness, effectiveness and efficiency of ACCs and GP video consultation from the perspectives of aged care recipients, service providers, and the health and aged care systems
- identify the barriers and enablers for trial implementation and achieving outcomes
- identify lessons for improving access to, and delivering, multidisciplinary health care for aged care recipients.

2.3 Target Population and Key Stakeholders

The target population for the Program evaluation included:

- staff of residential aged care facilities and aged care providers
- aged care recipients and their families in residential care and the community
- GPs participating in the video consultation pilot
- ACCs employed under the Program
- allied health professionals
- medical specialists.

Key stakeholder groups included:

- site Managers - PHN Executive and Managers
- representatives of LHNs
- representatives from the DOH.

2.4 Methodology

2.4.1 Project Establishment

An establishment meeting was held at the commencement of the evaluation (February 2017) between KBC Australia and Department program managers to discuss and confirm:

- background of the Program and implementation
- the purpose and intended use of the evaluation
• the process of engagement between KBC and the Department
• evaluation methodology.

2.4.2 Environmental Scan and development of Evaluation Plan

An environmental scan of published and grey literature, policy and program documentation was undertaken to develop the Evaluation Plan and subsequent ethics application, and to contextualise the findings.

Program policy documentation and site reporting templates were reviewed to: inform and revise the program logic; determine the administration and service data expected to be captured in progress reports; and identify issues for exploration in the evaluation.

KBC engaged with ACCs by a group teleconference during the evaluation planning to outline key topics areas for the evaluation and determine additional topics/issues to be investigated.

A KBC project team workshop was held in March 2017 to finalise the program logic, finalise the evaluation questions and develop the Evaluation Plan.

Ethics approval for the project was gained through Bellberry Ltd, a private not-for-profit organisation providing scientific and ethical review of human research projects across Australia. Ethics approval was obtained in early May 2017. A copy of Participant Information Sheets, Participant Consent Forms and Interview Schedules is included in Appendix 2.

2.4.3 Analysis of administrative and service data

Available progress reports from each site were provided to the evaluators in early April 2017. During the ML Phase (July 2013-June 2015) available documentation from most sites (including Feros Care) included the executed agreement, project plan, budget, risk management plan, evaluation plan, six monthly performance reports, final reports, and financial statement. During the PHN Phase (July 2015 – June 2017) available documentation for the eight PHN sites usually included the executed agreement, six-monthly performance reports and end of project financial statement.

All sites were required to maintain data logs for each video consultation undertaken. These were used to trigger GP payments and assist in the evaluation. Data collected through these logs were not routinely reported on in six monthly reports, with the exception of payments made to GPs.

Due to the variability of data captured in the six-monthly performance reports, KBC asked each site to complete a supplementary data report to complement the routine reports collected by the Department. The supplementary data reports included a collation of data from the GP video consultation data logs and additional information on activities undertaken in relation to the multidisciplinary care and coordination advisory service. Supplementary data reports were returned to the evaluators in mid-July 2017.
2.4.4 Site visits and consultations

Site visits were conducted over a six-week period from early May to mid-June 2017, to ensure completion by the end of funding of the Program.

KBC provided a template to ACCs to identify potential interview participants including:

- Trial managers
- ACCs
- RACF Managers and key staff
- GPs and practice staff
- Allied health professionals
- Community aged care providers
- LHN contacts.

Participants interviewed at each site varied, depending on contact details made available to KBC, and willingness of informants to participate (although very few declined an interview). A telephone interview and a face-to-face interview were also held with two RACFs that had actively withdrawn from the Program.

Three evaluators undertook site visits. Where possible interviews were conducted face-to-face. Some interviews were conducted by telephone where a suitable face-to-face time could not be arranged. Due to unforeseen events, the site visit to Western Australia did not occur, and was replaced with a teleconference with each of the identified program participants, the PHN, and the contracted provider of Aged Care Coordination services.

Participating RACF managers were asked to identify residents who were eligible to take part in an interview or group discussion, either directly or through their authorised representative. Where residents agreed, these interviews were conducted as part of the site visit to the relevant RACF.
A total of 120 interviews were conducted (Table 2.1)

<table>
<thead>
<tr>
<th>Interview participants</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial managers</td>
<td>9</td>
</tr>
<tr>
<td>Aged Care Coordinators</td>
<td>9</td>
</tr>
<tr>
<td>PHN managers and other staff</td>
<td>10</td>
</tr>
<tr>
<td>Participating GPs</td>
<td>19</td>
</tr>
<tr>
<td>Specialists using video consultations into RACFs</td>
<td>2</td>
</tr>
<tr>
<td>GP practice staff (practice nurses, practice managers)</td>
<td>4</td>
</tr>
<tr>
<td>Allied health professionals providing services to participating RACFs</td>
<td>3</td>
</tr>
<tr>
<td>RACF managers</td>
<td>27</td>
</tr>
<tr>
<td>RACF staff (nurses, carers)</td>
<td>15</td>
</tr>
<tr>
<td>RACF residents/families</td>
<td>10</td>
</tr>
<tr>
<td>LHN representative</td>
<td>2</td>
</tr>
<tr>
<td>Local Government representative</td>
<td>1</td>
</tr>
<tr>
<td>Department representative</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

*Table 2.1 Evaluation interview participants*

2.4.5 Information synthesis and reporting

Interview summaries were analysed using thematic analysis. Site reports were prepared incorporating analysis of administrative and service data, supplementary report information and qualitative findings.

A project team workshop was conducted to synthesise the quantitative, qualitative and secondary data to form evaluative judgements, make evaluative conclusions and identify lessons learned. The outcomes of the workshop formed the basis for the Final Report.

2.5 Methodological limitations

There were a number of methodological limitations to the evaluation.

- While sites were issued with standard contracts and reporting templates, administrative and service data included in progress reports to the Department were inconsistent in content, format and reporting timeframes, which limited the capacity to compare and contrast data between sites.
- Performance Indicators (PIs) in the performance reporting template were unclear and lacked specificity. As a result, there was considerable variation between sites in the interpretation
and reporting of the PIs, precluding meaningful comparison between sites and assessment of impact over time. Appendix 3 provides a summary of how different sites reported against each of the PIs.

- Progress and supplementary reports were the only source of information about the first two years of the program at three of the nine sites, as there was limited continuity of personnel from the ML phase to the PHN phase. This limited the capacity to draw meaningful conclusions about the operation of the program during the ML period.
- Intended outcomes of the Program included a decline in acute events, emergency admissions and hospitalisations. Baseline measures relevant to these outcomes were not determined at the commencement of the Program at a site level, therefore, outcome or trend analysis could not be completed. As a result, the evaluation has not been able to address the questions:
  - To what extent has the Aged Care Coordination and Advisory Service improved the health outcomes for aged care recipients in the community?
  - To what extent has the Aged Care Coordination and Advisory Service improved the health outcomes for residents of aged care facilities?
- Interview participants varied in numbers, positions and experience of the Program across sites. Some interviewees were new to their positions limiting their capacity to provide meaningful feedback for the evaluation.
- The evaluation does not provide an assessment of the Program in the community aged care setting as there was minimal Program activity undertaken in the community. As a result, the evaluation has predominantly focused on the residential aged care setting.
- There was limited participation in the evaluation by broader stakeholder groups. Contact details for LHN representatives were only provided in one site, and for a community aged care partner linked to local government in one site. Contact details for community aged care providers were not provided to the evaluators by any site across the program.
- Interviews with residents and/or their families were planned for the evaluation. These were to be facilitated by the participating RACFs with support from the ACCs. However, interviews rarely occurred due to limited access by evaluators to residents and families. In some cases where an interview with a resident was conducted the data obtained was of poor quality due to the limited memory or understanding residents had of the video consultation process.
3 IMPLEMENTATION OF THE BETTER HEALTH CARE CONNECTIONS PROGRAM

3.1 Introduction and Chapter Overview

This Chapter provides an overview of the implementation and context in which the Program operated, and addresses the evaluation question:

To what extent did implementation of the program align with the program manual and contracts with the Trial Managers?

This Chapter provides background to the implementation of the Program across the nine sites and a description of the key activities undertaken to implement each of the two Program elements. The Key Findings section provides an assessment of the extent to which the implementation of each element aligned with the program manual and contracts with the Department.

The Program commenced in July 2013 in nine sites across Australia. The Program was initially administered by the then Department of Health and Ageing. Under machinery of government changes, all Ageing and Aged Care programs moved to the Department of Social Services in 2013. In 2015 further machinery of government changes moved these programs back to the DOH.
Eight MLs were funded to implement the Program while the ninth funded organisation was an aged care provider (Feros Care). Following the change in policy settings resulting in the cessation of funding to MLs in June 2015 and the establishment of PHNs, the PHN that had coverage of the respective regions in which the Program operated were contracted by the Department to continue management of the Program. The exact commencement dates of Program contracts with PHN sites varied, depending on contract negotiations. For most sites there was a gap of about four months between the end of the ML funding and commencement of PHN funding. Funding to Feros Care continued throughout the four year program period. Where applicable, reference is made to ML or PHN phases of the Program as activities and approaches differed for some sites. The location of sites and funded organisations are presented in Table 3.1.

<table>
<thead>
<tr>
<th>State</th>
<th>Location</th>
<th>Funded Organisation 2013-15</th>
<th>Funded Organisation 2015-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Australia</td>
<td>Barossa Valley</td>
<td>Country North SA Medicare Local (CNSAML)</td>
<td>Country SA Primary Health Network (CSAPHN)</td>
</tr>
<tr>
<td>NSW</td>
<td>Central Coast</td>
<td>Central Coast Medicare Local (CCML)</td>
<td>Hunter New England Central Coast Primary Health Network (HNECCPHN)</td>
</tr>
<tr>
<td>NSW</td>
<td>Dubbo (ML)</td>
<td>Western NSW Medicare Local (WNSWML)</td>
<td>Western NSW Primary Health Network (WNSWPHN)</td>
</tr>
<tr>
<td>NSW</td>
<td>Broken Hill (PHN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>North Coast</td>
<td>Feros Care</td>
<td>Feros Care</td>
</tr>
<tr>
<td>Victoria</td>
<td>Inner Melbourne</td>
<td>Inner Melbourne Medicare Local (IMML)</td>
<td>Melbourne Primary Care Network (MPCN)</td>
</tr>
<tr>
<td>Victoria</td>
<td>Frankston and Mornington Peninsula</td>
<td>Frankston Mornington Peninsula Medicare Local (FMPML)</td>
<td>South East Melbourne Primary Health Network (SEMPHN)</td>
</tr>
<tr>
<td>Queensland</td>
<td>North Queensland</td>
<td>Townsville Mackay Medicare Local (TMML)</td>
<td>North Queensland Primary Health Network (NQPHN)</td>
</tr>
<tr>
<td>Queensland</td>
<td>Gold Coast</td>
<td>Gold Coast Medicare Local (GCML)</td>
<td>Primary Care Gold Coast (PCGC)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>South Perth</td>
<td>Perth South Medicare Local (PSML)</td>
<td>Western Australia Primary Health Alliance (WAPHA)</td>
</tr>
</tbody>
</table>

*Table 3.1 Program Sites*
3.1.1 Establishment of the Program

All sites employed an ACC, or in the case of WAPHA, contracted another provider to employ an ACC. The nature of the work undertaken by each ACC differed according to local conditions and interpretation of the contract requirements and Program Manual. The ACC was responsible for activities relating to both Element 1 and Element 2.

Several sites established an advisory group or steering committee to oversee the development and implementation of the Program (see Table 3.3). These groups usually included representation of the ML/PHN, GPs, participating RACFs and the LHN. In addition to providing direction and support in the early establishment of the Program, Trial Managers and ACCs reported these groups to be useful mechanisms to identify barriers and solutions to support access to, or enhancement of multidisciplinary services when needed.

3.2 Element 1: Trial of the Aged Care Multidisciplinary Care Coordination and Advisory Service

The requirements of the contracts for Element 1 for the ML phase of the Program are set out in Table 3.2. Contract requirements for the PHN phase were similar, with minor variation in wording (not shown).

<table>
<thead>
<tr>
<th>Requirements of MLs, Feros Care (pre-June 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a full-time aged care coordinator position and recruit candidate(s) with appropriate qualification and experience</td>
</tr>
<tr>
<td>Develop coordinated care protocols for aged care recipients with complex needs</td>
</tr>
<tr>
<td>Facilitate GP-led multidisciplinary care for recipients of aged care services</td>
</tr>
<tr>
<td>Liaise with local/regional health services – primary specialist allied health and acute care</td>
</tr>
<tr>
<td>Improve health outcomes for aged care recipients and people with complex needs within the Medicare Local region</td>
</tr>
<tr>
<td>Promote the multidisciplinary care model with participating RACFs and other aged care services within the Medicare Local region</td>
</tr>
</tbody>
</table>

Table 3.2 Requirements for Aged Care Multidisciplinary Care Coordination and Advisory Service

Under Element 1 each ACC was required to provide MDC coordination and advice with the intention of progressing objectives relating to:

- promoting expansion of in-reach health services to RACFs
- promoting development of regional or locally based visiting multidisciplinary teams
- developing better links between the health system and aged care sector (community and residential care)
- creating links that assist specialists, GPs and allied health professionals and aged care providers to deliver MDC and inform allied health professionals about the availability of relevant MBS items (if available), incentives and resources.
3.2.1 Overview of Key Activities - Element 1

The range of activities undertaken by the ACCs in each site to implement Element 1 are outlined in Table 3.3 and have been notionally separated to describe:

- expansion and enhancement of allied health and specialist services for MDC
- care coordination and advice.

Under Element 1, the ACCs broadly focused efforts on:

- networking with aged care services and local health sector
- undertaking needs assessment and service mapping to develop understanding of the local and regional service system and identifying opportunities to address service or system gaps
- developing knowledge of the complexity of the aged care system in order to target service enhancements that aligned with organisational and legislative requirements
- developing or contributing to development of health pathways relevant to aged care
- building capacity within the local general practice and residential aged care sector to support care planning and care coordination, and knowledge of clinical care of older people.

<table>
<thead>
<tr>
<th>Trial Site</th>
<th>Multidisciplinary Care Coordination and Advisory Service Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNSAML/CSAPHN</td>
<td>MDC expansion and enhancement</td>
</tr>
<tr>
<td></td>
<td>• needs analysis and service gap analysis with RACFs and GPs</td>
</tr>
<tr>
<td></td>
<td>• engagement of providers to fill service gaps (visits to RACFs, *including private dental services, SA Health providers; and via telehealth for medical specialists)</td>
</tr>
<tr>
<td></td>
<td>• promotion of clinical guidelines</td>
</tr>
<tr>
<td></td>
<td>• list of telehealth enabled specialists provided to RACFs.</td>
</tr>
<tr>
<td></td>
<td>Care Coordination and advisory service</td>
</tr>
<tr>
<td></td>
<td>• convened steering group to oversight project</td>
</tr>
<tr>
<td></td>
<td>• MBS fact sheet – RACF and 75 years and over</td>
</tr>
<tr>
<td></td>
<td>• aged care reform:</td>
</tr>
<tr>
<td></td>
<td>o education and training for GPs and RACFs in funding mechanisms, ACFI, Comprehensive Medical Assessments (CMAs)</td>
</tr>
<tr>
<td></td>
<td>o template for general practice software for My Aged Care referrals</td>
</tr>
<tr>
<td></td>
<td>o linkage with Collaborations Project Officer (Aged care) – promote and support community based Aged Care Expos, Aged care advisory services run through local government</td>
</tr>
<tr>
<td></td>
<td>• education and training sessions for GPs, practice nurses, allied health, pharmacy, RACF staff, acute care nurses and other professions where relevant (i.e. advanced care planning)</td>
</tr>
<tr>
<td></td>
<td>• maintenance of Active Ageing website information (services and referral pathways).</td>
</tr>
<tr>
<td>FMPML/SEMPHN</td>
<td>MDC expansion and enhancement</td>
</tr>
<tr>
<td></td>
<td>• needs analysis and service gap analysis with RACFs</td>
</tr>
<tr>
<td></td>
<td>• information to RACF staff on types of services provided by allied health professionals</td>
</tr>
<tr>
<td></td>
<td>• service/ provider identification and navigation support to RACFs and GPs</td>
</tr>
</tbody>
</table>
### Trial Site

<table>
<thead>
<tr>
<th>Multidisciplinary Care Coordination and Advisory Service Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>- list of medical specialists with telehealth capability and promotion to RACFs</td>
</tr>
<tr>
<td>- building relationships with the Frankston Hospital Residential Outreach service to support service delivery into RACFs including geriatrician support via telehealth</td>
</tr>
<tr>
<td>- use of Map of Medicine to develop aged care relevant clinical pathways.</td>
</tr>
</tbody>
</table>

#### Care Coordination and Advisory Service

- using “yellow envelope” to improve handover procedures, RACF and hospitals
- aged Care reform – flow chart to support transition period for GP referrals to My Aged Care
- education and training for RACFs, GPs and practice staff, allied health, community health, hospital staff
- participation in Ageing Well Expo.

### IMML/ NWMPHN

<table>
<thead>
<tr>
<th>MDC expansion and enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- needs assessment / gap analysis with RAFCs</td>
</tr>
<tr>
<td>- promotion of the Pearly Whites mobile dental service to increase access to oral health care for residents</td>
</tr>
<tr>
<td>- liaison with the St Vincent’s and Royal Melbourne Hospitals’ residential in-reach services to develop and disseminate information sheets, resources and newsletters to RACFs and GPs</td>
</tr>
<tr>
<td>- development and publication of 32 Health Pathways older adults/ aged care themes (relevant to community and RACFs).</td>
</tr>
</tbody>
</table>

#### Care Coordination and Advisory Service

- MBS fact sheets for RACF
- establishment of an Aged Care Advisory Committee to drive development of pathways, development and oversight of the Program
- facilitating development of procedures in RACFs for advanced care planning.

### WNSW PHN phase

<table>
<thead>
<tr>
<th>MDC expansion and enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- needs analysis with RAFCs</td>
</tr>
<tr>
<td>- engaged providers to fill service gaps (predominantly using telehealth)</td>
</tr>
<tr>
<td>- supported implementation of respiratory care pathway and integration of COPD Action plan into general practice software.</td>
</tr>
</tbody>
</table>

#### Care Coordination and Advisory Service

- established and maintained advisory group to support implementation of the Program
- MBS fact sheet - RACFs
- education and training for RACF staff.

### CCML/ HNECC

<table>
<thead>
<tr>
<th>MDC expansion and enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- needs analysis of community aged care providers</td>
</tr>
<tr>
<td>- development of a web portal for Home Care Package providers and the Aged Care Assessment Team (ACAT) to share de-identified information (waiting lists and vacancies for services/packages)</td>
</tr>
<tr>
<td>- reviewed workflow patterns within each RACF to demonstrate benefits of a MDC approach.</td>
</tr>
<tr>
<td>- service navigation and go-to person for resources and information for providers</td>
</tr>
<tr>
<td>Trial Site</td>
</tr>
<tr>
<td>------------</td>
</tr>
</tbody>
</table>
|            | • promotion of in-reach services to RACFs (i.e. extended care paramedics)  
|            |   *Engaged providers to fill service gaps i.e. Mobile X-Ray services, oral health services (University of Newcastle), physiotherapy.*  
|            |   **Care Coordination and Advisory Service**  
|            |   • neutral “networker” to identify barriers to optimal care across the whole of system, and to develop local solutions with the key parties to improve individual outcomes for residents  
|            |   • promoted service referral information and resources contained on Health Pathways  
|            |   • promotion and use of digital health to share clinical information (GPs, specialists, community pharmacy, Central Coast Local Health District)  
|            |   • training opportunities for RACF staff, GP practice staff and GPs including improved clinical handover, clinical information sharing.  
| PSML/WAPHA | **MDC expansion and enhancement**  
|            |   • needs analysis and service mapping  
|            |   • development of palliative care pathway/flowchart identifying providers and contact information  
|            |   **Care Coordination and Advisory Service**  
|            |   • transfer envelopes to support clinical information transfer between RACFs and local hospital  
|            |   • DVDs to support Advanced Care Planning.  
| GCML/PCGC  | **MDC expansion and enhancement**  
|            |   • needs assessment and gap analysis (service and system issues)  
|            |   • service/ provider identification and navigation role, including identification of appropriate funding sources  
|            |   **Care Coordination and Advisory Service**  
|            |   • development and implementation of an annual cycle of care for people in RACFs including: mapping an annual cycle of care in line with RACGP Silver Book guidelines; providing resources to GPs, in line with practice support role of PHNs; preparing and distributing summaries of MBS items  
|            |   • education sessions for GPs, practice staff and RACFs to improve understanding of aged care system, MBS and ACFI funding sources  
|            |   • supporting access to education and professional development for RACFs relevant to resident population e.g. Advanced Care Directives, clinical handover, management of outbreaks  
| TMML/NQPHN | **MDC expansion and enhancement**  
|            |   • identification of service gaps  
|            |   *engaging providers to fill gaps, through telehealth*  
|            |   **Care Coordination and Advisory Service**  
|            |   • MBS Fact Sheet – RACFs  
|            |   • education sessions for RACF staff.  
| Feros Care | **Care Coordination and Advisory Service**  

### Trial Site

<table>
<thead>
<tr>
<th>Multidisciplinary Care Coordination and Advisory Service Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• development of care pathways (internal to Feros Care RACFs)</td>
</tr>
<tr>
<td>• education and professional development for RACF staff</td>
</tr>
<tr>
<td>• establishment of linkage with LHD to improve admission procedures and information transfer between the hospital and RACFs.</td>
</tr>
</tbody>
</table>

*Italicised indicates during ML phase only*

#### 3.2.2 Key Findings

**Comparison of the contract requirements of Element 1 and key activities of the ACC indicated limited alignment.**

Trial Managers and ACCs reported:

- Program Manual governing the Trial parameters were confusing, particularly the intent of the Multidisciplinary Care Coordination and Advisory Service trial. For example, terms such as ‘care coordination’, ‘multidisciplinary care model’, and ‘GP-led multidisciplinary care’ were not defined and were interpreted differently by different trial sites.

- The assumption that the ACC would have a role in developing care protocols, facilitate GP-led MDC for aged care recipients and develop MDC teams was incongruent with the way care planning and care delivery currently occurs in residential care. These issues are further explored in Chapter 4.

Feros Care reported that activity of their ACC predominantly focused on Element 2.

**The level at which the ACC operated to support care coordination was not clearly described in the Program Manual.**

The Program Manual did not clearly indicate whether care planning by the ACCs should occur at the aged care recipient level, the service level, or both. None of the ACCs at any of the Trial sites (ML phase, PHN phase and Feros Care) had a role in care coordination at an aged care recipient level. Trial sites reported that activity focused at a service level rather than an aged care recipient level as a result of a number of factors:

- RACFs employ Care Managers or have a designated employee to organise care for residents and hence an external provider was identified to be duplicative.
- ACCs were employed during usual office hours and hence not available if issues arose for a resident after hours or on weekends (if they were operating at a resident level).
- Each trial site was asked to enrol up to four RACFs per site. The number of residents in a RACF ranged from under 30 to over 200. Therefore, the potential client load could be 200-400 at a site level and not feasible for care coordination at a client level for one full time equivalent employee.
- Geographic distribution of RACFs within a trial site impacted on time available at individual RACFs, limiting capacity to operate at either a RACF or resident level.
- ACCs were also responsible for establishing and managing the GP video consultation pilot and this required substantial time.
The evaluators reviewed the Program Manual, contract and PIs. It is the view of the evaluators that there is a lack of definition and specificity regarding the extent of the ACC role in the community setting and at what level the ACC is to operate i.e. an individual resident/client level or service level (see Table 3.4). For example, some PIs explicitly identify the RACF setting and it is unclear whether PIs that do not specify RACF should be interpreted as relating to the community aged care setting. Furthermore, the reporting templates did not provide separate rows or sections to report on activity in the residential setting AND in the community. If sites were working in both settings this would have been combined in the provided templates making interpretation difficult.

<table>
<thead>
<tr>
<th>PI</th>
<th>Proposed Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff involved in the multidisciplinary model</td>
<td>50</td>
</tr>
<tr>
<td>Number of multi-disciplinary health care teams</td>
<td>10</td>
</tr>
<tr>
<td>Number of individual sessions of clients of participating RACFs receiving medical care (following aged care coordinator activity)</td>
<td>Up to 1200</td>
</tr>
<tr>
<td>Number of allied health services instances within the RACF (following aged care coordinator activity)</td>
<td>50</td>
</tr>
<tr>
<td>Number of specialist services referrals within the RACF (following aged care coordinator activity)*</td>
<td>40</td>
</tr>
</tbody>
</table>

*This PI could also be relevant to the care coordination and advisory role of the ACC.

Table 3.4 PIs and Proposed targets relevant to enhancement of MDC (PHN Phase)
3.3 Element 2: Pilot of GP video consultations in RACFs

The requirements of the contract to establish and implement the GP video consultation pilot in the ML phase are set out in Table 3.5.

<table>
<thead>
<tr>
<th>Requirements of MLs, Feros (pre June 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a Memorandum of Understanding (MoU) with each RACF participating in the Program</td>
</tr>
<tr>
<td>Ensure each RACF participating in the Program maintains, and provides a quarterly log of video consultations by GPs</td>
</tr>
<tr>
<td>Make quarterly payments of $2,500 (inc GST) for each three month period of participation by a participating RACF</td>
</tr>
<tr>
<td>Facilitate GP video consultations to clients of participating RACFs</td>
</tr>
<tr>
<td>Develop video conference protocols with GPs and participating RACFs</td>
</tr>
<tr>
<td>Ensure each GP providing video consultation under the Program maintains, and provides a quarterly log of video consultations provided to clients of participating RACFs</td>
</tr>
<tr>
<td>Promote and coordinate GP-led multidisciplinary models with RACFs and local health services in your region including primary, allied and specialist health services and local hospitals</td>
</tr>
<tr>
<td>Make payment to GPs in accordance with the (specified amounts)</td>
</tr>
<tr>
<td>Collect data on MBS claims for GP consultations via video consultation for aged care clients</td>
</tr>
</tbody>
</table>

At each site, considerable effort went into establishing GP video conferencing. Few, if any, participating GPs and RACFs had prior experience in video conferencing for GP consultations, although some had participated in specialist telehealth consultations. As a result, ACCs reported that engaging both GPs and RACFs was very time consuming.

Generally, RACFs were signed up to the pilot before GPs. This was largely a result of the initial Program design where applicants (MLs and/or existing aged care providers) were to provide letters of support from at least two RACFs (and up to four), indicating their willingness to enter into a funding agreement with the DoH for the purposes of participating in the Pilot. As a result of the original Program design, GPs were not directly engaged with the Pilot until after the RACFs had committed to the Pilot i.e. signed an MoU with the ML. This required the ACCs to then engage specific GPs who already provided services into the nominated facilities, rather than seeking out GPs who may have had an interest in and experience with telehealth.

ACCs undertook a range of activities to support establishment of video conferencing including:

- developing service agreements or MoUs with RACFs, GPs and GP practices outlining the roles and responsibilities of each participating party
- developing protocols for implementation
- purchasing and distributing equipment. In most cases iPads/Tablets were provided to both GPs and RACFs for use in video consultations
- developing consultation logs and payment systems to enable payments to GPs
• providing training for RACF staff, GPs and practice staff e.g. introduction to the relevant software, use of iPads/Tablets
• developing resources for RACFs and GPs such as implementation or “how to” guides, troubleshooting guides
• developing information and consent processes for residents and families
• where applicable, arranging for payment and permission to use licensed software
• trouble shooting connectivity issues.

3.3.1 Key Findings

Analysis of activity with contract requirements demonstrated strong alignment for Element 2, establishing the GP video consultation pilot.

ACCs reported spending more time on Element 2 (the GP video consultation pilot) than Element 1 as it required substantial time for establishment, ongoing recruitment and training of RACF staff and GPs, and the contractual requirements and guidelines were clear.

Change of management organisation at a site level disrupted the GP Video consultation pilot.

The change of policy settings from MLs to PHNs and the subsequent establishment of new contracts resulted in loss of GPs and RACFs in several sites and need for re-establishment of the Pilot including recruitment of new RACFs and GPs in 2015. Sites in which there was greater continuity were NSW North Coast (Feros Care), Gold Coast (GCML and PCGC) and South Australia (CNSAML and CSAPHN).

3.4 Program Governance

Changes in Program governance impacted on the reporting requirements by sites, timely communication with sites and timely review of performance reports and final reports from the ML Phase.

The ML Phase Final Reports highlighted limitations of the Program, in particular lack of clarity of the ACC role in Element 1, concerns whether assumptions of the Program aligned with service arrangements in RACFs and difficulties in establishing processes to assess changes in health outcomes and ED transfers. However, the contract requirements for the PHN phase did not differ from the ML phase in any material way.

More timely review of progress reports by the Department with co-ordinated feedback as a group and to individual sites, could have improved the implementation of the program. Most sites reported issues encountered in the early implementation of the program and follow up with sites individually or collectively would have provided an opportunity to realign activity and reporting requirements (PIs) for a more informative program.

Limited financial data were available for consideration, with not all income and expenditure statements available at the time of the evaluation. As such it was not possible to reconcile the financial information available through income and expenditure statements with payments to GPs reported in the performance reports to the Department and data reported to the evaluators in supplementary data reports. There were also inconsistencies between reports and sites in how financial data were provided, for example some reports used GST inclusive data while others used
GST exclusive data and sometimes there was no indication if reported amounts were GST inclusive or GST exclusive.
4 ELEMENT 1: TRIAL OF THE AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE

4.1 Introduction and Chapter Overview

The Aged Care Multidisciplinary Care Coordination and Advisory Service, through the employment of a dedicated ACC, was intended to improve health outcomes for aged care recipients in both residential and community settings. The Care Coordination and Advisory Service was to facilitate links between aged care providers and the health system to enhance and expand access to multidisciplinary services and improve care coordination for aged care recipients.

This chapter addresses the Key Evaluation Questions:

- What difference did the Multidisciplinary Aged Care Coordination and Advisory Service make to the provision of allied health and medical specialist services in RACFs and the community?
- What difference has the Care Coordination and Advisory Service made to care coordination for aged care recipients in RACFs and the Community?

This Chapter provides background and context to the delivery of MDC and care coordination in residential aged care. The impact of the Trial on service enhancement and expansion and care coordination could not be reliably assessed due to the variation in interpretation and reporting of PIs. As a result, the achievements of the role have been outlined on a descriptive basis in sections 4.3 and 4.5. The Key Findings section outlines the perceived benefits of the Trial and a discussion of enablers and barriers identified through the evaluation. The final section of the chapter provides an assessment of the overall appropriateness, effectiveness and efficiency of the Trial based on the triangulation of evaluation findings.

4.2 Multidisciplinary Care – Background and Context

Multidisciplinary care involves professionals from a range of different disciplines who have complementary skills, knowledge and experience working together to plan and/or deliver comprehensive health care. Multidisciplinary care has been demonstrated to improve outcomes especially for patients with chronic illnesses. It has been shown to be effective in both primary and acute settings measured by such indicators as reduced hospital admissions.

Multidisciplinary care (by definition) is usually provided by a team of health professionals from a range of disciplines that are relevant to the health issue or disease in scope. However, the concept of a team, who leads it, and how it operates can be very broad. There are various mechanisms through which MDC planning and care delivery can occur. This can include assessment of the patient (or resident), development of care plans, conduct of team/care conferencing and identification of actions for members of the care team, delivery of those actions or care, and review

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of the patient which may result in a change to the care plan.\textsuperscript{9} However, there is variation in the extent to which these activities are undertaken synchronously by the members of a care team i.e. there are situations where a patient receives care from multiple providers with minimal coordination and communication between them, to more integrated models where teams of health professionals jointly plan and manage care in collaboration with the patient.

4.2.1 Context for Multidisciplinary care for Aged Care Recipients

A key driver of the Trial was to promote the delivery of multidisciplinary health care for aged care recipients and expand the use of in-reach services in RACFs. It is important to understand how MDC is resourced and provided in residential and community aged care settings to provide context to the Trial and enable accurate interpretation of the findings to inform future policy development.

In the residential aged care setting, providers of MDC are allied health professionals, nurses (aged care and specialist nurses), GPs and medical specialists.

Provision of GP and medical specialist services to residential aged care recipients are generally resourced through the MBS. Some medical specialist services may be provided through publicly funded health services.

Provision of allied health and specialised nursing services in RACFs is available through the following mechanisms:

- ACFI funding where the quantum is determined on the basis of care needs of individual residents. The RACF aggregates funding and determines how best to meet operational requirements, including care delivery. RACFs use various arrangements to contract or employ allied health professionals. The Australian Aged Care Quality Agency’s Quality of Care Principles 2014 mandate what services must be provided by a RACF. Under the Aged Care Act 1997, RACFs are expected to provide:
  - Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain residents’ levels of independence in activities of daily living; and
  - More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow residents to reach a level of independence at which maintenance therapy will meet their needs.\textsuperscript{10}

- Allied health services can also be funded under the MBS if the GP has made a referral as part of a care plan (MBS Item 731). A resident can claim a Medicare rebate for up to five individual allied health services each year (MBS items 10950-10970), subject to the ACFI care rating for the resident and allied health service required.

- Purchasing services from private providers paid for by the resident or facility.


\textsuperscript{10} Department of Health Chronic Disease Management - Individual Allied Health Services Under Medicare - Residential Aged Care Facilities
- Publicly funded state government community health providers, in particular, specialist nurses e.g. wound care or continence care. However, these may be on an as-needs basis, or one-off rather than a regular service.

In the community aged care setting, Home Care Packages Level 3 and 4 include funding for clinical care such as nutrition, continence management, nursing and allied health. Community aged care recipients can also access additional clinical services through the MBS Team Care Arrangements (up to 5 rebated allied health services in a calendar year for patients with a chronic or terminal condition or complex needs), GP Mental health plan, and public community health and medical specialist services.

4.2.2 In-reach services

There are various in-reach service models operating in parts of Australia, under the management of LHNs, with the purpose of early intervention and support to RACF staff to facilitate the provision of acute care for non-life threatening issues to reduce the incidence of avoidable attendances to ED and hospitals.

There is variation between jurisdictions in availability, and variation between LHNs in approach and availability. In Victoria, residential outreach services operate in most health districts, with a hospital/ED nurse responding to a referral from a RACF, with access to medical advice when required.\(^{11}\) There are various models in place in NSW, such as telephone triage and advice from hospital staff to RACFs (e.g. Geriatric Rapid Acute Care Evaluation, Aged Care Emergency Service\(^ {12}\)), and Geriatric Flying Squad (nurse with support from geriatrician and allied health providing in-reach assessment following referral from RACF).\(^ {13}\) In Queensland, Hospital in The Home models have been piloted in metropolitan hospitals, where ED clinical staff are allocated to manage aged care residents in the RACF with symptoms that would potentially require admission to ED or hospital.\(^ {14}\) In regional Queensland, a mobile aged care Nurse Practitioner model has been trialled to complement service where the GP is the primary care provider.\(^ {15}\) In-reach service models are not in place in South Australia.

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\(^{13}\) Burchfield K. (2014). Directions for integrated care: how do RACFs, primary care and community services fit in? Presentation to Better Health Care Connections Conference.


4.3 Multidisciplinary Care – Trial Activities

There was considerable variation across sites in the type of activities undertaken to expand provision of allied health and other specialist services to aged care recipients residing in residential aged care facilities (Chapter 3, Table 3.3).

4.3.1 Community aged care setting

Very limited activity occurred in the community care setting. One objective of the Program was to develop better links with the health system in both the community and residential aged care settings. During the Trial (ML phase), there is evidence that some sites tried to engage with the community aged care sector:

- FMPML/SEMPHN reported attempts to link with the community providers but were not able to identify areas where the ACC could effect change.
- The CC NSW ML (now the HNECC PHN trial site) undertook a needs analysis of community aged care providers and developed a web portal for Home Care Package providers and ACAT to share de-identified information about waiting lists and vacancies for services/packages. However, this did not carry through to the PHN phase of the Trial.
- The CNSAML/CSAPHN ACC liaised with the Collaborations Project Officer (Aged Care) to resource the marketing and promotion of Aged Care Expos in the region and the Aged Care Advisory Service run by local government (i.e. provides information on My Aged Care and the Regional Assessment Service to community members and wider health professional networks). This continued for the duration of the Trial.
- Where clinical pathways have been developed and published (Health Pathways or Map of Medicine), these are available to community aged care providers.
- In some sites, community aged care providers were also invited to training and education sessions organised by the ACCs.

4.3.2 Responding to service mapping and needs analysis

Service mapping and/or needs assessment were conducted by most sites to identify aged care related allied health and specialist services available in the region and determine those services the RACFs had difficulty accessing for their clients. This was a structured mapping process across the region in some sites (e.g. SEMPHN), while in others it was a more targeted discussion of service availability and service gaps with participating RACFs (e.g. NQPHN during the ML phase).

In response, the ACCs sought to enhance access to allied health, specialist nursing and/or medical specialists using a range of approaches including:

- the ACC operating like a service navigator to source a service for residents on an as-needs basis, usually from a LHN
- promoting and supporting the use of telehealth for medical specialist consultations with residents, funded through MBS
- using telehealth for allied health professionals to consult with residents or with RACF staff
- establishing visiting dental services to RACFs through various arrangements such as negotiations with a private dentist to provide a visiting service to RACFs under the
Commonwealth Chronic Disease dental program while available (CSAPHN), partnering with a University School of Oral Health (CCNSWML), or linking with a state funded dental in-reach program (NWMPHN)

- linking with state funded services and programs to promote in-reach services to RACFs. For example, as part of the GP telehealth pilot in SEMPHN, the ACC negotiated LHN residential in-reach doctor and nurse team support to RACFs using telehealth as an adjunct to the established in-reach support, and LHN geriatrician discharge follow-up via telehealth for residents following hospitalisations. Note this was modified for older people living in the community where a LHN nurse practitioner supported geriatrician follow up for people discharged from the geriatric unit.

Trial Managers reported service mapping and needs assessment provided the PHNs with a localised aged care market analysis providing intelligence for future planning and commissioning.

4.3.3 Clinical pathways

There was extensive activity undertaken in trial sites to develop clinical care pathways for numerous areas of clinical need that commonly impact on older adults whether residing in aged care facilities or the community.

NWMPHN and HNECC PHN used the Canterbury Health Pathways licence and SEMPHN used the Map of Medicine as platforms to develop localised best practice referral pathways to enhance access to allied health and specialist services in a timely manner. Examples of pathways include: “Preventing avoidable admissions for residents of aged care”, End of life care in adults, Dementia Assessment and Behaviour, Heart Failure.

Participation in the Trial focused attention on development of pathways relevant to the residential aged care sector.
Case Examples: Clinical pathways relevant to aged care

The “Allied Health consultations in residential aged care” pathway was developed in the SEMPHN trial site during the ML phase. This pathway focuses on early identification of clinical signs that warrant a referral to an allied health practitioner for six priority streams (speech pathology, occupational therapy, physiotherapy, mental health care, dietitian and podiatry). The aim is for early intervention so that residents can be managed appropriately maximising ability and mobility and reducing morbidity. The pathway identifies funding streams and appropriate use of MBS items.

Clinical pathways were developed by the ACCs in conjunction with the RACFs, LHNs and other health care providers. Examples include:

- WNSW PHN worked with the Broken Hill Health Service to implement the Lung Foundation Action Plan as a respiratory care pathway.
- Feros CARE developed internal care pathways to guide care of individual residents incorporating the use of GP video consultations.
- WAPHA and PCGC developed palliative care pathways.
- CSAPHN promoted clinical guidelines to RACFs including Diabetes Management, management of influenza outbreaks, and a Palliative care toolkit.

Clinical care pathways and guidelines were made available to RACFs participating in the Trial i.e. GP pilot sites, and other RACFs in the region. The Health Pathways/ Map of Medicine are published on the internet and are available to community care providers.

The extent to which the development of aged care relevant clinical pathways can be directly attributed to the Trial is unclear in sites that had been using processes such as Map of Medicine and Health Pathways for wider health care navigation activities of the respective MLs and PHNs. The extent to which published clinical pathways translate to the delivery of team based care was not assessed by Trial sites or the evaluation.

4.4 Care Coordination – Background and Context

Care coordination is a broadly defined concept. A review of published definitions identified over 50 unique definitions of “care coordination”.\(^{16}\) The five core elements common across the majority of those definitions were:

- numerous participants (i.e. health professionals) involved in the care
- coordination is necessary when participants are dependent on each other to carry out disparate activities in a patient’s care
- to coordinate, participants need to understand their own and others’ roles and available resources

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• participants rely on exchange of information in order to manage required patient care
• coordination activities aim to facilitate appropriate healthcare service delivery.

A useful working description of care coordination is:

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.  

Care coordination can operate at a patient, health provider/service, and system level.

4.5 Care Coordination and Advisory Services – Trial Activities

As highlighted in Chapter 3, there was variation across trial sites in the range of activities undertaken as a component of the care coordination and advisory service (Chapter 3, Table 3.3). ACCs progressed activities in response to the needs analysis, advice from advisory groups, or in alignment with priorities of the funded organisation. Care coordination activities of the ACCs were directed at a service level not at a patient/resident level.

4.5.1 Education and Training to enhance care planning and coordination

Most trial sites provided training for health professionals and carers. The target audience could include:

• staff of participating RACFs i.e. usually Registered Nurses (RNs), Enrolled Nurses (EN), Care coordinators, managers
• GPs and practice staff
• Community aged care providers (in some trial sites)
• LHN staff (in some trial sites where relevant to clinical pathways)
• staff of non-participating RACFs.

Topic areas for training and education to support care planning and coordination included:

• ISBAR (Identification, Situation, Background, Assessment and Recommendation) communication to improve safety and transfer of critical information
• Advanced Care Planning (with training extended to older people in RACFs, the community and their families in some sites)
• Clinical pathways relevant to the Trial site.

Most of the Trial sites offered training in a range of topics to more broadly improve knowledge in clinical care. Across the Trial sites, topics relating to older persons’ care included:

• early recognition of deterioration

Most education and training events were one off activities. The 6 monthly performance reports did not usually provide an indication of the reach of the activity nor any reported assessment of impact on knowledge, skills or behaviour change of participants. Advanced care planning is increasingly being adopted in RACFs and training provided through the Trial has supported this in some sites. GPs reported the use of ISBAR tools, supported by training, improved the information provided by RACF nurses when referring residents for video consultations. RACFs participating in the video consultations reported their appreciation of the various education and training events that were made available to their staff through the Program.

4.5.2 Supporting general practice systems

Locating the Multidisciplinary Care Coordination and Advisory Service Trial with MLs and PHNs provided opportunities to leverage on those organisations’ resources and build care coordination into general practice systems.

- Most sites developed information sheets outlining the MBS items applicable for GP care in RACFs and for older people (75 years and over health assessments). These were available to GPs and practice staff.
- In the CSAPHN and SEMPHN trial sites, the ACC worked with the PHN practice support team to develop templates for General Practice software for My Aged Care referrals.
- The PCGC site worked with GPs and RACFs involved in the GP Video consultation pilot to implement an annual cycle of care for aged care residents (Case Example).

**Case example: Gold Coast RACF Annual Cycle of Care**

The PCGC mapped an annual cycle of care for RACF residents in line with the RACGP Silver Book guidelines. The cycle of care is based on a new admission to a RACF and steps out the early work required (within the first 6 weeks). This starts with the GP undertaking a Comprehensive Medical Assessment (CMA), referring the resident for a Residential Medication Management Review (RMMR), contributing to the care plan so that the RACF can prepare a Multidisciplinary Care Plan (RACF plan) to support ACFI validation for funding for the resident. The cycle of care protocol includes timing for review of CMA, review of care plan, case conferencing and RMMR (Appendix 4).
These examples demonstrate the benefits of placing the Trial with the ML/PHN, using their practice support capability and capacity to build general practice systems for team care arrangements, extend this to aged care, and document the role of the GP in coordination of care for residents.

4.5.3 Transfer Envelopes for clinical information exchange

The WAPHA trial site and SEMPHN progressed the development and use of Transfer Envelopes. This initiative aims to improve clinical information transfer between the RACF and the ED as part of a hospital presentation and potential admission. Transfer envelopes are also intended for transfer of discharge information back to the RACF. RACFs reported that the transfer envelopes are useful checklists to ensure that the necessary clinical information is transferred with the resident to the ED. However, the receipt of discharge information, through the envelope from hospitals was variable.

4.5.4 Aged Care Reforms

The trial was initiated as part of the LLLB aged care reform package during which there was extensive structural and funding changes occurring within the aged care sector. Three of the Trial sites undertook activities directed at improving understanding of the age care system and aged care reforms. Target groups included GPs, RACFs, community aged care providers and community members.

Case Example: CSAPHN advisory services

In the CSAPHN trial site the ACC:

- organised education and training activities about aged care reform, aged care funding, the use of the CMA to inform the ACFI, and MBS item numbers relevant to RACFs and people over 75 living in the community. The key target group was GPs and practice staff
- liaised with the Collaborations Project Officer (Aged Care) to resource marketing and promotion of Aged Care Expos in the region and the Aged Care Advisory Service run by local government which provides information on My Aged Care and the Regional Assessment Service to community members and wider health professional networks
- acted as a conduit for information to GPs and RACFs about My Aged Care and the regional Assessment Service.

4.5.5 Aged Care Advisory Groups

Aged Care Advisory Groups were established in several sites to oversee the development and implementation of the Trial. Finding the appropriate mechanism to engage with the aged care sector which is populated by multiple small and diverse providers as well as large corporate entities was an emergent challenge in the Trial. Trial Managers reported that the Advisory Groups provided a good foundation for broader engagement between the aged care and health sectors that could be built on over time.
4.6 Key Findings

4.6.1 Perceived benefits of Multidisciplinary Care Coordination and Advisory Service

The extent to which the Multidisciplinary Care Coordination and Advisory Service expanded the provision of MDC cannot be determined in the absence of quantitative data. Limited participation of residents and their families and representatives of the LHNs in the evaluation has precluded triangulation of some qualitative information. Therefore, the evaluation looked at the perceived benefits of the Trial, drawing on the supplementary reports provided by the Trial Sites and interviews with RACF personnel, ACCs, Trial Site Managers, GPs and allied health professionals. The extent to which perceived benefits are all attributable to the Trial is confounded where PHNs have concurrent activities occurring within an aged care portfolio or other PHN priorities (e.g. Health Pathways, Decision Assist training).

Perceived benefits of care coordination and advisory service activities to residents of RACFs included:

- access to specific allied health, specialised nursing and/or medical specialist services, some of which were ad hoc and as needed, while others were available over a prolonged period e.g. the Senior Smiles project, Pearly Whites program, in-reach geriatric team service
- timely access to care and best practice care due to Health pathways e.g. palliative care pathways
- reduced waiting time to see specialists
- increased understanding of advanced care planning by health professionals, care providers, the resident and their family, and increased completion of advanced care directives to align with the wishes of the resident
- greater GP involvement in development of care plans.

Potential benefits to aged care recipients residing in the community may result as a consequence of Health Pathways and Map of Medicine supporting GPs to navigate the local service system to deliver best practice care e.g. palliative care; LHN geriatrician follow up post hospital discharge. Potential benefits to community aged care recipients may arise from activities undertaken by the ACCs in partnership with local government and/or community aged care providers to run community forums to provide information about My Aged Care gateway and how to access services, availability of local aged care services, promotion of healthy ageing materials and websites.

With respect to RACFs, the ACCs assisted in the identification of allied health professionals as potential resources/contractors for service provision, and in some sites brokered arrangements with LHNs to provide specialised nursing and/or medical specialist services.

Perceived benefits to RACFs and GPs through care coordination and advisory service activities were identified to be:

- better understanding of My Aged Care reforms
- educational/learning outcomes from the range of training activities
- improved quality of referrals (specifically through the ISBAR training)
• improved support for RACF care plans (PCGC) and referral to My Aged Care (CSAPHN) through development of templates for GP software packages
• links between RACFs and GPs developed or strengthened
• a better understanding of aged care funding arrangements by RACFs and GPs i.e. ACFI and MBS items, and understanding of the respective business models of residential aged care sector and general practice (CSAPHN, PCGC).

Benefits for the PHN identified by Trial Managers included:

• establishment of linkages with RACFs and the aged care sector
• development of a better understanding of the aged care sector, and service and system issues impacting on the delivery of MDC in RACFs
• better positioning PHNs for their key activities of regional needs assessment, service planning, commissioning, and service and system integration.

4.6.2 Enablers to service enhancement and care coordination

Enablers for the Trial were identified through interviews with ACCs, Trial managers, RACF management and GPs as well as progress, final and supplementary reports.

The ACC position provided a conduit between the aged care sector and the broader health sector.

This position provided the capacity and capability to map and find services and resources at both regional and local levels and determine how these could be accessed by the RACFs. While expansion of MDC in RACFs was limited, the attributes of the ACC that facilitated this included:

• being an effective networker and conduit between the aged care sector and the broader health sector, underpinned by the development of relationships with RACFs, general practices, and the local service system
• developing a grounded understanding of the local and regional service system and identifying and progressing opportunities to fill or address service and system gaps. Placement of the ACCs with MLs and later with PHNs, facilitated this and enabled the development and progression of activities responsive to the local context
• knowledge of the complexity of the aged care system and the organisational and legislative requirements or working in an environment where this understanding was shared, facilitating targeted activities for service enhancement
• understanding how general practice operates, GP business systems and practice software facilitated activities to streamline a cycle of care for residents of aged care facilities e.g. PCGC. Locating the ACC role with the MLs and then the PHNs enabled leveraging the organisations’ general practice support capabilities and technical support.

Establishment of the Aged Care Advisory Groups were useful mechanism to build relationships between aged care providers, health services and GPs.

While the composition and focus of the Advisory Groups differed between sites, they provided a forum for discussion of issues arising in implementation of the Trial and GP video consultation Pilot, clinical pathway development and identifying opportunities to address service gaps.
4.6.3 Barriers to service enhancement, care coordination and improvement in outcomes for residents

Interviews with ACCs, Trial managers, RACF management and GPs and written reports identified factors that challenged the enhancement or expansion of health service provision in RACFs, particularly allied health.

**RACF managers did not perceive a role for the ACCs to develop new allied health services or teams.**

RACFs provide allied health services to residents as a requirement under the Quality Care Principles 2014, funded under the ACFI. RACF managers provided detailed descriptions of the type of allied health professions, frequency of service and mechanism of engagement used at a facility level.

RACFs preferred to negotiate service arrangements directly with the allied health providers rather than using a third party. For those RACFs that were part of a larger chain, there can be central control of resources and/or contracts with key providers negotiated at the corporate level and the local RACF does not have discretion in who or how allied health services are engaged.

**Limited opportunity to use MBS to fund allied health services in residential settings.**

While GPs can refer a resident for five allied health services a year under an MBS Item 731, there is limited utilisation of this item for the purpose of allied health service provision. This is because:

- It is a maximum of five allied health services per annum (across all disciplines) and this was considered an inadequate quantum of therapy to make a clinical difference and hence not worth starting the therapy, or if commenced, there was the question of how the additional or continued sessions would be paid for.
- The classification of care needs of residents determines whether they can access allied health services under MBS. Residents with a high rating in any ACFI category, or a medium rating in two or more categories, requires the RACF to provide therapy services (i.e. recreational, speech, podiatry, occupational therapy and physiotherapy). This means that GPs must be aware of the ACFI classification for a resident (which can be quite labile) before referring for allied health services through the MBS. Under the Aged Care Act 1997 and Quality of Care Principles, Medicare rebates for allied health services should not replace the services that are expected to be provided to residents of the facility. Hence, GPs can only refer residents with lower care needs to an allied health professional.
- The remuneration to the allied health professional through the MBS may not be adequate to cover time and travel to visit the RACF and provide the service, particularly if there is only one resident to be seen.

**Absence of additional funding for allied health services through the Trial limited opportunities to expand services**

There was no funding allocated through the Program for allied health services. Therefore, any additional services sourced had to be funded by the RACF, sourced from the public sector, or paid

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18 Australian Federal Government (2014) *Quality of Care Principles 2014*
for by the resident or family where there could be inability to pay or reluctance to do so because of the perception that when a person became a resident of a facility their care costs were met by the facility and the resident contribution.

A proposal was developed by an ACC in conjunction with participating RACFs to provide allied health and dental services that were not deemed to be maintenance therapy. This included: access to a dental hygienist as an extension to a dental prosthetist’s service; and contracting an exercise physiologist to work in a RACF, in collaboration with the occupational therapist employed by the RACF to undertake assessment of residents and prescribe exercise and rehabilitation interventions to improve functional capacity. It was proposed by one Trial site to use Program underspends to support these services. However, the DoH could not support this proposal as Program funds could not be used to fund services delivered by allied health professionals.

**Policy, funding and logistical issues are barriers to residential aged care recipients accessing public allied health and medical specialist services**

The complexity of the policy and funding environment can impede residential aged care recipients accessing publicly funded health services (Case Example).

**Case Example: Policy and funding barriers to provision of public services into RACFs**

Examples were identified where the provision of LHN funded services were unable to be accessed in the residential care setting as a result of policy settings and inability to negotiate arrangements for LHN employed staff specialists.

In WNSW PHN site, negotiations commenced with the Far West LHN and a metropolitan LHN to utilise video consultation to provide geriatrician services into three RACFs participating in the GP Video Consultation Pilot. A geriatrician employed by a metropolitan LHN provides visiting services to Broken Hill Health Service, supplemented by video consultations. Aged care residents must attend the Health Service to see the geriatrician – whether face-to-face or by video consultation. Inability to negotiate an arrangement for the metropolitan LHN employed geriatrician to video consult with residents in the facility limited the opportunity to improve access to a publicly available service through this medium. Residents could attend the hospital to see the geriatrician but required ambulance transfer.

Similarly, public allied health professionals may not be able to provide services into a RACF. This was also encountered in Broken Hill where the hospital based dietitian was “not covered” to visit residents in a facility post-discharge. This led to initiation of an agreement for the publicly employed dietitian to provide outpatient consultation via video consultation as part of the GP video consultation Pilot.

The policy settings for residents of aged care facilities to access LHN services is complex and appears to vary between jurisdictions, between LHNs and between professions. For example, the Trial highlighted situations where LHN in-reach services provide nursing care into RACFs, specialised community nursing services and dental services will visit residents of a facility, but allied health professionals employed by a LHN could not.
Current approaches to care planning in the residential setting have limitations for clinical care planning and management.

It is a requirement under the Australian Aged Care Standards Agency that an RACF develops a MDC plan for each resident to inform resource allocation. GPs indicated that the RACF multidisciplinary plans were not as useful as a GP Management plan or Team Care Arrangement for planning and reviewing clinical care on a scheduled basis. GPs reported that as the RACF has a multidisciplinary plan for each resident they tend to write up specific orders and include these in the plan (and may bill for a contribution to a care plan, MBS Item 731). There was the view by GPs that care planning in residential aged care was led by the RACF, not by the GP.

These findings align with a review of the ACFI, that found while the instrument is used to assess care need to inform funding levels for individuals, it is disconnected from care planning and care provision for the individual, and some of the assessment tools prescribed in the ACFI do not align with contemporary evidence to optimise resident health and wellbeing and therefore, are not used to inform care plans.\(^\text{19}\) Furthermore, a recent study showed that while the volume of GP services to RACFs increased between 2005 and 2014, and the number of GP services per resident increased, there was a much smaller increase in collaborative GP services (i.e. Contribution to care plan, Item 713, and Residential Medication Management Review, Item 903), with less than 50% of the residential aged care population having received these services.\(^\text{20}\)

Care planning occurs outside usual General practice systems.

From the GP perspective, most care planning and care delivery in RACFs is piecemeal and ad hoc, occurring outside their usual care planning and review processes where care planning is facilitated by the practice nurse and underpinned by: patient register and recall; GP Management Plan or Team Care Arrangement; and access to clinical records. While GPs attended RACFs on a scheduled and/or as needs basis, the residents to be seen by the GP were usually identified by the RACF staff, and not usually a planned review process.

Lack of shared understanding of funding models for RACFs and general practice negatively impact on care planning processes.

Lack of shared understanding of funding arrangements and documentation required to support care planning by both RACFs and GPs hinders collaborative care planning processes. Funding for residential aged care is driven by the ACFI. ACCs reported varying awareness by GPs of the importance of updating CMAs and documentation for resourcing purposes as the health needs of the resident change. Conversely, RACFs may not be aware of the purpose of the GP team care and management plans, when they consider there is already a multidisciplinary plan in place, seeing the development of GP management plan as duplicative or a “money grab” by the GP. As a result, RACF


staff can be resistant to working with the GP or practice nurse to provide information to inform the development of CMAs and GP Management plans for residents.

A number of trial sites conducted information sessions for GPs and RACFs on aged care and general practice funding models and documentation required in aged care as a strategy to improve care planning for residents.

**ACFI does not reward wellness and re-ablement.**

Improved health outcomes including re-ablement, improved functional ability and increased independence for aged care recipients was an intended outcome of the Program. However, under the ACFI, RACFs are paid according to the level of need for a resident, receiving higher amount of funding for residents with high care. Several ACCs identified that the funding mechanism does not reward wellness or provide an incentive for RACFs to source services to support re-ablement of residents. Hence the funding environment in which the Trial operated was not supportive of the intended outcome.

### 4.7 Sustainability of activities

**Overall, there were few initiatives that were established under the Trial that would be continued beyond the Trial.**

Supplementary reports provided information on the multidisciplinary services and care coordination activities that would continue after the Trial ended. Table 4.1 has synthesised the information from the sites and differentiates between those services that were initiated through the Trial and those that could be considered usual activity of the PHN or Feros Care.

The exception is the Gold Coast model, where the PCGC is seeking to extend the model to 10 RACFs in the PHN and has called for expressions of interest from general practices and RACFs to participate in the “RACF Service Navigation Pilot”.

As Table 4.1 indicates, having established linkages between the RACFs and various allied health providers, it is likely that the RACFs will continue to call in these services as required. Services such as the Pearly Whites program in NWMPHN will continue to be available dependent on state government funding. Similarly, the delivery of private psychology and mental health nursing services to RACFs will continue in the RACFs funded by the PHN.
<table>
<thead>
<tr>
<th>Continuing services, programs and activities</th>
<th>Initiated through Program activity</th>
<th>No. Trial sites</th>
<th>Initiated as part of usual business (for ML/PHN/Feros Care)</th>
<th>No. Trial sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multidisciplinary care expansion/enhancement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health, specialist nursing services and medical specialist consultations (via VC or F2F)</td>
<td>✓</td>
<td>5</td>
<td>✓</td>
<td>2</td>
</tr>
<tr>
<td>Private Psychology/Mental health nurse in-reach to RACF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LHN in-reach services (hospital avoidance)</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>LHN Nurse practitioner supported geriatrician follow up post discharge</td>
<td>✓</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination and advisory activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My Aged Care community forums and aged care expos</td>
<td>✓</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAC referral GP software template</td>
<td>✓</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP/RACF annual cycle of care</td>
<td>✓</td>
<td>1 (expanding to 10 RACFs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance of aged care websites</td>
<td>✓</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged Care Advisory Service (local government operated)</td>
<td>✓</td>
<td>1 (dependent on evaluation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting GPs to refer to MAC</td>
<td>✓</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Care Planning DVDs</td>
<td>✓</td>
<td>1 (but may end when current stock is exhausted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training for RACF staff</td>
<td>✓</td>
<td>1 (time limited to 2018)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Combined service expansion and care coordination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged Care taskforce</td>
<td>✓</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical pathways (independent of Map of Medicine, Health Pathways)</td>
<td>✓</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Pathways – Map of</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>
Continuing services, programs and activities

Initiated through Program activity | No. Trial sites | Initiated as part of usual business (for ML/PHN/Feros Care) | No. Trial sites
--- | --- | --- | ---
Multidisciplinary care expansion/ enhancement |  |  |  |
Medicine/Health Pathways |  |  |  |

Table 4.1 Continuing services, programs and activities

### 4.8 Appropriateness, Effectiveness and Efficiency of the Trial

Based on triangulation and analysis of data collected, this section draws conclusions about the overall appropriateness, effectiveness and efficiency of the Trial from the perspectives of service providers in the health and aged care sectors, with a view to identifying key learnings for improving health care for aged care recipients.

#### 4.8.1 Appropriateness of the Trial

Appropriateness of a program considers:

- suitability of program design in the context in which it is operating
- fit of the Trial activities with Trial objectives
- whether the underlying assumptions were correct
- extent the program meets the priorities and needs of stakeholders.

Appropriateness of the Trial was demonstrated to the extent that:

- Each site adopted a different approach to the program, reflected in the range of activities undertaken. Sites approached implementation in response to local context, their understanding of local needs and existing networks and linkages and their interpretation of Program Manual and PIs.
- PHNs, and to a large extent MLs, were appropriate organisations to implement the Trial because of their organisational role in general practice support and health service and system redesign.

The evaluation identified *factors that limited the appropriateness* of the Trial and consequently limited its effectiveness and efficiency.

#### Program Design

The absence of a sound program design challenged implementation of the Trial at a site level and subsequently this evaluation. There was not a clear linkage between objectives, activities and outcomes as set out in the Program Manual, and PIs were not clearly defined or specific.

While the Program Manual referred to “persistent barriers that exist for aged care recipients, particularly in residential aged care, in accessing primary health care”, these barriers were not clearly articulated in the Program Manual. A limitation to the Program, and in particular Element 1,
was the lack of a clearly articulated problem that the Program was seeking to address. Therefore, it was difficult to determine how the ‘need’ was to be addressed. For example, it was not clear whether the intention was to have “more” MDC, more of particular professions, different types of services or care, or “more” GP services, more timely care, or a combination of all of these. Additionally, there was a lack of clarity about whether care coordination was intended to occur at the aged care recipient level or service level, or both.

**Assumptions underpinning the Trial incongruent with the context of care planning and delivery in RACGs**

Underpinning assumptions of the Trial about the role that the ACC could play in care planning, care coordination and service development were incongruent with the way care planning, resourcing, and delivery occurs in residential care.

RACFs are required to provide a range of allied health and nursing services to meet standards of care, funded under ACFI, with a focus on maintenance of a level of independence in activities. RACF management interviewed for the evaluation did not identify unmet allied health need relative to the maintenance needs of their residents and hence did not perceive a significant role for the ACC in sourcing or establishing multidisciplinary teams.

The assumption that MBS funded allied health services could be mobilised more extensively in RACFs was challenged by the complexity of residential aged care funding mechanisms, differentiation between the type of care provided under ACFI for maintenance therapy and type of care that the MBS could fund to support re-ablement, the lability of a resident’s care needs (and hence ACFI assessment and eligibility for allied health MBS services), and the complex needs of residents.

While the Trial was intended to support re-ablement and improve the functional ability of aged care recipients, the extent to which this could occur is limited by the complexity of the health needs of the cohort. In 2016, the average age of people in residential aged care was 85. The proportion of people in residential care who are assessed as having high care needs has progressively increased over time. Between 2009 and 2016 the percentage of people with high needs rating on the complex health care domain increased from 13% to 61%. These increasing care needs were reflected in feedback from evaluation informants about the facilities involved in the program and more generally in the residential care sector. As one RACF representative put it: “our place looks more like a hospital than a home”. Increased levels of frailty of residents contributes to a greater focus on maintenance care rather than rehabilitation. In sites that developed health pathways, these were often built around end of life and palliative care as well as dementia care, rather than on re-ablement.

A greater emphasis on re-ablement may have been more applicable for the program sites if they had had a greater focus on the community aged care sector. However, as previously identified, the program sites all focussed almost exclusively on residential care.

Care planning and coordination in RACFs is usually undertaken by an employed or designated care manager/ care coordinator. RACFs did not see a role for an external provider to undertake these.

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21 AIHW GEN Aged Care data: People using Aged Care
22 AIHW GEN Aged Care data: People using Aged Care
functions. Furthermore, each resident has a Multidisciplinary Care plan developed by the RACF under ACFI, to which the GP can contribute. In essence, care planning is led by the RACF, rather than the GP. While limitations in the ACFI care planning process are recognised, changes to this process with greater involvement of GPs supported by relevant clinical assessment tools would require policy intervention and possibly legislative change.

Intended outcomes of the program included declines in acute events, emergency admissions and hospitalisations. There are varying views in the literature on the extent to which transfers to hospital for aged care residents can be avoided, but there appears to be consensus that alternative models of acute care are required in RACFs. While a key objective of the Trial was to promote the expanded use of in-reach services to RACFs, these are state-funded services and were only available to the NWMPHN and SEMPHN Trial sites. Hence the other sites had no influence on availability of services. More recently, various in-reach services models and hospital in the home programs are being developed in jurisdictions. PHNs could play a key role in working with their LHNs in the design and/or implementation of models.

Overall, it is considered that the Trial design (Element 1) was not appropriate to the context in which it operated.

4.8.2 Effectiveness of the Trial

Effectiveness of a program considers:

- fidelity of implementation
- achievement of program objectives
- an assessment of quality and value of the program.

This report has documented issues with the clarity of the role of the ACC, differing understandings of the Program materials in focus of activity, inconsistent interpretation and reporting of PIs and as a result, limitations in the evaluation to assess achievements of the Trial in any meaningful way.

Based on qualitative data, the Trial had limited effect in enhancing access to MDC in RACFs. However, the Trial has enabled the PHNs to establish better connection with, and intelligence of the aged care sector in their respective regions that will have benefit in their role in service development, system integration and commissioning.

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4.8.3 Efficiency of the Trial

The efficiency of a program considers:

- the conversion of outputs to results
- governance and management.

The outputs identified in the Program Logic were used to assess the efficiency of the Trial as shown in Table 4.2. Note that the Program Logic was developed with the expectation that sites would be undertaking work in the community, where some outputs would have greater relevance. Issues with the governance and management of the Program, and their impact on the efficiency of the Program, were discussed in Chapter 3.

<table>
<thead>
<tr>
<th>Intended Outputs</th>
<th>Outputs Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC positions established in sites</td>
<td>ACC positions established in all sites</td>
</tr>
<tr>
<td>Multidisciplinary care teams established</td>
<td>No teams established as a result of the Trial</td>
</tr>
<tr>
<td>Coordinated care protocols between Multidisciplinary care providers and GPs for aged care recipients with complex needs</td>
<td>Coordinated care protocols not established in any site</td>
</tr>
<tr>
<td>Multidisciplinary care planning in place – service level and client level</td>
<td>Multidisciplinary care planning occurred through usual ACFI processes at a client level. ACC had no role in this</td>
</tr>
<tr>
<td></td>
<td>Minimal service level Multidisciplinary care planning across all sites</td>
</tr>
<tr>
<td>Multidisciplinary care provided to aged care recipients</td>
<td>Most sites assisted RACFs to access additional allied health and specialist nursing and/or medical services for some residents, however this was ad hoc and in low numbers</td>
</tr>
<tr>
<td>Information on local resources and support provided to MD teams and GPs</td>
<td>Majority of sites undertook networking and information sharing activities</td>
</tr>
</tbody>
</table>

Table 4.2 Assessment of outputs delivered under Element 1

4.9 Summary

The evaluation showed that each site (with the exception of Feros Care) implemented a range of activities aimed at improving MDC and care coordination, based on their interpretation of the intent of the Trial and in response to local conditions. However, few of these activities appear to have resulted in systemic or sustainable change. The design and implementation of the Trial could potentially have been improved through better alignment with the way care planning, resourcing and MDC delivery occurs in residential aged care.

Differences in interpretation of Trial parameters and PIs precluded the evaluation making meaningful comparisons between sites and/or objectively assessing the impact of the Trial. Early investment in the development of a robust monitoring and evaluation framework as a component of
the program design, and formative evaluation could identify potential issues in implementation and allow timely review and revision of Trial activity.
5 ELEMENT 2: PILOT OF GP VIDEO CONSULTATIONS

5.1 Introduction and Chapter Overview

The rationale for the video consultation pilot, as part of the Program was to test how GP video consultations could improve access to GP care for residents in RACFs, with a view that timely access could reduce exacerbation of acute events and decrease presentations to hospital EDs and avoidable hospital admissions.

This chapter addresses the following Key Evaluation Question:

- What difference did GP video consultation make to the provision of GP care in RACFs?

This chapter provides background and context to the delivery of GP video consultations in RACFs. The impact of the Pilot is considered across the nine sites. Data are provided about the quantum and nature of video consultations undertaken. The Key Findings section outlines the perceived benefits of GP video consultations and a discussion of enablers and barriers identified through the evaluation. The final section of the chapter provides an assessment of the overall appropriateness, effectiveness and efficiency of the Pilot based on the triangulation of evaluation findings.

5.2 Background and Context

It is important to understand the context in which GP care is provided and resourced in residential aged care as well as the current telehealth environment in order to provide context in which the Pilot operated and enable accurate interpretation of the findings.

The Australian Government is interested in the potential of telehealth as a mechanism to improve access to health care particularly for people living in rural and remote areas, or for people with restricted mobility. MBS items for video consultations between a medical specialist and patient were introduced in 2011. MBS items for other medical practitioners/GPs to participate in the consultation with the patient and consultant were also made available, as was equipment grants for the purchase of Video Conference units. The RACGP has developed standards for use of GP video consultations. Currently there are no MBS items for a GP to conduct telehealth consultations directly with their patients.

5.2.1 GP care arrangements in RACFs

Delivery of GP care in RACFs is provided in various ways. Often there are one or several general practices/GPs that provide care to a facility, scheduling time to visit the facility to review residents on a regular basis e.g. one afternoon a week or fortnight, as well as provide on-call to the facility. Some residents in the facility may continue to see their own GP who provided care prior to entering residential care (i.e. visit the patient at the facility), or the resident sees the GP in their practice (dependent on mobility). Other models include RACFs partnering with particular GPs and GPs with

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27 Royal Australian College of General Practitioners Standards for Video Consultations
special Interest in Residential Aged Care. There is limited evidence for which of these models is most effective and in what circumstances.\textsuperscript{28}

GPs provide care to residents of RACFs under specific MBS items (Table 5.1).

<table>
<thead>
<tr>
<th>Item</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health assessments</strong></td>
<td></td>
</tr>
<tr>
<td>MBS items 701, 703, 705, 707 (time based)</td>
<td>Comprehensive Medical Assessment</td>
</tr>
<tr>
<td></td>
<td>Once a year or at a major change in health</td>
</tr>
<tr>
<td><strong>Care planning</strong></td>
<td></td>
</tr>
<tr>
<td>MBS item 731</td>
<td>Contribution to a MDC plan</td>
</tr>
<tr>
<td></td>
<td>Enables referral to allied health services</td>
</tr>
<tr>
<td>MBS item 732</td>
<td>Review MDC plan/discharge plan</td>
</tr>
<tr>
<td><strong>Case Conferencing</strong></td>
<td></td>
</tr>
<tr>
<td>MBS 735, 739, 743 (time based)</td>
<td>GP organises a case conference</td>
</tr>
<tr>
<td>MBS 747, 750, 758 (time based)</td>
<td>GP participates in case conference</td>
</tr>
<tr>
<td><strong>Consultations at RACF</strong></td>
<td></td>
</tr>
<tr>
<td>MBS 20, 35, 43, 44 (Level A,B,C, D) + $46.70 divided by number of patients</td>
<td></td>
</tr>
<tr>
<td>MBS 5010, 5028, 5049, 5056 (Level A,B,C, D) + $46.70 divided by number of patients</td>
<td>After hours</td>
</tr>
<tr>
<td><strong>Other non-referred consultations at a RACF</strong></td>
<td></td>
</tr>
<tr>
<td>MBS 92,83,95, 96 (Brief, standard, long, prolonged) + $27.95 divided by number of patients</td>
<td></td>
</tr>
<tr>
<td>MBS 5260, 5263, 5265, 5267 (Brief, standard, long, prolonged) + $27.95 divided by number of patients</td>
<td>After hours</td>
</tr>
<tr>
<td><strong>Medication management</strong></td>
<td></td>
</tr>
<tr>
<td>MBS 903</td>
<td>Residential Medication Management Review</td>
</tr>
<tr>
<td></td>
<td>Once a year in collaboration with reviewing pharmacist</td>
</tr>
</tbody>
</table>

Table 5.1 MBS items for services provided to residents in RACFs

The Practice Incentives Program GP Aged Care Access Incentive (ACAI) aims to encourage GPs to provide continuing and increased services in RACFs. GPs are eligible for this tiered incentive payment where they provide a required number of eligible MBS services in RACFs within a financial year.

5.2.2 GP payments under the Pilot

Under the Pilot, GP payments for video consultation were based on time and complexity.

<table>
<thead>
<tr>
<th>Payment level</th>
<th>Payment</th>
<th>Consultation type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A</td>
<td>$25.20</td>
<td>Straight forward consultation</td>
</tr>
<tr>
<td>Level B</td>
<td>$44.50</td>
<td>Consultation lasting less than 20 minutes for cases that are not obvious or straight forward in relation to one or more health related issues</td>
</tr>
<tr>
<td>Level C</td>
<td>$78.87</td>
<td>Consultation lasting at least 20 minutes for cases relating to one or more health related issue</td>
</tr>
<tr>
<td>Level D</td>
<td>$116.10</td>
<td>Consultation lasting at least 40 minutes for cases in relation to one or more health related issues</td>
</tr>
</tbody>
</table>

*Table 5.2 Video Consultation Payment Levels at end of Pilot*

5.3 Video Consultation – Pilot Models

The model of video consultation adopted in each site was tailored to the requirements of the participating RACFs and GPs. The most common models adopted were:

- *Scheduled “clinic” time*: the GP would allocate a session (usually 30 minutes or one hour per week or fortnight) for video consultations. Generally, RACF nursing staff would identify which residents would be seen during the clinic and notify the practice prior to the scheduled time and send through any relevant clinical information in preparation for the consultation.

- *Ad hoc or acute events*: some GPs were happy to use video consultations for ad hoc requests. Often this would involve the RACF staff notifying the GP practice of the need for a consultation and the GP allocating a time slot, often prior to or after lunch or at the end of the day or when the GP had a vacant consultation appointment.

- *Combination of clinic and ad hoc*: GPs had regular scheduled clinic times for video consultations but also accepted ad hoc requests as required.
Table 5.3 provides an overview of the different models adopted by each site.

<table>
<thead>
<tr>
<th>Pilot Site</th>
<th>Video consultation model</th>
</tr>
</thead>
</table>
| CNSAML/CSAPHN       | • scheduled weekly video consultation slot (30 minutes) where RACF identified residents where advice or review is required. The RACF sends the list of residents to the practice with supporting clinical information in preparation for the consultations.  
• ad hoc where RACF staff identify a need, request consultation by fax or phone call. Consultations scheduled during vacant slot or prior to or after lunch. |
| SEMPHN              | • ad hoc consultations predominantly that would have otherwise been conducted as a phone call  
• structured sessions with GP allocated time for video consultations. RACF nurses identified if needed and if not would let the GP know.  
• occasional use by a GP where they could not be at the RACF e.g. during school holidays.                                                                 |
| NWMPHN              | • scheduled consultations in addition to face-to-face visits with an emphasis on using these for comprehensive review while GP had access to usual medical notes  
• semi-urgent (but not urgent) issues as a complement to a phone call to the GP.                                                                                                                                   |
| WNSW PHN            | • substitute for face-to-face visits. 2 hour scheduled timeslot each day for video consultations. If not needed RACF would notify GP by 10am  
• structured sessions / timeslots and RACFs notified by an agreed time if not needed.                                                                                                                     |
| HNECC               | • scheduled clinic time for video consultations with GPs. RACFs identify residents and notify GPs of who they were to see  
• occasional ad hoc appointments as required.                                                                                                                                                                        |
| WAPHA               | • video consultations used as an adjunct to weekly visits and telephone/email requests.                                                                                                                                 |
| PCGC                | • scheduled video consultation clinic times. RACFs notify the GP of which residents needed consultations. All GPs also provided face-to-face visits.                                                                        |
| TMML/NQPHN          | • scheduled video consultations as an adjunct to face to face consultations.                                                                                                                                              |
| Feros Care          | • scheduled weekly video consultation clinics in addition to weekly face-to-face visits  
• ad hoc video consultation appointments arranged by RACF staff notifying GP practice and requesting appointment slot or video consultation prior to or after lunch.                                  |

*Table 5.3 Video consultation models by site*

Video consultations were used to complement continued face-to-face visits to the RACF by the GP, with one exception (one GP in WNSW PHN). A variety of combinations were adopted, for example:

- A GP who had previously visited twice a week conducted one face-to-face visit and one video consultation session each week.
• A GP would visit fortnightly and conduct video consultations in the alternate weeks.
• Groups of GPs shared rostering of visits to a facility. For example, three GPs from the same practice visiting an RACF would do face-to-face visits two weeks out of three and the third week would conduct video consultations on a rotating basis.

Platforms for video conferencing were selected by sites and included Skype, Cisco Jabber, Vidyo, Clear Sea, Health Direct and Facetime. Factors influencing selections made included existing systems, usability and security. Several sites started using one platform before changing to another during the Pilot. By the end of the Pilot most sites were using Skype or Facetime as these were considered to be the most user friendly and people were comfortable in using them as they were more likely to be familiar with their use for other purposes.

5.4 Video Consultations – Impact of Pilot

5.4.1 Number of Video Consultations

Data reported in this section were collected through GP video logs. GPs were required to complete these logs for each consultation to receive payment. The example of GP video consultation logs provided to sites in the program manual is at Appendix 5.

Overall a total of 5,029 GP video consultations were conducted across all nine sites over four years. This represents approximately 14% of the aspirational target of 36,000 (based on targets in individual site Grant Agreements). Table 5.4 shows the total number of GP video consultations compared with the combined targets specified in the Grant Agreements with each site, broken down into the ML period (first two years) and PHN period (second two years). Although targets were reduced slightly for the PHN contracts (in most cases from 300 per RACF per year to 250 per RACF per year), overall the sites were still only able to meet 21% of the target number between July 2015 and June 2017. Factors influencing adoption of video consultation at a site level and RACF level are described in Sections 5.5.3, 5.5.4 and 5.5.5.

<table>
<thead>
<tr>
<th>Pilot Period</th>
<th>Total number of VC</th>
<th>Target</th>
<th>% of target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-15</td>
<td>1,686</td>
<td>20,400</td>
<td>8</td>
</tr>
<tr>
<td>2015-17</td>
<td>3,343</td>
<td>15,600</td>
<td>21</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,029</td>
<td>36,000</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 5.4 Percentage of video conferencing target met
Figure 5.1 shows that fewer than 120 video consultations were conducted in the first year of the Pilot reflecting the considerable effort required to establish video conferencing with both RACFs and GPs. Barriers to achieving the targets are discussed further in Section 5.5.5 of this report.

![Figure 5.1 Total number of GP video consultations per year (all sites combined)](image)

Figure 5.1 shows that the overall number of GP video consultations were maintained after the change to PHNs from MLs. However, data from individual sites (Table 5.5) confirms that this was due to three sites in particular (CSAPHN, PCGC and WNSWPHN). For several sites (HNECCPHN, NQPHN and SEMPHN), the change from ML to PHNs resulted in some RACFs and GPs withdrawing from the Pilot and required ACCs to engage new RACFs and GPs in the PHN phase. It is not clear why Feros Care, with no change in local management, had a similar drop in the number of video consultations in 2015/16 as compared with 2014/15. Two sites (WAPHA and NWMPHN) had very low uptake of video consultations throughout the four year pilot.
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CC Medicare Local</td>
<td>0</td>
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<td>HNECC PHN 7</td>
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<td>CNSA Medicare Local</td>
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<td>CSA PHN 426</td>
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<td>Feros Care</td>
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<td>288</td>
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<td>234</td>
<td>639</td>
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<td>SEM PHN 35</td>
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<td>GC Medicare Local</td>
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<td>PC GC 501</td>
<td>430</td>
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<tr>
<td>IM Medicare Local</td>
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<td>27</td>
<td>NWMPHN 15</td>
<td>58</td>
<td>100</td>
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<tr>
<td>PS Medicare Local</td>
<td>0</td>
<td>20</td>
<td>WA PHA 12</td>
<td>0</td>
<td>32</td>
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<td>TM Medicare Local</td>
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<td>163</td>
<td>NQ PHN 0</td>
<td>0</td>
<td>163</td>
</tr>
<tr>
<td>WNSW Medicare Local</td>
<td>0</td>
<td>14</td>
<td>WNSW PHN 558</td>
<td>282</td>
<td>854</td>
</tr>
</tbody>
</table>

Table 5.5 Total video consultations by site and year

The drop in number of video consultations in PCGC, WNSWPHN and CSA PHN in 2016/17 can be, at least partially, attributed to a loss of engagement due to the imminent finish of the Program in June 2017 and associated tapering of interest and effort.

Several GPs reported they had been interested in the Pilot and agreed to participate with the expectation that the Pilot would lead to the introduction of an MBS item for video consultations. There was some tapering of interest when it was clear that this would not be immediately pursued following the Pilot.
Figure 5.2 Total number of GP video consultations by pilot site
5.4.2 Payment levels

Sites were provided with up to $24,000 per annum per RACF for payments to GPs for video consultations. Figure 5.3 shows the percentage of video consultations at each payment level for each of the four years of the Pilot. The majority of consultations were charged at level B, with only 3% of consultations charged at level D. This reflects the models of video consultation implemented, with most sites having limited times allocated for video consultations. Longer consultations (Level C and Level D) would have severely restricted the number of consultations any individual GP could undertake in the time allocated.

Figure 5.3 Percentage of video consultations by payment level and year

![Percentage of video conferences by payment level and year](image-url)
5.4.3 Consultation type and patient need

GPs were asked to record the type of consultation on the data logs. Figure 5.4 shows that the types of consultations were relatively similar across the four year period with almost a third being initial consultations and a further third being follow up consultations. There were slightly more medication reviews in the first year and again in the third year. There was a corresponding increase in progress reviews in the second and fourth years. This corresponds with qualitative information gained from stakeholder interviews suggesting medication reviews were used by some sites as a way of initially introducing video conferencing for RACF staff and GPs.

![Figure 5.4 Type of video consultation as a percentage of annual total](image)

The evaluation revealed considerable variation in the views of GPs about what video consultation was useful for. Key factors influencing these views included:

- level of trust by the GP of the nursing and other staff at the RACF
- GP confidence in their own diagnostic skills using video consultation rather than being able to undertake a physical examination
- skills of the nurses in the RACFs to assess and communicate effectively with GPs
- confidence of individual GPs in using technology.

Video consultations were used for a wide range of health conditions and purposes including:

- skin conditions
- wound management
- palliative care including case conferencing
- general well-being assessments
- care planning
- routine follow up including test results
- acute changes of health status
- monitoring gait and mobility
- medication reviews and script writing
- hearing assessments.

Although the GP data logs did not provide detail about all conditions or resident needs, Figure 5.5 provides an overview. Notably in the first year more than half of the consultations were used for episodic or event based care while in the third and fourth years there was increased use of video consultation for the management of ongoing or chronic health conditions.

![Number of video consultations by patient need](image)

**Figure 5.5 Type of patient need as a percentage of annual total**

Several GPs reported difficulties using video consultations with people with dementia and people who have hearing impairments as their ability to use the technology can be limited.

From this Pilot, it is not possible to generalise about types of conditions for which video consultations could be useful should there be a wider roll out, due to variation of responses between GPs, based on their individual experience, skill and preferences.

However, previous studies provide some evidence for the effectiveness of telehealth in different situations. In residential aged care telehealth has effectively been used for teledermatology,\(^\text{29}\)

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telepodiatry,\textsuperscript{30} dementia diagnosis,\textsuperscript{31} and cognitive assessment more generally.\textsuperscript{32} A UK study found telehealth also has application in palliative care settings, including nursing homes, and while the technology was useable and acceptable to patients and health professionals there were challenges in integrating it into routine practice.\textsuperscript{33}


5.4.4  Quality of video consultations

Across all four years GPs rated over half of video consultations as equal to or better than face-to-face, with a further 10-20% rated as sufficient for need (Figure 5.6). Overall very few consultations were rated as unsuitable. It should be noted, however, that GP logs were only completed for video consultations that were actually completed. Qualitative data from stakeholder interviews suggests that many video consultation sessions, not included in logs, were unsuccessful or abandoned due to technical and other issues that are discussed later in this chapter.

5.5  Key Findings

5.5.1  Perceived benefits of video conferencing

Consultations identified a number of perceived benefits of GP video consults for residents and families, GPs, RACFs and the health and aged care systems more broadly. It should be noted that the extent to which these benefits actually accrued in the pilot sites directly as a result of the Pilot has not been quantified as different comparators were used by different sites to assess benefits. For GPs and RACFs, several perceived benefits were considered in comparison to telephone consultations rather than in comparison to face-to-face visits.

Perceived benefits identified for residents and families using video consultations included:

- seeing the GP without having to leave their bed or room. This can be an advantage for residents with mobility problems or when they are suffering from an acute health issue
- families can be involved in video consultations from another location with examples of this use identified in the Pilot. Participants suggested this could be particularly beneficial in
palliative care situations to involve family members in decisions about end of life or other care issues

- timeliness of care for acute issues, rather than waiting for the next scheduled visit or having to be transferred to an ED
- improved use of technology more generally can have social benefits for residents. For example, with the assistance of RACF staff one resident was able to use the I-pad to Skype into her grandson’s wedding in England.

Benefits identified by GPs using video consultations included:

- reduced travel time by being able to stay in the practice to conduct consultations
- access to electronic notes in the practice, in contrast to having to enter information collected on paper at the facility on return from a face-to-face visit
- remuneration for services provided which does not occur if respond by telephone
- increased rapport with RACF staff because the GP could see who they were talking to which in turn, provided the GP with more confidence in decisions made than discussing a resident’s needs over the telephone where they may be unsure who the nurse is
- more comprehensive consultation than a telephone call
- continuity of care at times when the GP may not be able to visit such as when the facility is in lock down or when the GP is on leave or unwell.

Benefits identified by RACFs using video consultations included:

- timeliness of care improved
- confidence in being able to consult with the resident’s regular GP rather than using after hours or locum services
- rapport and communication improved between the RACF staff and the GP compared to telephone calls
- changes in clinical management can be implemented more promptly than waiting for a face-to-face visit
- access to I-pads which can be used for other purposes
- potential cost savings for nurse escorts if residents have to be transferred to hospital or to the general practice.

5.5.2 Impact of Pilot on ED transfers and hospitalisation of residents

Intended outcomes of the Program included reductions in exacerbation of acute events, transfer of residents to ED and hospital admissions. Baselines on these parameters were not established at the commencement of the Pilot. Data on hospital transfers were not systematically collected by all sites. However, some sites estimated the extent to which this occurred:

- CSAPHN collected data through the GP logs which indicated that 25-30% of consultations mitigated transfer to hospital.
- Feros Care estimated that approximately 62 hospital transfers were prevented during the course of the Pilot.
• NWMPHN estimated that video consultation potentially prevented 9 transfers to hospital
due to early VC discussion with GP and enabled 2 appropriate admissions due to early advice
by GP through video-consultation.
• WNSWPHN made some progress towards a process to monitor hospital transfers during the
PHN period of the program, through a daily data review of transfers by the Executive
Manager of the three participating RACFs. The collated monthly data showed a 59% reduction
in transfers to ED (compared with the first quarter of the Pilot period) and a 19% reduction
in hospitalisations. While these data look promising, the numbers are small, there
has not been consideration of seasonal factors, and the participating RACFs have instigated a
Palliative Care Link nurse position to support end of life care in the RACFs which is a
potential confounder.

Multiple factors contribute to a decision to transfer a resident to hospital. Facilities in the program
reported that sending residents to hospital is a last resort and only done so if there was a clear
medical need. Participants suggested that the definition of “avoidable” hospitalisation is inherently
problematic and open to subjective interpretation. Factors identified by evaluation participants that
impact on hospitalisations of residents of participating RACFs included:

• availability of after-hours GP services. One facility identified that improved access to after-
hours services has reduced their need to transfer residents to hospital
• whether a resident has an Advanced Care Directive clearly stating preferences for end of life
care
• unrealistic expectations of families resulting in pressure to send residents to hospital, particularly at the end of life
• RACF staffing levels and availability of qualified nursing staff to care for unwell residents
when they may be the only nurse on duty for high numbers of residents, particularly overnight and on weekends
• lack of capacity to provide some clinical services in facilities (e.g. intravenous antibiotics, catheterisation) due to management decisions and/or skills and qualifications of nursing
staff.

Current funding arrangements were identified as a disincentive for RACFs to provide acute care in
the facility. Several RACF managers indicated that they have trained nurses skilled to provide higher
level care such as intravenous antibiotics, and this is provided to residents rather than transferring
them to hospital. However, in providing this care the RACF bears the cost of the antibiotic, giving set,
and nurse time to focus care on the unwell resident, when a transfer to hospital would be a cost to
the state government/LHN.

5.5.3 Impact of general practice models on uptake of video consultations

The model of GP service provision to the RACFs impacted on adoption of video consultation. The
three sites with the lowest uptake of video consultation were WAPHA, NWMPHN and SEMPHN
(Table 5.5). Note that NQPHN did not progress any video consultations in the PHN phase and has
been excluded from this analysis.

In the WAPHA site, the RACFs participating in the Pilot were serviced by the same GP who had
retired from office-based general practice and was continuing to provide services to residents in the
three participating RACFs, as well as a retirement village and two other facilities. The GP visited each participating RACF weekly and was available to the RACFs 24/7 by phone and email. The nursing workforce in the RACFs was stable and hence the GP had a good understanding of the skills and competencies of the nurses and was confident in issues/conditions that could be managed by phone. This was considered a more convenient medium than organising a video conference.

In both SEMPHN and NWMPHN, GPs provide services to residents of multiple RACFs. The Pilot required the Trial sites to engage up to 4 RACFs per site, however, GPs willing to participate in the video consultation had small numbers of residents at each participating RACF and hence uptake of video consultation was low. Both sites made a request to the Department to change the Pilot requirements from an RACF-led approach to a GP-led approach i.e. where the video consultation model follows the GP and as a result would engage more RACFs than the planned and funded 4. Approval to move to a GP led video consultation model was approved by the Department, however, as there was only 1 GP engaged in the latter part of the Pilot, numbers remained low.

PCGC had higher numbers of GP video consultations than several other sites. This reflects the model of delivery adopted in that site, where the ACC would attend each facility, or in some cases the relevant GP practice, at the time video consultations were scheduled to support RACF staff and ensure the consultations went ahead. The ACC was therefore available on site to facilitate the scheduled sessions and to troubleshoot as required.

The sites where uptake was higher tended to be locations where participating GPs had a concentration of patients residing in the participating RACFs and hence video consultation became more embedded in the model of care at the facility e.g. CSAPHN, Feros Care, HNECC and TMML.

5.5.4 Enablers to the establishment and maintenance of GP video consultation in RACFs.

A dedicated resource to establish the video consultation model at each site was essential to adoption and ongoing utilisation.

ACCs played a critical role in promoting, negotiating and coordinating establishment of the model. While the ongoing operation of video consultations relies on GPs and RACFs, it is difficult to conceive how the process could have been established without dedicated resources to undertake the range of tasks required, including development of protocols and agreements, purchase of equipment and training. The time required to establish video consultation took nearly a year, evidenced in the by the low number of consultations in 2013-14. data showing few video consultations occurring in the first year (Table 5.5, Figure 5.2).

Identifying “champions” at both RACFs and in GP practices was essential to driving the change necessary to implement the Pilot.

Furthermore, existing strong relationships between facilities, GPs and families/residents facilitated uptake of video consultation.

Staged implementation was a feature of sites that had higher uptake of video consultation.

Bringing facilities on one at a time and commencing with straightforward consultations such as medication or pathology reviews assisted to familiarise all parties with the process.
Implementation was considerably enhanced where there was a complement of technology enablers in place at both facilities and GP practices.

- reliable connectivity
- good IT support and trouble-shooting capacity. This could be either at the RACF, GP practice or through the pilot management organisation
- capacity for electronic sharing of resident records between the RACF and GP practice
- user friendly and familiar software such as Skype enhanced participation and required minimal training and support
- previous experience with technology, either specifically video consultations or more generally using I-pads for other purposes
- use of headphones or speakers was found to optimise the audio quality of video consultations which is particularly beneficial for residents with hearing loss.

Adoption of video consultation by RACFs was strongly influenced by organisational factors with support from management.

- organisational culture and readiness to support innovative models of care and management practices
- management supportive of the model
- stable workforce and support from key staff
- integration of video consultation into the model of care supported by:
  - a dedicated staff member who has the time and responsibility for accompanying the resident for each video consultation
  - having a number of residents participating in video consultations making it more worthwhile for facilities to allocate staff
  - commitment to staff training in the use of video consultation
  - using the ISBAR for communication between the GP and RACF staff to focuses on relevant clinical information of the resident.

Organisational, logistical and financial factors influenced GP participation in video consultation. These included:

- where GPs and general practices were already using technology effectively and had an interest in innovation
- support from GP practice principals to participate in the Pilot
- logistical support provided by practice managers and practice nurses in organising practice schedules, booking appointments and managing the time of GPs. Therefore, engaging with practice staff was an important enabler for establishing and maintaining video consultations. Facilities that had strong relationships with practice staff reported high levels of trust and rapport which facilitated their willingness to participate in video consultations, particularly for ad hoc or unscheduled requests.
- where GPs had several or more residents they could see using video consultations, maximising the benefit for the time taken to set up and participate in video consultation.
• good understanding between the GP and RACF about what conditions or issues were appropriate for video consultation and only making appropriate referrals.
• where GPs were confident in the skill and knowledge of the RNs participating in the video consultation with the residents.

Payments for video consultations supported GP participation during the Pilot. There were varying views whether the 10% administration payment factored into the consultation fee was adequate for the effort required by practice staff to organise video consultations. However, GPs and ACCs reported that remuneration for the consultation was welcomed when much of the work in managing aged care residents is unremunerated i.e. responding to phone calls, emails, faxes from the RACFs often resulting in renewing scripts, medication change, ordering pathology, reviewing pathology results, which occurs outside a scheduled visit to the facility.

5.5.5 Barriers and challenges to implementation of video consultation

Technology problems were most commonly cited as a factor limiting video consultation.
• Poor internet connection and frequent drop outs were experienced by both urban and rural sites and both RACFs and GP practices.
• Poor Wi-Fi capacity in some facilities, particularly in some older buildings. In some cases this was rectified through additional boosters or other technology but in other cases continued to be a problem throughout the Pilot.
• Upgrades of hardware and IT systems were needed to accommodate the video consultations. This was costly for some services.
• Loss of confidence in the model due to problems with technology which ultimately reduced its effectiveness.

Staffing capacity, turnover and familiarity with technology presented challenges to RACFs to implement video consultation.
• RACF staff reported being very busy and video consultations were seen as an additional responsibility, with no associated relief from other tasks. Although participating RACFs received funding as part of the Pilot, this was not necessarily reflected in the allocation of staff to support video consultations.
• Availability of RNs to support the resident during a video consultation, although in some cases ENs fulfilled this role. Evidence collected through the evaluation reflects the declining numbers of RNs in residential care.
• Variation of RNs and ENs in skill level and interest in telehealth and innovation, high staff turnover and use of agency staff in RACFs and the subsequent need for ongoing training and support from the ACC to sustain the model.
• High staff turnover was a barrier to embedding video consultations into practice.
  o Turnover is often associated with high use of agency staff, who are not familiar with the process for conducting video consultations nor with the residents and GPs and their approaches to care.
  o Even where permanent staff are appointed to fill vacancies, they need to be adequately trained and supported to participate in the model.
Logistics and organisational issues presented challenges for RACFs and GPs to implement video consultation.

- All parties (resident, RACF and GP) need to be ready and connected at the same time. GPs running late in their scheduled appointments or staff at the RACF being tied up with other residents can mean that the window of opportunity for a consultation is lost.
- Concern about the availability of appropriate places within some facilities to allow for appropriate confidentiality. However, this was not a universal issue and relates largely to the structure and layout of particular buildings.
- Uncertainty about legislative requirements such as signing medication charts
- Different organisational processes employed by GPs and RACFs sometimes made it difficult to coordinate video consultations.
- Difficulty embedding a different billing process associated with the Pilot into GP systems
- Proximity of the GP to the RACF influences viability of video consultation over face-to-face visits.

5.6 Appropriateness, Efficiency and Effectiveness of the Pilot

Based on triangulation and analysis of data collected, this section draws conclusions about the overall appropriateness, effectiveness and efficiency of the Pilot with a view to identifying key learnings.

5.6.1 Appropriateness of the Program

The appropriateness of the Pilot was demonstrated by:

- Each site tailoring the approach to the Pilot to the requirements of participating RACFs and GPs.
- Remuneration for participating in video consultations was effective in enabling ACCs to engage and sustain the involvement of both GPs and RACFs in the Pilot although there was variation across sites.

The literature reports that GPs are unwilling to provide services to RACFs due to a range of factors including:

- Inadequate remuneration
- Time constraints impacting on attendance at RACFs
- Out of hours workload
- Cumbersome communication between RACFs and general practice
- Lack of interoperability of systems between general practice and RACFs.

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These issues were also identified in the evaluation by GPs and ACCs.

Inadequate remuneration for activities to meet the complex care needs of residents (in addition to face-to-face visits), and time consuming and duplicative processes for documentation of care were identified as key issues by GPs and ACCs in attracting doctors to provide services in residential aged care. Some participating RACFs still have paper based resident records while others moved to electronic records during the period of the Pilot. However, interoperability between general practice software and residential aged care software is limited and GPs reported considerable time required to cut and paste information from residential records to the practice records at the end of a scheduled visit to RACFs.

The capacity to reduce hospital transfers from RACFs is impacted by the workforce capacity and capability in the facility. The number of RNs on a shift in relation to client load, availability of supporting ENs and care staff, clinical skills and scope of practice of nurses’ impact on decisions to transfer unwell residents to hospital. While the GP video consultation Pilot sought to provide clinical advice and support to RNs, this generally occurred during usual hours when there was capacity for the RACF to organise and support the video consultations and instigate change in management and medication when required. Site visits undertaken through the evaluation provided information on staffing arrangements and identified that most RACFs operate on low RN: client ratios on weekends and after hours, hence the GP video consultation model would not be appropriate under these conditions.

Therefore, while GP video consultation is an appropriate adjunct to the delivery of care to residents of aged care facilities it has no impact on other factors that contribute to GP willingness to provide services in residential aged care.

5.6.2 Effectiveness of the Pilot

The evaluation found that GP video consultation Pilot was implemented as intended in that all sites established video consultation capability between RACFs and GPs, and all sites had a quantum of video consultations occur during the ML Phase or PHN phase or both.
The four PIs relating to GP video consultation produced reliable data. As outlined in Table 5.6, assessment of the PIs against the targets indicated that:

- There was adequate to good engagement with RACFs to participate in the video consultation pilot, with most sites consistently engaging with 2 or more over the four years.
- Sites were able to engage between 10 and 15 GPs per site to participate in the Pilot, although in most cases there tended to be a smaller number of GPs actively involved at any one time.
- Less than a quarter of the target number of GP video consultations were undertaken, consequently there was poor uptake of GP payments.

<table>
<thead>
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<th>Excellent (75%-100% of target)</th>
<th>Good (50%-75% of target)</th>
<th>Adequate (25%-50% of target)</th>
<th>Poor (less than 25% of target)</th>
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<td>Number of RACFs involved in the model Target: maximum 4 per site</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Number of GPs participating in the Trials Target: 20 per site</td>
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<tr>
<td>Number of GP consultations undertaken via video link Target: 250/up to 300 per RACF per annum</td>
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<tr>
<td>Total value of GP claims per participating RACF Target: up to $24,000 per year</td>
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*Table 5.6 Assessment of performance against video consultation targets*
5.6.3 Efficiency of the Pilot

The outputs identified in the Program Logic were used to assess the efficiency of the Pilot as shown in Table 5.7.

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<thead>
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<th>Outputs</th>
<th>Delivery</th>
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<td>ACC positions established in sites</td>
<td>ACC positions established in all sites</td>
</tr>
<tr>
<td>RACFs recruited to program</td>
<td>All sites recruited RACFs to the program although numbers fluctuated over time</td>
</tr>
<tr>
<td>GP led model developed</td>
<td>All sites developed video consultation models. The models were generally developed by the ACC in collaboration with the RACFs and GPs. However, in most sites the RACF was the instigator of video consultations, not the GP.</td>
</tr>
<tr>
<td>GPs recruited to provide VC services</td>
<td>All sites recruited GPs to provide video consultations, however numbers fluctuated considerably over time</td>
</tr>
<tr>
<td>GP billing processes established</td>
<td>All sites established GP billing processes</td>
</tr>
<tr>
<td>Capacity building to use VC (for GPs and RACFs)</td>
<td>All sites undertook capacity building for video consultations with GPs and RACFs</td>
</tr>
<tr>
<td>MD care plans developed and reviewed</td>
<td>Some GPs contributed to care plans, but this varied considerably across sites and between GPs</td>
</tr>
<tr>
<td>GP VC consultations delivered</td>
<td>All sites delivered some video consultations however numbers differed considerably between pilot sites</td>
</tr>
</tbody>
</table>

Table 5.7 Delivery of outputs under Element 2

5.7 Summary

The Pilot demonstrated the capacity for GPs and RACFs to use GP video consultations effectively as a component of resident care. However, a number of systemic challenges remain before this approach could be more widely adopted. These include the robustness and reliability of the available technology and the need for ongoing support and training to develop and implement the chosen model. The evaluation highlighted a number of issues related to the wider context of GP service provision in RACFs that remain a barrier for improving access to GP care.
6 Lessons Learned

6.1 Introduction and Chapter Overview

The underpinning aim of the Program was to improve the quality of health care for aged care recipients in both the community and residential aged care settings through better linkages between the aged care sector and wider health system that would enable and promote access to MDC. GP video consultation was piloted as a mechanism to improve residents’ access to primary health care services and facilitate GP involvement in MDC.

This section draws on the findings of the evaluation including analysis of reports, interviews and review of relevant literature to synthesise key findings into key lessons learned.

The findings of the evaluation and lessons learned predominantly relate to residential aged care as limited Program activity was directed toward community aged care.

6.2 Improving access to GP care for residents of aged care facilities

GP Video Consultation

The pilot demonstrated that GP video consultations have the potential to work as a component of primary health care for people living in RACFs. A number of strategies could be implemented to ensure readiness for wider adoption and sustainability.

- Reliable connectivity is required but is not currently universally available, as demonstrated by the problems experienced across all pilot sites. Both GPs and RACFs require appropriate quality and capability of equipment as well as strong and reliable internet access.
- The workforce needs to be trained and skilled to work effectively with telehealth. Ongoing commitment to training in skills and knowledge for use of telehealth technology is needed within the RACF context where there is a high rate of staff turnover.
- Commitment to the change in practices by GPs and RACFs to make video consultations a normal and sustainable part of care for residents is required. The logistics of organising and implementing a video consultation session need to be seen as a legitimate responsibility and priority for staff.
- A dedicated role or resource is required for the establishment of systems and processes to support video consultation between general practices and RACFs. This role needs to be sustained for a period of time to assist to embed video consultation into the model of care.
- The evaluation showed that there are costs associated with GP video consultations for both GPs and RACFs. Adequate remuneration for both parties, and nurse staffing capacity in RACFs are essential considerations in wider implementation of this model.

Promoting provision of GP care to RACFs

Improving access to primary health care for residents of aged care facilities was a key driver of the Program. The use of video consultation to reduce time constraints for the GP to visit the RACF, and remuneration for the video consult under a fee for service model was tested as an approach to improve access to GP care. While the GP video consultation could be an adjunct to primary care, the findings of the evaluation support other studies that highlight challenges for GPs in providing care in
residential aged care settings. The volume of time and unremunerated work is a common barrier to provision of care to residents in RACFs e.g. multiple faxed, emailed or telephone requests each day from a facility for script renewals or pathology requests. Cumbersome communication between GPs and RACFs, and lack of interoperability of systems between general practice and RACFs, results in duplication of effort by the GP in transferring notes between the RACF records and general practice management system. The fee for service model does not remunerate GPs for these time consuming aspects of providing care in RACFs.

The model of remuneration for GPs providing quality care to residents of aged care facilities needs to consider differences in scope and nature to that provided in the community, and the utility of a fee for service model when much of the activity does not directly involve the resident.

Given the nature of the care provided, consideration of a different model of remuneration is worthy, for example along similar lines to the Health Care Homes model where GPs could be remunerated for care of a resident for a defined period, factoring in the multifaceted requirements of GPs to provide that care, or mechanism to remunerate GPs for responding to care requests from RACFs via telephone.

6.3 Care planning and coordination

The Trial demonstrated that there was not an identified or obvious role for the ACC as an external position, in care planning and coordination at a resident level. This was the case in both the PHN Trial sites and Feros Care. Holistic MDC planning is currently undertaken by nurses employed by the RACF under the ACFI, and opportunities for GPs to play a lead role in clinical care planning were limited.

Acknowledging the current ACFI process for clinical care planning purposes, and the increasing average age and complexity of health care needs of residents of aged care facilities, strategies are needed to better support and enable GPs and practices to systemise an annual cycle of care for RACF residents in line with the RACGP Silver Book guidelines and relevant clinical care guidelines.

- Improving the interoperability of general practice and RACF systems would enable the GP to have access to the resident’s clinical record, medications, recent pathology and investigation reports, and capacity for real-time pathology requests and scripts, hence streamlining care and addressing issues of duplication of effort.
- Care planning and coordination activities in residential aged care are best undertaken by health providers directly involved in the individual’s care. Facilitating processes to use general practice-based care planning supports including practice nurses, access to clinical records, patient register and recall systems, and team care planning arrangements, in collaboration with RACFs are required. PHNs have a direct role in general practice support and can leverage these functions to support GPs and RACFs to develop locally relevant approaches.

6.4 Promoting access to MDC

The Program evaluation has highlighted the complexity of the legislative and funding environment of the residential aged care system, and variation in LHN and state government policies and programs in relation to service provision into RACFs.
Future programs to promote access to MDC in RACFs need to consider:

- ACFI funding mechanism and the type of services required to be provided by RACFs to meet accreditation requirements
- The regulations under which the MBS can be applied for individual residents based on their ACFI assessment
- Limitations of the utility of the MBS to support re-ablement of residents, where eligible, as only five allied health services can be accessed in a calendar year, and the quantum of remuneration for an allied health service as an appropriate incentive for a provider as a one-off or ad hoc clinical encounter
- LHN and state government policies in relation to service delivery into RACFs.

6.5 Opportunities to build links between the aged care and health care sectors.

The evaluation of the Program provided evidence that there is a lack of understanding of funding models, service availability and delivery mechanisms between the primary health care providers, aged care services, and the broader health system. Trial managers identified the complexity of the aged care sector at a local level where it is populated with multiple small and diverse providers as well as larger not for profit and for-profit corporate entities, presented challenges for engagement.

Activities undertaken under the Program to establish Aged Care Advisory Groups, undertake service mapping and needs analysis, and develop clinical pathways, were useful mechanisms for participating PHNs to engage providers and develop local intelligence of the aged care service system. This intelligence can inform their work as systems innovators, change agents and commissioners to improve the connections and interface between the aged care sector and other parts of the health system.

Linkage between the aged care and the health sectors could be improved by greater understanding of respective funding mechanisms, business models and service models.

6.6 Overall program design

The Program tasked trial sites to increase access to MDC. However, this did not fit well with the responsibility of residential aged care providers to fund necessary allied health services to meet individual residents’ needs. Similarly, the Program contracts and Program Manual refer to the expectation that the Trial would facilitate GP-led multidisciplinary care for aged care services. While this may have been relevant for the community aged care sector, it did not align well in the residential setting.

Program design could be strengthened by bringing together industry knowledge from the aged care sector and general practice to co-design the program to ensure it is grounded in evidence and context and there is congruency between program objectives and the complexities of the existing processes, routines and funding mechanisms.

Program design needs to include development of a robust program logic informed by evidence and industry knowledge to support development of clear objectives, alignment of key activities and outputs linked with outcomes and PIs. This could be documented in a program manual and considered in development of a monitoring and evaluation framework prior to trial commencement.
Engaging evaluators in this early work as a basis for a formative evaluation provides the opportunity to re-orient aspects of the program and/or data collection mechanisms for a more robust program and evaluation.
7 References


Appendix 1 – Program Logic

**BHCC: Aged Care Multidisciplinary Care Coordination & Advisory Service**

**PURPOSE**

- To expand the provision of multidisciplinary care to aged care recipients residing in the community and aged care facilities
- To create better linkages between the aged care sector and health system for the delivery of multidisciplinary care
- To use technology to improve access to care in residential aged care facilities

**CRITICAL ISSUES**

- Barriers to primary and acute health care for aged care recipients contribute to acute events, emergency presentations, avoidable hospital admissions
- GP time constraints and physical location impact on timely care for residents of RACFs
- Effective linkages between aged care sector, acute and secondary health system for timely and appropriate health services needed
- Limited utilisation of MBS and other incentives to support multidisciplinary care

**INPUTS**

Program Funding:
- Aged care coordination service ($145K/yr/site)
- GP VC consultations ($24K/RACF/yr)
- RACF ($10k/RACF/yr)

Resources:
- VC capability (incl training)
- Reporting templates (RACF and GP)

Other funding:
- MBS items
- Aged Care Funding Instrument

Human Resources:
- Trial partners (PHNs, Feros) – program management
- ACCs
- RACF staff
- GPs

**ACTIVITIES/ OUTPUTS**

- **Aged care Coordination and Advisory Services**
  - ACC positions established in trial sites
  - MD teams established
  - Coordinated care protocols between MD care providers and GPs for aged care recipients with complex needs
  - MD care planning in place – service level and client level
  - MD care provided to aged care recipients
  - Information on local resources and support provided to MD teams and GPs

- **GP Video consultations**
  - RACFs recruited to program
  - GP led model developed
  - GPs recruited to provide VC services
  - GP billing processes established
  - Capacity building to use VC (for RACFs and GPs)
  - MD care plans developed and reviewed
  - GP VC consultations delivered

- Monthly and quarterly reports

**OUTCOMES**

**Short Term**

- Increased provision of allied health care to aged care recipients in RACFs and community
- Increased and more timely provision of GP care to aged care residents

**Intermediate**

- Reduced acute events
- Reduced presentations to hospital ED
- Reduced avoidable admissions
- Improved satisfaction with care (aged care recipient, family, GPs, RACF staff, AHPs, Med specialists)
- Improved care coordination for aged care recipients in RACFs and community (i.e. increased care plans and reviews)
- Improved re-ablement and functionality

**Long Term**

- Increased efficiency of health workforce (GPs, AHPs, Med Specialists)
- More efficient use of health resources

Legend:
- ACC – Aged Care Coordinator, MD – Multidisciplinary, RACF residential aged care facility, AHP - Allied health professional, VC – video consultation, MBS - Medicare Benefits Schedule

Version 1 - 21042017, F Battye
Evaluation of Better Health Care Connections Aged Care Multidisciplinary Care Coordination and Advisory Service Program

PARTICIPANT INFORMATION STATEMENT: Aged Care Coordinator

Principal Researcher: Dr Kristine Battye

Associate Researchers: Dr Cath Sefton, Mr Wayne Kinrade, Dr Ruth Barker, Dr Peter Stanley-Davies, Ms Christina Wolfe, Dr Debra Roczo.

This Plain Language Statement is three pages long. Please make sure you have all the pages.

1. Description of the Project

KBC Australia has been commissioned by the Department of Health to undertake an evaluation of the Better Health Care Connections Aged Care Multidisciplinary Care Coordination and Advisory Service Trial (the trial). The purpose of this evaluation is to assess the implementation of the trial and how it has impacted on those who have participated and to inform government policy on mechanisms to improve health outcomes for older people living in the community and residential aged care facilities.

The trial was conducted to increase access to General Practitioners (GPs) and to support the delivery of multidisciplinary care for older people living in aged care facilities and in the community by GPs, nurses, allied health, medical specialists and aged care providers.

The objectives of the evaluation are to:

- Assess the implementation of the trial
- Assess the appropriateness, effectiveness and efficiency of Aged Care Coordinators and GP video consultation from the perspectives of aged care recipients, service providers, and the health and aged care systems
- Identify the barriers and enablers for trial implementation and achieving outcomes, and
- Identify lessons for improving access to, and delivering, multidisciplinary health care for aged care recipients.

2. Approach

The evaluation will involve analysis of data gathered during the trial and interviews with people who have had involvement in the trial. You are invited to participate in the evaluation because you have first hand experience of the trial that can contribute to understanding how appropriate and effective it has been in improving access to GP and allied health care for older people.

3. Your Consent
You are invited to take part in the evaluation by participating in an interview.

You will not be asked to give any personal information and your responses will be confidential. You will not be identified in any reports or other documents produced as part of the evaluation.

The interview will include discussion of the following topics:

- The role of the PHN/Feros Care in the provision of aged care and/or promoting access to aged care services and how the trial fits with this role
- Role of the Aged Care Coordinator
- Activities undertaken to:
  - Establish video conferencing
  - Improve coordination and linkages between aged care services, GPs, allied health professionals and medical specialists
  - Improve care coordination for older people (residents of aged care and those living in the community)
- Barriers and enablers to improving care coordination for older people
- Governance arrangements of the trial
- Strengths and weaknesses of the trial
- Unintended consequences of the trial.

Once you understand what the project is about and if you agree to take part in it, you will be asked to participate in either a face to face or a telephone interview. You will be asked at the beginning of the interview to acknowledge that you understand the information outlined in this document and that you give your consent to participate in this evaluation project.

4. Possible Benefits

We cannot guarantee or promise that you will receive any benefits from this project. However, your contribution will be used to make improvements to government policy and programs to support the delivery of primary health care to residents in aged care facilities.

5. Possible risk

It is not anticipated that there are any risks associated with your participation in this project.

6. Confidentiality and Disclosure of Information

Any information obtained in connection with this evaluation and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law.

If any information is published as a result of this evaluation, your information will be provided in such a way that you cannot be identified and it will be published in accordance with the Privacy Act 1988.

Only members of the evaluation team will have access to information you provide.

7. Results of Project

Results of this project will be reported to the Department of Health. Any disclosure of the findings of the evaluation will be at the discretion of the Department.

8. Participation is Voluntary
Participation in this research project is voluntary. If you do not wish to take part in this evaluation project you are not obliged to do so. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You will not be penalised in any way if you make a decision to withdraw from the project.

Your decision on whether to take part or not, or to take part and then withdraw, will not affect your relationship with any of the organisations involved.

You can ask for any information you want. Only agree to participate in the interview once you have had a chance to ask your questions and have received satisfactory answers.

9. Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Human Research 2007 (Updated March 2014) as issued by the National Health and Medical Research Council. The National Statement provides the guidelines by which the Department of Health Human Research Ethics Committee and other Human Research Ethics Committees operate.

10. Advice and Information

If you have any further questions regarding this study, please do not hesitate to contact the principal researcher, Dr Kristine Battye. Suite 7, Level 1, 24 Sale Street, Orange NSW 2800. Phone: (02) 6361 4000 or kbattye@kbconsult.com.au

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007)—incorporating all updates.

This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Committee Chair, Bellberry Human Research Ethics Committee 129 Glen Osmond Road Eastwood South Australia 5063. Phone: 08 8361 3222.

Consent Form for Health Professionals and organisational representatives

Evaluation of the Evaluation of Better Health Care Connections Aged Care Multidisciplinary Care Coordination and Advisory Service Trial

I freely agree to participate in this evaluation according to the terms in the Participant Information Sheet which I confirm has been provided to me.

I understand that I am free to withdraw from the evaluation at any stage and that there will be no consequences if I choose to withdraw and that my decision to withdraw will have no effect on my services, care or employment.

The investigator has given the undertaking that my identity and personal details will not be revealed if information about this project is published or presented publicly.

Participant’s Name (printed) ………………………………………………………
Signature………………………………………………….Date......................

Investigator’s Name (printed) ........................................................................
Signature..................................................................................Date..........

Note: All parties signing the Consent Form must date their own signature.
EVALUATION OF BETTER HEALTH CARE CONNECTIONS AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE PROGRAM

Interview Schedule – Aged Care Coordinators

Date of interview:

Interviewer:

Introduction

KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

- The establishment of an Aged Care Multidisciplinary Care Coordination and Advisory Service and
- The establishment of GP video consultations into residential aged care facilities.

The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately 2 hours. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?
Aged Care Coordinators

Development and Implementation of the program

- How did the ACC go about establishing the care coordination and advisory service with GPs, AHPs, RACFs, Hospitals, Community health and Local Health Network?
  - How were RACF sites identified?
  - What were the factors that contributed to RACF participation in the trial?
  - What were the factors that contributed to ACATs/ LHN engaging in the trial?

- How did the ACC go about establishing the GP VC service?
  - How was access to VC equipment organised for GPs and RACFs?
  - What protocols and processes were developed?
  - What training was provided to GPs, RACF staff and others?

- How did the ACC go about recruiting the multidisciplinary teams?

  Topic to cover off:
  - Were there existing teams/links in place between allied health and specialists with RACFs or were new ones established? What were these?
  - Were MD team members, recruited by ACC, available for all participating RACFs in the trial site?
  - What role did the ACC have in recruiting multidisciplinary teams for community aged care recipients?
  - To what extent did community health services engage with the trial? – for the RACFs and Community residents?
  - Was there difficulty recruiting MD team members for specific professions?

GP VC

- How is GP VC being used in the RACFs?
  - Is it substituting for or complementary to F2F consultations? OR telephone advice?
  - When is it being used? Routine, acute issues, after hours, ongoing care management?

What are the characteristics of residents where VC is used?

  - Are there particular conditions, health issues that is suited to/ not suited to?
  - What proportion of residents in each facility participate in GP VC?
  - Have VCs been delivered to Aboriginal and Torres Strait Islander people or those from culturally and linguistically diverse backgrounds?
  - To what extent were VC provided to existing patients v new patients?

What are the characteristics of the GPs participating in VC – age, practice type?

Who usually initiates the Video Consultation?

  - Who organises the VC at the patient end?

To what extent do other professions get involved in VC? E.g. Practice Nurse, Nurse Practitioners, Allied Health?

Multidisciplinary care planning

- How is care planned and coordinated for residents?
  - Who usually initiates the development of care/mental health care plans?
  - What is the trigger for developing care plans? (routine, ED presentation, hospital discharge?)
  - Who leads the planning and coordination? ACC, RACF staff member, GP, Practice Nurse, other?
    - Is anyone paid to plan and coordinate care? Who? How?

- What difference has the trial made to care planning and coordination in RACFs?
• How are post-discharge hospital services coordinated between the GPs and MD team?
• How has this changed compared with before the trial?

To what extent were allied health and medical specialists available/ have adequate capacity to provide multidisciplinary care? What factors facilitated or hindered participation?

Consider:
• RACFs
• Community aged care

Advisory Service (aspect of the Aged care coordination and advisory service)
• What advisory activities did the ACC undertake? To whom were these activities delivered?

Topics to cover off:
• How broad was consultation with providers as part of the advisory service? (public, private, NGO, hospital, community based etc)
• Did the ACC provide advice on Commonwealth/State/private funding for services or initiatives that could support care for older people in residential care or community setting?

Engagement with Community
When reading the BHCC Program Manual it appears that the ACC role includes care coordination and advisory services for aged care recipients – (older people in both residential care and the community):
• What engagement has occurred with ACAT teams and older people living in the community including recipients of home care packages?
• What support has the ACC provided to assist aged care recipients in the community to access multidisciplinary care?

Barriers and Enablers to implementation
• What were the barriers and enablers to implementation of two elements of the trial:
  ▪ Aged care coordination and Advisory Service (RACF and community)
  ▪ GP Video consultation?

Prompts
• GP recruitment and continuation
• Proximity of GPs to RACF
• RACF recruitment and continuation
• Training (GPs and RACF)
• Change management in RACFs and for GPs
• Available staff/time for the RACF to sit on VC
• Logistics
• Legal issues and standards
• Technology availability, quality and maintenance
• Availability/ recruitment of Allied health and medical specialists
• Data collection (e.g. VC logs, care planning, hospital transfers) and reporting.

Did these differ between RACFs within trial sites? How/why?

Reporting and measuring performance
There appears to be variations between trial sites in how some of the PIs have been reported. Please explain how PIs have been interpreted and measured?
• No. staff involved in the multidisciplinary model
• No. Multidisciplinary health care teams
• No. of individual sessions of clients of participating RACFs receiving medical care (following aged care coordinator activity)
• No. of allied health services instances within the RACF (following aged care coordinator activity)

Sustainability
• Would you assess the BHCC program as being successful?
  o What are features of success?
  o What aspects of the trial were beneficial?
• Some RACFs withdrew from the Program. What factors contributed to this?
  o How were new sites identified?

• Are you aware of any unexpected benefits or unintended consequences of the program?

• Have any cost savings been achieved through the care coordination and advisory service and/or GP VC consultations?

• Based on your experience with the trial, do you believe that GP VC is scaleable?

• Are the aged care coordination functions scaleable? (across more sites, other regions)
  • How could these be resourced beyond the life of the trial?

• What aspects of the role do you feel provided the most benefit and should be sustained?

Is there anything else that you have observed that should be highlighted in the evaluation?
EVALUATION OF BETTER HEALTH CARE CONNECTIONS AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE PROGRAM

Interview schedule: General Practitioners and Practice Managers

Date of interview:

Interviewer:

Introduction

KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

- The establishment of an Aged Care Multidisciplinary Care Coordination and Advisory Service and
- The establishment of GP video consultations into residential aged care facilities.

The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately 15-20mins. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?

General Practitioners and Practice Managers (Practice Nurses if involved)

Please describe your general practice model (Seek this information from the Practice Manager)

- Type of practice (solo, group, corporate)
- To what extent does the practice have enhanced primary care systems in place?
  - Register and recall systems
  - Health checks
  - GPMPs
  - Employ a Practice Nurse(s)? Role

What enhanced primary health care systems do you have in place in your practice?

GP Services in RACF

- How do you provide GP services in residential aged care facilities?
- Which facilities do you provide services to?
- What are the challenges of providing care in residential aged care facilities?
- Has any of this changed compared with before trial?

Why did you participate in the trial and what were you hoping would be achieved?

Multidisciplinary care planning and coordination (General Practitioners)

What role do you play in care planning and coordination for your patients in residential aged care facilities?

Prompts:

- Who usually initiates the development of care/mental health care plans?
- What is the trigger for developing care plans? (routine, ED presentation, hospital discharge?)
Who leads the planning and coordination? ACC, RACF staff member, GP, Practice Nurse, other?
Is anyone paid to plan and coordinate care? Who? How?
How does this differ from care planning and coordination for older patients living in the community?

**Role of the Aged Care Coordinator (this might be more relevant to the Practice Manager)**
- What did the ACC do to facilitate the establishment of the GP VC service and care coordination?
- Did the ACC assist you in any way in developing a multidisciplinary team?
- To what extent were referrals to AHPs/specialists a result of ACC activity vs through existing relationships/referral networks?
- Did the ACC provide advice on services, funding or initiatives that may be available to your patients?

**Appropriateness of GP Video consultation**

**How are you using video conferencing with your patients in residential aged care?**

Prompts
- Is it substituting for or complementary to F2F consultations? OR telephone advice?
- When is it being used? Routine, acute issues, after hour

**Are there particular conditions, health issues that is suited to/ not suited to?**

**How well does video consultation fit in the general care of patients in aged care facilities?**
- How did it enhance care for residents?
- Any change in acute events, hospital transfers, admissions?

**How well does video consultation fit with the general practice business model?**

Prompts: remuneration, billing process, 10% admin loading, patient documentation updating, equipment, booking processes)?

**Equipment and Processes (Practice manager)**
- What system do you use? How did you decide on this system?
- What are the strengths and weaknesses of this equipment?
- What processes have been established in the practice to support video conferencing?

**How well does video consultation fit with the general practice business model?**

Prompts: remuneration, billing process, 10% admin loading, patient documentation updating, equipment, booking processes)?

**Linkages (GPs and Practice Manager)**

Do you have any links with other parts of the health and aged care system that you did not have prior to the commencement of the trial? What new links are in place?

Prompts
- Specialists
- Allied health
- Community health (who/how)

**Sustainability (Practice Manager and GPs)**
- How would you assess the success of the BHCC trial?
  - What are the features of success
- Are you aware of any positive spin offs from the trial?
  - Any unintended consequences?

Have any cost savings been achieved through the care coordination and/or GP VC consultations?

Based on your experience with the trial, do you believe that GP VC is scaleable?

Do you think the aged care coordination and advisory service has been beneficial?

What aspects of the service would you continue to use if it were available?
EVALUATION OF BETTER HEALTH CARE CONNECTIONS AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE PROGRAM

Interview schedule: Residential Aged Care Facilities manager and staff

Date of interview:

Interviewer:

Introduction

KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

- The establishment of an Aged Care Multidisciplinary Care Coordination and Advisory Service and
- The establishment of GP video consultations into residential aged care facilities.

The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately 1 to 1.5 hours. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?

Residential Aged Care Facility Managers/ DONs

GP Services
How are GP services currently being provided in your facility?
How does this differ from what occurred prior to the trial?

Allied health and specialist nursing and medical services
- How are allied health services provided in the RACF? (employ their own, +/- inreach)
- How are AHPs funded/paid?

- What is the current mix of allied health and specialist nursing services?
  - Have any of these services been established or enhanced as result of the trial?

- Are there any gaps in AHP or specialist nursing services?

Multidisciplinary care planning and coordination
- How is care planned and coordinated for residents?
Cover off:
- Who usually initiates the development of care/mental health care plans?
- What is the trigger for developing care plans? (routine, ED presentation, hospital discharge?)
- Who leads the planning and coordination? ACC, RACF staff member, GP, Practice Nurse, other?
- What is the role of GPs in care coordination for residents?
• Is anyone paid to plan and coordinate care? Who? How?

• To what extent has the GP VC contributed to development of care plans for residents?
  • What proportion of residents participating in VC had care plans prior to engagement in the trial?
  • What proportion of these plans were GP vs RACF care plans?

• How has care coordination changed as a result of the trial?

Role of Aged Care Coordinator
• What did the ACC do to facilitate the establishment of the GP VC service and care coordination?
  ▪ Did the ACC assist you in any way in developing a multidisciplinary team?
  ▪ Did the ACC provide advice on services, initiatives or funding support that could benefit your residents?

Appropriateness of GP Video Consultation
• How is GP VC being used in the RACF?
  • Is it substituting for or complementary to F2F consultations? OR telephone advice?
  • When is it being used? Routine, acute issues, after hours?

• What are the characteristics of residents where VC is used?
  • Are there particular conditions, health issues that is suited to/ not suited to?
  • What proportion of residents participate in GP VC?
  • Have VCs been delivered to Aboriginal and Torres Strait Islander people or those from culturally and linguistically diverse backgrounds?

• What are the characteristics of the GPs participating in VC – age, practice type?

• Who usually initiates the Video Consultation?
  • Who organises the VC at the patient end?

• To what extent do other professions get involved in VC?

VC Equipment and Process
• What VC system do you use? How did you decide on this system?
• How well has it been working?

What were the barriers and enablers to implementing GP video consultations?
• What supports were provided by the ACC/Trial Manager to establish the system in the RACF?

• What processes have been established in the RACF to support GP video consultations?

Prompts
  o GP recruitment and continuation
  o Training (GPs and RACF)
  o Change management in RACFs and for GPs
  o Available staff/time for the RACF to sit on VC
  o Logistics
  o Legal issues and standards
  o Technology availability, quality and maintenance
  o Recruitment of Allied health and medical specialists
  o Data collection (e.g. VC logs, care planning, hospital transfers) and reporting.

Effectiveness
• To what extent has GP VC enhanced the care arrangements for residents? How?
• Has there been any negative consequences?
• What have been the benefits of the GP VC to the RACF?
• Has there been any negative consequences?

*Key purpose of the trial was to determine if easier/more timely access to GP care and multidisciplinary care could reduce acute events for residents, or reduce ED presentations and avoidable hospitalisations.*

• Do you have any data or evidence of the impact of the **GP video consultations** on health indicators or outcomes for residents?

• Have the **changes to multidisciplinary care arrangements** (if there has been) had any impact on acute events, hospital transfers or hospitalisations? (e.g. access to dementia behaviour management services might have an impact on transfers)

If changes have been observed – check

Could there be other factors/activities that may be contributing to any change in health outcomes for residents?

**Linkages with other parts of the health service system**

Has the **GP VC program** promoted linkages between the RACF and other parts of the health system?

Prefixes

• Medical specialists (which ones)?
• Hospital (how)
• Community Health (who, how)
• Other General Practices (e.g. for residents from other locations?)

Has the **ACC** promoted linkages between the RACF and other services independently of the VC program? Which services? What’s the result?

**Sustainability**

• **How would you assess the success of the BHCC trial?**
  o What are the features of success?
• Are you aware of any **unexpected positive spin offs or benefits** of the trial?
• Has there been the **unintended consequences** of the trial?
• **Have any cost savings been achieved** through the care coordination and/or GP VC consultations?
• Based on your experience do you think that **GP VC is scaleable**?
• **With respect to the Aged Care Coordination role, what aspects of the role provided the most benefit and should be sustained?**
• Do you think these aged care coordination functions scaleable? How could they be resourced beyond the trial?
EVALUATION OF BETTER HEALTH CARE CONNECTIONS AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE PROGRAM

Interview Schedule – PHN/Feros Care CEOs and trial managers

Date of interview:

Interviewer:

Introduction

KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

- The establishment of an Aged Care Multidisciplinary Care Coordination and Advisory Service and
- The establishment of GP video consultations into residential aged care facilities.

The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately one hour. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?
What is the role of the PHN/Feros Care in the provision of aged care and/or promoting access to aged care services?

Prompts
- Service coordination
- Patient care coordination
- System coordination

Do you know how the PHN/Feros was selected as a trial site?

Where does the BHCC trial fit with this role?

Prompts
- Building on existing ACC role
- Meeting needs identified through regional needs assessments
- Supporting GPs and/or AHPs in care coordination and care delivery – RACF and/or community

What is the role of the Aged Care Coordinator?

Sub questions:
- For the role that the Aged Care Coordinator performs with respect to the Aged Care Multidisciplinary Care Coordination and Advisory service, is it appropriate that the ACC is based in the PHN/Feros Care?
- Would the role be more effective in another setting/organisation?

What other agencies/activities promote better aged care coordination in the catchment area?

Sub question
- Are there overlaps between the services offered through the BHCC Program and other services or initiatives in the PHN/Feros Care region?

What enablers or challenges have you encountered in establishing and implementing the:
- Aged care coordination and advisory service?
- GP Video consultations

Sub topics
- Existing services and infrastructure, relationships, partnerships
- Measures to address challenges? How successful were these?

What aspects of the BHCC program were successful?

- Some RACFs withdrew from the Program. What factors contributed to this?
  - How were new sites identified?

Are you aware of any unexpected benefits or unintended consequences of the program?

Based on your experience of the trial do you believe GP Video consultations are scaleable?

Are the aged care coordination functions scaleable?

- How could these be resourced beyond the life of the trial?

What governance arrangements are in place between the PHN/Feros Care and the Department of Health?

- How was the program transitioned from the Medicare Local to the PHN? How did this go?

- Has there been any regular communication from the Dept to the PHN about what is happening through the BHCC program? What it is hoping to achieve?
The PHN/Feros has provided 6 monthly reports to the Department. To what extent do these capture the breadth of work undertaken through the BHCC? Is there activity or outcomes that aren’t reflected in the reports?

To what extent has there been engagement with the LHN and state health department to leverage existing services and initiatives to support the BHCC Aged Care Multidisciplinary care coordination program?

What are the governance or management arrangements in place with the RACFs and GPs?

How well are these working to support the implementation of the trial?

What was the annual budget for the trial in the PHN/Feros Care region?

Were the funds expended as budgeted? If not, why not?

Are you aware of any cost savings being achieved through care coordination and advisory service and/or the VC consultations?

Is there anything else that you have observed that should be highlighted in the evaluation?
EVALUATION OF BETTER HEALTH CARE CONNECTIONS AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE PROGRAM

Interview schedule: Aged Care Facility Residents and Families/carers

Date of interview:

Interviewer:

Introduction

KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

- The establishment of an Aged Care Multidisciplinary Care Coordination and Advisory Service and
- The establishment of GP video consultations into residential aged care facilities.

The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately 30 mins. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?
• How did you hear about the video consultations with GPs? (RACF DON, ACC, GP)
• How often have you used video conferencing with your general practitioner?
• How often do you still see your general practitioner face to face?
• What did you like about using video conferencing?
• How easy was it to talk to your general practitioner using video conferencing?
• What didn’t you like about using video conferencing?
• How could this be improved?
• Do you think you have benefited from videoconferencing with your GP? How?

Thank you for your time
KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

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- The establishment of GP video consultations into residential aged care facilities.

The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately 30-40 mins. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?

Allied health and Medical Specialists

Characteristics of the Practice

Please describe your practice model
Prompts: Type of practice (solo, group, corporate, employed by RACF)
To what extent do you routinely participate in enhanced primary care with GPs?

Services into RACFs

- How do you provide services in residential aged care facilities? employed, referral, sessional?
  - Frequency?

- Which facilities do you provide services to?

- How has this changed compared with before the trial?

- Did the Aged Care Coordinator have a role in linking you into the RACF/ being part of a multidisciplinary team?

- What are the challenges of providing care in residential aged care facilities?

Why did you participate in the trial and what were you hoping would be achieved?

Multidisciplinary care planning and coordination

What role do you play in care planning and coordination for your patients in residential aged care facilities?

If AHP not a key player find out who is?

Topics to cover:
• Who usually initiates the development of care/mental health care plans?
• What is the trigger for developing care plans? (routine, ED presentation, hospital discharge?)
• Who leads the planning and coordination? ACC, RACF staff member, GP, Practice Nurse, other?

How does this differ from care planning and coordination for older patients living in the community?
• Prompt: Different initiators (GP in community v RACF)? Method of remuneration?

Role of the Aged Care Coordinator
• What did the ACC do to facilitate the establishment of the multidisciplinary care team and care coordination?
• Did the ACC assist you in any way in being part of a multidisciplinary team?
• Did the ACC provide advice on funding, initiatives or services that may be available to your patients?
• What difference has the Aged Care Coordination and Advisory service made to the provision of GP and Allied health services into RACFs? Has your engagement with the ACC increased your provision of services in RACFs?
• What difference has the Aged Care Coordination and Advisory service made to the provision of GP and Allied health services for older people living in the community?

Appropriateness of GP Video Consultation
• Are you aware of the GP VC being used in the RACF?
• Have you provided services to patients from referrals following GP VC consultations?
• To what extent do you or other professions get involved in VC?

Effectiveness
RACFs
• To what extent has the care coordination advisory service enhanced care arrangements for residents? How?
• Are there other factors/activities that may be contributing to any change in care arrangements for residents?
• What are the strengths and weaknesses of the care coordination and advisory service for the resident?

Home care packages /community
• To what extent has the care coordination advisory service enhanced care arrangements for Home care recipients? How?
• Are there other factors/activities that may be contributing to any change in care arrangements for aged care recipients?
• What are the strengths and weaknesses of the care coordination and advisory service for the home care recipient?

Linkages
Has the AHP developed linkages with other parts of the health and aged care sectors that weren’t in place before the trial?

Prompts
• Has the Aged care and advisory service promoted linkages for the AHP with:
  • Medical specialists (which ones)?
  • Hospital (how)
  • Community Health (who, how)
  • Other General Practices (e.g. for residents from other locations?)
• Has the GP VC promoted linkages for the AHP with:
  • Medical specialists (which ones)?
Hospital (how)
Community Health (who, how)
Other General Practices (e.g. for residents from other locations?)

**Sustainability**

- **How would you assess the success of the BHCC trial?**
  - What are the features of success
- **Are you aware of any positive spin offs from the trial?**
  - Any unintended consequences?
- **Have any cost savings been achieved through the care coordination and/or GP VC consultations?**
- **Do you think the aged care coordination and advisory service has been beneficial?** (Prompt - for whom? Resident, RACF, health and aged care sectors)
- **What aspects of the service would you continue to use if it were available?**
- **Do you believe the GP VC has been beneficial?** (Prompt - for whom? Resident, RACF, health and aged care sectors)
EVALUATION OF BETTER HEALTH CARE CONNECTIONS AGED CARE MULTIDISCIPLINARY CARE COORDINATION AND ADVISORY SERVICE PROGRAM

Interview schedule: LHN personnel – ACAT, Directors of Aged Care and Rehab, Directors of ED, Community Health

Date of interview:

Interviewer:

Introduction

KBC Australia has been commissioned by the Department of Health to evaluate the Better Health Connections Aged Care Multi-disciplinary Coordination and Advisory Trial. The trial was developed to address barriers for GPs to providing timely services to residential aged care facilities and to increase the delivery of multidisciplinary care for aged care recipients by GPs, nurses, allied health, medical specialists and aged care providers. As you are aware the two key interventions were:

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The Department of Health is seeking to assess the implementation of the trial and the appropriateness, effectiveness and efficiency of the trial interventions, with the findings from the evaluation to inform future government policy.

Thank you for agreeing to participate in this interview. I anticipate the interview will take approximately 30-40 mins. You have been provided with a Participant Information Sheet and Consent Form. Have you read and understood these documents?

Do you have any questions before we begin?

LHN personnel – ACAT, Directors of Aged Care and Rehab, Directors of ED, Community Health

Engagement

- To what extent are you aware of the Better Health Care Connections trial?
- What has been your engagement with the trial?
- Are you aware of other parts of the LHN that have been involved in the trial?

Interface between hospital and RACFs

A key purpose of the trial was to determine if easier/more timely access to GP care and multidisciplinary care could reduce acute events for residents, or reduce ED presentations and avoidable hospitalisations.

- What proportion of presentations to LHN hospitals of people over 65 are from residential aged care facilities?
- Do you have any data or evidence of the impact of the GP video consultations on health indicators or outcomes for residents?
- Have the changes to multidisciplinary care arrangements (if there has been) had any impact on acute events, hospital transfers or hospitalisations? (e.g. access to dementia behaviour management services might have an impact on transfers)

If changes have been observed – check

Could there be other factors/ activities that may be contributing to any change in health outcomes for residents?
Linkages

- What linkages have been established between the Aged Care Coordination and Advisory service, residential aged care facilities and LHN to support care coordination prior to and post discharge from hospital?

- What have been the outcomes/benefits of these?

- What linkages are there between the LHN and aged care facilities for specialised aged care services (e.g. continence, dementia)? To what extent has the Better Health Care Connections trial facilitated these?

- What have been the outcomes/benefits of these?

Interface between ACAT/Community Health and BHCC

- What linkages have been established between the Aged Care Advisory Service, ACAT and/or the LHN community services to enhance multidisciplinary care for home care package recipients?

- What have been the outcomes/benefits of these?
## Medicare Local Performance Indicator analysis

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Targets (range)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of RACFs involved in the model</td>
<td>2-4</td>
<td>Numbers of facilities varied across the time period as facilities joined or dropped out</td>
</tr>
<tr>
<td>Percentage of urban/regional split</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of staff and percentage of time employed as the Aged Care Coordinator (ACC) (staffing must ensure there is an FTE ACC position)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number of staff involved in the multidisciplinary model (aged care and health, not including ACC)</td>
<td>Up to 50</td>
<td>Sites reported variously:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Numbers (ranging from 1-30) with no explanation of who is counted in this number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ML program staff, RACF staff, consultants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RACF managers only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of staff in each RACF participating in VC</td>
</tr>
<tr>
<td>Number of multi-disciplinary health care teams (providing complex care to clients of participating RACFs)</td>
<td>Up to 10</td>
<td>Sites reported variously:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Already established services contracted or employed by RACFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Numbers (ranging from 1-30) with no explanation of who is counted in this number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Average number of allied health sessions per week per facility</td>
</tr>
<tr>
<td>Decline in acute events, emergency admissions and hospitalisation</td>
<td></td>
<td>Mostly reported as subjective information relating to the initiative</td>
</tr>
<tr>
<td>Number of clients of participating RACFs receiving care through the project –</td>
<td>Up to 1,200 per year</td>
<td>Sites reported variously:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Total number of beds across all facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Residents participating in VC</td>
</tr>
<tr>
<td>Postcodes across which service delivery occurs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>Targets (range)</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of meetings the ACC has with GPs, specialists, allied health providers</td>
<td>Up to twelve a year</td>
<td>Sites reported variously:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Regional committee meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Meetings with RACF staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CPD events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Monthly meetings with GPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Meetings with specific allied health/specialists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• GP education session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Networking meetings</td>
</tr>
<tr>
<td>Type and number of allied health services coordinated by the ACC</td>
<td>Up to 10</td>
<td>Sites reported variously:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Already established services contracted or employed by RACFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Difficult to report given RACFs already have to provide allied health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Listed types of allied health provided in RACFs</td>
</tr>
<tr>
<td>Number of GPs participating</td>
<td>Up to Twenty</td>
<td>Numbers of GPs has fluctuated across the project so difficult to analyse across reports</td>
</tr>
<tr>
<td>Number of GP consultations via video consultation</td>
<td>Up to 300 per residential aged care facility per year</td>
<td>Only some sites/facilities able to provide this information</td>
</tr>
<tr>
<td>Percentage of videoconferencing consultations as a proportion of total consultations by GPs to clients in the facility/facilities</td>
<td>As identified in the Activity work plan 20%</td>
<td>Percentage differed between RACFs, but this PI implies site level reporting</td>
</tr>
<tr>
<td>Number of referrals by GPs to specialists and other health services</td>
<td>As identified in the Activity work plan</td>
<td>Facilities reported variously:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to report as referrals made by RACFs not by ACC</td>
</tr>
<tr>
<td>Number of hospital transfers through referrals by GPs conducting videoconferencing</td>
<td>As identified in the Activity work plan</td>
<td>Predominantly reported as subjective information relating to the initiative as this information not collected routinely on GP data logs</td>
</tr>
<tr>
<td>Total value of GP claims</td>
<td>Up to $24,000 (including GST) per year</td>
<td></td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>Proposed target -</td>
<td>Achievement against target</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of RACFs involved in the model</td>
<td>Four (maximum)</td>
<td>Numbers of facilities varied across the time period as facilities joined or dropped out</td>
</tr>
<tr>
<td>Number of staff involved in the multidisciplinary model</td>
<td>50</td>
<td>Sites have variably reported:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No data because facilities provide allied health – not due to BHCC activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Single number with no explanation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- BHCC PHN program staff numbers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- RACF contracted allied health providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- RACF staff and GPs involved in VC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Services contracted or employed by RACFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Community allied health providers identified for in-reach care pathway</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Specialists identified as telehealth capable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Avoidable hospitalisation pathway clinicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- RACF managers and allied health professionals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- All staff involved including GP practice staff, RACF managers and staff, non-pilot facility staff PHN, community stakeholders</td>
</tr>
<tr>
<td>Number of multi-disciplinary health care teams</td>
<td>10</td>
<td>Sites have variably reported:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lists of allied health types of services provided (not clear if additional for what provided by RACFs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Single number with no explanation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Numbers participating in various programs (advanced care, dental)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Services contracted or employed by RACFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sessions provided by practitioners at RACFs following training delivered by trial managers</td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>Proposed target</td>
<td>Achievement against target</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| **Number of individual sessions of clients of participating RACFs receiving medical care service** (following aged care coordinator activity) | Up to 1200 | Sites have variably reported:  
  - Total number of residents in participating facilities  
  - Number of GP video consultations  
  - Participation of health professionals in HealthPathways  
  - Single number (0) with no explanation  
  - Pie chart of allied health services  
  - Not easy to report as ACC does not deliver care  
  - Individual multidisciplinary care events |
| **Number of meetings held by aged care coordinator with general practitioners, allied health and specialist providers** | 12 per annum | Sites have variably reported:  
  - Stakeholder meetings  
  - Aged care advisory council meetings  
  - Single number with no explanation  
  - Weekly or fortnightly meetings with RACFs to support VC  
  - Meetings with allied health providers, specialists  
  - Meetings with GPs  
  - Training sessions |
| **Number of allied health services instances within the RACF** (following aged care coordinator activity) | 50 | Sites have variably reported:  
  - As per above – facilities contract services, ACC has an advisory role only  
  - Unable to report  
  - VC which involved referral to allied health  
  - Single number with no explanation  
  - Increase in allied health services in line RACGP Silver Book – in particular contribution to care plans  
  - Lists of support provided by ACC to RACFs to access individual services  
  - Training for care staff  
  - Allied health video consultations |
<p>| <strong>Number of specialist services referrals within the</strong> | 40 | Sites have variably reported: |</p>
<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Proposed target</th>
<th>Achievement against target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACF (following aged care coordinator activity)</td>
<td></td>
<td>• Unable to report as referrals made through RACF systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Single number with no explanation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Difficult to report so based on the information provided by RACFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Specialist video consultations</td>
</tr>
<tr>
<td>Number of GPs participating in the trials</td>
<td>20</td>
<td>Numbers of GPs has fluctuated across the project so difficult to analyse across reports</td>
</tr>
<tr>
<td>Number of GP consultations undertaken via video link</td>
<td>250 per RACF, per annum</td>
<td></td>
</tr>
<tr>
<td>Total value of GP claims per participating RACF</td>
<td>Up to $24,000 (incl. GST) per year</td>
<td></td>
</tr>
<tr>
<td>Decline in acute events, emergency admissions and hospitalisations</td>
<td>Measure the percentage of any decline</td>
<td>Sites have variably reported:</td>
</tr>
<tr>
<td>(following aged care coordinator activity)</td>
<td>observed, identify trends.</td>
<td>• Estimation based on video logs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No events recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Data collected by project, including based on reflective practice between ACC and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>clinical teams discussion post hospitalisation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Estimates provided based on information provided by GPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Data on hospital transfers in each facility</td>
</tr>
</tbody>
</table>
Appendix 4 – Primary Care Gold Coast Cycle of Care

GP Steps - New Admission to RACF

The Residential Aged Care Facility (RACF) will spend the first 5 weeks preparing a Multidisciplinary Care Plan, and submitting ACFI Validation for the appropriate level of funding required caring for the resident. The following is a suggested routine for the GP to manage a new admission.

Day 1

- Medication Chart: The new resident may have a medication chart that can be used for a few days if admitted from an Acute Hospital or possibly when transferred from another RACF. Residents admitted from home will need a medication chart written on the day of admission.

Day 1

- Quick Medical Review, Client information entered into Practice Software

Week 1

- Transfer of Medical Records: Practice to arrange for transfer of resident medical records

Week 1

- RACF to send to Practice required documentation NOK, MPOA, Advanced Health Directive (if the resident has one)

Week 2

- Commence time based CMA in consultation with RACF plan Case Conference, including the Resident, Resident’s support network, RACF staff and Allied Health Professional or other Multidisciplinary Care team members. RACF to advise family that Advance Care Planning will be discussed during the Case Conference

Week 3-4

- Case Conference - Advance Care Plan discussed utilising recognised documentation (eg: Statement of Choices)

Week 3-4

- Contribute to Care Plan

Week 5-6

- Complete time based CMA

Week 5-6

- Refer resident for RMR in consultation with the Pharmacist
## Appendix 5 – Example of GP Video Consultation Log

<table>
<thead>
<tr>
<th>Column in electronic log</th>
<th>Definition</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACF Name</td>
<td>Name of the participating RACF hosting the video consultation</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Date video consultation is being provided</td>
<td></td>
</tr>
<tr>
<td>Start Time</td>
<td>Time video consultation commenced</td>
<td></td>
</tr>
<tr>
<td>End Time</td>
<td>Time video consultation concluded</td>
<td></td>
</tr>
</tbody>
</table>
| Patient need             | This is a general indicator of the resident’s need to access a GP. Responses include:  
  - Episode/event based care need  
  - Ongoing/Chronic health issues  
  - Falls Management  
  - Wound Management  
  - Care Planning  
  - Other (please specify in comments)  
  Where the resident's need is described as other, please provide a short description of the need under comments. This will allow for fine tuning of the log over the course of the pilot and assist in understanding the scope of services that can be provided via video consultation. |
| Consultation Type        | This is a general indicator of the type of consultation the GP will provide. Responses include:  
  - Initial consultation  
  - Follow up consultation  
  - Progress review  
  - Medication review  
  - Other (please specify in comments)  
  Where the consultation type is described as other, please provide a short description of the consultation under comments. This will allow for fine tuning of the log over the course of the pilot and assist in understanding the scope of services that can be provided via video consultation. |
<p>| Appropriate Connection Speed? (Y/N - if no please comment) | |
| Appropriate Audio connection? (Y/N - if no please comment) | |
| Technical Issues (Y/N - if Yes please comment) | |
| Quality of video         | This is a general indicator of the | This item is looking at the utility of the video |</p>
<table>
<thead>
<tr>
<th>Column in electronic log</th>
<th>Definition</th>
<th>Other information</th>
</tr>
</thead>
</table>
| consultation compared to face-to-face consultation | quality of the video consultation based on the environmental factors associated with this type of service. Responses include:  
• Better  
• Equal to  
• Sufficient for the need  
• Less than  
• Unsuitable | conference experience relative to a similar consultation provided face-to-face. It is not intended to reflect on the service provided |
| Comments | Use this column to provide any further comments regarding the video consultation, especially where the comments allow for greater understanding of the pilot and/or provide an opportunity to fine tune the initiative |