PRIMARY HEALTH NETWORK

phn HUNTER NEW ENGLAND AND CENTRAL COAST

An Australian Government Initiative

Rebbeck

Internal consultation

HNECC Palliative and Aged Care

Integrated care consultation

May 2023

Internal consultation

Agenda

01 Key questions

02 Our approach

03 Needs of Older People

04 Prioritisation

05 Recommendations for implementation

06 Questions

Key questions

What are the **integrative models of care** delivered in the **home** for **older people** (over 65yrs or over 50yrs for First Nations) with **complex needs**

Who was our target population?

Patients over 65yrs (or 50Yrs for First Nations)

What health issues did we investigate?

- Palliative Care Older people's health (greater than 65 years of age, or greater than 55 for First Nation people)
- After hours care
- Prevention of chronic disease

What did we hope to achieve?

Recommendations for models of integrated care which address unmet needs, and/or address an increase in trend of needs in the community

Approach

Current state

We identified the current needs of older people by conducting desk-based research, reviewing HNECC older persons program strategy documentation and consulting with stakeholders within HNECC PHN

Market scan

We reviewed the commissioned services provided by HNECC PHN to identify gaps in services. This allowed us to develop an understanding of the unmet needs of older people in the region

Initial prioritisation

We conducted a rapid prioritisation / screening of the unmet needs to inform the horizon scan

8 unmet needs were identified

Horizon scan

For each of the unmet needs, we researched and produced a list of best practice models of care with supporting evidence

25 need-model pairs were produced

Prioritisation

We prioritised the need-model pairs according to a defined criteria for size, severity and effectiveness

6 needs and models of care were prioritised

Report

The report includes implementation recommendations of the 6 identified models of integrated care which address older people's needs

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Unmet needs

The following needs were identified as important for older people's health in the HNECC region (1/2)

1		Older people in the HNECC region living with complex health needs, social care needs, and/or deteriorating health have higher ED presentations and higher preventable admissions than older people elsewhere in Australia. Services for clinical and transitional care coordination exist, but a significant service gap has been identified at 50-80%
2	A	Older people in the HNECC region experience greater rates of chronic disease contributing to earlier death and reduction in DALYs
	B	Older First Nations people in the HNECC region experience greater rates of chronic disease, contributing to earlier death and reduction in DALYs
3	A	Older people with dementia experience changes in mood, cognition, physical activity and social settings. This affects their ability to live independently, socialise, remain with family or community and maintain medication routines, nutrition & physical health, resulting in reduced DALYs and earlier death
	B	First Nations people in the HNECC region experience increased risk factors for dementia and higher rates of dementia, resulting in earlier death and a greater reduction in DALYs. Eleven services offer support for older people's mental health. The service gap is estimated at between 50-80%
4		Patients who require palliative care experience delayed interventions, specifically low referrals for over 65-year-olds with a diagnosis of dementia and non-malignant, life-limiting disease. There is a lack of data on the extent of the problem (though research is ongoing), and a highly significant service gap has been identified (80-100%)

The following needs were identified as important for older people's health in the HNECC region (2/2)

5	Older people experience grief, bereavement, and poorer mental health due to the loss of loved ones, changes in community and residential settings and social isolation. Eleven services offer support for older people's mental health. The service gap is estimated at between 50-80%
6	Older people in aged care facilities and men over 80 years experience poorer mental health and are at high risk of suicide. Eleven services offer support for older people's mental health. The service gap is estimated at between 50-80%
7	Older people in the HNECC region experience higher cancer incidence and mortality
8	Aboriginal and Torres Strait Islander People and patients in RACFs needing after-hours GP care experience poor management of care

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We prioritised the needs and models of care in three steps

Step 1
Need-model pairs

The eight needs were each mapped to different models of care from the Horizon scan

Step 2
Score calculation

- Four assessors scored each need-model pair against a defined criteria of size, severity and effectiveness
- We calculated the score for each need-model pair

Need	Size	Severity	Model of Care	Effectiveness	Score
Need 1	7.25	7.25	Model 1.1	4.25	92
			Model 1.2	4.25	92
Need 2 A	7.5	7.5	Model 2A.1	7	158

Step 3
Rank and prioritise

We ranked the need-model pairs according to their scores

Ranked Needs Against Models		
Need	**Model of Care**	**Score**
Need 1	Model 1.3	158
Need 2 A	Model 2A.1	158
Need 3 A	Model 3A.1	149
Need 3 A	Model 3A.2	146

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Priority 1: Home-based care

Need 1

Older people in the HNECC region living with complex health needs, social care needs, and/or deteriorating health have higher ED presentations and higher preventable admissions than older people elsewhere in Australia. Services for clinical and transitional care coordination exist, but a significant service gap has been identified at 50-80%

Model 1.3: Home-based care

Home-based care is an intermittent care model focused on providing support in an older person's home or care home if that is where they normally live

Goals

- Avoid hospital admission
- Support faster recovery from illness
- Timely discharge from hospital
- Support independent living

Who it involves

- Predominantly delivered by health professionals
- Might involve:
  - nurses
  - physiotherapists
  - occupational therapists

Stages

1. Assessment by health professional
2. Goal planning
3. Provision of identified support
4. Transition to community services

Priority 1: Home-based care implementation

To implement the home-based care service model in the HNECC region, we recommend that the PHN considers a **pilot.**

The pilot would include:

- 20-30 participants
- Participants will be referred to the service, where they will receive home-based care for up to 6 weeks (depending on their goals and progress).
- The pilot will run for approximately 4-6 months.

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Priority 2: Guided Care®

Need 2A

Older people in the HNECC region experience greater rates of chronic disease contributing to earlier death and reduction in DALYs

Model 2A.1: Guided Care

The Guided Care® model includes integrating a Guided Care nurse into a primary care practice.

Goals

The Guided care nurse works with 2 to 5 physicians and other care team members to provide coordinated, patient-centred, cost-effective health care to chronically ill patients.

Role of Guided Care nurse

The nurses coordinate care, monitor patients and teach patients and families self-management skills, including identifying deteriorating symptoms that can be addressed before unnecessary admission to the emergency department.

Priority 2: Guided Care® implementation

To implement the Guided Care® model in the HNECC region, the PHN could consider offering **small grants** to general practices to upskill their nurses in care coordination, such as to become Guided Care nurses.

- General practice would enrol their nurses into The Guided Care Nursing course offered by John Hopkins Nursing.
- The course is made up of 20 core courses and 19 clinical courses and is delivered online.

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Priority 3: Oxleas Advanced Dementia Care Service

Need 3A

Older people with dementia experience changes in mood, cognition, physical activity and social settings which affect their ability to live independently, socialise, remain with family or community and maintain medication routines, nutrition & physical health. This results in reduced DALYs and earlier death.

Model 3A.1: Oxleas Advanced Dementia Care Services

Goals

- Support people to live at home for as long as possible in the last year of life with support from family and/or caregivers
- Support the carer and/or family to provide palliative care

Who it involves

- The service's core team includes a psychiatrist who works closely with specialist nurses called ***community matrons***.
- These are care coordinators responsible for liaising with community mental health services and general practitioners to provide care in a patient's home.

Priority 3: Oxleas Advanced Dementia Care Service implementation

We recommend that HNECC PHN **commissions programs and services** to support the care of dementia patients within the community through care coordination of teams

The PHN should consider selecting a service provider with a wide range of skilled and experienced local health care workers including:

- dementia carer support workers
- senior mental health clinicians
- allied health physicians
- primary health care nurses

The provider should have previous experience providing support to dementia carers to assist them in caring for dementia patients.

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Priority 4: Geriant

Need 3A

Older people with dementia experience changes in mood, cognition, physical activity and social settings which affect their ability to live independently, socialise, remain with family or community and maintain medication routines, nutrition & physical health. This results in reduced DALYs and earlier death.

Model 3A.2: Geriant

The Geriant model provides community-based care services for people suffering from dementia.

Goal

Provide clients and their caregivers with care and support from the first presumption of dementia (based on a GP referral) until the client moves to a care home or dies.

Services offered

- Diagnostics
- Clinical case management
- Treatment

Who it involves

- Multidisciplinary dementia care teams
- Collaboration with network partners, including GPs, hospitals, care homes, nursing homes, home care and social care organisations

Priority 4: Geriant implementation

We recommend that HNECC PHN **commissions programs and services** to support the care of dementia patients within the community through care coordination of teams

The PHN should consider selecting a service provider with a wide range of skilled and experienced local health care workers including:

- dementia carer support workers
- senior mental health clinicians
- allied health physicians
- primary health care nurses

The provider should have previous experience providing support to dementia carers to assist them in caring for dementia patients.

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Priority 5: Re-ablement

Need 1

Older people in the HNECC region living with complex health needs, social care needs, and/or deteriorating health have higher ED presentations and higher preventable admissions than older people elsewhere in Australia. Services for clinical and transitional care coordination exist, but a significant service gap has been identified at 50-80%

Model 1.4: Re-ablement

Goals

- Help older people recover their skills
- Improve older people's confidence
- Maximise older people's level of independence
- Support ongoing homecare needs

Who it involves

- A mix of health and social care professionals with various skills provide the service
- The team might include nurses, social workers, doctors and a range of therapists

Stages

1. Assessment by health professional
2. Goal planning
3. Provision of identified support
4. Transition to community services

Priority 5: Re-ablement implementation

To implement the re-ablement care service model in the HNECC region, we recommend that the PHN considers a **pilot.**

The pilot would include:

- 20-30 participants
- Participants will be referred to the service, where they will receive home-based care for up to 6 weeks (depending on their goals and progress).
- The pilot will run for approximately 4-6 months.

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Priority 6: Chronic and complex disease management programs

Need 2B

Older First Nations people in the HNECC region experience greater rates of chronic disease, contributing to earlier death and reduction in DALYs

Model 2B.1: Chronic and complex disease management programs

The Walgan Tilly Project

The Walgan Tilly Project: Chronic Care for Aboriginal People Model highlights 8 fundamental elements for chronic disease management in First Nations communities. These are: Trust, Screening and Assessment, Clinical Indicators, Treatment, Education, Referral and Follow up.

Integrated Team Care (ITC) Program

The ITC program supports First Nations people who live with complex chronic conditions. It connects patients with care coordinators, First Nations outreach workers, supplementary services and social supports.

The Too Deadly for Diabetes Program

A 10 week program aimed at promoting good nutrition, physical activity, weight loss, and lower blood glucose levels for First Nations people with diabetes. The program includes tailored meal and exercise plans, education and motivation factors.

Priority 6: Chronic and complex disease management programs

To implement the chronic and complex disease management program models in the HNECC region, we recommend that the PHN **implements elements into existing programs / services that focus on care coordination and chronic disease management.** The three programs below all involve essential elements that target chronic and complex disease management for First Nations communities.

The ITC program and the Walgan Tilly model of care share similar characteristics, including the workforce structure, the importance of prevention and education and engagement with the First Nations community. However, the ITC program focuses more on complex chronic disease conditions. **Care coordination** is an important element in both models and improving health outcomes for First Nations people with chronic conditions. The funding for the ITC program is currently uncertain, but it is an effective program for managing complex chronic disease cases.

The Too Deadly for Diabetes Program is an effective **preventative and management** program for First Nation communities.

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Summary of recommendations

Priority 1
Model 1.3: Home-based care

Priority 2
Model 2A.1: Guided Care

Priority 3
Model 3A.1: Oxleas Advanced Dementia Care Services

Priority 4
Model 3A.2: Geriant

Priority 5
Model 1.4: Re-ablement

Priority 6
Model 2B.1: Chronic and complex disease management programs

Considerations for implementation

- Is this recommendation **feasible**?
- Do we believe we have the **appropriate infrastructure** (i.e. workforce, technology etc.)?
- Do we believe there will be an **interest** and **willingness to adopt** the model of care?
- Are there any **partnerships** we need to form that will benefit the implementation?
- What **role** can HNECC PHN play to support the implementation of the model of care?
- What **other factors** do we need to consider?

Questions

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