Senate Community Affairs References Committee

Submission to the Inquiry into Aged Care

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This submission refers to one of the Inquiry's Terms of reference, i.e., (e) The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

It is submitted by the Queensland Divisions of General Practice (QDGP). QDGP is the State based organisation for divisions of general practice in Queensland. Established in 1997, QDGP promotes the central role of general practice in primary health care by ensuring that key stakeholders and general practice work together in a supported environment.

Divisions of General Practice are local networks of General Practitioners, established in 1992 by the Commonwealth Department of Health and Ageing to promote the central role of general practice within the wider health system. There are 119 Divisions of General Practice throughout Australia, with 19 of these situated in Qld.

General Practice and Aged Care

Like the experience of the Aged Care Sector, the past decade has been one of significant and sustained reform for General Practice in Australia. These changes have spanned workforce issues, General Practice financing and structure, accreditation, as well as information management and technology.

The continued funding of the Divisions of General Practice Program has created valuable opportunities for General Practitioners to link with other parts of the health and aged care system. In particular, Divisions are increasingly focussed on the importance of improved linkages and collaboration with other primary care services and providers to facilitate a stronger and less fragmented primary care sector. Whilst some linkages have always existed between General Practitioners and the Aged Care sector at a local level, new initiatives between Divisions and the Residential and Community Care sector (for example, the Strengthening Medicare Aged Care General Practitioner Panels Initiative) are creating new roles and opportunities for partnership.

The Divisions of General Practice Program also has a focus on vertical integration across health settings, better links with hospitals, and improved horizontal integration within sectors. Initiatives such as Enhanced Primary Care (EPC), More Allied Health Services (MAHS), and Strengthening Medicare have helped to reinforce the importance of strong linkages and to reconsider the role of general practice.

New and emerging roles for General Practice

At a primary care level:

- GP as collaborator, multidisciplinary team member
- GP as coordinator and planner of patient care
- GP as partner with patient/consumer and family

At a Division level:

- GP as change agent of health system
- GP as clinical leader
- GP as partner with other key health and community service providers, including residential and community services

The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community

Main Issues Identified from a GP perspective

- coordination of care issues, such as communication between health professionals (eg between GPs and hospitals, and GPs and residential and community care providers) that is required for effective transition and continuing service delivery;
- the availability of allied health professionals to support GPs and aged care facilities in the care of older people following an acute hospitalisation.
- communication between patients/residents, health professionals, and other relevant stakeholders (in residential and community settings)
- enhancements to the means of communicating electronically between general practitioners and the residential and community care sectors
- patient discharge planning from hospital to residential care and/or the community, eg hospitals need to inform GPs of patient discharge after acute illness, or of the details of hospital care which might pertain to the resident's/patients' effective follow-up; and unclear or inadequate discharge summaries that need to inform care provision in residential and community settings.
- Insufficient remuneration and time for GPs in aged care homes (ACHs)
- Availability of key ACH staff at critical junctures
- The need for medication management arrangements to be clearly documented and communicated to all stakeholders
- Documentation and record management generally
- Further training in geriatric care for GPs and ACH staff

Potential solutions:

Communication/information provision

- develop and implement more widely initiatives such as the Continuity of Care Planning Framework for Qld (copy attached as a PDF file), in consultation with Divisions of General Practice and other community-based groups, aimed at improving communication and information transfers between GPs, hospitals and residential and community care services.
- Safeguard information transfer between GPs and hospitals, addressing consumer issues such as access, security and confidentiality.
- Provide information to consumers about the role of GPs and other health professionals in their ongoing care in the community or residential setting.

Structural/procedural changes

- Further mechanisms to enhance the GP/hospitals interface should be considered in consultation with Divisions of General Practice, hospitals, and the aged and community care sector, e.g., GP liaison officer.
- Consideration should be given to establishing special procedures and protocols for potential high risk patients/residents
- Mechanisms to improve information dissemination, avoid resource duplication (eg tests, investigations), inform stakeholders about transition care policy and practice issues, and promote strategies for change

Useful documents to inform further activity by the Commonwealth and State and Territory Governments.

Because for the significance of this issue and its interrelationship with Commonwealth and State and Territory programs and funding arrangements, QDGP considers that the work undertaken for the Australian Health Ministers' Advisory Council Working Group on the Care of Older Australians provides a useful context for further work in this area. These reports include:

1. *Mapping of Services at the Interfaces of Acute and Aged Care.*
2. *Service Provision for Older People in the Acute-Aged Care System*
3. *Examination of Length of Stay for Older Persons in Acute Care and Sub-Acute Sectors.*
4. *AIHW Feasibility Study on linking hospital morbidity and residential aged care data to examine the interface between the two sectors*.
5. *Report to the Australian Health Ministers' Conference from the Australian Health Care Reference Group*

These reports advocate for a significant improvement in the effectiveness of services. They also argue for an irreducible diversity of services affecting the flows between acute and aged care services. Notwithstanding this, however, several common features are identified:

- Continuity of care characterized by vertical integration (of primary, community, acute, sub-acute, transition and aged care) and horizontal

integration (for example, among community care services such as respite care, nursing services, personal care);
- Assessment links among ACATs, geriatric medicine and community care services;
- Effective discharge planning among the primary, community, acute, sub-acute, transition and aged care sectors;
- Quick response times;
- Widespread use of care planning/case management approaches;
- Effective support to unpaid carers and their families; and
- Carer and client-centred decision-making.

4. Conclusion

Gaps in the effectiveness of current transitional care arrangements have been reviewed and documented extensively. They are evident across all sectors, including primary, community, acute, sub-acute, transition and aged care. These gaps are a continuing barrier to realising optimal care and health outcomes for older Australians.

It is also important to note that achieving more effective transitional care cannot be done within current funding levels nor by existing programs. Providing coordinated, quality services will require new ways of thinking and additional funds.

[Attachment: Continuity of Care Planning Framework: The Continuity of Care Planning Framework has been developed by the General Practice Advisory Council Qld (GPAC) and outlines best practice in the continuity of care planning process.

Frameworkfor web.pdf