ACI NSW Agency for Clinical Innovation

Regional Aged Care Hospital Avoidance Compendium Report (Rural and Metropolitan)

At a Glance 2014

"We are making great strides in ensuring that people in rural and regional areas receive the right care, at the right time, and in the right place".

The Hon. Minister Skinner, NSW Rural Health Plan – Towards 2021

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ABOUT ACI

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

- **Service redesign and evaluation** – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services.
- **Specialist advice on healthcare innovation** – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment.
- **Initiatives including Guidelines and Models of Care** – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system.
- **Implementation support** – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW.
- **Knowledge sharing** – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement.
- **Continuous capability building** – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

EXECUTIVE SUMMARY

Older people require emergency care more often than other population groups, have higher admission and readmission rates and account for greater than 60% of hospital admissions with many at risk from hospitalisation itself, particularly delirium and falls (1). Older people who become acutely unwell in Community Based or Residential Aged Care Facilities (RACF) are a considerable proportion of Emergency Department (ED) presentations. A number of studies have found that for certain disorders or comorbidities, effective treatment does not necessitate presentation to ED from the RACF or community and can potentially be prevented. For example, those with acute infections treated in their residence have similar or better survival and fewer complications compared to those transferred to hospital for treatment, even accounting for severity. A gap exists in emergency care support for residents in the community or RACF to access acute care without transportation to the hospital EDs.

To alleviate the pressure on hospitals, there has been significant progress aimed at improving access to the right care, at the right time, in the right place; to receive the care needed anywhere across the NSW Health System (Regional and Metropolitan). These include strategies for hospital avoidance, reduced readmissions, shorter length of stay and community based approaches. It is evident that there can be no "one size fits all" hospital avoidance strategy across NSW, as every town is different. In an attempt to close (or reduce) the gap, there have been numerous programs and partnerships established across NSW, and adapted to meet local need.

Some programs have been developed in isolation; building partnerships and workforce models between local aged care service providers, NSW Ambulance and acute care services within a Local Health District (LHD). Some programs have engaged Private / Public partnerships to share resources. Some programs have been introduced in a systematic way across the state using blended funding models and service agreements and others are at the research or developmental stage, with some being piloted.

An Agency for Clinical Innovation (ACI) Rural Health Network working party has developed a Compendium of current established Aged Care Hospital Avoidance strategies as a 'one stop shop' for service providers to review a sample of the diverse range of innovative programs across the state when considering options which might meet local need. The strategies presented in this Compendium represent a synthesis and analysis of options (metropolitan and regional); listing programs, resources and partnerships required for implementation and sustainability, including key stakeholder contacts and websites for further information.

For the purpose of this report:

- The term 'Regional' will be defined as the *geographical location outside the metropolitan areas of Sydney, Newcastle and Wollongong.*
- The term 'Aged Care' will include *persons 65 years and above residing at home or in community based or Residential Aged Care Facilities.*
- The Compendium Report is a high level snapshot of a diversity of hospital avoidance Models of Care relating to care of the older person and not necessarily clinically specific areas such as pain and medication related unplanned and potentially avoidable admissions to hospital.
- Mental Health conditions have been included in the scope of Compendium strategies as frequently people receiving Specialist Mental Health Services for Older People (SMHSOP) and people with Behavioural and Psychological Symptoms (BPSD) can have coexisting conditions.

BACKGROUND

Rural NSW includes major regional centres, coastal cities, small towns and remote communities. It is home to 1.9 million (27%) of the state's population and covers approximately 99% of the state's land mass (2). Facilities in rural areas offer a broad range of services but generally have limited availability of specialist care.

The message conveyed by the ACI Framework for Integrating Care for Older People with Complex Health Needs (3) is that older people should be cared for in the most appropriate setting as close to home as possible: whether it is home, in the hospital or in an aged care facility. It is well understood that older people who become acutely unwell in Community Based or Residential Aged Care Facilities (RACF) are a considerable proportion of ED presentations, and a number of studies have found that for certain disorders or conditions effective treatment does not necessitate presentation to ED and can be potentially prevented. In a recent extensive meta-analysis of randomised controlled trials comparing outcomes, costs and patient / carer satisfaction between Hospital in the Home (HITH) and in-hospital care, Caplan et al (4) showed that HITH is safer and more efficient, demonstrating:

- a 19% reduction in mortality
- a 23% reduction in readmission to hospital
- HITH costs 26.5% less than in-hospital care
- High patient and carer satisfaction.

An extensive literature review and state-wide consultation undertaken by the Rural Health Network Working Party in 2014 also shows that literature, evaluation and policy documents consistently identify the need to improve cognitive assessment, pain management, advance care planning, hospital in the home and transitional care between RACFs and EDs. There is a need to incorporate Palliative Care, NSW Ambulance, Mental Health and Transitional Care hospital avoidance Models of Care have been included in a continuum, spanning community based and residential aged care sectors. Delirium could also be classified as 'preventable' and is often the catalyst for presentation to hospital from Community or Residential Aged Care.

- Education about delirium, cognition, dementia and Advance Care Planning in RACF can enable residents to receive treatment for acute illness in the RACF rather than in hospital.
- Some acute / subacute health care models have demonstrated that care closer to home whether it is home, a clinic or an aged care facility can avoid hospitalisation and are safer and more efficient.

ED PRESENTATIONS, 65+ YEARS, 2005-2013

Data regarding all patients aged 65 years and above who presented to a NSW Emergency Department (ED) from 2005 to 2013 (inclusive) was extracted from the NSW Emergency Department Data Collection by the ACI Health Economics and Evaluation Team (HEET), analysing presentations for Potentially Preventable conditions. Potentially Preventable Hospitalisations have been defined by Royal Melbourne Hospital (5) as those hospitalisations which could have been avoided with access to quality primary care and preventative care.

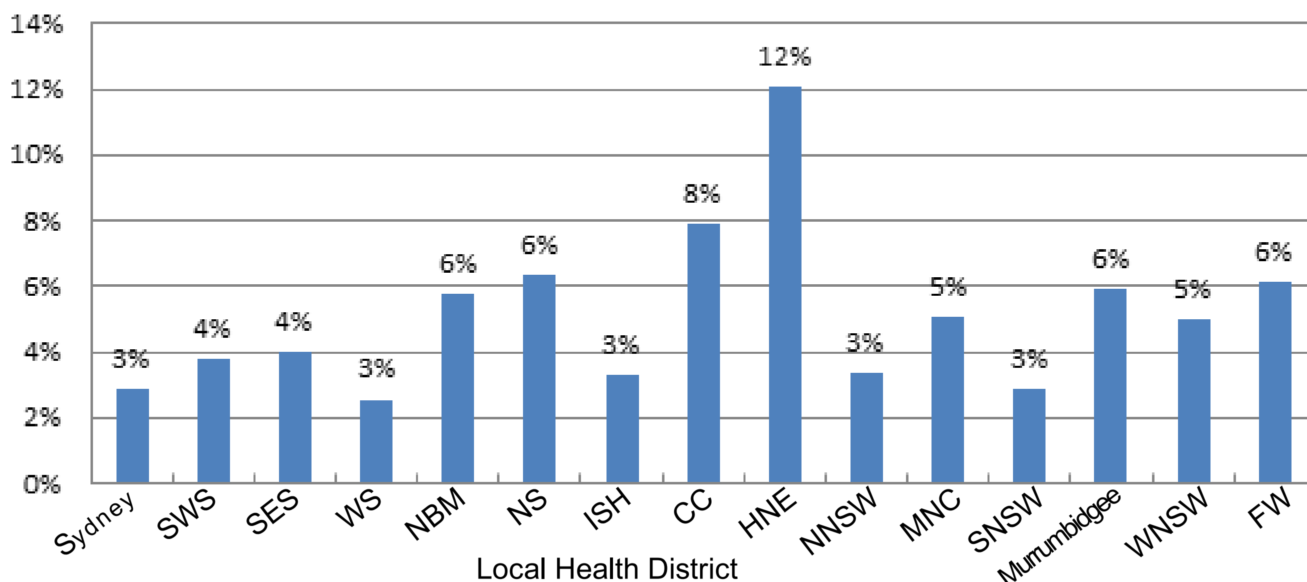
NB: The data presented in this report is high level data collected over 7 years. Further analysis of data to identify changes (increases or decreases in Potentially Preventable Hospitalisations (PPH)), is being considered.

This data showed that:

- Of the 3.7M presentations, 210,000 (6%) were for a Potentially Preventable condition, but this varied across LHDs. (Figure 1)
- 1.6M ED presentations occurred in a regional LHD and of these 118,854 (7.5%) presentations was for a Potentially Preventable condition. (Figure 2)
- The most frequent Potentially Preventable conditions which presented to the ED across NSW were Congestive Heart Failure (17%), COPD (15%), Angina (12%) and Dehydration and Gastroenteritis (10%). (Table 1)
- Variation exists between regional LHDs in the contribution of each condition to all Potentially Preventable Presentations to ED:
    - For influenza, HNE had the lowest proportion with 2% with Western NSW the highest at 15% (NSW = 7%); HNE also had the lowest proportion of COPD with 10% and Central Coast the largest with 24% (NSW=15%).
    - Conversely, HNE had the highest proportions of UTI (15%) and Cellulitis (13%) – NSW was 6% for each
    - Angina varied from 8% in ISH to 21% in Far West NSW (NSW=12%)

Figure 1: Proportion of ED presentations for people aged 65 years+ which were for Potentially Preventable Conditions by LHD, 2005-2013

(Sourced from Sapphari, NSW Ministry of Health, ACI Health Economics and Evaluation Team)



- Potentially Preventable conditions were classified as per Health Statistics NSW and based on either the ICD9 or ICD10 diagnosis provided in the Emergency Department Data Collection (EDDC). See Appendix 1.
- 4% (n=9,764) of all Potentially Preventable ED presentations were referred by a Residential Aged Care Facility[1].

Figure 2: Proportion of Potentially Preventable Presentations for people aged 65 years+ by condition, NSW, 2005-2013

(Sourced from Sapphari, NSW Ministry of Health, ACI Health Economics and Evaluation Team)

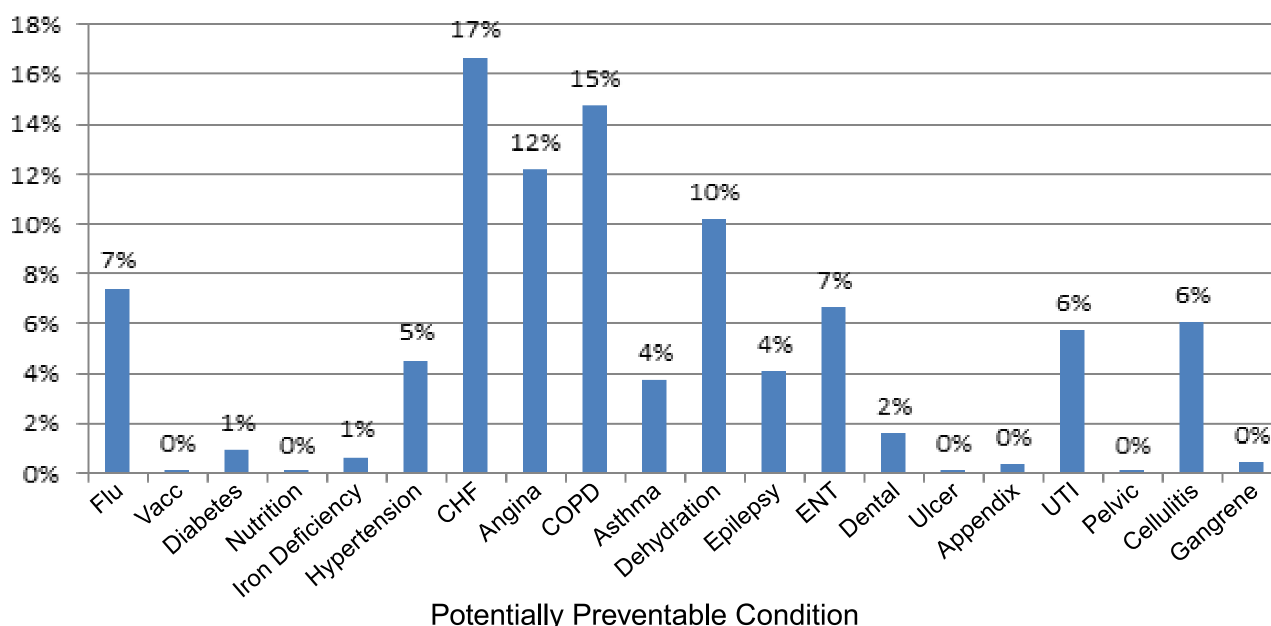


Table 1: Proportion of Potentially Preventable Presentations for people aged 65 years+ by condition, NSW, 2005-2013

LHD	ANY PPP	INFLUENZA	HYPERTENSION	CHF	ANGINA	COPD
ISH*	5,280	443 (8%)	398 (8%)	894 (17%)	446 (8%)	1,083 (21%)
CC	18,388	2,068 (11%)	697 (4%)	3,075 (17%)	3,069 (17%)	4,432 (24%)
HNE#	63,516	1,116 (2%)	2,843 (4%)	8,169 (13%)	7,314 (12%)	6,426 (10%)
NNSW	7,408	818 (11%)	391 (5%)	1,205 (16%)	1,314 (18%)	1,128 (15%)
MNC	8,373	827 (10%)	420 (5%)	1,519 (18%)	1,073 (13%)	1,554 (19%)
SNSW	1,742	237 (14%)	89 (5%)	331 (19%)	232 (13%)	323 (19%)
Murrumbidgee	5,888	628 (11%)	363 (6%)	1,176 (20%)	599 (10%)	1,060 (18%)
WNSW	6,092	901 (15%)	309 (5%)	1,084 (18%)	890 (15%)	1,174 (19%)
FW	2,167	176 (8%)	85 (4%)	319 (15%)	301 (21%)	455 (21%)

1. NB: over 8% of the 'Referred By' variable had missing data, hence this may not be a reliable variable.

Table 2: Potentially Preventable Presentations for people aged 65 years+ to the ED per Regional LHDs, 2005-2013 (Sourced from Sapphari, NSW Ministry of Health, ACI Heath Economics and Evaluation Team)

LHD	ANY PPP	ASTHMA	DEHYDRATION	EPILEPSY	ENT	UTI	CELLULITIS
ISH*	5,280	191 (4%)	769 (15%)	283 (5%)	335 (6%)	46 (1%)	179 (3%)
CC	18,388	543 (3%)	1,749 (10%)	1,011 (5%)	564 (3%)	166 (1%)	385 (2%)
HNE#	63,516	2,071 (3%)	6,819 (11%)	1,833 (3%)	6,740 (11%)	9,447 (15%)	8,059 (13%)
NNSW	7,408	396 (5%)	662 (9%)	334 (5%)	489 (7%)	55 (1%)	208 (3%)
MNC	8,373	333 (4%)	828 (10%)	326 (4%)	851 (10%)	92 (1%)	201 (2%)
SNSW	1,742	44 (3%)	184 (11%)	48 (3%)	100 (6%)	10 (1%)	81 (5%)
Murrumbidgee	5,888	350 (6%)	545 (9%)	183 (3%)	485 (8%)	31 (1%)	158 (3%)
WNSW	6,092	178 (3%)	592 (10%)	171 (3%)	264 (4%)	34 (1%)	177 (3%)
FW	2,167	68 (3%)	268 (12%)	67 (3%)	259 (12%)	9 (1%)	55 (3%)

Table 3: By Comparison, the following table represents total presentations to ED, 65 years+ per LHD, 2005-2013 (Sourced from Sapphari, NSW Ministry of Health, ACI Heath Economics and Evaluation Team)

LHD	ISH*	CC	HNE#	NNSW	MNC	SNSW	MURRUM-BIDGEE	WNSW	FW
TOTAL ED PRESENTATIONS	151,464	233,084	499,306	221,905	165,320	61,287	99,799	122,744	35,414

OBJECTIVES

Develop a compendium of different Regional Aged Care hospital avoidance strategies / programs currently in use in 2014 as a 'one stop shop' which service providers can refer to when considering options.

There are many examples of locally-led hospital avoidance programs and partnerships, and the strategies presented in this document represent a snapshot synthesis and analysis of some of the options; listing programs, the resources and partnerships required for implementation and sustainability, key stakeholder contacts and websites for further information.

The Compendium Report is a living document; reviewed regularly to maintain currency, and is available electronically on the ACI Website.

Case study

Mary is 86 years old and lives in residential aged care in in a small rural town in NSW, and suffers from several co-morbidities including Ischaemic Heart Disease – Atrial Fibrillation, Insulin Dependent Diabetes Mellitus, Osteoarthritis, Gastro Oesophageal Reflux Disease, Urinary Incontinence, Dementia, Macular Degeneration and Chronic back pain.

Mary is seen by her General Practitioner each month and has a comprehensive care plan which is allowing Mary to live comfortably with full assistance from care staff at the Residential Aged Care facility and she has not had any admissions to hospital for over two years.

Mary started to refuse fluids and meals and after several days developed a fever. The General Practitioner was contacted on Friday afternoon and he ordered Mary to have a urine and blood test, which was scheduled for Monday morning as there was no weekend Pathology Service. Full care was provided but by Sunday Mary was acutely unwell and was transferred to the Local Health District Hospital. Mary was admitted to the ward 6 hours after arriving in Emergency Department as the Emergency Department had been exceptionally busy having received three patients from a motor vehicle accident.

On arrival at the ward Mary was confused and disorientated and lashing out at the nursing staff who were trying to attend to her treatment and patient care needs. The transfer summary identified that Mary was a falls risk and to manage this risk bed rails were put in place by the hospital. On the 3rd day Mary climbed over the bed rails and fractured her left femur. Mary required surgery but had to wait for the regional hospital to clear a bed for her admission.

The following principles or frameworks may have assisted in preventing this adverse experience for Mary:

1. Supporting residential aged care staff to improve their knowledge and skills in early recognition of the deteriorating resident, and cognitive assessment and management of delirium – Delirium Care Pathways
2. Assisting Residential Aged Care staff to utilise the Emergency Decision Guidelines – a guide for the acutely unwell, deteriorating resident
3. Introducing TOP 5 Project into Residential Aged Care to assist nursing staff at the hospital individualise care for Mary
4. Implementation of the Key Principles for the Care of the Confused Hospitalised Older Persons (CHOPS) and the Integrated Care for Older People with Complex Needs Framework into the hospital settings.

SCOPE

There are numerous hospital avoidance strategies in use in 2014, with many more in the Research or Pilot stage of development. For the purpose of this document, only programs which are established will be included in scope.

The Compendium Report is a high level snapshot of a diversity of hospital avoidance strategies relating to care of the older person, and does not include clinically specific conditions or areas such as pain and medication related unplanned and potentially preventable admissions to hospital.

Mental Health, NSW Ambulance and Palliative Care approaches have been included in the scope of Compendium strategies. Frequently people receiving Specialist Mental Health Services for Older People (SMHSOP), and older people with Behavioural and Psychological Symptoms (BPSD) have co-existing conditions.

STAKEHOLDERS

- Local Health Districts and regional hospitals
    - Chief Executives
    - Consumer Advisory Councils
    - Aged and Chronic Care Program Managers
    - Aged Care Assessment Teams
    - Nurse Practitioners – Aged Care
    - Emergency Medicine
- RACFs and the Residential Aged Care Sector
    - Aged and Community Services (ACS) mail@acs.asn.au
    - Leading Aged Services Australia (LASA) news@lasa.asn.au
- Department of Social Services – Aged Care Assessment Teams (ACAT)
- Rural Doctors Network - General Practitioners / GP Visiting Medical Officers
- Medicare Locals
- NSW Ambulance Service
- Royal Flying Doctor Service
- Aboriginal Health and Medical Research Council - Aboriginal Medical Services
- Community Based Organisations eg HACC
- The Agency for Clinical innovation, NSW Cancer Institute, Clinical Excellence Commission
- The NSW Ministry of Health
- Older People's Mental Health Policy Unit, Mental Health and Drug and Alcohol Office (MHDAO), NSW Ministry of Health

RISKS, BARRIERS AND ASSUMPTIONS

Aged Care is based on a Person-Centred Model of Care spanning a range of services to optimise the effectiveness of healthcare and wellbeing. Aged Care is not a medical model based on caring for the sick. To establish embedded partnerships, good relationships and communication is critical.

Lack of communication can result in:

- limited opportunity to share information and problem solve
- competing for resources and clientele
- underdeveloped service integration across sectors of Aged Care; fragmented continuum of care
- lack of understanding in regard to interdisciplinary and intersectoral aged care service responsibilities (Private / Public)
- the assumption that 'one size fits all' – differing staffing levels, qualifications and training requirements require flexible approaches to implementing strategies
- a deficit in availability of aged care education
- the need to routinely introduce knowledge and understanding of Advance Care Directives
- confusion and difficulty navigating the maize of Aged Care Provider Organisations
    - community based organisations
    - for profit / not for profit
    - public / private.

ENABLERS

- Capacity Building with RACFs
- Utilise existing data to provide service recommendations
- The importance of engaging and establishing good relationships and partnerships with all aged health service providers to improve communication systems (Primary Care, General Practice, Acute Care, Community Health, Public and Private)
- Increase the use of existing resources and technology e.g. telehealth
- Improve access to Aged Care Education (continence, pain management, nutrition, cognitive decline and assessment, delirium / dementia management, hip fracture, falls prevention, hydration, early identification of infection, stroke management).

KEY MESSAGES

The key messages underpinning the Regional Aged Care Working Party are:

- Aged Care is based on a person centred care wellness model, not a medical model caring for the sick
- integration of services will better guide efficacy of hospital avoidance strategies
- clear communication and collaboration is the key to effective implementation of hospital avoidance strategies, reducing fragmentation and better co-ordinating initiatives
- it is preferable that Advance Care Planning be in place long before admission to a Residential Aged Care Facility
- consider replacing 'Not for Resuscitation' (NFR) order with 'Allow Natural Death' (AND).
    - The words 'Not for Resuscitation' imply treatment being withheld; 'allow natural death' suggests that something is being given.

STRATEGIES (PER COMPENDIUM)

- Advance Care Directives
- Advanced Aged Care Clinical Workshops – UOW / Illawarra Shoalhaven Medicare Local
- Allow Natural Death Orders (AND)
- Medical Officer Life Sustaining Treatment (MOLST)
- After-hours Practice Incentive Program (PIP); Southern NSW Medicare Local, Goulburn Health Service June 2013, North Coast Medicare Local
- ISBAR – (Introduction, Situation, Background, Assessment, Recommendation)
- Hospital in the Home (HITH)
- Yellow Transfer Envelope
- Emergency Decision Guidelines Southern Tasmania Health Service Nurse Practitioner Model – Aged Care and General Practice South July 2012
- Aged Care Emergency (ACE) – Nurse led Model of Care for the older people in the Emergency Department: John Hunter Hospital May 2012
- DETECT – Between the Flags – Early identification of the deteriorating resident
- The Confused Hospitalised Older Persons (CHOPs); ACI Aged Health Network 2014
- The NSW Chronic Disease Management Program (CDMP) – Connecting Care

- Connecting Care – The Chronic Disease Management Program
- The Geriatric Specialist Consultation Service – (Telehealth and public / private partnerships)
- Health Pathways
- Hospital in the Home (HITH)
- Integrated Care of the Older Person with Complex Health Needs Framework– ACI Aged Health Network 2014
- Integrated Model of Care – Shoalhaven District Memorial Hospital Aged Care Team June 2013
- Mental Health Approaches
  - Dementia Behaviour Assessment Management Service (DBMAS)
  - Transitional Behavioural Assessment and Intervention Service (T-BASIS)
  - Behavioural Assessment and Intervention Service (BASIS)
  - Specialist Mental Health Services for Older People (SMHSOP) community teams
- Palliative Care Approaches
  - Hammond Care
  - Silver Chain
  - REACHout in Dementia end of life care toolkit
  - Palliative Care Extended Aged Care at Home (PEACH
  - Guidelines Palliative Approach for Aged Care in the Community Setting – Australian Government of Health and Ageing 2011
  - National Palliative Care Projects
- NSW Ambulance
  - Palliative Authorised Care Plans
  - Low Acuity Patient Pathways
  - Extended Care Paramedics
  - Paramedic Connect
  - Critical Emergency Response Service (CERS)
- Transitional or Fast Track Programs
  - Residential In Reach (RIR)
  - Hospital Admission Risk Program (HARP)
  - Friend in Need – Emergency (FINE)
- Point of contact for Residential Aged Care Facilities
  - Aged Care Nurse Practitioner outreach – Coffs Harbour 2014
  - CNC, ASET Nurse, Nurse Practitioner, Registrar, GP
- TOP 5
- Co-funding arrangements between Medicare Locals, LHDs and RACFs (RACF, Hospital, Medicare Local, Ambulance, Community Health, GP)
  - Regular intersectoral meetings with stakeholders and co-funding arrangements
  - Integrated education, training and mentoring
- Home Based Aged Care Packages
  - Level 1 & 2 Homecare Packages
  - Level 3 & 4 Homecare Packages
- Home and Community Care (HACC)
- Stop and Watch
- Projects under development
  - Telehealth – outreach services to RACFs
  - Clinical Redesign - Aged, Chronic and Complex Care Services: Southern NSW LHD June 2013
  - Whole of Hospital Program (WOHP): NSW Ministry of Health
  - The Mental Health Aged Care Partnership Initiative (MHACPI): NSW Ministry of Health 2011
  - Framework for the State-Wide Model for Palliative and End of Life Care Service Provision: The Agency for Clinical Innovation (ACI)
  - Aged Care Multidisciplinary Care Coordination and Advisory Service Program, WNSW Medicare Local.

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OTHER RESOURCES

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- Regional Dementia Management Strategy. http://www.dementiamanagementstrategy.com/.
- Assessment and management of people with behavioural and psychological symptoms of dementia: A handbook for clinicians. Includes guides for acute, community and residential care settings. https://www.ranzcp.org/Files/Publications/A-Handbook-for-NSW-Health-Clinicians-BPSD_June13_W.aspx.
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GLOSSARY OF TERMS

ABF	Activity Based Funding
ACD	Advance Care Directive
ACAT	Aged Care Assessment Team
ACE	Aged Care Emergency
AND	Allow Natural Death
AARCS Nurse	Acute Aged Related Care Services
ASET Nurse	Aged Services Emergency Team nurse
BASIS	Behavioural Assessment and Intervention Service
BPSD	Behavioural and Psychological Symptoms
BTF	Between the Flags
CC	Central Coast
CDMP	Chronic Disease Management Program
CERS	Clinical Emergency Response Services
CHOPS	Confused Hospitalised Older Persons
CNC	Clinical Nurse Consultant
COAG	Councils of Australian Government
COPD	Chronic Obstructive Pulmonary Disease
DETECT	Deterioration, Evaluate, Treatment, Escalate, Communicating in Teams
ECP	Extended Care Paramedic
ED	Emergency Department
EDDC	Emergency Department Date Collection
FACEM	Fellow of the Australasian College for Emergency Medicine
FINE	Friends in Need - Emergency
FWNSW	Far Western NSW
GP	General Practitioner
GPVMO	General Practitioner Visiting Medical Officer
HACC	Home and Community Care
HITH	Hospital in the Home
HNE	Hunter New England
ISH	Illawarra Shoalhaven Hospital
ISLHD	Illawarra Shoalhaven Local Health District

IV	Intravenous Therapy
LAP	Low Acuity Patient
LHD	Local Health District
MHACPI	The Mental Health Aged Care Partnership Initiative
MLHD	Murrumbidgee Local Health District
MNC	Mid North Coast
MoC	Model of Care
MOLST	Medical Order for Life Sustaining Treatment
NFR	Not For Resuscitation
NP	Nurse Practitioner
NNSW	Northern NSW
PIP	Practice Incentive Program
PEACH	Palliative Care Extended Aged Care at Home
RACF	Residential Aged Care Facility
RRMA	Rural, Remote Metropolitan Area classifications
SDMH	Shoalhaven District Memorial Hospital
S4	Schedule 4 drug
S8	Schedule 8 drug
SNSW	Southern NSW
SMHSOP	Specialist Mental Health Services for Older People
TACP	Transitional Aged Care Package
UOW	University of Wollongong
UTI	Urinary Tract Infection
WNSW	Western NSW
WOHP	Whole of Hospital Program

APPENDIX 1
POTENTIALLY PREVENTABLE CONDITIONS BY CODE

- Potentially Preventable conditions were classified as per Health Statistics NSW and based on either the ICD9 or ICD10 diagnosis provided in the Emergency Department Data Collection (EDDC).
- Regional LHD ED (Central Coast, Hunter New England [excluding John Hunter Hospital], Northern NSW, Mid North Coast, Southern NSW, Murrumbidgee, Western NSW, Far West and Illawarra Shoalhaven [excluding Wollongong Hospital]).

DESCRIPTION	ICD-9 AND ICD-9-CM	ICD-10 AND ICD-10-AM
Vaccine-preventable		
Influenza and pneumonia	481, 482.2, 482.3, 482.9, 483, 487.0, 487.1, 487.8	J10, J11, J13, J14, J15.3, J15.4, J15.7, J15.9, J16.8, J18.1, J18.8
Other vaccine preventable	032, 033.0, 033.1, 033.8, 033.9, 037, 045, 055, 056, 070.3, 072, 320.0	A35, A36, A37, A80, B05, B06, B16.1, B16.9, B18.0, B18.1, B26, G00.0, M01.4
Chronic		
Diabetes complications	250.1-250.9	E10.0-E10.8, E11.0-E11.8, E12.0-E12.8, E13.0-E13.8, E14.0-E14.8
Nutritional deficiencies	260, 261, 262, 268.0, 268.1	E40-E43, E55.0, E64.3
Iron deficiency anaemia	280.1, 280.8, 280.9	D50.1-D50.9
Hypertension	401.0, 401.9, 402.00, 402.10, 402.90	I10, I11.9
Congestive heart failure	402.01, 402.11, 402.91, 428, 518.4	I11.0, I50, J81
Angina	411.1, 411.8, 413	I20, I24.0, I24.8, I24.9
Chronic obstructive pulmonary disease	491, 492, 494, 496, (466.0)	J41-J44, J47, (J20)
Asthma	493	J45, J46
Acute		
Dehydration and gastroenteritis	276.5, 558.9	E86, K52.2, K52.8, K52.9 and from 1 July 2008 additionally: A09.9
Convulsions and epilepsy	345, 642.6, 780.3	G40, G41, O15, R56
Ear, nose and throat infections	382, 462, 463, 465, 472.1	H66, H67, J02, J03, J06, J31.2
Dental conditions	521, 522, 523, 525, 528	K02-K06, K08, K09.8, K09.9, K12, K13

DESCRIPTION	ICD-9 AND ICD-9-CM	ICD-10 AND ICD-10-AM
Acute (cont.)		
Perforated/bleeding ulcer	531.0-531.2, 531.4-531.6, 532.0-532.2, 532.4-532.6, 533.0-533.2, 533.4-533.6, 534.0-534.2, 534.4-534.6	K25.0- K25.2, K25.4-K25.6, K26.0-K26.2, K26.4-K26.6, K27.0-K27.2, K27.4-K27.6, K28.0-K28.2, K28.4-K28.6
Ruptured appendix	540	K35.0 from 1 July 2010 replaced by new codes K35.2 and K35.3
Urinary tract infections including pyelonephritis	590.0, 590.1, 590.8	N10, N11, N12, N13.6, N39.0
Pelvic inflammatory disease	614	N70.0, N70.1, N70.9, N73, N74.0-N74.1, N74.2-N74.8
Cellulitis	681, 682, 683, 686	L03, L04, L08, L88, L98.0, L98.3
Gangrene	785.4	R02

Compendium Regional Aged Care Hospital Avoidance Strategies 2014

<table>
<tr><th>PROGRAM</th><th>DESCRIPTOR</th><th>CONTACT</th><th>RESOURCES</th><th>COST</th><th>POTENTIAL USE</th></tr>
<tr><td>Advance Care Directives</td><td>There is a growing expectation that one's wishes for medical care at the end of life will be respected even if progressive disease takes away decision-making capacity. There is a need for improved mechanisms whereby a person with diminished capacity can make known prior wishes about end of life care to be considered at the time that treatment decisions need to be made.</td><td>Southern NSW Medicare Local
www.snswml.com.au
View Guidelines
www0.health.nsw.gov.au/policies/gl/2005/GL2005_056.html</td><td>• Training resources
• Become core business
• Guidelines available</td><td>Agreement LHDs, Medicare Locals, RACFs</td><td>RACF
LHD
GP
PHC
Ambulance
AMS
NGOs</td></tr>
<tr><td>Advanced Aged Care Clinical Workshops</td><td>Utilising simulation labs:
• recognising deteriorating health conditions in older people
• escalating and reporting deteriorating health conditions in older people
• advanced Catheter Care
• administration and management of sub-cutaneous fluids and medication, including pain management.</td><td>University Of Wollongong School of Nursing and Midwifery
smah.uow.edu.au/nursing/index.html
Illawarra Shoalhaven Medicare Local (ISML) Aged Care Task Force
www.isml.org.au</td><td>• 4 learning modules
• Pre and Post Workbook
• Simulation Lab</td><td>Funded by Illawarra Shoalhaven Medicare Local</td><td>RACF
Community based service providers</td></tr>
<tr><td>After hours Practice Incentive Program (PIP)</td><td>A three tiered after - hours service offering third party, General Practice and 24 x 7 accessibility to care. PIP payments paid for:
• Tier 1: Access to 24x7 GP care through formal arrangement with accredited medical practice
• Tier 2: Minimum levels of after-hours GP care (at least 10-15 hours access per week)
• Tier 3: Access to 24x7 care to GP care in patients' homes, RACFs, Hospitals.
Doctor on Duty offers a bulk billed after hours home visiting service www.doctoroncall.com.au
Rural loadings payable for RRMA Classifications 3,4,5</td><td>North Coast NSW Medicare Local
www.ncml.org.au
Australian Standard of Geographical Classification Remoteness Area (ASGC-RA)
www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator
<table><tr><td>RRMA</td><td>Description</td><td>Rural Load</td></tr><tr><td>1</td><td>Capital city</td><td>Nil</td></tr><tr><td>2</td><td>Other Metro</td><td>Nil</td></tr><tr><td>3</td><td>Large rural</td><td>15%</td></tr><tr><td>4</td><td>Small rural</td><td>20%</td></tr><tr><td>5</td><td>Other rural</td><td>40%</td></tr></table></td><td>• Accredited GP practice
• PIP payments
• Formal agreement with alternative provider
• After hours care arrangements</td><td>PIP payments</td><td>GP
RACF
PHC
LHD
Ambulance
Medicare Local
AMS</td></tr>
</table>

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Aged Care Emergency (ACE)	The ACE Program is a state-wide nurse led integrated Model of Care which has been successfully implemented and evaluated in metropolitan and regional areas, improving emergency care for people living in RACFs through dedicated services in the form of telephone support and advice, telehealth, on site triage, and education to RACF staff and proactive case management guidance to assist RACF staff to respond more appropriately to healthcare needs of residents. Evidence based algorithms and tools have been developed to guide care provision. • Each LHD needs to determine the outreach model that would work in their locality.	View Model of Care, Manual, Tools and Evaluations (Tamworth, Lismore, Orange) at www.ecinsw.com.au/ace Evaluation has shown: • better demand management and reduced ED presentation, admissions and occupied bed days for patients from RACFs • improved patient journey • building clinical capacity in the RACF.	• Nurse Practitioners • CNC • ED ASET Nurse • AARCS Nurse • FACEMs • Career Medical Officer / Registrar • Telehealth • Emergency Physician • Partnerships with GPs, RACFs, LHDs, Medicare Locals, NSW Ambulance	Potentially cost neutral with the savings made through bed days saved, less readmissions and shorter LOS	RACF LHD Ambulance GP Medicare Local AMS
Aged Care Nurse Practitioner Outreach	Nurse Practitioner works from the ED with direct access to Medical Officers for clinical support to RACFs. Community clients can also be referred if they do not wish to be treated in hospital. Allows Palliative Care residents to stay in RACF with the NP prescribing S4 and S8 medications e.g. syringe drivers, IV antibiotics, IV Therapy, investigations and education for RACF staff.	Established Coffs Harbour and Port Macquarie Hospitals. For Information: Shin Hwa Kang-Breen (Coffs Harbour) ShinHwa.Kang-Breen@ncahs.health.nsw.gov.au Debbie Deasey (Port Macquarie) Debbie.Deasy@ncahs.health.nsw.gov.au	Aged Care Nurse Practitioner	Agreement LHDs, Medicare Locals, RACFs, Palliative Care Assoc	LHD RACF AMS Ambulance GP Medicare Local

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Allow Natural Death (AND) Orders	An AND Order, replaces Not For Resuscitation (NFR) order and goes into effect when death is expected soon and a person does not wish to prolong life using aggressive or artificial means. Cardiopulmonary Resuscitation (CPR), Intubation and Mechanical Ventilation are emergency medical procedures which could interfere with the patient's wish for a natural, peaceful and dignified death. The words "do not resuscitate" imply crucial treatment is somehow being withheld; "allow natural death," conversely, suggests that something is being given.	Wikipedia, Allow Natural Death en.wikipedia.org/wiki/Allow_natural_death View Brochure Nambucca Valley Care www.aci.health.nsw.gov.au/resources/rural-health/aged-care-hospital-avoidance/nambucca-valley-care.pdf	• Discussion with GP, patient and family • Documentation • Brochure	Within existing resources	RACF LHD GP PHC Ambulance AMS
Building Partnerships - Framework for Integrating Care for Older People with Complex Health needs	The Framework outlines integration of care by aligning resources, policy and performance incentives at both State and Regional level. A range of models and services that achieve timely access to care and empower other services to deliver care as close to home as possible	The Agency for Clinical Innovation Glen.Pang@aci.health.nsw.gov.au View Building Partnerships Framework ww.aci.health.nsw.gov.au/networks/aged-health/integrated-healthcare-of-the-older-person	• The Framework • Options for integrated care (Medicare Locals, LHDs, Aboriginal Medical Services, RACF, Community Aged Care)	Utilising available funding: COAG, Block, ABF, Case Based, Private Healthcare Insurers	LHD Medicare Local NGO RACF AMS

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Confused Hospitalised Older Person (CHOPS)	7 key Principles and tools developed to provide appropriate care for older people with confusion in hospital, including cognitive screening tool, delirium risk identification, management, staff education and supportive care environments. The Resource Kit assists early identification of delirium to avoid hospitalisation.	The Agency for Clinical Innovation Anthea.Temple@aci.health.nsw.gov.au View Principles and Resource Kit www.aci.health.nsw.gov.au/chops	• National Health and Medical Research Council (NHMRC) • Cognitive Decline Partnership Centre	Within existing resources	LHD RACF PHC GP Medicare Local AMS
DETECT Between the Flags (BTF)	Between the Flags provides a foundation on which identify the deteriorating patient early. The fundamental clinical practice of taking and recording vital sign observations linked to minimum standard calling criteria incorporated into a standard observation chart could be used in RACF; for example, Sepsis Kills and BTF.	Clinical Excellence Commission www.cec.health.nsw.gov.au/programs/between-the-flags	Minimum standards for call criteria as per observation chart.	Within Existing Resources	LHD AMS RACF Ambulance Medicare Local

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Emergency Decision Guidelines for staff	This guideline is a clinical support tool directed towards the care of residents living in RACFs and is aimed to assist staff in RACFs to determine the clinical needs of residents. The flip chart is a visual guide for the acutely unwell deteriorating resident with headings to prompt RACF staff and assist in directing clinical assessment and action. The goals of care are: • Treatment and hospital if required • Treatment but not for transfer to hospital • Palliative treatment • Residents and patient's wishes • Residents care plan and advance care directive.	View Guidelines www.tasmedicarelocal.com.au/resources/emergency-decision-guidelines-south View Aged Care Emergency Generic Manual: locally customisable for flow charts, guidelines and pathways www.ecinsw.com.au/ace Strategy Examples • Establishing within each hospital a point of contact who can be the liaison person for each RACF as a nominated 'go to' person. • Integrated education, training, mentoring - RACF managers are supportive of ongoing education for staff and are keen to implement any training that improves staff skills around recognising and triaging unwell residents. RACF staff does not readily have access to training offered to health service staff. • Batemans Bay GP VMO Project - Four practices share a GPVMO roster to service 5 RACFs in the region. RACF use Emergency Decision Guideline tool, then contact ED for VMO on call support. • After Hours Aged Care Initiative Project: a partnership between the SNSW Medicare Local and Goulburn Health Service to improve after hours care in RACFs using Emergency Care Guidelines, ISBAR tool and staff training.	• Flip chart used in ED as triage tool • Emergency Decision Guidelines • CNC ASET Nurse • Partnership Medicare Local and LHD • Communication Tool and training package	Agreement LHDs, Medicare Locals, RACFs	RACF PHC GP Medicare Local AMS

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Geriatric Specialist Consultation Service	WNSW LHD has designed a new service to improve access for older people to access specialist geriatric consultations utilising technology, and a range of public / private partnerships. A regular geriatric consulting clinic service was established using credentialed Sydney LHD based physicians via telehealth in 2010. A centralised Aged Care Access Intake Centre is also established to provide a consistent management framework for all District programs and initiatives.	For Information: Debra.Tooley@health.nsw.gov.au Dubbo Aged Care Central Hub www.dailyliberal.com.au/story/128539/dubbo-a-hub-for-aged-care	• Formalised agreement • Partnerships ACAT, GP, LHD, RACFs, Specialist Geriatricians	MBS Funding for telehealth	LHD RACF GP Medicare Local AMS
Health Pathways	An online information portal on referral and management pathways helping clinicians to navigate the patient through the complex primary, community and acute health care system within the Hunter and New England region. HealthPathways is designed to be used at the point of care, primarily for General Practitioners but is also available to specialists, nurses, allied health and other health professionals looking for clinical pathways and referral information.	View HNE LHD Webpage and Evaluation hneproject.healthpathways.org.au	• Log in Access to Portal • Management options for common medical conditions • Referral to local services and specialists • Educational resources for patients	Website access	GP LHD PHC NGO Medicare Local AMS

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Home based aged care packages	Level 1 and 2 Homecare Packages Low level aged care in the home (personal care, domestic assistance, meal preparation) Level 3 and 4 Homecare Packages Higher level care; includes all of the above plus respite and dementia care Home and Community Care (HACC) Provides services – Community Transport, Meals on Wheels, Home Modifications, Day Care, Carer support	See Department of Social Services www.myagedcare.gov.au/aged-care-services/home-care-packages See Level 1 & 2 www.agedcareguide.com.au/home-community-care-information.asp?c=53&i=110 See Level 3 & 4 www.agedcareguide.com.au/home-community-care-information.asp?c=53&i=4 See HACC www.health.gov.au/hacc	Aged Care Assessment Teams(ACAT) required to undertake assessment for eligibility	Funded by Federal Government. Nominal user fee	PHC GP Medicare Local HACC LHD AMS
Hospital in the Home (HITH)	Hospital in the Home (HITH) services deliver a range of multidisciplinary sub-acute and acute care to suitable, consenting patients at their home or clinic setting (including RACFs) as an alternative to inpatient (hospital) care. This guideline has been developed by clinicians to provide clear, standardised guidance to Local Health Districts and Specialty Networks regarding terminology, key elements and principles of HITH in NSW.	View HITH Guidelines www0.health.nsw.gov.au/policies/gl/2013/GL2013_006.html Guidelines provide planning consistency - definitions, key elements, principles, referral process, data collection and reporting rules.	• Shared Care • GP Care • Interdisciplinary team	• Service Agreement • Hospital funding eg ABF • Medicare Funding • Private Health Funds	GPs LHD / ED PHC Medicare Local AMS
Intersectoral meetings of all District aged care providers	Communication strategies to enhance collaboration across the District, share resources, identify barriers and enablers, and provide care as close to home as possible to integrate aged care services (private / public) and multidisciplinary teams. Regular interdisciplinary meetings enable clinical practice redesign by engaging with local stakeholders such as RACFs, Health, Medicare Locals, Ambulance.	For Information: Shoalhaven District Memorial Hospital Aged Care Service Steve.Swan@sesiahs.health.nsw.gov.au Karen.Shepherd@sesiahs.health.nsw.gov.au	Terms of Reference www.aci.health.nsw.gov.au/resources/rural-health/aged-care-hospital-avoidance/aged-care-providers-tor.pdf	Agreement LHDs, RACFs, Medicare Locals, GP	LHD RACF GP Medicare Local Ambulance

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Introduction, **S**ituation, **B**ackground, **A**ssessment, **R**ecommend (ISBAR)	ISBAR, a standard mnemonic used to improve clinical communication is widely used across Australia in health settings and hospitals. As a 'safety net' for patients who are cared for in NSW public hospitals and health care facilities, it is designed to protect patients from deteriorating unnoticed and to ensure they receive appropriate care.	Clinical Excellence Commission nswhealth.moodle.com.au/DOH/DETECT/content/00_worry/when_to_worry_06.htm NSW Ambulance Clinical Handover IMISTAMBO Clinical Excellenbce Commission, In Safe Hands www.cec.health.nsw.gov.au/programs/insafehands/clinical-handover	ISBAR form tear off pad Electronic template ISBAR mnemonic posters	Agreement LHDs, Medicare Locals, RACFs, Ambulance	RACF PHC GP Medicare Local AMS
Medical Order for Life Sustaining Treatment (MOLST)	MOLST is an easily identifiable medical order, used between community and acute care sectors. The MOLST is designed for people with a projected life expectancy of less than two years due to advanced disease and /or frailty and is completed as part of an Advance Care Planning (ACP) discussion / process. MOLST delivers concise information about health status, treatment choices and medical decisions to Ambulance Officers, Emergency Department doctors and/or visiting or after hours GP's.	www.health.ny.gov/professionals/patients/patient_rights/molst/	MOLST is always printed on bright coloured paper, for easy identification in an emergency	Withing existing resources	RACF GP LHD PHC Ambulance AMS

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
The NSW Chronic Disease Management Program (CDMP) Connecting Care	The NSW Chronic Disease Management Program – Connecting Care in the Community provides care coordination and self-management support to help people with chronic disease better manage their condition, access appropriate services, prevent complications and reduce the need for hospitalisation. The CDMP connects participants with appropriate primary, community and acute care services by: • Identifying people most in need of and likely to benefit • Undertaking comprehensive assessment • Supporting shared care planning • Delivering care coordination and self-management support services • Regularly monitoring and reviewing participants.	The Agency for Clinical Innovation chroniccare@aci.health.nsw.gov.au View Service Model www.eih.health.nsw.gov.au/initiatives/chronic-disease-management-program-connecting-care-in-the-community	• Service Model • Self-Assessment Tool	Funding targeting • Diabetes • Congestive Heart Failure • Coronary Heart Disease • COPD Hypertension	LHD RACF PHC GP Medicare Local AMS Ambulance
Shoalhaven Integrated Aged Care Model	Illawarra Shoalhaven LHD developed an integrated care program for all Aged Care patients / residents by building partnerships with local Residential Aged Care facilities, the Medicare Local and Community Service providers to create an effective and supportive local Aged Care Network in the Shoalhaven District. This included geriatric outreach clinics in aged care facilities, workshops covering dementia, advance care directives and changes to the transfer process for residents.	For Information: SDMH Aged Care Service Steve.Swan@sesiahs.health.nsw.gov.au Karen.Shepherd@sesiahs.health.nsw.gov.au	• Transfer Form between RACF's and ED • Ten RACF • Considerations for Emergency Hospital Transfer • Guide for RACF staff	Within existing resources	LHD NGO RACF AMS PHC Medicare Local GP

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Stop and Watch	An early warning tool developed to identify an important change in a resident's condition and discuss with Nurse in Charge before the end of the shift. **S**eems different · **T**alks less · **O**verall needs more help · **P**articipates less · **A**te less · **N** · **D**rank less · **W**eight change · **A**gitated or nervous · **T**ired, weak, drowsy · **C**hange in condition · **H**elp required more	Adapted by IS Medicare Local from INTERACT (Interventions to Reduce Acute Care Transfers, Florida Atlantic University) and implemented in Wollongong. Stop and Watch is an End of Life Pathway and Emergency Decision Making Guideline to enhance the skills of residential aged care staff. www.aic-learn.sg/uploadedFiles/Resources/Archives/INTERACT%20Communication%20Tools.pdf	Flip Chart Early warning check list Staff Training INTERACT website interact.fau.edu/index.aspx	Within existing resources	RACF Community based aged care service providers
TOP 5	An approach to gain carer information to personalise care for people with dementia when they are admitted to hospital, recording tips for effective communication, behaviour management and supportive care. **T**alk to the carer **O**btain the information **P**ersonalise the Care **5** strategies developed	Clinical Excellence Commission www.cec.health.nsw.gov.au/__documents/programs/one-page-flyers/11-2013/cec-program-top-5.pdf	Checklist to standardise communication and assessment	Within existing resources	LHD RACF AMS GP Medicare Local PHC
Yellow Transfer Envelope	The "Yellow Envelope" is the key communication tool between RACFS and the hospitals. It is a large yellow coloured envelope containing the resident's medical information and other documents which go with a resident when transferred to hospital. When the resident returns to the RACF the Yellow Envelope containing handover information from the hospital is returned to the RACF.	The Envelope template, Procedures, Minimum information set for transfer form can be found at www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/national-clinical-handover-initiative-pilot-program/transfer-to-hospital-envelope	• C4 Kraft Gold Envelopes (324 x 229mm). • Printed both sides in black ink	Approximately $400 per 1,000	RACF LHD Ambulance AMS

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Mental Health Approaches					
Behavioural Assessment and Intervention Service (BASIS)	Provide specialist, multidisciplinary mental health (and aged care) assessment and some case management for older people with complex and severe behavioural and psychological symptoms of dementia (BPSD) in community settings	Mental Health Telephone Access Line (MHTAL) for referrals – 1800 011 511 LHD mental health service	Mental Health service information	LHD funding	Consumers Carers
Dementia Behaviour Assessment Management Service (DBMAS)	The DBMAS program provides clinical support for people caring for someone with dementia who is demonstrating behavioural and psychological symptoms which are impacting on their care.	HammondCare DBMAS Program provides a statewide service across NSW and is accessible through the National 24 hour helpline number 1800 699 799 dbmas.org.au	• Education packs • Fact Sheets • Activities, Tools, • Guidelines online for Primary Care Workers, family, carers	Access resources online	LHD RACF AMS Ambulance GP Medicare Local
Specialist Mental Health Services for Older People (SMHSOP)	Provide specialist mental health assessment, community team care planning and case management for SMHSOP target group. Provide consultation/liaison to other key services, capacity building with other key services and preventative / early intervention activities	Mental Health Telephone Access Line (MHTAL) for referrals – 1800 011 511 LHD mental health service	• Mental Health service information		Consumers Carers RACF, NGO LHDs PHC, GP
Transitional Behavioural Assessment and Intervention Service (T-BASIS)	Provides a non-acute assessment treatment/ management-discharge inpatient service for older people with severe behavioural and psychological symptoms of dementia (BPSD), including both a 'step down' role from the acute inpatient care and a 'step up' role from community care (including residential aged care), as well as an outreach role.	Mental Health Telephone Access Line (MHTAL) for referrals – 1800 011 511 LHD mental health service (please note T-BASIS units are located in SNSW LHD, HNE LHD and SW LHD)	• Evaluation of the T-BASIS unit initiative and model of care	LHD funding	LHD RACF PHC GP

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Palliative Care Approaches					
End stage dementia	The REACH Out in Dementia project aimed to improve end-of-life care for people with end stage dementia living in regional Residential Aged Care Facilities (RACF). The toolkit is a useful and cost effective way of improving care at end-of-life in dementia.	View Illawarra Health and Medical Research Program ihmri.uow.edu.au/research-program/spotlight/UOW132040.html	REACH Toolkit Carer Education Advance Care Directives Care Plans	No additional cost	NGO PHC GP HACC LHD AMS Ambulance
Guidelines Palliative Approach for Aged Care in the Community Setting	The Australian Government Department of Health and Ageing have released electronic guidelines; approved by the NH&MRC, for health professionals providing palliative care to older people in the community setting; including General Practitioners, community nurses, care workers and Organisations.	View Guidelines www.health.gov.au/internet/main/publishing.nsf/Content/palliativecare-pubs-compac-guidelines.htm	• Standards • Procedures • Assessment tools • Resources • Staff Education	Within existing resources	GP PHC NGO RACF AMS
National Palliative Care Projects	The Australian Government funds a range of national palliative care projects primarily focused on education, training, quality improvement and advance care planning	View range of projects funded www.health.gov.au/internet/main/publishing.nsf/Content/palliativecare-program.htm	• Available on the website	Source funding	All

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Palliative Care Approaches (cont.)					
Palliative Extended Aged Care at Home (PEACH) Program	Three last-days-of-life' home support packages provided by South Western Sydney LHD, HammondCare, Silver Chain • Hammond Care Consortium palliative care packages - (personal care, domestic assistance, carer support) and education services • Silverchain Group limited – provides short term specialist palliative care nursing, after hours telephone support helpline, paediatric palliative care This 'last days of life home support package' program assists patients to stay at home for up to 48 hrs to die. Intensive nurse-led model provides rapid response, short term specialist Palliative Care nursing and service co-ordination. PEACH was expanded to provide more specialist palliative care involvement into RACFs across five Sydney LHDs	Hammond Care Consortium Ms Sally Yule syule@hammond.com.au SilverChain – MNC, HNE, NNSW LHDs Ms Kath Skinner Kath.Skinner@silverchain.org.au www.silverchain.org.au/nsw/health-care/palliative-care SW Sydney LHD Josephine Chow josephine.chow@sswahs.nsw.gov.au Lea Samuels, NSW Health lsamu@doh.health.nsw.gov.au	• NSW Govt plan to Increase access to Palliative Care 2012 – 2018 • COAG funding for 2 years • Links to specialist Palliative Care Team • Package Manager • Hammond Care have been funded in sites across the state	Agreement LHDs, Medicare Locals, RACFs, Palliative Care Assoc. Cost analysis and formal evaluation Referral by Palliative Care Specialist Team	NGO PHC GP HACC LHD AMS Ambulance

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
NSW Ambulance					
CERS Assist (Critical Emergency Response Services)	CERS Assist is the provision of urgent additional clinical assistance in response to a rapidly deteriorating patient in a public health care facility. A CERS Assist request should be considered when a facility is unable to provide sufficient clinical resources to manage the rapidly deteriorating patient (red zone) as defined in the respective LHD CERS Plan. Whilst a statewide program, the primary focus of CERS Assist is in rural remote locations where high level nursing and medical services may not be immediately available.	Clinical Excellence Commission www.cec.health.nsw.gov.au/programs/between-the-flags/clinical-emergency-response-systems	• All CERS Assist requests are made through Triple Zero (000).	Enhances existing health care services, not a substitute for existing or planned services	Ambulance PHC GP LHD Medicare Local AMS
Extended Care Paramedics	Extended Care Paramedics (ECPs) have undertaken an intensive period of additional training to extend their scope of practice and are able to provide emergency care in accordance with current ambulance practice. ECPs can assess and manage a wide range of minor illness and injury presentations e.g. allergic reactions, asthma, back pain, mammal bites, minor burns, catheter problems, wounds, dislocations, falls in the elderly, urinary tract infections	ECPs are authorised to perform a range of extended skills. These include wound care (glue and sutures); catheterisation including supra-pubic; replacing gastric tubes; back slab plasters for immobilisation of limb injuries; reduction of certain dislocations; digital nerve blocks; Quick Screen falls assessment	• Limited number of trained ECPs, working in two models - • Dedicated ECP response • ECPs working as a double crew, some in regional locations	Analysis shows cost savings to Ambulance and the Wider Health System	
Low Acuity Patient Pathways	Low Acuity Patient (LAP) protocols provide a safe framework for treating low acuity patients outside of an emergency department (ED). There are 13 clinical pathways contained within LAP for a range of conditions e.g . asthma, spider bite, diabetes that can be implemented by all paramedics.	After hours Palliative Care www.snswml.com.au/primary-care-support/palliative-care.html NSW Ambulance protocolp1@ambulance.nsw.gov.au	• LAP training is now included in general paramedic education	Within the range of ambulance response fees	

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
NSW Ambulance (cont.)					
Palliative Authorised Care Plans	Authorised Care Program supports paramedic decision making via an end-of-life pathway document (care plan) to provide ambulance with a predetermined care pathway for a terminally ill patient.	View Palliative Care Authorised Care Plan www.snswml.com.au/.../GP_Info_Palliative_Care_Plan	Uses existing Paramedic resources. Consultation with the patient, carer and/or family.	Within existing resources	Ambulance PHC GP LHD Medicare Local AMS
Paramedic Connect	In low ambulance activity areas, Paramedics provide community health services; dressings, medication supervision post discharge, health promotion and ED support to allow community nurses to manage complex needs of patients with multiple medical conditions.	View Paramedic Connect Program Fact Sheet www.aci.health.nsw.gov.au/resources/rural-health/aged-care-hospital-avoidance/paramedic-connect.pdf	• Uses existing paramedic resources in rural and remote communities	No additional cost	Ambulance PHC GP LHD Medicare Local AMS

PROGRAM	DESCRIPTOR	CONTACT	RESOURCES	COST	POTENTIAL USE
Transitional or Fast Track Programs					
Friend in Need – Emergency (FINE)	The Friend in Need – Emergency (FINE) program provides older and chronically-ill patients with an alternative to an emergency department presentation or admission to hospital through a range of programs. Home Hospital services are available to the community, including RACFs. Priority Response Assessment (PRA) - 24 hour, 7 days a week access to an advanced clinical assessment Post - Acute Care (PAC) Services - immediate post-discharge period from a public hospital, PRA or HITH episode of acute care	View WA Programs www.agedcare.health.wa.gov.au/home/fine.cfm	SilverChain Home Hospital Referral through GP, RN, Public Hospital	ED Care Co-ordinator Residential Care Line	
Hospital Admission Risk Program (HARP)	Care Co-ordination, self-management support and specialist medical care are key components of HARP. The main focus is to reduce readmissions and demands on the Acute system for clients with chronic and complex needs.	View Victorian HARP Guidelines www/health.vic.gov.au/harp/about.htm#guidelines	COAG Funding Eligibility Criteria Guidelines		
Residential In Reach (RIR)	Assessment and management of acute medical conditions in collaboration with the GP, to avoid what would otherwise result in a resident unnecessarily going to hospital.	View Victorian RIR Program www.health.vic.gov.au/residentialinreach	Hospital based nurses and doctors	Within existing resources	RACF, LHD, GP, Medicare Local, Ambulance

PROJECTS UNDER DEVELOPMENT 2014 / 2015					
PROGRAM	**DESCRIPTOR**	**CONTACT**	**RESOURCES**	**COST**	**POTENTIAL USE**
Aged Care Multidisciplinary Care Coordination and Advisory Service Program	A Pilot program being run by WNSW Medicare Local aiming to develop liaison and consultation between GPs and RACFs.	View Qld Pilot Model (2013 – 2017) www.qld.lasa.asn.au/health-care-connections-aged-care-multidisciplinary-care-coordination-and-advisory-service-program	Framework available on line Partnerships and Integrated Care strategies	Clinical governance	Primary Care Providers GP LHD Medicare Local Palliative Care Specialist teams Families and Carers
Clinical Redesign, Aged, Chronic and Complex Care Services	SNSW LHD are redesigning services to provide care by coordinating primary care services, targeting preventable hospitalisations and developing a Strategy to streamline referral and intake to community programs (ASET/ AARC, Transitional Aged Care, ComPacs, DVA, HACC nursing and allied health, HITH and Chronic Disease Management).	For information Anka.Radmanovich@gsahs.health.nsw.gov.au	Multidisciplinary team meetings Aged Chronic and Complex Care Services	Clinical governance	PHC LHD GP Medicare Local AMS

PROJECTS UNDER DEVELOPMENT 2014 / 2015					
PROGRAM	**DESCRIPTOR**	**CONTACT**	**RESOURCES**	**COST**	**POTENTIAL USE**
Framework for the State-Wide Model for Palliative and End of Life Care Service Provision	This Framework is the first step in developing a statewide model for palliative and end of life care. It describes some of the complexities faced in providing quality palliative and end of life care across a range of acute, sub-acute, primary care and community settings, including the home. It sets the groundwork for further developing the Model of Care by identifying the principles, service definitions and structural arrangements that are required for the delivery of effective, accessible and efficient care to people in NSW who are approaching or reaching the end of life, their families and carers.	Palliative Care Network, The Agency for Clinical Innovation www.aci.health.nsw.gov.au/networks/palliative-care/resources View Framework Report www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/184600/ACI-Framework-for-Statewide-Model-of-PEoLC-Service-Provision.pdf	• Framework available on line • Partnerships and Integrated Care strategies	Clinical governance	Primary Care Providers GP LHD Medicare Local Palliative Care Specialist teams Families and Carers
The Mental Health Aged Care Partnership Initiative (MHACPI	Partnerships between Mental Health Services and Residential Aged Care providers are being piloted in two metropolitan sites, and being considered in a number of rural LHDs to address the need for more appropriate, community based, long-term care options for older people with severe behavioural and psychological symptoms associated with dementia and / or mental illness. Processes developed assist in the transition of clients into mainstream residential aged care places	See Evaluation www.health.nsw.gov.au/mhdao/Documents/mhacpi-evaluation.pdf	• Catholic Health Care • Hammond Care	• NSW Health Funding	GP Medicare Local AMS Ambulance PHC RACF

PROJECTS UNDER DEVELOPMENT 2014 / 2015					
PROGRAM	**DESCRIPTOR**	**CONTACT**	**RESOURCES**	**COST**	**POTENTIAL USE**
Telehealth outreach to RACFs	The 2nd phase of the NSW Health Connecting Critical Care Emergency Department expansion will develop a service model and/or augment current models linking RACFs to hospitals using Telehealth modalities linking Emergency Departments to Residential Aged Care Facilities 2014 – 2016. To be evaluated 2016	Further Information: Sandra Haynes, MNC and NNSW LHD Telehealth Manager sandra.haynes@ncahs.health.nsw.gov.au	VC equipment / network upgrade 3 year managed service contract with RACFs ED Physician	COAG Funding	GP Medicare Local AMS RACF, NGO LHD
Whole of Hospital Program (WOHP)	A ‘Whole of system’ approach which is a collaborative and integrated project designed to improve access to care. WHOP takes into account not only what happens within hospitals but also the impact that hospital avoidance and post discharge care programs offer. Introduced to 7 hospitals in 2013, there are 42 hospitals (metropolitan, regional and small), now directly engaged in 2014 aiming to improve patient flow efficiencies and new Models of Care which reduce unnecessary delays and demand for acute hospital attendances and admissions across the whole patient journey. This will have a flow on effect to help achieve National Emergency Access Targets (NEAT).	Further information www.health.nsw.gov.au/wohp/Pages/default.aspx Contacts www.health.nsw.gov.au/wohp/Pages/contacts.aspx Suggested tools and resources www.health.nsw.gov.au/wohp/Pages/toolkit.aspx View case studies www.health.nsw.gov.au/wohp/Pages/news.aspx	WHOP Redesign Panel Care connections with external partners	Ministry of Health Funding	RACF LHD GP Medicare Local AMS Ambulance PHC