delivering geriatrician SERVICES TO rural AGED CARE RESIDENTS

Many older adults in residential aged care facilities, especially those with complex chronic health conditions, would benefit from a comprehensive geriatric assessment. However, accessing specialist geriatric services can be challenging in regional Victoria due to the time and travel required. The Geri-Connect service used video conferencing to connect geriatricians with residents in aged care facilities in the Loddon Mallee region of Victoria without requiring them to travel to receive care.

## Background

In 2016, high, unmet demand for specialist geriatric medicine services in the Loddon Mallee region of Victoria led to an increase in presentations to regional emergency departments and transfers of patients to Bendigo Health’s Geriatric Evaluation and Management service and rehabilitation wards.

As at November 2016, more than 750 of the 800 residential aged care facility (RACF) residents in the region had not had any geriatric medical input into their care plan. The wait time to see a geriatrician was approximately two to three months, and many residents had to travel to Bendigo for their appointment as only one geriatrician was servicing the region at the time.

Older adults in metropolitan areas tend to have greater access to specialist geriatricians, receiving supportive care after being in hospital as well as in RACF settings. Through these services, they are offered a comprehensive geriatric assessment, which, where appropriate, may lead to a restorative program of care designed to reverse or slow decline in the patient’s bodily function and enhance their independence.

Despite their benefits, small rural hospitals are usually unable to provide such assessments and restorative programs to their older patients because they do not have access to specialist geriatricians, and their access to allied health professionals is variable.

The Geri-Connect project aimed to use telehealth technology to bridge the geographic divide and establish a sustainable specialist geriatrician service to improve the equity, timeliness, and quality of care provided to older people in RACFs across the Loddon Mallee region of Victoria.

Geri-Connect

**Leads** Kyabram District Health, Loddon Mallee Rural Health Alliance

**Partners** Bendigo Health, Murray Primary Health Network, regional aged care facilities in the Loddon Mallee region

**Duration** December 2016 – December 2017

**Key outcomes**

* Made it easier and more convenient for older patients in rural RACFs to access specialist geriatrician services, reducing travel time and freeing up more clinical hours for geriatricians
* Completed 237 consultations in nine months
* Completed comprehensive geriatric assessments for 30 per cent of clients at participating RACFs, compared with 5 per cent prior to the project
* Reduced response times for ACAS assessments by 83 per cent
* Recommended a reduction in polypharmacy for 89 per cent of patients seen

## Key activity

The Geri-Connect service was implemented in a phased approach from March 2017, with the supporting telehealth technology fully implemented at 14 RACFs by August 2017.

A ‘hub and spoke’ model was used, where large towns in the Loddon Mallee region – Bendigo, Castlemaine, Kyabram Sea Lake and Swan Hill – acted as a central hub for smaller rural health services in their area.

Each hub had a dedicated geriatrician and was the point of contact for RACF residents in their local area. Previously, one geriatrician covered all regional sites, with patients often having to travel to Bendigo to access the specialist services.

While initial setup was funded by the Better Care Victoria Innovation Fund, the service’s ongoing operation could be fully sustained through the Medicare Benefits Schedule.

### The Geri-Connect service model

* A clinical nurse coordinator works with general practitioners (GPs) and RACFs to identify and triage patients appropriate for the Geri-Connect service.
* A geriatrician reviews the referrals to confirm whether the patients and their health concerns are suitable for a telehealth consultation.
* For those deemed suitable, an administrative support officer coordinates and schedules a consultation at the patient’s RACF.
* On the day of the appointment, the nurse unit manager at the RACF prepares the patient and their family for the consultation.
* The geriatrician dials in to the RACF and consults with the patient via telehealth, developing a detailed management plan that includes:
	+ a prioritised list of the patient’s health problems and care needs
	+ short- and long-term management goals
	+ recommended actions or intervention strategies to improve or maintain the patient’s health status.
* The geriatrician explains and discusses the management plan with the patient and, as appropriate, with their family and any carers.
* Following the consultation, the geriatrician communicates the management plan in writing to the referring GP and the patient’s RACF to facilitate ongoing management of the patient’s care.



## Outcomes

* From 1 March to 30 November 2017, Geri-Connect delivered 237 consultations. All 14 RACFs and 51 (53 per cent) of the 97 GPs in the Loddon Mallee region referred to the service.
* 30 per cent of clients at participating RACFs had assessments completed, compared with 5 per cent prior to the project.
* 160 comprehensive geriatric assessments were conducted via telehealth, bringing the number of annual assessments completed in line with Queensland and New South Wales.
* Offering consultations via telehealth made the service more convenient for patients while reducing travel for geriatricians, allowing them to redirect this time to other clinical needs. It was estimated that the Geri-Connect service saved more than 21,000km of travel and provided an additional 448 clinical hours to the region.
* Geri-Connect enabled eligible patients at regional hospitals to be assessed for suitability for residential aged care via video conferencing instead of having an Aged Care Assessment Services (ACAS) clinician asses them in person. This improved ACAS response times. The time from ACAS referral acceptance to assessment decreased from six days to one day (an 83 per cent reduction), and the time from assessment to a decision on whether or not the patient was eligible for permanent care decreased from 2.5 days to less than one day (a 60 per cent reduction).
* Polypharmacy, the use of multiple medications at the same time, can lead to negative health outcomes. As a result of Geri-Connect, 206 patients received recommendations to change their medications, including to reduce their dosage or cease the medication altogether.
* 68 patients received referrals to allied health or other healthcare providers.
* The service was positively received by clinicians, patients, families and carers.
* RACF staff and GPs said the consultations helped confirm they were on the right track in terms of the care they were providing to patients, especially complex cases, with some staff adding that this increased their confidence in making clinical decisions.
* The project resulted in a replicable model that can be applied in other regions and transferred to other areas of healthcare, such as palliative care and rehabilitation medicine.
* The project also strengthened ties between regional GPs and specialist services, as GPs saw the benefits of referring patients to the service.

‘Residents enjoyed being able to have a real face-to-face consultation with a doctor. Many of them had not had this experience for many years. All of their issues were heard at once … Families were very happy with the opportunity to have input into care.’

**– RACF Director of Nursing**

‘Several of the residents had a reduction of medication which is a cost saving to them.’

**– RACF staff**

‘[A] great, convenient, reassuring and friendly way [to get the information I needed].’

**– Family member**

 ‘Just like seeing a doctor in the surgery.’

**– Patient**

## Key learnings

* **Stakeholder management is important to generate interest, engagement and support for Geri-Connect –** The project team put a number of strong stakeholder management strategies in place, including actively engaging with directors of nursing and nurse champions at each RACF, and visiting regional GPs to build rapport and work through their concerns. The latter strategy helped overcome some initial resistance from a small percentage of GPs who felt their knowledge in managing older patients was being questioned. A brochure was also developed to promote the service and an education workshop was held for clinicians.
* **Word of mouth is an effective promotional tool –**The project team selected services that were interested in change and innovation to be early adopters of the Geri-Connect service. The positive word of mouth from these services assisted in promoting the service to other sites, encouraging uptake.
* **Allow time and funding to thoroughly investigate the telehealth technology and ensure it is fit for purpose –** The project team found that the technology initially recommended was not fit for purpose for geriatrician consultations at RACFs, and reductions in funding for the technical elements of the project led to delays in procurement and delivery of the new technology to participating sites.
* **Plan for personnel movements –** The conclusion of the clinical nurse consultant’s contract and annual leave taken by one of the geriatricians caused a sudden drop in consultations during one month of the pilot. The project team has now put a contingency plan in place to ensure a geriatrician is available at all times.