Rural Research: 2016 Aged Care Survey

16 February 2016

Rationale

Research conducted by the RACGP in 2014[1] indicated a strong demand for aged care advanced skills to meet the needs of rural and remote communities. The top five identified advanced skills to meet community needs were: Emergency Medicine, Palliative Care, Paediatrics, Mental Health and Aged Care. More broadly, the research identified barriers and enablers for rural GPs to access training and utilise advanced skillsets.

In implementing the key findings of this research, our more recent work has focused on a number of priority rural skill areas to progress outcomes for our members through strategic projects which include:

- A focus on skill acquisition and maintenance, through key education projects, developing rurally accessible training solutions as well as curriculum development and renewal;
- Supporting skill utilisation, through increased advocacy, to address the key policy barriers impacting rural service delivery and access constraints for both the patient and the GP;
- Developing service solutions, through policy advancement, to support viable rural models of care.

The **2016 RACGP Rural Aged Care Survey**, released in February, will help us develop a greater understanding of the specific supports required to enable rural GPs to provide aged care services in their community across a range of service settings. These results will inform our advocacy in guiding the direction of future workforce strategies particularly in identifying service gaps and training requirements.

Introduction

One of the biggest health service challenges in the future in Australia is in aged care. It is vital to plan now to target areas of critical need to meet the growing demand. Ensuring continuity of care for rural patients is made more complex due to diminished services as well as an already overstretched workforce. Policies are needed to support and increase effective GP-led rural models for home-based, Residential Aged Care Facilities (RACF) and hospital-based aged care.

The 2016 RACGP Rural Aged Care Survey was developed specifically to work through these key service and workforce requirements with our rural membership and develop solutions to provide for more rurally viable service models. Structured in three parts, the first survey section addressed **service provision** specifically at the level of GP-led care in the community consistent with current service constructs and service demand. Section two, **policy and system reform**, sought to identify key barriers and possible GP-led solutions in aged care. In Section three, **training and skills**, explored the availability of aged care training opportunities and need for specific areas of upskilling for GPs.

Aim

To determine the extent of, and demand for, GP-led aged care services in rural and remote communities.

Method

An online survey of RACGP Rural members (practising GPs in ASGC-RA 2-5) was conducted in February 2016, with a cohort of **8,261,** sourced through the membership database[1] [2]. A targeted survey with multiple choice and free-response survey questions was sent via eblast on 3 February 2016 to rural members. The survey was kept open for a ten day period. A reminder email was sent on 10 February to maximise the survey response rate.

[1] Membership categories: Full Time; GP Spouse/Partner; Life Members; New Fellow; Part Time; Registrar member; Residents/Interns.
[2] Rurality factor: Those who either have a preferred address in RA 2-5 **OR** a practice or home address in RA 2-5.

Results

The qualitative and quantitative results from the survey reported below forms our initial analysis of the 2016 **RACGP Rural Aged Care Survey**. Results are reported at a national level with further state and territory level data provided where appropriate.

Demographics

Of the **8,261**[3] RACGP Rural members invited to participate in the survey, **450** completed the entire survey (5.5 % response rate). Of those, **2,731** people opened the survey (33%) after receiving the first email, and **3,186** (38.5%) opened the second (reminder) email. The age distribution was relatively well-balanced against the workforce and included under 35 (17%), 35-45 (29%), 46-55 (27%), 56+ (26%) and unanswered (1%).

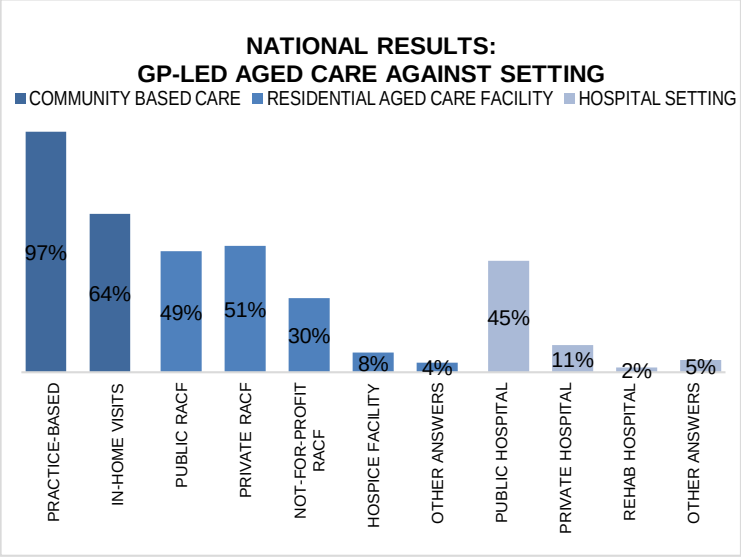
The ASGC-RA distribution of aged care services showed half of respondents were working and providing services in Inner Regional (50%) and Outer Regional (30%) locations. Participants also represented Remote Australia (10%) and Very Remote Australia (8%) a further 2% providing services in Major Cities of Australia. In terms of career stage most participants were vocationally registered (76%) with non-VR GP (8%), GP Registrar (15%) and Intern/Resident (0%) while 1% fell outside of these categories. Further geographic spread through state and territory-level participation provided a national coverage with the strongest response coming from rural members in the larger states of New South Wales (25%), Victoria (23%), and Queensland (18%) but with a smaller proportion of results from South Australia (11%), Western Australia (11%), Tasmania (6%) and the Northern Territory (6%). No respondents were received from ACT. In the sections which follow any reference to state or state-level data includes the Northern Territory. Individual state-level results are only shown if relevant.

Section 1 Service provision across settings

1.1 **Extent of rural GP-led service care**

In determining the extent of GP-led care in the rural service setting, participants were asked to provide details on the extent to which they provide aged care services in their community across each of three key service settings: within the hospital (public, private and rehabilitation), RACF (including public, private, not-for-profit charitable or hospice facility) and within community based care (practice based and in-home visits). Both national and state-level data is provided.

1.1.1 **Nationally**, respondents showed that whilst GP-led aged care services in rural areas are provided across all settings, the majority of GPs were providing community based care: of the 480 GP sample[4], 97% provide practice-based aged care services while 64% indicated they provide in-home visits. For those providing services within a RACF GP-led care was reported as 51% for private facilities and 49% in a public RACF. GP care in a charitable or religious RACF comprised 30% of respondents and hospice care facility at 8%. Rural GP-led services within the hospital setting demonstrated 45% within public and 11% for private hospital work and rehabilitation hospital aged care services at 2%.



[3] Delivery rate: Delivered successfully to **7,365** members (99.1%)

[4] Question response sample: There was variation between the numbers of GPs who answered each question of the survey. Percentage calculations are based on the responses received for each question set, not overall response rate (or completion rate) reported for the full survey.

Other answers

Other answers to the questions of setting of aged care work within the RACF (4%) and hospital (5%) provided a further perspective on the broad range of settings. For the RACF section: there were a number of additional prompts including from those working in Aboriginal Health and within an Aboriginal Elders Facility (Victoria). Northern Territory respondents advised that they were involved in RACF day coverage only, with some indicating that there was no service (RACF) coverage at all, despite these services being needed. In the hospital setting: broader service prompts from respondents included from those working within hospital in the home services (Victoria). A Queensland respondent indicated that there was no local hospital in their area, while respondents from New South Wales reported their work extended across a number of settings including the Transitional Behavioural Assessment and Intervention Service (T-BASIS) Dementia Unit, private day surgery and working within the Aboriginal Medical Service (AMS).

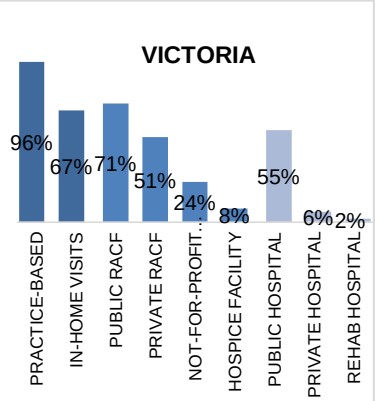
1.1.2 **State-level results**

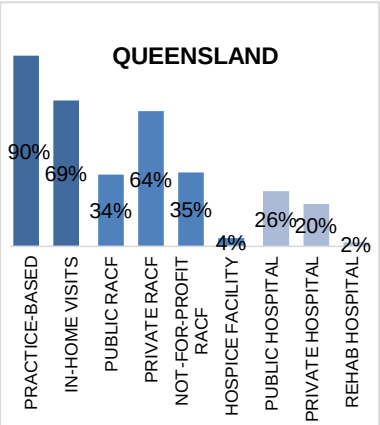
The state responses are presented in Figures 1.1.2.1 to 1.1.2.7 below. The participation results were comparable across the **community setting** (practice-based and in-home visits). Proportions of respondents who conduction in-home aged care were greater than 60% in all states except the Northern Territory (50%) and Western Australia (48%).

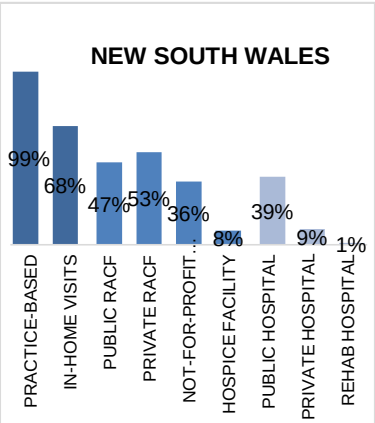
In **RACF** GP-led aged care, there was some variance between the states with public RACF participation higher than private RACF participation in Victoria (71% vs 51%), South Australia (70% vs 50%) and Western Australia (52% vs 39%). Lower participation in the public compared with private RACF setting was noted in Queensland (34% vs 64%), New South Wales (47% vs 53%) Tasmania (16% vs 66%) and Northern Territory (4% vs 8%) were noted. The actual infrastructure distribution per state (public versus private) is not known and further analysis is recommended on a state basis.

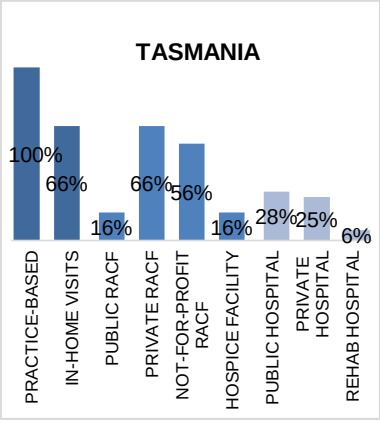
In the **hospital setting**, there was a majority of respondents providing GP-led aged care in the public sector from Victoria (55%) and South Australia (90%). There was a more even split in the participation in public versus private hospital setting in Queensland (26% vs 20%) and Tasmanian (28% and 25%). The private hospital rates of GP-led aged care service provision in the remaining states are below 10%. These results suggest further investigation by policy planners to ensure incentives and structures are in place to promote improved GP-led care within private hospital facilities.

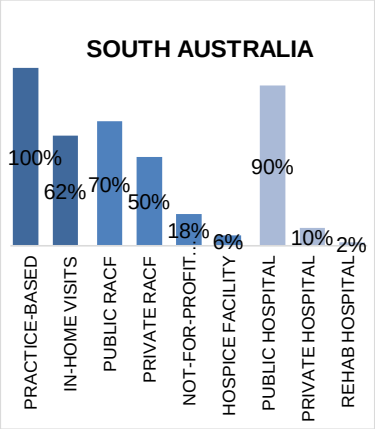
The respondent rates from the Northern Territory should be interpreted with caution due to the small sample size and no RACF or hospitals in some areas.

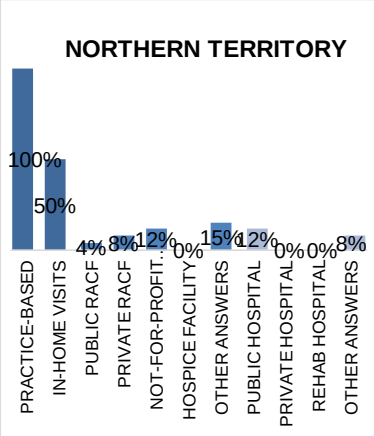


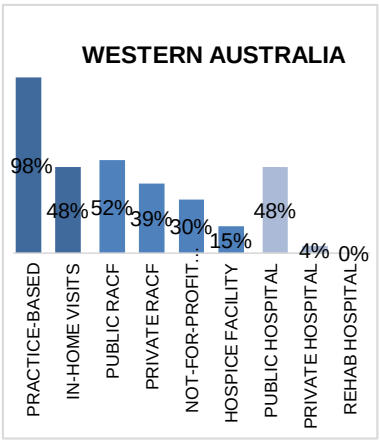










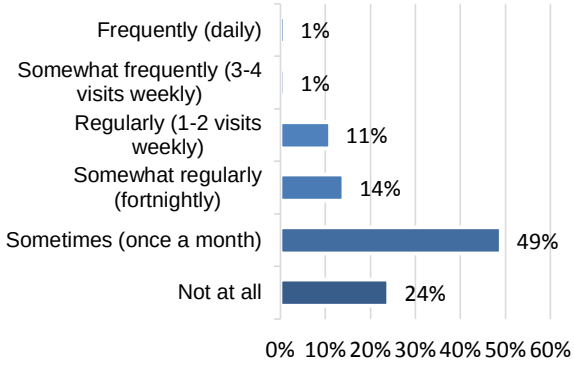


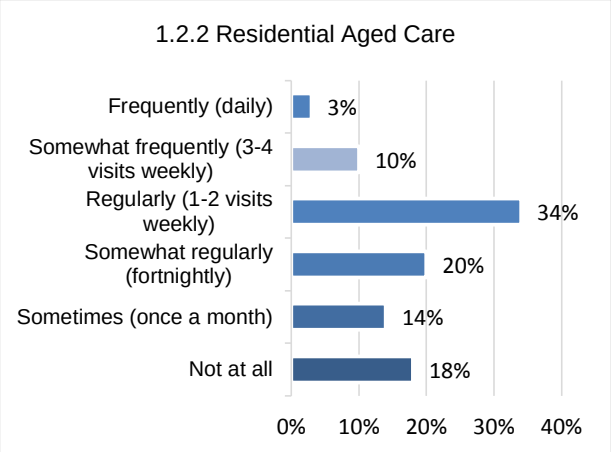
1.2 **Service constructs and demand across settings**

Service constructs and service demand was investigated through asking about the **frequency of GP-led services** in the three care settings and the national results are presented below in Figures 1.2.1 to 1.2.3. A time guide was placed against each of the five prompts as bracketed: Frequently (daily), Somewhat frequently (3-4 visits weekly), Regularly (1-2 visits weekly), Somewhat regularly (fortnightly) and Sometimes (once a month). The results demonstrate minimal *Regular* service (1-2 visits per week) for in-home aged care (11%) and the hospital setting (9%). These services take the GP out of the practice setting. This could indicate an area where support and incentives could make these hospital and RACF services more viable for the workforce and economic needs of rural GPs.

1.2.1

Whilst 64% of rural GPs nationally indicated that they were providing **in-home** aged care (at 1.1.1 above), when asked on frequency of visits a total of 76% indicated that they were providing in-home visits as outlined in figure 1.2.1 National survey results indicated that 49% indicated that they were providing this care *Sometimes* (monthly), whilst nearly a quarter (24%) replied "*Not at all"* or providing no in-home aged care. To enhance home based health care provision to the Australian aged care population the barriers to more frequent service provision need to be examined.

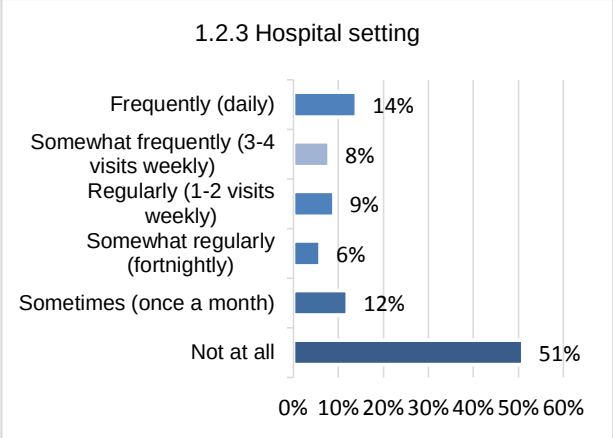




1.2.2

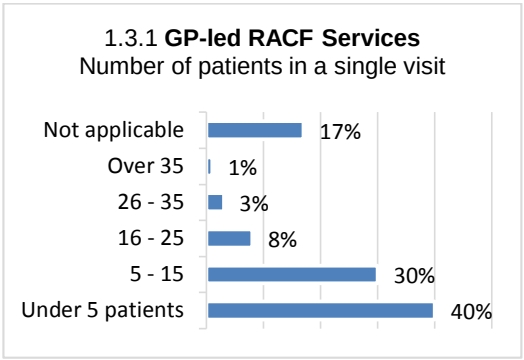
Frequency of service provision in **RACF** setting across the five sub-setting options, was higher than GP in-home visits reported in section 1.2.1. Again, more answered (14.3%) this question than the same question in section 1.1.1. This was due to a methodological issue with the survey structure and had no identifiable impact on data collected. Of the 82% of rural GPs stating they are providing services in RACFs 34% stated that they were providing these *Regularly*, *Somewhat frequently* (10%) and *Daily* visits (3%) which is an increased frequency compared with the community setting in 1.2.1. 14% of GPs stated that they were providing these services *Sometimes* and 18% of GPs of survey respondents were not providing any RACF visits.

1.2.3
For the 49% of rural GPs who indicated they were providing aged care services within the **hospital setting**, 14% were providing these *Frequently*, 8% *Somewhat frequently* and 9% *Regularly* (or 1-2 visits weekly). Those rural GPs providing services within the hospital less frequently: 6% indicated that this was *Somewhat regularly* with 12% indicating *Sometimes*.



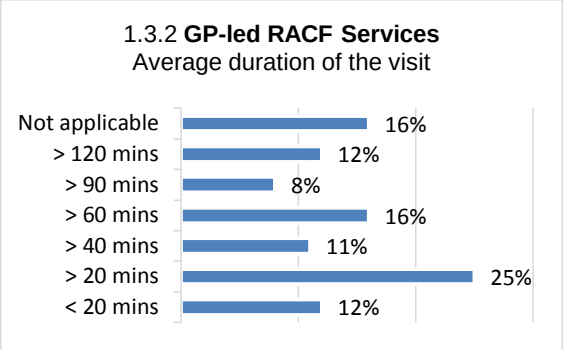
1.3 **Rural-GP led RACF services**

Rural GPs currently providing services within a RACF provided details around the number of patients under their care in a single visit and the average duration of the visit.



1.3.1 **Case load:** The results in figure 1.3.1 indicate that of the 82% or 490 GPs who indicated that they were providing services to RACFs 40% reported consulting on less than five patients per visit and 30% seeing 5-15 patient per visit. The much larger patient numbers consulted one during on visit of 16-24, 26-35 and over 35 were 8%, 3% and 1% of the respondents respectively. These results when considered with the reported service frequencies in section 1.2.2, where the majority were providing 1 to 2 visits per week, provide further insights to service structure and coverage.

1.3.2 **Time factors:** In addition to case load, the average duration of each visit to the RACF was reported. The results showed that a quarter of GP visits were over 20 minutes (25%). No statistically significant difference between visit durations and 16% choosing to indicate time factors as not applicable.

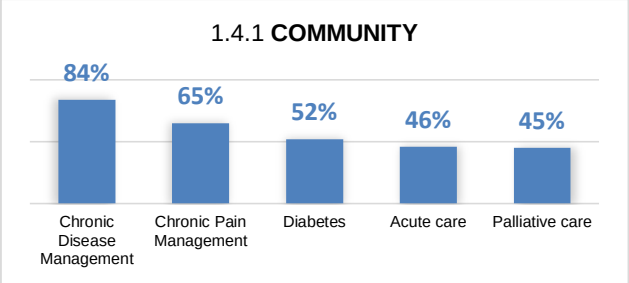


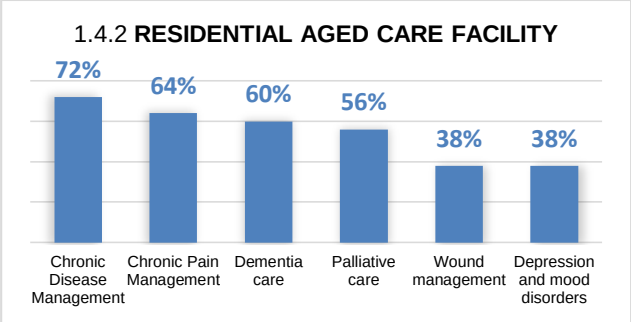
1.4 **Priority skills**

To support future sector planning, the survey sought to examine **current service mix** and complexity in the rural context as well as further identify any major variance in skill utilisation between the settings. Rural GPs provided the five most frequent types of specialist medical services in each of the three key care settings investigated. A choice of 16 skills were provided in community and resident aged care with 14 skills in the hospital setting, with some specific to setting such as *Community-geriatrics* in the community setting and *Hospital delirium* in the hospital setting. The national results are detailed in Figures 1.4.1 to 1.4.3.

1.4.1

Chronic Disease Management rated highly across all settings and was the top response for specialist medical services provided in the **community setting** at 84%. Second most prominent in this setting was *Chronic Pain Management* (65%) followed by *Diabetes* (52%), *Acute care* (46%) and *Palliative care* (45%).



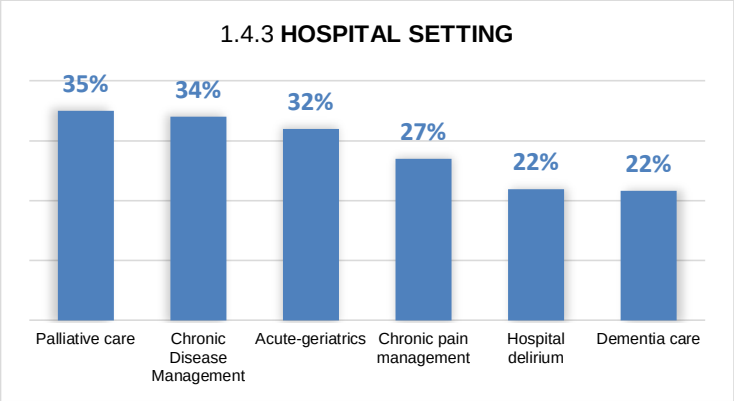


1.4.2

In the **RACF** setting, the same prioritised skills were reported for the most common two specialist services; *Chronic Disease Management* at 72% and *Chronic Pain Management* at 64%. *Dementia care* (60%) was the third most frequent service skill reported as needed in RACF GP-led care, followed by *Palliative care* (56%), and *Wound management* (38.19%) ranking alongside D*epression and mood disorders* (37.99%) skills.

1.4.3

Results for specialised skill sets needed for GP-led aged care in the **hospital sector** was impacted by 48%, of respondents, indicating that they do not provide services in this setting. For those GPs who do provide hospital based aged care, *Palliative care* (35%), *Chronic Disease Management* (34%) and *Acute-geriatrics* (27%) were ranked top three most frequent type of specialist medical services. This followed *Chronic pain management* (ranked fourth 27%) with *Hospital delirium* (22.85%) and *Dementia care* (21.65%) essentially tied at the 5th and 6th priority skills within the hospital care setting.



1.5 **Remuneration as a key barrier to participation**

Barriers **limiting participation** of rural GP-led aged care were explored through the survey. Rural GPs were asked to indicate which aged care activities, across the three care settings they participate in, which are not paid or renumerated. The national results are provided in figure 1.5 below.

1.5 Remuneration barriers (across settings)		
Community setting		
	Advice to nursing staff (pain relief, clinical decisions)	91%
	Advice and discussion with family and non-professional carers	90%
	1.5.2 Other Answers	17%
Residential Aged Care Facility		
	Printing scripts requested by pharmacy	91%
	Advice to nursing staff (pain relief, clinical decisions)	90%
	Advice and discussion with family and non-professional carers	85%
	Residential in-reach services to patients in RACF	27%
	1.5.2 Other Answers	10%
Hospital setting		
	Advice to nursing staff (pain relief, clinical decisions)	81%
	Advice and discussion with family and non-professional carers	81%
	Printing scripts requested by pharmacy	78%
	Call from DEM/ED or Specialists for patient advice	74%
	1.5.2 Other Answers	10%

1.5.1

Similar results were seen across the three settings for the advice to nursing staff (91%, 90% and 81% respectively) and family/carer discussion elements (90%, 85% and 81% respectively). Printing of scripts comprised 91% of the non-renumerated work by GPs in the RACF setting for 78% within the hospital setting.

A further consideration for rural GPs is the close connection to the local hospital and the need to deal with DEM/ED or Specialist calls (74%) for issues impacting on their patients. With upcoming changes to how practice incentive payments (PIPs) are paid for eHealth work in General Practice the uptake of Shared Health Summaries to "My Health Record" will hopefully improve the transferability of health information across different care settings.[2] This could reduce one of the top reported barriers to participation in GP-led aged care in the hospital setting as well as improving patient care.

1.5.2

In terms of the additional advice provided by rural GPs in the freeform areas, other answers -17%, 10% and 10% respectively, respondents' statements reinforced the extensive paperwork and follow up requirements in enabling integration across settings for patients.

1.5.2.1 Across all states in the **community setting** there were extensive mentions about non-remunerated aspects of on call phone advice; specifics around scripts (Webster pack and authority scripts); writing up of admission notes and updating medical charts. Legal matters including Guardianship and Advance Care Directive discussions.

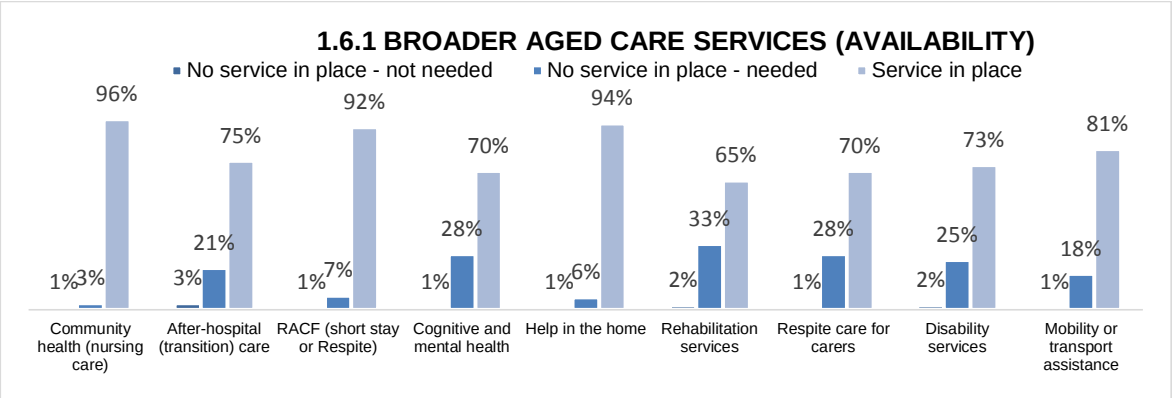
1.5.2.2 Within the **RACF setting** the specific examples from respondents on non-remuneration issues (when not seeing the patient) relating to time commitments on warfarin management, provision of health summaries and medication charts and broader government forms including the writing of death certificates.

1.5.2.3 The **hospital setting** respondents included doctors undertaking salaried arrangements. For non-salaried respondents reporting unpaid elements to the care, the issues outlined were predominantly the same as against the RACF but also included teaching obligations (junior doctors, nursing and allied health staff).

1.6 **Broader aged care services**

Rural GP respondents in the survey indicated the types of **services available** in their rural community in addition to GP-led care as well as perceived gaps. The national results are represented in figure 1.6.1.

These results indicate a strong service system already in place for *Community Health* (96%) and *Help in the Home* (94%). Service deficits of around a quarter of services needed for *After-hospital (transition) care* (21%), *Cognitive and mental health* (28%) and *Disability services* (25%). Approximately a third of respondents reported a need for *Rehabilitation services (33%)* and less of a service gap indicated for *Mobility or transport assistance* (18%). Further analysis around the location of the rural GPs reporting 'No service in place and needed' would provide the gap analysis.



Section 2 Policy and system reform

The challenge of managing aged care patients, in the rural context and across the different care settings was raised within the survey. Questions were structured in order to gain a further understanding of the **supports required** to manage a rural case load, with often complex disability and chronic conditions, for the rural GP, with and without access to a multidisciplinary team.

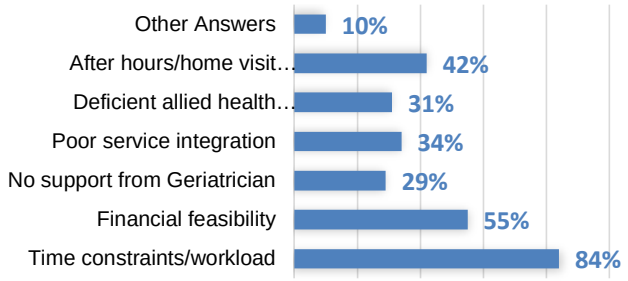
2.1 Key workforce and service barriers

To identify improved management strategies, the key barriers were reported as service constraints (Figure 2.1.1) as well as workforce factors (Figure 2.1.2). These were then addressed with possible service solutions from the perspective of the rural GP (Figure 2.1.3).

2.1.1 Service constraints

Across all settings the most commonly **identified barrier** to provision of GP-led aged care were time constraints and workload (84%). Financial feasibility (55%) and after hours and home visit requirements (42%) were seen as the next most common barriers to care. Rural GPs also indicated that poor service integration (34%), deficient allied health service mix (31%) and lack of support from Geriatrician (29%) to be less frequent barriers to providing aged care services in different care settings.

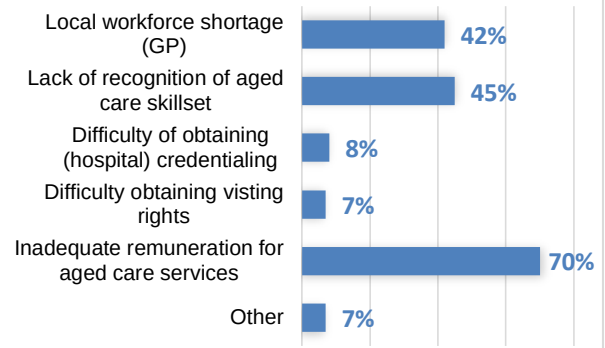
2.1.1 **SERVICE CONTRAINTS**



2.1.1.1

The freeform field, captured as **other answers** (10%), provided further insight into the service limitations in rural areas. Despite services being available, GPs report that these are often fractionated and poorly integrated, with distance factoring strongly as service provision is often dispersed across a region (which can be over an hour away for frail elderly patients). For those working within the RACF, the duplication of notes, in the absence of electronic health records (EHR) systems, and staff liaison more broadly as well as unqualified staff after hours were also cited as problematic. Scripts and drug charts also factoring highly on time. Restrictions to participation including those imposed by health insurers as well as privacy and accreditation restrictions in accessing RACF notes. Access to geriatric support was reported in South Australia including support for acute mental health. The more remote perspectives included an overall lack of facilities and services which include the provision of imaging services and overnight residential accommodation for some Aboriginal communities resulting in transfer to the mainland (Northern Territory).

2.1.2 **WORKFORCE FACTORS**



2.1.2

The most frequently reported **workforce** barriers to GP-led aged care identified remuneration for 70% of survey respondents nationally. This is consistent with results outlined in section 1.5 (which also identified un-paid service elements). Skill recognition is another key issue reported by 45% of GPs followed by local general practice workforce shortages (42%). Difficulty obtaining (hospital) credentialing (8%) or visiting rights (7%) were not seen as major barriers.

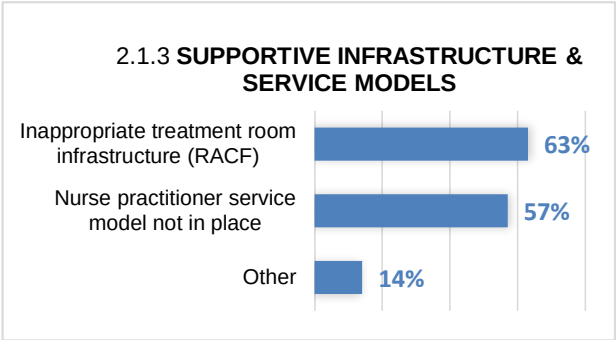
2.1.2.1

For the freeform response field, shown as other (7%) above, ensuring there are adequately qualified nursing staff in the RACF was seen as important. Dental services, lack of, was cited as another deficient area. Bureaucracy and red tape, which was not specified as a prompted factor, came through as well. Deficiencies in skillset of younger cohort and willingness to undertake aged care work was highlighted including the provision of after-hours cover. Practice viability issues including employing practice nurse. The remote perspective included a service deficit in the Northern Territory across aged care limiting service capacity and workforce capability.

2.1.3 **Supportive infrastructure or models**

Rural GPs were asked to indicate which **infrastructure and system factors** were the strongest driving factors limiting service provision.

Formal infrastructure in the form of a treatment room within the RACF was the strongest indicator at 63%. The lack of a nurse practitioner model, was also identified as a constraint (57%). It is important to note that only two multiple choice options were provided in order to field policy responses from participants in the freeform section (shown as other 14%).



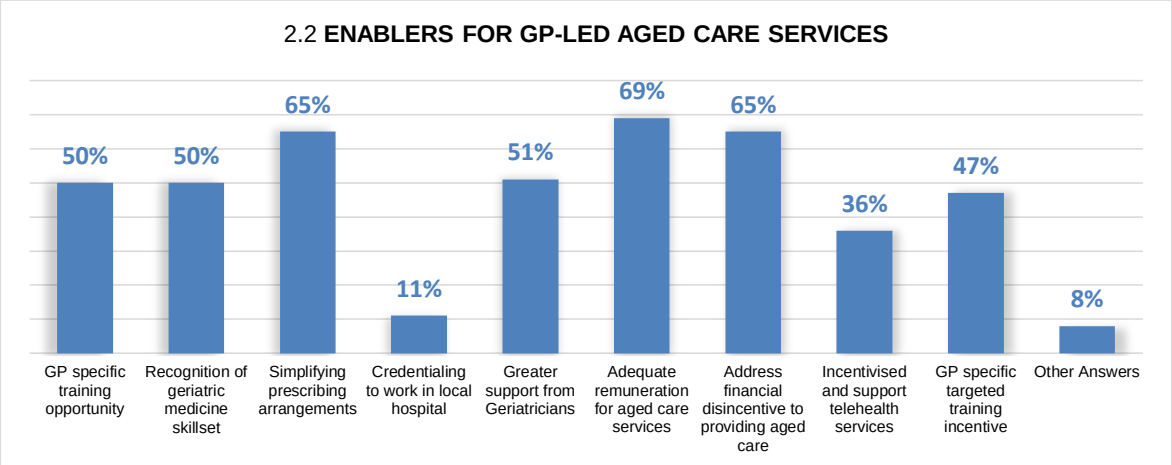
2.1.3.1

Other answers (14%) to the questions of supportive infrastructure and service models indicated a lack of specialist mental health care; poor integration between practice and RACF; and lack of facilities (RACF and hospital). The need for stronger integrated systems including those relating to charting and changing medications and avoiding duplication more broadly. The capacity of the nursing workforce factored strongly with a deficiency in the provision of experienced staff (RN Division 1) in the RACF and hospice setting resulting in trivial call outs. Private insurers servicing with own doctor was cited again as impacting patient/own doctor continuity.

In terms of models of care or service structures working efficiently, one example of where a service or integrated model has proven to work was provided in Victoria where the practice is co-located with the RACF and private not-for-profit community owned hospital.

2.2 **Key enablers to GP-led Aged Care in the community**

In identifying **system enablers**, the survey sought to explore the supports required to assist rural GPs in providing aged care services in their community. National results are illustrated in Figure 2.2.



2.2.1

Measures seen to alleviate service burden were simplifying prescribing arrangements (65%) adequate remuneration (69%) and addressing financial disincentives (65%). Greater Geriatrician support, training opportunity, skill recognition and targeted training incentives were considered enabling factors by approximately half of the GPs who participated in the survey. Credentialing to work in local hospital was not seen as a strong enabler (11%).

2.2.2

The freeform responses, although not a significant proportion at 8%, again provided more insights for areas of policy expansion including rewarding the full multidisciplinary team acknowledging the sector is underpaid for time consuming and complex work with many aspects done voluntarily and not funded.

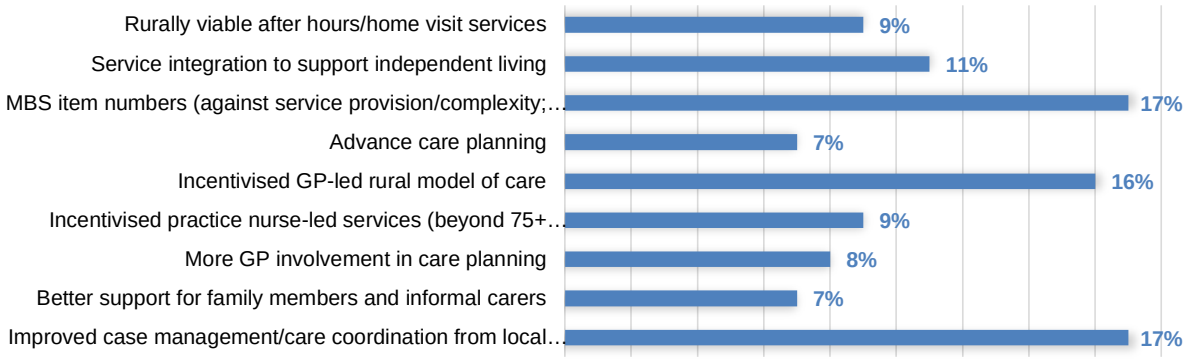
Broader workforce perspectives include recognition around time commitment, currently non-remunerated or underfunded, for the provision of aged care work. The need to address workforce shortages particularly in nursing to ensure stable levels and appropriately qualified and experienced nurses in RACFs was raised. Utilising interns in this space which requires reinstatement of previous training incentives, namely the PGPPP, at previous levels would also improve capacity.

Respondents provided a number of broader service expansion requirements including facilitating outpatient clinics at local hospital or community health centres. The need to prioritise rural and remote locations where RACFs are needed, which are particularly underserviced in the Northern Territory. Broader system improvement strategies were offered which included integrated IT systems (GP software) including the secure transfer of information between the GP and RACF interface with simplified processes for accessing notes. Addressing fragmentation in allied health services where the GP is not kept informed, as well as processes to ensure more transparency around individual GP incentives (RACF), as opposed to practice incentive, was also raised.

2.3 **Policy solutions to improve patient access and service**

The survey sought rural GPs views on the areas which, if supported, they believe would make a difference for their patients both in terms of **ensuring quality services** and in addressing access constraints. National results are outlined in Figures 2.3.1 to 2.3.4.

2.3.1 **EARLY INTERVENTION STRATEGIES**

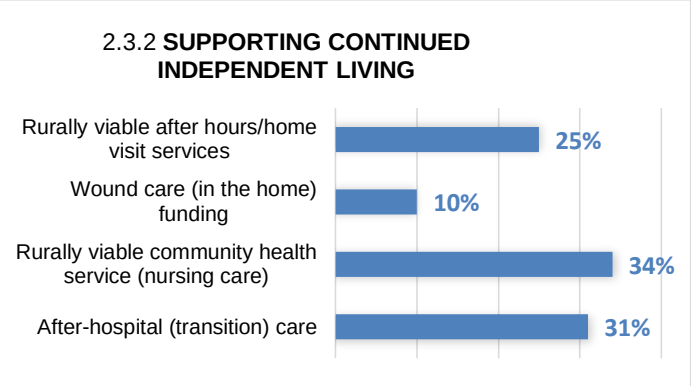


2.3.1

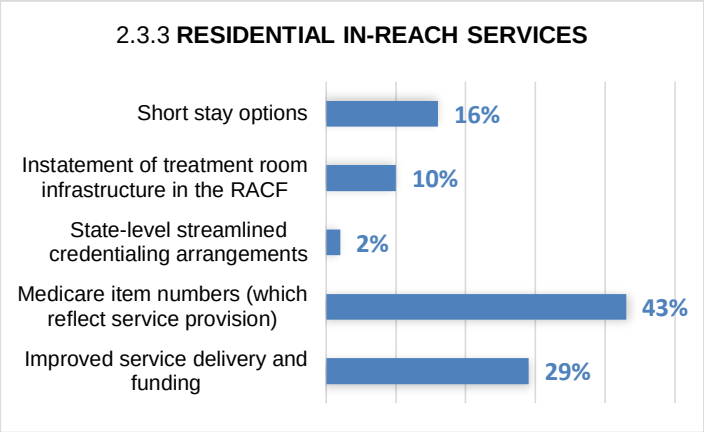
The strategies that rural GPs identified with most strongly to support care were evenly split between Medicare item numbers to reflect complexity of service and carer input, improved case management and coordination of care (17%), and incentivised GP-led rural model of care (16%). The other identified strategies listed in figure 2.3.1 ranged from 7% to 11%.

2.3.2

Around a third of rural GP responses ranking enablers that best **support continued independent living** identified more rurally viable community health service (nursing care) at 34% and after-hospital (transition) care (31%). After-hours/home visit services were 25%. Wound care (in the home) funding was only identified by 10% of respondents however in some areas community nursing might be providing the wound care required in certain areas resulting in lower reporting.



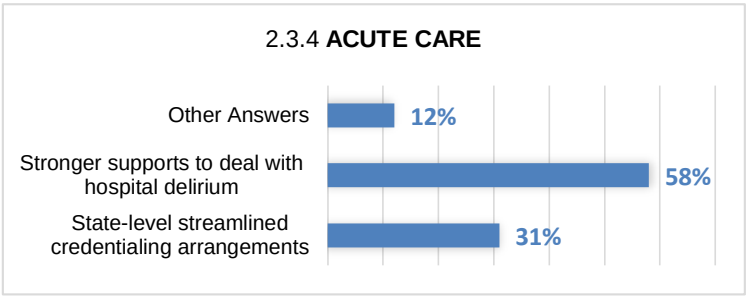
2.3.3



Improvements in **residential in-reach services** to enhance service provision again demonstrated strong support from survey respondents toward Medicare reform and instatement of appropriate item numbers at 43%, improved service delivery and funding was the next highest option selected at 29% and more funding to provide for short stay options at 16%. Infrastructure provision such as through the funding of appropriate treatment rooms in the RACF was only 10%, despite the findings in section 2.1.3, and credentialing issues again a lower service priority issue at 2% of respondents.

2.3.4

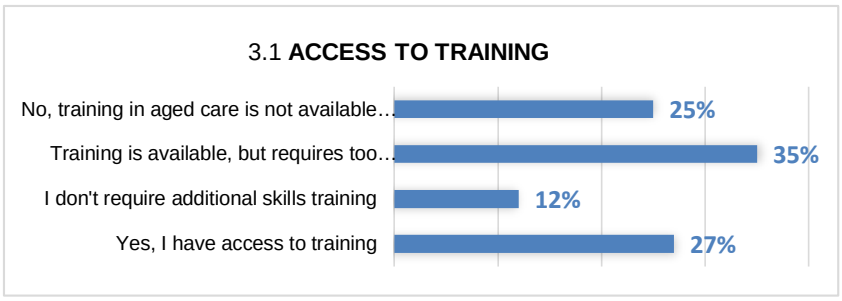
Solutions for **acute care** included a significant response for stronger supports to deal with hospital delirium (58%). State-level streamlined credentialing arrangements at 31% or just under a third conflicts with the earlier responses around credentialing .This could be reflective of the lower population of GPs dealing with acute hospital care patients.



The others answers, 12% showed: Enabling GPs to provide care in the hospital through appropriate remuneration structure and support at the hospital administration level to facilitate GP-led care. System improvements such as streamlined discharge planning to ensure more efficient release processes and stronger recognition of the GPs role in continuity of care with direct involvement beyond Discharge Summary. Adequate resourcing for hospitals including appropriate staffing levels and funding for more beds (to meet demand) and for short stay acute geriatric presentations. Interim facility for patients waiting placement in nursing homes. Appropriate resources including mobility aids and access to services which include occupational therapy, social work, paramedical services and broader specialist support through Telehealth (including to geriatricians).

Section 3 Training and skills

A discussion of skills has been presented from the results in sections 1 and 2 of this report, Survey participants were also asked to provide information around their **access to training** to help meet the needs of their aged care patients in their respective communities. In addition, the preferred format of training was explored. The results regarding access to appropriate training is detailed in figure 3.1 for policy purposes.



Survey results about access to training demonstrated that the distance constraints (35%) are an issue for rural GPs as well as the accessibility barriers for a quarter of respondents (25%). Some GPs reported that they don't need to upskill (12%), whilst 27% indicated that they have access to training.

Discussion

The **2016 RACGP Rural Aged Care Survey** results provide useful data for policy planners around GP-led aged care in rural and remote Australia. The survey demonstrates that the rural context adds to the challenge of managing patients, across each of the service settings investigated and the specific supports required to enhance GP-led care. The details around workforce and system barriers help to inform the key requirements for the development of rural models of care, in providing integrated and improved patient-care strategies.

(1) Service provision across settings

Addressing the difficulties faced by older patients as they access health care relies on strong system capacity to enable continuity of care. The complex needs and the broad range of services utilised by aged care patients requires careful planning to develop appropriate models of care in a changing workforce structure and aging population. Complexities arise as patients move in and out of primary and tertiary care, as some transfer between hospitals and aged care facilities while others may need support returning to a home setting or just to stay at home longer.

The barriers facing GP-led aged care, particularly within the RACF, are well documented.[3] These include the many non-costed elements such as travelling time and printing of scripts and the extensive non-clinical time required to provide high quality aged care and continuity of care through service integration in rural areas. The results of this research show that there are significant barriers preventing GPs from undertaking this important work across each of the key settings.

Participation factors

It is important to highlight that whilst the broad participation results indicate that there is strong rural GP participation across all of these settings, the **frequency of service** results shows a clear underutilisation with limited patient reach in each setting outside of the practice.

To facilitate greater access to aged care in rural communities, this research provides important input to the key policy requirements to secure stronger GP-led aged care in rural Australia. Future policy must prioritise the required structural shifts and incentivised supports in addressing low participation. Rural GPs need targeted incentives to increase their capacity to work outside of the practice setting. Particular policy attention is needed to lift the key barriers restricting hospital and RACF service participation as a priority, with more work required to increase participation in the private hospital setting in most states.

A clear finding is that the barriers to more frequent service provision need to be addressed across all settings. The results underpinning this requirement are clear: on a regular basis, or 1-2 visits weekly if set as an optimal service rate, in-home aged care provision in the community is very low. Whilst stronger provision was reported for

the RACF, regular participation still requires improvement with very minimal regular cover in the hospital setting requiring attention. For a further overlay of patient reach, RACF participation was tested, with the number of patients in a single visit against duration of the visit again sees limited patient reach. Against patient numbers, under 5 patients being the medium, but average duration of the visit less conclusive.

Remuneration constraints

Remuneration is key and it factored as a major barrier to participation outside of the practice throughout the survey. Examination of the fee structure by policy makers could turn one of the largest identified barriers to care into an enabler by recognising and adequately compensating GPs for the complex care required in aged care across all settings. Improved transferability of information using My Health Record as well as reducing the redundancy in non-renumerated system issues like printing scripts for RACF patients by utilising the *National Residential Medication Chart* would provide for more efficient services. Lifting the constraints confirmed throughout the survey, on both unfunded and underfunded service elements, across all settings, particularly as these relate to the family/carer interactions, will help to lift participation. Extending MBS items to capture unpaid service elements such as GPs doing a ward round, giving advice to nurses or undertaking family meetings would improve service frequency across these settings and improve patient access.

(2) Policy and system reform

It is well understood that the needs of aged care patients differ across service settings and each cohort has differing and complex care needs and are at different stages in their illness trajectory. Working through the service mix, as determined by local need and available resources, helps to clarify service gaps and improve skill utilisation.

Key barriers and enablers

The results show that despite services being available, they are often fragmented which can limit GP participation, with **time constraints and workload** impacting on the rural GP in providing such care. Inadequate remuneration is a constant barrier reported throughout the related survey parts. It is clear that responsive policy measures to address participation issues and aged care service reach rely strongly on adequate remuneration and addressing financial disincentives. A number of infrastructure and skilled workforce factors are also limiting service provision and quality of care. Solutions which include ensuring adequate infrastructure, such as a treatment room in the RACF, reducing the need for inappropriate transfers, simplifying prescribing arrangements and addressing duplication including through shared information system, would work to address some of these barriers and reduce system costs.

Service integration

Policy enablers to **promote integration** across each service setting would support stronger collaboration across full multidisciplinary teams. Integrated electronic records would simplify processes for accessing notes as patients move between the RACF and hospital setting and reduce the risk of medication errors from transcribing.

In promoting integration and avoiding duplication, there are some policy measures already in place which need broader coverage. Existing shared data systems including My Health Record need to be fully utilised to reduce system redundancy issues and over ordering of results. By extending the initiative of the 2014 Victorian amendment to the *Drugs, Poisons and Controlled Substances Regulations 2006*[4], the number of printed scripts required would be greatly reduced if the RACF was using the *National Residential Medication Chart.* This would address the largest reported barrier to RACF aged care in our rural GP respondents if this approach was adopted nationally and reduce duplication of scripts, medication charts and electronic medication records.

Quality workforce and utilisation

There was extensive additional input by members, in the freeform sections, which acknowledge a reliance on the full multidisciplinary team in providing quality aged care services. Ensuring there is appropriately qualified nursing cover also a high priority among the membership. Utilising trainees including medical students and interns would provide early exposure, promote interest in the field of aged care and help to lift local workforce constraints.

Service supports across settings

For continued independent living, enabling integrated support across the full multidisciplinary team including support for more rurally viable community health services and transition care arrangements is required to lift system constraints. By improving the integration between services as people move between them during their health care journey would assist in reducing unplanned readmissions and pressure on emergency departments as well as promoting continued supported living within the community. Expanded targeted incentives are required to support rural GPs to provide this care, particularly at the community level (in-home visits) which help the patient stay at home longer. **Rurally viable models of care** are reliant on a commitment to continued funding at levels which can sustain these services to reduce reliance on in-reach services and hospitalisations. These community level strategies also provide an incentive to the state as they offer a more affordable policy solution over time. Addressing poor service integration including fragmentation in allied health services where patient information flows are restricted would support stronger GP-led models of care.

Training and skills

Priority skills

The priority skills section showed very clear results of the most frequent types of medical services in each of three settings. The skills in demand do not differ significantly between settings: chronic disease management, chronic pain management, palliative care and acute care, however dementia and mental health issues factored more in the RACF and hospital setting. Specifically, dementia care and depression including mood disorders factored in the RACF and hospital delirium and dementia care relevant to the hospital setting.

Closer examination of the patterns across settings provide more perspective on the supports available in the community, or rural context, particularly as these relate to serious dementia or serious physical constraint (large and disabled). Palliative care, as another example, may often be managed in a dedicated unit or hospice but in a rural community this is often managed in aged care. There are also increased challenges in terms of those with limited mobility to remain in the home with many forced into institutional care early due to service limitations.

These results support future workforce planning and highlight a need to prioritise psycho-geriatrics, dementia and behavioural and psychological symptoms of dementia (BPSD) skillsets. A supportive strategy to ensure rural GPs have access to advice around the management of difficult psychogeriatric patients in these settings could be achieved through the investment in an online resource, similar to Tele-Derm. An eHealth store and forward national telehealth service would provide rural GPs access to specialist advice in a timely manner as well as provide a platform for learning and discussion. Other broader constraints such as those relating to Aricept (donepezil), which can only be initiated by a specialist, should also be reviewed to ensure access for rural patients with Alzheimer's.

Accessible training

Supporting skill utilisation and enabling GP-led aged care services provides for a more viable services solution in rural communities. In meeting current and future skill need through a highly skilled rural GP workforce it is clear that access to upskilling opportunities are key. The results of this research shows that there is a need to ensure training is accessible and can be undertaken in the local setting from within the rural community to reduce service impacts and time away from patients. This is consistent with broader research undertaken by the RACGP in advanced skills in 2014 where access to training is reliant on a supportive framework which enables service continuity and practice viability in rural areas.[5]

Limitations

The jurisdictional spread of survey respondents was limited in some states and territories but with no notable inconsistencies between responses comparable between states (unless otherwise reported). There was variation between the numbers of GPs who answered each question of the survey. Percentage calculations were based on the responses received for each question set, not overall response rate (or completion rate) reported for the full survey.

Conclusion

A common theme that has emerged through analysis of the responses to the 2016 RACGP Rural Aged Care Survey has been that care is being performed in many different models as seen in the freeform answers that enable local resources to be maximised. However GPs responses to the survey do show us that the valuable work that they perform in these different care settings are limited by the time they can take away from in practice work and that they are not being renumerated for the bulk of this work. Reducing redundancies in the system and restructuring the fee structure for aged care work in different settings would reduce the workforce burden and hopefully stimulate more interest in this growing area of healthcare.

Acknowledgements

RACGP Rural would like to acknowledge the 450+ rural GPs who prioritised their time to participate in this survey. The input of our members ensure our contribution to rural health policy remains well targeted and can address their needs and their patients' needs. Clinical lead Dr Claire Hepper who provided principal oversight of the survey development and post-survey data analysis and reporting. Dr Dimity Pond for contributions to the survey development.

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