RACGP

A best practice guide for collaborative care

Between general practitioners and residential aged care facilities

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Background

The Australian Government subsidised residential aged care as one of the primary types of formal care delivery for frail or disabled older people administered under the *Aged Care Act 1997*. From 1 July 2012, the Australian Government's Living Longer, Living Better aged care reform is being implemented progressively.

Primary medical care for older persons in residential aged care facilities (RACFs) includes management of chronic diseases and geriatric syndromes, acute episodic care, rehabilitation, preventive care, and palliative end-of-life care. While General Practitioners (GPs) are the primary medical care providers for older people in the community, including those living in RACFs, the patient's multidisciplinary care is provided by nurses, personal care assistants, allied health practitioners, specialist medical practitioners, pharmacists and nurse practitioners.

Providing medical care for residents requires the use of effective and robust practice systems with clear and transparent arrangements that support GPs working with multiple RACFs, as well as other members of the healthcare team. Due to the complexity of multidisciplinary care needs and multiple care providers, it is essential that systems of care and collaborative arrangements are clearly defined to ensure access to safe, timely, comprehensive and quality care.

General practice services are generally provided by GPs who are based in practices remote from RACFs. GP attendances at RACFs are funded through the Medicare Benefits Schedule (MBS), which operates on a fee-for-service basis. Thus, GPs are remunerated using item numbers based on the length and complexity of the consultation for each patient (or resident) they see at an RACF, and for specific services including comprehensive medical assessments, residential medication management reviews and participation in case conferences. Practice incentive payments are an additional payment to GP practices based on two tiers of qualifying service levels. GPs may directly bill clinical services or alternatively charge a fee that includes a patient contribution. Due to the nature of work in RACFs, GPs provide a variety of services that are not face-to-face, which are unremunerated by Medicare and may attract a fee. Face-to-face services usually will attract a fee, which may in whole or in part be covered by Medicare.

Purpose of collaborative arrangements guide

This guide serves to provide GPs, general practice staff and RACF staff with advice regarding best practice for collaborative arrangements for the care of older persons ('residents') in RACFs in Australia, and has been designed to be read in conjunction with the RACGP (silver book) *Medical care of older persons in residential aged care facilities.*

The advice provided here is in alignment with the Living Longer, Living Better aged care reforms in Australia, which aims to provide older Australians with more choice, control and better access to care informed by clinical need – regardless of whether they are new or existing residents, and across both high- and low-care RACFs.

Specifically, the guide has been developed with the following aims in mind:

- To offer older Australians living in RACFs access to the safest, highest quality ongoing and timely primary care
- To identify favourable processes to assist parties in creating an efficient and effective service provision environment
- To clearly identify roles and responsibilities, mutually agreeable processes for consultation, referral and transfer of a resident's care, and to provide clarity between both parties
- To facilitate a continuum of care
- To minimise the potential litigation risk to GPs and practice and RACF staff
- To foster solid working relationships that will subsequently serve to assist, retain and encourage more GPs to work in RACFs
- To address the current barriers to providing care to residents of RACFs
- To achieve high levels of satisfaction for all parties involved
- To ensure residents are aware of likely costs of GP services.

Included in the guide are eight key areas for consideration:

1. Access to clinical care and management of medical records
2. Protocols for referral arrangements
3. Communication protocols
4. Medication management
5. Pathology and imaging
6. After-hours and emergency care
7. Remuneration for services including non-MBS-reimbursed work
8. Ongoing review of collaboration and quality assurance.

It is highly recommended for resident (patient) safety that the appropriate time is taken to read and, in turn, discuss the key areas and accompanying issues in the guide, with the aim to reach mutual understanding and agreement between the GPs (and their practice staff) and the RACF staff.

1. Access to clinical care and management of medical records

GPs caring for people in RACFs should ideally be able to provide routine visits during business hours at mutually convenient times for general practice and nursing staff. In committing to care for residents, GPs should ensure that they will be able to undertake regular clinical visits to the RACF. This is more likely to be practical when a GP provides care for multiple residents in a limited number of RACFs convenient to their practice, than to commit to care for individual residents over a wide geographical area.

It is important that the scope of clinical care and practice are clearly defined and understood to avoid unnecessary confusion and adversarial situations.

Both the GP and the RACF should be mutually agreeable to, and clearly understand, the roles and responsibilities regarding the provision of clinical care and management of medical records.

Discussions may also include members of the extended healthcare team, such as local pathology and imaging services, local/contracting pharmacist and other allied health professionals who may receive referrals from the GP.

Medical records, including electronic medical records, should ideally be routinely shared between the GP and the RACF to ensure access is available at all times, and that up-to-date pathology and radiology results are included and signed off by all parties involved.

Arrangements should also be in place for when the GP deems it is appropriate, or is required in an emergency situation, to share relevant information from the resident's medical record with a third party. For further information in relation to sharing relevant information from the patient's medical record, please refer to:

- The RACGP *Standards for general practices* (4th edition, 2010), available at www.racgp.org.au/standards
- The RACGP Handbook for the *management of health information in general practice* (2012), also available at www.racgp.org.au.

2. Protocols for referral arrangements

General practice cannot be expected to work alone in the complex care of residents in aged care facilities. Multidisciplinary care is essential, via the provision of aged care assessment teams, geriatrician consultations and other essential specialist and allied health services including psycho-geriatricians or palliative care specialists, dentistry, optometry, podiatry, speech therapy and pharmacy.

Medical specialist referrals are generally made by a GP. However, where RACFs employ a nurse practitioner, protocols for effective and appropriate referral should be clearly articulated and documented if possible. General nursing staff and residents themselves may initiate referrals to allied health professionals including physiotherapists, dentists and optometrists as would occur in the general community. Records of such referrals and subsequent allied health consultations should be provided to the GP. GPs may also from time-to-time recommend or refer to additional allied health services.

3. Communication protocols

Clarification and agreement in relation to expectations around communication is pivotal to effective and efficient collaboration. Communication represents the greatest area of risk in terms of quality and safety, and consequently may lead to issues of indemnity. Arrangements around two-way communication and the handover of clinical details between the GP and the RACF are critical to help ensure high-quality patient outcomes and the minimisation of disputes.

It is important to clearly identify the expectations and requirements of both the GP and RACF, including:

- the preferred method of contact across different circumstances, from routine care to emergency care, and for the handling of pathology and imaging results
- the provision of discharge information and prior medical records to a GP resuming care when their patient is transferred to an aged care facility
- the compatibility of and access to medical software
- respectful and appropriate communication with the enduring guardian(s) and carer(s) of the resident regarding their clinical condition and care plans (with regard to the relevant carer and privacy Acts) – this may include participation in case conferencing.

4. Medication management

The RACGP believes the quality use of medicines requires the close cooperation of all prescribers before the addition of any new medication for an individual resident. Medication misadventure is a common cause of adverse patient events, avoidable hospitalisation in the elderly and indemnity risk.

Poly-pharmacy, the concurrent use of 5 or more prescription medicines and-over-the counter or complementary medicines, constitute a particular risk. This highlights the importance of involving the usual or treating GP in avoiding drug–drug or disease–drug interactions.

Residential medication management reviews provide an important support for the treating GP in the quality use of medicines.

5. Pathology and imaging

It is highly recommended that arrangements be put in place to allow for routine results and seriously abnormal and life-threatening results, identified by a pathology provider, to be conveyed to both the treating GP and the RACF in a timely way. By implementing these arrangements, both the treating GP and the RACF can make an informed and appropriate decision for the resident's health and wellbeing, which is acted on promptly. The RACF should aim to file all pathology and imaging results for all residents after ensuring these have been reviewed and signed off by the treating GP.

6. After-hours and emergency care

In the event that the treating GP is unavailable, and/or urgent and emergency care is required, it is important that appropriate care for the resident is determined and agreed upon.

The effective follow-up of abnormal and life-threatening results relies on robust and reliable systems for contact and escalation of care.

Incidents that may need hospital assessment and/or treatment include:

- profuse bleeding of unknown cause
- altered state of consciousness
- new acute condition, e.g. fit, chest pain

- persistent acute symptoms of existing conditions not relieved by RACF care, e.g. respiratory distress
- infection requiring intravenous therapy
- gastroscopy tube replacement
- bone fracture.

Incidents that may need after-hours GP care include:

- symptomatic infection, e.g.urinary tract infection, cellulitis, chest infection
- behavioural problems
- significant change in wellbeing
- lacerations
- catheter replacement for low-care residents
- medical assessment of acute incidents, e.g. unwell, fall, injury.

The general condition of the resident, family preferences and any existing advanced care plan should also be taken into consideration before transferring a resident to hospital. To prevent inappropriate transfers to acute facilities, it is preferable that the treating GP or their delegate be consulted prior to transfers occurring.

7. Remuneration for services including non-MBS reimbursed work

Staff at the RACF need to be aware that GPs provide a wide range of services to residents, and some may be partially or not at all remunerated under Medicare. These include:

- phone calls, sending and receipt of faxes
- provision of prescriptions
- gathering information in relation to previous history
- interviews with relatives
- liaison with other health professionals.

Efficient protocols for information gathering and communication facilitate more effective use of GP services. This ensures that resident's costs for these services are minimised.

Where GPs are requested to provide consultative services to the RACF, including participating in committee work, consideration should be given to the GP's costs and time payment arrangements.

8. Ongoing review of collaboration and quality assurance

It is recommended that the collaborative care arrangement should be subject-to-continuing quality improvement and, from time to time, a review process as deemed appropriate by the treating GP and the RACF. The review of the arrangement should be a positive initiative to identify opportunities for improvement, and could be triggered early by either party if concerns are raised.