RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part B. Older people in rural and remote communities

General principles

- Providing care for older people is a key role for rural and remote community general practitioners (GPs) as there is high demand, the care needs are complex and the access to services limited.
- Older patients often migrate towards urban areas as their care needs increase, but the experienced rural GP can advocate, coordinate and recruit appropriate services to the township and strengthen the community.
- New GPs who arrive to a rural or remote community should seek to understand the pathways older people often follow and seek opportunities to support care in their home location.
- Completing an Advanced Rural Skills Training qualification in internal medicine or palliative care provides important aged care skills and is an important enabler for other GPs and health services.
- A key enabler for better aged care in rural and remote locations is for the GP to actively communicate and build relationships with relevant public and private aged care medical and allied healthcare services, including private and public telehealth services.
- Models of care for residential aged care facility (RACF) medical services in rural and remote areas need to balance the need for GP-led care with the reality of GP workforce constraints.
- Collaborative models of care involving nurse practitioners, nurses and other health professionals may be required to prevent fatigue and burnout in rural clinicians to manage the 24-hour health needs of the RACF community.

Introduction

Australia's ageing population is more prominent in rural and remote communities: 40% of all Australians aged 70–74 years live outside the capital cities, compared with 25% of those aged 25–29 years.[1] The provision of quality medical care for older people remains core business for rural and remote general practitioners (GPs), and they are well skilled to navigate the complex decision making involved.

While younger patients may be willing to travel to regional and city communities for sub-specialist level care or investigations, older people are more likely to decline treatment or investigation options based on the inconvenience of travel or potential displacement.[2] This therefore places more pressure on rural and remote GPs to make clinical decisions with limited information.

Older people in rural and remote communities are also more likely to use community aged care services than residential aged care facilities (RACFs), most likely because of a lack of available facilities and beds. The largest challenge for rural and remote GPs therefore largely centres on supporting patients to remain in their home location when there are limited in-home and assisted living facility options. Many rural locations benefit from the federally funded Multi-Purpose Services Program, which provides some accommodation options to areas of need. The rural GP might need to advocate for such services to come to their town.

Characteristics of older people

Older people in rural and remote areas generally have lower incomes, experience greater levels of disability, reside in poorer quality housing, and have lower levels of completed education.[3] All of the factors aforementioned have been associated with worse health outcomes and higher per-capita need for aged care support.

These factors are even more compounded when adding in the complexities of older Aboriginal and Torres Strait Islander peoples in rural and remote communities, who generally require access to aged care services at a much younger age than their non-Indigenous Australian counterparts (refer to Part B. Older Aboriginal and Torres Strait Islander people). In addition, they are likely to experience poorer health status and lower average life expectancy.

Role of rural and remote GPs

The role of the GP within the aged care team in rural and remote communities will vary according to the resources of the town and relative access to secondary and tertiary services. There are many aspects of care that are well within the scope of the experienced GP that would otherwise be provided by a geriatrician in a resource-rich environment.

This may include working up new cognitive decline in patients, and managing multiple complex conditions in the one patient (eg renal failure, advanced stages of Parkinson's disease). The complex care may also include navigating the non-pharmacological and pharmacological options to treat the behavioural and psychological symptoms of dementia (BPSD; refer to Part A. Behavioural and psychological symptoms of dementia).

Doctors who find that this work becomes a significant part of their rural workload may consider completing an Advanced Rural Skills Training (ARST) qualification in internal medicine with The Royal Australian College of General Practitioners (RACGP) Rural as a structured and supported way of gathering experience, confidence and recognition of the additional skills needed to care for this population. The ARST in palliative care would similarly be an important contribution to the rural and remote communities as an enabler for in-home care and support for other clinicians.

Rural and remote GPs serve as the subject matter expert in understanding local community resources and available federal, state and private health services. Despite aged care being well within the skill set of the GP specialist qualification, there are still some areas where sub-specialist involvement is clearly required. This may be to enable access to certain Pharmaceutical Benefits Schedule (PBS) medications for assistance in complex diagnoses or for treatment plans in complex disease, and there are several methods available for accessing support.

Appropriate lines of communication

It is important that rural and remote GPs develop appropriate lines of communication and links with tertiary services in order to provide the maximum amount of care possible within the rural or remote environment. Good communication between rural and remote clinicians and tertiary-led physician care can save patients from travel, and can often lead to quicker diagnosis and management of some conditions. Options for lines of communication include the following:

- Many rural and remote sites will benefit from visiting non-GP specialist services, and the local state health facility should have a record of the frequency and referral pathway for visiting services.
- GPs should consider using telehealth services where sufficient communications infrastructure is available.
- There has been a significant rise in the number of bulk-billed telehealth services, with private physicians and geriatricians making themselves available across the country. This provides an important access point for some rural and remote patients, especially where waiting lists at the state-run tertiary supporting facility might be long.
- It is worth developing a good relationship with physician and aged care services at the nearest state-run service. Generally, the physicians will be very supportive of providing remote care, advice and support to enable the patient to receive treatment in their home location.
- Patient–nurse teleconferences with sub-specialists via telehealth referral with written response and plan given to the GP.
- Ad-hoc telephone calls with relevant sub-specialists can be made on a case-by-case basis.
- If the GP is remunerated by a state salary, teleconferencing and ward rounds for case discussions should be scheduled with the relevant tertiary facility.
- Patients may travel to tertiary services and receive clearly written management plans and appropriate follow-up support for the rural and remote clinician.
- Tertiary delivery of rural and remote specific education programs can be made to the GP in their home location with a focus on relationship and capacity building between the two services.

Barriers

No single rural and remote community's healthcare and aged care needs will be the same, and solutions must be tailored accordingly depending on the patient demographic. Often, the most significant challenges in rural and remote aged care relate to:

- cost
- access to other specialist medical practitioners and allied health professionals (eg physiotherapists, occupational therapists, speech pathologists, social workers, dentists, pharmacists)
- recruiting, training and supporting professional care staff
- professional isolation and lack of networking opportunities.

Access limitations

Despite the ability of rural and remote GPs to meet many of the primary-care needs of the rural and remote aged cohort, there remains a propensity for the ageing population to migrate towards more regional or urban settings. Australian Institute of Health and Welfare (AIHW) data found that those aged ≥65 years make up 13% of the population in major cities, but only 10% of the population in remote and 7% in very remote areas.[4] Factors for this will include the following:[5]

- Access to routine medical services is limited the more remotely people live; however, the needs for these services increase exponentially with age (ie pharmacy, general practice appointments, imaging, allied health, nursing care).
- Access to home services and modifications is absent in most remote areas and many rural communities. There remains an invisible but impervious barrier around most tertiary facilities; home services will cease beyond just a handful of kilometres.
- Many rural and remote townships will not have facilities for assisted living or high-level nursing care, so forward-planning retirees will often plan wisely for their increasing care needs and move closer to advanced health services.

A skilled and well-equipped rural and remote GP who provides an excellent standard of aged care builds capacity for the township, as the effect of an exodus of retirees from a rural and remote community should not be underestimated. There is a significant 'brain drain' that occurs when aged care recipients migrate towards regional centres. For example, the wisdom of years of experience on the land, the mentorship and support for the next generation, and even the childcare for the younger families serve as important enablers for community prosperity.

The high healthcare needs of an ageing population in a rural and remote community can sometimes draw in health services, including allied health, GPs and general practice registrars, pharmacy and imaging facilities. This therefore restores vigour and activity to a dwindling community. Healthcare staff, facilities and their families bring new life to the community, and, here, the confident and skilled GP has served as the conductor, recruiter and enabler for the community.

Workforce shortages

RACF patients have high care needs that span all hours of the day and week, and GP-led care is a core component of quality aged care. In areas of workforce shortage, the tendency will be for the on-call burden to be carried by a small number of GPs, and this can be a contributor to GP burnout and stress. Models of care for aged or RACF patients in areas of workforce shortage must protect the GP from low-value clinical interactions and allow them to take the role of diagnostician, collaborator and manager of the care needs. Care models should consider:

- written clinical pathways for common conditions after hours that do not require attendance of a doctor (refer to Part B. Provision of after-hours aged care services)
- adequate senior nursing staff at the facility in the after-hours period to provide independent clinical assessment and management
- collaborative models of care with nurse practitioners used to their full scope of practice in partnership with general practice
- collaborative models of care across multiple smaller GP practices to share the after-hours needs of the residents.

Checklist for newly arrived GP

GPs who arrive at a new location to provide rural and remote care to older people may find a change in their clinical workload, with a significant increase in complexity, which can be overwhelming. These new GPs may benefit from familiarising themselves with the contents of the Silver Book, and seek to understand the following contextual issues:

- Pathways for imaging and pathology for cognitive workup. For example, understand which town has the necessary facilities, and what waiting lists, travel subsidy entitlements and distances are involved.
- Allied health availability and referral pathway for managing common aspects of ageing. For example, occupational therapy, speech pathology, physiotherapy, pharmacy, My Aged Care services, home nursing, Meals on Wheels or other community services.
- Clearly understand the capability of telehealth services in the patient's home or in your facility. For example, type and cost of internet access, speeds and accessibility.
- Pathway for referring to other specialist medical practitioners for involvement in prescribing and decision making in aged care. For example, state-based hospital referral options including telehealth or face-to-face options; alternatively, private telehealth or face-to-face services.
- Communication pathways for seeking other specialist medical practitioner support in managing complex chronic disease in older people, which will generally come from the nearest tertiary referral centre. These relationships are highly valuable for effective patient care and, sometimes, it means picking up the phone and asking for the consultant on call.
- Understand the geographic decision making and pathways that your community members commonly follow as they age and as their medical care needs escalate. This will enable GPs to better understand the considerations involved during shared decision making.

GPs who provide aged care services in their rural and remote locations support intergenerational growth and multidisciplinary health capacity for the region. With appropriate lines of communication and an understanding of the resources and context in which they work, GPs are well within their scope to provide excellent aged care services.

References

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