NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Spotlight on virtual care: Geriatric Medicine Outreach Service

Sydney Local Health District
Western NSW Local Health District
Far West Local Health District

MAY 2021

Virtual Care Initiative

A collaboration between local health districts, speciality health networks, the ACI and eHealth NSW.

The 'Spotlight on Virtual Care' reports showcase innovation and leadership in virtual health care delivery across NSW. The series aims to support sharing of learnings across the health system and outlines the key considerations for implementation as identified by local teams.

Each initiative within the series was selected and reviewed through a peer-based process. While many of the initiatives have not undergone a full health and economic evaluation process, they provide models that others may wish to consider and learn from.

These reports have been documented by the Virtual Care Accelerator (VCA). The VCA is a multiagency, clinically focused unit established as a key partnership between eHealth NSW and the ACI to accelerate and optimise the use of virtual care across NSW Health as a result of COVID-19. The Virtual Care Accelerator works closely with Local Health Districts (LHDs) and Specialty Health Networks (SHNs), other Pillars and the Ministry of Health.

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Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**

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Introduction

The Geriatric Medicine Outreach Service (GMOS) provides cross-district virtual geriatric consults to people living in rural and remote areas. It addresses the gap in specialist geriatric services available in rural and remote West and Far West NSW. Improved access to specialist geriatric care strengthens health outcomes through a multidisciplinary approach to care.

The GMOS began in the year 2000 as a partnership between Concord Hospital (Sydney Local Health District – SLHD) and the Broken Hill aged care team to improve access to specialist geriatric care in Far West Local Health District (FWLHD). In 2009, the model expanded to provide care into Western NSW Local Health District (WNSWLHD). The service has evolved to now provide a hybrid model of face-to-face and virtual care to patients requiring access to specialist geriatricians.

People are referred by their general practitioner (GP) or community health services. A package of care is provided, which includes:

- an assessment and triage of the referral by the local aged care team
- a home visit by a WNSWLHD or FWLHD aged care clinician to complete the pre-consultation assessment, assist with the virtual consultation and to connect the patient to support services
- a virtual consultation with a SLHD geriatrician supported by the WNSWLHD or FWLHD aged care clinician to address results of the pre-consultation checklist
- a comprehensive assessment and geriatrician report sent to the patient's GP with recommendations to support onward management and continuity of care.

SLHD provides approximately 10 virtual sessions a month across WNSWLHD and FWLHD. Two to three patients are seen each session. In 2019-20, SLHD geriatricians provided 79 virtual sessions, providing specialist geriatric consultations to 160 people within WNSWLHD and FWLHD. These were complemented by 10 face-to-face sessions in WNSWLHD where 56 patients were reviewed.

The GMOS support people at home or in residential aged care who require comprehensive specialist aged care management. It does not provide care to those who are inpatients and acutely unwell. Patient cohorts who are not clinically appropriate for this service are described in the service model on page 8.

The model operates as a partnership between SLHD and the patient's LHD (WNSWLHD or FWLHD) and is underpinned by a formal service level agreement.

Reported benefits of the model

Patient benefits:

- Access to specialist geriatric care close to home (which is usually not available without significant travel, associated costs and the need for escort by family/carers)
- Access to a virtual appointment faster than a face-to-face appointment, without the need to travel. The service aims to conduct a geriatric review within six weeks of receiving a referral
- Less reliance on carers and families to assist with travel
- Family members and carers can easily participate in the virtual consult to support the patient receiving care (with their consent) without the need to travel
- Improved health outcomes through a multidisciplinary team approach to care (specialist aged care clinician, geriatricians and GPs).

Clinician benefits:

- Improved access to specialist geriatric care into rural areas
- Geriatrician input provides primary care staff and aged care teams with enhanced knowledge and confidence, strengthening their capacity to better manage a patient's care
- Ensures continuity of care with the patient's GP in the local community
- Increased support for rural GPs to manage their patients' complex healthcare needs.

Service benefits:

- Improved provision of geriatric specialist services locally
- Supports existing workforces in rural and remote communities
- Cross-organisational collaboration has become business as usual
- Operates in a cost neutral way for all LHDs involved
- Underpinned by simple technology and processes (see page 11).

'Our outreach geriatric medicine model is a successful and sustained collaboration, which has become business as usual. It has provided a vulnerable older population access to a clinical service where previously there was no other option... My participation in this service is one of the most worthwhile and enjoyable aspects of my clinical practice.'

ASSOCIATE PROFESSOR JOHN CULLEN, SENIOR STAFF SPECIALIST, CONCORD HOSPITAL, SLHD

Overview of the model

Key elements of the model

Element	Detail
Patient population/service users	• People living in WNSWLHD or FWLHD who require a specialist geriatrician assessment.
Referral pathway	• A GP referral is required to access the service. • People are referred into their local aged care service and scheduled an appointment with a geriatrician • People requiring a specialist geriatric assessment are managed by the referring LHDs.
Healthcare team	Members of the healthcare team who may be involved include: • specialist aged care clinician • geriatricians • community nurses, Multipurpose Service (MPS) nurses • GPs • Residential Aged Care Facility (RACF) staff.
Technology	• Pexip (videoconferencing platform) • Clinicians use desktop videoconferencing machines (Cisco DX80) • Patients join using staff laptops or videoconferencing machines • Family members use personal devices • Electronic medical record (eMR) for uploading of patient notes and geriatrician letters.
Funding	• Consultations are bulk-billed to Medicare by the rural LHD • A service level agreement is in place between LHDs, whereby SLHD invoices the rural service for clinician time/sessions.

Services

This service provides specialist geriatric input to rural LHDs. The virtual components provided by this service complement existing face-to-face aged care services.*

Most referrals received by the service require specialist geriatric input for:

- cognitive assessment
- medication optimisation
- fall reviews
- driving reviews
- chronic disease management
- multiple comorbidities and complex health conditions
- gait assessments
- carer support and education.

'This program allows for confidential patient consultation and if suitable to the patient, involvement with carers and others to address all aspects of care.'

DEBRA TOOLEY, DISTRICT MANAGER AGED CARE DIVISION, WNSWLHD

* See aged care service information booklet and geriatric medicine service brochure in Supporting documents list

A carer's experience:

'We don't have a geriatrician in Dubbo. The nearest one is in Orange… two hours away in the car. We would never be able to do that with mum. She doesn't understand that there is anything wrong.

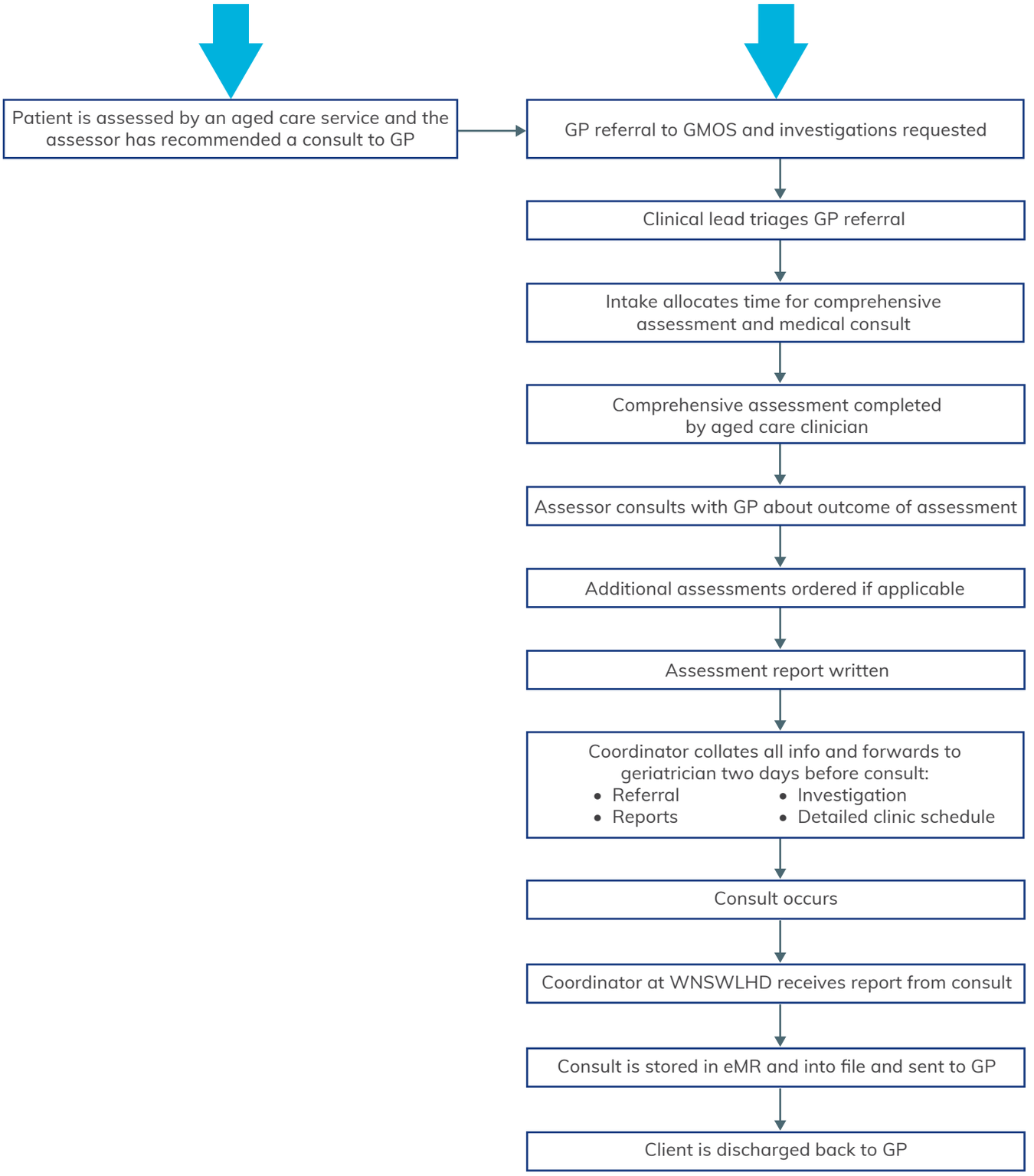
The nurse came to our house first. She asked a bunch of questions and made an appointment for us to go to the hospital in Dubbo for an appointment. The same nurse who was at the house was at the appointment. Mum remembered her so that really helped.

The doctor on the computer was in Sydney. He diagnosed mum with dementia. Getting a definite diagnosis made such a difference. It meant everything made more sense and should mean that she can get the care she needs. I think other people should think about seeing the geriatrician this way. It has been so reassuring to get the diagnosis and I don't think we missed out on anything by doing it via the computer.'

CARER OF PATIENT IN WNSWLHD

Workflow diagram

The large arrows in the diagram below represent where a patient may enter the service. Irrespective of how a patient enters the service, a GP referral is required.



Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the supporting documents section at the end of this report also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

Service model

- The service has a clearly defined scope to ensure virtual care is only used when clinically appropriate. This type of outpatient management is not appropriate for people who are acutely unwell and in hospital. Patients who may be out of scope for virtual care include:
  - people with behavioural problems who may be hard to engage
  - people who are deaf or hard of hearing, may need the support of an LHD interpreter

  In these cases, a patient may need to be seen by the geriatrician face-to-face.
- SLHD geriatricians are credentialed in the rural LHD they are providing care to. The geriatricians have access to eMR to record directly into the patient record. This access allows clinicians to review results including imaging and pathology.
- A pre-consultation patient checklist (in WNSW this is a comprehensive aged care assessment report) is completed by the referring LHD's aged care team and patient's GP and provided to the geriatrician. This is managed within existing aged care services.
  - Pre-consultation checklist:
    - Dementia/delirium screens
    - Mini-Mental State Examination (MMSE)
    - Geriatric Depression Scale (GDS) assessment
    - Medication list
    - Medical history
    - Relevant pathology or imaging.
- Most patients will only have one geriatric medicine consultation. Follow-up care is provided where clinically required. A key feature of this service is the information provided prior to the consultation, which defines the matters needing to be addressed.

Processes and clinical protocols

- The referring LHD schedules appointments and manages clinic lists.*
- Referrals are triaged and scheduled by the intake centre or aged care service in the referring LHD. The service aims to conduct a geriatric review with all patients within six weeks of the referral being received.
- Clinic lists, patient information and clinical history are electronically provided to the geriatrician two days before the clinic.**
- Patients who access a virtual geriatric consultation are accompanied by an aged care clinician, community nurse or Aboriginal health worker who provides support.
- To ensure continuity of care, the patient's existing GP continues to have medical responsibility. This service provides GPs with management recommendations.***
- The service does not manage acutely unwell patients. In the event of deterioration, the patient or their family/carer will be directed to present to their local emergency department.

Clinical governance

- Clinical governance is predominately managed by rural LHDs, as the Geriatric Medicine Outreach Service is complementary to the face-to-face services they offer. The aged care services in the rural LHDs report within their existing governance structures.
- For both virtual and face-to-face services, a monthly meeting occurs to review:
  - the quality of the service provided
  - incidents and near misses
  - complaints and compliments.

Considerations for implementation: service level agreement

- A service level agreement between the LHDs clearly describes the services this model provides. The agreement identifies responsibilities, details of the service, allocated time, escalation pathways and the funding arrangements between the referring LHD and the LHD providing the consult service.
- Rural LHDs are responsible for:
  - management of referrals
  - comprehensive client assessment
  - liaising with GPs to arrange appropriate diagnostic tests
  - preparing client assessment reports and transmitting these to geriatricians at least 48 hours prior to clinics.
- SLHD is responsible for:
  - providing consultant geriatricians to provide virtual care services to the rural LHDs
  - providing rural LHDs with virtual care clinic dates at least three months in advance
  - preparing comprehensive patient records and transmitting these to rural LHDs within seven working days of the patient consultation.

* See Appointment clinic template in Supporting documents list.

** See Geriatrician medicine consult checklist and Clinicians report template in Supporting documents list.

*** See Geriatric medicine consultation for GPs and Geriatric medicine clinic referral in Supporting documents list.

Building engagement

Key partners and stakeholders

- Family and carers are key partners in the management of the patient's care. Aged care teams and other specialists rely on their interactions with family and carers to understand more about the patient's condition at home.
- The local aged care team directly supports the patient during the consultation, providing and managing the technology to ensure a successful connection. GPs are the referrers into the service and work closely with the aged care team to organise any investigations prior to the consultation. GPs manage patient care in partnership with the geriatrician and continue management of care after a patient is discharged from the service.
- The Concord Hospital (SLHD) geriatricians are critical to the model as they provide the specialist medical input.

Clinician engagement

- Initially, some local GPs raised concerns that specialist geriatric services could not be delivered virtually. These concerns were addressed by establishing a strong partnership between service providers. GPs retain medical management of their patients, which increases engagement. GPs are provided with a report with recommendations following the virtual consultation.

Patient and carer engagement

- People are always supported at the consultation by a staff member, either in their own home or at a health facility.
- Family members and carers are encouraged to attend consultations with the patient (with their consent), or from another location. The use of virtual care allows for this, when distance may have previously prevented them from being a part of the consultation.

Considerations for implementation

- Engage local GPs in the planning, implementation and evaluation of the service.
- Building strong relationships between the local healthcare team (GPs, aged care teams, community nurses, Aboriginal health workers) and the geriatricians and supporting specialist aged care teams is critical to the success and sustainability of the service.
- A program coordinator acts as a key point of contact for all incoming referrals and manages all enquiries (clinics, Medicare claiming and reports) related to the service.

'I didn't think this would be 'real care' via a virtual platform, but strong and enabling partnerships gave WNSW a sustainable and creditable specialist aged care service which is available across all rural and remote towns, reducing the burden previously associated with accessing specialist care.'

DEBRA TOOLEY, DISTRICT MANAGER AGED CARE DIVISION, WNSWLHD

Workforce, technology and resourcing

Technology

- The model uses existing NSW Health videoconferencing platforms to facilitate a video link between SLHD and the rural LHD. These platforms include Pexip or a direct call on videoconferencing endpoints.
- At SLHD:
  - clinicians use a videoconferencing endpoint
  - clinicians have access to the referring LHD's eMR, allowing patient notes to be documented directly into the system. A letter is sent to the patient's GP following the consultation.
- At the rural (receiving) LHD:
  - patients are supported to access care by a specialist aged care team member, Aboriginal health worker, or in some cases a community health nurse
  - patients either join using a videoconferencing end point at a NSW Health facility, or a laptop in their home or residential aged care facility. Family members unable to be with the patient are provided instructions to join the call
  - LHD devices can be used with a Wi-Fi connection or mobile phone internet hotspot at a patient's home or other location. Where the internet connection is insufficient to allow a videocall, arrangements will be made for the patient to connect from a NSW Health facility.

Training and Development

- Service staff are provided with comprehensive training and education to support the successful use of virtual care as a day-to-day practice tool. This includes the use of videoconferencing platforms and how to troubleshoot issues.
- Geriatricians use videoconferencing to provide continuing education and case conferencing with staff in the rural LHDs.

Staffing Model

- This model has been implemented using existing staffing.
- The medical model provides a geriatric specialist service which is not available in the LHD. It is supported by face-to-face clinics in WNSWLHD approximately 10 days per year.
- Six geriatricians dedicate over 10 virtual clinics each month. Three geriatricians provide face-to-face clinics in WNSWLHD.

Workforce

- Delivering care virtually is embedded within the service and orientation programme.
- Despite the service having face-to-face and virtual components, there is a focus on providing patients with all required care at the same time.

Data

- All data is recorded and captured by the rural LHD. Medicare claiming is completed by the rural LHD.
- The aged care teams and community nursing clinicians providing the service are employed by the rural LHD and the SLHD geriatricians are credentialed by WNSWLHD and FWLHD. Therefore, activity is only reported by the rural LHDs.
- Patient records are only kept by the patient's GP and the rural LHD.

Benefits of the model

Results

Since 2009, the GMOS has grown significantly, and the number of sessions provided has increased:

In 2010, **10 clinics were held and a total of 36 consults** were provided.

In 2019, **86 clinics were held and 265 consults were provided across WNSWLHD and FWLHD**.

The **service continues to see an increase in referrals each year**, except for 2020 when face-to-face clinics could not be offered due to COVID-19.

SLHD provide up to **10 virtual clinics per month** and run over 80 clinics each calendar year.

SLHD **see over 250 patients every year**, enabling access to **specialist geriatric care closer to home**.

89% of people surveyed in 2019 were satisfied with the service they received.

100% of referring **GPs were happy with the support** provided by this service.

Benefits

1. **Specialist care close to home.**
2. **No need for patients or family and carers to travel.**
3. **Ensures continuity of care** as the patient's care continues to be managed by their LHD and their local GP.
4. **Families and carers are supported** and given the opportunity to be involved and provide input into the patient's care.
5. **Partnership formed between rural and metro LHDs.**
6. **Alleviates the pressure on GPs in small rural communities** as they are supported to manage complex conditions.

'This is an excellent service: thorough and efficient, especially for those patients who find it difficult to travel as it overcomes the problems of distance and the associated travel.'

DR PATRICK GILTRAP, GP RURAL AND REMOTE MEDICAL SERVICES (RARMS)

Monitoring and evaluation

Patient and clinician surveys:

- Patient surveys were conducted twice a year, however due to the nature of their illnesses it has proved challenging to obtain data.
- Electronic surveys are not compatible with this patient cohort. Surveys are now provided at the time of consultation with a reply-paid envelope.
- Surveys focus on the patient's experience of receiving care and their outcomes from their perspective. Patients are asked to evaluate both face-to-face and virtual components.
- Clinicians are invited to complete a survey once a year. This includes clinicians in the community who refer into the program such as GPs.

Opportunities

- Whilst this model focuses on the delivery of specialist geriatric care, it could easily be applied to many other specialties.
- This model of care is cost neutral, so if resourcing is available the model can be implemented elsewhere without additional funding.
- This service is looking to partner with Aboriginal medical services in Western NSW to provide culturally safe virtual care to Aboriginal community members.

Supporting documents

Geriatrician medicine consult checklist: A checklist for all documentation and tests required prior to a consultation with the geriatrician.

Aged care service information booklet: provides clients with information about the aged care service.

WNSWLHD aged care services client consent form: Filled in by all clients prior to accessing aged care services.

Clinicians report template: Used by aged care clinicians and provided to SLHD geriatricians.

Appointment clinic template: This is provided to the geriatrician for every appointment with clinic information.

Geriatric medicine clinic referral: A referral template used for GMOS clinics.

Geriatric medicine consultation for GPs: Provides GPs with information about the GMOS, including guidelines and how to refer.

Geriatric medicine service brochure: Provides information to patients about the GMOS.

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The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
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Our vision is to create the future of healthcare, and healthier futures for the people of NSW.