# Aged Care Activity Work Plan 2019 - 2024











The purpose of the Aged Care program is to undertake and commission dedicated activities which support better health and wellbeing, access to primary care and aged care services for senior Australians in country SA.

Country SA PHN's objectives are to:

- Commissioning services which address identified needs and gaps in your local primary health and aged care systems;
- Enhancing access to general practitioners and other primary health care providers;
- Supporting access to aged care services and other relevant supports in the community;
- Building the capacity of health and aged care professionals to deliver high quality care; and
- Improving coordination, integration and continuity of care, and working collaboratively with general practitioners.

## **Aged Care Program**

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The aim of this activity is to support better health and wellbeing, access to primary care and aged care services for senior Australians in country SA.

#### **Care Finder Program**

The aim of this activity is to establish and maintain a national care finder network that will provide specialist and intensive assistance to help people within the Care Finder Target Population to understand and access aged care and connect with other relevant supports in the community.

The activity will improve outcomes for people within in the Care Finder Target Population. This activity includes improvements in:

- Coordination of support when seeking to access aged care
- Provide specialist and intensive assistance to help people within the target population to understand and access aged care and connect with other relevant supports in the community.

- Undertake assertive outreach to proactively identify and engage with people in the Care Finder target population.
- Support clients to interact with My Aged Care, explaining and guiding clients through assessment processes and helping clients to find the aged care supports and services required.
- Provide specialist and intensive assistance to help people who are homeless or at risk of homelessness to connect with appropriate and sustainable housing and other supports in the community.
- Ensure clients are connected with other relevant supports in the community before assisting the person to access aged care.
- Ensure Care Finder organisations are undertaking high-level check-ins on a periodic basis and provide follow-up support once services have commenced to make sure clients are still receiving services and needs are being met.
- Understanding of aged care services and how to access them.
- Openness to engage with the aged care system







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- Care Finder Workforce capability to meet client needs.
- Rates of access to aged care services and connections with other relevant supports.
- Rates of staying connected to the services needed post service commencement.
- Integration between the health, aged care, and other systems at the local level within the context of the Care Finder Program.

In alignment with the Care Finder Guidelines that will establish and maintain a national Care Finder Network that:

- Provides specialist and intensive assistance to help people in the Care Finder Target Population to understand and access aged care and connect with other relevant supports in the community.
- Address the specific local needs of Country SA PHN communities in relation to care finder support.
- Transition the Assistance with Care and Housing (ACH) program to the Care Finder Program is supported to build knowledge and skills is an integrated part of the local aged care system.
- Collects data and information to support an evaluation of the Care Finder Program.
- Supports and promotes continuous improvement of the Care Finder Program Supports improved integration between the health, aged care, and other systems at the local level within the context of the Care Finder Program.

# Early intervention initiatives for healthy ageing

This activity aims to provide people with early intervention activities that will support healthy ageing and ongoing management of their chronic conditions, to minimise the effects on functional decline and deterioration as they advance in years.

This activity will commission early intervention activity to support:

 People with chronic condition self-management to minimise health decline and optimise health and

vellbeing

 Carers, family, significant others, and health professionals in the management of people's care to support healthy ageing and reduce unnecessary transfers from home to hospital.

### This activity will;

- Commission services which address identified needs and gaps in your local primary health and aged care systems.
- Enhance access to general practitioners and other primary health care providers.
- Build the capacity of health and aged care professionals to deliver high quality care.
- Improve coordination, integration, and continuity of care at the aged care and primary health care interface.

As people age, the number of chronic conditions that impact on health, wellbeing and independence, can become more complex and additional early targeted intervention and care, at the right time, can prevent deterioration and functional decline.

Early intervention activities to support healthy ageing well in place, or chosen place of residence, and manage ongoing chronic conditions, is tailored to the needs of people living in Country SA regions in an integrated model of care.

This activity will include but are not limited to:

- Providing adequate supports in primary care that recognise and respond to chronic conditions in the advancing age population to ensure selfmanagement that minimises the impacts that ageing and chronic conditions have on each other.
- Establishment and implementation of flexible models of care, including telehealth solution, that can identify and respond to early changes in chronic conditions, encourage self-management and maintain quality of life.
- Early identification and activation of a primary health response where risk of deterioration and frailty are identified.



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- Early intervention when diagnosed with dementia, supported to create a better quality of life, reduce the need for crisis care, manage chronic conditions and symptoms and when the time comes, die with dignity in their place of choice.
- Early intervention exercise programs and disease management resources to include a multidisciplinary primary care team of allied health services including a dietitian, occupational therapist, and social worker for clients and their families to promote disease awareness, healthy behaviours, and ways to minimise chronic disease and symptom management.

# Support Residential Aged Care Facilities to increase availability and use of telehealth care for aged care residents

This activity aims to achieve better integration across the aged care and health care systems for the benefit of people is country South Australia. This activity will support Residential Aged Care Facilities to support healthy ageing and reduce avoidable hospitalisations by having appropriate virtual consultation facilities and support people having greater access to telehealth from primary health care providers.

As people age, they may require additional supports from the residential aged care sector. It is important that timely access and integration of virtual models of primary care with enhanced use of digital health care is available and embedded in an integrated model of care across all of Country SA. Using technical digital solutions to facilitate integrated and coordinated care across the health system and timely access to primary health care professionals, whether through face-to-face consultation or telehealth, is recognised as an issue for many Residential Aged Care Facilities in Country SA, that in some cases can lead to potentially preventable hospitalisations.

#### This activity will:

 Assist Residential Aged Care Facilities in telehealth facilities and equipment to enable residents for virtual consultation with primary health care professionals, this will be guided by recognised telehealth standards.

- Provide training for Residential Aged Care Facilities staff to support them to have the capabilities to assist their residents in accessing virtual consultation services.
- Promote the use of enablers such as My Health
  Record to improve the availability and secure transfer
  of resident's health care information between
  Residential Aged Care Facilities, primary care and
  acute care.
- Improve technological interoperability between the aged care and health systems.
- Consult with South Australia authorities, SA
  aged care stakeholders to ensure the initiatives
  are complimentary to improve technological
  interoperability between the aged care and health
  systems.

Virtual care technology will be applied to coordinated and integrated care models, these include telehealth, videoconferencing, remote monitoring devices and mobile applications where appropriate. This will improve access to quality care by delivering care that does not discriminate by geography and provides people with a choice on how they want to receive care in the Residential Aged Care Facilities. This will also support families, carers, clinicians, and aged care communities to have greater access to primary care support and services, to ensure health care needs are met safely, securely and is effective.

Initiatives under this activity are designed to be integrated across systems to:

- Establish and implement flexible virtual and digital models of care.
- Provide training to participating Residential Aged Care Facilities staff to support them to have the capabilities to assist residents in accessing virtual consultation services
- Promote the use of enablers of digital health (such as My Health Record)
- Consult with South Australian Aged Care Agencies to ensure the initiative complements to improve technological interoperability between the aged care and health systems.







- Implement and deliver services and resources that enable telehealth and digital care solutions.
- Include and integrate GP, families/carers as part of the multidisciplinary care team.

### In this activity Country SA PHN will:

- Determine the digital health maturity and ability in Residential Aged Care Facilities in Country SA PHN region.
- Identify and resolve barriers to uptake and use of telehealth and digital health in Residential Aged Care Facilities.
- Develop agreed models of care between Residential Aged Care Facilities, General Practice and Allied Health providers, including escalation pathways with regional Local Health Networks and SA Health for care and support.
- Provide support funding for Residential Aged
   Care Facilities to establish a suitable virtual health consultation facility/capability.
- Use of secure message delivery to exchange clinical details between providers.
- Registration and use of the My Health Record to support care planning and information exchange.
- Trial and implement remote medical device monitoring to support expanded telehealth consultation and early intervention and after-hours activities.

# Enhanced out of hours support for residential aged care

The aim of this activity is to ensure that Residential Aged Care Facilities have plans in place to support people with access to after-hours care including managing deteriorations in their health and wellbeing, and support carers and health professionals in the management of people's care in place, avoiding any unnecessary transfer to hospital.

This activity will ensure that Residential Aged Care Facilities have plans in place to access local out of hours services in the country SA.

#### This activity will:

- Assist participating Residential Aged Care Facilities
  with the development and implementation of afterhours action plans that will support residents to
  access the most appropriate medical services out-ofhours.
- Provide education support for Residential Aged
   Care Facilities staff in out-of-hours care options and processes.
- Assist the Residential Aged Care Facilities to implement procedures for keeping residents' digital medical records up to date, particularly following an episode where after-hours care was required.
- Support engagement between Residential Aged Care Facilities and their residents GPs or other relevant health professionals.
- Support the establishment and implementation of flexible, integrated, and best practice models of afterhours care.
- Include and integrate GP, families/carers as part of the multidisciplinary care team including through telehealth.



