Evaluation of Primary and Secondary Health Care Services Project Report

Ageing, Disability and Home Care
Department of Family and Community Services NSW
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Executive Summary

In 1998 the Minister for Disability Services and Community Services announced a Boarding House Reform Package (BHRP) which included provision of new support standards for residents of Boarding Houses with the aim of consequent improvement in the standards of support provided. One of the elements was the Primary and Secondary Health Care program, which is designed to improve access to suitable primary and secondary health services for these residents who typically have a range of chronic health conditions which without P&SHC would likely be unmet.

In the NSW Ombudsman’s Report of Reviewable Deaths 2007 reference was made to the NSW Health review of health needs of residents of licensed boarding houses (LRCs) in the Inner West of Sydney. A recommendation arising was that ADHC should provide advice about any actions it intends to take in relation to the findings and recommendations arising from the 2007 review which included recommendations relevant to the P&SHC program.

ADHC engaged Mercury Advisory to undertake an evaluation of the Primary and Secondary Health Care (P&SHC) services provided under this program, to determine if

- the P&SHC has provided services as intended including services designed around individual plans
- whether the program is achieving intended outcomes
- identify variation in service delivery across regions and services
- identify the most effective service model to achieve service outcomes for LRC residents
- advise of other community participation models and approaches that exist which may better inform P&SHC and the broader aims of the BHRP.

Evaluation Findings

- The results from the survey would demonstrate that all residents are accessing GP services, and the majority of residents with psychiatric disability are accessing psychiatrist/mental health teams on a regular basis. However, there were concerns regarding a lack of data regarding access to dental and preventative health checks which would warrant further investigation.
- There is significant variation in service across and within ADHC regions, and even within regions there is no standard approach. This can in part be attributed to the varied backgrounds of the organisations contracted to provide P&SHC in the ADHC regions and sectors. It is understood these contractual arrangements are in place to 2012.
- Only the Central Coast sector of the Hunter region can demonstrate individual health planning, with the majority of LRCs depending upon GPs to undertake individual plans. There was a view that GPs are undertaking individual plans however this was not substantiated.
- There is clear evidence that residents of LRCs are accessing health and allied health services; however, it was unclear if all services provided were appropriate and designed to meet individual needs due to the limited data available.
- The funding provided was effective in reducing barriers for residents to access health services. However, transport was a potential barrier for access in some areas. Sydney South
West Area Health Service had financial delegations that delayed purchase of equipment which was limiting service delivery.

- Some GPs were reluctant to utilise Medicare EPC\(^1\) item numbers to fullest extent possible which can have a negative impact on P&SHC brokered funds. Without the EPC some services (e.g. dental) would then need to be purchased with P&SHC funds.
- From the consultation the key features of an effective service model emerged as:
  - A registered nurse employed through the Community Health division of the local Area Health Service
  - Undertaking individual plans on entry into LRCs and then reviewed annually
  - Standardised approach i.e. Care Plans
  - Services delivered in-house to extent feasible
  - Transport funding also administered through P&SHC worker
  - Regular formal regional or sectoral meetings between key stakeholders
  - Data available to allow analysis of P&SHC expenditure and service types accessed.
- Not all regions were able to provide data on the P&SHC brokered funding utilisation in a form where analysis could be undertaken. For those regions where such data was provided there were significant variances in the utilisation i.e. high cost of pharmacy per resident in one LRC which could suggest the safety net may not be utilised.

**Recommendations and Next Steps**

- ADHC undertakes further work to obtain statistically significant information regarding the provision of primary and secondary health services outside of GP and Psychiatry access to either confirm or refute findings of the initial survey.
- ADHC review utilisation of P&SHC brokered funding by obtaining data for all Regions by LRC. A full understanding of existing variations should be obtained in order to address any opportunities through education or referral to appropriate mechanisms such as the pharmacy safety net system.
- ADHC undertake education both internally and externally regarding the new regulations relating to LRCs, to ensure all key stakeholders utilise the P&SHC expenditure accordingly.
- ADHC liaise with the relevant GP organisations (e.g. Division of General Practice) to discuss strategies to address issues identified with GP perceived reluctance to utilise EPC for these residents.
- ADHC develop a reporting system for all P&SHC funding that provides ADHC with feedback on expenditure by category which will allow ADHC to understand the utilisation of the funding, identify variation by region or LRC for investigation as necessary, and ensure relative equity in application. Reporting should also highlight:
  - The % of clients with EPC
  - The % of clients with an individual care plan
- ADHC implement framework which as a minimum ensures that all residents have a community nurse developed individual health plan reviewed annually separate to, but in conjunction with the GP developed individual plan, to ensure that all services provided are in response to the individuals' identified need.

\(^1\) Within this document there are references made to Medicare GP Enhanced Primary Care (EPC) item numbers. The references to EPC were maintained as this is the terminology used in interviews however the current terminology is Chronic Disease Management (CDM).
ADHC consider framework in 2012, or earlier if contracts allow that implement all identified key features of the effective service delivery model as outlined above.
1. **Background and Understanding**

The Department of Human Services - ADHC and the NSW Government have extensive plans for the improvement of services to people living with a disability through the Better Together and Stronger Together plans, the NSW State Plan, Ageing 2030 and many of the issues below have been addressed in these plans. Work is currently in progress on Stronger Together 2, with a number of projects and community consultation in progress. Nationally the Commonwealth and States and Territories have worked together on the “The Way Forward – A New Disability Policy Framework for Australia”.

Licensed Residential Centres (LRCs), as licensed Boarding Houses are formally known, are one of the accommodation models available to people with a disability. In the ADHC Paper Innovative Accommodation Support Options for NSW, Boarding Houses are identified for people requiring a low level of support, with minimal direct support being board and lodging provided by licensee. ADL, IADL and skills development may be provided by other funded agencies. The Youth and Community Services (YACS) Act provides the legislative base on which these premises are licensed. In May 2010 regulations were amended to clarify the legal status of conditions previously considered “Ultra Vires” by ADHC.

In October 1998 Minister Faye Lo Po announced a Boarding House Reform Package. Part of these reforms included the provision of new support services for Boarding House residents with the aim of consequent improvement of the standards of support provided to residents, known as the Resident Support Program. The elements of the Resident Support Program were:-

- Case Management
- Primary and Secondary Health Care
- Active Linking Initiative (ALI) Program; and
- Advocacy Services.

Residents are also eligible for Personal Care Services and Transport (funded through the Home and Community Care Program).

**Overview of the Program**

Consistent with the above, ADHC wished to evaluate the Primary and Secondary Health Care service (P&SHC) for residents of LRCs. The review is timely given recent changes. One change is the responsibility for the administration of the screening tool to ensure that the referral to a licensed facility is appropriate was transferred from ACAT to Home Care RAC (Referral and Assessment Centre). The other change is the Youth And Community Services Amendment (Obligation of Licensees) Regulation 2010 which also has implications for P&SHC services. Under the new regulations, LRCs are required to maintain certain information relating to clients including some limited information related to health service access and medication which is relevant for this evaluation.

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3 Stronger Together NSW Government 2006-2016
4 Innovative Accommodation Support Options for NSW, ADHC January 2009
At the time of evaluation there were 39 LRCs with 781 beds in NSW which are operated independently, normally for profit, offering basic accommodation services with the number continuing to decline, at the time of writing there are now 35 LRCs with 721 beds capacity.

Residents occupying LRC beds must meet certain criteria to occupy beds which are evaluated through the Screening Tool now administered through Home Care RAC. The profile of residents (majority being male with average age of 47) who live in LRCs in NSW are:

- Psychiatric disability 67%
- Intellectual disability 19%
- Alcohol related brain damage 8%

Other including not identified or unknown 6%

The LRC sector provides limited services. Given the profile of residents and the basic nature of LRCs, there is a significant need for a range of support services to assist LRC residents to lead independent lives in an optimal manner. P&SHC is a significant component of support funded via ADHC to improve access to suitable primary and secondary health services for LRC residents who typically have a range of chronic health conditions which without the P&SHC would likely be unmet. The P&SHC and other support programmes were introduced as part of the Boarding House Reform Program (BHRP) introduced in 1998, the aims of which remain relevant today.

In the NSW Ombudsman’s Report of Reviewable Deaths in 2007 which includes data collected and information relating to reviewable deaths pursuant to S43 of the Community Services (Complaints, Reviews and Monitoring) Act 1993, (which includes residents of LRCs), reference was made to the NSW Health review of health needs of licensed boarding house residents in the Inner West of Sydney. A recommendation arising was that ADHC should provide advice about any action it intends to take in relation to the findings and recommendations of the 2007 review of the health needs of licensed boarding house residents in the inner west of Sydney.

The Primary and Secondary Health Care Service originated with the Central Sydney Area Health Boarding House Team around 1995, before the Boarding House Reform Program. Original funding for the program after the 1998 reform went directly to NSW Health.

Boarding House Support Services commenced through the Boarding House Reform Program strategy which was announced in 1998 specifically to assist boarding house residents. Services include Boarding House Reform Care Workers, Active Linking Initiative (ALI), and Primary and Secondary Health Care Service. Residents are also eligible for Personal Care and Community Transport.

In 2006/07 NSW Health agreed to the re-auspice of P&SHC services and ADHC regions were asked to identify their current and preferred arrangements. This has led to a variety of service models and approaches which vary considerably from region to region.

**Objectives of the Primary and Secondary Health Care Service**

The objectives of the Primary and Secondary Health Care Service are to:

- Facilitate and support residents to access primary and secondary health care services
- Co-ordinate the provision of health care services to residents
- Provide a holistic health care approach to residents, so as to enhance their quality of life
- Enable residents to manage their health care needs independently
- Provide services within a collaborative framework
- Provide flexible and innovative service delivery responsive to the needs of residents

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5 Operational Performance Committee – Review of the Boarding House Reform Program
4 Ibid p 4 2010 data
- Promote health care education and awareness in LRCs
- Remove financial barriers for residents accessing health care services, through the use of brokerage funds where required.

**Evaluation project objectives**

The key outcome of the P&SHC evaluation will be this report that covers:

- Detailed consultations schedule including names of people consulted
- Detailed analysis of findings, including key themes
- Comparative analysis of models and approaches employed internally and by other jurisdictions
- Case studies
- Recommendations.

**Key evaluation questions**

The scope specifically required addressing of the following key evaluation questions in conducting the work:

I. Whether the P&SHC has provided services as intended (in relation to the service type descriptions), including services designed around individual plans

II. Whether the program is achieving its intended outcomes:
   a. To facilitate access of LRC residents to appropriate health and allied health services
   b. To support LRC residents to access primary and secondary health care services and providing holistic health care services
   c. To reduce financial barriers for residents accessing health care services

III. Identify any variation in service delivery across regions and between services

IV. What type of service model is most effective in achieving service outcomes for LRC residents

V. How do services respond to people from an Aboriginal or CALD background

VI. What other community participation models and approaches (including from other jurisdictions) exist which may better inform P&SHC and the broader aims of BHRP.

**Limitations of evaluation**

The evaluation did not allow a review of clinical records or discussions with a significant number of direct health service providers (eg. GPs and allied health workers). We have relied upon the feedback of the service providers including P&SHC workers, generally employed by NSW Area Health Services, LRC proprietors, in some cases advocacy groups, and ADHC case managers. Six resident interviews were conducted which in the main supported the views of the service providers, although it should be noted that the residents were not in a position to determine if services provided were clinically appropriate, e.g. one resident spoke of always having regular podiatry services and yet not having any history or knowledge of any current foot problems. A review of the P&SHC expenditure also tended to support the views of the service providers, although there was limited information available, as when approached not all regions were able to provide data readily available in a format suitable for analysis.

The majority of the recommendations therefore have been formed from a qualitative perspective as opposed to a mix of qualitative and quantitative approaches.
Previous Findings from Review of the Screening Tool for Entry to Licensed Residential Centres

In a recent article published\(^7\) in 2009 regarding an audit of the screening tool then used in NSW, a need was identified for a GP to be nominated as the GP was considered an “important coordinator of medical care who should be involved in the development of the care plan with responsibility for goal setting, outcome monitoring and adaption to evolving health care needs.”\(^8\) The revised screening tool now includes a section to record details regarding the person’s GP, and also attempts to identify if the person has had a comprehensive health assessment in the past 2 years.

\(^7\) “The state of residential care for people with a mental illness: insights from an audit of the screening tool for entry to licensed residential facilities” Lauren J Bailey, Australian and New Zealand Journal of Public Health, 2009 vol 33 No 2 p140-143

\(^8\) Ibid p 143
2. Evaluation Methodology

There are a number of factors that have influenced the methodology design. These factors were:

- The concentration of many of the 721 clients in 35 Licensed Boarding Houses (LRC) in Metro South Region, with smaller numbers in Hunter and Western Regions and one only in Metro North Region
- That the primary disability for a high proportion of LRC residents was listed as a psychiatric disability (approximately 70-80%)
- That there was potential for significant variation between the Regions in how primary and secondary health care services were managed and delivered to residents
- The need for the project to have clear implementable recommendations
- The project was designed and project managed to meet ADHC’s timeframe requirements.

There were three stages (in line with ADHC’s brief) containing eight steps in the approach, which are shown in the following figure and then detailed below.

**Figure 1 Overview of Approach**

This evaluation has been conducted through:

**Qualitative data collection**

- Consultation visits to each of the four regions with more time allocated for Hunter and Metro South who had the greatest number of LRC clients. In the case of these two regions visits were undertaken to two parts of the Region – for the Hunter – to Newcastle and the Central Coast; and for Metro South - to Burwood and the Southern Highlands
Focus groups were conducted with case managers, health service managers and providers. Key individuals were followed up to clarify points of interest raised within focus groups.

Six in-depth interviews were conducted with residents and their supporters to develop three case studies.

Table 1 Overview of Consultation Participants

<table>
<thead>
<tr>
<th>Date</th>
<th>Region</th>
<th>Sector</th>
<th>Consultation Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-Jun-10</td>
<td>Western</td>
<td></td>
<td>ADHC Case Manager, 1 LRC Manager, PWD Representative, ALI Service Provider, Other Service Providers</td>
</tr>
<tr>
<td>9-Jun-10</td>
<td>Hunter</td>
<td>Central Coast</td>
<td>ADHC Case Manager, P&amp;SHC Worker, 1 LRC Manager, HACC Service Provider, ALI Service Provider</td>
</tr>
<tr>
<td>9-Jun-10</td>
<td>Hunter</td>
<td></td>
<td>1 Resident Interview</td>
</tr>
<tr>
<td>16-Jun-10</td>
<td>Hunter</td>
<td></td>
<td>ADHC Case Manager, P&amp;SHC Worker, 2 LRC Managers, HACC Service Provider, ALI Service Provider</td>
</tr>
<tr>
<td>21-Jun-10</td>
<td>Metro South</td>
<td>Sydney</td>
<td>ADHC Boarding House Team, 2 LRC Managers, HACC Service Providers, ALI Service Providers, Area Mental Health Team representative</td>
</tr>
<tr>
<td>21-Jun-10</td>
<td>Metro South</td>
<td></td>
<td>2 Resident Interviews</td>
</tr>
<tr>
<td>23-Jun-10</td>
<td>Metro South</td>
<td>Southern Highlands</td>
<td>ADHC Boarding House Team, 2 LRC Managers, HACC Service Providers, ALI Service Providers</td>
</tr>
<tr>
<td>25-Jun-10</td>
<td>Metro North</td>
<td></td>
<td>ADHC Case Manager, 1 LRC Manager, PWD Representative, ALI Service Provider, Area Mental Health representative</td>
</tr>
<tr>
<td>25-Jun-10</td>
<td>Metro North</td>
<td></td>
<td>1 Resident Interview</td>
</tr>
<tr>
<td>25-Jun-10</td>
<td>Metro North</td>
<td></td>
<td>1 Resident Interview</td>
</tr>
</tbody>
</table>

A full list of names of those participating in the consultations, excluding residents, is attached at Appendix A.

Quantitative data collection

- Analysis of CSTDA data and HACC data provided by ADHC
- Review of the utilisation of the P&SHC funding by region, and where available by LRC
- Survey of all LRCs regarding patterns of P&SHC provision by LRC.

Our conclusions were drawn through discussions with P&SHC workers, LRC managers and other service providers (eg. ALI and HACC), both as a group and individually, and then triangulated through specific resident interviews to support findings, and surveys of LRCs and P&SHC funding expenditure records.
3. Findings from Literature Scan

The different naming conventions for residents in Licensed Residential Centres include but are not limited to:
- Boarding House (Queensland)
- Supported Residential Services (SRS) (Victoria)
- Supported Residential Facilities (SA)
- Group Homes or Supported Housing (UK)
- Sheltered or Supportive Housing (US)
- Domiciliary Hostels (Canada).

The use of the different naming conventions limited the amount of literature that could be identified through conventional data base searches. Even with the change of approach to targeted searches, limited research was found.

Many of the websites reviewed made reference to some form of support to access medical services although the detail was not available. Even within the Housing and Accommodation Support Initiative (NSW) Stage 1 Evaluation Report, whilst it was identified that supporting residents to access health services was vital for the residents to maintain physical and mental health, and reported good outcomes there was no outline of the models utilised to achieve these outcomes. A subsequent evaluation focused upon care planning reports; however, these care plans excluded clinical components as these were seen to be the domain of the Area Mental Health Service. No mention was made of how physical health needs were supported.

One program was identified in the UK, which was a 2 year program open to a wide range of clients whereby supports, including health care supports were provided to transition clients into longer term accommodation. As the supports followed the client the program was referred to as “Floating Supports”. Supports included support to access health services, however the model was not detailed and there was no clear evaluation of the success in terms of client health outcomes. A number of articles were identified that focused upon housing and homelessness for those with mental illness. One article “Putting Housing First, Making Housing Last: Housing Policy for Persons with Severe Mental Illness” (Newman and Goldman, 2008) stated that most of what the authors needed to know to translate ideas into evidence base policy and practice did not exist. This view was also supported by Hwang et al “A Survey of Domiciliary Hostel Program Tenants in Ontario Final Report” (Hwang, Chio and Watkins, 2009).

On this basis we would suggest that little research has been done into identification of models to ensure residents of boarding houses or similar facilities maximise their health outcomes.
4. Profile of Residents and Health Service Utilisation

A profile of LRC residents has been developed from MDS and other data, including internal ADHC papers. The majority of residents have a psychiatric disability, and the proportion has increased over the past twelve years.

Table 2 Diagnosis of People who live in Licensed Residential Centres

<table>
<thead>
<tr>
<th>Diagnosis / Type of Disability</th>
<th>State-wide Assessment of 1,772 LRC residents from February 1998</th>
<th>Review of 830 LRC residents for ALI Review in September 2008</th>
<th>Review of 697 LRC Residents in April 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric disability</td>
<td>40%</td>
<td>63%</td>
<td>67%</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>31%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Alcohol related brain damage</td>
<td>15%</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Age Related Disability</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical or Sensory Disability</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic Brain Syndrome</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (inc not identified or unknown)</td>
<td>1%</td>
<td>13%*</td>
<td>6%</td>
</tr>
</tbody>
</table>

60% of the LRC residents were aged 48-67 years as at April 2010 with a further 17% being aged 38-47 years and a further 14% aged 68 years and over. Licensing conditions prohibit anyone under the age of 16 from residing in a LRC, and only 1% of residents were in the 18-27 age group.

71% of the LRC residents are male. 8% of clients are from a CALD background – the majority are in the Metro South region and 1.5% are from an Aboriginal background.

In 2007 DADHC (as ADHC was then known) commissioned NSW Health to undertake a review of the health needs of residents of licensed boarding house residents in the inner west of Sydney, although a NSW Health website refers to a review of boarding house residents in NSW. This review involved a clinician undertaking a comprehensive health assessment of each resident who consented, and a plan developed to address any identified health needs. These comprehensive health assessments have formed the basis for targeted health interventions for those residents in the Inner West of Sydney. Due to the large number of health issues identified in the 241 residents who participated in the review (721 issues were identified and actioned) one of the recommendations arising from this review was that an ongoing system for review of the health
needs of all residents be developed, and primary health care providers be supported to undertake regular health screening for this group.\textsuperscript{12}

It was identified through this evaluation that a very small proportion of LRC residents were identified as having individual health plans. Only the Central Coast area of the Hunter region advised that their residents had individual health plans, which were developed by the P&SHC funded worker, who was a Registered Nurse (RN), working in Community Health. These plans were documented and updated regularly. The P&SHC RN developed these plans in consultation with the LRC residents’ GP.

Other regions, including Sydney’s Inner West where the initial comprehensive health review was undertaken advised that the residents’ GP was responsible for development and management of health plans. One P&SHC worker advised that some GPs were reluctant to develop individual health plans, despite being requested to do so.

The response to the survey of all LRCs was limited. Only 5 LRCs responded, despite a telephone follow up 2 weeks after initial distribution. Those 5 surveys represented 23% of all surveyed but in terms of resident numbers this could be under-represented as only these LRCs only represented 8% of potential population. The respondents included metropolitan and rural providers, but were predominately from the smaller providers, the largest having 23 residents.

This sample was somewhat over-represented with 78% of respondents having a psychiatric disability as opposed to 67% as identified in the Review of the Boarding House Program paper\textsuperscript{13}, and under-represented in terms of those with an Intellectual disability although this may not have any impact upon the survey outcomes.

43% received HACC services, 9% self managed their own health care and for 80% another party managed the residents’ health care. All LRCs reported the manager had a role in managing the residents’ health care, with a further 3 LRCs indicating the Case Manager had a role and 2 nominating the Community Nurse as having a role, although this is unclear as one of the LRCs nominating the Community Nurse did not have a RN in the role of P&SHC worker.

Less than half of the residents were considered to have an Individual Plan, and only 28% had a Community Health Plan.

All residents within the LRC surveyed had seen a doctor within six months, with the majority having seen a doctor within the past two months. Out of the 47 with a psychiatric disability, 96% had seen a psychiatrist in the past 12 months – there was no information provided about the other 2 with a psychiatric disability.

70% of residents had seen a dentist within the last 12 months and 12% were not consenting – there was no data provided regarding 11 or 18% of these residents. 40% of residents had received a flu vaccination within the last 12 months, 17% did not consent but for 37% of the residents the LRC did not have information and there was no data provided regarding 7% of residents. For the female population 50% had received a pap smear in the past 2 years, 1 did not consent but for the remaining 42% there was no data provided.

\textsuperscript{12} Draft Inner West Licensed Residential Centres’ Health Report – SSWAHS Community Health Nursing and ADHC  
\textsuperscript{13} Op Cit p 4
Given the small sample size it is unlikely that this survey can be taken to be statistically representative. Whilst the residents are routinely accessing GP and in the case of those with a psychiatric disability the majority are being reviewed by a psychiatrist on a routine basis, given the lack of data regarding dental and preventative health checks some further follow up work would be recommended to obtain a more representative view.
5. Findings from Evaluation

Introduction

The consultations were conducted with representatives including LRC operators/managers, ADHC Case Managers, P&SHC workers, HACC providers, ALI providers and other individuals as the ADHC regions determined appropriate. The questions used for these focus groups are attached at Appendix F.

Aims

- To understand how ADHC regions manage the P&SHC program
- To understand the relationships with the different health service providers
- To understand how the case management services are provided
- Identify service delivery/broking arrangement for services purchased for clients to gain appropriate access
- Identification key issues impacting access and identify potential representative case studies
- Generate key themes common across regions and key success factors.

HACC and ALI workers were included as part of the consultation strategy as both interact with the residents in different ways. The HACC workers provide personal care to those residents who are assessed as eligible for such services, and therefore are able to scrutinise the resident and identify any physical symptoms that may require medical intervention i.e. rashes, abrasions. The ALI workers interact with the residents on a regular basis, and as a result of the community participation activities they undertake with the clients, will be considered as a “friend” by the resident who may feel confident in disclosing personal information to them, including health concerns. Due to the periodic nature of the contact, the ALI worker can also become sufficiently knowledgeable about the resident to identify when they may be unwell, including potential symptoms of a deteriorating mental state if the resident has a psychiatric disability.

Evaluation Questions

I. Whether the P&SHC has provided services as intended (in relation to the service type descriptions), including services designed around individual plans?

Summary

Whilst we are of the view that the majority of LRC residents are receiving P&SHC services which meet identified health needs of the resident, with the exception of the Central Coast area of the Hunter region, service delivery is not designed around comprehensive individual plans, unless they are developed by the GP, which was supported by the results of the survey. There are concerns regarding the level of P&SHC delivery in Western region as two of the LRC managers operate their residences as “closed shops” therefore a view regarding the level of P&SHC service delivery can not be formed.
Hunter Region

As two area health services operate in the ADHC Hunter region, services are separated between Central Coast (through the Northern Sydney Central Coast Area Health Service) and the Hunter (Hunter New England Area Health Service). Subsequently there are different models of care operating within the same ADHC region.

The Central Coast has a P&SHC funded registered nurse servicing the residents of the LRC on the Central Coast. Each resident had a documented individual plan developed by the nurse, with services delivered to meet the identified primary and secondary health needs of the residents, mainly in house. The P&SHC RN liaised closely with the GP and other health service providers to ensure an integrated service was provided.

“Having [P&SHC Worker] on board here makes a difference ...she’s probably one of the best operators I’ve come across in the last 10 years and anyone you speak to will say the same – she’s excellent. The clients get so much benefit and our job’s much smoother because of her involvement”

The Hunter group of 5 LRCs, whilst serviced by a Health Worker responsible for P&SHC who is employed two days per week to address P&SHC issues for 144 clients across the Hunter region, did not have individual plans. However, the view was that the GPs were responsible for health plans, and an assumption that the GPs were developing individual plans. The P&SHC worker stated she had a good relationship with the GPs and worked with them to monitor resident appointments to ensure that the identified health needs of all residents were met. There was general agreement of those consulted that residents were receiving adequate P&SHC services to meet residents’ health needs, and data was provided by the Hunter to ADHC indicated that 18% of residents listed were under a EPC although this varied by LRC.

Southern Metro Region

Sydney South West Area Health Service is responsible for provision of P&SHC for the Southern Highlands clients. Home Care is responsible for administering P&SHC services in Sydney’s Metro South.

In the Southern Highlands the P&SHC funded worker is a Registered Nurse. Whilst in the view of those consulted, the residents are receiving adequate P&SHC services, the view was that the GPs were responsible for development of health plans, and there was an assumption that the GPs were in fact developing individual plans, rather than the P&SHC funded nurse.

There were differing views about the role of the P&SHC RN. One LRC received no direct services; the other receiving support services. The LRC managers were very strongly of the view that they coordinated resident health care – the manager of the LRC receiving support from the P&SHC RN indicating that the P&SHC RN provided a supporting rather than coordinating role.
Within Sydney Metro South – Sydney sector, the P&SHC funding is utilised to engage a person through Home Care who coordinates health service delivery within the LRC. All the service providers consulted were very supportive of the services provided and viewed this as a positive, and that residents were receiving P&SHC services which met their health needs. However the development of individual plans was seen as the jurisdiction of the resident’s GP, however the coordinator did admit that not all GPs would develop these individual plans despite the obvious benefits.

**Western Region**

Issues were identified with two of the three LRCs providing limited or no access to ADHC regional staff (operating as a “closed shop”) so we were unable to form a view as to whether the residents had an individual plan. The one LRC that did have a good working relationship with ADHC did not have individual plans for residents, although ADHC did fund a RN to develop individual plans for those residents approximately 3 years ago. The other LRCs elected not to participate in that program. This LRC was somewhat unique in that the provider was not for profit and the target demographic was aged care (i.e. aged over 65 years). Those clients of this LRC capable of self managing their health care were allowed to do so. Those incapable either had families managing their health care, or the manager of the LRC would undertake that role. The LRC manager was of the view that each resident had received P&SHC services to meet their health needs.

“They just go to their GP on a regular basis and the GP contacts me...Some of them do their own [appointments]...others I will do or their family....The information comes back to me and I have a record of all their medications.”

For the remaining Western region LRCs through a review of the utilisation of the P&SHC funds it is evident there are primary health services (e.g. podiatry, optometry) being delivered to residents but there was no information regarding secondary services delivery e.g. resident hospital service, although this may not be evident through the P&SHC funding as these services may have been Medicare funded, or may not have been required.

**Metro North Region**

The Non Government Organisation (NGO) New Horizons is contracted to deliver P&SHC services to the residents of the two LRCs within Metro North region. The P&SHC worker advised that the residents’ GPs are responsible for developing health care plans for the residents of the LRC, although the focus had primarily been on Katoomba, with the closure of the Eildon in the past 12 months. The P&SHC worker, who is an RN, works with the GPs to ensure services are delivered in accordance with the resident’s health plan. All those consulted were of the view that the LRC residents were receiving P&SHC services to meet resident health needs.
II. Whether the program is achieving its intended outcomes:

a. To facilitate access of LRC residents to appropriate and holistic health and allied health services

**Summary**

Whilst there is clear evidence of the facilitation of health and allied health service to all residents of LRCs, it is unclear if all appropriate health and allied health services are being provided due to the limited number of residents having evidence of individual plans. Whilst some P&SHC workers in various regions (Hunter area, Metro South) hold the view that GPs are undertaking individual plans, one P&HSC worker was open that not all GPs did undertake individual health plans, and one resident interview identified an issue (unable to identify date of last psychiatric review including medication) which would have been immediately addressed if comprehensive individual health planning had occurred at point of entry to the LRC. Due to the limitations of this evaluation we were unable to verify that GPs were in fact undertaking individual planning and there would be a need to collect and analyse data to determine the validity of these statements.

There was a common theme expressed through the consultations that the GPs serving residents were not utilising the EPC to the fullest extent possible, possibly due to concerns regarding perception of over servicing, lack of practice nurses or lack of available time. Accessing the EPC allows residents to access services, including dental services which otherwise would have to be funded out of P&SHC brokered funding. Further education for the GPs through the local Divisions of GPS was suggested as a strategy to address this issue.

**Hunter Region**

The residents of the LRC in Central Coast had no identified barriers to access to appropriate health and allied health services. Health care was coordinated through a Registered Nurse working in conjunction with the manager of the LRC. From a review of the documentation gathered, supported through feedback from the service providers, the health services provided to residents are coordinated and comprehensive, and achieve the outcome of facilitating access for LRC residents to appropriate health and allied health services. The P&HSC nurse develops an individual health plan shortly after a resident’s entry into the LRC, and then coordinates with the relevant health care providers to facilitate access to services. The delivery of the majority of the services in-house to the extent possible was also a factor in reducing barriers to access, given the LRC had very limited public transport options available to residents. However the GP servicing these residents was apparently reluctant to fully utilise the EPC for all clients that the RN identified as potentially entitled, and it was speculated that this GP was concerned about the potential to be perceived by Medicare to be “over servicing”.

Within the Hunter sector residents were receiving health and allied health services facilitated through the systems implemented by the P&SHC worker to ensure all health and allied health services required by the GP were provided. GPs were encouraged to use the EPC however again there was talk of reluctance by GPs to utilise to the full extent considered eligible. However, whether all residents received all appropriate services is unclear due to the lack of evidence regarding individual health plans. There is a question if all services
delivered were done as a result of a GP assessment for individual need, or delivered generically in response to a perceived general need. On entry to a LRC, managers would slot residents into the existing schedules of health services delivered. It was not clear if there was any consideration of the individual need for each specific health service.

**Southern Metro Region**

In 2007 the residents of LRCs in the inner west of Sydney all received full health assessments undertaken by members of the Community Health nursing team of the then SSWAHS. Those health assessments identified a number of issues with residents, and health services were targeted to address those identified issues. Those assessments formed the basis for the service delivery now provided. However, the responsibility for annual reviews lies with the residents’ GPs and the P&SHC coordinator had the view that not all GPs were developing and reviewing regular individual health plans for the residents. It is also unclear what process there is for assessment of residents entering the LRC after the 2007 assessments had been concluded. As the P&SHC coordinator has close working relationships with the LRC Managers, GP and other service providers it is likely that the health and allied health services are appropriately facilitated for LRC residents, although there are concerns regarding those clients who entered the LRC after the 2007 review, particularly if their GP is not completing individual health plans or updating them.

In the Southern Highlands, from the review of the P&SHC funding it was clear that there were targeted health interventions provided to residents of LRC, more so in the LRC where the relationship between the manager and the P&SHC nurse was positive. However, as the role of coordination of health services seems to lie more with the LRC managers rather than the P&SHC Nurse, it is difficult to assess if all services provided were appropriate, due to the LRC managers’ lack of clinical qualifications, and the lack of evidence of individual health plans.

> All the appointments for these things [health services] are coordinated through our [LRC] office...99% of the time it works well”

> “New residents are instantly put into the GP and relevant services for review”

Access to EPC for all residents was again raised as an issue in this forum.

**Western Region**

Due to the lack of data on the majority of the residents in the LRCs of this region we are unable to make any informed evaluation in relation to the appropriateness of health and allied health services delivered to residents of LRC in this region. The manager of the LRC that was cooperative with ADHC indicated that all residents were seeing their GP on a routine basis. However, due to that individual’s lack of clinical qualifications we could not form a view as to whether the services provided were appropriate, and if there were any unmet gaps in health care service delivery, as there was no evidence of individual plans. In mitigation, there was evidence of P&SHC funding expended on primary care for all 3 LRCs in this region although it is unclear if all residents benefited from this expenditure.
Metro North Region

Due to the close working relationship between the P&SHC Nurse, the GP and other health service providers, there was evidence health services were delivered to meet the identified needs of the residents. However, this was not always delivered in a consistent fashion. As outlined as part of our case study, see box below for summary it was identified that due to a lack of a comprehensive health plan delivered upon entry into a LRC, some health needs were not immediately identified, as would have occurred if a comprehensive individual plan was completed on intake.

One issue identified by R’s P&SHC worker was that it could not be established when R last had his psychiatric medications reviewed by a psychiatrist. R has been a resident of this LRC for over a year however, there was no information available on this aspect of R’s medical history. R now has an appointment to have his medications reviewed by a psychiatrist.

b. To reduce financial or other barriers for residents to accessing health care services

Summary

The information from all regions was the funding was effective in reducing financial barriers for residents to health care services, particularly when waiting lists for public services would have imposed a significant delay to accessing service (e.g. dental and optical).

However for some regions, transport was a potential barrier to access. The Southern Highlands area of Metro South was using P&SHC funding for taxis for residents of Bundanoon, particularly for appointments arranged at short notice, due to the limitations of the available community transport. The Hunter region and Western region also had issues with the community transport.

The Sydney area of Metro South was effective in coordinating transport, as the P&SHC coordinator also managed the community transport funding; ensuring services were responsive to LRC residents’ needs.

Hunter Region

It was identified that there was a limitation in the funding available for health promotion (e.g. education on strategies to reduce the likelihood of diabetes). However, no financial barriers to residents accessing primary and secondary health services were identified. In the Central Coast the majority of services were delivered in-house at the boarding house as far as feasible to minimise the need to transport residents, as the LRC had limited public transport options.

For the Hunter sector the only potential barrier to access was the remoteness of one of the LRCs, and the limitations of the community transport due to the wide geographical distance between LRCs. LRC managers outlined that some community transport operators did not
appreciate the nature of the clientele, and were difficult to utilise if specified numbers were not available for transport as booked, or if appointments needed to be changed at short notice, due to the resident’s lack of motivation. The ALI coordinators advised they would sometimes assist through provision of transport to overcome these issues. There was some discussion regarding the options of services delivered in-house and many of the service providers consulted were of the view that there was significant merit in having the residents engage with the community when seeking appointments, rather than the convenience of in-house service delivery.

**Southern Metro Region**

No financial barriers to health services were identified and as the P&SHC coordinator in Metro Sydney – Inner West Sydney also coordinates community transport there were no issues with transport. No other barriers were identified.

In the Southern Highlands, there were issues with community transport having limited capacity, particularly for appointments arising at short notice, and particularly at the LRC where relationships had deteriorated, although the reason given was the remoteness of the facility from the local community transport centre. P&SHC funding was utilised for taxis to overcome this issue.

In the Southern Highlands there was a barrier identified in the provision of items funded under the P&SHC funding. The Sydney South Western Area Health Service as the provider had imposed its requirements regarding financial delegations to include the funds available to broker P&SHC services. Both the managers of the LRCs in the area, HACC and ALI service providers voiced concerns regarding delays caused by the complex process to have goods above a certain value provided. The HACC providers gave an example where two shower chairs requested for LRC residents had taken 4-6 weeks to arrive due to the delays in the approval process. As HACC had specific OH&S obligations this had resulted in the residents having very limited personal care until the chairs finally arrived, which has health implications.

**Western Region**

For the residents of the cooperative LRC no financial barriers were identified to accessing health services. We are unable to identify any barriers for other LRCs. However there was evidence that P&SHC funding was utilised to purchase health and related services for residents of those LRCs.

One potential issue identified was transport of residents for diagnostic and specialist services, as many specialist diagnostic imaging services (i.e. ultrasound) and specialist services were provided in Sydney. Transport for residents requiring these services was provided through Translink. The local Translink provider relied heavily upon volunteers. Some volunteers did not possess the necessary license for the larger vehicle, and some would not drive to Sydney. So far this has not adversely affected the residents of the LRC (although this has affected the general community). However, the potential does exist for barriers to access health services should issues arise with transport in the future.
Metro North Region

There were no issues identified as creating barriers to residents accessing health care services, apart from limits on available funding.

III. Identify any variation in service delivery across regions and between services

Summary

There is significant variation in service across and within ADHC Regions. The variations include time allocated, employer, qualification, and services provided as outlined in Table 3 below.

Table 3 Summary of Key Regional Variations

<table>
<thead>
<tr>
<th>Region</th>
<th>LRC</th>
<th>Residents</th>
<th>FTE PSHC Worker</th>
<th>PSHC Worker in RN</th>
<th>PSHC Worker does Care Plan</th>
<th>PSHC Worker holds Transport Funding</th>
<th>Data provided re utilisation of PSHC brokered funds</th>
</tr>
</thead>
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<tr>
<td>Hunter Central Coast</td>
<td>2</td>
<td>102</td>
<td>0.60</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
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<td>5</td>
<td>137</td>
<td>0.40</td>
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<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Metro North (1)</td>
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<td>0.60</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Metro South Sydney</td>
<td>9</td>
<td>247</td>
<td>1.00</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Metro South Southern Highlands</td>
<td>2</td>
<td>165</td>
<td>1.20</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
<td>98</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(1) Whilst one LRC has closed the PSHC worker provides services to a number of clients in an interim facility - figures based on April data

Hunter Region

In the Central Coast the P&SHC worker is a registered nurse employed through their local Area Health Service in Community Health working 3 days a week to service 102 LRC residents. The other worker in Hunter has a degree in education with a post-graduate qualification in women’s health, is employed through Community Options and works 2 days a week to service 137 LRC residents.

In the Central Coast a key variation in service delivery was the involvement of a registered community nurse who developed the individual plan when the resident first entered the LRC, ensured all appropriate health checks were undertaken and reviewed plans annually. Central Coast undertook a standardised approach to care delivery, ensuring the same service provider serviced all residents, and where possible services were delivered in house to residents.

In the Hunter sector not all services were delivered in house. It was considered the benefits in community participation for LRC residents in accessing health services (despite the fact that the ALI program offered other opportunities for community participation) outweighed the benefits of in house service provision, overcoming reluctance of unmotivated residents and providing a more consistent approach.

Both sectors indicated they had regular meetings between managers of LRCs, ADHC Case Managers, P&SHC workers, HACC, and ALI service providers.

Southern Metro Region

In Metro South Sydney the P&SHC worker is not a registered nurse and is employed through Home Care. This role is full time servicing 247 LRC residents. This employee’s role was more
health service coordination between LRC managers, health service providers, residents and other stakeholders. The P&SHC worker also held the community transport funding and coordinated transport for residents to appointments as required. However, the coordination may not always involve the GP with one LRC manager advising that a GP was unaware of residents having received breast screening arranged through the P&SH coordinator, and had started to arrange screening when a free option became available, until advised otherwise.

There was an approach to maximising service delivery in house, although alternate service providers were accessed in the community, if this meant the services could be provided as a free or cheaper service.

Dental services are provided through the Sydney Dental Hospital’s special needs program which is open on a State-wide basis for those with a mental illness/disability living in a LRC who are not suitable for the routine stream of dental care, as far as possible.

In the Southern Highlands the RN is employed by the Area Mental Health Service, as opposed to Community Health. GP, psychiatry and podiatry services are delivered in house, the other services within the community. There are 2 RNs in this role in the equivalent of a 1.2 FTE servicing up to a potential 165 residents although one LRC consistently maintains occupancy about 20 places below licensed capacity and also prefers not to utilise the P&SHC worker, but will utilise brokered funding. These RNs do not seem to undertake individual planning or coordinating roles. One of the RNs employed in a 0.4 FTE apparently provides routine exercise programs for one of the LRCs.

Whilst not explored for Sydney, it was stated that in the Southern Highlands there had not been a meeting between managers of LRCs, ADHC Case Managers, HACC and ALI service providers for over a year.

**Western Region**

Western has not engaged a P&SHC worker previously due to the wide geographic dispersion of the LRCs. However, with the reduction of the LRCs to three within a smaller geographic region the ADHC case manager indicated an interest in reviewing this position as merit was seen in engaging a P&SHC worker who could prepare individual health plans for residents and review them annually.

Services are delivered within the community as far as can be established, given the limited information available.

Western does attempt to have regular meetings; however, this is difficult given 2 of the 3 LRC managers do not attend.

**Metro North Region**

The P&SHC worker, whilst an RN, is not employed through the local area health service, although this does not seemed to have prevented this person creating strong linkages with other LRC resident health service providers. This person is employed 3 days a week, servicing 26 residents, including the temporary facility accommodating 18 residents who formerly resided at the Eildon.
The mode of service delivery varies between the two LRCs with one offering some in house service, and the other having services delivered in the community.

IV. What type of service model is most effective in achieving service outcomes for LRC residents

Summary

Key features of an effective service model are:

- Registered Nurse employed through the Community Health division of the local Area Health Services
- Undertaking individual plans on entry into LRC and then annual reviews
- Standardised approach (e.g. care plans)
- Services delivered in-house to extent feasible
- Transport funding also administered through P&SHC worker
- Regular formal regional or sectoral meetings between key stakeholders
- Data available to allow analysis of P&SHC expenditure.

As ADHC has outsourced the provision of the P&SHC services to a number of providers, some Health, some Home Care and some private providers, there have been a number of different approaches developed, and it is understood these arrangements are in place until 2012.

From the focus groups conducted with the service providers, there seemed to be general consensus that the most effective model was one where services were delivered in house as far as is practical, including GP and Psychiatry consultations. Whilst merit is seen in having individuals engage within the community, the ALI program has the aim of encouraging community participation. Given the poor motivation of some residents, any services that can be provided readily available to overcome poor motivation will have obvious benefits on residents’ health status, and overcome any potential barriers caused by transport limitations. There are services within residential aged care where a range of allied health services, including optometry, physiotherapy, and dental screenings are delivered in-house, which is a model could be explored further for LRCs.

Some regions saw the development of the individual health plan as being the jurisdiction of the GP only. Issues were identified as being the reluctance of some GPs to develop individual health plans using the EPC item numbers, and the gaps that can occur through a lack of undertaking a comprehensive health plan at point of entry to the LRC. Therefore it is concluded that a model where an individual health plan is done after entry to the LRC, where the P&SHC worker liaises with the GP and updates these plans annually, maximises resident health outcomes. This plan should be done by a community based RN. Whether this RN is the P&SHC worker, and can also coordinate services, or whether ADHC may chose to explore working with NSW Health in accessing someone to undertake the individual health assessment and planning, and focus upon service coordination is something ADHC may wish to consider. There is merit in the second model, particularly where there are is a concentration of LRCs.
It is recommended that a standardised framework be implemented, particularly in the development of care plans, to ensure some consistency. This should include some direction about the timing and review of care plans, and the delivery of health services. Although restriction in the choice of health service provider conflicts with the rights of the individual to choose, it does allow better outcomes through consistency of approach, and ability to select a provider which best meets the clientele’s specific health needs. Whilst the framework should be standardised, there should be flexibility for different providers to utilise different care planning tools as it is recognised that the current P&SHC workers come from a variety of different organisations, each with their own views on documentation. It may be preferable to allow a variety of different care planning tools, as long as those tools ensure the LRC residents have optimal health care rather than be prescriptive about the care planning tool used.

A Registered Nurse should be involved in coordinating health services and undertaking annual reviews of individual health plans, to ensure effective health outcomes for LRC residents. A Registered Nurse could also act as an advocate for LRC residents in those circumstances where it has been identified that it is useful to have advocacy informed by local clinical knowledge.

The Area Health Service engages as part of the team delivering health services and facilitates access to services for residents as required, including community health, health promotion and other services as deemed necessary including facilitation of culturally appropriate social support networks for those from a CALD background to prevent social isolation.

The ability of the P&SHC worker to access/coordinate community transport to ensure the residents of the LRC maximise transport options is also seen as an optimal approach from the LRC resident perspective.

Regular formal meetings between the managers of the LRCs, ADHC Case Managers, the P&SHC worker, HACC service providers and ALI service providers within the area as a forum to discuss issues, and undertake regular reviews is also seen as optimal.

Mechanisms should be developed to ensure visibility and accountability for the use of the P&SHC funding at a level which ensures ADHC can form a view if funds are being used efficiently, effectively and on an equitable basis. This is discussed further in vii (c).

V. How do services respond to people from an Aboriginal or CALD background?

Those regions that had persons from an Aboriginal or CALD background reported that they did not have any issues with health services access for this group. In the Hunter and Metro South Regions, both areas reported being able to link into specific Aboriginal or CALD services, including social support groups as required.

Western Region did not have any issues identified, but again there may be unidentified issues given the barriers that currently exist to identifying resident needs.

Whilst Metro North was able to overcome CALD issues in accessing health services through the provision of interpreter services, there may be an issue with identification and establishments of appropriate social networks for those from a resident from a CALD background with minimal English.
R is a male from a non English speaking background and has a poor command of English, although he is attending English classes through his ALI program. R appears socially isolated, as it was identified there were few opportunities for R to interact with others who spoke his language, apart from contact with his family, as there is no-one within the LRC who speaks his language.
VI. What other community participation models and approaches (including from other jurisdictions) exist which may better inform P&SHC and the broader aims of BHRP?

From the literature scan it was evident that there had been little research undertaken in this specific area. However there are articles on coordinated care which may better inform P&SHC and BHRP.

Victoria has implemented a state-wide approach to align practices, processes, protocols and systems through functional integration in all human services. This approach is known as Service Coordination. In the publication “Good Practice Guide 2009 – A Resource of the Victorian Service Coordination Practice Manual” practice standards for a number of aspects of service coordination are provided including care planning. It is noted that coordinated care planning is particularly important for individuals with complex needs such as those with a chronic condition, high or ongoing support needs and advocates the involvement of the GP where the consumer has a chronic disease and or complex or multiple needs.

Victoria has also developed a Care Planning Manual for SRS Residents, and has undertaken 2 censuses of SRS facilities in 2003 and 2008 which provides a snapshot of what occurs within SRS including some information regarding health services received by residents.

A study in South Australia into the provision of coordinated care in the general population, using nurses as service coordinators who conducted the assessment of the patients defined life problems, collated information from other providers and initiated the care plan with the GP being the care coordinator found that up to 60% of the service coordinators and patients found that the problems identified had improved.

In the article “Special Delivery: How Coordinated Care Programs Can Improve Quality and Contain Costs” the authors identify the benefits of coordinated care as anticipating the needs of the whole person, both medical and non-medical, allowing for the patient to receive ongoing appropriate services across a range of settings. A single provider working with the person and family or carer will develop a plan to meet their medical and social needs, oversee delivery of all services “across disciplines, organisations, providers and settings” with this approach allowing providers to flag and address issues with their care, intervene earlier and prevent problems from getting worse keeping patients healthier and reducing costs.

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17 Jessica Curtis and Renee Hodin, Community Catalyst Robert W Seifert Centre for Health Law and Economics University of Massachusetts Medical School “Special Delivery: How Coordinated Care Programs Can Improve Quality and Contain Costs” May 2009

18 Ibid p 6
VII. Other issues for consideration

a) Changes to legislation

Under recent amendments to the Youth and Community Services Regulation (Obligations of Licensees) May 2010, operators are now obliged to maintain a register of residents including but not limited to “name and telephone number of the residents doctor; any serious illnesses suffered by the resident; any sensitivities or allergies to any medication suffered by the resident; any assistance in taking or administering any medication required by the resident” (22F-i). In addition the licensees are now also obligated to keep written detailed directions from the prescribing doctor regarding the administering of any prescribed psychotropic PRN medications on the residents file, and also maintain a register of PRN medication administered to each resident (13)\(^{19}\).

Should a standardised approach be adopted, these requirements should also be considered as part of the standardised approach, as this could capture some of the requirements outlined above which could prevent duplication and improve compliance by the licensee.

b) Equity

From what data we have been able to obtain on the utilisation of P&SHC funding it was clear that:

- P&SHC funding was not utilised equitably between LRCs
- There were variations in approach undertaken to the engagement of a P&SHC worker, between regions.

Table 2 in the section below highlights the potential inequity in funding utilisation.

c) Utilisation of P&SHC funds

Information provided through consultations, and a subsequent review of the limited information available on the utilisation of the P&SHC brokered funds showed that some funds may have been used for items and services not strictly considered to be health care. It was identified that P&SHC brokered funding had been used to purchase shoes, bras and clothes, toothbrushes, relaxation and exercise services. Although these goods and services can impact upon resident’s health these would usually not be considered primary or secondary health services.

It is noted that with the change in the YACS Regulation, the onus will now be on the owner/manager of the LRC to provide toothbrushes, toothpaste, soap, toilet paper and a supply of bath towels and face washers, although the ADHC regional staff did not seem aware of this potential change, and some education of the ADHC and P&SHC staff may be required.

\(^{19}\) Youth and Community Services Amendment (Obligation of Licensees) Regulation 2010
In the review of the utilisation of the P&SHC funding there were some significant variances in the utilisation of the funding which should be explored further as not all regions were able to provide data on expenditure in a form which could be reviewed within this project’s timeframes. One LRC in particular showed a significantly higher pharmacy cost per resident than other LRCs as demonstrated in Table 4.

Table 4 P&SHC Brokered Funding Utilisation by Region/Sector/LRC

<table>
<thead>
<tr>
<th>WESTERN BOARDING HOUSES</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Overall</th>
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<tr>
<td>BOARDING HOUSE</td>
<td>No of Residents</td>
<td>TOTAL INVOICES</td>
<td>Overall Exp per Resident</td>
<td>Dental</td>
<td>Podiatry</td>
<td>Pharmacy</td>
<td>Counselling</td>
<td>Exercise</td>
<td>Optical</td>
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<td>$1,617.87</td>
<td>$12,894.00</td>
<td>$6,385.50</td>
<td>$5,406.63</td>
<td>$2,185.00</td>
<td>$13,387.00</td>
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<td>$173.50</td>
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<td>$13,412.14</td>
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</table>

<table>
<thead>
<tr>
<th>Metro South SH</th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOARDING HOUSE</td>
<td>Approx No of Residents</td>
<td>TOTAL INVOICES</td>
<td>Overall Exp per Resident</td>
<td>Dental</td>
<td>Podiatry</td>
<td>Pharmacy</td>
<td>Counselling</td>
<td>Exercise</td>
<td>Optical</td>
</tr>
<tr>
<td>Rosnel</td>
<td>48</td>
<td>18,431.43</td>
<td>$383.99</td>
<td>$5,967.50</td>
<td>$1,330.50</td>
<td>$335.76</td>
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<td>$310.00</td>
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<tr>
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<tr>
<th>WESTERN BOARDING HOUSES</th>
<th></th>
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<th>Per Resident</th>
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</thead>
<tbody>
<tr>
<td>BOARDING HOUSE</td>
<td>Dental</td>
<td>Podiatry</td>
<td>Pharmacy</td>
<td>Counselling</td>
<td>Exercise</td>
<td>Optical</td>
<td>Other</td>
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<tr>
<td>WALLERAWANG</td>
<td>$263.14</td>
<td>$130.32</td>
<td>$110.34</td>
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<td>COLEMAN HOUSE</td>
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<td>$93.92</td>
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<td>$13.10</td>
<td>$104.13</td>
<td>$309.18</td>
<td>-</td>
<td>-</td>
<td>$105.40</td>
<td>-</td>
<td>$30.28</td>
<td></td>
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<tr>
<td>MIDDLE HOUSE DUBBO</td>
<td>$4.61</td>
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<td>-</td>
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<td></td>
<td>$92.55</td>
<td>$92.23</td>
<td>$149.05</td>
<td>$21.44</td>
<td>$181.08</td>
<td>$39.05</td>
<td>$308.42</td>
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</table>

<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th>Per Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOARDING HOUSE</td>
<td>Dental</td>
<td>Podiatry</td>
<td>Pharmacy</td>
<td>Counselling</td>
<td>Exercise</td>
<td>Optical</td>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>Rosnel</td>
<td>$111.82</td>
<td>$27.09</td>
<td>$7.00</td>
<td>-</td>
<td>$11.46</td>
<td>$4.02</td>
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<tr>
<td>Sunshine</td>
<td>$429.40</td>
<td>$11.34</td>
<td>$58.42</td>
<td>-</td>
<td>$14.29</td>
<td>$22.01</td>
<td>$262.91</td>
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<td></td>
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<tr>
<td></td>
<td>$320.52</td>
<td>$16.74</td>
<td>$40.79</td>
<td>-</td>
<td>$13.32</td>
<td>$15.85</td>
<td>$249.09</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 2 Total Overall Expenses

![Chart of Total Overall Expenses]

Figure 3 Average Expenses per Resident

![Chart of Average Expenses per Resident]
Whilst this was not an audit, the high expenditure per resident for Wallerawang for “Other” expenses was reviewed in light of the significant variation to other LRCs; of the total $39k expended in this category $32k of this expenditure was allocated to 3 organisations. Based on the detail in the names of the organisations, $11k was utilised on skin care, $9k on massage and $12k on retail items.

There may be benefit in undertaking further work to:

- examine patterns of expenditure by LRC and by region throughout NSW to understand the existing variations identified
- determine if there are further issues in the LRCs not represented
- evaluate if P&SHC brokered funding is being utilised on an equitable basis
- to determine if all mechanisms available are being utilised to minimise financial outlay from brokerage funds i.e. pharmaceutical safety net, maximising usage of generics, maximising Medicare etc.

Some key questions to be included would be

- % of residents covered by EPC. Sub optimal EPC coverage would require utilisation of P&SHC brokered funds to address resident health issues i.e. dental, physiotherapy
- Why the significant variation in dental expenditure per resident and are there EPC implications?
- Why the significant variation in pharmaceutical expenditure per resident and is the safety net being utilised? Are generics being used to minimise expense? Are there residents who may require reassessment in light of current health needs?

As outlined under question II some P&SHC workers alluded to some GPs being reluctant to utilise the Medicare EPC items for LRC residents, and mechanisms should be explored to educate those GPs regarding the EPC items. ADHC should explore if the RACGP or AMA, or
the local GP Divisions or Primary Healthcare Organisations could assist in this endeavour as this would have a financial impact.

In the Southern Highlands it was identified that the P&SHC nurses comprised 1.2 FTE which was significantly higher P&SHC RN to resident ratio than in other areas. This is of specific concern when advised the role of 0.4 of that FTE has the primary duty of ensuring resident exercise in addition to local ALI programs. Whilst there are specific health benefits in exercise, this activity is not considered to require the specific competencies of a RN, particularly a highly experienced RN, and should be reviewed.
Appendix A – Schedule of Consultation Participants

Hunter
Shannon Hill
Anthony Goodwin
Matthew Innes
Sharon Wood
Tracey Alsop
Dianne Sinclair
Michelle O’Neill
Rachael Steele

Metro North
Sharon Naylor
Ainsley Brown
Donna Blayney
Johanna Davies
Gerard Nolan
Linda Morgan
Susan Barnes

Metro South
Peter Matthews
Stephen Kelly
Christopher Young
Mario Barbarcu
F Moursulla
Mark Spruan
Karen Chapman
Geraldine Smith
Irene Strong
Angela Beatty
Leigh Connell
Salavtricr Rome
Nigel Watkin
Liz Spiller
Meg Tecles
Joan Piallos
Myra Harrison
Mandy Manns
Jeanelle Currie
Rosalee Angelosante
Elaine Bloomfield
Marina Varone

Western
David Hyland
Levente Boda
Robin Mason
Susan Barnes
Julie Favell
Vicki Dick
Appendix B – Resident Case Studies

Case Study One

B is a female approximately in her fifties with an intellectual disability.

A doctor visits the LRC weekly and B is aware she can see them any time she has a health issue. If the problem is urgent she will talk to a member of staff about the problem and they will assist her. As part of her interview B demonstrated her awareness of preventative health checks by indicating she has had a breast check.

B contracted a disease earlier in life which caused contraction of the right hand and shortening of the right leg resulting in a limp. As part of the P&SHC services, B indicated that in the last 2 years she started exercise therapy on her right hand which now has increased in strength and flexibility to the extent that the grip is now almost equal in both hands. B was unable to identify who developed this program for her. B also received an orthotic boot for her right foot which has improved her mobility.

“They got my hands going too….I've got a rubber ball – exercises….They came here today to do exercises”.

B has missing teeth, and received a denture. However she did state that when she wears them the denture “makes me choke and cough” although she has glue for them. Despite this B seems pleased with the dental care provided, despite not wearing the denture at interview.

B has also recently seen an optometrist and will be receiving glasses in the near future.

“They're getting me glasses – the eye doctor – they were good”.

B participated in a recent talk about Diabetes and demonstrated awareness of some of the changes that occurred as a result of this education (use of artificial sweeteners to replace sugar).

“What food to eat and not too much cake and sugar – Angie got me sugar tablets for a cup of tea and that”

B is very satisfied with the level of P&SHC services she receives as a resident of a LRC.

<table>
<thead>
<tr>
<th>Health problem</th>
<th>How addressed through Primary &amp; Secondary Health Care interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited mobility from polio</td>
<td>Regular exercise program developed for C and orthotic obtained</td>
</tr>
<tr>
<td>Missing teeth</td>
<td>Denture provided and periodic dental checks</td>
</tr>
<tr>
<td>Poor vision</td>
<td>Optometrist screening</td>
</tr>
<tr>
<td>Health checks</td>
<td>GP available on weekly basis</td>
</tr>
<tr>
<td>Review of health checks/coordination of appointments/provision of transport</td>
<td>Coordinator funded through P&amp;SHC funding</td>
</tr>
</tbody>
</table>
Case Study Two

K is a male approximately in his fifties with a psychiatric disability. K has relocated into the current LRC in the past 12 months.

K is very positive about the move. The new residence has fewer people and a more stable environment as there are no new arrivals. The new residence has better facilities including a garden area. K was motivated to give up drinking alcohol unsupported since the move to the new premises, and enjoys participating in the new programs including the Coffee Shop. K considers this new residence as supportive and appropriate environment with staff who he feels he can trust, and feels that if he remains in this environment he should be in a position to start making his own decisions, including seeking employment in another year. K considers this change has been positive not only for him but fellow residents.

“I was living in crisis for like 25 years....I’m getting good the way the (new) place is run – I’m getting really well because there’s not the pressure on you – you don’t have to put up your guard and if you put up your guard and get paranoid you’re just getting locked into your illness.”

“I suffer from agoraphobia so things like that [trips to nearby town] are good for me – gradually getting better and it’s not just me it’s the other people in the house coming out of themselves and their illness.”

“I used to be a drinker – a heavy drinker but since I’ve moved to this residence I’ve hardly touched a drop”.

“I’m thinking of going back to work in a few years time”

K sees a GP fortnightly, and is aware that she has developed a health plan for him, which is updated annually, including a full physical. K will talk to a key worker he trusts within the LRC if he is feeling mentally unwell and this will often help in working through K’s issues. If this does not work they will contact the appropriate clinician. K sees a psychiatrist regularly who visits in-house every 4-6 weeks but also sees a psychologist who he is very satisfied with.

“I see a Psychologist – she [K’s GP] set me up with that.”

K stated he does not understand the relationship with the psychiatrist properly. K is also supported by one of the Mental Health support nurses but does not trust this person and does not actively seek her support.

If K has a general health issue he will either contact the P&SHC worker or if it is urgent talk to a staff member of the LRC. The P&SHC worker will make appointments, accompany him if required, organise transport and arrange for scripts to be made up and delivered.

“Mentally I talk to a staff person, physically I talk to [the P&SHC worker]”

K was diagnosed with an umbilical hernia by his GP in the last twelve months, was placed on the waiting list and was due to have an operation to correct it the next week. He knows what he should do before the operation (nil by mouth, no smoking 24 hours before hand) but is not aware of how long he would be in hospital. K thinks a staff member of the LRC will take him to hospital. He is aware that the people coordinating his care were also not too aware of what was happening but reassured by the fact they were not too concerned.
K receives regular dental services – about once a year, and is satisfied with the services. He has only 5 teeth left and has a denture. He didn’t like one prior dentist and as such was happy to have a new provider. K has glasses for reading and has his eyes checked on a regular basis, which is important as K enjoys reading. He also received regular podiatry services but states he needs little services as he has good feet.

“[P&SHC worker] got me a pair of glasses recently so I could read.”

K is very satisfied with the level of P&SHC services he receives as a resident of the current LRC.

“I’m really happy with the way it is run.”

<table>
<thead>
<tr>
<th>Health problem</th>
<th>How addressed through Primary &amp; Secondary Health Care interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric diagnosis</td>
<td>Regular Psychiatric visits, Psychologist interventions</td>
</tr>
<tr>
<td>Missing teeth</td>
<td>Denture provided and periodic dental checks</td>
</tr>
<tr>
<td>Poor vision</td>
<td>Optometrist screening, glasses provided</td>
</tr>
<tr>
<td>Health checks</td>
<td>GP available on fortnightly basis</td>
</tr>
<tr>
<td>Review of health checks/coordination of appointments/provision of transport</td>
<td>Coordinator funded through P&amp;SHC funding</td>
</tr>
</tbody>
</table>

Case Study Three

R is a male approximately in his early forties with a psychiatric disability residing from a non English speaking background with poor command of English. He is attending English classes through his ALI program. An interpreter was engaged to assist in conducting the interview. R appears socially isolated, as it was identified there were few opportunities for R to interact with others who spoke his language, apart from contact with his family, as there is no-one within the LRC who speaks his language.

R came to the LRC approximately a year ago. Prior to the move to the LRC, R was living with family. The family were taking R to a general practitioner who spoke his language however the P&SHC worker encountered some difficulty in obtaining information about R’s health needs, and R now attends the clinic of the GP who looks after all the residents of the LRC. Prior to any GP appointment a member of R’s family is contacted by the P&SHC worker. The P&SHC worker provides the details of the appointment so that the family member can advise R of the details accordingly. A phone translator is engaged for the appointment and this seems to work well as R confirmed he did not have communication issues when he saw his doctor. R is satisfied with his doctor, is aware that the doctor reviews his health regularly and has a physical examination every six months.

R advises that when he is feeling unwell he advises the LRC manager who will arrange an appointment and transportation. The LRC manager is contacted out of hours if necessary.

R sees a dentist twice a year. The P&SHC worker advised that the dental clinic has a staff member who speaks his language. R is satisfied with the dental care provided.
R has had his eyes checked within the last 12 months. R did not recall having any podiatry services, and also did not recall any flu vaccinations although this was confirmed by the P&SHC worker, who reviewed R’s case notes to determine dates of service.

R stated he was satisfied with the level of P&SHC services he receives as a resident of a LRC.

One issue identified by R’s P&SHC worker was that it could not be established when R last had his psychiatric medications reviewed by a psychiatrist. R has been a resident of this LRC for over a year however there was no information available on this aspect of R’s medical history. R now has an appointment to have his medications reviewed by a psychiatrist.

**How health problems are addressed and care is co-ordinated**

<table>
<thead>
<tr>
<th>Health problem</th>
<th>How addressed through Primary &amp; Secondary Health Care interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric diagnosis</td>
<td>Psychiatric appointment now made</td>
</tr>
<tr>
<td>Health checks</td>
<td>GP seen regularly. Periodic dental, optical and podiatry appointments made.</td>
</tr>
<tr>
<td>Review of health checks/coordination of appointments/provision of transport</td>
<td>Coordinator funded through P&amp;SHC funding</td>
</tr>
</tbody>
</table>
Appendix C - Detailed Methodology

Stage One Evaluation Project Plan and Agreed Methodology

Step 1 Initiating meeting, document review and Literature Scan
The tasks included:
- Workshop with ADHC and agree draft project plan, project arrangements, and draft evaluation methodology
- Obtain relevant documents, including service type description 2.01 and any funding and service data available from ADHC
- Review documents received
- Develop key search terms and undertake a Literature Scan which would include a review of the evidence to identify good practice models and approaches (including other jurisdictions).

Step 2 Initial stakeholder consultation
- Initial consultation with selected region/case manager
- Attend the LRC Reference Group meeting (13th May) to discuss the project with case managers
- Formalise our minimum information/data requirements and discuss evaluation approach

Step 3 Develop Evaluation Methodology, Project Plan & Draft Outline for Reports & Present to Steering Group
- Refine and finalise evaluation methodology, project plan and draft outline for reports.
- The project plan would include the aims and objectives of the project, the project tasks and methods, timeframes, milestones and deliverables.
- The evaluation methodology would be based on a summative evaluation design which addresses both processes and interventions along with outcomes and results. A first draft framework for methodology is illustrated below.
- Presentation to the Steering Group.

**Deliverable:** Final Project Plan, Evaluation Methodology and structure of interim and final reports.
### Table 5 Evaluation Framework

<table>
<thead>
<tr>
<th>Key Evaluation Question</th>
<th>Minor Evaluation Questions</th>
<th>Process Indicators</th>
<th>Outcome Indicators (Intermediate)</th>
<th>Outcome Indicators (Ultimate)/Results</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Determine whether the P&amp;SHC has provided services as intended in relation to the service type description, including services designed around individual plans.</td>
<td>How many residents have individual plans? How often are the individual plans reviewed?</td>
<td>Number of residents with an up to date individual plan</td>
<td>Improved quality of life of the LRC residents</td>
<td>Interviews Focus groups Data re no. of IPs</td>
<td></td>
</tr>
</tbody>
</table>

II. Identify whether the P&SHC program is achieving its intended outcomes:  
- To facilitate access of LRC residents to access primary and secondary health care services (eg. dental, optometry and podiatry)  
- To support LRC residents to access primary and secondary health care services, provide holistic health care services  
- To reduce financial barriers for residents accessing health care services re skilling  
| Are the residents able to manage their health care needs independently? Are services delivered within a collaborative framework? How are health services for residents co-ordinated? Are there health care education sessions conducted? Do residents require transport to doctor appointments? | Degree of compliance in attending appointments and with medication No. health care education sessions conducted Use of brokerage funds | Evidence of networking between case managers and health service providers Improved access to primary and secondary health care services | Interviews Focus groups Case studies |

III. Identify any variation in service delivery across regions and between services  
<p>| How are services delivered in your region? Are there different service models for different LRCs? Or different clients? What role does the Area Health Service play? Eg. mental health team, allied health services What role does the resident’s GP play? Do you brokerage funds/services? If yes, how are | | | | | Interviews Focus groups |</p>
<table>
<thead>
<tr>
<th>Questions</th>
<th>Indicators</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. What type of service model is most effective in achieving service</td>
<td>What elements of the service model work well?</td>
<td>Interviews, Focus groups, Case studies</td>
</tr>
<tr>
<td>outcomes for LRC residents?</td>
<td>What elements of the service model could be improved?</td>
<td>Evidence from literature scan</td>
</tr>
<tr>
<td>V. How do services respond to people from Aboriginal or CALD backgrounds?</td>
<td>Are there specific services delivered for Aboriginal people?</td>
<td>Interviews, Focus groups, Case studies</td>
</tr>
<tr>
<td></td>
<td>Are there specific services delivered for people with CALD backgrounds?</td>
<td>Evidence from literature scan</td>
</tr>
<tr>
<td>VI. What other community participation models and approaches (including</td>
<td></td>
<td></td>
</tr>
<tr>
<td>approaches (including from other jurisdictions) exist which may better</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inform P&amp;HSC and broader aims of the Boarding House Reform Program?</td>
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</table>

**Stage 2 Conduct the Evaluation**

**Step 4   Develop consultation instruments and consent forms**

- This step would involve the development of the consultation instruments to use with interviews and focus groups, as well as the associated consent forms.
- Consultation instruments and consent forms would be developed in line with National Statement on Ethical Conduct in Research Involving Humans 2007 published by the National Health and Medical Research Council (NH&MRC). For consultation with Aboriginal people, the Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research, also published by the NH&MRC would be adopted.
- The consultation instruments would be developed in line with Evaluation Methodology.

**Deliverable: consultation instruments and consent forms**

**Step 5   Conduct the Evaluation**

This evaluation would be conducted through:

- Consultation visits to each of the four regions with more time allocated for Hunter and Metro South who have greatest number of LRC clients.
- Interviews and focus groups would be conducted with case managers, regional managers and clients.
- Three in-depth interviews would be conducted with clients to develop three case studies.
The objective would be to understand the key activities, processes and service delivery arrangements (or business models) at each of the regions:
- To understand how ADHC regions manage the P&SHC program
- To understand the relationships with the different health service providers
- To understand how the case management services are provided
- Identify service delivery/broking arrangement for services purchased for clients to gain appropriate access
- Identification key issues impacting access and identify potential representative case studies
- Generate key themes common across regions and key success factors.

**Step 6 Analysis of findings and data from evaluation activities**

The tasks include:
- Analyse the findings of the review and data from evaluation activities including:
  - Focus groups
  - Interviews
  - Other data.
- Develop three case studies
- Thematic analysis and identification of key themes.

**Stage 3 Reporting**

**Step 7 Develop Interim Report**

In this step the main task is to develop the interim report.

The interim report would identify:

- Summary of current case management and services
- Key themes including key issues and success factors
- Case studies demonstrating key themes
- Draft recommendations.

Mercury Advisory would aim to deliver additional recommendations supported by a clear picture of what is happening now.

Additional observations are likely to include:

- Critical success factors for maximising access including types of infrastructure (IT/logistics etc)
- Considerations of changes to health service funding and delivery models since 1998 which may provide opportunities for enhanced access. These may include the expansion of ageing in place initiatives and expansion of Medicare to include case management and chronic disease management services
- Consideration should also be given to likely health reforms currently being planned by the Rudd government. Shifting responsibility for ambulatory and community care to federal government is likely to significantly expand the type of service provided under Medicare.
- Maximising interface with larger Area Health Service following 2005 Area amalgamations.
Step 8  Develop Draft and Final Reports

In this step we would develop our draft report incorporating our interim report and outcomes from feedback from ADHC. We would then finalise our report and present to the Project Steering Group. The LRC Reference Group meeting is on 12th August where the report would be presented.

**Deliverables:**  Draft and Final Reports.
## Appendix D – Evaluation Overview

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Planned</th>
<th>Actual</th>
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</thead>
<tbody>
<tr>
<td>Regional Consultations</td>
<td>Four</td>
<td>Six, including one CALD resident requiring interpreter</td>
</tr>
<tr>
<td>Resident Interviews</td>
<td>Three</td>
<td>Six</td>
</tr>
<tr>
<td>Additional people consulted outside of Regional Consultations</td>
<td>-</td>
<td>Surveys of all LRCs conducted</td>
</tr>
<tr>
<td>Data Collection</td>
<td>-</td>
<td>Collection of P&amp;SHC brokered funds utilisation data where available</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>-</td>
<td>Results of LRC Surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P&amp;SHC brokered funds utilisation as available</td>
</tr>
</tbody>
</table>
Evaluation of Primary and Secondary Health Care Services Provided to Residents of Licensed Residential Centres

INFORMATION SHEET FOR STAKEHOLDER

Introduction

You are invited to take part in a research study which will investigate whether the support services funded by Ageing, Disability and Home Care, Department of Human Services (ADHC) have provided services as intended including delivery of services designed around individual plans, facilitating access of licensed residential centre residents to appropriate health and allied health services and reducing financial barriers for residents accessing health services.

The study is being conducted by Mercury Advisory (on behalf of ADHC). Helen Favelle is the project manager of the study. She has worked with disability service organisations, and will be assisted by Tina Sinclair who has also worked with health and disability service providers as a health service manager, and Deb Charlton who has a background as an experienced aged and community care nurse and aged care service manager.

ADHC is overseeing the study.

Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to participate in a focus group discussion which will seek your views on the primary and secondary health care services provided to residents of licensed residential centres. The focus group will be held at Raintree at Green Point on 9th June. It is expected to last about 2 hours. The discussion will be audio taped for later transcription if permission is given.

Risks

There are no risks from participating in this study.

Benefits

While we intend that this research study furthers knowledge about the delivery of primary and secondary health care services delivered to residents of licensed residential centres and may improve treatment of people residing in licensed residential centres in the future, it may not be of direct benefit to yourself or anyone you currently have contact with in a licensed residential centre.
Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not affect your employment, or relationships with other service providers.

Confidentiality

All the information collected from you will be treated confidentially, and only the researchers named above will have access to it. The study results will contain a schedule of the names of the participants in the consultations however all feedback will be de-identified.

Further Information

When you have read this information, Helen Favelie, Tina Sinclair and Deb Charlton will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Tina on (02) 9239 9086.

This information sheet is for you to keep.

Complaints

The conduct of this study has been authorised by ADHC. Any person with concerns or complaints about the conduct of this study may also contact Janice Denehy on (02) 8270 2447.
Evaluation of the Primary and Secondary Health Care (P&SHC) Services

Name of Participant:

Name of Evaluator(s):

1. I consent to participate in the evaluation named above, the particulars of which – participation in a focus group about the primary and secondary health services received within a licensed residential centre - has been explained to me. A written copy of the information sheet has been given to me to keep.

2. I authorise the evaluator or assistant to use for this purpose the evaluation the information obtained from focus groups regarding the provision of primary and secondary health services to residents of licensed residential centres referred to under (1.1A) above.

3. I acknowledge that:
   a. The possible effects of the interviews regarding the provision of primary and secondary health services to residents of licensed residential centres have been explained to my satisfaction;
   b. I have been informed that I am free to withdraw from the evaluation at any time explanation or prejudice and to withdraw any unprocessed data previously supplied.
   c. The evaluation study is for the purpose of evaluating the primary and secondary health services provided to residents of licensed residential centres;
   d. I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
   e. I consent to the interviews being audio-taped;
   f. I consent to my name being provided as part of the consultation schedule in the final report.

Signature __________________________ Date ________________

(Participant)

Signature __________________________ Date ________________

(Parent/Guardian)

MASTER Participant Consent Form, Version 1, May 2010
Evaluation of Primary and Secondary Health Care Services Provided to Residents of Licensed Residential Centres

INFORMATION SHEET FOR RESIDENTS OF LICENSED RESIDENTIAL CENTRES OR THEIR FAMILIES/CARERS

Introduction

You are invited to take part in a research study which will investigate whether the support services funded by Ageing, Disability and Home Care, Department of Human Services (ADHC) have provided services as intended including delivery of services designed around individual plans, facilitating access of licensed residential centre residents to appropriate health and allied health services and reducing financial barriers for residents accessing health services.

The study is being conducted by Mercury Advisory (on behalf of ADHC). Helen Favelle is the project manager of the study. She has worked with disability service organisations, and will be assisted by Tina Sinclair who has also worked with health and disability service providers as a health service manager, and Deb Charlton who has a background as an experienced aged and community care nurse and aged care service manager.

ADHC is overseeing the study.

Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to participate in an interview which will seek your views on the primary and secondary health care services provided to residents of licensed residential centres. The interview will be held at x on the x week in June. It is expected to last about 2 hours. The discussion will be audio taped for later transcription if you give permission.

Risks

There are no risks from participating in this study.

Benefits

While we intend that this research study furthers knowledge about the delivery of primary and secondary health care services delivered to residents of licensed residential centres and may improve treatment of people residing in licensed residential centres in the future, it may not be of direct benefit to yourself or anyone you currently have contact with in a licensed residential centre.
Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not have any impact upon you or your friend/relative’s accommodation within their licensed residential centre or the provision of support services for primary or secondary health care services.

Confidentiality

All the information collected from you will be treated confidentially, and only the researchers named above will have access to it. The study results will contain a schedule of the names of the participants in the consultations however all feedback will be de-identified.

Further Information

When you have read this information, Helen Favelle, Tina Sinclair and Deb Charlton will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Tina on (02) 9239 9086.

This information sheet is for you to keep.

Complaints

The conduct of this study has been authorised by ADHC. Any person with concerns or complaints about the conduct of this study may also contact Janice Denehy on (02) 8270 2447.
Evaluation of the Primary and Secondary Health Care (P&SHC) Services

Name of Participant:

Name of Evaluator(s):

1. I consent to participate in the evaluation named above, the particulars of which – participation in a face-to-face interview about the primary and secondary health services received within a licensed residential centre - has been explained to me. A written copy of the information sheet has been given to me to keep.

1A I provide my consent for ........................................... (name of person consent is being provided on behalf of) to participate in the evaluation named above, the particulars of which - participation in a face-to-face interview about the primary and secondary health services received within a licensed residential centre – has been explained to me. A written copy of the information has been given to me to keep.

2. I authorise the evaluator or assistant to use for this purpose the evaluation the information obtained from the interviews regarding the provision of primary and secondary health services to residents of licensed residential centres referred to under (1,1A) above.

3. I acknowledge that:

   a. The possible effects of the interviews regarding the provision of primary and secondary health services to residents of licensed residential centres have been explained to my satisfaction;

   b. I have been informed that I am free to withdraw from the evaluation at any time explanation or prejudice and to withdraw any unprocessed data previously supplied.

   c. The evaluation study is for the purpose of evaluating the primary and secondary health services provided to residents of licensed residential centres;

   d. I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;

   e. I consent to the interviews being audio-taped.

Signature ___________________________ Date ____________
(Participant)

Signature ___________________________ Date ____________
(Parent/Guardian)

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1 MASTER Participant Consent Form, Version 1, May 2010

51 Evaluation of Primary and Secondary Health Care Services – Report to ADHC
Appendix F – Focus Group Topics

Workshop/Focus group topics – Evaluation of Primary and Secondary Health Care Services – Licensed Residential Centres - ADHC

Services

A. Individual Plans and Health Care Plans

How many residents have individual plans and Health Care Plans?

How often are they reviewed?

B. Access and Support

Are the residents able to manage their health care needs independently? [Prompts: who is involved? How does it work? How is this monitored in the LRC?]

Do services work collaboratively? [Prompts: How does information get shared about a resident’s health needs? What happens?]

How are health services for residents co-ordinated? [Prompts: Who makes appointments? Who supports the resident? What happens?]

How are services delivered in your region? [Prompts: Are there differences across the Region?]

Are there different service models for different LRCs? Or different clients?

What role does the Area Health Service play? Eg. mental health team [Prompts: Does their roles vary across the Region (eg. if covered by more than one Area Health Service?)

What role does the resident’s GP play? [Prompts: Does the same GP visit all residents at an LRC? Do the clients visit different GPs? How does it work?]

Are there health care education/health promotion sessions conducted? [Prompts: who is involved? What happens?]

Do residents require transport to doctor appointments?

Are there specific services delivered for Aboriginal people?

Are there specific services delivered for people with CALD backgrounds?

C. Reduction in Financial Barriers

Do you brokerage funds/services? If yes - how are brokerage funds used? [Prompts: What services are paid for? Who are the services purchased from? How does it work?]
D. Service Improvement

What elements of the service model work well?

What elements of the service model could be improved?
Appendix G – Survey Tool distributed to LRCs

EVALUATION OF PRIMARY AND SECONDARY HEALTH SERVICES IN LICENSED RESIDENTIAL CENTRES

RESIDENT HEALTH DATA COLLECTION FORM

1. Name of Licensed Residential Centre: ________________________________________

2. Number of current Residents: ______  Number of Female Residents: ________

3. Please list the number of residents who have the following primary disability
   Psychiatric: ________  Intellectual: ________  Physical: ________  
   Aged Care: ________  All Other: ________

4. Number of residents receiving HACC personal care services: ________________

5. Number of residents who self-manage their health care: ________________

6. Number of residents whose families/carers manage their health care: ________________

7. Number of residents whose health care is managed by another party: ________________

If so please nominate

☐ Manager of LRC  ☐ Case Manager  ☐ Community Nurse

Other: __________________________________________

8. Number of Residents with an Individual Plan: ________  Community Health Plan: ________

9. Number of Residents who have seen a GP within the last:
   One Month: ________  Two Months: ________  Six Months: ________  Twelve Months: ________
   Information not available at LRC: ________  Resident Does not consent: ________

10. Number of Residents who have seen a Dentist within the last Twelve Months: ________
    Information not available at LRC: ________  Resident Does not consent: ________

11. Number of Residents who have had a Flu Vaccination in the past 12 months: ________
    Information not available at LRC: ________  Resident Does not consent: ________
EVALUATION OF PRIMARY AND SECONDARY HEALTH SERVICES IN LICENSED RESIDENTIAL CENTRES
RESIDENT HEALTH DATA COLLECTION FORM

12. Number of Female Residents who had a Pap Smear in the past 2 years: _______________

Information not available at LRC: ________  Resident Does not consent: _______________

13. Number of Residents who saw a Psychiatrist in the past 12 months: _______________

Information not available at LRC: ________  Resident Does not consent: _______________

14. Other clinical services provided to residents within past 12 months (please tick)

<table>
<thead>
<tr>
<th>Service</th>
<th>In Residence</th>
<th>In Community</th>
<th>Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometrist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OT</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Can you please also attach copies of all forms used within your licensed residential centre to record details of the residents’ health care.

Thank you for your participation
Appendix H – Survey Results

EVALUATION OF PRIMARY AND SECONDARY HEALTH SERVICES IN LICENSED RESIDENTIAL CENTRES
RESIDENT HEALTH DATA COLLECTION RESULTS

1. Responses were received from 5 LRC, 22% of all LRC.

2. Number of current Residents represented in the survey were 60, 7% of the potential population based on total licensed beds. 12 females were represented, being 20% of the residents surveyed.

3. The number of residents with the following primary disability

<table>
<thead>
<tr>
<th>Psychiatric:</th>
<th>47 (78%)</th>
<th>Intellectual:</th>
<th>3 (5%)</th>
<th>Physical:</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care:</td>
<td>8 (13%)</td>
<td>All Other:</td>
<td>2 (3%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Number of residents receiving HACC personal care services: 26 (43%)
5. Number of residents who self-manage their health care: 9 (15%)
6. Number of residents whose families/carers manage their health care: 3 (5%)
7. Number of residents whose health care is managed by another party: 48 (80%)

If so please nominate

5/5 Manager of LRC 3/5 Case Manager 2/5 Community Nurse 0/5 Other

8. Number of Residents with an Individual Plan: 24 (40%) Community Health Plan: 17 (28%)
9. Number of Residents who have seen a GP within the last:
   - One Month: 14 (23%)
   - Two Months: 26 (43%)
   - Six Months: 20 (33%)
10. Number of Residents who have seen a Dentist within the last Twelve Months: 42 (70%)
    - Information not available at LRC: 0
    - Resident Does not consent: 7 (12%)
    - No data provided: 11 (18%)
11. Number of Residents who have had a Flu Vaccination in the past 12 months: 24 (40%)
    - Information not available at LRC: 22 (37%)
    - Resident Does not consent: 10 (17%)
    - No data provided: 4 (7%)
12. Number of Female Residents who had a Pap Smear in the past 2 years: 6 (50%)
    - Information not available at LRC: 0
    - Resident Does not consent: 1 (8%)
    - No data provided: 5 (42%)
13. Number of Residents who saw a Psychiatrist in the past 12 months: 45 96%
    - Information not available at LRC: 0
    - Resident Does not consent: 0
    - No data provided: 2 (4%)
### EVALUATION OF PRIMARY AND SECONDARY HEALTH SERVICES IN LICENSED RESIDENTIAL CENTRES

#### RESIDENT HEALTH DATA COLLECTION RESULTS

14. Other clinical services provided to residents within past 12 months (please tick)

<table>
<thead>
<tr>
<th></th>
<th>In Residence</th>
<th>In Community</th>
<th>Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>0/5</td>
<td>5/5</td>
<td>0/5</td>
</tr>
<tr>
<td>Dietician</td>
<td>0/5</td>
<td>2/5</td>
<td>1/5</td>
</tr>
<tr>
<td>Optometrist</td>
<td>1/5</td>
<td>3/5</td>
<td>0/5</td>
</tr>
<tr>
<td>OT</td>
<td>0/5</td>
<td>0/5</td>
<td>2/5</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>0/5</td>
<td>1/5</td>
<td>1/5</td>
</tr>
<tr>
<td>Podiatry</td>
<td>3/5</td>
<td>2/5</td>
<td>0/5</td>
</tr>
</tbody>
</table>

Only 1 LRC provided forms.
Appendix I – Outline of Chronic Disease Management MBS Items (formerly EPC)

Within this document there are references made to Medicare GP Enhanced Primary Care (EPC) item numbers. The references to EPC were maintained as this is the terminology used in interviews however the current terminology is Chronic Disease Management (CDM).

“The Department of Health and Ageing is removing references to EPC in the (Medicare Benefits Schedule (MBS) Group A15 (GP management plans, team care arrangements, multidisciplinary care plans and case conferences) items (721-779) and in the Miscellaneous Group 3 (allied health individual) items (10950-10970).

The change has been made because the GP Enhanced Primary Care (EPC) care planning items were removed from the MBS in 2005 and replaced by the Chronic Disease Management (CDM) items (721-731). The term 'EPC plan' is now obsolete.

There are no changes to the eligibility requirements for the CDM items, including the allied health services for people with chronic disease. This is simply a change to terminology to bring it up to date.

Medicare Australia and provider organisations have been advised of the change.

EPC language has also been removed from the MBS Group A14 (Health Assessments) items.”

Chronic Disease Management Medicare Items

“Eligibility

Patients who have a chronic or terminal medical condition (with or without multidisciplinary care needs) can have a GP Management Plan (GPMP) service.

Patients with a chronic or terminal medical condition and complex care needs requiring care from a multidisciplinary team can have a GPMP and Team Care Arrangements (TCAs).

A ‘chronic medical condition’ is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke.

These items are designed for patients who require a structured approach to their care.

Overview of the items

There are six CDM items that provide rebates for GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to CDM plans.

The CDM items are intended to be provided by the patient’s usual GP, that is, the GP who has provided the majority of care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 months.

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A review item is the key component for assessing and managing the patient’s progress once a GPMP or TCAs have been prepared.

GPMPs and TCAs can be reviewed by a GP from the same practice or, if the patient changes practices, by their new GP.

Using the CDM items, GPs can contribute to other provider’s multidisciplinary care plans and to a review of these plans.

GP can be assisted by practice nurses, Aboriginal health workers and other health professionals in preparing and reviewing the CDM items.

The items

Preparation of a GP Management Plan (GPMP - item 721)

- Provides a rebate for a GP to prepare a management plan for a patient who has a chronic or terminal medical condition with or without multidisciplinary care needs.
- The recommended frequency is once every two years, supported by regular review services.
- Involves the GP assessing the patient, agreeing management goals with the patient, identifying actions to be taken by the patient, identifying treatment and ongoing services to be provided, and documenting these and a review date in the GPMP.

Review of a GP Management Plan (Item 732)

- Provides a rebate for a GP to review a GP Management Plan (see above).
- Recommended frequency is once every six months; can be earlier if clinically required.
- Involves reviewing the patient’s GP Management Plan, documenting any changes and setting the next review date.

Coordination of Team Care Arrangements (TCAs - item 723)

- Provides a rebate for a GP to coordinate the preparation of TCAs for a patient who has a chronic or terminal medical condition and also requires ongoing care from a multidisciplinary team of at least three health or care providers.
- In most cases the patient will already have a GPMP in place (but this is not mandatory).
- Recommended frequency is once every two years, supported by regular review services.
- Involves the GP collaborating with the other participating providers on required treatment/services, agreeing the arrangements with the patient, documenting the arrangements and a review date in the patient’s TCAs, and providing copies of the relevant document to the collaborating providers.

Coordination of a Review of Team Care Arrangements (Item 732)

- For patients who have a current TCA and require a review of their TCA.
- Recommended frequency is once every six months; can be earlier if clinically required.
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient’s TCA.
Contribution to a multidisciplinary care plan being prepared by another health or care provider (Item 729)

- For patients who are having a multidisciplinary care plan prepared or reviewed by another health or care provider (other than their usual GP).
- Recommended frequency is once every six months; can be earlier if clinically required.
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the providers preparing or reviewing the plan and including their contribution in the patient’s records.

Contribution to a multidisciplinary care plan being prepared for a resident of an aged care facility (Item 731)

- This is for patients in residential aged care facilities and is otherwise identical to Item 729 (immediately above).

Access to allied health items

Patients who have both a GPMP (item 721) and TCAs (item 723) have access to the allied health individual services on the Medicare Benefits Schedule.

Similarly, residents of aged care homes whose GP has contributed to a care plan prepared by the residential aged care facility (item 731) may also have access to these allied health items.

Eligible patients can claim a maximum of five (5) allied health services per calendar year (MBS items 10950-10970).

Patients with a GPMP (item 721) and type 2 diabetes can also access Medicare rebates for allied health group services (MBS items 81100 to 81125).

Patients need to be referred by their GP for services recommended in their care plan, using the referral form issued by the Department that can be found at: http://www.health.gov.au/mbsprimarycareitems or a form that contains all the components of the Department’s form.

Practice Nurse Monitoring and Support

Patients with either a GPMP or TCAs can also receive monitoring and support services from a practice nurse or registered Aboriginal health worker on behalf of the GP (MBS item 10997).

Further information

More detailed information on the CDM items is available at www.health.gov.au – use the A-Z Index to go to ‘C’ and select ‘Chronic Disease Management Medicare items’.

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