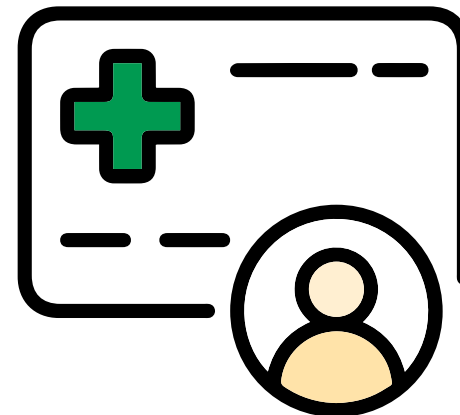


General Practice in Aged Care Incentive

Patient journeys: An illustration of primary
health care in residential aged care homes

Effective - August 2024

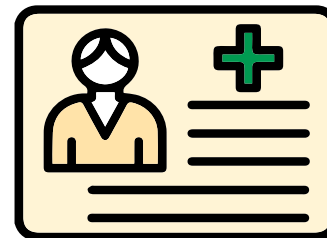


Patient journeys include a person's thoughts, feelings, actions and outcomes throughout their experience of care.

Patient journeys are helpful communication tools. They illustrate the importance of:

- adopting a person-centred care approach, recognising that different people have unique needs and expectations
- continuous care across the whole patient journey
- the experience of care and outcomes
- identifying opportunities for proactive, planned and coordinated care
- reflection, system learning and the ability to identify opportunities for improvement.

People living in residential aged care homes have complex health and care needs. Two hypothetical aged care residents and their patient journeys are provided below to illustrate how the General Practice in Aged Care Incentive can be applied to deliver best practice quality primary care. The incentive supports GPs and practices to deliver more proactive, planned and continuous care for aged care residents.



Mavis' and Bernie's journeys illustrate:

- the impact of their health conditions on their physical and cognitive ability and level of interaction with others
- what they are thinking and feeling
- any health risks that need addressing
- the critical role of quality primary healthcare and the significant role the GP plays in coordinating comprehensive and continuous care
- how the incentive has been tailored to their individual and health care needs to provide proactive, planned and continuous care
- the health care contacts and interventions, and reviews and care planning services delivered by their GP and practice care team under the incentive
- referrals to and involvement of other health professionals to help achieve holistic health gains
- how the incentive can help achieve a positive experience of care, improve health outcomes and quality of life for people living in aged care homes.

These journeys have been developed using the Journey Map Templates developed by the NSW Agency for Clinical Innovation¹ and are provided for illustrative purposes only.

Patient journeys for the incentive aim to support those participating to better understand and communicate how the incentive may be delivered in person.

The patient journey should be used as an example of possible care and not as a requirement of the delivery of care for the General Practice in Aged Care Incentive. The eligibility and servicing requirements of the incentive are outlined in the program guidelines at health.gov.au/our-work/gpaci.

GPs and care teams are required to deliver care that aligns with the needs and expectations of a patient. These journeys are not to be taken as medical advice.

¹ NSW Health Agency for Clinical Innovation (2018) Journey Map. Available at: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0010/419797/EBCD_Toolkit-Journey_Map.pdf (Accessed: 14 June 2024).

Mavis' journey

Mavis is an 89-year longstanding resident of an aged care home in regional NSW. She is widowed and has two adult children, one of whom lives nearby. Both children are busy with their careers and family commitments. Mavis does not socialise much with other residents. She is well educated and had a career in school administration before she retired. She has a long-standing GP who has regularly visited her in the aged care home over the past 3 years.

Mavis has chronic obstructive pulmonary disease, is oxygen-dependent and lives with other conditions including sleep apnoea, congestive heart failure, and arthritis – a source of chronic pain. She experiences recurrent urinary tract infections. Mavis is on 7 different medications. Her mobility is good across short distances, and she has no history of falls. She becomes very breathless and often requires a wheelchair.

Mavis understands how her condition impacts on her ability to conduct day-to-day functions and is keen to stay well. She has some confidence in her own ability to manage her condition with the support of staff at her aged care home but recently has experienced frequent trips to hospital.

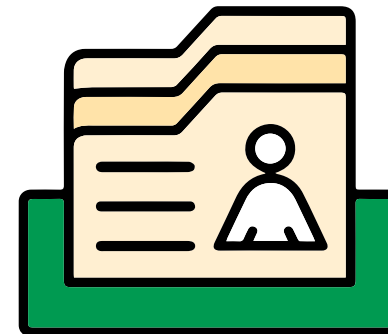
She is seeing a physiotherapist to help with her lung health and mobility. While she is keen to avoid any further trips to hospital, she is resistant to the physiotherapist's suggested exercises. What matters to Mavis at this stage of her life is quality time with her family. She has lost some capacity to do the reading she used to enjoy, but she still gets to it when she can. While not diagnosed, Mavis is likely to be depressed.

Mavis' 12-month journey

This journey map is designed to be read both vertically and horizontally:

- ✚ At each three-month interval it describes what Mavis is doing, thinking and saying; her main health risks, who she is interacting with and how she is feeling; her health care contacts and interventions, and services provided under the General Practice in Aged Care Incentive, and; her subsequent health and experience gains following those health care contacts.
- ✚ When read from left to right, over a period of 12 months, it describes how Mavis' health condition changes over time and how this impacts on what she's doing, thinking and saying; her changing health risks; who she is interacting with and how she is feeling as her condition changes; her health care contacts and interventions, and services provided across those 12 months under the General Practice in Aged Care Incentive; and, the health gains she has experienced as a result of her changing care that are tailored to her personal and holistic needs.

Service requirements of the General Practice in Aged Care Incentive are bolded in the 'Health care contact' row. Mavis' journey illustrates that her GP and practice team have met all their incentive requirements.



Mavis' 12-month journey

Mavis' primary care journey over a year



	1 - 3 months	4 - 6 months	7 - 9 months	10 - 12 months
DOING	<ul style="list-style-type: none"> Reading new books Gaining weight 	<ul style="list-style-type: none"> Struggling to stay motivated to read and exercise Ceased moderate exercise 	<ul style="list-style-type: none"> Very inactive Reluctant to leave her room 	<ul style="list-style-type: none"> Learning computer and online skills
THINKING AND SAYING	<ul style="list-style-type: none"> Reading books gives me joy I'm feeling involved in my care planning 	<ul style="list-style-type: none"> What's the point in exercises? 	<ul style="list-style-type: none"> I can't be bothered I can't live with this pain I don't want to leave my room It's time for me to die 	<ul style="list-style-type: none"> My pain is so much better The internet has opened a whole new world for me
HEALTH RISKS	<ul style="list-style-type: none"> Risk of depression 	<ul style="list-style-type: none"> Persistent signs of depression 	<ul style="list-style-type: none"> Mild pneumonia Depression 	<ul style="list-style-type: none"> Urinary tract infection
INTERACTING WITH	<ul style="list-style-type: none"> Family 	<ul style="list-style-type: none"> Persistent little social contact Residential staff Care team – GP, clinical care nurse at her aged care home, pharmacist, exercise physiologist, dietician, activities coordinator at her aged care home, personal carers 		
FEELING	<ul style="list-style-type: none"> Buoyed 	<ul style="list-style-type: none"> Despondent 	<ul style="list-style-type: none"> Exhausted, abandoned 	<ul style="list-style-type: none"> Optimistic
HEALTH CARE CONTACT	<ul style="list-style-type: none"> COVID and flu vaccination Comprehensive medical assessment* Care plan contribution* 2 regular follow-up visits at aged care home** 	<ul style="list-style-type: none"> 2 regular visits** by GP and allied health at aged care home Follow-up care conferences* with allied health Continuous positive airway pressure (CPAP) machine review with pharmacist 	<ul style="list-style-type: none"> Regular visit via telehealth** Care planning service* Residential medicines management review (RMMR)* Care conferences* Regular visit at aged care home** 	<ul style="list-style-type: none"> Extended consultation** Regular visit at aged care home**
HEALTH GAINS	<ul style="list-style-type: none"> Referral to a dietician for healthy eating advice Referral to exercise physiologist for gentle exercise Self-care tips 	<ul style="list-style-type: none"> Referral to a psychologist 	<ul style="list-style-type: none"> Hospital admission avoided Pain management plan including non-pharmacological approaches as well as medication 	<ul style="list-style-type: none"> A social prescription for a computer skills course and online book club

* Service is an example of the care planning services that could contribute to the yearly requirements under the incentive (2 in total per year)

** Service is an illustration of how the 8 consultations required per year under the incentive can be deployed

Bernie's journey

Bernie is an 86-year-old man. He is a retired civil engineer. Since retiring he has lived in the same house for the past 25 years with his wife, Alice. Bernie and Alice have been married for over 60 years. They have little family support with 2 children residing overseas and only one, their son Paul, living closer to them. Paul has enduring power of attorney. They have had domestic and gardening assistance through the Commonwealth Home Support Programme. Carers help Bernie with washing and dressing, and they also help with medication. They are a social couple and have a wide network of friends. Despite being speech impaired, Bernie is social and enjoys company, good food and wine.

Bernie experienced a major stroke some years ago. In the intervening time Bernie has become more immobile, increasingly frail and at risk of a fall. He lives with diabetes, chronic heart failure and prostate cancer. He is under the care of a GP who has seen him for over 15 years and an oncologist, and he was recently referred to a geriatrician.

Bernie's health and speech impairment have rapidly declined. His capacity to live independently and Alice's incapacity to care for him confidently and safely has led to the decision for Bernie to transition to an aged care home following an Aged Care Assessment Team assessment.

The aged care home is some distance from his GP's practice. His GP has indicated that, reluctantly, they will not visit him in his new home, and he must find a new GP. Alice will continue to live independently in the family home.

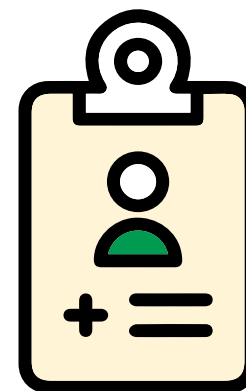
Bernie's 12-month journey

This journey is designed to be read both vertically and horizontally:

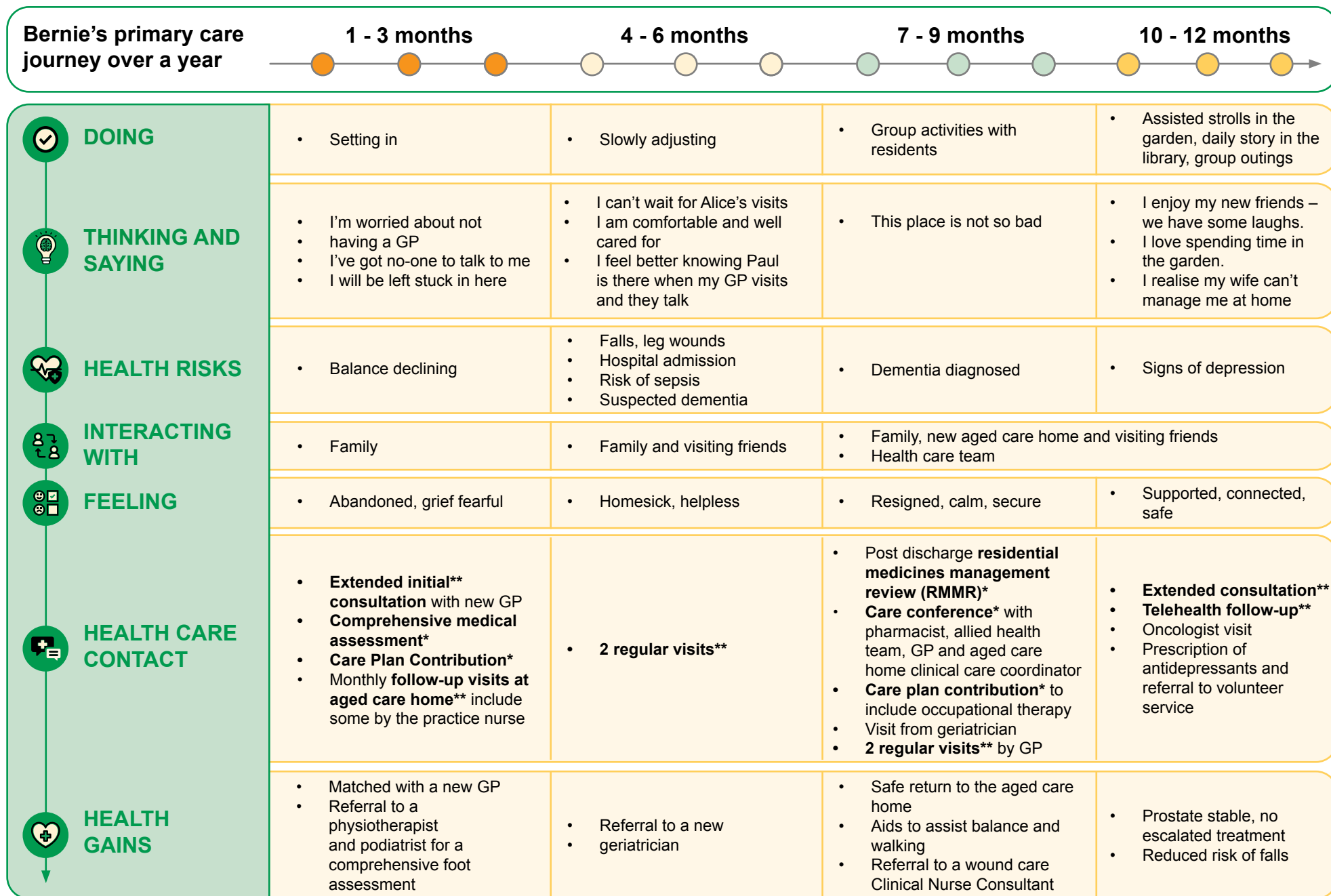
✚ At each three-month interval it describes what Bernie is doing, thinking and saying; his main health risks, who he is interacting with and how he is feeling; his health care contacts and interventions, and services provided under the General Practice in Aged Care Incentive, and; his subsequent health and experience gains following those health care contacts.

✚ When read from left to right, over a period of 12 months, it describes how Bernie's health condition changes over time and how this impacts on what he's doing, thinking and saying; his changing health risks; who he is interacting with and how he is feeling as his condition changes; his health care contacts and interventions, and services provided across those 12 months under the General Practice in Aged Care Incentive; and, the health gains he has experienced as a result of his changing care that are tailored to his personal and holistic needs.

Service requirements of the General Practice in Aged Care Incentive are bolded in the 'Health care contact' row. Bernie's journey illustrates that his GP and practice team have met all requirements of the incentive.



Bernie's 12-month journey



* Service is an example of the care planning services that could contribute to the yearly requirements under the incentive (2 in total per year)

** Service is an illustration of how the 8 consultations required per year under the incentive can be deployed