GRAMPIANS REGION
HEALTH SERVICE PARTNERSHIP

Grampians Region Health Service Partnership Residential in Reach Model of care

Version 1.2, 22nd April 2025

Beaufort & Skipton Health Service
Central Highlands Rural Health
East Grampians Health Service
East Wimmera Health Service
Grampians Health
MDHS
RURALnorthwestHEALTH centred on you
WWHS

Contents

1. Definitions

BSHS	Beaufort Skipton Health Service
CHRH	Central Highlands Rural Health
CNC	Clinical Nurse Consultant
ED	Emergency Department
EGHS	East Grampians Region Health Service
EWHS	East Wimmera Health Service
GRHSP	Grampians Region Health Service Partnership
GH	Grampians Health
GP	General Practitioner
HITH	Hospital in the Home
LOS	Length of stay
MPOA	Medical Power of Attorney
NWAU	National Weighted Activity Unit
NP	Nurse Practitioner
RACH	Residential Aged Care Home
RIR	Residential in Reach
RN	Registered Nurse
RNH	Rural Northwest Health
MDHS	Maryborough District Health Service
UCC	Urgent Care Centre
VVED	Victorian Virtual Emergency Department
WWHS	West Wimmera Health Service

2. Introduction and purpose

The purpose of this document is to outline the Grampians Region Health Service Partnership (GRHSP) Residential in Reach model of care. The document provides guidance and outlines the scope and process for how care in this expanded Residential in Reach (RIR) model will be delivered.

Within the Grampians region there are eight public health services that form the GRHSP. The Health Service Partnership (HSP) model is designed to enable health services to collaborate on strategic system priorities, that can be enhanced by working together.

The GRHSP consists of

- Beaufort Skipton Health Service
- Central Highlands Rural Health
- East Grampians Region Health Service
- East Wimmera Health Service
- Rural Northwest Health
- West Wimmera Health Service
- Maryborough District Health Service
- Grampians Health

The Grampians region RIR model aims to improve access and equity of care in rural and regional aged care homes, enhance quality and timeliness of care, and improve access to specialised care within a person-centred framework. The model aligns with the Victorian Department of Health's operational plan to deliver more healthcare in local communities closer to home, so that Victorians can access the care they need, no matter where they live. RIR services help by allowing aged care

residents to receive care where they live, easing the challenges of getting care outside their aged care home. This approach also reduces the chances of residents needing to go to the hospital for care that could be provided at home.

3. Background

RIR programs are designed to deliver specialist consultative care directly to residents in residential aged care homes (RACHs). Their primary goal is to prevent unnecessary hospital transfers and provide comprehensive support following hospitalisations. By keeping care within the residential setting, RIR programs enhance the quality of life for older adults while reducing the strain on hospital resources.

The 2023-2024 Victorian state budget allocated $11.7 million over three years to sustain and expand Residential In-Reach across Victoria. The funding aims to maximize opportunities for residents to receive care in their own homes, including reducing emergency department visits and urgent care presentations, as well as decreasing the length of stay (LOS) for older adults in hospitals.

To support this goal, GRHSP has developed a RIR model of care that extends across the Grampians region. Within the GRHSP there are 54 public and private RACHs encompassing 2596 residential aged care beds. As of October 2024, Grampians Health (GH) Ballarat RIR covers 1259 public and private aged care beds in the Ballarat and surrounding area. The expansion of the RIR model of care to the region will ensure the remaining 1333 residential aged care beds gain access to RIR, 7 days a week.

Within the Grampians region there are 18 Urgent Care Centres (UCC) and 3 public and private Emergency Departments (ED). In rural and regional areas, urgent care centres and emergency departments vary in their level of care. Urgent care centres treat non-life-threatening conditions, are equipped with basic resources and often staffed by acute ward or aged care home nurses with a general practitioner (GP) on call. The UCC may be required to transfer a resident on to a regional emergency department for more specialised care.

In contrast, emergency departments are open 24/7 and provide comprehensive care for critical cases, with access to advanced diagnostic tools and specialised medical professionals.

List of UCC/ ED location can be found in appendix

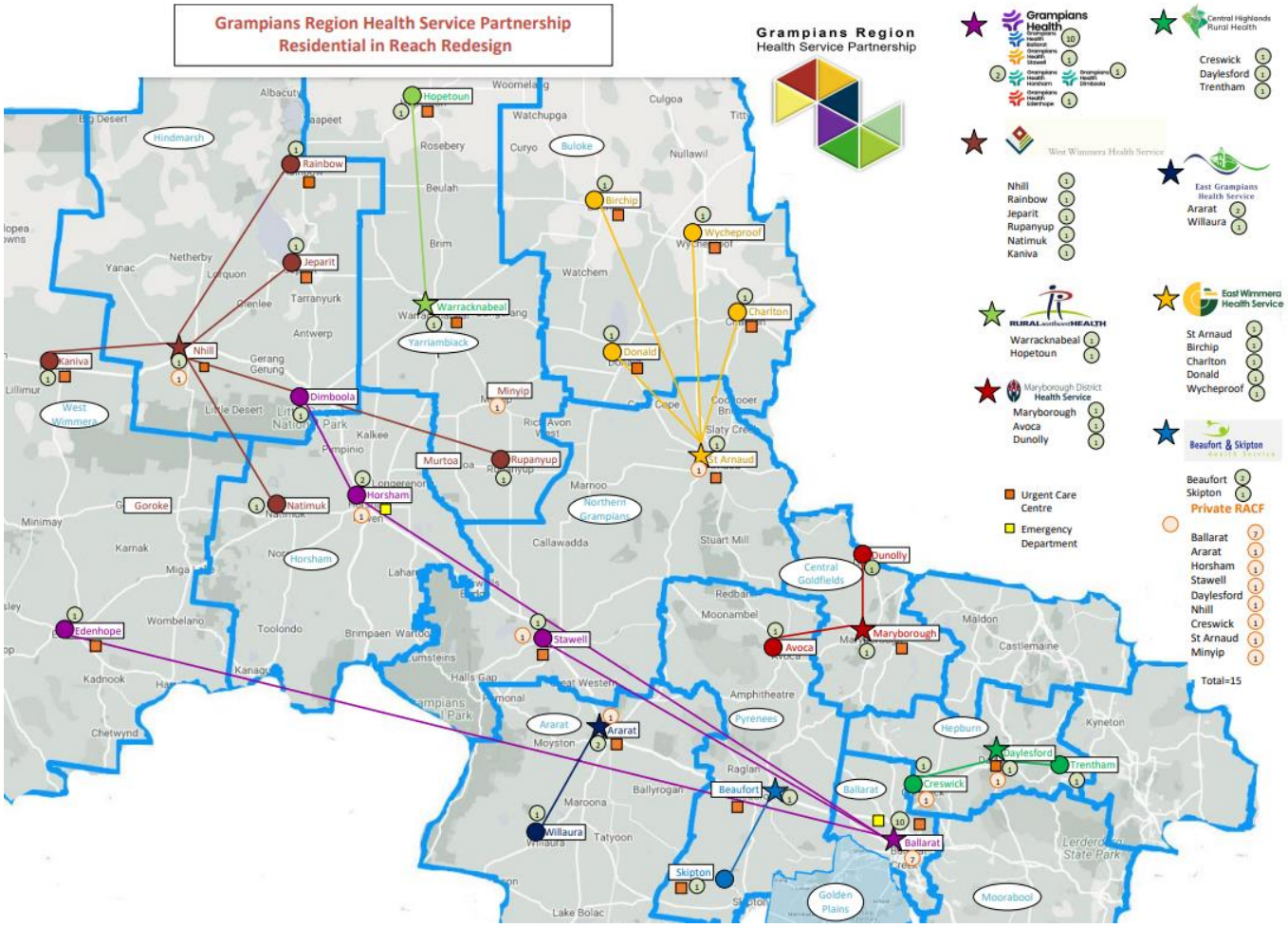


Diagram: Grampians Region map depicts the locations of the GRHSP Health Services, RACHs, EDs/ UCCs

4. Model of care

The model of care framework outlines key principles that guide care delivery, defines the structure and roles of the care team, establishes governance for quality and compliance, details the referral and assessment processes, and describes how care planning and coordination of care are delivered.

The GRHSP RIR model of care is evidence based, and person centred. We aimed to ensure that the model is grounded in the latest evidence, leading to more effective, sustainable outcomes. The RIR Redesign project partnered with the DELIVER Research team (Western Alliance Academic Health Science Centre and the Deakin University Institute for Health) to inform the model development and framework for outcome evaluation.

The DELIVER team were invited to join the Grampians region RIR Redesign steering committee, to support our commitment to innovation and evidence based best practice. The DELIVER team provided expertise to review the evidence on in-reach models of care focusing on what models of RIR are described in the literature, and the reported strengths and weaknesses of those models. Telehealth specific evidence was also considered in the research literature review.

The key findings from the literature were summarised in a rapid evidence summary report provided by the DELIVER research team in July 2024. These findings were presented to the steering committee and to stakeholders at a Grampians region-wide co-design workshop in August 2024. The research evidence, and other key findings from data review and gap analysis led the working group to develop a framework for the model of care, which was endorsed by the steering committee in October 2024. The Rapid evidence summary report is available in the appendix of this document.

Key principles

Developed by the RIR Redesign working group and endorsed by the RIR Redesign Steering Committee the key principles of the RIR regional model of care provide the foundational guidelines that shape the delivery of the RIR service. These principles guide the design, implementation, and evaluation of care, ensuring it is effective, equitable, and responsive to the needs of individuals living in aged care homes in the Grampians region.

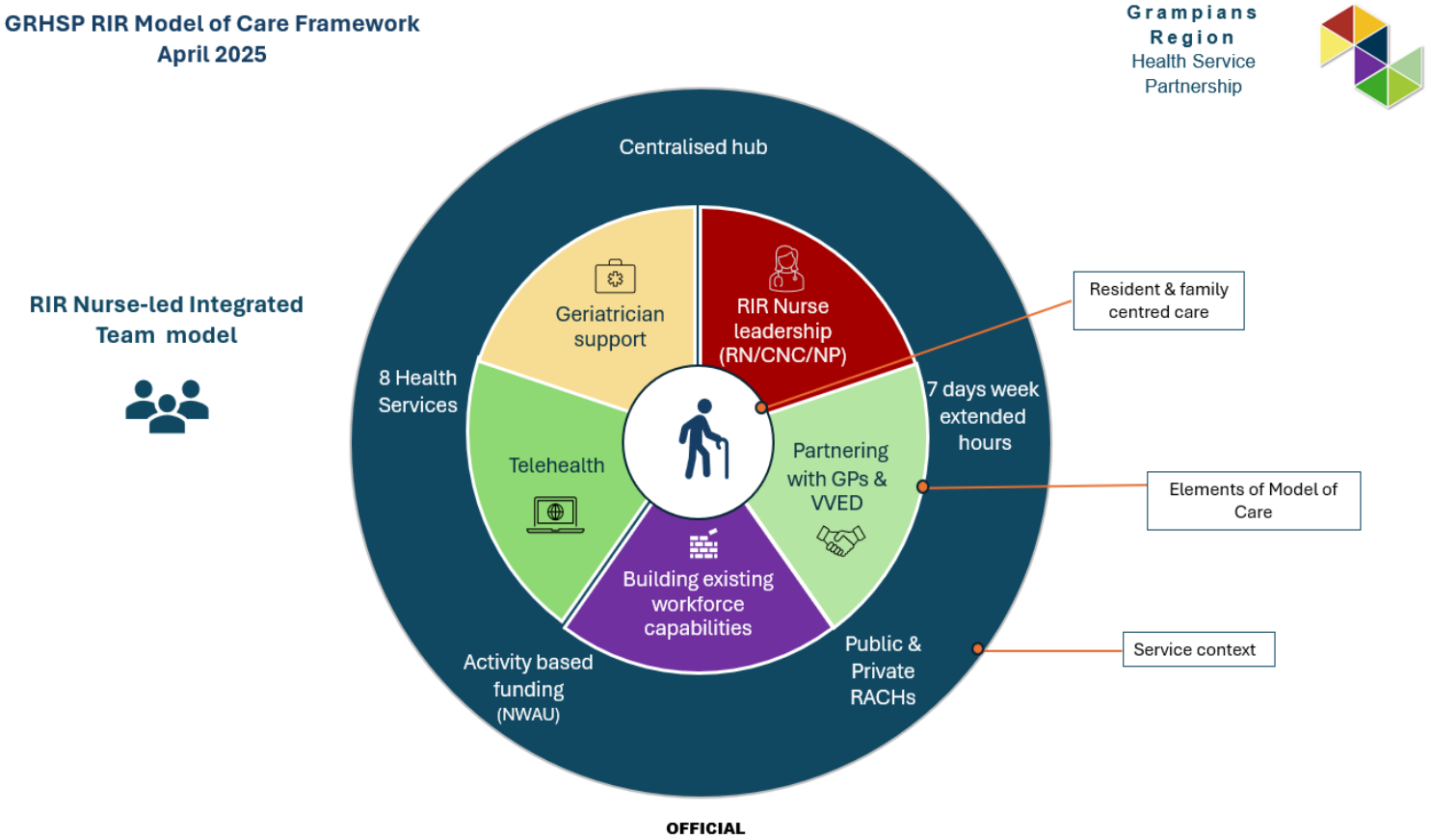
1. **Activity based funding model**:
   The RIR service is initially supported by the Department of Health sustaining RIR funding and ongoing self-funded on the National Weighted Activity Unit (NWAU).
2. **Private and public aged care facilities**:
   The RIR program is inclusive of both private and public residential facilities.
3. **7 Days a week service**:
   The RIR service is available 7 days a week
4. **Telehealth**:
   The RIR service offers primarily telehealth services, ensuring accessibility and timely care regardless of resident's location.
5. **Protected scope of practice**:
   The scope of practice for RIR staff role and responsibilities is clearly defined, ensuring all team members work within their professional competencies and legal boundaries.
6. **Escalation protocols for all sites**:
   Standardised escalation protocols are in place across all sites to ensure consistent and effective process.
7. **Shared standardised documentation:**
   Access to standardised shared documentation to ensure consistency and clarity across all sites and teams.
8. **Family and consumer focus**:
   Emphasise family and consumer engagement, ensuring that the services are designed and delivered in partnership with residents and their families.
9. **Partnership with GPs:**
   Include GPs in care planning and fostering strong partnerships to enhance care coordination and outcomes for residents.
10. **Building existing capabilities within the workforce**:
    Emphasise the development and enhancement of the skills and competencies of the current workforce for ensuring sustainable and effective service delivery.

Care delivery

The Grampians Region RIR model is a nurse led, integrated team model in which nurses take the central role in comprehensive assessment, coordination and short-term care management. The Grampians region RIR service operates 7:30am -7:30pm, seven-days a week, providing comprehensive assessment and consultation for unwell residents living in both public and private aged care homes across the region.

The RIR team is composed of clinical nurse consultants (CNC), nurse practitioner candidates (NPC), nurse practitioners (NP), physician advanced trainees, and geriatricians. Within the integrated team approach, delegation or escalation within the team follows a clear pathway to the senior clinician or General Practitioners (GP).

Initial assessments and consultations are predominately conducted via telehealth with the RIR CNC managing communication with the RACH and GPs while coordinating referrals to specialist teams, such as palliative care, when necessary. Additionally, the team collaborates with support systems including Victorian Virtual Emergency Department (VVED) Ambulance Victoria, health services and their UCCs/ EDs.



Pictured: GRHSP RIR framework provides guidance on the key components of the model of care

Central Hub Structure

The Grampians region RIR model utilises a central hub structure to improve healthcare delivery by enhancing accessibility, efficiency, and quality of care. This approach ensures that patients, particularly those in rural RACHs, receive timely, specialised care while minimising travel burdens and optimising resource use. Additionally, this structure addresses regional workforce challenges, as the limited availability of Nurse Practitioners (NPs) and Clinical Nurse Consultants (CNCs) currently makes it difficult to establish satellite RIR hubs with full-service coverage and face-to-face capacity.

Central Hub- Ballarat

The central Hub in Ballarat serves as the primary point for receiving all referrals from various sources, including GPs, RACHs, VVED and health services. This centralised structure streamlines the referral process, ensuring that patient information, resources, and funding are effectively managed. By consolidating referrals and resources at the central hub, this enables more efficient care coordination, prioritisation and timely allocation of services.

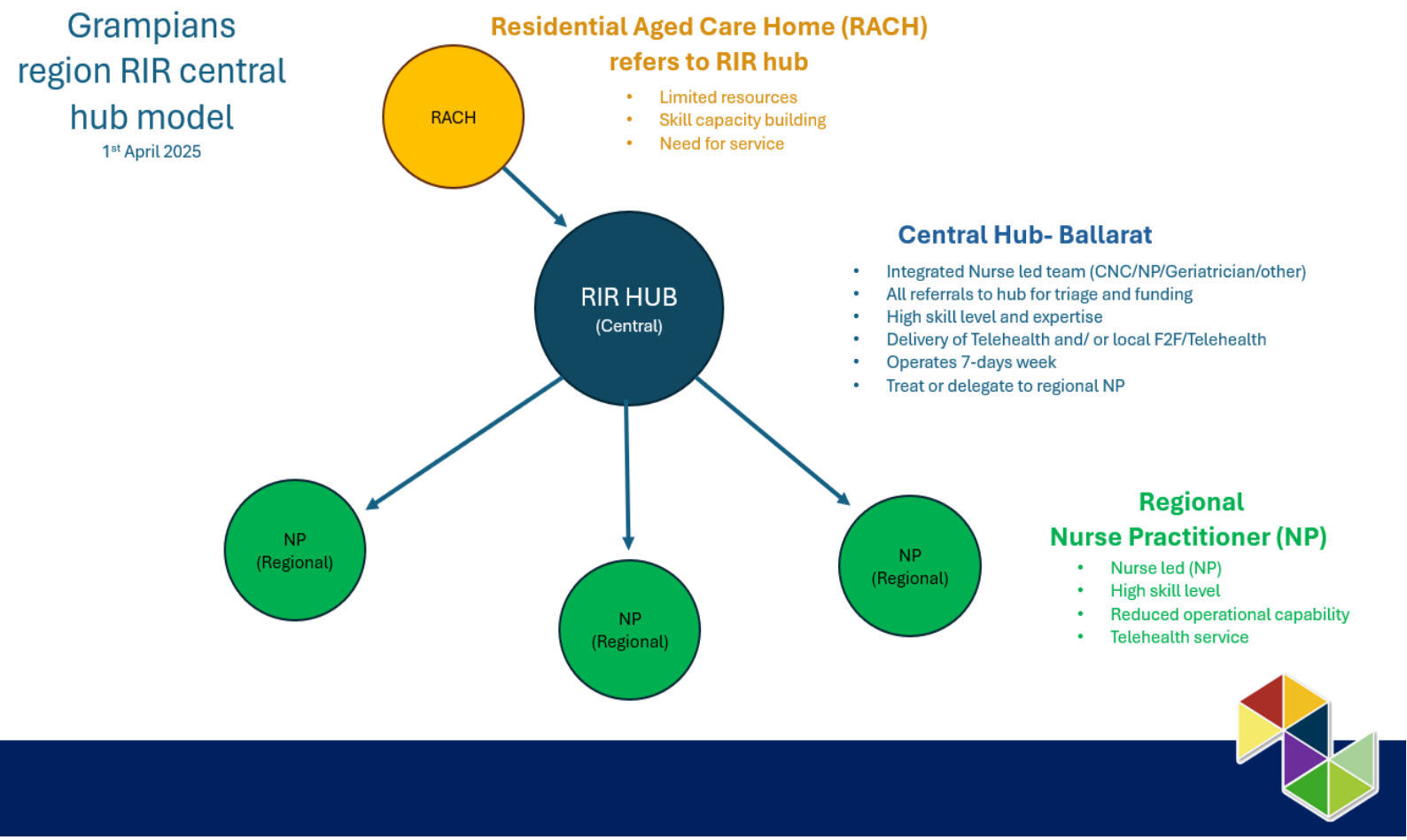
Referrals are triaged centrally by the RIR CNC, who assesses clinical need and resources to prioritise care. The CNC collaborates with the RIR team and residents' GPs to assess needs, align care plans with residents' goals and advance care plans, and refers complex cases to the NP. Telehealth is widely used to support RACHs with timely consultations and expert advice. The central hub operates seven days a week, ensuring consistent and coordinated care.

Key features:

- Integrated Nurse led team (CNC/NP/ Geriatrician/other)
- Receive referrals for triage and activity-based funding
- High skill level and access to specialised team
- Use of Telehealth, and face- to -face consultations locally, when indicated
- Delegation to regional or local NP for more complex cases or specialised care
- Seamless communication and collaboration with all regional partners

Residential Aged Care Homes

Grampians region public and private RACHs, are key partners in the RIR regional model, referring residents for specialised care. The RACHs refer residents to the service when specialised care or support is needed. The RIR team collaborates with these homes to overcome challenges like limited resources, delayed access to GPs or specialists, and geographic isolation. The central hub supports delivery of specialised care on-site, while also building local capacity through staff education and development.



Above diagram updated to reflect central hub structure, with regional NPs

Referrals

Referrals to the Grampians region RIR can be made by residential aged care nursing staff, health service staff, GPs, VVED, or AV.

How to refer:

Internal referrals (Grampians Health Ballarat only) -submit the referral via e-referral on Opal.

External referrals- complete and submit the referral form available on the Residential in reach webpage URL: https://www.bhs.org.au/services-and-clinics/community-services/residential-in-reach/

Referral Timing Guidelines

- **Urgent (Same Day):** Call RIR per below phone number and complete the referral form.
- **Within 1-3 Days:** Complete and submit the referral form.
- **Within 7 Days:** Complete and submit the referral form.

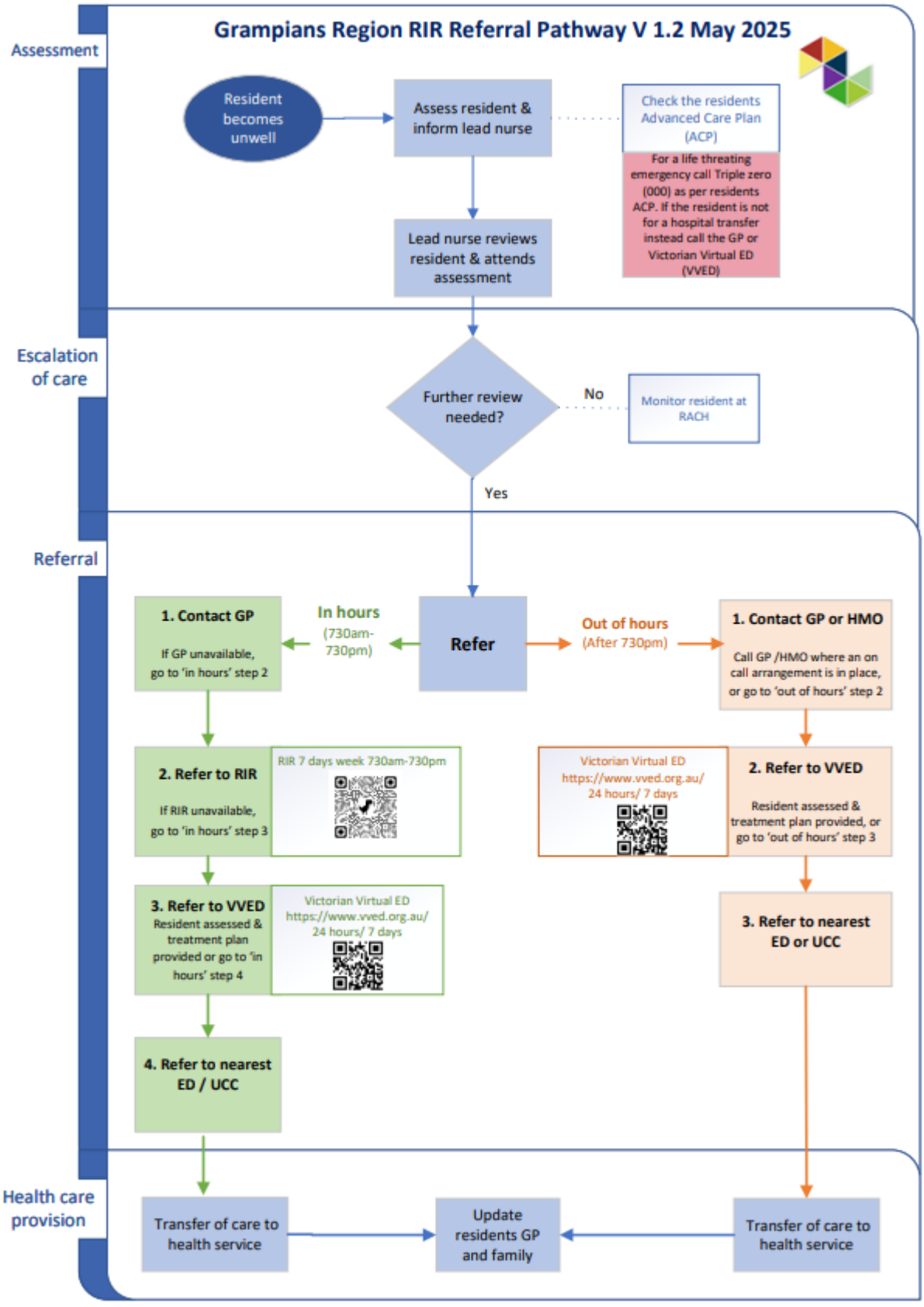
RIR Phone contact:

- 730am -4pm : 0478 305 011
- 11am-730pm: 0417 799 135
- Office hours 5320 4748

Referral triage is carried out by the Grampians region RIR CNC using the referral form information, and as appropriate a phone call may be made by the RIR CNC for clarification. Clinical assessment and consultation via telehealth, may be delegated to a local or regional NP. In person consultation currently may be provided in Ballarat only. In person visits may not be able to be facilitated on the same day and can be arranged to occur within a few days, as per triage.

When to refer- Grampians Region RIR referral pathway

The Grampians region RIR Referral pathway guides RACH staff when care escalation is needed to identify the appropriate in-hours and out-of-hours services for referral. Please refer to pathway below.



Grampians Region RIR Referral pathway V 1.2 May 2025

Conditions that can be referred to RIR

The Grampians region RIR service provides clinical assessments and oversees treatment for newly unwell residents, offering a range of medical interventions to support their care. RIR also provides expert guidance on wound management, falls risk assessment and management, and end-of-life care support. Additionally, the service facilitates referrals to relevant healthcare professionals for ongoing support i.e. palliative care.

Verbal consent from the resident or MPOA must be obtained first and documented in RACH medical record.

Referrals to Grampians region RIR are for non-life-threatening or palliative conditions only. Please see below a list of medical conditions that may be referred.

Escalation of care

In hours: (7:30am-7:30pm)
The Grampians region RIR service operates from 7:30 AM to 7:30 PM. During these hours clinical care should be at first escalated to the lead nurse and then the residents GP. If the GP is not available, then RACH nursing staff should next refer to RIR (following RIR referral pathway above).

After hours (After 7:30 PM 7 days a week)
Escalation of care outside of RIR operating hours should follow the RACH or relevant health services escalation protocol, which outlines the specific procedures for managing acute or urgent health concerns when usual healthcare staff may not be available. This may involve contacting the on-call GP, the local hospital, or other healthcare professionals as per the RACH established after hours protocol.

Assessment

Initial assessment is conducted typically by the RIR CNC via telehealth consultation. Telehealth can be easily accessed via the Health Direct platform. The RIR CNC undertakes initial triage assessment, including liaison and communication with the referrer as indicated. The CNC delegates more complex cases to NPs as needed. If further specialised input is required, it is then escalated to the RIR Geriatrician for advanced care. This structured process ensures that each case receives the appropriate level of expertise.

Telehealth- Primarily RIR assessment and consultation is conducted via telehealth. Telehealth involves video calls between residents and the RIR nurse for virtual health care. This approach reduces travel time and costs for both residents and staff, alleviates the stress associated with travel or transfers, and provides equitable service by increasing access to specialist services, particularly for residents living in rural aged care homes. Verbal consent from the resident or MPOA must be obtained first and documented in the RIR telehealth initial assessment documentation.

Care delivery

Care in the Grampians region RIR model of care is nurse-led and delivered in partnership with a range of healthcare providers, including the RACH, local GPs, VVED, and palliative care services. The model is designed to be person-centered, tailoring care to the individual health care goals of each resident. Incorporating the foundations of Age-friendly care, the RIR model promotes the use of the 4Ms framework in developing care plans for each resident.

The 4 Ms framework aims to improve outcomes for older adults by focusing on four key aspects of care: What Matters, Medication, Mind and Mobility

What Matters refers to understanding and prioritizing what is most important to the resident in terms of their values, preferences, and health care goals.
Mind, the model supports cognitive health and mental well-being, ensuring that conditions like dementia and depression are identified and managed effectively.

Mobility component focuses on preserving independence through mobility assessments and interventions to reduce falls risk and improve functional outcomes.
Medications promote safer prescribing practices, addressing polypharmacy and reducing adverse drug interactions.

Prescriptions- MedPoint prescribing is the medication management system used by the Grampians region RIR Nurse practitioners and Geriatricians. MedPoint is an electronic prescribing platform that streamlines the prescribing process to provide safe, efficient medication prescribing. The Grampians region RIR Nurse Practitioner (NP) can only prescribe medications after a consultation is conducted and the medication is deemed necessary. RACHs that do not use the MedPoint system can still have medication prescribed via a faxed paper-based prescription form. All NPs and Geriatricians working in the RIR team are credentialed to prescribe at individual health services in the region.

Please note: The resident should continue to see their regular GP for routine prescriptions or chronic medications.

Discharge from the Residential In-Reach Program occurs when the service has provided responsive, short-term support. Discharge is documented by the RIR nurse in the RACH icare clinical records and communicated to the GP when indicated, via phone call and / or discharge letter sent to the GP as a secure email attachment.

Roles and responsibilities

RIR Nurse /Clinical Nurse Consultant (CNC)

The RIR CNC works alongside the RIR NP to deliver timely, person-centred assessment service to Residents of Grampians region aged care homes. The key responsibilities of the RIR CNC include:

- Providing a consultative service that provides prompt assessment and short-term case management to prevent unnecessary admission to acute care where appropriate. Working with residential aged care nursing staff, RIR NP, resident's GP, RIR Geriatrician or alternatively, VVED to establish timely treatment and care.
- Undertake initial triage and intake of all referrals, including liaison and communication with the referrer as indicated.
- Initial assessment is completed by the CNC nurse or NP, either via telehealth or face to face depending on location/ need. Coordination of care is the responsibility of the CNC or NP nurse
- Education to residential aged care home staff, resident and resident's family.
- Consult and advise in the provision of client care within the Registered Nurses' scope of practice.
- Liaison with Grampians region services, including UCC/ED and health service wards to provide acute intervention within the parameters of a Resident's Advance Care Plan (ACP).

RIR Nurse practitioner (NP)

The RIR older person Nurse Practitioner (NP) role is responsible for developing, implementing and delivering a quality assessment and intervention service to residents of residential aged care homes. The RIR NP consults and advises in the provision of the resident's care within the NP scope of practice. RIR NP works with RACHs and the resident's GP, to provide short-term person-centred nursing care to the elderly in their place of residence, preventing ED presentation. RIR NP also works collaboratively

with RIR Gerontologist, providing an assessment service which aims at maximising functional abilities. The key responsibilities of the RIR NP include:

- Conducting comprehensive health assessments and diagnostics to identify and address physical, emotional, and cognitive needs for more complex cases.
- Advanced management of common health conditions, medication review, medication prescribing and performing procedures within their scope of practice.
- Collaborating with the RIR and multidisciplinary team to develop, implement, and review care plans.
- Providing education to residents, families, and staff on health management and disease prevention.
- Acting as an advocate for residents, ensuring their preferences and needs are reflected in care planning.
- Working closely with GPs, Geriatricians and allied health professionals, and aged care staff to deliver coordinated, evidence-based care.

RIR Geriatrician

The RIR nursing team is supported in their delivery of care to the resident by the residents GP and the RIR geriatrician. The RIR geriatrician will case conference complex patients identified by the RIR CNC/NP and directly consult with residents if necessary or requested by the residents GP or the RIR staff.

The RIR Geriatrician will refrain from becoming involved in the care of a resident who already has an external geriatrician, ensuring that their role does not overlap with the existing care provided.

The key interventions of the RIR geriatrician when requested may include:

- Conducting comprehensive assessments of residents to evaluate their physical, cognitive, and functional health, identifying both acute and chronic conditions that may impact their well-being.
- Collaborating with the multidisciplinary team to develop and review individualised care plans that address the medical, psychological, and social needs of each resident.
- Providing expert consultation and guidance on managing complex medical conditions, polypharmacy, and frailty, with a focus on optimising quality of life and minimising unnecessary hospitalisations.
- Collaboration with nurses, GPs, allied health professionals, and care staff to ensure holistic, coordinated care that aligns with both clinical guidelines and the preferences of residents and their families.

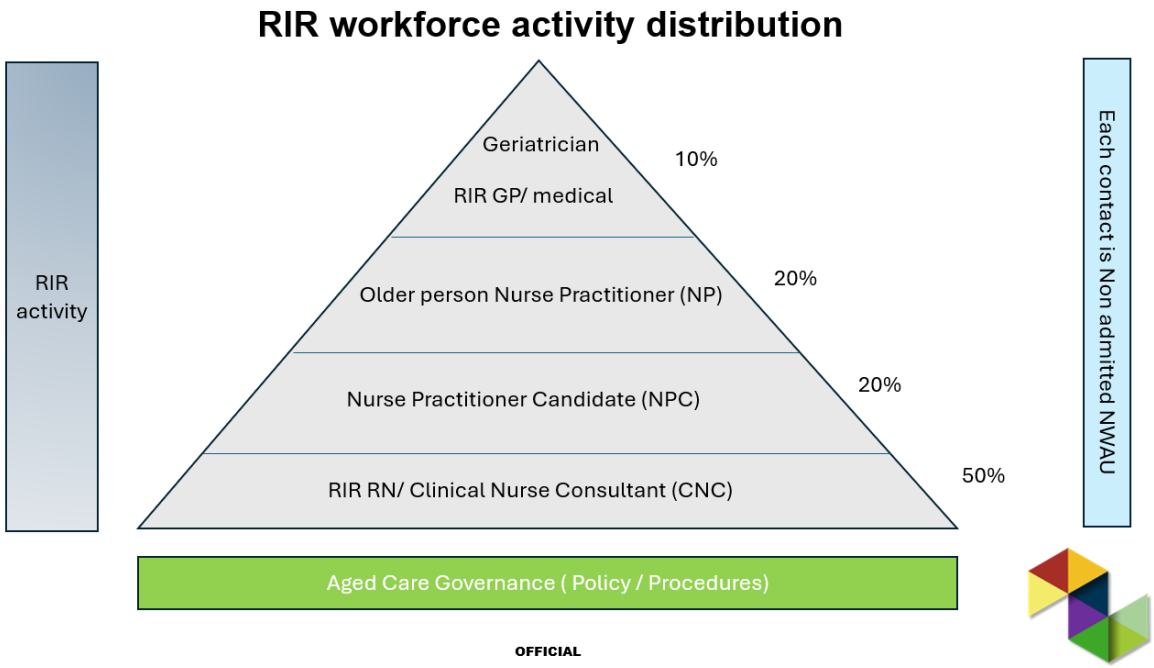
Physician trainees and RIR GPs

As the regional RIR model evolves, physician trainees and RIR GPs are likely to be integrated into the care team to support its growth and development.

Workforce Resources for Consultation Distribution

In the RIR Nurse-Led model of care, consultations are distributed to optimise the expertise of various healthcare professionals. The CNC is responsible for completing approximately 50% of the triage and clinical assessments, delivering essential frontline care. Nurse Practitioner candidates handle around 15-20% of the cases, contributing their advanced clinical skills. The older person Nurse Practitioner

(NP) is involved in reviewing around 20% of referrals, focusing on more complex cases related to geriatric care. The Physician trainee/ RIR GP or Geriatrician reviews the most complex cases, addressing the more challenging medical concerns, which make up about 10% of the referrals. This collaborative approach ensures a structured pathway for comprehensive distribution of consultations and resources.



5. Integration with services

Effective care coordination is a key component of the RIR model, ensuring streamlined communication and collaboration among various service providers. The RIR CNC or NP, plays a central role in coordinating care across these services. This integration enables timely, responsive, and person-centered care, helping to maintain continuity and reduce unnecessary hospital admissions. The RIR team works closely with all relevant services, tailoring care to the specific needs of each resident while ensuring that their healthcare goals are supported.

- **General Practitioners (GPs)**

Regular communication with the residents GP ensures clinical decisions align with the resident's overall health plan, with GPs being actively involved in the development and adjustment of care plans.

- **Palliative care**

For residents with life-limiting conditions, integration with palliative care services offers expert advice on symptom management, ensuring comfort and dignity in end-of-life care.

- **Victorian Virtual Emergency Department (VVED)**

The RIR model works in partnership with VVED, accepting referrals.

- **Hospital in the Home/ District nursing**

RIR facilitates integration with Hospital in the Home (HITH) services, allowing eligible residents to receive acute care in their residential setting. Liaison with regional and rural District nursing and community services further enhance the support available to residents, ensuring coordinated holistic care.

- **ED / UCC**

The RIR service integrates with ED/UCC by providing timely support and consultation for residents in aged care homes, helping to manage potential emergencies and avoid unnecessary hospital admissions. When an ED transfer is indicated and the RIR service is involved, RIR supports a smooth transition and appropriate care for residents in aged care homes.

- **Mental Health**

In the Grampians region, mental health support for residents in aged care homes is available through Grampians Health Mental Health Services, Uniting in Ballarat, and Grampians Community Health in the Wimmera. As the RIR model evolves, referral pathways for mental health support will be developed.

6. Governance

The Grampians region RIR Redesign Steering Committee, made up of senior leaders from all health services in the region, primary care representatives, and researchers, oversees the implementation and monitoring of the RIR model. The committee meets monthly. Regular reports from the RIR project team ensure the committee is informed of progress, challenges, and achievements. Key performance indicators (KPIs) track outcomes like resource use, quality of care, risk, stakeholder engagement.

The RIR project lead coordinates the model, ensuring resources, timelines, and milestones are on track. The RIR and RACH leadership team and site clinical champions help ensure the model is followed and monitor its effectiveness.

The expert research team ensures the project maintains research integrity and follows best practices. The research team measure the effectiveness and cost effectiveness of the RIR model, ensuring ethical standards, including quality assurance, data oversight and integrity. Research protocols and methodology is followed throughout the research trial.

Procedures are in place for RIR team to report issues, including communication with leadership and monitoring systems such as incident reporting in Riskman system. Ongoing monitoring ensures follow up and regular feedback loops to adjust strategies. Regular meetings review

progress, address concerns, and track solutions. These structures and procedures ensure the RIR model is implemented, monitored, and adjusted to maintain high-quality care and improve outcomes.

7. Training and development

In the Grampians region RIR model of care, ongoing training and professional development for residential aged care staff will be supported through the dedicated efforts of the RIR team. The RIR team will play a role in promoting and supporting continuous education to ensure that staff are equipped with the latest knowledge and skills in aged care. Education opportunities will focus on best practices, emerging trends, and innovations in care, ensuring that all staff are well-informed and able to deliver high-quality services.

To further enhance learning, a RIR Community of Practice will be introduced, fostering peer collaboration and knowledge sharing. This community will serve as a platform for staff to engage in ongoing learning, exchange experiences, and stay informed about current guidelines and evidence-based practices, promoting a culture of continuous improvement and excellence in care delivery.

8. Quality and performance

Quality and performance will be measured through a combination of quantitative and qualitative data. Key performance indicators will include Emergency Department (ED) and Urgent Care Centre (UCC) presentation data, Referrals to RIR, telehealth consultation activity, VVED referrals, and qualitative feedback gathered from interviews with residents, their families, and staff from both RIR and RACHs.

Regular monitoring and review procedures will be in place to evaluate care practices, identify areas for improvement, and implement necessary adjustments. KPI data will provide comprehensive insights into the effectiveness and cost effectiveness of the care model and guide improvements in service delivery.

9. Implementation plan

With support from the DELIVER research team, we have used an implementation science framework in our approach, which includes strategies to support the adoption of the RIR model of care. Pre-implementation strategies may involve team meetings, feedback, and appointing RIR champions to motivate peers and offer support. Key to the successful implementation of the new RIR model are consultations and communication with staff, training and educational support, additional resources and guidelines, and strong leadership and organisational support.

Throughout the RIR regional implementation, meetings such as clinical huddles and leadership discussions will be introduced to evaluate stages, inform improvements and implement any necessary changes to the model.

10. Evaluation

The evaluation of the Grampians region RIR model of care will involve systematic processes to assess its effectiveness through regular performance reviews and feedback mechanisms. Feedback from residents, families, and staff, along with performance data, will be closely analysed by the DELIVER research team and through embedded monitoring and reporting processes to identify any areas that require improvement. Based on this analysis, necessary adjustments will be made to optimise the model's effectiveness and ensure high-quality care is consistently delivered. This ongoing evaluation process will support a responsive and flexible model.

A full research trial in the Grampians region 'Evaluation of a region wide RIR program in regional and rural Health services: A stepped wedge trial' is planned to commence in April 2025, through the RIR redesign projects collaboration with the DELIVER research team.

Appendix

DELIVER Evidence Summary report

DELIVER Evidence Summary RiR 16 07 2

Grampians Region Map of Health Service/ RACH/ UCC/ ED locations

GRHSP RiR Redesign Map with

Grampians region RIR referral pathway tool V 1.2

RIR Referral pathway flowchart v

Conditions to refer to Grampians region RIR V 1.0

RIR condtions to refer- updated with