ACTION PLAN

Aged Care

phn COUNTRY SA
An Australian Government Initiative

Planning to support those aged over 75 years:

- In accessing Home Care support service;
- Planning a preventative and supportive framework for ageing;
- Supporting medication management for those over 75.

Rationale

Active planning an prevention will support early access to services and better patient health outcomes.

Aged Band 75 plus selected

Approach

- Regular Health assessments, annual review of changes to conditions
- Preparing information to support those accessing home care and aged care facilities
- Prepare information to assist in Care Planning
- Opportunity to discuss care needs
- Opportunity to provide information on aged care services to patients

Completed by

- Practice Nurse and GP shared assessment
- Home visit by Practice Nurse
- Completion of Health assessment MBS Descriptors
- Provision of information to Patient
- Discussion of Health Assessment outcomes and care options with patient

Identification of children to recall (using CAT4 program)

1. *Identify those 75 plus for Health Assessments* – set filters to include:
    a. Active Patients only
    b. Select age band to be 75 plus
    c. Press Recalculate
    d. Go to MBS item tab
    e. Select sub tab of Items not recorded
    f. Highlight Health Assessment to re-identify
2. *Identify those with 5 plus medications for Medicines Review* – Set filters to include:

1. Active Patients only
2. Select age band to be 75 plus
3. Press Recalculate
4. Go to Medication tab
5. Select sub tab of Medication Prevalence
6. Highlight those in 8 plus medications to re-identify first
7. Work through segments

Resource listing

- COTA – Handbook for Home Care Services
- MBS for Aged Care at Home and RACF
- Referral form for MyAgedCare
- MyAgedCare – Information Brief
- Over 75 Health Assessment template

MBS Billing for Aged Care Cycle of Care

Suggested model for General Practice:

1. Register of over 75's created, reminders set to Patient notes to book for Health Assessment
2. Practice Nurse to become familiar with Over 75 health assessment requirements and tools relevant to them
3. Practice Nurse to complete Home visit for Activities of Daily Living and care needs
4. Practice Nurse to prepare assessment, demographics, case history etc.
5. GP discusses with patient outcomes and options
6. Generate referral for HMR (Home Medicine Review) with Over 75 as supporting documentation
7. GP can schedule for GPMP / TCA
8. In the circumstance of Dementia NOT being a diagnosis, and the Patient has depression and or other mental health conditions; the GP may consider using a Mental Health Care Plan

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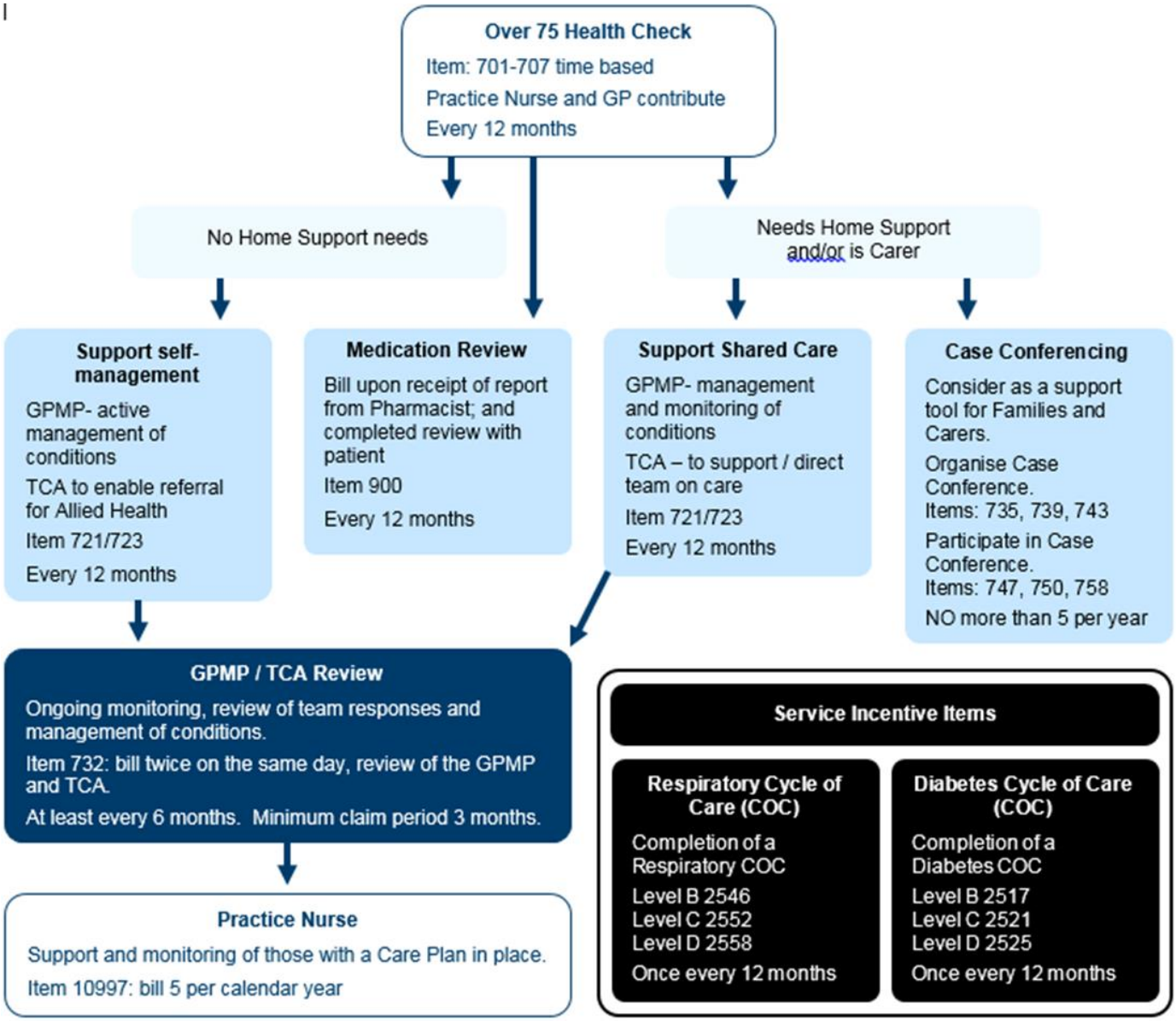

Website Links

- MyAgedCare: http://www.myagedcare.gov.au/
- Council of the Ageing (COTA) support: http://www.cota.org.au/australia/
- Home Care Information and Checklists: http://www.homecaretoday.org.au/