Service provider perspectives for optimising system interfaces within the geriatric evaluation and management (GEM) model of care

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BACKGROUND

Allied health professionals have a central role in assessment, management and discharge coordination in the GEM model of care for older people with complex care needs. Due to system fragmentation, this model of care is unlikely to improve patient outcomes unless system interface issues are understood and addressed.

METHODS

Three focus groups with a purposive sample of 23 health and social care providers from the government and non-government sector. Focus groups explored experiences with older people, coordination of patient transitions, sub-acute services, gaps in services and strategies to optimise coordination of primary and sub-acute care. Qualitative thematic analysis.

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RESULTS

INDETERMINATE DYNAMIC TRANSITIONS

THEME 1. UNPREDICTABLE DISLOCATING TRANSITIONS

- Unspecified complex pathways, **"the plan changes from ward to ward"**
- Uncertain or unknown referral pathways and discharge tensions
- Service performance targets, **"a finite time to decide to admit"**
- Access to community resources, **"timely access is just disastrous"**
- Complex service landscape and constant change, **"navigating it is a massive challenge"**
- Varied quality of flow and type of communication
- Sudden changes in patient health status and needs
- Older peoples' help seeking practices, **"very ambivalent about accepting any services"**

THEME 2. WEAKLY CONNECTED AGENTS OF CARE

- Transition "tasks" location specific, weakly connected across the system
- Focus on referral to the next point, **"at the moment you hedge your bets … cast a wide net for all of them"**
- Confusion and miscommunication about referral pathways
- Information boundaries between hospital and community
- Chance communication
- Multiple, disparate care plans, **"a lot of double handling of patients"**

THEME 3. PIVOTAL TOUCH POINTS

- Challenge of, **"getting people to the effective touch points so they're not having to do all the useless ones…"**
- GPs are a critical touch point for coordination and avoidance of admission
- ED is a critical touch point for risk management and early intervention
- Sub-acute care critical for responding appropriately and holistically
- GP unfamiliarity about Older Persons Ward and GEM model of care, **"GPs don't know enough about (Older Persons Ward) … don't know how to access it"**
- Transition Care Program (TCP) seen as a bridge between primary and secondary care

THEME 4. DISCRETIONARY AND EMERGENT PRACTICES

- Local solutions for dealing with unpredictability and disconnectedness across services
- Allied health involvement viewed positively
- Utilising GP practice nurses, **"there are a couple of practice nurses who are very keen to go out and do more home visits"**
- Carers relied upon to address service gaps
- Judicious decision-making with limited resources
- TCP favoured as, **"short-term, goal orientated, client-directed care"**

SERVICE PROVIDER GENERATED SOLUTIONS

- **Early intervention in ED**
- **Coordination and prevention practice in General Practice utilising practice nurses**
- **Single point of contact with system knowledge and expertise to coordinate transitions**
- **Enhanced case management in the community, single point of contact for referrals**

DISCUSSION

The ED, GEM services and GPs are critical touch points for early intervention and prevention, positioning patients for successful subsequent transitions and improved patient experiences. Allied health professionals are well placed to take a lead role as system navigators to pro-actively manage care transitions for older people.