

## **AHMAC and Beyond:**

### ***A Strategic Framework for Health Care for Older People: at home, in residential care, in hospital and in transition between settings***

#### **A RESPONSE TO THE**

Australian Health Ministers' Advisory Council, *From Hospital to Home: Improving the outcomes for older people*, July 2004

## **1 INTRODUCTION**

The National Aged Care Alliance (the Alliance) is a representative body of 25 peak national organizations in aged care and includes consumer groups, providers, unions, and health professionals, working together to determine a more positive future for the aged care sector in Australia.

The Alliance was formed in April 2000, and has developed a united policy agenda to achieve better outcomes for the care of older people in Australia. At the February 2004 National Aged Care Summit, the Alliance recognised the importance of quality health care as a critical component of quality aged care. Alliance members are therefore keen to ensure the provision of world-class health care for older Australians.

As people age, they are more likely to require health care, not only acute care for sudden illnesses but ongoing care and monitoring of chronic conditions. The ageing of the Baby Boomers will significantly increase the number of people who are 65 yrs and over during the next two decades. Improved life expectancy will also see the numbers of people aged 80 yrs and over doubling during the following two decades. The majority of those over 65 years are well and independent, often providing services to families and communities. The majority of those over 80 have complex health concerns and rapidly increasing levels of disability. Towards the end of life, for many older people health care and aged care need to become integrally linked.

The aim is to develop a model system of health care for the increasing numbers of older people in Australia, which gives the best care for the older person, in the best setting, using best practice to achieve maximum physical and mental capacity and minimum disability. This paper draws on Alliance Issues paper No 1, which outlined an open model for provision of health services to residential care facilities but extends it to the provision of services across all sectors, including acute hospitals and older people living in the community.

The fundamental goals and principles, which underpin any strategic framework for health care of older Australians, have already been clearly outlined in The National Strategy for an Ageing Australia<sup>1</sup> and in the Australian Health Ministers' Advisory Council (AHMAC) National Action Plan for Care of Older People. Key supporting documents include *From Hospital to Home: Improving the outcomes for older people*<sup>2</sup> and *Age-friendly principles and practices: Managing older people in the health service environment*<sup>3</sup>, developed on behalf of AHMAC by the Care of Older Australians Working Group. The AHMAC National Action Plan provides a framework through which government can establish and maintain world-class health care for older Australians. The plan however, while providing a framework which is fully supported by the Alliance, provides limited direction in terms of methodology for service delivery. In addition it

<sup>1</sup> Commonwealth of Australia, *National Strategy for an Ageing Australia*, AGPS, Canberra 2001

<sup>2</sup> Australian Health Ministers' Advisory Council (AHMAC), *From Hospital to Home: Improving the outcomes for older people*, July 2004

<sup>3</sup> Australian Health Ministers' Advisory Council (AHMAC) *Age-friendly principles and practices: Managing older people in the health service environment*, July 2004

is focused on the transition of patients from hospital to home and while this is an essential element of sound health care, a strategic framework for health care needs to have a broader scope and to consider the wider needs of older people, whether living in the community, in residential care or having an episode of acute care.

This paper represents the Alliance response to the AHMAC National Action Plan. It proposes a methodology to assist implementation of the AHMAC Plan and identifies areas where further action plans need to be developed.

The AHMAC Action Plan provides little detail with respect to health care within the residential care setting or for those still living in the community, although this remains the largest component of health care for older people. The Alliance therefore has prepared this paper to outline a strategic framework for health care for older Australians, which addresses the needs of all older people across each of the settings in which services are provided. The majority of older people live in the community and will continue to do so. A growing number but still a minority will live in residential aged care, while most older people will have short episodic need for hospital care. These are the principal settings for health care that need to be addressed in a strategic plan. Transitions across these three settings also need to be considered in a comprehensive framework.

The alliance accepts and supports the seven principles identified in the AHMAC National Action Plan (see Box 1)

#### Box 1: AHMAC National Action Plan Principles

**Principle 1:** Older people have access to an appropriate level of health and aged care services that match their changing needs  
**Principle 2:** Services are shaped around the diverse needs of older people  
**Principle 3:** Avoidable admissions to hospitals or premature admissions to long term residential aged care are prevented where possible  
**Principle 4:** Older people have access to transition care services within the acute-aged care continuum  
**Principle 5:** The health and aged care sectors at both the service provider and government level operate to deliver an integrated suite of services and care for older people across the acute-aged care continuum  
**Principle 6:** The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs  
**Principle 7:** Informal carers and family members are well equipped to provide support and care

To these 7 principles the Alliance adds a further basic principle - **that there must be recognition of the right of older people to accurate diagnosis, to minimisation of disability and minimisation of handicap.**

## 2 VISION

The challenge of a truly effective health care system is to promote a longer period of healthy active life, with extension of our (non-disabled) life span and the provision of world class healthcare for the frail aged, the disabled and those with chronic and complex conditions and those with a terminal disease.

Health services for older people are provided across three settings:

- ❖ Hospitals (including subacute facilities)
- ❖ Residential aged care facilities
- ❖ Within the community in the older persons home or that of a relative or carer.

The Alliance's vision for health care for older Australians is that all older people in Australia have access to planned and properly resourced integrated quality health care that is flexible,

equitable, accessible and affordable, that recognizes diversity and promotes choice and respect for users and workers.

The elements of an effective health framework are:

- A comprehensive community healthcare program delivering services to the frail elderly living in the community, with affordable and accessible primary care and ambulatory care services, which are well integrated with hospital, residential care and other community services;
- A quality residential aged care health system for those unable to remain at home or in the care of friends or relatives;
- A accessible hospital system that caters for the frail aged with multifactorial geriatric conditions; and
- A robust private health system which is well integrated with other elements of the health framework and which complements the public sector health services.

All elements of the care system- acute hospitals, residential aged care or community delivered support must be efficient, well-funded, affordable, accessible and equitably distributed.

The Alliance recognizes:

- That prevention is better than cure, treatment or management and there is need to stress “healthy ageing” initiatives early in life.
- That the best setting for health care of older people is increasingly in their own homes, with appropriate supports, but that there will continue to be a need for residential care places for highly dependent older people or for those lacking alternative social support.
- That all health professionals will need to learn and practice aged and palliative care.
- That there will always be a significant number of acutely ill older people who need the facilities of the modern acute hospital.

The Alliance supports the Principles of the *Age-friendly principles and practices: Managing older people in the health service environment (APP)* (See Box 2)

**Box 2 Age-friendly principles and practices: Managing older people in the health service environment**

1. Health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life.
2. Health services will recognize and address older people’s complex needs.
3. Health treatment and care are respectful and recognize individual differences and specific needs, such as cultural, religious and sexual differences.
4. Health treatment and care are delivered in a coordinated and timely manner across care settings.
5. Unnecessary admission to hospital and extended hospital stays of the frail elderly are avoided.
6. The care of older people is a primary focus for all health services.
7. Where safe and cost-effective to do so, older people receive health treatment and care in a setting that best meets their needs and preferences

**3 CONTEXT**

Average life expectancy in Australia is now more than 80 years. As the population ages and the proportion of the population 80 years and over rises, barriers to the provision of health care to older people will become increasingly severe unless immediate action is taken. While the baby boomer bulge ages from 60 to 80 we have a window of opportunity over the next two decades to plan for a much older population. However it is important in discussing the health of older people that the outdated use of population categories which group together all older people over 65 years is modified. The health care needs of those in the 65-75 age group are widely different from those in the 85+ group and planners must begin to readjust thinking and

terminology to reflect the real demographic pattern today. A more appropriate and functional set of age categories are shown in Box 3. The appropriate use of an extended age structure (young old, older old and very old) and functional categories (healthy, at risk and frail) without imposing too rigid boundaries, can focus policy development and health care research and can improve the delivery of aged care and health care for older people.

**Box 3: Redefining Older Age Categories in Australia**

**Centenarians** - will soon be the fastest growing age group in Australia, however they now number some 3000 people and we have little evidence on which to assess their current functional status. Centenarians will come into their own around 2060 when average survival for women at birth reaches 100 years. A separate age category for this group is premature, although a separate research category is vital as they epitomize the large numbers of people growing “seriously old” in developed countries.

**The “very old” age group (85 years and over)** - is of immediate importance to both service planners and researchers despite relatively small current numbers and slower growth, as they carry a disproportionate level of “frailty”. From the “Sydney Older Persons Study” we know that 80% need assistance with some domestic tasks and more than 30% are dependent for aspects of personal care, due mainly to early impairments in cognition, capacity, gait and balance from neurodegenerative or brain disorders (of unknown cause or prevention). We have a short planning window, two to three decades, to support age-related preventive research and develop age-related services, before we need to seriously consider the rapid rise to 1.3 million people aged 85 years and over we will have by 2051, in a total Australian population of around 26 million.

**The “older old” age group (75 to 84 years)** - will grow more rapidly over coming decades. They are generally active, mobile and independent, and often able to provide care and run businesses as well as care for themselves. However they carry high levels of physical ill health (22% lung disease, 46% heart disease, 68% painful hips and knees) and are “at risk” of entering hospital (60% per annum). Most importantly, as a group, they carry a rapidly rising burden of underlying (often symptom free) neurodegenerative brain changes. Moreover, these changes are largely responsible for their “at risk of hospital” status, causing reduced mobility, loss of balance, or cognitive loss and delirium, which complicate acute reversible illness in this age group, but recover with appropriate multidisciplinary acute and sub-acute care.

**The “young old” (65 to 74 years)** - are the largest, fastest growing and by far the healthiest of our three age groups, even before the first baby boomers join them in 2010. As a group, they are healthy, mobile, independent and cognitively intact with good judgment and capacity. Their physical health is improving as levels of heart and lung disease and cancer continue to fall in the community. They are a potential economic and educational resource. “Healthy Ageing” research is most appropriate to this group. Paradoxically, however, the young old, rather than their older compatriots, will drive future health costs with their expectations of a high technology health system largely designed to revitalize and renew their hearts, joints, kidneys etc.

**4 IMPACT ON SERVICES**

Demand for general practice and specialist geriatric services and palliative care will certainly increase. Chronic non-communicable disorders (heart and lung diseases, bone and joint disease, cerebrovascular disease and diabetes) are now the major cause of both acute exacerbations of illness and chronic disability in Australia. We can expect these chronic disorders to remain at high levels, but to be overtaken by the neurodegenerative disorders as the major cause of severe disability and death in the rapidly growing numbers of “older-old” - those 75 years and over.

With ageing of the aged, we will see an increasing number of “older-old” people with neurodegenerative disorders, depression and mental health problems. The incidence of neurodegenerative conditions such as gait disorders with slowing and instability leading to Parkinson’s disease, cognitive impairment leading to dementia, and with sensory loss (vision and hearing) increases steeply as average survival increases beyond 75 years. This group of “older-old” people, admitted to acute hospitals, are more likely to have significant co-morbidities, chronic and complex conditions, high dependency levels, vulnerability to adverse events, and needs for rehabilitation and post-hospital support, than are “young-old” patients. A single illness model of care does not meet the medical or functional needs of this group. Rather, a broad multidisciplinary team approach that addresses the range of assessed needs is required. Such a multidisciplinary approach needs to embrace patients and their carers and it needs to make decisions in a truly collaborative manner between family and medical, nursing and allied health personnel.

Our Geriatric Medicine system, which includes Aged Care Assessment Teams (ACATs) has good world standing, but it is creaking at the seams. It needs a funding upgrade to care for the burgeoning over 75s and coming over 85s. It also needs to expand and work closely with developing interdisciplinary teams such as palliative care, community care teams. Cross training amongst related and overlapping disciplines is strongly supported – for example palliative care and geriatric care.

While developments in community and primary care may be expected to reduce the need for hospital care for the elderly, population ageing will still see large proportions of the acute hospital caseload made up of older Australians. There will be a growing need for multidisciplinary geriatric services to manage the sudden onset of acute illness in older people; management which is made more complex by falls, immobility, confusion, incontinence, sensory loss, depression etc., defining the group known as “frail aged”.

Demand for elective surgery and high technology medicine will increase even more rapidly, largely driven by baby boomers in younger age groups (50 to 75 years of age). Such treatments are increasingly (and not unreasonably) expected to provide longer periods of healthy independent living. They include joint replacement, cardiovascular surgery, support or replacement of failing organs, surgery for treatable cancers and increasing use of pharmacological treatments. High technology health care, for the “younger-old” will be the major driver of increased demand on an already stretched hospital capacity. Care should be taken that adequate capacity is maintained for health care of the rising numbers of “older-old”, the core group for specialist aged care health services.

With more pressure of frail older people on community delivered health services demand for services will increase. This will extend not just to primary health care providers, but also to the many community support services needed to maintain frail older people living in their own homes. Shortages of primary health care workers may be expected and consequent pressure on rehabilitation services, residential care places and palliative care services will all increase.

## **5 RESPONSE TO THE AHMAC PRINCIPLES**

The overall Alliance approach is consistent with the seven principles underpinning the AHMAC National Action Plan for Care of Older people although it may need strengthening in some areas. Moreover, the Alliance stresses that while it may be easy to develop principles of care, implementation is more challenging.

### ***Principle 1: Older people have access to an appropriate level of health and aged care services that match their changing needs***

The AHMAC lists of basic services should include access to primary health care, including nursing, dental care, physiotherapy, occupational and speech therapy and dieticians as well as GPs. It should also acknowledge that there must be adequate access to acute hospital care when needed. Access to quality Residential Aged Care and Supported Community Care must also be acknowledged.

***Principle 2: Services are shaped around the diverse needs of older people***

The alliance recognizes the importance of this fundamental principle

***Principle 3: Avoidable admissions to hospitals or premature admissions to long term residential aged care are prevented where possible***

It is anticipated that as the population ages the proportion of patients presenting with age related emergencies will increase. This is a priority area for action with expected benefits for patients, service providers and those funding health services.

***Principle 4: Older people have access to transition care services within the acute-aged care continuum***

Often highlighted as a prime area of concern, especially as it relates to cost shifting, most Nursing Home Type Patients (NHTP) in hospital beds are in smaller rural hospitals rather than major metropolitan hospitals. While there will be an on-going need for transitional beds, especially as the effectiveness of rehabilitation programs improves, the demand for Transitional Care beds and units should not distract the States from the primary role of providing sufficient Acute Care and sub-acute rehabilitation for older people with complex needs.

Subacute and rehabilitation beds need to be increased to meet expected demand. To the extent that these beds promote discharge back home rather than to residential care, they will prove successful. While typically provided in hospitals there are many complementary models of service delivery for rehabilitation. However, where patients are cognitively impaired, changes of residential environment or surroundings should be minimised.

It must be recognised also that patients in Interim Care/Transitional Care beds also need OT & Physiotherapy input

However, as a long term goal the need for transitional beds should remain modest. If there are adequate places in Residential Aged Care Facilities (RACF) and enough community support packages, coupled with good rehabilitation and post acute services in the community or in RACF, there should not be a need for a large numbers of transitional care places. In order to ensure that the aims of transition care are achieved and that patient outcomes are optimal, there is a need to define adequate funding and multidisciplinary staffing models for these new places in both residential facilities and the community. In addition to adequate resources and multidisciplinary staffing, the new transition care model should incorporate partnership arrangements between hospitals, geriatric services, residential facilities and community care providers, in which there is a structure that facilitates the overview by geriatricians throughout the processes of selection for, management within and discharge from, transition care.

***Principle 5: The health and aged care sectors at both the service provider and government level operate to deliver an integrated suite of services and care for older people across the acute-aged care continuum***

This AHMAC principle is fundamental but the paper provides only limited information on steps to achieve this outcome. It is the purpose of this alliance paper to outline a care framework that gives a model through which services can be integrated.

***Principle 6: The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs***

AHMAC has highlighted perhaps one of the single biggest problems potentially facing the appropriate care for our aging community, namely the decreasing supply of a well-trained workforce. Shortages of medical practitioners and nurses are already apparent and this shortage is expected to grow. This paper and the models outlined is predicated on there being available an effective, efficient medical, clinical and support workforce.

Possible shortage of trained workers is a growing area of concern and the Alliance calls for urgent government action to research, review and address this emerging issue.

The Alliance stresses however that the role of different health service providers should be clearly defined and well integrated to minimise interface problems.

***Principle 7: Informal carers and family members are well equipped to provide support and care***

Informal care is the principal form of support given to older people and this need is likely to increase with time. As the ratio of older people to fit healthy younger people increases in parallel with a scarcity of health workers, pressure to use carers as a substitute for professional care may be increased. This trend has the capacity to adversely affect the most disadvantaged in the community and should be resisted. While in many situations there will be families who have the time, skills, commitment and energy to perform such roles to a very high standard, this will not be universal and it is important that expectations of families to care for older people are reasonable and achievable and recognise that the carers sometimes may be disadvantaged on the basis of health, stress, time or education. In many cases, the emotional commitment for quality professional care may be lacking.

The Alliance notes that the role of carers should not be confused with that of health workers.

## **6 CARE MODEL**

Providing a continuum of care requires effective integration of services and patient centred management that supports and tracks the movement of a patient between settings. This will require a structured framework so that "frail" elderly get the services they need and do not "fall between the cracks". Options for providing this structure will vary between health services sectors. Ideally, it would be GP centred with assistance provided to the general practice team. It would be supported by a local geriatric medicine service, which includes ACATS, other multidisciplinary teams and outreach homecare services, often based at the local hospital.

Using the AHMAC National Action Plan as a foundation for more comprehensive models, the Alliance proposes a strategic framework for Health Care for older Australians that incorporates each of the essential elements of best practice health care but remains flexible to adapt to differing needs.

The aims of the health care model are to,

- (i) Provide a continuum of care across the three settings where older people need and use health services - in the community, in the acute hospital and in the residential care setting,
- (ii) Provide a dynamic model that allows the supply of places across the three settings to adjust to meet fluctuating demand
- (iii) Provide a seamless service that integrates health promotion and prevention, primary health care and community health, acute, rehabilitation and sub-acute care, and health care in the Residential Aged Care (RAC) sector,
- (iv) Integrate health services within the broader systems of aged care provision

The essential elements of the model are:

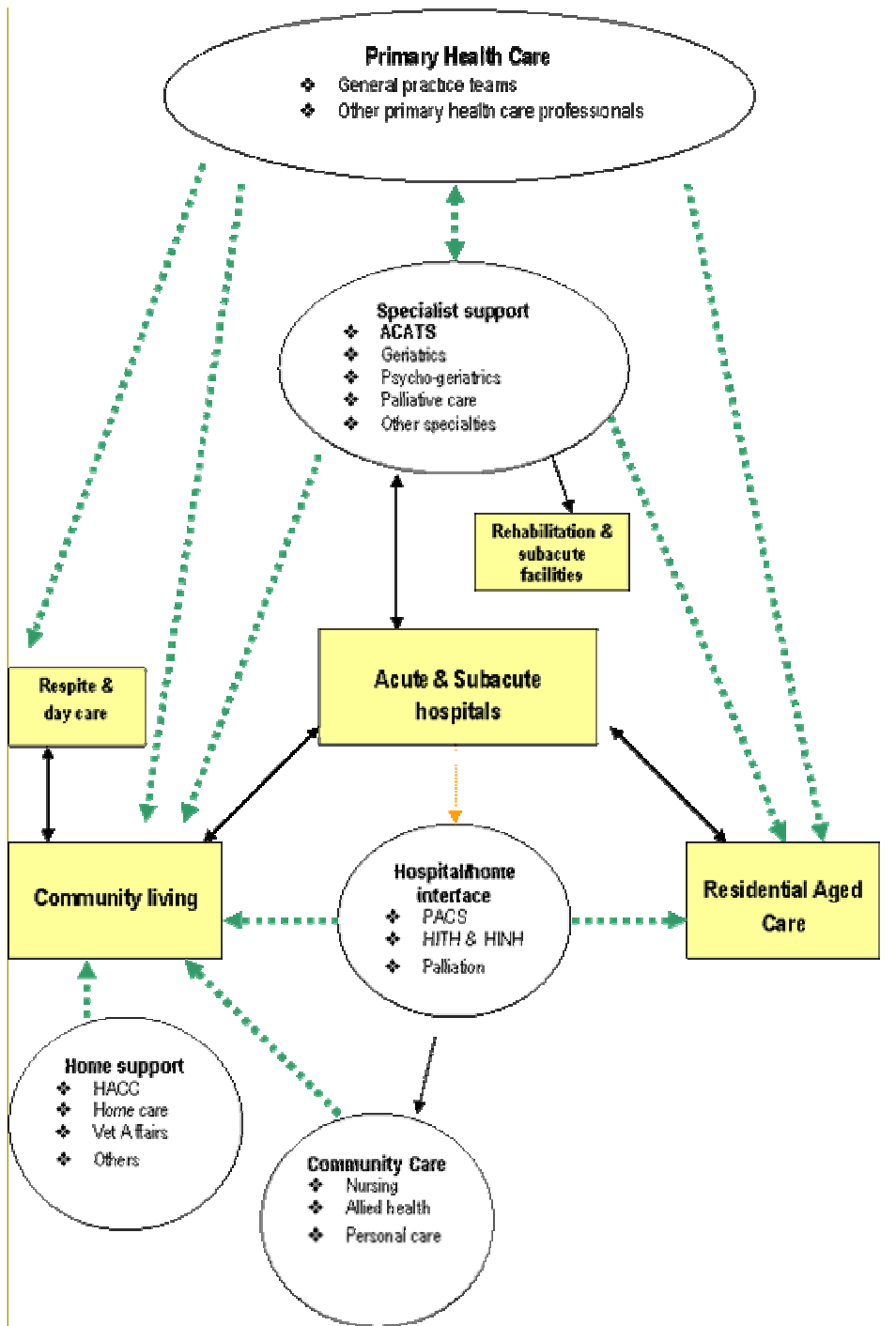
1. **An affordable and accessible primary health care service** which ensures that all older people have access to general practice teams and other service providers as required, without the need to rely on acute hospitals to fill gaps in service availability. This will require ensuring there are sufficient primary health care providers to meet growing needs, plus a system for ensuring that primary health care services can reach those with limited mobility. This primary health care service must incorporate preventative health and wellness programs.
2. **An effective system of secondary referrals** which ensures older people have access to specialists particularly geriatricians when required.

3. **Community and care centred services**, which provide to older people the nursing, allied health and personal services needed to allow them to stay at home as long as possible. Adjuncts to this service are carer support services, respite care and day care facilities, which could be provided through acute hospitals, RACF, local government or independent providers.
4. **Hospital community interface programs** including as far as possible Post Acute Care services and “hospital in the home or nursing home” type services which may avoid unnecessary hospital admissions or reduce length of stay. It would include also a specialist support network, integrated with all care settings and able to provide support for GPs and patient review and assessment.
5. **Quality RACF** for frail older people no longer able to reside in the community. This should be integrated with hospital outreach services to prevent avoidable admissions. Residents should have access to primary care, rehabilitation, or palliative care as required.
6. **An acute hospital system**, which has the capacity and skills to manage complex older patients. Adjuncts to the hospital service should include adequate subacute/ rehabilitation places. The acute system should adapt to the growing older population by integrating specialist geriatric and palliative care into hospital activity, initially at the point of entry (usually through ED), but also by providing trained staff and/or specialist advisory services in other areas of the hospital.

At the core of the proposed model is support for GPs as primary care providers for older people in residential care and community settings. This means better use of specialist geriatric and/or palliative care teams which ideally will be well integrated with the relevant acute or community health services and generic community service providers and residential aged care homes, as well as with the acute and rehabilitation hospitals. Specialist geriatric, psycho-geriatric and palliative services would support local GPs, practice teams and the Divisions of General Practice to provide complex care for frail older people, for older people in the community and in residential aged care.

There are some older people who do not fit easily into any specific setting e.g. homeless older people and it will be essential to develop services other than acute hospitals for providing for the needs of this group.

**Comment [j1]:** Need to add practice nurses and allied health workers next to general practitioners i.e. defining the general practice team



**Figure 1: Interrelationship of health care sectors**

## 7 QUALITY HEALTH SERVICES FOR THOSE LIVING IN THE COMMUNITY

### *An affordable accessible primary health care service*

- **Availability of general medical services in particular GPs and general practice teams.** The services, which are accessed directly by mobile patients, should also be available at home, when the patient is no longer mobile. GPs have traditionally provided this service and it is therefore of concern that home visits by GPs have declined in recent years. A more coordinated timely response from primary health care providers including GPs needs to be available 24 hrs to avoid unnecessary Emergency Department presentations, hospital admissions and reliance on medical deputising services for routine care, so that more old people can stay at home. This will require a change in the way primary health care is practised and a move to preventative health care and wellness models of care. It will also need an increase in the willingness of GPs to undertake home visits for frail or disabled elderly or at times and locations where public transport is not available. Governments and service providers will need to consider: recruitment, retention and adequate financial incentives for providing the service.
- **Home visiting should also be undertaken by other care professionals.** Home based physiotherapy, occupational therapy, nutrition, speech therapy, podiatry, psychology & counselling etc may be needed for many older patients to ensure continuity of care. Systems need to be put in place to ensure that home bound patients have access to the same types of services that they are eligible to receive (and need) whether living in residential care, at home or undergoing acute care or rehabilitation. Well-integrated community services programs may in part be able to deliver such services, but there may be scope also for a wider use of home delivered health care services. Innovative ways of delivering such services, including for example using nurses or other health professionals in a wider range of roles, needs research. Primary care coordination must form a component of primary care.
- **Access to specialist support and advice.** Currently access to specialist geriatrician services, psycho-geriatricians or palliative care specialists is limited for those living in the community with diminished mobility or dependent on poor public transport. Access to other specialists is rarely available, except where admitted into acute care. Home visits by specialists are rare to non-existent although in limited number of locations there is access to community geriatricians or palliative care physicians.
- **Access to the full range of essential allied health professional services.** Residents will have need for dental care, physiotherapy, podiatry, occupational therapy speech therapy as well as social workers or counsellors, while living in care, as well as when living in the community
- **Access to a well-integrated specialist geriatric care service** (the extended ACAT and Community Palliative Care/Homecare models), should allow more referrals directly from GPs. However, these services need to work in an integrated manner to dovetail with, build and enhance GP networks. If services tend to disempower or compete, there could be a further decrease the provision of services in and after hours by GPs to many vulnerable patients and their families.
- **Transport:** Patients need to access services. A system of transport that gets patients to GPs, specialists, allied health or outpatient services is essential. This needs to be available firstly to ambulatory patients able to travel to services but also to the growing number of mobility-limited people living in the community or in RACF.

### *Effective referral to specialists, geriatricians and multidisciplinary teams*

Primary health care workers should have support from specialists when needed. Frail or complex dependent older people whether living in residential care or in the community, with

multiple pathology and impairments in cognition and gait, cannot access multiple specialists or private rooms and will all too readily find their way into unnecessary acute care. GPs also need the support of multidisciplinary teams and specialists to manage the complex needs of the frail elderly.

To assist GPs to provide Complex Disease Management, GPs and their patients require improved access to the resources of the multidisciplinary aged care teams including specialist geriatric consultation. Geriatrician Evaluation Models (GEM) which allow assessment of patient needs before entry into either acute or residential care are strongly supported. The most effective means of delivering this service would be to build on the existing ACAT and Divisions of General Practice Network to develop an Extended ACAT Model and is discussed in Box 4. Improved access to the extended multidisciplinary ACAT with a community geriatrician would be an invaluable support for GPs and would assist them to provide appropriate health care specific to the care needs of frail older people.

**Box 4: Community Geriatricians and extended ACAT Model.**

An effective focus for health service delivery for older people would be to build on and re-integrate the existing Regional Geriatric Medicine – ACAT framework and to link this core regional system with GP divisions. An additional capacity for effective privately funded geriatric medicine will be essential because of variable and vulnerable funding commitments for public geriatric medicine in far-flung jurisdictions throughout the Nation. The most effective means of delivering this service would be to build on the existing ACAT and role of the Divisions of General Practice Network.

- Most States have Geriatric Medicine Services funded on ACAT boundaries often on a local hospital base. Some States fund extended ACATs.
- The Commonwealth funds 118 GP Divisions (many on the same boundaries as ACATs). The number of solo or small general practice surgeries in each Division varies.
- A specialist geriatrician should be added to each of the ACATs, working with local Divisions of General Practice. This would provide essential back up to GPs and their practice teams and reduce the need for older people to access multiple specialists.
- The states and Commonwealth should resolve funding boundaries to ensure that this service is available and that it is well integrated with the hospital, residential care, and community services programs and particularly with the local GPs and other local health professionals.
- Ensuring that a community geriatrician can also visit those in residential care, undertake periodic patient reviews (especially medication review) and work closely with GPs for ongoing care will reduce rather than increase overall costs, while at the same time enhancing patient welfare.

***Provision of Care and support services***

There are some essential services that must be provided to those living in the community. These must be accessible, affordable and meet the needs of all patients from diverse backgrounds.

- **Access to continuing nursing management.** Generally provided through community health services these must provide post-discharge care, and continuing care, with support programs in: rehabilitation, continence, heart and respiratory failure, dementia nursing and palliative care. Nursing services must be available 24 hrs for specialised services such as palliative care or HIH type services.

- **Access to multidisciplinary teams:** geriatricians, psycho geriatricians, palliative care specialists, general practice teams, pharmacists, physiotherapists, occupational therapists, podiatrists and other primary health care givers.
- **Day care centres for frail elderly** or those with dementia and non terminal phase palliative care needs are a potential alternative to long-term residential care. Such centres allow carers to continue in the workforce while at the same time being assured that patients will receive necessary care. Such centres need to be integrated with wider health services (through extended ACATS, community care services, community health centres or outpatient services) providing access to primary health care providers.
- **Respite centres and / or opportunity for short-term placement in Residential Aged Care.** The use of such centres to give carers a break, to provide for periods of short term intensive rehabilitation or stabilisation will grow and such centres are an essential component of an effective community support.
- **Community Hospice beds.** These will need to be adequately staffed to provide for the 24 hour terminal care needs of palliative care patients who are unable to die at home or choose to die in this type of environment.
- **Carer and home support services:** The clinical side of community health should be supplemented by a well-resourced community services component, providing necessary domestic support and personal care. Partnering with community providers should be established to ensure an integrated service approach. There are some essential components of a home support network that need to be provided in parallel with clinical services. Packages for domestic and personal support need to be expanded to meet growing needs. The packages and or services provided should include essentials such as food, cleaning, and shopping and should also include provision for transportation to appointments and to social activities.

## 8 A WORLD CLASS SYSTEM OF RESIDENTIAL HEALTH CARE

A world class system of residential health care is required, particularly for those frail or older people with dementia and conditions that render them immobile and unable to care for themselves. Longer stay RACF populations are by their nature, at high risk of (often preventable) illness and injury; and inadequate medical management, rehabilitation, and symptom control as a result of medical conditions. These conditions require residential care-based multidisciplinary health services with specialist inputs. However, people in residential care are currently in receipt of sub-optimal internal health service largely, as well as having sub-optimal exposure to external health service inputs. This unacceptable state of affairs also inhibits upgraded levels of medical, behavioural and palliative health care within residential aged care services. The essential elements of a health framework for those in residential care are:

- **Access to quality nursing care.** This should include access to appropriately trained nursing staff when needed. If admissions to hospital are to be avoided then there should be access to adequately trained nursing staff able to manage Hospital in the Nursing Home (HINH) services such as intravenous pyelogram (IVP) radiography, injections, medications etc. The range of nursing services should prevent unnecessary or inappropriate hospital visits. It must include access to specialist nursing care for common problems of ageing such as dementia and palliative care.
- **Access to quality personal care.** High standards of nutrition, accommodation and personal care and hygiene are essential to quality residential care. When people live in RACF it is stressed that the care and services are not just health care nor are they simply basic services such as food cleaning or shelter. People actually live in these facilities and as such their care should extend not just to the basic services and/or health care but should include aspects of daily life that make life meaningful. Diversion therapies and social interaction should be an integral part of the services provided.
- **Access to quality of life services.** The care in RACF must not be just about the medicalisation of ageing but must also incorporate the essential services which give quality of life to residents. Communication with others, access to meaningful activities

and opportunity to participate as far as possible in daily life are also fundamental components in the provision of quality residential aged care.

- **Availability of general medical services in particular GPs.** Just as for those living in the community access of residents in RACF to GP services are essential, however the GP participation in Residential Aged Care facilities has declined sharply. Only 16% of GPs visit nursing homes on more than 50 occasions per year (i.e. more than 1 per week). If admissions to acute care facilities are to be avoided, access to appropriate clinical care for residential care patients is essential. Incentives for support of GPs to visit residential aged care facilities are needed. Purpose-built consulting rooms within aged care homes, with adequate examination facilities, modern clinical equipment, and access to electronic prescribing, records and billing services, are needed if aged care residents are to get the health care they deserve.
- **Access to specialist support and advice** including specialised services is needed for the management of complex multifactorial geriatric conditions, behavioural disorders and to multidisciplinary palliative care teams. Currently access to specialist geriatrician services, psycho-geriatricians or palliative care specialists is limited for most RACF residents. Access to other specialists is rarely available, except where admitted into acute care. Home visits by specialists are rare to non-existent and where there are community geriatricians or palliative care physicians, funding barriers mean these typically are not available to nursing home residents.
- **Access to the full range of essential allied health professional services.** Residents will have need for dental care, physiotherapy, podiatry, occupational therapy speech therapy as well as social workers or counsellors, while living in care.

## 9 HOSPITAL / HOME INTERFACE

Hospitals should be fully integrated with other elements of the health system and will supply services at the interface between acute episodes and return home to provide truly seamless care across the acute / aged care / community care continuum. There is a wide range of potential "hospital outreach" programs which may provide a seamless interface between care settings. These include, but are not limited to, the services described in Box 5.

The principles of such hospital outreach programs are:

- ❖ The service is integrated with the acute hospital system and has access to the expertise of the hospital;
- ❖ The service provides a quality of care that is similar to that of a hospital but in a setting that minimises disruption for the patient;
- ❖ The service is flexible and able to go to the patient where appropriate; and
- ❖ The service provides a cost effective intermediate service which keeps older people out of hospital and/or care as long as possible.

Box 5: Models for providing support to GPs in care of older people in the community or in RACF

- ❖ GP emergency clinics to support local GPs who have older dependent community living patients requiring a complex assessment (often including imaging, blood count, micro-urine and other pathology) that would otherwise be directed to ED. These clinics could provide an Emergency Department alternative through a “quick response” clinic for GPs, providing acute assessment, investigations, diagnosis and a management plan with necessary community supports and would support, not replace, general practitioners in chronic and complex care.
- ❖ Rapid outreach programs which would include multidisciplinary squads able to undertake home visits. This type of service could also be provided by practice nurses/allied health professionals if there was an MBS item to allow general practice to be remunerated for this service.
- ❖ A hospital based Ambulatory Care Unit would complement domiciliary based and primary health care services in the home, by providing a hospital site for the ambulatory management of suitable conditions through hospital transport and/or taxi voucher service for patient attendance for intravenous antibiotics, blood transfusions, anticoagulant therapy, investigations and dressings. Ambulatory services should not be limited to just hospital services but should connect patients with the full range of community delivered health services. Given the importance of fitness (both in mind and body) ambulatory services, which get older people to health, welfare, fitness or educational activities, should also be established.
- ❖ Post Acute Care Services (PACS) provide acute and post acute care outside the confines of the acute hospital. The service should operate 7 days per week with evening and on-call services included. It can provide medical co-management, pre-admission, discharge planning, rehabilitation of older patients with fractures or joint replacement surgery and home based rehabilitation of complex dependent older people
- ❖ Hospital in the Home (HIH) or Hospital in the Aged Care Facility may be a continuation of inpatient treatment at the residence or avoidance of admission. It may include for example intravenous antibiotics, or management of anticoagulation therapy.

## 10 QUALITY CARE IN ACUTE HOSPITALS

### *Emergency departments*

The Emergency Department is the first point of entry into the acute hospital system for many older people. An essential element of an Emergency Department system needed to cater for older people is integration of **geriatric specialists into routine Emergency Department activities**. Depending on community profile and Emergency Department activity, this could involve including specialist geriatric trained medical and nursing staff in the Emergency Department or close integration with specialist geriatric hospital staff through rapid response advisory services. However, this service should be available 24 hrs per day. As the population ages, the proportion of frail older people presenting at Emergency Departments could reach 20 percent or more. In this scenario staff should also have the skills to identify patients with cognitive disorders and be able to instigate appropriate discharge / transfer procedures.

The Alliance stresses that adequate well-staffed emergency rooms capable of coping with the expected patient load without excess waiting time or ambulance diversions is a fundamental requirement of world class health care and should in no way be compromised. In the face of an ageing community and expected growth in demand for emergency services, there is an urgent need to plan for these expected Emergency Department needs.

### *In-patient care*

The AHMAC National Action Plan deliberately restricted its focus to areas of interface between the acute care sector and the patient's home environment. However, a comprehensive health care model needs to include consideration of the acute hospital system, which is required to achieve best outcomes for older people. The alliance therefore stresses that while Emergency Departments and effective discharge planning are essential, there will also be an ongoing and increasing need for multidisciplinary care of a “core” older patient group – “Frail” older people. This will require:

- An adequate (and slowly increasing) number of specialist geriatric and palliative care beds available to care for a core group of patients who do not reach criteria for initial admission to another specialized service or program, and who do require the care of a multi-disciplinary aged care team. Current provision of such units is inadequate for the current population and should be expanded substantially as the population ages. Once established, such units would become a model for education and training for other hospital staff, and provide essential hands on experience.
- An adequate number of beds and services available in disciplines that are essential to the care of frail older people including psychogeriatric services and palliative care.
- Hospital staffing set up to manage patients with age related conditions such as dementia induced wandering, delirium (exacerbated by the hospital environment), continence issues, and communication issues due to combination of sensory loss and cognitive impairment. It will be essential that staff move from the mindset that focuses on a specific organ problem ignoring the complications of age and sometimes relegating the elderly to lower priority. The hospital staff should be capable of assessment and management of medication use, cognition, delirium and acute behaviour disorder and of preventing deconditioning and functional decline. This will require training of ALL acute care staff in general hospitals in the basics of geriatric care. This is expected to best be achieved through education and exposure to best practice in the multidisciplinary geriatric unit.
- Specialist geriatric advice throughout all parts of the hospital. Because older people will form the majority of patients and many will have some geriatric conditions there will be a need for specialist geriatric advice throughout all parts of the hospital. This advice requires a geriatric advisory service which would allow consultations to support specialist physicians and surgeons with aged care services for complex dependent older people through a consultative or shared care model. Specialist medical and surgical care would continue to be provided by the sub-specialty physicians and surgeons, their house staff, and nursing staff but geriatric teams would provide advice, additional resources, and education in aged care.

**Box 6: Options for ensuring geriatric care in acute hospitals**

- Acute geriatric medicine units staffed by geriatricians and multidisciplinary teams.
- Acute Care of the Elderly (ACE) units in which “general physicians” are supported by consultant geriatricians and the multi-disciplinary team
- Admission under specialist physicians on acute roster with geriatrician consultation and subsequent transfer for sub-acute rehabilitation
- Geriatric rehabilitation units in the acute or district hospital
- Geriatric rehabilitation in a sub-acute hospital on a separate campus.

***Rehabilitation and subacute care***

Access to multi-disciplinary services is essential for rehabilitation care. Frail older patients whether in general wards or geriatric units need access to multi-disciplinary services essential for rehabilitation and / or palliative care. All older hospital patients should have access to physiotherapists and occupational therapists for prevention of deconditioning and for mobilization and restoration of function, rehabilitation, discharge and pre-discharge home visits. These should not exclude those in the last months of life who have a right to enhanced Quality of Life.

Also there should be access to speech pathologists and dieticians (to address nutrition and swallowing) and clinical neuro-psychologists with expertise in assessment and setting up behaviour management programs for demented and delirious patients and with expertise in mental capacity and guardianship.

## **11 ROLES OF THE CARE PROVIDERS**

### General Practice Teams

General practice is the basic building block of Australia's aged care health services and is an integral component of any strategic health care framework. GPs are responsible for much acute episodic care and for most of the management of chronic conditions. GPs should also take a leading role in disease prevention & health promotion. Increasingly, multidisciplinary general practice teams, with GPs as essential members, are central to the delivery of comprehensive and continuous care and wellness services to older Australians.

Practice nurses are core members of the general practice team. They provide valuable support to GPs in the provision of primary care services to patients. Evidence indicates that practice nurses can bring improved health outcomes in chronic disease<sup>4</sup>, assistance in primary-acute integration, better coordination of care and an enhancement in the range of services available at the practice<sup>5</sup>.

Practice nurses are already involved in the provision of a range services to older people including wound management, immunisation and assisting GPs with chronic disease management through initiatives such as Comprehensive Medical Assessment, home health assessments, GP Management Plans, Team Care Arrangements, Diabetes Cycles of Care and Asthma 3+ Plans.

As the population ages, general practice teams will increasingly be required to manage chronic and complex conditions. General practice teams need to be adequately trained and supported with access to allied health and community services to assist in the management of complex co-morbidities in older patients. This will involve facilitating the establishment of ongoing training programs to ensure GPs, practice nurses and allied health professionals, have the skills and knowledge needed for management of complex chronic illnesses, supported by robust systems for referral and collaborative care.

General practice cannot be expected to work alone in the complex care of frail older people. To assist GPs to provide Complex Disease Management GPs and their patients require improved access to the resources of the multidisciplinary teams, including through extended ACATs. The model could assist GPs access to an extended ACATs with adequately resourced Intake System, Community Geriatrician Consultations and other essential specialists such as psycho-geriatricians or palliative care specialists.

General practice teams are more likely than other health professionals (excluding community care workers) to build up an on-going personal relationship with patients and their families/carers and therefore should have a major role in management of the increasingly frail elderly. In particular, GP teams should be actively involved in discharge planning and rehabilitation and palliative care programs so that they are kept fully informed of patient needs, particularly after a period of acute hospital care.

If GPs are to adequately service older patients there will need to be incentives for GPs to handle complex chronic cases. The current GP fee structure is having some success in attracting GPs to increase their role in the management of chronically ill elderly. Although a number of government initiatives, including the *Strengthening Medicare Aged Care GP Panels*, General Practice Evaluation Program (GPEP), Shared Care, Enhanced Primary Care (EPC) and the Practice Nurse initiative, have gone some way towards addressing this they have not fully solved this disincentive.

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<sup>4</sup> Wagner E, Austin B, Von Korff M, *Organizing Care for Patients with Chronic Illness*. The Millbank Quarterly 1996 (74) 511-534

<sup>5</sup> Watts I, Foley E, Hutchinson R, Pascoe T, Whitecross L, Snowden T. *General Practice Nursing in Australia*. 2004. RACGP/RCNA.

An effective general practice service will have sufficient GPs and practice teams available in all areas including outer suburban and regional areas, will be available 24 hrs a day and will be accessible and affordable to all older Australians. To be able to adequately coordinate interdisciplinary teams for the management of their patients, GPs will need to be financed to attend IDT meetings to discuss and plan for the integrated care of their patients and also to adequately coordinate care for their patients' families/carers. There is a well-recognised shortage in the number of GPs especially in rural and outer suburban areas. To overcome this shortfall will require a range of actions including increased training, recruitment, and retention of older GPs.

#### Geriatricians

Equity of service provision for older people requires the entitlement to access the expertise of geriatricians in settings outside public hospital services.

To cater for the expected increased in the number of frail aged, increased numbers of geriatricians need to be trained. If geriatrician training places are to be filled, incentives should be in place to encourage medical practitioners to choose geriatrics as a specialty. In addition incentives will be needed to ensure geriatricians are prepared to undertake the home and community visits which are required of this specialty, given the poor mobility of most of the patients. The introduction of fee for service payments including payments for home visits or visits to residential care facilities, private hospitals and community centres, coupled with new fee structures for core geriatrician activities such as complex cognitive assessments, is likely to prove the most effective means of increasing the number and availability of trained geriatricians in the medium term. Other models of service delivery including the appointment of community geriatricians (Box 4) will also be needed to provide the full range of essential community based services.

As with all areas of clinical practice there is currently a shortage of geriatricians, however there are positive signs of growing interest in specialist training places and if complemented by use of other well trained clinicians access to geriatrician specialists may not prove a major barrier to quality care for older people.

#### Psycho-geriatricians

In parallel with the increasing need for specialist geriatricians there will be a need for an increase in the number of specialist psycho-geriatricians to cater for the subset of older people with dementia who display severe behavioural disorders and for the projected ageing of people who currently have psychiatric disorders. Currently access to psycho-geriatricians is restricted and many main stream psychiatrists are unwilling to take on older patients. As is the case for geriatrician access to psycho-geriatricians should not be restricted to hospital only patients.

#### Palliative Care Physicians

Many terminally ill patients are appropriately cared for by their primary care physicians (mostly GPs, but also other non-pall health care specialists) in the community (14-20%) or hospital (>50%). However, these practitioners need to be able to refer to patients for specialist services where necessary. For many patients this will be for assessment and periodic review, with responsibility for ongoing care remaining with the primary health practitioner. For patients with more complex care needs, ongoing care may involve a specialist palliative care service in conjunction with the primary health care service. Guaranteed 24 hour access to support is vital for primary care doctors, the patients and their families or carers.

#### Nursing

The increasingly important role of practice nurses as part of general practice teams has been discussed above.

Whatever systems are in place there will be a need for increased patient nursing care. This must include:

- **Specialist nursing** tasks such as dementia or palliative care nursing
- **Skilled nursing** tasks such as delivery of medications, injections, IVPs, wound dressings etc
- **Patient personal care** – bathing etc
- **Patient support** and assistance

There is a range of **specialist nursing** services that should be available for older people. Geriatric dementia care and palliative care nurses need to be included in multidisciplinary teams and need to be available in hospitals, in RACF, in community services and in hospital outreach services. However shortages of skilled clinical practitioners are an Australia wide problem. Gerontic nurses will be encouraged to take on a wider role either as nurse practitioners or as practice nurses. While this will partially address shortages in some very high skill areas it may further reduce the availability of skilled nurses for general patient care.

Access to **general nurses** will also be essential to treat older people in hospital, in RACF or in community nursing services. For people opting to “age in place” ready access to community nurses will be essential for age related conditions such as dressings or medications.

Personal care services are another essential component of geriatric nursing and require considerable skill levels. Bathing, dressing and feeding the frail aged required skilled nursing care. Attracting suitably qualified nursing staff is proving increasingly difficult.

Personal support services are also an essential component of nursing care which requires dedication and empathy from staff. In an environment where skilled labour is in short supply attracting sufficient care workers with the dedication to manage severely demented older people will become increasingly difficult. It is anticipated that many of the most enthusiastic will retrain as general or specialist nurses, resulting in the need for constant recruitment of relatively unskilled care workers.

As with so much of the health work force access to skilled nursing specialists is becoming increasingly difficult and there is an urgent need to expand the nursing workforce at all levels from care and support workers through to specialist nurses and nurse practitioners. As the rest of the world ages, access to a pool of skilled nurses will also become more restricted. Addressing this workforce issue is a priority issue for consideration and requires more in-depth consideration. This can partially be achieved through increased training places, through improving conditions so that retention rates increase and more trained nurses are encouraged returning to nursing.

#### Other primary health professionals

Allied health professionals should be encouraged to visit patients at home and in RACF and models of care need to incorporate the right mix of incentives to ensure services are provided. Not all RAC facilities provide extensive multidisciplinary care so that residents may not get access to physiotherapy, podiatry or other primary health care.

Older people will access an increasing range of clinical services including, podiatrists, physiotherapists, occupational therapists, speech therapists, psychologists, nutritionists, dentists, optometrists, pharmacists, pathologists, social workers and counsellors. Most of these services are provided privately and are a crucial component of the health system. However, as people age and become frail, accessing these services will become more difficult. Co-location of services, easy access by public transport and communication between providers will be essential if these services are to meet the demands of an ageing population.

The role of all health professionals needs to be examined to determine what is a sensible contribution to care for the frail aged. Integration with community health services, increased

role in patient advocacy or in medications review are all areas where a very wide range of health professionals might expand their role.

Funding the provision of such services is also an issue of some concern. Levels of government subsidy for allied health services are quite limited and private funding of access to these services typical. For those with limited retirement income some funding support to access these services may be needed. Commonwealth, state and local government and the private sector should all co-operate to ensure these services interact seamlessly and are affordable and accessible to older Australians.

#### **Box 7: Specialist Palliative Care**

These services augment general practice or other specialist care with focused, intermittent, specific input as required, for example:

- help with assessment and treatment of complex symptoms (physical, psychological, social, cultural and spiritual) experienced by the resident
- provide information and advice on such challenging issues as the ethical dilemmas of nutrition and hydration; management of depression and existential issues and many other relevant issues for the resident and their family/carers at the end-of-life
- facilitate access to a broadly based specialised interdisciplinary team which often includes: doctors, nurses, physiotherapists, occupational therapists, social workers, clinical pharmacists, dieticians, speech therapists and pastoral care workers
- be available to discuss issues with the individual resident and family members
- proactive provision of information, advice and education of RACF staff in evidence-based management of distressing symptoms that may be troubling to the resident or family
- assistance in maintaining a sense of therapeutic partnership with residents and their families, especially when there are difficult family relationships or a lot of complex “unfinished business” exists
- facilitate discussions about: the goals of care and advance care planning, prognosis, when to recruit the help of other specialists for more effective symptom control or when to admit a terminally ill patient to hospital to further investigate symptoms for more efficacious symptom management and improvement in QOL for patients and their families/carers; facilitate this admission in a seamless and non-traumatic manner.
- provide advice on resources available for bereavement management and facilitate appropriate referrals

## **12 CHALLENGES**

The model outlined sets up a framework for what will provide quality health care for older people in Australia. This paper outlines strategic health care objective which will meet our stated aim to “develop a model system of health care for the increasing numbers of older people in Australia, which gives the best care for the older person, in the best setting, using best practice to achieve maximum physical and mental capacity and minimum disability.”

There are serious barriers to the delivery of appropriate health care for the aged including:

- Separation of responsibilities (particularly between Commonwealth and state) and the development of “silos” for service types often with inflexibility in health funding programs
- Inadequate integration of health services for older people across community, hospital and residential care settings on a local geographic sector base
- Lack of sub-acute rehabilitation and other options for “transitional care” between settings
- Limited availability of acute and post acute care services delivered “at-home” in the community or residential care setting
- Shortage of community care and community supports
- Shortage or mal-distribution of nursing home beds

- Inadequate development of “core” multidisciplinary and palliative geriatric medicine acute hospital services for frail complex older people in the “older-old” age group
- Consequent public hospital access block and emergency department overcrowding.

It is recognised that these challenges are dwarfed relative to the potential for scarcity of trained clinical staff – nurses, GPs and specialists- which is and expected to intensify in coming years. This important issue is being addressed by the Alliance in other forums and is only briefly acknowledged in this paper.

There are major structural impediments to effective and equitable service delivery to older people in Australia. Our governments need to act urgently to introduce policies to achieve a system of services to which access is determined by the needs of older people, rather than the particular point of contact or service setting in which they may find themselves. It is now acknowledged that our current service models, across the three settings, fail to meet the needs of older people who require a level of health care that falls between current community, hospital and residential care provision. This includes components of care variously described as sub-acute rehabilitation/restoration of function, and sub-acute, transitional or interim care. These issues have been addressed by AHMAC, which calls for a more collaborative approach to planning and delivery of services by different government levels

The final challenge is ensuring adequate funding for health services. The way the health system is funded cannot be divorced from the overall health framework and the range, quality and accessibility of the services provided. The current Commonwealth/State divide discourages good use of services since funding source depends upon condition classification rather than patient need. State funded hospitals have incentive to discharge patients to commonwealth funded residential care facilities, while residential care facilities have an incentive to place ill residents in acute hospital care if additional staffing or care is needed. In an ideal world, there would be a single funding source and these allocation issues would not arise. Both state and Federal services have an incentive to send people back into the community where they expect carers to provide voluntary or poorly paid and supported care for often quite complex geriatric and palliative care patient populations.

In essence, the clinical service provided by community health represents an alternative to services that would otherwise be provided in hospitals or residential care. It is generally accepted that community services are not only less costly than alternative service delivery options but also have better clinical and social outcomes. It is therefore imperative that this type of service is strongly supported and encouraged to grow in line with the demands of the population. However, with the rapidly ageing population these services are going to face enormous pressures as the demand for community support increases. The temptation governments will face to control expenditure on these services needs to be balanced against the outcomes of inadequate care, resulting in more costly hospitalisation, premature admission to residential care or excessive levels of family/carer burden that will impact on society as a whole.