



# Enhancing the independence and care of the older person

## Context

- The Western Australian population is ageing, with people living longer than they ever did before. Approximately one in eight Western Australians are aged 65 and over, which is projected to increase to almost one in five (18%) by 2050. In the next 10 years this older adult group is projected to increase by 50 per cent (from 340,000 to 518,000 people).<sup>(1)</sup>
- Older people are generally high bed day users in hospitals, particularly community dwelling older people with complex comorbidities and/or frailty, and those nearing end of life (regardless of age). This trend is only going to increase with our ageing population. The increased demand on the health system is one of the most significant challenges facing our health system and threatens its ability to be financially sustainable in the years to come. However, the care of the older person is a delicate, complex and a challenging task for which there are no simple solutions.
- Sub-acute services such as rehabilitation, palliative care, geriatric evaluation management and psychogeriatric care, are necessary for optimising patients' functioning and quality of life.<sup>(2)</sup> These have an important role in restoring and maintaining abilities for people of all ages.
- The notion of 'ageing', and what is considered 'elderly' is changing and sub-acute services link significantly to geriatric and care of the older person services to support transitions between acute, subacute and community care including residential aged care (RAC). Well-coordinated and linked subacute care services improve patient functional outcomes, hospital efficiency and cost management. Currently, Western Australia's (WA) health system is under-invested in sub and non-acute care resulting in care taking place in inappropriate places, such as acute hospitals.
- Whilst aged care is a Commonwealth responsibility, the State through necessity is increasingly being required to invest in this sector. In 2017, WA successfully lobbied the Commonwealth to release additional Transition Care Program (TCP) places to offset the ongoing low rate of operational places with the Minister for Health, Roger Cook, announcing the provision of an additional 60 TCP beds in Perth. The TCP provides a non-hospital environment for older people to receive care while improving or maintaining their independence.
- The Premier, Mark McGowan, announced in March 2018 that work had begun on fast-tracking the development of new aged care facilities with various projects expect to create at least another 1,500 aged care beds across WA in the coming years. Several facilities such as the aged care precinct in High Wycombe have already begun construction.

- The Aged Care sector has been undergoing significant reforms under the Commonwealth Government's *Living Longer Living Better* aged reform package. These reforms signify a commitment by the Commonwealth to support ageing-in-place so older Australians can continue to live in their own home, if that is their preference. The 2018-19 Commonwealth budget has committed \$1.6 billion to Aged Care over the next four years, providing a further 14,000 high-level home care packages across Australia. Although there has been a funding commitment for care packages, substantial waiting lists for eligibility assessments remains a barrier to accessing care. While funding has been committed, the increase in waiting lists means people are waiting in state facilities, such as hospitals, prior to accessing in-home care.

The Panel heard through a range of submissions and engagement events about key issues and opportunities to enhance independence and care of the older person. These included:

- *Access to urgent care* within residential aged care to specialists and general practitioners (GPs) as a means to reduce the necessity of hospital transfers amongst this cohort. Access to specialist medical assessment is a major issue for elderly clients living in the community and in aged care facilities. There is a gap in medical outreach services that provide triage support for urgent medical assessments that should occur at home or in residential aged care.
- *Improve Advance Care Planning* - There is an evident lack of advance care planning across the system and a clear need for it to be more widely accepted for patients' wishes to be known and to reduce the incidence of invasive treatments within hospital settings. There is an increased need for promotion and the need for every residential aged care facility (RACF) resident to have an Advanced Care Directive. Submissions highlighted, especially for older persons, end of life care services should provide high-quality care, support, choice and control, and should avoid 'over medicalising' what is a natural phase of the ageing life course.
- *Country service provider limitations* - The lack of aged care service providers in country WA is making consumer-driven models difficult. There is a need to explore alternative models of service provision to fill service gaps.
- *Outreach and Community Services* - Submissions indicated there are not enough outreach specialists (and GPs), such as geriatricians, working in the community, including in residential aged care, to respond to the health complexities that elder people experience. Suggestions from submissions include:
  - Managing and intervening early in the care of the elderly frail patient to keep them in their own home as long as possible and reduce their presentations to tertiary hospitals.
  - Geriatricians, psychogeriatricians and other specialists could provide more outreach to nursing homes, rather than automatically defaulting to inpatient admissions.
- *Vulnerable population* - A staggering number of older people experience elder abuse. Elder abuse is reported to affect one in six older adults worldwide and potentially 75,000 older people in WA.

## **Reducing the demand on our public hospitals and a greater investment in healthy ageing**

- To date, in order to reduce the demand for acute hospital care amongst the elderly, two main strategies have been pursued: prevention and diversion.<sup>(3)</sup> However, there are two other strategies that are not as widely implemented within our health system: emphasis on discharge

planning and improved access to Aged Care assessment; and improving the quality of in-hospital care for our older populations.

- In looking to reduce the demand on our acute public hospital amongst this cohort, themes have been identified as areas for change within the WA health system. These are:
  - the promotion of healthy ageing and supporting independence
  - improved access to urgent care in the community
  - supporting those with co-morbidities and/or frailty
  - the provision of high-quality person-centred acute hospital care
  - access to quality long-term care
  - seamless access to subacute and transition care
  - choice, control and support at the end of life.
- Overall, as an immediate direction for the WA health system, there is a clear need to reduce the demand for acute tertiary level care through greater investment in hospital avoidance which falls more broadly into care in the community.

## Exemplars considered

A range of exemplars were identified throughout the course of the SHR in public submissions, Clinical and Consumer and Carer Reference Groups, Working Groups and in public forums. The following exemplars are indicative, however are not an exhaustive list of the exemplars considered throughout the SHR.

### Existing services within WA

- *Rehabilitation in the Home* is a non-admitted early supported discharge rehabilitation program. The program is an interdisciplinary model of care delivering best practice short-term rehabilitation for patients across metropolitan Perth.
- Hospital substitution services such as hospital in the home and the *Silver Chain Home Hospital Program*; Community nursing services; and post-acute care.
- *Community Physiotherapy Services* provide an out of hospital discharge option for patients requiring further physiotherapy intervention following an episode of Inpatient, Rehabilitation in the Home, or Outpatient care. The aim of all programs is to assist the patient to regain or improve their function and independence, thereby improving quality of life, to enable patients to better manage their condition, and to assist in reducing unplanned healthcare utilisation.
- *Rehabilitation and Aged Care Intervention Liaison Service (RAILS)* is a rapid response team made up of multidisciplinary members: clinical nurses, senior physiotherapists, senior occupational therapists and senior social workers. The RAILS team provides both home-based and ward-based intervention to achieve the main aims of avoiding emergency department (ED) presentations and reducing hospital lengths of stay.

### Southcare Geriatric Flying Squad, New South Wales<sup>(4)</sup>

- Southcare Geriatric Flying Squad (GFS) is a geriatrician-led 7-day rapid outreach service which is able to provide comprehensive assessment within two to four hours to RACFs.

- The service aims to improve acute services within RACF to improve quality of care and reduce ambulance travel, ED presentations and hospital admissions through collaboration with facilities.
- The GFS worked to improve the skills, competencies and confidence of the nurses working with the RACFs focused on three main pathways of care; treatment in the facility with close follow up; direct admission onto ward for investigation and management or; referral to the ED.
- In an evaluation of the service, over an 18 month period, the GFS saw 640 acutely unwell RACF residents, with results showing:
  - 578 of the 640 residents (90.3%) were managed in the RACF without the need for transfer to hospital or other health service.
  - Only 35 (5.5%) required an ED visit, with 27 (4.2%) admitted directly to a medical ward).
  - The cost of the program deemed more cost effective than the cost of admission to hospital.<sup>(5)</sup>

### Discharge to Assess (D2A/Home First), United Kingdom<sup>(6)</sup>

- The Discharge to Assess model of care has been utilised in the National Health Service in the United Kingdom and aims to return patients to the community from hospital as soon as possible and provide the necessary community care at short notice.
- It can also help prevent patients entering long-term care by providing appropriate additional support in their preferred home environment.
- Results show that through the program in Medway (UK) Delayed Transfer of Care rates were down by 25 per cent in three months, and in Sheffield, the Health Foundation reported a 37 per cent increase in patients who could be discharged on their day of admission or the following day, highlighting the effectiveness of the model.



This background paper was developed by the Sustainable Health Review secretariat to inform the work of the Sustainable Health Review Panel. Every effort has been taken to ensure accuracy, currency and reliability of the content. The background paper is not intended to be a comprehensive overview of the subject nor does it represent the position of the Western Australian Government. Changes in circumstances after the time of publication may impact the quality of the information. Background papers are published in full at: [www.health.wa.gov.au/sustainablehealthreview](http://www.health.wa.gov.au/sustainablehealthreview).

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