Strategic Framework for Integrated care of the older person with complex health needs

DRAFT FOR CONSULTATION

December 2013
Acknowledgements

We would like to thank the ACI Aged Health Network Executive for their support and guidance of this important work. We would also like to thank the following organisations for their participation in the project to date through site visits, consultations, attendance at the Solution Design Workshop and the provision of contextual information:

- Aged Care Services Association (NSW & ACT)
- Ambulance Service of NSW
- Association of Relatives And Friends of the Mentally Ill
- Clinical Excellence Commission
- Carers NSW and the individual carers that donated their time
- Central Coast LHD
- Central Coast ML
- Council on the Ageing NSW and the individual consumers that donated their time
- Eastern Sydney ML
- Far West LHD
- Hunter ML
- Hunter New England LHD
- Illawarra Shoalhaven ML
- Mid North Coast LHD
- Mid North Coast ML
- NSW Ministry of Health Aboriginal health Strategic Leadership Group
- NSW Ministry of Health, Aged Care Unit
- Ministry of Health, Older People’s Mental Health Policy Unit
- Murrumbidgee LHD
- Nepean Blue Mountains LHD
- Nepean Blue Mountains ML
- New England ML
- North Sydney LHD
- Northern NSW LHD
- South East Sydney LHD
- South Western Sydney LHD
- South Western Sydney ML
- Southern NSW LHD
- Sydney LHD
- Western NSW LHD

AGENCY FOR CLINICAL INNOVATION
Level 4, Sage Building
67 Albert Avenue
Chatswood NSW 2067

Agency for Clinical Innovation
PO Box 699 Chatswood NSW 2057
T +61 2 9464 4666 | F +61 2 9464 4728
E info@aci.nsw.gov.au | www.aci.health.nsw.gov.au

Produced by: Agency for Clinical Innovation
Ph. +61 2 9464 4666
Email. info@aci.nsw.gov.au

Further copies of this publication can be obtained from:
Agency for Clinical Innovation website at: www.aci.health.nsw.gov.au

Disclaimer: Content within this publication was accurate at the time of publication. This work is copyright. It may be reproduced in whole or part for study or training purposes subject to the inclusion of an acknowledgment of the source.

It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above, requires written permission from the Agency for Clinical Innovation.

Produced in conjunction with: PwC Australia (PwC)

This report has been prepared solely for the use by the NSW Agency for Clinical Innovation for the purpose set out in the contract and is not to be used for any other purpose or distributed to any other party. PwC do not accept any responsibility for losses occasioned to the NSW Agency for Clinical Innovation or to any other party as a result of the circulation, reproduction or use of our report contrary to the provisions of this paragraph.

The report is based on information supplied to PwC by the Agency for Clinical Innovation and other NSW Health organisations during the project. This information has not been independently verified by us and we therefore do not provide any assurance as to its completeness or accuracy. The information may not be used or reproduced for or by third parties (in particular competitors of PwC) without the written consent of PwC.

© Agency for Clinical Innovation 2013
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>1</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>2</td>
</tr>
<tr>
<td>SECTION 1. INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>SECTION 2. THE FRAMEWORK</td>
<td>10</td>
</tr>
<tr>
<td>SECTION 3. SYSTEM DESIGN PRINCIPLES</td>
<td>12</td>
</tr>
<tr>
<td>SECTION 4. COMPONENTS OF THE OLDER PERSON’S HEALTH JOURNEY</td>
<td>13</td>
</tr>
<tr>
<td>SECTION 5. MAKING INTEGRATION HAPPEN</td>
<td>26</td>
</tr>
<tr>
<td>SECTION 6. MOVING TOWARDS INTEGRATED CARE</td>
<td>29</td>
</tr>
<tr>
<td>SECTION 7. LOCAL LEVEL IMPLEMENTATION</td>
<td>32</td>
</tr>
<tr>
<td>APPENDIX A – GLOSSARY OF TERMS AND ABBREVIATIONS</td>
<td>46</td>
</tr>
<tr>
<td>APPENDIX B – PARTICIPANTS IN AGED HEALTH AND SOCIAL CARE</td>
<td>48</td>
</tr>
<tr>
<td>APPENDIX C - BROADER GOVERNANCE STAKEHOLDERS</td>
<td>51</td>
</tr>
<tr>
<td>APPENDIX D – MODELS OF GOOD PRACTICE AND INNOVATION IN NSW</td>
<td>55</td>
</tr>
<tr>
<td>APPENDIX E: FUNDING TYPES</td>
<td>73</td>
</tr>
<tr>
<td>APPENDIX F: CASE STUDIES</td>
<td>75</td>
</tr>
<tr>
<td>APPENDIX G: KINGS FUND TOP 16 NEEDS TO MAKE INTEGRATED CARE HAPPEN</td>
<td>80</td>
</tr>
<tr>
<td>APPENDIX H: REFERENCES</td>
<td>81</td>
</tr>
</tbody>
</table>
Executive Summary

In NSW, life expectancy is increasing and the proportion of people living longer is also increasing. A growing and significant proportion of older people are living with complex health needs including chronic diseases such as dementia which is expected to affect 1 in 10 Australians aged 65 years and over.

Older people, their carers and family currently have multiple, disconnected and often duplicative interactions with the health system and longer lengths of stay in hospitals. In addition, the demand for home care and community support services outweighs supply, often resulting in excessive stress on carers and unnecessary hospital admissions. As such, the appropriate provision of services for this population cannot be met by one provider nor one sector. That is, services for older people with complex health needs, their carers and families must be coordinated through a shared plan with joint accountability.

The Framework

This Framework (Figure 1) provides a comprehensive overview of the key components, principles and next steps as services look to integrate care for older people with complex needs, their carers and families through collaborative service design and delivery across sectors. The Framework supports the move towards consistent good practice across NSW. While it is acknowledged that services operate in a variety of environments, the Framework and the components of the older person’s journey aim to provide consistency and good practice guidance while allowing local services operational flexibility for innovation in work practices.

Figure 1: The Framework for Integrated Care for Older People with Complex Health Needs

Adapted from MacColl Institute for Healthcare Innovation
This Framework is neither static nor siloed, all of the elements interact. Also, the Framework alone will not lead to integrated models of service delivery. There is an intrinsic need for behaviour change at all levels by all stakeholders. This Framework provides a common and consistent conceptual model to align behaviours around. The Framework presents the following core components that together aim to strengthen existing services and relationships and address the systemic causes of current fragmentation of services.

The audience for this Framework include Local Health Districts (LHDs) and the broader set of stakeholders at the local level including Medicare Locals (MLs), Ambulance Service of NSW, Aboriginal health services, aged care service providers and community services.

System Design Principles

System Design Principles describes the whole-of-system view to deliver integrated health care for older people with complex health needs, the overall system context and the core system design principles on which the Framework is based. These principles include:

1. Develop a shared vision for aged health services in our local community with agreed goals and measures of success.
2. Promote clear and transparent multi-sector governance and leadership in every setting to drive system change.
3. Implement models and services that achieve timely access to care and empower other services to deliver appropriate care as close to home as possible.
4. Involve older people, their carers and families at every step of their journey and value their experiences as much as clinical effectiveness.
5. Ensure technology supports integrated service delivery that shares information to effectively support multi-sector decision making.

Core to these are a focus on shared governance, partnerships and relationships at the local level.

Components of Older Person’s Health Journey

Components of Older Person’s Health Journey describes the alignment of stakeholders around consistent care components and considerations for person-centred care delivery in any setting, to address specific care needs of the older person with complex health needs. Through the consultation process, it has been established there are six specific care needs related to the care journey for older people with complex health needs:

- Initial contact/ access
- Management & Planning
- Crisis/ acute care
- Specialised health care
- Recovery/ rehabilitation
- Supportive, palliative & end-of-life care.

This is a starting point to consider resource (services, health professionals) distribution across care settings.

Making Integration Happen

Making Integration Happen describes key enablers and actions required to realise a system-wide vision of integrated care for older people with complex health needs. It includes enablers such as engaging older people, their carers and families; supporting providers to deliver shared care; and the alignment of Alignment of resources, policy and performance incentives.

Moving towards Integrated Care

Moving towards Integrated Care describes the types of implementation – oriented activities that should be put in place at both the State and Regional levels.
Section 1. Introduction

Context

Older people are enjoying more years of healthy, active living than any generation before them. In NSW, life expectancy is increasing as is the proportion of people living longer. The predicted growth rate for people over the age of 65 years will be 34% by 2021.

Older people are living longer productive lives and are important contributors to local communities. Many continue to work, help their families and friends, volunteer their time and pursue their personal interests. However, a growing and significant proportion of older people are also living with complex health needs. This is particularly highlighted by the projected rise in the number of people diagnosed with dementia from 322,000 people in 2013 to 400,000 by 2020 and around 900,000 by 2050.

The healthcare needs for this group do not follow a linear process. More often, they involve many periods of wellness and sickness. Effective healthcare of this group therefore, requires a diverse range of health professionals, community care workers, and volunteers working together to support older people with complex health needs their carers and families to experience the benefits of living longer, productive lives. To meet the needs of this group, the NSW Agency for Clinical Innovation (ACI) under the auspices of the NSW Ministry of Health (MoH), has led the development of a framework to enable and encourage providers across all sectors to work together in ensuring older people, their carers and families receive proactive, person-centred and evidence-based care, regardless of how or where they access it.

The appropriate provision of these services cannot be met by one provider nor one sector alone. That is, services for older people with complex health needs, their carers and families must be co-ordinated through a shared plan with joint accountability.

Local Health Districts (LHDs), Medicare Locals (MLs), primary healthcare practitioners, aged care service providers and community services all have the opportunity to take the first step in jointly rethinking current service delivery models to provide more efficient, cost effective and person-centred care for this group. In the context of current health reforms and a shift towards person-centred care design – it is an opportune time to align on what can be done to better integrate care for the older person with complex health needs.

For the purposes of this Framework, an older person with complex health needs is defined as:

One whose underlying co-morbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis.

This definition is not age dependent but does most often pertain to those over 75 years of age.

Purpose of the Framework

The Framework provides the platform to stimulate open discussion at a local level and to promote collaborative actions towards integration among those who have a role to play in improving the health and wellbeing outcomes for older people with complex needs, their carers and families.

The Framework supports the move towards consistent good practice across NSW. While it is acknowledged that services operate in a variety of environments, the Framework and the core principles within it, aims to provide consistency and good practice guidance while allowing local services the operational flexibility for innovation in their work practices. In this way, it seeks to build on previous work undertaken by NSW Health (i.e. the 2004-2006 Framework for integrated support and management of older people in NSW health care system*), strengthen existing services and relationships and address the systemic cause of current fragmentation of services.
Key tenets of the framework

- This framework has been developed to support and align with national and state frameworks.
- Integration cannot be achieved by one provider alone but must cross boundaries including sector, professional and geographical boundaries. This framework is not prescriptive but provides overarching principles to guide local service planning. It does not delineate roles rather provides impetus for local decisions to be made.
- The local system of care delivery for older people with complex needs does not exist in isolation of the broader policy and governance arrangements for aged health and social care. There are various levels of governance and policy that must be recognised and considered in implementation of this Framework, these are described and defined further in Appendix B.
- There are multiple stakeholders in the journey of the older person with complex health needs and it was not possible to identify all of these in this document. Local communities will need to identify and include all relevant stakeholders.
- Older people with complex health needs should be cared for in a setting as close to home as possible where appropriate. The focus is not on hospital avoidance but providing care in the most appropriate setting whether that is at home, in the hospital or in a aged care facility.
- The Framework acknowledges the diversity of older people in NSW. Providers will need to consider the needs of older Aboriginal and Torres Strait islander people, lesbian, gay, bisexual, transgender and intersex individuals and those from culturally and linguistically diverse backgrounds.
- There are many other factors that influence an older person's health, including: housing, support services and transport. As identified in the NSW Government Ageing Strategy 2012, care for this group will need a whole of Government and Community approach.

The various levels of the health system in Australia, and more specifically, NSW are presented in Figure 2. The focus of this Framework is to strengthen the regional (meso) level of the NSW aged health care system in order to influence strategic level change at the National/State (macro) and local (micro) level. The Framework is intended for executives and decision makers at this regional level with transferability to service providers.

Figure 2: Health system levels

Examples include:
- Australian Government
- Australian Department of Social Services
- NSW Ministry of Health
- NSW Health pillars
- NSW Family and Community Services
- Australian Medicare Local Alliance
- Aboriginal Health and Medical Research council

Examples include:
- Local Health Districts
- Medicare Locals
- Ambulance NSW
- Aboriginal Community Controlled Health Services
- Large NGO aged or social care providers
- Local Governments Areas (LGAs)
- Speciality Health Networks
- Disability Services

Examples include:
- Specialist Aged Health Services
- General practice
- Primary health care services
- Local residential/ community aged care providers
- Carer support groups
- Specialist mental health care services
- Palliative care services
- Private specialist services
Vision for integrated care

The following vision was developed by the ACI Aged Health Executive and supported by participants in the solution design workshop undertaken as part of developing the Framework:

*Older people, their carers and families in NSW, as partners in their care, are able to access appropriate, high quality, evidence-based health care that is provided in a timely, equitable and coordinated manner and delivered safely as close to home as is possible.*

The need for integrated care

Having the right care at the right time, in the right place to help older people, their carers and families stay healthy and independent is the fundamental responsibility of all communities and healthcare systems. An essential principle in fulfilling this responsibility is a commitment to providing care and support around the needs of the person receiving it, not the needs of the providers or the system.

This person-centred approach to care involves a relationship between a person, their carer and family and their health and social care team based on mutual respect, trust and collaboration – where the older person feels empowered to make the right decisions about their care and well-being, no matter the location or circumstance.

It also requires a healthcare system whose parts work in collaboration and coordination with each other, in other words- they are integrated. The thinking that underlies this coordination, collaboration and integration in health and community care is not new; the challenge is implementing and sustaining this.

For the purposes of this Framework, the following definition of integrated care has been used:

*Integrated care for the older person with complex health needs brings together the older person, their carer and family, the different organisations, processes, systems and professionals to deliver the best possible care that is centred on the older person’s needs.*

Historically, healthcare in Australia has been complex, fragmented and disconnected. This lack of connectivity has been due to the different roles, responsibilities and funding models between health and social service delivery across public, private and non-government sectors. For example, care of the older person is provided across three specific sectors (community-based aged care, acute healthcare and primary healthcare) with separate and different funding and management structures. For this reason, care is often provided in parallel by different healthcare professionals and different services with little coordination or linkages between them.

In acute care specifically, historical service design has been based on single-diagnosis-related acute care paths. This has resulted in exponentially increasing acute care costs for older persons with multiple and complex health needs and increasing rates of admission to residential care.

‘If I am sick, I ring the GP and am told it is a two-week wait. So I get sicker and then it gets to 2 am and I am really sick, breathless and alone at home so I call the ambulance to take me to ED where they keep me in for about two days doing tests and send me home with antibiotics. I would have just preferred to see the GP.’

Female consumer, 84 years old

In order to create a better, more efficient and cost effective system, care delivery needs to be integrated with a shared vision and practical implications. Integrated care provides the opportunity to structure services to be person-centred rather than provider-centred and to bridge the gaps in communication that cause duplications in care delivery and other inefficiencies to occur.

---

1 This includes a broad range of services that older people, their carer and families access across multiple providers and sectors including residential aged care facilities, community aged care services and community services.
This context is continually evolving, at present, the Commonwealth, State and Territory Governments have agreed to a national reform of the health and aged care systems. The reforms aim to improve health outcomes and ensure the sustainability of the health system and the way in which sectors relate to each other.

These reforms bring opportunities that should be leveraged:

- They will help drive improvements in the way in which health services work together. For example, the establishment of LHDs and MLs with shared geographic boundaries and the requirements for shared governance will facilitate shared planning and service models.
- They will create drivers for better integration of care. For example, the introduction of activity based funding for the hospital sector will lead to the consideration of the most efficient and effective service delivery models (and who within the system is best to deliver these).
- They will encourage more patient and consumer-centred models of care to be considered. For example, the move to consumer-directed care in the community aged care sector.
- They will provide information that can support the evaluation of strategies and interventions implemented to address this issue.

Equally the reforms present challenges:

- The ways in which some services are delivered, funded and resourced will change over time meaning that flexibility will need to be built into service models. For example, exactly how aged care assessments will be administered is uncertain and will impact assessment responsibilities at a local level.
- There is the possibility that additional layers of duplication may be created in the short term. For example, with the introduction of consumer-centred care in community aged care, care plans will be developed for the client, building on care plans that may already exist within the primary care and the acute sectors.
- Implementation will take time, so initial investments and 'work arounds' may be required. An example is the Personally Controlled Electronic Health Record (PCEHR) which presents a key enabler to better information sharing and self-management but will take some time before it can enable a shared care plan.

The key to maximising these opportunities and managing these challenges lies in the ability of providers to collaborate and for governing bodies to put in place the right leadership, mechanisms and incentives to facilitate this. For example, local providers can begin to target limited resources in a coordinated way, share budgets (if possible) and reduce duplication to improve outcomes for older people with complex health needs. They can also agree on a starting point for further initiatives to be developed.

The Framework recognises the influence and importance of State/National (macro) level change on practice. However it primarily seeks to strengthen the foundations of the Regional (meso) level and cross sector relationships that facilitate integration.

Background to the framework

The Framework forms part of the response to the NSW Government Ageing Strategy. This whole of government strategy identifies the following action to “develop integrated health service delivery models that support older people with complex health needs”.

The ACI Aged Health Network Executive Committee was the steering committee for the development of the Framework. The Aged Health Executive Committee includes consumers, geriatricians, old aged psychiatrists, general practitioners, specialist aged health nurses, allied health and service managers from across NSW.
Methodology

Development of the Framework followed the NSW Health Redesign methodology including four distinct stages of work as illustrated by Figure 3 below. This Framework represents the outputs of the Solution Design stage.

Figure 3: Developing the Framework

1. Project Initiation
The project initiation stage included defining the scope and definitions of the integrated care of older people with complex health needs Framework project.

2. Diagnostic
The diagnostic stage was a snapshot of the current landscape based on 10 site visits across rural, regional and metropolitan NSW Health services, literature and data review and further consultations with key stakeholders.

The purpose of the site visits was to understand the ‘as is state’ of aged health services delivered across NSW; the care journey and experience of an older person with complex needs (and their carer and family) through these services and the components that underpin the integration of care. The diagnostic describes best practice models of care, consistent themes and the enablers and barriers to integrated care for older people with complex health needs. The stakeholders consulted were dependent on the availability and/or willingness of people to attend on the day of the consultation. The findings of the diagnostic stage are presented in the Final Diagnostic Report which is available at: http://www.aci.health.nsw.gov.au/networks/aged-health/integrated-healthcare-of-the-older-person

3. Solution Design
The solution design stage included a facilitated two-day workshop to inform the development of a strategic Framework for Integrated Care for Older People with Complex Health Needs. The workshop was attended by over fifty participants from LHDs, MLs, primary health care providers, Ambulance Service of NSW, Aboriginal health services, aged care and community care services and carer representatives. The workshop was aimed at verifying findings so far and to design the individual components of the Framework:

- Developed and prioritised the system design principles
- Discussed current barriers and enablers to delivering integrated care
- Detailed the care needs for an older person with complex health needs across settings
• Identified the *quick wins and big ideas* that informed the development of the three year action plan for realising integrated care in the next three years.
Section 2. The Framework

This section describes the structure of the Framework, the key elements of successful integration and the necessary components of integrated care for the older person with complex health needs, their carers and families.

Structure of the Framework

This Strategic Framework (‘the Framework’) provides a comprehensive overview of the key components, principles and next steps for LHDs and the broader stakeholders (MLs, Ambulance Service of NSW, Aboriginal health services, and residential and community aged care services) in integrating care for older people with complex needs, their carers and families through collaborative service design and delivery across sectors.

This Framework is neither static nor siloed with all of the elements interacting. Also, the Framework alone will not lead to integrated models of service delivery. There is an intrinsic need for behaviour change at all levels by all stakeholders. Indeed, even if all structural elements of this integrated care journey exist, it is still reliant on the behaviours of the key players within it to make it successful. This Framework provides a common and consistent conceptual model to align behaviours and understanding of service providers.

Figure 4: The Framework for Integrated Care for Older People with Complex Health Needs

(Adapted from MacColl Institute for Healthcare Innovation)
Road Map

System Design Principles

This section describes the whole-of-system view to deliver integrated health care for older people with complex health needs, the overall system context and the core system design principles on which the Framework is based.

Components of the Older Person’s Health Journey

This section provides an overview of the different components in the health journey of older people with complex health needs. This recognises that older people with complex health needs, their carer and family require different levels and types of care at different points of their health journey and that their care does not follow a linear progression. This is a starting point to align thinking and consider the resources needed at different points in time.

The different components of the journey for older people with complex health needs are:

- Initial contact/ access
- Management & planning
- Crisis/ acute care
- Specialised health care
- Recovery/ rehabilitation
- Supportive, palliative & end-of-life care.

Making Integration Happen

This section describes key enablers and actions required to realise a system–wide vision of integrated care for older people with complex health needs. It includes enablers such as: Engaging older people, their carers and families; Health and other service providers and policy, governance and relationships.

Moving towards Integrated Care

As the Framework illustrates, successful integration of care is a journey that begins with bringing providers together to align around a vision and goals for integrating care within their region. The Framework also acknowledges that there are many components that influence integration.

Achieving integrated care is not expected to be easily or quickly achieved. If used to its potential, this Framework provides the platform to stimulate open discussion at a local level and to promote collaborative actions towards integration among those who have a role to play. This section describes the key activities for the State (macro) and Regional (meso) level which include:

**State (Macro) Level:**

1. Developing a communication and dissemination plan
2. Undertaking an utilisation and economic analysis
3. Considering implementation support requirements
4. Supporting service mapping and gap analysis
5. Developing an evaluation framework and supporting KPIs

**Regional (Meso) level:**

1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care
2. Aligning stakeholders to a regional shared vision and purpose of integrated care
3. Undertaking a joint gap analysis/needs assessment and service planning
4. Developing shared processes, tools and guidelines to support regional implementation
5. Implementing the vision
Section 3. System Design Principles

This section describes the whole-of-system view to deliver integrated health care for older people with complex health needs, the overall system context and the core system design principles on which the Framework is based.

Systems design thinking considers how relationships and interactions of the individual components of a system contribute to success and failure of the whole system. This shifts the focus away from the individual components and instead places importance on their interactions and relationship within the larger system. This creates an effective basis from which to define roles, prioritise funding and work together to improve the overall system. This systems-thinking approach has been utilised internationally by healthcare systems that have successfully integrated care services.

The Framework provides steps required to reorient the current system to support truly person-centred care, by aligning the component parts of the system to the same care goals – with the goal of eliminating waste in current delivery models.

System Design Principles

The following principles define a shared vision for integrated care for older people with complex health needs, their carers and family at local service level.

1. Develop a shared vision for aged health services in our local community with agreed goals and measures of success.
2. Promote clear and transparent multi-sector governance and leadership in every setting to drive system change.
3. Implement models and services that achieve timely access to care and empower other services to deliver appropriate care as close to home as possible.
4. Involve older people, their carers and families at every step of their journey and value their experiences as much as clinical effectiveness.
5. Ensure technology supports integrated service delivery that shares information to effectively support multi-sector decision making.

The system design principles underpin the vision of the ‘future system’. Their purpose is to help local level services to jointly:

1. Target effort, reduce unnecessary duplication and improve outcomes
2. Identify a path of coordinated action amongst diverse stakeholders
3. Consider unique contextual factors, such as the needs of the population, strategic priorities and availability of resources
4. Improve consistency and sustainability through flexible standardisation.

Stakeholders at all health system levels in NSW should assess their services against the design principles. In this way, service providers can use the system design principles as a platform for defining a shared vision, to guide improvements through aligned decision making and priority setting.
Section 4. Components of the older person’s health journey

This section provides an overview of the different components in the health journey of older people with complex health needs. This recognises that older people with complex health needs, their carer and family require different levels and types of care at different points of their health journey and their care does not follow a linear progression. This is a starting point to align thinking and consider the resources needed at all points of the older person’s health journey.

Older people with complex health needs, their carer and family require different levels and types of care at different points in their journey which include episodes of increasing and decreasing clinical and bio-psychosocial stability. Their care does not follow a linear progression that can be methodically progressed or ‘fit in’ with health service structures based on singular diagnosis pathways. It is instead, undulating in nature and characterised by periods or components of crisis/acute care, periods of recovery and progressive physical and/or psychological frailty and an extended palliative or end of life period. This is described and compared with other trajectories of disease in Figure 5 below.

Figure 5: Three key trajectories at end of life

Currently care of the older person is provided across the health journey by three specific sectors (acute, primary and community) with separate funding and management structures. For this reason, care is often provided in parallel by different healthcare professionals and different services with little coordination or linkages between them.

The point of access to care is generally not able to be controlled by service providers and is instead defined by the consumer. Older people currently choose to access care in different ways and in different settings for specific reasons (e.g. cost, location, familiarity, perceived acuity) or often by default due to inability to access the care provider they initially wished to see.

For this reason, there is currently significant duplication across settings as little information is transferred between providers and each episode is not connected to previous or future episodes of care. Dependent on local supply and demand for these services, duplication of care is not necessarily negative. However, it often adds to fragmentation of services from the perspective of an older person, their carer and family and the silos between providers and added pressure to the healthcare system as a whole.
There is potential for these services to better utilise current resources by determining:

a) Which providers are best placed to provide specific aspects of care,

b) Where care should occur (e.g. community based clinics, at home)

c) How services can be better connected to enhance clinical decision making and inform future episodes of care

d) Potential ways to manage or direct referrals and enquiries.

In an integrated person-centred care approach to care, the setting in which care takes place should be principally determined by the care need of the older person at any point in time. It should not follow where care is accessed but instead what care is needed and how this meets the need of the older person.

As explored in the Diagnostic Report, this is a shift from current models which are based on or around the provider. For this reason, care needs of the older person with complex needs are often not adequately met as role delineation between providers and responsibility for continuity of care are not clearly defined.

The health journey for older people with complex health needs has six specific components of care (Figure 6). These components, together with care planning and care coordination, are necessary across the older person’s health journey.

**Figure 6: The Older Person with Complex Health needs expectations of care**
Best practice elements across all components

This model for delivery of care for an older person across care settings/sectors is ideally underpinned by best practice elements such as a co-developed care plan that is shared and updated continuously by all service providers with the older person, their carer and family as well as a clear care coordination and continuous communication/information sharing between stakeholders. These are defined as:

Care Plans:

Care plans are a best practice mechanism for consistent, connected and clear communication regarding an older person’s situation, current treatment regime and key health and functional goals. While each provider will have slightly different assessments, plans for their services and monitoring of the older person – these should all be able to be part of one comprehensive holistic care plan. Current ability to share such a plan between providers is limited. However, there are some key steps that can be taken in the short term to move towards a consistent approach. This includes –

- An agreed template for multidisciplinary input,
- A mechanism to update and transfer that information with the older person and their carer,
- Communication protocols by providers around the care plan.

The owner of the care plan should ultimately be the older person and their carer. However, it should also fall with the most appropriate service provider to keep this plan updated.

Care coordination:

Care coordination is a best practice comprehensive approach to deliver more effective health management for people who have multiple and often chronic morbidities and who require timely and consistent care and self-management support.

In the context of care for older people with complex health needs, care coordination encompasses multiple aspects of care delivery including multidisciplinary team meetings, the management of chronic disease, psychosocial assessment and the provision of required care, referral practices, data collection, the development of common protocols, information provision and shared care plan and individual clinical treatments.

These models recognise General Practitioners as the main medical care providers who provide strong support for patient self-management. In designating the role of care coordinator, several factors should be considered including the service provider who has the appropriate resources and capacity and the degree of complexity of the health conditions of the older person. Key actions of care coordination in this model include which applies to all parts of the whole journey

- Initiating links between the care team members and continuous communication and information sharing
- Continuously reviewing and updating the care plan and facilitating case conferencing Supporting robust transfer of care,
- Cross-sector delivery of integrated care across the components of the older person’s health journey
Initial contact / access

Initial contact / access describes the point, provider or care setting in which an older person with complex needs or their carer seeks health or social care support.

The core purpose of this component of older person’s health journey is to

a) Triage need through an initial bio-psychosocial assessment
b) Address the immediate need of the older person/stabilise presenting problem
c) Identify immediate next steps to connect this older person and their carer to a more comprehensive assessment and care planning program.
d) Initiate immediate links with any immediate initial support/service providers

There are several key considerations that must be addressed in this component of older person’s health journey in order to enable older person and their carer to better navigate the system:

- Determine if the older person has a regular GP and if not, ensure this is facilitated
- Focus on supporting and empowering the older person, carer and family to manage the issues they are facing and to seek appropriate follow-on care.
- All older people and their carers require consideration of their social context. Specifically:
  - Aboriginal and Torres Strait Islander people may require specific consideration of their cultural and community/social context in developing an appropriate care plan
  - Culturally and linguistically diverse populations and older people with hearing difficulties may require a different style of communication in order to understand what their health issues are
  - Older people from rural and remote areas may require different types of support in order to address their geographic complexity

Ingredients for optimising initial access

- Single hotline for referrals
- Service directories
- Standardised bio-psychosocial assessment
- Linking local providers
- Communication/education tools based on local area services
- Information sharing across providers and the older person and carer (e.g. PCEHR)
Management and planning

Management and planning describes the initiation, development and continuous review of care plans. Evidence suggests that those who have a structured management and treatment plan have greater success in self-management and appropriate and timely access to health care services.

The core purpose of this component of older person’s health journey is for providers to:

a) Undertake a comprehensive geriatric assessment including assessing for co-morbidities
b) Manage symptoms and side effects of disease and treatment including managing co-morbidities
c) Co-develop a care plan that addresses the needs of the older person and their carer (short, medium and long term) including prevention, management and escalation plans
d) Initiate links with the care team to be involved in their care plan including providing or coordinating appropriate initial support
e) Continuously review and update the care plan based on disease progression, changes to the plan or medication and the level of services accessed.

There are several key considerations that must be addressed in this component of care for older people to have access to coordinated care and a co-developed care plan in place:

- The older person and their carer should understand the plan for ongoing care and what role they play in participating in this process.
- The care team should be enabled around the older person and carer with joint conversations and case conferencing where possible.
- The older person’s goal-orientated care plan should be jointly owned and accessible by the older person, the carer, the GP, the care coordinator/nurse and the allied health and support services.
- Older people should be able to access a comprehensive assessment and care plan from any access point in the healthcare system.

Ingredients for optimising management and planning:

- Improved engagement between specialist aged health services and general practices.
- Standardised care planning tool that can be shared across providers
- Start with the needs of the older person and carer and include health and bio-psychosocial needs
- Team care arrangements and case conferencing
- Consider social supports outside of health services e.g. community organisations
Crisis/ acute care –

Crisis/acute care is predominantly unplanned in nature which denotes the need for an immediate response to the care demand.

The core purpose of this component of older person’s health journey is to provide access to:

a) Immediate 24/7 specialised triage or assessment of an older person and their carer situation

b) Provide appropriate
   i. Carer assistance
   ii. Assessment of risks
   iii. Treatment of the immediate issue
   iv. Management advice for the next 24hrs
   v. Referrals for further care

c) Facilitate transfer to acute care service

There are several key considerations that must be addressed in this component of care for older people to have timely access to care and for services to be responsive in an unplanned situation:

- Timely access to diagnostics and expert aged health advice to provide swift and accurate clinical decision making that allows immediate commencement of a treatment plan.
- Use of hospital alternatives that assess and resolve issues closer to home.
- Treatment actions and intensity should consider the wishes of the older person and their carer in relation to use of resources and comfort.
- Timely access to appropriate acute care interventions and specialist service consultations as identified (e.g. respiratory, geriatrics, cardiology, mental health, palliative care such as care of the confused hospitalised older persons (CHOPs), orthogeriatrics, pain protocols).
- Older people presenting with acute needs and no current care plan should be appropriately referred for a comprehensive assessment and care plan management.

Ingredients for optimising crisis/acute care

- Training and skill development that supports rapid and appropriate response/resources for this population
- ED bypass strategies utilised where appropriate (e.g. MAU, ACE/GRACE)
- Clinical handover i.e. care plans, care coordination, access to clinical information
- IT systems that allow access or sharing of information (e.g. PCEHR - essential in rural settings)
- Partnerships and coaching relationships between providers (e.g. aged health specialists and on the ground clinicians)
- Use of telehealth for rural access to specialists
- Future: build capacity in things we have now that work (AAP red book app for smart phones)
Specialised aged health care –

Specialised aged health care services describe the provision of services by Specialist Aged Health and Specialist Mental Health Services for Older People (SMHSOP). These services address issues that are unable to be addressed by organ-specific or disease-specific disciplines or other providers with the end goal being to maximise independence through optimising physical, psychological and cognitive function.

Older people with complex health needs transition to specialised aged health care services from other services that cannot meet these specific needs. Specialist Aged Health includes geriatricians, specialist aged health nurses and allied health professionals with expertise in aged health problems. SMHSOP includes old age psychiatrists, nurses and allied health professionals with expertise in mental health problems affecting older people. The specialised aged health care team support other services through direct care and capacity building to recognise and manage older people with increasingly complex care and support needs.

The core purpose is to provide aged health specialist:

a) Assessment
b) Diagnosis
c) Treatment
d) Self-management/primary care management advice
e) Care plan input/oversight
f) Capacity building within other services

There are several key considerations that must be addressed in this component of care for older people to have timely access to appropriate specialised aged health care and continuity of care in the community:

- Timely access to aged health specialist health assessment and advice to provide immediate commencement of a treatment plan and to review current care plan based on new needs identified (e.g. changes in physical/psychosocial/cognitive decline).
- Direct links and discussion with the manager of the current primary care plan. (e.g. General Practitioner or care coordinator) current care plan and follow-up service linkages.
- Bio-psychosocial aspects of care should be considered by all clinicians involved in care.
- Treatment actions and intensity should consider the wishes of the older person and their carer in relation to use of resources and comfort (End of life care/guardianship).
- Care delivery will include specialised carer support (e.g. counselling, respite, coping strategies, education).

Ingredients for optimising specialised aged health care

- Multidisciplinary input from clinicians with appropriate capabilities
- GP, specialised aged health, and other relevant service providers working together to optimise outcomes and continuity of care across settings and over time
- Transparency of acute service availability/access (e.g. crisis response or ED bypass models)
- Reduce barriers to access – e.g. community based clinics or response services
- GP and non-age specialist service access to specialised support/consultation as required - especially in rural/remote (e.g. Case conferencing or telehealth)
- Maximising the older persons ability to maintain capacity and independence based on ongoing awareness of their cognitive and psychological status
- Grouping of specialised services with primary health care services
Recovery/ rehabilitation -

Recovery/ rehabilitation looks to support the rehabilitation and recovery of the older person as close to home as possible. The core purpose of this component of older person’s health journey is to:

a) Identify deconditioning, avoidable frailty, ongoing psychological impairment and social exclusion of older people

b) Identify the functional goals of older people that will support their return to previous level of function (e.g. activities of daily living goals)

c) Bring together a multidisciplinary team to support the older person to achieve their rehabilitation goals and return to their previous level of function

d) Measure and evaluate progress towards individual goals

e) Educate and support older people and their carers to participate in this process, and prepare for their return home

There are several key considerations that must be addressed in this component of care to support the recovery and rehabilitation of the older person with complex health needs:

- The benefits of physical reconditioning and rehabilitation should be accessible for older people with complex needs who wish to recover, maintain or improve their functional ability. Failure to offer this support has significant ramifications for the older person, their carer and family and sets them up for readmission to hospital.

- Timely access to appropriate reconditioning is imperative to avoid further functional and psychological decline. Rehabilitation care is best provided where intensity and specificity can be achieved through access to appropriate equipment and clinicians as well as access to the older person’s context/natural environment. Where required access to Mental Health and/or psychological support and treatment should be provided.

- The enablement philosophy/method of care has proven to be effective from the point of admission and throughout care delivery. Enablement actively seeks to enhance older people’s function and ability to self-manage.

- Social participation and continued activities of daily living function are relevant goals for this population and can make significant difference to their future physical and psychological health.

Ingredients to optimise rehabilitation and recovery:

- Care coordination across a multidisciplinary team that extends to services at home.
- Shared care plan across disciplines
- Co-location of services/providers to encourage information sharing and teaming
- Shared information across providers (Electronic Medical Records, case conferencing, standardised assessment tools)
- Defined end point (goal reached or supported care)
- Recovery/ rehab stage occurs at the crisis/acute component
Supportive, palliative and end of life care -

Supportive, palliative and end of life care is focused on planning for end-of-life and it encompasses the transition of care from treatment and planning to palliative management.

It is important to acknowledge that the trajectory for ageing with declining psychological and physical function is prolonged and difficult to predict or manage. Therefore, early acknowledgment of progressive decline and end of life discussion allows for individual preferences to be addressed and managed.

The core purpose of this component of older person’s health journey is to:

a) Identify as early as possible (as part of comprehensive assessment or care plan review) if it is believed the older person will die in the near future
b) Establish what their needs are in relation to whole of person care
c) Manage the side-effects of both treatment and disease and modify care plans as necessary to reflect the changing prognosis
d) Confirm or establish an advance care directive
e) Empower the older person and their carer to choose their care preferences.
f) Ensure the end of life wishes are shared across health care providers

There are key points in the care journey where supportive, palliative and end of life care discussions should be had. These are:

- Initial contact
- Comprehensive assessment and care planning
- Acute episodes
- Entering a RACF
- Diagnosis of any terminal/progressive disease e.g. Dementia

Specialist palliative care services are available to provide palliative care in NSW, however all clinicians should have an understanding of appropriate supportive and palliative care.

Ingredients to optimise supportive, palliative and end of life care:

- Standardised forms or processes to communicate this information (eg. PCEHR )
- Accountability or ownership of this role including
  - Symptom and side-effect management
  - Spiritual, psychological and physical support
  - Information on ACD and other preferences
- Support to die in the way the older person wishes to die (e.g. at home, in a hospice)
- Policy to support appropriate pain and symptom management in all settings (e.g. RACFs, home, hospice, hospital) by all clinicians
Components of the Older Person’s Journey within an LHD

To achieve greater integration of services within LHDs, there will need to be a focus on ensuring current services for the older person with complex health needs, their carer and families, align to a transparent common vision. Services will need to be highly collaborative with clear coordination of the older person’s care. Some LHDs have already invested in a strategic approach to management of older people with complex health needs across their services and have demonstrated improved delivery of better care outcomes, improved service efficiency and improved experiences of the older person, carer and family (Figure 7). Each of these five strategic aged health service delivery components, their objectives, benefits and examples are described below.

**Figure 7: Strategic aged health service delivery cycle**

The diagnostic and solution design identified A snapshot review of LHD services suggested that an absence of one or more of these core strategic service types) was reported to result in:

- Inappropriate acute admissions
- Delayed assessment and treatment
- Exacerbation of disease, symptoms and rapid deterioration
- Increased infection risk
- Increased behavioural management issues
- Longer lengths of stay
- Exacerbated functional decline of older people
- Higher level of care or support on discharge required
- Readmissions due to discharges without support
- Increased morbidity in the community
- Inappropriate community management or support
- Increased pressure on carers and family
- Inappropriate RACF admissions
In community care/ admission avoidance

**Objective:** to provide assessment and care in the community as possible through
   a) the redistribution of resources or
   b) Delegation/enablement of community based care providers to address common reasons for ED attendance.

**Benefits:**
- Person-centred care delivery closer to home
- Improved patient experience and continuity of care in community
- Reduced cost of care episode
- Reduced use of diagnostics and assessment resources

**Examples:**
- Single point referral for care need triage (eg. aged health hotlines, ASET and AARC in ED)
- Acute care/crisis response teams or alternative providers (e.g. Ambulance ECPs, after-hours GPs, nurse practitioners) for assessment and treatment at residence
- Management plans jointly developed by General Practice and RACFs
- Community based resources (e.g. diagnostics, Hospital in the Home (HITH), residential support, community nursing, geriatrician support)
- Planned admission pathways via ED bypass models (eg. specialist assessment by Mental Health Services for Older People)
- Early intervention rehabilitation or restorative care programs in the community (similar to TACP models)

Early assessment and fast track treatment

**Objective:** This involves the ‘front-loading’ of specialist geriatric resources in ED or MAUs to ensure right care is initiated from the very beginning of the care journey through a specialised aged health team. The core purpose is to:
   a) avoid further deterioration of older person with complex health needs on presentation to ED and
   b) support immediate initiation of a geriatric specialist led clinical care plan.

**Benefits:**
- Immediately directs care to the right place/provider in a timely manner resulting in:
  - Reduced deterioration of older people waiting for appropriate care
  - Reduced LoS (due to improved efficiency in care, reduced deterioration and need for rehabilitation)
  - Improved experience for older person and their carer with potentially reduced behavioural issues
- Resourcing reflects person-centred care need
- Targeted use of diagnostics and assessment resources

**Examples:**
- ED bypass or fast-track models for older people with complex health needs (e.g. ED bypass plans could be added to care plans as a planned response to escalating need)
- Specialist support on assessment and decision making at the very beginning of the patient journey (e.g. ASET, ED teams, aged specific MAUs)
- Appropriate environment for assessment and management (e.g. Dedicated ED areas, aged specific MAUs, dementia or delirium support)
- Fast track diagnostics that consider needs of managing and older person with complex needs (e.g. mobile diagnostics, access and proximity)

Appropriate and specialised acute/sub-acute care management

**Objective:** to specifically and proactively address the unique care needs of older people with
complex health needs to:

a) reduce complications or environments that trigger physical and/or psychological functional decline and
b) return the older person to optimal function as soon as possible.

Benefits:
- Directs care to the right place/provider in a timely
- Reduces the need for behaviour management responses and restraints
- Reduces avoidable deterioration and medical complications due to specialised knowledge and protocols in place.
- Returns older people to optimal function more efficiently and effectively
- Educates and builds the capacity and capability of other staff in the hospital to appropriately manage older people with complex health needs and behaviours.

Examples:
- Aged health specific wards/beds/teams that work to provide:
  - an aged appropriate environment
  - enablement philosophy of care (proactive management and mobilisation)
  - specialised team care
  - Cognitive impairment/functional impairment friendly
- Shared specialist care/in-reach models for older people with multiple specialist needs (e.g. orthogeriatric care models, geriatrician/other specialty parallel management)
- Specialist Mental Health Services for Older People units and community teams
- Dementia/delirium CNC or Champions on wards

Optimal discharge processes

Objective: Optimal discharge processes begin on admission in order to provide timely progression of:

a) Communication to the older person, carers and family about discharge destination and what to expect
b) Access to sub-acute care, services, assessments, care packages or home modifications
c) Contact and continuity of care with primary health care provider/care coordinator
d) Guardianship or other administrative issues

Benefits:
- Early access to rehabilitation during admission
- Reduced LoS due to delays in access to services or resolution of administrative issues
- Optimised support for return home or entry into residential care
- Reduced anxiety of carers and family in relation to return home
- Early understanding of service availability
- Improved ability for an older person to return home with support if they wish and reduced unnecessary RACF admissions

Examples:
- Functional goal setting based on discharge destination and ADL goals
- Pro-active planning for:
- Capacity and capability assessments
- Rehabilitation or restorative care
- Modifications to home environments
- Transition to RACFs
- Respite care options for carers
- Guardianship or other administrative issues

- Initiation of early discussion with the older person’s nominated primary health care provider or care coordinator and identification or establishment of a care plan for the older person to extend into community

- Development of an action plan for deterioration post discharge. This may include a number for business hours services, after-hours support or ED bypass pathways.

In community continuity of care

**Objective:** Continuity of care that reaches into the community and links with primary care providers and community-based support services is imperative to the ability of older people with complex health needs to re-establish themselves at home after an acute care episode. Three core aspects are:

a) Updates to care plan and medication are discussed with the older person and carer and communicated to the nominated general practice/ care coordinator
b) Bio-psychosocial needs are identified and supported
c) Follow-up appointments and deterioration action plans are in place

**Benefits:**

- Reduced unplanned and avoidable readmissions
- Reduced unsupported morbidity in the community
- Improved capacity and capability of the older person and their carer to cope at home, therefore reducing the need for higher level care
- Improved communication between care providers
- Improved experience of the older person with complex health needs and their carer

**Examples:**

- Access to sub-acute (i.e. palliative, rehabilitation or psychogeriatric) support as appropriate
- Access to restorative, personal care or aged care packages as appropriate (eg. TACP, COMPACKS, HACC)
- Co-designed management plans with general practice/primary health care teams
- In-community management action plans for any escalation/decline in condition (e.g. drop in clinics, mental health support, after-hours GP care, acute response teams and extended care paramedics in the area)
- Links with aged care and community service providers as part of the extended care team
- Capacity and capability building of carers, including education, ongoing communication and respite care.
- ED Bypass models for admissions agreed by admitting specialist (or GP)

*Further details on the specific models that contribute to this approach are in Appendix D*
Engage older people, their carers and families

Engaging older people, their carers and families is a crucial aspect of delivering ‘person-centred care’. Older people have a right to choose their care, participate and make decisions about their care. Their care experience should be valued as much as the clinical effectiveness achieved by care delivery. An integrated model of care needs to include the older person, their carer and family as key members of the care team and to empower the older person to be engaged and actively participate in their care.

Engaging older people (and their carer) in their care begins with better communication of information by service providers about accessing care and what options are available. Care providers better communicating the information that older people, their carers and families need to make informed decisions about their care in a timely and effective manner through training on interpersonal/communication skills and education on person-centred care. Older people and their carers also need to be supported in improving their ability to understand information about their care (health literacy) and service options to actively participate in decision making about their care.

The voice of older person and their carer in making decisions about their care and the consideration of their values is as important as the outcomes of care delivery. The integrated care model needs to support older people in accessing services and information both for and beyond their immediate care.

Assessments of the older person with complex health needs should consider the holistic needs of the person e.g. a bio-psychosocial assessment, which involves the input of carer and family. A shared care plan providing agreed key interventions and goals so that all care providers understand their roles and responsibilities. Having a care coordinator for older people with complex health needs should be encouraged. This role can be played by any stakeholder involved in care delivery depending on who has the suitable skill set and supporting resources. Shared care plans in cancer care are examples of how this can work effectively, and also support rural and regional residents to access specialist care oversight without needing to travel.

This includes action plans for sudden deterioration or information on what is a currently in its initial stages but ultimately a progressive disease.

- **Empower the older person, carer and family to be a key member of the care team** and ensure they are included in all decision making processes.
- **Support and educate the older person, carer and family** to ensure they are well informed to make decisions (e.g. increase understanding in accessing care, understanding who the key contacts, supporting their improvement in health literacy, having an emergency action plan).
- **Train and educate** service providers and other staff in interacting with this population that takes into account their specific needs (e.g. they may have hearing difficulties, not be able to access information online as easily, more time may be required).
- **Consider and address** specific needs of older people (e.g. they may have hearing difficulties, not be able to access information online as easily) as well as their non-immediate health needs in the way that communication and information is shared.
- **Ensure accessible and transparent information** on care services is available at the local level, and that it follows the care journey – not the service structure.
- **Co-develop and co-own** care plans by all service providers involved in providing care as well as the older person, their carer and family.
Support providers to deliver care

To help transition from the current state of siloed delivery of care to a future model of integrated care, it will be important to support and enable providers through infrastructure, tools, communication and information sharing, education and training, shared processes and guidelines. Potentially, the most significant shift is deterring current behaviours and attitudes and enabling collaboration.

1. Timely and effective sharing of information between care providers

Timely communication between care providers is crucial to improving quality of care delivery and in building a working relationship. Technology solutions such as telehealth and electronic medical records can enable exchange of information but cannot be solely relied on as the only means of communication between care providers. A move towards using electronic referrals, discharge summaries and medical records needs to be consistent between service providers. The integrated care model should look to support timely communication across care settings underpinned by best practice, communication guidelines and standards as to when and what information should be shared. Similarly, timely and effective case-conferencing methods need to be considered.

2. Shared processes, guidelines and tools help to streamline working in an integrated model

One of the common enablers of integrated care is timely, effective transfer of information across settings facilitated by having shared guidelines and standards around minimum requirements of data in place. Other tools and processes that enable better collaborative working include having: consistent templates for sharing information (e.g. referrals, discharge); co-creating a shared care plan which outlines the roles and responsibilities of each of the stakeholders involved and having standards for ways of working in an integrated (endorsed by the professional peak bodies) and having one shared directory of care providers.

3. Interprofessional training and education is key in providing person-centred care

Higher education is currently delivered in professional silos with little multidisciplinary interaction. In order to shift this behaviour to an integrated model, interprofessional education and interdisciplinary work placements are necessary. This can be included in the curriculum of higher education and continuing professional development. In addition, interprofessional education and interdisciplinary work placements are a good opportunity to build greater understanding of other professionals’ roles and capabilities. There should be a clear career progression pathway for those with an interest in aged health care designed to strengthen and build this workforce. For example, all staff should be educated on management of dementia or delirium.

4. Shifting behaviours and attitudes from the current state

Mechanisms to support integrated care such as shared information systems, processes and guidelines should be complemented by efforts to shift current behaviours and attitudes at all levels. Leadership must exhibit model behaviours aligned to the vision they want to achieve in order for care providers at the ground level to follow suit. Stakeholders at every level need to be engaged in the new vision and understand the necessity for change otherwise they will not be on board with future initiatives. Current ways of working in professional silos have led to ingrained interprofessional bias which needs to be addressed in order to effectively work in an integrated model. Co-location of teams or services is an effective way to propagate collaborative behaviours as are team case conferences and interdisciplinary training.

Making it happen:

- Develop communication guidelines and standards on the minimum requirements for information sharing and communication so it is as effective and timely as possible for all.
- Ensure consistent use of technology solutions such as telehealth and electronic medical records through training and education for all stakeholders.
- Develop tools for sharing information about referrals, discharge and care planning.
- Implement cross-sector training and opportunities to work collaboratively within an integrated model; educate on professional roles and responsibilities and communicating with older people with complex health needs, their carers and families.
- Develop clear career progression pathways for those who are interested in aged health care.
- Model the behaviour reflecting the vision for integrated care by leadership in every sector so as to set an example for care providers at the ground level.
Alignment of resources, policy and performance incentives

Resources, policy, funding and performance incentives are a major consideration and can be a significant enabler or barrier to achieving integrated care. Historically, continuity of services has been negatively impacted by the complexity and fragmentation of Australian healthcare funding models, differing performance targets and differing policy positions. Seemingly simple tasks such as shared recruitment of staff by MLs and LHDs are proving difficult due to differing industrial awards across providers for similarly skilled staff. There is currently no consensus view on what funding and incentive models work best for integrated care but it is widely acknowledged that one size does not fit all. Part of working within the current funding constraints is to consider examples of innovative practice in NSW where LHDs have worked together with MLs and other services to provide integrated care to older people with complex health needs in a sustainable way and how this can be applied locally. Examples of different funding models are available in Appendix B.

While funding can assist in enabling integrated care, it is not able to solely change behaviours. It is however, important that incentives are aligned to the change in behaviour that is required. Efforts to shift behaviour also need to extend beyond policy and funding mechanisms and consider other incentives such as a shared vision, a strong case for change and an engaged stakeholder group.

Making it happen:

✓ Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care and review
  ✓ current policies across organisations that potentially conflict (e.g. recruitment and industrial entitlements) and may require consideration in implementation
  ✓ current performance or reporting requirements that potentially disincentivise the desired collaborative or proactive behaviours and identify solutions.
  ✓ current funding and how it may be more efficiently resourced in line with the system design principles (e.g. pooled funding, joint recruitment, delegation of service to a new setting) and service mapping/gap analysis activities.
  ✓ new funding coming into the region for specific aged health and social care initiatives and where that funding is best directed in line with the joint vision and system design principles.

✓ Jointly review potential tenders and grants coming from NSW Health and Federal departments to understand what a joint response might be, who will lead and what support can be provided across agencies.

✓ Ensure that decision makers are accountable and that there is a direct transparent approval process (e.g. as part of the Terms of Reference, define the delegation/escalation of decisions across all parties).
Section 6. Moving towards Integrated Care

Next Steps: State (Macro) Level

The following activities are required at the state (macro) level to enable stakeholders at the regional (meso) and local (micro) levels to work together around a consistent framework for the provision of integrated care for older people with complex health needs, their carers and families. These include:

1. Developing a communication and dissemination plan

It is important that all health care providers in NSW have an agreed conceptual framework for the delivery of integrated care for older people with complex health needs, their carers and families. To support this objective, a communication plan will need to be developed to provide awareness of the framework across all stakeholders and clarity on the required steps to be undertaken.

2. Undertaking an utilisation and economic analysis

Changes to existing practice will require investments of time and effort and reinvestment and or reallocation of funds. The ACI, in conjunction with the required stakeholders will develop a “business as usual” analysis identifying the resource utilised and the costs of continuing current practice. Due to a lack of robust non-acute data this will focus on the utilisation of acute resources. This will help guide where changes are required at a state-level and inform service providers of the benefits of change and the potential for the development of shared investment and reallocation of resources strategies. Supplementing this will be population profiles and analysis as well as state level analysis of utilisation of MBS funded services.

3. Considering implementation support requirements

To support shared working and implementation, consistent tools and resources will need to be developed to support service providers in a model of integrated care. These could include:

- Governance terms of reference
- Stakeholder engagement/ management strategies
- Change management tools
- Enablers and framework components (e.g. best practice care plan, terms of reference, role definitions, clinical governance, communications standards)
- KPIs relevant to performance improvement / performance management
- Defined workforce standards and required skill mix to support the Framework

4. Supporting service mapping and gap analysis

At a state-wide level, a service mapping exercise is required to better understand the current service delivery landscape, where there are duplications and gaps and best practice examples of integrated care. The findings of these activities can be disseminated widely to allow local service providers to undertake a joint needs assessment and service planning in a more comprehensive and cohesive manner.

Optimising current and future funding arrangements by examining what resources are needed to deliver the most appropriate services will assist in facilitating behaviour change in service providers.

5. Developing an evaluation framework and supporting KPIs

As with any project, an exploratory exercise to determine the best way to evaluate and measure progress will be required to ensure objectives are being met and there is continuous improvement. This will need to include KPI’s that could be built into performance frameworks at all levels to drive behaviour change. The KPI’s will need to include person-centred outcome indicators such as older person experience in addition to traditional impact and process indicators.

In addition, it is good practice to have fair and transparent ways of incentivising integrated care for all participants involved.
Next Steps: Regional (Meso) level

Achieving integrated care is not expected to be easily or quickly achieved. If used to its potential, this Framework provides the platform to stimulate open discussion at a regional level and to promote collaborative action towards integration among those who have a role to play. Section 7 provides greater detail on what is required at a regional level to implement the framework in LHDs, MLs, Ambulance Service of NSW, Aboriginal health services, and Aged Care and community providers.

1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care

Dedicated multi-sector aged health governance is necessary to provide leadership to all stakeholders involved and drive the agenda of integrated care. This group should include representation from all stakeholder groups; have clear terms of reference to define the roles and responsibilities of different participants; and set the standards by which they will deliver care. This group would facilitate regional leadership, drive the agenda of integrated care and model the behaviours necessary for integrated care using the Framework as a reference to guide decision making.

2. Aligning stakeholders to a regional shared vision and purpose of integrated care

The first task of a dedicated multi-sector aged health governance group will be to agree on a shared vision and purpose for integrated care. The vision describes the ideal state of care for an older person with complex health needs, their carer and families and how the services work together to achieve this. In order to create a better, more efficient and cost effective system, care delivery needs to be aligned to a shared vision with practical implications considered. This vision provides the opportunity to pivot services to be person-centred rather than provider-centred and to bridge the gaps in communication that cause care delivery duplications and other inefficiencies to occur.

3. Undertaking a joint gap analysis/needs assessment and service planning

With NSW Health Executive level endorsement, stakeholders have the opportunity to work with a common framework to examine their current services and approaches and undertake a collaborative ‘gap analysis’. LHDs, MLs, local governments, regional human services agencies and NGOs are already encouraged to undertake a needs assessment and evaluation of aged health care services as part of their operational remit/responsibility. The undertaking of a collaborative gap analysis will provide a starting point to achieve consistent practice and implement good practice where gaps exist.

A key initial consideration for each LHD and ML will be how they can potentially partner with each other and other organisations to undertake a regional and collaborative joint needs assessment and identify key actions to address needs across services and sectors. For example, some LHDs and MLs have jointly recruited population health planning officers who are jointly funded and work across both organisations. It was reported that access to data by both parties has proven to be mutually beneficial. Together, they can plan to meet the needs of the local population in the most efficient and effective way.

4. Developing shared processes, tools and guidelines to support regional implementation

Shared processes, guidelines and tools for working together will enable and support service providers in a model of integrated care. Timely and consistent communication between service providers is important to inform decision making including:

- co-developed minimum requirements for information outlined in shared communication guideline
- shared care plan, shared IT systems or consistent use of existing technology,
- a regionally relevant terms of reference
- a single directory for care providers.

5. Implementing the vision

Working relationships need to be built, nurtured and maintained at every level e.g. at governance and at service delivery level. Additionally, all relevant stakeholders who provide care should be engaged so that they can work together effectively. For this reason, participants are encouraged to establish or actively participate in their regional aged health care networks to develop and facilitate working relationships, identify key issues and prioritise areas of need across services. For example, ED staff developing relationships with RACF staff has led to significant benefits to older people in their care, the staff and system.
**Figure 8: Local implementation planning**

<table>
<thead>
<tr>
<th>Initiation and engagement (Short term)</th>
<th>Progress and execution (Medium term)</th>
<th>Evaluation and refinement (Longer term)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared vision and governance</strong></td>
<td><strong>Apply</strong></td>
<td><strong>Evaluate</strong></td>
</tr>
<tr>
<td>• Establish dedicated multi-sector aged health governance.</td>
<td>• Develop policy positions and solutions to align to the shared vision of integrated care.</td>
<td>• Ongoing evaluation and monitoring of integrated processes leading to continuous performance improvement.</td>
</tr>
<tr>
<td>• Jointly develop a shared vision for integrated aged health and aged care with local stakeholders.</td>
<td></td>
<td>• Continual refinement and adaption of models and services to meet changing population health needs.</td>
</tr>
<tr>
<td><strong>Joint assessment and planning</strong></td>
<td><strong>Appropriately incentivised service providers</strong></td>
<td></td>
</tr>
<tr>
<td>• Undertake a service mapping and gap analysis exercise to understand current service delivery.</td>
<td>• Optmise current and future funding arrangements by examining what resources are needed to deliver the most appropriate services as close to home as possible.</td>
<td></td>
</tr>
<tr>
<td>• Evaluate current services to understand where there is good practice and widely disseminate findings.</td>
<td>• Develop key performance indicators that reflect and align to the shared vision to build into performance frameworks.</td>
<td></td>
</tr>
<tr>
<td>• Assess local needs and plan services through the multi-sector aged health governance to meet these needs.</td>
<td>• Identify measures that can be incentivised for service providers</td>
<td></td>
</tr>
<tr>
<td>• Design how the regional aged health care system will look in an integrated model of care.</td>
<td><strong>Shifting existing behaviours</strong></td>
<td></td>
</tr>
<tr>
<td>• Define the roles, responsibilities and needs of different providers for the system to operate effectively.</td>
<td>• Develop and deliver interdisciplinary training to up-skill providers on working collaboratively and understanding others’ roles and expertise.</td>
<td></td>
</tr>
<tr>
<td>• Agree on an implementation plan for achieving integrated aged health care.</td>
<td><strong>Empowering older people</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Shared processes, guidelines and tools</strong></td>
<td></td>
<td><strong>Ideal state</strong></td>
</tr>
<tr>
<td>• Co-develop and agree on cross-sector guidelines for transfer of information that encourages all stakeholders delivering services to develop cross sector working relationships.</td>
<td>• Empower the older person, their carer and family by:</td>
<td>• National and state-wide policy reflects and supports the importance of integrated care.</td>
</tr>
<tr>
<td>• Identify enablers, tools and resources needed to achieve integrated care across different settings.</td>
<td>- Involving them in all decision making (e.g. care planning) activities</td>
<td>• Care is designed around the holistic needs of the older person:</td>
</tr>
<tr>
<td></td>
<td>- Educating them in the different services available</td>
<td>- Provided as close to home as possible</td>
</tr>
<tr>
<td></td>
<td>- Encouraging the use of individualised shared care plans across providers.</td>
<td>- The experience of the older person, their carer and family is considered as much as clinical effectiveness</td>
</tr>
<tr>
<td></td>
<td>- Providing relevant information on services</td>
<td>- Timely access to the right care in the right place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A skilled and growing workforce of service providers with expertise in providing aged health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Engaged older people, carers and families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Full adoption of eHealth solutions and compatibility of information sharing systems</td>
</tr>
</tbody>
</table>
Section 7. Local level implementation

This section outlines the key considerations for the following stakeholder groups for implementing the Framework:

- LHDs
- MLs
- Ambulance Service of NSW
- Aboriginal health services
- Aged care and community service providers.

Implementation by Local Health Districts

The infrastructure and expertise of LHDs and specialist staff in the delivery of health services to older people with complex needs, their carers and families is critical to the success of integrating care.

With the introduction of person-centred and integrated care approaches, LHDs will need to rethink their historical service structures and reorient their infrastructure, workforce and support services towards delivering or supporting the delivery of care closer to home and in local communities.

1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care

Within the LHD

A key first step will be to establish an interdisciplinary aged health network to facilitate systemic leadership and to drive the agenda of older people with complex health needs and integrated care within the LHD. This group should be multidisciplinary and include representation from all individual stakeholder groups and have the authority to make decisions.

This group should initially:

- Develop a clear terms of reference to define the roles and responsibilities of different participants and sets the standards by which they will deliver care.
- Develop a vision for Aged Health care within the LHD
- Develop meeting schedules, governance arrangements, and locally relevant terms of reference which align to the vision and the system design principles.
- Facilitate systemic leadership at all levels including modelling the behaviours required to support integration.

With other stakeholders

Dedicated multi-sector aged health governance is necessary to provide leadership to all stakeholders involved to drive the agenda of integrated care. This group should include representation from all individual stakeholder groups to facilitate local leadership, drive the agenda of integrated care and model the behaviours necessary for integrated care using the Framework as a reference. The representatives in this group should have the authority to make decisions.

This group should initially:

- Develop a clear terms of reference to define the roles and responsibilities of different participants and sets the standards by which they will deliver care.
- Develop a shared vision for integrated Aged Health care.
- Develop meeting schedules, governance arrangements, and locally relevant terms of reference which align to the shared vision and the system design principles.
- Identify the enablers, tools and resources needed to achieving integrated care across different settings.
- Facilitate systemic leadership at all levels (across sectors) to support integration.
2. Aligning stakeholders to a regional shared vision and purpose of integrated care

In order to create a better, more efficient and cost effective system, care delivery needs to be integrated towards the shared vision with practical implications considered. This vision provides the opportunity to structure services to be person-centred rather than service/provider-centred and to bridge the gaps in communication that cause duplications in care delivery and other inefficiencies to occur.

The vision describes the ideal state of care for an older person with complex health needs, their carer and families and how the services work together to achieve this.

In the LHD context this would require a shared vision for the aged health and aged care service as well as a jointly developed shared multi-sector vision for integrated aged health and aged care with all local stakeholders. This would be one of the first tasks to be completed by the dedicated multi-sector aged health governance group.

3. Undertaking a joint gap analysis/needs assessment and service planning

Person-centred service design starts with the older person, their carer and family and what their care needs are. It however, also identifies system inefficiencies that are currently accepted as ‘normal practice’.

Within the LHD

These proactive attempts to reorganise services to strategically meet the needs of older people, their carers and family has at the same time reduced waste and identified efficiencies in their service. They have also identified efficiencies in their broader service delivery context and have invested in enabling care providers in the community to better support older people with complex health needs and their carers closer to home. As an outcome, there have been some significant benefits realised for both care and service wide performance metrics which suggests there is merit in this approach. As some of these services may be impacted by national level funding changes, it will be important to look at different ways to maintain these services and their current integration into service provision.

LHDs should consider the following interventions or service type options when assessing gaps in current service delivery, service planning and when designing future models of care:

- Undertake or compile the service mapping and gap analysis information from all stakeholders to understand the existing service delivery landscape and where there are duplications and gaps.
- Undertake an evaluation of current services to understand where there is good practice and widely disseminate the findings of the evaluations.
- Review current funding and how it may be more efficiently resourced in line with the system design principles (e.g. pooled funding, joint recruitment, delegation of service to a new setting) and service mapping/gap analysis activities.

With other stakeholders

This document provides the opportunity to work with a common framework to examine current services and approaches, and undertake a ‘gap analysis’. The undertaking of a gap analysis will provide services with a starting point to achieve consistent practice and implement integrated good practice models where gaps exist.

LHDs are required to undertake strategic planning for their region - to guide their strategic directions and inform their resource allocation. Other organisations similarly undertake a similar review of local population health needs and service distributions (e.g. ML needs assessment based on population health assessments and gap analysis). Therefore, in future there is significant opportunity to minimise cost and effort in undertaking these reviews by doing them with joint resources. Together, they can plan to meet the needs of the local population in the most efficient and effective way.

- Initial contact/access
- Management & Planning
- Crisis/acute care
- Specialised aged health care
• Recovery/ rehabilitation
• Supportive, palliative & end-of-life care.

A key initial consideration for each LHD and ML will be how they can potentially partner with each other and other organisations to undertake a local joint needs assessment and identify key actions to address needs across services and sectors. For example, some LHDs and MLs have jointly recruited population health planning officers who are jointly funded and work across both organisations. It was reported that access to data by both parties has proven to be mutually beneficial. Immediate opportunities include:

• Undertake or compile the service mapping and gap analysis information from all stakeholders to understand the existing service delivery landscape and where there are duplications and gaps.
• Undertake an evaluation of current services to understand where there is good practice and widely disseminate the findings of the evaluations.
• Review current funding and how it may be more efficiently resourced in line with the system design principles (e.g. pooled funding, joint recruitment, delegation of service to a new setting) and service mapping/gap analysis activities.
• Review new funding coming into the region for specific aged health and social care initiatives and where that funding is best directed in line with the joint vision and system design principles.
• Jointly review potential tenders and grants coming from NSW Health and federal departments to understand what a joint response might be, who will lead and what support can be provided across agencies.
• Partner to address specific areas of need identified through joint initiatives.

4. Developing shared processes, tools and guidelines to support regional implementation

Working across services, sectors and providers requires clear standardisation and clarification of processes and protocols, minimum information sharing requirements and terminology. With the ultimate aim of developing shared processes, guidelines and tools for working together.

Effective (timely and consistent) communication between service providers is important and processes, standards and feedback loops will be imperative to enabling integration across providers. As providers come from different training and perspectives, it may be necessary to flag potential areas of conflicting frames of reference by identifying a common language and develop a shared set of processes for working together. The minimum requirements for information need to be outlined in shared communication guideline/standards which will be important to co-develop and have in place. Health pathways is an example of providers coming together to find common ground and exploring solutions to address local health needs collaboratively.

Other shared tools to consider include a shared care plan, shared IT systems or consistent use of existing technology, a locally relevant terms of reference and a single directory for care providers. Existing tools and templates that enable integration have been developed that can be adapted for local use. Some examples of these include care plans, multidisciplinary assessment forms, eHealth forms, yellow envelopes (RACF) and Advance Care Directives.

The benefits of having standardised processes and tools across sectors and providers are:
• Being able to establish a minimum level of care, information transfer requirements and the existence of Advance Care Directives.
• Reducing administration and management reporting and assisting with the high volume of older person transfers between residential care, ED, acute care and subacute care.
• Identify opportunities for systemic tools and processes including access to Advance Care Directives, dementia assessments, ACAT assessment results and carer status.

5. Implementing the vision

Working relationships need to be built, nurtured and maintained at every level, at the governance and at service delivery level. Additionally, all relevant stakeholders who provide care should be engaged (e.g. RACFs, NGOs, Ambulance Service of NSW, Aboriginal health services) so that they can work together effectively. For this reason, participants are encouraged to establish or actively participate in
their local aged care networks to develop and facilitate working relationships, identify key issues and prioritise areas of need across services. For example, ED staff developing relationships with RACF staff has led to significant benefits to the system, the staff and older people in their care.

An exploratory exercise to determine the best way to evaluate and measure integrated care followed by regular measuring and monitoring will ensure objectives are being met and there is continuous improvement. This should include person-centred outcome indicators such as older person experience in addition to traditional impact, process, system and utilisation indicators.

There are four key elements of consider for implementation of the vision:

i. **Training and education**

Multidisciplinary cross-sector training and education is important in up-skilling the workforce in working effectively together, to create opportunities to develop relationships and understand service providers’ roles from other sectors.

Training and education would help to develop skills to work collaboratively and grow understanding of other service providers’ roles. Coordinating local multidisciplinary secondment opportunities would help put such learning into practice.

Resourcing and capacity are often considered to be a limitation for both metropolitan and rural and remote sites in providing education and training. Understanding the current and future workforce and identifying individuals interested in working in aged health care, creating a clear career progress plan and speciality training allows for improved provision of services, mentoring and successful future workforce planning.

ii. **Resourcing**

One of the key ingredients to service design is resourcing. There is an opportunity to align with the strategic vision of an integrated person-centred model of care through, alternative resourcing or better utilisation of wider healthcare services such as primary care and community services.

Thinking differently about resourcing has allowed services to redistribute resources to where they can make most impact and eliminate future costs. For example, the implementation of residential aged care liaisons and specialised aged care staff in ED has led to more appropriate care being arranged in the older person’s place of residence and has avoided any unnecessary admissions.

The benefit of front-loading specialised resources to the component of the older person’s care journey has benefits to both care outcomes and service performance metrics. Likewise, there are alternatives to current staffing structures that would better utilise non-medical and generalist staff.

iii. **Infrastructure**

Currently, service providers are geographically distributed by funding stream. For example, private providers are located near commercial centres and LHD aged health services are currently positioned on the periphery of the hospital campus – that is they are neither facility nor community based. Similarly, the type of service provided is often funded by Medical Benefits Schedule (MBS) and LHD.

Co-location of services can facilitate integration by allowing regular face-to-face community and shared care activities to occur. Both of these help to build effective working relationships between stakeholders and decrease division between service providers.

Ease of access is an important benefit of co-location for this group of older people. The solution design stage of this project identified community based “one stop shops” with a full range of aged health specialist services (allied health and nursing), salaried GP oversight and specialist input. It was proposed that services such as these could be targeted at areas where service delivery could be improved and where specific groups could benefit such as the older people with complex health needs.

Recognising that co-location is not always appropriate or possible, the virtual integration of information sharing systems and records will be encouraged as minimum requirement to facilitate integrated care.

Another consideration for the Older Person with complex health needs, especially in planned renovations or rebuilds are design features such as natural light, courtyards and simulated home environments. These are reported to improve the experience and behaviour of older people at risk of becoming distressed or exhibiting difficult behaviours. Providing an environment that supports these individuals and their carers in acute care (including ED bypass) is proven to reduce resource intensity and provides a better person-centred care service.
Simple design features such as well-located diagnostic services impact both the well-being of the older person and staffing resources required to support the transfer of these patients to and from these services. Similarly, secure units for older people with behavioural and psychological symptoms of dementia (BPSD) reduce the prevalence of physical and pharmacological restraints being used and the need for increased staffing. Such considerations in design have significant impact on enabling care providers to do their job.

iv. Technology/information flow

A major barrier to timely decision-making and communications between professions and care settings is incomplete patient information. For example, patient files were often part electronic and part hard-copy, making them harder to connect.

Whilst it is acknowledged that the limitations of Information and communications technology (ICT) structures are a significant barrier to this, there are potential steps that can be taken to improve short, medium and long term progress towards shared information systems.

Key steps in working towards a shared electronic medical record are:

- Encouraging system, software and behaviour uptake
- Defining minimum data and information required by different parties to be effective in their role
- Enabling two-way electronic communication between all care providers.

In particular community based care teams need to be enabled to work more efficiently. Current systems require duplicative data entry and limited access to information. Mobile devices that link and upload patient data entered into LHD systems should be accessible and able to be edited immediately. Inability to do so limits the number of older people that can be supported per community-based resource and therefore, has significant cost and efficiency implications. Secure messaging ability for community care, RACFs and LHD would greatly enhance communication regarding common patients (e.g. ARGUS).

The ability and use of telehealth is progressing. Examples of how telehealth is being used to connect care providers with consumers are:

1. Specialist consultation
2. Health monitoring
3. Residential Aged Care GP support
4. Emergency assessment/support.

**Telehealth**

**What is it:** Telehealth is the delivery of health-related services via information and communication technologies such as video conferencing.

**How it works:** A metropolitan hospital will establish an arrangement with a regional or rural facility to provide health services via information and communication technologies. The two facilities will determine a funding arrangement for providing the services. For example, a geriatrician from a metropolitan hospital provides dementia telehealth services to a regional ML which has a Registered Nurse (RN) to help facilitate the assessment. The state funds the telehealth equipment, the ML funds the RN, and the Metropolitan facility receives MBS funding from the federal government for each patient that is assessed.

**Resourcing:** These models are delivered across community, primary and acute care and are facilitated by a mix of clinical and non-clinical staff including RNs, geriatricians, Clinical Nurse Consultants and administrative coordinators.

**Success factors:**

- Strong governance arrangements between telehealth facilities
- Procedures and guidelines to support the telehealth service model
- IT frameworks that support telehealth

**Examples in use:**

Consultative Geriatric Service (Concord-WNSWLHD), Telehealth Dementia Clinic (Hornsby-Armidale), Telehealth service (Wagga Wagga), Residential Aged Care Support (Nepean)
Opportunities for Medicare Locals

The objectives of MLs are to:

- Improve the care journey through developing integrated and coordinated services
- Provide support to clinicians and service providers to improve care
- Identify the health needs of the local area and develop locally focused and responsive services
- Facilitate the implementation of primary health care initiatives and programs
- Be efficient and accountable with strong governance and effective management.

In practice, this means MLs are well positioned to look broadly across the components of care needs experienced by an older person, their carer and family to; understand how current services in local areas meets care demand; identify opportunities to better integrate and coordinate services between primary health care providers, LHDs and other care providers; and, to develop locally tailored primary health care services that fit local catchment needs and priorities in aged health.

MLs are already implementing key activities and programs that support the key elements of this Framework. For example, these include:

- Comprehensive Needs Assessment
- After Hours Program
- eHealth implementation
- Health Pathways

‘Health pathways is really just about having open dialogue about processes and overcoming the barriers you identify jointly. One solution we came up with was as simple as buying a $200 colour printer to cut out three steps in a process.’

A good example of engagement of MLs in aged care programs is the Metro North Brisbane ML who have demonstrated the capacity that MLs may have in the future by taking on the management and administration of home care services in their region as detailed in Table 1 case study.

Table 1 Metro North Brisbane Medicare Local Case Study

<table>
<thead>
<tr>
<th>What it is:</th>
<th>The Metro North Brisbane Medicare Local currently delivers HACC services across the Metro North region through a Consortium of 10 contracted service providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How it works</td>
<td>The ML is the lead agency and is responsible for the procurement, coordination, management and reporting of service delivery.</td>
</tr>
<tr>
<td>In May 2013, the Medicare Local used this consortium model to successfully transition 3,500 HACC clients from the Hospital and Health Services (HHS) to community partners in six weeks with only five complaints.</td>
<td></td>
</tr>
<tr>
<td>The Consortium delivery model of commissioning services from a range of providers enables much greater capacity to meet diverse clients’ specific needs such as CALD and homelessness. The model aims to: strengthen links, integration and coordination amongst the various providers of HACC-funded services in the region; enable the identification of areas for improvement and the opportunity to work together to increase and improve service provision.</td>
<td></td>
</tr>
<tr>
<td>Success factors:</td>
<td>Consortium members are diverse in size, skills and experience and all have strong connections with their local communities and a track record of delivering consumer-focused community care. They were selected on their willingness and capacity to collaborate, their consumer-centred philosophy and their ability to respond flexibly to client needs.</td>
</tr>
</tbody>
</table>
1. Establishing a dedicated multi-sector aged health governance structure to lead and drive integrated care

Part of the MLs’ role within this framework will be to enable primary health care providers and organisations to think differently and more systemically about care provision and educate them on individual provider roles and responsibilities in delivering care to older people with complex health needs.

Current arrangements and communication between specialist and primary health care is ad-hoc and often reported to be problematic. International research suggests that 70 per cent of patient-related adverse events were caused by a lack of basic communication and collaboration between health professionals.\textsuperscript{xii}

Dedicated multi-sector aged health governance is necessary to provide leadership to all stakeholders involved to drive the agenda of integrated care. This group should include representation from all individual stakeholder groups to facilitate local leadership, drive the agenda of integrated care and model the behaviours necessary for integrated care using the Framework as a reference. The representatives in this group should have the authority to make decisions.

This group should initially:

- Develop a clear terms of reference to define the roles and responsibilities of different participants and sets the standards by which they will deliver care.
- Develop a shared vision for integrated Aged Health care.
- Develop meeting schedules, governance arrangements, and locally relevant terms of reference which align to the shared vision and the system design principles.
- Identify the enablers, tools and resources needed to achieving integrated care across different settings.
- Facilitate systemic leadership at all levels (across sectors) to support integration.

2. Aligning stakeholders to a regional shared vision and purpose of integrated care

In order to create a better, more efficient and cost effective system, care delivery needs to be integrated towards the shared vision with practical implications considered. This vision provides the opportunity to structure services to be person-centred rather than service/provider-centred and to bridge the gaps in communication that cause duplications in care delivery and other inefficiencies to occur.

The vision describes the ideal state of care for an older person with complex health needs, their carer and families and how the services work together to achieve this.

MLs have multiple and varied stakeholders within their circle of influence. For this reason, it is important that MLs become a champion for integrated aged health care by modelling, promoting and enabling the desired behaviours aligned to the shared vision for integrated aged health care and reflecting the importance of this in their strategic priorities. This will need to include engaging the various local primary health care providers in the vision of integrated care for older people with complex health needs.

3. Undertaking a joint gap analysis/needs assessment and service planning

Within the ML

MLs are required to undertake a comprehensive needs assessment locally to guide their strategic directions and inform their resource allocation. The needs assessment will have a three-year time horizon with provision for annual review and updating, in particular in relation to ML priorities and activities. The objective of the local needs assessment is for MLs to work together with community, consumers, GPs, health professionals to:

- Assess the health status of the population and identify the key health issues/ needs and problems for the region, including the causes of ill health, level of risk and burden of disease.
Consider evidence on types of interventions available to address the health issue(s)/need(s) or concerns effectively and opportunities for change

Identify the population groups or localities most affected and identify the social determinants at play and/or health inequities present

They can also advocate for indicators of integrated care to be reflected in their performance framework.

**With other stakeholders**

MLs receive funding to deliver specific programs (e.g., afterhours primary care services, eHealth support) as well as flexible funding to meet locally identified needs or areas of priority based on their health needs assessment. Collaboration would benefit from exploring how joint investment could promote better integration of service delivery for the older person with complex health needs.

There is an opportunity for MLs to undertake this local needs assessment jointly with LHDs and other service providers:

- Leveraging, sharing or co-developing local needs analysis with LHDs and aged care and community service providers.
- Identifying core strategic priorities that are best driven within primary healthcare and supported by MLs
- Representing the views and needs of primary care providers whilst also identifying systemic solutions
- Service mapping of current services and subsequent gap analysis
- Service directory support comprising geographical information on services and programs
- Defining and delineating different primary health care professionals roles and responsibilities in delivering care across sectors to the older person with complex health needs, their carer and family

4. Developing shared processes, tools and guidelines to support regional implementation

There are specific MLs that have already established joint governance programs with LHDs and other providers and potentially have experience, tools, terms of reference, and plans that can be leveraged to support local implementation. In this way, MLs are encouraged to enhance their own networks in order to progress forward more rapidly.

Working across services, sectors and providers requires clear standardisation and clarification of processes and protocols, minimum information sharing requirements and terminology. With the ultimate aim of developing shared processes, guidelines and tools for working together.

Effective (timely and consistent) communication between service providers is important and processes, standards and feedback loops will be imperative to enabling integration across providers. As providers come from different training and perspectives, it may be necessary to flag potential areas of conflicting frames of reference by identifying a common language and develop a shared set of processes for working together. The minimum requirements for information need to be outlined in shared communication guideline/standards which will be important to co-develop and have in place. Health pathways is an example of providers coming together to find common ground and exploring solutions to address local health needs collaboratively.

Other shared tools to consider include a shared care plan, shared IT systems or consistent use of existing technology, a locally relevant terms of reference and a single directory for care providers. Existing tools and templates that enable integration have been developed that can be adapted for local use.

The benefits of having standardised processes and tools across sectors and providers are:

- Being able to establish a minimum level of care, information transfer requirements and the existence of Advance Care Directives.
- Reducing administration and management reporting and assisting with the high volume of older person transfers between residential care, ED, acute care and subacute care.
- Identify opportunities for systemic tools and processes including access to Advance Care Directives, dementia assessments, ACAT assessment results and carer status.
5. Implementing the vision

Working relationships need to be built, nurtured and maintained at every level, at the governance and at service delivery level. Additionally, all relevant stakeholders who provide care should be engaged (e.g. RACFs, NGOs, Ambulance Service of NSW, Aboriginal health services) so that they can work together effectively. For this reason, participants are encouraged to establish or actively participate in their local aged care networks to develop and facilitate working relationships, identify key issues and prioritise areas of need across services.

Due to its proximity and accessibility, older people with complex health needs will initially access primary health care in the early stages of their care journey and the following experience is therefore highly dependent on the proactivity of their primary health care provider to:

- Undertake a holistic assessment of their bio-psychosocial and health care needs
- Devise a care plan with structured follow-up and monitoring
- Link with other services and providers

MLs will have a specific role in ensuring providers have the tools they need to be successful in achieving this and that these standards of care are upheld across providers thus avoiding unnecessary morbidity and mortality caused by communication breakdowns.

At a system level they will have a role in encouraging the right care is delivered at the right time in the right setting and as close to home as possible by:

- Ensuring that resourcing of monitoring and care coordination is appropriately delegated and resourced to best utilise skills of all health professionals
- Coordinating and facilitating relationships between the different stakeholders involved to support efforts to work as collaboratively as possible

“There is significant value in a comprehensive GP assessment and care plan after acute admission in at-risk groups such as older people with complex needs – the problem is there is currently no consistent process or incentive.”

There are many elements of consider for implementation of the vision for Medicare Locals:

- Shared Care - MLs have the potential to play a key role in formalising shared care arrangements between LHDs and primary care.
- Care coordination - MLs have a key role in identifying and supporting opportunities for better care coordination between primary health care, LHD and other service providers. Care coordination is a comprehensive approach to deliver more effective management of care for people who have multiple, often chronic, morbidities who require timely and consistent care and self-management support. It includes multiple aspects of care delivery including multidisciplinary team meetings, management of chronic disease, provision of required care, referral, data collection, common protocols, information provision and treatment.
- Access - The care experience of older people with complex health needs, their carer and family is highly influenced by where, how and when they initially seek health care and can be informed by accessability, health needs and health literacy.
- eHealth - MLs have a responsibility to encourage the adoption and use of eHealth (and the Personally Controlled Electronic Health Record) within general practice, allied health, aged care and pharmacy. There are current challenges facing eHealth, however over time this will provide a key enabler for the sharing of information across care boundaries.
- Communication to the community - MLs will have a key role in communicating service information and treatment options to older people, their carers and family. This includes location, opening hours, cost, rebates available, specific programs. Ultimately, this should be available at one point of contact and may include a hotline number, a website, or flagging specific ‘aged friendly’ primary health care practices where the appropriate care is facilitated.
Other considerations for MLs that integrate care are:

- **Shared resourcing** - In order to coordinate and facilitate the working relationships between sectors delivering care for the older person with complex health needs, MLs may wish to allocate specific resources to this role (e.g., an Integration Manager) to provide oversight and project management for local initiatives. Some MLs in NSW have already arranged for such a position to be jointly funded by LHDs.
- **Development of a national information resource that provides older persons, their carers and families with information about services and conditions**
- **Training and education for primary healthcare providers on working collaboratively**
- **Clinical governance for local service delivery against care standards outlined in this framework**
- **Knowledge management and dissemination of best practice/case studies**
- **Supporting local tenders and funding applications that will enable providers to better meet care standards outlined in this framework**
- **Encouraging the use of telehealth and advances in technology to support care**
- **Care coordination of older persons with complex health needs to support a better flow of care between providers**
- **Commissioning of services where gaps in primary health care services or service inefficiency exists (potentially on behalf of LHDs):**
- **Shared performance reporting on this area through governance**
Opportunities for aged care providers and community services

Aged care providers include both Residential Aged Care Facilities (RACFs) and other community aged care providers. There are over 300 such aged care organisations in NSW. RACFs are a special-purpose facility providing accommodation and other types of support, including assistance with day-to-day living, intense forms of care and assistance for independent living to frail and aged services. Community aged care providers provide services designed for older people to support them living and staying healthy in the community for as long as possible.

Community aged care services are services that provide support and services to the older person, their carer and family outside of those addressing their immediate health needs but supports them to stay at home and be more independent in the community (eg. HACC services). These are providers whose services may/may not focus specifically on older people and includes a number of NGOs (e.g., religious organisations).

Both aged care service providers and community services have an important role in realising the vision of integrated care and delivering care as close to the home as possible. The multimorbid nature of older people with complex health needs means that no singular organisation can address all aspects of health and social care.

Currently relationships between aged care service providers and community services and health providers are mixed with some having strong, effective relationships and others having little interaction. The inclusion of this group in multi-sector aged health governance will enable discussion across the full spectrum of aged services, and identify potential areas of collaboration or delegation.

Specifically aged care service providers and community services can support implementation by:

- Engaging the various local primary health care providers in the vision of integrated care for older people with complex health needs
- Sharing current data and information on older people with complex needs in their care. This data and information is not readily accessible by LHDs and provides important information on the health needs of this population.
- Map aged care services or packages that are currently funded for the region and how these apply to service demand projections
- Sharing or co-developing strategic plans for local aged care services and how they interact with aged health specialist services and primary health care providers.
- Identifying core strategic priorities that are best driven within aged care services
- Representing the views and needs aged care service providers whilst also identifying systemic solutions.
- Large NGO organisations and insurers have significant experience in developing integrated care solutions that are cost effective. Engaging and working with these NGOs on models of care for this group and identifying best use of resources in the region has significant benefits in rapidly progressing changes to delivery models.

Other opportunities include:

- Co-funding arrangements between LHDs and RACFs to expand the initiatives and
- Increase in staffing numbers and hours of operation
- Developing a palliative care outreach program;
- Including more community nurses and Nurse Practitioners providing services in RACFs
Table 4 Silverchain Case Study

**What it is**  Silver Chain is a not-for-profit organisation based in Western Australia who provides Hospital at the Home services to non-emergency hospital level care in metro Perth. This enables services to be delivered to older people in the home who would otherwise need to visit or stay in hospital. Services can include acute, post-acute, community and primary care services.

**How it works**  
**Hospital at Home**: A 24/7 hospital substitution program. Older people will receive quality and responsive acute care at home for which they would otherwise require a hospital admission or extended hospital stay by virtue of a medical condition and necessary treatment. Referrals can be through a public hospital/ED, GP, specialist or RACF.

**Resourcing**  
The health team consists of:
- Allied Health Professionals.
- Enrolled Nurses
- Registered Nurses
- Case Coordinators
- Clinical Nurse Specialists
- Clinical Nurse Consultant Managers
- Nurse Practitioners
- Medical Practitioner

**Success factors:**
- No cost to the referrer or older person – it is part of the Home Hospital and the Friend in Need Emergency Scheme, a WA Government initiative
- Older people are treated at home, avoid the stress of being transferred to hospital
- The older person’s usual GP may be involved in care
- Supports early discharge from acute setting
- Older people are able to access allied health services on assessed need
- Reduced ED presentation, admission to hospital and less pressed on hospital beds

Aged care service providers have noted the difficulty in having GPs attend residences to clinically review older people with complex health needs. The outcome of this is often that there is rapid deterioration and/or an unnecessary transfer to the emergency department. This not only creates increased stress on the older person, carer and family but is a significant cost to the system.

For this reason, hospitals in NSW have implemented various clinical response programs for Emergency assessment at residences of older people and specifically RACFs.

These programs are hospital outreach services that deliver care to older people that are not critical but acute enough to warrant a same day review. Hospital staff also work in collaboration with GPs and RACF staff to provide education on prevention, management and triage of acuity and provide resources to support older people remaining in place where possible.

The reported benefits of having such programs in place include:
- Reduced stress on the older person, carer and family as they do not need to be transferred to ED
- Reduced ambulance transfers, ED presentations, hospital admissions and use of diagnostics
- Better continuity of care and opportunities to provide care as close to home as possible
- Cross-sector skills transfer and upskilling of RACF staff
- Better HealthCare Connections: Aged Care Multidisciplinary Care Coordination and Advisory Service Program (the Program) is a new program under the *Living Longer Living Better* reform. The Program will provide $9.969 million over five years to support older Australians with complex health needs
  o increased access to multidisciplinary teams of health professional to coordinate care and treatment.
  o an innovative pilot of GP consultations via video conferencing to RACFs.
Opportunities for Ambulance NSW

The Ambulance Service of NSW (Ambulance) has a historical role in the health system of responding to emergencies. However, increasingly its role has been in responding to non-emergency requests for services. Ambulance data shows that 27% of call outs in 2011/2012 were for non-emergencies.2 Many of these call-outs are to older persons living alone who require clinical support after hours.

Given this increase in the use of ambulance services for this purpose and the broader health system aim to reduce ED presentations, the Ambulance Service of NSW acted to implement a number of initiatives to improve the services to this group of non-emergency callouts by tailoring the make-up of their workforce. In this way, Ambulance have significant experience in allocating roles, redesigning services, processes and ICT systems for the needs of older people already.

Ambulance NSW currently provides a number of initiatives to reduce transfer to ED by managing older people at or close to home with programs such as:

- **Extended Care Paramedics (ECPs)** - ECPs are dispatched to emergency calls to undertake specific assessment and care management. Their scope of practice is guided by predetermined care pathways.
- **Authorised Care Program (ACP)** – An end-of-life pathway document (care plan) led by Ambulance of NSW to provide ambulance services with a predetermined care pathway for a terminally ill patient.
- **Critical Emergency Response Services (CERS)** - A rural facility with a limited ED workforce is able to draw on local ambulance resources to provide assistance with emergencies in the ED.
- **Paramedic Connect** – In low ambulance activity areas, paramedics provide community health services such as dressings, medications at home post-discharge, compression stockings, health promotion and ED support.

These models have been specifically implemented to address system failures that were exponentially increasing ED presentations and care costs. Specifically each model has required training and education of paramedics in new skills and roles. There are some practical steps in delineating clinical scope of practice and encouraging roles that are very different to core paramedic roles.

Older people (in the case of the ECPs) were extremely positive with feedback with their overall encounters with these services.

> ‘Our Extended Care Paramedics have really embraced the opportunity to think more laterally about the care of older people for whom they are called out to. They feel well supported by having a direct line to an on-call geriatrician at Nepean.’

Currently, these models are being delivered in pockets across NSW (e.g. Nepean, Kyogle, Wagga Wagga) but have the potential to be rolled out state-wide and adapted or selectively implemented where local needs exist.

Ambulance has a pivotal role in the NSW aged health and social care system as it is an intermediary or touch-point between all providers involved in this system (e.g. hospital, primary care, RACFs, carers). Similarly it is a 24hr service that delivers assessments support or treatment at home and in the case of ECPs have appropriate skills to triage care need of an older person specifically.

Currently, relationships between Ambulance are at an LHD or state-wide level. Therefore they have little interaction with MLs, primary care or aged care service providers specifically. The inclusion of this group in regional multi-sector aged health governance will enable discussion around crisis and acute response, planned transfers and logistics of in community care.

---

2 Ambulance Year in Review 2011/12 http://www.ambulance.nsw.gov.au/Media/docs/Year%20in%20Review%202011%202012-f0937949-c33e-4990-9887-ec166c5931a7-0.pdf
Specifically Ambulance NSW can support implementation by:

- Engaging the Ambulance NSW Service in the vision of integrated care for older people with complex health needs
- Sharing current data and information on call-outs and older people with complex needs in their care. This data and information is not readily accessible by LHDs and provides important information on the service utilisation of this population.
- Sharing or co-developing strategic plans for local aged care services and identifying best use of resources
- Identify core strategic priorities that are best driven by Ambulance
- Representing the views and needs Ambulance services whilst also identifying systemic solutions.

Table 6: Extended Care Paramedics Case Study

**What is it?** ECP is a program delivered by Ambulance NSW that increases the clinical role of a small group of selected paramedics in:
- Patient assessment
- Recognition and management of minor illness and minor injury presentations
- The provision of definitive care
- Referral to community-based health services for a range of presentations

**How it works:** ECPs are dispatched to emergency calls to undertake specific assessment and care management. Their scope of practice is guided by predetermined care pathways that are in addition to ambulance standard care protocols.

**Clinical roles include:**
- Replacement of catheters in emergency situations
- Provision of initial wound assessment and care (dressings/sutures)
- Replacement of percutaneous endoscopic gastrostomy (PEG) tubes
- Provision of falls screening and assessment for referral purposes
- Provision of aged care screening and assessment for referral purposes
- Commencement of pharmacotherapy administration
- Education and Clinical Practice for ECPs is undertaken at the Nepean Clinical School and Nepean Hospital, specific training and telephone support by geriatricians is provided to these paramedics in relation to
- Clinical management
- Dementia and Delirium
- Pharmacy – effectiveness and adversity in the elderly

**Resourcing:** ECP are experienced paramedics that undergo specialised training. They operate out of a small single response vehicle. The ECP program has been both internally and externally evaluated. The cost effectiveness is realised through:
- Salary of a single paramedic response rather than a double crew,
- Vehicle savings (ECP vehicles are less expensive to set up and lease as well as lower ongoing running costs)
- ECPs show a higher non-transport rate: an ECP average non-transport rate of 39.5% compared to SC 14%, and a regional ECP non-transport rate is 40–54%
- Reduced average case cycle time (CST) 60minutes (10–20 mins less than average non ECP vehicle) due to non-transport

**Success factors:**
- Support of a senior aged health decision-maker such as a geriatrician
- Paramedics with good clinical skills
- Strong relationship with RACFs including through educating them on the model
- Strong communication links with ED regarding those that require admission and opportunities to bypass ED.

**Where this service been implemented:**
- The dedicated ECP modules are located in Illawarra, across Sydney, Central Coast and Hunter.
- The ECPs working as part of a double crew are located across the state at Murwillumbah, Port Macquarie, Tweed Heads, Leeton, Cootamundra, Armidale, Shoalhaven, Wagga Wagga and a number of metropolitan locations.
## Appendix A – Glossary of terms and abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AARCS</td>
<td>Aged to Aged Related Care Service</td>
</tr>
<tr>
<td>ABF</td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
</tr>
<tr>
<td>ACE</td>
<td>Aged Care Emergency</td>
</tr>
<tr>
<td>ACI</td>
<td>Agency for Clinical Innovation, NSW</td>
</tr>
<tr>
<td>ACP</td>
<td>Advance Care Planning</td>
</tr>
<tr>
<td>ACQHS</td>
<td>Australian Commission on Safety and Quality in Health</td>
</tr>
<tr>
<td>ADHC</td>
<td>Department of Ageing, Disability and Home Care</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AIC</td>
<td>Agency for Integrated Care</td>
</tr>
<tr>
<td>ALoS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Services</td>
</tr>
<tr>
<td>ANPHA</td>
<td>Australian National Preventative Health Agency</td>
</tr>
<tr>
<td>APCD</td>
<td>Admitted Patient Data Collection</td>
</tr>
<tr>
<td>ARCHI</td>
<td>Australian Resource Centre for Healthcare Innovation</td>
</tr>
<tr>
<td>ASET</td>
<td>Aged Care Services Emergency Teams</td>
</tr>
<tr>
<td>CACPs</td>
<td>Community Aged Care Packages</td>
</tr>
<tr>
<td>CERS</td>
<td>Critical Emergency Response Services</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHF</td>
<td>Consumer Health Forum of Australia</td>
</tr>
<tr>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>COTA</td>
<td>Council of the Ageing</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>DoHA</td>
<td>Australian Government Department of Health and Ageing</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>EACH</td>
<td>Extended Aged Care at Home Packages</td>
</tr>
<tr>
<td>ECP</td>
<td>Extended Care Paramedics</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>EOL</td>
<td>End of Life</td>
</tr>
<tr>
<td>FACS</td>
<td>Department of Family and Community Services</td>
</tr>
<tr>
<td>GEM</td>
<td>Geriatric Evaluation and Management</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner: the collective term used for doctors/physicians who are the main prescriber of medicines</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HARP</td>
<td>Hospital Admission Risk Program</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital In The Home</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and communications technology</td>
</tr>
<tr>
<td>IPC</td>
<td>Inala Primary Care</td>
</tr>
<tr>
<td>LoS</td>
<td>Length of stay</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Hospital District</td>
</tr>
<tr>
<td>LHN</td>
<td>Local Health Network</td>
</tr>
<tr>
<td>MAU</td>
<td>Medical Assessment Unit</td>
</tr>
<tr>
<td>MBS</td>
<td>Medical Benefits Schedule</td>
</tr>
<tr>
<td>ML</td>
<td>Medical Local</td>
</tr>
<tr>
<td>MPS</td>
<td>Multipurpose Services</td>
</tr>
<tr>
<td>MRN</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NHPA</td>
<td>National Health Performance Authority</td>
</tr>
<tr>
<td>NHRA</td>
<td>National Health Reform Agreement</td>
</tr>
<tr>
<td>NOF</td>
<td>Neck of Femur</td>
</tr>
<tr>
<td>NPA</td>
<td>National Partnership Agreement</td>
</tr>
<tr>
<td>NPS</td>
<td>National Prescribing Service</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PCEHR</td>
<td>Personally Controlled Electronic Health Record</td>
</tr>
<tr>
<td>PET</td>
<td>Patient Experience Tracker</td>
</tr>
<tr>
<td>PIR</td>
<td>Patients In Recovery</td>
</tr>
<tr>
<td>RACF</td>
<td>Residential Aged Care Facility</td>
</tr>
<tr>
<td>SIPA</td>
<td>System of Integrated Care for Older Persons</td>
</tr>
<tr>
<td>SMART</td>
<td>Specific, Measurable, Achievable, Realistic and Timely</td>
</tr>
<tr>
<td>SPICE</td>
<td>Singapore Programme for Integrated Care for the Elderly</td>
</tr>
<tr>
<td>TACP</td>
<td>Transitional Aged Care Program</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
<tr>
<td>UK</td>
<td>The United Kingdom</td>
</tr>
<tr>
<td>USA/US</td>
<td>The United States of America (noun/adjective)</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>VWO</td>
<td>Volunteer Welfare Organisations</td>
</tr>
</tbody>
</table>
Appendix B – Participants in aged health and social care

A simplified local/regional representation of an integrated health and social support system for older people with complex health needs, their carers and family is presented in Figure 9.

Figure 9: Whole of system view - aged health and social care at local/regional level
(This lists key participants and is by no means a list of every provider involved in their care).

<table>
<thead>
<tr>
<th>Participants</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Older person with complex health needs</strong></td>
<td>For the purposes of this Framework, an older person with complex health needs is one whose underlying co-morbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis.</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>The care of an older person with complex health needs has impacts beyond the individual. Carers and family are usually relied upon to provide significant care (often unpaid) and often face emotional, social and financial impacts themselves. This impact is not always visible, as it often happens in the home and often reaches a crisis point before carers will seek help. It is therefore, critical that the important role of carers and families are recognised for this population.</td>
</tr>
<tr>
<td><strong>Local Health Districts</strong></td>
<td>LHDs are regional (meso level) organisations responsible for providing health services in a wide range of settings. Eight LHDs and one Local Health Network (LHN) cover the greater Sydney metropolitan region and seven cover rural and regional NSW.</td>
</tr>
<tr>
<td><strong>Medicare Locals</strong></td>
<td>MLs are regional (meso level) primary health care organisations funded by the Australian Government. MLs have five specific strategic objectives.</td>
</tr>
<tr>
<td></td>
<td>• Improving the patient journey through developing integrated and coordinated services</td>
</tr>
<tr>
<td></td>
<td>• Providing support to clinicians and service providers to improve patient care</td>
</tr>
<tr>
<td></td>
<td>• Identifying the health needs of their local areas and development of locally focused and responsive services</td>
</tr>
<tr>
<td></td>
<td>• Facilitating the implementation of primary healthcare initiatives and programs</td>
</tr>
<tr>
<td></td>
<td>• Being efficient and accountable with strong governance and effective management.</td>
</tr>
<tr>
<td><strong>Aboriginal Health Services</strong></td>
<td>The vision for Aboriginal health services is health equity for Aboriginal people, with strong, respected Aboriginal communities in NSW, whose families and individuals enjoy good health and wellbeing. This recognises importance of partnerships between the NSW Government and the Aboriginal Health and Medical Research Council (AH&amp;MRC) at the state level, and the continued need for strong partnerships between NSW Local Health Districts (LHDs) and Aboriginal Community Controlled Health Services (ACCHSs) at the local level. Aboriginal Community Controlled Health Services (ACCHS) are incorporated Aboriginal organisations, initiated by and based in a local Aboriginal community that delivers a wholistic and culturally appropriate health service to the community that controls it. Aboriginal Hospital Liaison Officers (AHLO) provide a liaison service to Aboriginal and Torres Strait Islander patients admitted to hospital.</td>
</tr>
<tr>
<td><strong>Community services</strong></td>
<td>Community services are services those that provide support and services to the older person, their carer and family outside of those addressing their immediate health needs. These are providers whose services may not focus specifically on older people and includes a number of NGOs who have significant expertise and resources to offer. Community services have an important role in realising the vision to deliver care as close to home as possible and to connect older people and carers with bio-psychosocial supports and tangible support such as respite options.</td>
</tr>
<tr>
<td>Participants</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Primary Health Care Providers**  | Primary health care providers include GPs, nurses, allied health professionals and pharmacists. Groups of networked or co-located primary health care providers are often referred to as “general practice”  
Aboriginal Medical Services are also an example of a grouping of primary health and social care providers together address the specific health and cultural needs of Aboriginal and Torres Strait Islander people. |
| **Residential and community aged care providers** | This includes both Residential Aged Care Facilities (RACFs) and other community-based aged care providers. There are over 300 such aged care organisations in NSW funded by the Australian Government. RACFs are a special-purpose facility providing accommodation and other types of support, including assistance with day-to-day living, intense forms of care and assistance for independent living to frail and aged. Community aged care providers provide services designed for older people to support their living and staying healthy in the community for as long as possible. |
| **Ambulance Service of NSW**       | Ambulance Service of NSW (Ambulance) provides a core role in responding to emergencies as well as providing care in non-emergency requests.  
Ambulance provide a number of initiatives to reduce patient transfers to Emergency Departments (ED) by managing older people at home and providing health promotion and prophylactic management of conditions. |
| **Specialised aged health care providers** | Specialised aged health care services describe the provision of services by Specialist Aged Health and Specialist Mental Health Services for Older People (SMHSOP). These services address issues that are unable to be addressed by organ-specific or disease-specific disciplines or other providers with the end goal being to maximise independence through optimising physical, psychological and cognitive function. |
| **Diagnostic services**            | Diagnostic services are provided by private providers in the community or as part of a health care facility. Access to diagnostics is via a GP or specialist referral. Services delivered in the community attract some MBS rebates, and those delivered in a hospital are funded by the LHD. |
Appendix C - Broader governance stakeholders

The local system of care delivery for older people with complex needs does not exist in isolation of the broader policy and governance arrangements for aged health and social care. There are various levels of governance and policy that must be recognised and considered in implementation of this Framework, these are described and defined in Table 7 below:

Broader governance stakeholders in the system of aged health and social care

<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Health Districts (LHDs)</strong></td>
<td>LHDs are regional (meso level) organisations responsible for providing health services in a wide range of settings. Eight LHDs and one Local Health Network (LHN) cover the greater Sydney metropolitan region and seven cover rural and regional NSW.</td>
<td>LHDs have responsibility and accountability for managing all aspects of hospital and health service delivery for their local district.</td>
</tr>
</tbody>
</table>
| **Medicare Locals (MLs)**        | MLs are regional (meso level) primary health care organisations. MLs have five specific strategic objectives:  
• Improving the patient journey through developing integrated and coordinated services  
• Providing support to clinicians and service providers to improve patient care  
• Identifying the health needs of their local areas and development of locally focused and responsive services  
• Facilitating the implementation of primary healthcare initiatives and programs  
• Being efficient and accountable with strong governance and effective management. | MLs are tasked with:  
• population needs analysis and service mapping for primary health care services  
• planning and supporting the effective local delivery of coordinated and integrated primary health care services  
• enabling and supporting the implementation of a range of community-based national programs and aspects of National Health Reform (e.g. ehealth, telehealth) |
| **NSW Ministry of Health**       | The NSW Ministry of Health (MoH) has a core role in advising the Minister on policy, legislation and governance arrangements and stimulating system-wide initiatives that improve quality and efficiency, negotiating Service Agreements with LHDs, specialty Networks, Pillars and HealthShare, monitoring against agreements and securing resources needed to deliver on policies. |  
• NSW Health policy makers  
• Funders of LHDs, specialty Networks, Pillars and HealthShare  
• Performance monitoring and management  
• Commissioners of services |
### NSW Health Pillars

<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSW Health</strong>&lt;br&gt;Pillars</td>
<td><strong>Agency for Clinical Innovation (ACI)</strong> is the lead agency in NSW for promoting innovation, engaging clinicians and designing and implementing new models of care.</td>
<td>• ACI builds models of care based on the needs of patients and which are underpinned by extensive research conducted in collaboration with leading researchers, universities and research institutions.</td>
</tr>
<tr>
<td></td>
<td><strong>Health Education and Training Institute (HETI)</strong> supports and promotes coordinated education and training across NSW Health.</td>
<td>• HETI ensures that world-class education and training resources are available to support the full range of roles across the public health system including patient care, administration and support services.</td>
</tr>
<tr>
<td></td>
<td><strong>The Clinical Excellence Commission (CEC)</strong>. It was established to promote and support improved clinical care, safety and quality across NSW.</td>
<td>• CEC has a central role in the responsibility for quality and safety in the NSW health system.</td>
</tr>
<tr>
<td></td>
<td><strong>Bureau of Health Information (BHI)</strong> seeks to achieve excellence in the provision of relevant and impartial information for the people of NSW about their public health system.</td>
<td>• The BHI works to inform, evaluate and advise on efforts to improve patient care and is the leading source of information on the performance of the NSW public health system.</td>
</tr>
</tbody>
</table>

### Department of Health

<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
</table>
| **Department of Health** | The Australian Government Department of Health (DoH) provides all funding and policy responsibility for primary care. Their aim to achieve better health for all Australians is through:  
- Strengthening evidence-based policy advice,  
- Improving program management  
- Research  
- Regulation  
- Partnerships with other government agencies, consumers and stakeholders | • National policy makers  
• Funders of:  
  - MLs  
  - Medicare Benefit Scheme  
  - Pharmaceutical Benefit Scheme  
  - Specific initiatives (eg. telehealth, ehealth)  
• Performance monitoring |

### Department of Social Services

<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
</table>
| **Department of Social Services** | The Australian Government Department of Social Services’ (DSS) vision is a strong and fair society for all Australians achieved through supporting our Minister by collaboratively developing and implementing excellent social policy.  
In particular, DSS will help to support seniors through programs and services and benefits and payments through grants and funding for organisations providing services for seniors. | • National social service policy makers  
• Funders of:  
  - Aged Care Assessment teams  
  - Community Aged Care Packages  
  - Residential Aged Care Facilities  
  - HACC services  
  - Aged Care Gateway  
• Performance monitoring |
<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
</table>
| AMLA      | Australian Medicare Local Alliance (AMLA) is a national, government-funded non-profit organisation established in 2012 to lead the organised system for primary healthcare across the country through a network of independent organisations called Medicare Locals.                                                                                       | • Setting policy and systems for Australia’s primary health care services  
• Providing support to Medicare Locals through promoting improvement, providing more integrated care, supporting performance                                                                                               |
| ACSA & LASA | Aged and Community Services Australia (ACSA) is the national peak body for mission-based providers of aged and community care in Australia. It represents not-for-profit and faith based providers for residential and community care and housing and support for people with a disability and their carers. Leading Age Services Australia represent all industry participants for age services across Australia. They are committed to improving standards, equality and efficiency for the aged services industry and advocate for the health, community and accommodation needs for older Australians, working with government and other stakeholders to advance the interests of all aged service providers. | • ACSA provide a voice for aged care providers and advocating in public and political arenas and undertake policy development  
• LASA plays a leadership role in shaping the strategic direction and vision for the care and wellbeing of older Australians for the benefit and betterment of older persons in Australia                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                 |
| AMA       | The Australian Medical Association (AMA) is an independent organisation which represents more than 27,000 doctors and is the peak body representing registered medical practitioners and medical students of Australia. The AMA promotes and protects the professional interests of doctors and healthcare needs of patients and communities.                                                                                       | • Working with governments to Maintain and increase provision of medical care to Australians  
• Tracking and reporting government performance on health policy, financing, services and programs  
• Providing policy position statements to the government  
• Providing informed expert medical commentary  
• Developing and promoting health policies and responding to issues in the health debate                                                                                                                                   |
<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
</table>
| **Professional Associations and groups** | The Royal Australian College of General practice (RACGP)  
Australian and New Zealand Society for Geriatric Medicine (ANZSGM)  
Faculty of Psychiatry of Old Age (FPOA) Royal Australian and New Zealand College of Psychiatrists  
Royal Australian and New Zealand College of Physicians (RANZCP)  
Psychogeriatric Nurses’ Association Australia (PGNA)  
Australian Practice Nurses Association (APNA)  
Allied Health Associations | • Maintain professional standards  
• Lobby and advocate on issues that influence their membership  
• Provide education and training resources |
| **Mental Health Commission of NSW** | To prepare a strategic plan of Mental Health services in NSW. | • Monitor its implementation and provide oversight of and advocacy for Mental Health care |
Appendix D – Models of good practice and innovation in NSW

The models or good practice identified during the snapshot review of services in NSW identified several specific purposes of care delivered (often delivered in models with similar components but called different things. These are further described in below in Table 7.

### Table 2: Good practice models and innovations identified across the care continuum

<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation</th>
</tr>
</thead>
</table>
| Emergency assessment at residence    | **What it is:** A hospital outreach service that delivers care to Residential Aged Care Facilities (RACFs) or to the home to reduce the need for people to be transferred to hospital. This decreases hospital presentations/admissions and increases the comfort of the older person and carer by allowing them to remain in their familiar home environment. This decreases older person, carer and family stress and anxiety about being transferred and admitted to hospital. **How it works:** The model is usually requested for older people that are non-critical but acute enough to warrant a same-day review, rather than having them wait days for a GP assessment and risk the patient deteriorating, or alternatively, calling an ambulance or sending the older person to the ED. The method for receiving care from the model is as follows: Residential Aged Care Facilities, GPs or persons known to the service will contact the service regarding a person’s deteriorating health needs (this is usually only undertaken after the person’s GP has been notified and provides consent). The team will then attend the RACF or home and provide assessment and treatment of the person. This can include Hospital in the Home type activities such as diagnoses (pathology) and intravenous medication/therapy. Consultations found that this model has significantly reduced the number of transfers to the ED from RACF. The operating hours are during business hours, Monday to Friday. After-hours care is available but dependent on the facility. **Resourcing:** Staff consists of either a geriatrician and/or nurse practitioner (NP). After-hours consultations are usually performed by the NP. One site noted the use of a mobile x-ray service in their area as a significant benefit in preventing the transfer of many older people after a fall or suspected fracture. **Success factors:**  
  - A senior aged care decision-maker such as a geriatrician as a point of clinical guidance or follow-up of complex cases.  
  - Skilled liaison with strong communication and clinical skills – which builds trust  
  - Fast response to requests, e.g. the model is deployed within two hours of request  
  - Strong relationship with Residential Aged Care Facilities including through educating them on the model  
  - Strong communication links with GPs to provide an understanding of the services and provide an update of the model’s management  
  - Ability for nurse practitioner to order diagnostics and prescribe – which is not always the case. | VACS (Nepean), Geriatric Flying Squad (Sutherland), GREAT (Westmead), GRACE (Hornsby), Aged and Chronic Care Triage (Concord) |
### Extended Care Paramedic

**What is it:** ECP is a program delivered by Ambulance NSW that increases the clinical role of a small group of selected paramedics in:

- Patient assessment
- Recognition and management of minor illness and minor injury presentations
- The provision of definitive care
- Referral to community-based health services for a range of presentations

**How it works:** ECPs are dispatched to emergency calls to undertake specific assessment and care management. Their scope of practice is guided by predetermined care pathways that are in addition to SC ambulance protocols.

**Clinical roles include:**

- Replacement of catheters in emergency situations
- Provision of initial wound assessment and care (dressings/sutures)
- Replacement of PEG tubes
- Provision of falls screening and assessment for referral purposes
- Provision of aged care screening and assessment for referral purposes
- Commencement of pharmacotherapy administration

**Education and Clinical Practice for ECPs** is undertaken at the Nepean Clinical School and Nepean Hospital, specific training and telephone support by geriatricians is provided to these paramedics in relation to

- Clinical management
- Dementia and Delirium
- Pharmacy – effectiveness and adversity in the elderly
- Falls in the elderly

**Resourcing:** ECP are experienced paramedics that undergo specialised training. They operate out of a small single response vehicle. The ECP program has been both internally and externally evaluated. The cost effectiveness is realised through:

- Salary of a single paramedic response rather than a double crew,
- Vehicle savings (ECP vehicles are less expensive to set up and lease as well as lower ongoing running costs)
- ECPs show a higher non-transport rate: an ECP average non-transport rate of 39.5% compared to SC 14%, and a regional ECP non-transport rate is 40–54%
- Reduced average case cycle time (CST) 60 minutes (10–20 mins less than average non ECP vehicle) due to non-transport.

**Success factors:**

- Support of a senior aged health decision-maker such as a geriatrician
- Paramedics with good clinical skills
- Strong relationship with Residential Aged Care Facilities including through educating them on the model
- Strong communication links with ED regarding those that require admission and opportunities to bypass ED.

**Models in operation:**

Dedicated module – The dedicated ECP modules are located in Illawarra, across Sydney, Central Coast and Hunter.

Part of a double crew – The ECPs working as part of a double crew are located across the state at Murwillumbah, Port Macquarie, Tweed Heads, Leeton, Cootamundra, Armidale, Shoalhaven, Wagga Wagga and a number of metropolitan locations.
<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
</table>
| **ED assessment/bypass specific to older persons** | **What it is:** A dedicated area in the ED that is quarantined to provide early specialist assessment of an older person and to provide a care plan early in an older person’s hospital journey.  
**How it works:** The older person is either transferred directly from triage after assessment by the triage nurse, or pulled from the acute/subacute areas in ED by the model’s staff (doctor or nurse). The model targets patients aged 65–70 years and older or those with age-related symptoms.  
Aged health specialists assess the older person, and create a care plan to be implemented on transfer to the ward (MAU, acute aged health ward) or as part of their discharge home. The aim is for an aged health specialist to establish a care plan as soon as possible in the journey in order to decrease the amount of time a patient spends in hospital. Older people that are discharged are referred to their GP or community services as appropriate although the linkage here is sometimes absent.  
**Resourcing:** The model is staffed by aged health specialists such as geriatricians, aged health registrars, aged health CNCs and RNs. The model is located in the ED with access to diagnostic services such as x-ray, pathology and Aged Care Service Emergency Teams (ASET) services.  
**Success factors:**  
- Due to the complexity of the older patient, it is essential to utilise senior decision-makers that specialise in aged care such as geriatricians, aged health registrars and senior clinical nurse consultants (CNCs). CNCs show success in establishing a diagnosis and care plan early, rather than risking deterioration in the older patient by management by a junior staff member).  
- Educating ED staff on which people that are eligible for and should be referred to the model. | HOPE ED (Westmead), ED MAU (Nepean) |
| **Fast track acute assessment for older persons** | **What it is:** A dedicated hospital ward that is staffed and equipped to receive non-critical older people with complex needs. The model provides specialist assessment, care and treatment of the older person for up to a designated period (usually between 48–72 hours) prior to transfer to a ward or home if appropriate. The aim of the model is to improve the processes and clinical care of older people with acute needs and to facilitate the progression and early discharge from the acute care setting back into more appropriate community-based care.  
**How it works:** Patients can be transferred into this ward from the ED or from external sources such as primary care practitioners or programs, for example known GPs, GRACE, VACS and the geriatric flying squad can all make direct admissions to this ward for further assessment. The short turnaround allows for older people to undergo extensive medical and multidisciplinary assessment from experienced staff in order to initiate immediate and appropriate care planning, treatment and investigations in a timely manner.  
Most patients that are admitted to the model are expecting to be discharged home with community assistance as needed. A minority will require transfer to an acute or subacute ward.  
Consultation revealed that cardiac telemetry monitoring can improve the provision of services and patient flow because it allows a larger cohort of patients to be admitted to the ward – that is those presenting with a cardiac issue or comorbidity. As this is highly prevalent in this cohort, and is often undiagnosed, parallel | OPERA, ACAU, MAU/OPERA |
monitoring of telemetry on this ward allows for an efficient use of time and holistic care approach. Purpose-built or closed/secure assessment units also offer the benefit of being able to manage delirium or disturbed behaviour better, without the use of pharmacological or physical restraints.

**Resourcing:** The model is staffed by a multidisciplinary team comprising of geriatricians and senior nursing staff such as the NUM, Nurse Practitioner or CNC, as well as increased input from Allied Health team members. Priority access to diagnostics services is a key feature of the model.

**Success factors:**
- Extended assessment period to resolve often complex issues (e.g. OPERA)
- Multidisciplinary team, including for example, a social worker, OT and/or physiotherapist
- A geriatrician that is able to establish an early care plan
- Collaboration with ED and patient flow managers to facilitate the transfer of patients between ED and the model
- A process to facilitate transfer from primary care to the model.

---

**Geriatric Acute Wards**

**What is it:** Geriatric Acute Wards provide dedicated acute care spaces for the older person and provide multidisciplinary team approaches to improve the management of the older patient by providing specialised aged care early to improve patient outcomes.

**How it works:** Patients are transferred to the acute ward generally from ED, although in some locations, admission is available directly from either community teams or GPs and confirmed by the admitting geriatrician.

On admission, patients will undergo an assessment by an aged health specialist (i.e. a geriatrician or aged health advanced trainee) who will work in collaboration with nurses and allied health to establish a management plan for the patient that involves the most appropriate care pathway or disposition for the patient.

**Principles of this model of care include:**
- Shared care between physicians, geriatricians and their multidisciplinary teams
- Optimal medical and nursing care of patients through integrated geriatric assessment in an interdisciplinary environment
- Comprehensive holistic geriatric assessment beyond the presenting illness
- The optimisation of care by focusing on promoting independence and function – that is, a nursing and care philosophy of enablement.
- Early discharge planning, including timely referral to appropriate community services.

**Resourcing:** The model is staffed by a multidisciplinary team comprising of senior aged health decision-makers such as geriatricians/aged health advanced trainees, nurses (included CNS, CNC) and allied health staff (i.e. social workers, physiotherapists, occupational therapists, speech pathologist, dietitians, and pharmacists).

ACE (Hornsby)  
OPERA  
(MA) (Keppel)  
Aged Health acute and rehabilitation wards (Sutherland, Concord)  
Dedicated Stroke Services Ward Model (Wagga and Westmead)  
AARCS
<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
</table>
| **Success factors:**          | • Establishing an early management plan  
• An enablement philosophy of care operationalised by a multidisciplinary team.  
• Establishing a discharge plan on admission and working towards discharge from the point of admission  
• A process to facilitate a bypass of ED when transferring from primary/community care to an acute model.                                                                                                                                                                                                                                           | Ortho-geriatric model – Sutherland, Hornsby, Nepean, Concord (Pre- & post-operative), Surgi-geriatric model – Nepean – (Post-op only)  
Complex health needs – (Sutherland, Nepean)                                                                                                                                                                                                                                                                   |
| **Acute shared care models/ pathways** | **What is it:** Acute shared care models refer to the joint clinical care of a patient by two specialists.  
The models identified at site included:  
• **Pre-operative** – where the preoperative medical care and risk assessments of admitted older person surgical patients were managed by both the geriatrician and the surgeon on the surgical ward (such as in the orthogeriatrics model of care at Nepean) and then specific risk prevention pathways commenced.  
• **Post-operative** – where the post-operative medical care of the admitted older surgical patient was managed predominantly by the geriatrician and the surgical outcomes by the surgeon on the surgical ward (e.g. in Sutherland, Nepean and Hornsby). Specific wound care and osteoporotic prevention pathways then commenced.  
• **Complex health needs** – where the day-to-day medical care of the admitted older person with one or more comorbidities was managed predominantly by the geriatrician in a specialised aged health ward with parallel care from specialists of various disciplines (e.g. cardiovascular and respiratory).  
The key benefits reported include the reduced deterioration of older surgical patients, appropriate risk assessment and management prior to surgery, improved management of behavioural issues through management by experienced aged early discharge planning, and fast-track rehabilitation resulting in an overall shorter LoS.  
Consultative/liaison models were observed but reported to be far less effective than a structured referral based on criteria.  
Those with post-operative models expressed a pre-operative and post-operative model would be ideal if resources did not limit this.  
**How it works:**  
Patients are admitted under a primary speciality and supported by the secondary speciality. Often a single speciality will take over the care of the older person once the other speciality has completed their management plan. For example, an older person with a fracture of the neck of femur (NOF) is admitted under the orthopaedic surgeon and supported by the geriatrician. The orthopaedic surgeon will undertake all care related to the NOF fracture and the geriatrician will take responsibility for managing all other health, social and behavioural issues. Once the older person no longer requires management of the NOF fracture, all responsibilities will be handed over to the geriatrician.  
**Resourcing:** The primary admitting specialists vary between hospitals. Often, the primary complaint of the older person is who the person is they will be admitted under. For example, a patient with cardiac complaints will be admitted under the cardiologist and |
<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia &amp; delirium assessment/management</strong></td>
<td>supported by the geriatrician. Alternatively, patients can be admitted under the geriatrician and supported by a specialist such as a cardiologist. These arrangements are determined by the facility. The model generally has experienced nurses and allied health staff to support this model. <strong>Success factors:</strong></td>
<td>TOP5 Program (Wagga, Dubbo, Westmead, Kyogle) Assistance in Nursing Dementia/ Delirium (Wagga) Acute &amp; Community CNC Dementia/ Delirium (across all sites visited) DBMAS in-reach to ED (Nepean &amp; Taree) Hornsby Telehealth Dementia Clinic</td>
</tr>
<tr>
<td><strong>What is it:</strong> Specific assessment and management options for dementia and delirium patients. There are various models in place across the state to deliver services and support for patients with dementia and delirium. These models work across primary, acute, subacute and community settings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How it works:</strong> These models operate across two spectrums: 1. Firstly they provide education to clinical and non-clinical staff on delivering care to older persons with dementia/delirium. They also work directly with patients to facilitate continuity of care by linking older patients with appropriate follow-up care and support, and providing specialised dementia and delirium care. Some models focus on providing in-reach services to ED from the community to provide continuity of care for patients who may otherwise be confused by their care journey. <strong>Resourcing:</strong> These models are predominately resourced by CNCs in both acute and community settings (some of which service entire LHDs on 1 FTE). Other hospitals (such as Wagga Wagga Base) utilise AINs to deliver support services to the dementia and delirium cohort. This has been a particularly effective model as there have been enough AINs to provide ‘activities of daily living’ support to patients. <strong>Success factors:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Involvement of the carer and family in care and understanding what triggers behaviours</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dedicated staff/champions experienced in working with patients with dementia and/or delirium to educate and support other staff on assessment and management plans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Confirmed protocols and process on how to manage dementia and delirium patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioural Management Units</strong></td>
<td>Secure wards that provide a safe environment for older persons with dementia or delirium. The unit reduces the need for nurse specials (or 1:1 nursing), restraints or pharmacological sedation. Bed numbers are generally smaller compared to general wards, due to the intensity of staffing that is required for these patients, for example 10–12 beds. <strong>How it works:</strong> The ward allows older people with cognitive disturbance to walk freely in a contained and safe environment. The unit involves multidisciplinary assessment, care planning and</td>
<td>Concord, for up to 10 people), Sutherland, planned for Hornsby</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model purpose</td>
<td>Description</td>
<td>Models in operation:</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
|                | intensive treatment for older people with severe behavioural disturbance associated with dementia and/or mental illness. The layout of the units varies, although all units had natural lighting, windows with an outside view and courtyards accessible for older people. Some hospitals had single rooms that helped to reduce disturbances caused by staff attending other patients in the same room. **Resourcing:** Staffing consists of geriatricians, RNs ENs and AINs CNCs/NPs and old aged psychiatrists/registrar, and allied health such as occupational therapists, psychologists, dietitians, social workers and physiotherapists. Nursing staff ratios are higher due to the extra needs and supervision required for dementia and delirium patients, for example, 1 nurse to 4 patients. **Success factors:**  
- Open plan design to allow all patients to be supervised from the clinical station  
- Environmental considerations to engage patients and create a calming familiar environment that simulates routine lifestyle activities and promotes purposeful activity. Examples include music therapy, pet therapy, orientation strategies, walking tracks, bird aviaries, men’s sheds and even false bus stops.  
- A secure environment that allows patients to walk around  
- Common areas for patients to interact  
- Lighting appropriate to the time of day  
- Single rooms to reduce noise and disturbances  
- Encouragement of family and carer involvement – including visits. | In-reach to acute Geriatric rehabilitation inpatient unit - Concord Rehabilitation Day Hospital - Westmead, Concord Home-based rehabilitation – Hornsby, Concord *Note: TACP is a DoHA-funded variation on this model Outpatient clinics; Outreach/slow stream rehab or support at outlying facilities – Nepean See NSW Rehabilitation Model of Care for |
| Rehabilitation | **What is it:** Aged health rehabilitation models describe the journey that an older person takes from an acute episode to return to a previous residence and, where possible, to independent living. All programs use a process of interdisciplinary evaluation and management to deal with the healthcare issues of sick, older persons. **How it works:** The model’s integrated components include acute assessment and treatment with the establishment of a care plan, enablement goals, rehabilitation and a discharge plan. The rehabilitation philosophy is one of enablement from early in a patient journey. Delay in rehabilitation or services that are disconnected are clinically proven to increase functional decline and increase LoS. **Resourcing:** This model is dependent on the availability of rehabilitation trained allied health and nursing staff and a geriatrician or rehabilitation physician. Therapy aids and assistants in nursing are highly useful resources in maintaining or encouraging patient mobility. The resourcing requirements vary based on care setting. **Success factors:**  
- Strong geriatrician/rehabilitation physician leadership  
- Enablement philosophy from the acute ward onwards (e.g. ACE, OPERA)  
- Quarantined allied health staff to deliver appropriate intensity of therapy  
- Seven-day care models that avoid deterioration |
<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Goal-oriented to independent living and what that means for each individual.</td>
<td>detail</td>
</tr>
<tr>
<td>Social/</td>
<td><strong>What it is:</strong> Social activities and/or respite services to improve social interactions and provide temporary relief to carers.</td>
<td>Aged health socialisation activities</td>
</tr>
<tr>
<td>respite care</td>
<td><strong>How it works:</strong> Aged health socialisation activities are provided in community centres by volunteers. Activities are developed by physiotherapists and diversional therapists to promote social inclusion and to monitor patients for any age-related health issues and to provide support and care options for participants.</td>
<td>(Sutherland)</td>
</tr>
<tr>
<td></td>
<td>Respite services can be accessed by carers through either the GP or the hospital’s aged health service. Alternatively, community health staff (community nursing) can organise them directly.</td>
<td>Respite services (Sutherland, Kyogle, Concord)</td>
</tr>
<tr>
<td></td>
<td>The services provide temporary (day only) relief for carers who may otherwise require permanent placement in a facility outside of the home.</td>
<td>Pole Depot Community Centre – social groups</td>
</tr>
<tr>
<td></td>
<td>Respite services are provided in the community and in hospital campus centres. A key challenge for the services is transport options for patients. Some facilities are able to provide mini-bus transport to and from the patient’s home; however, most rely on transport from carers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Resourcing:</strong> Staffing includes nurses, volunteers, and community allied health workers such as physiotherapists and diversional therapists</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Success factors:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strong volunteer network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use of community centres which decrease the cost of services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Established transportation options.</td>
<td></td>
</tr>
<tr>
<td>Ambulatory</td>
<td><strong>What is it:</strong> Scheduled services that deliver health care to older persons from the hospital campus to both reduce hospital readmission and support the transition from hospital to the home (assisting in continuity of care for these individuals). These services can also prevent the need for a hospital presentation or stay, with many people accessing these services directly from the community.</td>
<td>Osteoporosis Primary Care Program (Wagga)</td>
</tr>
<tr>
<td>Clinics</td>
<td><strong>How it works:</strong> Patients, hospital staff, GPs or community staff can request ambulatory care by directly arranging it with the facility. Patients present to the clinic and are provided with care. The clinics comprise a range of services and programs that deliver multidisciplinary care across acute, subacute and community program areas (some also include dedicated services delivered to Residential Aged Care Facilities).</td>
<td>Fracture Clinic (Wagga Wagga, Hornsby)</td>
</tr>
<tr>
<td></td>
<td><strong>Resourcing:</strong> Ambulatory care staff includes but is not limited to: physiotherapists, orthopaedic surgeons, geriatricians, occupational therapists, social workers, speech pathologists, dietitians, diabetes educators, podiatrists and allied health assistants.</td>
<td>Podiatry services (Wagga)</td>
</tr>
<tr>
<td></td>
<td><strong>Success factors:</strong></td>
<td>Cognitive disorders clinic (Concord)</td>
</tr>
<tr>
<td></td>
<td>• Strong administration process to facilitate booking appointments</td>
<td>Memory Clinic via Telehealth (Hornsby)</td>
</tr>
<tr>
<td></td>
<td>• Multidisciplinary staff that are able to run clinics, e.g. from podiatry and speech pathology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Senior aged health staff to undertake clinics, e.g. geriatricians</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Using ambulatory clinics as a key part of the hospital’s aged health strategy</td>
<td></td>
</tr>
<tr>
<td>Model purpose</td>
<td>Description</td>
<td>Models in operation:</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| Care Coordination | What is it: Care coordination is a comprehensive approach to deliver more effective health management for people with chronic diseases. **How it works:** In the context of care for older people, care coordination encompasses multiple aspects of care delivery including multidisciplinary team meetings, the management of chronic disease, psychosocial assessment and the provision of required care, referral practices, data collection, development of common protocols, information provision and individual clinical treatment. The NSW Chronic Disease Management program works on proactive identification, assessment, enrolment and monitoring of people with complex needs. Five priority disease groups are used to identify people 16 upwards. The key is to proactively identify people at very high risk or high risk of unplanned hospital or Emergency Department presentation. **Resourcing:** These models recognise General Practitioners as main medical care providers who provide strong support for patient self-management. Information and communication technology systems provide an enabling infrastructure supported by shared assessment tools and protocols. **Success factors:**  
- Strong links between Primary Care Practice and Hospital facilities  
- Shared information and communication technology systems  
- Performance measures and clear accountabilities  
- Ring fenced funding and dedicated care coordinators co-located with acute and primary care facilities | Chronic Disease Management program (most sites)  
Local relationships between aged care services and Chronic Disease Management program are embryonic |
| Drop-in clinics | What it is: A drop-in service (no booking required) for patients that have concerns regarding their health. The model provides continuation of care by providing a drop-in clinic for patients with age-related issues. The key criteria are that all patients must have been an inpatient at the hospital and have an age-related condition. Patients usually present with existing chronic conditions that require management. The model aims to improve continuation of care provided to the older patient while reducing ED presentations and readmissions. **How it works:** Patients call the service and a geriatrician determines if a patient is suitable for the service. If so, the patient presents to the clinic located in the hospital for assessment, and a care plan is established. From the clinic, the patient can bypass ED and be directly admitted to the ward or discharged to home if appropriate. **Resourcing:** The services are provided by on-call geriatricians or Nurse Practitioners and GPs in rural areas. **Success factors:**  
- Dedicated area to facilitate the clinic  
- Passionate staff to run the model  
- Executive support to operate the model | Aged care drop-in clinic (Nepean)  
Nurse Practitioner – roaming/ on-call (Kyogle) |
<p>| Telehealth | What is it: Telehealth is the delivery of health-related services and information via telecommunications technologies such as video conferencing. | Consultative Geriatric Service (Concord and |</p>
<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How it works:</td>
<td>A metropolitan hospital will establish an arrangement with a regional or rural facility to provide health services via videoconference. The two facilities will determine a funding arrangement for providing the services. For example, a geriatrician from a metropolitan hospital provides dementia telehealth services to a regional ML which has a RN to help facilitate the assessment. The state funds the telehealth equipment, the ML funds the RN, and the Metropolitan facility receives MBS funding from the federal government for each patient that is assessed.</td>
<td>Telehealth Dementia Clinic (Hornsby-Armidale)</td>
</tr>
<tr>
<td>Resourcing:</td>
<td>These models are delivered across community, primary and acute care and are facilitated by a mix of clinical and non-clinical staff including RNs, geriatricians, CNCs and administrative coordinators.</td>
<td>Telehealth service (Wagga Wagga)</td>
</tr>
<tr>
<td>Success factors:</td>
<td>Strong governance arrangements between telehealth facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT frameworks that support telehealth</td>
<td></td>
</tr>
<tr>
<td>Home-based aged care packages</td>
<td>What is it: The Federal Government currently funds three types of home care packages designed to assist older Australians to remain living in their own homes:</td>
<td>MPS, hospitals, in community care</td>
</tr>
<tr>
<td></td>
<td>• Community Aged Care Packages (CACPs) – provide low-level aged care in the home for people needing personal care, domestic assistance and similar services.</td>
<td>For more detail on these services and recent and ongoing changes to these services under the Living Better, Living Longer reforms please consult the Department of Health and Ageing website.</td>
</tr>
<tr>
<td></td>
<td>• Extended Aged Care at Home Packages (EACH) – provide high-level care to people who need more help than a Community Aged Care Package can provide.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home and Community Care (HACC) – provides services that support older people to stay at home and be more independent in the community. The program is jointly funded by the Australian, State and Territory Governments and administered by ADHC. Australian Government provides around 60 per cent of the funding.</td>
<td></td>
</tr>
<tr>
<td>How it works:</td>
<td>To receive the above packages, patients must be assessed for eligibility based on their ability to undertake activities of daily living. The CACP and EACH packages require an Aged Care Assessment Team (ACAT) to determine care needs. Once a package has been allocated, services are provided by a variety of organisations in the patient’s local area, although the coordination and planning of services will be undertaken by an approved aged care service provider.</td>
<td></td>
</tr>
<tr>
<td>Resourcing:</td>
<td>ACAT teams are required to undertake the assessments.</td>
<td></td>
</tr>
<tr>
<td>Success factors:</td>
<td>Structured communication link with ACAT staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ability of ACAT to see patients in a timely period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to the packages by ACAT</td>
<td></td>
</tr>
<tr>
<td>Carer Support</td>
<td>What is it: A program that provides support and assistance to family and carers who are caring for people at home who are unable to care for themselves because of disability or frailty.</td>
<td>Sutherland, Kyogle (day respite) (overnight respite options)</td>
</tr>
<tr>
<td>How it works:</td>
<td>The federal government provides funding for:</td>
<td>Pole Depot Community Centre</td>
</tr>
<tr>
<td></td>
<td>• Respite services – allowing respite for carers. Examples include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Part/full day respite in day care centres</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− In-home respite services, including overnight care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Activity programs in the community.</td>
<td></td>
</tr>
<tr>
<td>Model purpose</td>
<td>Description</td>
<td>Models in operation:</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Commonwealth Respite and Carelink Centres – that specialise in helping people find information on services in their local area. Centres have local knowledge about: Personal, nursing and respite care</td>
<td>- Household help, home modification and maintenance - Transport and meal services - Disability services - Day care and therapy centres - Assessment, including Aged Care Assessment Teams - Special services for dementia - Continence assistance - Support for carers - Community Aged Care packages.</td>
<td><strong>Resourcing:</strong> Respite services are staffed by nurses, allied health staff and volunteers. <strong>Success factors:</strong> - Infrastructure that supports respite services, for example, dedicated respite buildings - Transportation options to escort patients, for example, a mini-bus to pick up and drop off patients.</td>
</tr>
</tbody>
</table>

**In-community Prevention**

As part of site visits, a number of prevention-based programs were identified to be operating in communities, often linked to or supported by the LHD aged health services and/or the ML. These programs have multiple purposes:

a) Primary prevention and healthy ageing  
b) Risk reduction – through physical strengthening and education on symptoms management  
c) Social and clinical support for specific chronic conditions (e.g. Parkinson’s, cardiovascular disease)  
d) Continuity of care and readmission avoidance  

**Resourcing:** Many of these programs were staffed by volunteers or with minimal allied health/nursing support utilising the rehabilitation gym or another accessible space. Some had received local government or Commonwealth funding grants, while others were run as part of service delivery.  

**Success factors:**  
- Community space to meet and run the program  
- Dedicated volunteers with and employed coordinator  
- Referrals and word of mouth.  

**Examples included:**  
- Parkinson’s Exercise Groups (Hornsby)  
- Falls Prevention (Hornsby, Kyogle, Sutherland)  
- Cardiopulmonary Exercise groups (Kyogle, Sutherland)  
- Healthy Ageing programs (Wagga Wagga, Kyogle)  

**Ambulance Service of NSW – other initiatives**

**What is it:** Ambulance Service of NSW provides a number of initiatives to reduce patient transfers to ED by managing patients at home and providing health promotion and prophylactic management of conditions, for example:

- **Authorised Care Program (ACP)** – An end-of-life pathway document (care plan) led by Ambulance Service of NSW to provide ambulance with a predetermined care pathway for a terminally ill patient.  
- **Critical Emergency Response Services (CERS)** – A rural facility with a limited ED workforce drawing on local ambulance resources to provide assistance with emergencies in the ED  

**Authorised Care Program (ACP), Extended care paramedic (ECPs) – Nepean, Critical Emergency Response Services (CERS) – Kyogle, Paramedic Connect**
<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paramedic Connect – In low ambulance activity areas, paramedics provide community health services such as dressings, meds at home post D/C, TEDS, health promotion and ED support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How it works:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACPs – are used to strengthen systems to support paramedic decision-making in meeting the needs of individual patients with special medical conditions, and respecting palliative wishes when an ambulance responds to an ACP. The document can be obtained from the ambulance and must be endorsed by the patient’s treating clinician. Once complete, it is sent to the ambulance to be endorsed by the Executive Director of Clinical governance. The document is valid for the next 12 months; in this time, the document provides ambulance officers with the care pathway for the patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CERS – The ED calls CERs when clinical resources are required in the ED. In rural facilities, there can be limited workforce with emergency experience; therefore, the ambulance workforce is leveraged for support when the ED requires addition support. This is achieved by calling the ambulance services and asking for assistance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paramedic connect – The station manager and the LHD establish specific community health services so that paramedics can provide dressings, medications etc. Paramedics provide these services during their scheduled shifts when there is low activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resourcing: All ambulance services are provided by paramedics; the ECP are paramedics with additional speciality training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success factors:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A clear governance structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong education programs for paramedics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong relationships with LHD and ED facilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What it is: SMHSOP community teams are central to the provision of coordinated services to older people with mental health problems. These teams have three major functions: specialist mental health assessment and treatment, care planning and case management.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How it works: Provides specialist mental health assessment and treatment, community team care planning and case management for older people with severe mental health problems. The model provides consultation / liaison and conducts capacity building with other key services as well as activities with a prevention and early intervention focus. SMHSOP community teams may be involved in hospital admission and discharge processes, and work in partnership with other services such as aged health, aged care and GPs. There are SMHSOP community teams in each Local Health District, and consumers are referred to the service via the Mental Health Line (1800 011 511) or directly to the local SMHSOP service. Wherever possible, community care is provided in the person’s normal place of residence (home, supported accommodation or residential aged care). A mid-term evaluation of the NSW Service Plan for SMHSOP found that in 2009-10, there were more than 141,000 contacts provided by community SMHSOP teams to close</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Models in operation:

Resourcing: Multidisciplinary teams comprising clinicians specialising in older people’s mental health such as nurses, psychologists, social workers, occupational therapists and old age psychiatrists.

Success factors:
- Clear point/s of entry and access arrangements
- Multidisciplinary team with specialist mental health and aged care knowledge
- Specialist geriatric/psychogeriatric assessment
- Case management functions
- Strong partnerships and collaboration with key partner services from mental health and aged care, and GPs
- Capacity building with families, carers and other service providers
- Provision of integrated bio-psychosocial care
- Strong clinical governance
- Involvement in benchmarking
- Integration of SMHSOP clinical service stream within the broader mental health service
- Support from adult mental health services, especially for acute responses
- Use of financial incentives to encourage less expensive, community-based care.

### Specialist Mental Health Services for Older People – Acute Inpatient Unit

**What it is:** SMHSOP acute inpatient services provide specialist psychiatric care for people who present with acute, severe symptoms of mental illness.

**How it works:** Acute SMHSOP inpatient units may be discrete facilities or sub-units within acute mental health facilities or acute hospitals. The units provide multidisciplinary assessment of a person’s mental and behavioural status, including with physical health and psycho-social issues and short term clinical treatment (voluntary or involuntary) for the acute phase of an illness which cannot be managed in the community. Service options of acute inpatient treatment depend upon population size, catchment, infrastructure, workforce and resources. SMHSOP acute inpatient units have linkages with adult mental health teams and units, acute geriatric medical inpatient services, Emergency Department staff and aged care teams. In 2009-10, SMHSOP acute admission units provided just over 2,000 episodes of care.

The *SMHSOP Acute Inpatient Unit Model of Care Project Report* was developed as a guide to support consistency and best practice for these units.

**Resourcing:**
Units require a multidisciplinary team approach, and staff require extensive skills and knowledge and the capacity to work in collaboration with a range of key stakeholders. Staff require
specialist training to manage older consumers with mental illness and problems associated with cognitive impairment, restricted mobility, physical illness and sensory impairment. Staffing numbers will vary on the acuity, dependency and presenting problems of the older consumers admitted (with higher staff ratios required for older consumers with severe agitation or BPSD).

Success factors:
- A range of factors for a good practice model of care are outlined in the SMHSOP Acute Inpatient Unit Model of Care Project Report, including:
  - Person-centred, recovery-focused biopsychosocial philosophy of care
  - Primary target population of older people with acute, severe clinical symptoms of mental illness, preferably with capacity to manage BPSD
  - Appropriate physical health care
  - Effective functional relationships with a range of other services, particularly SMHSOP community teams, aged health and aged care services, and adult mental health services, and other operational arrangements (such as access to ECT facilities and geriatric inpatient units) that support integrated service provision across inpatient, community and residential settings.
  - Key processes, including entry procedures to support most appropriate admission, assessment and care planning, and multidisciplinary case review
  - Recovery focused clinical interventions
  - Minimising use of seclusion and restraint
  - Appropriate and therapeutic facility design
  - Multidisciplinary staffing
  - Performance frameworks.
- The ability to manage BPSD depends upon a workforce who is trained and oriented towards managing BPSD, programs which are suitable for people with BPSD, and facility design which allows some form of segregation of consumers with severe agitation or aggression.

<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>specialist training to manage older consumers with mental illness and problems associated with cognitive impairment, restricted mobility, physical illness and sensory impairment. Staffing numbers will vary on the acuity, dependency and presenting problems of the older consumers admitted (with higher staff ratios required for older consumers with severe agitation or BPSD).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success factors:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- A range of factors for a good practice model of care are outlined in the SMHSOP Acute Inpatient Unit Model of Care Project Report, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Person-centred, recovery-focused biopsychosocial philosophy of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Primary target population of older people with acute, severe clinical symptoms of mental illness, preferably with capacity to manage BPSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Appropriate physical health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Effective functional relationships with a range of other services, particularly SMHSOP community teams, aged health and aged care services, and adult mental health services, and other operational arrangements (such as access to ECT facilities and geriatric inpatient units) that support integrated service provision across inpatient, community and residential settings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Key processes, including entry procedures to support most appropriate admission, assessment and care planning, and multidisciplinary case review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Recovery focused clinical interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Minimising use of seclusion and restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Appropriate and therapeutic facility design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Multidisciplinary staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Performance frameworks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The ability to manage BPSD depends upon a workforce who is trained and oriented towards managing BPSD, programs which are suitable for people with BPSD, and facility design which allows some form of segregation of consumers with severe agitation or aggression.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specialist Mental Health Services for Older People – Non-acute inpatient service (including Transitional Behavioural Assessment and Intervention Service Units)

What it is: Non acute mental health inpatient services have a primary focus on intervention to reduce functional impairments that limit the independence of the person and promote recovery.

How it works: Non acute mental health inpatient services provide specialist clinical assessment, treatment and rehabilitation where patients are not able to be managed in the community, with an expectation that consumers will improve sufficiently for discharge to a mainstream service or community setting with additional support from SMHSOP and other services. Strong links with residential and community services are important in these models.

Transitional Behavioural Assessment and Intervention Service (T-BASIS) Units

Specialist interim care inpatient facilities provide multidisciplinary assessment, care planning and intensive treatment for older people with severe behavioural and psychological symptoms of dementia (BPSD). This includes iterative behavioural assessment and treatment, such as medication planning, psychosocial interventions and environmental approaches. The T-BASIS Unit is a model which

Non-acute SMHSOP inpatient units (Southern NSW, Western NSW, Northern Sydney, Hunter New England LHDs)

SMHSOP sub-acute/non-acute inpatient unit in South Eastern Sydney LHD (opening late-2013).

T-BASIS Units (Western Sydney, Hunter New...
Models in operation:

<table>
<thead>
<tr>
<th>Model purpose</th>
<th>Description</th>
<th>Models in operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Mental Health Services for Older People – Community Residential Care Models</td>
<td><strong>What it is:</strong> Community residential care or extended care models provide long term care for people with severe and persistent psychiatric symptoms associated with dementia and/or mental illness through partnerships between SMHSOP, aged care services/ACATS and the residential aged care sector.</td>
<td>England, Southern NSW, Murrumbidgee LHDs</td>
</tr>
<tr>
<td></td>
<td><strong>How it works:</strong> One model of community residential care for older people with complex and persistent psychiatric symptoms associated with dementia and/or mental illness is the Mental Health Aged Care Partnership Initiative model. This model has been operating in two pilot sites for a number of years, and has been formally evaluated. Further models of community residential care are still in development.</td>
<td>Mental Health Aged Care Partnership Initiative (MHACPI) – 2 pilot services: HammondCare (South Western Sydney LHD) Catholic Health Care (Sydney LHD)</td>
</tr>
</tbody>
</table>
and function as purposed designed “Special Care Units” within the facility, operated by the residential aged care provider. Specialist consultation-liaison and case management support is provided by SMHSOP. The person is supported through the MHACPI “Special Care Unit” to transition to mainstream residential aged care. An evaluation of the MHACPI demonstrated that the model can successfully deliver quality care for older people with severe BPSD and/or mental illness within a mainstream residential aged care setting, improving their quality of life, and their access to long-term, community-based care. The cost-effectiveness of the model has also been demonstrated through a further evaluation.

**Resourcing:** Residential aged care facility staffing with specialist input from SMHSOP (old age psychiatrist and / or other members of multidisciplinary team). A MHACPI economic evaluation has examined the appropriate funding model and arrangements for MHACPI services.

**Success factors:**

- A well-designed Service Agreement (developed through collaboration and negotiation) and partnership between the residential aged care provider and the SMHSOP / Mental Health Service
- Operational factors such as a committed residential aged care provider and board of management, effective clinical advisory committee with clearly defined functions and processes, and the ability to access on-call support staff as required
- Committed and skilled staff, with appropriate (multidisciplinary) training, experience and expertise (and low staff turnover)
- Strong, effective MHACPI leadership and teamwork
- Strong training and support for MHACPI staff
- Use of psychosocial approaches and alternatives to medication
- Access to on-call staff support when required
- Specialist support from psychiatric services complemented by the services of an interested GP
- Appropriate, purpose-designed facility and environment
- Design of effective and efficient data collection and reporting.

**SMHSOP Severe and persistently challenging behaviours model**

**What it is:** An integrated specialist assessment model which provides specialist, multidisciplinary mental health (and aged care) assessment and some case management for older people with complex and severe behavioural and psychological symptoms in community and inpatient settings. This model includes a number of elements, with the key community-based service element being Behavioural Assessment and Intervention services. Other components (T-BASIS and MHACPI) are outlined above or are under development. The model may include extended inpatient care for older people with extreme behavioural symptoms who cannot be managed in other inpatient or community settings.

**How it works:**

*Behavioural Assessment and Intervention Service (BASIS)*

The BASIS model is an extension of services provided by ACATs and SMHSOP community teams, providing a more structured, integrated and intensive role in assessment and case management.
### Model purpose

for older people with severe and complex behavioural and psychosocial symptoms, often associated with dementia. The model provides integrated, comprehensive, multidisciplinary assessment, intervention and referral for the target group. In the example of the Behavioural Assessment and Intervention Services (BASIS) model, the key functions of the model are: development of formal links between SMHSOP and aged care services; provision of integrated assessment and intervention, and consultation, liaison and case management. Services are provided to identified clients in the community and residential aged care services. BASIS are generally integrated yet distinct components of SMHSOP community teams.

The T-BASIS Unit initiative is also an example of an interim assessment and treatment facilities under the severe and persistently challenging behaviours model (see above entry).

**Resourcing:** Specialist nursing and/or allied health clinicians, with access to and input from specialist medical support as required.

**Success factors:**
- Clear integration with SMHSOP clinical service stream
- As per SMHSOP community team:
  - Clear point/s of entry and access arrangements
  - Multidisciplinary team with specialist mental health and aged care knowledge
  - Specialist geriatric/psychogeriatric assessment
  - Case management functions
  - Strong partnerships and collaboration with key partner services from mental health and aged care (particular focus of services)
  - Capacity building with families, carers and other service providers (particular focus of services)
  - Provision of integrated bio-psychosocial care
  - Strong clinical governance
  - Involvement in benchmarking
  - Integration of SMHSOP clinical service stream within the broader mental health service
  - Support from adult mental health services, especially for acute responses
  - Use of financial incentives to encourage less expensive, community-based care.

### SMHSOP Consultation/Liaison

**What it is:** Consultation/liaison models provide specialist older people’s mental health advice and support for staff and teams in hospital settings who are primarily responsible for the care of the patient. Priority is given to people within geriatric wards, existing consumers of SMHSOP services or consumers within adult mental health services.

**How it works:** Consultation/liaison services can include assessment, referral and training with other service providers or teams. The core role of SMHSOP consultation/liaison involves assisting in the management of patients known to the service and in supporting staff of adult mental health and geriatric medical wards in supporting older people with mental health disorders. In some areas, additional roles are also a component of consultation liaison. A lesser resourced consultation-liaison model would involve the consultation service providing advice regarding management of

<table>
<thead>
<tr>
<th>SMHSOP Consultation / Liaison</th>
<th>What it is: Consultation/liaison models provide specialist older people’s mental health advice and support for staff and teams in hospital settings who are primarily responsible for the care of the patient. Priority is given to people within geriatric wards, existing consumers of SMHSOP services or consumers within adult mental health services.</th>
<th>Predominately in metropolitan services - early stages of development.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>How it works:</strong> Consultation/liaison services can include assessment, referral and training with other service providers or teams. The core role of SMHSOP consultation/liaison involves assisting in the management of patients known to the service and in supporting staff of adult mental health and geriatric medical wards in supporting older people with mental health disorders. In some areas, additional roles are also a component of consultation liaison. A lesser resourced consultation-liaison model would involve the consultation service providing advice regarding management of</td>
<td>BPSD Grand Rounds – Central Coast LHD (SMHSOP service)</td>
</tr>
<tr>
<td>Model purpose</td>
<td>Description</td>
<td>Models in operation:</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>individual patients. In a more developed model, the liaison element is further established where there is joint development of capacity between the consultation/liaison team and identified services (such as geriatrics). Examples of joint capacity building work include the development of relevant protocols, joint case conferencing, or ‘Grand Rounds’. There is strong evidence for consultation/liaison in reducing length of stay and some evidence for the effectiveness of SMHSOP consultation/liaison services in medical wards, particularly in relation to recognition of and treatment outcomes for depression.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resourcing:</strong> Psychiatrist or old age psychiatrist and nursing. <strong>Success factors:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Role clarity • Allocated time • Development of capacity to incorporate liaison activities into service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tele-psychiatry</strong></td>
<td><strong>What it is:</strong> Tele-psychiatry (access to a specialist mental health clinical input via telehealth) as a supplement to face to face services, primarily providing assessment and case conference functions. <strong>How it works:</strong> Assessment may be undertaken by psychiatrist or case conferencing by a senior clinician. Tele-psychiatry may be used for specialist consultation in rural and remote areas, and for providing clinical support to clinicians working in these areas, often with a strong focus on capacity building. A study conducted by the Faculty of Psychiatry of Old Age found that tele-psychiatry for SMHSOP can be effectively used in patient assessment and case conference as an adjunct to face-to-face psychiatry services but not as an alternative to these services. However, recent service evaluations relevant to SMHSOP are limited. Examples within SMHSOP services include regular use of videoconferencing for clinical review of consumers, as well as clinical supervision and discussion of other clinical issues with staff and consumers in rural areas. <strong>Resourcing:</strong> Psychiatrist or senior clinical with specialist older people’s mental health skills. <strong>Success factors:</strong></td>
<td></td>
</tr>
<tr>
<td>• Clear and agreed protocols for patient referral, selection, prioritisation, preparation and reporting • Appropriate technology, administrative and technical support, space for equipment and conferencing • Staff training, and staff who can work with both the SMHSOP clinician and the consumer and / or family on the receiving end of the service • Clear operational management and clinical governance arrangements.</td>
<td>Case conferencing and assessment (for adult) through MHEC-RAP in Western NSW LHD Concord Hospital to Mid North Coast</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Funding types

The following table describes the funding models currently in operation in Australia and internationally that provide alternative funding options to drive integration. No one model is specifically best for this purpose however funding models such as pathway/episode of care, pay for performance, capitation and bundled payments provide mechanisms that may support integration.

Table 3: Funding models

<table>
<thead>
<tr>
<th>Payment term/system</th>
<th>Description</th>
<th>Further description/examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block</td>
<td>Payment/lump sum for a specific, usually broadly defined service, independent of number of consumers</td>
<td>Block funding examples in Australia include State government payments to hospitals and DoHA payments to State Governments and other health agencies.</td>
</tr>
<tr>
<td>Capitation</td>
<td>Lump sum payment per consumer served by a provider for comprehensive services or particular categories of service regardless of treatment received.</td>
<td>The NHS currently funds the majority of GPs in this way. Payment is related to the number of consumers on their list (weighted by age and other characteristics). The activities they are expected to deliver for these consumers under these payments are defined broadly by the GP National Contract In a competitive market. This payment model is strong in prevention of health issues in consumers and reducing costs. However, critics of this model argue that quality of care suffers. Kaiser Permanente and ACOs in the US are examples of capitation payments to a network of institutional providers; however, these have specific quality targets not present in most capitation models.</td>
</tr>
<tr>
<td>Pathway/episode of care</td>
<td>Single payment to cover an entire episode/pathway of care.</td>
<td>Pathway/episode payments may cover all the activities after initial identification of a problem or need, from diagnostic investigation through to rehabilitation. In the Netherlands, an initial evaluation of episode-based payments for the standard care of patients with a number of common chronic health issues found an improvement in coordination of care between providers and improved adherence to care protocols by patients (Nutfield Trust, 2012).</td>
</tr>
<tr>
<td>Case-based</td>
<td>Activity-based reimbursement per patient based prospectively on diagnosis/patient characteristics.</td>
<td>Under activity–based funding, acute hospitals in Australia will receive payments for case-mix classification according to the Diagnostic Related Groups (DRGs) classification system.</td>
</tr>
<tr>
<td>Per Diem</td>
<td>Lump sum payment per patient per day of care regardless of consumption of care.</td>
<td>Many private healthcare insurers in Australia operate on Per Diem payments for hospital admissions. That is, the hospital receives a payment per day in hospital; however, the price per day usually decreases to encourage discharge.</td>
</tr>
<tr>
<td>Payment term/system</td>
<td>Description</td>
<td>Further description/examples</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fee for service</td>
<td>Activity-based (prospectively set) unit payment for a defined intervention regardless of patient characteristics or complexity.</td>
<td>GPs and specific allied health professionals in Australia receive fee for service payments for MBS items. For example, a GP is paid per consultation with a person regardless of complexity. This is often also accompanied by a gap payment by consumers. The form of payment does not encourage any efficiency in care pathway and is weak in enhancing technical and allocative efficiency. This payment model increases activity. It is very weak in controlling overall health care costs and encourages 'transactional' provider behaviour.</td>
</tr>
<tr>
<td>Pay for performance</td>
<td>Payment is linked to achievement of specific performance targets.</td>
<td>Australian GPs currently receive extra payments for meeting practice accreditation standards that represent this payment model. The biggest pay for performance system in the world, the quality and outcomes Framework was introduced in UK primary care in 2004. It is a voluntary scheme but almost all practices participate as they receive a substantial proportion of income through the scheme. Early evaluation suggests a positive impact on quality.</td>
</tr>
<tr>
<td>Bundled payments</td>
<td>A single payment covering multiple elements of a person’s treatment</td>
<td>Bundled payments involve the aggregation of different care requirements that were previously paid for separately, e.g. diagnostics, medication and treatment for specified condition. This model is considered to support collaboration across health professionals. In the Netherlands, bundled payments are being used to incentivise organisations to work more closely together for three specific chronic conditions: Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and vascular risk management.</td>
</tr>
<tr>
<td>Unbundled</td>
<td>Separate payments for disaggregated elements of a person’s care</td>
<td>Unbundling relates to services that were previously covered by a single payment to one provider – but are potentially better delivered in collaboration with other providers and multiple payments.</td>
</tr>
<tr>
<td>Mixed or blended systems</td>
<td>A combination of different payment methods.</td>
<td>In practice payment, systems may include some or all of these systems. For example, Australian GPs are currently paid through several of the models listed.</td>
</tr>
<tr>
<td>Individual care budgets</td>
<td>Provides individual budgets to people with long-term conditions to cover non-medical support services such as therapy and nursing services, home care, day care and meal services, complementary therapies, mobility assistance, leisure services and equipment.</td>
<td>These have been piloted in the UK since 2009. This funding model forms the basis of the National Disability Insurance Scheme to be introduced in Australia in 2013.</td>
</tr>
<tr>
<td>Accountable Care Organisations</td>
<td>Ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.</td>
<td>Traditional fee-for-service program who are assigned to it (centres for Medicare and Medicaid Services). This model is currently used in the US.</td>
</tr>
</tbody>
</table>
Appendix F: Case studies

The Diagnostic Report explored the current literature on integrated care and identified existing models of integrated care in Australia and internationally. The guiding principles of these models, challenges faced, lessons learned and outcomes achieved provided working examples of how integrated care can be achieved, and a selection are provided here for future reference.

National examples of integrated care

There are several examples of models of integrated care in Australia that target priority population groups or address specific diseases. Table 9 provides some practical examples of what action towards integration can be taken.

Table 4: Australian examples of integrated care applicable to integration of care for the older person with complex needs

<table>
<thead>
<tr>
<th>Health Pathways</th>
<th>What is HealthPathways?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Pathways</td>
<td>Health Pathways is an online health information portal for GPs to be used at the point of care. It provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the timeliest way. The name ‘Health Pathways’ reflects the referral lines or ‘pathways’ which link patients to the best treatment, local service or specialist.</td>
</tr>
<tr>
<td><strong>Who is involved?</strong></td>
<td>Health Pathways is aimed at General Practitioners but can also be used by hospital specialists, practice nurses/managers, and community and allied health providers. Health Pathways is the first online health information portal of its kind in Australia and is based on a highly successful model of collaboration developed in New Zealand by a group called the Canterbury Initiative.</td>
</tr>
<tr>
<td><strong>How is integrated care being achieved?</strong></td>
<td>Health Pathways is a dynamic collaboration between LHDs, Medical Locals, GPs, hospital specialists, nursing, and community and allied health providers. All are involved in creating Health Pathways and have been invited to be a part of its continuing development. Examples of some of the health pathways undertaken by partnerships so far include Chronic Obstructive Pulmonary Disease, chronic pain, paediatrics (i.e. UTIs, food allergies, eczema), maternity (i.e. anaemia, hypertension, epilepsy), psychosis, osteoarthritis, and wound management (i.e. burns, tears, cellulitis). Over time, more work will be done to create extra pathways, according to demand. Reported benefits of the Health Pathways approach are:</td>
</tr>
<tr>
<td>- GPs and primary health care providers manage a condition or accurately refer a patient to local specialists and services in as little as a few seconds.</td>
<td></td>
</tr>
<tr>
<td>- More patients get the right treatment or specialist care with less waiting time.</td>
<td></td>
</tr>
<tr>
<td>- GPs are enabled to better help patients by outlining information their patients need to know.</td>
<td></td>
</tr>
</tbody>
</table>

**ACI** is currently supporting the implementation of Health Pathways at three ML and LHD partnerships across NSW. Other LHDs and MLs are jointly self-funding the program.

<table>
<thead>
<tr>
<th>Inala Primary Care</th>
<th>What is Inala Primary Care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inala Primary Care</td>
<td>Inala Primary Care (IPC) was established in April 2007 as a collaboration between the University of Queensland and Queensland Health. The purpose and objectives of Inala are to:</td>
</tr>
<tr>
<td>- Provide best practice, patient-focused primary care to disadvantaged urban communities</td>
<td></td>
</tr>
<tr>
<td>- Integrate health care to control and prevent the progression of disease</td>
<td></td>
</tr>
<tr>
<td>- Provide facilities for research, teaching and education</td>
<td></td>
</tr>
</tbody>
</table>
• Increase the skills available within the medical community
• Disseminate health information and models to facilitate improved health outcomes
• Reinvest surplus revenues into projects designed to moderate the impact of disease
• Promote the development and adoption of clinical standards and evidence-based practice.

IPC’s approach is defined in academic literature as Primary Care Amplification. This approach includes first assessing the healthcare needs of the catchment and then developing services and recruiting specialised clinical expertise to work within novel models of care. This usually involves creating localised team care and shared care arrangements.

IPC’s approach has demonstrated success in managing even very complex patients, in a general practice setting, reducing the referral rate and admissions to acute providers.

IPC’s promise is that ‘No patient will leave feeling like a number because every consultation makes a difference!’

Within their local area in Queensland, Inala acts as a hub of ideas and professional development that other healthcare professionals and practices can access. It also acts as a central setting for the delivery of specialised care needed in the local area and provides partnership opportunities for less specialised practices wishing to utilise avenues for local, low-cost, high-quality care.

IPC’s core values reflect this focus and the way in which the teams work together. IPC is:
• Dedicated to making a difference for every patient
• Focused on innovation which matters to our patients and community
• Investing in people, relationships and systems to deliver great care
• Driven by passion for excellence in primary care, teaching and research
• Responsive to each other and flexible as we deliver care for others
• People you can trust and depend on who deliver results
• Courageous enough to change, learn and grow.

The IPC team includes a growing team of over eight full-time equivalent doctors. They are ably supported by three practice nurses and a range of allied health providers who operate from the practice. In addition, the practice houses a full-time Diabetic Educator, the Brisbane South Complex Diabetes Service and a Mental Health Nurse.

IPC has just over 300 patients concurrently enrolled in the clinic, which replaces the support traditionally delivered in hospital outpatient departments. In 2013 IPC aim to supplement this specialty by initiating new services for kidney and respiratory disease.

IPC is a not-for-profit company managed by a Board. Company Directors are drawn from the health sector, local community and the University of Queensland. All have management qualifications and experience, with most being members of the Australian Institute of Company Directors.

A Clinical Governance Sub-Committee defines IPC’s research and clinical delivery priorities and approves any new research projects or clinical services. It also reviews the teaching program, any serious adverse events or near misses, and recommends the clinical staffing composition and professional development needs of the business.

**Medical Staff:** 8.5 FTE doctors (Total Staffing 18.5)
**Total Allied Health Attendances:** 14 sessions across 5 disciplines per week
**Expected Turnover 2012–13:** $2.1 million (excluding Allied Health revenue)
**Patient Appointments Per Week:** 550 per week serving over 2300 active patients
**Average Patient:** 55 years old (over 80% concession card)

---

**Western Australia Dementia Model of Care**

This service delivery model of care is for older people with dementia and their carers across the continuum of care.

Most people with dementia are best managed in the community. A close partnership with the General Practitioner is important so that the person with dementia and their carer can feel safe and confident to live as independently as possible in the community. This model
focuses on improved assessment of care needs and clear communication processes at every point along the continuum of care with a focus on ‘Person-Centred Care’.

This model recommends eight broad key areas:

1. Adoption of identified Australian Best Practice Frameworks – These include age-friendly principles and practices, approaches to minimising functional decline and psychiatric/palliative care approaches
2. Community Care – Simplified access to information, eligibility, assessment, referral options and coordination of community care services
3. Risk Screening, Assessment and Diagnosis – Facilitate early risk screening, assessment, diagnosis and management of dementia across the continuum of care and enhanced communication of the needs of the person with dementia and their carer across the continuum of care.
4. Geriatric and Aged Care Consultation and Liaison Services – Formalised access and partnership between GPs, geriatricians, psycho-geriatric services and other specialist services, in relation to the assessment and management of patients with dementia within the hospital system and in the community. Strengthening of services specifically for older people in rural and remote areas.
5. Discharge Planning – Hospital discharge care plans to address the needs of the person with dementia and their carer and be clearly communicated to the recipients of care, General Practitioners and community service providers for ongoing management.
6. Older Person and Carers and Partners in Care – Carers and the older person with dementia to be provided with simplified access to information and education to assist them to understand dementia and the support needs of the person with dementia.
7. Workforce Education and Training – Access to quality education for staff who care for dementia patients, and dementia education to be included in appropriate curricula for all education levels.

The Yellow Envelope Project

The Transfer-to-Hospital Envelope (“the yellow envelope”) is a stand-alone tool with simple, clear instructions needing little implementation support or training to be used effectively.

Features of the Envelope are:

- A container for clinical and other handover information.
- A tick box checklist for aged care home staff on the back on the Envelope to readily identify clinical and other handover information required when transferring a resident hospital.
- The tick box checklist facilitates standardised content of clinical and other handover information going to hospital.
- The Envelope flags the patient in the Emergency Department as a resident of an aged care home.
- It informs hospital staff of the level of care of the aged care home the resident has come from and will return to.
- It provides a brief description for hospital staff of the range of levels of care in aged care homes.
- It has simple, succinct instructions.
- It preserves privacy by having no confidential clinical information on the outside of the envelope.
- It is resealable to enable ambulance officers and others repeated access to documents.
- It is used one-way for transfer in to hospital.
- It is a big (C4 i.e. bigger than A4) yellow envelope and low cost
International examples of integrated care

There are several international examples of how concepts of care integration have been successfully applied to aged health and social care. The examples described in Table 10 below are further described in the Literature Scan of the diagnostic report.

Table 5: International examples of integrated care for the older person with complex needs

<table>
<thead>
<tr>
<th>The LinkAGE – Leading Integration for Older People (New Zealand)</th>
<th>What is LinkAGE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Canterbury District Health Board is leading the implementation of the Integrated Continuum of Care model through the LinkAGE program. This system of care has been designed based on the assumption that the majority of older people have the most contact with primary health care professionals in the community and the service they require. These services need to be coordinated.</td>
<td></td>
</tr>
</tbody>
</table>

Who is involved?
The LinkAGE project’s Steering Group, which includes members of the Elder Care Canterbury Project, provides advice to the District Health Board about putting an integrated continuum of care into practice. The first step includes developing a system of care, establishing gaps and barriers to implementation, and looking at priority areas for future work.

How is integrated care being achieved?
Some of the objectives and tasks included in the LinkAGE action plan include:

1. **Strengthening primary care** by implementing and evaluating the Coordinator of Services for the Elderly model, which includes the role of a key worker to reduce the number of assessments and services involved in service provision and to coordinate the relationship between the older person and their primary health professional. This model has been successful in demonstrating reduced hospital admissions and/or the need for complex home care packages and ensure people stay in their homes for as long as possible.

2. **Simplifying funding available to older persons.**

3. **A focus on health promotion** by supporting and implementing programs such as ‘Stay on Your Feet’, which involves health professionals delivering home-based education to prevent falls for people 65+ over a six-month period. Another program is the Working Together for Winter group, involving primary, secondary, community services and the District Health Board, educating older people with information about flu vaccinations during winter.

4. **Piloting and evaluating an assessment tool that aims to have a tiered approach which allows for screening as well as more comprehensive assessments.**

5. **Developing a mental health strategy for older people.**

6. **Developing and strengthening the health profession and carer workforce.**

7. **Working collaboratively with other sectors and other Health District Boards.**

<table>
<thead>
<tr>
<th>The Singapore Programme for Integrated Care for the Elderly (Singapore)</th>
<th>What is SPICE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Singapore Programme for Integrated Care for the Elderly (SPICE) is a model of care developed by the Agency for Integrated Care to provide comprehensive, integrated centre-based and home-based services to support caring for the frail elderly. The SPICE model aims to deliver a more holistic model of care than what currently exists.</td>
<td></td>
</tr>
</tbody>
</table>

Who is involved?
AIC partners with Volunteer Welfare Organisations to operate SPICE Centres. These centres collaborate with public hospitals and nearby GPs to form an integrated model of care. Existing day rehabilitation centres are enhanced to enable the VWOs to deliver a higher quality of care.

How is integrated care being achieved?
The SPICE model enables the frail elderly who have high care needs and are eligible for admissions into nursing homes to recover within the community. Through SPICE centres, a multidisciplinary team made up of medical, nursing,
allied health and ancillary professionals provide a suite of patient-centric services, e.g. primary and preventative care; nursing care; rehabilitation services; personal care; and social and leisure activities. These services are delivered at both centres or at home depending on the patient’s needs.

Efforts to support this model of integrated care include increasing the physical capacity of existing day rehabilitation centres, increasing the capability to provide effective case management and working closely with health professionals, particularly GPs to provide medical support.

---

### A System of Integrated Care for Older Persons (Canada)

**What is SIPA**

A System of Integrated Care for Older Persons (SIPA) is a program of integrated care for the vulnerable community-dwelling elderly person. It offers community-based care with local professionals responsible for the full range and coordination of community, acute and long-term health and social services. SIPA serves as a single point for all frail elderly who are deemed eligible if they have severe disability.

**Who is involved?**

One SIPA Centre is responsible for the entire population of frail elderly in a given region. Care is planned and delivered by a community-based interdisciplinary team including the patient’s GP and a case manager.

**How is integrated care being achieved?**

Within SIPA, care is delivered by community-based interdisciplinary teams with full clinical responsibility for planning and delivering integrated care through the patient’s care trajectory. Patient’s needs are assessed on admission to SIPA and a series of evidence-based interdisciplinary protocols are developed and applied in collaboration with the patient’s GP.

To avoid inappropriate hospitalisation and long-term institutional stays, intensive home care, group homes and a 24-hour on-call service are available for rapid mobilisation if needed as an alternative to hospital and institutional care.

Case managers liaise with patients, and their GPs and caregivers, and actively follow patients throughout the care trajectory, ensuring continuity and easing the transition between hospital and community.

Benefits observed from a randomised controlled trial found a 50% reduction in hospital alternate-level inpatient stays (“bed blockers”) and increased patient satisfaction.
Appendix G: Kings Fund top 16 needs to make integrated care happen

The following are The Kings Fund’s top 16 needs to make integrated care happen at scale and pace.

1. Find common cause with partners and be prepared to share sovereignty
2. Develop a shared narrative to explain why integrated care matters
3. Develop a persuasive vision to describe what integrated care will achieve
4. Establish shared leadership
5. Create time and space to develop understanding and new ways of working
6. Identify services & user groups where benefits from integrated care are the greatest
7. Build integrated care from the bottom up as well as the top down
8. Pool resources to enable commissioners and integrated teams to use resources flexibly
9. Recognise that there is no ‘best way’ of integrating care
10. Support and empower users to take more control over their health and well-being
11. Share information about users with the support of appropriate information governance
12. Use the workforce effectively and be open to innovations in skill mix and staff substitution.
13. Innovate in the use of contracting & payment mechanisms & use of the independent sector
14. Set specific objectives and measure and evaluate progress towards these objectives
15. Be realistic about the costs of integrated care
16. Act on all these lessons together as part of a coherent strategy
Appendix H: References


ii ABS (2011) NSW population


