ACI NSW Agency for Clinical Innovation

ACI Aged Health Network

Integrated care for older people with complex health needs

Final

Diagnostic Report

September 2013

Version 2

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EXECUTIVE SUMMARY

The NSW Agency for Clinical Innovation is developing a strategic framework to support providers to help ensure older people, their carers and families receive high quality and evidence-based care i.e. where care is provided in a timely, equitable and coordinated way and delivered safely as close to home as is possible.

This project aimed to inform the development of the strategic framework by undertaking a snapshot diagnostic of healthcare services delivered across NSW for the older person with complex health needs, their carers and families and to identify best practice models and consistent themes of what works for whom and when and how it is integrated.

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 itself.

This person-centred care involves a relationship between a person, their carer and family and their clinical team based on mutual respect and collaboration – where people feel empowered to make the right decisions about their care and well-being, no matter what location or circumstance.

It also requires and needs to be based on 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; it has been heard in the rhetoric of 'partnerships' for many years now. The term 'integrated care' has been often used as a specific reference to apply to:

> *An approach that aims to improve the quality of care for individual patients, service users and carers by ensuring services are well-coordinated around the individual patient's needs.*[i]

The National Health Reform agenda has introduced integration of care as one of the key strategies to meet the 'different' care needs of individuals in 'settings of their choice' while also reducing national healthcare costs.

Internationally and in Australia, governments have realised that achieving healthy communities requires better integration of health care, community and environmental systems. Accordingly, they have set about strengthening the healthcare system as a whole. The concept of integrating care across services and sectors addresses many of the challenges faced by health care in Australia, in particular, the complex and fragmented method of delivering care and the difficult path for a consumer to navigate through the system.

The challenge for those who fund and provide care is in how to support, sustain and expand examples of good practice in integrated care that make the most of available assets and best utilise the health workforce; combined with the assurance of quality and safety, these are important pieces of the puzzle to deliver the right care, at the right time in the right place.

Summary of Findings

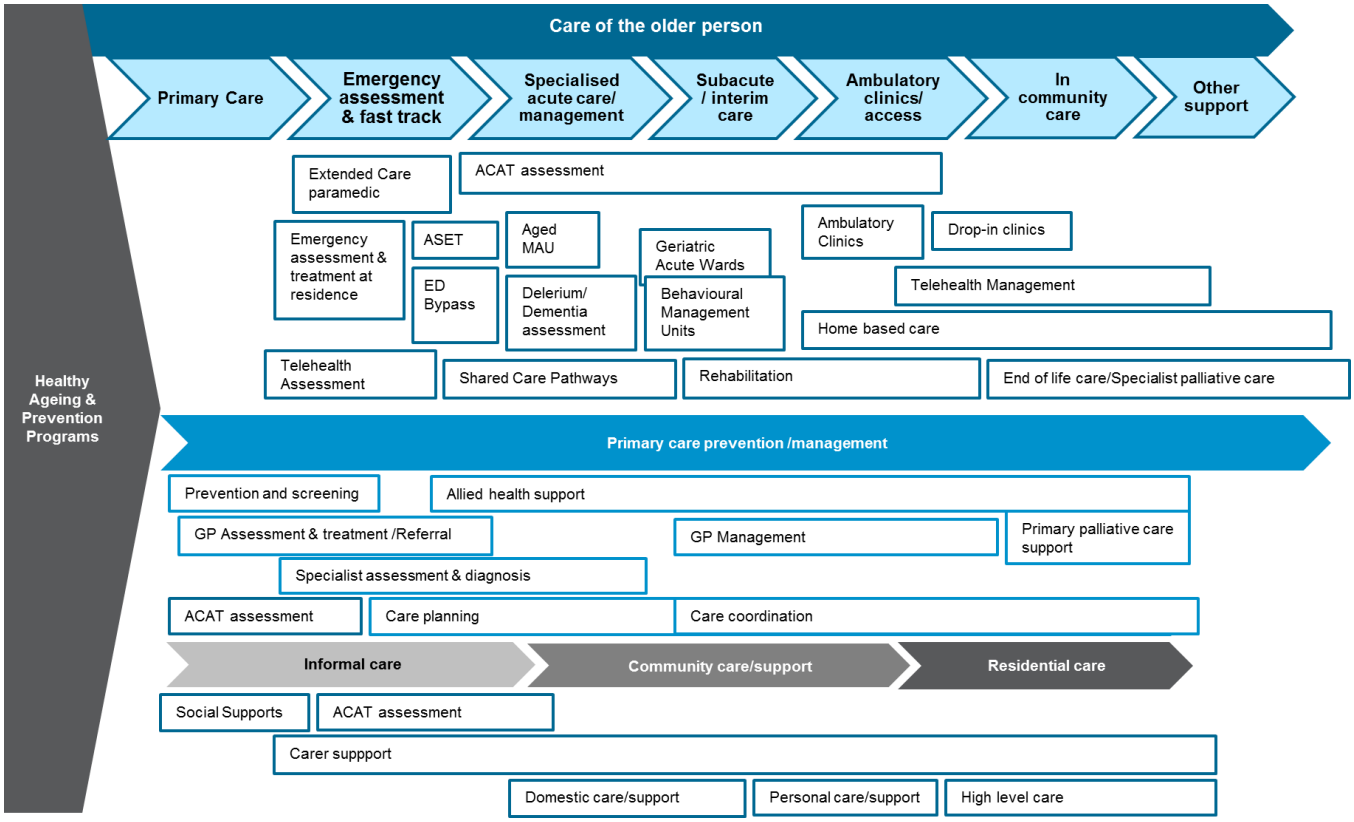
It is well established that older persons with complex health needs require resource-intensive care and on average have longer lengths of stay in hospital. In 2011–12 in NSW, older people in public hospitals accounted for 53 per cent of total bed days but only 38 per cent of hospital separations and had an Average Length of Stay (ALoS) of 8.4 days, almost double the 4.5 days for patients aged less than 65 years.[ii] It is also understood that there is significant care delivered out of hospitals, in the community and through aged care facilities; however, this data was not available for inclusion in this report.

This illustrates the fact that care of the older person is not a linear process and often involves many phases of their increasing and decreasing acuity and clinical stability. It also has many variables related to the older person's needs including their health literacy, ability to self-manage, social support and access to timely appropriate care.

While complex, care of the older person is provided across the continuum of care across three specific sectors with separate funding and management structures. For this reason, care is often provided in parallel by different healthcare professionals and different services with little communication or

linkages between them. There is no start or end point to this journey and it occurs across various settings. This continuum and the various services involved can broadly be illustrated as in Figure 1 with the recognition that older people with complex needs move between these services frequently as various issues arise. This diagram also describes the current lack of a person-centric approach and the division, duplication and potential gaps that occur between acute, community and primary care where there is little to no current communication between providers.[1]

Figure 1: Whole-of-system view of services for older people, their carers and family



This diagnostic report found that in NSW, there are many models of care and programs involved in the older person's journey through the health system but they are not integrated. There are numerous examples of networked or cooperative care between providers that represent examples of practitioners attempting to improve integration at the practice level. However, overall services for older people, their carers and family are often not connected at all, resulting in older people with multiple or complex health needs experiencing delays and gaps in treatment. The impact of this was reported by clinicians and consumers as being negative for the older person, carers and family members, often limiting access to care and exacerbating disease or the need for care.

To illustrate this, it was found that 86 per cent of hospital admissions of the over-65 age group (based on five years of historical data) are via the Emergency Department (ED), and approximately 59 per cent of these were for exacerbations of *chronic* rather than acute conditions.[iii] Further, readmission rates for the over-65 age group represented 18 per cent of separations for this age group compared to the 7 per cent average across other age groups.[iv] From the site visits, the most commonly reported reasons for hospital presentation included falls, urinary tract infections, delirium or dementia, and wounds. Often, it is therefore not the condition itself that makes the needs of an older person complex; rather it is the combination of conditions, their social situation or level of frailty which creates the 'complexity'. These issues are not easily captured in the routinely collected data.

[1] Please note less detail on primary and community-based care services was available through consultations and therefore is a limitation of this diagram.

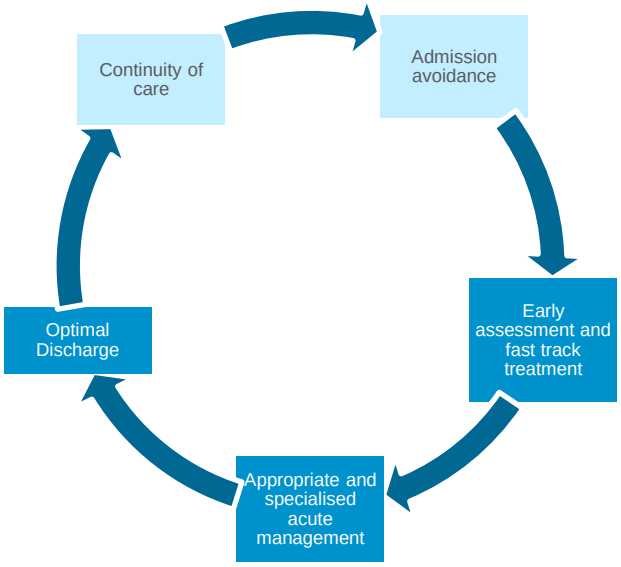
Key themes

The ten sites visited illustrated a range of good practices and innovations across the care continuum that roughly align with a strategic intent to better meet the needs of the older person with complex health needs more rapidly and more holistically. These are detailed in Section 4 of this report.

The following points summarise the key diagnostic themes explored through consultations (which are presented in detail in Sections 5 and 6)

- **Philosophy of care** – While there was alignment on the importance of 'person-centred care', this was rarely translated in service design or represented in anecdotal accounts of delivery. In practice, clinicians refer to older people as patients and report person-centred care as 'nice to have' but feel limited in their ability to be truly person-centred due to the design, established processes and pace of the acute facility environment. It was suggested that community-based care is 'better placed to provide this support'; community-based providers supported this view. Aged health services which had multidisciplinary services that stretched across the continuum of care and embraced an enablement philosophy were identified to have the most 'person-centred' approach.
- **Strategic purpose** – LHDs that had invested in a strategic approach to the management of older people with complex health needs across their services identified key factors to enhance care and reduce risks of deterioration: admission avoidance; early assessment and fast-track treatment; appropriate and specialised acute management; optimising discharge processes; and continuing care into the community.

Figure 2: Strategic purpose of aged health services delivered by an LHD



- **Access** – Older people with complex health needs often present to ED and are unnecessarily admitted to acute care. The most common reasons given for this occurring included:
    - A person's inability to access timely and appropriate clinical care or support services outside of the hospital which then led to rapid deterioration
    - Social admissions for the purpose of respite care
    - Inappropriate ambulance transfers in the absence of timely GP access (for this reason, some specific models have been developed to reduce transfers by Ambulance Service of NSW and Residential Aged Care Facilities (RACF) through the development of capacity and support to assess and treat issues common to older people directly without the need to go to hospital).

'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*

- **Eligibility** – Most services did not have specific age eligibility criteria for management by specialist aged health services, but instead use a set of age-related conditions or symptoms. Nevertheless, most services utilised a criteria of over 65 or over 70 years of age for general patient identification. However, the reported average patient age is over 80 years. This finding is significant to interpret data regarding this cohort, and further determine their characteristics and care needs.
- **Relationships** – Relationships between LHDs and Medicare Locals varied significantly between the ten sites visited. Some sites had well-established relationships, joint planning initiatives and partnership agreements in place; others had very little contact and no sign of coordinated efforts. The relationship with HACC or Aged Care Package providers was reported as most problematic, with extended waits to access services of up to 12 months.
- **Older person, their carers and families** – A consistent theme from the consultations was a lack of understanding among older people, their carers and families about what services are available, how to access them and where to get further support. Similarly, consultations with carers and family revealed a disconnection between their expectations of staff and the actual experience. While carer and families recognised the effort that individual staff make in providing care, they were critical of the lack of communication and explanation from clinical staff regarding diagnoses, future care requirements and the challenges associated in navigating through the aged health landscape. It was also noted that for people with poor health literacy or communication issues (such as limited English in CALD populations or the deteriorating ability to communicate due to age-related issues), there were neither robust nor standardised support services in place. This was often reported to be 'left to the social worker' who worked only part-time or on a consultation basis.

  Current service structures historically find it difficult to manage the drawn-out timeframe in which deterioration, due to frailty or other geriatric syndrome issues, occurs. That is, the decline of older people's health is unpredictable but often prolonged with periods of increased acuity and is difficult to plan for. However, this ambiguity does not mean that planning, structure and information is not necessary for older people, their carers and family to manage the psychosocial impact of deteriorating health. This type of proactive inclusion of individuals and carers in care planning was observed to be absent in most sites, contrary to consumer and carer preference and resulting, detrimentally, in an increased demand for acute service demand.

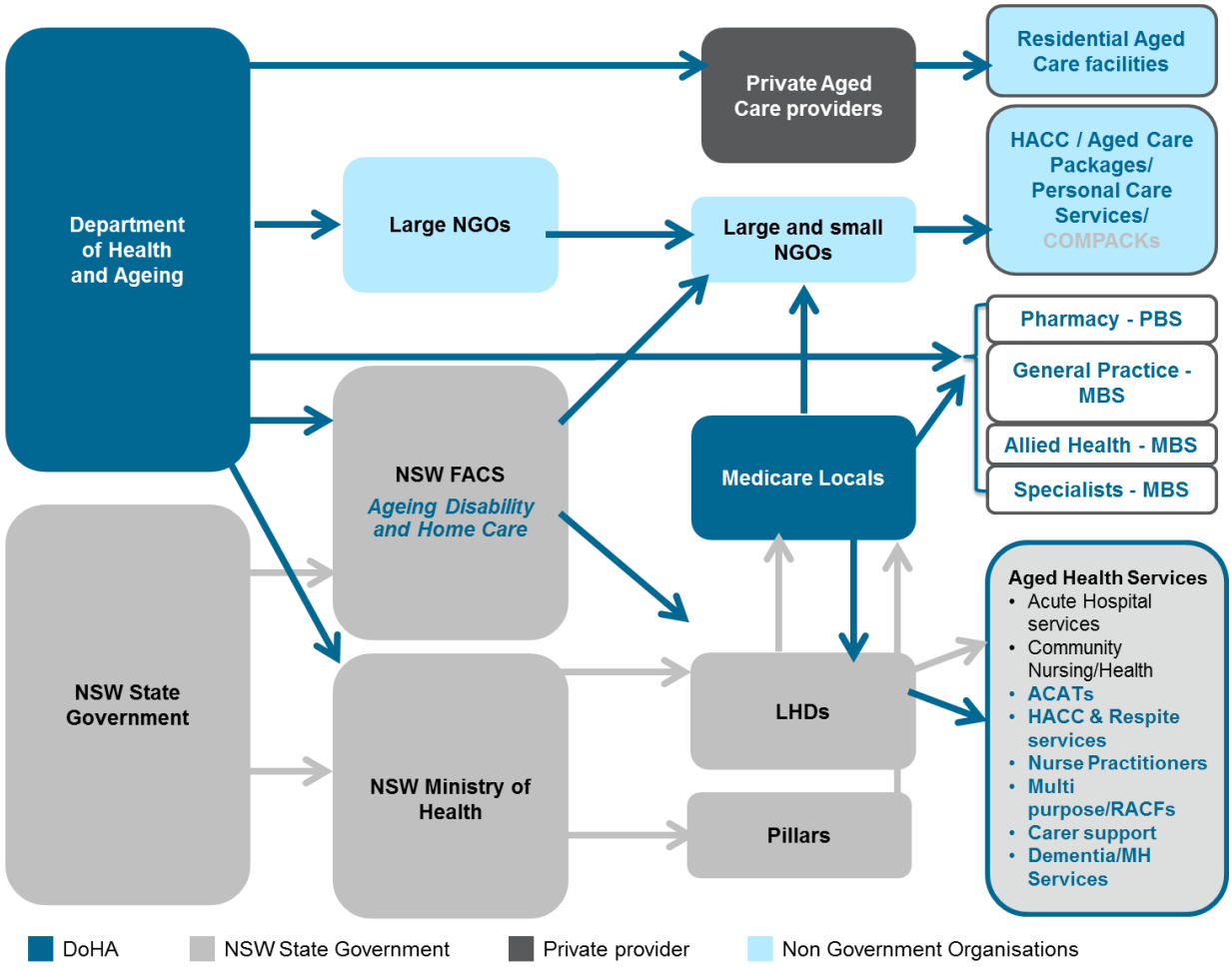
'All I would really like to understand is what to expect – if I had a plan for what to expect I'd be okay. That, and a number to call when he falls and I can't get him up off the floor would be great.' *Jan, 68 years old, carer for her husband with dementia*

- **People and staffing** – Most aged health services reviewed were led by dedicated and charismatic leaders who continually promoted the importance of effective aged health services within their hospital and community health service. Moreover, many of the aged health services are driven by committed staff who are passionate about aged health. Yet, challenges remain:
    - Workforce planning is based on historical or reactive recruitment practices that currently reinforce models of care that are not integrated or not person-centred
    - Resourcing and capacity are often considered to be a limitation for both metropolitan and rural and remote sites.

  Consumers expressed a vision for the future of aged health services with readily available access to services at home or in the community through doctors, nurses or allied health staff. There was significant support for primary care clinics co-located with other support services such as pathology, radiology and allied health. In particular, a 'one-stop shop' of multidisciplinary care, services and programs for older people would be ideal.
- **Funding** – The funding environment for aged health services in NSW is complex, including multiple sources of funding (including time-limited grants) from a range of agencies as set out in Figure 3 below. This makes longer term planning hard. Likewise, the distribution of funding towards aged health services by LHDs was reported as being variable across the state. On the positive side, there were a number of examples of LHDs realising direct cost savings where services had implemented specific initiatives targeting the needs of older people and carers in the community as

an adjunct or alternative to acute facility-based care. Similar savings and service efficiencies were realised by the Ambulance Service of NSW by redirecting resources in a targeted way.

Figure 3: Funding flow in NSW



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

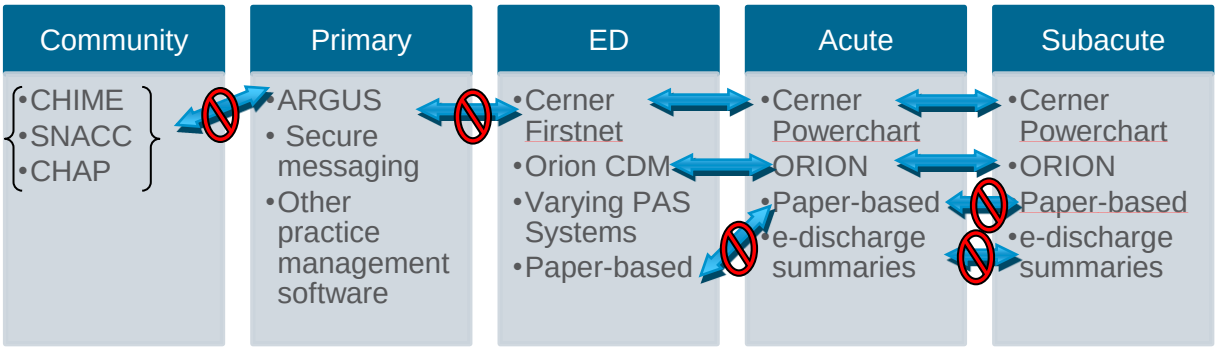
Consumers also noted cost and administrative burden as barriers to accessing early or preventative care.

- **Infrastructure** – An absence of proactive planning for the needs of older people with complex health needs was noted in most facilities, even in recent or planned renovations and rebuilds. Design features such as natural light, courtyards and simulated home environments were reported to improve the experience and behaviour of older people at risk of becoming distressed or exhibiting difficult behaviours.

  Carers of dementia sufferers noted the impact of the acute atmosphere on increasing difficult behaviours, including the necessity to go through ED and the lack of consideration in placing known dementia sufferers in busy areas.

- **Technology/information flow –** A major barrier to timely decision-making and communications between professions and care settings was an incomplete set of patient information. For example, patient files were often part electronic and part hard-copy, making them harder to connect up. It was acknowledged by LHDs, community providers and Medicare Locals that the limitations of ICT are a significant barrier to continuity of care as well as integration.

Figure 4: Technology systems and software across the care setting in NSW



- **Governance –** Strong multidisciplinary governance structures were an identified enabler to integration. Some sites visited had successfully created aged health governance arrangements at the meso-level, extending across all local aged health providers including RACFs, local non-government organisations (NGOs), Medicare Locals and General Practice. However, it was noted at some sites visited that the medical staff continue to meet separately from the nursing and allied health staff. Key executive and leadership meetings were also structured at these facilities to keep professions and specialties separate. Some positive developments were noted: joint planning and governance mechanisms are occurring between some LHDS and Medicare Locals and/or large NGOs. However, these governance and partnership arrangements are in early stages of development.
- **Discharge and continuity of care** – Proactive discharge planning was reported to have reduced ALoS for older people in acute care facilities as well as unplanned readmission rates. Timeliness of discharge and continuity of care are reported to be most impacted by the presence of a carer or that the person needing care is living alone, access to medical staff at the right time, and limited access to equipment, community care packages and high/low-level residential care beds. Receipt of discharge summaries by GPs was reported as improving with introduction of e-discharges but is not consistent.

  It was noted that the increase in complex clinical needs of older persons staying in the community and/or home environment is leading to an increase in pressure and demands on community services to support them. Therefore, it is important to consider the feasibility of the discharge plan and the implication on carers and family where these services are not available.

Key steps to greater integration

The key themes of this diagnostic report were used to recommend five clear steps forward in order to progress better integrated care for the older person with complex needs.

1. An agreed strategic purpose

Establishing an agreed strategic purpose for integrating care for older people with complex health needs in NSW will guide the day-to-day performance and decision-making of support services to achieve the best health outcomes for this cohort.

2. Aligning governance and funding

Strong and appropriate governance and funding models are critical to supporting the implementation of strategic vision and purpose, and to support integration and cost-effective services. These models will recognise the contributions of different stakeholders, prioritise the needs of relevant populations and identify how to best support and provide incentives for local integration.

3. Enabling providers

Better integration will enable providers to provide timely and efficient care through a solid and stable foundation of core services specific to aged health that cover the continuum of care. Contributing to this action will be appropriate workforce planning, better collaboration between providers and the application of improved technology, as well as tools, guidelines and processes to support integrated care, and much improved care planning and coordination.

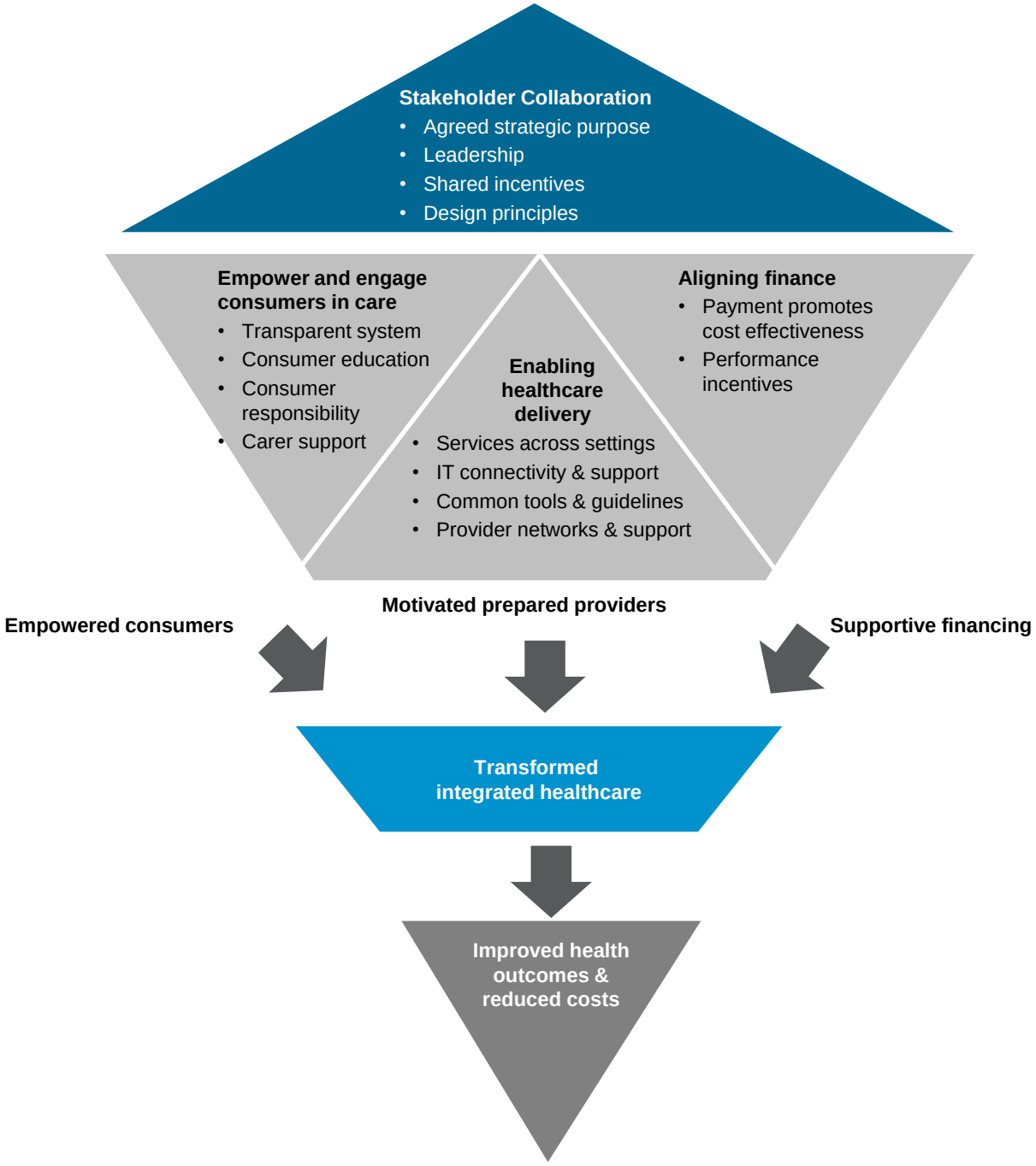
4. Empowering and engaging older persons in their care

Improving communication and involving people in decisions about their care is key to integrated care, as is linking them to support services and information. Also, recognising and supporting the significant and unpaid contribution to the health system made by carers reduces the demand for care of older people with complex needs, contributing to overall efficient use of resources in the system.

5. Shifting behaviours and attitudes

A final area for action underpins all of the others, and is the most important: the establishment and radical improvement of interprofessional or interorganisational collaboration, leveraging the skills of different health professionals to deliver effective care.

The diagnosis of the integration of services for older people with complex health needs in NSW was guided by the elements in Figure 5: Key elements of successful integration.



Conclusion

The design and implementation of a framework for integrated care for older people with complex health needs will support person-centred care and aim to eliminate the wasted time and effort that goes into delivering services for the same cohort in disconnected and different ways. The framework will aim to systematically remove barriers and implement enablers to connect care. Instead of dealing with issues in isolation (e.g. disease or treatment specific models of care), a systems-thinking approach is needed to identify the right care, right skills, right time, right place, right questions and the right next steps.

This diagnostic review of ten sites across NSW has identified practices for systemic implementation that will move services for older people with complex health needs toward integrated care delivery. At the centre of these practices is to place the needs of the older person with complex needs at the forefront and design services around the ways in which they wish to access care and self-manage needs.

This will mean that healthcare providers can no longer work in silos and may need to accept significant changes to their routine and professional hierarchy. Integration cannot be achieved by one provider but must reach across systemic boundaries including professional and geographical boundaries and across sectors. This includes cross-organisational and cross-sectoral partnerships to support the care of the older person and to facilitate an integrated care journey.

Improving and investing in models of care is not sufficient. It would ignore the lack of a joint plan between acute and community service sectors. It is clear that while there are numerous models of care in place to target effort at the most prevalent DRGs and LoS, gaps in communication and unmet demand for home and community care limits their effectiveness.

There are clear challenges to integrating the care for older people with complex health needs. In the early stages, it is necessary to demonstrate the immediate value of investment for all stakeholders prior to deciding on how care 'should' be delivered. It may mean breaking down the current system into components and putting it back together in a way that better fits the needs of the older person cohort, rather than according to professional groupings or funding streams. All of this may feel like a leap of faith. However, in the context of current healthcare reform, the strong evidence base of the benefits of multidisciplinary care, and the need to address current duplication of efforts and workforce inefficiency, it is clear that now is the time for change.

1. Introduction

Currently, older people[2] with multiple and complex health needs account for a disproportionately large share of the total cost of health care in Australia. Older people, their carers and families, and health professionals often have difficulty identifying and accessing appropriate services to suit their needs. The needs of an ageing population are reported to not be dealt with appropriately within the current restraints of primary care, yet not efficiently addressed in the hospital setting either. The demand for home care and community support outweighs supply, often resulting in unnecessary hospital admissions.

Where the health needs of older people with complex health needs are not adequately addressed, the consequences are often multiplied. However, older persons with multiple or complex health needs often experience treatment that is disconnected or delayed because of the disjointed application of existing models of care.

Older people and their carers have reported they require a system of care that is integrated and well-coordinated across specialist medical, primary care, community and aged care services. There is strong evidence that this approach to care and actively engaging the older person in planning and decision-making improves well-being and outcomes for older people

This report seeks to address the first step in achieving this: developing an understanding of the current services provided to older people with complex health need, identifying the challenges in providing these services and potential areas for their improved integration in health care.

The focus of this report will be on the acute care/LHD provided services and how they currently link or interact with other services.

1.1 Diagnostic report

The Agency for Clinical Innovation (ACI), Aged Health Network commissioned this project to provide a summation of healthcare services delivered across NSW, for older people with complex needs, their carers and families in NSW, identifying best practice models.

For the purposes of this project:

> *An older person with complex health needs is defined as one whose underlying comorbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis.*

This diagnostic report will inform the development of a NSW strategic framework for *The Integrated Healthcare of the Older Person with Complex Health Needs*.

The approach was to provide a snapshot overview – based on a review of national and international literature and analysis of ten site visits – of what is occurring in the local context of aged health care services in NSW, including what works for whom, how and when across settings.

The discussion of the findings from the ten site visits includes good practices and innovations, gaps in service provision, the impacts of current care delivery models, opportunities for improvement and enablers and strategies to support integration.[3]

Note, while sites were asked to invite key aged health stakeholders and participants including clinicians, consumers, carers, Medicare Locals, and community health providers as available, the focus of this diagnostic is predominantly focused on acute care.

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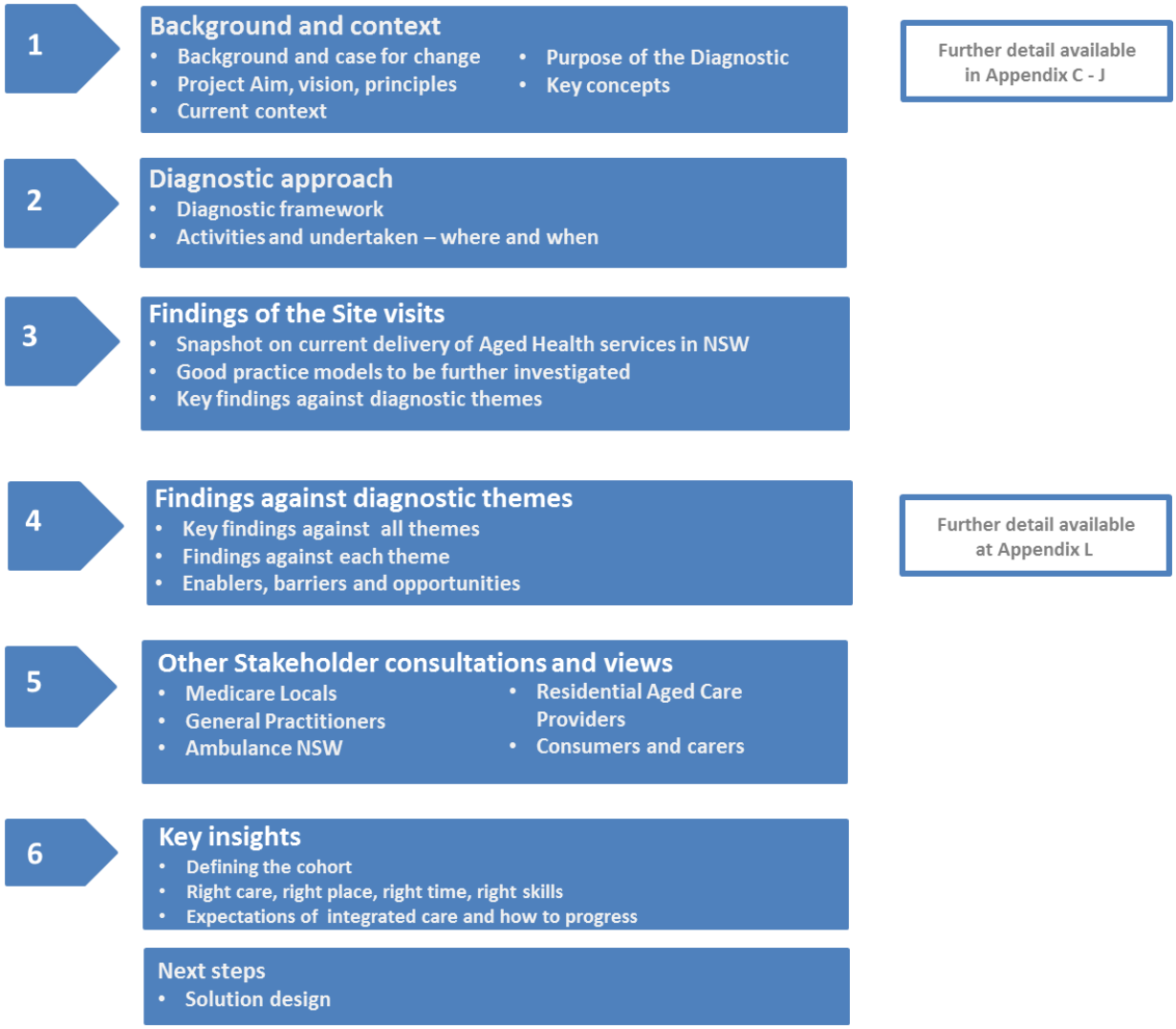
[2] An older person is defined as an individual over the age of 65 as defined by the NSW Ageing Strategy (NSW Government, 2012). Accessed 23 July 2013 at: <http://www.adhc.nsw.gov.au/about_us/strategies/nsw_ageing_strategy#strategy >

[3] Please note specific summaries of site visits do not form part of this report and were instead provided to ACI and participating sites separately.

1.2 Roadmap to this report



2. Background and context

2.1 Background and case for change

Research suggests that on the whole, older people in NSW are engaged community members, actively involved in volunteering, caring and informal community leadership roles and increasingly engaged in the workforce.[v] However, it is also widely recognised that the largest users of heath care are increasingly older people with multiple and complex health needs. At present in NSW, older people (aged 65 years and over) make up a substantial proportion of overall healthcare utilisation (e.g. bed days), despite representing a relatively lower proportion of separations. This is driven by the fact that this cohort has longer length of stays – almost double that of patients aged less than 65 years (8.4 days compared to 4.5 days).[vi] This longer length of stay is consistent with the national picture: in 2010–11, older people accounted for 38% of separations nationally but 48% of patient days.[vii]

Older people, their carers and families, and health professionals often have difficulty identifying and accessing appropriate services to suit their needs. The needs of an ageing population are reported to not be dealt with appropriately within the current restraints of primary care, yet not efficiently addressed in the hospital setting either. Issues such as chronic disease, end-of-life care, and subacute and comorbid conditions are complicated further by the inability of the healthcare system to enable older people to remain independent within a setting of their choice. The demand for home care and community support outweighs supply, often resulting in unnecessary hospital admissions.

Hospitalisation for older people is often traumatic and frequently associated with their functional decline (Birmingham City Council, 2011)[viii]. Where the health needs of older people with complex health needs are not adequately addressed, the consequences are often multiplied. For example, the failure to address smaller problems in primary care or ambulatory care in a timely manner can escalate into medical emergencies ultimately costing the health system more in terms of avoidable hospital admissions than if timely and appropriate care were available.[ix]

It can be argued that there are already many specific models of care that impact on specific parts of the older person's journey through the health system. However, older persons with multiple or complex health needs often experience treatment that is disconnected or delayed because of the disjointed application of these models.

Against this backdrop, the NSW Agency for Clinical Innovation (ACI) Aged Health Network has sought to understand how and when health care can be delivered differently or better to meet the needs of older people, their carers and families. This report seeks to address the first step in achieving this: developing an understanding of the current services provided to older people with complex health need and identifying the challenges in providing these services.

For the purpose of this project, an **older person with complex health needs** is defined as:

> *Someone whose underlying comorbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis.*

Contemporary definitions of complex health needs suggest individuals are multi-morbid rather than complex or comorbid. Older people are more likely to experience multimorbidity[4] – having three or more chronic conditions or contextual issues that complicate care. Multimorbidity has been associated with greater functional impairment, lower quality of life, increased disability, and the greater use of health care, aged care services and supported living arrangements. As the concept of complex health needs recognise the social, environmental, emotional and physical health needs of a person, care that addresses these needs must therefore also address each of these areas.

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 unpaid care and often face emotional, social and financial impacts. This impact is not 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 cohort.

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4 The definition of multimorbidity provides a person-centred and population-focused approach as it considers the impact of multiple conditions and issues on the person as a whole.

Older people and their carers have also reported they require a system of care that is integrated and well-coordinated across specialist medical, primary care, community and aged care services. There is strong evidence that this approach to care and actively engaging the older person in planning and decision-making improves well-being and outcomes for older people.[x]

Importantly, there are a significant number of older people in Australia who are in good health, participating in physical activity and living independently of aged care services.[xi,xii] Therefore the challenge lies in designing a health system that enhances the factors that promote healthy ageing and identifies risk factors at an early stage that threaten older people's ability to function or maintain independence.

In other words, it is a health system that:

> *Provides the right care, at the right time, in the right place to help older people, their carers and families stay healthy and independent*

Internationally and in Australia, governments have realised that achieving healthy communities requires better integration of healthcare, social and environmental systems. Accordingly, they have aimed to strengthen their healthcare systems as a whole. Every year:[xiii]

Australians of all ages have an average of 22 interactions with the health system, including four visits to a GP, three to a specialist and 12 prescriptions. Most of these services occur in a disconnected manner and important information regarding patients is not communicated or fed back. Some of these services may even be duplicative in purpose.

The National Health Reform agenda has introduced integration of care as one of the key strategies to meet the 'different' care needs of individuals in 'settings of their choice' while also reducing national healthcare costs. The concept of integrating care across services and sectors addresses many of the challenges faced by health care in Australia, in particular, the complex and fragmented method of delivering care and the difficult path for a person to navigate through the system.

The utilisation of historical service design and specific single-diagnosis-related care paths for older persons with multiple and complex health needs has resulted in exponentially increasing acute care costs and increased rates of admission to residential care. Currently providers are focused on the performance of their own individual care settings rather than supporting person-centred navigation through the system, as they are measured and incentivised accordingly to do so. This specialty approach has particularly negative effects for older people who tend to be viewed as problematic and burdensome when treated with this siloed approach. Research reports on the impact of negative attitudes of health care staff towards older people and how this negatively contributes to access and quality issues relating to their care.[xiv] The Australian Human Rights Commission (2012) advocates for an approach to health delivery that is non-discriminatory and promotes equality; ensures that services are available, accessible, appropriate and of good quality; and has an adequate monitoring mechanism to ensure government accountability.[xv]

Similarly there are safety and quality risks to people that must be addressed systemically in order to improve the basic level of care delivered and avoid unnecessary morbidity and mortality caused by communication breakdowns. 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.[xvi]

2.2 Aim

The NSW Agency for Clinical Innovation (ACI) will develop a strategic framework to support providers to help ensure older people, their carers and families receive high quality, evidence-based health care, i.e. where care is provided in a timely, equitable and coordinated way and delivered safely as close to home as is possible.

This framework will describe key components of an evidence-based, coordinated, timely, equitable and efficient *journey* in partnership with and for *older people with complex healthcare needs their carers and families* that is adaptable across metropolitan, regional, rural and remote areas in NSW.

2.3 Vision

The vision for the project established by the ACI Aged Health Network Executive is:

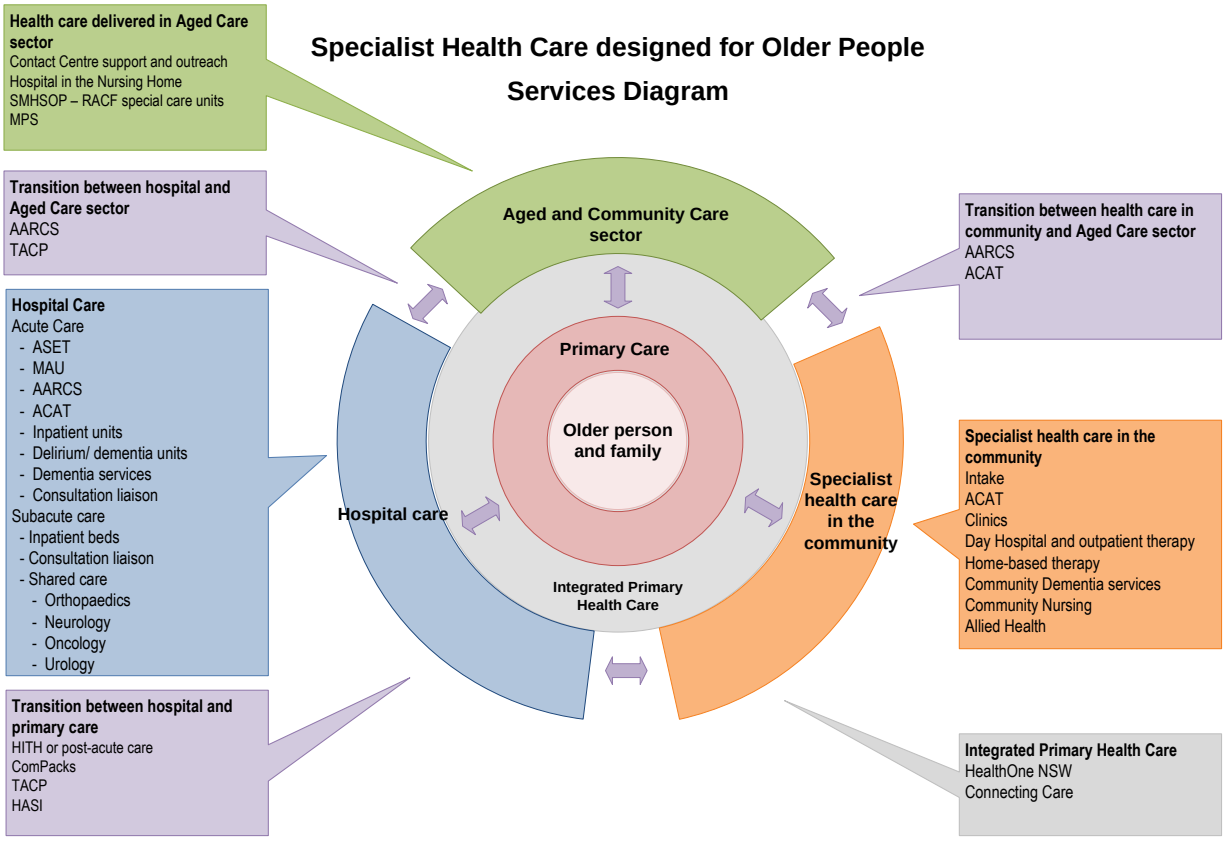
> *Older people, their carers and families in NSW, as partners in their care, are able to access appropriate, quality, evidence-based health care that is provided in a timely, equitable and coordinated manner and delivered safely as close to home as is possible.*

2.4 Current state

This framework will build on the following work undertaken in this area.

1. The Framework for integrated support and management of older people in the NSW health care system 2004-2006.xvii The framework aimed to guide and coordinate necessary improvements to service delivery for older people in NSW and to achieve a level of consistency in approach across the State.
2. The Specialist Health Care for Older People Framework which aimed to inform the development of Local Health District implementation plans that will help ensure that the health system is better equipped to care for all older people, regardless of their place of residence or reason for presentation to a health service.

Figure 6: Specialist Health Care designed for Older People Services



These frameworks have led to improvements in how healthcare is delivered to older people. Current specialist healthcare services designed for older people are represented in Figure 6. At the commencement of this project, the ACI Aged Health Network described the current state of aged health service delivery in NSW as having good practice in the integration of care for older persons with complex health needs “in pockets”. However, there is still significant work required to address the following:

- Inconsistency in care and patient journey experience across services
- Increasing demand for aged health services

- Increase in the cost of care for this population
- Under-utilisation of cross-sectoral partnerships.

2.5 Project principles

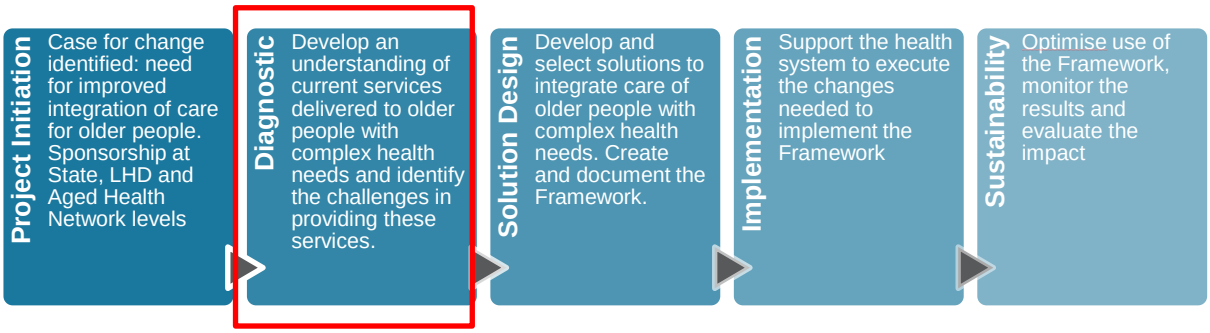
The following principles were developed by the ACI Aged Health Network Executive (based on the NSW Specialist Mental Health Services for Older People Service Plan 2005–2015) to guide understanding of what signifies 'good practice':

1. Promote independence, dignity and quality of life for older people with complex health needs, their families and carers
2. Embrace diversity in older people
3. Respect the rights of individual older people, their families and carers, and their goals in accessing health care
4. Respond to the special needs of priority population groups
5. Promote a holistic and multidisciplinary approach to care
6. Take a person-centered and flexible approach
7. Support continuity of care for older people with complex health problems.

2.6 Purpose of this diagnostic

To undertake a snapshot diagnostic of healthcare services delivered across NSW for the older person with complex healthcare needs, their carers and families, and to identify best practice models and consistent themes of what works for whom and when and how it is integrated. This phase and where it fits in the overall project is illustrated below in Figure 7.

Figure 7: Role of the Diagnostic within the overarching ACI process for framework development



Source: NSW Agency for Clinical Innovation

2.6.1 Objectives

The specific objectives of the diagnostic phase of the project are:

- To undertake a snapshot **diagnostic** of healthcare services delivered across NSW for older people with complex healthcare needs, their carers and families
- To identify **best practice models of care**
- To identify and document **consistent themes, enablers and barriers to integration**

2.6.2 Scope

For the purpose of this project:

> *An older person with complex health needs is defined as one whose underlying comorbidities and individual circumstances have a direct impact on their ability to function and maintain independence on a daily basis*
>
> *The NSW Health system is defined as services that are funded by the NSW Ministry of Health and are delivered by or interface with services of NSW Local Health Districts (LHDs).*

The following areas are considered to be a part of the project's scope:

- Healthcare services provided to older persons with complex needs, their carers and families, funded by the Department of Health and Ageing (DoHA), NSW Ministry Health and LHDs
- Services delivered in primary, acute, subacute and ambulatory care; outreach; State Government Residential Aged Care Facilities; and Multipurpose Services (MPSs) and via telehealth
- Services in metropolitan, regional, rural and remote settings.

Table 1: Diagnostic scope clarifications

The following services were defined as areas within scope for this project: • Non-government Residential Aged Care Facilities (RACF) and care provided within non-government RACF by NSW Health staff • Medicare Locals • Ambulance Service of NSW • Rehabilitation, Palliative Care and Chronic Disease Services. • Consumer and carer forums • Home Care of NSW	The following areas were defined as out of scope for this project: • Care provided within a non-government RACF by staff not employed by NSW Health • Care provided within Private Hospitals • Interstate care • Justice Health • The development of new models of care.

2.6.3 Methodology

The basis of this report is the information provided to us by LHDs, Medicare Locals and other interviewed stakeholders. Therefore, this report relies on the completeness and accuracy of this information. Validation checks have been performed where possible with information provided in publicly available literature.

Sites were selected by the ACI Aged Health Network Executive as potential examples of good practice in delivery and integration of aged health services.

The stakeholders and services involved in consultations at these sites were those who deliver aged health services. Consultations were dependent on stakeholders' willingness and/or availability to attend on the day of consultations.

Where specific stakeholders in scope were deemed to be underrepresented the project team sought out stakeholder views through further independent consultations. These views are summarised in Section 6.

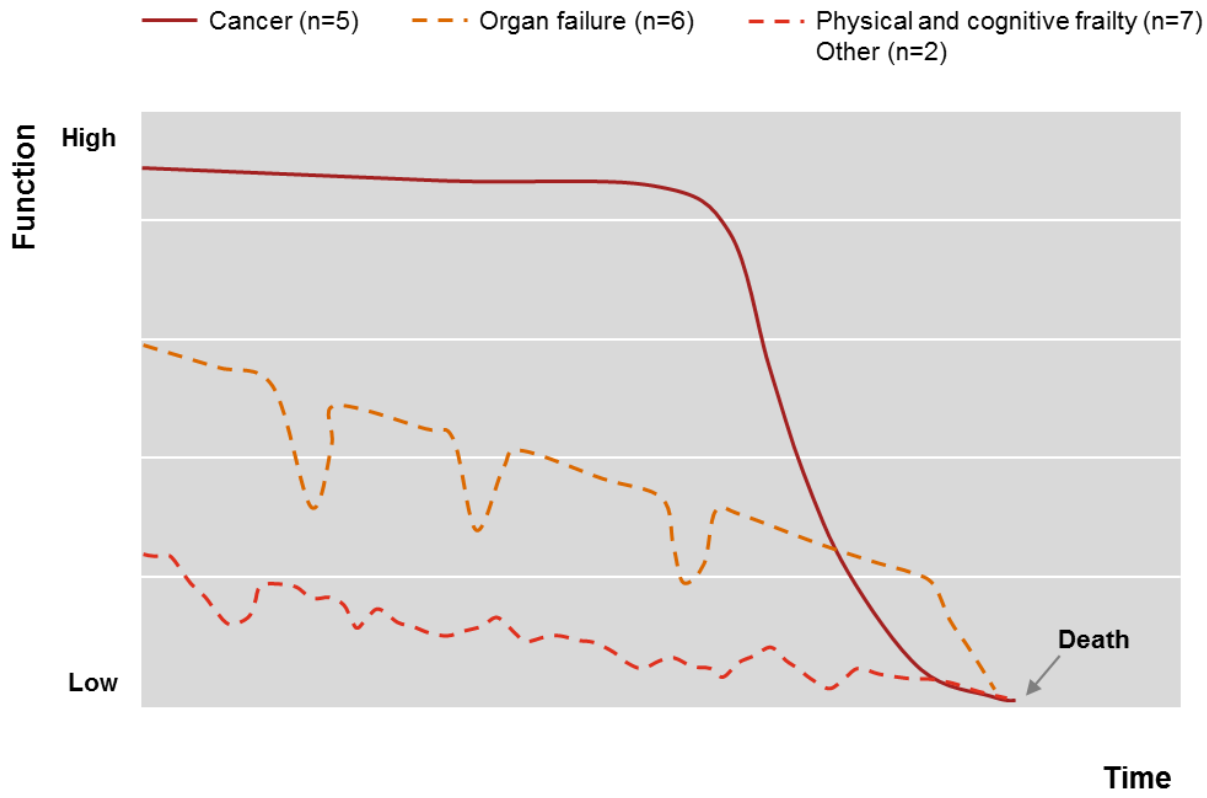
2.7 Defining the current context

Historically, health care in Australia has been complex, fragmented and disconnected. This lack of connectivity has been due to the different roles, responsibilities and funding models between different levels of government, as well as to the diversity of delivery systems involving the public, private and non-government sectors.

This historical service and workforce design and specific single-diagnosis-related acute care paths for older persons with multiple and complex health needs has resulted in exponentially increasing acute care costs and increased rates of admission to residential care.

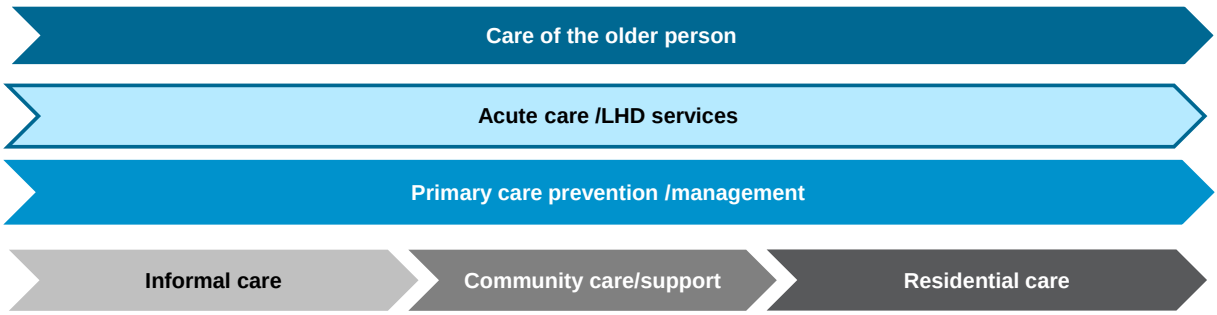
Care of the older person is not a linear process. It often involves many phases of increasing and decreasing acuity and clinical stability. Figure 8 illustrates the prolonged and undulating trajectory of decline for people with physical and/or cognitive frailty (e.g. dementia). Care of the older person also involves many other variables related to the older person's needs including their health literacy, ability to self-manage, social support and access to timely appropriate care. Due to these variables care of the older person is perceived to be unpredictable and therefore unable to be planned for or managed.

Figure 8: Three key trajectories for decline at end of life (Murray et al., 2008)



Care of the older person is, however, provided across the continuum of care across three specific sectors with separate funding and management structures. For this reason care is often provided in parallel by different healthcare professionals and different services with little communication or linkages between them. This continuum and the various services involved can broadly be illustrated as in Figure 9 with the recognition that older people with complex needs move between these services frequently as various issues arise.

Figure 9: Care of older people across the continuum of care and sectors



The consequences of the design of this system have been negative for the older person, often limiting access to care and exacerbating the progression of disease or the need for care. The focus of this

report will be on the acute care/LHD provided services and how they currently link or interact with other services.

The Commonwealth, State and Territory Governments have agreed to a national reform of the health system. The reforms aim to improve health outcomes and ensure the sustainability of the health system, and have already begun to change the way in which sectors relate to each other. These national health care reforms will help drive improvements in the way in which health services work together and similarly, the way in which people access care.

The expected benefits of reform for people who use health services include better access to the right services at the right time and improved coordination across settings and sectors, with a net gain in both health outcomes and the long-term containment of cost to the system. Of specific note, for the purpose of this project are the changes to aged health services through the *Living Longer, Living Better aged care* reforms which specifically aim to *'build a better, more accessible, sustainable and nationally consistent aged care system for older Australians and their families.'* The package represents the start of a ten-year reform program aimed at providing older Australians with more choice, control and easier access to a full range of services including[xviii]:

- *Increasing support for older Australians to age at home* through expanding the Home Support program, increased choice and control for consumers, and a fairer means-testing assessment. This includes a new Home Care Packages Program providing four levels of care to help older Australians living at home. The number of Home Care packages will increase from 60,000 to 100,000 over the next five years and will be delivered under a 'Consumer Directed Care' model, giving people choice and flexibility in how that care is provided.
- *Establishing the Aged Care Gateway* call centre and My Aged Care website and quality indicators
- *Significant changes to funding for residential aged care*: building more residential care facilities; supporting the viability of services in regional, remote and rural areas; trialling Consumer-Directed Care; improving the means-testing for residential care, and the Aged Care Funding assessment
- *Strengthening the aged care workforce*
- *Improving consumer advocacy*
- *Improving Dementia support:* Introducing a Dementia Supplement in home and residential care; increasing focus on people with younger onset dementia; and reducing time between symptoms and diagnosis
- *Supporting older Australians from diverse backgrounds*: more aged care places for Indigenous Australians; support for veterans with mental health problems; staff training and helping homeless people stay in the community.

These reforms will have a significant impact for Government bodies, service providers such as LHDs and health professionals. The aims of building a better, more accessible, sustainable and nationally consistent aged care system is aligned to the objectives of the NSW Ageing Strategy, particularly with regards to keeping older people healthy and in the community for as long as possible.[xix]

More information on some of these specific reforms is available at Appendices E to G.

The implications of these reforms on the funding arrangements for care are discussed at a high level in Section 5.2.6

2.7.1 The NSW context

The NSW Government has identified the following goals in their NSW 2021 Plan[xx]:

1. Supporting the most vulnerable members of the community and breaking the cycle of disadvantage
2. Better supporting people with a disability by providing support that meet their needs
3. Keeping people healthy and out of hospital
4. Providing world-class clinical services with timely access and effective infrastructure.

These targets are highly relevant to this project because people aged 65 and over account for 14 per cent of the NSW population, 38 per cent of hospital separations and 48 per cent of patient bed days.[xxi,xxii]

Further, based on the recent NSW Government's ***45 and Up study***, the greatest predictors for hospitalisation in those Aboriginal and over 45 years or non-Aboriginal and over 65 years of age are:[xxiii]

- Previous unplanned admissions/ ED presentations
- Older age
- Cognitive and/or physical functional status (e.g. dementia or musculoskeletal).

NSW Health data projects that from 2011 to 2021 the NSW population will grow by around 3.5 per cent (400,000) and the growth in the population over 65 will be 34 per cent (ten times higher).[xxiv] Further estimates suggest that the number of people aged 65 years and over will increase from 14 per cent to 24 per cent of the NSW population between 2012 and 2050.[xxv] Table 2 provides the numerical breakdown and projections by LHD.[5]

It is well established that older persons with complex health needs require resource-intensive care and on average have longer lengths of stay in hospital. In 2011–12 in NSW, older people in public hospitals accounted for 53 per cent of total bed days but only 38 per cent of hospital separations. They had an ALoS of 8.4 days, almost double the 4.5 days for patients aged less than 65 years.

It is also understood that there is significant care delivered out of hospitals, in the community and through aged care facilities however this data was not available for inclusion in this report.

Table 2: Current and projected LHD 65+ year age group populations

LHD	2011–12	2021–22	% growth
Central Coast	60,090	74,347	24%
Far West	5,482	6,438	17%
Hunter New England	148,578	201,714	36%
Illawarra Shoalhaven	67,762	91,855	36%
Mid North Coast	43,514	64,784	49%
Murrumbidgee	40,632	53,164	31%
Nepean Blue Mountains	40,462	57,049	41%
Network with Vic	7,343	10,883	48%
Northern NSW	55,772	79,943	43%
Northern Sydney	125,748	153,361	22%
South Eastern Sydney	115,781	142,166	23%
South Western Sydney	100,402	145,538	45%
Southern NSW	33,308	49,942	50%
Sydney	67,968	88,160	30%
Western NSW	43,546	56,332	29%
Western Sydney	87,935	124,075	41%
Grand Total	**1,044,323**	**1,399,752**	**34%**

Source: *NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.*

Data analysis undertaken by the ACI shows that volume (separations) bed-days and cost-weighted separations over a five-year period reveals the demand for acute health care in the aged is being driven by only a few conditions. That is - it was found that 20 Diagnosis-Related Groups (DRG) represented 25 per cent of all activity in those aged 65–74, 28 per cent in those aged 75–84 and 35 per cent in those aged 85 and over.[6] The main DRG drivers relating to volume of those aged 65 and

[5] It should be noted that this data does not include Aboriginal and Torres Strait Islander people that are over 45 but under 65 years of age. This is an area noted for further investigation given the findings of the 45 and Up study described above.

[6] As above, this data does not include Aboriginal and Torres Strait Islander people over 45 years of age but under 65 years.

over is chronic obstructive airways disease (COAD) and rehabilitation (specifically reconditioning related to their hospital stay). Table 3 provides a breakdown of the top three DRGs by volume in three age cohorts (as coded per diem).[xxvi]

Table 3: Top three DRGs in terms of volume for age cohorts 65 and over

65 to 74 years	75 to 84 years	85+ years
1. Chest Pain 2. Chronic obstructive airways disease (COAD) without Catastrophic (Cat) of Severe (Sev) CC 3. Rehabilitation with Cat or Severe CC	1. Rehabilitation with Cat or Severe CC 2. COAD W/O Cat or Severe CC 3. Heart Failure and Shock W/O Cat CC	1. Rehabilitation with Cat or Severe CC 2. Other Factors Influencing Health Status changes to Rehabilitation 3. COAD and the Heart Failure and Shock W/O Cat CC

In terms of bed-day utilisation, the top four DRGs were uniform across the three age groups. While chest pain represented the highest volume in those aged 65 to 74 years, COAD [with or without CCs] was the most common DRG by volume. Rehabilitation (with or without CCs) was the most common in those 75 and over. Interestingly, the most common principal diagnosis in 'Other factors influencing health status' (DRG Z64A) was 'Person awaiting admission to residential aged care service', representing half (51 per cent) of all the principal diagnoses.

Three of the DRGs (Rehabilitation W Cat or Sev CC, Rehabilitation W/O Cat or Sev CC and Other Factors influencing Health Status) associated with the highest number of bed days are DRGs that relate to subacute or other health services. That is, these are not the reason for original admission but an outcome of the hospital stay. In regards to rehabilitation this is most often associated with the significant functional decline that occurs in this cohort.

The comorbidities were similar in those aged 65–74 and 75–84 but different to those aged 85+. Dementia, unspecified urinary tract infection and volume depletion were more common in the oldest age group (85+). Also, those aged 85 years and over with dementia were seen to stay twice as long in hospital when compared with those aged 65–84 years with dementia within the exact same DRG.

A recent analysis of data from 2007–08 to 2011–12 for those people aged 65 years in NSW found that two key conditions for which older people enter hospital are respiratory (DRGs E62A, E62B, E65A, E65B) and cardiac conditions (DRGs F62A, F62B, F74Z, F76A, F76B).

The analysis also revealed that 86% of admissions for the 65+ group were via ED; and for patients 65+ with respiratory conditions, this accounted for 92%. An assessment of these admissions also revealed that 59% of the 65+ cohort were for chronic respiratory conditions as opposed to acute ones. Existing research suggests that a proportion of admissions and readmissions for chronic conditions generally can be prevented.

Readmission rates on average for all separations in NSW is 6 to 7%, but was reported to be much higher at 18% for the 65+ cohort. For the 65+ with respiratory conditions, readmission rates were at 21% to 23%. The same review found that system and patient benefits could be realised through reducing Emergency Department presentations particularly for people with chronic conditions through:

- Better community management and/or an increase in planned admissions
- Reducing the readmission rate within 28 days for older people with a respiratory condition
- Reducing unnecessary respiratory admissions, where older people have a chronic non-complex respiratory condition (with no comorbidities).

The results of this cost-benefit analysis estimates the net benefits of the combination of the three changes outlined above to equal $5.1 million in 2013–14 and a total benefit of $10.3 million in 2021–22. Total net benefit over the 10-year timeframe is equal to $73.4 million. This benefit is the equivalent to approximately $500 per patient per year (an approximately 6% reduction to the average cost of a separation).

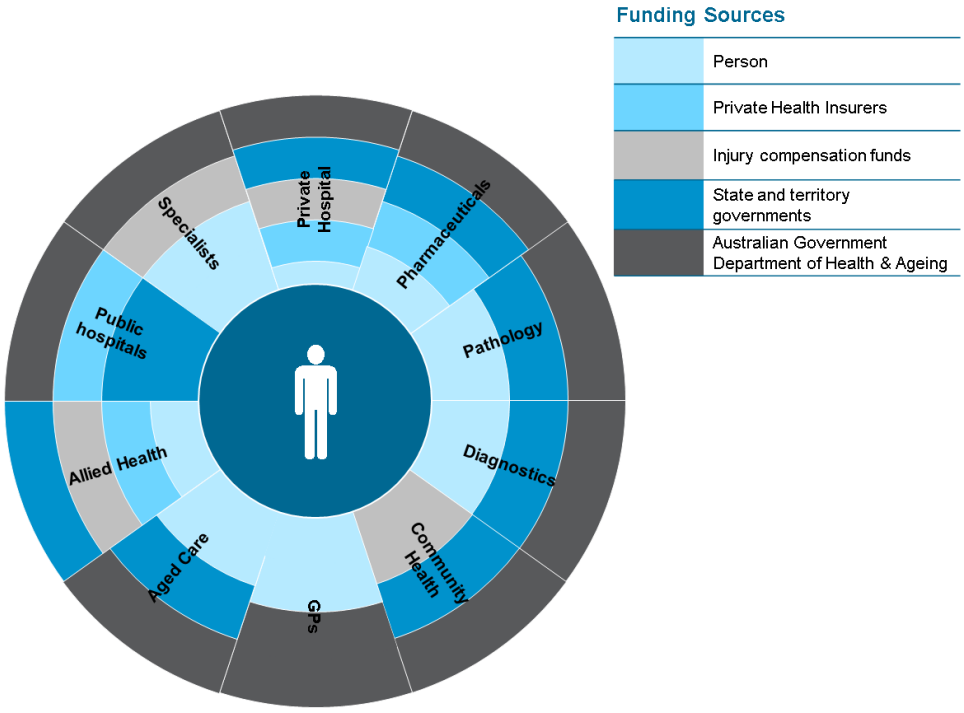
Source: ***ACI and PwC, (2013) Using Activity Based Costing in design of patient pathways for older people***

2.7.2 Funding context

Historically continuity of services has been negatively impacted by the complexity and fragmentation of Australian healthcare funding models. Figure 10 provides an overview of how health services are funded in Australia.

The current reforms in both the health and disability sectors have brought unprecedented structural change across the primary, hospital and aged care sectors with concomitant implications for funding. This section provides a high-level summary of these changes.

Figure 10: Funding Sources in the Australian healthcare system[xxvii]



The question of the best funding mechanisms to promote quality and sustainable integrated care is complex and not yet resolved in the Australian context, therefore there is no current view on what would work best for integration of care for older people with complex needs. While funding models are an important instrument to help implement health policy objectives, one size does not fit all.[xxviii,xxix]

Under the national health and disability reforms, new funding models are being developed and tested in a range of settings and sectors including:

Activity Based Funding – which links funding allocations for public hospitals to services delivered. For this reason, the appropriate 'coding' of patients for diagnosis and complexity is highly important in order to receive funding that is relative to cost of care. This is particularly the case with older persons with multi-morbidities and complex needs.

Medicare Local Flexible Funding – Medicare Locals now receive funding under multiple service contracts (including many aged health and chronic disease initiative) as well as a pool of funds for 'flexible' use based on local identified needs.

National Disability Insurance Scheme (NDIS) – People with disability living in select pilot sites will be phased into the NDIS on a month-by-month basis and allocated individualised funding packages, allowing them to pick and choose the support services they need.[xxx]

Further details on funding models for collaborative care are located at Appendix E

As part of the National Partnership Agreement (NPA) on Hospital and Workforce Reform, NSW received $165.7 million for the specific enhancement of subacute care service volume and quality

across rehabilitation, palliative care, geriatric evaluation and management (GEM), and psycho-geriatric care in order to achieve 20 per cent growth between 2009–10 and 2012–13. To do so, each LHD selected and put in place key strategies to enhance subacute care, some of which have had a direct impact on services related to aged health. Funding finished on 1 July 2013 and specific services supported by this funding were either disbanded or continue to be supported by the LHD. LHDs have collectively been funded $100 million to review and assess the models of care for those patient services previously funded under the NPA.

2.8 Key concepts

Before delving further into this diagnostic report, a few key concepts need to be defined and understood, as described below:

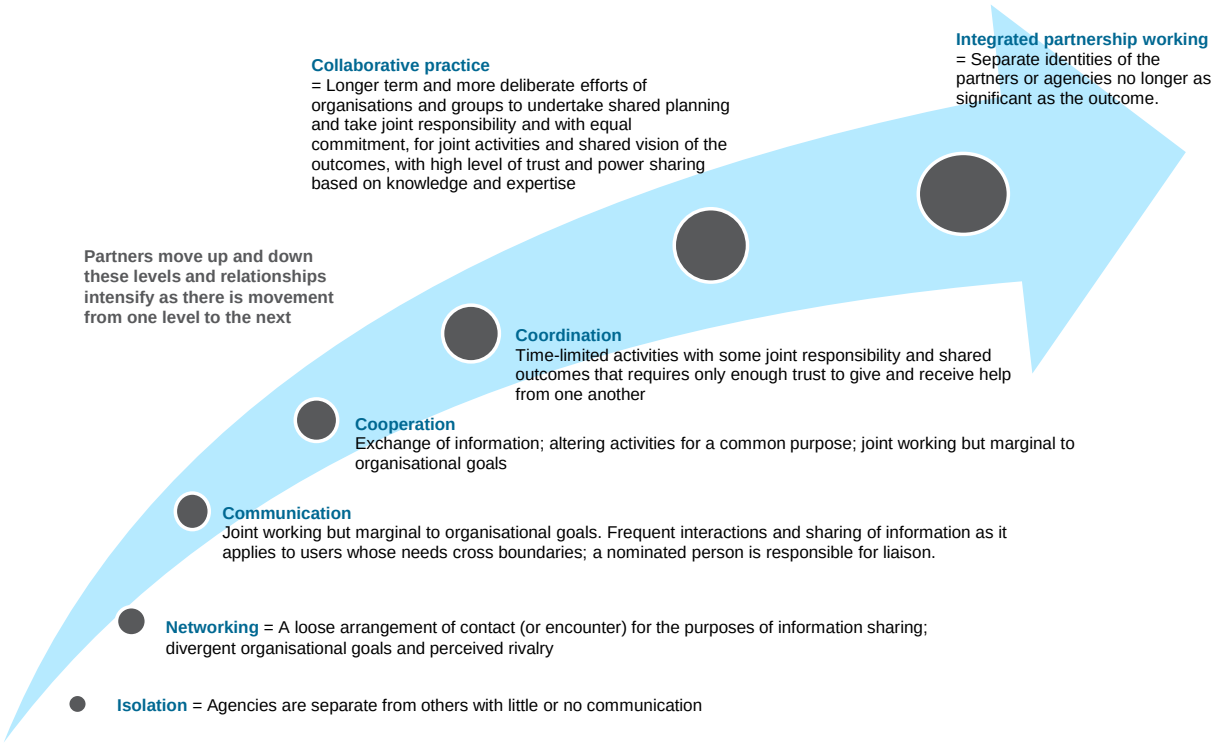
2.8.1 What is integrated care?

This diagnostic report specifically seeks to understand the integration of care in aged health services across NSW; therefore it is important to first define this concept. However, it is difficult to propose a single definition of integrated care or integration that is universally agreed upon, as there are many conceptual frameworks available.[xxxi] (See Appendix C for more detail on these)

A definition also needs to differentiate the overall concept of integrated care from its component such as communication, cooperation, coordination, or collaboration. These are often incorrectly used interchangeably and mean similar but different things. Keleher's (2012) framework Figure 11 provides a useful point of reference to see the progression of relationships between providers as integrated care efforts are being implemented.[xxxii]

Integrated care can be thought of as a progression of stages through which individuals and organisations move upwards. As relationships intensify, there is movement from one level to the next in the direction away from isolation towards integrated working partnerships.

Figure 11: Stages of integration (Keleher, 2012)



A popular definition of integrated care by the Kings Fund (2012) that describes **integrated care** as:

> *An approach that aims to improve the quality of care for individual patients, service users and carers by ensuring services are well-coordinated around the individual patient's needs.*[xxxiii]

A 'narrative' around **integrated care** developed by users of health care with the assistance of National Voices UK is also useful.[xxxiv] This narrative defined **integrated care as *person-centred coordinated care*.** This definition reduces the focus on integration of services while increasing the focus on coordination around the person and the patient experience.

For the purpose of this project, the following working definition has been adapted by the ACI Aged Health Network Executive of integrated care for older persons with complex needs:

> *Integrated care of the older person brings together different organisations, processes, systems and professionals involved in delivering person-centred care.*
>
> *The aim of integrated care is to improve quality of care and the experience of the older person, their carer and family's experience through better-coordinated and more effective delivery.*

***Integration** of care* can be thought of as occurring at different but connected levels: macro, meso and micro.[xxxv]

Macro-level integration is across the entire healthcare system. It is achieved through aligned and supportive legislation, regulations, policies, funding models, professional education, accreditation and liability at the national and state levels. For the purpose of this report, this level represents the federal and NSW State Government services as well as those provided by professional peak bodies and national or state level NGO or private providers.

Meso-level integration is at a regional or local level and addresses a population cohort need within a specific region. This can be achieved by connecting and bringing organisations together through collaborative agreements, working groups and service networks e.g. for a specific population or disease group. For the purpose of this report, this level refers to LHDs, large NGO or private providers and Medicare Locals.

Micro-level integration refers to that which occurs at the level of the practice and individual. This can be achieved through developing good working relationships characterised by trust and respect and centred on care planning and case management of a single person or a small group of people. This would include individual clinicians or small groups of service providers (e.g. ward, specialty or clinic) working together towards a common goal.

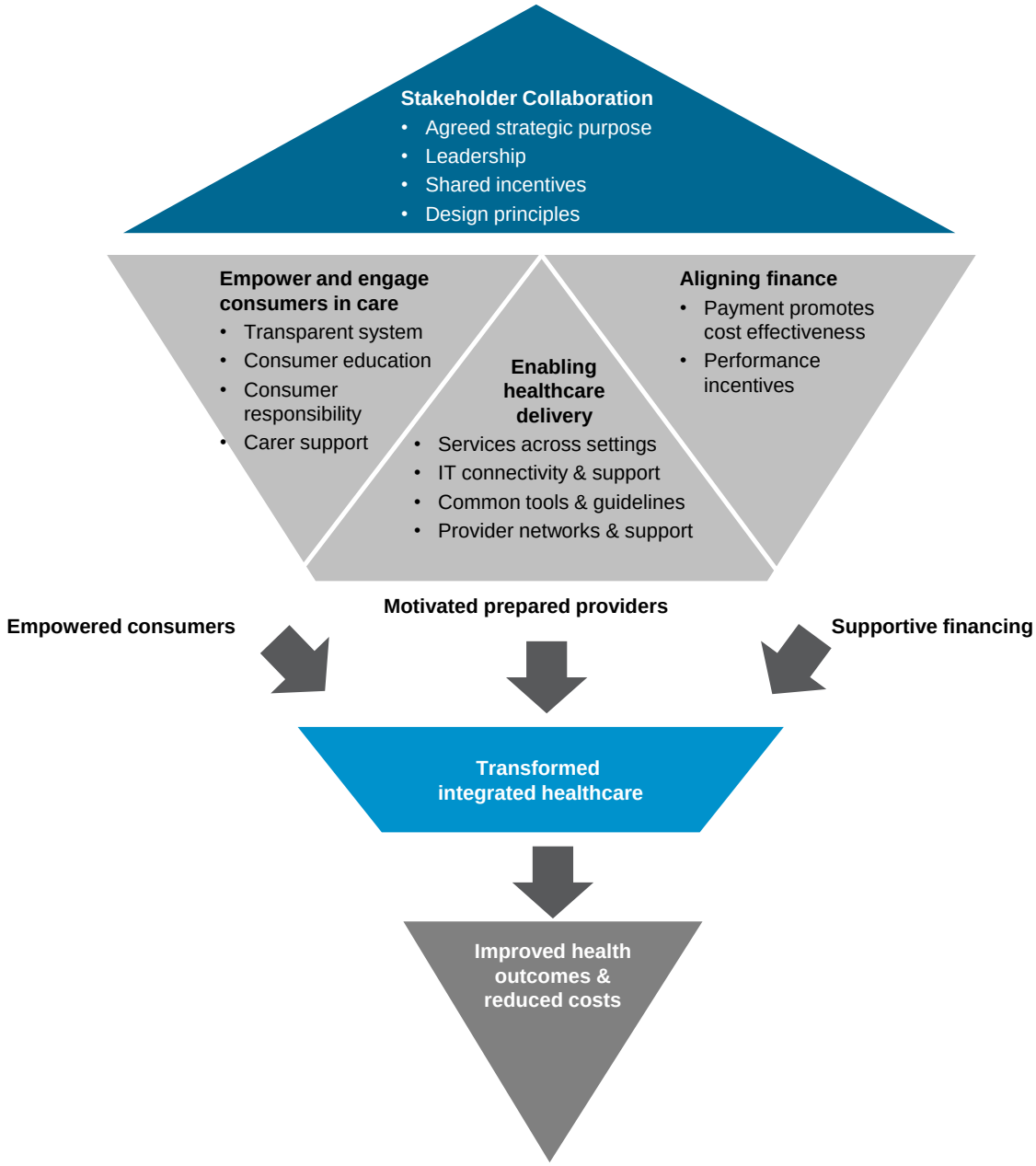
What makes integration work?

International health systems have also been wrestling with how to integrate care.

There are numerous and well established summaries of lessons learned in integrating care including Leutz's (1999) Nine Laws of Integration[xxxvi] and most recently the Kings Fund's (2013) top 16 needs to make integrated care happen at scale and pace[xxxvii] (available in Appendix D for reference)

Below at Figure 12 is an adaptation of a well-referenced model of integration (2006 MacColl Institute for Healthcare Innovation[xxxviii]) that highlights the key elements required for successful integration. These elements will guide our diagnosis of the integration of services for older people with complex health needs in NSW.

Figure 12: Key elements of successful integration



One of the key elements of integrated care captured here is the way in which all elements interact, as well as the intrinsic need for behaviour change at all levels and by all stakeholders. Indeed, even if all structural elements of this integrated care journey exist, it is reliant on the behaviours of the key players within it to make it successful.

More information on integrated care is available at Appendix C.

2.8.2 Person-centred health care

The reform initiatives described above are aligned to a major healthcare reform that is conceptual in nature: the design of a healthcare system that places the person at the centre of it. A 'person-centred' model draws on the values of the World Health Organization's (2006) definition of 'person-centred health care'.[xxxix] These values include empowerment, participation, access, and the central role of family and community. This means that people have the right and duty to participate in and make

decisions about their health care, not only regarding treatment and management, but also for broader issues of healthcare planning and implementation.

Person-centred care is an evolving concept, not yet widely accepted by all professions as it involves a significant shift from a historically ingrained approach that centres on providers and institutions to a more person-centred model involving a multidisciplinary healthcare team utilise the skills of different health professionals.

Internationally, health systems that have successfully integrated care services have done so with this concept of person centrality. The Canterbury District Health Board in New Zealand went as far as making all decisions on the basis of 'not wasting people's' time'.[xl]

DoHA (2009) has articulated a 'person-centred' primary healthcare system as:[xli]

> *… a system which is designed around supporting the individual, their family and carers to be in control and actively supported in their care. It is also about a system which is easy for them to access the care they need and which helps them to manage their health care needs and stay as healthy as possible.*

Specific existing programs and changes to healthcare governance and infrastructure, with the introduction of Medicare Locals, GP Super Clinics and Chronic Disease Management program, support this movement towards person-centred care by allowing better coordination between service providers and giving people easier access to providers. The person-centred care model focuses on the consumer's choice as to where, how and when they initially seek health care and can be informed by:

- **Accessibility of care/advice**: This can include wait times, opening hours, the need for or ability to make appointments, location, cost, and cultural appropriateness/safety
- **Health needs**: This can range from concern regarding potential risk factors, through to highly complex chronic or acute needs
- **Health literacy**: This can depend on variables such as socioeconomic status, specific disease and treatment experience, age, prior training, previous treatment provided and gender.

Recent results of the 2011 NSW Health Patient Satisfaction survey suggests that lack of person-centred care and lack of integration of services are their greatest challenges experienced. This is evident from the top five issues identified as:[xlii]

- Health care professionals not working well together
- Lack of courtesy of healthcare professionals towards people they are treating
- Organisation of the facility or service
- Lack of explanation about treatment and care
- Lack of completeness of care.

2.9 Designing for a diverse population

In order to provide care for a diverse population of older people, their carers and family and to consider the future growth of relevant services, it is critical to understand a population's health needs and how they change over time, and the relationship between demand for services and the type of service. Given that improvements in health outcomes must occur within finite resources, it is important that the limited capacity for change inherent in any system is directed at specific population cohorts where the most value can be realised most quickly, or specific interventions can stem future demand. In this way, resources are targeted to where there is greatest opportunity to reduce subsequent cost.

This approach is supported by Leutz's Nine Laws of Integration which first and foremost suggests that:

> *You can integrate some of the services for all of the people or all of the services for some of the people, but you can't integrate all the services for all the people.*

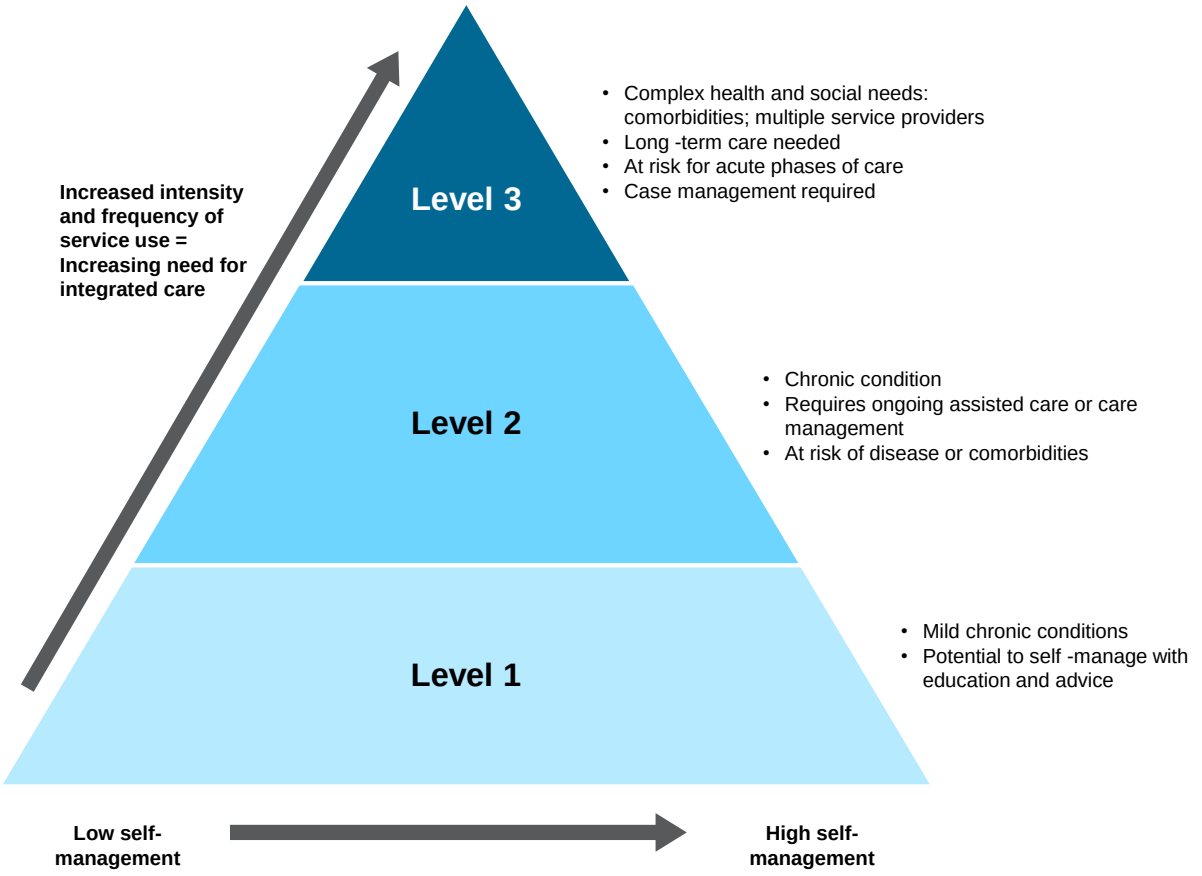
Integration of care for a diverse population of older people is therefore complex. It is first necessary to confirm the goals of integrated care (i.e. to reduce the risk of hospitalisation of long-term care costs) and then to stratify the cohort of older people according to their needs in order to target the most

effective population cohorts as described above. It will also be necessary to ask what level of integration is needed.

Data alone will not answer these questions. As with most populations, the health and well-being of older people in NSW is varied. Some older people experience good health without any additional care needs, some live with long-term but well-controlled chronic conditions, and others experience increasing ill health, multiple comorbidities, disabilities and functional limitations. So while it is clear that inequitable care and treatment of older people should be targeted and there is opportunity to improve this, not all older people require the same level or frequency of care. Similarly, their level of health literacy and ability to self-manage their conditions will vary.

Figure 13 below outlines an approach to stratifying the differing needs of a population in order to identify what makes an older person more at risk of having complex needs, and requiring more intense care and coordination, as aligned to the Kaiser Permanente pyramid approach to chronic disease management.[xliii] As illustrated, older people with complex social and health needs sit at the top of the pyramid, where the need for integrated care is high.

Figure 13: Stratification of need for integration of care services (adapted from Kaiser Permanente Risk Pyramid)[xliv]



Similarly, other risk factors and inequalities must also be considered in identifying priority populations. It is well established that people who are socially disadvantaged experience worse health outcomes, including greater complexity of chronic conditions and comorbidities including mental illness. In particular, Aboriginal and Torres Strait Islanders experience far greater impacts of chronic conditions, experiencing earlier onset, increased complications, hospitalisations and mortality rates.

More information on integrated care is available at Appendix C

3. Diagnostic Approach

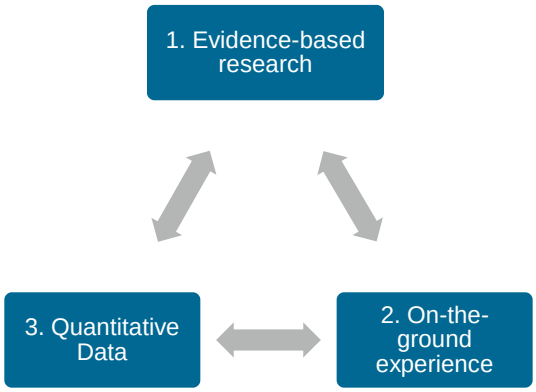
This section describes the approach taken to explore healthcare services delivered across NSW for the older person with complex healthcare needs, their carers and families, and to identify best practice models and consistent themes of what works for whom and when and how it is integrated.

The overall approach to this diagnostic report was based on three core questions related to the integration of care of older persons with complex health needs:

- **What is the benefit to the older person/carer/family?**
- **What is the benefit to the health system?**
- **What are the barriers and enablers of implementation?**

The information that informed our research came from the three sources illustrated in Figure 14.

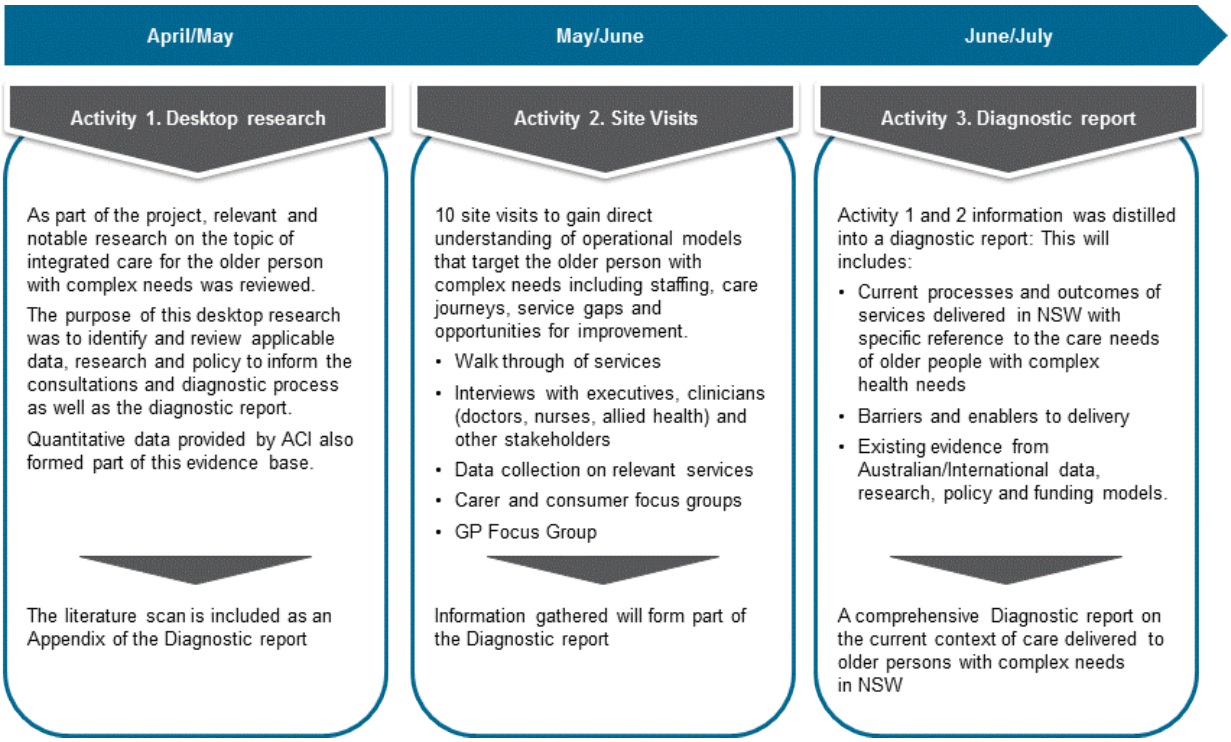
Figure 14: Research information sources



3.1 Activities undertaken

There were three core research activities undertaken in this phase of the project. These are summarised in Figure 15 below and further described in this section.

Figure 15: Core research activities undertaken



3.1.1 Literature Scan

The purpose of the literature scan was to identify and review the current policy context for providing health care for older Australians and research on integrated care, as well as examine existing models of integrated care in Australia and internationally from published and grey literature. The literature review built on the existing evidence base that is available through ARCHI.

Policy covered in the literature scan was included when it was directly relevant to the context of health care in NSW or to providing health care to older Australians. The literature scan was not a comprehensive or systematic review of research on integrated care; instead, the literature reviewed was the result of a targeted search.

The literature scan informed the development of the diagnostic report by providing the current context and understanding of integrated care. It looked at the benefits of integrated care and the enablers and barriers to achieving integration. Existing models of integrated care from Australia and internationally were examined. The literature scan identified guiding principles of these models, and looked at challenges faced, lessons learnt and outcomes.

More information on integrated care is available at Appendix C

3.1.2 Site visits

Central to our diagnostic approach was engaging stakeholders across ten sites across rural, regional and metropolitan NSW Health services. This included people working at different parts of the care continuum, from early intervention, diagnosis and assessment to acute care and rehabilitation.

The purpose of the site visits was to understand the 'as is state' of aged health services delivered at each LHD site; to better understand the patient journey experience of an older person with complex needs (and their carer or family) through these services; and to understand the conceptual and structural components that underpin the models of care and how care is integrated.

This included walk-throughs and scheduled interviews with key informants and stakeholders (including patients and carers) to understand:

- What **innovative and good practice models** exist for this cohort and the key characteristics of each model
- **How the models improve the care journey** of an older person with complex health needs and/or their carer or family
- What **infrastructure, processes and relationships** support these models
- How care could be **improved** even further and what **barriers** exist to achieving this.

Sites were nominated and selected by the ACI Aged Health Network Executive on the basis of delivering innovative and/or integrated care and/or support programs to older persons, their carers and families across one or more care settings. The map in Figure 16 illustrates the geographic distribution of sites visited and their metropolitan and regional/rural status, while Table 4 outlines the site visit timetable.

Figure 16: Site visit locations

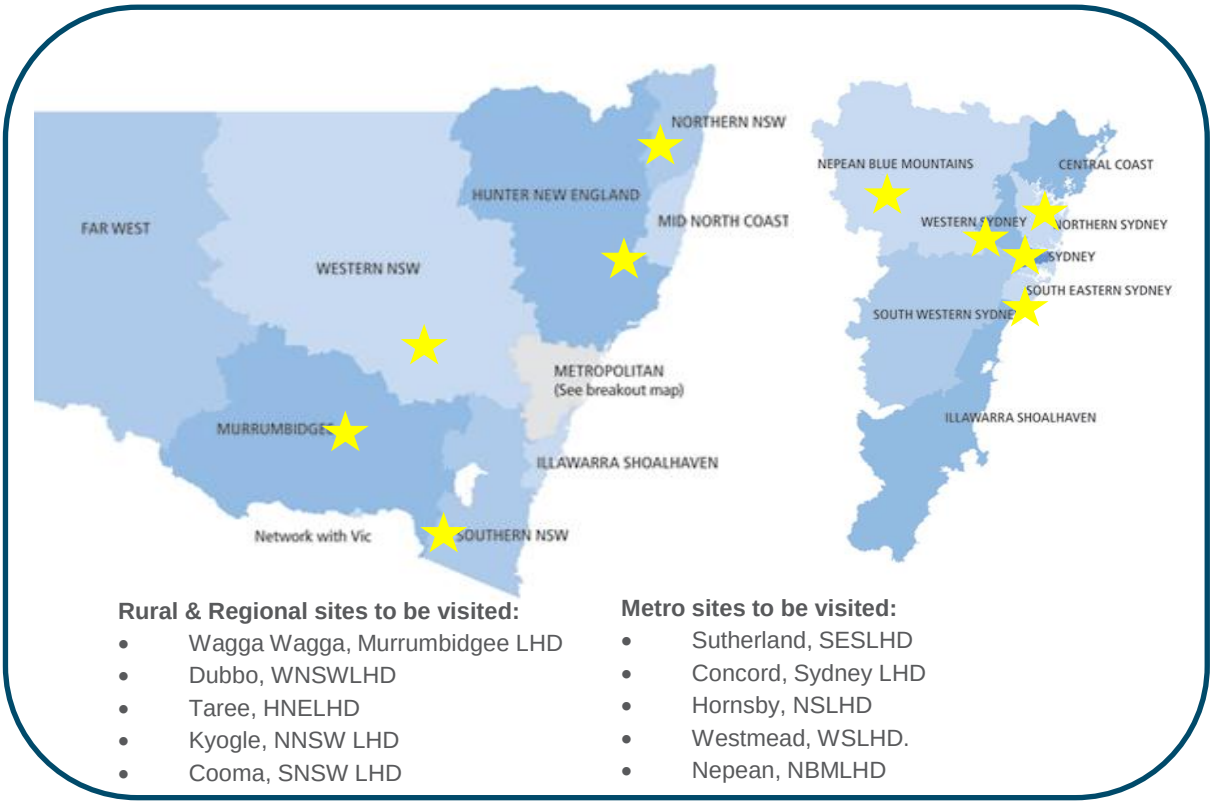


Table 4: Site visit timetable

Site	Regional/Metro	LHD	Date
Dubbo	Regional	Western NSW	21 May 2013
Westmead	Metro	South Western Sydney	23 May 2013
Nepean	Metro	Nepean Blue Mountains	24 May 2013
Concord	Metro	Sydney	27 May 2013

Site	Regional/Metro	LHD	Date
Taree	Regional	Hunter New England	29 May 2013
Cooma	Regional	Southern NSW	31 May 2013
Wagga Wagga	Regional	Murrumbidgee	5 June 2013
Sutherland	Metro	South East Sydney	7 June 2013
Kyogle	Regional	North Coast	12 June 2013
Hornsby	Metro	North Sydney	14 June 2013

Specific people and organisations consulted were those that were invited by LHD Aged Health Site Leads and available to do so. Suggested invitees included:

- Key service managers/directors and executive-level sponsors responsible for some or all aged health services at the LHD
- Key staff who work within the aged health service at the site and in the community
- Key external stakeholders that support older persons with complex needs, their carers and family outside of LHD services (e.g. Medicare Locals, local GPs, HACC, RACFs or home care providers)

The site visit interviews were undertaken using a semi-structured thematic approach to allow core topics of interest to the project to be covered from various perspectives. Following the consultation process, the qualitative information was collated and summarised into the themes of the diagnostic framework as outlined in Section 5.

3.1.3 Other stakeholder consultations

To understand views of other stakeholders and providers of care for older people with complex needs, their carers and families (beyond the LHD services and those consumers, carers and external stakeholders interviewed as part of site visits), the project team undertook further consultations with specific external stakeholder groups. This included:

- **Ambulance Service of NSW**
- **Wentwest Medicare Local**
- **Hunter Medicare Local**
- **ACI GP Advisory Council**
- **ACI Consumer Network**
- **Carers NSW – Dementia Carer Support Group**
- **Council of the Ageing NSW – Central Coast Consumer Group**
- **Aged and Community Services Association (NSW and ACT)**

A summary of these consultations is available under Section 6 of this report.

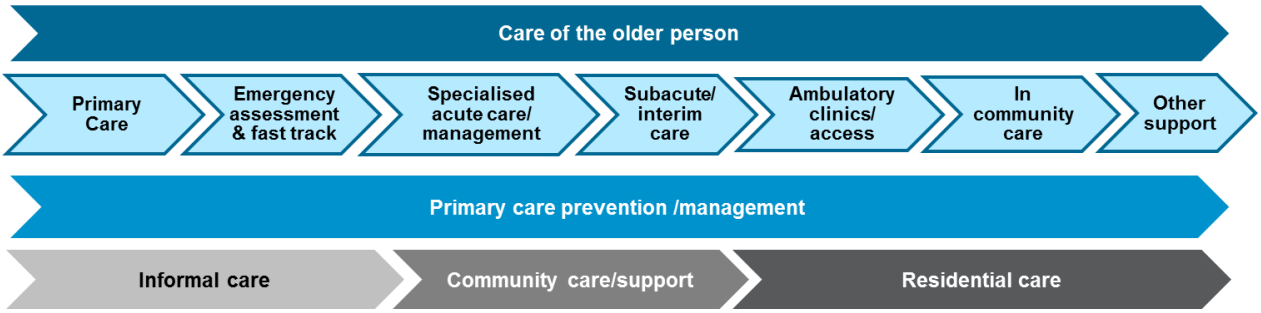
4. Site visit consultation findings

This section provides an overview of the site visit findings regarding how, where and why aged health services are delivered at ten sites across NSW.

Care of the older person is not a linear process. It often involves many phases of their increasing and decreasing acuity and clinical stability. There is no start or end point to this journey and it occurs across various settings with a high level of variability based on the services available in the local area. This phenomenon of repetitive improvement and deterioration of health was clearly recognised and planned for at some sites visited – but not all. Care of the older person was, however, found to be provided across the continuum of care, in parallel by different healthcare professionals and different services/sectors. Little crossover or systematic collaboration was identified between the acute, primary and community service providers, although some successful work had been done between acute (ED) and residential aged care facilities.

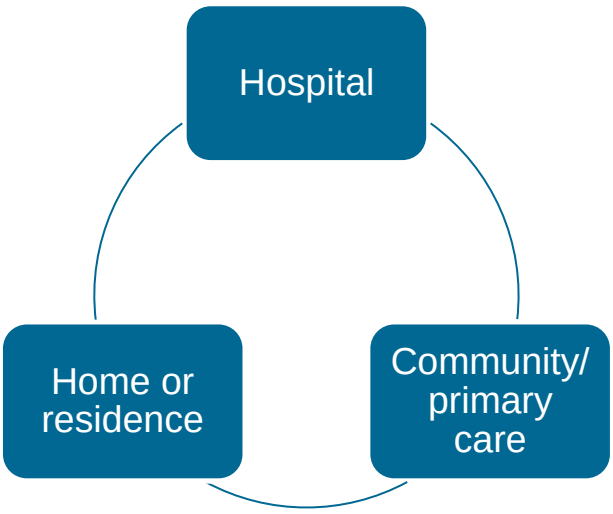
For the purposes of collating and presenting the information gained from the sites, the following stages of care have been utilised to describe the intent or purpose of care at a specific phase of the acute service (or LHD) care continuum.

Figure 17: Care of older people across the continuum of care



While Figure 17 above explains a health service perspective of care delivery, Figure 18 below describes a more simplistic view of how and where consumers access care. Consumers make little differentiation of who is providing or funding the service and instead simply identify where they go to access it: the hospital (or ambulance), a community service or general practice, or their home or residence (including residential aged care). This difference in the way service delivery is viewed by providers and consumers highlights why consumer expectations of care connectivity are rarely met under current service design.

Figure 18: Care settings from the older person's (consumer) perspective



Consumer consultations suggest that how and where older people with complex health needs access care is largely defined by:

- Access to and availability of care (e.g. wait time for a GP booking)
- Their perceived clinical acuity
- Time of day (e.g. after hours)
- Access to service information
- Appropriate referrals
- Their functional status/risk
- Presence of a carer or support structures
- Whether they have previously had an acute care episode.
- Their understanding of their condition.

At each of the ten sites visited, the way in which specific aged healthcare services were delivered was examined, including the extent to which they are focused across the continuum of care and across care settings. The inclusion of metropolitan, regional and rural sites provided insights into the key features and challenges applicable to different geographical locations.

A summary of each of these themes and related key findings, enablers, barriers and opportunities are provided in this section.

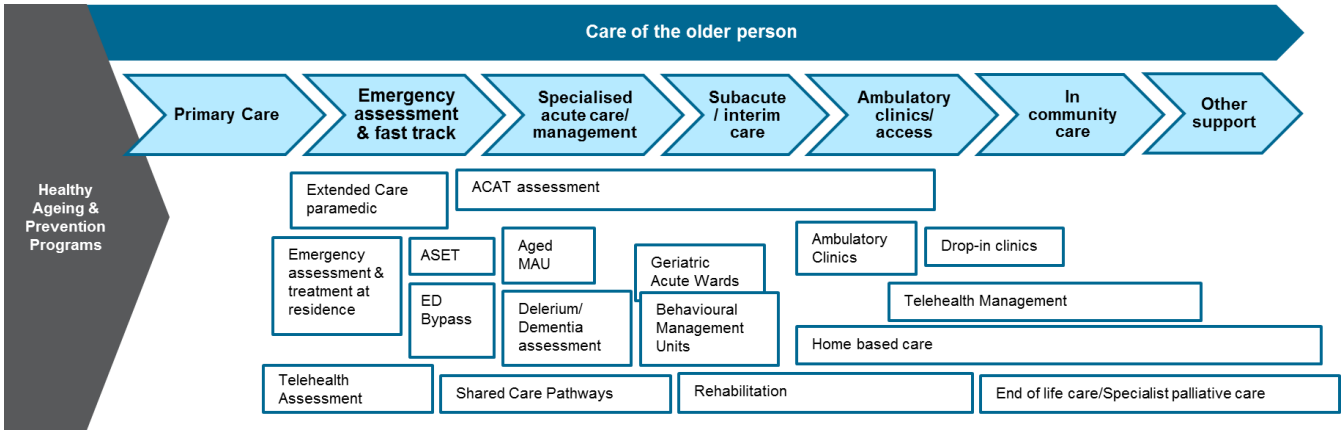
Note on services included in consultations – It is recognised that rehabilitation, palliative care and specialist mental health services for older people provide important services to older people with complex health needs. Statewide models of care for rehabilitation, palliative care and specialist mental health services for older people have been developed or are in development. Site visits showed considerable variation in the interaction of these specialist services with aged health services. It will be important to consider how these services are addressed in the framework.

4.1 Overview of services delivered

The ten sites visits illustrated a range of good practices and innovations across the care continuum that roughly align with a strategic intent to better meet the needs of the older person with complex health needs more rapidly and more holistically. The majority of the services reviewed cannot be described as integrated care as they are mostly examples of networked or cooperative care between providers. However, they do represent examples of practitioners attempting to improve integration at the practice level. The services reviewed also provide numerous examples of innovative models with a sound evidence base and some clear benefits that can potentially improve aspects of care connectivity and prevent unnecessary hospital admissions or return people to their place of residence in a more efficient and coordinated way.

Figure 19 below illustrates how innovative models and care delivery methods identified to be 'good practice' across the ten sites visited provide a spectrum of interventions across the continuum of care that when utilised together could improve the integration of care across this continuum.

Figure 19: Key innovations and interventions in LHD services across the care continuum



As this diagnostic did not set out to evaluate specific models and little data was provided, it is difficult to make a categorical analysis of their benefit. However, they are certainly worth further investigation in improving care journey and outcomes for older persons based on the project principles of good practice as described in Figure 20.

Figure 20: Assessments of services against project principles and "good practice"

- **Right time**
- **Right care**
- **Right place**
- **Right skills/equipment**

- Early intervention = Avoidance of deterioration or admission
- Care specific to older people's unique needs
- At home or as close to it as possible
- Specialised staff frontloaded and supported by infrastructure

Similarly, it will be necessary to investigate the financial cost-benefit of these models under ABF mechanisms that are currently being defined and tested.

Building on Figure 19 above, the models or good practice identified all fell into specific purposes of care delivered. These are illustrated in Figure 21 and further described in below.

Figure 21: Specific purposes of models of care identified[xlv]

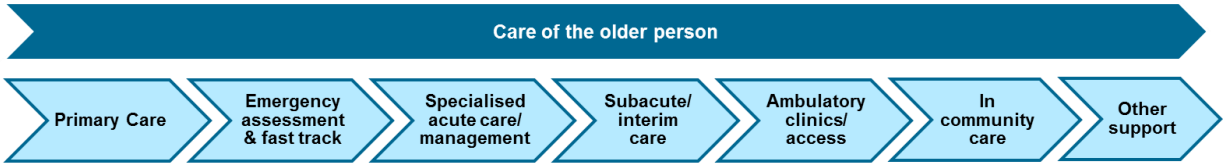


Table 5: Good practice models and innovations identified across the care continuum

Model purpose	Description	Models in operation:
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)
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	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, ShoalhavenWagga

Model purpose	Description	Models in operation:
	NepeanClincal 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) 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 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.	Wagga and a number of metropolitan locations.
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	OPERA, ACAU, MAU/OPERA

Model purpose	Description	Models in operation:
	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 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.	ACE (Hornsby) OPERA (Westmead) MAU (Nepean) Aged Health acute and rehabilitation wards (Sutherland) Dedicated Stroke Services Ward Model (Wagga and Westmead) AARCS

Model purpose	Description	Models in operation:
	social workers, physiotherapists, occupational therapists, speech pathologist, dietitians, and pharmacists). **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.	
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 ortho-geriatrics model of care[1] 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 specialty 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 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. **Success factors:** • Collaborative surgical team/absence of silos	**Ortho-geriatric model –** Sutherland, Hornsby, Nepean (Pre- & post-operative), **Surgi-geriatric model** – Nepean – (Post-op only) **Complex health needs** – (Sutherland, Nepean)

Model purpose	Description	Models in operation:
	• Clear administrative procedures that support shared care • Clear delineation of roles between two specialists • Good communication between specialists – not through the patient. • Often reported to be more successful where the geriatrician assumes full medical care and the other specialty provides a 'consultant' role.	
Dementia & delirium assessment/ management	**What is it:** 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. **How it works:** 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. 2. 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 by confused by their care journey. **Resourcing:** 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. **Success factors:** • Involvement of the carer and family in care and understanding what triggers behaviours • Dedicated staff/champions experienced in working with patients with dementia and/or delirium to educate and support other staff on assessment and management plans • Confirmed protocols and process on how to manage dementia and delirium patients	TOP5 Program (Wagga, Dubbo, Westmead, Kyogle) Assistance in Nursing Dementia/ Delirium (Wagga) Acute & Community CNC Dementia/ Delirium (across all sites visited) DBMAS in-reach to ED (Nepean & Taree) Hornsby Telehealth Dementia Clinic
Behavioural Management Units	**What is it:** 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. **How it works:** 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 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/registrars, 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	Concord, for up to 10 people), Sutherland, planned for Hornsby

Model purpose	Description	Models in operation:
	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.	
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 • Goal-oriented to independent living and what that means for each individual.	In-reach to acute Geriatric rehabilitation inpatient unit; Rehabilitation Day Hospital (Westmead), Home-based rehabilitation – Hornsby **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 detail*
Social/ respite care	**What it is:** Social activities and/or respite services to improve social interactions and provide temporary relief to carers. **How it works:** 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. 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. The services provide temporary (day only) relief for carers who may otherwise require permanent placement in a facility outside of the home. 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. **Resourcing:** Staffing includes nurses, volunteers, and community allied health workers such as physiotherapists and diversional therapists **Success factors:** • Strong volunteer network • Use of community centres which decrease the cost of services • Established transportation options.	Aged health socialisation activities (Sutherland) Respite services (Sutherland, Kyogle) Pole Depot Community Centre – social groups
Ambulatory Clinics	**What is it:** 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	Osteoporosis Primary Care Program (Wagga) Fracture Clinic (Wagga Wagga,

Model purpose	Description	Models in operation:
	the community. **How it works:** 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). **Resourcing:** 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. **Success factors:** • Strong administration process to facilitate booking appointments • Multidisciplinary staff that are able to run clinics, e.g. from podiatry and speech pathology • Senior aged health staff to undertake clinics, e.g. geriatricians • Using ambulatory clinics as a key part of the hospital's aged health strategy • Evaluation framework to measure the success of clinics.	Hornsby) Podiatry services (Wagga) Memory Clinic via Telehealth (Hornsby)
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, the 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.	Aged care drop-in clinic (Nepean) Nurse Practitioner – roaming/ on-call (Kyogle)

Model purpose	Description	Models in operation:
	Success factors: • Dedicated area to facilitate the clinic • Passionate staff to run the model • Executive support to operate the model	
Telehealth	**What is it:** Telehealth is the delivery of health-related services and information via telecommunications 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 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 Medicare Local which has a RN to help facilitate the assessment. The state funds the telehealth equipment, the Medicare Local 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, CNCs and administrative coordinators. **Success factors:** • Strong governance arrangements between telehealth facilities • IT frameworks that support telehealth	Consultative Geriatric Service (Dubbo and Concord) Telehealth Dementia Clinic (Hornsby-Armidale) Telehealth service (Wagga Wagga)
Home-based aged care packages	**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: • Community Aged Care Packages (CACPs) – provide low-level aged care in the home for people needing personal care, domestic assistance and similar services. • 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. • 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. **How it works:** 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. **Resourcing:** ACAT teams are required to undertake the assessments. **Success factors:** • Structured communication link with ACAT staff • Ability of ACAT to see patients in a timely period • Access to the packages by ACAT	MPS, hospitals, in community care 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.
Carer Support	**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. **How it works:** The federal government provides funding for: • Respite services – allowing respite for carers. Examples include: – Part/full day respite in day care centres – In-home respite services, including overnight care – Activity programs in the community. • Commonwealth Respite and Carelink Centres – that specialise in helping people find information on services in their local area. Centres have local knowledge about:	Sutherland, Kyogle (day respite) (overnight respite options) Pole Depot Community Centre

Model purpose	Description	Models in operation:
	– Personal, nursing and respite care – 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. **Resourcing:** Respite services are staffed by nurses, allied health staff and volunteers. **Success factors:** • 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.	
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 Medicare Local. 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 • *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. **How it works:** • *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	Authorised Care Program (ACP), Extended care paramedic (ECPs) – Nepean, *Critical Emergency Response Services* (CERS) – Kyogle, *Paramedic Connect*

Model purpose	Description	Models in operation:
	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. • *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. • *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. **Resourcing:** All ambulance services are provided by paramedics; the ECP are paramedics with additional speciality training. **Success factors:** • A clear governance structure • Strong education programs for paramedics • Strong relationships with LHD and ED facilities.	

5. Findings against diagnostic themes

This section provides an overview of the key findings of the site visits as they pertain to the themes identified in the Diagnostic Framework. A summary of each of these themes and related key findings, enablers, barriers and opportunities are provided in this section.

5.1 Key findings against themes

As outlined in the Project Methodology, themes that relate closely to integration of care were explored at each of the site visits and throughout all of the consultations. Below, the diagnostic themes are matched to the key findings found through consultations (and presented in detail later in this section):

Theme	Key Finding
Philosophy of care	While there was alignment on the importance of 'person-centred care', this was rarely translated into service design or represented in anecdotal accounts of delivery. In practice, clinicians refer to older people as patients and report person-centred care as 'nice to have' but feel limited in their ability to be truly person-centred due to the design, established processes and pace of the acute facility environment. It was suggested that community-based care is 'better placed to provide this support' (this was supported by the community-based providers). Aged health services which had multidisciplinary services that stretched across the continuum of care and embraced an enablement philosophy were identified to have the most 'person-centred' approach.
Strategic purpose	LHDs that had invested in a strategic approach to the management of older people with complex health needs across their services identified the following factors as key to enhancing care and reducing risks of deterioration: admission avoidance; early assessment and fast track treatment; appropriate and specialised acute management; optimising discharge processes; and continuing care into the community. These key strategic activities are summarised in Figure 15.
Access	Older people with complex health needs often present to ED and are unnecessarily admitted to acute care. The most common reasons given for this occurring included: • A person's inability to access timely and appropriate clinical care or support services outside of the hospital which then led to rapid deterioration • Social admissions for the purpose of respite care • Inappropriate ambulance transfers in the absence of timely GP access (for this reason, some specific models have been developed to reduce transfers by Ambulance Service of NSW and from Residential Aged Care Facilities (RACF) through developing capacity and support to assess and treat issues common to older people on the spot).
Eligibility	Most services did not have specific age eligibility criteria for management by specialist aged health services, and instead use a set of age-related conditions or symptoms. Nevertheless, most services utilised a criteria of over 65 years or 70 years of age for general patient identification, though the reported average patient age is over 80 years. This finding is significant to interpreting data regarding this cohort, and further determining their characteristics and care needs.
Relationships	Relationships between LHDs and Medicare Locals varied significantly between the ten sites visited. Some sites had well-established relationships, joint planning initiatives and partnership agreements in place; others had very little contact and no sign of coordinated efforts. The relationship with HACC or Aged Care Package providers was reported as most problematic, with extended waits of up to 12 months reported to access services.
Older person, their carer and family	A consistent theme from the consultations was a lack of understanding among older people, their carers and families about what services are available, how to access them and where to get further support. Similarly, consultations with carers and family revealed a disconnection between expectations of the carer and family of staff with their actual experiences. While carers and family recognise the effort that individual staff make in providing care, they were critical of the lack of communication and explanation from clinical staff regarding diagnoses or future care requirements. Many sites do not undertake 'patient experience' surveys. No site reported having implemented changes based on such feedback. If a shift towards a more person-centred approach to care is to occur, better monitoring and assessment of care performance is needed. Further, carers provide an important and full-time role in the health system which is often unrecognised and undervalued. The services required by carers and the people for whom they care were overwhelmingly reported to be difficult to access and not integrated with hospital services or other health services. The most common interaction with the hospital was an assessment or diagnosis by a geriatrician with little follow-up care. Carers interviewed ultimately

	did not wish to have to call an ambulance or go to the ED and reported doing this as a last resort when they had nowhere to turn, as it 'makes things harder, not easier.'
People and staffing	Most aged health services reviewed were led by dedicated and charismatic leaders who continually promoted the importance of effective aged health services within their hospital and community health service. Moreover, many of the aged health services are driven by dedicated staff that are passionate about aged health. Yet, challenges remain. Workforce planning is based on historical or reactive recruitment practices that currently reinforce non-integrated or non-person-centred models of care. There is an opportunity (particularly in the context of an ageing workforce) to better align this 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. Likewise, there are alternatives to current staffing structures that would better utilise non-medical and generalist staff. For example, the appropriate use of volunteers can provide the dual benefit of improved service quality and social support for the older person. Resourcing and capacity are often considered to be a limitation for both metropolitan and rural and remote sites. Speciality training in aged health allows for improved provision of services, mentoring and successful future workforce planning. Rural services are currently supported by visiting medical staff. Telehealth from metropolitan services was reported as not always ideal although new and innovative models in telehealth services are in some instances improving access and service quality.
Funding	The funding environment for aged health services in NSW is complex, including multiple sources of funding (including time-limited grants) from a range of agencies (refer to Figure 24 in Section 5.2.7 for more detail). This makes longer term planning hard. Likewise, the distribution of funding towards aged health services by LHDs was reported as being variable across the state. There were a number of examples of LHDs realising direct cost savings where services had implemented specific initiatives targeting the needs of older people and carers in the community as an adjunct or alternative to acute facility-based care. Similar savings and service efficiencies were realised by Ambulance Service of NSW by redirecting resources in a targeted way.
Infrastructure	An absence of proactively planning for the needs of older people with complex health needs was noted in most facilities, even in recent or planned renovations and rebuilds. Design features such as natural light, courtyards and simulated home environments were reported to improve the experience and behaviour of older people at risk of becoming distressed or exhibiting difficult behaviours.
Technology	A major barrier to timely decision-making and communications between professions and care settings was not having a complete set of patient information. For example, patient files were often part electronic and part hard-copy making them harder to connect up. It was acknowledged by LHDs, community providers and Medicare Locals that the limitations of ICT are a significant barrier to continuity of care as well as integration.
Governance	Strong multidisciplinary governance structures were an identified enabler to integration. Some sites visited had successfully created aged health governance arrangements at the meso level, extending across all local aged health providers including RACFs, local non-government organisations (NGOs), Medicare Locals and General Practice. It should be noted, however, that the definition of 'multidisciplinary' varied between sites. At some sites visited, the medical staff continue to meet separately from the nursing and allied health staff. It was noted that at these facilities, key executive and leadership meetings were also structured to keep professions and specialties separate.
Discharge and continuity of care	Proactive discharge planning was reported to have reduced LoS for older people in acute care facilities and reduced unplanned readmission rates. Proactive communication with carers and families about discharge, early in the care journey, was identified as a successful method to reduce carer and family apprehension and allow a smooth process at the time of discharge. Timeliness of discharge and continuity of care is reportedly most impacted by the presence of a carer and living alone, having access to medical staff at the right time and limited access to equipment, community care packages and high/low-level residential care beds. Receipt of discharge summaries by GPs was reported as improving with the introduction of e-discharges but is not consistent. Some consumers interviewed suggested their GP always knew when they had been in hospital whereas others reported this as a gap.

5.2 Findings against each theme

A summary of each of these themes and related findings, enablers, barriers and opportunities are provided here against the following key of enablers, barriers and opportunities:

Enablers **Barriers** **Opportunities**

More details on findings against each theme is available in Appendix L.

5.2.1 Philosophy of Care

Site consultations produced consistent themes regarding a desire to provide the appropriate care for older persons with complex needs, in a timely manner and in the most appropriate care setting for their needs. However, this desire was often not translated into practice through the model of care or the settings provided. For example, clinical processes or workforce and infrastructure needs were often given priority over the personal needs of the older person

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Key Findings:

- While there was reported alignment on the importance of 'person-centred care', this was rarely translated into service design or anecdotal accounts of delivery.
- Most sites had no defined service philosophy of care and different views were expressed by staff. Two sites visited had their philosophy published and publicly displayed.
- The organisational structure of care was often described as services provided in hospital facilities with community care considered an adjunct and primary care as a separate service entirely.
- Services that had multidisciplinary services that stretched across the continuum of care and embraced an enablement philosophy were identified to have the most 'person-centred' approach.
- On acute aged health wards, the 'enablement approach' was highly utilised. However, on those that had no specific aged health acute services, this approach was absent and anecdotally, it was reported that these wards have poorer outcomes.

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Philosophy of care – enablers, barriers and opportunities	
	• Alignment of philosophy, strategy and service delivery • Governance that allows services to deliver against the philosophy • Leadership and lateral thinking • An established vision for the service that is published and available • Engagement of staff in the philosophy • Training that supports the philosophy
	• Philosophies of care unsuited to the reality of the environment • Lack of governance • Lack of executive-level sponsorship to support change • Funding that limits the ability to deliver on the philosophy
	• Endorsement of a statewide cross-sectoral philosophy of care • Consumer involvement in defining the philosophy of care • Develop SMART goals to translate the philosophy • Identify and implement relevant KPIs • Development of an outcome-focused framework

5.2.2 Strategic Purpose and Intent

Those that had invested in a strategic approach to the management of older people with complex health needs across their services collectively identified the following interventions as strategically imperative in order to benefit the outcome of care, the efficiency of the system, and the experience of the older person, carer and family.

- Admission avoidance/redistribution of resources to community
- Early assessment by specialist staff (medical, nursing, allied health) and fast-track treatment and discharge
- Appropriate and specialised acute care management (e.g. appropriate environment, enablement philosophy, specialised staff)
- Optimal discharge that includes early planning, preparation, timing, home support and an action plan for deterioration.
- Continuity of care that reaches into the community and links with primary care providers and community-based support services. This may include co-designed management plans with GPs.

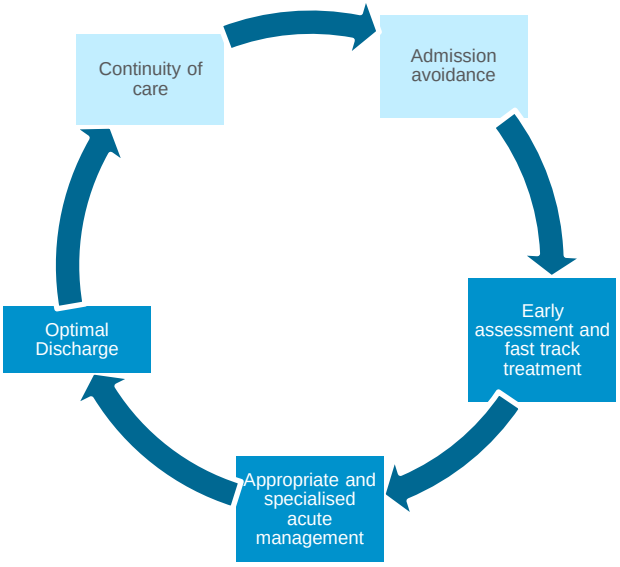
Sites that had no such proactive management and maintained a speciality focus continued to view this cohort as large, costly and generally problematic.

Key Findings:

- Where there was executive-level sponsorship, there was also understanding of the benefits of designing services around the needs of older people. Similarly, the impact of *not* managing the needs of older people with complex health needs proactively was understood.
- LHDs that had invested in a strategic approach to the management of older people with complex health needs across their services identified admission avoidance, early assessment and fast-track treatment, appropriate and specialised acute management, optimising discharge processes and continuing care into the community as key to enhancing care and reducing risks of deterioration.
- Anecdotally, where there was little understanding of the strategic imperative to treat older persons as a specific cohort with specific and holistic needs, poorer care outcomes were reported.
- Continuity of care and support across care settings were often cited as strategic intents although services were mostly provided in clinical settings such as a hospital.
- Most sites emphasised the importance of early detection of issues to delay the onset of conditions associated with old age. Few achieved this. However, some services recognised their role in linking to social and community groups to actively manage this.

- Integrated care is only possible if based on a solid foundation of core services such as inpatient, ambulatory care, community care and residential aged care facility settings. Lack of services, or 'nowhere to go', is potentially the greatest challenge to hospital length of stay.

Figure 22: Strategic purpose of aged health services delivered by an LHD



It was clear from sites visited that if one or more of these components were absent or weak, then care for the older person with complex health needs would be sub-optimal.

An absence of one or more of these interventions across core services 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 failed discharges without support
- Increased morbidity in the community
- Inappropriate community management or support
- Increased pressure on carers and family
- Inappropriate RACF admissions

Strategic purpose/intent – enablers, barriers and opportunities	
	• Executive sponsorship and support to refocus resources • Creating and sustaining community relationships • Managing, recording and reporting of the impact of strategies • Data on required resource allocation based on percentage of hospital days/beds used by this cohort • Data on potential cost savings and improved patient care outcomes • Connecting care between departments, wards and community-based care • Sharing of information that follows the older person
	• Traditional models of care delivery that follow a set process • Historical resource allocation funding models • Lack of flexibility to target resources to need • Historical patient flow models • Social belief that 'in hospital' care is the right care in all acute situations • Lack of shared information • Lack of sustainable service coordination
	• Identifying unnecessary steps that waste people's time • Agreeing on the key strategic imperatives to deliver care differently • Agreeing on a common set of design principles to guide service delivery • Assessing programs and models against this benchmark and targeting effort • Reprioritisation of acute facility resources to cater for this cohort • A system-based strategic model that cuts across departments, organisations, professions, sectors, and funding streams • Develop SMART goals to translate philosophy • Identify and implement relevant KPIs • Development of an outcome-focused framework

5.2.3 Eligibility and Access

Older people were reported to have difficulty accessing primary or community care support to meet low-level acuity needs, and instead waited until conditions escalated or reached crisis point. Older people with complex health needs and their carers also reported difficulty accessing low-level domestic and social support services, as did ASET team staff when these people presented to ED.

Key Findings:

- Key points for accessing specialised aged health services are via the hospital (ED), primary care (GPs) and via community services referral (community health or ACAT).
- Benefits for the older people and the health system were reported when care was determined by the results of a Comprehensive Geriatric Assessment.
- Sites that do not have specialist aged health services, in ED in particular, report higher admission rates and poor outcomes for older people, as well as inappropriate diagnoses.
- Eligibility criteria for aged health services were based on the presence of age-related health conditions and/or symptoms or disabilities. Most services utilised an over 65 years or over 70 years age criteria for general patient identification (50 and over for those of Aboriginal and Torres Strait Islander descent). However, other ages were accepted and all services reported an average age of over 80 years.
- Older people with complex health needs often unnecessarily attend ED and are admitted to hospital facilities. The most common reason cited is being unable to access timely and appropriate support outside of the hospital.

- Sites reported benefits in having one phone number for all referrals in order to triage aged health service needs and enquiries.

Eligibility and access – enablers, barriers and opportunities	
	• Direct admission ED bypass following admitting doctor consultation • Flexible eligibility criteria that identifies older people early in the patient journey • Education of health providers/practitioners on available services, eligibility and access • Central intake services that direct referrals to the most appropriate program or speciality • Referrals for Comprehensive Geriatric Assessments
	• Lack of information on what services are available and how to access them • Service demand outweighing supply – 'nowhere to go' • Early intervention/prevention approach often not available prior to deterioration • Rural areas burdened with complicated patients that do not fit aged care criteria, for example alcohol abuse patients • Lack of a coordinated view of services provided to the older person
	• Specialised clinics in the community that can manage and plan holistic care needs of older people • Linking people with available resources, support services and information to enable them to make an informed choice • Increased awareness on when and how to access core health services • A 'one stop' shop for all aged health service information • Utilisation of other health professionals where medical staff are not available or are unwarranted to address demand for care coordination and information. • Aged health services should be equipped for the type of referral that is likely to arise, for example: timely and intensive support for older people at high risk of deterioration, and prioritisation for low-level support when living alone.

5.2.4 Relationships

Services and relationships observed during site visits spread along the spectrum of these relationships and were often represented as integration. However, when under closer scrutiny, they represent networking, communication or cooperation at best.

Specifically, it was noted that the relationship with Medicare Locals varied significantly between the ten sites visited. Some sites had well-established relationships, joint planning initiatives and agreements in place; however, others had very little contact and no sign of coordinated efforts. This is potentially a missed opportunity, as due to their funding agreement with DoHA, the Medicare Locals have a vested interest in making it easier for patients to access the services they need by linking local GPs, nursing and other health professionals, hospitals and aged care, as well as Aboriginal and Torres Strait Islander health organisations.

Consistently, the relationship with HACC or Care Package services was reported as distant. In the spectrum of relationships, this could be described as ad hoc communication with little cooperation or coordination occurring.

Connectivity between and across organisations, models of care and programs rely on informal relationships and the type of processes which enable this, for example, co-location,

frequency of contact, trust and respect. It is prevented when there are organisational, funding and structural barriers with inflexible approaches.

Key Findings:

- Multidisciplinary teams endeavour to work collaboratively across services and programs to deliver the best outcome for older persons, their carers and family.
- Relationships between LHDs and Medicare Locals varied significantly between the ten sites visited. Some sites had well-established relationships, joint planning initiatives and embryonic agreements in place while others had very little contact and no sign of coordinated efforts.
- Good working relationships between professionals increased the likelihood of older people being linked with support services and services across settings
- The relationship with HACC or Care Package providers was reported as most problematic. This often resulted in one-way communication with no planning or discussion of the unmet demand for care packages and better usage of those that were allocated. For example, older people often retained a package even when their care needs changed.

Relationships – enablers, barriers and opportunities	
	• Great leadership that supports staff to think laterally and build relationships • Investment of time in collaboration and knowledge sharing • Defined and shared goals of mutual benefit for providers • Understanding and acceptance of difference • Development of Shared Agreements • Clear governance frameworks • Mutual and collegiate respect
	• Lack of resources, capacity and time • Perceived rivalry or separation of resources • One-sided investment • A dominant partner organisation or facility • Funding arrangements
	• Shared information • Clear and consistent communication • Consortium approaches (e.g. Partners in Recovery) • Joint commissioning and/or investment • Addressing workforce issues

5.2.5 Older Person, their Carer and Family

Consultations with family and carers revealed a disconnection between expectations of the staff by carer and family and their actual experience. Staff believed their patients had easy access to a range of services and that these services functioned smoothly and that patients, carers and family were happy with the service. While patients, carers and family recognise the great effort that individual staff perform in providing care, they were critical of the challenges associated in navigating through the aged health landscape, especially those in the hospital and community. It was also noted that for people with poor health literacy or communication issues (such as limited English in CALD populations or the deteriorating ability to communicate due to age-related issues), there were not robust or standardised support services in place. This was often reported to be ‘left to the social worker’ who worked only part-time or on a consultation basis.

The strongest complaints came from the lack of understanding about what services are available, how to access them and knowing the associated costs. Particular criticism was reserved for ED experiences due to long wait times, inadequate services and a lack of consideration for the older person. For example, older patients often have to wait for long periods in the waiting room and left in cold corridors before being admitted to the ward. Post-discharge care was cited as problematic with older people and their carers unclear where and how to access community support once home from the hospital.

Key Findings:

- Sites described a philosophical and strategic intent to deliver person and carer-centred care although this is often not reflected in practice.
- Clinicians feel limited in their ability to be truly person-centred due to the processes and pace of the acute facility environment. The prioritisation of the older person, carer and family's psychosocial needs was higher in community-based teams than acute-care teams.
- There is minimal data on patient or carer experience being captured. This corresponds with lack of support services for carers across all sites and minimal KPIs reported in place to measure patient and carer satisfaction.
- There is a lack of understanding among older people, their carers and families about what services are available, how to access them and what the associated costs are. Post-discharge care was cited as particularly problematic with older people and their carers unclear where and how to access community support services once back at home from the hospital.
- There is a lack of care planning with older people, their carers and family, and minimal advocacy, often in times of most need when they are seeking support and information.
- Particular criticism was noted from experiences in Emergency Departments: long wait times, inadequate services and a lack of consideration for the older person.
- Respite services were reported consistently to be difficult to access by ED staff, ASET teams and carers. The result of this is exhausted and unwell carers and social admissions based on emergency respite needs of carers.
- ASET team staff and Community Nurses were reported to be the primary contact with carers and family and the hospital.
- While General Practice was identified as the core access point for older people and their carers, it was acknowledged that wait times are prohibitive and care is often not comprehensive or holistic. There are currently no care plans in place for carers of older people with geriatric syndromes, degenerative disease and/or identified dementia.
- The architecture and setting of care were noted as enablers or barriers to person-centred care and support or involvement in that care by carers and families.

The older person, their carer and their family – enablers, barriers and opportunities	
	• Linking older people, carers and families with available resources, support services and information to provide them with informed choices • Planning with older people, their carers and families, and assistance to access appropriate support • Providing advocacy and support • Timeliness and appropriateness of response • Clear and consistent communication and support
	• Not knowing where to go for what type of support. • Having to give the same information to different people • Not getting care and support early enough – 'I have to deteriorate sufficiently to be eligible for care' • ED and discharge protocols • Lack of shared information • Lack of service coordination and help to navigate the maze of services • Lack of individualised care and support
	• Care plans that are friendly to the older person, carer and family. These will provide information and promote self-management. • More provision of low-intensity care and support • Dramatically more support for carers as they define their care needs • Better access to allied health – dentist and podiatry • Improved flexibility and responsiveness of service provision • Increased options for and supply of respite • Improved patient transport.

5.2.6 People and Staffing

The composition of staff involved in delivering aged health services is broad and varied depending on the service being provided. People consulted at site visits work in Emergency Departments, Acute Care units, Rehabilitation units, inpatient geriatric units, consultation and liaison roles, Ambulatory Care Clinics, GP facilities providing assessment and care management in domiciliary settings, dementia and general respite centres, and in-home respite and carer support. In addition, for residents of Residential Aged Care Facilities and older people accessing RACF staff and GPs, some LHDs provide and facilitate various additional services: telephone advice and triage; hospital admissions when required; consultations and interventions within facilities by expert nurses, geriatricians and psychogeriatrician; and end-of-life planning. Collaboration between medical specialities (geriatric, rehabilitation, orthopaedics, urology and surgical) was found to be inconsistent and fragmented.

Common themes in successful staffing models included:

- Collaborative multidisciplinary teams
- Interdisciplinary links between specialties
- Strong communication
- Co-location of staff
- Alternative staffing

Key Findings

- Workforce planning is based on historical or reactive recruitment practices that currently reinforce models of care that are not integrated and not person-centred. There is opportunity to better align this with the strategic vision and a person-centred model of care through alternative resourcing or better utilisation of the wider healthcare.
- Most aged health services reviewed were led by dedicated and charismatic leaders that continually push the aged health agenda in their hospital and community service. Moreover, many of the aged health services are driven by dedicated staff who are passionate about aged health. This workforce is also recognised to be ageing, with a higher average age.
- Resourcing and capacity are often considered to be a limitation for both metropolitan and rural and remote sites. Speciality training in aged health allows for improved provision of services, mentoring and success in future workforce planning. Rural services are currently supported by visiting medical staff or telehealth from metropolitan services; this is not ideal.
- There are various alternatives to current staffing structures that would better utilise non-medical and generalist staff. Utilising volunteers to support staff and models of care provides a dual benefit as it can improve services and provide a social benefit to this specific age cohort.
- Collaboration between medical specialities (geriatric, rehabilitation, orthopaedics, urology and surgical) was found to be inconsistent and fragmented.

Figure 23: Workforce across aged health services

Hospital	Primary care	RACF	Community
Core team • Geriatrician • Registered nurse • Enrolled nurse • Assistant in nursing • Physiotherapists • Occupational therapists • Podiatrists • Speech pathologist • Therapy aides • Discharge planner **Other** • Volunteers • Diversional therapist • Exercise physiologist • Dietitians	**Core team** • General practitioners • Nurse practitioner • Practice nurses **Other** • Enrolled nurse • Allied health • Private specialists	**Core team** • Registered nurse • Enrolled nurse • Assistant in nursing **Other** • General practitioners • Geriatrician • Allied health	**Core team** • Registered nurses • Personal care providers • Carers • Social workers • Physiotherapists • Occupational therapists **Other** • Volunteers • Diversional therapist • Enrolled nurses • Speech pathologist • Dietitians

People and staffing – enablers, barriers and opportunities

- A workforce that is flexible and well trained, has clear roles and responsibilities and works collaboratively.
- Co-location of multidisciplinary staff
- Regular interdisciplinary meetings
- Specific aged health education
- Managing, recording and reporting that is fit for purpose

- Excessive administration, and complex reporting and recording processes
- Poor ICT infrastructure to support communication
- Silos between medical specialists, departments and out-of-hospital care
- Lack of career pathway and development
- Lack of communication and sharing of information between providers
- Inefficient use of specialist resources (e.g. geriatricians)

People and staffing – enablers, barriers and opportunities

- Utilisation of non-medical workforce
- Co-location of academic, community and primary care teams
- Shared care agreements between providers
- Dedicated aged health education/curriculum
- Building intentional relationships with older people and their families
- Flexibility and responsiveness of approach
- Co-developing and managing funding applications
- Consistency in all aspects of planning, support, communication and reporting.

5.2.7 Funding Arrangements

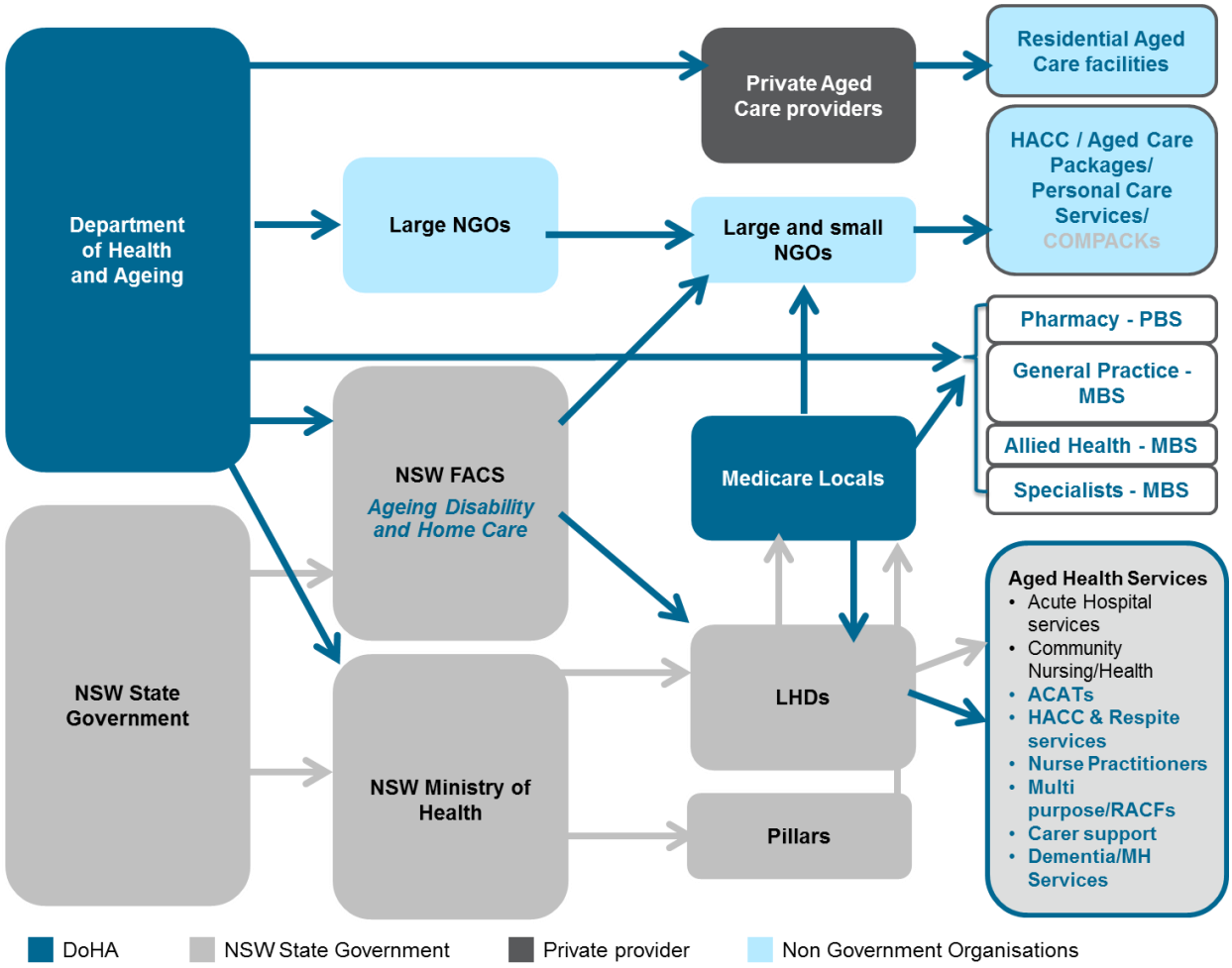
The conflict between federal and state funding is not new. The administrative burden associated with implementing programs and the inability to flexibly move resources to higher value areas are regularly cited. This has been found to impact on the flow of patients and care across settings, resulting in duplication, service gaps and poorer health outcomes.

NSW Health alone, it was reported that there were multiple short-term funding programs or specialised recurrent funding programs available, but not consistently applied across services (e.g. from ACI and CEC, or internal MoH branches). Figure 24 below provides a diagrammatic representation of the funding flow in NSW. The other funding from NSW Health was reliant on LHD decision-making and the strategic prioritisation of care of the older person in that LHD. Again, this varied across LHDs and services within LHDs.

Key Findings:

- Funding comes mainly from federal and state budgets. One of the most common issues cited was that funding goes through several layers of administration before being allocated to the provider. There is ongoing administrative burden to monitor and report on spending.
- The services provided to older people with complex health needs are funded from a mix of federal grants (COAG, HACC and ADHAC), state grants and facility budgets, which are allocated to specific aged health programs.
- COAG funding and other discretionary grants are researched and targeted with programs that data and evidence suggest will provide biggest return on investment. A number of programs funded by COAG are cited as successful.
- At the state level in NSW, there is multiple funding from various sources that is duplicative and inconsistently distributed, and often in the form of time-limited grants (refer to Figure 24 below for more detail)
- LHD funding of aged health services was reported as variable; some who skewed funding towards aged health saw dramatic cost savings in other areas as a result.
- The number of approvals required to introduce a shared agreement discourages this practice at the meso-level of integration. This challenge sometimes drives informal decision-making and reliance on relationships.
- The development of a ratio allocation based on complexity and demographic and geographic considerations was highlighted as a more appropriate approach.
- There is a need for more consistent support for aged care teams when preparing funding applications.
- Funding of diagnostics ordered by state employees working in the community were identified as a funding barrier.

Figure 24: Funding flow in NSW



Funding arrangements – enablers, barriers and opportunities

- COAG funding grants where investment was well evidenced and will continue to be supported by the LHD
- ABF for appropriately coded episodes of care
- Collaborative funding agreements between multiple aged health service providers
- Innovative use of funding to reduce future cost burden (e.g. hyper-acute community visits vs. ambulance ED arrival)

- Short-term funding cycles
- Disparity in funding and one-off grants received across NSW
- Lack of federal and state coordination when commissioning funds
- Lack of visibility of costs vs. funding and outcomes achieved
- Lack of incentive for GPs to manage older persons with complex health needs in the community or in Residential Aged Care Facilities

- Collaboration across federal and state organisations to meet targets
- Development of a dedicated service to support aged care teams to identify, develop and manage funding applications
- Development of an outcomes framework with shared targets
- Funding aged cohort specific pathways of care

5.2.8 Infrastructure

Infrastructure and design of services is an important and significant investment that is required to last for a significant period of time. Lack of appropriate infrastructure was identified as a major challenge across most sites. A common finding was an absence of planning consideration for the needs of older people with complex needs. This was noted in most facilities and most significantly in recent or planned renovations and rebuilds. This may suggest service providers and older people are not engaged in the design phase, or that their requirements are too specific and expensive to implement.

Key Findings:

- An absence of planning consideration for the needs of older people with complex health needs was noted in most facilities and most significantly in recent or planned renovations and rebuilds.
- Dedicated buildings for aged health services are usually positioned on the periphery of the hospital campus. This makes them easier to access but often hard to find and disconnected from other services.
- Design features that included natural light, courtyards and simulated home environments were reported to improve the experience and behaviour of older people at risk of becoming distressed or exhibiting difficult behaviours.
- Simple design features such as well-located diagnostics services were reported to 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.
- Secure units for dementia and delirium patients reduce the prevalence of physical and pharmacological restraints being used and the need for increased staffing.

Infrastructure – enablers, barriers and opportunities	
	• Aged health positioned as a hospital priority to influence the design of hospital infrastructure • Simple design features such as location and distance of services • Dedicated aged health infrastructure for dementia and delirium patients • All community health staff had access to cars to visit patients
	• Lack of appropriate infrastructure and absence of planning consideration for the needs of older people • Universal lack of equipment specially designed for aged health patients • Acute and subacute services which are noisy, bright and unfamiliar • Lack of patient transport was continually noted as a barrier in providing continuation of care • Lack of funding to build dedicated aged health facilities and wards • Aged health not perceived as a hospital priority • Infrastructure challenges impact on FTE usage and extra requirements, ultimately driving up cost of care
	• More transport and transport options for patients to avoid unnecessary LoS and elderly patients being discharged after long waits • Architectural designs that facilitate care of the elderly patient and focus on their needs • Infrastructure for ambulatory clinics should cater for the elderly, e.g. additional parking, bus stops or drop-off zones • Co-location of core provision for older people with close proximity between high usage services.

5.2.9 Technology/Information Flow

Site visits revealed that there are currently three key software Electronic Medical Record (EMR) layer solutions used in the community healthcare setting: CHIME, SNACC and CHAP. While these solutions function relatively well as stand-alone systems, they offer no interface with other community, primary, acute or subacute solutions

ARGUS is the secure messaging system utilised by GPs and some health specialists. However, as with the aforementioned community healthcare systems, it has no integration properties with community, acute or subacute technological solutions apart from secure messaging capability

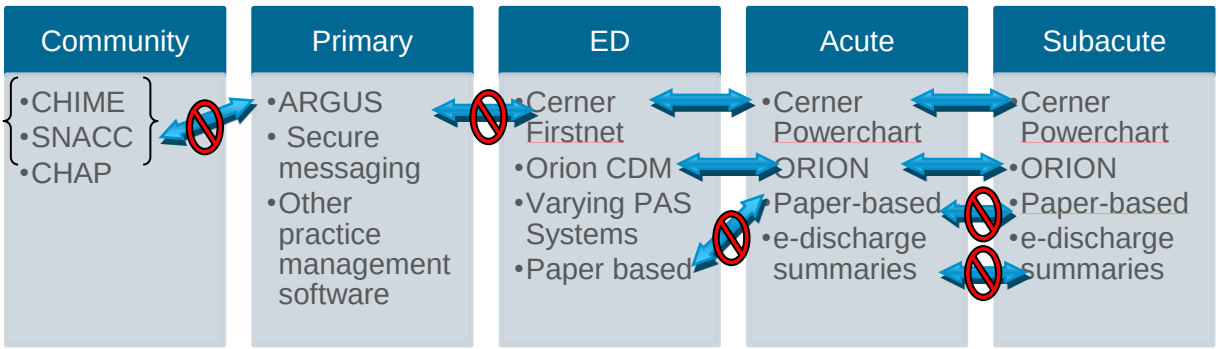
The lack of integration of IT systems is such that each person presenting to an acute care facility receives a unique Medical Record Number (MRN) different from that allocated in the primary and community care settings. This means that the care of an older person in an acute care facility cannot be monitored by a primary care provider (such as a GP) during that person's discharge or post-discharge. It is also important to note that while most GPs have access to electronic discharge summary functionality (based on secure messaging), there is still a proportion across NSW who do not. Commentary from site visits included concern regarding the flow of important information to those GPs without access to e-discharge now that additional fax or letter discharges are becoming more rare.

Key Findings:

- A major barrier to timely decision-making and communications between professions is not having a complete set of information.
- Patient files are often part electronic and part hardcopy. This impacts both the collection and use of quantitative data and measurement of performance.
- It is acknowledged by LHDs, community providers and Medicare Locals that the limitations of ICT are a barrier to continuity of care.
- An electronic discharge summary specifically developed for the older person is present but often has to be faxed or mailed due to lack of eHealth connectivity by local GPs.
- Advanced Care Directives and other EOL information are not readily available.
- The lack of integration or interface of stand-alone software and communication platforms has impacted on the continuity of care for patients and has created additional administrative burden for both clinical and non-clinical staff.
- E-medication has been introduced in some aged care wards which has reduced medication errors.

The figure below is a representative snapshot highlighting the different software and systems across care settings in NSW. Further, it demonstrates where there is continuity (integration) of these systems across settings and where there is no common interface.

Figure 25: Technology systems and software across the care setting in NSW



Technology/information flow – enablers, barriers and opportunities	
	• An electronic mechanism that facilitates coordination among healthcare specialists • Shared vendor EMR systems across acute and subacute settings • E-medication to reduce medication errors
	• Not having a complete set of information • Multiple stand-alone vendor systems with no interface • Lack of electronic information-sharing across care settings • Fragmented provider market, making it difficult to sign up to a core system, software or tools and templates.
	• For sites and stakeholders to agree on a common communication and information-sharing approach across core services (as they define core services) • Handheld technology for community-based staff integrated into health service systems • Simplified tools and processes to meet administrative and management reporting • Develop an information strategy to ensure consistent dissemination of information to older people, their carers and families • Adopt enabling technology as a mechanism to facilitate consistent and responsive support from providers including transport providers.

5.2.10 Governance

A framework for governance is important to hold relevant stakeholders and staff accountable while they carry out the objectives of a strategy.

Executive engagement varied between facilities with some hospitals having strong executive engagement and others having poor engagement. Of note, aged health services that were able to engage with the executive level and demonstrate how the governance structure of aged health services affects the hospital's performance appeared to have the most successful engagement.

Some sites visited had successfully created aged health governance arrangements at the meso-level, extending across all local aged health providers including RACFs, local NGOs, Medicare Locals and GPs.

Key Findings:

- No one organisation, team or service has the whole picture of an older person's needs.
- Most aged health governance is provided by a Clinical Director for Aged Health or Geriatrics, overseeing a service that manages large numbers of separations across acute care, subacute care, ambulatory and community settings.
- Governance of aged health services at the ten sites visited was variable. Even those with similar structure and scope had different governance, leadership, resources and performance management approaches.
- Good leadership and support for a holistic and proactive vision of aged health was identified to empower and enable staff performance and quality and appropriateness of care.
- A multidisciplinary management structure that provides clinical rigour but also is able to think laterally and solve problems was cited as a good example of governance.
- Services that utilised both the standard hospital or LHD governance mechanisms and specific aged health collaborations were identified to be most successful in integrating care within and outside of the service.

- Geriatrician leadership and influence across broader specialities such as urology, vascular and respiratory is important to champion the 'aged health specific lens' to assessment and treatment plans.
- Multidisciplinary means different things at sites visited. At some sites, the medical staff continue to meet separately from the nursing and allied health staff, and key executive and leadership meetings were also structured at these facilities to keep professions and specialties separate.
- Co-locating teams and services was reported to provide a natural integrated governance structure, as did multidisciplinary approaches to care.

Governance – enablers, barriers and opportunities	
	• Strong leadership with executive-level engagement • Governance through aged health speciality i.e. led by geriatricians • Formalised governance structure to provide accountability and direction for aged health services as well as a point of escalation for issues or challenges to the agreed strategy. • A management structure that provides structure, clinical rigour and a framework for problem solving • Team approach with a culture of open and transparent communication • Regular internal and external meetings between disciplines and a collective understanding of each discipline.
	• Lack of executive support and understanding of aged health • Passive or informal governance with ill-defined roles and responsibilities • Lack of geriatrician leadership among broader specialities • Overly bureaucratic rules which stifle new ways of working • Too many NGOs with whom to engage and develop accountabilities • Time constraints because staff are very busy. Integration and communication need to be built into day-to-day working and not be an add-on to it.
	• Expand governance of aged health to allow a critical mass of staff to work together across care settings and specialities across and beyond the hospital • Agree a common governance approach and design principles for inpatient, ambulatory care, community care and residential aged care facility settings • Simplify governance arrangements with clear roles and responsibilities • Agree on shared KPIs and non-bureaucratic ways to collect supporting information • Increase the flexibility of governance to provide opportunity to formalise relationships which are working well • Include transport services with the governance of aged care.

5.2.11 Discharge and Continuity of Care

Consultations among both metropolitan and regional sites highlighted the vast array of models and services in place aimed at facilitating earlier and more efficient discharge for older people. However, a key barrier to the delivery of these service roles is the limited hours under which most ASET, AARCS and discharge planners operate (usually business hours, Monday to Friday). It was also noted that in some acute facilities, multiple patient movements between wards caused confusion and was a barrier to delivering continuity of care. Continuity of care in the community setting (especially regional areas) was identified as a gap. This was reported to often be due to the lack of GPs and specialists in the area, meaning older people would often see different and multiple clinicians for their care. Housing arrangements are also a central consideration for older people and associated with independence and community participation. There are minimal linkages between health and services responsible for assisting with housing.

Key Findings:

- Strong relationships, both clinical and non-clinical are pivotal to continuity of care outside of the hospital
- Implementation of proactive discharge planning was reported to have reduced LoS for older people in acute care facilities and to have reduced unplanned readmission rates.
- Proactive communication with carers and families about discharge from early in the care journey was identified as a successful method to reduce carer/family apprehension, help them plan for changes to their routines and allow smooth processing at the time of discharge.
- Timeliness of discharge and continuity of care is reported to be most impacted by the presence of a carer or the person living alone, access to medical staff at the right time and limited access to equipment, community care packages and high/low-level residential care beds.
- Receipt of discharge summaries by GPs was reported as improving with introduction of e-discharges but is not consistent. Some consumers interviewed suggested their GP always knew when they had been in hospital where as others reported this as a gap.
- There is a gap in early identification of older people with risk factors for specific conditions likely to cause ongoing morbidity issues and health deterioration. Care coordination and social support services available (such as hotlines) would likely prevent many ED presentations that occur due to lack of action and escalation care planning.
- ACAT receive e-referrals from inpatient settings and streamline referrals and care. ACAT has strong links to inpatient facilities and a 24-hour follow-up protocol for all patients referred for screening or additional support.
- Lack of patient transport also delays discharge.

Discharge and continuity of care – enablers, barriers and opportunities

- Dedicated Discharge Planners in acute settings
- Full implementation of AARCS/ASETS models
- Electronic discharge to GPs when done well
- Multidisciplinary Teams daily whiteboard meetings
- Dedicated Care Coordinators (including Chronic Disease Management Program Coordinators in the community)
- Nurse Practitioner in-reach to place of residence and RACF programs
- Strong relationships between acute and community care including daily teleconferences to discuss package and community bed availability
- 'Yellow Envelope' admit and discharge forms from RACF to acute settings

- Lack of access to community packages (especially domestic assistance such as HACC)
- Lack of access to other post-hospital transition packages such as TACP
- Lack of RACF or MPS beds
- Multiple patient movements between acute care wards during singular stays
- Limited access (in some facilities) to 'step down' beds (e.g. subacute, outlier facilities or GEM) creating longer length of stays in acute care wards
- Lack of options for ambulances to take patient anywhere other than ED

- Increase operating hours for ASETS/AARCS and limited access to allied health for ASET teams
- Allow nurses to discharge patients
- GP in-reach, co-admission (new).
- Increase availability to patient transport for non-emergency discharge use
- Increase access (in some facilities) to 'drop down' or GEM-type beds creating longer length of stays in acute care wards
- Strengthen and expand Nurse Practitioner in-reach to place of residence and RACF programs
- Increase capacity of community care providers to support older people once discharged.

Where do staff feel the hotspots are?

Site consultations anecdotally highlighted a number of commonly presenting issues in older people. These included (but were not limited to):

- **Dementia/Delirium**
- **Wounds**
- **Injuries as a result of falls**
- **Dehydration**
- **Respiratory difficulty**
- **Urinary Tract Infections**
- **Cardiovascular issues**
- **Hypertension**
- **Syncope**
- **Acopia**
- **Falls without injury**
- **Parkinson's/Motor Neurone Diseases**
- **Carer respite**
- **Social needs**

- MAU/OPERA most commonly report dealing with UTIs, wound infections, delirium and dementia.
- Use of telemetry units on one MAU has successfully identified underlying cardiovascular issues in a number of older persons that potentially explain their health deterioration
- Community nursing and acute care facilities suggest respiratory issues, cardiovascular issues/hypertension dementia/delirium, depression and COPD.
- Sites reported a prevalent lack of appreciation by ED staff for age-related illness that may impact on the accuracy of DRGs formally reported in the data.
- Management of routine medications while in hospital (e.g. Parkinson's medication) was identified as an emerging issue that contributes to deterioration and LoS (e.g. at Hornsby).

6. Consultations with other stakeholders

This section provides an overview of consultations undertaken with key stakeholder groups that work alongside and interact with NSW Health services.

As part of the site visit and broader diagnostic process, consultations were held with several specific stakeholder groups that work alongside and interact with NSW Health services. These stakeholder consultations provided a broad range of views on the key enablers and barriers to integration from a view external to NSW Health services. These consultations also identified several examples where professional integration is currently working well in NSW.

6.1 Medicare Locals

As part of their strategic objective, Medicare Locals have a vested interest in making it easier for patients to access the services they need by linking local GPs, nursing and other health professionals, hospitals and aged care, as well as Aboriginal and Torres Strait Islander health organisations.

As part of the consultation process, three NSW Medicare Locals were interviewed independently, as well as staff from other Medicare Locals that attended consultations at LHD sites. It was broadly acknowledged that services for older people are not currently integrated between primary and acute healthcare services at the local level; however, several initiatives with this purpose were identified. These included*:*

Co-funding and collaborative partnerships with LHDs – These arrangements are embryonic but becoming more common (e.g. After Hours and Chronic Disease Management programs, population health planning roles). Such initiatives require some clear conceptual agreement around governance and commissioning processes for both organisations involved.

HealthPathways: It is a key aim of the HealthPathways project to address a specific pathway to support the flow of care for this group, reduce duplication and increase efficiency. HealthPathways has been successful in part due to putting key stakeholders in the same room to discuss issues and develop work plans focusing on the local redesign of the healthcare system.

Joint planning and governance: This was occurring to a certain extent in some Medicare Locals with ongoing advice from New Zealand's Canterbury Health Board.

Prevention and screening: Several examples were identified of prevention programs either run or developed in collaboration (e.g. Osteoporosis refracture, Murrumbidgee; Healthy Ageing programs; Falls prevention programs).

Some common issues identified by Medicare Locals and LHDs in working together were:

- Capability and capacity gaps for Medicare Locals as new and emerging organisations, and for LHDs as they continue to restructure.
- Not understanding how the different systems function in order to access or utilise services on offer (e.g. eligibility, referral, nurse-led vs. GP-led)
- Difficultly in accessing or communicating with primary healthcare professionals and in particular those not linked to Medicare Locals (e.g. corporate practices and solo practitioners).

'Healthpathways 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.'

Medicare Locals – enablers, barriers and opportunities	
	• Strong engagement with LHD based on mutual trust and respect • Joint funding and governance arrangements • Identified common purpose and need • Having the right infrastructure in place (e.g. eHealth solutions such as PCEHR) • Open discussion between health professionals that identifies joint work plans to resolve hurdles in the care pathway (e.g. the HealthPathways approach)
	• Limited capability and capacity of organisations in growth or restructure phases • Access/referral pathways that are LHD-centric as opposed to how primary care would do business • Awareness of services available • Access to specific diagnostics from primary care • Appropriate medical professional training in needs of older people • Reimbursing all professionals for their time and participation in identifying solutions • Lack of communication regarding changing services and eligibility criteria
	• Specific pathways for older persons with complex health needs • Clear roles and responsibilities of care providers in various aspects of care • Consortium approaches as opposed to partnerships/MOUs • LHD and Medicare Local-funded clinics for priority groups • Joint rural support structures

6.2 General Practitioners

The role of the GP in the health care of an older person is important and in most cases is central to the older person's health journey. It is a key point of intervention that will either enhance or detract from how this journey is experienced. GPs often have an ongoing relationship with the older person as well as their carer and wider family, as well as an understanding of the social context within which they function. They are therefore in an opportune position to deliver holistic care and link older people with the care and support services that are available to them.

The challenges expressed in achieving this by GPs were the following:

Knowledge of services available: GPs often may not know what is available in the local community and what they can access for the patient. In addition, there is often a communication breakdown when a patient has gone into a service and the GP is not aware of what is happening. This is partially the result of a long history of general practice working in isolation.

Communication and agreed process: There is a feeling by GPs that services are consistently run with an acute or LHD focus. This includes a lack of communication with a GP about an older person for whom they are the nominated GP, as well as a need to consider the additional layers that are added when the LHD commences a new service or initiative. For example, the Chronic Disease Management program is considered to have added a layer to services as opposed to integrating into primary care to enhance the connectivity. GP buy-in has been challenging as they feel there was little consultation and feel the service would be better targeted on the basis of GP referrals.

Access to services and the various levels of eligibility: There are currently gaps in the ability to access ACAT assessments and post-discharge packages for older persons. The different care and funding package eligibility criteria as well as extended delays in service make navigating the system for GPs particularly difficult.

'I try to keep up with what services are available for patients that have extra needs – but to be honest it all seems to change and I fall behind.'

Time: GPs are, for the most part, generalists, which mean they are many things to many people. The time allowed for GP consultations will often not allow for the types of complex health needs that many older people present with.

Personal cost vs. value delivered: It would be good to see increased capacity in the medical home model, with case coordination and other medical services which will bring value to the patient. The patient would also benefit from a more comprehensive service. For example, there needs to be a way to make it financially viable for GPs who provide quality service (e.g. visits at home or Residential Aged Care Facilities for this difficult cohort). Otherwise, there is no incentive or sustainability of this type of care.

'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.'

General Practitioners – enablers, barriers and opportunities	
	• Developing relationships with other service providers • Well maintained e-health patient records • Incentivising thorough care which prevents escalation in disease that results in readmission
	• Time and financial viability to perform home visits or provide extended care and support • Lack of awareness of services available • Lack of access to specific diagnostics from primary care • Lack of appropriate medical professional training in needs of older people • Lack of communication regarding changing services and eligibility criteria
	• Patient-centred care/medical home models that provide more comprehensive service and create individual care plans • Care planning and coordination roles that involve and support carers and families and liaise across the sectors • One-stop shop for services information and access • GP portal to access service availability in the local area • Using technology such as telehealth that can improve continuity of care through ease of home/RACF visits.

6.3 Ambulance Service of NSW

Ambulance Service of NSW is faced with a challenge between preserving its core role in the health system of responding to emergencies and its role of providing care in non-emergency requests for services.

While its traditional, core role has been to attend emergencies; recent data (2011–12) shows that 27% of call outs are for non-emergencies.[7] Many of these call-outs are to older persons living alone whom 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.

Programs implemented with the support of other system stakeholders are:

Extended Care Paramedics (ECP): ECPs are dispatched to emergency calls to undertake specific assessment and care management. Their scope of practice is guided by predetermined care pathways.

7 Ambulance Year in Review 2011/12 http://www.ambulance.nsw.gov.au/Media/docs/Year%20in%20Review%2011%2012-f0937949-c33e-4990-9887-ec166c5931a7-0.pdf

Authorised Care Program (ACP): An end-of-life pathway document (care plan) led by Ambulance Service 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.

'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.'

These strategies are aimed at improving services to the older person by providing care in their usual place of residence if appropriate, leading to less stress for the patient by not transferring them to a hospital. There are also benefits that flow on to the broader health system, such as reducing the number of patients being transferred to hospital leading to less pressure on EDs and reducing the chance of bed block. This in turn increases the availability of ambulances to response to emergency calls, considering that recent ambulance off stretcher times revealed that 48,955 hours[8] a year are wasted by ambulances not being able to off-load patients in ED due to bed block.

Benefits to the older person and health system have also proven to be benefits to Ambulance Service of NSW performance and costs. ECPs have proven to be a successful model to assess and treat older people in their home, thereby reducing the number of older people being transported to hospital and decreasing *case cycle times*[9] compared to standard paramedic care. Furthermore, older people treated by ECPs are extremely positive with feedback showing 99.1% of people were satisfied or very satisfied with the care they received, 99.0% satisfied with the recommendation they were given and 98.9% satisfied with their overall encounter with these services.

Ambulance Service of NSW – enablers, barriers and opportunities	
	• Improved relationships with hospitals to coordinate care • Strong education and training program for paramedics • Telephone-based support from a senior clinician
	• Political barriers within professional organisations to support members undertaking wider scope of practice (e.g. resistance within paramedic profession around taking on these perceived 'non-emergent' tasks) • No IT system that supports transfer of clinical information between the hospital, GP, community services and ambulance • Lack of communication of services available between LHDs and Ambulance Service of NSW • Potential abuse of services from patients requesting home visits from ambulance services
	• Using paramedics for more front-line primary care initiatives • IT system that allows paramedics to access existing medical history • Ambulance Service of NSW to participate in assisting care planning and coordination roles to assess, treat and refer to primary care services, e.g. ACAT • Using technology such as telehealth to improve the delivery of care.

8 Ambulance Service of NSW - Ambulance off Stretcher Times http://data.nsw.gov.au/data/dataset/ambulance-off-stretcher-times

9 Shorter case cycle times refer to a measure of time between the time the emergency call is received and the time the crew are 'cleared' to have completed that call and are free to attend another case.

6.4 Residential and other Aged Care Services

As part of the consultation process, information was sought from several RACFs as well as the Aged and Community Services Association (NSW and ACT) who represent over 300 aged care organisations.

The following were some of the key current challenges identified by these stakeholders:

Engagement: The engagement between RACFs and LHDs was described as erratic in that some had strong effective relationships whereas others had no interaction and no outreach services provided to RACFs. In addition, the RACF perceive GP engagement as limited, noting a lack of GP interface, long distances and limited choice as key issues.

Strategy and planning: Consultations revealed that these stakeholders are only sometimes consulted in LHD aged health service strategies for the region. This has often led to a disconnection between LHD and RACF services. Some facilities report regular (quarterly or bi-monthly) meetings with the aged health team at the local hospital; one region reported hosting a multidisciplinary/cross-sectoral Ageing Collaborative meeting. In particular the transfer of information on medical history and Advanced Care Directives was identified as something these types of forums can and have resolved.

Complexity of patients: The increase in complex clinical needs of ageing patients staying in the community/home environment is leading to an increase in pressure and demands on community services to support them. Therefore it is important to consider the implications of residential discharge for carers and organisations in order to support the patient's discharge plan

Lack of access to clinical services for residents: It was noted that the rate to which GPs are willing to support or visit an aged care facility has significantly reduced. The lack of clinical care available has been an identified trigger for hospital transfer. For this reason, hospitals in NSW have implemented various education and in-reach programs into Residential Aged Care Facilities (e.g. the Geriatric Flying Squad, Sutherland and GRACE, Hornsby). The benefits of such initiatives include decreasing hospital admissions and better continuity of care by decreasing stress for the older person, as they are able to stay in their usual place of residence. The tangible benefit to not only the hospital but also the RACF of these programs has led to an LHD negotiating with a large RACF to co-fund an expansion of the initiative. This would increase the staffing number and hours of operation for the service.

The following provides a high-level overview of key developments that residential and aged care services would value in the future:

- An increase in services provided in community and RACFs to reduce the need for hospital admission (includes multiple models implemented under *Sustainable Access* program or independently)
- Expanding the Hospital in the Home (HITH) model to provide support for managing patients with complex care needs
- A Palliative Care outreach program, e.g. access to intravenous medications for RACF.
- More community nurses and Nurse Practitioners providing services in RACF (e.g. AARCS roles)
- Greater engagement from LHDs and GPs to access services and coordinate care programs
- More inclusion from LHDs in their strategic planning for delivery of clinical services.

Residential and other Aged Care Services – enablers, barrier and opportunities	
	• Regular meetings between LHDs and RACFs to coordinate care • Structured communication system between RACFs and LHDs to drive effecting care between care settings • IT system that supports seamless transfer of information between care settings
	• Unequal cost distribution between the RACF and LHD for investment in initiatives • Limited staff available to undertake services outside of the hospital • Historically, care is delivered by medical profession in RACFs • Lack of coordination of care for services to RACFs • Limited scope of services for nursing services in RACFs
	• Expand services provided to RACFs • Increasing the scope of services provided by nurses and include allied health services such as physiotherapists and exercise physiologist • Develop a strategy to improve engagement between the RACF, hospital and GP • Develop a coordinated approach to providing services to RACFs. For example, this may include linking LHD or primary care services.

6.5 Older Persons Consumer groups

As part of the consultation process, an older person consumer focus group of 17 older people from the Council of the Ageing (COTA) was undertaken in addition to a consultation with ACI Consumer Representatives. The group included those with an average age of approximately 80 years, from different cultures and life experience. Primarily, the consultation revealed that consumers of aged health services value easy and timely access to healthcare services in a centralised location or at home with minimal out-of-pocket expenses.

'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

Key challenges described by the group were:

Knowledge on what services are available and how to access them: Due to changing services, either new or evolving, older people, their carers and family have difficulty in understanding what services are available to them and how they can access them.

Long waiting time to access GPs: Access to GPs was reported to be particularly challenging, given wait times are between 2–6 weeks for an appointment. It was noted that the practice of home visits by GPs had become rare if not non-existent.

Health information sharing: Consumers reported a sense of loyalty to GPs they have seen for a long time because of their familiarity with their medical history and access to historical information. The group agreed that electronic health records should be transferable between health services such as GPs, pharmacists, and private and public hospitals.

Emergency Department and MAUs: It was noted that long waits are often experienced in the ED, although when critical emergencies occur, participants agreed they were all seen in an acceptable timeframe and progressed in a timely manner. They noted special consideration was given to their social situation – in particular those that lived alone.

Out-of-pocket expenses: The group identified cost to be a significant barrier to timely care when access is limited in the region to GPs that bulk bill. Consumers reported delaying their treatment for this reason, and then allowing the issue to progress before either finally seeing a GP, attending the ED, or having an acute incident for which they called an ambulance.

Accessing rebates: Consumers reported a significant administrative burden due to GPs not providing Medicare rebates on the spot. This resulted in transport challenges and associated waits.

Furthermore, it was reported that many Aboriginal patients are not being offered 'Close the Gap' rebates, even though GPs are fully reimbursed for all payments.

Accessing home services: Consumers noted a lack of home services such as home visits by doctors or nurses and home maintenance that would support them to remain independent and in their own homes. Access to home maintenance is an issue because it is only granted to consumers that are old and frail; many do not meet the latter criteria and feel pressured to attempt gardening or maintenance activities that place them at further risk of injury.

Final suggestions include:

- Consumers see the future of aged health services as readily available access to services at home or in the community through doctors, nurses or allied health staff.
- There was significant support for primary care clinics co-located with other support services such as pathology, radiology and allied health. In particular, a 'one-stop shop' specialising in care, services and programs for older people would be ideal. Consumers are also keen to access services at other locations, such as pharmacies for medication management and basic diagnostics such as blood pressure and blood sugar levels.
- Better integration of older people into the community by improving interaction between older people and the community, especially younger people, was suggested. This could be in the form of school children visiting older people, or older people coming to schools. It is anticipated that this would better connect the older person with the younger generation and promote more understanding of older people and their challenges.

Older Persons – enablers, barriers and opportunities	
	• Central point to access aged care information, including phone services • Multidisciplinary staff to coordinate care • Care coordination that originates from a primary care practice (as opposed to from acute)
	• Out-of-pocket expenses of accessing care • Limited transport options to access care • Limited availability of GPs • Rigid eligibility criteria for home care services • Difficulty in accessing rebates services • Current acute services are not well designed for the older patient • Historically home care has been provided by the GP
	• Improvement of home care options • Making it mandatory for GPs to have on-the-spot Medicare rebate options available in their practice (e.g. HiCAPS) • A flexible staffing model that allows nurses and allied health to provide home care options • Home telehealth to provide assessment, treatment and care plan • Expanding the types of health workers (e.g. pharmacists, nurses) that can provide routine health checks such as blood pressure and blood sugar levels

6.6 Carers

Carers reported many challenges in accessing services or support for the older persons for whom they care, and in accessing support or care for themselves.

The services required by carers and the people for whom they care were overwhelmingly reported to occur outside of a hospital and not to be integrated with hospital services. The most common interaction with the hospital was an assessment or diagnosis by a geriatrician with little follow-up care. Carers perceived having to call an ambulance or go to the ED as a point of crisis that they would prefer to avoid, as it 'makes things harder, not easier.'

> ***'I'm not knocking hospitals – but hospital care is for emergency issues whereas our problems are long and ongoing with multiple parts to the story. They are not quick – they take time – but hospital staff don't have any time and neither do GPs.'***
>
> *Janice, 78 years old and carer of husband with dementia*

The role of a carer was identified to be full-time. Often, they faced many emotional challenges as the role is often involuntary, often expected, and can be the result of a persistent guilt and feeling of obligation to their loved one.

Carers suggested the following key issues related to how services are accessed and provided:

Access to services: This was described to be extremely difficult, with a lack of supply and many eligibility criteria to overcome for carers and the individual. Respite services (day respite or longer-term respite) were commonly reported to be one of the most needed services by carers. They also felt that better access to HACC services such as household support, transport support and access to a case manager should be more available in varying levels.

Support for carers: Carers reported getting the most value out of their Carer Support Group, as they were able to talk about their experience and feelings as a carer. They noted that there had been little discussion with them with GPs or other specialists in regards to what they should expect or how to look after their own emotional well-being in this journey.

Assessment and diagnosis: Access to assessment and diagnosis or support was mixed (in particular, ACAT assessments). Some carers expressed a smooth process of referral from their GP to assessments and then to support services while others suggested it had been messy and extremely difficult to move between the GP, the geriatrician and the ACAT team. The outcome was that little to no support was provided.

Information about services available: Some of the websites (i.e. HACC) did not provide the most up-to-date information on services available and as a result, most of the information required by the carer is acquired through word of mouth or proactive research.

Care plans: There was a reported absence of any care plan for these multimorbid older persons with significant care needs. Instead it was left to the carer to navigate what service may be needed and when and from where. Care planning for the individual with dementia with continual check-in points would provide a useful framework for the carer as well as be helpful in identifying those that may be at risk of requiring additional support as a carer. It would also provide the carer with a key contact for situations they are uncertain of how to manage.

Sharing of history and information: There was a lack of access to medical history for individuals who have had numerous interactions with services across sectors. It was felt that it was left to the carer to transfer and provide information about the individual to multiple service providers to ensure the continuity of care and avoid any 'steps backward'.

Privacy Laws/Guardianship: Recognition of the carer's need to undertake administrative duties on behalf of the person they care for was recognised as a significant hurdle. This includes accessing Medicare rebates on services, private health insurance, and Centrelink benefits. It was suggested that better processes to support this are required.

Carers – enablers, barriers and opportunities	
	• A Carers Support Group or network to share with and learn from • A supportive GP or NGO service • Being recognised as an unpaid carer – rather than it being assumed. • Care for the health and well-being of the carer
	• Cost of carer support and services • Lack of a person to contact when things go wrong • Sudden escalation vs. planned management • Unhelpful ED and ambulance staff • GPs that 'only diagnose the problem' • Transport of disabled or mentally unstable older persons to and from clinics • Privacy Laws and Guardianship needs in carer role
	• One-stop shop for services and information and access where all these things are connected • Care plans for older people with significant care needs and morbidity that a carer and a case manager can discuss and track • Care plans for carers that address their own health needs • Acute response team that can come to the home to assist with sudden decline in function or a fall. This does not need to result in an ambulance and ED visit. • Proactive telephone support for carers that suggests support services available and tracks any issues and helps the carer plan for their own needs.

Note on Aboriginal-specific service inclusion in consultations *– It is recognised that Aboriginal Community Controlled Health Organisations (including Aboriginal Medical Services) provide important services to older people with complex health needs outside of the hospital environment. Site visits demonstrated considerable variation in interaction with these services. It is also noted that the federal and state governments have invested in specific initiatives for this group that overlap with the mainstream services explored (e.g. Close the Gap MBS rebates, care coordination and area-specific Aboriginal Health Alliances). The Aboriginal Medical Service models of comprehensive primary care for chronic disease also provides an interesting model for further exploration in the solution design phase of this project.*

7. Key insights

This section describes the key insights gained from current practice across NSW which will inform the questions which need to be addressed as part of the Solution Design phase of the project.

Taking into account the findings, the literature scan, site visits and other consultations, a number of consistent themes have emerged around how 1) the cohort is defined 2) the right care, at the right time, in the right place with the right skills is enabled, and 3) expected outcomes from better integrated care can be defined. These are considered in turn below.

7.1 Defining the cohort

As the findings demonstrate, what is considered care for older persons with complex needs has a multitude of variables that are not mutually exclusive and therefore difficult to fully describe or quantify.

Throughout consultations, the definitions of complexity by aged health staff at LHDs and stakeholders were found to straddle the space between both a population health concept of complexity (represented by the concept of multimorbidity) and a clinical/diagnostic definition of complexity (represented by two or more diagnosed comorbidities and DRGs). Both are technically correct but drive different responses to care.

In order to move this exploration forward into solution design, the current project definition of complex health needs in older people requires further articulation. Rather than 'inclusion and exclusion criteria', the way forward may be to separate out key issues that have similar but different courses of care and look at an ideal integrated care path that addresses all of them in some way but still targets the most important issues such as falls and frailty, organ failure/system decline, dementia and other behavioural issues, social isolation.

The current data available from acute care services similarly falls short in providing a clear path for solution design. Cohort DRG inclusions and exclusions are similarly unclear for this group as the social and historical context of the older person is not well accounted for in looking at the acute inpatient data isolation. For this reason, the data describes the progression of increasing acuity and deterioration of health with increasing age but does not suggest specific points of optimal intervention or changes in treatment.

Therefore this cohort is best described by both qualitative and quantitative information, and will require further out-of-hospital data to address the needs of this cohort at their most vulnerable.

7.2 Enabling the right care, at the right time, in the right place with the right skills

While good practice models and programs exist for older people with complex needs, they were found to often be stand-alone 'interventions' or 'process' responses to system-wide problems that instead require a response at system level. In this sense, past efforts to implement 'integrated care' may be seen as an example of overlaying a set of superficial processes onto a fractured series of separate services. Integration will only be possible if based upon a solid foundation of core services at home, in the community, in hospital and other settings.

It is well evidenced that the care needs of older persons are often complex. Potentially more important for how services are designed and resourced is the recognition that their health status is volatile, often unpredictable and difficult to regain. The risk of deterioration causing further complications is well evidenced, as are the multiple issues that coincide with hospitalisation. Some clinicians and administrators view this as a challenge and have put in place diversions and frontloaded their services with expertise accordingly; others see it as a natural course or business as usual and a burden on service resources and time. This dual perspective is evident in the different ways aged health services were observed to be delivered across the ten sites.

Key factors in service effectiveness and agility were found to be:

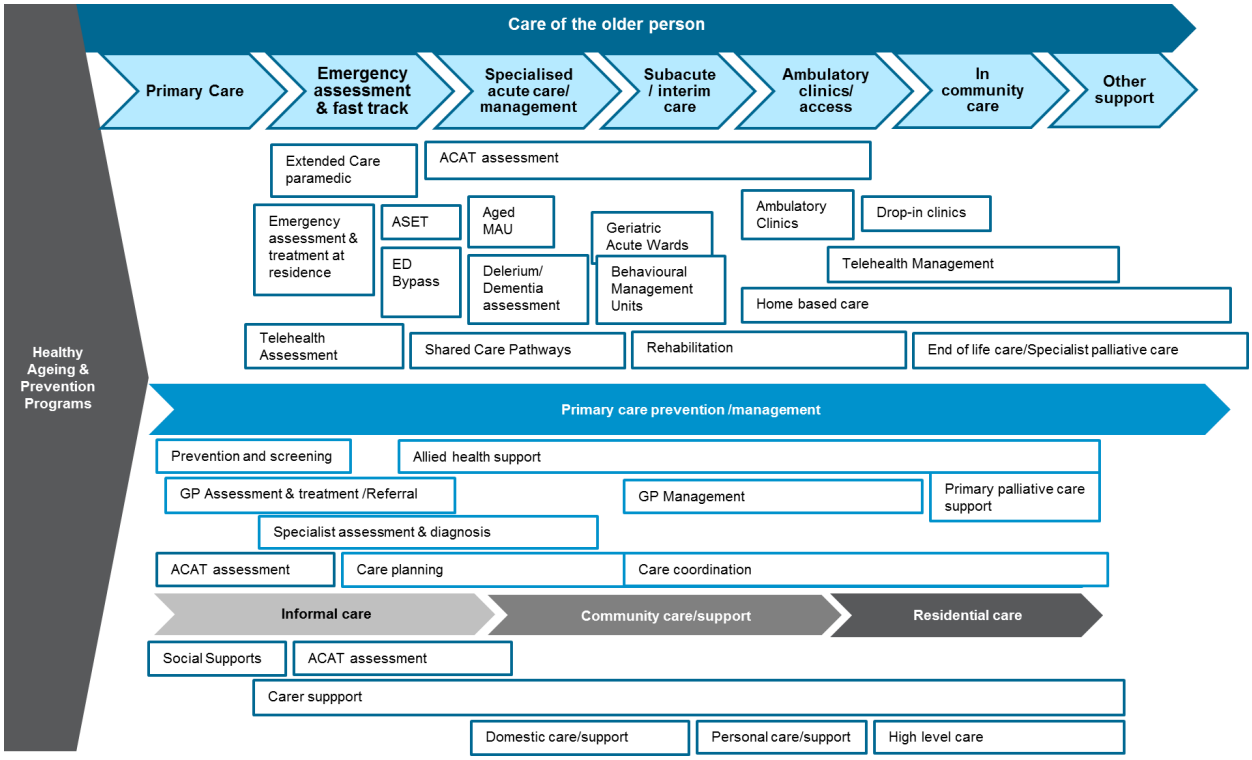
- Service resourcing – The ability to frontload staff and maintain a seven-day roster for continuity. Some sites with great initiatives only operated five days during business hours and reported a significant decrease in performance outside these hours.
- Access to appropriate care in the right setting and a spectrum of services across the continuum. This included outreach into community settings or working in partnership with community-based providers.
- Integrated multidisciplinary collaborative governance
- Good leadership and executive-level sponsorship
- Systems that share information between community, acute and primary care.

Similarly, models of care delivered in the acute and community settings currently vary in their level of person-centricity and how they address purely clinical needs versus the social, environmental, emotional and functional health needs of older people. This is clear both structurally through historical governance, workforce and service design, and at some sites attitudinally – although there are many passionate staff that would like to see things done differently. It is clear that consumer-centricity and the psychosocial well-being needs of older people and their carers is a significant factor in care. It must be addressed in any future model.

The findings of this diagnostic suggest that the multiple providers potentially involved in care of the older persons at different stages of the care continuum or disease progression contribute to complexity rather than reducing it. There appears to be no consistency in who delivers what care and when across acute, community and primary care services. There is little navigation support and the absence of person-centricity in current service design further compounds this again.

Figure 26 below illustrates, based on the findings and observations of this project, a detailed whole-of-system perspective of what parallel services are provided for older people, their carers and family, and by whom across the continuum of care. In doing so, it describes the lack of person-centricity in the current state and the division; and duplication and potential gaps that occur between acute, community and primary care where there is little to no current communication between providers (Please note this is for illustrative purposes and less detail on primary and community-based care services is included than what is delivered).

Figure 26: Whole-of-system view of services for older people, their carers and family



This cross-sectoral view magnifies the complexity of service delivery and access for this group; however, it also highlights the negative impact of when these services are not available or are not delivered in a connected way.

The other issue that historical service structures and philosophies find difficult to manage is the drawn out timeframe in which deterioration occurs due to frailty or other geriatric syndrome issues. The decline of older people's health is unpredictable but often prolonged with periods of increased acuity. That is, as described by Murray et al., 2008.

Figure 8, the trajectory for frailty, dementia and other geriatric disorders is undulating and difficult to plan for.[xlvi] However, this ambiguity does not mean that planning, structure and information is not necessary for older people, their carers and family to manage the psychosocial impact of deteriorating health. This type of proactive inclusion of individuals and carers in care planning was observed to be absent in most sites, which is against consumer and carer preference and at the detriment of acute service demand. Cancer services and palliative care approaches have a number of useful tools and approaches that identify key milestones in care, and plan for escalation needs and times when care 'changes of gear' are required.

'All I would really like to understand is what to expect – if I had a plan for what to expect I'd be okay. That, and a number to call when he falls and I can't get him up off the floor would be great.' *Jan, 68 years old, carer for her husband with dementia*

Similarly, a workforce that is able to deliver advice and provide support to this cohort at various stages of care need not be based on historical models of delivery. Nurses, allied health practitioners and even volunteers have an important role to play in future service design through prevention, early intervention, social support and care coordination.

7.3 Defining expected outcomes of an integrated approach

Integrated care provides a conceptual framework to achieve the design of person-centred care at the frontline. It eliminates the wasted time and effort that goes into delivering services for the same cohort in disconnected and different ways. Integrated care works to systematically remove barriers and

implement enablers to connected care. Instead of dealing with issues in isolation (e.g. models of care for a fractured neck of femur), integrated care applies a systems-thinking approach to identify the right care, right skills, right time, right place, right questions and the right next steps.

One of the well-documented challenges faced in the early stages of integrating care is to demonstrate the immediate value of investment for all stakeholders prior to taking a leap of faith based on how care 'should' be delivered. Considering current healthcare reform, the strong evidence base of the benefits of multidisciplinary care, and the need to address current duplication of efforts and workforce inefficiency, it is clear that now is the time to leap.

Integration cannot be achieved by one provider but must reach across systemic boundaries including professional and geographical boundaries and across sectors. This includes cross-organisational and cross-sectoral partnerships being utilised to support the care of the older person as well as facilitate an integrated care journey. While there are a number of models of care in place to target effort at most prevalent DRGs and LoS, gaps in communication and unmet demand for home and community care limit their effectiveness. To only invest in models of care ignores the problem that there is no joint plan between acute and community service sectors.

This snapshot review of ten sites across NSW has identified potential practices for systemic implementation that will move services towards integration of care delivery. However for integrated care to occur with this cohort in particular, the way in which they wish to access care and self-manage needs to become a focal point of service design. Therefore, providers can no longer work in silos and may need to accept some significant changes to routine and professional hierarchy. This potentially means breaking down the current system into components and putting them back together in a way that better fits the needs of an older person with ongoing health issues, rather than according to professional groupings or funding streams. Described below is a high-level set of considerations (based upon Figure 7 in Section 1) to progress integration from a systems-thinking approach.

7.4 Key steps to progress greater integration

1. Establishing an agreed strategic purpose for integrating care of older people in NSW

A key finding of the diagnostic process was the gap between the desired care and the care delivered for older people with complex health needs. This was most apparent in the difference between the philosophy of care and the descriptions of actual care delivered, as well as the lack of clarity around the strategic purpose of care within the wider context of the care-continuum. For example, where community health teams are delivering reactive services and are unclear of the purpose of this service in the wider continuum of care, an agreed strategic purpose for each element of care delivery is necessary to guide the day-to-day performance and decision-making of support services. Similarly, services that focused on specific strategies, such as admission avoidance or early assessment and fast-track treatment, were able to make resourcing and service design decisions that aligned to their strategy, and individual staff members were able to make similar decisions autonomously. Where strategies were absent or not person-centred, there was significant disconnection between the stated philosophy of care and what was being delivered.

While specific aged health services made up of passionate people existed at all sites visited, the strategic intent of these services – within the broader context of improving care, optimising the system and improving the experience of older persons, their carers and families – was not apparent or able to be articulated.

Still, there are many examples of models of care and programs that improve specific parts of the older person's journey through the NSW Health system, and of services and communities where care is somewhat integrated across sectors.

These examples of good practice were identified as a response to four key strategic needs:

- Alignment around a well-articulated strategic vision of comprehensive and person-centred care for older adults with complex needs
- Models of care that seek to address the range of older people's needs
- Good clinical leadership, governance and executive-level support
- Professional collaboration across specialties and sectors.

Where sites had an agreed and clear strategic vision for integrating care services for older people, carers and their family, there was not only a shared understanding of what each team's role and responsibilities were but also a clear and articulated understanding of the cohort of older persons, their unique needs and elevated risk for deterioration, and how they interact with the healthcare system.

A shared strategic purpose needs to be practical and implementable through operational arms or teams. In this way, it should include core objectives and principles to guide implementation and to set agreed standards of care delivery.

A shared purpose will depend on the quality of leadership across sites and the progress of stakeholder organisations in taking forward decisions about reprioritisation, decommissioning and reinvestment to develop and implement the new strategic intention of better integrated care for older persons with complex needs, their carers and families.

2. Aligning governance and funding to support integration and cost-effective services

Governance and funding alignment are critical to supporting the implementation of strategic vision and purpose. It was clear from site visits that current governance and funding structures were significant barriers to optimal service delivery across specialties, wards, services and community and primary care teams. Centrally imposed priorities were reported as unsuccessful for integrating services.

The absence of an integrated multidisciplinary governance framework with joint investment, accountability, and escalation mechanisms was noted at the majority of sites visited. Good governance is critical to provide a role model, and to drive and sustain behaviour that supports both individual and organisational integration. It is this structural commitment to integration across providers that ultimately enables more connected care at the frontline of service delivery, and also impacts how older people perceive their care.

Similarly, for integration of services across current funding silo boundaries, clearer and more streamlined funding mechanisms need to be established. It was evident from site visits that the current multiplicity of funding mechanisms, funding points and accountability mechanisms detracts from both care and integration. There also appears to be no overarching plan for funding aged health services in NSW efficiently, consistently and equitably across LHD's services and respective populations. Instead, this was seen to be significantly fragmented and inconsistent across populations. Optimal integrated funding models recognise the contributions of different stakeholders, prioritise the needs of relevant populations and identify how to best support and provide incentives for local integration.

However, it should also be recognised that funding will only incentivise, not shift behaviour. An example of this is that despite the existence of numerous primary healthcare funding incentives for planning care, the delivery of primary health care to priority groups such as older people is still fragmented and often unplanned. Effective funding and governance mechanisms must be supported by change management processes to be successful.

3. Enabling providers to deliver timely and efficient care

Better integration will enable providers to provide timely and efficient care – which is ultimately what most health professionals strive to achieve.

A solid and stable foundation of core services specific to aged health – such as inpatient, ambulatory care, community care and high-level or residential aged care – represent services across the continuum of care that, together, meet the needs of older people with complex health needs and have positive health outcomes. It was found that resourcing and prioritising of those resources needs to align with a person-centred model of care that is strategically integrated. Those services that had significant gaps in the continuum of care provision reported a reduced ability to meet the needs of older people with complex health needs and influence positive outcomes.

Similarly, workforce planning needs to support and reflect the strategic vision of care. Historical or reactive recruitment practices currently reinforce models of care that are not integrated or person-centred. There are significant opportunities for alternative resourcing and capacity building of current functions within the wider healthcare system that align better with a person-centred model of care and the strategic intent of care.

Examples observed include:

- The role of a Nurse Practitioner who specialises in aged health or chronic and complex disease provides a valuable link between GPs and acute care.

- Therapy aids/assistants are currently used to support the work of physiotherapists or provide continuity of mobility support and enablement models on weekends at a number of sites.
- Volunteers provide an important role in the social and emotional support of older persons receiving care at a number of sites, and are often older people themselves looking for community engagement opportunities.
- Within General Practice, the role of the practice nurse has been identified as a significant and evolving resource in the management of chronic and complex conditions and in supporting carers. There was also recognition that connecting and coordinating care services are a great resource if better integrated with primary healthcare delivery models.
- Better collaboration and mutual learning and respect between medical specialities such as geriatric, rehabilitation, orthopaedic surgery, urology and surgery, all of which were found to be fragmented.

Speciality training in aged health also allows for improved provision of services, mentoring and success in planning for a future workforce. Specific programs to enhance generalist staff skills in aged health issues and complexity provide an opportunity to provide better care to this cohort, regardless of where they seek care. Some sites used upskilled CMO roles or Nurse Practitioners in place of and/or supporting fully qualified geriatricians. In the absence of super-specialised staff, those that express specific interest and skills were supported to learn and develop specialist skills in aged health. This is currently being trialled as a career development initiative for nurses in some rural sites with specific modules on aged health.

Transparent and timely service access

Service integration also supports transparent and timely service access. As demonstrated at some sites, a streamlined or single access point with strong service eligibility criteria can be used to screen and triage for suitability of services and to facilitate a service response. It was also clear that transparency of service availability contributes to acute care presentations and lengths of stay. For example, sites suggested that improved access to low-level HACC and Care Package support could help to avert acute admission. Post-discharge care needs to proactively include referrals and access to information on community support after a person has been released from the hospital.

Improved access to specialist geriatric support in the community avoids costly ED presentations. Examples of successful ED bypass and admission avoidance were identified at a number of sites by either resolving issues within the community setting or appropriate referral for direct admission. Successful ED bypass and admission avoidance was observed as achieved through investment in appropriate resources (sometimes less costly), education and training, and stronger support of non-acute (community and primary) healthcare professionals.

Provider collaboration

Collaboration between providers is necessary in order to deliver better care through an integrated framework. This needs to improve at all levels – macro, meso and micro – through collaborative agreements, working groups and service networks, and formalised agreements of shared professional responsibility. As a starting point, individual practitioners and organisations need to understand and commit to the benefits for older people of integrated care that reaches beyond the clinical setting; currently, few see their role as improving this connectivity.

Services identified that could be considered collaborative were often the result of personal relationships developed between individual health professionals rather than in a systemic fashion. Unfortunately, these examples are not sustainable as collaboration falls apart when people leave their positions. However, they do provide working examples of successful micro-level integration.

IT connectivity and support

Technology was identified as both a significant barrier and a major opportunity for integrated care. The inability to share information about older people and their medical history or treatment needs, across the boundaries of acute, community, primary and residential care, was considered to be a major issue that impacts on timely decision-making and reinforces silos of care delivery. Opportunities presented by IT included mobile devices which can support community care teams in the field and can facilitate patient satisfaction with health services, and telehealth that can be used to reduce unnecessary transfers.

Simple tools, guidelines and processes shared in common among healthcare providers would enable integrated care but are lacking. These need to be standardised and could include establishing a minimum level of care, information transfer requirements and the existence of Advanced Care Directives. They would also reduce administration and management reporting and would assist with the high volume of older person transfers between residential care, ED, acute care and subacute care.

Key opportunities for systemic tools and processes included access to Advanced Care Directives, dementia assessments, ACAT assessment results and carer status.

Care planning and coordination

Finally, care planning and coordination for this cohort was identified as lacking. In improving this, emphasis needs to be shifted from diagnosis, assessment and acute and crisis care to integration with community and low-level support, including involving the community care sector who are well placed to play this role. Currently, there does not seem to be a systematic approach that consistently addresses this need. This lack of a comprehensive approach reduces the impact of existing services and care. It was often identified as the cause of deterioration or readmission.

A case study that demonstrates cost-efficiency is that of the Aetna telephonic care management program, targeting older people at high risk of hospitalisation. Aetna nurses work one on one with older people with complex needs, building care plans and overseeing their regular care requirements. Small rewards are offered to older people who meet personal milestones.

4. Empowering and engaging older persons in their care

Person-centred approach

The dual approach to integrating care in a way that empowers and engages older persons in their care (including carers and families) is to emphasise a person-centred approach while also turning to the need to support carers.

Delivering care centred on the needs of people and their carers is not happening in a comprehensive way. Instead, clinicians in acute care feel limited to do this by the processes and pace of their environment. Further, services are usually structured based on the historical division of sectors, specialties and funding arrangements, and programs that integrate care are not utilised due to lack of awareness or access.

Opportunity exists to improve communication, involve people in decisions about their care, and link them to available support services and information beyond their immediate care setting including through ‘one-stop shops’ for integrated and connected local service information and access.

Supporting carers

Carers provide a significant and unpaid contribution to the health system by reducing the demand for care of older people with complex needs. This positively impacts health and community care services but can equally be a negative impact on the carer’s health and well-being, their ability to work or care for their families and is often a financial and administrative strain. Informal carers require better access to basic levels of support if this care arrangement is to continue for any extended period of time.

There is a vast range of interventions which could be defined as carer support – from information, advice and guidance through to care planning and respite care. Consultations across ten sites suggest a significant lack of services available to specifically support carers, and a lack of assessment, education and access to respite services at all sites. ED staff expressed significant challenges in finding appropriate community-based support or care for carers in crisis who attend ED as a last resort. Some carers reported struggling to find respite support even when they themselves needed to undergo surgery.

5. Shifting behaviours and attitudes

This additional area for action is not a separate point but the most important theme, and one that underpins all of the other areas of action. While there is no simple solution, the most significant barrier to integration is the failure of interprofessional or interorganisational collaboration, the impact of which was evident across all services visited during the diagnostic phase.

Australia's current healthcare reforms are encouraging a shift from a central focus on healthcare providers delivering care in a series of transactions (i.e. consultations, operations) to a holistic model that focuses on the older person. This model involves a health team that is integrated and where possible located on the same premises, and that leverages the skills of different health professionals. This practice is evolving and is not yet widely accepted by all professions.

Opportunities identified during site visits include skills development to support working in teams across different settings, creating win-win solutions and approaches, exercising sensitivity, and removing silos.

Perhaps the most difficult behaviours and attitudes to overcome are those modelled by those in leadership and teaching roles. The need for change in this respect is urgent, as education and training currently delivered will determine the way in which future health professionals perceive each other and work together.

While enthusiasm for person-centred integrated care was a consistent theme, it was agreed that a lack of continuous commitment and leadership over the past decade has been a barrier to providing a truly integrated approach to care delivery. The type of change required to achieve person-centred care will create uncertainty and ambiguity and require strong, consistent and continuous collaborative leadership across multiple levels.

7.5 Questions for Solution Design

Some of the key questions raised by this report that need to be addressed as part of the Solution Design phase of this project include:

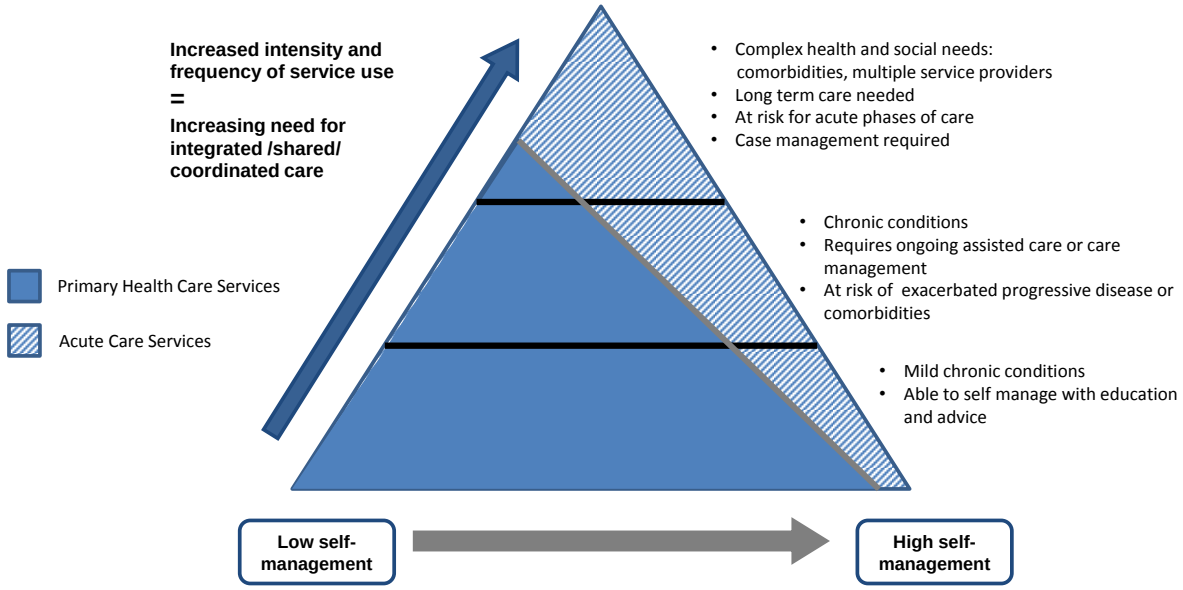
1. ***What is the key strategy to convince various stakeholders to improve collaborative aged health services for this cohort?***

2. ***What characteristics define the 'older person with complex health needs' population cohort?***

As described in Figure 27, while some older people experience good health without any additional care needs (apart from prevention practices) and some live with long-term, but well-controlled chronic conditions, others experience increasing ill health, multiple comorbidities, disabilities and functional limitations. So in framing the potential solution – to improve the effectiveness and efficiency of the care provided – it is important to understand and consider:

- *Where do they access care? And why?*
- *When do they access care versus social support?*
- *What risks and triggers are apparent in the sudden deterioration of an older person? And can they be managed?*
- *What represents connected care to this cohort?*

Figure 27: Stratification of need for integration of care services by primary and acute services (adapted from Kaiser Permanente Risk Pyramid)[xlvii]



3. ***How can person-centred care be achieved? What changes to the way in which care is delivered need to happen for this to occur?***
4. ***What are the basic service components required to improve the 'quality of care and experience' of older people in NSW through 'better coordinated care and more effective delivery' of health care to older people, their carers and family across a continuum of care that will benefit the person, system efficiency and cost of care?***

– *How can this can be applied within those systems and services directly managed and controlled by LHDs?*

– *How can this be applied across a diverse population with varied needs in the form of prevention, management and treatment of disease or palliative needs (as described in* Figure 27*)?*

– *Where, when and by whom should these services be delivered? What other community-based services are available to support this?*

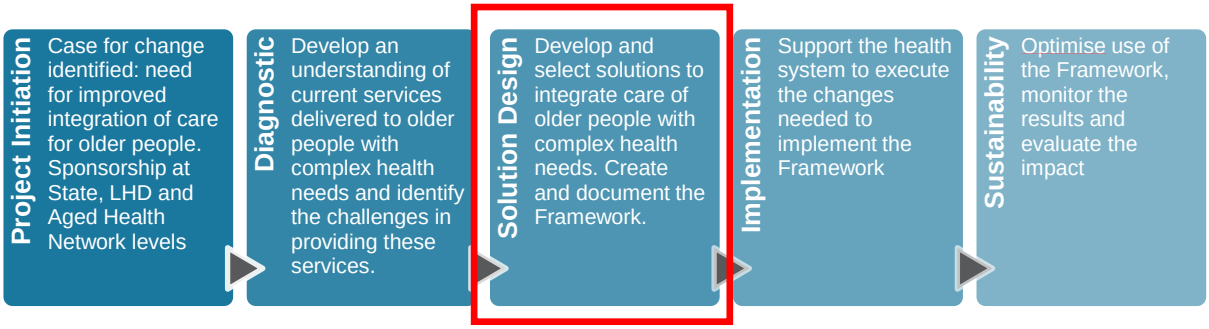
5. ***Who of the many stakeholder organisations involved are best positioned to deliver which aspects of care? What governance framework ought to be in place to manage this?***
6. ***How can current system funding be utilised to achieve the strategic intent of integrated care?***
7. ***Where should the focus for change be prioritised? How will success be measured?***

8. Next steps

This diagnostic report will inform the development of a NSW strategic framework for the Integrated Care of the Older Person with Complex Health Needs. This section sets out the next steps in the process for the project.

8.1 Solution Design phase

The site visits, consultations, literature scan and international and interstate comparisons presented in this report will inform the Solution Design phase of the project.



Prior to the solution design phase, the identified good practices and key findings as identified in this report will be grouped into:

- Those that will inform the development of the models of care
- Operational processes or practices that will impact on the later execution of the models of care and may require further validation or improvement prior to this stage.

For further consideration is what design principles should be used to guide the development of the framework. During consultations, there was some alignment on common principles for designing a framework for older people, their carers and families with complex needs. This included agreement that care should be:

- Personalised to the individual
- Maximise independence and quality of life
- Sustainable, flexible and scalable
- Easy to navigate
- Achievable and affordable.

Design principles should be agreed and models and programs selected against these principles.

8.2 Conclusion

In summary, this diagnostic report found that the many models of care and programming in NSW involved in the older person's journey through the health system are not integrated, resulting in the older people with multiple or complex health needs experiencing delays and gaps in treatment. In order to resolve this, this report offers different key recommendations including:

- Establishing a core foundation of local services upon which to build a wider model of integrated care.
- Achieving a common understanding of population health needs and how to address them through a collective and coordinated view by Medicare Locals, Local Health Districts, and relevant organisations, teams and services.

Integrated care based on high-quality relationships is possible. It could be specifically targeted to address fragmentation between services, and to address risk factors among the cohort that require

early intervention. It will require placing the needs of the older person with complex needs at the forefront and design services around the ways in which they wish to access care and self-manage needs. It will also likely require significant changes in structures and attitudes. Healthcare providers can no longer work in silos and may need to accept significant changes to their routine and professional hierarchy. Integration must reach across systemic, geographical, professional, organisational and sectoral boundaries to support the care of the older person and to facilitate an integrated care journey. It will require leadership and vision.

But it is necessary and will have clear benefits. It will eliminate the wasted time and effort that goes into delivering services for the same cohort in disconnected and different ways. It will apply a systems-thinking approach to identify the right care, right skills, right time, right place, right questions and the right next steps.

For many involved, it may feel like a leap of faith to agree on a concept before understanding how it will be delivered, and to consider radical changes in both philosophy and infrastructure. But considering the context of current healthcare reform, the strong evidence base of the benefits of multidisciplinary care, and the need to address current duplication of efforts and workforce inefficiency, it is clear that now is the time to leap.

9. Appendices

Appendix A: Glossary of Terms and Abbreviations

Abbreviation	Description
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACE	Aged Care Emergency
ACI	Agency for Clinical Innovation, NSW
ACP	Advanced Care Planning
ACQHS	Australian Commission on Safety and Quality in Health
ADHC	Department of Ageing, Disability and Home Care
AHW	Aboriginal Health Worker
AIC	Agency for Integrated Care
ALoS	Average Length of Stay
AMA	Australian Medical Association
AMS	Aboriginal Medical Services
ANPHA	Australian National Preventative Health Agency
APCD	Admitted Patient Data Collection
ARCHI	Australian Resource Centre for Healthcare Innovation
ASET	Aged Care Services Emergency Teams
CACPs	Community Aged Care Packages
CERS	Critical Emergency Response Services
CEO	Chief Executive Officer
CHF	Consumer Health Forum of Australia
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
COAG	Council of Australian Governments
COTA	Council of the Ageing
COPD	Chronic Obstructive Pulmonary Disease
DoHA	Australian Government Department of Health and Ageing
DRG	Diagnosis-related group
EACH	Extended Aged Care at Home Packages
ECP	Extended Care Paramedics
ED	Emergency Department
EMR	Electronic Medical Record

Abbreviation	Description
EOL	End of Life
FACS	Department of Community and Family Services
GEM	Geriatric Evaluation and Management
GP	General Practitioner: the collective term used for doctors/physicians who are the main prescriber of medicines
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
HITH	Hospital In The Home
ICT	Information and communications technology
IPC	Inala Primary Care
LoS	Length of stay
KPI	Key Performance Indicators
LHD	Local Hospital District
LHD	Local Health Network
MAU	Medical Assessment Unit
MBS	Medical Benefits Schedule
ML	Medical Local
MPS	Multipurpose Services
MRN	Medical Record Number
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement
NOF	Neck of Femur
NPA	National Partnership Agreement
NPS	National Prescribing Service
NUM	Nurse Unit Manager
OT	Occupational Therapist
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PET	Patient Experience Tracker
PIR	Patients In Recovery
RACF	Residential Aged Care Facility
SIPA	System of Integrated Care for Older Persons

Abbreviation	Description
SMART	Specific, Measurable, Achievable, Realistic and Timely
SPICE	Singapore Programme for Integrated Care for the Elderly
TACP	Transitional Aged Care Program
TGA	Therapeutic Goods Administration
UK	The United Kingdom
USA/US	The United States of America (noun/adjective)
UTI	Urinary Tract Infection
VWO	Volunteer Welfare Organisations

Appendix B: Definitions

General Practice

General practice provides person-centred, continuing, comprehensive and coordinated whole of person health care to individuals and families in their communities. As a sector, general practice, its practice teams and their primary health care relationships comprise the foundations of an effective healthcare system (The Royal Australian College of General Practitioners, nd).

Health care

Healthcare (*adjective)* or health care (*noun*) is the maintenance and improvement of physical and mental health, especially through the provision of medical services (Oxford Dictionary, nd).

Interdisciplinary approaches

Interdisciplinary team approaches integrate separate discipline approaches into a single consultation. The patient is intimately involved in any discussions regarding their condition or prognosis and plans about their care. A common understanding and holistic view of all aspects of the patient's care ensues, with the patient empowered to form part of the decision-making process, including the setting of long and short-term goals. Individuals from different disciplines, as well as the patient themself, are encouraged to question each other and explore alternate avenues, stepping out of discipline silos to work toward the best outcome for the patient (Jessup, 2007).

Multidisciplinary approaches

Multidisciplinary team approaches utilise the skills and experience of individuals from different disciplines, with each discipline approaching the patient from their own perspective. Most often, this approach involves separate individual consultations. It is common for multidisciplinary teams to meet regularly, in the absence of the patient, to 'case conference' findings and discuss future directions for the patient's care. Multidisciplinary teams provide more knowledge and experience than disciplines operating in isolation (Jessup, 2007).

Person-centred care

A 'person-centred' model draws on the values of the World Health Organization's definition of 'person-centred health care' (2006). These values include empowerment, participation, access and the central role of family and community. This means that people have the right and duty to participate in making decisions about their health care, not only regarding treatment and management, but also for broader issues of health care planning and implementation. DoHA has articulated this as 'a primary health care system which is designed around supporting the individual, their family and carers to be in control and actively supported in their care. It is also about a system which is easy for them to access the care they need and which helps them to manage their health care needs and stay as healthy as possible' (Australian Government Department of Health and Ageing, 2009).

Primary health care setting

Primary health care is understood to be 'the care provided at the first level of contact with the health care system, the point at which health services are mobilized and coordinated to promote health, prevent illness, care for common illness, and manage health problems' (National Forum on Health, *Canada Health Action: Building on the legacy. The final report of the National Forum on Health. Ottawa.* Health Canada Communications, 1997, p.22).

Appendix C: What is integrated care?

This project specifically set out to look at the integration of care in aged health services across NSW, therefore it is important to first define this concept.

A recent international review of the literature on integrated care revealed some 175 definitions and concepts.[xlviii] It is therefore difficult to propose a single definition of integrated care or integration that is universally agreed on. Within a working definition, it is also important to separate the concepts of communication, cooperation, coordination, collaboration and integration as they are often used interchangeably. However, there is some consensus on the differentiation between integration and integrated care.

A popular definition is that published by the Kings Fund (2012) that describes **integrated care** as:

> *An approach that aims to improve the quality of care for individual patients, service users and carers by ensuring services are well-coordinated around the individual patient's needs.*[xlix]

A 'narrative' around **integrated care** developed by users of health care with the assistance of National Voices UK is also worthy of note.[l] This narrative defined **integrated care as *person-centred coordinated care*.** This definition reduces the focus on integration of services and increases the focus on coordination around the person and the patient experience.

Additionally, these users of health care developed the following statement to describe person-centred coordinated care:

> *My care is planned with people who work together to understand me and my carer(s), put me in control [and] coordinate and deliver services to achieve my best outcomes.*

This definition provides a different perspective of integrated care, and an important one, that of the person receiving care. This perspective is central to the development of an integrated approach to care, where the system needs to work as a whole across program; service; professional, organisational and sectoral boundaries; and across several episodes of care.

For the purpose of this project the following **working definition** has been adapted by the ACI Aged Health Network Executive of **integrated care for older persons with complex needs:**

> *Integrated care of the older person brings together different organisations, processes, systems and professionals involved in delivering person-centred care.*

The aim of integrated care is to improve quality of care and the experience of the older person, their carer and family's experience through better-coordinated and more effective delivery.

Healthcare integration can be thought of as occurring at different but connected levels: macro, meso and micro.[li]

Macro-level integration is across the entire healthcare system. This can be achieved through aligned and supportive legislation, regulations, policies, funding models, professional education, accreditation and liability at the national and state levels. For the purpose of this report this would be the federal and NSW State Government services as well as professional peak bodies and national or state level NGO or private providers.

Meso-level integration is that at a regional or local level that addresses a population cohort need within a specific region. This can be achieved by connecting and bringing organisations together through collaborative agreements, working groups and service networks e.g. for a specific population or disease group. For the purpose of this report this would refer to LHDs, large NGO or private providers and Medicare Locals.

Micro-level integration refers to which occurs at the level of the practice and individual. This can be achieved through developing good working relationships characterised by trust and respect and centred on care planning and case management of a single person or a small group of people. This would include individual clinicians or small groups of service providers (e.g. ward, specialty or clinic) working together towards a common goal.

Types of healthcare integration

Integration in any significant form is likely to mean changes to existing systems and services. Fulop (2006) identified the six types of integration most commonly described in healthcare literature and where integrated care can be pursued. The ultimate aim is to achieve integrated care for the person receiving it through.[lii]

Organisational integration – bringing organisations together to support integrated care through coordinating structures, governance and relationships, e.g. service networks, collaborative agreements and working groups

Functional integration – building systems that support better-integrated care, e.g. shared records, communication systems and service directories

Service integration – coordinating different clinical services at an organisational level, e.g. through multidisciplinary teams and co-locating services

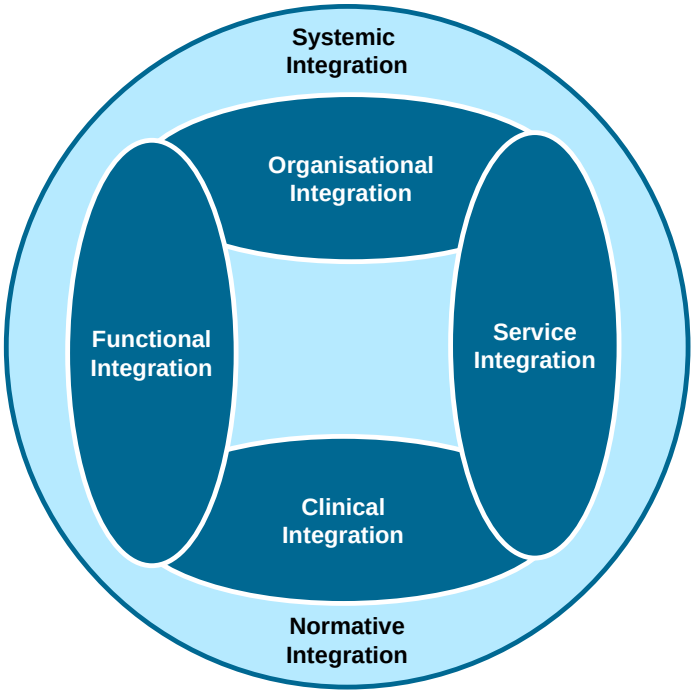
Clinical integration – coordinating information, services and care through a single process, e.g. shared guidelines, protocols and care programs

In order for integrated care to be successful, systemic integration and normative integration are also necessary:

Systemic integration – aligning policies and regulatory frameworks to support integrated care

Normative integration – creating shared values, culture and vision to support integrated care.

Figure 28: Six Types of Integrated Care (Fulop 2006)



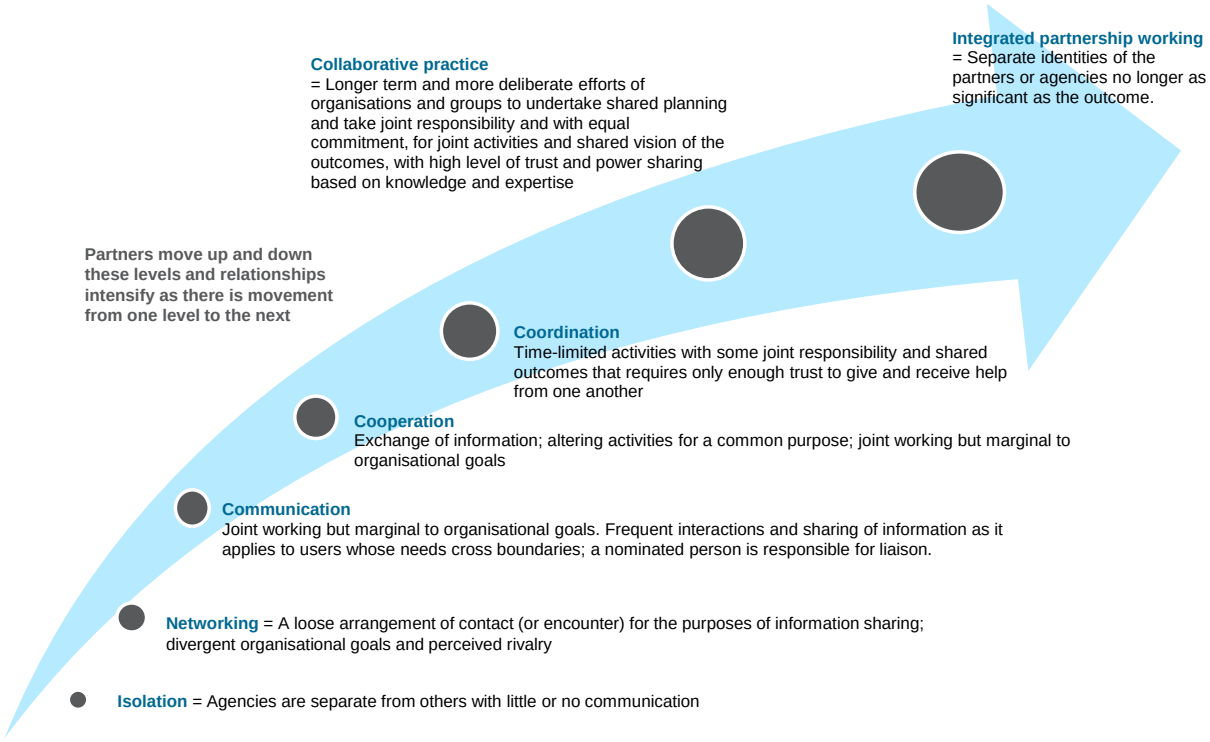
Conversely, a major weakness of many developed countries' health systems is the fragmentation of care between different parts of the system, such as between acute, subacute, primary and community care. Integration is most likely to break down for patients who have complex and ongoing care needs; requires care from multiple providers; are on multiple medicines; are not well connected to the healthcare system and have limited resources to coordinate care on their own. Incidentally, this is the same cohort who requires integrated care the most.[liii]

In an increasing number of instances these arrangements are informal and unstructured which means older people fall into gaps between services, and find it difficult to access appropriate care in a timely manner or receive inconsistent care.

The continuum of integration

Integrated care can be thought of as a progression of stages through which individuals and organisations move upwards. As relationships intensify, there is movement from one level to the next in the direction away from isolation towards integrated working partnerships. Keleher's (2012) framework provides a useful point of reference to see the progression of relationships between providers as integrated care efforts are being implemented.[liv]

Figure 29: Stages of integration (Keleher, 2012)



Benefits for integration

A number of studies have demonstrated the benefits of successful integrated care in many different contexts across the healthcare system. Below is a high-level examination of the types of benefits that have been attributed to an integrated care approach. It is intended for illustration only. Further research is required to understand the specific benefits for older people with particular health conditions within a given context. Benefits of integrated care can be thought about as positive outcomes for the patients and their carers, for care providers and for the services providing care. [lv]

Table 6: Benefits of integration of care for stakeholders

Individuals, their carers and families	More comprehensive care Better health and quality of life Convenience and ease of access 'no wrong door'	Cheaper cost of care Greater satisfaction with care received Better support for self-management
Health professionals	Better patient outcomes Greater professional satisfaction More effective of resources and time	Potential for greater income Improved professional standing
Providers of Services	Greater efficiency and reduced cost Improved quality and safety Meeting external targets	Reduced hospital use and use of nursing homes/long-term care facilities

Enablers and barriers to integrated care

Enablers and barriers to achieving integrated care have been studied extensively in recent years. International and Australian literature propose a commonly faced set of enablers and barriers, seen as two sides of the same coin. For example, where strong and committed leadership exists, this can facilitate integrated care; where it is absent, it can pose a significant challenge. [lvi]

Table 7: Enablers and barriers to integrated care identified in the literature [lx, lxi]

Enablers	Barriers
Leadership and professional relationships: Strong and committed leadership Clinical leaders in the role of change champions Commitment of health professionals Good existing working relationships between health professionals	*Power struggle and loss of autonomy:* Health professionals with different professional standing and pay Professional cultures that emphasis autonomy and current practice of working in silos A lack of role clarity in a new way of working Lack of incentives to change
Infrastructure and systems: Physical co-location Virtual integration through shared information systems and communication protocols Shared metrics and performance measures	*Change fatigue and adoption of integrated care* Change fatigue due to constant policy and structural changes in the healthcare system New patterns of care can only reach a large population when the majority of providers adopt them
Training and education: Training and education specific to providing integrated care, beginning at university/training commencement Focus on how to enhance proactive factors and reduce susceptibility to risk Population health and clinical health perspective	*Time and other investments* Additional workloads for time-poor clinicians Incentives and KPIs are not aligned and do not result in positive outcomes for all stakeholders
Changing attitudes and behaviour Shaping attitudes through shared values and vision Widespread stakeholder engagement	*Funding* Fee-for-service model can often reinforce a culture focused on procedures and intervention rather than patient outcome Funding delineation between service type and federal/state responsibility No framework for commissioning for outcomes
Patient engagement Working together with and empowering patients	*Short-term view on benefits of integrated care* Long-term benefits are sometimes harder to justify and measure

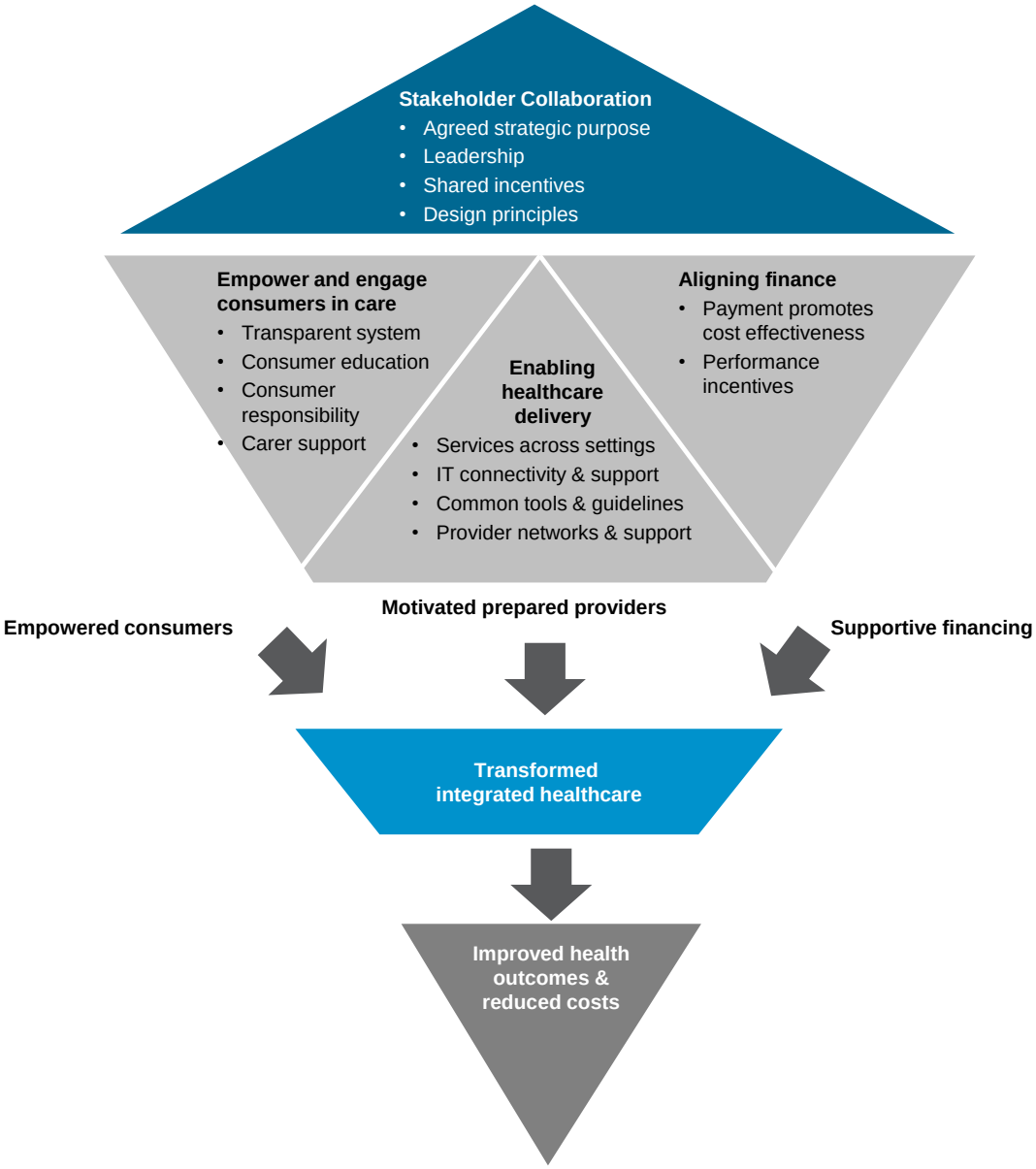
What makes integration work?

International health systems have also been wrestling with the question of how to go about integrating care.

There are numerous and well established summaries of lessons learned in integrating care including Leutz's (1999) Nine Laws of Integration[lvii] and most recently the Kings Fund's (2013) top 16 needs to make integrated care happen at scale and pace[lviii] (available in Appendix D for reference)

Below at Figure 30 is an adaptation of a well-referenced model of integration that highlights the key elements required for successful integration. We will utilise these elements to guide insights into integration of services for older people with complex health needs in NSW.

Figure 30: Key elements of successful integration (Adapted from 2006 MacColl Institute for Healthcare Innovation)[lix]



One of the key elements of integrated care that is captured here is the way in which all elements interact and the intrinsic need for behaviour change at all levels and by all stakeholders. Indeed even if all structural elements of this integrated care journey exist it is reliant on the behaviours of the key players within it.

Appendix D: Making Integrated Care happen

Nine Laws of Integration *(Leutz W, 1999 and 2005)*

1. You can integrate some of the services for all of the people or all of the services for some of the people, but you can't integrate all the services for all the people.
2. Integration costs before it pays.
3. Your integration is my fragmentation.
4. You can't integrate a square peg and a round hole.
5. The one who integrates calls the tune.
6. All integration is local.
7. Keep it simple, stupid.
8. Don't try to integrate everything.
9. Integration isn't built in a day.

Kings Fund's 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 E: Funding Models

The following table describes the funding models currently in operation in Australia and internationally

Table 8: Funding models

Payment term/system	Description	Further description/examples
Block	Payment/lump sum for a specific, usually broadly defined service, independent of number of consumers	Block funding examples in Australia include State government payments to hospitals and DoHA payments to State Governments and other health agencies.
Capitation	Lump sum payment per consumer served by a provider for comprehensive services or particular categories of service regardless of treatment received.	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 is 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.
Pathway/episode of care	Single payment to cover an entire episode/pathway of care.	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).
Case-based	Activity-based reimbursement per patient based prospectively on diagnosis/patient characteristics.	Under activity–based funding, acute hospitals in Australia will receive payments for case-mix classification according to the Diagnostic Related Groups (DRGs) classification system.
Per Diem	Lump sum payment per patient per day of care regardless of consumption of care.	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.

Payment term/system	Description	Further description/examples
Fee for service	Activity-based (prospectively set) unit payment for a defined intervention regardless of patient characteristics or complexity.	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.
Pay for performance	Payment is linked to achievement of specific performance targets.	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.
Bundled payments	A single payment covering multiple elements of a person's treatment	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.
Unbundled	Separate payments for disaggregated elements of a person's care	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.
Mixed or blended systems	A combination of different payment methods.	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.

Payment term/system	Description	Further description/examples
Individual care budgets	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.	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.
Accountable Care Organisations	Ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.	Traditional fee-for-service program who are assigned to it (centres for Medicare and Medicaid Services).This model is currently used in the US.

Appendix F: Health Reforms - Summary

State-based reform

- Local Health Networks (LHNs): new administrative structures for public hospitals and some health services. In NSW, 15 Local Health Districts (LHDs) have replaced the former eight Area Health Services.
- New funding arrangements for public hospitals. As from 1 July 2012, Hospitals are being funded for the services they provide on an activity basis (Activity Based Funding). The Commonwealth is to fund half the 'efficient' growth cost from 2014/15.

Federal primary care reform

- Medicare Locals (MLs): new independent organisations, replacing Divisions of General Practice, to coordinate access to local primary healthcare services. They will have similar geographical boundaries to LHNs.
- GP Super Clinics
- Investment in primary health care infrastructure

Infrastructure reforms

- The introduction of the national eHealth records system (i.e. the personally controlled electronic health record or PCEHR)
- Efforts to boost the primary healthcare workforce

National aged care reform

- Increasing home-based support
- Funding changes of residential aged care

Community care reform

- Federal funding and program responsibility for basic community care services for people aged 65 years or over. This includes full operational responsibility for HACC services for people aged 65/50 years and over and for specialist disability services delivered under the National Disability Agreement for people aged 65/50 years and over.

National disability reform

- National Disability Insurance Scheme

Appendix G: Primary health care reform in Australia - Summary

The primary health care system is increasingly considered the foundation of any healthcare system. Contemporary definitions of primary health care recognise that health is in fact determined by complex interactions between health care, social and environmental context. Primary health care works at this interface of health care and the social determinants of health. It deals with the complex interaction of biological and social causation of illness and defines interventions on the social context of consumers and communities.

Historically, primary health care in Australia has been complex, fragmented and disconnected. This lack of cohesion has been due to the diversity of funding models, incentives systems and providers across public, private and non-government sectors. The consequences of this has been a significant disconnection between primary care and acute or subacute care delivered by state governments – to the detriment especially of people with complex health needs,

In 2010, DoHA in partnership with State and Territory governments and other key stakeholders embarked on an ambitious health reform agenda to transform the primary health care sector. Key reforms have included:

The establishment of a nation-wide network of Medicare Locals

Medicare Locals are the flagship for the national health reform in relation to primary health care. Like similar organisations around the world, Medicare Locals have an ambitious mandate to use population health planning to integrate innovative local service design and provision with the social, environmental, and economic determinants of health. Medicare Locals aim to coordinate and integrate primary healthcare delivery in a particular geographical area, focusing on local health needs and service gaps, while linking GPs, nurses and other primary health professionals and Aboriginal and Torres Strait Islander health organisations with acute and aged care services. Currently, all 61 Medicare Locals have commenced establishment and operational activities. Medicare Locals are seen as a key way to improve the integration of care, and to provide consumers and communities with health care services (Australian Medicare Local Alliance, 2012).

GP Super Clinics

GP Super Clinics are physical infrastructures where community members can access a range of health professionals such as GPs, nurses, and pharmacists and receive a varied range of health care services (Australian Government Department of Health and Ageing, 2011). Funding has been invested to establish 64 GP Super Clinics across Australia. They represent a significant investment in primary health care infrastructure. In an evaluation of the set-up of GP Super Clinics in 2007–2008, it was found that consumers have increased access to primary health care in a multidisciplinary setting and report positive experiences about access to and the quality of their care. Furthermore, retention and recruitment of GPs was supported (Consan Consulting, 2012).

A national eHealth record system

An investment of $466.7 million in the national eHealth record system is being made over a two-year period and will allow improved healthcare delivery by improving access to information and cutting waste and duplication. It will be a secure system of personally controlled electronic health records that will provide: summaries of consumers' health information including medications; immunisations and medical test results; secure access for consumers and health care providers to eHealth records through the internet regardless of their physical location; and rigorous governance and oversight to maintain privacy (Australian Government Department of Health and Ageing, 2010).

It is anticipated that a national eHealth record system will allow consumers to be empowered with easy-to-access information about their medical history and to make informed choices about their health care with improved consumer safety. They will be able to present for treatment anywhere in the country and give permission for health professionals to access their relevant history at the touch of a button.

Investment in primary health care infrastructure such as access to the after hours GP helpline

Greater investment has been made in primary health care infrastructure through the Primary Care Infrastructure Grants and with investment in the *after hours GP helpline*. Primary Care Infrastructure Grants are provided to general practices, primary health care, community health services and Aboriginal Medical Services (AMS) to improve consumer access to integrated GP and primary health care. In 2010–2011, the Australian Government invested $117 million in these grants to upgrade around 425 services.

DoHA will also increase access to after-hours services through the availability of the *after hours GP helpline*, delivered through the National Health Call Centre Network, and by tasking Medicare Locals with a range of after-hours primary health care responsibilities (Australian Government Department of Health and Ageing, 2010).

Boosting the primary healthcare workforce

In addition to structural changes in primary health care, the roles of some health professionals are also changing. One of the five key building blocks of the national strategy is a skilled workforce, a workforce that is flexible and well trained, has clear roles and responsibilities built around core competencies and works collaboratively. Due to the increase in the incidence of chronic diseases in Australia, and workforce misalignments more widely, DoHA has increased the emphasis on enabling multidisciplinary care within a primary healthcare setting. Mechanisms to do this include increased prescribing rights for nurses, larger roles for practice nurses and increased roles of pharmacists in medication management services.

Appendix H: National Aged Care Reform - Summary

On 20 April 2012, the Federal Government announced a five-year $3.7 billion aged care reform package in Australia. The *Living Longer, Living Better* reform was informed by the Productivity Commission's report, *Caring for Older Australia*, and aims to build a better, more accessible, sustainable and nationally consistent aged care system for older Australians and their families. Key focus of the reform includes[lx]:

- ***Increasing support for older Australians to age at home*** through expanding the Home Support program, increased choice and control for consumers, and a fairer means-testing assessment
- ***Establish the Aged Care Gateway*** with a new national call centre and My Aged Care website, which includes quality indicators for consumers to compare different providers
- ***Significant changes to funding for residential aged care:*** building more residential care facilities; supporting the viability of services in regional, remote and rural areas; trialling Consumer-Directed Care; improving the means-testing for residential care, and the Aged Care Funding assessment
- ***Strengthening the aged care workforce***
- ***Improving consumer advocacy***
- ***Tackling dementia*** by introducing a Dementia Supplement in home and residential care; increasing focus on people with younger onset dementia; and reducing time between symptoms and diagnosis
- ***Supporting older Australians from diverse backgrounds:*** more aged care places for Indigenous Australians; support for veterans with mental health problems; staff training and helping homeless people stay in the community.

These reforms have a significant impact for Government bodies, service providers and health professionals and ultimately benefit older Australians and their families. The aims of building a better, more accessible, sustainable and nationally consistent aged care system is aligned to the objectives of the NSW Ageing Strategy, particularly with regards to keeping older people healthy and in the community for as long as possible.[lxi] The aims of the national aged care reforms also match the vision of ACI for older people and their ability to access appropriate, quality healthcare that is provided in an equitable and coordinated manner and delivered as close to home as possible.

The expected benefits of reform for people who use health services include better access to the right services at the right time and improved coordination across settings and sectors, with a net gain in both health outcomes and the long-term cost containment to the system.

Appendix I: Community Care Reform - Summary

The introduction of the National Health Reform Agreement (NHRA) along with other reforms challenges the fundamental role of Community Care providers in NSW. Under the NHRA, responsibilities for aged care and disability services are split at age 65, or at age 50 for Indigenous Australians.

Up until 1 July 2012, the HACC program was jointly funded by the Commonwealth and State/Territory governments. The Commonwealth government funded 60 per cent and the state governments 40 per cent of the program. The HACC program was administered by the states/territories.

What is the role of the Commonwealth government?

Funding and program responsibility for basic community care services for people aged **65 years or over** (and 50 years or over for Indigenous Australians) in line with its responsibilities for the rest of the national aged care system.

Funding responsibility for **specialist disability services** delivered under the National Disability Agreement for people aged **65/50 years and over**.

This includes **full operational responsibility** for HACC services for people aged 65/50 years and over.

The Commonwealth will not substantially alter service delivery mechanisms before 1 July 2015.

The funding model for 2015 is unknown but is expected to be either on a competitive tendering basis or on an agreed national unit price per services delivered.

What is the role of the NSW government?

Funding and program responsibility for people **under the age of 65/50** in line with the NSW Government principal responsibility for the delivery of **disability services.**

Funding responsibility for packaged community care services and residential aged care services delivered through the Commonwealth aged care program to people under the age of 65/50.

Indigenous clients aged between **50–64 years** are able to **receive services** from an appropriate provider under programs from **either level of government.**

NSW Government will continue to fund service providers for the provision of basic community care services in NSW for people under the age of 65/50.

There are risks related to the NSW HACC sector's ability to respond if the NSW funding approach was to significantly change.

Home Care of NSW (Home Care) is the largest provider of HACC-funded services in NSW. In 2011–12, Home Care received 81% of its funding from the HACC program. It received 31% of NSW HACC funding and provided approximately 27% of total service hours. Despite this, there is already a high and sustained level of unmet need for Home Care Services.

The primary role of Home Care (under the Act) is to assist people to live independently in their own home and avoid institutional care. Other services types are provided on a smaller scale, mostly in rural and remote areas under Aboriginal Home Care (AHC).

Home Care will be significantly affected by the NHRA and other disability reform which includes the introduction of person-centred planning and individual support packages under Stronger Together 2 and the NDIS.

Appendix J: Key national and international models identified as part of the Literature Scan

The literature scan 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 were examined and are described in this section.

National examples of integrated care

There are several examples of models of integrated care in Australia that target other priority population groups or address specific chronic diseases. The following are highlighted as part of the Literature Scan available at Appendix K.

Health Pathways

What is HealthPathways?

HealthPathways 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 'HealthPathways' reflects the referral lines or 'pathways' which link patients to the best treatment, local service or specialist.

Who is involved?

HealthPathways is aimed at General Professionals but can also be used by hospital specialists, practice nurses/managers, and community and allied health providers. HealthPathways 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*.

How is integrated care being achieved?

HealthPathways is a dynamic collaboration between LHDs, Medical Locals, GPs, hospital specialists, nursing, and community and allied health providers, All are involved in creating HealthPathways 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 HealthPathways approach are:

- 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.
- More patients get the right treatment or specialist care with less waiting time.
- GPs are enabled to better help patients by outlining information their patients need to know.

ACI is currently supporting the implementation of Health Pathways at three Medicare Local and LHD partnerships across NSW.

Partners in Recovery

What is Partners in Recovery?

The Partners in Recovery (PIR) program, funded by DoHA, is an example of current models of collaborative practices, provided by a multidisciplinary team and facilitated by one point of contact. A key feature of this program is that each team member signs an MOU which outlines their formal roles within the care action plan and regularly reviews progress against the plan.

Who is involved?

PIR organisations aim to better support people experiencing severe and persistent mental illness with complex health needs by engaging the multiple sectors, services and supports to facilitate a more collaborative, coordinated and integrated service delivery.

The range of organisations engaged who act as local partners reflects the existing suite of sectors, services and supports required by the target group. PIR will bring these organisations together to promote collective ownership and the development of innovative solutions to ensure timely and effective access for the consumer. Local partners may include: primary health care (health and mental health), state/ territory specialist mental health system, the mental health and broader NGO sector, alcohol and other drug services, and income support services, as well as education, employment and housing supports.

The PIR program will employ Support Facilitators who will review referrals, undertake an assessment of the client's holistic needs and develop an action plan in collaboration with the local partners within the region to schedule and prioritise the delivery of services, engage with existing case managers, and be the point of contact for clients, their families and carers (as appropriate).

How is integrated care being achieved?

1. A client is admitted to a local hospital with a history of sporadic engagement with community mental health and crisis intervention services, substance misuse and homelessness. The Hospital Social Worker contacts PIR and the local state clinical mental health team.
2. The PIR Support Facilitator meets with the client to assess their needs and develops a step-by-step plan to access the services required.
3. The PIR Support Facilitator works with the client to clarify their personal recovery goals and associated service and support needs including: local supported accommodation, the local Personal Helpers and Mentors service, Centrelink, community mental health services, a GP, drug and alcohol services and a dentist.
4. The PIR organisation has established MOUs with local partners which outline how they work together in partnership to support clients in the region. The client's recovery plan is discussed at the PIR working group which is composed of representatives from the local partners. They review and discuss the recovery plan before formally committing to their identified roles and contribution.
5. The local community mental health worker is established as the client's clinical case manager and works closely with the PIR Support Facilitator and the client to coordinate discharge and planning a move into supported accommodation. The clinical case manager also arranges for the client to link to a case coordinator team at the local Centrelink service centre and meet with a GP and psychiatrist. The case coordinator sends weekly progress updates to the PIR Support Facilitator.

Partners in Recovery consortium approaches were reported to be under development in South Eastern Sydney/Sutherland, Wentwest/Westmead and Murrumbidgee/Wagga Wagga. Whilst this model is not yet used for older persons with mental health issues it provides a working example of integrated governance and service delivery.

Inala Primary Care

What is Inala Primary Care?

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:

- Provide best practice, patient-focused primary care to disadvantaged urban communities

- Integrate health care to control and prevent the progression of disease
- Provide facilities for research, teaching and education
- 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)

Hospital Admission Risk Program

What is HARP?

The Hospital Admission Risk Program (HARP) is a program for individuals at risk of repeated hospitalisation at the time of emergency presentation, hospital admission or at discharge from hospital in order to provide alternative interventions at appropriate points, which may include an interdisciplinary or multidisciplinary care approach, coordinated care provided by different health professionals, medication management and other services. Overall, HARP had a positive overall impact on individuals and their need for hospital utilisation. The HARP Chronic Disease Management program is available at 21 health services across Victoria.

Who is involved?

The HARP Chronic Disease Management program is available at 21 health services across Victoria.

How is integrated care being achieved?

The Victorian Government committed $582 million as an initial investment from 2001–02 to 2004–05 to implement the Hospital Demand Management Strategy. Of this total, $150 million was invested to develop new approaches to demand management, providing more appropriate care for 'at risk' individuals and preventing avoidable hospital use in the future. These new approaches to care were funded, monitored and evaluated under HARP. The HARP Chronic Disease Management program builds on this investment with additionally funding since 2002.

The majority of HARP projects focused on key objectives relating to:

- Improving communication and cohesion between services (78%)
- Improving the management of 'at risk' individuals (67%)
- Improving the proactive management of individuals (59%)

Many HARP projects also focused on providing better continuity of care, improving responsiveness to peoples' needs and increasing capacity within the health system to manage people's health needs.

System-level interventions were focused on improving the coordination between different services, implementing changes in the overall approach to clinical practice or providing additional workforce support through professional development and training opportunities.

In general, people utilising HARP experience:

- 35% fewer emergency department attendances
- 52% fewer emergency admissions
- 41% fewer days in hospital.

The impact of HARP on the need of hospital utilisation was shown in reduced need equivalent to approximately one emergency department attendance, two emergency admissions and six days spent in hospital for every HARP consumer.

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.
8. Legal Issues – Access to information on supported decision-making and end-of-life issues including Enduring Power of Guardianship, Enduring Power of Attorney, Advance Health Directive and making of wills.

International examples of integrated care

Similarly, there are several international examples of how concepts of care integration have been successfully applied. The examples described in Table 9 below are further described in the Literature Scan available in Appendix K.

Table 9: International examples of integrated care for the older person with complex needs

The LinkAGE – Leading Integration for Older People (New Zealand)	**What is LinkAGE?** 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. **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.*
The Singapore Programme for Integrated Care for the Elderly (Singapore)	**What is SPICE?** 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. **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 K: Literature Scan – Annotated Bibliography

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
Medical Journal of Australia, June 2009	North East Valley Division of General Practice, Victoria	Pushing the envelope: clinical handover from the aged-care home to the emergency department	*Mary K Belfrage, Clare Chiminello, Diana Cooper, Sally Douglas*	This paper evaluated the use and usefulness of an aged-care home (ACH) transfer to hospital envelope as a tool to support safe clinical handover when an ACH resident is transferred to an emergency department. Participants in the study were 26 ACHs (1545 beds), the EDs of six major metropolitan public teaching hospitals in Melbourne, and ambulance officers involved in transferring residents from ACHs to hospitals. Transfer data were collected over an 18-week period. Evaluation methods included written surveys and semi-structured face-to-face interviews.	The Transfer-to-Hospital 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. • It is low cost (49-66 cents each depending on size of print run). The envelope was used for the large majority of ACH residents transferred to hospital. ACH staff (99%) through the Envelope was useful, and 90% said it was easy to use. 78% ACH staff and all interviewees believed that using the Envelope improve clinical handover and 92% of ACH staff indicated they would continue to use the Envelope. All interviewees thought that using the envelope had raised awareness of the need for clinical handover.
Department of	Western	Dementia	*Aged Care*	This paper describes the	This paper is high level in intent and articulates a service delivery

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
Health Western Australia 2011	Australia	Model of Care	*Network, Department of Health*	WA Model of Care for dementia patients. The Aged Care Network with the support of the Aged and Continuing Care Directorate of WA Health produced this paper in collaboration with key stakeholders through the Clinical Advisory Committee, WA Aged Care Advisory Council and the WA Community Care Reform Advisory Group.	model of care 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 is focused 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 highlighted eight broad key recommendation 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 GP, Geriatricians Psycho-Geriatric services and other specialist services in relation to 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 understand dementia and the support needs of the person with dementia.

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					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. 8. Legal Issues- Access to information on supported decision-making and end of life issues including Enduring Power of Guardianship, Enduring Power of Attorney, Advance Health Directive and making of wills.
Australian Research Centre for Healthcare Innovations	Hunter New England Local Health District NSW	Older Person Acute Care (OPAC) Model of Care	*Hunter New England OPAC Project Team*	The Older Person Acute Care Model (OPAC) is based on international best practice and underpinned by the principles of person-centricity, multidisciplinary teamwork and practice development. The model aims to improve patient experiences and health outcomes while developing a workplace culture that values and embraces the care of older people.	The model focuses on the older person with complex needs, based on principles of best practice multidisciplinary care. Principles and standards of care are respect, dignity, involvement, communication, choice and individualized care in areas such as continence, dementia and confusion, mental health needs, mobility, nutrition and hydration, pain, palliation, and pressure damage. Staff members engage in critical reflection to identify practice issues. Initiatives are evidenced based. During implementation the OPAC team: • Identified indicators of change - improved patient experiences and outcomes, a workplace culture that values older people through positive attitudes, dynamic teams, empowered staff and clinical leadership. • Realigned nursing positions to focus on older person care. • Promoted the model through multidisciplinary in-service. • Formed a leadership group for support, critical reflection and action on OPAC issues. • Supported nurses to take a leadership role when implementing the OPAC model, using practice development, change and education. • Sponsored nurses to attend practice development workshops and stewardship programs for research. • Enhanced links with the University of Newcastle for clinical research. • Published and presented project work locally, nationally and internationally (Peek et al. 2007; Higgins et al. 2007ab; Day et al. in press). The following OPAC projects were undertaken:

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					1. Developed a delirium alert protocol (DAP) and evaluated its effectiveness. 2. Improved assessment and management of pain. 3. Developed clinical guidelines for assessing pain in older people. 4. Researched the needs of the relatives in the acute care setting. 5. Developed a problem-based, person-centred approach to the management of older people with respiratory diseases. 6. Developed and implemented bowel management guidelines for older people in acute care. 7. Conducted a study of the attitudes and behaviours of health care workers towards older people (Higgins et al 2007). 8. Designed promotional media depicting the model. The OPAC Model was developed within a practice development framework. Achievements to date include: • 14% reduction in hospital acquired pressure areas. • Design and implementation of bowel management guidelines. • Delirium detection and early management. • Development of prevention and early detection protocol. • Improved staff knowledge of delirium. • 25% improvement in the detection of delirium. • Assessment and pain management. • Pain guidelines for older people in acute care setting. • Improved knowledge of pain assessment and management of older people. • Reduced reliance by staff on the use of physical restraints. • Improved workplace valuing of older people. Staff encouraged to undertake practice development and research involving older person care as evidenced in the 13 project areas and researchable topics undertaken to date.

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
Australian Research Centre for Healthcare Innovations	Hornsby Ku-ring-gai NSW	Geriatric Rapid Acute Care Evaluation (GRACE) model	*Ass Professor Sue Kurrie, Jenny Houston*	Hornsby Ku-ring-gai Hospital Service (HKHS) has developed the Geriatric Rapid Acute Care Evaluation (GRACE) model of care to improve the health care journey of aged care residents. Under the GRACE model hospital staff work in collaboration with general practitioners and aged care facilities to avoid hospital admissions and reduce access block and length of stay for older patients	Residents of aged care facilities get access to rapid treatment and appropriate care either in the hospital or their home environment under the GRACE model of care There is strong evidence that treating nursing home and hostel residents in the home improves their outcomes. While the benefits of caring for residents in their home rather than a hospital are increasingly recognised, facilities are often challenged in managing acute and subacute illness. Under GRACE, hospital staff work in collaboration with general practitioners (GPs) and aged care facility staff to provide enhanced care 'at home' for aged care facility residents. There is provision of hospital resources not traditionally available to aged care facilities. When hospital admission is necessary, GRACE patients are given access to rapid treatment to ensure their hospital stay is as short as possible. Key to the model is the GRACE CNC who takes responsibility for the telephone triage service and case manages all patients. GRACE aims to: • Supporting GPs and aged care facilities with enhanced hospital resources to provide care 'at home' and reduce unnecessary hospital admissions. • Reduce the average length of stay of aged care facility residents in the ED and hospital. • Collaborate with the GPs and aged care facilities to develop a model of care that: ○ provides a decision support system ○ provides hospital resources to assist with assessment and care provision ○ provides coordinated management plans. ○ increases the profile and uptake of Advance Care Directives in aged care facilities.

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Department of Health Western Australia 2008	Perth, Western Australia	Rehabilitations and Restorative Care Services Model of Care for the Older Person in WA	*Aged Care Network, Department of Health WA*	The model has sought to address challenges (including comorbidities due to chronic and long term illnesses coupled with condition associated with ageing) through the application of geriatric expertise in the management of older people who require rehabilitation and restorative care services and a shift in focus from care in the acute setting to less intensive forms of care in the sub-acute care setting.	The vision for the service delivery model for rehabilitation services is 'a coordinated statewide rehabilitation service that offers a range of appropriate rehabilitation service options and promotes equity of access across the continuum of care'. The elements of the model are congruent with the strategic vision for the WA Health system presented in 'A Healthy Future for Western Australians' and include: • State Rehabilitation Centre (SRC) for medical conditions requiring statewide tertiary rehabilitation services • metropolitan secondary rehabilitation services comprising Aged Care Rehabilitation sub-units (ACRU's) and dedicated stroke rehabilitation sub-units • provision of appropriate step-down subacute rehabilitation services • rural rehabilitation and aged care inpatient units in nominated rural regions • ambulatory care services that substitute hospital based rehabilitation in the home and support the individual to return to maximum functional independence • community-based rehabilitation services The model of care for service delivery builds on this configuration by identifying appropriate rehabilitation service options within the framework in order to meet the varying care needs of people who require such services as they move along the continuum of care and links to geriatric medical services and ambulatory care services. The key features of the model are: • a focus on health promotion and prevention campaigns targeting older people and lifestyle behaviours that are risk factors for diseases and conditions that produce the need for rehabilitation therapy • strengthening of in-patient substitution strategies through risk screening at emergency departments and direct linkages to primary health and community support services • demand amelioration strategies for acute inpatient rehabilitation services

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					• a strengthening of cost effective outcomes for the WA health system through the substitution of acute care models with subacute, ambulatory and community based rehabilitation services, particularly in rural areas • recognition of the complexity of the ageing process, impact of comorbidities in the recovery process and resulting recovery time, particularly as a person becomes increasingly frail • inclusion of the carer as a partner in the health care team • interdisciplinary care model that considers the holistic care needs of the older person • recognition that rehabilitation should be seen as an investment in maintaining good health rather than a cost to the health system.
Australian Journal of Advanced Nursing Vol.27	Australia	Acute care and older people: challenges and ways forward	*David Edvardsson, Rhonda Nay*	This meta-analysis draws on evidence regarding the challenges for older people in acute care hospitals and the concept of person-centred care to (a) suggest ways in which acute hospital environments might be modified to better meet the needs of the older person and (b) question whether options other than acute care should be canvassed for older people	Adopting a person-centred approach to care for older people in acute settings begins with trying to establish a philosophy of care that puts the older person's experiences at centre stage. This can then be merged with gold standard clinical guidelines and best practice approaches to the assessment and maintenance of health among older people in acute hospital settings. The following aspects were discussed in this paper and have been extracted from the literature as making up the cornerstones of person-centred care for older people, and are presented to illustrate how acute hospitals can better meet the needs of older people and family members. 1. Establishing a philosophy of care that is person-centred and holistic 2. Developing care systems that support person-centred care 3. Collecting personal history of patients 4. Establishing a trusting relationship 5. Adapting environments to assist comprehension rather than confusion 6. Developing care plans with emphasis on strengths rather than problems 7. Offering a calm place and optimal stimulation 8. Having expert staff Most acute hospitals are not 'fit for purpose' in responding to the needs of the major users of their services, old, frail people with

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					multiple comorbidities. There is an inevitable culture clash between acute care where speed may be the essence in saving life and consultation with the patient is not an option, versus the slower paced, person-centred consultation and optimised stimulation that is quality elder care.
Australian Research Centre for Healthcare Innovations	Sydney West Area Health Service	Healthcare for Older Persons Earlier (HOPE) Strategy	*Rosio Cordova*	The HOPE Strategy aims to provide older people, their families and carers with immediate access to skilled clinicians and responsive and appropriate care that is designed to restore and maintain a person's optimum level of function and independence. The strategy was developed in response to the increasing numbers of patients presenting to the hospital, particularly via the Emergency Department (ED). It involved the early provision of comprehensive geriatric multidisciplinary assessment to determine the pathological disorder and consequent physiological, psychological and functional impact	The HOPE Strategy is designed to provide better health care to the elderly mainly by improving their access to services. This was seen to require a better approximation of patients with the skill mix most suited to satisfying their complex care needs. This skill mix is encapsulated in concept of comprehensive geriatric, multidisciplinary assessment to determine the pathological disorder and consequent physiological, psychological and functional impact. Direct admission to an area with such a skill mix necessitated a bypassing of the traditional Emergency Department processing role. A four-bed area was established adjacent to the Emergency Department and staffed by the Geriatric Medicine Department. HOPE was developed in partnership with residential aged care facilities (RACF) and a range of other service providers. Full executive support was provided and proved critical in successful service rollout. While an earlier strategy OPERA (Older Persons Evaluation Review and Assessment) aimed to fast track elderly patients through the ED to a specialised ward (an improvement on the old models of care, but still reliant on ED); HOPE bypasses the ED altogether. This has involved: • Developing closer working relationships with Emergency Department and Patient Flow Unit. • Simple eligibility criteria (aged 70 years and over, Triage categories 3-5). • Direct referral from Triage to specialist assessment area (HOPE-ED), staffed by members of Geriatric Medicine Department. • Arrangements with Imaging and pathology services to ensure rapid access to diagnostic services (< 4 hour KPIs). • Arrangements with other clinical services to ensure rapid response to requested specialist inputs or transfers of care. • Close linkages with already established comprehensive aged

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					care service and other service providers to ensure options other than admission, or to facilitate early discharge. • Development of comprehensive business rules to ensure safe and efficient patient care. • Additional ward capacity to ensure ongoing specialist assessment and treatment. • Since the opening of the HOPE Strategy at Westmead Hospital: There has been a demonstrable flow on improvement in ED key performance indicators in areas of access block, off stretcher times and triage performance. Waiting times from triage to treatment time for >75 years has improved from an average of 70 minutes to 21 minutes. HOPE ED performance is on average 10% above benchmark, 100% of the time. These have further improved the patient journey by: • Reducing ED stay, treatment times, access block and exit block. • Enabling earlier diagnosis, treatment and management plan formulation. All this has contributed to a consistent 3% improvement in the Westmead Hospital bed occupancy rates
Australian Resource Centre for Healthcare Innovations	Sydney LHD, NSW	Aged Care Therapeutic Interventions by Volunteers (ACTIVe program)	*Rola Tawbe (Project Officer)*	The ACTIVe Program on the Acute Aged Care Ward at Royal Prince Alfred Hospital was designed to improve the hospital experience of older patients. Volunteers were recruited to provided one or more of four main interventions: • Meal assistance • Mobility assistance • Companionship	Elderly hospitalised patients can experience a decline in their physical and mental abilities. This can make it difficult for them to fully recover from illness and return to their previous ability to function. The ACTIVe program provides trained volunteers who deliver therapeutic interventions. These interventions reduce the consequences of delirium and assist in maintaining patient cognition and physical functioning. Volunteers play an important role in providing sympathetic support, encouragement and companionship to older patients and families. Since commencement of the program: • 20 volunteers recruited • 266 patients were visited by volunteers

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				• Therapeutic activities • Exercise classes The Nursing Unit Manager and the Clinical Nurse Educator provided education and training on dementia/delirium management as well as practical demonstrations on how to provide companionship and deliver diversional activities to patients. The volunteers also receive education from the speech pathologist, dietitian and physiotherapist to assist them in carrying out meal and mobility assistance.	• more than 1020 interventions provided • more than 55 attendances at exercise class which only commenced in early September 2011 • decrease in the number of nurse specials required for patients who are a high falls risk and have a delirium The volunteers keep patients up to date with current events and news as well as taking time out to reminisce about old times by looking through photo albums and books. This has encouraged patient's families and carers to be more involved in the patient's management during hospitalisation. Patients who are confused are generally reorientated to time, place and person and are kept stimulated during the day. This reduces the likelihood of confusion and agitation in the evening. Positive feedback from staff and volunteers has shown that the program supports ward staff in the prevention and/or management of delirium and functional decline in elderly patients. It has also shown that the program has contributed to improved patient, family and carer satisfaction.
Victorian Government Department of Human Services	Victoria	Best practice approaches to minimise functional decline in the older person across the acute, subacute and residential aged care setting: Update 2007	*Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health*	In November 2004, the Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health, in collaboration with a clinical reference group and multidisciplinary advisory group developed the 'Best practice approaches to minimise functional decline in the older person across the acute, subacute and residential care settings'. The document was commissioned on behalf of the Australian Health Ministers' Advisory Council (AHMAC) by the AHMAC Care of Older	The overall objectives of this review were: • to present the current evidence of interventions for the prevention and minimisation of functional decline in the care domains of: cognition and emotional health; mobility, vigour and self-care; continence; nutrition; and skin integrity • to develop recommendations based on the current evidence • to update the links to care domain specific guidelines Please see full report for detail on findings in each care domain.

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				Australians Working Group. This literature review was conducted to provide an update of the evidence provided in the above mentioned clinical practice resource in the following domains: cognition and emotional health; mobility, vigour and self-care; continence; nutrition; and skin integrity.	
NSW Health	Westmead Hospital NSW	Older Persons Evaluation Review and Assessment (OPERA)	*Angela Littleford, Judith Carll*	OPERA is designed on the principles outlined in the 'Framework for Integrated Support and Management of Older People in the NSW Health Care System 2004-06'. Its purpose is to reduce the waiting and treatment time for older people, reduce access block and improve the process of care by giving older patient, their families and carer, options that are designed to maintain and restore an older person's function and independence. This paper outlines the key components and implementation of this model.	The OPERA program at Westmead Hospital places the older person at the centre of the care pathway to achieve better processes of care and improved outcomes. The key component of this model of care is the specialist evaluation, review and assessment of the older person at the beginning of the hospital care pathway. The skills of senior clinicians with expertise in the care of the older person are aligned to the needs of the unwell older person with minimum delay. In the Emergency Department context, these skills provide an added focus on the identification of underlying chronic diseases and/or the ageing process in addition to the acute presenting condition. A multidisciplinary team capable of providing a comprehensive geriatric assessment supports these senior clinicians within a dedicated short stay unit for older people designed to achieve better processes of care and improved patient outcomes. OPERA provides options for older people, their families and carers to immediately access responsive and appropriate care that is designed to restore and maintain the older person's function and independence in the community. A key outcome of SOPERA is to enable each individual to attain their goals in terms of remaining as independent and health as possible and participate in community and family life.
The University of New South Wales/Australian Medicare Local	Australia	Improving integration of care- A discussion	*Australian Medicare Local Alliance*	Australian Medicare Local Alliance developed a discussion paper in conjunction with University	Integration is firmly on the agenda of Medicare Locals and working with the Local Health Networks, they are expected to play a leading role in achieving more integrated primary health care. Integrated care proposed in this paper is organised around the needs of those

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Alliance		paper for Medicare Locals		of New South Wales Research Centre for Primary Health Care and Equity to help Medicare Locals and their partners identify what they can do to provide more integrated primary health care for patients and communities.	receiving it, and should be: • Comprehensive: meeting all relevant health and social care needs • Coherent: making sense to those providing and receiving care • Well coordinated: convenient, avoiding duplication and wasting as little time as possible for all concerned • Patient or community centred: taking account of the patient's and communities' perspective on their health and care needs and the reality of their lives. The paper proposes that a stepped approach is one way to approach integrated care using the steps, corresponding roughly to the levels in the Kaiser Permanent triangle, e.g. as care becomes more specialised and complex, more structured arrangements are needed. In regards to improving integration, a number of areas within which changes can be made were discussed with the goal being integration of care to the patient or services to the community. These areas included: • Organisational integration, e.g. joint ventures, liaison officers, service networks • Functional integration, e.g. shared records, service directories, single point of contact for referral • Service integration, e.g. multidisciplinary teams, 'one-stop shops' • Clinical integration, e.g. shared care programs, use of clinical pathways • Normative integration, e.g. multidisciplinary training and education • Systemic integration, e.g. consistent privacy policies, pooled funding arrangements Cost and benefits specific for different Medicare Local stakeholder groups were listed as well as enablers and barriers to integration. In particular, integration is generally helped by the commitment of health services staff to providing good health care and evidence of patient or community benefit. Better systems for supporting integration and co-location can help. Barriers that are frequently

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					underestimated including power struggles between professionals, tunnel vision, autonomous working cultures, time, frequent changes, different drivers (economic or otherwise and scalability of new patterns of care.
Australian Health Ministers' Advisory Council (2010)	Australia	From hospital to home – Improving care outcomes for older people: Final Report 2004-08.	*Published by the Acute Care Division, Commonwealth Government Department of Health and Ageing on behalf of AHMAC*	Final report on achievements under the Australian Health Ministers' Advisory Council's National action plan for improving the care of older people across the acute-aged care continuum 2004-08	The National Action Plan (NAP) aimed to create pathways of care for older people, ensuring access to timely and appropriate care and allowing patients and their carers to make informed health choices. The plan provided a national framework to complement a large number of initiatives and strategies occurring at all levels of government and also included initiatives and strategies to support older people in maximising their health potential and avoiding the consequences of hospitalisation. Seven principles that have underpinned the NAP are: 1. Older people have access to an appropriate level of health and aged care services that meet their changing needs 2. Services are shaped around the needs of older people 3. Avoidable admissions to hospitals or premature admissions to long-term residential aged care are prevented where possible 4. Older people have access to transition care services to smooth their way across the acute-aged care continuum 5. The health and aged care system to operate to deliver an integrated suite of services for older people 6. The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs 7. Informal carers and family members are well equipped to provide support and care.
Aged Care Network	Western Australia	Model of care for the older person in Western Australia	*Aged Care Network*	The document was developed as a required first stage of the development of the Model of Care for the Older person by the Aged Care Network.	The document outlines the recommended policy approaches that will inform Area Health Services and other key stakeholders about the way in which services can be delivered to the older population across the continuum of care and services. It also serves as an underlying framework for a model of care. The overall objectives of the model are to: • Extend the period in which people are well aged • Compress the periods in which people transition to ill-health and become frail and increasingly dependent on care

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					• Promote services and programs that keep people out of hospitals and shift the balance of care to the community • Deliver services that are integrated across the continuum of care and promote smooth transitions between the interfaces in different care settings • Reduce dependency on the health and aged sector over the long term • Promote cost-effective outcomes for WA Health The key points of the WA MOC are: • Current challenges arising from an older person's movement between the many interfaces along the continuum of care • Focus on effective management of older patients in an emergency department • Integration of chronic disease management principles of early detection and self management in service delivery models • Strengthening of services at the primary care level for older people that target health promotion, prevention and self management strategies • Development of clinical service delivery MOC that are specific to the ageing process • Integrated approach to the assessment process of an older person at al stages along the continuum of care • Focus on the MOC service delivery for the provision of community care services from one of dependency to one of capacity building that encourages independence and self-management for older people
NSW Department of Health	NSW	Framework for integrated support and management of older people in the NSW health care system 2004-2006	*NSW Health*	The framework aims to guide and coordinate necessary improvements to service delivery for older people in NSW and to achieve consistency in approach across the State	The anticipated outcome of this integrated approach to service delivery developed by NSW Health is twofold: The consumer (i.e. the older person and their families/carers) will more easily access the services required to meet their needs and NSW Health will deliver timely and appropriate services that meet the needs of the consumer. Two standards with associated criteria have been developed to facilitate consistency and best practice. Underpinning these standards is that older people in NSW are entitled to timely and equitable access to services which support their ability to remain as

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					independent and health as possible and able to participate in community life. • Standard 1. Care and support of older people and their families/carers • Standard 2: Leadership and management structures The principles of this approach are: • The majority of older people can live independently within the community with varying degrees of support • Older people may need to be in contact with a range of organisations in order to maintain, improve or prevent deterioration in their health and QOL • Smooth transition between services should be possible • An acute episode may trigger the need for: (1) adjustment to existing support system; (2) acute health care; (3) change in accommodation arrangements • The likelihood of return to previous lifestyle is optimised by: (1) early response to acute episode; (2) timely access to least disruptive intervention options; (3) timely service or intervention delivery with minimal disruption to current lifestyle; (4) appropriate brokerage of support services to optimise outcomes • Older people need: (1) access to safe and appropriate care and support; (2) access to information about their health care and service availability; (3) access to ongoing support through effective partnership of service providers; (4) coordinated continuity of care including regular assessment • Core values of care and delivery should include: (1) forming a partnership with other people to achieve the best outcome; (2) respect of older people and their values; (3) client and family/carer satisfaction; (4) respect for the privacy, dignity and cultural diversity of individuals; (5) respect for the views of older people • No person or group should be discriminated against on groups of age • The framework is builds on the following assumptions: • Care is best provided in a multidisciplinary environment

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					• Older people who have disabling conditions and who require specialist clinical and personal support have their needs best met by comprehensive, multidisciplinary, aged care assessment and management • Services providing these special care and support needs should adopt evidence-based practice models • In aged care-specific services, acute care and rehabilitation may occur simultaneously • All disciplines involved with the care of older people should have special training in aged care
NSW Government	NSW	NSW Ageing Strategy	*NSW Government*	The NSW Government developed the NSW Ageing Strategy to respond to the challenges of Australia's ageing population. The Strategy provides an opportunity to realise aspects of *Smarter, Stronger, Healthier, Safer.*	The NSW Ageing Strategy describes how the NSW Government will work towards its vision. The Strategy is an initiative of NSW 2021, the Government's plan for NSW. It describes how the Government will work with people at different life stages to help them remain health and independent for as long as possible. A number of principles underpin the strategy. These are: • Local decision-making and partnerships • Older people's rights and autonomy • Personal responsibility • High-quality, timely and equitable services • Engagement and accountability One of the aims of the Strategy is to keep people healthy and out of hospital, several of which relate to integrated care. These include: • Develop integrated health service deliver models that support older people with complex care • Support mode flexible, integrated models of health and aged care service delivery in Aboriginal communities
NSW Health (2011)	NSW	Specialist Health Care for Older People Framework	*NSW Health*	NSW Health designed this framework to drive reform within the health system to facilitate a more proactive and responsive approach to the needs of older people and their carers.	The framework provides guidance on potential service models that can be implemented, as well as tools to assist service planners in designing health services for the future. The framework aligns with the goals of the NSW Government's 2021 Plan, Whole of Government Ageing Strategy, NSW Dementia Framework, the NSW Carers Action Plan and Specialist Mental Health Services for Older People Framework. The framework was developed with the following principles

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					underpinning health services for older people: • Older people will be treated with respect in a way that maintains their dignity and autonomy • Older people will be enabled to remain as independent as possible wherever they live • Older people and their carers will be enabled to make informed decisions and timely choices about health and future care that will be respected and implemented • The system will strive to prevent illness, minimise functional decline with acute illness and reduce disability wherever older people receive care • Older patients will have access to high quality, safe evidence-based health care delivered by a skilled workforce and aimed at achieving best possible outcome • The care provided will be appropriate for addressing the assessed needs, and delivered in the most appropriate setting with optimal efficiency Services will operate in a manner Key recommendations of the framework include: 1. Increase access to geriatric care for older people to restorative care and rehabilitation 2. Increased capacity to prevent functional decline of older people in hospital 3. Improved communication and coordination in and between sectors, settings and services 4. Improve liaison with and provide training for other specialists, general practitioners and the aged and community care sec 5. Develop high level indicators to monitor and evaluate the systems responsiveness to the care and support needs of older people
War Memorial Hospital Waverly	NSW	Geriatric Flying Squad (GFS)	*n/a*	Description of the GFS model as outlined on the War Memorial Hospital Waverly (WMH) website	The GFS is a multidisciplinary care team for patients with subacute functional decline and multiple and chronic conditions occurring in the 65+ population established with funding from COAG. The aim of the service is to assist clients to continue to live in their own homes and to maximise their quality of life. A key benefit is the reduction in presentations to emergency departments for older

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					people. The model responds to community referrals with an inbuilt triage system to be able to give priority to urgent cases. The multidisciplinary team is based in the outpatients department at WMH and provides both clinic—based and domiciliary assessment. The GFS are geared to respond to emergency calls from community care providers and GPs. The GFS can, for a short period, manage the patient at home, utilising community services and outpatient department at WMH and where required, admission to subacute care can be arranged to avoid ED. The multidisciplinary team consists of: • Geriatrician • Clinical Nurse Consultant (CNC) • Clinical Nurse Specialist (CNS) • Social Work • Physiotherapy • Occupational Therapy • Clinical Psychologist Additional services can be accessed at the WMH, e.g. speech pathology, specialist clinics etc. Referrals to the GFS will be assessed by the CNC. A telephone call will be made to the referrer and the patient triaged based on the referral and telephone call. Patients will be visited at home by the CNC or the CNS for an initial assessment followed by a discussion of the patient case at a multidisciplinary case meeting. The team aims to see clients within 24-48hrs of referral where possible Subsequently the geriatrician and other members of the team may visit the patient at home to conduct further assessments or the patient will go into the WMH outpatient department for review. Comprehensive assessments in the care recipient's home include medical, social, cognitive and environmental dimensions, with patients discharged after 3-4 months. Team members meet weekly to discuss current cases and coordinate goals and treatments. Once the assessment is completed, a plan of care will be

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					developed and discussed with patients and caregivers. Referrals can be from various sources including the older person, a carer/family member, a GP, an ACAT, community care provider, police or paramedic

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NSW Health website	NSW	**NSW Chronic Disease Management Program**	*NSW Health*	Describing the features of the NSW Chronic Disease Management Program	The aim of NSW Chronic Disease Management Program: • Improve the care of patients with chronic and complex decision by improving the patient's capacity to manage their own conditions; support their carers and families • Enable better advance care planning and end of life decision-making reducing unplanned and avoidable hospital admissions and improving the health system's capacity to respond to the needs of patients with complex needs The five priority disease include: Diabetes, Congestive Heart Failure, Coronary Artery Disease, COPD and Hypertension targeting those with very high or high risk of hospitalisation or presentation. The program adopts a proactive, coordinated approach and strongly supports multidisciplinary care, care planning and care coordination. It recognises that GPs are the main medical care provider. A crucial aspect of the program is health coaching, coordinated care planning and a shared health plan. Other key features of the program include new regional CDM services, new information and communication technology systems, new Statewide Health Contact Centre Capacity and new funding, organisational and governance structure as part of this program.
Australian Commission of Safety and Quality in Healthcare/ **GP Partners, 2009**	Brisbane QLD	What's missing? Linking patient information to patient care- An audit of admission and discharge practices between residential aged care facilities and the Royal Brisbane & Women's Hospital	*Helen Hoare*	GP Partners developed an assessment audit toolkit based on the General Practice Advisory Council Guidelines. Audits on information received at the ED from RACFs were performed by two hospital-based project officers. Audits on information received from the hospital by the RACFs were audited by two GPs who currently treat residents in residential aged care.	The project goal was to deploy a patient care quality improvement initiative targeting the interfaces, hand-over processes and clinical information flow between RACFs, hospitals and their treating GPs. This project was designated to achieve safer, more effective and more responsive clinical handovers for residential aged care residents as they transfer to and from acute facilities. These patients are recognised as high risk. Two audits were performed at the Royal Brisbane & Women's Hospital three month apart, on both admissions and discharges of residents in RACFs. Two methods for improving patient information flow in these transfers were promoted between the first and second audits- the Yellow Envelope (paper based) and Health Records eXchange (electronic). From the 295 hospital charts involved, this study found that there was improvement on some indicators in the second audit, such as an increase of clinical information included in admission and also an increase in discharges received with the

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					resident. However, a longer time for implementation to witness a practice change was identified- in particular in relation to general education and the electronic health summary. This audit enabled staff from the hospital, RACFs and GPs to be more aware of the increased risk of injury to patients from the lack of appropriate information during a transfer.
Australian Research Centre for Healthcare Innovations	Hunter New England Local Health District NSW	Osteoporosis Model of Care	*Kerry Cooper, John Van der Kallen, Michelle Giles, Kerri Gill*	The Osteoporosis Model of Care is a multidisciplinary team-based model. This care model is designed for patients over 50 years of age, presenting to the Emergency Department (ED) with a minimal trauma fracture (MTF). The patients are identified, referred and managed with intervention and follow up.	The strength of the model is that it has the ability to detect all patients who present with a minimal trauma fracture for referral and assessment of osteoporosis, thus reducing the numbers of subsequent re-fractures. A multidisciplinary fracture prevention team was established. The team included stakeholders from the osteoporosis fracture prevention clinic, ED, fracture clinics, orthopaedic wards, community health teams, physiotherapy, falls prevention team, allied health and General Practitioners (GP) as well as consumer representation and health information technology experts. • A fracture prevention Liaison Coordinator role was developed. • An electronic report from patient information management system (Pims) was developed to identify all fractures presenting to the hospital. • A fracture referral pathway was developed and implemented. • A fracture prevention protocol was developed for the orthopaedic rehabilitation wards. • The electronic discharge referral system was modified to include prompts for both GPs and hospital based medical officers to refer patients to the osteoporosis fracture prevention clinic. • All minimal trauma fracture patients receive some follow-up for osteoporosis assessment and/or management. • Management and follow up are recorded in a database. A comparative prospective study with formal evaluation of this model of care was undertaken independently on identified patients over 50 years with a minimal trauma fracture. Patient interviews, phone surveys and electronic audits were undertaken. The osteoporosis clinic referrals of eligible people (excludes nursing home patients) increased from 6% in 2007 to 68% in 2011. • Patients reviewed in the osteoporosis clinic had a 65%

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					decreased risk of subsequent fracture compared to those not reviewed • Refracture rates in clinic groups is 5.1% whereas those not attending the clinic has a re-fracture rate of 16.4%. • Mean time between fracture and attending clinic has improved from 136 days in 2007 to 35 days in 2010. • In this study of 434 patients, 43 bed days were required to treat subsequent fractures in the clinic attendee group whereas non-clinic attendees required 313 bed days.
International Literature					
Journal of Multidisciplinary Healthcare, March 2013	Canada	Outcome mapping for health system integration	*Peter Tsasis,* *Jenna M Evans,* *David Forrest,* *Richard Keith Jones,*	The paper describes an outcome-mapping exercise conducted at a Local Health Integration Network in Ontario, Canada, using consensus development conferences. Participants identified the end-goal of health care as 'caring communities, healthier people, and health system sustainability.' They identified the key strategic outcomes as and the capabilities required to achieve these outcomes.	Integrated care is defined broadly as care that is coordinated across multiple health care professionals, organizations, and sectors and that is attuned to patient needs and preferences. Political, financial, geographical, technological, inter-organisational, and inter-professional factors are identified to influence the capacity and motivation of different components of the system to work together. Prerequisites for integrated care are identified to include a shared vision, clear roles and responsibilities, and a common understanding of how the vision will be realized Outcome mapping is proposed as a tool to facilitate stakeholder alignment on the vision, roles, and processes of integrated care delivery via participative and focused dialogue among diverse stakeholders on desired outcomes and enabling actions. Preliminary findings suggest that outcome mapping may help stakeholders make sense of a complex system and foster collaborative capital, a resource that can support information sharing, trust, and coordinated change toward integration across organizational and professional boundaries. The article suggests outcome mapping be used as a tool not only for identifying and linking strategic outcomes and actions, but also for studying the boundaries, gaps, and ties that characterize social networks across the continuum of care.

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
International Journal of Integrated Care, March 2013	Netherlands	Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care	*Pim P. Valentijn, Sanneke M. Schepman, Wilfrid Opheij, Marc A. Bruijnzeels,*	The framework was developed through an iterative process of: (1) a narrative literature review, and (2) group meetings and expert panels to synthesise the literature.	This paper proposes a conceptual framework that combines the concepts of primary care and integrated care, in order to understand the complexity of integrated care. Person-focused and population-based care serve as guiding principles for achieving integration across the care continuum. Integration plays complementary roles on the micro (clinical integration), meso (professional and organisational integration) and macro (system integration) level. Functional and normative integration ensure connectivity between the levels. The proposed conceptual framework is identified as a first step to achieve a better understanding of the inter-relationships among the dimensions of integrated care from a primary care perspective.
Age and Ageing, Issue 34, 2005	United Kingdom	A whole system study of intermediate care services for older people	*John B.Young, Mike Robinson, Sue Chell, Diana Sanderson, Stephen Chaplin, Eileen Burns, John Fear*	This was a quasi-experimental study comparing a group of older people before and after the introduction of an Intermediate Care Service in Leeds, U.K. Subjects were patients presenting as emergency admissions to two elderly care departments with falls, confusion, incontinence or immobility.	Intermediate care services have been widely introduced in England and have the strategic objectives of reducing hospital and long term care use. There is uncertainty about the clinical outcomes of these services and whether their strategic aims will be realised. Leeds Health Authority and Leeds City Council developed jointly a commissioning framework for older people's services designed to provide support and rehabilitation either at home or through short term care home placements. It is a city wide service in which a joint management team (multi-disciplinary and multi-agency) assesses need and purchases services for individuals delivered through primary care trust based Intermediate Care teams promising nurses, therapists and social service staff. There was an expectation, in line with national policy, that short-term contact following hospital admission or during a health crisis at home would reduce demand for hospital and institutional care. There were 800 and 848 patients, respectively, in the control and intervention groups. Clinical outcomes, hospital and long-term care use were similar between the groups. Uptake of intermediate care was lower than anticipated at 29%. An embedded case-control study comparing the 246 patients who received Intermediate care with a match sample from the control group demonstrated similar clinical outcomes but increased hospital bed days used over 12 months. Conclusion: The Leeds Intermediate Care service was associated with similar clinical outcomes to control group but did not achieve its strategic objectives of reducing long term care and hospital use.

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
Department of Health	United Kingdom	National Evaluation of the Department of Health	**RAND Europe, Ernst & Young LLP prepared for the Department of Health (2012)**	This document provides a summary provides a summary of an evaluation of the 16 DH integrated care pilots (ICPs)	ICPs were developed and implemented a loosed collection of 'integrating activities' based on local circumstances instead of a 'model' of integrated care. Despite variations between the pilots, the aims of ICPs were shared: • Bringing care closer to the service user • Providing service users with a greater sense of continuity of care • Identifying and supporting those with greatest needs • Providing more preventative care • Reducing the amount of care provided unnecessarily in hospital settings Most ICPs concentrated on horizontal integration, e.g. integration between community based services rather than vertical integration, e.g. between primary and secondary care Integration led to process improvements such as increased use of care plans, development of new roles which staff believed were leading to improvements in care even when these improvements were not yet apparent The patients did not see much improvements with the implementation of ICPs, perhaps in part due to a professional rather than user-driven change (1) because it was too early to identify impact within the timescale and partly the changes itself were difficult to achieve. There was no evidence of reduction in emergency admissions as a result of ICPs but reductions in planned admissions and in outpatient attendance. No overall significant changes in the costs of secondary care utilisation was found but for case management sites, there was a net reduction in combined inpatient and outpatient costs. Common barriers and facilitators, as expected in any major organisational change were found: Facilitators include: strong leadership; pre-existing relationships at a personal level; shared values; investment of effort in widespread staff engagement and provision of education and training Barriers include: large scale, complex integrations; roles of staff under threat; changes to staff employment involving certain regulations; unrelated organisational and budgetary changes;

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					national policies, processes and legislation and poor IT connectivity ICPs also provided steps to providing integrated care: 1. Building governance and performance management systems 2. Making and developing local business case for integrated care 3. Changing attitudes and behaviours 4. Developing the necessary infrastructure including IT 5. Establishing supportive financial systems and incentives Lessons learnt from the ICPs include • Not underestimating the scale and complexity of delivering integrated care even with strong leadership and competent project management • Improved quality of care can be achieved if care is well managed, tailored to local circumstances and patient needs but are not likely to be evident in the short run • NHS as a whole should work to enable local, transitional changes • The focus on the needs and preferences of the end user can be easily lost and using performance metrics that focus can avoid this • Integration does not have one approach that suits all occasion but involves finding multiple creative ways of reorganising work
McKinsey Quarterly	NA	What does it take to make integrated care work?	*Jenny Grant*	Useful lessons from health care providers around the world for organisations that want to pilot integrated care programs	Three broad categories of approaches have been identified: 1. *Integration between primary care and secondary care* - These efforts are usually designed to provide 'one stop shop', particularly for those requiring long-term care. Polikum polyclinics in Germany exemplifies this approach where the aim is to provide all types of outpatient care under one roof. It was estimated that within a year of adoption, hospitalisation rates were reduced by about half 2. *Integration between health care and community care* – involves coordinating a wider range of services. In Sweden, before an elderly or disable patient can be discharged from hospital to go home or to a lower-acuity care setting, a physician from the hospital and case worker to develop a management plan so they will receive appropriate follow-up

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					services. This has helped to reduce the number of patients kept in the hospital once they no longer need high-acuity treatment 3. *Integration between payors and providers* –to more closely coordinate care planning, commissioning and delivery and makes it easier to ensure that the incentives within the system encourage all the providers to maximise care quality while minimizing cost. Kaiser Permanent was able to identify patients who have suffered an acute coronary event and offer closely coordinated follow-up care while decreasing emergency interventions and risk of death
Journal of Multidisciplinary Healthcare (2013), Vol 13:6 p.99–107	Canada	Outcome mapping for health system integration	*Tsasis, Peter, Evans, Jenna M., Forrest, David. and Jones, Richard Keith.*	This document describes an outcome mapping exercise undertaken at a Local Health Integration Network in Ontario, Canada.	Outcome mapping provides a practical tool to aid leaders and managers in building the prerequisites to integrated care. Outcome mapping helps stakeholders make sense of a complex system and foster collaborative capital, a resource that can support information sharing, trust and coordinated change toward integration across organisational and professional boundaries. The prerequisites for integrated care include: • A shared vision • Clear roles and responsibilities • A common understanding of how the vision will be realised Outcomes-based thinking is the concept used for building these prerequisites integrated care. An outcome map visually depicts how particular actions or processes contribute to improvements in higher-level outcomes. This process is premised on the idea that behavioural change is fundamental to improvement and facilitated by a learning-based and stakeholder-driven approach. Outcome mapping s particularly suited to multistakeholder initiatives such as partnerships and interorganisational networks – where alignment, collaborative commitment and shared purpose are urgently needed. The outcome-mapping project was initiated with the Central LHIN for the purpose of creating stakeholder alignment around a shared vision and producing a comprehensive, clear and actionable roadmap to guide decisions and actions. The key strategic outcomes were • clients have access to an integrated health care system,

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					• service is delivered by appropriate provider in the appropriate location and • information, support, advocacy and other health moves through a continuum of care. The capabilities required to achieve these outcomes were categorised into four broad areas: (1) Integration, coordination and information access (2) Service delivery, which encompasses capacity, breadth, efficiency, access and effectiveness (3) Adaption, which refers to continuous performance improvement and capacity for change (4) Sustainability
Agency of Integrated Care	Singapore	Singapore Programme for Integrated Care for the Elderly (SPICE)	*Agency of Integrated Care*		The Singapore Programme for Integrated Care for the Elderly (SPICE) is a model of care developed by the Agency for Integrated Care (AIC) to provide comprehensive, integrated centre- and home-based services to support caring of the frail elderly. SPICE enables frail elderly who have high care needs and are eligible for admissions into nursing homes, to recover and age within the community. Through SPICE Centres, a multi-disciplinary team comprising medical, nursing, allied health and ancillary professionals provides a suite of patient-centric services such as primary and preventative care, nursing care, rehabilitation services, personal care and social and leisure activities. These services are delivered both at the centre and at the patients' homes, depending on their needs. AIC will partner Volunteer Welfare Organisations (VWOs) to operate SPICE centres in various regions of the island. The centres will collaborate with the Restructured Hospitals (RHs) and surrounding general practitioners (GPs) to form a seamless model of care. Existing day rehabilitation centres will be enhanced to enable the VWOs to deliver a higher level of care to the participants. Enhancements include expansions to increase physical capacity, increase in manpower and capability to enable effective management of frail elderly with higher care needs, as well as collaboration with a medical network to provide medical support for the frail elderly. The services provided at these SPICE Centres will be more holistic in comparison to existing day rehabilitation centres

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					in the community.
The King's Fund	United Kingdom	Networks in Care – Strategies used be effective networks to support implementation	*Nick Goodwin*	Presentation at the Network to Network 2012 Conference on networks in health care	The 10 rules of Network Management: 1. Achieve a position of centrality 2. Clarity of goals 3. Be inclusive 4. Avoid large networks 5. Develop cohesive forces 6. Avoid mandated networks 7. Engage professional leaders 8. Avoid organisational capture 9. Maintain 'net worth' 10. Gain the 'mandate to manage' • The process of managing networks effectively not ostensibly different from managing organisations. Networks do not flourish without professional mutual reliance and open dialogue. • Networks that rely solely on voluntary or mutual relationships tend to fail as there is no lever for effective coordination or oversight but at the same time, imposed or mandated partnerships mostly fail. • Most networks are time-limited, few are long lasting • Networks are not a panacea for managing services but necessary for system redesign
Lucian Leape Institute Roundtable on Care	USA	Order from chaos: Accelerating Care Integration	*National Patient Safety Foundation*	This paper discusses the critical components of care integration as well as the enablers and barriers to integrated care	For practical purposes, care integration includes several critical components: 1. Handovers: practitioners' work is largely independent but each depends on receiving critical information from another 2. Sequencing: One task or decision often must await completion of another 3. Interdependency: Members of a multidisciplinary team engage in back-and-forth of decision-making and task execution 4. Storage and retrieval: Key information that might be relevant later in a patient's care is stored for future access: Care integration can occur at two levels: the process of care and

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					the activities that make up these processes. Sequential processes are those that can be well defined ahead of time and are roughly linear. Iterative processes are those with multiple feedback loops, branch points and dependencies. Barriers which make care integration difficult to achieve include: • GP autonomy • Absence of a generally agreed framework or management system • Lack of expertise • Lack of leadership • Reimbursement and regulation Accelerating care integration can be gained through: • Shared understanding • Patient engagement • Measures • Evaluation • Education and training • National spread
Canterbury District Health Board	New Zealand	The Integrated Continuum of Care for Older People's Health Services	Gill Coe	A background document to the Elder Care Canterbury Project	The Canterbury district has been addressing the integrated continuum of care over the past five years though the Elder Care Canterbury Project's aim of enhancing and integrating health services for older people. From this project, the key principles underpinning an integrated continuum of care include: • Focus on wellness through health promotion and maintenance • Older people are well-informed and maintain a healthy lifestyle • Older people have a choice about where they live and are involved in decision-making • Equitable, easily accessed services are available • Culturally appropriate services • Primary health care plays a key role in care including health promotion/prevention/early intervention

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					• Focus on rehabilitation • Collaboration between health sector professions. A system of care has been designed which is based on the assumption that the majority of older people have the most contact with primary health care providers in the community and require services to be well coordinated. The system of care includes the following components: • Enhancing the role of primary care for early intervention and case management • Key worker in service coordination role to reduce number of assessments and number of providers • Ongoing, coordinated relationships between the older person and their key primary health professional • Adequate, quality workforce in all areas, including strategies for caring for carers • Integrated services, both between health providers and sectors • Easy access to information at all levels, including timely sharing of information between providers • Education at all levels • Clarity of roles among health providers • Information systems that provide adequate information for planning • Comprehensive, consistent tiered assessment tool • Simplified, flexible funding • Satisfactory quality systems, including audit and evaluation
Age and Ageing, Issue 35, 2006	United Kingdom	Intermediate Care in England: where next?	*John Young, Jan Stevenson*	This paper introduces the concept of intermediate care for the elderly, discuses the use of it as targets in service provision and reflects on its future.	The strategic aim of intermediate care is '…to promote faster recovery from illness and prevent unnecessary acute hospital admissions, support, timely discharge and maximise independent living'. There was an expectation that acute hospital care was a blunt instrument for chronic disease management, and there was insufficient time for rehabilitation and functional recovery for older people. Intermediate care is a new national community care service in England designed to bridge the gap between hospital and home.

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					Although targets have been set, it is still unclear whether strategic aims for these have been achieved. Despite obligations of primary care trusts to reduce acute admissions, there has been a 7.8% increase in acute admissions since intermediate care has become a healthcare policy. However, delayed discharge rates have fallen. Studies have concluded that many intermediate care services are too small, inadequately targeted or insufficiently integrated to achieve a whole system change for older people In order for intermediate care to achieve its objectives, it has to become an embedded function of the care delivered by staff engaged in supporting older people in the community rather than as a service in its own right with most of the community staff adopting a rehabilitation philosophy and incorporating the principles of intermediate care in daily practice. The key to this approach is having a sufficiently large pool of well-trained and well-supported generic rehabilitation/care support staff, working as teams and under guidance from clinical managers to provide day-to-day support and continuity of care. The future of community care for older people is hopefully one where well-resourced health and social care locality teams are jointly commissioned by the local planning partners. Such teams bring together a range of skills and professions, underpinned by many trained rehabilitation support workers able to offer continuity of care and respond flexibly and quickly to changing needs.
Healthcare Quarterly (2009) October 13, p.16-23	Canada	Ten Key Principles for Successful Health Systems Integration	*E. Suter, N. Oelke, c. Adair and G. Armitage*	A systematic review summarising current research literature on health systems integration.	The review focuses on definitions, processes and impact of integrated health service delivery systems. These were grouped into ten key principles for successful health systems integration. 1. Integrated health systems is the comprehensive scope of clinical and health related services covered 2. Integrated health systems need to meet the needs of the patient rather than the needs of the providers 3. Many integrated health systems provide geographic coverage to maximise patient access to the services and to minimise duplication 4. Integrated health systems is characterised by standardised care delivered by interprofessional teams enabling continuity of care process

Type/Source	Jurisdiction	Title	Authors	Approach / Methods	Summary of key points / findings
					5. Success of integrated health systems s dependent on well-developed performance monitoring systems that include indicators to measure outcomes at all levels. 6. Processes in integrated health systems require support from system-wide information systems that allow data management, effective evaluation and communication capabilities 7. Implementation and operation of an integrated health system requires leadership with vision as well as an organisational culture that is congruent with the vision 8. GPs need to be effectively integrated at all levels of the system and play leadership roles in the design, implementation and operation of an integrated health system. 9. Governance structures of integrated health systems must promote coordination, be diversified to ensure representation from a variety of stakeholders and a flatter more responsible organisational structure is encouraged. 10. One of the outcomes of integrated health systems is cost savings, however, the integration process itself may result in increased costs before they provide savings A review of successfully integrated health systems have all focused on a combination of many, if not all, of the guiding principles above.

Appendix L: Findings against each theme

A summary of each of these themes and related findings, enablers, barriers and opportunities are provided here against the following key of enablers, barriers and opportunities:

Enablers 

Barriers 

Opportunities 

Philosophy of Care

Key Findings:

- While there was reported alignment on the importance of 'person-centred care', this was rarely translated into service design or anecdotal accounts of delivery.
- Most sites had no defined service philosophy of care and different views were expressed by staff. Two sites visited had their philosophy published and publicly displayed.
- The organisational structure of care was often described as services provided in hospital facilities with community care considered an adjunct and primary care as a separate service entirely.
- Services that had multidisciplinary services that stretched across the continuum of care and embraced an enablement philosophy were identified to have the most 'person-centred' approach.
- On acute aged health wards, the 'enablement approach' was highly utilised. However, on those that had no specific aged health acute services, this approach was absent and anecdotally, it was reported that these wards have poorer outcomes.

Site consultations produced consistent themes regarding a desire to provide the appropriate care for older persons with complex needs, in a timely manner and in the most appropriate care setting for their needs. However, this desire was often not translated into practice through the model of care or the settings provided. For example, clinical processes or workforce and infrastructure needs were often given priority over the personal needs of the older person. Some sites acknowledged the gap between what they understood to be good practice and the care that is currently provided. The concept of holistic and person-centred care was in this way considered to not be a realistic aspiration within the limitations of their resources and service design.

Similarly, many sites reported care to be most often centred on the acute service clinical setting (i.e. hospitals) with discharges supported by available community-based services as an adjunct to care. Primary care provision was often not considered in the patient journey. This focus was reinforced by the older person often being referred to as 'the patient' rather than as 'a person' other than in the context of policy or research.

Sites that actively delivered care in peoples' place of residence, or that actively supported the importance of social interaction and support for this cohort, noted the importance of understanding a person's context fully in order to address the psychosocial aspects of care and proactively address emerging issues.

Rural and regional sites more commonly expressed interdependency with their local community. This was often accompanied by a higher level of expectation of services from the community and a feeling of accountability by service staff to the community.

Philosophy of care – enablers, barriers and opportunities	
	• Alignment of philosophy, strategy and service delivery • Governance that allows services to deliver against the philosophy • Leadership and lateral thinking • An established vision for the service that is published and available • Engagement of staff in the philosophy • Training that supports the philosophy
	• Philosophies of care unsuited to the reality of the environment • Lack of governance • Lack of executive-level sponsorship to support change • Funding that limits the ability to deliver on the philosophy
	• Endorsement of a statewide cross-sectoral philosophy of care • Consumer involvement in defining the philosophy of care • Develop SMART goals to translate the philosophy • Identify and implement relevant KPIs • Development of an outcome-focused framework

Strategic Purpose and Intent

Key Findings:

- Where there was executive-level sponsorship, there was also understanding of the benefits of designing services around the needs of older people. Similarly, the impact of *not* managing the needs of older people with complex health needs proactively was understood.
- LHDs that had invested in a strategic approach to the management of older people with complex health needs across their services identified admission avoidance, early assessment and fast-track treatment, appropriate and specialised acute management, optimising discharge processes and continuing care into the community as key to enhancing care and reducing risks of deterioration.
- Where there was little understanding of the strategic imperative to treat older persons as a specific cohort with specific and holistic needs, poorer care outcomes were reported.
- Continuity of care and support across care settings were often cited as strategic intents although services were mostly provided in clinical settings such as a hospital.
- Most sites emphasised the importance of early detection of issues to delay the onset of conditions associated with old age. Few achieved this. However, some services recognised their role in linking to social and community groups to actively manage this.
- Integrated care is only possible if based on a solid foundation of core services such as inpatient, ambulatory care, community care and residential aged care facility settings. Lack of services, or 'nowhere to go', is potentially the greatest challenge to hospital length of stay.

Site consultations reported the largest number of presentations, clinically avoidable admissions and extended length of stay at acute facilities are by older persons with often-complex health and social issues. This is supported by data analysis undertaken by ACI on this group.

Some sites had recognised that the costs and care burden of this cohort were significant enough to warrant specific investment in a geriatric stream of resources and services. They then used evidence-based strategies to address issues early and avoid admission as possible by utilising alternative resources.

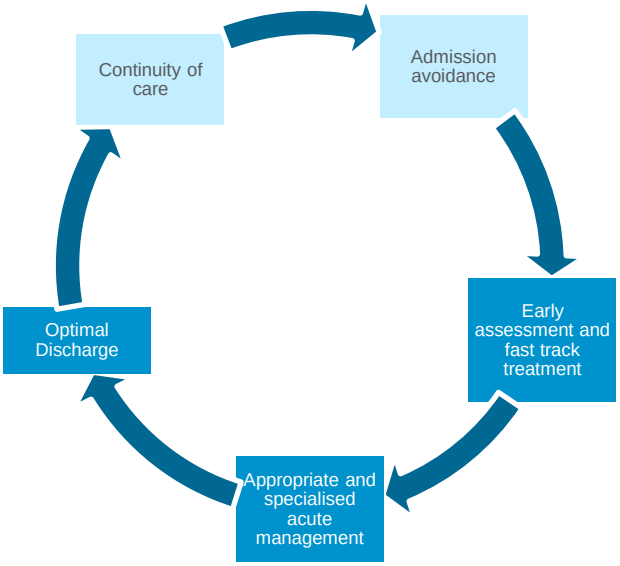
Those that had invested in a strategic approach to the management of older people with complex health needs across their services collectively identified the following interventions as strategically imperative in order to benefit the outcome of care, the efficiency of the system, and the experience of the older person, carer and family.

- Admission avoidance/redistribution of resources to community
- Early assessment by specialist staff (medical, nursing, allied health) and fast-track treatment and discharge

- Appropriate and specialised acute care management (e.g. appropriate environment, enablement philosophy, specialised staff)
- Optimal discharge that includes early planning, preparation, timing, home support and an action plan for deterioration.
- Continuity of care that reaches into the community and links with primary care providers and community-based support services. This may include co-designed management plans with GPs.

Sites that had no such proactive management and maintained a speciality focus continued to view this cohort as large, costly and generally problematic.

Figure 31: Strategic purpose of aged health services delivered by an LHD



It was clear from sites visited that if one or more of these components were absent or weak, then care for the older person with complex health needs would be sub-optimal.

An absence of one or more of these interventions across core services 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 failed discharges without support
- Increased morbidity in the community
- Inappropriate community management or support
- Increased pressure on carers and family
- Inappropriate RACF admissions

Strategic purpose/intent – enablers, barriers and opportunities	
	• Executive sponsorship and support to refocus resources • Creating and sustaining community relationships • Managing, recording and reporting of the impact of strategies • Data on required resource allocation based on percentage of hospital days/beds used by this cohort • Data on potential cost savings and improved patient care outcomes • Connecting care between departments, wards and community-based care • Sharing of information that follows the older person
	• Traditional models of care delivery that follow a set process • Historical resource allocation funding models • Lack of flexibility to target resources to need • Historical patient flow models • Social belief that 'in hospital' care is the right care in all acute situations • Lack of shared information • Lack of sustainable service coordination
	• Identifying unnecessary steps that waste people's time • Agreeing on the key strategic imperatives to deliver care differently • Agreeing on a common set of design principles to guide service delivery • Assessing programs and models against this benchmark and targeting effort • Reprioritisation of acute facility resources to cater for this cohort • A system-based strategic model that cuts across departments, organisations, professions, sectors, and funding streams • Develop SMART goals to translate philosophy • Identify and implement relevant KPIs • Development of an outcome-focused framework

Eligibility and Access

Key Findings:

- Key points for accessing specialised aged health services are via the hospital (ED), primary care (GPs) and via community services referral (community health or ACAT).
- Benefits for the older people and the health system were reported when care was determined by the results of a Comprehensive Geriatric Assessment.
- Sites that do not have specialist aged health services, in ED in particular, report higher admission rates and poor outcomes for older people, as well as inappropriate diagnoses.
- Eligibility criteria for aged health services were based on the presence of age-related health conditions and/or symptoms or disabilities. Most services utilised an over 65 years or over 70 years age criteria for general patient identification (50 and over for those of Aboriginal and Torres Strait Islander descent). However, other ages were accepted and all services reported an average age of over 80 years.
- Older people with complex health needs often unnecessarily attend ED and are admitted to hospital facilities. The most common reason cited is being unable to access timely and appropriate support outside of the hospital.
- Sites reported benefits in having one phone number for all referrals in order to triage aged health service needs and enquiries.

Older people were reported to have difficulty accessing primary or community care support to meet low-level acuity needs, and instead waited until conditions escalated or reached crisis point. Older people with complex health needs and their carers also reported to have difficulty accessing low-level domestic and social support services, as did ASET team staff when these people presented to ED.

There are multiple ways that aged health services can be accessed:

- Hospital – Older people access services in the ED (through ASET), ambulatory clinics and via intake services. Many facilities had intake services that acted as a triage/gatekeeper role. The services provided a centralised referral point for all hospital referrals, for example if a patient

reviewed by allied health staff in the community is determined to require podiatry, the staff will call intake (or submit a referral) and intake will direct the referral to the most appropriate services for the patient.

- Community care referrals – Referrals to ACAT can be made by GPs, carers or family. ACAT provides assessments at home and in hospital and residential aged care settings. The ASET team will often also refer for ACAT assessment or book in home visits with the community nursing and allied health team.
- Primary care – GPs direct patients to aged health services either in the hospital or community.
- Residential Aged Care Facilities – Primary and acute care services are provided by GPs and the hospital in the RACF to avoid deterioration or a hospital transfer. Examples of this service included GRACE (Hornsby), GREAT (Westmead), VACS (Nepean) and the Geriatric Flying Squad (Sutherland). Generally, all these services had access to directly admit patients to the ward following consultation with an admitting specialist.
- Comprehensive Geriatric Assessment –With the goals of maximising the functioning and optimising the health of an older person, this assessment includes formulation of an accurate diagnosis; verification that relevant interventions have been applied and, importantly, given time to work; identification of any potentially modifiable disability; and access to rehabilitation support as required.

Eligibility and access – enablers, barriers and opportunities	
	• Direct admission ED bypass following admitting doctor consultation • Flexible eligibility criteria that identifies older people early in the patient journey • Education of health providers/practitioners on available services, eligibility and access • Central intake services that direct referrals to the most appropriate program or speciality • Referrals for Comprehensive Geriatric Assessments
	• Lack of information on what services are available and how to access them • Service demand outweighing supply – ‘nowhere to go’ • Early intervention/prevention approach often not available prior to deterioration • Rural areas burdened with complicated patients that do not fit aged care criteria, for example alcohol abuse patients • Lack of a coordinated view of services provided to the older person
	• Specialised clinics in the community that can manage and plan holistic care needs of older people • Linking people with available resources, support services and information to enable them to make an informed choice • Increased awareness on when and how to access core health services • A ‘one stop’ shop for all aged health service information • Utilisation of other health professionals where medical staff are not available or are unwarranted to address demand for care coordination and information. • Aged health services should be equipped for the type of referral that is likely to arise, for example: timely and intensive support for older people at high risk of deterioration, and prioritisation for low-level support when living alone.

Relationships

Key Findings:

- Multidisciplinary teams endeavour to work collaboratively across services and programs to deliver the best outcome for older persons, their carers and family.
- Relationships between LHDs and Medicare Locals varied significantly between the ten sites visited. Some sites had well-established relationships, joint planning initiatives and embryonic agreements in place while others had very little contact and no sign of coordinated efforts.
- Good working relationships between professionals increased the likelihood of older people being linked with support services and services across settings
- The relationship with HACC or Care Package providers was reported as most problematic. This often resulted in one-way communication with no planning or discussion of the unmet demand for care packages and better usage of those that were allocated. For example, older people often retained a package even when their care needs changed.

Integrated care can be thought of as a progression of stages through which individuals and organisations move upwards. As relationships intensify, there is movement from one level to the next in the direction away from isolation towards integrated working partnerships. Keleher's (2012) framework as shown in Figure 11 provides a useful point of reference to see the progression of relationships between providers as efforts at integrated care are being implemented.[lxii]

In this way, integrated care is built through increasingly collaborative practice and is realised when a strong and enduring relationship makes a significant shift towards joint vision, planning, responsibility, and investment with mutual trust and knowledge sharing. Successful integration is where the outcome becomes more significant than the separate identities of the partners.

Integration is a systemic issue, that is, individual health organisations cannot solve the problem of fragmented care on their own. Collaborative and integrated relationships are a key enabler to the integration of care at the macro, meso and micro levels. In considering integrated care, it is important to recognise the stages of relationship that are precursors or building blocks to integration and similarly, where they are to be appropriately used. It is also useful to note when they fall short of the desired outcome.

Services and relationships observed during site visits spread along the spectrum of these relationships and were often represented as integration. However, when under closer scrutiny, they represent networking, communication or cooperation at best.

Specifically, it was noted that the relationship with Medicare Locals varied significantly between the ten sites visited. Some sites had well-established relationships, joint planning initiatives and agreements in place; however, others had very little contact and no sign of coordinated efforts. This is potentially a missed opportunity, as due to their funding agreement with DoHA, the Medicare Locals have a vested interest in making it easier for patients to access the services they need by linking local GPs, nursing and other health professionals, hospitals and aged care, as well as Aboriginal and Torres Strait Islander health organisations.

Consistently, the relationship with HACC or Care Package services was reported as distant. In the spectrum of relationships, this could be described as ad hoc communication with little cooperation or coordination occurring.

Integrated care was found mostly at the micro level (individual relationships) with some evidence of meso (organisational and relationship-based) integration. Examples of relationships with key stakeholders identified at the meso and micro levels are listed below.

Table 10: Summary of relationships observed at sites

Level	Relationship with the Aged Health Services	Examples
1	**Isolation –** Separate from others with little or no communication No sharing of information Governed by separate goals	HACC services – all sites Medicare Locals – few sites Home Care of NSW
2	**Networked** A loose arrangement of contact (or encounter) for the purposes of information sharing Divergent outcome goals	Networked acute facilities – two rural sites Community Groups – some sites Medicare Locals – majority of sites GP Practices – most sites. Lack of consistent information flow to and from GPs.
3	**Communication** Joint working relationship but marginal to organisational goals. Frequent interaction and sharing of information as it applies to a user that crosses boundaries – often one way A nominated person is responsible for liaison	Medicare Locals – some sites GP Practices – Very few examples of two-way communication Wards in acute facilities Discharge planning at most sites
4	**Cooperation** Two-way exchange of information Altering activities for a common purpose Joint work but marginal to organisational goal	GP Liaison role GP practices in rural areas or tight metropolitan communities (e.g. Wagga Wagga and Hornsby) Dementia CNC roles in acute facilities Chronic Disease Management program – most sites RACFs – some sites
5	**Coordination** Time-limited activities with some joint responsibility Shared outcomes Requires only enough trust to give and receive help from one another	Specialist relationships for acute shared-care models GP and Aged Health Services post-discharge MTD Case conferencing –most sites Close the Gap Care Coordination Chronic Disease Management program – some sites In-reach to RACFs – most sites
6	**Collaboration** Longer-term and more deliberate efforts of organisations and groups to undertake shared planning Shared vision of the outcomes, Joint responsibility and equal commitment for joint activities High level of trust and power-sharing based on knowledge and expertise	MTD Case conferencing – few sites Medicare Locals and LHD – Hornsby and Westmead In-reach to RACFs – Sutherland, Hornsby, Nepean Health Pathways – multiple sites Extended care paramedics – Nepean Acute ward enablement models –Hornsby, Westmead, Sutherland
7	**Integration** Collaborative partnerships where the separate identities of the partners are not as significant as achieving the outcome.	Health Pathways – Hunter New England MPS model – Kyogle Ortho-geriatric shared care model at Nepean ED Bypass models Medicare Locals and LHD – Hunter New England and Wagga Wagga

Level	Relationship with the Aged Health Services	Examples
		Aged Care Collaborative – Wagga Wagga

Connectivity between and across organisations, models of care and programs rely on informal relationships and the type of processes which enable this, for example, co-location, frequency of contact, trust and respect. It is prevented when there are organisational, funding and structural barriers with inflexible approaches.

Care and support facilitated by good working relationships was seen as the norm, part of the 'service' delivered to older people. Using the definitions in the table above, most examples of integration reported across sites were 'relationship-based'; it is only this level of collaborative practice that is attainable at a practice level.

Overall, current practice in aged health care in NSW fits best against level 2: that is, *'networked'* but inconsistent. At the organisational level, some providers report '*communication'* when required and will sometimes '*cooperate'* in relation to an older person's care needs.

Health professionals only report examples of '*coordinating'* care when joint responsibility is granted. This is to the extent that they can retain individual practitioner or organisation status while giving and receiving assistance from one another. Services identified that could be considered collaborative were often the result of personal relationships developed between individual health professionals rather than because of a systemic approach.

Relationships – enablers, barriers and opportunities

- Great leadership that supports staff to think laterally and build relationships
- Investment of time in collaboration and knowledge sharing
- Defined and shared goals of mutual benefit for providers
- Understanding and acceptance of difference
- Development of Shared Agreements
- Clear governance frameworks
- Mutual and collegiate respect

- Lack of resources, capacity and time
- Perceived rivalry or separation of resources
- One-sided investment
- A dominant partner organisation or facility
- Funding arrangements

- Shared information
- Clear and consistent communication
- Consortium approaches (e.g. Partners in Recovery)
- Joint commissioning and/or investment
- Addressing workforce issues

Older Person, their Carer and Family

Key Findings:

- Sites described a philosophical and strategic intent to deliver person and carer-centred care although this is often not reflected in practice.
- Clinicians feel limited in their ability to be truly person-centred due to the processes and pace of the acute facility environment. The prioritisation of the older person, carer and family's psychosocial needs was higher in community-based teams than acute-care teams.
- There is minimal data on patient or carer experience being captured. This corresponds with lack of support services for carers across all sites and minimal KPIs reported in place to measure patient and carer satisfaction.

- There is a lack of understanding among older people, their carers and families about what services are available, how to access them and what the associated costs are. Post-discharge care was cited as particularly problematic with older people and their carers unclear where and how to access community support services once back at home from the hospital.
- There is a lack of care planning with older people, their carers and family, and minimal advocacy, often in times of most need when they are seeking support and information.
- Particular criticism was noted from experiences in Emergency Departments: long wait times, inadequate services and a lack of consideration for the older person.
- Respite services were reported consistently to be difficult to access by ED staff, ASET teams and carers. The result of this is exhausted and unwell carers and social admissions based on emergency respite needs of carers.
- ASET team staff and Community Nurses were reported to be the primary contact with carers and family and the hospital.
- While General Practice was identified as the core access point for older people and their carers, it was acknowledged that wait times are prohibitive and care is often not comprehensive or holistic. There are currently no care plans in place for carers of older people with geriatric syndromes, degenerative disease and/or identified dementia.
- The architecture and setting of care were noted as enablers or barriers to person-centred care and support or involvement in that care by carers and families.

The experience of the patient, carer and family is not routinely captured by aged health services. This is consistent in the hospital, community and primary care setting. When ‘experience’ surveys are undertaken, they are sporadic and rarely used to inform service delivery. Instead, they are often token gestures to say that views have been sought with no attention to sample size or approach. For example, most experience data that is captured pertains to the performance of staff, rather than the patient, carer or families’ experience of service integration or ease of access services across hospital, primary care and the community. Across sites visited, there was no example of experience data that was used to change or alter services to improve the experience for the older patient or for the carer or family member(s).

Consultations with family and carers revealed a disconnection between expectations of the staff by carer and family and their actual experience. Staff believed their patients had easy access to a range of services and that these services functioned smoothly and that patients, carers and family were happy with the service. While patients, carers and family recognise the great effort that individual staff perform in providing care, they were critical of the challenges associated in navigating through the aged health landscape, especially those in the hospital and community. It was also noted that for people with poor health literacy or communication issues (such as limited English in CALD populations or the deteriorating ability to communicate due to age-related issues), there were not robust or standardised support services in place. This was often reported to be ‘left to the social worker’ who worked only part-time or on a consultation basis.

The strongest complaints came from the lack of understanding about what services are available, how to access them and knowing the associated costs. Particular criticism was reserved for ED experiences due to long wait times, inadequate services and a lack of consideration for the older person. For example, older patients often have to wait for long periods in the waiting room and left in cold corridors before being admitted to the ward. Post-discharge care was cited as problematic with older people and their carers unclear where and how to access community support once home from the hospital.

The main services provided to carers and family are community nursing and respite services. Within LHD services, ASET teams in ED and Community Nurses are reported as the frontline contact for carers. They are reported to often undertake carer and family assessments to determine how they are coping with caring for the older person and what potential support or personal health needs exist. Some facilities provide HACC-funded respite service such as daily dementia and delirium centres or aged care day centres. However, most services reported a significant gap in respite availability which often led to 'social need' admissions in order to relieve carer stress.

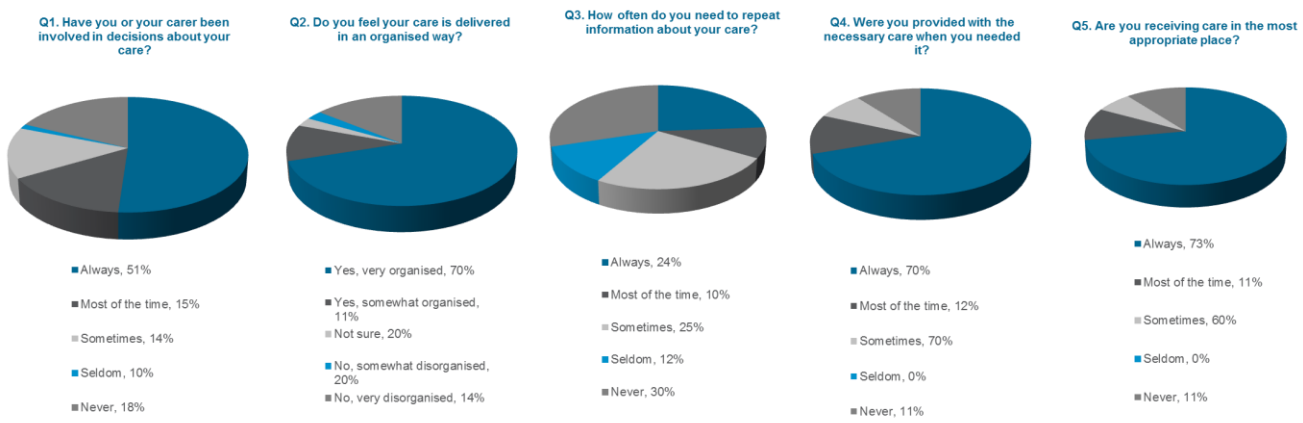
Facilities identified that a consistent access issue for these types of social type services is transport to and from the service. Some services provide transport options such as a mini-bus that collects patients; however, these are rare. Generally, the carer or family must provide transportation, which can be problematic because many of them are unable to do so because they do not drive or due to limited access to a car.

Carers Program provides support to those caring at home for people who are unable to care for themselves because of disability or frailty. This is not a program specific to the older person but covers this group of carers. Other formal carer support programs were not apparent through support services at the sites; however, separate consultations through Carers NSW identified that Carer Support Groups, NGOs and community centres offer the most significant level of support to this group. Carers consulted suggested the most significant issues were:

- Not having disease or diagnosis explained properly to them
- Not having a care plan or understanding of how a diagnosis may progress
- Not knowing whom to contact when health deteriorates.

The perception of older people, their carer or family of service flow and connectivity was assessed at each site with the assistance of the Patient Experience Tracker. The brief five-question survey was self-administered by the carer or older person in care. The results below reflect the results across 10 sites and 84 responses received. Due to the small sample size, one-off collection and varied settings and services, it is difficult to draw any specific conclusions on the level of perceived connectivity or integration of care, except to say that there is variation in how care is experienced from the consumer perspective when compared to what is reported by the site staff. This is supported by other research that suggests the consumer view of healthcare delivery and what is important to them is quite disconnected from what service providers believe to be good or integrated care.

Figure 32: Patient Experience Tracker (PET) results across sites



If there is to be a shift towards a person-centred approach to care, there needs to be greater emphasis on the older person's experience of care as an assessment of care performance.

The older person, their carer and their family – enablers, barriers and opportunities	
	• Linking older people, carers and families with available resources, support services and information to provide them with informed choices • Planning with older people, their carers and families, and assistance to access appropriate support • Proving advocacy and support • Timeliness and appropriateness of response • Clear and consistent communication and support
	• Not knowing where to go for what type of support. • Having to give the same information to different people • Not getting care and support early enough – 'I have to deteriorate sufficiently to be eligible for care' • ED and discharge protocols • Lack of shared information • Lack of service coordination and help to navigate the maze of services • Lack of individualised care and support
	• Care plans that are friendly to the older person, carer and family. These will provide information and promote self-management. • More provision of low-intensity care and support • Dramatically more support for carers as they define their care needs • Better access to allied health – dentist and podiatry • Improved flexibility and responsiveness of service provision • Increase options for and supply of respite • Improve patient transport.

People and Staffing

Key Findings:

- Workforce planning is based on historical or reactive recruitment practices that currently reinforce models of care that are not integrated and not person-centred. There is opportunity to better align this with the strategic vision and a person-centred model of care through alternative resourcing or better utilisation of the wider healthcare.
- Most aged health services reviewed were led by dedicated and charismatic leaders that continually push the aged health agenda in their hospital and community service. Moreover, many of the aged health services are driven by dedicated staff who are passionate about aged health. This workforce is also recognised to be ageing, with a higher average age.
- Resourcing and capacity are often considered to be a limitation for both metropolitan and rural and remote sites. Speciality training in aged health allows for improved provision of services, mentoring and success in future workforce planning. Rural services are currently supported by visiting medical staff, or telehealth from metropolitan services; this is not ideal.
- There are various alternatives to current staffing structures that would better utilise non-medical and generalist staff. Utilising volunteers to support staff and models of care provides a dual benefit as it can improve services and provide a social benefit to this specific age cohort.
- Collaboration between medical specialities (geriatric, rehabilitation, orthopaedics, urology and surgical) was found to be inconsistent and fragmented.

Figure 33: Workforce across aged health services

Hospital	Primary care	RACF	Community
Core team • Geriatrician • Registered nurse • Enrolled nurse • Assistant in nursing • Physiotherapists • Occupational therapists • Podiatrists • Speech pathologist • Therapy aides • Discharge planner **Other** • Volunteers • Diversional therapist • Exercise physiologist • Dietitians	**Core team** • General practitioners • Nurse practitioner • Practice nurses **Other** • Enrolled nurse • Allied health • Private specialists	**Core team** • Registered nurse • Enrolled nurse • Assistant in nursing **Other** • General practitioners • Geriatrician • Allied health	**Core team** • Registered nurses • Personal care providers • Carers • Social workers • Physiotherapists • Occupational therapists **Other** • Volunteers • Diversional therapist • Enrolled nurses • Speech pathologist • Dietitians

The composition of staff involved in delivering aged health services is broad and varied depending on the service being provided. People consulted at site visits work in Emergency Departments, Acute Care units, Rehabilitation units, inpatient geriatric units, consultation and liaison roles, Ambulatory Care Clinics, GP facilities providing assessment and care management in domiciliary settings, dementia and general respite centres, and in-home respite and carer support. In addition, for residents of Residential Aged Care Facilities and older people accessing RACF staff and GPs, some LHDs provide and facilitate various additional services: telephone advice and triage; hospital admissions when required; consultations and interventions within facilities by expert nurses, geriatricians and psychogeriatrician; and end-of-life planning.

Figure 23 provides an overview of the types of professions and disciplines that provide care across aged health services. Within the acute sector, ED services are predominantly provided by medical and nursing staff, although other acute models such as ASET and MAU have allied health staff such as occupational therapists (OTs) and physiotherapists, social workers and speech pathologists. The subacute sector has a strong allied health component which is particularly focused around delivering rehabilitation services to the elderly patient, for example by physiotherapists, OTs and speech pathologists. Hospitals have also been able to use volunteers in the subacute sector to assist with

monitoring patient, assist with falls and provide social interaction. Ambulatory clinics are led by medical, nursing and allied health, depending on the services being provided.

Community care services are predominantly provided by experienced highly qualified nurses (CNCs) and allied health staff such as OTs, physiotherapists and diversional therapists, although geriatricians are part of outreach teams that provide care in Residential Aged Care Facilities and at an older person's home (such as the 'Geriatric Flying Squad', Sutherland and VACS, Nepean).

Collaboration between medical specialities (geriatric, rehabilitation, orthopaedics, urology and surgical) was found to be inconsistent and fragmented. Many hospitals have made progress in collaboration of care, for example, between orthopaedics and geriatrics, in particular for fractured NOF patients, although this is limited only to some sites. Nevertheless, apart from orthopaedics, there is still a lack of coordination between specialists to collaborate with geriatricians in providing shared and/or parallel care. The cause appears to stem from the historical separation of care and the existing barriers to breaking down professional silos between specialities.

Most aged health services reviewed were led by very dedicated and charismatic leaders that continually push the aged health agenda in their hospital and community. Moreover, many of the aged health services are driven by dedicated staff that are passionate about aged health.

During the consultation it was noted that staff believe multidisciplinary teams provide a more comprehensive approach to care. They prefer to work in this manner for their own professional fulfilment and learning.

Common themes in successful staffing models included:

- Collaborative multidisciplinary teams – Most commonly, multidisciplinary teams consist of staff from the following disciplines: medical nursing, occupational therapy and physiotherapy. Less common disciplines included podiatry and diversional therapy.
- Interdisciplinary links between specialties – Geriatric and orthopaedics were found to most commonly have links due to established models of care for older people with fractured neck of femur – although other collaborations included geriatrics with urology and surgery. To establish these relationships required demonstrating the benefits that geriatric care provides to not only the patient experience but also to performance outcomes, for example, shorter lengths of stay. Some sites reported struggling to implement such models due to differences in opinion between specialists and department heads.
- Strong communication – Regular communication through formal and informal mediums was recognised as essential to provide aged health services due to the large amount of services required for this cohort.
- Co-location of staff – Sites that had co-located staff noted that this facilitated communication between disciplines due to the ease of communication and frequent impromptu case management discussions regarding patients. It also decreased the perception of division or bias between disciplines.
- Alternative staffing – There are significant opportunities for alternative resourcing of current functions where specialised staff are constrained. For example at sites visited, the role of a Nurse Practitioner that specialised in aged health or chronic and complex disease was a valuable link between GPs and acute care. Similarly, therapy aids were used to support the work of physiotherapists or provide continuity of mobility support and enablement models on weekends. Similarly within General Practice, the role of the practice nurse was identified as a significant and evolving resource in the management of chronic and complex conditions and in supporting carers.

The aged health workforce is ageing and there is difficulty in attracting younger staff. This was particular common in rural areas where there are significant challenges in recruiting allied health professionals.

There is a significant gap between desired aged health specialist skills and the availability of those skills. This has resulted in a significant spectrum of care that ranges from highly specialised multidisciplinary teams to care by generalists with an absence of knowledge regarding the unique needs of older people with complex needs. In some rural locations, there was a complete absence of any specialised aged health skills in the acute service, and of some specialised skills in the community. Not having any aged care specialist or geriatrician in a region can make it significantly difficult to attract aged health specialist skills due to a lack of mentoring or professional development.

Rural and regional areas are currently implementing specialised modules in aged health and palliative care into their local undergraduate nursing program in order to address this need within their general nursing pool.

People and staffing – enablers, barriers and opportunities	
	• A workforce that is flexible and well trained, has clear roles and responsibilities and works collaboratively. • Co-location of multidisciplinary staff • Regular interdisciplinary meetings • Specific aged health education • Managing, recording and reporting that is fit for purpose
	• Excessive administration, and complex reporting and recording processes • Poor ICT infrastructure to support communication • Silos between medical specialists, departments and out-of-hospital care • Lack of career pathway and development • Lack of communication and sharing of information between providers • Inefficient use of specialist resources (e.g. geriatricians)
	• Utilisation of non-medical workforce • Co-location of academic, community and primary care teams • Shared care agreements between providers • Dedicated aged health education/curriculum • Building intentional relationships with older people and their families • Flexibility and responsiveness of approach • Co-developing and managing funding applications • Consistency in all aspects of planning, support, communication and reporting.

Funding Arrangements

Key Findings:

- Funding comes mainly from federal and state budgets. One of the most common issues cited was that funding goes through several layers of administration before being allocated to the provider. There is ongoing administrative burden to monitor and report on spending.
- The services provided to older people with complex health needs are funded from a mix of federal grants (COAG, HACC and ADHAC), state grants and facility budgets, which are allocated to specific aged health programs.
- COAG funding and other discretionary grants are researched and targeted with programs that data and evidence suggest will provide biggest return on investment. A number of programs funded by COAG are cited as successful.
- At the state level in NSW, there is multiple funding from various sources that is duplicative and inconsistently distributed, and often in the form of time-limited grants.
- LHD funding of aged health services was reported as variable; some who skewed funding towards aged health saw dramatic cost savings in other areas as a result.
- The number of approvals required to introduce a shared agreement discourages this practice at the meso-level of integration. This challenge sometimes drives informal decision-making and reliance on relationships.

- The development of a ratio allocation based on complexity and demographic and geographic considerations was highlighted as a more appropriate approach.
- There is a need for more consistent support for aged care teams when preparing funding applications.
- Funding of diagnostics ordered by state employees working in the community were identified as a funding barrier.

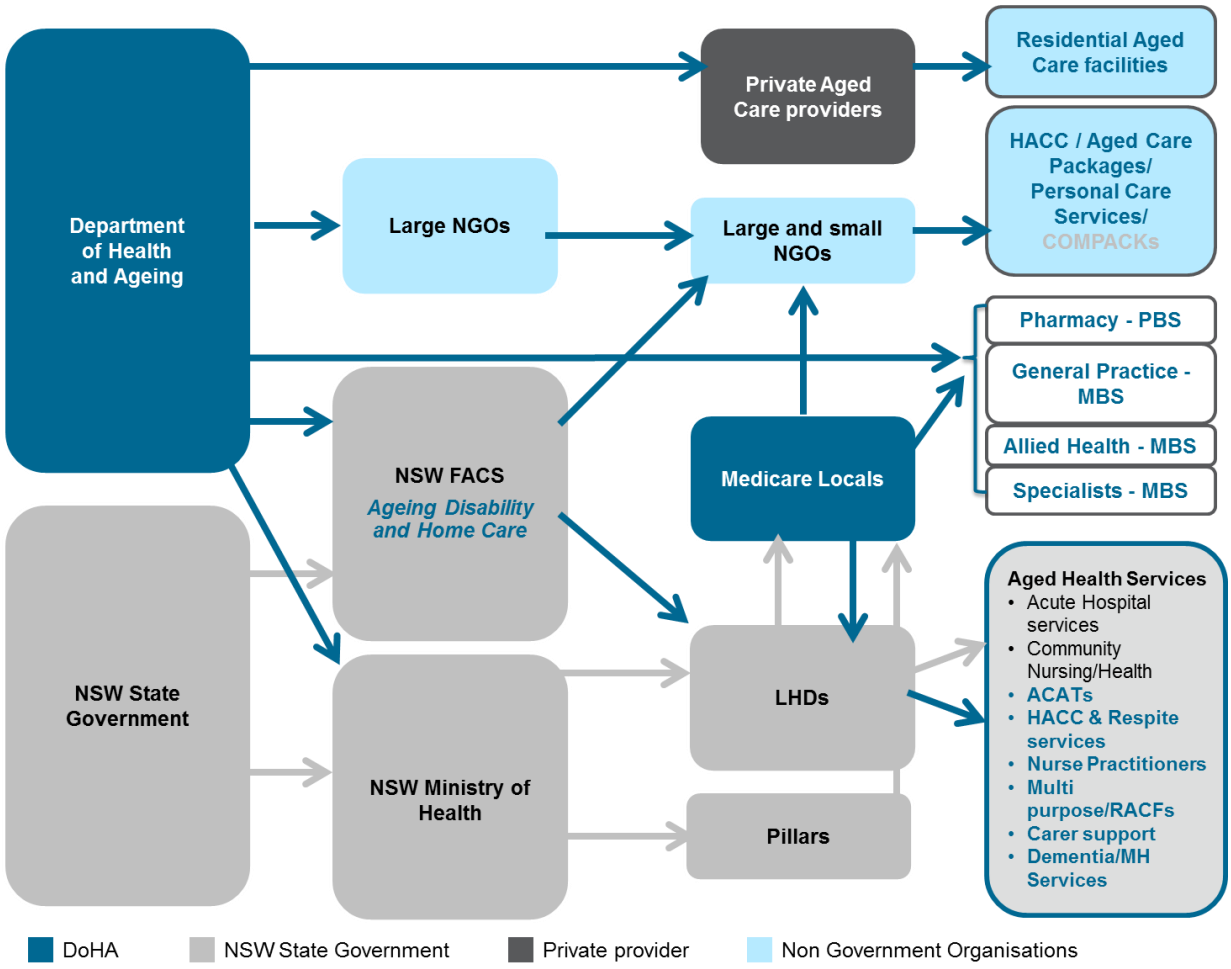
The conflict between federal and state funding is not new. The administrative burden associated with implementing programs and the inability to flexibly move resources to higher value areas are regularly cited. This has been found to impact on the flow of patients and care across settings, resulting in duplication, service gaps and poorer health outcomes.

The uncertainly about the continuation of HACC funding is reported to have had a debilitating impact on staff, who are increasingly concerned about the morale of their workplace and the impact on older people. No site or stakeholder consulted reported to have proactively considered other options should funding be discontinued. None reported to be aware of a risk mitigation strategy if services were to cease or had ongoing dialogue with their executive management to plan one.

Some sites suggested that the lack of ability to manage or have an impact on care budgets left them feeling disempowered and somewhat 'defeated' in creating change. Conversely, sites that had devolved budgets and recruitment authorities had a more optimistic view on the potential of services to achieve the desired goals within budget. They also had a plan for future enhancements (based on evidence) and had identified revenue streams and project/research funding opportunities, and career development pathways for their team.

In NSW Health alone, there were multiple short-term funding programs or specialised recurrent funding programs available, but not consistently applied across services (e.g. from ACI and CEC, or internal MoH branches). The other funding from NSW Health was reliant on LHD decision-making and the strategic prioritisation of care of the older person in that LHD. Again, this varied across LHDs and services within LHDs.

Figure 34: Funding flow in NSW



It was noted that the process for accessing funding for low and high-level care needs is the most difficult. Simplifying this process would decrease the workload for staff and speed access to care.

Broadly speaking, most funding models were considered problematic and unfit for purpose. Some sites described how funding rules and requirements had been altered to allow more flexibility and partnering between organisations. However, internationally there are specific funding models that are broadly agreed to incentivise integration of care across continuums of care and meet the needs of older people, their carers and family and those of providers.

A comparison and contrast of funding models that support or detract from integrated care are located in Appendix E.

Funding arrangements – enablers, barriers and opportunities	
	• COAG funding grants where investment was well evidenced and will continue to be supported by the LHD • ABF for appropriately coded episodes of care • Collaborative funding agreements between multiple aged health service providers • Innovative use of funding to reduce future cost burden (e.g. hyper-acute community visits vs. ambulance ED arrival)
	• Short-term funding cycles • Disparity in funding and one-off grants received across NSW • Lack of federal and state coordination when commissioning funds • Lack of visibility of costs vs. funding and outcomes achieved • Lack of incentive for GPs to manage older persons with complex health needs in

	the community or in Residential Aged Care Facilities
	• Collaboration across federal and state organisations to meet targets • Development of a dedicated service to support aged care teams to identify, develop and manage funding applications • Development of an outcomes framework with shared targets • Funding aged cohort specific pathways of care

Infrastructure

Key Findings:

- An absence of planning considerations for the needs of older people with complex health needs was noted in most facilities and most significantly in recent or planned renovations and rebuilds.
- Dedicated buildings for aged health facilities are usually positioned on the periphery of the hospital campus. This makes them easier to access but often hard to find and disconnected from other services.
- Design features that included natural light, courtyards and simulated home environments were reported to improve the experience and behaviour of older people at risk of becoming distressed or exhibiting difficult behaviours.
- Simple design features such as well-located diagnostics services were reported to 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
- Secure units for dementia and delirium patients reduce the prevalence of physical and pharmacological restraints being used and the need for increased staffing

Infrastructure and design of services is an important and significant investment that is required to last for a significant period of time. Lack of appropriate infrastructure was identified as a major challenge across most sites. A common finding was an absence of planning consideration for the needs of older people with complex needs. This was noted in most facilities and most significantly in recent or planned renovations and rebuilds. This may suggest service providers and older people are not engaged in the design phase, or that their requirements are too specific and expensive to implement.

Although there has been some progress in hospital design to support reduced mobility, consideration of non-clinical infrastructure to cater for the needs of older persons was not apparent at most sites visited. Examples of this are soothing colour schemes, noise-reducing designs, low lighting, soft music and architecture that resemble a familiar home environment rather than a hospital. Consultations revealed a universal lack of equipment specially designed for aged health patients, for example beds that can be lowered to the floor to minimise injury from falls out of bed.

Most acute and subacute services are instead provided through traditional wards which are noisy, bright and unfamiliar. In these conditions, it is well established that older people with specific risk factors have the potential to become irritated, confused and disoriented. Addressing this often requires an increase to staffing ratios or the use of pharmacological restraints which have financial and health implications. Some sites spend a large amount of money each year repairing suboptimal buildings. The poor design of wards means additional nursing stations are required. The layout of wards is reported as inefficient and unsafe, especially for older people at risk of falls. Speciality infrastructure includes a secure locked-down ward for up to ten people.

Simple design features such as the location and distance of diagnostics services were reported to have a negative impact on an older person's behaviour and level of confusion, often requiring two staff to escort them to have simple diagnostics such as x-rays performed. This has resourcing implications for the ward or unit, and affects the emotional well-being of the older person. Similarly, access to diagnostics after hours was noted as a challenge at rural sites.

Some hospitals have been able to build dedicated aged health infrastructure, such as secure wards for dementia and delirium patients, or rehabilitation wards with large gym areas that can be accessed by subacute and ambulatory patients. Ambulatory infrastructure was usually found to be based on peripheral parts of the campus which can often make it easier to access. However, it is also significantly disconnected from the hospital itself and sometimes difficult to locate. Positive design features were facilities that had courtyards for patients to access at will. This was seen as providing older people in care with choice and freedom to walk and get fresh air.

All community health staff had access to cars to visit patients, although only a few had patient transport options via mini-bus for services such as respite care. Lack of patient transport was continually noted as a barrier in providing continuation of care for patients. For example, it is not uncommon for patients to wait most of the day for transport via ambulance services to return to a Residential Aged Care Facility. This is complicated further if elderly patients are transported at night-time, which can lead to confusion.

Infrastructure – enablers, barriers and opportunities	
	• Position Aged health positioned as a hospital priority to influence the design of hospital infrastructure • Simple design features such as location and distance of services • Dedicated aged health infrastructure for dementia and delirium patients • All community health staff had access to cars to visit patients
	• Lack of appropriate infrastructure and absence of planning consideration for the needs of older people • Universal lack of equipment specially designed for aged health patients • Acute and subacute services which are noisy, bright and unfamiliar • Lack of patient transport was continually noted as a barrier in providing continuation of care • Lack of funding to build dedicated aged health facilities and wards • Aged health not perceived as a hospital priority • Infrastructure challenges impact on FTE usage and extra requirements, ultimately driving up cost of care
	• More transport and transport options for patients to avoid unnecessary LoS and elderly patients being discharged after long waits • Architectural designs that facilitate care of the elderly patient and focus on their needs • Infrastructure for ambulatory clinics should cater for the elderly, e.g. additional parking, bus stops or drop-off zones • Co-location of core provision for older people with close proximity between high usage services.

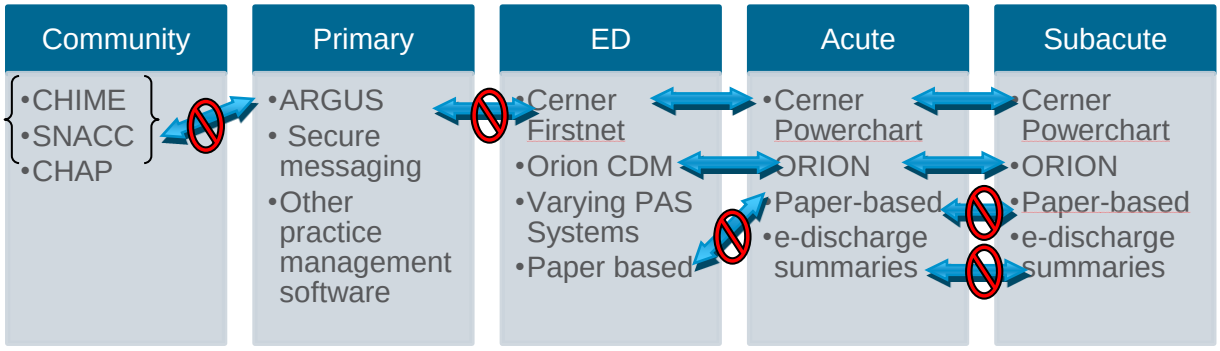
Technology/Information Flow

Key Findings:

- Patient files are often part electronic and part hardcopy. This impacts both the collection and use of quantitative data and measurement of performance.
- It is acknowledged by LHDs, community providers and Medicare Locals that the limitations of ICT are a barrier to continuity of care.
- An electronic discharge summary specifically developed for the older person is present but often has to be faxed or mailed due to lack of eHealth connectivity by local GPs.
- Advanced Care Directives and other EOL information are not readily available.
- The lack of integration or interface of stand-alone software and communication platforms has impacted on the continuity of care for patients and has created additional administrative burden for both clinical and non-clinical staff.
- The lack of integration or interface of stand-alone software and communication platforms has impacted on the continuity of care for patients and has created additional administrative burden for both clinical and non-clinical staff.
- E-medication has been introduced in some aged care wards which has reduced medical errors.

The figure below is a representative snapshot highlighting the different software and systems across care settings in NSW. Further, it demonstrates where there is continuity (integration) of these systems across settings and where there is no common interface.

Figure 35: Technology systems and software across the care setting in NSW



Site visits revealed that there are currently three key software Electronic Medical Record (EMR) layer solutions used in the community healthcare setting: CHIME, SNACC and CHAP. While these solutions function relatively well as stand-alone systems, they offer no interface with other community, primary, acute or subacute solutions. A project to create one interface between CHIME and SNACC systems has reportedly been unsuccessful and required additional duplication of work for staff. They are also not currently accessible from mobile devices, even though by definition the community health team are mobile.

ARGUS is the secure messaging system utilised by GPs and some health specialists. However, as with the aforementioned community healthcare systems, it has no integration properties with community, acute or subacute technological solutions apart from secure messaging capability. This means that GPs cannot access community nursing files and vice versa. Also of note, Argus is only capable of sending word-based messages and cannot process PDF or other image files (this limits the ability to send and share patient diagnostics). It is also not the main solution to receive e-discharge summaries.

In the ED, acute and subacute care settings, there is a mix of either electronic or paper-based patient record systems, or a combination of both. Many of the acute care facilities visited have duplicate patient records. Most report using EMR and Firstnet in ED and the parallel use of Powerchart and paper-based notes in the acute and subacute wards with the addition of Synaptix in rehabilitation. Neither the electronic nor the hard-copy record could be considered a complete record in isolation and

staff often reported having to check both. This creates a barrier to continuity of care and leads to excessive time (for clinical and non-clinical staff) spent locating patient's historical and current records. Staff also reported that this can lead to errors in the provision of medication management and delays in organising appropriate referrals to additional services (especially community) for older patients. Ultimately, this lack of information transfer can lead to extended length of stays in acute care and/or subacute facilities.

The lack of integration of IT systems is such that each person presenting to an acute care facility receives a unique Medical Record Number (MRN) different from that allocated in the primary and community care settings. This means that the care of an older person in an acute care facility cannot be monitored by a primary care provider (such as a GP) during that person's discharge or post-discharge. It is also important to note that while most GPs have access to electronic discharge summary functionality (based on secure messaging), there is still a proportion across NSW who do not. Commentary from site visits included concern regarding the flow of important information to those GPs without access to e-discharge now that additional fax or letter discharges are becoming more rare.

Technology/information flow – enablers, barriers and opportunities	
	• An electronic mechanism that facilitates coordination among healthcare specialists • Shared vendor EMR systems across acute and subacute settings • E-medication to reduce medication errors
	• Not having a complete set of information • Multiple stand-alone vendor systems with no interface • Lack of electronic information-sharing across care settings • Fragmented provider market, making it difficult to sign up to a core system, software or tools and templates.
	• For sites and stakeholders to agree on a common communication and information-sharing approach across core services (as they define core services) • Handheld technology for community-based staff integrated into health service systems • Simplified tools and processes to meet administrative and management reporting • Develop an information strategy to ensure consistent dissemination of information to older people, their carers and families • Adopt enabling technology as a mechanism to facilitate consistent and responsive support from providers including transport providers.

Governance

Key Findings:

- No one organisation, team or service has the whole picture of an older person's needs.
- Most aged health governance is provided by a Clinical Director for Aged Health or Geriatrics, overseeing a service that manages large numbers of separations across acute care, subacute care, ambulatory and community settings.
- Governance of aged health services at the ten sites visited was variable. Even those with similar structure and scope had different governance, leadership, resources and performance management approaches.
- Good leadership and support for a holistic and proactive vision of aged health was identified to empower and enable staff performance and quality and appropriateness of care.
- A multidisciplinary management structure that provides clinical rigour but also is able to think laterally and solve problems was cited as a good example of governance.
- Services that utilised both the standard hospital or LHD governance mechanisms and specific aged health collaborations were identified to be most successful in integrating care within and outside of the service.

- Geriatrician leadership and influence across broader specialities such as urology, vascular and respiratory is important to champion the ‘aged health specific lens’ to assessment and treatment plans.
- Multidisciplinary means different things at sites visited. At some sites, the medical staff continue to meet separately from the nursing and allied health staff, and key executive and leadership meetings were also structured at these facilities to keep professions and specialties separate.
- Co-locating teams and services was reported to provide a natural integrated governance structure, as did multidisciplinary approaches to care.

A framework for governance is important to hold relevant stakeholders and staff accountable while they carry out the objectives of a strategy.

Most direct aged health service governance is provided by a Clinical Director for Aged Health or Geriatrics. The governance provides strategic direction for aged health service across the hospital and into the community and is responsible for executive engagement. This position is often supported by a medical or nursing Clinical Manager. In the absence of an appointed director, strategic leadership tends to fall to a junior or part-time geriatrician. This is problematic as it leaves the service somewhat vulnerable to reprioritisation at the facility or service level. In some sites, the nursing manager fulfilled the leadership role but often struggled with influencing and engaging other specialties due to interprofessional bias and historical silos. For this reason, a strong clinical leader and aged health advocate was noted as a key enabler to a strong governance structure.

Executive engagement varied between facilities with some hospitals having strong executive engagement and others having poor engagement. Of note, aged health services that were able to engage with the executive level and demonstrate how the governance structure of aged health services affects the hospital’s performance appeared to have the most successful engagement.

Governance is generally achieved by structured management meetings at the hospital, service or ward levels. Multidisciplinary case conferencing meetings were a common daily governance mechanism to determine clinical care plans and discharge options for patients. It should be noted, however, that multidisciplinary means different things at sites visited. At some sites, the medical staff continue to meet separately from the nursing and allied health staff, and key executive and leadership meetings were also structured at these facilities to keep professions and specialties separate.

Some sites visited had successfully created aged health governance arrangements at the meso-level, extending across all local aged health providers including RACFs, local NGOs, Medicare Locals and GPs.

Governance – enablers, barriers and opportunities	
	• Strong leadership with executive-level engagement • Governance through aged health speciality i.e. led by geriatricians • Formalised governance structure to provide accountability and direction for aged health services as well as a point of escalation for issues or challenges to the agreed strategy. • A management structure that provides structure, clinical rigour and a framework for problem solving • Team approach with a culture of open and transparent communication • Regular internal and external meetings between disciplines and a collective understanding of each discipline.
	• Lack of executive support and understanding of aged health • Passive or informal governance with ill-defined roles and responsibilities • Lack of geriatrician leadership among broader specialities • Overly bureaucratic rules which stifle new ways of working • Too many NGOs with whom to engage and develop accountabilities • Time constraints because staff are very busy. Integration and communication need to be built into day-to-day working and not be an add-on to it.
	• Expand governance of aged health to allow a critical mass of staff to work together across care settings and specialities across and beyond the hospital • Agree a common governance approach and design principles for inpatient, ambulatory care, community care and residential aged care facility settings • Simplify governance arrangements with clear roles and responsibilities • Agree on shared KPIs and non-bureaucratic ways to collect supporting information • Increase the flexibility of governance to provide opportunity to formalise relationships which are working well • Include transport services with the governance of aged care.

Discharge and Continuity of Care

Key Findings:

- Strong relationships, both clinical and non-clinical are pivotal to continuity of care outside of the hospital
- Implementation of proactive discharge planning was reported to have reduced LoS for older people in acute care facilities and to have reduced unplanned readmission rates.
- Proactive communication with carers and families about discharge from early in the care journey was identified as a successful method to reduce carer/family apprehension, help them plan for changes to their routines and allow smooth processing at the time of discharge.
- Timeliness of discharge and continuity of care is reported to be most impacted by the presence of a carer or the person living alone, access to medical staff at the right time and limited access to equipment, community care packages and high/low-level residential care beds.
- Receipt of discharge summaries by GPs was reported as improving with introduction of e-discharges but is not consistent. Some consumers interviewed suggested their GP always knew when they had been in hospital where as others reported this as a gap.
- likely to cause ongoing morbidity issues and health deterioration. Care coordination and social support services available (such as hotlines) would likely prevent many ED presentations that occur due to lack of action and escalation care planning.
- ACAT receive e-referrals from inpatient settings and streamline referrals and care. ACAT has strong links to inpatient facilities and a 24-hour follow-up protocol for all patients referred for screening or additional support.
- Lack of patient transport also delays discharge.

Site visit consultations highlighted the strategic intent of LHDs to deliver continuity of care for older people and facilitate early discharge where appropriate.

Continuity of care was identified as a key driver to holistic integration and of particular importance for this cohort of older people. In the acute care setting, most sites visited had implemented ASET and/or ARRC roles. These roles aim at the early identification of the older person with complex health needs and facilitating their appropriate care delivery (including across care settings) and discharge to place of residence or Residential Aged Care Facility in a timely manner. It was recognised that these roles worked particularly well when supported by dedicated discharge planners or acute care coordinators.

However, a key barrier to the delivery of these service roles is the limited hours under which most ASET, AARCS and discharge planners operate (usually business hours, Monday to Friday). It was also noted that in some acute facilities, multiple patient movements between wards caused confusion and was a barrier to delivering continuity of care. Continuity of care in the community setting (especially regional areas) was identified as a gap. This was reported to often be due to the lack of GPs and specialists in the area, meaning older people would often see different and multiple clinicians for their care. Housing arrangements are also a central consideration for older people and associated with independence and community participation. There are minimal linkages between health and services responsible for assisting with housing.

Consultations among both metropolitan and regional sites highlighted the vast array of models and services in place aimed at facilitating earlier and more efficient discharge for older people. Multidisciplinary Team whiteboard meetings (both in the acute and community setting) were identified as a key vehicle for communication for all specialties involved in the care of the older patient. These meetings (and similar teleconferences between acute and community care) aid in the identification of obstacles to discharge and assist in forward planning for services required for discharge from within the acute setting and into a community setting. Models involving nurse practitioners in Residential Age Care Facilities (such as GREAT at Westmead) not only assist in preventing unnecessary admissions to hospital, but with follow-up care in the residence setting, rather than extended stays in hospital. The ‘Yellow Envelope’ model implemented in several LHDs assists in planning for a patient’s return to their Residential Aged Care Facility and continuity in the delivery of their care.

While there were several good models aimed at facilitating early and appropriate discharge, consultations still identified several barriers. These are listed in the following table.

Discharge and continuity of care – enablers, barriers and opportunities	
	• Dedicated Discharge Planners in acute settings • Full implementation of AARCS/ASETS models • Electronic discharge to GPs when done well • Multidisciplinary Teams daily whiteboard meetings • Dedicated Care Coordinators (including Chronic Disease Management Program Coordinators in the community) • Nurse Practitioner in-reach to place of residence and RACF programs • Strong relationships between acute and community care including daily teleconferences to discuss package and community bed availability • 'Yellow Envelope' admit and discharge forms from RACF to acute settings
	• Lack of access to community packages (especially domestic assistance such as HACC) • Lack of access to other post-hospital transition packages such as TACP • Lack of RACF or MPS beds • Multiple patient movements between acute care wards during singular stays • Limited access (in some facilities) to 'step down' beds (e.g. subacute, outlier facilities or GEM) creating longer length of stays in acute care wards • Lack of options for ambulances to take patient anywhere other than ED
	• Increase operating hours for ASETS/AARCS and limited access to allied health for ASET teams • Allow nurses to discharge patients • GP in-reach, co-admission (new). • Increase availability to patient transport for non-emergency discharge use • Increase access (in some facilities) to 'drop down' or GEM-type beds creating longer length of stays in acute care wards • Strengthen and expand Nurse Practitioner in-reach to place of residence and RACF programs • Increase capacity of community care providers to support older people once discharged.

Where do staff feel the hotspots are?

Site consultations anecdotally highlighted a number of commonly presenting issues in older people. These included (but were not limited to):

- **Dementia/Delirium**
- **Wounds**
- **Injuries as a result of falls**
- **Dehydration**
- **Respiratory difficulty**
- **Urinary Tract Infections**
- **Cardiovascular issues**
- **Hypertension**
- **Syncope**
- **Acopia**
- **Falls without injury**
- **Parkinson's/Motor Neurone Diseases**
- **Carer respite**
- **Social needs**

- MAU/OPERA most commonly report dealing with UTIs, wound infections, delirium and dementia.
- Use of telemetry units on one MAU has successfully identified underlying cardiovascular issues in a number of older persons that potentially explain their health deterioration
- Community nursing and acute care facilities suggest respiratory issues, cardiovascular issues/hypertension dementia/delirium, depression and COPD.
- Sites reported a prevalent lack of appreciation by ED staff for age-related illness that may impact on the accuracy of DRGs formally reported in the data.
- Management of routine medications while in hospital (e.g. Parkinson's medication) was identified as an emerging issue that contributes to deterioration and LoS (e.g. at Hornsby).

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