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Aged health services in NSW

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AGENCY FOR CLINICAL INNOVATION

Aged Health Network

The information is not a substitute for healthcare providers' professional judgement.

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Contents

Executive summary

Care of the older person is a complex and specialised field. As people age, they often accumulate deficits and frailty, and this can result in rapid and significant changes in their health care needs. Their journey is often non-linear, with phases of increased and decreased acuity, interspersed with phases of clinical stability. Their social situation can often add an increased layer of complexity.

Aged health care in NSW is delivered for older people across multiple settings, both in and out of hospital. In-hospital care may be resource intensive and costly due to the complex nature and care needs of the older person. Sometimes, in-hospital care is required for the best patient outcome. However, there are certain types of care that can be provided in the community or at home, preventing potentially avoidable hospital admissions. Providing the right care, in the right place, at the right time is key to ensuring person-centred quality care of older people. It is the responsibility of the aged health system to deliver this care to older people, their carers and families.

The structure and delivery of the Commonwealth aged care system has changed over the years and continues to undergo reform. Currently, NSW Health delivers a range of aged care services in NSW on behalf of the Commonwealth, including aged care assessment services (aged care assessment teams and regional assessment services), community services through the Commonwealth Home Support Program and transition care through the jointly funded Transition Care Program. NSW Health also provides residential aged care services through the state government residential aged care facilities and multipurpose services.

This document was created in the context of a request from the Secretary of NSW Health and a review into NSW Health's future role as a provider of Commonwealth funded aged care services. Notably, changes in Commonwealth aged care service arrangements present opportunities regarding the profile of aged health services delivered through local health districts.

The purpose of this document is to develop an ideal model for NSW Health to deliver aged health services, with the aim of improving the care of older people. The model builds on previous work by the Aged Health Network in *Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs*. It is acknowledged that while current and future health and aged care reforms may affect the delivery of services and care, the principles and key service elements in this document can be applied regardless of future policy and funding environments. The service models in this document are:

- intended as a practical tool to demonstrate the current and ideal aged health services requirements for care of the older person in NSW
- accompanied by a decision support tool to assist in identifying the impact on patient care, service and the aged health system, if services are transferred, reduced, changed or enhanced.

To understand what is required to transition services to an optimal state, it is important to understand the current configuration of NSW Health aged health services. To this purpose, three different service models are presented that reflect different aspects of aged health services in NSW.

1. Aged health service settings: this model represents the delivery of aged health services across inpatient, outpatient and community settings. This model emphasises the importance of transition services in connecting care across different settings.

2. The older person's hospital pathway: acknowledging that the older person's health journey is often non-linear, this model illustrates the range of services required to provide comprehensive care across the older person's health pathway.

3. Service distribution with the progression of frailty: as people age, they often become increasingly frail and require more intensive support and services. This model illustrates the distribution of aged health services along key stages in the older person's health journey.

The document acknowledges that service models must be adaptable as national reforms and the delivery, funding and resourcing of aged health services may change over time. To optimise patient outcomes, it is critical that the future provision of aged health services considers service capabilities and where care is best delivered. Considerations for a shift to an optimal aged health service model include:

- increasing the role of primary care as the primary medical care providers
- expanding the role of transition services
- optimising the role and expertise of service partners
- reducing potentially preventable hospital admissions and readmissions.

While a single model may not account for all possible contexts and scenarios, the key components of an optimal service model should be broadly applicable. It will be important for health services to consider how the ideal service model components can best be tailored and applied locally. To assist health services in this task, the decision support tool included in this document can be used. The tool can be used to identify and manage risks, opportunities to patient care, services and the aged health system, if services are removed or transferred from NSW Health.

Introduction

To optimise health outcomes, it is critical that the future provision of aged health services considers service capabilities and where care is best delivered. The growing burden of chronic disease, the ageing population living longer and concerns about healthcare costs have precipitated concerns about the future delivery of aged health services.

In 2017, 3.8 million people (15% of the Australian population) were aged 65 and over, with this proportion projected to steadily grow over coming decades.[1] The *2017-18 National Health Survey* reported over one-third (36.7%) of people aged 75 years and over rated their health as being excellent or very good.[2] The survey also reported chronic conditions prevalence increased with age, with four in five (80%) people aged 65 years and over declaring one or more chronic conditions.[2]

The burden of disease among older people aged 75-84 years was highest for coronary heart disease, followed by dementia, chronic obstructive pulmonary disease, stroke and lung cancer.[3] These five diseases are also the leading causes of death in Australia.[3]

Older people also represent a significant and increasing proportion of emergency department (ED) presentations and inpatient admissions, often presenting with complex health issues or illnesses. In 2016–17, there were around 7.8 million presentations to public hospital EDs.[3] Some population groups were over-represented in these emergency department presentations, compared with their representation in the population as a whole: 21% were aged 65 and over (15% of the population).[3]

In 2017-18, people aged 65 and over accounted for 49% of patient days and people aged 85 and over accounted for 13% of patient days.[4] The hospital setting may not be the safest place for older people as they have higher adverse event rates and are more likely to become deconditioned compared with the general population.[5] Longer and potentially unnecessary lengths of stay experienced by older people may be a result of perceived complex issues related to care coordination and discharge planning.[5]

Developing a system of aged care service delivery that is sustainable and integrated with the wider health system is a priority for NSW Health as the proportion of Australia's ageing population (people over the age of 65 years) is forecast to increase. In 2017, there were 3.8 million Australians aged 65 and over (15% of the population); by 2057, it is projected there will be 8.8 million older people in Australia (22% of the population) and by 2097, 12.8 million people (25% of the population) will be aged 65 and over.[1]

Aged health care should be delivered in the place most appropriate for the individual's needs, capacity and wishes, and should adapt to changing health needs. Older people with chronic conditions, disabilities and complex health needs require care that brings together a range of professionals and skills from the public and private health and social care sectors.

This document defines an ideal model for NSW Health aged health services (irrespective of funding source) that will guide and inform future service planning and delivery in the NSW Health system. The document presents current service models in aged health services from three perspectives health settings, the patient journey and service distribution as frailty increases. It considers how to ideally deliver aged health services for NSW.

Principles for NSW Health aged health services

The following principles define a shared vision for NSW Health aged health services. These principles should guide the development and delivery of the services to support best practice and patient-centred approaches. They are informed by research, key guidelines and consultation with NSW geriatricians.

1. Assessment and delivery of aged health care should be person-centred, comprehensive, adaptable to changing needs and accessible.

The ageing population is a heterogeneous group with constantly changing health needs. Multimorbidity, frailty and disability become increasingly common with advancing age and acute illnesses can cause dramatic changes in healthcare needs. Each older person has a unique set of health problems and circumstances that require comprehensive assessment and management. Aged health delivery needs to consider these factors and be adaptable to the changing health needs of the older person. It also needs to be accessible, so that even the most frail older person can have access to comprehensive, person-centred care.

2. Care should be interdisciplinary, understanding the complexity of the older person and their health needs.

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 daily.[6] Consumers with complex needs will have relationships with multiple clinicians and services across different settings. The geriatrician is the medical specialist in this area and is trained in performing comprehensive geriatric assessments.

An interdisciplinary approach involving the general practitioner, nursing and other medical and allied health professionals is essential to delivering comprehensive care for older people with complex needs. Services should be offered and delivered to older people based on their assessed needs.

3. Care should be integrated and coordinated.

For healthcare to be effective and efficient, it should be delivered in a coordinated way, with all members of the healthcare team working together towards common goals. Good communication between members of the healthcare team and associated partners is essential. Partners may include other government, non-government and community organisations. Effective partnerships between consumers and healthcare providers and organisations enable better care. The role of the general practitioner is crucial. They are ideally placed to oversee chronic care and facilitate an integrated, coordinated approach. Maintenance of an accurate and up-to-date shared electronic medical record system aids accurate and timely communication and integration and helps to avoid service duplication.

4. Healthcare should be delivered in the place most appropriate for the individual.

New technologies should be used to aid healthcare delivery where appropriate. Care settings will differ according to individual needs, resources, capacity and wishes, as well as the local health and social support arrangements. Settings include homes, aged care facilities, ambulatory facilities or hospitals because appropriate and equitable care is not constrained to traditional inpatient or outpatient approaches.

5. As frailty increases, the focus of care should shift to preserving quality of life and planning for the end of life.

Healthcare delivery should always consider the frailty, comorbidities and wishes of the individual. Health outcomes for people, their carers and their families improve when they can talk through their concerns, decisions, preferences and choices with health professionals.[7] Advance care planning for end of life should be an expected part of clinical care. Patients should be provided with care that is consistent with their wishes, within therapeutic limits, always focused on quality symptom management and best practice.[8]

6. Focus should be placed on health maintenance including maintenance of physical function, mental health and preventing deterioration where possible.

Healthcare that is proactive rather than reactive will lead to better outcomes for the older person. Every older person should have access to care that focuses on maintenance of their physical and mental health to preserve and sustain physical health, mental health and daily functioning. This would include promotion of good nutrition, falls prevention interventions, appropriate exercise and socialisation.

7. Recognising dementia is important as it significantly impacts the intensity and type of care required for the older person.

In 2016-17, dementia was recorded as the principal diagnosis in 1 in 5 (22%) dementia hospitalisations and as an additional diagnosis in 4 in 5 (78%).[9] Almost 1 in 2 (48%) ended with the person going home; 1 in 3 (29%) ended with the person continuing care in hospital; 1 in 5 (17%) ended in a new admission to residential aged care; and 6% ended with the person dying in hospital.[9] In 2017, dementia caused more than 13,700 deaths and was the second-leading cause of death in Australia.[9]

About 9 in 10 (92%) hospitalisations involved at least one overnight stay; with the average length of stay 13 days.[9] Almost all hospitalisations (97%) with at least one diagnosis of dementia were of the highest or second-highest clinical complexity.[9] The majority (71%) were of the highest clinical complexity, compared with 16% of hospitalisations without a diagnosis of dementia.[9]

As dementia progresses, people may lose the capacity to make decisions for themselves. Therefore, people with dementia should have access to experts who can assess their capacity and facilitate supported decision making or appropriate substitute decision making. It is also important that healthcare providers recognise dementia as a terminal illness and facilitate an approach that focuses on quality of life, advance care planning, and supporting carers to make appropriate decisions with and for their loved ones.

8. The health and wellbeing of unpaid carers, who play a pivotal role, is important and should always be a consideration when caring for the older person.

In 2018, there were 2.65 million carers in Australia, representing 10.8% of all Australians.[10] Around one in nine (10.8%) Australians provided unpaid care to people with disability and older Australians.[10] Of all primary carers over half (54.8%) of those providing care to a spouse or partner were aged 65 years and over.[10] Most older Australians (persons aged 65 years and over) were living in households (95.3%), with 4.6% living in care accommodation.[10]

Around 1.3 million older Australians living at home needed some assistance with everyday activities, and of these, almost two-thirds (65.9%) had their need fully met.[10] Aged health care needs to consider the physical and psychological burden on caregivers.

The ideal model for NSW Health aged health services

A range of policies, funding and performance arrangements have informed the current configuration of aged health services. Service models must be adaptable as the delivery, funding and resourcing of services may change over time. NSW Health aged health services provision is also highly heterogeneous across local health districts (LHDs) and at different time points.

Delivery of aged health care in the future will also be affected by current national reforms to the health and aged care systems. These reforms, including My Aged Care, and other health reforms provide a range of opportunities and potential challenges to the delivery of NSW Health aged health services.

To optimise patient outcomes, it is critical that the future provision of aged health services considers service capabilities and where care is best delivered. The purpose of the ideal model is to represent health services that are provided under the umbrella of NSW Health aged health services.

Figure 1. The ideal model for NSW Health aged health services

Model description

The shift to an optimal aged health service model will achieve four outcomes.

- Provide care of the older person in the community. By relying on primary care as the primary medical care providers, general practitioners (GPs) are best positioned to provide a range of support for the care of older people in the community. Given their in-depth knowledge and close relationships with the older person, their carer and family, they suitably act as the care coordinator.
- Expand the role of transition services. These services have a critical role in 'joining up the dots' in the aged health system. These services will integrate patient assessment, referral and follow-up across multiple services and settings.
- Optimise the role and expertise of service partners. This involves clear role delineation, strong partnerships, care planning and coordination to deliver care to the older person.
- Reduce potentially preventable hospital admissions and readmissions. The provision of more services in the community and the home in a timely fashion, when it is safe and appropriate to do so.

It is widely acknowledged that one model may not accommodate the needs of all. However, the characteristics listed are universally applicable to help define an optimal service model. A part of working towards leveraging future opportunities and managing challenges to aged health services is to consider the ideal service model components and how these can be applied and tailored locally.

NSW Health aged health services can plan for a transition towards an optimal future service model that best uses resources by locally determining:

- providers that are most suited and provide specific aspects of care
- where care should occur (e.g. community-based clinics or homes)
- connections between services to enhance clinical decision making and inform future episodes of care
- potential ways to manage or direct referrals and enquiries.

Mapping and planning aged health services at a local LHD and primary health network level is an effective way to gain a better understanding of:

- the current service delivery landscape
- where there are duplications, gaps, service partners
- what an ideal service model looks like in the LHD.
- A decision support template is provided in the next section to assist health services with this task.

Existing NSW Health aged health services models

This section describes health services that are currently provided under the umbrella of NSW Health aged health services.

The delivery of NSW Health aged health services is complex and is characterised by numerous interdependent and dynamic interactions between health services, providers and care teams. There is considerable heterogeneity across LHDs and speciality health networks in how aged health services are configured, provided and funded. Components of care for the older person are provided by various service partners including primary care, residential aged care facilities (RACFs) and the private sector.

There is no single view of the current state of NSW Health aged health services. In this document, several different service models are presented that reflect different aspects of aged health service configurations in NSW. These models are intended to provide practical tools to help demonstrate the role and interdependence of aged health services in providing components of care for the older person.

Models

- **Aged health service settings:** this model represents the delivery of aged health services across inpatient, outpatient and community settings. The model emphasises the importance of transition services in connecting care across different settings.
- **The older person's hospital pathway:** acknowledging that the older person's health journey is often nonlinear, this model illustrates the range of services required to provide comprehensive care across the older person's health pathway.
- **Service distribution with the progression of frailty:** as people age, they often become increasingly frail and require more intensive support and services. This model illustrates the distribution of aged health services along key stages in the older person's health journey.

For descriptions of the aged health services that are included in these models, see Appendix A.

Aged health service settings

Older people, their carers and families can have multiple interactions with the NSW Health aged health system across inpatient, outpatient and community settings. Without appropriate care coordination and transitions between service settings, there is risk of duplication in assessment, and care provision or omissions of important information which may inform care decisions.

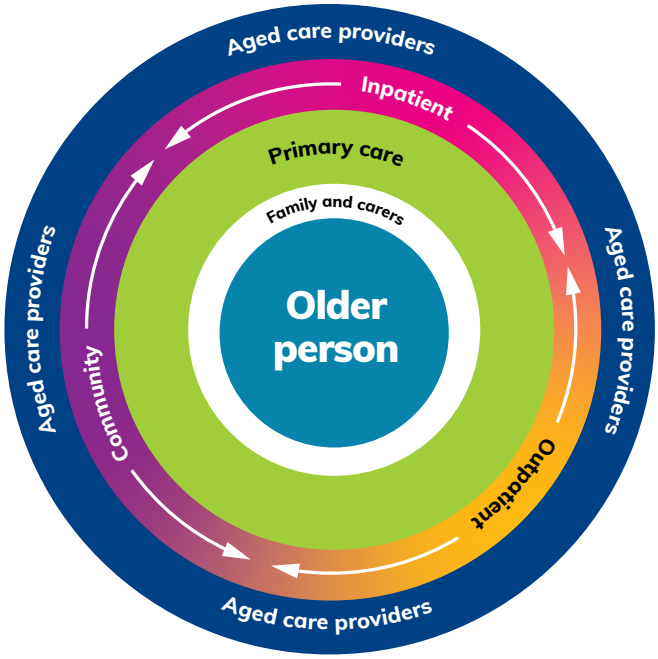
Telehealth technologies enabling virtual consultations and service delivery are also key enablers of improved access to care and care coordination, particularly for the older person and health professionals in regional, rural and remote settings.

> Transition services play a critical role in facilitating the continuity of care for the older person across different health and aged health services and settings.

Model description

- **Inpatient setting** – the inpatient setting refers to the aged health services provided during an admission to hospital. They may be provided on admission (e.g. assessment), or as part of treatment and/or care during the hospital stay.
- **Outpatient setting** – the outpatient setting refers to the aged health services that do not require hospital admission but are usually delivered on the premises of a hospital (e.g. outpatient clinic).
- **Community setting** – the community setting refers to the aged health services that are provided in the community or home of the older person including outreach and home visiting services.
- **Primary care** – primary care is often the first layer of services encountered by the older person, either through a GP, nurse (including general practice nurses, community nurses and nurse practitioners), allied health professional, pharmacist or Aboriginal health worker. Services delivered include health maintenance, falls prevention, screening, assessment, early intervention, treatment, management and referral to specialist services.
- **Partners** – a wide range of service partners outside of NSW Health and the aged care sector also provide critical components of care for the older person, such as palliative care, private hospital services, ambulance and paramedic services.
- **Transition services** – transition services usually play a time limited role in assisting the older person to move seamlessly between different services and care settings. Functions often include assessment, intake and referral, discharge, follow-up and short-term care.

Figure 2. Aged health service settings model



Inpatient	Community	Outpatient
• Aged care services in emergency teams assessment • ACAT assessment – respite, residential care, Transitional Aged Care Program • Rapid assessment units • Acute geriatric inpatient care • Consultation and liaison services • Specialist shared care services • Inpatient rehabilitation • Older people's mental health units	• Intake and referral services • Rapid response services • ACAT and regional assessment service assessment – Commonwealth Home Support Program, home care packages, short-term restorative care • Home based rehabilitation • In-reach and outreach services • Older people's mental health assessment and management • Dementia counselling and support services • Medical home visits • Community nursing, home visiting services • Community allied health, home visiting services • Day centres and respite services • Community groups, services and education in falls prevention • Non-clinical home support services (includes domestic assistance, home maintenance and modifications, meals, personal care, individual social support)	• Allied health clinics • Medical outpatient clinics • Ambulatory and day hospital services • Neuropsychology clinics

Aged care providers	
• Primary care • Residential aged care • Community aged care • End of life and palliative care services • NSW Ambulance • Private hospitals • Non-government organisations and private services	• My Aged Care • Other My Aged Care services (non-government Commonwealth Home Support Program and home care package providers) • Commonwealth Department of Veterans Affairs • Dementia Support Australia • Mental health services and providers • Primary health network commissioned services

TRANSITION SERVICES
• Transitional Aged Care Program • Post discharge follow up • Rapid response services • ComPacks • Hospital in the Home

Case study

Rapid response teams (the Geriatric Flying Squad)

Liliana, a 92-year-old woman from a residential care facility, suddenly becomes unwell with confusion, shortness of breath and fever. Her advance care plan states that she is for active treatment of potentially reversible problems, but not for cardiopulmonary resuscitation in the event of a cardiorespiratory arrest.

She needs urgent medical attention. Rather than calling an ambulance and sending her to hospital, where she would likely spend hours in an ED before being admitted, the residential care facility calls the local Geriatric Flying Squad. Liliana is reviewed within two hours by a nurse practitioner specialised in the care of the older person and started on intravenous antibiotics in consultation with her family and her GP. She remains in the comfort of her residential care facility to be treated for her respiratory infection.

Case study

Aged care assessment teams

Peter, an 86-year-old man, lives at home alone since his wife passed away suddenly two months ago. His GP notices that he is becoming more dishevelled and is losing weight. Peter has no family close by and does not receive any community services.

The GP is concerned that if something is not done quickly, Peter will either be hospitalised or need residential care and requests an urgent aged care assessment team (ACAT) assessment. The ACAT team visit and note that Peter is vague, his house is disorganised and the washing basket is overflowing. His fridge is empty and his bed linen is soiled.

They organise an urgent geriatrician review to assess his cognition. They also approve Peter for a package of home care, which is immediately put in place. The geriatrician diagnoses dementia, and feels Peter was probably relying on his wife while she was alive. He prescribes some medication for Peter's dementia and, in consultation with the GP, reduces some of Peter's other medications. Community services help with Peter's shopping, cleaning and remind him to take his medications. Peter remains living at home with the help of community services.

The older person's hospital pathway

The hospital pathway for the older person is highly individualised and often non-linear. This model illustrates how NSW Health aged health services are organised along different points in the journey and the high levels of service interdependence across the pre-acute, acute and post-acute segments of the pathway. Potentially preventable hospital admissions should be avoided wherever possible. However, people with severe or rapid deterioration require fast-tracked assessment and timely treatment in hospital.

Model description

- **Initial contact and access** – this is the point where an older person with complex needs, or their carer, presents for health or social care support.
- **Management and planning** – these include the services involved in the initiation, planning, development and continuous review of treatment, care planning and management.
- **Crisis or acute deterioration** – these are the services addressing predominantly unplanned rapid deterioration, which require an immediate response.

Figure 3. The older person's hospital pathway model

Initial contact and access	Management and planning	Crisis and acute deterioration	Acute and specialised healthcare	Recovery and rehabilitation	Palliative and end of life care
Pre-acute		Acute		Post-acute	
• Intake and referral services • General practitioner	• Medical outpatient and home visiting services • Nursing outpatient and home visiting services • Allied health outpatient and home visiting services • Rapid response services • In-reach and outreach services • ACAT and regional assessment service assessment • Wound care, continence care, falls prevention • Ambulatory and day hospital services • Day centre and respite services • Neuropsychology services • Dementia counselling and support services • Older people's mental health assessment and management	• Rapid response services • Aged care services in emergency teams assessment • In-reach and outreach services	• Rapid assessment units • Acute geriatric inpatient care • Consultation and liaison services • Specialist shared care services • Inpatient rehabilitation • Neuropsychology services • Older people's mental health units	• ACAT and regional assessment service assessment • Post discharge follow up • Transitional Aged Care Program • ComPacks • Medical outpatient and home visiting services • Nursing outpatient and home visiting services • Allied health outpatient and home visiting services • Home based rehabilitation • Ambulatory and day hospital services • Wound care, continence care, falls prevention • Day centres and respite services • Neuropsychology services • Dementia counselling and support services • Specialist mental health services for older persons assessment and management	• ACAT and regional assessment service assessment • Medical home visiting • Community nursing and home visiting services • Community allied health home visiting services • End of life and palliative care services • Non-clinical home support services (includes domestic assistance, home maintenance and modifications, meals, personal care, individual social support) • Hospice care

PARTNERS • Primary care • Non-government organisations • Commonwealth Department of Veterans Affairs • My Aged Care • Multipurpose services • Residential aged care • End of life and palliative care services • NSW Ambulance • Private hospitals

- **Acute or specialised healthcare services** – the provision of services provided by specialist aged health services that focus on issues that are unable to be addressed by organ or disease-specific disciplines (e.g. cardiologists or oncologists) or other providers.
- **Recovery or rehabilitation** – a broad range of services that support the holistic needs of the older person as close to their home as possible.
- **Palliative and end of life care** – services provided by an interdisciplinary team of care professionals, whose substantive work is symptom management with people approaching the end of life. Coordination between specialised aged health care services and other aged health services along the pathway are particularly important to ensure specialist advice and input into all stages of patient care planning, treatment and management.

Determining the components of care for the older person should be based on their care requirements and how it meets the needs of the person at any point in time.

It is necessary to have services that undertake care planning and coordination roles across the entire older person's health pathway.

Case study

Home rehabilitation

Elsie, an 82-year-old woman, falls at home and fractures her hip. She undergoes an uncomplicated operation and is well after the surgery. However, her mobility and function are below her baseline level of function.

The local hospital organises for her to have a transitional aged care package so that she can leave hospital early and continue her rehabilitation at home. Elsie is discharged from the hospital, and the interdisciplinary rehabilitation team offer her support and rehabilitation at home until she reaches her peak mobility and functioning.

At the same time, they organise modifications to the home to improve home safety and reduce her risk of further falls. They also communicate directly with Elsie's GP who organises for her to have osteoporosis treatment to reduce her risk of further fractures.

Case study

Advance care planning

Marcus, an 87-year-old man, has advanced dementia and is cared for by his wife Jean.

Since Marcus was diagnosed seven years ago, they have had a strong relationship with their geriatrician and the local hospital. Jean has been looking after Marcus at home with the help of community services delivered through a non-government organisation. Over the years, the geriatrician has communicated with Jean about the terminal nature of dementia.

Jean, Marcus's GP and the geriatrician have discussed an advance care plan for Marcus that revolves around a palliative approach. When Marcus stops walking, Jean can no longer look after him and he enters residential care. The geriatrician continues to care for Marcus in his care facility and the residential care facility is aware of the advance care plan.

When Marcus develops aspiration pneumonia, he already has a plan in place for palliation and he receives comfort care promptly without having to leave his residential care facility or having any unnecessary investigations or interventions. He passes away peacefully in the residential care facility.

Case study

Rapid assessment unit and geriatric rehabilitation

Bill, a 76-year-old man, has lived at home alone since his partner died three years ago. He has a history of hypertension, congestive cardiac failure, bilateral hip replacements and localised prostate cancer. He mobilises with a walking stick indoors and a frame outdoors. He has some home services to assist with housework and shopping, but otherwise manages most daily tasks fairly well.

Bill develops a fever and cough. His legs start to become more swollen. His son visits and notes that he is confused, unsteady on his feet, and too short of breath to perform any of his usual daily tasks. His son takes him straight to the GP. The GP suspects influenza with associated worsening of chronic heart failure and development of delirium. The GP calls the local hospital's geriatrician-on-call and organises admission to the hospital's rapid assessment unit. Bill is comprehensively assessed in a timely fashion and spends a week on the acute geriatric ward being treated by an interdisciplinary team for his acute conditions.

Following resolution of his acute problems, he remains weak and below his baseline level of functioning, and so he spends a further 10 days in the hospital's geriatric rehabilitation ward improving his strength and function. The hospital organises some extra equipment and services to support Bill's discharge and he is discharged back home with a good level of function.

Service distribution with the progression of frailty

Frailty is a common geriatric syndrome that involves increased vulnerability to adverse health outcomes. The health journey of the older person is undulating in nature with episodes of increasing and decreasing biopsychosocial stability. Care for the older person is often characterised by periods of crisis or high acuity, recovery and progressive physical and/or psychological frailty and an extended palliative or end of life period. As a result of increasing frailty, the older person may need a wider range or higher intensity of aged health services.

In this model, each level of frailty lists only the additional aged health services usually needed as a result of increasing frailty. For example, an acutely deteriorating older person may also use aged health services listed under the frail or pre-frail levels.

Model description

Frailty is characterised by five phenotypic criteria: low grip strength, low energy, slowed waking speed, low physical activity, and/or unintentional weight loss.[11] Levels of frailty are often categorised into several different domains, including:

- **non-frail** – the older person is not dependent on others for daily help, however their symptoms may often limit activities. A common complaint is being 'slowed up' and/or being tired during the day
- **pre-frail** – the older person is not dependent on others for daily help but is likely to present one or two phenotypic symptoms
- **frail** – the older person is vulnerable to poor health outcomes and is less able to recover from an acute stress as a result of physiological changes
- **acute deterioration** – a sudden decline in either physical health or function, mental health or cognitive function, or any combination of these.[12]

Figure 4. Service distribution with the progression of frailty model

Non-frail	Pre-frail	Frail	Acute deterioration
Level of frailty ◄ ►			
Key services			
• Falls prevention • Health promotion • Education and activity groups	• Intake and referral services • Medical, nursing and allied health outpatient clinics • In-reach and outreach services • Ambulatory and day hospital services	• ACAT and regional assessment service assessment • Transitional Aged Care Program • ComPacks • Community nursing and allied health home visiting services • Day centres and respite services • Dementia services	• Rapid response services • Aged care services in emergency teams assessment • Rapid assessment units • Acute geriatric inpatient care • Consultation and liaison services • Inpatient rehabilitation

Partners: primary care, residential aged care, palliative care services, NSW Ambulance and non-government organisations

Although frail and acutely deteriorating older people represent a smaller proportion of the population at any given point in time, there is significant service concentration of aged health services providing care to this group.

Services supporting health maintenance for non-frail and pre-frail populations may prevent or delay the older person from reaching frail or acute deterioration.

Partnerships with primary care, community and private health providers play an important role in preventative services and aged care in the home and community.

Case study

Health maintenance

Mavis, an 82-year-old woman, lives on her own and is quite independent. A few of her friends have had nasty falls which have resulted in hospitalisation and some having to enter residential care afterwards due to poor mobility.

Mavis takes the proactive step and visits her GP to talk about her concern that this might happen to her. Her GP refers her to a geriatrician for a comprehensive assessment as well as referring her to the Stepping On program in the LHD. The geriatrician rationalises Mavis's medications to help reduce her risk of falling from polypharmacy. They also identify osteoporosis, for which Mavis begins treatment.

Case study

Home rehabilitation

Nora, a 69-year-old woman, lives at home with Bob, her 67-year-old husband who has frontotemporal dementia. His behaviour can be distressing to Nora at times, and the need for constant supervision has left her feeling tired and stressed. He has also become incontinent, which has caused yet more distress for Nora. Nora's children are worried about her, but don't know what to do. They suggest that Nora takes Bob to the local ED so that he can be assessed and hopefully admitted, giving Nora a break.

Instead, Nora calls the local hospital and is put through to the aged care intake service. Following a brief discussion, the local health service organises a social worker and nurse for Nora and Bob. In addition, the intake officer also puts Nora in contact with a non-government organisation that offers dementia education and support.

After the home visit, the social worker organises day respite for Bob at the local dementia day respite centre and the nurse provides advice around incontinence and continence products. Nora receives invaluable education and support from the non-government organisation. Following these interventions, a crisis is avoided and Nora continues to care for Bob at home.

Decision support template

Purpose of this template

This template determines the potential risks if specific aged health services are defunded or devolved from the LHD to other services providers. It can be used by senior executives, service planners, specialist aged health service staff or clinicians.

While service components and functions for aged health care are described individually and separately in this document, it remains important to keep in mind that these services and functions must be integrated and coordinated for the greatest efficiency and impact. This will often be under the auspices of an aged health focused clinical stream or division within an LHD.

How to use this template

The template can be amended for local requirements to assess the involvement of NSW Health aged health services in an optimal state for specific services. The template provides a structure and guidance to consider the following key areas.

1. Involvement level required by NSW Health aged health services.
2. Identifying the critical components of NSW Health aged health services involvement.
3. Importance of involvement by NSW Health aged health services.
4. Alternative providers that could provide this service.
5. Potential impacts if this service is not delivered effectively.
6. Strategies to help mitigate risk of the impacts.

For each aspect of care, answer the following questions.

1. **What is the required level of involvement by NSW Health aged health services?**

   Rate the level of involvement to ensure best practice care as high, medium or low.

2. **What are the critical components of NSW Health aged health services involvement?**

   List the essential service elements (e.g. rapid assessment, specialist advice).

3. **What is the importance of involvement by NSW Health aged health services?**

   Rate the importance of involvement as critical, important or less important.

4. **What other providers could provide this service?**

   List other non-NSW Health services that could provide this function.

5. **What are the potential impacts if this service is not delivered effectively?**

   Consider risks to patients, NSW Health aged health services and the health system

6. **What strategies can mitigate the risk of these impacts?**

   Describe ways to mitigate the risks identified in question 5 (e.g. referral pathways, service partnerships)

Several examples analysing important aged health services are provided. Modify these examples for your own service.

Examples analysing aged health services

Acute aged health care

1. **Involvement** – High

2. **Critical components**

   - Geriatrician or other physician, with skills in the management of multiple organ system dysfunction, geriatric syndromes including delirium and dementia, polypharmacy, disability and discharge planning of frail older inpatients, and older people with acute disabling illnesses
   - Nursing staff who are skilled and experienced in providing safe care to older inpatients
   - Appropriate ward environment
   - Allied health support (physiotherapist, occupational therapist, social worker, speech pathologist, dietitian, clinical pharmacist, etc.)
   - Geriatric medicine model of care
   - Links to subacute inpatient and community aged health service, ACAT, Hospital in the Home, RACFs, etc. which facilitate discharge or provide an alternative to admission
   - Access to consultations from organ specific specialists.

3. **Importance** – Critical

4. **Other providers**

   Private hospitals (could provide this model of care for privately insured patients within their own facilities).

5. **Impacts**

   - Avoidable admissions
   - Fragmented and incomplete inpatient management
   - Increased length of stay
   - Polypharmacy, including unnecessary use of psychotropic medications
   - Inpatient falls, pressure injuries
   - Deficient discharge planning
   - Avoidable disability
   - Avoidable readmissions
   - Avoidable admissions to RACFs.

6. **Risk mitigation**

   - Universally adopt a geriatric medicine model of care for all older inpatients
   - Develop a generalist perspective, and clinical skills for all staff involved in care of older patients
   - Employ adequate allied health staffing for all inpatient areas (i.e. requires a refashioning of the whole system).

Aged care assessment teams (ACAT)

1. **Involvement** – Low
2. **Critical components**
   - Aged health expertise
   - Medical diagnoses and management.
3. **Importance** – Critical
4. **Other providers**
   - Other medical specialists
   - Allied health
   - Nursing.
5. **Impacts**
   - Increased length of hospital stay
   - Limited communication and integration between hospital and ACAT services.
6. **Risk mitigation**

   Establish strong links to specialist aged health services and geriatricians.

Aged care services emergency team

1. **Involvement** – High
2. **Critical components**
   - Embedded in the ED
   - Nursing and allied health staff with extensive aged health expertise and experience
   - Prompt multi-domain assessment of older people presenting to ED (functional, social, behavioural, carer and support service needs)
   - Strong links with inpatient and community aged health services, RACFs and GPs.
3. **Importance** – Important
4. **Other providers**

   Nil, this service is based in the public hospital ED.
5. **Impacts**
   - Incomplete assessments of elderly ED patients
   - Avoidable admissions
   - Inappropriate and unsafe discharges
   - Representations
   - Poor follow-up (inadequate linkages to community aged health services and aged care support services).
6. **Risk mitigation**

   Enhance general allied health staffing to EDs and deploy geriatric medicine advanced trainees to ED (funding and workforce issues).

Behaviour units

1. **Involvement** – High
2. **Critical components**
   - Specialised unit within acute hospital
   - Dementia friendly environment
   - Nursing staff with expertise and training in managing cognitive impairment
   - Geriatrician and aged care psychiatrist input.
3. **Importance** – Critical
4. **Other providers**

   Nil as needs to be within acute hospital.
5. **Impacts**
   - Poor care of older patients with delirium and/or dementia
   - Longer length of stay
   - Inability to meet National Safety and Quality Health Service standards.[13]
6. **Risk mitigation**

   Use of a delirium dementia clinical nurse consultant within acute hospital wards to provide nursing support.

Community case management

1. **Involvement** – Medium
2. **Critical components**
   - Skilled and experienced aged health clinician
   - Providing support, coordination, monitoring, to older people with complex needs, who live in the community, and who lack the capacity to negotiate, arrange, and adjust their care arrangements. These clients often have cognitive impairments or mental health diagnoses
   - Needs are both short term (set-up) and medium to long term (for some)
   - Connections with other elements of the aged health service, including access to geriatricians.
3. **Importance** – Important
4. **Other providers**
   - Australian Government approved community aged care package
   - Providers (tend to focus on the services provided through the package not overall needs)
   - Private care coordination services (for those who can meet the cost)
   - GPs and general practice nurses (does not fit corporate GP model of care)
   - Fragmented medical care.
5. **Impacts**

   Complications, readmissions, ED presentations, increased length of stay, mortality, avoidable transfers to RACFs, increased complexity of discharge planning.
6. **Risk mitigation**
   - Establish partnerships with or contracting to non-government organisations
   - Add such patients to the target group for the NSW Health Integrated Care Program.

Consultation services

1. **Involvement** – High
2. **Critical components**
   - Specialist advice
   - Shared care.
3. **Importance** – Critical
4. **Other providers** – Nil
5. **Impacts**
   - Increased morbidity
   - Increased mortality
   - Decreased function
   - Poor cognitive outcomes
   - Decreased quality of life
   - More aged care facility admissions.
6. **Risk mitigation**
   - Contract private aged care specialists
   - Employ aged care nurse practitioners
   - Train GPs in comprehensive assessments.

Dementia services (community based)

1. **Involvement** – Low
2. **Critical components**
   - Geriatrician, aged care psychiatrist, neurologist
   - Allied health
   - Nursing including specialist clinical nurse consultants
   - Day centre.
3. **Importance** – Important
4. **Other providers**
   - Non-government providers
   - Private sector.
5. **Impacts**
   - Higher demands on state public sector health services (hospital admissions, ED presentations, etc.)
   - Less carer support
   - Increased RACFs admissions.
6. **Risk mitigation**

   Create strong links to specialist aged health care services (medical, allied health, nursing).

Home-based rehabilitation (post-acute)

1. **Involvement** – Low
2. **Critical components**
   - Geriatric assessment as required
   - Ongoing medical diagnosis
   - Supporting interdisciplinary team with advice with complex patients or deteriorating patient
3. **Importance**

   Less important (although critical for complex patients).
4. **Other providers**
   - Aged care services in emergency teams or Transitional Aged Care Program
   - Other medical specialists
   - Allied health
5. **Impacts**
   - Longer length of hospital stay
   - Increased hospital readmissions
   - Reduced function
   - Increased need for community services.
6. **Risk mitigation**

   Formalise partnerships between providers (private home-based providers, GPs and inpatient aged health service specialists).

Hospital in the Home or specialist geriatric outreach

1. **Involvement** – High
2. **Critical components**
   - (Specialist) medical practitioner
   - Nurses
   - Allied health practitioners.
3. **Importance** – Critical
4. **Other providers** – Private hospital sector.
5. **Impacts**
   - Limited or no alternatives to hospital inpatient admission or management for public hospital patients
   - Access to Hospital in the Home or specialist geriatric outreach subject to cherry picking with more difficult cases left with fewer options except public sector
   - Poorer patient outcomes from service (e.g. readmission, adverse events, etc.).
6. **Risk mitigation**
   - Retain service in public sector
   - Use private sector or alternative providers only if alternative service is superior to public sector model (e.g. volume, skill mix, etc.)
   - Establish service level agreements or contracts with alternative providers, specifying that public patients will have equitable access to care
   - Establish private-public partnerships with public oversight of private operation.

Inpatient geriatric rehabilitation

1. **Involvement** – High

2. **Critical components**
   - Inpatient unit or service
   - Links with acute care and centre-based and domiciliary rehabilitation services
   - Multidisciplinary team (nursing and allied health)
   - Led by a physician with appropriate training, skills and interest, usually a geriatrician
   - Focus on restoring or enhancing independence of frail older patients, who have multiple morbidities, and who have been deconditioned and made dependent by acute illnesses, or disabled by fracture, stroke or other acute events
   - Suitable environment
   - Defined goals and timeframes
   - Regular reviews of patient progress and service performance
   - Comprehensive discharge planning.

3. **Importance** – Critical

4. **Other providers**

   Private rehabilitation facilities for privately insured, less complex, less medically unstable, and better prognosis patients, who need shorter periods of inpatient subacute care.

5. **Impacts**
   - Suboptimal functional outcomes for patients
   - Prolonged acute length of stay
   - Increased rates of transfer to long term RACFs care.

6. **Risk mitigation**
   - Establish a multidisciplinary rehabilitation in-reach services in all NSW Health acute facilities
   - Purchase rehabilitation services from private hospitals for patients with lesser complexity, better prognoses and need for shorter periods of inpatient subacute care
   - Expand NSW Health community-based geriatric rehabilitation services
   - Expand contracts with private providers of community-based geriatric rehabilitation services.

Medical home visits

1. **Involvement** – High
2. **Critical components**
   - Comprehensive assessment
   - Specialist advice
   - Referral to allied health
   - Referral to community services.
3. **Importance** – Critical
4. **Other providers**
   - Private geriatricians
   - Interested GPs.
5. **Impacts**
   - Increased morbidity
   - Reduced quality of life
   - Increased hospital admissions
   - Premature aged care facility admission.
6. **Risk mitigation**
   - Optimise GP and specialist partnerships
   - Optimise GP and specialist referral pathways.

Medical outpatient clinics

1. **Involvement** – High
2. **Critical components**
   - Comprehensive assessment
   - Specialist advice
   - Referral to community services
   - Referral to allied health.
3. **Importance** – Critical
4. **Other providers**
   - Private clinics
   - Interested GPs.
5. **Impacts**
   - Premature hospital admission
   - More hospitalisations
   - Premature aged care facility admissions
   - Reduced quality of life.
6. **Risk mitigation**
   - Optimise GP and specialist partnerships
   - Optimise GP and specialist referral pathways.

Rapid assessment units

1. **Involvement** – High
2. **Critical components**

   Medical specialists, nursing, allied health.
3. **Importance** – Critical
4. **Other providers** – Nil in public hospitals.
5. **Impacts**
   - Increased ED stay
   - Increased ED morbidity
   - Increased total hospital stay
   - Increased hospital morbidity.
6. **Risk mitigation**

   Establish and maintain such services.

Rapid response services

1. **Involvement** – High
2. **Critical components**

   Medical specialists, aged care nurses.
3. **Importance** – Critical
4. **Other providers**

   Private and community services.
5. **Impacts**
   - Increased ED admissions
   - Increased hospital admissions
   - Increased ambulance usage
   - Reduced morbidity
   - Better functional and cognitive outcomes.
6. **Risk mitigation**
   - Involve community and private services (this will only partially mitigate impacts)
   - Develop good relationships and integration between hospital, community and aged care facilities.

Specialist shared care services: acute care of the elderly (ACE) units

1. **Involvement** – High
2. **Critical components**
   - Shared care of older patient between admitting physician and geriatrician
   - Specialised nursing expertise with clinical nurse consultant or clinical nurse specialist in aged care, and multidisciplinary team including pharmacy
   - Age friendly hospital environment
   - Emphasis on patient function and encouragement to remain independent.
3. **Importance** – Critical
4. **Other providers**

   Nil as needs to be within acute public hospital.
5. **Impacts**

   Siloing of care of older patient with organ specific medicine rather than whole person care.
6. **Risk mitigation**

   Use of an ACE clinical nurse consultant and geriatrician to provide care on a consultation basis.

Specialist shared care services: orthogeriatrics

1. **Involvement** – High
2. **Critical components**
   - Shared care of older patients with fragility fractures in the acute hospital between orthopaedic surgeon and geriatrician
   - Includes focus on perioperative care, rehabilitation, and appropriate discharge arrangements
   - High level of allied health input.
3. **Importance** – Critical
4. **Other providers**

   Nil as needs to be within acute public hospital.
5. **Impacts**
   - Less than optimal care for older person with fragility fracture
   - More morbidity, mortality and longer length of stay.
6. **Risk mitigation**

   Establish a consultation service by geriatrician to orthopaedic wards.

Specialist shared care services: surgogeriatrics

1. **Involvement** – High
2. **Critical components**
   - Shared care of older surgical patients between surgeon and geriatrician
   - Focus on perioperative care particularly reduction of delirium and early mobilisation.
3. **Importance** – Critical
4. **Other providers**

   Nil as needs to be within acute public hospital.
5. **Impacts**
   - Less than optimal care for the older surgical patient
   - More morbidity, mortality, and longer length of stay.
6. **Risk mitigation**

   Establish a consultation service by geriatrician to the surgical wards.

Transitional aged care services

1. **Involvement** – Medium
2. **Critical components**
   - Allied health
   - Nursing
   - Geriatrician medical input.
3. **Importance** – Important
4. **Other providers**
   - Private sector rehabilitation services
   - Non-government organisation community service providers
   - Private medical practitioners.
5. **Impacts**
   - Delayed discharge from public hospital from patients who could transition to home
   - Reduced recovery of function post hospital discharge with subsequent greater reliance on health services
   - Increased demand on inpatient rehabilitation services
   - Access to transitional aged care packages subject to cherry picking, with more difficult cases left with fewer options
   - Poorer patient outcomes (e.g. readmissions, adverse events, goal attainment and functional recovery, RACFs admissions, etc.).
6. **Risk mitigation**
   - Retain governance within public sector
   - Develop service level agreements or contracts with alternative providers specifying goals and outcomes
   - Establish private-public partnerships with public oversight of private operation.

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Glossary

ACAT	aged care assessment team
ACE	acute care of the elderly
ACI	Agency for Clinical Innovation
ED	emergency department
GP	general practitioner
LHD	local health districts
RACFs	residential aged care facilities

Appendix A: Service descriptors

Aged care assessment teams and regional assessment services

Purpose

To assess whether older persons are eligible to receive government-subsidised aged care services including home care, transitional care or residential aged care.

Description

Aged care assessment teams and regional assessment services.

Service provider

Nurses, social workers, other health service professionals.

Acute geriatric

Purpose

To care for someone with an acute illness or issue.

Description

Inpatient care provided by a geriatrician and multidisciplinary team.

Service provider

Geriatricians, nurses (including clinical nurse consultants and clinical nurse specialists) and allied health professionals.

Examples

Older persons review and assessment (Westmead), medical assessment units.

Allied health clinics

Purpose

To provide allied health services.

Description

Scheduled allied health services delivered to older persons from the hospital campus.

Service provider

Allied health professionals including speech pathologists, dietitians, physiotherapists, occupational therapists, social workers and podiatrists.

Ambulatory or day hospital

Purpose

To reduce hospital readmission and support transition from hospital to the home.

Description

Care provided to outpatients (often based at a hospital) for acute or chronic conditions.

Service provider

Geriatricians, other medical professionals, nurses and allied health professionals.

Examples

Blood transfusions, antibiotic infusions, other drug infusions, minor procedures.

Aged care services in emergency teams

Purpose

To provide specialised care, assessment and treatment planning in ED with the aim of improving discharge.

Description

Specialised care, assessment and treatment planning in ED for people over 70 years of age.

Service provider

Nurses, medical officers, allied health professionals.

Behaviour units

Purpose

To provide clinical care for dementia and delirium patients.

Description

Specialised units for older people with behaviours related to dementia or delirium.

Service provider

Geriatricians and their medical teams, nurses, psychogeriatricians and their teams, allied health professionals.

Community allied health and outreach

Purpose

- To help the older person with health issues to stay in their own home where possible and practical.
- To provide home assessments to those that, due to frailty or poor mobility, may not present to clinics.

Description

Home or community visits by allied health professionals. Provides home assessment.

Service provider

Community allied health professional teams.

Examples

Dietetics, physiotherapy, podiatry, speech pathology, occupational therapy.

Community nursing

Purpose

To help prevent disease, maintain health and treat any existing health problems. Community nursing aims to support and maintain patient independence, safety and a healthy lifestyle, and assist carers.

Description

Nursing professionals visit the older person at their place of residence. Various functions including assessment, education, health maintenance, treatment of acute conditions, management of devices including catheters and drains.

Service provider

Community health nurses.

Examples

Hospital in the home, hospital follow-up care, general nursing care (including assistance with chronic conditions), palliative care nursing, wound management and continence care.

ComPacks

Purpose

To support older people at home.

Description

ComPacks is a non-clinical case-managed package of community care available for people being transferred home from a participating NSW public hospital.

Service provider

Case managers.

Consultation

Purpose

To provide assessment and management advice.

Description

A consultancy service, led by a geriatrician, for patients admitted under the care of surgeons or non-geriatrician physicians.

Service provider

Geriatricians.

Day centres and respite

Purpose

Centre-based care services that provide short term or temporary care to relieve carers and enhance wellbeing and socialisation for older people.

Description

Social activities and/or day respite services.

Service provider

Community workers.

Examples

Dementia day services, frail elderly care day centres.

Dementia services

Purpose

To provide support to people in the community living with dementia and their carers.

Description

Specific assessment and management options for dementia and delirium patients.

Service provider

Medical, nursing and allied health professionals.

Emergency department assessment unit

Purpose

To provide early specialist assessment of an older person.

Description

Dedicated area in ED for older persons.

Service provider

Geriatricians and trainees, nurses including specialised aged health clinical nurse consultants and registered nurses.

Examples

Health care for Older Persons Earlier (Westmead), ED medical assessment unit (Nepean).

Falls prevention programs

Purpose

To reduce falls in older people.

Description

Programs providing falls prevention information.

Service provider

Various health professionals.

Examples

Stepping On.

Hospital in the home and specialist geriatric outreach

Purpose

To provide an alternative to inpatient (hospital) care.

Description

Clinical care that manages a range of clinical conditions in the home or a residential aged care facility.

Service provider

Geriatricians, nurses including clinical nurse consultants and clinical nurse specialists, other medical professionals, GPs and allied health professionals.

Intake and referral

Purpose

To determine appropriate treatment pathways and referrals.

Description

Point of entry services for patients receiving care that undertake screening and/or assessment.

Service provider

Various health professionals.

Medical home visits

Purpose

To provide specialist care to older people.

Description

Medical assessment in the older person's usual place of residence for a range of acute and chronic medical conditions or for palliative care.

Service provider

Geriatricians.

Medical outpatient clinics

Purpose

To deliver medical assessment and management in a clinic environment.

Description

Either a general focus or a focus on particular issues such as falls or cognition.

Service provider

Geriatricians or trainees.

Older person mental health units

Purpose

To manage care of older people with mental health conditions.

Description

Secure units providing multidisciplinary assessment, care planning and treatment for older people with mental health conditions.

Service provider

Geriatricians, trainees, aged care psychiatrists and trainees and allied health professionals.

Examples

Euroa at Prince of Wales Hospital

Neuropsychology clinics

Purpose

To assess the older person with suspected cognitive impairment.

Description

Provides specialised cognitive and capacity assessment.

Service provider

Neuropsychologists.

Examples

Cognitive Dementia and Memory Service at St Vincent's Hospital.

Palliative care

Purpose

To care for people with a life-limiting illness.

Description

Specialised holistic care as people approach the end of their lives.

Service provider

Palliative care physicians, other medical officers, nurses and allied health professionals.

Post-discharge follow-up care

Purpose

To support the older person following their discharge from hospital.

Description

Assists the older person's transition back home or their place of care.

Service provider

Geriatricians, other medical, nursing and allied health professionals.

Primary care

Purpose

To provide a broad range of holistic care for older people.

Description

A broad range of care including health promotion, prevention and screening, early intervention, treatment, and management of non-admitted patients.

Service provider

GPs, general practice nurses, community nurses and nurse practitioners, allied health professionals, pharmacists, dentists, and Aboriginal health workers.

Residential aged care facilities

Purpose

To provide alternative accommodation for older people who have high-level dependencies and may not be able to live at home.

Description

Provides permanent and/or respite stays to older people.

Service provider

Nurses (registered nurses, enrolled nurses, assistants in nursing), personal care assistants and GPs.

Rapid assessment units

Purpose

To provide specialist assessment, care and treatment for older people for a designated period (usually 48-72 hours) prior to ward or home transfer.

Description

Multidisciplinary assessment for older people with an acute decompensation.

Service provider

Geriatricians and teams, nursing staff and allied health professionals.

Examples

Older persons review and assessment (Westmead), acute care assessment units, medical assessment units.

Rapid response service

Purpose

To avoid hospital presentation by assessing older people at home or in residential aged care facilities.

Description

Rapid community-based assessment and management of acute conditions in frail older people that might otherwise require ED care.

Service provider

Geriatricians, other medical, nursing and treating teams.

Examples

Aged care rapid response teams, Virtual Aged Care Service, Geriatric Rapid Acute Care Evaluation (GRACE), Geriatric Flying Squad.

Rehabilitation

Purpose

Aged health rehabilitation including acute assessment, treatment and return to a previous residence and where possible, independent living.

Description

Services with the aim of restoring function to the older person.

Service provider

Allied health and nursing staff, geriatricians and rehabilitation physicians.

Specialist mental health services for older persons

Purpose

To provide public mental health services for the older person.

Description

Specialist public mental health services for older people.

Service provider

Clinicians specialising in older people's mental health, e.g. nurses, psychologists, social workers, occupational therapists and aged care psychiatrists.

Examples

Local health district community teams, acute and non-acute inpatient units.

Specialist shared care services

Purpose

To provide medical shared care services for older people.

Description

Specialist medical care of older people shared between surgeons, orthopaedic surgeons, physicians and geriatricians.

Service provider

Surgogeriatrician, orthogeriatricians, physicians, geriatricians, nursing and treating teams.

Examples

Acute Care of the Elderly program.

Stroke units

Purpose

To care for patients who have experienced acute stroke.

Description

Specialised management of patients who have experienced acute stroke.

Service provider

Neurologists, geriatricians, other medical professionals, nurses, and allied health professionals including physiotherapists, occupational therapists, speech therapists, dietitians and social workers.

Examples

Multiple acute stroke units.

Transitional Aged Care Program

Purpose

To assist older people to regain physical and psychosocial functioning after a hospital stay.

Description

Short-term restorative care.

Service provider

Nurses, personal carers, allied health professionals and social workers.

Appendix B: NSW Health aged health services decision support template

Service

1. What is the required level of involvement by NSW Health aged health services?

Rate the level of involvement to ensure best practice care

☐ High ☐ Medium ☐ Low

2. What are the critical components of NSW Health aged health services involvement?

List the essential service elements, e.g. rapid assessment, specialist advice. [250 words]

3. What is the importance of involvement by NSW Health aged health services?

Rate the importance of involvement

☐ Critical ☐ Important ☐ Less important

4. What other providers could provide this service?

List other non-NSW Health services that could provide this function. [100 words]

5. What are the potential impacts if this service is not delivered effectively?

Consider risks to patients, NSW Health aged health services and the health system. [100 words]

6. What strategies can mitigate the risk of these impacts?

Describe ways to mitigate the risks identified in question 5, e.g. referral pathways, service partnerships. [250 words]

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
- clinically-led
- evidence-based
- value-driven.

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Our vision is to create the future of healthcare, and healthier futures for the people of NSW.