

National Aged Care Alliance Issues Paper

The Aged Care – Health Care Interface

March 2003

Purpose and Context

Progress toward a “continuum of care” for older people requires policies and strategies for the integration of primary care; community care; health promotion and prevention; rehabilitation; acute; sub-acute; and residential care.

Within this overall context this paper focuses on the Aged Care – Health Care interface and in particular the need for integration of the health service within the Residential Aged Care (RAC) sector with the broader systems of health service provision.

This paper demonstrates that people in residential care are currently in receipt of a sub-optimal internal health service, as well as having sub-optimal exposure to external health service inputs; and argues that this unacceptable state of affairs also has inhibitory implications for the potential introduction of upgraded levels of transitional and palliative health care within residential aged care services.

The paper proposes and specifies an augmented and integrated health service model for the long-term care population.

Introduction

There are major structural impediments to effective and equitable service delivery to older people in Australia that have their roots in the fragmentation of health and aged care services under our Federal system of Government. Our governments need to act urgently to introduce policies to achieve a system of services to which access is determined by the needs of people, rather than the particular point of contact or service setting in which they may find themselves.

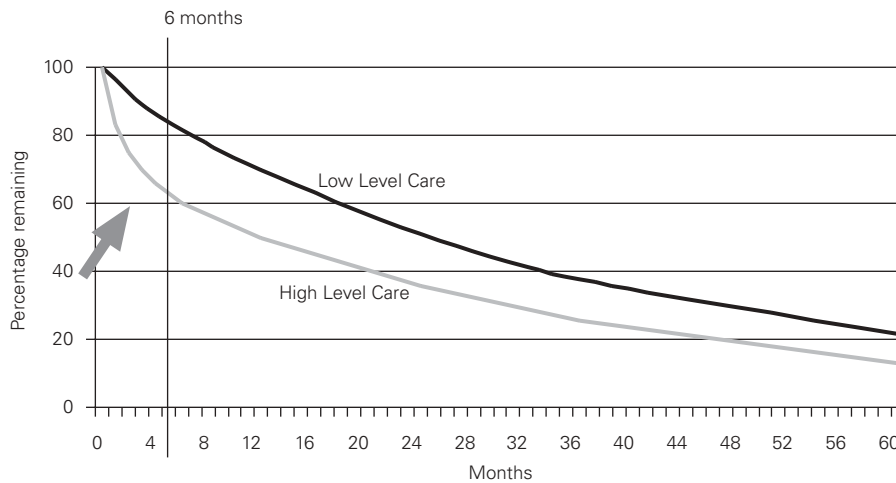
It is now acknowledged that our current service models and settings fail to meet the needs of older people who require a level of care that lies between current hospital and residential care provision: variously described as “sub-acute” or “transitional” or “interim” care.

There are less well-understood but equally significant impediments to effective and equitable health service delivery to older Australians who are housed within Residential Aged Care Services.

Health Care Needs of the Residential Care Population

Figure 1 indicates that many people admitted to high care facilities have a limited life expectancy. However the admission process has financial and legal similarities to purchasing a residential unit, and is inappropriate for people with a short life expectancy, whose care status should really be regarded as transitional, or palliative, rather than residential.

Figure 1 Length of stay 1999–2000 (AIHW: Residential care statistics 1999–2000)



Longer stay RAC populations are by their nature at high risk of, often preventable, illness and injury; and inadequate medical management, rehabilitation, and symptom control as a result of medical conditions shown in Table 1. These conditions require an integrated multidisciplinary health service with specialist inputs and are best managed through the development, implementation and adherence to care pathways based on multidisciplinary clinical guidelines and valid outcome indicators⁽¹⁾.

Table 1 Medical characteristics of residential high care population

Condition	Prevalence %	Reference
Dementia	60*	Rosewarne R, et al. 1997
Chronic Pain	40–80	Ferrell B, 1995
Depression	30–40	Mann AH, et al. 2000
Sensory Loss	80+*	Worrall HL, et al. 1993
Sleep Disorder	45+	Ancoly-Israel S, 1989
Urinary Incontinence	50	Ouslander JG, et al. 1993
Falls	30	Kiely D, et al. 1998
Hip Fracture	7* (incidence)	Pocock NA, et al. 1999

* Australian data

1. Scherer SC. 2001. Australian Society for Geriatric Medicine. Position Statement No. 9, Medical Care for People in Residential Aged Care Facilities. *Australasian Journal on Ageing*. 20, 4, 204–208

Stand Alone Versus Open Long Term Care Health Service Models

The USA has established a 'stand alone' nursing home health service model that includes internal doctors and therapists. The American quality assurance and funding systems aim to jointly drive a high quality internal multidisciplinary health service, designed specifically for the needs of the resident population.

The current Australian RAC subsidy and accreditation systems demand repeated assessment procedures and documentation and purport to fund and assure a quality internal multidisciplinary health service. Whilst accommodation, lifestyle support and personal and nursing care delivery may be of high quality, these systems fail to adequately target effective multidisciplinary evidence-based management for residents' key health care needs⁽²⁾. Doctors have no formal relationship or responsibility to the RAC service and allied health presence is patchy and often at no more than a token level.

Australian RAC residents receive a sub-optimal internal health service, and, partly because they are already in receipt of this "pseudo-stand-alone" health service, they have sub-optimal exposure to external health service inputs – the worst of both worlds.

Toward an Open RAC Health Service Model

Overall, a fully financed, quality-governed, stand-alone RAC health service in Australia is difficult to achieve, and probably not the ideal. The alternative is an open health service model and this has many potential benefits including being in keeping with a health service continuum. Figure 2 outlines the model from the RAC Perspective.

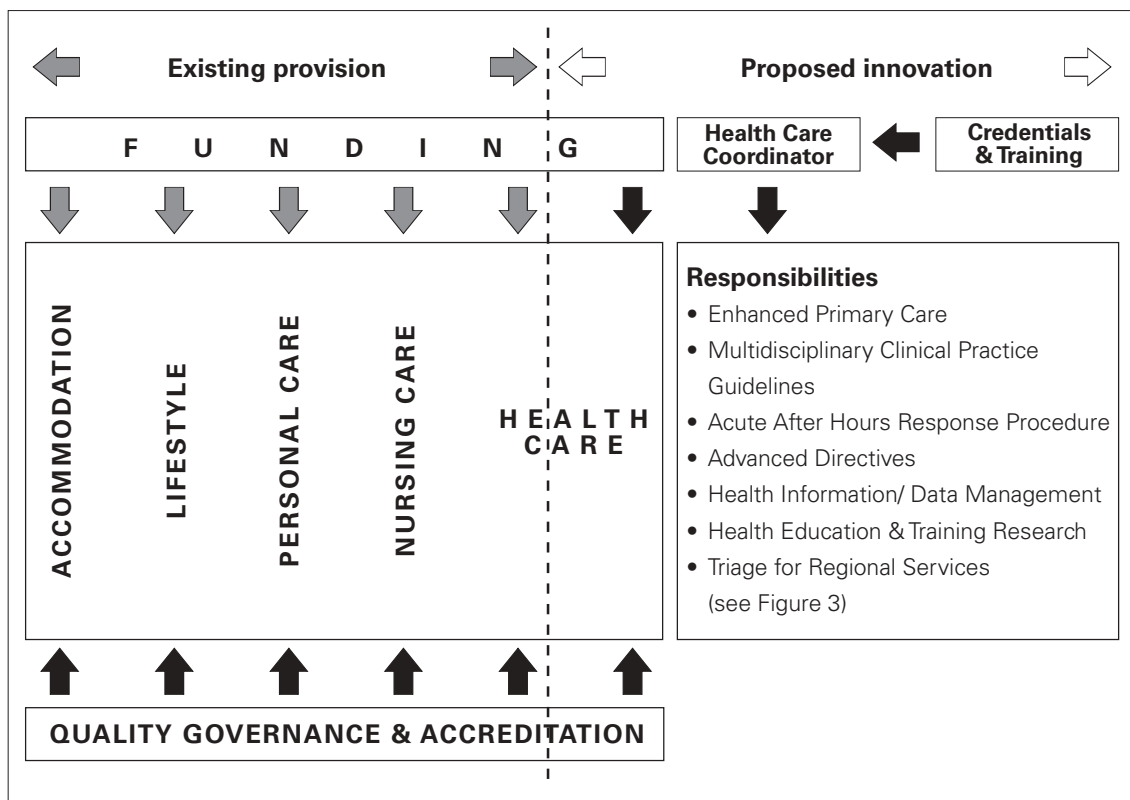
This model would provide the RAC sector with a health service capacity that is equal to the complex multidisciplinary interventional and palliative management needs of current long-term residents, as well as for the introduction of transitional care services. The model is applicable to Community Aged Care Packages and Extended Aged Care at Home programs.

The model preserves the generally positive non-health-service components of RAC, whilst opening the sector to allow it to participate reciprocally with health service providers in a structure that can deliver consistent care pathways across a continuum of health services for older people.

This open RAC health service model would provide the sector with an enhanced capacity to coordinate high quality programs for the prevention and early treatment of acute medical problems such as hip fractures and chest and urinary infections; thereby offering potential overall efficiencies in terms of hospital health care expenditure.

2. Scherer SC. 2002. Australian Society for Geriatric Medicine. Position Statement No. 10, Residential Aged Care from the Geriatricians Perspective. *Australasian Journal on Ageing*. 21, 1, 46–51

Figure 2 Open Health Service Model from the RAC perspective



The model would facilitate the aims of the Enhanced Primary Care (EPC) initiative in integrating the medical dimension of care, and addressing the current low uptake of EPC in RAC. It would also provide the necessary clinical infrastructure for the introduction of international benchmark care systems such as the Resident Assessment Instrument.

In contrast to current wasteful assessment and documentation focused RCS and Accreditation related health care activities; the open model offers productive and effective intervention and outcome-directed health care.

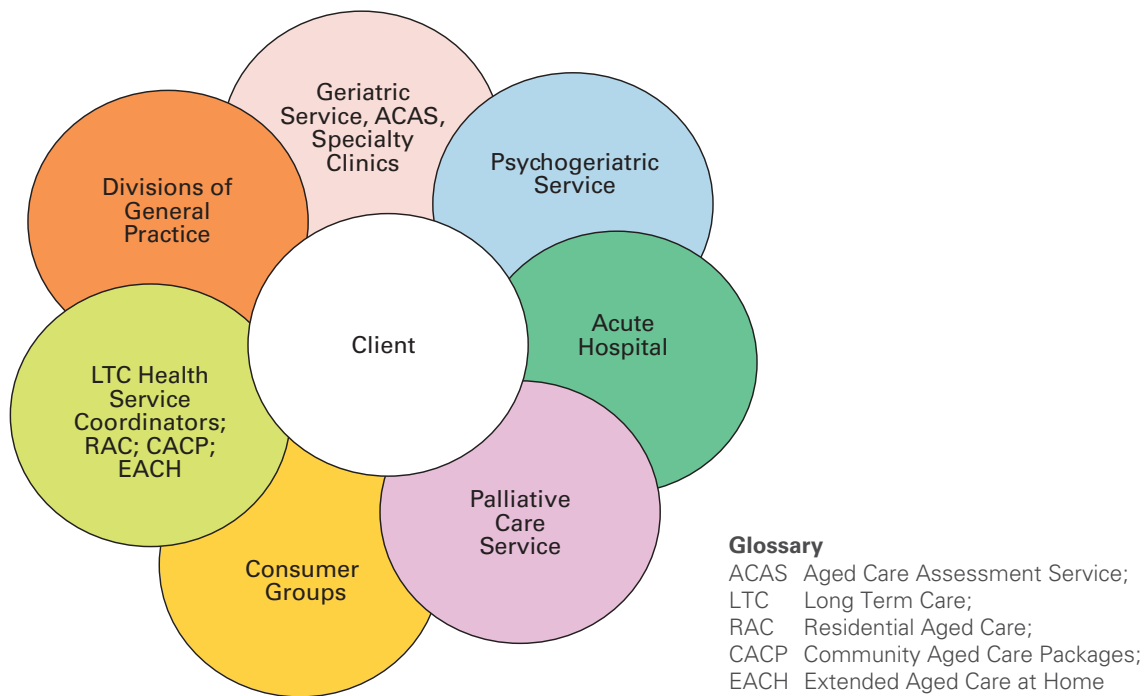
Health service quality governance and accreditation has to date been idiosyncratically managed by the Accreditation Agency, and there is an urgent need for linkage of our RAC health care standards with those pertaining in hospital and community settings.

Credentials and training for the key coordination function will need to be defined. The coordinator would work closely with the general medical practitioner to link the Enhanced Primary Care initiative with agreed care pathways and multidisciplinary practice guidelines, which should include prompts for arranging specialist support in complex cases.

The coordinator function would also incorporate a much needed health information management program for this population and be a focal point for education and training of staff and health professionals, as well as research activities.

Under the model RAC coordinators would have access to a regional network of hospital and ambulatory services. Figure 3 outlines an organisational framework for a regionally based continuum of health services for older people. Networks of RAC Health Care Coordinators would establish formal relationships with: Divisions of General Practice; hospitals (with their developing inpatient bed substitution programs); Community Health Centres; Geriatric Services; Psychogeriatric Services; Palliative Care Services; community nursing and allied health providers; and consumer groups.

Figure 3 Organisational Framework for a Regionally-Based Health Service for Older People



Among other benefits such regional networks will ensure that people in Commonwealth subsidised programs enjoy equal access to regional State and Territory-funded specialty clinical services. Memory Clinics; Regional Continence Services; Falls and Balance Clinics; Movement Disorder Clinics; Pain Management Services; Wound Management Services; and Community Health Centres; all have expertise pertinent to the needs of long term care (LTC) service recipients, but to date funding demarcation and resource issues have limited their penetration into residential care settings.

This health service model would make possible the productive interaction of stakeholders and health services providers across the continuum of care at the regional level: thereby enriching the resources and service options available to both the RAC sector and the health sector; and more especially the effectiveness, economy, range, and equity of access to health services, for current and future older patients and clients of both sectors.

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