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Project Team

Project Steering Committee

Project Reference Group

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<table>
<thead>
<tr>
<th>Table of Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister’s foreword 1</td>
</tr>
<tr>
<td>Introduction 2</td>
</tr>
<tr>
<td>Profile of older people 3</td>
</tr>
<tr>
<td>Normal ageing 3</td>
</tr>
<tr>
<td>Growing numbers of older people living longer 3</td>
</tr>
<tr>
<td>Older Aboriginal people 4</td>
</tr>
<tr>
<td>Cultural and linguistic diversity in the older population 4</td>
</tr>
<tr>
<td>Chronic diseases 4</td>
</tr>
<tr>
<td>Dementia 5</td>
</tr>
<tr>
<td>Growing demand for health services 6</td>
</tr>
<tr>
<td>Other specific risk factors 6</td>
</tr>
<tr>
<td>The health profiles of older people 7</td>
</tr>
<tr>
<td>Adjusting services to match the shifting patient profile 10</td>
</tr>
<tr>
<td>The impact of environment on health and healing 10</td>
</tr>
<tr>
<td>Planning Principles 11</td>
</tr>
<tr>
<td>Service delivery enablers 12</td>
</tr>
<tr>
<td>Supporting older people to take the best care of their health 12</td>
</tr>
<tr>
<td>Improved health promotion and primary care 12</td>
</tr>
<tr>
<td>Improving the restorative care focus of all health services 13</td>
</tr>
<tr>
<td>The health service model for older people 14</td>
</tr>
<tr>
<td>Integrated services 14</td>
</tr>
<tr>
<td>The team approach to providing older people's health service 15</td>
</tr>
<tr>
<td>Regional Older People’s Health Services 15</td>
</tr>
<tr>
<td>Mrs K’s Journey 20</td>
</tr>
<tr>
<td>Regional older people’s health services and facilities profiles 21</td>
</tr>
<tr>
<td>Service delineation 21</td>
</tr>
<tr>
<td>Projected requirements for inpatient and ambulatory care of older people 21</td>
</tr>
<tr>
<td>Health workforce changes 22</td>
</tr>
<tr>
<td>Addressing the needs of specific populations 23</td>
</tr>
<tr>
<td>Older people with dementia, delirium and cognitive impairment 23</td>
</tr>
<tr>
<td>Meeting the needs of older people with mental health conditions 24</td>
</tr>
<tr>
<td>Meeting the needs of older Aboriginal people 24</td>
</tr>
<tr>
<td>Meeting the needs of people of culturally and linguistically diverse background 25</td>
</tr>
<tr>
<td>Meeting the needs of older people in rural and remote areas 25</td>
</tr>
<tr>
<td>Supporting carers 25</td>
</tr>
<tr>
<td>Specialised services 26</td>
</tr>
<tr>
<td>Specialised restorative and rehabilitation services for older people 26</td>
</tr>
<tr>
<td>Cancer care 26</td>
</tr>
<tr>
<td>Stroke care 26</td>
</tr>
<tr>
<td>End of life care for older people 26</td>
</tr>
<tr>
<td>Ageing health and aged care workforce 28</td>
</tr>
<tr>
<td>Adjusting services to match the shifting patient profile 28</td>
</tr>
<tr>
<td>Strengthening partnerships 29</td>
</tr>
<tr>
<td>Working alongside other regionalised services 29</td>
</tr>
<tr>
<td>Next steps 30</td>
</tr>
<tr>
<td>The Statewide Geriatric Clinical Network 30</td>
</tr>
<tr>
<td>Responding to changes 30</td>
</tr>
<tr>
<td>Evaluating the outcomes of the framework 32</td>
</tr>
<tr>
<td>Timeframe for action 32</td>
</tr>
<tr>
<td>Appendix 1: Policy context 33</td>
</tr>
<tr>
<td>Appendix 2: Developing the framework 35</td>
</tr>
<tr>
<td>Appendix 3: Feedback used to inform the framework 36</td>
</tr>
<tr>
<td>Glossary 38</td>
</tr>
<tr>
<td>References 41</td>
</tr>
</tbody>
</table>
Minister’s foreword

South Australia, like all other states and territories, has an increasingly older population. The number of older people in our community is steadily increasing as the baby boom generation ages.

There is great diversity in the older population in terms of life experience, cultural background, lifestyle and health and well-being.

South Australia respects and recognises the integral role older people play in the community as active and participatory citizens. Older people continue to make significant contributions to many aspects of our community prosperity, cultural richness and well-being.

They provide a wealth of valuable experience, through participation in social and cultural life and as custodians of our history. Older people work as volunteers, play an active role in the lives of grandchildren, provide care to family members and act as mentors to future generations.

Older people want to enjoy good health and remain active and independent for as long as possible. As people get older, remaining independent often depends on health and social care services being effective enough to support them.

South Australians want a sustainable health service that can meet the needs of current and future generations of older people and support them to age positively.

This Health Service Framework for Older People sets out the government’s directions for health services for older people now and into the future.

It recognises that older people are more likely to have more complex health needs and require access to a full range of primary, chronic and acute care services. They will benefit too from intermediate care initiatives designed to bridge the gap between hospital, community-based service and home either as part of rehabilitation after an acute event or where a problem can be more appropriately managed by out-of-hospital measures.

The Framework identifies the strategic directions and investments that will be made by SA Health to better meet the health care needs of older people.

The Framework has as its foundation:

> supporting older people, inclusive of specific needs populations, to take the best care of their health
> strengthening the restorative focus of health services to better meet the needs of older people
> establishing coordinated specialist services to ensure high quality health care for older people with complex needs
> strengthening partnerships with general practice and aged and community care sector
> supporting informal care/carers.

Hon John Hill MP
Minister for Health
Introduction

South Australia’s Health Care Plan 2007–2016 describes an increasing demand for services for older people in the coming years\(^1\). Planning to meet this increase presents a series of challenges which include the community’s expectations of continued access to high quality evidence driven services for people as they age, who increasingly are living alone and with fewer available family members able to provide support.

This Framework sets out the strategies and investments that SA Health will undertake in response to the future health service needs of older people. The key initiatives contained within the Framework and the enablers for achieving the intended outcomes are summarised in Table 3 on page 31.

The overall objectives of this Framework are to:

- maximise the period in which older people maintain good health and wellness
- compress the period in which they transition to ill-health, become frail and increasingly dependent on care
- deliver services and programs that keep older people out of hospitals and shift the balance of care toward care provided in the community
- deliver services that are integrated across the continuum of care and promote smooth transitions between the care settings that exists along that continuum
- position at the ‘right places’ along the continuum of care, the right types of services that specialise in care of older people in ways that ensure the sustainability and efficacy of those services
- reduce dependence on the health and aged sector over the long term and promote cost effective outcomes for SA Health.

Vision Statement

Older people will have healthy lives at home
Wellness, functional independence and enhanced resilience
Access to right service, right time, right place and right team
Quality care at end of life with dignity and respect
Profile of older people

Normal ageing

There is great diversity in the health and wellbeing of older people. Many older people remain healthy well into their seventies and beyond while others experience increasing levels of ill health. Normal ageing involves physical and mental changes which may impact on sight, hearing, memory, motor sensory skills, mobility and balance. Ageing also brings an increased risk of developing chronic diseases and other age related diseases such as cancer. The rate of ageing varies between individuals and is influenced by genes, behaviours and environments. Socioeconomic disadvantage and a range of environmental factors are known to increase the incidence of disease or disability later in life.

The ageing process is experienced and understood by older people and the broader community in many different ways. Differing values, cultural beliefs, expectations, experiences and stages in the life span all influence the meaning of health and wellbeing for older people.

Growing numbers of older people living longer

The population of South Australia is ageing rapidly. South Australia has one of the highest proportions of older people in the nation, with one in six people over the age of 65. In 15 years, this rate will nearly double, as the “baby boomer” generation ages. The increase in the number of South Australians aged over 85 is expected to peak during 2010–2015 and is not expected to slow until 2020.

Figure 1

SA projected population profile in 2016

Copyright Government of South Australia (Planning SA) 2008

Women are living longer than men with the number of women aged 80 years and over predicted to be almost double that of men in 2016.

The population of older people across SA is scattered unevenly across SA and allocation of services for older people need to take account of this.
Table 1
Profile of SA's population of older people across SA.

<table>
<thead>
<tr>
<th></th>
<th>Project number of people over 70 in 2016</th>
<th>% of all South Australians over 70 yrs</th>
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</thead>
<tbody>
<tr>
<td>Northern Adelaide</td>
<td>41,667</td>
<td>19.7</td>
</tr>
<tr>
<td>Central Adelaide</td>
<td>59,558</td>
<td>28.1</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>45,254</td>
<td>21.3</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>146,479</td>
<td>69.1</td>
</tr>
<tr>
<td>Mt Gambier</td>
<td>7,662</td>
<td>3.6</td>
</tr>
<tr>
<td>Riverland</td>
<td>4,363</td>
<td>2.1</td>
</tr>
<tr>
<td>Pt Lincoln</td>
<td>3,162</td>
<td>1.5</td>
</tr>
<tr>
<td>Whyalla</td>
<td>5,380</td>
<td>2.5</td>
</tr>
<tr>
<td>Country – Country General Hospitals</td>
<td>40,996</td>
<td>19.3</td>
</tr>
<tr>
<td>Gawler</td>
<td>8,305</td>
<td>3.9</td>
</tr>
<tr>
<td>Southern Fleurieu</td>
<td>9,187</td>
<td>4.3</td>
</tr>
<tr>
<td>Adelaide Hills</td>
<td>7002</td>
<td>3.3</td>
</tr>
<tr>
<td>Country – periurban</td>
<td>24,494</td>
<td>11.6</td>
</tr>
<tr>
<td>Total</td>
<td>211,969</td>
<td>100</td>
</tr>
</tbody>
</table>

Older Aboriginal people

In general terms, this Framework refers to older people as those aged over 65 years. Consistent with current Australian Government guidelines, older age for Aboriginal and Torres Strait Islander peoples starts at 50 years. Although individual Aboriginal people may not feel themselves to be old at 50, the reduced average lifespan and the compounding effects of co-morbidities in this population often mean that the effects of ageing can be manifest in people as young as 45 and services designed with older people in mind, may be beneficial. Only 3.5% of the South Australian Aboriginal population are aged 65 and over. The Framework returns to the care of older Aboriginal people on page 24.

Additional information and planning is required to ensure SA Health’s services are properly targeted to meet the needs of older Aboriginal people. The development of an Aboriginal Health Strategy will assist with this task.

Cultural and linguistic diversity in the older population

One in five (48,400) of the older SA population were born overseas, mainly in non-English speaking countries. This population is expected to grow to over 57,000 by 2011 with the largest growth in the Italian, Greek and German communities followed by the Chinese and Vietnamese.

This cultural and linguistic diversity presents challenges for the provision of services in terms of the need for bilingual support and culturally safe services and ability to access care from families.

Chronic diseases

Older age is a phase of life in which people expect to continue to build on their plans, aspirations and goals. However, these possibilities are compromised when ageing is associated with chronic disease and social marginalisation.

Older people are more likely to have chronic diseases (e.g. diabetes, cardiovascular disease), with often increased co-morbidity which can include neurodegenerative conditions e.g. memory, cognition, behaviour, motor sensory functioning, mobility and balance disorders.

In 2006/07, older people reported that their highest prevalence of chronic conditions were arthritis and cardiovascular disease, with diabetes and osteoporosis (for women) the second highest.
The risk of developing cancer, dementia and Parkinson’s disease or serious injury from falls also increases with age. When coupled with smoking and/or excess consumption of alcohol the risk is even higher.

The more chronic conditions an individual has, the greater the risk of serious illness and disability, injury from falls, reduced mobility, increased usage of health and community services (especially in the last two years of their life) and premature death.

These conditions and the associated effects of polypharmacy affect an individual’s ability to stay active and retain their health and wellbeing.

South Australia’s Health Chronic Disease Action Plan describes the expanded and redesigned services that will be put in place to prevent and/or manage avoidable chronic diseases. The Health Service Framework for Older People compliments this plan and includes specific services for older people with a range of chronic disease, such as dementia.

**Dementia**

Dementia will be a continuing health care issue for South Australia. Dementia affects the functioning of the brain, often leading to personality changes. The effects are severe and affect the physical, social and emotional life of the person with dementia and their carers. Although dementia mainly affects older people, it is not a normal part of ageing.

Dementia can be found across the social gradient, in rural populations and culturally and linguistically diverse communities. Older Aboriginal people have a different pattern of dementia due to shorter life expectancy and increased risk of vascular disease. Dementia onset can also be present in people younger than sixty years of age and people with disabilities.

The health care sector must be able to effectively care for people with dementia in the light of increased demand. There is a particular need to strengthen the overall workforce understanding and responsiveness across dementia care, along with improved care across the acute, sub-acute, aged care interface.

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Profile of older people

Growing demand for health services

In 2005, two out of three older South Australians self-reported as having good, very good or excellent health and many healthy older people manage their own health and wellbeing. They rely mostly on primary health care services with occasional use of hospital services for emergency or planned treatments including elective surgery.

However, as people age, they are more likely to access health care and take advantage of the technological and medical advances designed to improve joint, heart and kidney functions, and treatable cancers.

SA Health is experiencing significant demand for emergency and other hospital services by older people with complex health needs. In 2007, there was a 10.7% increase in the number of hospital admissions from emergency departments and older people requiring general hospital services, along with discernable increases in demand for care at home.

People aged between 65–75 years are twice as likely to be admitted to hospitals as the rest of the population and those aged over 85 years are more than five times likely to be admitted to hospitals.

Older people with complex health needs due to multiple medical, social, cognitive and physical issues tend to have more visits to general practitioners and allied health professionals, use hospitals more frequently and for longer periods and are prescribed more medication.

They also often take longer to recover from an illness or injury resulting in the need for interventions over a lengthier period and involvement of community and aged care services.

Reduced access to general practice and other primary health care services in some metropolitan and country areas contributes to a well-described trend where people who don’t need to be admitted to hospitals seek treatment through hospital emergency services.

Older people also have particular health service needs. Those over 65 years currently make up 15.3% of the South Australian population, but make up 65.5% of those hospitalised for injuries caused by falls. They account for 74.1% of all hip replacements and 64.2% of all knee replacements.

The demand for sub acute, rehabilitation, palliative and ongoing care services is also higher among the older population.

Some older people will not benefit from rehabilitation following serious injury or illness and they require ongoing care provided by community and aged care services including residential care.

As demand for suitable community and aged care services grows, there will be increased need for ‘care waiting placement’ services that ensure the safe and smooth transition between health services and community and aged services. It is expected that demand will continue growing until 2020 when the rate of older population growth is predicted to start slowing.

With the majority of older people having a preference to remain in their own home as they age, there is increased need for community services and increased reliance on family and carers as their fragility increases.

The key challenge is to deliver person-centred health care for older people that maximises their function and independence through access to a flexible range of general and specialist health services.

These services will deliver the right care (including end of life care), by the right team, in the right place at the right time, reduce avoidable hospital admissions and provide quality safe coordinated care across the continuum.

Other specific risk factors

Caring long term for others can itself be a health risk. Over two thirds of the State’s primary carers are women and as they age, this role can adversely influence their own health and wellbeing.

Older people with low socioeconomic status and unmet health and wellbeing needs are likely to experience earlier the effects of ageing.

Older people value their independence and having choices and the respect of society, all of which can be undermined by increased frailty associated with ageing linked to poor health and or disability. This is particularly challenging for people with long-standing disabilities and those who age prematurely from other causes.
If left untreated, increasing frailty is a greater predictor of future disability and death, than age alone.\(^{11}\) The contributors to frailty are complex and interconnected. They include a history of weight loss, excessive fatigue, poor exercise tolerance, low activity during the day and poor grip strength linked to disease related, psychological and social problems.

Older people often find they have to cope with grief and loss associated with the death of life partners and others within their generation or community whilst coming to terms with their own mortality. There is evidence that loss of control of one's life leads to poor health outcomes.

### The health profiles of older people

The years ahead will bring a predictable increase in the number of older South Australians. In particular, this will also result in a growth in the number of older people developing complex health needs and requiring significant interventions and support from health, community and aged care services in order to maintain their quality of life and an independent lifestyle.

Notwithstanding the older person's age, it is their membership in one or more of the following health profiles that will determine their present or future health needs. It is important to understand that membership in these groups is not fixed and can vary overtime according to personal health circumstances. The health profiles are summarised in the following way:

#### Healthy older people

Health goals for healthy older people reflect their wish to retain independence and autonomy and remain healthy for as long as possible. This requires ongoing focus on maintaining physical and mental wellbeing including attention to oral health, strength and mobility and social connectedness.

#### Older people at risk

Health goals for older people at risk add a specific focus on modifying risk factors in addition to the overall focus on retaining health and wellbeing. This may include modifying diet and other lifestyle factors such as smoking or alcohol consumption, keeping control of blood glucose and cholesterol levels, and taking positive steps to maintain strong bones, a healthy weight and a healthy level of social integration.

#### Older people needing acute care

At times older people experience acute illnesses or traumatic injury that requires urgent presentation to hospital for intensive medical or surgical care. In these circumstances the goal is to recover quickly without suffering any long term functional decline. Maintenance of behaviours aimed at retaining health and wellbeing and managing risk factors during episodes of acute illness is very important. System-level planning to facilitate the movement of older people through the health care system on a pathway towards a return to full health is a major focus of this Framework. The ambulance service and the emergency department play key roles in the early phase of this care.

#### Older people with chronic conditions

Many older people live with chronic conditions such as arthritis, diabetes, chronic obstructive pulmonary disease and cardiovascular disease. In these circumstances the focus is on minimising disability arising from these conditions, preventing complications and acute exacerbations of the conditions as well as life style modification to address risk factors.

#### Older people with complex chronic conditions

Some older people have multiple chronic conditions, associated disabilities and or cognitive impairment. Older people in these circumstances require assistance to ‘navigate the system’ and support through coordinated management, treatment and care to reduce the combined impact of these conditions and to prevent complications and exacerbations which may further complicate care. Taking precautionary measures to prevent acute illness is a very important focus and requires continued attention to those actions associated generally with the maintenance of health and social connectedness combined with use of appropriate vaccinations and other preventive measures.
**Older people at end of life**

For most older people there is a period of time when the approach of death is recognised and acknowledged at some level. End of life care describes care that is planned for, negotiated with, or provided to a person at the end of their life. It is used without specific reference to timeframes and hinges instead on the orientation toward providing care appropriate for a natural life event and the ordinary place of death within a person’s lifespan. There is an emphasis on quality of life, and dignity-preserving care. Older people differ in their preferences and experiences at end of life. For some, this period is relatively short and sudden, while others experience gradual or fluctuating decline and increasing frailty due to a terminal illness such as cancer or from complications arising in the end stage of a chronic disease.

**Older people with specific needs**

There is a great deal of diversity within the older population living in South Australia and this influences the health goals of individuals and the responses which are appropriate. These specific factors including spiritual, cultural, environmental, emotional, social and economic will interplay across each health profile in different ways to influence the behaviour of the individual and their family and the role of health services in providing support, treatment and care.

**Older people with carer roles**

Many older people provide a carer role to their parents, spouse, children, grandchildren and others. It is very important that people caring for others are able to also focus on their own needs and receive support and assistance including respite from the carer role in order to retain their health and wellbeing.

**Living arrangements can influence health**

Most older people are able to live independently in their own homes and access family, friends and community assistance as their needs change. Only a minority move to some form of supported accommodation including residential aged care facilities.

Living arrangements particularly for frail older people have implications for health service delivery and access to informal care from family, friends and health professionals.

At the moment older men are twice as likely to be living with their partner as older women, and one in four people live alone with the majority of these being women.

One in three older people live in country locations. If driving a car is no longer possible using appropriate transport to access even local health services becomes a major challenge for both country and city residents.

In 2026 it is projected that up to 42% of the 75+ population in SA (62,000 women and 22,000 men) will live alone with the number living in non-private dwellings expected to be between 6–15% of all people in this age group. The remaining population will be living with their partner who is likely to be of a similar age.

**Planning better health services for older people**

Segmenting the population using health profiles helps health planners and clinicians rethink how health services need to be organised or redesigned to meet the varying needs that predictably arise for particular groups of older people. This planning approach can lead to a better system-wide understanding of the sorts of skills, roles and interventions that need to be in place, and where in the system they should be located, to have the best impact on health outcomes for older people. This type of planning aids in the delivery of a sensible and sustainable array of services and system responses to ensure safe, efficient, effective, timely, patient centred, and equitable health care to those who need it, where and when they need it.

The following diagram illustrates the relationship between various health profiles and the transitions between them made by older people.
Of particular value in this health planning approach is the value and importance of focusing on the transitions that older people will make as their health needs change. In this respect, phase changes such as ‘entering old age’, being diagnosed with a ‘age-related illness’ and those transitioning into an ‘end of life phase’ represent critical moments for rethinking the sorts of services, resources and intervention that are required, and just as importantly, where in the system these are best located or utilised.

For example, in the early phase of the ageing process as older age approaches, a ‘window of opportunity’ is present to build health literacy and reinforce the foundations of healthy lifestyles. This can be achieved through eating and exercising well, taking advantage of a variety of disease prevention programs and services which aim to maintain and extend the healthy living well into later years. These programs and services are best located in the primary care sector.

For those older people who have just received a diagnosis of a chronic health condition, and may be experiencing the early stages of that illness, the goal is to provide the right programs and services that identify emerging health problems early and encourage the development of effective self-management skills. Again the best place for this to take place is in primary care settings.

The planning focus is directed toward the provision of flexible community-based care and support service responses that optimise functional and psychosocial independence to ensure that older people maintain the highest possible levels of independent living and social integration within their community.

The planning and delivery of appropriately targeted health care and support services to older people who are transitioning through areas of the hospital as their level of acuity changes are critical, as is the planning about what takes place outside hospitals (both before they are needed, and after they are used).

This requires integrated planning along the entire continuum of care including primary care, acute care, sub-acute, and across transitional, community and residential aged care settings. Across this continuum services will need to support and reinforce a wellness and self-management approach.
With these profiles in mind, older people will need varying service responses and differing supports to:

> stay well at home for as long as possible whilst adapting to age related changes with assistance as and when required
> have access to relevant, understandable, quality health information
> have timely access to primary health care services
> have timely access to health services for single acute episodes and or ongoing management of chronic conditions in the primary health care, ambulatory, out-of-hospital and in-hospital settings
> have timely access to interventional, rehabilitative, restorative and end of life care services as required.

The South Australian Government and SA Health have already begun the process of system-wide reform through the Generational Health Review and South Australia’s Health Care Plan. Many innovative and creative initiatives are now in place and more will be done in the years ahead to build on these opportunities to improve services for older people.

These changes will ensure that older people have access to the best available health care in hospitals, health care centres, at ‘home’ and through an integrated team of primary care and specialist health practitioners and family/carers. The key directions outlined in the framework focus on:

> supporting older people to take the best care of their health
> strengthening partnerships across the in-hospital, community based and primary care sectors and residential and community aged care
> strengthening the preventative and restorative focus of health services to better meet needs of older people
> establishing coordinated specialist services to ensure high quality health care for older people with complex needs
> supporting informal care/carers.

Adjusting services to match the shifting patient profile

Historically, hospitals have been organised to meet the needs of a younger patient profile. Establishment and expansion of services driven by the rapid expansion of the population at the time of the ‘baby boom’ saw the development of service models and associated skill base of the workforce to match this young age profile.

The SA Health Care Plan identified the need to redefine these traditional service models, redesign access routes into hospital system and to adjust the workforce blend and skill mix in order to meet future requirements.

The existing workforce is dedicated and professional but will need additional support to respond to the increasingly complex needs of older people and increase demand for existing and different services. The health workforce needs to be skilled in delivering ‘age friendly’ services in and out of hospitals.

Reshaping and increasing services will require consideration of the involvement of carers, volunteers and other yet to be developed health professional roles.

The community and aged care sectors face similar workforce challenges and are interested in long term solutions that achieve a balanced workforce across the health, community and aged care sectors.

The impact of environment on health and healing

As the population ages the needs of older people require consideration in relation to facility design.

In line with the State Ageing Plan: Improving with Age, the Framework aims to ensure hospital facilities provide an environment that is older person-friendly, takes into account an older person’s strengths and abilities, protects against harm and empowers the person or their care giver to be actively involved in decision-making.

The hospital setting should be designed and managed to minimise the impact of an unfamiliar environment and cater to the specific needs of older people who may be experiencing declines in perception, cognition and control of movements associated with ageing.

The relationship between service providers and older people should be supported to promote health, maximise independence and minimise functional decline.
Planning Principles

The reshaping of health services to meet the diverse health needs of older people reflects the following principles:

> healthy ageing and individual responsibility for health will be promoted and supported across the health system
> older people are central in the delivery of right care, at the right time by the right team and have the right to make their own decisions unless unable to do so
> maintenance of physical and cognitive function and prevention of functional decline are a priority across the care continuum
> services will assess and manage the diverse and complex needs of older people in suitable age friendly environments as close to home as possible
> communication and teamwork between health professionals, older people and carers will achieve coordinated, safe, quality and effective care including end of life care.

These principles have been adapted from relevant national and state policy directions and guidelines for the health care of older people (See Appendix 1).
Service delivery enablers

The following diagram illustrates the enabling factors and opportunities that are present in a stepped health system, and the relationships between the aged and community care sector and the health goals of older people.

**Figure 4**

Enabling factors and opportunities that are present in a stepped health system

Supporting older people to take the best care of their health

An older person with a good health profile is usually the result of healthy genes, favourable socioeconomic, cultural and environmental circumstances, healthy lifestyles and good access to health care services.

Good health for older people involves healthy ageing. Healthy ageing is more than the sum of a health profile. It means older people are valued, are able to lead active lives as part of their communities and are engaged in decision-making about their health care along with maintaining healthy lifestyles. Access to appropriate health services, transport, adequate income and safe and suitable housing are essential to this goal.

The wellbeing and social integration of older South Australians can be supported by:

- promoting the ‘health in all policies’ approach taken by the SA Strategic Plan
- implementation of the State Ageing Plan ‘Improving with Age’ in particular actions that strengthen healthy ageing
- promoting a positive image of older people in service planning and service delivery.

Improved health promotion and primary care

Primary prevention strategies for older people are included in the SA Health Primary Prevention Plan. The foundations for healthy ageing are established early in life and continue throughout the lifespan.

This plan covers secondary and tertiary prevention, health promotion and early intervention strategies that help retain or regain the health and wellbeing of the older person consistent with their potential capacity. There is sound evidence that health is not fixed in childhood, small gains accumulated across the life span and preventative steps taken in middle age and older years can improve health and wellbeing.

The increasing prevalence of chronic diseases is linked to unhealthy lifestyles, particularly the consequences of under nutrition, obesity, smoking, alcohol and a lack of physical exercise.

Exposure to ageism or elder abuse further threatens the health and wellbeing of older people. In addition, older people often find they have to cope with grief and loss associated with the death of life partners and others within their generation or community whilst contemplating their own mortality.
Primary health care services have a key role in the provision of health and lifestyle education, illness prevention, the promotion of mobility, independence and positive living to support older people living socially connected lives. Preventive programs such as the Falls Prevention Program offer older people opportunities to access muscle strengthening programs and general awareness about preventing falls.

South Australian GP Plus Health Care Centres (which include Australian Government funded Super Clinics) will increasingly help older people take control of their health care, stay healthy and out of hospital. These centres and a range of other primary health care services will promote opportunities for older people to maintain and enhance their wellbeing and independence through:

> increased focus on healthy physical and mental activity, mobility and strength programs
> access to annual health checks including physical, mental and oral health, sight and hearing, strength and mobility and medication reviews
> better support for achieving good nutrition, reducing under-nutrition and promotion of evidence based practice in vitamin and calcium supplementation for older people
> screening of bone density for women entering menopause
> focussed anti-tobacco and alcohol harm minimisation programs
> promoting vaccination against infectious diseases
> promoting referral of older people with lifestyle risk factors to chronic disease lifestyle coordinators
> grief and loss counselling.

GP Plus Health Care Centres and other primary health services will continue to build on existing falls and fall-related injury prevention and early intervention strategies and expand regional wellness services that support at risk older people manage memory loss, continence issues, mobility problems and mood changes associated with grief and loss. Research and feedback consistently confirms that older people wish to stay in their homes as they age. Supporting this preference requires some reshaping of SA Health services. Delivering person-centred health care for older people involves maximising their function and independence through access to a flexible range of general practice, primary health care and ambulatory care services and specialised health services.

These services will deliver the right care (including end of life care), by the right team, in the right place at the right time, reduce avoidable hospital admissions and provide quality safe coordinated care across the continuum.

**Improving the restorative care focus of all health services**

As the population ages the majority of people admitted to hospitals will be aged over 65. Many of these people will have multiple chronic conditions in addition to any particular acute illness that precipitates their admission to hospital. Preventing loss of physical and cognitive function and exacerbation of chronic conditions while simultaneously treating the acute illness requires an integrated approach that will require different ways of working, assessing, treating and caring for patients.

An admission to hospital can often be associated with disability and cognitive disturbances such as confusion, delirium or dementia which impact on the older person's social networks and ability to remain independence. These conditions require expert assessment and management from interdisciplinary teams to achieve stability and improvement.

Emergency Departments are significant entry points to hospital care for older people. Increasingly with better management of chronic diseases and enhanced health care in the community, more older people can avoid the need for presentation at an Emergency Department and others will access hospital services via other flexible entry points. This may include direct planned admission from community to specialist services.
The health service model for older people

The integrated health service model described is person and family/carer centred. The service model spans the continuum of care and includes a specific focus on:

- promotion of healthy ageing and illness prevention
- early identification and management of lifestyle and age related risk factors
- effective management of chronic conditions and age related changes to enable people to remain at home for as long as possible consistent with their preferences
- promotion of advance care planning
- reducing unplanned admissions to hospitals
- timely comprehensive, interdisciplinary assessment and management of emergency and acute care and ongoing care needs
- appropriate restorative rehabilitation following illness or injury
- effective transition to community based aged care services for those requiring ongoing care
- end of life care that places an emphasis on quality of life, the relief of symptoms, support for family and the preservation of dignity at end of life.

SA Health will re-orientate services to improve health services for older South Australians. This means the health system will:

- promote mobility, independence and a positive outlook in older people
- support older people recover from illness and injury through restorative approaches
- provide specialised health services for those with complex health care needs.

As a result, older South Australians can expect that person-centred services will be delivered closer to home and be linked to appropriate community and aged care services as required. Effective partnerships between health and the community aged care sectors will support older people achieving:

- more healthy years of life
- enhanced function with reduced disability
- improved capacity for self care and self management of chronic diseases
- improved access to coordinated health services across the care continuum
- quality care, active symptom control and the preservation of dignity at end of life.

Integrated services

Effective collaboration across clinical settings and services, across disciplines and across the public and private sectors are hallmarks of system integration.

The key strategy of the Framework is the establishment of specialised interdisciplinary older people’s health care services that work across all care settings within a defined service catchment. This includes homes, residential care facilities, GP Plus Health Care Clinics, and the outpatient and inpatient areas (including rehabilitation services) of hospitals. These regionalised older people’s health services will use a common model of care and approach to service delivery utilising an integrated interdisciplinary approach.

These regional teams will apply their collective specialist expertise, knowledge and skills at key points along the continuum of care and deliver a range of older people-specific services that will be integrated with, support and enhance those services provided by generalist, acute and primary health service partners.
As well as direct care they will also assume a system-wide leadership role in championing the redesign of specialised in-hospital and community services to better meet the needs of older people through:

- the piloting and evaluation of new and advanced practice roles
- service innovations, and
- building evidence to support best-practice models of care for older people in hospital settings,
  in community-based health centres and in residential settings.

Their wider brief is to improve, through a range of direct and indirect means, the health outcomes of older South Australians, influence patterns of service use, and build the capacity of others working within the system to provide care that better meets the needs of older South Australians.

Three regional older people’s health services (Northern, Central and Southern) are planned for metropolitan Adelaide. The administrative centres of these three services will be located at the Modbury Hospital, The Queen Elizabeth Hospital and the Repatriation General Hospital respectively. They will develop and maintain strong links with general practice, a wide range of health care services providing acute and chronic care and with residential care services and facilities within their catchment.

Seven regional older people’s health services are planned for country South Australia. These services will be developed at each of the four Country General Hospitals, and at three key periurban centres.

The care of older Aboriginal people will be explored as the Pt Augusta Centre of Excellence in Aboriginal health care develops.

**The team approach to providing older people’s health services**

These interdisciplinary teams will have specialist knowledge and clinical expertise in the assessment and management of older people with complex, acute syndromes and chronic conditions. The interdisciplinary teams will include the following health professionals:

- geriatricians and advanced trainees
- aged care nurse practitioners and advanced practice nurses with mental health expertise
- allied health practitioners with geriatric and rehabilitation expertise
- social workers
- clinical psychologists and neuropsychologists
- clinical pharmacists.

These teams may also include, or have access to:

- General Practitioners with a special interest in care for older people
- rehabilitation specialists
- psychogeriatricians
- neurologists specialising in memory disorder.

**Regional Older People’s Health Services**

Regional Older People’s Health Services will be based at metropolitan and country general hospitals and key periurban health services and will work across their respective service catchments. Given the volume of service delivery expected in the community setting, team members should also be positioned in community-based locations.

As health reform progresses, and with the support of best practice and evidence, these teams will drive significant change in the way health services are delivered to older people.
Using a targeted developmental approach, Regional Older People's Health Services will work with other teams that provide specialist health services to older people including mental health for older people, chronic disease management, comprehensive pain and palliative care teams to ensure flexible coordinated care working relationships to better meet demand for complex health care across the range of care settings: in-hospital, community centre-based and residential aged care settings.

The service model has the following elements that together form an integrated service response for the complex and acute care needs of older people across each service catchment. These services will have the capacity to provide:

> specialist advice and support, through collaborative and shared care arrangements, to general practitioners and primary care teams in GP Plus Health Care Centres, other primary health care providers and community based service providers, to enhance primary health care and wellness services to older South Australians
> targeted programs and interventions in the community setting that enhance the health outcomes for older people in transitional support and care awaiting placement
> targeted mobile outreach support for screening, assessment and early intervention in the care of older people living in the community and residential setting who are at risk of acute medical crisis
> acute assessment and management in General and Major Hospitals, Emergency Departments and in the Acute Medical Assessment Units as they are developed
> overnight admitted care of acutely unwell and medically unstable older people
> overnight admitted care in Older People's Acute Assessment and Management Units established in General Hospitals
> the traditional role of Aged Care Assessment Teams within a fully integrated comprehensive service delivery model.

These services will also have significant training, teaching and capacity-building roles.

**Specialist advice and support**

Clinical leaders from a range of disciplines working in regional older people's health services will provide advice and support to health and community practitioners providing care to older people across SA.

**Ambulatory and home based rehabilitative care**

A proportion of older people gain little benefit from post acute rehabilitation and will require continuing supportive care in a residential care setting. In this instance the ongoing care plan, goals and discharge destination will be negotiated with that person, their caregivers and family.

Provision of rehabilitation services in the community is essential to ensure decreased hospital lengths of stay and enable older people to continue to rehabilitate in their own environments. This is particularly advantageous for those individuals who have cognitive decline as rehabilitation in familiar environments is usually more relevant and successful.

A flexible suite of ambulatory community based services with multiple access points will be available to older people, and will include day rehabilitation programs and rehabilitation in the home.

**Mobile support teams**

Regional aged care services will provide mobile support teams that will:

> accept referrals from a community program or general practitioner
> operate across homes and residential care settings within their service catchment
> provide timely comprehensive physical and psychosocial health assessment of older people with a particular focus on older people at risk of an acute health crisis that requires hospitalisation
> undertake a range of screening and diagnostic investigations and clinical therapeutic interventions as needed, and
> negotiate and tailor a care plan and organise planned admissions in collaboration with the referrer and other primary care providers.
These teams may have a once-only, short-term, or continuing role, as determined by the assessment and care plan. The care plan may, where required, make use of planned overnight and day-only admissions, draw in other specialist services, home-based rehabilitation, ambulatory rehabilitation and or community supports.

Examples of this approach include both:

> the ‘Integrated Community Care for Older People’ project currently underway in the western suburbs of Adelaide by RDNS. This project involves Advanced Practice Nurses working in close collaboration with local GPs and the Aged and Extended Care Service at TQEH, taking a lead role in the coordination and clinical management of a caseload of older people requiring complex and continuing home-based care

> the Rapid Assessment of the Deteriorating Aged at Risk Program (RADAR).

**Timely intervention**

These and other programs will be explored and developed by Regional Older People’s Health Services to achieve early identification and rapid response to address impending needs of older people who are approaching a critical ‘tipping point’ in their health status. These tipping points have in the past often been associated with an unplanned Emergency Department presentation, followed by a hospital admission that then typically cascades into a sustained or irreversible decline in functional health status. The end result of this is often a residential care placement.

These tipping points are relatively easy to identify in retrospect, but can be pre-empted by diligent observation and in-depth knowledge of the older person’s changing medical and psychosocial context. General practitioners, family and carers are well placed to anticipate these tipping points. With a targeted educational approach, systematic improvements can be made to lift the capacity of health and community services to anticipate tipping points.

Advanced Practice Nurses and Aged Care Nurse Practitioner roles, working in collaboration with Gerontologists are central to the success of these approaches. When utilised effectively, they can mitigate the need for a significant proportion of Emergency Department presentations, reduce the incidence of unplanned hospital admissions, and both increase the proportion of planned admissions while postponing or reducing the incidence of overnight admitted care17.18.19.

Access to early risk screening and assessment and pre-emptive management of functional decline in older people will be strong feature of the model of care utilised by regional aged care teams. To support this, timely use of inpatient care options through planned (as well as unplanned) admission for overnight admitted care will be available at appropriate sites across each service catchment. Ambulatory and day-only admission options for extended assessment, diagnostic intervention and evaluation will also be explored.

This approach is designed to facilitate the progress of older people through the right care pathways in a timely manner and enable better clinical outcomes, reduced functional decline and improved efficiency of inpatient care.

**Intervening in Emergency Department and Acute Medical Assessment Units**

Regional Older People's Health Services will position teams in the Emergency Departments and Acute Medical Assessment Units of major metropolitan hospitals and metropolitan general hospitals. They will screen all older people presenting to the Emergency Department to ensure early identification of the older person’s needs and identify appropriate strategies to improve outcomes. Comprehensive assessment and restorative-focussed intervention will help to reduce unnecessary re-presentations to the emergency department, avoid inappropriate admission to hospital and reduce length of stay through early identification of co-morbidities such as pressure wounds, delirium and high falls risk.

The positioning of teams in all Emergency Departments and Acute Medical Assessment Units is a first order priority.
They will provide much of the opportunity for supervised training and capacity development of the Aged Care Nurse Practitioners who will be key to the enabling the roll out of programs like RADAR.

Older People’s Acute Assessment Services

Services operate within major hospitals and provide acutely unwell older people with comprehensive assessment and restorative focussed interventions. Services are provided by multidisciplinary teams experienced in the assessment and management of geriatric syndromes.

Older People’s Acute Assessment Services:

> are staffed by multidisciplinary teams with specialist skills and expertise
> have dedicated access to diagnostics, intensive care, coronary care and high dependency services
> provide minor, intermediate, major diagnostic and treatment procedures in association with other specialties
> provide in-reach consultancy and liaison to other specialties
> support advanced training for all contributing disciplines
> are linked to units in General Hospitals (described below), mobile outreach ambulatory and specialist rehabilitation programs and services, and
> are linked to specialist community services providing support and assistance with memory, mobility and continence.

These services will have the capacity to admit older people directly from the community, in instances where their care needs cannot be appropriately managed in the home or community setting, as well as those identified by Older People's Health Teams operating in the setting of the hospital emergency department.

Older People’s Acute Assessment and Management Units

The needs and goals of care of all older people requiring admitted care will determine the most appropriate type of setting. Those with complex care needs will be managed in acute care beds that have been organised to best meet those needs. Once admitted, older people will have their complex care needs met through multidisciplinary coordinated care with appropriate and timely transition to post acute care options as required. Discharge options include their home, community transition care packages and community short term packages. Their families and carers will be actively involved in the care planning process.

In General Hospitals, specific units will be established to provide comprehensive services including:

> early (and ongoing) comprehensive multidisciplinary assessment of the biomedical, psychosocial and functional status of the older person
> tailored treatments, diagnostic and therapeutic interventions that focus on the syndromes and diseases associated ageing
> care planning in consultation with the older person, their family, carer and the community services involved in their care.

These units will be established in General Hospitals and will accommodate older people on an acuity spectrum that ranges from those who have high to relatively high, but reducing levels of acuity through to those requiring a longer stay, increased periods of restoration and rehabilitation and intensive input to facilitate discharge home. The early identification and referral of appropriate inpatients to these units accompanied by timely access to diagnostic services is essential to maximise both patient and hospital outcomes. The dynamics of transition pathways that operate within acuity-led models of care, the thresholds for transfer, and the criteria for admission will need to be determined as these units are established.

Not all older inpatients will be appropriate for admission to these units. Those requiring extensive specialist rehabilitation (including limb amputation, acquired brain or spinal cord injury) and those requiring ‘care waiting placement’ would not meet admission criteria and will have their care needs met in a more appropriate setting.

There is strong evidence in the literature that suggests older people are at risk of de-conditioning and irreversible functional decline as a result of immobility and bed rest in hospital, with functional decline occurring as soon as two days after hospitalisation21,22,23,24.
Dedicated inpatient units (referred to in the international literature as Geriatric Evaluation and Management or ‘GEM’ units) have been shown to cost-effectively improve patient outcomes, reduce physical and cognitive functional decline, reduce mortality and the need for long term care\textsuperscript{25,26,27,28}. Through their accommodation of older people with higher levels of acuity, the units proposed for General Hospitals are differentiated from most of the GEM units described in the literature.

Older people are more likely to experience increased hospital length of stay and have a premature admission to permanent residential care when there is insufficient access to older-people specific rehabilitation support. The high rate of GEM bed uptake and use in Victoria has been suggested as one of the reasons why that state can report the lowest rate of maintenance care bed days in Australia. In Victoria 7.06\% of all hospital bed days were provided in GEM beds in 2006/7 and that state reports that only 1.17\% of hospital bed days were used for maintenance care, compared with 11.01\% in SA during the same period. Maintenance care classification refers to bed days spent in hospital when the inpatient no longer requires active treatment and is discharge-ready but no suitable environment is available. Timely access to GEMs has also been linked to the seven week difference in length of permanent stay in residential care (Victoria 143.6 weeks compared with 150.6 weeks in South Australia as at 30 June 2007).

Regional Older People’s Health Services will develop flexible entry points to multi disciplinary and coordinated ambulatory and home based rehabilitation services to meet the varying needs and situations of older people across the state. This will involve liaison with community services, day therapy centres, residential aged care services and GPs in provision of service. This level of service flexibility and tailoring will help ensure the older people’s timely return home with an optimal level of health and independence.

Units will promote a strong focus on minimising loss of function, independence and confidence through multi-disciplinary input, timely access to neuropsychological assessment, diagnostic and imaging services and co-ordinated care.

These units will play a key role in the integrated management of conditions such as falls with soft tissue injury, cognitive decline, acute confusion, multiple medical issues, and simple orthopaedic conditions including hip, ankle, femur and humeral fractures.

**Transition care program and care awaiting placement**

Transition care services provide an effective alternative care option for supporting older people to maintain an independent lifestyle. These programs receive both State and Commonwealth funding to provide therapy, nursing support and/or personal care for short-term assistance following a hospital stay.

Transition care is an important service option for older people who require more time to recover from serious illness, are likely to benefit from further restorative care and are at risk of premature admission to residential aged care.

The current program supports approximately 1800 older people per year to access rehabilitation services and this will be expanded by an additional 171 Transition Care places over 2008–2011.

**Research and Innovation**

Each Regional Older People’s Health Service will be involved in research to improve health outcomes for older people. Working in conjunction with Universities and research foundations, SA Health will seek to increase focus on ageing research.
The health service model for older people

Mrs K’s Journey

The following scenario draws on a real life example and characterises some of the obstacles and challenges confronting older people across as they negotiate the health system and outlines how improved system design will provide outcomes.

<table>
<thead>
<tr>
<th>Prior to the framework for older people</th>
<th>After the framework for older people</th>
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<tbody>
<tr>
<td>Mrs K lives alone and receives community support two times a week to do her shopping and housework. She is nearing her 83rd birthday. Mrs K has a daughter and three grandchildren. Her husband died two years ago. Her local doctor prescribed medication for depression eighteen months ago. Last year her daughter took her to the local hospital because she had fallen over in her garden. Apart from a bruised hip, she was OK. Recently her daughter noticed she was getting more unsteady on her feet and wondered if she has been eating very well. She encouraged her to see her doctor. Her doctor wanted Mrs K to see a Geriatrician about her changing health and functional status, as she is sure it will impact on her health sooner rather than later. A referral to a Geriatrician is written and the next available appointment is in eight weeks time. Mrs K does not drive and her daughter works, so Mrs K is worried about how she will get to the appointment. Despite her uneasiness, Mrs K doesn’t want to be a bother and insists she will be OK in the mean time. Mrs K becomes progressively worse and eventually she calls an ambulance and is taken to a hospital emergency department. After a lengthy wait, she is admitted to a general ward with malnutrition, dehydration and marked functional decline. She then has a lengthy stay in hospital with a number of episodes of unexplained, but spontaneously resolving agitated delirium. During this stay her functional status does not improve and she loses her confidence. She is assessed as needing continuing supported care in a residential aged care facility, and after a further period of waiting, she is admitted to a nursing home.</td>
<td>Mrs K’s daughter noticed a decline in her function and health and encouraged her to see her local doctor. The GP refers Mrs K to the older people’s health service, an a Nurse Practitioner from the team visits her at home the next day, completes a comprehensive assessment and liaises with community and aged care sector to facilitate increase home supports. The assessment identifies a range if issues. Mrs K’s medication for her depression requires review and she is malnourished, all of which are affecting her function and health. The Nurse Practitioner visits a number of times, bringing with her an Occupational Therapist and a senior Registrar, and keeps in close contact with her doctor, daughter and community services to ensure that the team’s plan is on track, and the right interventions and supports are in place. She is reviewed by the Gerontologist and Nurse Practitioner who hold a shared clinic at the nearby GP Plus Centre. A back-up plan is also developed with Mrs K and her daughter. They both know what to look for and how and when to initiate help, should the need arise. At a timely moment, the Nurse Practitioner initiates a discussion with Mrs K and her daughter about advance care planning. The team suggests the daughter visit her GP for a check up as she is the primary carer for Mrs K and her health may be at risk. Mrs K’s health and function improve and she is able to return to her card group on Tuesdays and look after her five year old grand daughter for a short time on Friday mornings. Recently Mrs K has been thinking about her situation and has decided to write down her preferences about what she would want to happen in the future, in case she is unable to express them at the time.</td>
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Regional older people’s health services and facilities profiles

Service delineation

The delineation of services identifies the scope of practice and the services provided within these levels and provides important planning, resource allocation and accountability functions.

Three Level 6 Regional Older People’s Health Services will be developed for Adelaide (Northern, Central and Southern) and seven Level 4 Regional Older People’s Health Services will be developed to meet the needs of older South Australians living in periurban and country SA. The service and facility profiles of these services are set out in the service delineation table below.

Table 2
Service delineation table

| Level 6 Services | (Northern Adelaide) Older People’s Health Service |
|                 | (Central Adelaide) Older People’s Health Service |
|                 | (Southern Adelaide) Older People’s Health Service |
| Level 4 Services | (Mt Gambier) Older People’s Health Service |
|                 | (Riverland) Older People’s Health Service |
|                 | (Pt Lincoln) Older People’s Health Service |
|                 | (Whyalla) Older People’s Health Service |
|                 | (Barossa) Older People’s Health Service |
|                 | (Adelaide Hills) Older People’s Health Service |
|                 | (Southern Fleurieu) Older People’s Health Service |
| Level 1 & 2 Services | Level 1 Older People’s Health Service: |
|                     | > work in acute, chronic, residential and community settings to provide assessment, triage, care coordination & clinical management for older people with uncomplicated needs |
|                     | > a range of generalist providers and health care providers from a range of community and acute specialties and disciplines would be included at this level. |
| Level 2 Older People’s Health Service: | |
|                     | > provide quality care for older people, their caregivers and families whose needs exceed the capability of local primary care providers |
|                     | > provide assessment, triage & care coordination and clinical management |
|                     | > provide care consistent with needs and provide consultative support, information and advice to primary care and community and clinical education |
|                     | > have formal links with primary care providers and a formal partnering relationship with a Level 6 and 4 Service to meet the needs of patients, caregivers and families with complex problems |
|                     | > have quality and audit programs. |

Level 6 Regional Older People’s Health Services will engage in long term ‘partnering relationships’ with a number of Level 4 services from across the state to provide support in areas of service development, quality assurance, education and continuing professional development and outcomes evaluation. Support and guidance will be provided through these partnering relationships as they develop over time. The identification or selection of partners will be determined though consultation and on the basis of planning underway within Country Health SA.

Projected requirements for inpatient and ambulatory care of older people

The allocation and distribution of services across the state will change overtime in response to population changes and to meet national benchmarks. The national benchmark for GEM beds is currently set at 15 inpatient and 7 ambulatory places per 100,000. Using this formula, the target number of specialised inpatient GEM beds for SA in 2016 will be 254 with an allocation of 119 ambulatory GEM places. This will require a substantial reconfiguration of beds within key hospitals across the state. Careful planning and a staged approach to the development of services will be required. A ‘watching brief’ will be necessary to monitor patterns of demand and their impact on patient-level and system-level outcomes, and make adjustments to achieve the right mix and distribution of beds and units.
Health workforce changes

A skilled workforce is the foundation of an effective and responsive health system. SA Health will continue to invest in a workforce that delivers health services responsive to the needs of older people. New workforce arrangements and new ways of working together will be required to ensure high quality care for older people and to ensure health services are able to respond to the particular and diverse needs of older people.

They will include:

1. Working with Universities to develop and implement training and skill development programs that:
   - expand and extend the scope of practice of a range of disciplinary roles within the regional aged care teams to ensure that all roles are optimised and the capacity of interdisciplinary teams is sustainably enhanced over the long term
   - increase competence across the wider health workforce to recognise and eliminate ageism within the system, promote positive approaches to ageing, and to recognise and respond proactively to tipping points for older people at risk.

2. Support for clinical leaders in improving and expanding existing/future better practice service models.

3. Ensuring a suitable workforce is established and trained to meet these demands.

4. Exploring in collaboration with specialist and primary care service providers across community and aged care sectors:
   - the optimisation of all clinical roles and disciplinary contributions through the systematic development of new and emerging advanced practice roles
   - improved ways of working with volunteers and carers to better meet needs of older people
   - opportunities to expand and develop partnerships between teaching hospitals, teaching aged care centres of excellence, and relevant vocational and university partners.

The Australasian Faculty of Rehabilitation Medicine staffing formula suggests that the total ward-based staffing requirements for 254 inpatient beds is approximately 300 FTE of nursing, 32 FTE of physiotherapy 25 FTE of occupational therapy 15 FTE of social worker, 10 FTE of dietician and physician, and 5 FTE of speech pathology, clinical psychologist and neuropsychologists.

Additional FTE (particularly in the Emergency Department, mobile outreach, consultation, etc) will need to be determined through detailed service profiling and a comprehensive workforce strategy, developed as a component of work undertaken through the Statewide Geriatric Clinical Network.
**Addressing the needs of specific populations**

The integrated person- and carer-centred service model will support older people from specific needs populations to achieve equity of health outcomes to the rest of the older population.

Implementation of the integrated service model will improve the targeting of resources based on projected population demand and factors such as socio-economic status, geography, and at risk populations including the frail aged, those living in unsuitable accommodation and specific needs groups.

**Older people with dementia, delirium and cognitive impairment**

Anticipating and responding to the changing needs of people who experience deteriorating brain function from delirium and dementia and chronically progressive diseases like Parkinson's remains a continuing challenge for the health and aged care system as a whole.

Dementia in particular will be a continuing health care issue for South Australia. The anticipated growth in the rates of dementia is underscored by research from the Australian Institute of Health and Welfare, which reports that between 2003 and 2031, the number of people with dementia is projected to increase from 175,000 to 465,000; an overall increase of 166%.

SA Dementia Action Plan 2008–2011 has recently been developed by the South Australian Department of Families and Communities in consultation with SA Health. The Action Plan outlines a series of key actions and outcomes to be achieved across 5 priority areas aimed at improving health care for people with dementia and their families. The priority areas are: care and support, access and equity, information and education, research, and workforce and training.

Health and community services across South Australia will need to provide an integrated and collaborative response for the person with dementia, as their capacity for independence changes over time. As most people with dementia will continue living in their community, it is essential that health and community care service providers have the capacity to respond to the needs of these people. It is also important to strengthen support to carers to enable them to continue to care. Acknowledging the support that carers give to people with dementia is fundamentally important.

One of the key aims of this health framework is to strengthen the capacity of the whole health system to meet the health needs and support the wellbeing of people with cognitive impairment and dementia.

This framework will align its overall objectives for the care of people with dementia with the National Framework for Action on Dementia 2006–2010 and the initiatives of the Department of Families and Communities across dementia care.

The needs of older people experiencing delirium are also a strong priority of the Health Service Framework for Older People. Delirium is a complex and often misdiagnosed condition, which involves temporary cognitive impairment. The Framework sets out steps that will help build the capacity of the workforce and improve system-wide approaches to the care of older people with delirium.

Implementation of the integrated service model will deliver:

- implementation of prevention and health promotion strategies to foster community understanding and support of people with dementia
- improved early diagnosis and management of dementia in partnership with general practitioners and other community based health professionals
- improved service responsiveness to the overall health care needs of people with dementia (e.g. oral health, management of other chronic diseases)
- implementation of delirium prevention and management strategies across the health care continuum including older people with deteriorating brain function from dementia and other brain diseases (e.g. Parkinson’s Disease)
- improved access for people with dementia and Parkinson’s Disease to specialist geriatric medicine and psycho-geriatric medical services
Addressing the needs of specific populations

> improved chronic disease care management plans that promote self management across the care continuum including hospital admissions (e.g. older people with early stages of Parkinson's Disease supported to self manage during hospitalisation)

> increased uptake of advance care planning and Advance Directives.

**Meeting the needs of older people with mental health conditions**

With an increasing ageing population, there will be greater demands on services to meet the needs of older people with pre-existing mental illnesses and those people who first develop mental illness later in life.

Older people who have a mental illness as a co morbidity to other chronic conditions are less likely to achieve optimal management of their health. There is a need for an effective response to depression, the prevention of suicide and the underlying causes behind the social marginalisation of older people with mental illness.

Access to psychogeriatric advice will be available to the Older People's Acute Assessment Services and Older People's Acute Medical units through co-location in general hospitals with acute mental health units to facilitate consultation and liaison.

The SA Health *Older Persons Mental Health Future Service Model* outlines the key mental health issues for older people and the strategic priorities for older people's mental health. It defines the scope and actions for future service delivery across South Australia.

**Meeting the needs of older Aboriginal people**

There is an ongoing challenge to ensure health services are responsive to the needs of Aboriginal and Torres Strait Islander peoples.

The numbers of older Aboriginal people is very small compared with the general population but their roles as elders are extremely important to Aboriginal and Torres Strait Islander societal wellbeing.

Many Aboriginal and Torres Strait Islander people have a lifespan that is up to 17 years shorter than other Australians. Whereas older people in the general population are considered to be over 65 years old, it is sometimes appropriate to plan and deliver services of this type to Aboriginal people as young as 50 years in order to ensure that they receive equitable services consistent with their needs.

SA Health will work in partnership with Aboriginal people (including elders) and key agencies to strengthen the health system's ability to ensure respectful and culturally safe care to older Aboriginal people.

This framework is aligned with the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*, *SA Aboriginal Health Policy*, *South Australian Aboriginal Cultural Respect Framework* and the *SA Health Reconciliation Action Plan 2008–2010*.

Implementation of an integrated person-centred service model will deliver in collaboration with Aboriginal people:

> health services for older people consistent with the Aboriginal Cultural Respect Framework principles

> culturally appropriate models of health care for older Aboriginal people aged 50 years and older that promote healthy ageing, self management and access to general and specialist health care services (including grief and loss services) as close to home as possible

> partnerships with key agencies (Aboriginal Health Services and Aboriginal Community Controlled Organisations) that explore how the roles of traditional Aboriginal healers, elders and carers can be most effectively acknowledged and supported across the health care sector.
Meeting the needs of people of culturally and linguistically diverse background

The Framework recognises that older people come from a great variety of cultures and backgrounds. It is projected that by 2011, 20% of the South Australian population will consist of people of a culturally and linguistically diverse background.

Implementation of an integrated person-centred service model will deliver in collaboration with multicultural communities:

> cultural competence training across the mainstream health workforce to ensure services are able to provide an effective response to older people of culturally and linguistically diverse backgrounds
> improved access to general and specialist health services for older people culturally and linguistically diverse backgrounds
> effective and early use of the health care interpreter service by clinical staff.

Meeting the needs of older people in rural and remote areas

A key issue confronting people living in peri-urban, rural and remote areas is timely access to health and aged care services. The outcomes of further planning in Country Health SA will enhance the care provided to older people in country communities.

To ensure country services are able to respond to the particular needs of older people, Country Health SA will:

> establish formal links to metropolitan specialised health services for older people to increase availability of specialist visiting consultations and use of telemedicine
> systematically develop partnering relationships between metropolitan and country aged care services to ensure improved equity of access and outcomes for all older South Australians
> implement specialist programs to help their staff understand the special needs of older people who become ill
> establish systems to improve collaboration between health professionals to ensure older people get the right care, in the right place, at the right time, by the right care providers
> further develop dementia care services
> explore options to provide care as close to home as possible while regaining independence following acute illness or surgery.

Supporting carers

Partners, families, live-in carers, neighbours and friends play vital roles in assisting frail older people to live independently in their homes. This Framework recognises carers of older people as well as carers who are older.

There is particular recognition of the invaluable contribution of ‘family carers’.

Carers often have knowledge about the health and well being circumstances of the older person and it is therefore vital they are included in care planning processes.

This framework recognises that carers face significant difficulties in providing support to family members while confronting a range of complex circumstances including emotional, health and financial difficulties.

Implementation of integrated person-centred service model and collaboration with Carers SA, Council On The Ageing (COTA), SA Department for Families and Communities, Australian Government Department of Health and Ageing and the aged and community care sector will deliver:

> a workforce that understands the ‘carer role’ and its associated challenges, responds effectively to carer needs and works together with them in providing quality care for older people
> supported carers able to deliver the care needed by the older person
> improved identification of the carer throughout the health system
Addressing the needs of specific populations

> improved access to health and wellbeing information and services that assist carers manage their own health and the health of the older person receiving care

> exploration with the Australian Government of the feasibility of a carers Extended Package of Care (EPC) item

> involved carers in health planning and delivery of health services.

Specialised services

Older people are high users of the following specialised services:

> restorative and rehabilitation

> cancer care

> palliative care

> stroke care.

Specialised restorative and rehabilitation services for older people

The Statewide Rehabilitation Clinical Network has developed a statewide service plan which describes the expanded and reshaped services for people requiring specialist rehabilitation in instances of amputation, stroke, complex neurological syndromes and brain injury.

Cancer care

Age is a risk factor for developing some types of cancers. *South Australia’s Statewide Cancer Control Plan* describes the expanded and reshaped services that are evolving to meet the needs of South Australians with cancer. The ageing of the population means that older people will represent a greater proportion of all those who will be diagnosed and treated with cancer in the years ahead, and cancer services planning will reflect this.

Stroke care

Stroke is the second most common cause of death and disability in South Australia, and the incidence increases steadily with age. The median age at which Australians experience stroke is 79 years.

The care and management of older people who experience a stroke is outlined in SA Health: Stroke Service Plan 2009–2016. This plan provides a forward view of how stroke services will be streamlined to provide the best care for all South Australian’s who experience stroke.

The incidence of stroke can be reduced by targeted intervention around key risk factors, maintaining a healthy weight, healthy lifestyle and normal blood pressure.

Detailed planning will be required at the intersection between the Stroke Plan and the Health Service Framework for Older People in order to ensure a clear and consistent pathway for older people who have suffered stroke and subsequently require support for related dementia, depression and other conditions requiring the expertise of the Regional Older People's Health Services.

End of life care for older people

Whenever a person dies in South Australia, a range of effects can be felt across families, communities and workplaces. Although dying is a normal part of life, the impact of a death can have a profound effect on the health and wellbeing of close family members, friends and co-workers.

The quality of care provided to every South Australian at the end of his or her life is everyone’s business.
Within this Framework, the term end of life care is used to describe care that is planned for, negotiated with, or provided to a person at the end of their life. It is used without specific reference to timeframes and hinges instead on the orientation toward providing care appropriate for a natural life event and the ordinary place of death-as-a-part-of-life.

Older people differ in their end of life experiences. For some this period is short and sudden while others experience gradual or fluctuating decline and increasing frailty from terminal illness or complications from chronic diseases. These differing experiences will require different health service responses.

South Australia has a well established specialist palliative health care sector but demand for palliative services is growing as the population ages.

The Palliative Care Services Plan 2009–2016 describes the expanded and reshaped services that will respond to this demand and the end of life preferences of older people.

The Palliative Care Plan describes the work of palliative care services within the broader context of all the end of life care that takes place across the state. The noticeable trend towards an increasing proportion of this care being provided by palliative care services cannot be sustained, and the level of reliance on these services requires some adjustment.

With different health needs comes growing demand for a health care system that treats older people and their carers with respect, preserves their dignity and supports them to optimise their health and wellbeing, even in the last days, weeks and months of life.

The Palliative Care Plan recognises three end of life trajectories (excluding sudden death) which require varying degrees of input from specialist palliative care services. These are:

> short period of evident decline: The pace and service-level responses to the needs associated with this trajectory ideally match the capacity and model of care that has traditionally been associated with palliative care services. People whose end of life pathway follows this trajectory will have needs that challenge the capacity of generalist providers of end of life care and will benefit from timely referral to a palliative care service. For many, but not all people with advanced cancer direct and continuing palliative care service involvement will be necessary and appropriate

> long-term limitations with intermittent serious episodes: Both the pace and the types of care needed for people on this trajectory can be met through a shared model of care between community generalist care providers with support from the relevant chronic disease service

> prolonged decline: People whose end of life is characterised by this trajectory usually need continuing care in the community and supported care settings (e.g. residential aged care facilities) and will have their needs met by aged care providers with support of the local regional older people’s health services. Only a small proportion of these people will need or benefit from the involvement of a palliative care service.

**Palliative care services**

Much of the end of life care of older South Australians will be provided by those services that have had a continuing role in their care. Palliative care services support the work of all those who provide end of life care. Wherever the symptom control or psychosocial support needs of older South Australians exceeds the skills, capacity or resources of their usual care providers, palliative care services will be available to ensure high quality end of life care remains in place for all people regardless of age, diagnosis or setting of care. Palliative Care Services Plan 2009–2016 sets out in more detail the role of specialist providers of palliative care and their relationship to aged care services and other providers of end of life care.
Addressing the needs of specific populations

Ageing health and aged care workforce

Consistent with international and national experience, South Australia faces a substantial shortage of health professionals in the aged and community care sector. The current health workforce is ageing, and comprehensive and creative strategies will need to be put in place to assist the attraction and retention of good quality staff in health, without adversely affecting workforce capacity within other service sectors.

Adjusting services to match the shifting patient profile

Historically, hospitals have been organised to meet the needs of a younger patient profile. Establishment and expansion of services driven by the rapid expansion of the population at the time of the ‘baby boom’ saw the development of service models and associated skill base of the workforce to match this age profile.

The SA Health Care Plan identified the need to redefine these traditional service models, redesign access routes into the hospital system and to adjust the workforce blend and skill mix in order to meet future requirements.

The existing workforce is dedicated and professional but will need additional support to respond to the increasingly complex needs of older people and increased demand for existing and different services. The health workforce needs to be skilled in delivering ‘age friendly’ services in and out of hospitals.

Reshaping and increasing services will require consideration of the involvement of carers, volunteers and other yet to be developed health professional roles.

The community and aged care sectors face similar workforce challenges and are interested in long term solutions that achieve a balanced workforce across the health, community and aged care sectors.
Strengthening partnerships

Improving the health and wellbeing of older people will require us to take responsibility to develop a combined approach with individuals, community groups, government and non-government sectors and involve working closely with general practice, the community and aged care sector and other private health care providers.

General practice as the focal point of health care for older people provides a major access point to rest of the health, community and aged care system.

The non-government sector have a significant role in delivering residential and community care services via private operators, and not-for-profit organisations.

Strong partnerships provide the basis for effective, high quality and integrated healthcare for older people.

SA Health will establish a SA Health for Older People Interface Group comprising representatives from older people, carers, general practice and community and aged care sector. This group will:

> improve communication between public and private health, community and aged care sectors to ensure high quality and safe services for older people transitioning between services (e.g. from hospital care to a residential care facility)

> contribute to the efforts to reduce complexity and strengthen access point linkages across the health, community and aged care system that ensure safety and effective coordination of care

> improve flexibility of community based care streams across health, community and aged care sectors.

Working alongside other regionalised services

Each of the Regionalised Older People’s Health Services set out in this Framework shares the same service catchment with a number of other regionalised services including palliative care. For both of these services, key tasks related to population-based service-level planning, and outcomes evaluation overlap, suggesting a need for shared planning and analysis and high levels of inter-service collaboration and open lines of communication. Formal service-level arrangements, close working relationships and well designed referral pathways will need to be in place to ensure continuity of care for older people at end of life and the coordination of service contributions by the teams working across the same hospital, community and residential care settings.
Next steps

The Statewide Geriatric Clinical Network

To guide further development in reshaping these statewide and regional health services, a Statewide Geriatric Clinical Network will be established to provide expert advice on the health care of older people.

This network will provide leadership and strategic advice for clinical service development across the continuum of care and across all regional health services to ensure older people have access to high standards of health care.

The development of models of care for common geriatric conditions and an integrated regional service system will be a network priority. “Expert” older people and carers will participate on the Geriatric Network’s Steering Committee.

Responding to changes

The Health Service Framework for Older People anticipates many of the identifiable challenges that lie ahead. The dynamic nature of reform within a changing health care environment requires systems to be in place to monitor and respond to unanticipated risk or independent trends. This will require the Statewide Geriatric Clinical Network to adopt a watching brief on developments related to:

> the impact of the new acuity-based model of care in the major metropolitan hospitals
> the availability, recruitment and retention of specialist older people’s health practitioners of all disciplines
> barriers to role optimisation across advanced practice roles
> forthcoming National Health & Hospital Reform Commission performance reporting requirements
> changes in hospital flows and the role of GP Plus Health Care Centres
> the level of demand for Older People’s Acute Assessment Services and OPAM bed activity and barriers to meeting this need
> the independent impact of changes resulting from planned changes in the care of older people who experience stroke, require general or specialist rehabilitation services or a range of other reform programs
> access (or barriers to access) to quality care for older Aboriginal people and older people from cultural and linguistically diverse communities
> changes in the level of carer burden and in the demand for and uptake of volunteerism.

The key initiatives contained within the Framework and the enablers for achieving the intended outcomes are summarised in the following table.
## Table 3
### Key Initiatives and enablers of the Framework

| Statewide initiatives | | |
|-----------------------|-----------------------------|
| 1.1 Establishing a statewide geriatric clinical network. | 1.3 Using a shared model of care and common approach to service delivery. |
| 1.2 Strengthening primary health services to better meet the needs of older people. | 1.4 Rolling out an ‘Informed Choices Program’ across the state. |

| Service level redesign initiatives | | |
|-----------------------------------|-----------------------------|
| 2.1 Establishing three metropolitan and seven country regional older people’s health services. | 2.4 Developing community-based rapid response capacity across each regional older people’s health services catchment. |
| 2.2 Configuring Older People's Assessment and Management units in each Metropolitan and Country General Hospital. | 2.5 Greater integration between regional older people’s health services and transitional care programs including new governance and support arrangements. |
| 2.3 Establishing Older Persons Acute Assessment Services in each Major Metropolitan Hospital and in all Major and General Hospital Emergency Department. | |

| Collaborative enablers | | |
|------------------------|-----------------------------|
| 3.1 Establish an SA Health for Older People Interface Group. | 3.2 Strengthening service partnering arrangements across the state. |

| Workforce initiatives and enablers | | |
|------------------------------------|-----------------------------|
| 4.1 Developing a statewide older people’s health services workforce strategy. | 4.3 Exploring and using new and emerging roles. |
| 4.2 Growing the established workforce. | 4.4 Proliferating advanced practice roles. |

| Quality, data, reporting initiatives | | |
|--------------------------------------|-----------------------------|
| 5.1 Developing capacity to report on the quality and outcomes of care of all older people. | 5.3 Establishing a statewide reporting cycle. |
| 5.2 Implementing a statewide quality program. | 5.4 Putting in place IT solutions & support. |

| Research and education initiatives | | |
|------------------------------------|-----------------------------|
| 6.1 Establishing a statewide population-based aged care research collaborative. | 6.2 Using a statewide approach to education, training support and practice development. |
Evaluating the outcomes of the framework

Evaluation will be a core component of implementation and occur at key points across the life of the Framework and include:

> the ongoing piloting and adaptation of system and service-level reforms and innovations
> a 2012 midpoint report on the progress of the Framework, and
> a new statewide strategic plan for the period of 2017 and beyond.

Timeframe for action

The following action timeframe will be implemented by health regions and the statewide geriatric clinical network over the life of the Framework. There are some immediate next steps required to commence the implementation of the Framework.

Priority first actions
The anticipated program of work required in 2008–09 include the following areas:

Statewide
> The establishment of the statewide clinical leadership framework for older people’s health service provision (Statewide Geriatric Clinical Network).
> Establish SA Health for Older People Interface Group to continue collaboration between health, community and aged care sectors.
> Develop a detailed specialist workforce profile and implement a range of workforce initiatives that recruit and develop specialist older people’s health practitioners.

Metropolitan specific
> The formation of the 2 Level 6 services in CNAHS and 1 for the SAHS catchment. This will require bringing together the separate teams currently located in different hospitals and services in the community to form regionalised services.
> Develop processes needed to enable clinicians to work across multiple care facilities including the provision of acute assessment and management capacity in each Metropolitan Hospital Emergency Department.
> Systematically extend early assessment and intervention capacity beyond the Emergency Department into community settings with a rapid response capacity focussing on older people at risk of hospitalisation.
> Establishment of Acute Assessment and Management units in the general hospitals within the service catchment of each Level 6 service.

Country specific
> Development of Acute Assessment and Management units in country Level 4 sites.
> A workforce development strategy that focuses on the development of aged care specific or blended nurse practitioner roles across the Level 4 older people’s health services in country SA.
Appendix 1: Policy context

The Health Service Framework for Older People is set within the context of national and state based policies and strategies on ageing and associated health and wellbeing issues.

The work of the Health Care of Older Australians Standing Committee and in particular the National Strategy in Ageing; An Older Australia – Opportunities and Challenges for All including its annual reports and the following documents in particular:

> from Hospital to Home Improving Care Outcomes for Older Persons: A National Action Plan for Improving the Care of Older Persons across the Acute – Aged Care Continuum (2004)

> National Guidelines –
  – Best practice approaches to minimise functional decline in the older person across the acute, sub acute and residential aged care settings (2004)

Other key national policy documents are:

> The National Chronic Disease Strategy 2006
> The Third National Mental Health Plan 2003–2008
> National Dementia Plan (2006)
> National Transition Care Program (2006)
> National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

In addition to these national policies are a series of key state policies:

> South Australia’s Strategic Plan 2007
> State Ageing Plan – Improving with Age
> South Australia’s Health Care Plan 2007–2016
> Strategic Directions for SA Health
> SA Health Strategic Plan 2007–2009
> South Australia’s Country Health Care Plan
> Clinical Senate Model of Care Planning Principles
> South Australian Carers Recognition Act 2005 and SA Carers Policy 2006
> SA Health Aboriginal Health Policy 2007
> SA Health Aboriginal Cultural Respect Framework
> Chronic Disease Prevention & Management Opportunities for South Australia 2004
> GP Plus Health Care Strategy 2007
> Primary Prevention Strategy (under development)
> other state-wide plans, policies and strategies.
Appendix 1: Policy context

South Australia's Strategic Plan 2007–2016 informs the health reform agenda for South Australia and includes goals for the community to stay healthy, with a focus on preventing illness through improving lifestyle.

SA’s Health Care Plan outlines changes for the health system to effectively manage the changing health care needs of South Australians over the next ten years. It outlined the structural changes to services throughout the state, and all actions and outcomes in this Framework fall within the parameters set by this plan for South Australia.

The SA Health Strategic Plan 2007–2009 outlines the key strategic directions of SA Health over the next three years within the overarching context of South Australia’s Strategic Plan 2007.

The GP Plus Health Care Strategy 2007 is the overarching primary health care and out-of-hospital strategy for South Australia. As the majority of health care for older people occurs in primary health care settings, this strategy is integral to the SA Health Service Framework for Older People, and provides the context for many of the strategies described in this plan.
Appendix 2: Developing the framework

The development of this Framework has been highly consultative. Several hundred people from SA Health, Health Regions, lead clinicians, the aged and community services sector and older people and carers and their peak bodies participated in a range of engagement and consultation activities designed to:

> identify what key stakeholders believe is currently working well in the health and aged care system and needs to be continued
> identify what action key stakeholders believe inhibit progress and need to be discontinued
> identify what action key stakeholders recommend be started to improve health and wellbeing of older people
> confirm the evidence based key directions for improving the health and wellbeing of older people
> consider the current resources available and clarify the opportunities and gaps across the health, aged and community care continuum
> articulate an evidence based vision for health and wellbeing of older people across the community, health and aged care continuum
> consider the ongoing governance requirements for the implementation and evaluation of the Framework.

The outcomes of this engagement and consultation process identified a range of key principles that guided the development of the Framework. They included:

> valuing older people – respecting their right to choice and independence
> involving older people and carers in planning and delivering services
> promoting healthy ageing
> supporting a person centred approach to service provision as close to home as possible
> supporting collaboration across the community, health and aged care sectors including local government
> supporting a restorative focus to wellbeing and functionality
> enabling a culture that promotes and values evidence based care
> enhancing the capacity of key elements that provide the foundation for the health and aged care system – workforce, partnerships, information and system architecture and research.

These principles are consistent with National and State agreed policy directions and guidelines for the health care of older people.
Appendix 3: Feedback used to inform the framework

The following information obtained through separate stakeholder forums with older people/carers, senior health clinicians and representatives from the aged and community care sector has also guided development of this framework.

Older people and carers said that they:

- valued a health system that listens, responds to their health needs in a timely, safe and respectful manner, and provides restorative focussed services as close as possible to home
- placed great value on receiving care within their homes or at least within their local community. It was clear that their main preference is to manage disease, illness or frailty outside of the hospital system
- valued timely access to a flexible range of services that meet their individual needs. There was great importance placed on coordinated care and reducing the complexity of the current system
- valued a health system that adopted a balanced use of high technology with human approaches delivered in safe “age friendly” physical environments
- valued their general practitioners and the integrated way primary health and aged care services are delivered in many country areas
- disliked the repetitive nature of clinical assessments and the long waiting periods for services within health and the aged care sectors
- frequently found the acute health system hard to access. However once access was achieved they generally received quality, safe services from caring health professionals in spite of often challenging physical environments
- wanted another way to access acute services for emergency care
- mostly, older people and carers wanted the health and aged care system to treat them with respect and dignity and better understand their various needs as individuals.

Older people and health professionals alike agreed the current health system works best for individuals with specific, time limited health needs but those with complex health issues requiring ongoing management and services involving collaboration between health, community and aged care sector tended to fair less well.

Problems often arise when care involves individuals transitioning between health services and community and aged services or when they try to access scarce services closer to home (especially those from remote, rural communities).

Lead clinicians (medical, nursing and allied health) said:

- multi/interdisciplinary team approaches are needed to provide quality assessment and safe care to older people with complex wellbeing and functionality issues
- they valued access to geriatric specialisation and advice for management of older people with complex care needs in hospital and community settings
- the health workforce needed support to build skills in caring for older people with less complex needs
- the primary health and community care sector needed strengthening to reduce demand for acute services
- standardised care pathways are needed for older people with delirium, depression and dementia
- establishing a Health, Aged and Community care network would facilitate development of innovative service models and promote collaboration between staff from each sector.
What views did they share with their colleagues in the aged and community care services sector?

Health and aged care workers identified a range of issues they considered vital if the health and aged care systems are to enhance care for older people. Their key priorities included:

> strengthening resources and focus on the care of older people
> the need for a better balance of accessible services across the health care continuum
> the need for clear and easy to follow care pathways
> improved systems and processes for communication and coordination across the health care continuum
> increased training and education to better understand the needs of older people and carers and address ageism
> improved systems of care for older people within acute hospitals
> outcome measures based on the needs of individuals, not the health system.
Glossary

**Acute Care**
Treatment for patients with high level care needs associated with a short-term or episodic illness, injury, health problem, or recovering from surgery.

**Carers**
An unpaid person apart from any 'direct payments', who as a partner, other family member, friend or neighbour is informally looking after or providing a substantial amount of help on a regular basis for a sick, disabled or elderly person living in their own or in another household.

**Care pathways**
The route that a patient with a given pathology can be expected to take from her or his first contact with the health system (for instance, the GP in gate-keeper systems), through referral, to the completion of his or her treatment.

**Care Plan**
A written document collaboratively designed among patient and providers covering issues, aims, interventions and review processes in the patient's life. The plan should state the diagnosis, interventions (pharmaceutical and others) being undertaken to manage the illness, goals being strived for by the patient, have a interdisciplinary care focus and incorporate a self-management approach (including patient and carer education).

**Case Management**
Assessment, planning, coordination, monitoring, and decision-making processes around options and services required to meet the client's health and social needs. It is characterised by collaboration, advocacy, communication, and resource management.

**Continuing Care**
A system of service delivery which includes all of the services provided by long-term care, home care and home support.

**Chronic disease**
Diseases which have one or more of the following characteristics:
- is permanent, leaves residual disability
- is caused by non-reversible pathological alteration
- requires special training of the individual for rehabilitation
- may be expected to require a long period of supervision observation, or care

**Chronic disease management**
Improving the health of people who already have one or more chronic diseases. It includes strategies designed to:
- improve health-related quality of life for people with chronic diseases, particularly those with more than one condition
- improve the use of the health care system by people with chronic diseases
- enhance communication between health professionals, families, carers and people with chronic disease

**Co-morbidity**
The coexistence of two or more disease processes.

**Complex needs**
Complexity as it related to chronic disease and chronic conditions typically involves co-morbidities and psychosocial factors. This could include older people who are becoming frailer, carer stress or a reduced ability to function independently.

**Dementia**
Dementia is syndrome associated with diseases of the brain, usually of a chronic or progressive nature, which causes a decline in memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. The most common cause of dementia is Alzheimer's disease, a degenerative disease accounting for 50–70% of all cases of dementia.

**Equity**
Equity in health implies that everyone should have a fair opportunity to attain his or her full health opportunity, and that no one should be disadvantaged from achieving this potential.

**Evidence Based Practice**
Clinical decision-making based on a systematic review of the scientific evidence of the risks, benefits and costs of alternative forms of diagnosis and treatment.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>GP Plus</td>
<td>A South Australian initiative which identifies opportunities for health care professionals to work in a more collaborative way to strengthen primary health care services</td>
</tr>
<tr>
<td>Health Inequalities</td>
<td>Health inequalities are the differences between actual and optimal health status that are avoidable and unfair</td>
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<tr>
<td>Integrated model of care</td>
<td>A model that provides clients with appropriate levels of health care support depending on level of need</td>
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<tr>
<td>Interdisciplinary care</td>
<td>Comprehensive care provided by a team of various health professionals (medical – general and specialist, nursing and allied health), using a care team approach and tailored to decision-making regarding diagnosis, treatment planning and other aspects of care for individual patients.</td>
</tr>
<tr>
<td>Key Performance Indicators</td>
<td>A concise list of indicators, which are used to measure agency effectiveness in achieving outcomes</td>
</tr>
<tr>
<td>Outcome</td>
<td>Outcomes are the results, impacts or consequences of actions by SA Health on the South Australian community that SA Health wishes to achieve</td>
</tr>
<tr>
<td>Partnership</td>
<td>A voluntary arrangement developed between parties to work co-operatively towards shared and/or compatible goals. It implies sharing of decision-making, resources and risks, trust, cooperation and negotiation of shared goals towards interests in a shared future</td>
</tr>
<tr>
<td>Person Centred Care</td>
<td>A focus on the diverse needs and specific circumstances of a person with a chronic condition and their family and carers where appropriate. It requires the development of partnerships between the health professional and the person with a chronic condition, the family and carers in the prevention and management of their chronic conditions. It also involves care being provided across organisations and services in ways that appears seamless to the person</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>The use of five or more drugs, including prescribed, over-the-counter, and complementary medicines. Polypharmacy is often associated with older people, and often represents suboptimal prescribing, increased risk of adverse drug interactions, falls, and a prescribing cascade where more drugs are prescribed to counter the side effects of other drugs</td>
</tr>
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</table>
Glossary

**Self Management**
Involves (the person with the chronic disease) engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes.

**Self-Care**
The participation of individuals in managing the disease specific, everyday elements of their condition, such as medications and lifestyle choices.

**Social Determinants of Health**
The personal, social, cultural, economic and environmental factors that influence the health status of individuals or populations.

**Socio-economic status**
A relative position in the community as determined by occupation, income and level of education.

**Specialist health services for older people**
This refers to:
- specialist mobile outreach services
- older person acute assessment services
- older person assessment and management units
- specialist services for stroke management, dementia care, mental health, palliative care and rehabilitation
- specialist consultation and liaison services

**Stages of Disease**
For chronic, non-communicable disease there is a continuum from a disease-free state, to asymptomatic biological change to clinical illness, impairment and disability, development of complications, and, for many conditions, ultimately death.

**Sub acute/post acute care**
Terms denoting care provided following an acute episode, often used interchangeably. In Victoria, however, sub-acute care can refer to any formal care provided either as an inpatient or in an ambulatory setting, whereas, post-acute care is a short term community based package of personal or nursing/allied health care aimed at facilitating a supported discharge home when alternative support is unavailable.

**Whole of Population Services**
Refers to the following health services:
- primary health care – illness prevention, health promotion and early intervention, maintenance and therapy services
- general practice (general practitioners and practice nurses) minor acute and chronic disease management services
- acute and sub acute care – ambulatory, community based, and in hospitals providing general services within their catchment areas (including mental health), multi purpose facilities, community based mental health, restorative, rehabilitative and end of life/palliative care services
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