

# Aged Care Network

## Geriatric Evaluation & Management (GEM) Model of Care

For the Older Person in WA  
1 July 2008



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## EXECUTIVE SUMMARY

The proposed *Geriatric Evaluation and Management Model of Care for Western Australia* is a short term rehabilitation option that forms part of a larger rehabilitation framework of care needed for older people in the health system. It is part of a cascade of rehabilitation therapy options proposed for WA Health outlined in the Rehabilitation and Restorative Care Services Model of Care for the Older Person in WA (See Appendix One).

The GEM model of care provides an effective, early multi-disciplinary rehabilitation intervention model for assessment, management and treatment of geriatric syndromes of older people in the acute care sector.

The distinguishing feature of the proposed model for the WA health system is the early application of the principles of geriatric care in the inpatient, acute care setting with the introduction of the clinical care pathway once the older person's medical condition has stabilised.

The successful integration of the GEM model of care in the tertiary care setting rests on changes in clinical practice which sees the role of the geriatrician and the multi-disciplinary team involved at a much earlier stage in the acute care journey of the older person.

International research through randomised controlled trials has demonstrated that the inpatient GEM model is effective in reducing functional decline in the older patient, reducing mortality and reducing the need for long term care. The benefits to the health care system are proven reductions in hospital lengths of stay. There is also evidence to suggest reduction in hospital readmission rates.

Strengthening existing hospital aged care services through the introduction of this model is an effective way of preventing functional decline for conditions which are reversible. It also helps to support and promote independence and self-management for the older patient and assists the older person to be able to live independently in the community for as long as possible.

GEM is supported by national policy and guidelines through the ministerially endorsed National Action Plan, (*Aged Care Friendly Principles, From Hospital to Home, Best Practice Approach to Minimise Functional Decline in the Older Person across the acute, sub-acute and residential aged care setting and Guide to Assessing Older People in Hospital*)<sup>1</sup> and through the COAG Long Stay Older Patients' Initiative.

GEM inpatient units should be established in Tertiary (Level 6) Hospitals and in Level 5 hospitals where emergency departments are located. In rural and remote areas, GEM should be established in Regional Resource Hospitals where an emergency department is located.

To successfully support the implementation and integration of GEM in the health system, other home and residential care facility based rehabilitation and restorative options need to be established.

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<sup>1</sup> These materials were commissioned and published on behalf of the Australian Health Ministers' Advisory Council (AHMAC) by Care of the Older Australian Working Group in November 2004.



These options will need to be supported by adequate levels of community care support services where appropriate to gain the most benefit from the rehabilitation intervention when the older person returns to their usual place of residence.

A shared care model in which geriatric services are provided in an advisory role may also be appropriate for sites that wish to transition to the application of the GEM model of care, particularly in situations where workforce constraints operate. Alternatively, the multi-disciplinary team could include medical physicians with aged care expertise. This would be especially relevant in the case of Regional Resource Centre hospitals where geriatric services may be difficult to access.

*Peter Goldswain*

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## ACKNOWLEDGEMENTS

The Aged Care Network Sub-group for Geriatric Evaluation and Management was convened in September 2007 to undertake the development of a *Geriatric Evaluation and Management Model of Care for the Older Person in Western Australia*. The sub-group brought together geriatric expertise from the acute care sector, rural health and community care to explore the benefits of this model of care for older people in hospital and how the model could be integrated within the existing health system.

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The Aged Care Network commends the collaborative and professional approach of the sub-group and the invaluable direction and guidance they provided. Particular thanks go to the Royal Perth Hospital Geriatric Evaluation and Management team for their provision of project data and service information.

Further specific consultation has been undertaken at clinical physician level across the three metropolitan tertiary hospitals regarding viability and evidence for the GEM model of care.

Feedback on the model of care document was also sought from the three formal committees that form the Aged Care Network; the Clinical Advisory Committee, the WA Ministerial Aged Care Council and the WA Community Care Reference Advisory Group.

The GEM model of care was part of discussions and consultation at the Aged Care Network Forum held at the University Club WA in April 2008. Additional feedback was sought through a questionnaire distributed across the Aged Care Network and WA Health.



## RECOMMENDATIONS

### Recommendation One

Establishment of an inpatient GEM unit in Level 6 hospitals and Level 5 hospitals where an Emergency Department service is located as a way of early identification and minimisation of functional decline in older inpatients and hospital costs through reduced length of stays.

In the rural sector, inpatient GEM units to be established at Regional Resource Centres where an emergency department is located. Where workforce constraints prevail, a geriatrician will provide clinical advisory and consultation services supported by a multi-disciplinary therapy program.

Dedicated ward staff trained in the practices of rehabilitation intervention therapy should be available where dedicated wards or beds are not possible.

### Recommendation Two

Education and staff training frameworks for GEM to be developed and implemented across the state. Mutual understanding of the philosophy and key components of a GEM service model to be a key requirement of the training. and identification of opportunities for rural metropolitan education and training partnerships.

### Recommendation Three

Support the development and implementation of workforce recruitment strategies targeting gaps in the allied health workforce to support the implementation of the GEM model of care.

### Recommendation Four

Community and in-home rehabilitation and restorative care options to be strengthened or established to effectively support a GEM model of care.

- Ensure that Rehabilitation in the Home (RITH) programs are established from hospitals with GEM inpatient units to facilitate timely and appropriate discharge.
- Expand Rehabilitation in the Home (RITH) programs to include domestic and personal support so that the older person can be better supported at home during the recovery process.
- Promote the use of Transition Care Services community packages as a viable and suitable rehabilitation in the home therapy option.

### Recommendation Five

Development of a dedicated model of care that focuses on Day Therapy Centre (currently termed outpatient Day Hospital) service delivery.

### Recommendation Six

Options to provide rehabilitation units in rural and remote areas to be considered, especially in larger centres.



### **Recommendation Seven**

The development of a formal agreement between WACHS and the Departments of Geriatric Medicine/Aged Care Services at Level 6 metropolitan hospital sites to promote the organisation and distribution of visiting geriatrician services to WACHS Regional Resource Centres and support the development of GEM Units and GEM care principles.

### **Recommendation Seven**

Residential Transition Care services to be extended with the number of flexible places available increased.

### **Recommendation Eight**

Care Awaiting Placement services to be adapted to support the establishment of GEM inpatient units.

- A redistribution of CAP residential places to the south metropolitan area needs to be considered.
- Adapt the existing CAP residential program to a TCS model of care to improve access to residential transition and restorative care options for the older person.
- Secure an additional allocation of transition care places from the Australian Government.

### **Recommendation Nine**

Develop and implement a communications and marketing strategy that promotes the profile, key issues and trends relating to the care of older people in the WA health system.

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## 1. OVERVIEW

### 1.1 Scope

This document outlines the key elements of the Geriatric Evaluation and Management (GEM) model of care.

Research evidence strongly supports the establishment of this model of care in the acute care sector as a way to reducing hospital costs through reduced length of stay and reduced hospital readmissions while at the same time, improving the quality of life of older persons by promoting independence and self management.

In the context of the journey of the older patient through the acute care sector this document outlines the:

- key components of a GEM model
- requirements to establish a GEM model in the acute care sector in Western Australia
- way in which the service model can integrate with the existing health system.

This model is part of the *Aged Care Network Model of Care for the Older Person in WA*<sup>2</sup> and is founded on the underlying conceptual and strategic framework of the State Aged Care Plan, particularly the Transitions Action Plan<sup>3</sup>, where streamlining assessments and effective coordination are core goals.

### 1.2 Key Features

- focus on generic syndromes of ageing that require rehabilitation intervention
- focus on early identification processes
- focus on early intervention for reversible conditions
- focus on improved management and timely transitioning of elderly people in the acute setting
- recognition of the interplay of co-morbidities and conditions of ageing on management of elderly people in the acute setting
- sensitisation of medical and allied health staff to the early rehabilitation care needs of the older population
- an inpatient GEM model promotes a wellness and restorative model of care approach.

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<sup>2</sup> Aged Care Network. Model of Care for the Older Person in WA. Department of Health. 2007. Perth.

<sup>3</sup> WA Aged Care Advisory Council. Transitions Action Plan for WA 2004-2007. 2004. Department of Health. Perth.



## 2. BACKGROUND TO THE DEVELOPMENT OF THE GEM MODEL

The concepts of GEM models were first developed in Great Britain in the 1930s largely through the work of Dr Marjory Warren.

As far back as 1946 the potential application and benefits of geriatric care principles to the hospital system were observed by Dr Warren;

“the inclusion of the geriatric unit in a general hospital ... with the necessary staff for investigation, consultation and treatment, would raise the standard ... shorten the time of stay in hospital and avoid the unnecessary blocking of beds”.<sup>4</sup>

United States interest in GEM models began in the early 1970 when the National Institute of Ageing established research grants for researchers interested in aging and gerontology. Dr TF Williams undertook the first descriptive studies on an outpatient assessment clinic in 1973. LZ Rubenstein et al<sup>5</sup> described significant positive outcomes for the patient and the hospital in the first randomised control trial of a GEM Unit in 1984.

Interest in specialist geriatric assessment units began in Australian hospitals in the 1960s with the development of Extended Care Departments and Departments of Geriatric Medicine. The scope of these was expanded with the introduction of multidisciplinary Aged Care Assessment Teams in the 1980s.

Western Australia’s first inpatient GEM unit was established in 2002 in Royal Perth Hospital as part of the National Demonstrations Hospital Pilot (NDHP) Phase 4 program, which explored the use of multidisciplinary teams to manage elderly patients identified at risk.

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<sup>4</sup> page 3, Dr M Warren quote. Lefroy RB. Geriatric medicine: early policy and practice in Western Australia. 2005.

<sup>5</sup> Rubenstein LZ, Josephson KR, Weiland GD, English PA, Sayre JA, Kane RL. Effectiveness of a geriatric evaluation unit: A randomised clinical trial. *New England Journal of Medicine* 1984;311:1664-1670.



### 3. OBJECTIVES OF THE GEM MODEL

- reduction in hospital lengths of stay
- reduction in inappropriate use of acute care hospital beds by reducing bed blocking
- promote recovery and reduce functional decline
- decrease of risk of deconditioning
- reduction in hospital readmissions
- reduction in entry to higher levels of institutionalised care
- reduction in mortality outcomes
- prevent onset of development of pressure areas, decreased mobility and associated weakness and falls, the development of delirium, incontinence and malnutrition
- improve quality of life for the older person.

### 4. DRIVERS FOR CHANGE

- The projected growth of older people aged 65 years and over (13.4%) and especially the very old aged 85 years and over (5.6%) over the next 40 years combined with the reduced mortality and increased life expectancy of the ageing population will place increasing pressure on the demand for acute care services and rehabilitation services.<sup>6</sup>
- Inequity of access exists in the availability of dedicated GEM services across the tertiary hospitals in the metropolitan area (see Appendix Two - Part One).<sup>7</sup>
- Current utilisation of the GEM program indicates that the 85+ age group is the highest user of such services, with two thirds of admissions being female (see Appendix Two - Part Two).
- A high risk of iatrogenic harm is associated with hospital admission for older people. Hirsch et al<sup>8</sup> noted that functional decline could occur as early as day two of a hospitalisation episode.
- There is considerable evidence that during hospitalisation an older person, due to bed rest and immobility, is at significant risk of deconditioning and irreversible functional decline.<sup>9 10</sup>

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<sup>6</sup> Aged Care Network. Model of Care for Older Persons in WA. Department of Health WA. 2007.

<sup>7</sup> See Appendix Two-Part One: GEM Rehabilitation Service Level Activity. 2005-2007. Unpublished Data. Hospital and Morbidity System. Information Collection and Management Branch. Department of Health WA. October 2007.

<sup>8</sup> Hirsch C, Sommers L, Olsen A, Mullen L, Hunter WC. The natural history of functional morbidity in hospitalised older patients. *Journal of the American Geriatrics Society* 1990;38:1296-1303.

<sup>9</sup> Department of Human Services Victoria. Best practice approach to minimize functional decline in the older person across the acute, sub-acute and residential aged care setting. Victorian Government Department of Human Services. 2004.

<sup>10</sup> Vorhies D, Riley B. Deconditioning. *Clinics in Geriatric Medicine* 1993; 9(4):745.



- Research demonstrates that the early identification and early intervention for reversible geriatric syndromes is a critical prevention strategy for the older person. It also supports the health care system by reducing hospital length of stay. The potential to reduce hospital readmissions through the reversal of decline and effective discharge planning also exists.
- Inequity exists in the availability of dedicated generic sub-acute rehabilitation services for older patients in the metropolitan and rural and remote areas.
- Inequity exists in access to consultative geriatric clinical services, especially in rural and remote areas.
- Inadequate levels of ambulatory care services for older patients.
- Limited access to transition care rehabilitation services.
- The positive outcomes of the National Demonstrations Hospital Pilot (NDHP) Phase 4 program of a GEM inpatient unit at Royal Perth Hospital.
- National agreement to implement the National Action Plan<sup>11</sup> for improving the care of older people across the acute aged care continuum and adopting aged care friendly principles and practices.
- Implementation of the COAG Long Stay Older Patients' Initiative<sup>12</sup> to enhance system-wide coordination for older patients accessing aged care services and improve their management on entry to and as an inpatient of acute care to reduce avoidable admissions of older patients to hospital.

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<sup>11</sup> Australian Health Ministers' Advisory Council, Care of the Older Australian Working Group. From Hospital to Home: Improving outcomes for older people. July 2004

<sup>12</sup> Aged Care Policy Directorate. COAG Long Stay Older Patients Initiative Implementation Plan. Department of Health WA. November 2006.



## 5. EVIDENCE BASED BEST PRACTICE

### 5.1 Research Evidence

There is considerable clinical and evidence based research to support that an inpatient GEM model of care has significant benefits both for the older patient as well as for hospital and the broader health system. Despite some studies reporting little or no benefit of a geriatric evaluation and management model of care, there is substantial evidence to support the effectiveness of this model of care.

Appendix Three summarises evidence of randomised controlled trials involving GEM and the core outcomes achieved.

Rubenstein's seminal study in the United States in 1984<sup>13</sup> demonstrated that GEM was effective in reducing function decline in the older patient as well as being effective in the reduction of acute care bed days and hospital utilisation rates for patients of GEM units as compared to general medical admissions. Similar results are evident in a number of other studies undertaken in the US<sup>14</sup>, UK<sup>15 16</sup>, Sweden<sup>17</sup>, Germany<sup>18</sup> and Italy<sup>19</sup>.

Literature shows that a GEM model of care can be provided as an outpatient service, as a consultancy service and as an inpatient model.<sup>20</sup>

Randomised controlled trial evidence demonstrates however, that the most effective way to deliver a GEM model of care is through a hospital in-patient model in a dedicated inpatient unit.<sup>21 22 23 24 25</sup>

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<sup>13</sup> Rubenstein LZ, Josephson KR, Wieland GD, English PA, Sayre JA, Kane RL. Effectiveness of a geriatric unit. A randomised control trial. *New England Journal of Medicine*. 1984;311:1664-1670.

<sup>14</sup> Stuck AE, Siu AL, Weiland GD, Adams J, Rubenstein LZ. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet* 1993; 342:1032-1036

<sup>15</sup> Ellis G, Langhorne P. Comprehensive geriatric assessment for older hospital patients. *British Medical Bulletin* 31 2005; 71(1):45-59.

<sup>16</sup> Landefeld CS, Palmer RM, Kresevic DM, Fortinsky RH, Kowal J. Randomised trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *New England Journal Medicine*. 1995; 332:1338-1344.

<sup>17</sup> Asplund K, Gustafson Y, Jacobsson C, Bucht G, Wahlin A, Peterson J, Blow JO, Angquist KA. Geriatric-based versus general wards for older acute medical patients: a randomised comparison of outcomes and use of resource. *Journal of the American Geriatrics Society*. 2000; 48(11):1381-8

<sup>18</sup> Nikolaus T, Specht-Leible N, Bach M, Oster P, Schlierf G. A randomised trial of comprehensive geriatric assessment and home intervention in the care of hospitalised patients. *Age and Ageing*. 1998; 28:543-550.

<sup>19</sup> Trentini M, Semeraro S, Rossi E, Giannandrea E, Vanelli M, Pandiani G, Bardelli E, Tassini D, Lacetera A, Cortesi P, et al. A multicenter randomised trial of comprehensive geriatric assessment and management: experimental design, baseline data and six-month preliminary results. *Aging*. 1995; 7(3):224-33.

<sup>20</sup> NSW Framework for integrated support and management of older people in the NSW health care system 2004-2006. NSW Department of Health. 2004.

<sup>21</sup> Siggins Miller. Unnecessary and avoidable admissions for older people. A report to the Department of Health and Ageing. September 2003.

<sup>22</sup> Agostini JV, Baker DI, Godardus ST. Geriatric evaluation and management units for hospitalised patients. *Making Health Care Safer. A Critical Analysis of patient Safety*



Agostini et al<sup>26</sup> comprehensive survey on GEM units for hospitalised patients demonstrates that evidence supports the use of GEM inpatient units for effectiveness in preventing outcomes such as mortality, reduced functional decline and reduced nursing home placement.

This report identifies the hallmarks of a GEM unit as;

“multi-disciplinary team rounds and patient centred team conferences..., which in contrast to geriatric consultation services, have direct control over the implementation of team recommendations.<sup>27</sup>”

The presence of a dedicated geriatric nursing and rehabilitative staff associated with the unit and the benefits of a ward specifically designed to address the needs of older patients are also features of a GEM unit.

The evidence also demonstrates there is capacity to incorporate the GEM unit design and care principles within hospital acute care units that focus on care of the elderly or, alternatively referral pathways linked to such units.<sup>28</sup>

There are analogous units operating on a disparate basis across Australia that are focused on the early assessment and care planning for the elderly person. Such units are known as ACE, MAPUs and OPERA.<sup>29</sup> However, the distinguishing feature of the GEM Unit as proposed, is the early introduction of rehabilitation therapy, post admission into hospital.

## 5.2 Australian Health Minister Advisory Council (AHMAC) Endorsement of GEM care principles

Further clinical support for the GEM model of care is demonstrated through the nationally accepted guidelines commissioned by the Australian Health Ministers Advisory Council Care Of Older Australians Working Group and developed and guided by an expert clinical reference group.

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Practices. Evidence Report/Technology Assessment No.43. Chapter 30. AHRQ Publication 01-E058 Agency for Healthcare Research and Quality Rockville, MD. July 2001.

<http://www.ahrq.gov/clinic/ptsafety>

<sup>23</sup> Applegate WB, Millar ST, Graney MJ, Elam JT, Burns R, Akins DE. A randomised, controlled trial of a geriatric assessment unit in a community rehabilitation hospital. *New England Journal of Medicine*. 1990;322:1572-78.

<sup>24</sup> Williams TF, Hill JG, Fairbank ME et al. Appropriate placement of the chronically ill and aged: a successful approach by evaluation. *Journal of the American Medical Association* 1973;266:1332-35.

<sup>25</sup> Ellis G, Langhorne P. Comprehensive geriatric assessment for older hospital patients. *British Medical Bulletin* 31 2005. 71(1):45-59.

<sup>26</sup> Agostini JV, Baker DI, Godardus ST. Geriatric evaluation and management units for hospitalised patients. *Making Health Care Safer - A Critical Analysis of Patient Safety Practices. Evidence Report/Technology Assessment: No 43. Chapter 30. AHRQ Publication 01-E058. Agency for Healthcare Research and Quality Rockville, MD. July 2001.*

<http://www.ahrq.gov/clinic/ptsafety>

<sup>27</sup> page 1, *ibid*.

<sup>28</sup> Landefeld CS, Palmer MD, Kresevic MS, Fortinsky R, Kowal J MD. A randomised trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patient. *The New England Journal of Medicine*.1995;332:1338-1344.

<sup>29</sup> See glossary for terms.



The guidelines include:

- *Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care setting* November 2004. [www.health.vic.gov.au/acute-agedcare](http://www.health.vic.gov.au/acute-agedcare)
- A guide for assessing older people in hospitals September 2004. [www.health.vic.gov.au/acute-agedcare](http://www.health.vic.gov.au/acute-agedcare)

The guidelines were developed using the best available research findings and where research gaps existed, a consensus process was used. They provide interventions and management strategies, which are embedded in the GEM model of care.

### 5.3 WA Evidence - Royal Perth Hospital National Demonstrations Hospital Pilot Phase Four

Western Australia's first dedicated inpatient GEM unit was established in 2002 in Royal Perth Hospital as part of the National Demonstrations Hospital Pilot (NDHP) Phase 4 program using a prospective descriptive design model. This pilot explored the use of multidisciplinary teams to manage elderly patients identified at risk of functional decline. This service integrated with the existing hospital and was cost neutral.

The positive outcomes included:

- reduction in average length of hospital stay
- high rates of discharge to home for those patients living in the community.
- reconfiguration of the staffing model with more enrolled nurses employed
- maintained and improved function for a majority of patients.<sup>30</sup>

A summary of the key statistical outcomes on the pilot can be found in Appendix Four - Part Two. Figure One outlines the care pathway, indicating summary results pre and post the RPH GEM intervention.

An important outcome was the high rates of patient and care satisfaction, particularly satisfaction with the effectiveness of the discharge planning and the availability of support services once discharged from the GEM unit.

Another important outcome was satisfaction on the part of GPs with the communication processes between general practices and the GEM unit.

Clinical practices established during the pilot demonstration project have now become embedded in routine RPH service delivery.

The Australian Institute of Health and Welfare report *Older Australians in hospital*<sup>31</sup> shows that nationally in 2004-05 patients stay between 10.7 to 24.7 days in GEM with an the average length of stay of 22.6 days.

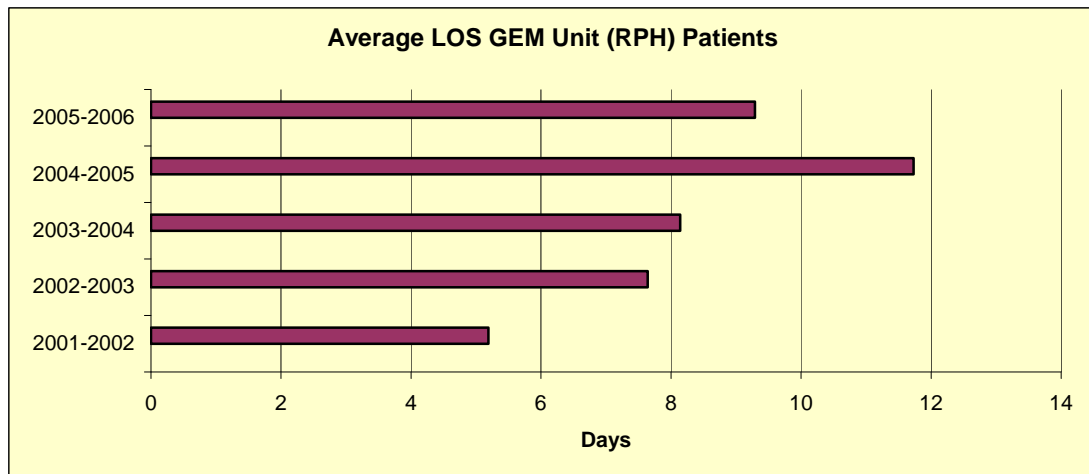
<sup>30</sup> Healthcare Management Advisors Pty Ltd. Department of Health and Ageing National Demonstration Hospitals Program Phase 4: National Evaluation of Project Impact Final Report. December 2003.

<sup>31</sup> Australian Institute of Health and Welfare. *Older Australians in hospital*. Bulletin 53. Table A12;31. Canberra AIHW. 2007.



Table One below shows the average length of stay (days) of patients in the RPH GEM Unit since the program started to financial year 2005-06. This data shows that the average length of stay in this unit is 8.3 days, significantly lower than the national average of 22.6 days.<sup>32</sup>

Table 1. GEM Average Length of Stay Royal Perth Hospital 2001 - 2006



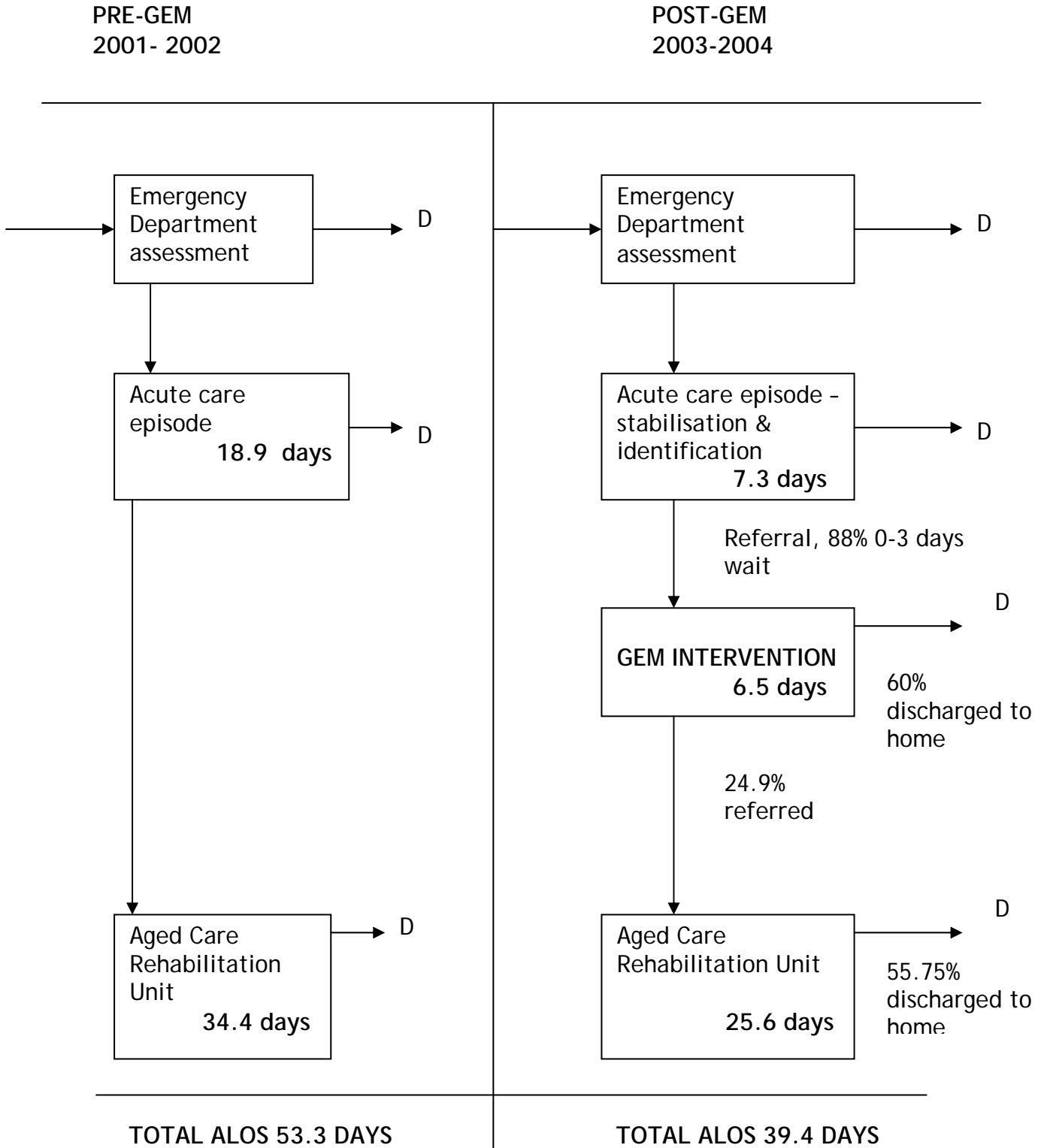
In 2007, over a three-month period June, July and August, the RPH GEM Unit had a total of 176 admissions with an average length of stay of 8 days.

<sup>32</sup> Unpublished data. Hospital Morbidity Data System. Information Collection and Management Branch. Department of Health WA. October 2007. Ref 3413.



Figure 1. Pre and post GEM Rehabilitation Interventions - Royal Perth Hospital National Demonstration Pilot

D= Discharge





## 6. FUTURE SERVICE DELIVERY MODEL OF CARE FOR GERIATRIC EVALUATION

### 6.1 A Model of Care

The Geriatric Evaluation and Management (GEM) Model of Care is not driven by a specific disease or condition of ageing, but a service model with principles and processes that traverse all geriatric syndromes.

The model is characterised by multidisciplinary management and regular assessments to attain negotiated goals within a specific timeframe.

Gallo et al purports that there are five key components to a geriatric evaluation and management model.<sup>33</sup>

These include:

- targeting of appropriate high risk patients
- a patient-centred focus of evaluation and care
- collaborative and interdisciplinary process
- implementation of diagnostic and care plans with involvement of general practitioners
- active participation in the management and coordination of treatment and services along a continuum of care.

A GEM model of care focuses on the older patient and tailors treatment and management to the assessed needs of the individual. It promotes independence of the older person and self-management.

The promotion of self-management empowers patients to acquire the skills, knowledge and confidence they need to better manage their own health condition.<sup>34</sup>

A GEM model provides multidisciplinary, comprehensive geriatric assessment of physical, emotional and functional status. It provides treatment planning for the prevention and management of common geriatric syndromes and functional impairment and decline.

An inpatient GEM model promotes a move away from an illness model of care where patients remain in bed with staff doing a majority of daily activities for patients to an alternative wellness and restorative model approach where people are functionally stimulated and are encouraged to “do for themselves”.

GEM Unit inpatients are encouraged to dress in day clothes and eat meals out of bed and where appropriate, are encouraged to attend to their own personal care needs, to mobilise safely and regularly.

This is under the guidance and supervision of trained geriatric professionals and within a well defined and staged management and treatment plan. The

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<sup>33</sup> Gallo JJ, Fulmer T, Paveza GJ, Reichel W. Handbook of geriatric assessment. Third Edition. Aspen Publishers. Maryland 2000.

<sup>34</sup> Health Reform Implementation Taskforce. Ambulatory and community-based care: a framework for non-inpatient care. Department of Health WA. June 2007.



décor and set-up of the unit, ideally, should be as similar to the home environment as possible.

This approach builds capacity in the older person and has a positive effect on their self esteem and ability to self-manage their day to day life.

Cultural values and special needs of indigenous people and those from non English speaking backgrounds are considered in the development and implementation of treatment, management and discharge plans.

The model also recognises, values and engages carers early in the development and implementation of a management plan. The model supports carers through the provision of information about care and services and through education and training in the management of care needs. Caregivers often play a vital role in helping the patient to maintain the highest possible level of health and functional independence.



## 7. CLINICAL PATHWAY FOR THE GEM MODEL

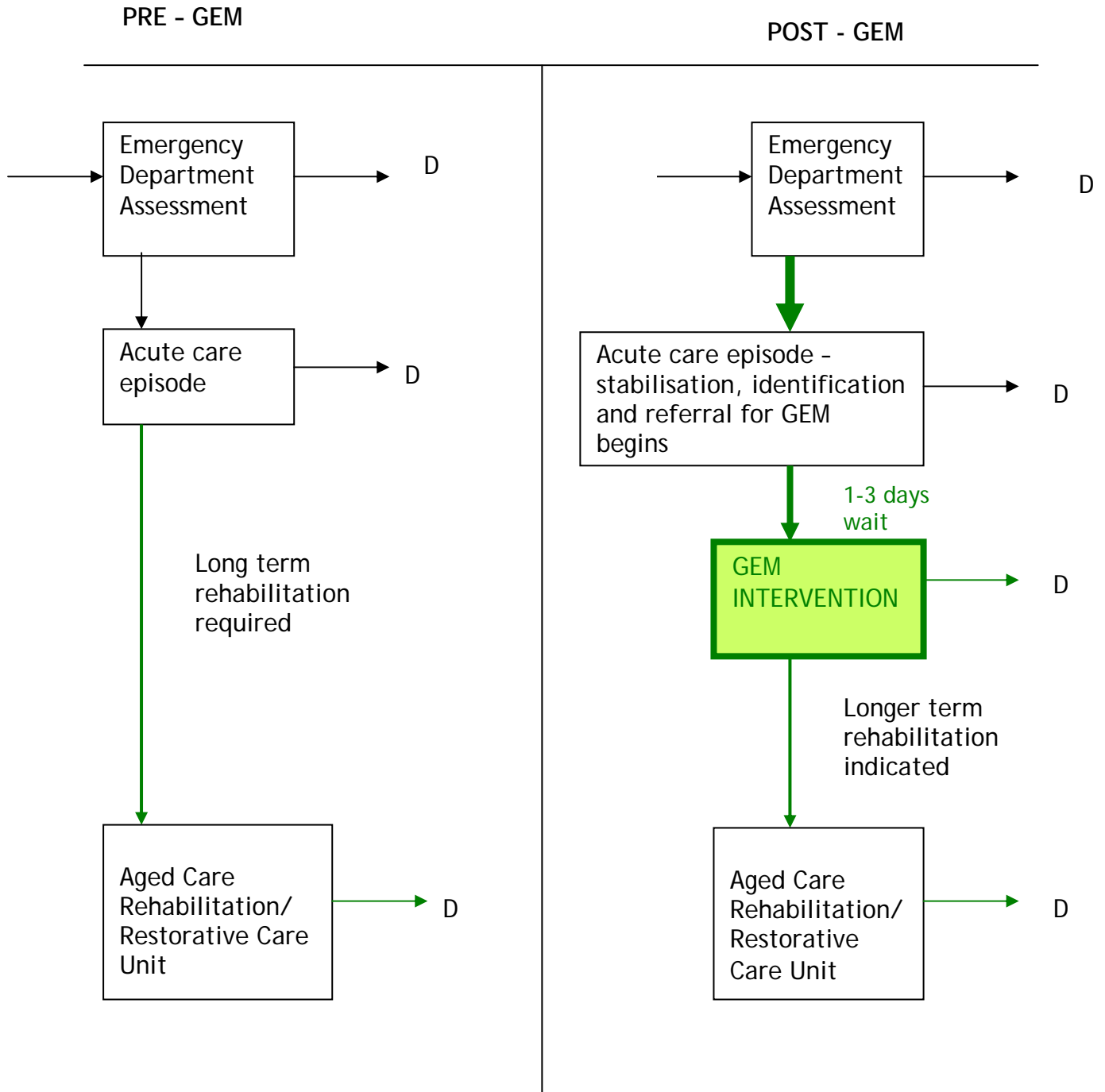
The key aims of the clinical pathway are:

1. to provide rapid and early access to rehabilitation for elderly people
2. increased access to geriatric inpatient care for elderly people across the hospital
3. improved liaison with other specialists and General Practitioners
4. improved discharge planning with linkages to the community care sector and outpatient based patient services.

Figure Two describes the care pathway pre and post the GEM rehabilitation intervention and the point at which integration along the care pathway takes place.



Figure 2. Rehabilitation Intervention



D = discharge to place of residence



## 8. ESTABLISHING AN INPATIENT GEM UNIT

There are a number of key components to establishing an inpatient GEM Unit.

These include:

### *1. An established mutual understanding of the philosophy and design of GEM*

This understanding is required both by the staff of the unit but also by the broader hospital staff and management to ensure smooth linkages with other areas of the acute system. This helps to facilitate appropriate and timely referrals, transfer and discharge planning, should a patient need to transfer to other wards of the hospital for example when an acute episode occurs in the GEM unit.

### *2. Employment of dedicated staff*

A dedicated team of professionals skilled in geriatric and rehabilitation care is essential to ensure the success of the model. There is descriptive evidence of positive and improved retention and recruitment of nursing staff to a GEM inpatient unit.<sup>35</sup>

### *3. Designated space adapted for the model*

Environmental factors such as cluttered hospital rooms and inadequate lighting are known to contribute to functional decline.<sup>36</sup> A designated area for GEM is required to visually and psychologically separate the model from the broader hospital culture of illness towards an enabling model of care.

A GEM unit can be established on a designated ward within an acute hospital setting where access to dedicated therapy (ideally located on the unit). Separate dining and activity areas are needed to promote the model of care. The décor and set-up of the unit, ideally, should be as similar to the home environment as possible.

### *4. Adequate resources*

Whilst cost neutral establishment and benefits of GEM have been reported it is essential to provide adequate resources to establish and maintain dedicated staff, the dedicated space and equipment and necessary training programs to ensure the success of the model.<sup>37 38 39</sup>

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<sup>35</sup> Burt C. Final National Demonstration Hospital Pilot 4 Report. The establishment of a geriatric evaluation and management unit at Royal Perth Hospital. August 2003.

<sup>36</sup> NSW Department of Health. Framework for integrated support and management of older people in NSW health care system 2004-2006. 2004.

<sup>37</sup> Burt C. Final National Demonstration Hospital Pilot 4 Report. The establishment of a geriatric evaluation and management unit at Royal Perth Hospital. August 2003.

<sup>38</sup> Cohen HJ, et al. A controlled trial of inpatient and outpatient geriatric evaluation and management. *New England Journal of Medicine* 2002;346:905-912.

<sup>39</sup> Veterans Health Administration. Geriatric evaluation and management procedures: VHA Handbook. February 2005. Washington DC.



## 5. Adequate training and education

A clear understanding of the rehabilitation philosophy of care is essential to the model. Education and training are therefore critical requirements. Training and education for the carer as part of the rehabilitation process is also necessary and should commence immediately when rehabilitation takes place in the GEM unit.

### 8.1 Target Group

The early identification and referral of appropriate inpatients to a GEM unit is essential to maximise patient and hospital outcomes. Not all older, acutely ill inpatients are appropriate for admission.

To be suitable for admission to a GEM unit, patients need to be medically stable and have had their acute care needs addressed or their acute care needs are in the process of resolving.

The following table provides a guideline of indicators<sup>40 41 42</sup> for selecting appropriate patients.

**Table 2. Guideline of indicators for selecting appropriate GEM patients**

Indicators for Inclusion	Indicators for Exclusion
<ul style="list-style-type: none"> <li>▪ 65 years and older (ATSI 55 years and older)</li> <li>▪ Have one or more medical condition with functional impairment</li> <li>▪ Able to engage in, be motivated for and benefit from rehabilitation as assessed by a geriatrician</li> <li>▪ Functionally active prior to admission to hospital</li> <li>▪ At risk of requiring increased levels of community care or residential care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Severe dementia or difficult behaviour which prevents engagement in therapy</li> <li>▪ Inability to engage in therapy</li> <li>▪ Patients needing major wound care or at risk in relation to infection control</li> <li>▪ Patients on dialysis</li> <li>▪ Active significant co-morbidities</li> <li>▪ Patients who require extensive rehabilitation including limb amputation and spinal cord</li> <li>▪ Are able to access an alternative rehabilitation pathway</li> <li>▪ Patients care awaiting placement</li> </ul>

### 8.2 Team Composition

Care is provided by a dedicated team of professionals skilled in geriatric and rehabilitative care under the leadership of a geriatrician. The composition

<sup>40</sup> Burt C. <sup>40</sup> Burt C. Final National Demonstration Hospital Pilot 4 Report. The establishment of a geriatric evaluation and management unit at Royal Perth Hospital. August 2003.

<sup>41</sup> Veterans Health Administration. Geriatric Evaluation and Management Procedures: VHA Handbook. Washington DC. 2005.

<sup>42</sup> Department of Health. Geriatric Evaluation and Management-Definitions and Reporting Requirements. Technical Bulletin 79/0. OP2031/06. January 2006.



and size of the in-patient team depends essentially on the primary function of the unit, the size of the unit and access to appropriate workforce.

As geriatric assessment, treatment and rehabilitation are core to the unit, the team includes the following components:

- geriatrician (registrar and resident medical officer/intern),
- nursing coordinator
- social worker.
- registered and enrolled nurses
- physiotherapist
- occupational therapist

Other professionals are consulted to assist with specialist needs. This may include but is not limited to speech therapy, dietician, podiatry and psychiatry.

In rural and remote areas where access to geriatricians and geriatric trained staff may be limited the use of technology, video and telephone conferencing can be utilised to access geriatric and rehabilitation specialist input. This access can support an established dedicated medical team in providing the treatment and management philosophy and skills needed for the model.



## 9. LINKAGES WITH A GEM UNIT

A description of the inpatient's journey assists in understanding where and how a GEM is linked to existing hospital services and its relationship with community care and the residential care system.

The following outline describes these potential pathways and shows the links with existing services. It also identifies areas in the current health care sector where gaps in service may exist and what is needed to support the establishment of an inpatient GEM.

### 9.1 Emergency Department

#### Risk assessment and identification

Patients enter hospital via the Emergency Department or via a planned admission for a specific treatment intervention, such as surgery. Regardless of the hospital entry point, or whether a planned or unplanned admission, the patient's acute care needs require to be addressed as a first priority.

Through the COAG Long Stay Older Patients Initiative<sup>43</sup>, patients are risk screened at admission for functional decline across a number of domains.<sup>44</sup> Those at higher risk are identified and a comprehensive assessment, if required, is commenced. Links to the Aged Care Services/ Department are also initiated. This provides an essential foundation for the identification of patients who would benefit from the services provided by a GEM unit and serves as the first step to commence the discharge planning process from an early point.

Usually within the first few days of admission, the patient's health is stabilised and the medical and surgical team addresses the acute care needs. The older patient's potential and need for rehabilitation is assessed during this stabilisation period. For patients with rehabilitation potential, it is at this stage where a referral and transfer to GEM would be made if clinically appropriate. Direct referrals from the emergency department to GEM are therefore less likely to occur.

Where possible all older patients with rehabilitation potential could be transitioned through the GEM unit. The Unit is a short stay unit and as such those older patients needing medium or long-term rehabilitation will need to transfer to other rehabilitation options. To enable this, a clear, timely and supported transition pathway upon discharge from GEM is required.

### 9.2 Acute Care Readmission

GEM patients who may become acutely ill will need to return to an acute care ward, to an appropriate specialty that best meets their needs. To ensure a

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<sup>43</sup> Aged Care Policy Directorate. COAG Long Stay Older Patients Initiative Implementation Plan. Department of Health. November 2006. The Eldercare Pathway is outlined in the implementation plan. The commencement of this pathway begins with a risk assessment in the emergency department followed by a comprehensive assessment if necessary.

<sup>44</sup> This occurs through Care Coordination teams in the metropolitan area and NAP Coordinators in the regional resource hospitals in rural areas.



smooth and timely transfer to the acute ward, a mutual understanding of the philosophy and key components of the service model are required. Education and staff training is essential.

### 9.3 Home to the Community

Patients who require further rehabilitation at home following discharge currently have four pathway options. Patients can be discharged under an ambulatory care program such as:

- Rehabilitation in the Home (RITH)
- Home Care Packages
- Personal Enablement Packages or
- Home and Community Care services

Patients can also be referred to outpatient Day Therapy Centre (Day Hospital) services located at Aged Care Rehabilitation Units (ACRU's) as part of the discharge planning process undertaken by the GEM Unit team.

One of the key components of the GEM service is to commence the discharge planning process from an early stage. A home visit by a member of the team is made to assess the need for modifications and assessment of environmental and social factors that will impact on recovery and readjustment to home or place of residence once discharged.

RITH programs<sup>45</sup>, staffed by the acute hospital, provide short-term rehabilitation services in the patient's home. This virtual bed program is available in the metropolitan area in varying capacities, and in limited rural areas.

In its current form, the RITH program does not provide additional domestic and personal care support, a service that the older patient group may require to maximize their rehabilitation potential. RITH should be available in all regions and a clear pathway from GEM to RITH programs needs to be facilitated.

Currently some metropolitan hospitals use Home Care Packages (HCP) with RITH programs to provide support for the older person and assist in achieving maximum benefit from RITH. This arrangement is limited by the number of HCPs available.

Patients who are HACC eligible and require rehabilitation post discharge may be suitable for a Personal Enablement Package (PEP). This package is short term and provides a range of services in a person's home directly upon hospital discharge. The package employs strategies such as task simplification, trialing aides and equipment, education on self-management for chronic health conditions and exercises to reduce or eliminate the need for ongoing services or readmission to hospital and prevent or delay functional decline. It is provided in the home for up to eight weeks by an interdisciplinary team of health professionals and carers.

Patients may be discharged home to the community with or without assistance. Patients with an ongoing disability and needing ongoing domestic

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<sup>45</sup> Other programs include RAILS (OPH) and Homelink (SCGH)



and personal care may be eligible for a Home and Community Care (HACC) Service.

As the GEM model utilises a wellness approach, referral to a HACC service which embraces a wellness approach (“Wellness Approach To Community Home Care” (W.A.T.C.H.)) in their service delivery should be encouraged to foster continuity of care. A GEM unit can foster links with these agencies through shared assessment communication of patient and carer needs.

The focus of the GEM service is to augment the skills learned in the rehabilitation setting that assist the older person in community reintegration. Older patients may also be suitable for a referral to other appropriate outpatient clinics and community physiotherapy and exercise programs.

### *Recommendation*

Community and in-home rehabilitation and restorative options need to be strengthened or established to effectively support a GEM model of care.

## 9.4 Rehabilitation Unit

Discharge to a Rehabilitation and Aged Care Unit (ACRU) is one possible pathway from GEM for those patients requiring longer-term rehabilitation. At present, rehabilitation and aged care units provide approximately 270 beds in total in the metropolitan area for rehabilitation, sub-acute care and maintenance care<sup>46</sup>.

The current location of the rehabilitation and aged care units with their number of beds is as follows:

- Armadale-Kelmscott Health Service (24)
- Bentley Health Service (36)
- Fremantle Hospital and Health Service (36)
- Joondalup Health Campus (24)
- Mercy Hospital (24)
- Peel Health Campus (10)
- Swan Health Service (24)
- Osborne Park Hospital (90)

Geraldton (6 beds) is the only dedicated Aged Care Rehabilitation Unit available in the rural sector.

At the completion of a rehabilitation unit stay, some older patients may benefit from attending outpatient a Day Therapy Centre (currently termed Day Hospital) which are co-located with Aged Care Rehabilitation (ACRUs). Day Hospitals provide short-term, active, targeted rehabilitation therapies for those older patients who would most benefit from a multidisciplinary environment.

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<sup>46</sup> Statewide Rehabilitation Service Plan for WA. Department of Health. Unpublished. April 2004.



Qualitative evidence from the GEM Aged Care Network sub-group has indicated that waiting lists exist for access to multi-disciplinary services provided by the Day Therapy Centres (currently termed outpatient Day Hospitals) across the metropolitan area.

### *Recommendation*

Options to provide rehabilitation units in rural and remote areas need to be considered, especially in larger centres where population demographics indicate a potential demand for such services.

### *Recommendation*

Development of a model of care that focuses on Day Therapy Centre service delivery as proposed by the Aged Care Network in the Rehabilitation and Restorative Care Services Model of Care for the Older Person in WA.

## 9.5 Transition Care

Older patients who require longer slow stream rehabilitation and a mix of domestic and personal care can receive this rehabilitation and care in their own home through a Transition Care Service (TCS). The primary aim is prevent the early admission into institutionalised residential care. This service, which is accessed directly upon the older patients discharge from hospital, can provide up to 12 weeks (18 weeks with extension) to continue their rehabilitation at home.

This program clearly embraces and utilises the multidisciplinary, comprehensive and rehabilitation philosophy and principles of a GEM unit.

Older patients who are not suitable for rehabilitation at home but require the support of 24 hour nursing care can be admitted to TCS residential. TCS provides lower level rehabilitation care for 12 weeks (up to 18 weeks with an extension). Older patients can enter TCS directly from a GEM Rehabilitation Unit or from an acute hospital bed.

Residential TCS is currently located in the north and south metropolitan area health regions. The north metropolitan region has access to 20 residential TCS places. The south metropolitan region has access to 30 residential TCS places.<sup>47</sup>

TCS became operational in the South West from September 2007, and services in the Midwest and Lower Great Southern began in January 2008 and May 2008 respectively. Residential TCS is not available in rural or remote areas. However, the South West has a 5 virtual bed TCS model successfully operating. The TCS model in the Great Southern and Midwest also provides this virtual bed option.

Demand for TCS residential currently outstrips the supply, especially in the north metropolitan area, where waiting lists for residential services exist. Qualitative information from the sub group and from transition care service

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<sup>47</sup> A waiting list of an average of 8 patients per week (as at June 8 2008)<sup>47</sup> were waiting to access a Transition Care place in the north metropolitan area.



providers indicate that there is potential for a greater number of referrals to the service if patients could be accommodated more quickly. Delays in access result in some older patients needing to stay longer in hospital. Increasing TCS residential places in the metropolitan area would enable a more appropriate and timely discharge of older patients from hospital.

As TCS is a jointly State and Commonwealth funded program, expansion is dependent on an offer of places from the Australian Government. Additional places should be pursued to expand the program and to secure Australian Government funding.

### *Recommendation*

Residential Transition Care Services to be extended with an increase in places available in the metropolitan area.

## **9.6 Care Awaiting Placement**

Some older patients are unable to benefit from rehabilitation and require permanent residential care. Due to a shortage of commonwealth funded aged care residential places in WA, patients need to be transferred to more appropriate accommodation to await a suitable vacancy, hence making available acute care beds. These patients can be transferred to Care Awaiting Placement (CAP).

Currently there are 223 CAP places available in the metropolitan area. These places are predominantly available in the north and east metropolitan areas. With expected population growth in the southern coastal strip and the expected development of the Southern Tertiary Campus (Fiona Stanley Hospital), CAP places in the south metropolitan area will need to be sourced. Redistribution of existing places should be considered.

Adding a restorative, multidisciplinary component to components of the existing CAP model and converting it to a transition style model which embraces and utilises the multidisciplinary, comprehensive and rehabilitation philosophy and principles of a GEM unit would enable another option for older patients requiring time and restorative intervention to maximise their potential. This adaptation would enable greater access to TCS and reduce hospital length of stay for this patient group. It would maximise options for the older patient, helping to reduce functional decline and would provide an opportunity to secure future funding from the Australian Government, reducing State government expenditure on this program.

### *Recommendation*

A redistribution of CAP residential places to the south metropolitan area needs to be considered.

### *Recommendation*

Adapt some of the existing CAP residential program to a TCS model of care to improve access to residential transition and restorative options for the older person.



### *Recommendation*

Secure an additional allocation of transition care places from the Australian Government.

### **9.7 Residential Care Facilities**

The focus on early risk assessment and rehabilitation interventions through the GEM model of care promotes and maintains functional independence and mobility. The GEM intervention has the potential to prevent delay of entry to a residential care facility, or progression to a higher level of residential care.

Quality of life is thereby enhanced for the older person and their carer.

A key feature of the GEM model is the early establishment of communication links and commencement of the discharge planning process. This process will support the care of the older person by the GP and the re/adjustment factors when the older person is discharged to a residential care facility.

### *Recommendation*

Adoption of the GEM model to ensure early access to rehabilitation on admission to an acute care hospital in order to prevent potential reversible functional decline for older people who are admitted from a residential care facility.



## 10. FUTURE GEOGRAPHIC LOCATION OF GEM UNITS

As identified in the WA Health Clinical Services Framework 2005-2015<sup>48</sup>, inpatient GEM units should be established in all Tertiary Hospitals (Level 6):

- Royal Perth Hospital
- Sir Charles Gairdner Hospital
- Fremantle Hospital
- Proposed southern tertiary campus (Fiona Stanley Hospital when constructed)

Inpatient GEM units can also be established in Level 5 hospitals where emergency departments are located and as part of a Department of Aged Care Services. These sites include:

- Swan District Hospital
- Armadale Hospital
- Rockingham Kwinana District Hospital
- Peel Health Campus
- Joondalup Health Campus

In the rural sector, inpatient GEM units should be implemented where WACHS Regional Resource Centres are established, in Level 5 hospitals where emergency departments are located.

WACHS Regional Resource Centres<sup>49</sup> are located in

- Broome
- Port Hedland
- Geraldton
- Kalgoorlie
- Albany
- Bunbury

WACHS Regional Resource Centres will provide an aged care management function to better coordinate the planning and delivery of aged care services, minimise duplication of processes including multiple assessments and better up-skilling and support of staff. This will help with integration within and across sectors.

In the rural sector, inpatient GEM units should be implemented where Regional Resource Centres are established and in Level 4/5 hospitals where an emergency department is located.

Where workforce constraints prevail, a geriatrician will provide clinical advisory and consultation services supported by a multi-disciplinary therapy program.

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<sup>48</sup> WA Health Clinical Services Framework 2005-2015. Department of Health. Perth. 2005.

<sup>49</sup> Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010. WA Country Health Service. Department of Health. Perth 2006.



Dedicated ward staff trained in the practices of GEM rehabilitation intervention therapy should be available where dedicated wards or beds are not possible.

Service models in the South West, Great Southern and Midwest Area Health Services, where transition care services and rehabilitation in the home options have been established, should also be initiated.

Appendix Five provides a suggested timeline for implementation of GEM units to year 2016. The suggested timeline is informed by the WA Health Clinical Services Framework 2005-2015 and the Foundations for Country Health Services Strategic Plan 2007-2010.

### *Recommendation*

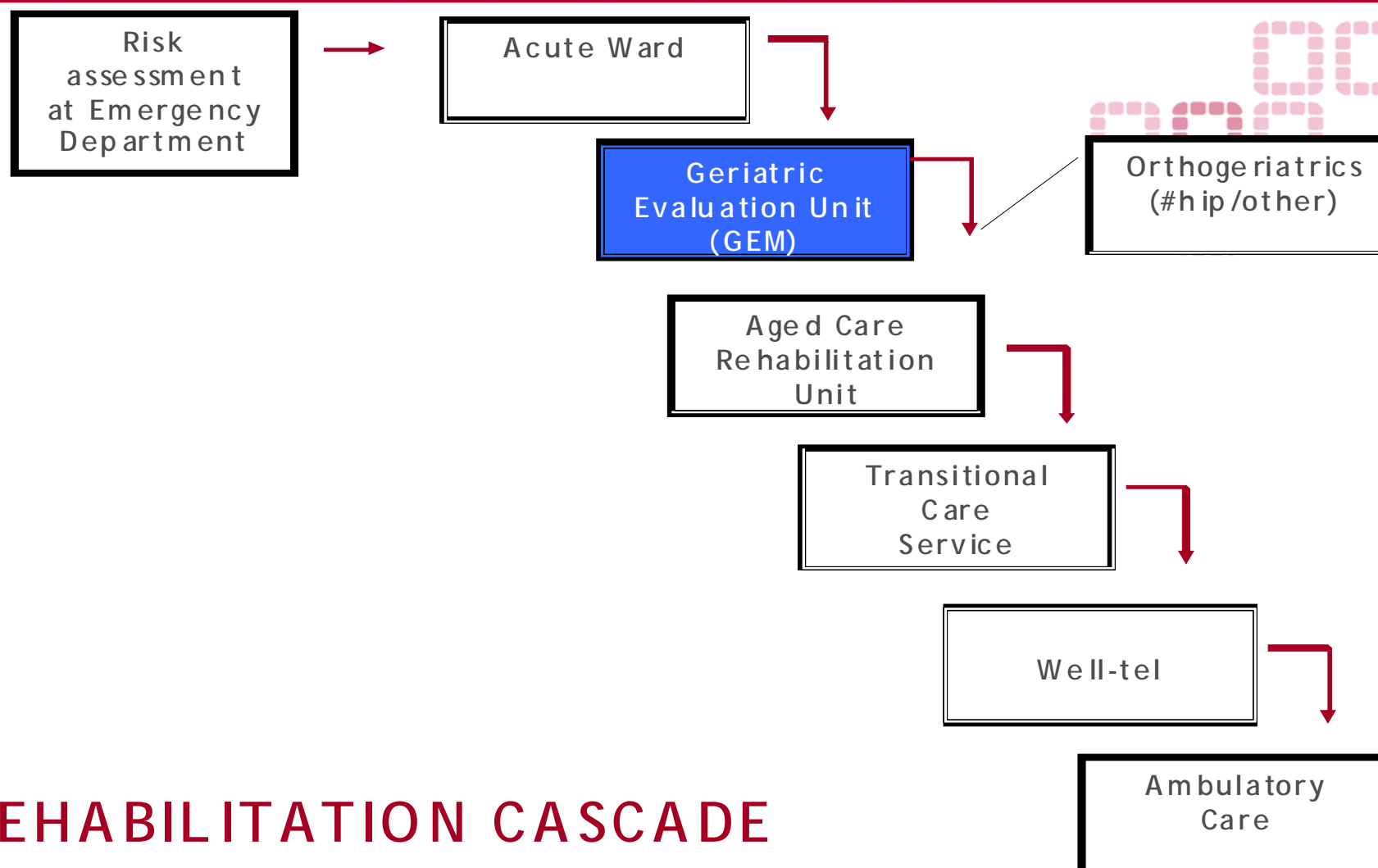
Establish an inpatient GEM unit in Level 6 hospitals and Level 5 hospitals where an Emergency Department service is located as a way of minimising avoidable and reversible functional decline in older inpatients and reducing hospital costs through reduced length of stays and hospital readmissions.



## APPENDICES

### Appendix 1: Rehabilitation Cascade

#### REHABILITATION AND RESTORATIVE CARE SERVICES MODEL OF CARE FOR THE OLDER PERSON IN WA



## REHABILITATION CASCADE



Appendix 2 - Part One Inpatient Rehabilitation Activity: WA Health System - Metropolitan Region

HEALTH REGION	HEALTH SERVICES IN THE REGION	ADMITTED (Inpatient) 2005-2006				ADMITTED (Inpatient) 2006-2007			
		Rehabilitation		GEM		Rehabilitation		GEM	
		Episodes	LOS	Episodes	LOS	Episodes	LOS	Episodes	LOS
NORTH METRO	Joondalup Health Campus	302	5358			294	5030		
	Kalamunda District Community Hospital	26	408			19	399		
	Mercy Hospital	271	7894			245	6522		
	Osborne Park Hospital	968	19879			904	19217		
	Royal Perth Hospital	398	3973	602	5508	403	4182	623	5696
	Royal Perth Hospital Shenton Park Camp	631	14496			636	12866		
	Selby Authorised Lodge (Mhs)	1	189						
	Sir Charles Gairdner Hospital	829	7492	1	2	923	8398	1	6
	Swan District Hospital	225	6851	8	116	240	7057	5	167
	<b>Total North</b>	3651	66540	611	5626	3664	63671	629	5869
SOUTH METRO	Armadale/Kelmscott District Memorial Hospital	269	7644			247	6807		
	Bentley Hospital	444	11860			420	11816		
	Fremantle Hospital	764	20756	4	72	782	15696	12	222
	Kaleeya Hospital	7	134			25	334	2	4
	Murray District Hospital [Pinjarra]					5	93		
	Peel Health Campus	134	3465			159	3371		
	Rockingham - Kwinana District Hospital	2	48			12	197		
	<b>TOTAL South</b>	1620	43907	4	72	1650	38314	14	226
	<b>TOTAL METROPOLITAN</b>			615	5698				6095



## Appendix 2: Part Two

**Table 1: Patients with an Episode of Care of GEM**

WA Hospital Morbidity Data (HMD) <sup>50</sup> shows that a total of 2886 patients have been recorded as having a GEM episode of care from 2001-2002 to 2005-2006 (financial year). The greater proportion of these inpatients are aged 80 yrs plus (69%). Approximately two thirds (63%) of all admissions are female.

The following table shows the number of GEM patients with a GEM episode of care and their age range per financial year.

Financial Year	Age Group							Grand Total
	00-49	50-64	65-69	70-74	75-79	80-84	85+	
2001-2002	1	2	22	2	1	1	3	32
2002-2003	2	14	14	34	99	117	255	535
2003-2004	4	12	26	56	128	185	319	730
2004-2005	5	27	33	71	154	236	424	950
2005-2006	5	19	23	47	99	142	304	639
Total Sum of Count	17	74	118	210	481	681	1305	2886

It is important to note that the HMD reports all GEM episodes recorded in WA. Whilst RPH has the only GEM Unit in WA, some health service sites record minor GEM activity.

WA Hospital Morbidity separation data also shows that on average over the financial period 2002/03-2005/06 that approximately 51% of admissions are recorded as patients being discharged home; 25% are transferred to restorative units or other acute care inpatient units and 12% are discharged to residential care. The remaining separations include those deceased or discharged against medical advice.

<sup>50</sup> Unpublished data. Hospital Morbidity Data System. Information Collection and Management Branch. Department of health. Ref 3413. October 2007.



### Appendix 3: Evidence Based Best Practice Research

There is considerable clinical and evidence based research to support that an inpatient GEM model of care has significant benefits both for the older patient as well as for hospital and the broader health system.

The following table summarises evidence of randomised controlled trials involving GEM and the core outcomes achieved.

Study	Study setting	Outcomes
Kircher 2007 <sup>51</sup>	345 patients in 5 hospitals in Germany 1997-2000	Inpatient consultancy GEM service is less effective in improving patient outcomes as an inpatient GEM unit.
Cohen 2002 <sup>52</sup>	1388 patients over 11 Veterans Affairs medical centres August 1995-January 1999	Inpatient units reduced functional decline. Outpatient GEM improved mental health
Saltvedt 2002 <sup>53</sup>	254 inpatients in Norway Department of Internal Medicine	Mortality was reduced with appropriately targeted patients in an inpatient GEM
Boult 2001 <sup>54</sup>	568 community patients at high risk of hospital admission	Targeted outpatient GEM slows functional decline
Asplund 2000 <sup>55</sup>	413 inpatients of University Hospital Sweden	Early rehabilitation and discharge planning reduced hospital length of stay with possible benefits of reducing long term care

<sup>51</sup> Kircher Tilo TJ, Wormstall H, Muller PH, Schwarzler F, Buchkremer G, Wild K, Hahn HM, Meisner C. A randomised trial of a geriatric evaluation and management consultation services in frail hospitalised patient. *Age and Ageing* 2007;36:36-42.

<sup>52</sup> Cohen HJ et al. A controlled trial of inpatient and outpatient geriatric evaluation and management. *New England Journal of Medicine* 2002;346:905-912.

<sup>53</sup> Saltvedt I, Saltnes T, Mo ES, Fayers P, Kaasa S, Sletvold O. Reduced mortality in treating acutely sick, frail older patients in a geriatric evaluation and management unit. A prospective randomised study. *Journal of the American Geriatrics Society* 2002; 50:792-798.

<sup>54</sup> Boult, C, Boult LB, Morishita L, Dowd B, Kane RL, Urdangarin CF. A randomised clinical trial of outpatient geriatric evaluation and management. *Journal of the American Geriatrics Society* 2001;49:351-359.

<sup>55</sup> Asplund K, Gustafson Y, Jacobsson C, Bucht G, Wahlin A, Peterson J, Blow JO, Angquist KA. Geriatric-based versus general wards for older acute medical patients: a randomised comparison of outcomes and use of resources. *Journal of the American Geriatrics Society* 2000; 48(11):1381-8.



Nikolaus 1999 <sup>56</sup>	545 patients admitted from home to a Geriatric inpatient unit	Improvement in functional status, reduction in initial hospital length of stay and subsequent readmissions; delay in nursing home placement; may reduce direct costs of hospitalised patients.
Trentini 1995 <sup>57</sup>	11 Northern Italian Geriatric units 1386 screened and 152 patients admitted October 1992-July 1993	GEM patients experienced shorter hospital and nursing home lengths of stay. Improved functional level, mental status and morale in intervention group. Similar health care costs.
Landefeld 1995 <sup>58</sup>	651 patients in a teaching hospital 1990-1992	Improved functional ability to perform ADLs in GEM intervention group. Fewer intervention group patients discharged to residential care. Shorter hospital length of stay in the intervention group.
Reuben 1995 <sup>59</sup>	2353 inpatients	Compared GEM consultation and specific screening with usual inpatient care with no improvement in health or survival rates identified.

<sup>56</sup>Nikolaus T, Specht-Leible N, Bach M, Oster P, Schlierf G. A randomised trial of comprehensive geriatric assessment and home intervention in the care of hospitalised patients. *Age and Ageing* 1999;28:543-550.

<sup>57</sup> Trentini M, Semeraro S, Rossi E, Giannandrea E, Vanelli M, Pandiani G, Bardelli E, Tassini D, Lacetera A, Cortesi P, et al. A multicenter randomised trial of comprehensive geriatric assessment and management: experimental design, baseline data and six-month preliminary results. *Aging* 1995;7(3):224-33.

<sup>58</sup> Landefeld CS, Palmer RM, Kresevic DM, Fortinsky RH, Kowal J. A randomised trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *New England Journal Medicine* 1995;332:1338-1344.

<sup>59</sup> Reuben DB, Borok GM, Wolde-Tsadik G, Ershoff DH, Fishman LK, Ambrosini VL, Liu Y, Rubenstein LZ, Beck JC. A Randomised Trial of Comprehensive Geriatric Assessment in the Care of Hospitalised Patients. *New England Journal Medicine* 1995;332:1345-1350.



Stuck 1993 <sup>60</sup>	6 Studies (published 1983-1991) in the US, UK, Australia and Canada involving 1090 patients	Statistically significant increase in the likelihood of home residence 6 months and 12 months post discharge from a GEM unit. Benefits of reducing need for long term care
Harris 1991 <sup>61</sup>	267 patients in an Adelaide Hospital 1985-1986	A selective admission policy of elderly patients is required to maximise the benefits of a rehabilitative and interdisciplinary approach.
Applegate 1990 <sup>62</sup>	155 patients in a community rehabilitation hospital 1985-1987	Decreased mortality in the GEM unit patients. Mortality significantly reduced for patients considered at risk of nursing home placement
Powell 1990 <sup>63</sup>	203 patients in two Canadian teaching hospitals	Lower mortality in the GEM intervention group. Fewer patients transferred to long term care in the intervention group.
Rubenstein 1984 <sup>64</sup>	123 inpatients of a Veterans Hospital 1981-1984	Control group had substantially more acute-care hospital days, nursing home days and acute-care hospital readmissions. The GEM intervention group were more likely to have improvement in functional status.

<sup>60</sup> Weiland GD, Adams J, Rubenstein LZ, Stuck AE, Siu AL. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet* 1993; 342:1032-1036.

<sup>61</sup> Harris RD, Henschke PJ, Popplewell PY, Radford AJ, Bond MJ, Turnbull RJ, Hobbin ER, Chalmers JP, Tonkin A, Stewart AM et al. A randomised study of outcomes in a defined group of acutely ill elderly patients managed in a geriatric assessment unit of a general medical unit. *Aust NZ J Med* 1991; 21(5):783-4.

<sup>62</sup> Applegate WB, Millar ST, Graney MJ, Elam JT, Burns R, Akins DE. A randomised, controlled trial of a geriatric assessment unit in a community rehabilitation hospital. *New England Journal of Medicine* 1990; 322:1572-78.

<sup>63</sup> Powell C, Montgomery P. The age study: the admission of geriatric patients through emergency (abstract). *Age and Ageing* 1990; 19 (suppl. 2):21-22.

<sup>64</sup> Rubenstein LZ, Josephson KR, Weiland GD, English PA, Sayre JA, Kane RL. Effectiveness of a geriatric evaluation unit. A randomised clinical trial. *New England Journal of Medicine* 1984 ;311:1664-1670.



## Appendix 4: A Current Service Model of Practice - Royal Perth Hospital

### Part One

The GEM inpatient unit at Royal Perth Hospital (RPH) provides the only dedicated inpatient GEM model of care in Western Australia. This unit has been successfully operating since 22 July 2002 when the service commenced as part of a National Demonstrations Hospital Pilot (NDHP) Phase 4.

The pilot service achieved positive outcomes for its patients by improving functional independence and reducing decline. For the hospital reduced hospital length of stay and cost neutrality were key results. These facilitated a successful integration of the service with the existing hospital.

RPH is one of Australia's largest and oldest hospitals. It is a leading teaching hospital, which provides a comprehensive range of adult services. Existing hospital aged care beds were used to accommodate a 17-bed GEM unit on a designated ward within the hospital. The designated area has separate patient therapy and dining rooms.

The unit is staffed by Department of Geriatric Medicine doctors and rehabilitation staff with a staffing complement similar to a normal acute medical ward.

A clinical nurse manager manages the unit, ensures the promotion and implementation of the rehabilitation philosophy and addresses any staff issues.

RPH has eight Geriatricians who facilitate assessments for admission to the unit following the receipt of referrals, written or verbal. Patients are referred to GEM from most acute areas of the hospital after their acute problem is resolved or is in the process of resolving. Referrals are mostly made by medical staff and increasingly by physiotherapists and occupational therapists.

Suitability of the patient for the GEM unit is determined following assessment of the older person by a Geriatrician, a GEM Unit Registrar or GEM Clinical Nurse Specialist in consultation with a Geriatrician or Registrar. It is also possible that a suitably experienced occupational therapist and/or physiotherapist is also able to carry out the assessment.

In this assessment the person's ability to engage and benefit from admission, the medical management needs of the person, level of risk and their preadmission functionality are considered in determining whether the patient is appropriate for admission to the GEM Unit.

Appropriate patients are transferred to the care of a Geriatrician on admission to the unit rather than remaining under their admitting speciality. This ensures the implementation of care and agreed rehabilitation goals. The average wait for a transfer to the unit is approximately 1-5 days.

Patients admitted to the unit are encouraged to bring their own clothes, shoes and personal effects that they would use at home. Patients receive a multidisciplinary assessment within the first 48 hours of GEM admission. This assessment is usually conducted by nursing staff and physiotherapists.



Clinically appropriate tools are used. Nurses utilise and complete Barthel's Index, Falls Risk Assessment Tool, and Abbreviated Mental Test Score. The physiotherapists complete a Clinical Outcome Variables (COVS) Mobility Scale, Time Up and Go (TUG) test and 10 metre self-paces walk test and Step Test. Other assessments are used as needed.

Goals, intervention and discharge planning are determined in conjunction with the patient, carers and team. Rehabilitation and the medical management of geriatric syndromes are the focus of clinical interventions. Weekly team meetings assist in discussing progress and determining changes in intervention and goals and facilitating appropriate discharge.

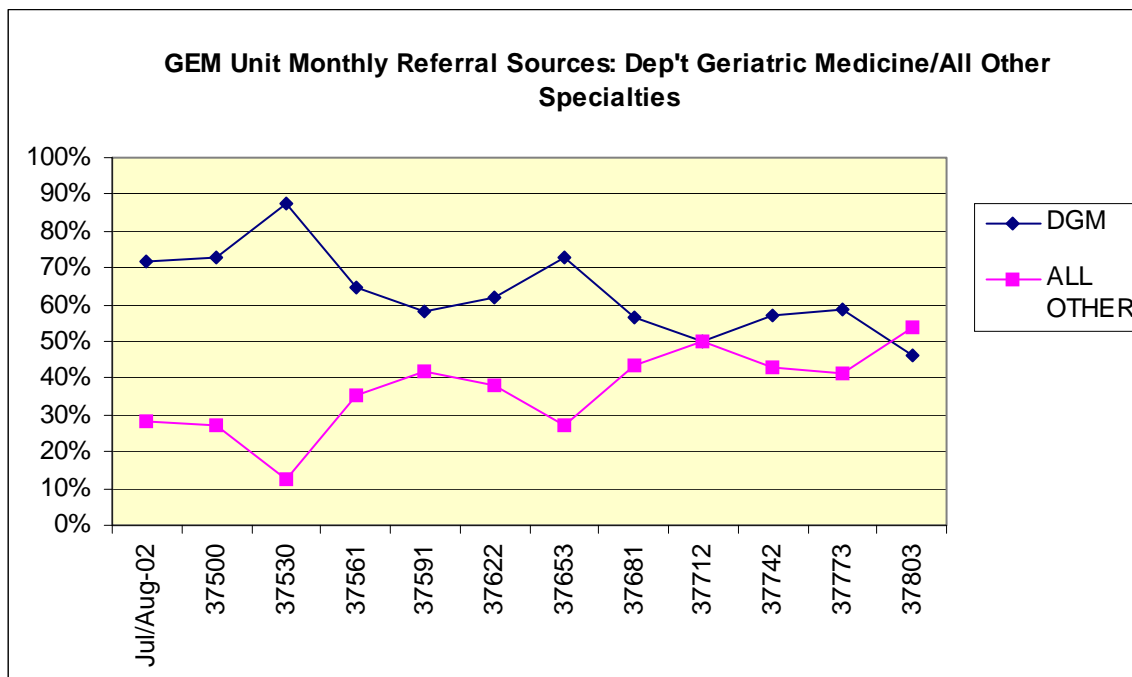
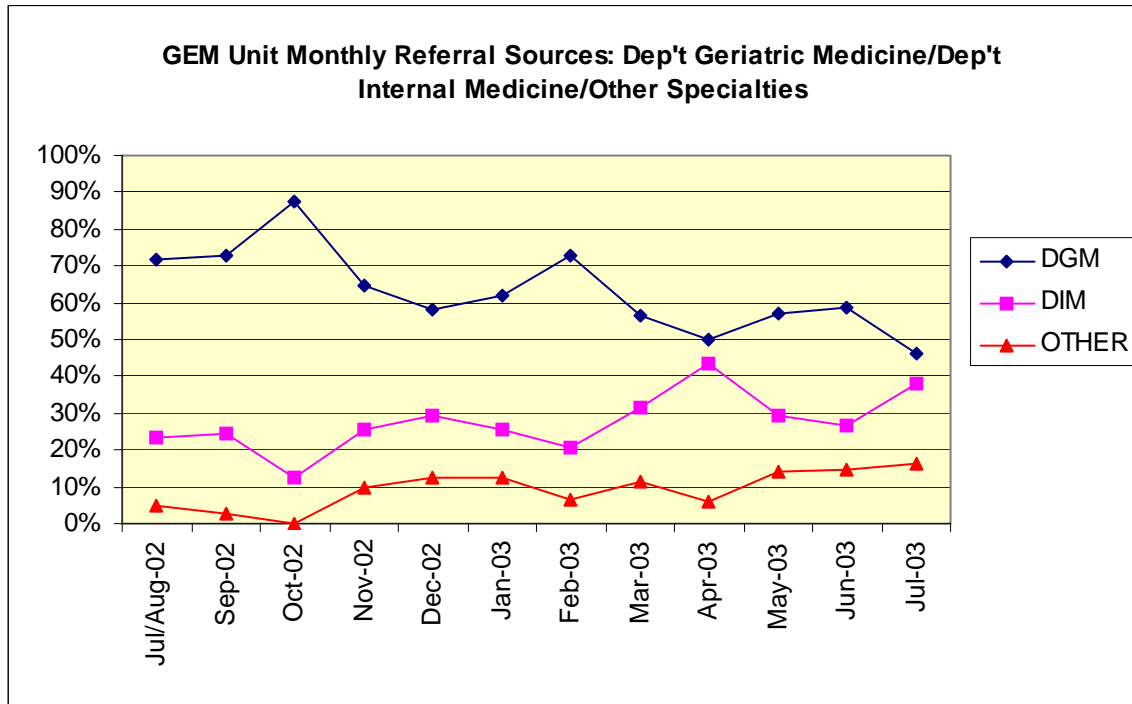
On average patients stay between 7-10 days. Patients are discharged home or to rehabilitation units, transition care or Care Awaiting Placement. Patients who become acute during their stay are transferred to appropriate specialty wards.

Links with General Practice (GP) are supported through discharge information via telephone contact pre discharge and post discharge. Ward clerks fax discharge summaries to appropriate GPs. These summaries encourage GP use of Medicare MBS items including health assessment, community care plan and home medication review to continue the restorative and care management process.



Part Two: Results reported to Department of Health and Ageing National Demonstration Hospitals Program Phase 4 - National Evaluation of Project Impact - Final Report December 2003.

**Appendix A: GEM Unit Monthly Referral Sources Comparison Graphs, 22/7/02 - 18/7/03 (52 weeks)**





DGM/DIM = Department of Geriatric Medicine/Internal Medicine

**Appendix B: GEM Unit Activity Data, 22/7/02 - 18/7/03 (52 weeks)**

**Table 1: Transfer times to GEM Unit**

Transfer time	Patient numbers	%
0 - 3 days	619	88.81%
4 - 5 days	54	7.75%
6 - 9 days	24	3.44%
<b>Totals:</b>	<b>697</b>	<b>100.00%</b>

**Table 2: Discharge destinations post GEM Unit**

Discharge destination	Patient numbers	%
Return to pre-admission residence	417	59.83%
Restorative Unit:	174	24.96%
Acute/other hospital:	51	7.32%
CAP:	38	5.45%
New low care placement:	11	1.58%
New high care placement:	3	0.43%
Deceased:	3	0.43%
<b>Totals:</b>	<b>697</b>	<b>100.00%</b>

**Table 3: Discharge outcomes for patients transferred to Restorative Unit post GEM Unit**

	Discharge destination post Restorative Unit						
	Return to pre-admission residence	Acute	New low care placement	New high care placement	Care Awaiting Placement	Dec'd	Still an in-patient at 1/8/03
<b>Restorative Unit:</b>							
Armadale (n=2)	50.00%		50.00%				
Bentley (n=76)	47.37%	7.89%	11.84%	18.42%	3.95%	7.89%	2.63%
Mercy (n=83)	65.06%	9.64%	4.82%	9.64%	2.41%	3.61%	4.82%
Swan (n=13)	46.15%	7.69%	30.77%	7.69%			7.69%
<b>Totals, patient numbers:</b>	<b>97</b>	<b>15</b>	<b>18</b>	<b>23</b>	<b>5</b>	<b>9</b>	<b>7</b>
<b>Totals, percentages:</b>	<b>55.75%</b>	<b>8.62%</b>	<b>10.34%</b>	<b>13.22%</b>	<b>2.87%</b>	<b>5.17%</b>	<b>4.02%</b>

**Table 4: DGM Multi Day Activity Comparison for the period of Aug - May 2000/01 - 2002/03**

	00/01	01/02	02/03
<b>ALOS (days)</b>	11.62	11.44	8.66
<b>Bed days</b>	14,690	11,188	15,731
<b>Episodes</b>	1,264	978	1,816

## Appendix D: GEM Unit Patient/Carer and GP Surveys Results

**Table 9: Patient and Carer Satisfaction Surveys (Feb and Apr - May 2003)**

Questions	Patient Responses (n=45)				Carer Responses (n=39)			
	Agree	Not Sure	Do Not Agree	Total	Agree	Not Sure	Do Not Agree	Total
1: I believe I/my relative/friend was well cared for while I/s/he was in the GEM Unit	98%	0%	2%	100%	87%	10%	3%	100%
2: I believe I/my relative/friend was well cared for after I/s/he was discharged from the GEM Unit	98%	2%	0%	100%	77%	20%	3%	100%
3: I believe I/my relative/friend was able to cope after I/s/he was discharged from the GEM Unit	71%	16%	13%	100%	55%	11%	34%	100%
4: I was confident that when I/my relative/friend was discharged from the GEM Unit I/s/he would be able to manage at home	70%	21%	9%	100%	49%	16%	35%	100%
5: Health professionals providing care to me/my relative/friend shared information about his/her care with each other	79%	19%	2%	100%	64%	28%	8%	100%
6: I believe health professionals treated my/my relative/friend's information confidentially and respected my/his/her privacy	93%	5%	2%	100%	87%	13%	0%	100%
7: Health professionals were able to answer all my questions and concerns	91%	7%	2%	100%	76%	8%	16%	100%
8: Health professionals involved me in making decisions about my/my relative/friend's treatment and care	59%	17%	24%	100%	58%	5%	37%	100%
9: When I/my relative/friend was discharged from the GEM Unit I/s/he received the services that I/s/he needed (answer only if receiving services after leaving the GEM Unit)	100%	0%	0%	100%	90%	10%	0%	100%

### Summary of General Practitioner Communication Surveys (June 2003):

The GEM Unit communications with GP's were evaluated by surveying 70 GP's who care for patients discharged from the GEM Unit with a 44% response rate (n=31). Summary of results:

#### GEM Unit Admission Notification Fax:

- 70% of GP's who remembered receiving a GEM Unit admission notification fax found it useful
- 84% of GP's who remembered receiving a GEM Unit admission notification fax recommended it continue

#### Phone calls to GP's from GEM Unit treating doctors:

- 73% of GP's who remember receiving a phone call from a GEM Unit treating doctor found it useful
- 56% of GP's who didn't remember receiving a phone call from a GEM Unit treating doctor would have preferred to, with only 1 GP replying 'no'

#### Faxing of Discharge Letters to GP's on day of patient discharge:

- 81% of GP's found it valuable to receive the discharge letter by fax on the day of discharge
- 83% of GP's recommend this continue
- 10% of GP's (3 GP's) found the information contained in the discharge letter was NOT useful for coordinating their patient's ongoing care

#### Enhanced Primary Care Items:

- 55% of GP's felt this patient group would benefit from the Enhanced Primary Care Item numbers, of which 24% Arranged one. Barriers such as difficulty identifying and liaising with other health care professionals and the time and red tape involved were identified.
- 50% considered their Division of General Practice a useful resource to access information on EPC items or community services. These results suggest there is continuing potential to highlight support available to GP's to assist them to utilise EPC items.



## Appendix 5: Suggested Timeline for Implementation of the GEM Model of Care

Health Service	2007-2013	2013	2016
<b>Metropolitan</b>			
RPH	X		
Fremantle	X		
SCGH	X	X	X
Southern Tertiary Campus - Fiona Stanley		X	X
Swan District	X	X	X
Armadale	X	X	X
Rockingham/Kwinana	X	X	X
Peel	X	X	X
Joondalup	X	X	X
<b>Rural</b>			
Geraldton	X	X	X
Kalgoorlie		X	X
Albany	X	X	X
Bunbury	X	X	X
<b>Remote</b>			
Broome		X	X
Port Hedland		X	X



## GLOSSARY

### Aged Care Assessment Team

ACATs determine the overall care needs of frail older Western Australians to assist them in gaining access to the most appropriate types of care services available, and to assess their eligibility for Commonwealth funded services under the Aged Care Act 1997.

<http://www.health.gov.au/internet/main/publishing.nsf/Content/Aged+Care+Assessment+Teams-1>

<http://dev.intranet.health.wa.gov.au/agedcare/acap/acats.cfm>

### Aged Care Network (previously Clinical Network for Aged Care)

The Aged Care Network is a group of interested people and organisations coming together to help plan and develop health policy and services across the State. The network encompasses existing key advisory groups including the WA Aged Care Advisory Council, the WA Community Care Reform Advisory Group and the Clinical Advisory Committee. It provides support for the planning of clinical and continuing care services for older people.

### ACE Unit

Acute Care of the Elderly Unit. Located in acute hospital care services.

### Acute care

The function of providing first class acute and chronic hospital and medical services to those in need. Includes the delivery of operational services across the state for specialised services. (Adapted from DOH Thesaurus)

### Acute care sector

Delivers acute and sub-acute care services via ED's, secondary and tertiary hospitals, ambulatory care services, assessment services (ACAP), post acute care services, home care packages and palliative care services

### Australian Health Ministers Advisory Council

AHMAC provides effective and efficient support to AHMC by advising on strategic issues relating to the coordination of health services across the nation and, as applicable, with New Zealand; and operating as a national forum for planning, information sharing and innovation. (adapted from AHMAC website information)

<http://www.ahmac.gov.au/site/home.aspx>

### AHS

Area Health Service



### Allied Health Service

The activities that include those occupational groups which provide clinical and other specialised services to support the primary role of the medical practitioner in the management of patients. (DOH Thesaurus)

### Ambulatory Care

is effective, efficient care for routine patients that have predictable needs and outcomes. Primarily, but not exclusively, Ambulatory Care occurs outside the hospital walls in the community. Many acute and chronic medical conditions can be efficiently managed by a combination of hospital-based or clinic-based services and home visits by doctors, nurses and allied health staff.

### Clinical Advisory Committee

The CAC ensures the involvement of clinicians in the planning of WA health and aged care services; provides a forum to comment on and develop policy (Policy and Service Level) from a health and aged care perspective; and facilitates effective communication, clinical partnerships and linkages involving Health Networks, Metropolitan Area and Country Health Services, General Practitioners, consumers and carers, as well as private and non-government organisations. Forms part of the formal structure of the Aged Care Network.

### Community Aged Care Package

Packages provide low level aged care to people in their own homes, complementing EACH, which provide high level care.

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-commcare-cacp.htm>

### Care Awaiting Placement

Care Awaiting Placement (CAP) was developed to provide time limited transition care options for aged care patients who are waiting in a public hospital bed for alternative aged care services to become available.

The program provides two pathway options, residential or home-based care:

- Residential - Frees up beds in the acute sector, through contracting with Approved Providers for the provision of unused and unlicensed beds in the non-govt sector, to provide interim accommodation in aged care facilities (North and South Metro) whilst patients wait for permanent placement. The residential service is specifically for clients who are awaiting transfer to permanent high care or low care accommodation. They must have been assessed by an Aged Care Assessment Team (ACAT) and approved for permanent residential aged care.



- Home Care Packages - Provides post acute home care/therapy and nursing services to facilitate earlier return home of older people after an acute illness.

<http://www.agedcare.health.wa.gov.au/transitioncare/cap.cfm>

### **Carer**

A person who (without being paid) provides ongoing care or assistance to another person who has a disability, chronic illness or a mental illness, or who is frail. (Carers WA)

### **Care Coordination Team**

Multidisciplinary team working to improve assessments of elderly people who present to ED, to prevent avoidable admissions, improve discharge outcomes and reduce the number of return visits.

### **Council of Australian Governments - COAG**

COAG is the peak intergovernmental forum in Australia. COAG comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA). The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action by Australian governments, e.g. National Competition Policy. The outcomes of COAG meetings are contained in communiqués released at the end of each meeting. Where formal agreements are reached, these may be embodied in Intergovernmental Agreements. (Adapted from COAG website)

### **COAG Packages**

As part of the LSOPI these provide a flexible package of care for those patients who can be safely and effectively discharged from ED, with the use of COAG package funding, when no other community service is available.

### **Community Care services**

Basic maintenance and support services for the frail aged and disabled people and their carers to allow them to live independently in the community.

### **Community Care sector**

Delivers aged care services via Home and Community Care (HACC), National Respite for Carers (NRCP), Continence Advice and Assistance Scheme (CAAS), CMAS, Domiciliary Oxygen Program, Personal Enablement Packages (PEP), Palliative Care Services.

### **Comprehensive assessment**

The detailed evaluation and/or management of health status that leads directly to diagnostic conclusions and assignment to intervention strategies.



It is an inter-disciplinary multi-dimensional process that includes medical health as well as physical, social and psychological functioning.

### **Continuum of care**

Range of health and community care services that span the primary care, acute care, community care and aged care sectors.

### **Elder care pathway**

A base “eldercare pathway” consists of risk screening [triage/CCT/MO]; comprehensive assessment [ACAT]; care planning and monitoring to build upon current good practice and strengthen components, and connection between components, of the pathway.

### **Episode of care**

The time between the formal admission to hospital and discharge, transfer to another health institution or death. If a patient is re-admitted for further treatment (even for the same condition), a second episode of care occurs.

### **Functional decline**

The reduced ability to perform tasks of everyday living, for example, walking or dressing, due to a decrease in physical and/or cognitive function.

### **Functional disability**

The restriction or lack of ability of a person to perform activities of daily living.

### **GEM Unit**

Geriatric Evaluation and Management Unit

### **GRACE Unit**

Geriatric Rapid Acute Care Evaluation Unit

### **Home and Community Care Program**

The activities related to the joint Commonwealth / State government program providing community care services to frail aged people and younger people with disabilities and their carers. It also provides funding for services that support people who live at home and whose capacity for independent living is at risk of premature or inappropriate admission to long-term residential care. (DOH Thesaurus) Cost shared between the Australian Government and the State, with a 2008/09 budget of \$180 million.

<http://www.health.wa.gov.au/hacc/home/>

### **Long Stay Older Patients Initiative**

Four-year program commenced in 2006 to assist older public patients who no longer require acute care or rehabilitation and are in hospital waiting for



residential aged care by providing more appropriate care for long-stay older patients in public hospitals, particularly in rural areas; improving the capacity of rural hospitals to provide more age friendly services, including through making capital improvements such as establishing new multi-purpose services; reducing avoidable or premature admission of older people to hospitals; assisting older public patients requiring long-term care to take up appropriate care options.

Source: COAG (2006).

Using the Eldercare Pathway as a foundation, WA has progressed the LSOPI initiative across all health regions. Central to the WA initiative has been the implementation of the clinical resource tools of the NAP with the Age Friendly Principles and Practices being the sentinel document. State funded Delirium projects are functionally linked into the LSOPI at the large hospitals. COAG Packages provide a flexible package of care for those patients who can be safely and effectively discharged from ED, with the use of COAG package funding, when no other community service is available.

### **MAP Unit (MAPU)**

Medical Assessment and Planning Unit

### **Model of Care**

A Model of Care is a framework that establishes how best practice health care services will be delivered within a health care system for a person or population group as they progress through the stages of a condition, injury or event. (Adapted from Health Networks presentation)

<http://www.healthnetworks.health.wa.gov.au/agedcare/moc.cfm>

### **Morbidity**

Any departure, subjective or objective, from a state of physiological or psychological wellbeing, or levels of ill health in a population or group.

### **Multi-disciplinary approach to care**

Team members from different disciplines individually collect assessment information, but collectively define the main issues, set management goals and develop and implement care plans. Encouragement of sharing of information among disciplines

### **National Action Plan**

“From Hospital to Home - Improving care outcomes for older people” is the NAP developed under COAWG, predecessor to HCOASC, that provides a framework for development, monitoring and improving care of older people across the acute-aged continuum. NAP focuses on acute, sub-acute and aged care, and introduces transition care services to cater for patients moving from the hospital system into longer term arrangements, including, where necessary, ongoing aged care. (Adapted from DOHA website)



<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/hcoasc-national-action-plan.htm>

### **Primary Care**

A suite of services delivered via General Practitioners, Nurses, Dentists, Allied Health Practitioners, PBS, and Diagnostic testing.

### **OPERA Unit**

Older Persons' Evaluation Review and Assessment Unit

### **Rehabilitaiton**

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible, often with the assistance of specialised medical professionals. The purpose of rehabilitation is to restore some or all of the patient's physical, sensory, and mental capabilities that were lost due to injury, illness, disease or addiction to substance misuse. Rehabilitation includes assisting the patient to compensate for deficits that cannot be reversed medically. (DOH Thesaurus)

### **Rehabilitation In The Home**

RITH provides short to medium term, hospital-substitution allied health therapy, allowing early hospital discharge, assistance in the hospital to home transition and prevention of readmission to hospital. RITH is designed to improve patient flow and patient outcomes as well as support demand management, by creating virtual beds in the community. (Fremantle Hospital website)

<http://www.fhhs.health.wa.gov.au/services/about.aspx?ServiceID=96&v=824766>

### **Sub-acute care**

Refers to rehabilitation hospitals, geriatric evaluation and management, step down facilities and transition care.

### **Transition Care Service (Transition Care Program)**

Program aims to reduce extended hospital lengths of stay, maximise functioning and reduce inappropriate admission to residential aged care. It provides goal oriented, short term, flexible care with a rehabilitative focus for the elderly being discharged from hospital, either in a RACF, or in the community. Recipients must be eligible for residential aged care.

<http://www.agedcare.health.wa.gov.au/transitioncare/index.cfm>

### **WA Aged Care Advisory Council**

Ministerial council convened in February 2002 to oversee a whole-of-sector approach to the planning and provision of State health and aged care



programs and to provide ongoing advice to government on the health and related aged care needs of older people in Western Australia. The Parliamentary Secretary to the Minister for Health, John Hyde MLA, attends the council. Forms part of the formal structure of the Aged Care Network.

<http://www.health.wa.gov.au/waacac/about/role.cfm>

### **WA Community Care Reform Advisory Group**

The purpose of the Group is to provide advice to the Department of Health (DOH) in regard to proposed reforms to common arrangements in community care as outlined in the Australian Government's A New Strategy for Community Care: The Way Forward. The Group will act as a forum through which the DOH will share information and seek advice in regard to the common arrangements, including the work of several national working groups addressing issues in community care: (1) Eligibility and Assessment; (2) Packaged Care; and (3) Planning and Accountability. Other issues pertinent to Home and Community Care in Western Australia may be discussed and advice sought as appropriate. (from TOR) Forms part of the formal structure of the Aged Care Network.

### **WA Country Health Services**

WACHS is the single biggest Area Health Service in Western Australia, and the largest country health system in Australia. It services an area of some 2.55 million square kilometres with a combined regional population of 454,000 people (almost a third of the State's population), including 44,900 Aboriginal people (around 10% of the State's total population). WACHS delivers acute and primary health services to regional WA, operating within a Regional Network Model and providing an integrated service delivery system that has earned broad community acceptance. The model includes Regional Resource Centres, Integrated District Health Services, and flexible services with a primary health care focus for small towns and isolated communities. (WACHS website)

<http://www.wacountry.health.wa.gov.au>

### **Wellness Approach to Community Healthcare**

WATCH has been adopted as HACC's approach to service delivery. It encourages a way of implementing and delivering services that can assist in maximising clients abilities and minimising their difficulties, and in turn works towards preventing the development of dependencies that are so common in community care.



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