

Aged care network

Model of care for the older person
in Western Australia



Delivering a Healthy WA



Executive summary

The *Model of Care for the Older Person* has been developed by the Aged Care Network¹ in response to the broad policy direction of the Health Policy and Clinical Reform Division and WA Health Networks to develop integrated health care policy across Western Australia for diseases, conditions or population groups.

In line with the ongoing reform agenda occurring across the WA health system, WA Health Networks identified the need to provide “a structure for outlining system change and redesign that incorporates the shared principles originally outlined in *A Healthy Future for Western Australians: Report of the Health Reform Committee*”.² The model of care approach developed by WA Health Networks has provided the framework to assist in completing this task.

This document describes the broad policy approaches for the *Model of Care for the Older Person* that relates to the continuum of care service delivery for older persons across the WA Health system and beyond. It will serve to inform the development of the specific models of care at the service model and local implementation levels that have been prescribed as the next stages in the document *Models of Care: Scoping Document*.³

The conceptual and strategic framework of the State Aged Care Plan for Western Australia 2003-2008⁴ has guided the work of the Aged Care Network since its inception in February 2006. The *Model of Care for the Older Person* is therefore founded on these frameworks. The model is cognisant of the stages in the ageing process and the unique challenges presented in the delivery of services to an ageing population.

The *Model of Care for the Older Person* focuses on the need to promote independence, well-being and quality of life for older people with a greater emphasis on prevention and promotion programs that encourage self management of health conditions. It focuses on the need for the health system to concentrate on service delivery that is more cost-effective, less hospital centric and more orientated to the care needs of the older person. Improved coordination and communication processes are central to this approach.

It also relies heavily on a partnership approach for the delivery of services to the aged population across the continuum of care that spans the primary, community, acute and residential aged care sectors. Most importantly, it addresses the challenges that lie at the interface between the sectors and calls upon those involved in the delivery of health and related aged care service to recognise and deliver on these challenges.

Dr Simon Towler
Executive Director
Health Policy and Clinical Reform Division

¹ The membership of the Aged Care Network is outlined in Appendix One.

² *A Healthy Future for Western Australians: Report of the Health Reform Committee*. Department of Health. 2004

³ *Models of Care: Scoping Document* Department of Health. 2006.

⁴ *State Aged Care Plan for Western Australia 2003-2008*. Department of Health. 2003.



Contents

1. Model of care overview	3
2. Model of care - key points	4
3. Delivery of services to the older population - drivers for change	5
4. Model of care for the older person in Western Australia	7
4.1 Objectives of the model	7
4.2 Objectives for each phase of ageing	7
5. Model of care for the older person	10
5.1 Principles and values of the model of care for the older person	10
5.2 Key focus areas of the model of care for the older person	10
5.3 Policy level model of care for the older person	12
6. Horizon scan	17
7. Key recommendations	18
Appendix One: Membership of the aged care network	19
Appendix Two: Model of care, service model and local implementation model linkages	22
Appendix Three: Discussion paper - model of care for the older person	23

Note: The supporting information that illustrates the current service provision environment and supports the findings regarding the Model of Care for the Older Person is contained in Appendix Three. Appendix Three is listed on the Aged Care Network website.

Please visit the Aged Care Network at the following address:
<http://www.healthnetworks.health.wa.gov.au/agedcare/publications.cfm>



1. Model of care overview

This document is the required first stage for the development of the Model of Care for the Older Person.⁵

It has been developed by the Aged Care Network and outlines the recommended policy approaches that will serve to inform Area Health Services and other key stakeholders about the way in which services can be delivered to the older population across the continuum of care and serves as an underlying framework for a Model of Care for the older population in Western Australia.

The policy approach for the Model of Care for the Older Person is based on the following:

- application of the ageing perspective to a population based model of care to inform planning needs⁶
- the delivery of health care and support services to the older person spanning the entire continuum of care across primary care, acute care, community care and aged care sectors
- adoption of a wellness and self-management approach across the continuum
- policy approaches need to focus not only on the addition of new services, but also on the improvement of existing processes within the system that result in more effective management of the flow of patients across the continuum of care and
- the different jurisdictional responsibilities for the funding of health and support services for the older person is reflected in a multi-faceted policy approach.

⁵ See Appendix Two.

⁶ This paper has focused on applying an ageing perspective to the development of a population based model of care for the older population cohort as they move through the three phases of ageing. Three phases have been described; “entering older age”, the transitional phase” and the “frail aged ” stage.



2. Model of care - key points

The key points are:

- emphasis on current challenges across WA Health arising from an older person's movement between the many interfaces along the continuum of care
- focus on effective management of older patients in an emergency department
- integration of chronic disease management principles of early detection and self-management in service delivery models
- strengthening of services at the primary care level for older people that target health promotion and prevention and self-management strategies
- development of clinical service delivery models of care that are specific to the ageing process
- integrated approach to the assessment process of an older person at all stages along the continuum of care and
- focus on model of care service delivery for the provision of community care services from one of dependency to one of capacity building for the older person that encourages independence and self-management

The model of care is intended to achieve the following objective:

“Ensuring people get the right care, at the right time, by the right team and in the right place.”



3. Delivery of services to the older population-drivers for change

Demographic ageing of the population, an increase in conditions and diseases associated with the ageing process and the rise in chronic disease prevalence levels will place significant pressure on the WA Health system into the future.

Declining mortality rates leading to higher life expectancies and overall declining fertility rates are contributing to the overall ageing of the population. The continued growth in the proportion of those aged 65+ will further increase after 2010 with the entry of the baby boomer generation into the 65+ age bracket. Added to this demographic trend is the predicted trebling of the proportion of over 80 year olds in the next 40 years with the proportion increasing from 1.7% in 2007 to 5.6% in 2047. Life expectancy of an indigenous person is 20 years less than that of a non-indigenous person, with the onset of conditions associated with ageing and/or chronic disease commencing from 45 years.^{7,8}

In Western Australia, demand for acute hospital services by the older population is significant. Analysis of the WA Health Hospital Morbidity System indicates the following:

- in 2006, the average age of a person in the over 65+ age group was 76 years
- the number of admitted inpatient episodes for the 65+ age group had increased from 116,138 episodes in 2000-2001 to 145,751 episodes in 2005-2006
- in 2005-2006 the percentage of inpatient hospital separations had increased to 32%, compared with 24.5% of total inpatient separations in 1996 for the 65+ age group and
- expenditure on inpatient admitted health care services for the 65+ age group comprised 38% of total inpatient admitted expenditure across the WA public hospital system in 2005-2006.⁹

Chronic disease prevalence is rising in Australia. Chronic disease is estimated to be responsible for 80% of the total burden of disease as measured in disability life adjusted years. Diseases that become chronic in nature can occur across the life cycle but become more prevalent with older age, particularly the frail aged. It is associated with high health care expenditure and in 2000-2001, accounted for \$34 billion, or 70% of allocated health expenditure.¹⁰

The implications of these drivers for WA Health will be a marked increase in the demand for health and aged care services spanning the entire continuum of care. There will be an increase in the numbers of older people with a range of complex conditions associated with the symptoms of chronic disease. They may have a carer, and conditions associated with the ageing process such as dementia, incontinence or limited vision will also impact on their health and well-being.

Conflicting jurisdictional funding responsibilities between the Australian and State Governments has created a complex mosaic of services and difficulties across the health and aged care sector in terms of the funding, administration and delivery of services across the continuum of care.

⁷ page 27, *Health Measures - A report on the health of the people of Western Australia*. Department of Health. Government of Western Australia. 2005.

⁸ There are also some groups within the population in WA that experience the premature onset of health conditions associated with the ageing process. This also impacts on the demand for health and support services across the WA Health system.

⁹ unpublished data, WA Hospital Morbidity System - HMDS extracts, 1996, 2000-2001, 2005-2006.

¹⁰ page 2-3, *National Chronic Disease Strategy*. Australian Government Department of Health and Ageing. Canberra 2006.



An extensive outline of the types of services that an older person accesses as they move along the continuum of care, identification of pressure points together with quantitative data that illustrates current service provision models are contained in the Discussion Paper: Model of Care for the Older Person in Western Australia (Appendix Three).

The broad policy direction adopted by WA Health to develop “Models of Care” presents a valuable and timely opportunity to meet the challenges that lie ahead and promote appropriate and cost effective models of care for the older person.

Note: The supporting information that illustrates the current service provision environment and supports the findings regarding the Model of Care for the Older Person is contained in Appendix Three. Appendix Three is listed on the Aged Care Network website.

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4. Model of care for the older person in Western Australia

The following section outlines a model of care that incorporates recommended policy approaches and identifies where service models can be developed at the local area health service level to reflect these approaches.

4.1 Objectives of the model

The overall objectives are to:

- extend the period in which people are well aged
- compress the periods in which people transition to ill-health and become frail and increasingly dependent on care
- promote services and programs that keep people out of hospitals and shift the balance of care to the community
- deliver services that are integrated across the continuum of care and promote smooth transitions between the interfaces in different care settings
- reduce dependency on the health and aged sector over the long term and
- promote cost-effective outcomes for WA Health.

4.2 Objectives for each phase of ageing

Entering older age

The goal for public health policy in this early phase of the ageing process is to **promote and extend** the period in which people are healthy, well and lead active, fulfilling lives.

A window of opportunity is present in this phase for health service providers to capitalise on the high levels of independence, optimism and mobility that are characteristic of this population and introduce a range of health promotion and prevention strategies that maintain and extend the healthy ageing process well into later years. The delivery of programs and services should be targeted at the primary care sector.

Transitional Stage

For those older people who are in the transitional phase where they experience the first stages of the onset of ill-health, the goal is to provide programs and services that identify emerging health problems early and encourage the development of **self-management skills** to effectively manage the symptoms of the health conditions they may have. The delivery of programs and services that promote these skills should also be targeted at the primary care sector.

Community care support services introduced should focus on encouraging older people to focus on their capacity to perform activities of daily living to optimise and maintain their functional and psychosocial independence and play a key role in allowing people to live independently in the community. The goal is also to provide services that are **flexible** to meet a range of fluctuating care needs during this transitional phase.



Frail Aged Stage

Older people, who have become physically and/or mentally frail, require a higher intensity and greater range of health and aged care services. The goal is to provide **flexible** services that meet the complex care needs that can often involve physical, mental and social care factors. A **multi-disciplinary approach** that involves comprehensive assessments for the management of older patients with complex care needs in the acute care setting is important. A strong emphasis on supporting the role of the carer as part of the health care team, both within in the acute and community care setting is vital.



Figure One: Objectives for a future model of care for older people

Status Quo		
ENTERING OLDER AGE	TRANSITIONAL STAGE	FRAIL AGED STAGE
Well aged At risk	Early symptoms	Advanced Conditions
Primary Care		
	Acute sub - acute care	
	Community Care	
		Residential care

Move towards alternative model of care		
ENTERING OLDER AGE	TRANSITIONAL STAGE	FRAIL AGED STAGE
Well aged	At risk	Advanced Conditions
Primary Care		
	Acute sub - acute care	
	Community Care	
		Residential care



5. Model of care for the older person

5.1 Principles and values of the model of care for the older person

Vision statement

- “Independence, well-being and quality of life for older people in Western Australia through responsive health and aged care services and supports across the continuum of care”

Value statement

- aged care is about the person and their carer and is built on participation and respect
- aged care is positive and enabling with service delivery based on flexibility and choice
- equity and inclusion are fundamental and
- quality systems are fundamental

Age-friendly principles and practices - managing older people in the health service environment¹¹

- health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life
- health services will recognize and address older people’s complex needs.
- health treatment and care are respectful and recognize individual differences and specific needs, such as cultural, religious and sexual differences
- health treatment and care are delivered in a coordinated and timely manner across care settings
- unnecessary admission to hospital and extended hospital stays of the frail elderly are avoided
- the care of older people is a primary focus for all health services
- services and supports developed for carers are flexible and responsive
- where safe and cost-effective to do so, older people receive health treatment and care in a setting that best meets their needs and preferences.

5.2 Key focus areas of the model of care for the older person

The key focus areas of the Model of Care for the Older Person are:

- change in the model of service delivery for the provision of community care services from one of dependency to one of capacity building for the older person and the carer where appropriate

¹¹ Australian Health Ministers’ Advisory Council, Care of the Older Australians Working Group (COAWG). Endorsed by Australian Health Ministers, July 2004.



- concentration on integration between interfaces along the continuum of care arising from an older person's movement between:
 - primary care and acute care
 - primary care and community care
 - emergency department and in-patient acute care and
 - acute care and residential care
- improvement in access to GP support services in the primary care sector
- introduction of geriatric expertise to the management of patients in emergency departments
- integration of chronic disease management principles of early detection and self-management in service delivery models
- development of clinical service delivery models that are specific to the ageing process
- integrated approach to the assessment process of older persons at all stages along the continuum of care and
- support for carers and recognition of their role as a partner in the care planning process as an older person moves along the continuum of care.

Table One outlines the **overall policy approach** recommended by the Aged Care Network for the proposed “*Model of Care for the Older Person*” in order to promote system change across WA Health and achieve more effective care outcomes for older people.

The capacity to manage the difference in jurisdictional funding responsibilities will play a key role in the successful implementation of new policies and programs that promote greater efficiencies, integration and continuity of care for the older person.

Where the Aged Care Network is able to directly implement the policy approaches either on a sole basis or in conjunction with the Australian Government, this is indicated by shading.

The Aged Care Network will be required to collaborate with other Health Networks that incorporate chronic disease models of care.



5.3 Policy level model of care for the older person
Table One

Stages	WHO will develop/ implement policy	WHAT policies will be developed/strengthened	WHERE will the policies be implemented
	1.1 State Government	Leadership in Aged Care Action Plan for WA 2004-2008 State Aged Care Plan for Western Australia 2003-2008	WA Health
	1.2 State Government	Reinforcement of the principles underlying the Carers' Recognition Act 2004. Continuation of awareness raising and education initiatives to promote the Carers' Recognition Act 2004 throughout the WA Health sector.	WA Health
Entering Older Age	2.1 State Government	Health Promotion and Prevention Policy <ul style="list-style-type: none"> ■ Mass media campaigns ■ State based ■ Local/regional promotion and prevention initiatives ■ Older population cohort specific 	Community
	2.2 State Government	Population based screening campaigns <ul style="list-style-type: none"> ■ Well aged specific 	Primary care sector - Community Health Centres
	2.3 Australian Government	Focus on risk screening initiatives that are Medicare bulk-billed	Primary care sector - General Practitioners
Transitional Stage	3.1 State Government	Adoption of overarching Age-Friendly Principles and Practices developed of Care of the Older Australian Working Group (COAWG).	Acute care
	3.2 State/Australian Government	Adoption of National Action Plan (NAP) for improving the care of older people across the acute-aged care continuum	Acute care - Residential aged care sector
	3.3 State Government/ Australian Government	Strengthening of basic maintenance and support systems that promote independent living the community	Community care



Stages	WHO will develop/ implement policy	WHAT policies will be developed/strengthened	WHERE will the policies be implemented
	3.4 State Government/ Australian Government	<p>Promotion of a consistent and coordinated policy approach to the assessment of an older person across the continuum of care through the adoption and implementation across the WA Health system of Council of Australian Government (COAG) policy approaches and initiatives of:</p> <ul style="list-style-type: none"> - COAG HACC/Regional Access Networks - COAG Aged Care Assessment Program - COAG Long Stay Older Patients 	Community care/Acute care/Residential aged care sector
	3.5 State Government/ Australian Government	<p>Strengthening of assessment processes for the provision of community care services:</p> <ul style="list-style-type: none"> - eligibility and determination of need for services through a generic referral instrument and revised assessment tool - strengthening of communication systems and process that manage the access to the community care system through the establishment of Regional Access Networks. - determination of level of assessment required and need for referral to other appropriate services 	Community care
	3.6 State Government/ Australian Government	Implementation of “wellness” approach to independent living in the community	Community care
	3.7 State Government	Implementation of Geriatric Medicine approach to Emergency Department Care	Acute care
	3.8 State Government	Multi-disciplinary approach to assessment of older people in the emergency care setting	Acute care
	3.9 State Government	Encouragement of self-management approach to chronic disease in the older population cohort through development of appropriate case management models.	Acute care - tertiary and secondary care General Practitioner - Primary Care



Stages	WHO will develop/ implement policy	WHAT policies will be developed/strengthened	WHERE will the policies be implemented
	3.10 State Government	Further reconfiguration of hospital based services that promote a greater delivery of ambulatory care solutions for elderly people with complex care needs. These include: <ul style="list-style-type: none"> ■ Non-hospital based rehabilitation therapy options ■ Post-acute discharge options 	Acute care - tertiary and secondary care
	3.11 State Government	Implementation of preventative approach to the self-management of continence	Community care sector
	3.12 State/Australian Government	Strengthening of flexible support and service systems that assist carers in the caring role	Acute care, community care sector
	3.13 State Government	Development of age-specific service models of care for: <ul style="list-style-type: none"> ■ Dementia ■ Delirium ■ Parkinson's disease ■ Falls ■ Geriatric Evaluation Management ■ Rehabilitation/Restorative Care ■ Orthogeriatrics 	Acute care - tertiary and secondary care
	3.14 State Government/ Australian Government	Initiatives to improve the co-ordination and communication processes between GP and the acute care sector	Acute care - primary care sector
	3.15 Australian Government	Strengthening of Enhanced Primary Care Initiatives across GP Divisions in metropolitan and rural areas for the management of chronic illnesses and multi-disciplinary care needs.	Primary care - General Practitioner
	3.16 Australian Government	Improvement in communication and co-ordination processes between the GP and residential aged care service providers.	Primary care - residential aged care sector



Stages	WHO will develop/ implement policy	WHAT policies will be developed/strengthened	WHERE will the policies be implemented
Frail Aged Stage	4.1 State Government	Appropriate and effective discharge planning practices and processes that reduce and prevent inappropriate discharges and readmissions of older people.	Acute care
	4.2 State Government	Strengthening of community care service delivery models to improve the transition process for older between different programs along the continuum of care.	Community care sector
	4.3 State Government	Effective management of elderly patients in emergency department care settings through implementation of: <ul style="list-style-type: none"> - COAG Long Stay Older Patients initiatives - re-configuration of existing services. 	Acute care
	4.4 State Government	Effective assessment processes that focus on a comprehensive assessment approach to the management and care of older people in the acute care sector as advocated in the COAWG National Action Plan - Improving care outcomes for older people.	Acute care
	4.5 State Government/ Australian Government	Strengthening of communication and co-ordination processes between acute care and residential care sector.	Acute and Residential aged care sector



Stages	WHO will develop/ implement policy	WHAT policies will be developed/strengthened	WHERE will the policies be implemented
	4.7 Australian Government/ State Government	Support and strengthening of Enhanced Primary Care Initiatives across GP Divisions in metropolitan and rural areas for residential aged care facilities for: <ul style="list-style-type: none"> - Comprehensive assessment - Medical management review - Care Planning and - Case conferencing 	Residential aged care sector
	4.8 State Government	In collaboration with the Mental Health Network, develop a model of care that focuses on the transition of the older person from the acute care sector to the residential care sector and where appropriate to the community.	Acute - Residential aged care sector



6. Horizon scan

A scan of the “ageing population landscape” indicates there will be factors that will re-shape pressures on the WA Health system.

- Technological changes will occur to bring about improvements in system capacities. For example, the widespread establishment of Tele-health networks across the state will greatly increase system capacity to treat rural and remote patients with complex conditions.
- Medical developments and research into treatments and therapy to reduce morbidity; for example stem cell research, Parkinson’s disease treatments and drugs for the treatment of dementia that slow progression will assist in reducing reduce levels of morbidity and mortality.
- Workforce demands across all professions and support services will place constraints on WA Health’s capacity to provide effective and quality services to the population that require care at all points along the continuum of care. This is particularly important in an industry that is heavily reliant on labour.
- The rising costs in terms of labour and technological improvements will place pressures on resourcing capabilities.
- It is anticipated that the “baby boomer” aged population cohort will have a higher level of expectation in terms of the type, choice and quality of care they will receive. It is also anticipated that they will have a greater ability to pay for health care services.



7. Key recommendations

- 7.1 Adoption by WA Health of the policy approach for the future model of care for the older person in Western Australia outlined in Table One (see page 12-16) incorporating:
 - the three phases of ageing
 - identification of responsibilities for implementation and
 - the continuum of care approach.
- 7.2 The recommended policy approaches to inform the development of service models of care across the continuum of care for conditions of old age.
- 7.3 Commitment to collaborative approach with Australian Government to promote partnerships for the development of programs that support model of care for the older person.

Dr Peter Goldswain
Clinical Lead
Aged Care Network



Appendix One

Aged Care Network (ACN)

Membership

Clinical Lead

- **Dr Peter Goldswain**, Clinical Advisor Aged Care Policy Directorate
Department of Geriatric Medicine Royal Perth Hospital
Chair Clinical Advisory Committee
Director Rehabilitation and Orthopaedic Division Royal Perth Hospital
Associate Clinical Professor of Geriatrics, University of Western Australia

Aged Care Policy Directorate Co-Lead

- **Gail Milner**, Director, Aged Care Policy Directorate, Department of Health

Members

- **Anne Marie Archer**, Executive Director, Aged Care Association Australia WA
- **Stephen Kobelke**, Executive Director, Aged and Community Services WA
- **Ross Bradshaw**, Chief Executive Officer, Silver Chain Nursing Association
- **John Buchanan**, Associate Professor, Metropolitan Allied Health representative
- **Homa Cerny**, Aged Care Assessment Team representative, Metropolitan Area Health Services
- **Dr Roger Clarnette**, Head of Department, Department of Community & Geriatric Medicine South Metropolitan Area Health Service
- **Dale D'Antoine**, Health Service Manager/ Director of Nursing, Goomalling Hospital
- **Dr Mark Donaldson**, Head of Department, Department of Geriatric Medicine Royal Perth Hospital
- **Helen Dullard**, Chief Executive Officer, Hills Community Support Group
- **Dr Rob Edis**, Neuro-Rehabilitation Physician, Royal Perth Hospital, Shenton Park Campus
- **Dr Penny Flett**, Chief Executive Officer, Brightwaters Care Group / Chair, WA Aged Care Advisory Council
- **Dr Leon Flicker**, Chair & Professor of Geriatric Medicine, University of Western Australia
- **Dr Kim Fong**, Rehabilitation Medicine Physician, Royal Perth Hospital, Shenton Park Campus
- **Neil Fong**, A/Director, Office of Aboriginal Health



- **Stephen French**, Assistant State Manager, Aged and Community Care, Commonwealth Department of Health & Ageing
- **Noreen Fynn**, Executive Director, Carers WA
- **Stephen Boylen**, Director, Office for Seniors and Carers, Department of Communities
- **Dr Charles Inderjeeth**, Director Clinical Training, Research & Programs, Sir Charles Gairdner Hospital
- **Lois Johnston**, Consumer's Advocate, Health Consumers' Council WA (Inc)
- **Stephen Jolly**, Executive Manager - Community Care, Churches of Christ Homes WA
- **Dr John Ker**, Rehabilitation Physician, Royal Perth Hospital/Shenton Park Campus
- **Dr Helen McGowan**, President, Faculty of Psychiatrists of Old Age, WA Branch
- **Jenni Perkins**, Director Policy and Planning and Information, Disability Services Commission
- **Ken Ridge**, Chief Executive Officer, Baptistcare
- **Frank Schaper**, Chief Executive Officer, Alzheimer's Australia WA
- **David Singe**, Chief Executive Officer, Wheatbelt Development Commission
- **Jenny Stevens**, Area Director, Aged Care, Western Australian Country Health Services
- **Dr Barry Vieira**, Head of Department Rehabilitation & Aged Care, Sir Charles Gardiner Hospital/Osborne Park Hospital
- **Marita Walker**, Chief Executive Officer, Perth Home Care
- **Rob Willday**, Manager, Community Services, Aged Care Policy Directorate, Department of Health

Executive Support Officer

Geoff Burrell, Senior Policy Officer, Aged Care Policy Directorate, Department of Health



Executive Committee - Aged Care Network

The membership of the Executive Committee of the Aged Care Network is drawn from three groups that support the formation of the Aged Care Network. The three groups are:

1. WA Aged Care Advisory Council - WAACAC
2. Clinical Advisory Committee - CAC
3. WA Community Care Reform Advisory Group - WACCRAG

The Executive Committee acts to:

- provide executive decision-making and coordination for the Aged Care Network
- strengthen multi-sectorial and multi-disciplinary relationships through partnerships and collaboration
- contribute to clinical services planning
- promote links to other networks
- provide expert advice on aged care issues to other networks

Membership

Executive Committee - Aged Care Network (ECACN) Membership

Chairperson

Dr Peter Goldswain, Clinical Lead, Clinical Network Aged Care

Members

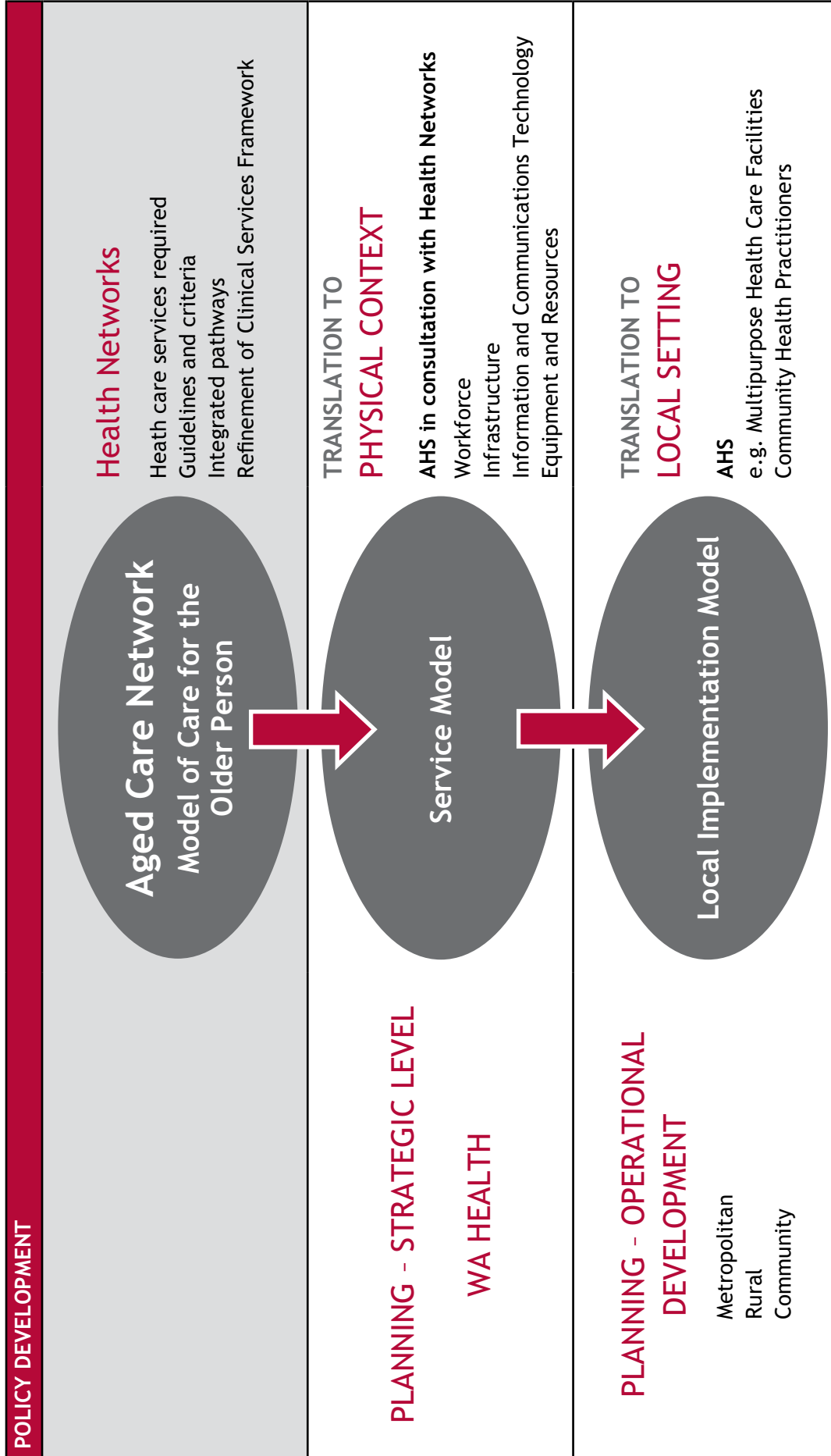
- **Dr Penny Flett**, Chair, WA Aged Care Advisory Council
- **Prof Leon Flicker**, for Chair, Clinical Advisory Committee
- **Mr Rob Willday**, Chair, WA Community Care Reform Advisory Group
- **Ms Gail Milner**, Director, Aged Care Policy Directorate
- **Mr Stephen Kobelke**, Executive Director, Aged and Community Services WA
- **Mr Ross Bradshaw**, Chief Executive Officer, Silver Chain Nursing Association
- **Ms Noreen Fynn**, Executive Director, Carers WA
- **Dr Mark Donaldson**, Head of Department of Geriatric Medicine, Royal Perth Hospital

Executive Support Officer

Geoff Burrell, Senior Policy Officer, Aged Care Policy Directorate



Appendix Two: Model of care, service model and local implementation model linkages



Source: Page 11, Models of Care - Scoping Document, November 2006 WA Health Networks - Health Policy and Clinical Reform



Appendix Three: Discussion paper: model of care for the older person

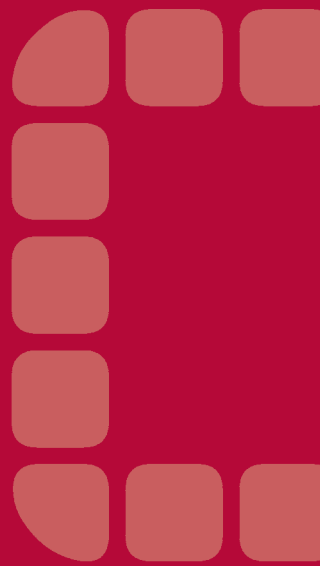
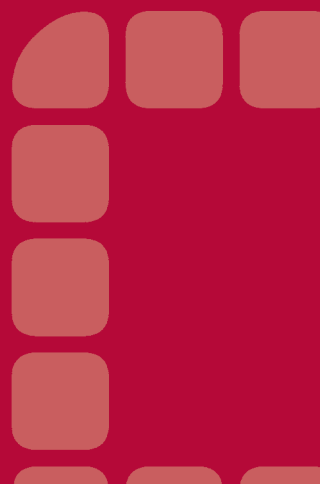
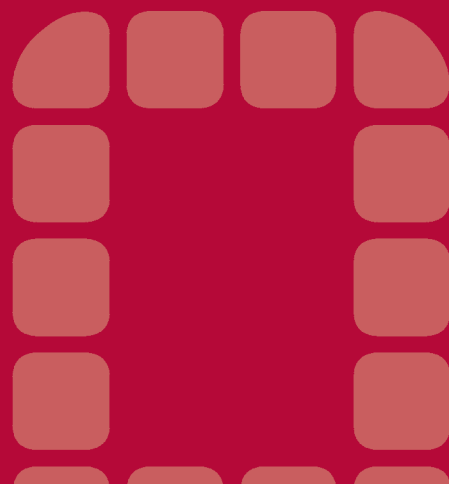
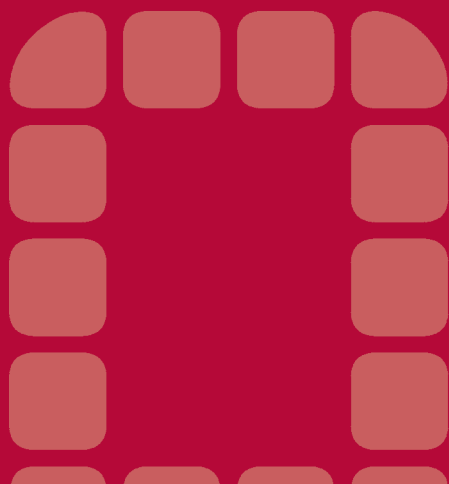
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Notes





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