

Patient Management Task Force

Paper No. 5

**Improving Hospital Care
for Older Victorians**

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Introduction

Older people use hospitals much more than younger people. In 1999–2000, people aged 70 and over comprised 9 per cent of the State’s population, but accounted for 24 per cent of separations from all Victorian public hospitals, and 40 per cent of patient days.

Half of all public hospital separations, as well as half the separations for patients aged 70 and over, occur in Melbourne’s 12 major general hospitals. But while these hospitals account for half the separations, they account for most of the growth, including 80 per cent of the growth in separations for patients aged 70 and over.

Based on the 1996 census, when local areas in Australia are ranked according to the number of older persons as a proportion of their total population, eight of the top 12 areas in Australia are in Melbourne.¹ An increasing proportion of older people will also be living alone in the future² and this can be associated with an increased need for hospitalisation (for example, from falls³), and an increased need for post-hospital care. When the same local areas are ranked according to the proportion of older lone person households within them, six of the top eight local areas were in Melbourne.⁴

The recent health insurance changes introduced by the Commonwealth Government are not expected to have a major impact on public hospital utilisation by older people, at least in the short to medium term. Over the past year the proportion of Victorians over 75 with health insurance coverage rose by only 2.4 per cent, and by only 7.7 per cent for Victorians aged from 65 to 74.⁵

Rising Numbers of Medical Separations

Most of the growth in hospital use is due to a rise in the number of medical separations. Patients aged 70 and over make up about 40 per cent of this growth (Figure 1).

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1 Australian Bureau of Statistics. 1996. *Australia In Profile—A Regional Analysis*. Cat. No. 2032.0

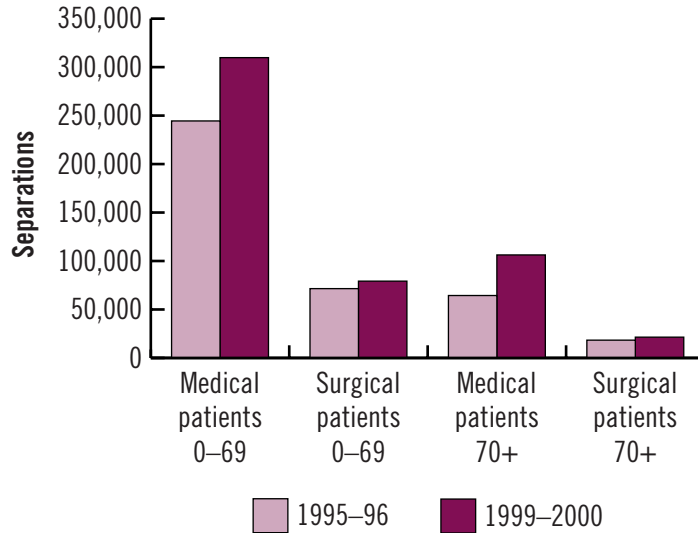
2 Australian Bureau of Statistics. 1999. *AusStats: Feature Article—Who’ll be home alone in 2021?*

3 Australian Bureau of Statistics. 1995. *Falls risk factors for persons aged 65 years and over, New South Wales*. Cat. No. 4393.1

4 Australian Bureau of Statistics. 1996. *Australia In Profile—A Regional Analysis*. Cat. No. 2032.0

5 Private Health Insurance Administration Council, December Quarter Statistics Available at www.phiac.gov.au

Figure 1: Separations, 12 Major Public General Hospitals by Age

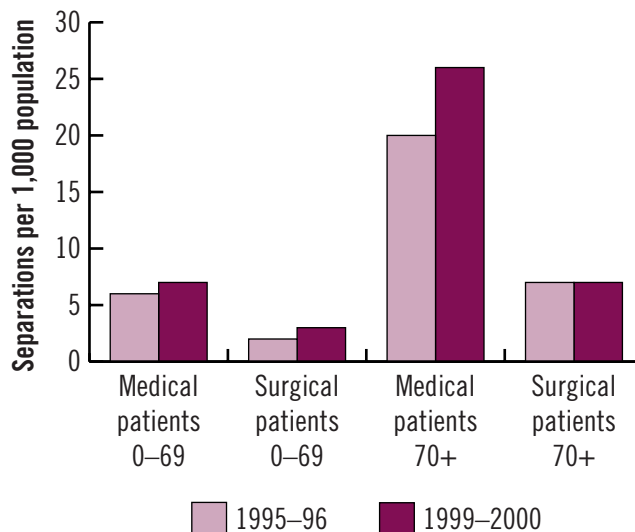


Source: Victorian Admitted Episodes Database (VAED)

The substantial growth in medical separations is largely due to a big increase in a relatively small number of patients with kidney failure who are admitted for renal dialysis on a sameday basis, generally three times a week. Excluding these separations, on a per capita basis the greatest rise over the past four years has been medical separations for older people (Figure 2).

Excluding renal dialysis and chemotherapy, emergency medical separations account for nine of the top 10 separations for people aged 70 and over (Appendix 2)

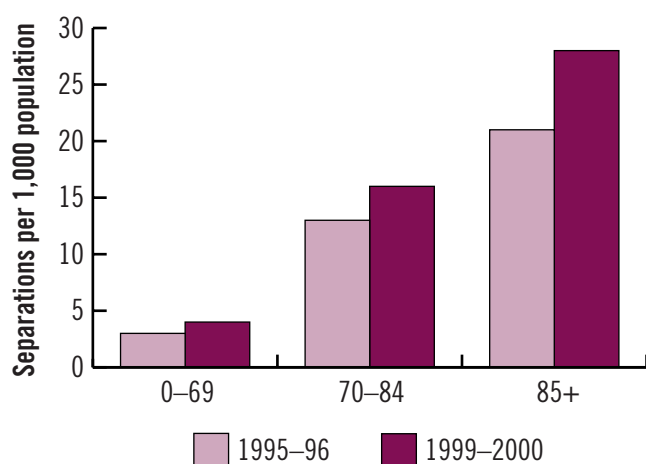
Figure 2: Separations Per 1,000 Population (Excluding Dialysis), 12 Major Hospitals



Source: Victorian Admitted Episodes Database (VAED) and Department of Infrastructure

The biggest contributor to the rapid growth in medical separations for older people is a 34 per cent increase in emergency medical separations for patients aged 85 and over (Figure 3). This increase accounts for 13 per cent of the total growth in demand for beds in the 12 major hospitals since 1995–96 as measured by growth in non-same day patient days.

Figure 3: Emergency Medical Separations Per 1,000 Population, 12 Major Hospitals



Source: Victorian Admitted Episodes Database (VAED) and Department of Infrastructure

These trends are likely to continue. For example, in terms of disability adjusted life years lost, the impact of cardiovascular disease, which is a major cause of emergency admissions for older people, rises exponentially with age, increasing 2-fold from age 70 to age 80 to make up 40 per cent of the total disease burden.⁶

With Melbourne’s population of people aged 80 and over projected to rise by around 4 per cent per annum over the next five years, trends like this clearly present major challenges.

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National Study of the Casemix of Older Patients

A comprehensive national study published last year by the Commonwealth Government⁷ analysed the casemix of older patients. It found that:

- the casemix of older people differs from that of other age groups, but substantial differences also exist between the ‘young old’ (65–74 years), the ‘old old’ (75–84 years) and the ‘very old’ (85+ years), as well as between males and females; and
- the amount of time that older people spend in hospital is commensurate with their severity of illness. It would appear that older people stay longer on average because they tend to be sicker.

6 DHS. 1999. *Victorian Burden of Disease Study: Morbidity*. Available at www.dhs.vic.gov.au/phd/9909065/index.htm

7 Nichol, B, Lonergan, J and Mould, M. (2000). *The use of hospitals by older people: a casemix analysis*. (Occasional Papers: New Series No. 11), Department of Health and Aged Care, Australia. Available at www.health.gov.au/pubs/hfsocc/occpdf.htm

In Victorian public hospitals, as in other States, the average length of stay for older people in hospitals has fallen faster in absolute and percentage terms than younger patients.

The study also pointed out that while older people tend to have higher lengths of stay and greater severity of illness, this did not necessarily mean that, for any given DRG, their admission to hospital results in higher-than-average treatment costs. As an example, it cited a study of hip replacement in Victorian public hospitals published in 1998 reporting that the average cost of hip replacement for patients aged 65+ was 15.5 per cent less than the total average cost of treating patients aged under 65.⁸

In Victorian public hospitals, as in other States, the average length of stay for older people in hospitals has fallen faster in absolute and percentage terms than younger patients. The average length of stay for patients aged 70 and over in all Victorian public hospitals has fallen from 12.2 days in 1990–91 to 6.4 days in 1999–2000. Factors contributing to this include the increasing health of the younger segment of the older population, clinical and technological advances and system process improvements.

Whether further length of stay reductions can be achieved without compromising quality of care will not just depend on what happens in hospitals. The availability of a strong primary care system, of appropriate home-based care and improved access to residential aged care facilities will be just as important.

The key themes that underlie much of the discussion in this paper are therefore:

- the likely increase in demand for services as the aged population group increases;
- counterbalanced by a reasonable expectation that much of this demand will be met by improved efficiency and productivity in managing older patients; but
- entailing a need to focus on demand management including prevention programs, diversion and substitution strategies (including community-based care) as well as disease management initiatives that provide flexibility to meet individual needs.

The Patient Management Task Force

An objective of the Task Force is to engage actively with hospital management and clinicians in dealing with problems of access to emergency services and elective surgery—both at the individual health service level and in professional forums.

The Patient Management Task Force was set up November 2000 to identify specific areas for improvement in in-hospital patient management processes and to advise on the system factors that will encourage the adoption of best practice in patient management. An objective of the Task Force is to engage actively with hospital management and clinicians in dealing with problems of access to emergency services and elective surgery—both at the individual health service level and in professional forums. The Task Force is also seeking to obtain views from a wide range of stakeholder groups on effective solutions. The Task Force's terms of reference and membership are at Appendix 1.

8 Duckett and Jackson 1998

The Task Force has a principal focus on major metropolitan hospitals⁹ and is carrying out its work in three stages:

- Stage 1, the information gathering stage, is now complete. An overview paper, *Serving the Needs of the Patient: Better Patient Management in Melbourne's Public Hospitals*, was released in March 2001.
- Stage 2 involves producing papers on 'action areas' for consideration and comment by the field. Papers have been or are being published on the following topics:
 - Emergency services
 - Ambulatory care
 - Multi-day medical and elective surgery patients
 - Services for older Victorians
 - Improving the system.
 - Care decision making
- Stage 3 of the Task Force's work will be the preparation of a short final paper which will include a summary of its principal themes, key areas for action and incorporating any changes to the views of the Task Force as a result of comments received.

Other Departmental Patient Management Initiatives Relating to Older Patients

The Department of Human Services has set up a separate process for examining ways of improving the interface between acute and sub-acute services. A discussion paper on this has been released recently and is available at <http://www.dhs.vic.gov.au/ahs/edcg/subacute.htm>.

The Discussion Paper makes four key findings and proposes 18 recommendations to improve patient care both across the acute/sub-acute boundary, and the sub-acute/home care boundary. In the light of this, the Task Force's observations in relation to sub-acute services are more limited than they would otherwise have been. It would strongly encourage readers of this paper to look at that paper as well and comment on it as necessary.

This paper draws extensively upon two literature reviews commissioned by the Patient Management Task Force from La Trobe University and the Centre for Clinical Effectiveness, Monash Institute of Public Health with the Planning and Development Unit, Southern Health. The literature reviews are available at the Task Force Web site at <http://www.dhs.vic.gov.au/ahs/patman>. However, it is acknowledged that the paper does not contain a detailed or comprehensive review of all the available data, especially with respect to variations in patterns of practice in Victoria (and the causes of those variations).

⁹ The Alfred Hospital (Bayside Health); Austin and Repatriation Medical Centre; Box Hill, Maroondah and Angliss Hospitals (Eastern Health); Frankston Hospital (Peninsula Health); Monash Medical Centre (Clayton and Moorabbin) and Dandenong Hospital (Southern Health); Northern Hospital (Northern Health); Royal Melbourne Hospital (Melbourne Health); St. Vincent's Hospital; Western and Sunshine Hospital (Western Health)

Providing Feedback

The Patient management Task Force invites you to submit your views and comments on this paper and its recommendations to:

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Recommendations

1. Metropolitan health services should implement available strategies for improving care for older patients in acute hospitals, but in particular:
 - an expanded role for general geriatric outpatient and assessment services;
 - the adoption of short stay medical assessment units or services;
 - increased senior staff availability in general medical units;
 - better access to geriatric expertise in medical wards and emergency departments;
 - programs to maintain the wellbeing of older patients in wards;
 - areas where older non-acute patients can be co-located to improve their care;
 - clinical pathways to improve care and timely transfer to sub-acute settings.
2. Metropolitan health services should ensure that services provided via the Post Acute Care program are made available to sub-acute patients and Department of Human Services should ensure that funding is available for this.
3. The Department of Human Services should identify factors leading to the increased utilisation of hospital emergency departments by older people.
4. The Department of Human Services should review existing data items collected by hospitals to establish a better information base on admissions and emergency department presentations by residents from aged care residential facilities.
5. Metropolitan health services should work with local divisions of general practice and residential aged care services to allow GPs and residential aged care nurses a greater role in managing a number of the simpler conditions commonly arising in residents.
6. Metropolitan health services should extend their care coordination services, to allow them to accept referrals from GPs focused particularly on older people at risk of presenting in an emergency department and for whom an immediate short term response may help avoid an admission.
7. The Department of Human Services should accelerate the introduction of health information strategies including clinical information systems, an electronic health record and unique patient identifier to support better clinical decision making and encourage better service integration across sectors.
8. The Department of Human Services should include a focus on older people in the proposed demonstration projects to improve the uptake among GPs of the new expanded primary care items.

9. Metropolitan health services should build links with GPs and GP divisions to develop their role in discharge planning and working with emergency departments.
10. Metropolitan health services should strengthen their relationships with surrounding residential care providers as part of an overall strategy of improving the management of patients awaiting residential care.
11. As part of the development of a broad health information strategy, the Department of Human Services should work with the Commonwealth and relevant aged care peak bodies to create a comprehensive on-line information service, including links to other relevant sites, where people could get accurate up-to-date information about residential aged care services in their region.
12. During 2001–02, the Department of Human Services should improve the sub-acute per diem price structure. This should be based on the need to better match prices with the cost of appropriate models of care, to create incentives to reduce excessively long stays in sub-acute care and to encourage direct admission to sub-acute where appropriate.
13. During 2001–02, the Department of Human Services should implement, in consultation with providers and professional bodies, a formal designation process for GEM and interim (non-acute) care.
14. Metropolitan health services and the Department of Human Services should establish a collaborative initiative in 2001–02 with a specific focus on benchmarking and re-engineering of the internal hospital processes that drive patient flows between sub-acute and acute services. It should provide data for the purposes of service planning and process redesign on how sub-acute activity affects (and is affected by) the operation of the acute sector.
15. As an outcome of recommendation 14, the Department of Human Services should ensure that key performance indicators covering length of episode, access block, care continuity, admissions avoided and RCS classification are routinely monitored.

Observations and Findings

1. Concentration of effort and resources on the needs of older patients will improve patient satisfaction, efficiency and outcomes.

Most of the growth in hospital use is due to a rise in the number of medical separations. Patients aged 70 and over make up about 40 per cent of this growth.

Older patients often have chronic conditions with an array of co-morbidities that are complex and may include depression, cognitive impairment, poor mobility and incontinence. They can also suffer functional decline during hospitalisation. These factors contribute to longer lengths of stay, increased risk of complications, adverse events and impairment of physical performance.

A range of initiatives with a focus on older patients have been suggested to the Task Force, or identified by it through the literature reviews or elsewhere, as models of practice that metropolitan health services should consider.

Pre-Admission Practices to Avoid Unnecessary Admissions to, and Prolonged Stays in, Acute Wards

- The establishment of rapid response short stay services to better manage patients presenting with medical conditions. Such services are often set up as special units (variously named).¹⁰ Ideally located in or adjacent to emergency departments, they may otherwise be attached to a general medical ward and are designed to avert inappropriate admissions to wards. They allow intensive clinical evaluation as well as a multidisciplinary assessment of functional status and ongoing care needs. The benefits of these units are discussed in a separate paper (*Meeting Demand for Emergency Services: Better Management of Emergency Patients*), however, the evidence so far shows that if they do not themselves become filled with patients awaiting transfer to a ward they are effective in reducing length of stay as well as improving patient outcomes. A high level of aged care clinical expertise is an important element in the efficient functioning of such units.
- Where separate short stay units are not appropriate, then protocols for improving the management of older patients who attend emergency departments but do not require admission, particularly those with a high risk of re-presentation, should be implemented. Such patients should be referred back to their local GP (see also Observation/ Finding 5), an aged care assessment team or a psychiatric assessment and treatment service as required. A component of such a strategy

Clearly, programs and initiatives directed at older patients have the capacity to deliver substantial whole-of-system gains.

A high level of aged care clinical expertise is an important element in the efficient functioning of rapid response and short stay services.

¹⁰ RAMU—'Rapid Assessment Medical Unit', MAPU—'Medical Assessment and Planning Unit', EMU—'Emergency Medical Unit'

would also be the inclusion of a gerontic nurse in the emergency department.¹¹

- The establishment of general geriatric outpatient clinics. Already operated by some hospitals, such clinics are staffed by geriatricians and can be established in either acute or sub-acute facilities. Outpatient geriatric clinics could offer:
 - support for certain chronically ill patients with conditions that would benefit from ongoing oversight from a geriatrician;
 - an alternative referral destination to an emergency department for patients who are likely to need admission, but whose condition may be best managed via direct admission to a sub-acute facility, or for whom assessment and care planning may be an alternative to an admission;¹² and
 - access to post-acute care (PAC) services (see below) for people at risk of imminent admission but which is potentially avoidable with a short period of intensive home-based care.

Post-Admission Practices To Improve Care

- Programs in general wards to maintain and improve the physical functioning of frail aged inpatients. For example, a daily exercise program for older patients has recently been developed at the Austin and Repatriation Medical Centre that aims to limit the physical deterioration that is associated with bed-based care and also prevent or reduce the need for restorative care in a rehabilitation bed. The program has only been running a short period of time, but early data has identified a reduction in average length of stay (ALOS) for this client group of 13 per cent or 2.8 days.¹³
- Increasing the geriatric and allied health expertise in general medical units, as well as ensuring more senior staffing in general medical units. There are two points here:
 - access to specialist geriatric advice and involvement in the care of older patients in general medical units; and
 - availability of full-time senior medical management of these patients. For example, the medical inpatient study considered that reliance on sessional consultant physicians might not be the most appropriate way of providing adequate clinical expertise and supervision to junior staff in general medical units.¹⁴

11 Submission to Task Force from Royal Australian College of Geriatricians.

12 Black, D.A. 1997. Emergency day hospital assessments. *Clinical Rehabilitation* 11(4):344–6.

13 Austin and Repatriation Medical Centre, unpublished internal evaluation

14 Nosworthy, J, Campbell, D, Byrnes, G and Staley, C. 2001. *Medical Inpatient Study Report*. Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health.

- The development and implementation of clinical pathways for the frail aged. Recent work at Caulfield General Medical Centre has shown that the development and implementation of a generic ‘clinical pathway’ and clinical practice guidelines for older patients improved patient outcomes, as measured by a significantly shorter length of stay and improved patient satisfaction.¹⁵
- Co-location of acute and sub-acute geriatric wards, wherever possible. This could occur via the establishment of geriatric wards within acute facilities, as in St Vincent’s Hospital, or via the establishment of acute wards in extended care centres, as in Caulfield General Medical Centre. This should have several substantial benefits including increasing the ‘critical mass’ of geriatric and allied health expertise within acute facilities, and improved efficiency and effectiveness by allowing more timely transfers to sub-acute care.
- Where acute and sub-acute facilities are separately located, hospitals should ensure that strong clinical links exist between the relevant acute wards and sub-acute facilities. Clinical pathways can be an important way of facilitating this. For example, Box Hill Hospital has implemented a clinical pathway for stroke that streamlines the process for patients moving from an acute medical ward to a sub-acute ward at the Peter James Centre.
- Where there are sufficient older patients whose period of acute treatment is finished but for whom discharge is likely to be delayed either due to a lack of home-based support or lack of a residential care bed, then a special area or ward should be developed to provide a more appropriate level of care than may be possible in a general acute ward. A different model of care would be required in such areas to maintain and improve the physical and social functioning of these patients.

Targeting discharge planning on patients with a high risk of re-admission, and ongoing care requirements is where the greatest gains are to be achieved.

Improved Discharge Planning Practices

Targeting discharge planning on patients with a high risk of re-admission, and/or ongoing care requirements is where the greatest potential gains are to be achieved. A recent Department of Human Services report, *Performance Indicators for Effective Discharge*, includes a risk-screening indicator as a way of encouraging improved targeting in discharge planning. The literature reviews commissioned by the Task Force cite several randomised controlled trials with older patients showing that effective discharge strategies, including follow-up care and monitoring, lead to improved patient outcomes and reduced overall cost.¹⁶

15 Fonda, D, Willinck, L, Bailey, M. *Developing ‘Clinical Pathways’ for the Frail Elderly*. Project report.

16 Naylor et al 1999 and Nikolaus 1999

Social circumstances, cognitive functioning, and nursing needs, not age, are the main factors in long lengths of stay.

Recommendation

1. Metropolitan health services should implement available strategies for improving care for older patients in acute hospitals, but in particular:
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 - increased senior staff availability in general medical units;
 - better access to geriatric expertise in medical wards and emergency departments;
 - programs to maintain the wellbeing of older patients in wards;
 - areas where older non-acute patients can be co-located to improve their care;
 - clinical pathways to improve care and timely transfer to sub-acute settings.

Post-Acute Care

A recent major study of medical inpatients at Melbourne's five major teaching hospitals found strong evidence that social circumstances, cognitive functioning and nursing needs, not age, were the main factors in long stay lengths (>13 days).¹⁷ These long stay patients represented only 13 per cent of multi-day medical cases but accounted for 48 per cent of total bed days. Most were not waiting for residential aged care since almost 60 per cent were discharged to their home, however many of them may have been waiting for access to other community-based services.

There has long been a problem in discharging patients who need home-based care since Commonwealth funding arrangements stipulate that HACC program funding not be used for post-acute services. This is especially a problem on weekends when it is more difficult to arrange for new services to commence.

The Post Acute Care (PAC) program, established in 1996, sought to address this problem. It provides additional services for individuals who require them, to improve care planning for patients discharged from public hospitals and to improve the links between hospitals and other health and community care providers. Eighteen PAC services are funded across the State to coordinate and purchase individually tailored packages of health and community care services for clients. All eligible patients discharged from acute public hospitals in Victoria now have equity of access to the program, which is well supported by both acute health and community sectors. In each of the first two years of operation, throughput increased at a rate of over 100 per cent, and since then, growth has continued at around

¹⁷ Nosworthy, J, Campbell, D, Byrnes, G and Staley, C. 2001. *Medical Inpatient Study Report*. Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health.

40 per cent. In 2000–01, the program aims to provide services to approximately 20,000 discharged patients.

Late last year a new funding model was implemented that provides funding according to where patients live. The model was introduced to address inequities in funding and also the issue of patients discharged outside a hospital's main catchment area. However, for the main tertiary teaching hospitals, which have many out of area patients, these new arrangements mean that they now have to deal with more than one PAC service.

A recent study conducted for the Department of Human Services¹⁸ examining the outcome of the PAC program for older patients concluded that the program is a viable and cost-effective approach to improving the transition of older patients from hospital to the community. Re-admission rates were reduced, where readmissions occurred length of stay was reduced, and there was a general improvement in patients' quality of life.

The Task Force has made a recommendation elsewhere (*Meeting Demand for Emergency Services: Better Management of Emergency Patients*) to increase uptake of PAC services, however one gap in the PAC program is that funds are not provided for home-based convalescent care for sub-acute patients. The Task Force considers that this is anomalous, and notes that the discussion paper on the Acute/Sub-Acute Interface also suggests that this gap be addressed.

Recommendation

2. Metropolitan health services should ensure that services provided via the Post Acute Care program are made available to sub-acute patients and Department of Human Services should ensure that funding is available for this.

2. The number of GP visits per capita by older people is declining more rapidly than for the rest of the population.

On a per capita basis over the past four years, the number of attendances by GPs at their rooms or at the patient's home for people younger than 75 fell by four per cent. There was a 14 per cent decline in the number of attendances for people aged 75 and over and a 35 per cent fall in home visits to this group (see Figure 4).

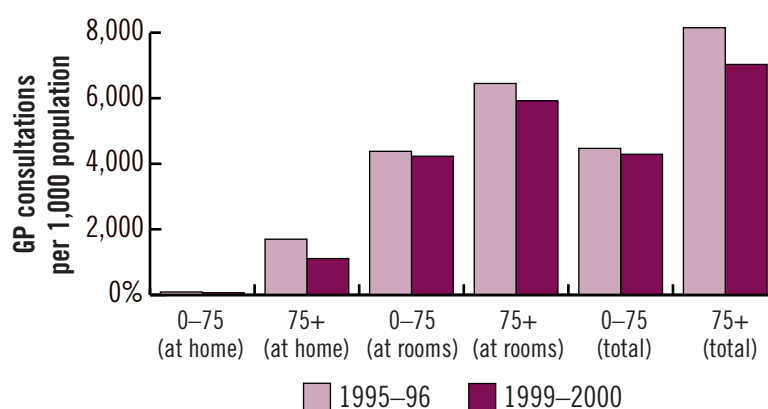
While there is a shift towards longer consultations across all age groups, longer consultations represent only around 10 per cent of all GP consultations and the net effect is still a disproportionate decline in the age group 75 and over compared to younger ages.

These trends are not confined to Victoria but are occurring across Australia.

¹⁸ Centre of Applied Gerontology. 2001. *Draft report: Post Acute care Study: Evaluation of Outcomes in Older Patients*.

The Post Acute Care (PAC) program is a viable and cost-effective approach to improving the transition of older patients from hospital to the community.

Figure 4: Non Institutional GP Attendances, Victoria



Source: Australian Institute of Health and Welfare (AIHW)

Possible factors contributing to these trends include:

- Medicare Benefits Schedule (MBS) reimbursement rates that may make older patients less financially viable for the doctor because of the longer time they take;
- the growth in population of the 75+ age group outstripping the supply of GPs;
- inadequate MBS reimbursement rates as well as personal safety concerns resulting in a reduced willingness to do home visits;
- a declining GP workforce in many socioeconomically disadvantaged areas¹⁹ resulting in less time available for GPs to make home visits;
- increased numbers of specialist physicians managing older patients for conditions that may previously have been managed by GPs;
- the availability of subsidised taxi vouchers that allow people to get to doctors' rooms more easily; and
- a desire among some GPs for more family-friendly working hours.

These trends may be related to the increasing number of emergency hospital admissions by older people (see Figure 3). Some of the increase is likely due to older people surviving with conditions that they previously may have died from (or died sooner from), but lack of access to primary care providers may also be a factor.

Perhaps decreased availability of GPs, together with restricted access to Home and Community Care (HACC) services and Commonwealth-funded community aged care packages (CACPs), is leading to poorer care continuity for some older people than may have been the case in the past, leading to an increased need for emergency medical attention.

The trends could also be a result of many GP practices having phone messages directing people to seek after hours attention from the nearest emergency department. Since older people, especially older women, tend

¹⁹ The General Practice Division of Victoria in its presentation to the Task Force (21/12/00) cited the situation in central Dandenong where over the past several decades what were multiple practices with as many as 38 GPs have now amalgamated to a single practice with only 6 GPs.

to live alone more than the rest of the population,²⁰ they may only seek help, or their problem only be noticed by someone else, after their condition has progressed beyond a point where younger, or less isolated, people would have sought help. Since they may also have other problems, older people may thus be less able to wait until business hours to see their GP. The Commonwealth Government has recently announced an increase in the Medicare rebate for after hours GP consultations and this should help address this problem.

A 1999 study of medical services to people in supported residential services (SRSs), many of whom are older people, found that residents had difficulty accessing appropriate quality after hours services, locum services were often unsatisfactory and lack of money and transport made it difficult for residents to visit GPs' rooms.²¹

Some actions that hospitals could consider to strengthen links between older people presenting at emergency departments and their local medical practitioner are set out elsewhere in this paper (see Observation/ Finding 5).

One way that the Commonwealth could encourage GPs to ensure that older people receive an appropriate level of care may be to boost the weightings for older patients in the Practice Incentives Program payment formula. Currently the weighting in the formula, for patients aged 75 and over is only double that for patients aged 45–64.

Consideration could also be given to restoring the patient continuity factor in the Practice Incentives Program formula (which existed prior to 1999–2000) and which is potentially more important for older people and other people with chronic conditions.

Recommendation

3. The Department of Human Services should identify factors leading to the increased utilisation of hospital emergency departments by older people.

3. Many presentations to hospital emergency departments could be prevented if a more flexible range of early intervention services were provided.

Although clear data on presentations in emergency departments from aged residential care facilities is presently not available, the Task Force has been advised that there has been a substantial increase in patients presenting from nursing homes and hostels. A variety of reasons have been proposed for this, including:

²⁰ Australian Bureau of Statistics. 1999. *AusStats: Feature Article—Who'll be home alone in 2021?*

²¹ Department of Human Services. 1999. *Review of the Adequacy of Medical Services to Residents of Supported Residential Services*. Government of Victoria

Residents within supported accommodation had difficulty accessing appropriate quality after hours services and a lack of money and transport made it difficult for residents to visit GPs' rooms.

- generally higher dependency among residents since the wider availability of home-based care now allows people with lower care requirements to remain in their own homes much longer;²²
- declining numbers of qualified and experienced nurses working in nursing homes²³ and absence of 24 hour nurse staffing in most hostels;
- heightened media attention on quality of aged residential care.

A number of hospitals have established, or intend to establish, rapid response services from their emergency department that could address the apparently growing number of presentations to hospital emergency departments from nursing homes by preventing any presentations that could be avoided by a rapid response from the hospital. The Winter Emergency Demand Strategy provided funding specifically to encourage the development of such services.

There is a need for good liaison and information flows between hospitals and aged care providers.

However, if these services are filling a gap that is partly a consequence of Commonwealth funding for GPs and residential aged care not keeping pace with the general increase in resident morbidity, or a lack of up-to-date skills in the aged care workforce, then these issues must also be addressed (see Box).

Staff Skill Enhancement at South Port Community Nursing Home

The Task Force has learnt of one nursing home, South Port Community Nursing Home in Albert Park, that has invested time and effort in upskilling nursing staff as a way of avoiding inappropriate hospital admissions. Residents were being referred to the Alfred Hospital with conditions such as urinary tract infections, dehydration, chest infections and cellulitis that, if initially well managed, may not require an acute admission. The nursing home contacted La Trobe University and a training course was developed. The Alfred Hospital was also involved. The Aged Care Accreditation Agency acknowledged the work as a model of good practice and had resulted in a situation where residents with more acute problems could now be managed in the nursing home.²⁴

The work also highlights the benefits of good liaison and information flows between local hospitals and residential aged care providers. The Alfred Hospital has established a liaison position and a mobile assessment team that can go out to any aged care facility in its area to deal with emerging problems and deflect possible admissions.

22 Australian Institute of Health and Welfare. *Media Release: Dependency levels continue to rise in residential aged care facilities*. 31 May 2000. At www.aihw.gov.au/media/2000/mr000602.html

23 See for example, *Victorian Aged Care Facilities Survey 2000, Media Summary* (survey conducted by a group of aged care peak bodies)

24 Assessment Team report of South Port Community Nursing Home, 7 August, 2000

The General Practice Divisions of Victoria proposed to the Task Force that a trial be conducted to fund GPs, through local Divisions, to manage and supervise acute care in nursing homes. An alternative approach would be for hospitals to work with local Divisions to ensure that training opportunities are available for GPs prepared to play a greater role in managing acute conditions in nursing homes. Additional funding may be needed for this, but it may be better to provide this via hospitals, rather than via Divisions. This would have the further benefit of strengthening the links between hospitals GPs and residential aged care services.

Opportunities to refresh the skills and knowledge of local GPs in managing higher acuity conditions commonly occurring among residents in nursing homes are required.

It may be appropriate to also involve locum services in any training opportunities to increase the role of GPs in managing more acute conditions in residential aged care facilities. Melbourne Medical Locum Service has advised the Task Force that 65 per cent of patients attended after hours by its GPs are in nursing homes or other residential care facilities.

Recommendations

4. The Department of Human Services should review existing data items collected by hospitals to establish a better information base on admissions and emergency department presentations by residents from aged care residential facilities.
5. Metropolitan health services should work with local divisions of general practice and residential aged care services to allow GPs and residential aged care nurses a greater role in managing a number of the simpler conditions commonly arising in residents.

Two initiatives have recently been trialled in South Australia that provide intensive rapid response, home-based services to older people at risk of admission to hospital who have either presented at an emergency departments or are likely to do so.

The 'GP Home Link' pilot program was conducted during 1997 and 1998. The aim was to avoid 'unnecessary' hospital admissions for older persons at risk of admission to hospital by working with GPs to provide short term intervention and home care services at no cost to the patient or the GP. Access to the service was via referral from the person's GP, with a coordinator assessing the person and determining eligibility and service mix.

A similar program, known as the Emergency to Home Outreach Service (ETHOS), is now established at Flinders Medical Centre in South Australia. The service is a partnership between Flinders Medical Centre, the Royal District Nursing Service and Southern Domiciliary Care and Rehabilitation Service and is focused primarily on older people. It receives referrals from the emergency department, local GPs and the ambulance service, and aims to provide support for people to manage at home, or in a respite facility, for up to seven days as an alternative to a hospital admission.

The days when patients expected to stay for long periods in hospitals while they recuperated are long gone.

As part of the care coordination funding first provided to Victorian hospitals last year under the Winter Emergency Demand Strategy, hospitals were encouraged to establish similar services. Frankston Hospital has now set up a Response Assessment and Discharge (RAD) team working out of the emergency departments that can provide immediate home-based services to people who attend emergency departments and may otherwise require admission. Northern Hospital has established a similar service, although in this case the service is available to support people prior to presentation at the emergency department if this will prevent the need for admission.

Recommendation

6. Metropolitan health services should extend their care coordination services, to allow them to accept referrals from GPs focused particularly on older people at risk of presenting in an emergency department and for whom an immediate short term response may help avoid an admission.

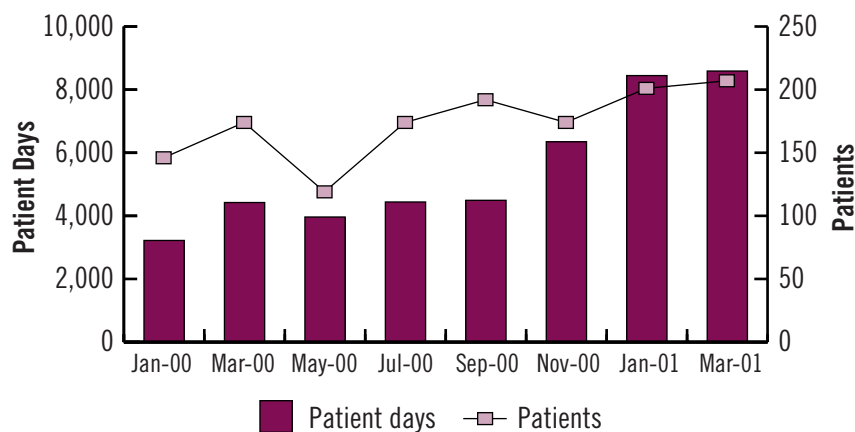
4. For most older and chronically ill patients, acute treatment is only one part of a complex care system involving home-based care, sub-acute care and other institutional care, and access to these services is restricted at multiple levels.

The efficiency and effectiveness of the acute hospital system is dependent on the ability to transfer patients to the most appropriate care setting, whether this be their home, a sub-acute bed, or a residential aged care bed, at the earliest opportunity. The issue of GP accessibility for older people is discussed elsewhere in this paper, however there is also variability in the accessibility of other associated services across the metropolitan area.

The efficiency and effectiveness of the acute hospital system is dependent on the ability to transfer patients to the most appropriate care setting.

Demand for aged residential care beds in Melbourne currently exceeds availability. The latest data indicate that waiting times have almost doubled over the past four months (see Figure 5). This latest increase in waiting times may be related to bed closures as a result of the Commonwealth Government's January deadline for its aged residential care accreditation requirements. However, bed closures have been proceeding for some time, both as a result of the accreditation requirements and transfer to areas that are relatively undersupplied.

Figure 5: Patients Aged 65 and Over in Acute Beds Awaiting Residential Care



Source: Department of Human Services Bed Surveys

For example, data provided to the Task Force by Bayside Health show that in the past four years in the three municipalities primarily serving the Alfred Hospital and the Caulfield General Medical Centre (Stonnington, Port Philip, Glen Eira), 631 beds have closed with 130 more closures planned. These closures have been offset to some extent by 221 new beds opening with a further 62 planned, but most of these new beds have been ‘extra service’ beds and so are effectively not available to many people. Extra service beds are beds that provide a higher accommodation and living standard than ordinary beds, but are effectively only available to more affluent residents.

The Task Force believes that further work needs to be done to establish best practice standards in this area. A way of approaching this would be to establish a collaborative project across metropolitan health services with benchmarking and sharing of results and learnings. The Task Force has recommended elsewhere the establishment of collaborative structures involving clinicians (doctors, nurses and other health care workers), hospital executive management and the Department to promote the achievement of the patient management and clinical practice improvement objectives proposed by the Task Force. This is an area in which such arrangements are currently required.

The changing number and distribution of residential aged care beds is under discussion between the Commonwealth and Victorian Governments.²⁵ However, even if new beds were approved immediately, there would still be a delay before they actually became available, both as a result of construction timeframes and because of likely staff recruitment problems due to the shortage of nurses.

A key question is whether the aged residential care beds that are available are being used appropriately. One way of examining this issue is to look at the relationship between ALOS and RCS classification.

²⁵ Minister for Health, *Media Release: Hospitals Stretched By Lack Of Nursing Home Beds*, December 9, 2000

Demand for HACC services to allow people to return home at the appropriate time also exceeds the available funding in many areas of Melbourne.

The Task Force understands that the Department of Human Services is negotiating with one metropolitan health service to open additional public nursing home beds using inactive bed licences. This initiative should take some pressure off the system in the short term, however, other options should also be considered.

For example, Eastern Health has been taking advantage of spare bed capacity in a number of nursing homes that were due to close as a result of the bed licences being transferred to other areas. Using funding from the Winter Emergency Demand Strategy, these nursing homes were paid a per diem rate to keep beds available for patients at Box Hill Hospital awaiting placement in a residential care facility.

The Task Force is also aware of a proposal that has been developed by Western Health in conjunction with a residential aged care provider that would allow patients awaiting transfer to a residential care facility to be cared for by the residential care provider under a sub-contract type of arrangement in a more appropriate setting than an acute or sub-acute ward.

As with proposals for rapid response outreach services to nursing homes from hospital emergency departments, an issue may be the extent to which the need to provide these services is partly a consequence of Commonwealth funding policies in relation to residential aged care (see Observation/Finding 6). However, even if sufficient residential care beds were available there can be other barriers. For example, patients with acquired brain injury (not all of whom are older people) are in acute beds because the extra funding for the slow-stream recovery program that would allow them to live at home or in a residential aged care facility is limited.

Demand for HACC services to allow people to return home at the appropriate time also exceeds the available funding in many areas of Melbourne. Increased funding would certainly allow many patients to go home sooner, but improved relationships with community providers would help too (see Observation/Finding 5).

5. Better integration of residential care, GPs and community-based services with hospital services will enhance efficiency and improve care.

Metropolitan health services do not just deliver hospital care. All of them have a substantial direct involvement in community-based services of some kind. Many of them are also significant providers of residential aged care services. However, linkages with, and understandings of, the other health and community services that their clients/patients may access are highly variable. Linkages with the private aged care sector are not always strong.

For older people with a continuing need for community-based support, holistic patient management can break down at the point of transition to the community-based care sector. Where failure occurs it can be because:

- community based services, particularly HACC, are overstretched by existing demand for services and cannot respond quickly;
- information flows between hospitals and primary care providers tend to be ad hoc, poorly defined, fragmented and inconsistent; and
- the primary care sector itself is fragmented.

For example, HACC providers often only learn that their client won't need help that day when the worker arrives at the home. It may be several days, or sometimes much longer, before they find out that the client is in hospital and will not need services for some time. Protocols ensuring that hospitals notified HACC providers in such cases would generate considerable goodwill between all partners in the system, as well as improving efficiency.

In a survey conducted last year by the Victorian Association of Health and Extended Care, half the responses from community care providers highlighted a lack of communication between the hospital, carer and community support services.²⁶

Better integration of primary care services is the main goal of the Government's Primary Care Partnerships Strategy. All health services are part of this initiative that aims to streamline both information flows and client navigability through the primary care system. Some metropolitan health services are taking a lead here, with Southern Health being the lead agency for the Monash Primary Care Partnership.

Other steps that have been taken at a whole of Government level to improve service integration and collaboration between hospitals and community-based providers include:

- All Metropolitan Health Services are obliged by legislation to establish Community Advisory Committees and Primary Care and Population Health Advisory Committees.
- As part of the Primary Care Partnerships strategy, each primary care partnership will be developing a 'service directory' that will be available on the Internet containing information on health and community services available in each area. It is proposed that the directory will contain information about service types, location, hours of operation, eligibility criteria, priority of access guidelines, waiting times, and so on.
- Part of the Enhanced Primary Care (EPC) package announced in the 1999–2000 Commonwealth Budget was the creation over four years of a national network of information centres to improve access to a range of community care services.

Linkages and understanding of other health and community services is highly variable across the acute sector.

²⁶ Victorian Association of Health and Extended Care. 2000. *Discharge Planning Survey Review*

- The Commonwealth, States and Territories have commissioned the development of a National Dependency Measure for the HACC program. This measure is being trialled by Kingston Bayside Primary Care Partnership. Ultimately this should both streamline entry to HACC services and improve the allocation of HACC resources.
- In 1999, as part of the Effective Discharge Strategy, a protocol was developed to improve information exchange between hospitals and GPs.²⁷ However, the Task Force has heard that compliance with this protocol is variable.

A major improvement could be achieved with the introduction of appropriate clinical information systems and an electronic health record based on a unique patient identifier. By linking health care providers there will be significantly improved capacity for early intervention and the coordination of care, and GPs, hospitals and community care providers will be better able to work towards delivering a seamless health care service. The Task Force will be making further observations on the importance of health information strategies in this and later papers.

Case Study—Community Health Providers Consultative Committee (CHPCC)

Background

Under the former North West Health Care Network each hospital was asked to set up a committee to deal with operational issues identified in consultation with primary care providers.

In 1998, Western Hospital established its CHPCC, chaired by the general manager, with each member reporting back within his or her respective management structure. The CHPCC is now a key forum for communication between Western Hospital and community-based health service providers, including Western Region Health Centre, Djerriwarrh Health Service, ISIS Primary Care, Mercy Hospice, Westgate Division of General Practice, Western Melbourne Division of General Practice, District Nursing, Post Acute Care Facilitation Unit, Western Aged Care and Rehabilitation Service, Drug and Alcohol Services and the Department of Human Services Regional office.

The committee aims to:

- Identify issues impacting on patient/client care.
- Establish pathways of communication to address issues.
- Undertake strategic service development.
- Enhance the way hospital and primary health sectors work together.

continues

²⁷ Department of Human Services, *Minimum Requirements for the Transfer of Information Between Hospitals and GPs*, 1999

What has been achieved?

- Enhanced communication, with good feed back mechanisms.
- Development of ongoing networks and linkages.
- Better understanding of service roles, achieved by site visits and presentations.
- Regular updates on changes in service provision.
- Development of a collaborative, partnership-oriented culture.
- Innovative projects and programs arising directly as a result of these meetings, including:
 - Chronic Disease Self Management Project (with ISIS primary care)
 - Access Triage Project (Western Hospital)
 - Effective Discharge Project (Western Hospital)
 - Hospital Community Placements (staff exchange between Western Hospital and Community Health)
 - Pulmonary Rehabilitation Program (Western Hospital and Western Region Health Centre)
 - Integrated Disease Management using patient transportable electronic record (Westgate Division of GPs).

Keys to success

- A shared commitment to the objectives and process of the committee.
- The general manager of Western Hospital (now health service CEO) has chaired and continues to chair the committee, reflecting the hospital's commitment.
- Recognition that resources in smaller organisations are limited and they will only continue to come if the committee is of value to them. This is achieved by:
 - Hospital providing a secretariat, and a central contact point
 - Meetings are held 8.00–9.00am and run to time
 - Sub-groups and informal networks progress issues as required
 - All items requiring resolution or follow-up are clearly identified, tracked and reported.

There is a need for 'boundary-spanning positions' that create the ongoing links across service sector boundaries.

The need for better service integration is also widely recognised internationally. A recent major Canadian study examined barriers in the effective transfer of patients from acute care to home care. Many of the measures it recommends are already in place here, however it strongly emphasises the need for 'boundary-spanning positions' that create the ongoing links across service sector boundaries.²⁸

²⁸ Canadian Policy Research Networks Inc. (2001) *An Analysis Of Blockage To The Effective Transfer Of Clients From Acute Care To Home Care (Draft)* Substudy 15 in the National Evaluation of the Cost-Effectiveness of Home Care.

In its discussions with hospitals and peak bodies, the Task Force learned of a range of other local initiatives that are underway to improve integration in different parts of the system.

The Community Health Providers Consultative Committee in Western Health is a model of cross-sectoral collaboration that has delivered a range of highly positive outcomes (see Case Study above). However, one issue with this committee is that it does not include local government representatives. Given the importance of local government as the major provider of HACC services, this limits the ability of the committee to deal with many of the important interface issues.

Recommendation

7. The Department of Human Services should accelerate the introduction of health information strategies including clinical information systems, an electronic health record and unique patient identifier to support better clinical decision making and encourage better service integration across sectors.

Relationships with General Practitioners

Divisions of General Practice were also created in part as a way of improving collaboration between hospitals and GPs, and these have now been operating for some years and have contributed to improvements across a range of areas.

The Commonwealth has acknowledged the need to improve the integration of GPs into the wider primary care system and is implementing this through its Enhanced Primary Care (EPC) initiative announced in the May 1999 budget. The EPC package includes new Medicare items for conducting health assessments for older people, for developing care plans, and for organising and participating in case conferences.

Since November 1999, around 10 per cent of Victorians aged 75+ have been given health assessments by their GP, however, the uptake of the new Medicare items for multidisciplinary care plans and case conferences has been much lower. Whereas a health assessment can be done by a GP alone, care plans and case conferences require two other health workers and are not always easy for GPs to access. The Commonwealth recently advertised a national tender to evaluate the uptake of these new MBS items.

The Task Force is advised that Department of Human Services is also planning to establish demonstration projects with the Commonwealth to look at ways of facilitating greater uptake of these new Medicare items. One approach may be for the Department to encourage primary care providers that already have strong community linkages, such as PAC agencies, to develop a market supporting local GPs in care plan development and monitoring.

Local general practitioners are a fundamental part of the primary care system and good collaboration with this sector has the capacity to assist and deliver a range of improvements to hospital-based care.

Since November 1999, around 10 per cent of Victorians aged 75+ have been given health assessments by their GP.

The Task Force also considers that there is an opportunity for hospitals to assist here, especially for older patients who present at hospital emergency departments. For example:

- for older people who are admitted through emergency departments without nominating a GP, hospitals could consider giving the person a letter on discharge setting out the names of local GPs who have an interest in developing care plans and health assessments with advice to contact them. This could perhaps be arranged via the local GP Division which could ask GPs to volunteer to be on such a referral list. or
- For those patients who present at emergency departments and nominate a GP, the hospital could write to the GP and inquire whether they have considered offering the patient a health assessment or care plan. or
- The hospital, in consultation with the Local Division of General Practice, could develop a list of GPs with an interest in developing care plans who could be invited in to the hospital to develop a care plan for the patient.

The role of GPs in discharge planning can be further developed through the use of the expanded care items in the MBS. Integrated information systems are again a key building block in bringing about better discharge planning.

The Task Force has emphasised elsewhere the importance of discharge planning as a key element of good patient management.

Recommendations

8. The Department of Human Services should include a focus on older people in the proposed demonstration projects to improve the uptake among GPs of the new expanded primary care items.
9. Metropolitan health services should build links with GPs and GP divisions to develop their role in discharge planning and working with emergency departments.

The Task Force has also learned of other innovations involving hospitals working with GPs that have clear potential to improve care for older patients, for example the Coordinated Electronic Patient-Held Information System. The Westgate Division of Family Medicine is working with Western Hospital on a project that involves giving selected patients who go through the hospital's new Rapid Assessment Medical Unit a patient button-sized transportable electronic record that they can attach, for example, to their wristwatch. Patients are selected on the basis of having a local GP and a condition that is likely to entail relatively frequent attendance at both hospital and by the GP. The record contains five pages of material and is updated by both parties as appropriate.

This is one of the initiatives that arose as a result of a regular structured hospital/community provider liaison process (see Case Study).

Relationships with Aged Residential Care Agencies

At meetings held with several major non-metropolitan health services, the Task Force gained the impression that access to residential care for public hospital patients, at least in these major provincial centres, is much less of a problem than in Melbourne. This seems to be largely due to these health services also being major providers of residential aged care. While this may be partly due to access priority being given to hospital patients, it is also true that the presence of a co-located hospital facility will make a residential aged care provider more comfortable about taking in residents with probable high care needs in the knowledge that they can quickly access acute care services or support where needs arise.

Nevertheless, in the survey conducted last year by the Victorian Association of Health and Extended Care, almost all respondents highlighted insufficient discharge information as a concern for patients discharged to residential care. Issues raised included:

- no medication chart/instructions
- no information as to why client admitted to hospital
- no information received at all, or incomplete information
- no instructions for follow-up care
- staff not trained to deal with situations.²⁹

A number of metropolitan health services have also established liaison committees with residential aged care service providers. This is a way of establishing protocols for the transfer of residents to hospital emergency departments where necessary, to determine what support that may be provided by hospitals to avoid inappropriate transfers and, in general, to facilitate exchange of mutually important information.

Potential advantages of improved liaison with the residential care sector (and residents' GPs) include fewer transfers to hospital emergency departments for conditions that could better be managed in the residential care setting, a greater willingness for private residential care providers to accept high needs patients if the care givers in the nursing home can access some hospital support services.

A strong relationship with surrounding residential care providers may be one reason why St Vincent's Hospital has fewer patients awaiting residential care placement than other metropolitan hospitals. Private placement agencies also exist to offer hospitals (or patients and their families) a brokerage service to help find a suitable residential aged care facility.

The Task Force has also heard a view that staff from private hospitals (or possibly placement agencies engaged by them) tend to convey a sense of greater anxiety and pressure in seeking a residential care place for their patients. This may be related to financial pressures although it may also relate to the priority placed on avoiding inappropriately long hospital stays.

However, for patients and their families, where the outcome of an acute episode means a permanent decline in functional status and a substantially shortened life expectancy, pressure to shift to a nursing home as soon as possible, especially given the current undersupply of residential aged care beds in Melbourne, can be strongly resented.

²⁹ Victorian Association of Health and Extended Care. 2000. *Discharge Planning Survey Review*

Resolution of these issues could be assisted by better information systems with general service availability and patient-specific information available (through an electronic health record with unique patient identifiers) anytime, anywhere through the Web. The current fragmentation and ‘dis-integration’ is a major safety and quality concern as well as cause for considerable consumer dissatisfaction.

Recommendations

10. Metropolitan health services should strengthen their relationships with surrounding residential care providers as part of an overall strategy of improving the management of patients awaiting residential care.
11. As part of the development of a broad health information strategy, the Department of Human Services should work with the Commonwealth and relevant aged care peak bodies to create a comprehensive on-line information service, including links to other relevant sites, where people could get accurate up-to-date information about residential aged care services in their region.

6. Existing funding incentives and structural barriers inhibit coordination and integration.

Primary care, acute, sub-acute, post-acute, aged residential and palliative care services all have different funding mechanisms. Such differing mechanisms and accountabilities can present dilemmas in managing the care of patients through the care continuum. Every funding system has strengths and weaknesses. For example, a fee-for-service system like casemix can encourage hospitals to admit patients to gain revenue. Bed day based payments, such as for geriatric evaluation and management (GEM) patients, can reduce the emphasis on moving patients to other more appropriate care types.

Improving overall system integration and developing patient-centred approaches is a slow process because of the different service sectors involved, and because these sectors have different funding sources (Commonwealth, local government, Department of Human Services divisions), differing governance and accountability structures and different funding models (block funding, output funding). For example, the coordinated care trials are a long-term exercise aimed at overcoming these funding barriers. Disease management approaches such as those being developed under the Primary Care Partnerships initiative offer opportunities to improve early detection, early intervention and the provision of care continuity between general practice, hospitals and community health providers. Such approaches should also assist in reducing urgent admissions through emergency departments by people experiencing chronic and complex conditions.

For older patients in particular, a single episode of care can span several care types, or sometimes the entire care continuum.

Disease management approaches assist in reducing urgent admissions through emergency departments by people experiencing chronic and complex conditions.

Where only a single funder, such as the State, is involved, options for better integrating services can be less problematic. Options for bundling the differing payment streams for State-funded services could include a capitation type approach for chronically ill patients—most of whom are older people—who are frequent hospital users. This would involve a single payment stream to one provider, based on a particular patient population or demographic group, designed to cover the full costs of their care over the funding period. Another would be to develop episode-based payment systems that provide a single payment for an episode of care, rather than for its separate elements as at present.

One of the impediments to developing funding and performance measures that run across the care continuum is that service usage cannot be identified without a standard patient identification system. In due course, the national HealthConnect initiative³⁰ will allow personal health information to be collected, safely stored and exchanged, with the individual health consumer's permission, across all levels of health care. In the meantime, the Task Force strongly supports the implementation of a health information strategy for Victoria that includes clinical information systems and, subject to appropriate privacy safeguards, an electronic health record with unique patient identifiers (see recommendations 8 and 11). This would support the development of episode of care analysis, allow better patient centred key performance measures (for example, whole of system unplanned readmission rates) and, subsequently, episode-based funding spanning outpatient, acute and post-acute care.

However, the development of capitation or episode-based payment systems are longer-term initiatives and there may be some improved funding measures that could be implemented sooner. Any such measures should be based on the need for prices to match costs, as well as create incentives to reduce excessively long stays in sub-acute care and encourage direct admission to sub-acute where appropriate.

For example, the current balance between bed day payment rates for GEM patients, and for non-acute patients does not reflect the relative costs of the appropriate care models for these two care types. It creates no incentive to reduce lengths of stay in sub-acute care, and by setting the cost of non-acute care at a level that appears to be below the full cost of properly managing such patients, it does not facilitate the adoption of appropriate models of care.

A more reasonable 'step-down' rate for non-acute care could potentially be implemented in a simple, cost-neutral way by requiring all sub-acute funding to revert to the lower rate after a set period, for example 35 or 40 days. The cost of increasing the funding rate for non-acute patients would thus be offset by a reduction in GEM-funded patient days and perhaps fewer outlier payments (WIES) for acute patients.

30 www.health.gov.au/healthonline/connect.htm

An incentive to encourage direct admission to sub-acute care could be considered by increasing the per diem rate for directly admitted GEM patients for the first few days, or week, of care. This is the period where the initial diagnostic costs and geriatrician input will generally be highest. It may be possible to implement this in a cost-neutral way by transferring some funding presently provided via the acute casemix payment system (by reducing the WIES allocation) to the sub-acute, based on the estimated number of acute admissions that this initiative will avoid.

This measure may also reduce any incentive to admit older medical patients for a short period as acute patients (thereby earning a casemix payment for that patient), and then transferring the patient to sub-acute care to earn the per diem payment.

It would also be desirable to address the lack of a clear distinction between GEM patients, rehabilitation patients, and acute older medical patients by developing and documenting appropriate models of care for GEM and non-acute patients. This could lead to a formal designation process with funding matched to the number and type of designated beds. For non-acute patients the model of care should reflect, as far as possible, elements of the accreditation requirements for residential aged care facilities.

The Department already has in place a process to involve geriatricians in this work, but development and implementation of a new model of care is still some way off.

Recommendations

12. During 2001–02, the Department of Human Services should improve the sub-acute per diem price structure. This should be based on the need to better match prices with the cost of appropriate models of care, to create incentives to reduce excessively long stays in sub-acute care and to encourage direct admission to sub-acute where appropriate.
13. During 2001–02, the Department of Human Services should implement, in consultation with providers and professional bodies, a formal designation process for GEM and interim (non-acute) care.

7. Development, standardisation and monitoring of a small number of key performance indicators dealing with high use groups is needed.

There are a number of factors that the Task Force considers to be particularly important in relation to the management of older patients. These include:

- length of episode,
- access block,
- care continuity,
- admissions avoided,
- RCS classification.

There is a lack of a clear distinction between GEM patients, rehabilitation patients, and acute older medical patients and the way in models of care are delivered.

Key system monitoring measures must be implemented if metropolitan health services are to be able to consistently track their performance through time and to compare this performance with other providers.

Length of Episode

The lack of a standard patient identification system has been noted as a barrier to developing performance measures that span the care continuum (see Observation/Finding 6). For example, in some metropolitan health services patients will have a different unit record (UR) number depending on the hospital they are admitted at. For conditions that often require both acute and sub-acute care, for example stroke or hip replacement, this makes it very hard to measure the total length of hospital stay.

Pending the implementation of common UR numbers across hospital campuses and the development of an electronic health record with unique patient identifiers, the Task Force considers that there are a number of steps that could be taken to allow improved whole of episode monitoring, for example using Medicare numbers. Measures to be considered here could focus on specified conditions of older people such as cardiovascular, fractured neck of femur, chronic obstructive pulmonary diseases, stroke, hip replacement and respiratory infections.

Access Block

The current bed survey that measures the number of patients awaiting placement in a residential care facility is a considerable improvement on the 'Nursing Home Type' (NHT) care type classification that preceded it. The use of this care-type classification had become distorted since classing a patient in that way had a number of adverse consequences for both the patient (a requirement to pay fees) and the hospital (reduced income compared to a per diem high outlier payment). Possible measures include:

- time between referral to ACAS for assessment, to the assessment being carried out;
- average length of stay in acute care for all separations with a sub-acute rehabilitation episode; and
- time from ACAS assessment to discharge

Care Continuity

A measure of care continuity is a critical element in ensuring that hospitals operate as an integral part of an overall care pathway. The recent publication by the Department of Human Services of Performance Indicators for Effective Discharge,³¹ is focused at the individual patient rather than system level but provides a valuable start for developing higher-level measures.

However, although there are a number of initiatives underway that may result in an indicator being developed, no suitable measure that could be easily implemented is available.

31 Health Services Research Unit, Faculty of Medicine, Monash University. 2000. Performance Indicators for Effective Discharge. Government of Victoria. Also at www.dhs.vic.gov.au

Admissions Avoided

The measures the Task Force is considering here cover both admissions and emergency department presentations. They include:

- admission rates (or unplanned readmission rates) for specified conditions, and
- changes in the rate of older people in triage categories 4 and 5 using the emergency department, by time of day.

Recommendation

14. Metropolitan health services and the Department of Human Services should establish a collaborative initiative in 2001–02 with a specific focus on benchmarking and re-engineering of the internal hospital processes that drive patient flows between sub-acute and acute services. It should provide data for the purposes of service planning and process redesign on how sub-acute activity affects (and is affected by) the operation of the acute sector.
15. As an outcome of recommendation 14, the Department of Human Services should ensure that key performance indicators covering length of episode, access block, care continuity, admissions avoided and RCS classification are routinely monitored.

Appendix 1: Patient Management Task Force

Terms of Reference

1. To identify essential organisational and patient management practices that should be in place in all hospitals.
2. To determine the extent to which these practices are occurring in metropolitan health services, identify specific areas where improvements should occur and advise on how these improvements could be quickly achieved.
3. To determine key indicators of good patient management practice and the benchmarks that should be achieved by health services.
4. To advise on incentives and other strategies that could be used to encourage health services to achieve benchmarks.
5. To communicate and engage with representative bodies of health professionals, practitioners, managers and other stakeholders in identifying and implementing good patient management practices.

Membership

Dr Michael Walsh (Chair)—Chief Executive, Bayside Health

Dr Jim Breheny (Deputy Chair)—Chair, Austin and Repatriation Medical Centre Board

Professor Gordon Clunie—Chair, Ministerial Advisory Emergency and Critical Care Committee

Ms Ella Lowe—Executive Director Operations, Peninsula Health

Mr Robert Burnham—General Manager, Northern Hospital

Dr Heather Buchan—Assistant Director, Quality and Care Continuity Branch, Acute Health Division, Department of Human Services

Mr Geoff Lavender—Regional Director, Barwon-South Western Region, Department of Human Services (Project Director)

Project Team

Ms Robynne Cooke, Austin & Repatriation Medical Centre

Mr Peter Lewis, Acute Health Division, Department of Human Services

Mr Nick Legge, Aged, Community & Mental Health Division, Department of Human Services

Mr Amos Yee, Acute Health Division, Department of Human Services

Ms Julie La Gamba, Acute Health Division, Department of Human Services

Appendix 2: Top 20 DRGs for Patients Aged 70 and Over

The following table sets out the top 20 DRGs for patients aged 70 and over, according to the number of separations, in the 12 major hospitals in 1999–2000.

AN-DRG3	Number of Separations	% Sameday	% Growth since 1995–96	Predominant Type
572 Admit for renal dialysis	25,633	100%	238%	elective
780 Chemotherapy	5,324	100%	76%	elective
252 Heart failure and shock	3,166	22%	4%	emergency
177 Chronic obstructive airways disease	2,986	17%	184%	emergency
170 Respiratory infections/inflamns age >54 w cc	2,731	8%	49%	emergency
794 Lymphoma & non-acute leukaemia w/o cc	1,897	86%	281%	elective
262 Chest pain	1,845	52%	85%	emergency
056 Dementia & global disturbances of cerebral function	1,788	11%	33%	emergency
037 Cerebrovascular disorders except tia w cc	1,780	8%	29%	emergency
348 Oesophagitis, gastroent and misc dig dis age >74	1,572	39%	65%	emergency
280 Non-major arrhythmia and conduction disorders age >69	1,492	39%	52%	emergency
269 Unstable angina w cc	1,437	16%	46%	emergency
332 Other gastroscopy for non-major digestive disease w/o cc	1,389	90%	7%	elective
099 Lens procedures w/o vitrectomy and w/o cc	1,293	89%	6%	elective
249 Circ disorders w ami w/o invasive cardiac inves proc w/o major cc	1,235	13%	18%	emergency
335 Other colonoscopy w/o cc	1,126	84%	20%	elective
941 Rehabilitation	1,084	0%	62%	sub-acute
270 Unstable angina w/o cc	989	32%	1%	emergency
936 Aftercare w sdx of history of malignancy w endoscopy	979	97%	104%	elective
587 Other kidney and urinary tract diagnoses w/o cc	927	66%	59%	elective

Source: VAED