GEM Evaluation

Stakeholder Engagement Report

October 2019

  

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# Executive Summary

In May 2019, Alfred Health, Austin Health and Bendigo Health were engaged by the Department of Health and Human Services (DHHS) to conduct a consultation with the GEM service workforce and stakeholders as part of the Victorian GEM service evaluation. The aim was to ascertain stakeholder views of the GEM program in Victoria, including how it is supporting and impacting health services, and to identify achievements to date, gaps across the system, and future focus areas for the Department and key stakeholders in delivering efficient and effective sub-acute care for older people in Victoria.

Geriatric Evaluation and Management (GEM) services have been operating in Victoria for over 20 years. Their primary purpose is to improve functioning of older people with multi-dimensional and complex health needs, through an inter-disciplinary model of care providing specialist assessment and management.

The consultation engaged a broad range of stakeholders including GEM services, key interface services comprising representatives from Acute Services, Transition Care Program (TCP) and Health Independence Program (HIP), and a diverse range of organisations whose workforce and/or consumers have a keen interest in the Victorian GEM service. The consultation consisted of three components, all of which received a high response rate:

1. Surveys for GEM services and their Acute Service, TCP and HIP colleagues. These were completed by 78% of GEM services
2. Workshops (three metropolitan and five rural/regional locations) attended by 117 participants from 92% of GEM services
3. Roundtable event with 33 participants, including representation from 12 GEM services, (8 metropolitan and 4 rural/regional services), Sub-Acute Peak Body members, DHHS, Safer Care Victoria (SCV) Care of Older People Clinical Network, National Ageing Research Institute (NARI), Health Issues Centre, Carers Victoria, Epworth, Bolton Clark Research Unit, Australia and New Zealand Society for Geriatric Medicine, and the Royal Australasian College of General Physicians.

Themes from the stakeholder feedback are summarised briefly as:

**Current GEM**

***Environment/Setting***

* GEM services are provided in a variety of settings and each setting has its own strengths and weaknesses.
* GEM at Home model is preferred by the majority of staff, patients and families, however inpatient GEM will still be required to manage the increasing complexity and acuity of older patients with complex care needs such as bariatric syndromes and those with dementia, delirium and/or Behavioral and Psychological Symptoms of Dementia (BPSD).

***Model of Care***

* Person centeredness and family involvement in holistic care, provided by a multi-disciplinary workforce skilled in the care of older people, is at the heart of GEM service provision across Victoria.
* Care is goal oriented with a focus on providing a range of therapy to improve functional outcomes and identified needs.
* Expert multi-disciplinary assessment and management remains key to the future GEM model of care.
* The GEM model of care facilitates patient flow and reduces length of stay, however this efficiency is impacted by access to appropriate community services.

***Workforce***

* The GEM workforce continues to provide specialist holistic care for older people, and is extending the traditional scope of practice in nursing and allied health.
* The profile of volunteers and family members is becoming more recognised in GEM services to supplement direct care provision.
* Access to geriatricians and other specialists such as Neurologists is important, but new models such as telehealth are needed to increase access.
* Staff wellbeing, engagement and safety are paramount to ensuring a positive patient experience of healthcare.

***Interface with other services***

* The efficiency of GEM to facilitate patient flow and reduce unnecessary length of stay in hospital settings is impacted by access to community services.
* There is a lack of community services, particularly in regional areas. Long waits for third parties such as Victorian Civil and Administrative Tribunal (VCAT) and Office of the Public Advocate (OPA), and community packages of care, impact care progression.
* Despite the fact that there are some in-reach models, GEM is still viewed as a service setting rather than a model of care, and there could be better integration of a GEM service model across the care continuum.

**Future GEM**

***Innovations for generations***

* Innovative GEM models of care will be required to meet the different goals and expectations of the Baby Boomers, GenX and GenY cohorts.
* Leveraging existing and new technologies to facilitate access to specialist services, increase social connectedness, and proactively maintain the health and quality of life for older people in their own homes, would value add to future GEM service delivery.
* State-wide approaches to sharing of patient records, protocols and key performance indicators would enhance consistency of the future GEM model of care.

***Evidence based practice***

* There was limited evidence/data collected to support the overwhelming positive view of the value of GEM services.
* International models of care for older people can inform the future GEM model of care.
* Research should be undertaken to generate evidence and help inform future models of care.

***Challenges for the future***

* Future models of care need to respond to the complexities of patients with a disability, delirium, dementia and bariatric needs.
* Funding models need to be flexible to support both direct and indirect care needs of patients, and to match changes in the GEM workforce.
* The need to address social isolation, social disadvantage, and younger patients with disability or conditions of ageing, will increasingly challenge traditional models of care.

**Suggested areas for future policy reform**

Feedback from the GEM stakeholder consultation identified that future DHHS policy direction must enable GEM funded services to:

Provide care flexibly in patients’ usual accommodation as a preference, while continuing to invest in purpose built environments for patients whom cannot be cared for outside of the hospital environment. Assessment and provision of support for carers will need to be considered when providing care in patients’ usual accommodation.

Evaluate and promote the effectiveness of models of care for older people, promoting and scaling innovative service platforms across the state.

Consider more robust outcome measures that are sensitive to the complexity of patient presentations, which will be paramount to support benchmarking across the sector and informed analysis of performance.

Support and develop the workforce of the future, acknowledging the changing patient cohort, and need for staff to retain and develop expertise in providing care for an increasingly acute and complex set of care needs. This should include further exploration of extended scope roles in allied health and nursing, and support for the growing assistant workforce. Consideration also needs to be given to initiatives that support staff wellbeing.

Develop a state-wide approach to supporting and developing the profile of volunteers and family members to supplement direct care provision.

Better interface with community services to reduce unnecessary delays to discharge within GEM programs. This should include consideration of how GEM funded programs can be delivered across the continuum of care alongside other programs in acute and the community.

Innovate rapidly, with fast adoption of new technological advances in health care monitoring and delivery for future generations of GEM consumers. Innovation should also be informed by emerging research in home based care, social isolation and best practice environments to meet the needs of our diverse older population.

**Suggested immediate actions**

Establish a platform to support the identification of **existing innovation** within GEM settings of care to promote and scale this across the broader sector. This should include consideration of:

* Short-term ‘collaborative’ activities to address targeted issues – supported by experts in Improvement Science
* Longer-term regular opportunities for funding bodies, peak bodies, and providers of GEM services to meet and discuss trending issues and opportunities in the delivery of care for older people.

Re-engage with the sector to validate themes identified through the stakeholder consultation process and progress to co-design **the future model** of GEM for Victorians:

* Given the extensive investment made by the sector in the GEM stakeholder consultation discussion, it is recommended that this commence as soon as practicable to build on good will and engagement.
* Focus of the ‘Future of GEM’ design should take a transformational approach to address key challenges in the system, and enable the service to continue to deliver best care in a more flexible and responsive manner.
* Co-design of the future GEM model of care must include current and future GEM service consumers, their representative peak bodies, and key stakeholders at all stages of the design process.

# 1 Background

Geriatric Evaluation and Management (GEM) services have been operating in Victoria for over 20 years. During that time GEM services have evolved in Victoria according to policy directions, local innovation and demand. In 2016–17 the Department introduced an episodic funding model for rehabilitation and geriatric evaluation and management admitted activity to provide further incentive for system efficiencies.

GEM services are widely available across the state with 27 health services funded to provide GEM. There are 10 metropolitan services and 17 regional and rural health services providing GEM across 49 campuses.

Key objectives of the GEM service:

* To improve the functioning of older people with multi-dimensional health needs
* Manage people who have complex and multiple medical, functional and often cognitive conditions requiring a Comprehensive Geriatric Assessment (CGA)
* To provide a service model delivering specialist assessment and management by an inter-disciplinary team where care, all assessment and planning occurs within GEM
  + To provide the service model in a variety of settings, including in the patient’s own home

The GEM service addresses the following DHHS strategic priorities:

* Services are appropriate and accessible in the right place, at the right time
* Services are efficient and sustainable
  + Services are safe, high quality and provide a positive experience

After more than 20 years of operation, the GEM service is being evaluated to:

* + Ensure it is continuing to meet the needs of patients and health services
  + Ensure the service is efficient and responsive
  + Identify the enablers and challenges to the service
  + Investigate its interface with other health and community services
  + Provide evidence for future reform directions

Stakeholder engagement was seen as a critical component of the comprehensive evaluation of the Victorian GEM program.

# 2 Stakeholder Consultation Overview

## 2.1 Aim

The aim of the GEM evaluation stakeholder consultation was to ascertain stakeholder views of the GEM program in Victoria, including how it is supporting and impacting health services, and to identify achievements to date, gaps across the system and future focus areas for DHHS and key stakeholders in delivering efficient and effective sub-acute care for older people into the future.

## 2.2 Objectives

GEM evaluation stakeholder consultation objectives were to:

* Undertake facilitated consultation sessions with key stakeholders about the GEM program in health services based on clusters of regional and metro groups – minimum of 8 and 2 broad based roundtable consultation sessions
* Prepare a thematic report and presentation based on the consultations to identify the issues about Victoria’s GEM service, including areas for potential reform

## 2.3 Deliverables

Stakeholder consultation deliverables were:

* Attend a project start-up meeting with the department to discuss the stakeholder consultation strategy
* Prepare a stakeholder consultation plan
* Undertake consultations with key stakeholders in health services based on clusters of regional and metro groups – minimum of 8 and 2 broad based roundtable consultation sessions
* Develop and present a draft report to the Advisory Group which brings together the analysis of the consultations around key themes and advises on discussion points and ideas raised about possible changes to GEM program to make it more efficient and effective considering the short, medium and long term
* Prepare and present a final report to the Advisory Group and key departmental stakeholders

## 2.4 Scope

Consultation scope was discussed during establishment of the project, with the following agreed:

### 2.4.1 Changes to deliverables

On reviewing the consultation plan with DHHS, it was agreed that surveys for GEM and interface services (Acute Services, Transition Care Program (TCP) and Health Independence Program (HIP)) would be added to the scope, and one roundtable event and patient and family/carer consultation would be removed from the scope. Patient and family/carer consultation is being sought by DHHS through a different component of the overall GEM evaluation process.

### 2.4.2 In Scope

* 27 Victorian health services funded to provide GEM, incorporating consultation with geriatricians, managers, allied health staff and nurses
* Victorian Sub-Acute Peak Body
* Care for Older People Clinical Network
* Australia and New Zealand Society of Geriatric Medicine
* Royal Australasian College of General Physicians
* Royal Australasian College of General Practitioners
* Rural General Practitioners

### 2.4.3 Out of scope

* Patients and family/ carers of GEM services. DHHS had identified other ways of gaining the consumer voice with regard to GEM services
* Non GEM funded services, consumers and associated stakeholders
* Individual representation from above mentioned representative organisations

# 3 Methodology

## 3.1 GEM Evaluation Stakeholder Engagement Working Group

A GEM Evaluation Stakeholder Engagement Working Group was established to deliver the stakeholder consultation component of the evaluation, reporting to the GEM Evaluation Advisory Group. Alfred Health, Austin Health and Bendigo Health provided Executive Sponsors/Chair, Alfred Health provided a Project Lead and resources to facilitate the workshops and roundtable, and Bendigo Health delivered the surveys and collated, analysed, themed and triangulated the data. DHHS provided three Working Group members to aid project consultation and guide the methodology.

## 3.2 Surveys

GEM service and interface service surveys were conducted first, designed using Survey Monkey® software.

Four surveys were sent to 10 metropolitan and 17 regional GEM service providers to complete as appropriate for their organisation:

* GEM service survey
* Acute service survey (particularly targeting General Medicine and Orthopaedics)
* TCP survey
* HIP survey

Survey monkey links were emailed to all GEM service providers across Victoria, and a PDF copy of the surveys were attached to the email. The emails were sent from the GEM Evaluation Stakeholder Engagement Working Group Chair to the CEO and sub-acute contact at each service. Stakeholders were given two weeks to complete the surveys. An email providing additional information and prompting survey completion by the due date of 19 July was sent a week prior to the closing date.

## 3.3 Workshops

Following survey completion, consultation workshops were conducted across Victoria, ensuring a workshop was held in each region. Building on survey results, the stakeholder workshops aimed to provide a consultation forum to gain a deeper perspective of:

* How GEM services are currently supporting and impacting on health services
* Achievements to date
* Gaps and opportunities for existing GEM services
* Ideas and recommendations to inform future GEM service policy and design

Over a four week period, 3 metropolitan and 5 rural and regional workshops were completed. The GEM Evaluation Stakeholder Engagement Working Group Chair sent workshop invitation emails with registration details to the CEO and sub-acute contact for each GEM service, as well as several follow-up reminder emails. DHHS and Working Group members also followed up several services via telephone call to encourage workshop participation.

Alfred Health’s Organisational Development team delivered the workshops, developing the 2-hour session plan in consultation with the Working Group. The first workshop was held at Alfred Health’s Caulfield campus, and the session evaluated to ensure it delivered the desired results, and met participant expectations. Minor session changes were made. Subsequent workshops were conducted in Sunshine, Heidelberg, Horsham, Warrnambool, Bendigo, Wangaratta and Traralgon. The same facilitator conducted all workshops for consistency, except Bendigo, which was conducted by another qualified consultant from the Organisational Development team due to unavailability.

3.4 Roundtable

The final consultation activity was a 3-hour roundtable event held in Melbourne city centre, with a broad range of stakeholders invited. The roundtable focussed on generating ideas and recommendations for the future of the Victorian GEM service. Participants were allocated into groups based on their generation, and asked to consider what they would like GEM to look like by the time they needed it.

# 4. Results

4.1 Survey consultation

The GEM survey was sent to the 10 metropolitan and 17 regional GEM service providers in Victoria. Providers could complete a separate survey for each of their campuses providing GEM services (N=49). As shown in Table 1, the overall response rate from GEM service providers was 78%. The response rate for metropolitan and regional services is also provided in Table 1.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Location | GEM service response rate | | | GEM campus response rate | | |
| **No. of services** | **No. of responses** | **% response** | **No. of campuses** | **No. of responses** | **% response** |
| Metropolitan | **10** | **10** | **100%** | **29** | **25** | **86%** |
| Rural/Regional | **17** | **10** | **59%** | **20** | **14** | **70%** |
| Total | **27** | **21 (78%)** |  | **49** | **39 (80%)** |  |

Table 1 GEM service response rate to evaluation survey

Providers could also complete a separate survey for each of their campuses providing acute services (N=49). Note the campus numbers for acute services may not be accurate as the campus relates to those that provide GEM services, not necessarily those that provide acute services. As shown in Table 2, the overall response rate from acute service providers was 67%. The response rate for metropolitan and regional services is also provided in Table 2.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Location** | **Acute services response rate** | | | **Acute campus response rate** | | |
| **No. of services** | **No. of responses** | **% response** | **No. of campuses** | **No. of responses** | **% response** |
| **Metropolitan** | **10** | **8** | **80%** | **29** | **16** | **55%** |
| **Rural/Regional** | **17** | **10** | **59%** | **20** | **10** | **50%** |
| **Total** | **27** | **18** | **67%** | **49** | **26** | **53%** |

Table 2 Acute service response rate to GEM evaluation survey

Providers could also complete a separate survey for each of their campuses providing TCP and/or HIP services (N=49). Note the campus numbers for TCP/HIP may not be accurate as the campus relates to those that provide GEM services, not necessarily those that provide TCP/HIP services. As shown in Table 3, the overall response rate from TCP/HIP service providers was 67%. There was an even response rate of 58% TCP and 52% HIP provider responses. The response rate for metropolitan and regional services is also provided in Table 3.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Location** | **TCP/HIP services response rate** | | | **TCP/HIP campus response rate** | | |
| **No. of services** | **No. of responses** | **% response** | **No. of campuses** | **No. of responses** | **% response** |
| **Metropolitan** | **10** | **8** | **80%** | **29** | **8** | **28%** |
| **Rural/Regional** | **17** | **12** | **70%** | **20** | **13** | **65%** |
| **Total** | **27** | **20** | **74%** | **49** | **21** | **43%** |

Table 3 TCP/HIP service response rate to GEM evaluation survey

4.2 Workshop consultation

Workshops were well attended across the state, with 117 participants representing 25 of 27 GEM services; all 10 metropolitan services and 15 rural and regional services. Approximately 69% of registrants were from GEM services and 31% from interface services, with workforce representation from senior leaders and managers, medical, nursing and allied health. Table 4 provides a summary of workshop attendees.

|  |  |  |
| --- | --- | --- |
| **Workshop**  **Location** | **Response** | |
| **No. of registrations** | **No. of attendees** |
| Caulfield | **25** | **25** |
| Sunshine | **15** | **16** |
| Heidelberg | **31** | **30** |
| Horsham | **5** | **5** |
| Warrnambool | **9** | **9** |
| Traralgon | **10** | **10** |
| Bendigo | **8** | **8** |
| Wangaratta | **15** | **14** |
| Total | **118** | **117** |

Table 4 Summary of workshop attendees

4.3 Roundtable participation

The roundtable was attended by 33 participants, with representation from 12 GEM services (8 metropolitan and 4 rural and regional services), Sub-Acute Peak Body members, DHHS, Safer Care Victoria Care of Older People Clinical Network, National Ageing Research Institute (NARI), Health Issues Centre, Carers Victoria, Epworth, Bolton Clark Research Unit, Australia and New Zealand Society for Geriatric Medicine, and the Royal Australasian College of General Physicians. The Royal Australian College of General Practitioners were invited to send a delegate, and declined. Despite patients and family/carers being out of scope, consumers were invited/sought to attend from Safer Care Victoria Care of Older People Clinical Network, NARI and University of the Third Age, however no-one was able to attend. Participation by rural General Practitioners was explored, however the time commitment required to attend meant GPs would need to close their practice for a day with subsequent loss of income, which was prohibitive.

4.4 Themes

Results from the three data sources used in the consultation process (surveys, workshops and roundtable) were triangulated to validate and understand stakeholder perspectives on GEM services. Triangulation facilitates validation of data through cross verification from more than two sources. It tests the consistency of findings obtained through different instruments and enables a more in-depth understanding of the results. Main themes were identified from the data and are outlined below.

### 4.4.1 Themes – current state

**Environment/Setting**

*Summary*

* GEM services are provided in a variety of settings and each setting has its own strengths and weaknesses.
* The option of a GEM at Home model is preferred by the majority of staff, patients and families, however inpatient GEM will still be required to manage the increasing complexity and acuity of older patients with complex care needs such as bariatric syndromes and those with dementia, delirium and/or Behavioral and Psychological Symptoms of Dementia BPSD.

A key objective of the GEM service is to provide the service model in a variety of settings, including patients’ usual accommodation. The data indicates that this objective is being achieved. Access to medical expertise for diagnostic assessment and specialist consultations, less bed movements and transfers between teams (particularly nursing and allied health) were identified as strengths of GEM located in acute services. However, it was also identified that there can be less of a holistic approach and more of a medical focus when GEM beds operate in the acute setting.

The sub-acute setting was identified by stakeholders as a more appropriate inpatient environment for patients admitted to GEM services, with better access to a multi-disciplinary workforce with the skills to care for patients with complex care needs, and to facilitate complex discharge planning. It was also reflected that there is a more goal oriented and activity focused model of care in the GEM designated sub-acute settings that facilitates optimal patient flow and length of stay. A lack of sufficient allied health workforce, particularly for backfill during leave, was identified as an issue, and sub-acute nursing ratios identified as inadequate to address increased acuity and complexity in the GEM patient cohort. Furthermore, metropolitan stakeholders also identified the commonplace 5 day a week service was a weakness of the sub-acute setting, whereas regional stakeholders raised concerns about the limited access to services such as radiology and mental health.

GEM at Home was overwhelmingly supported as the most person/family centered service setting, with patients happier and more comfortable in their own home. It was felt that more accurate assessments could be undertaken in the patient’s real living environment, patients avoid potential hospital complications and have better outcomes, and it reduces demand on hospital beds. Data from the workshops indicates that GEM at Home is perceived to be a more cost effective model when compared to the cost of a hospital bed, but interestingly in the survey of TCP/HIP providers there was a perception that the GEM at Home model required additional funding to meet patient needs. This contradictory perception of cost effectiveness of the GEM at Home service model requires further exploration to identify actual costs. Also of note were the number of suggestions from stakeholders that GEM should be provided in a purpose built environment. This suggestion seems at odds with GEM at Home being the preferred model, however may relate to a purpose built inpatient unit that caters for patients with greater complexity such as those with dementia, younger patients, NDIS eligible patients and those with bariatric needs. Geographical distance with the need to travel, particularly in regional areas, was also seen as a potential barrier in the provision of GEM at Home.

A number of health services provided GEM services in residential care settings. The residential care setting was perceived as providing a home-like environment, and one in which patients could ‘sample’ prior to them requiring entry into residential aged care. There was also a perception that the demand on hospital beds was reduced due to residential in-reach type services being available to support clients in the community or in residential care. Stakeholders did however identify a lack of clarity regarding the funding model, and that staff training and ratios varied.

**Model of care**

*Summary*

* Person centeredness and family involvement in the holistic care provided by a multi-disciplinary workforce skilled in the care of older people, is at the heart of GEM service provision across Victoria.
* Care is goal oriented with a focus on providing a range of therapy to improve functional outcomes and identified needs.
* Expert multi-disciplinary assessment and management remains key to the future GEM model of care.
* The GEM model of care facilitates patient flow and reduces acute hospital length of stay, however this efficiency is impacted by access to appropriate community services.

A key objective of GEM is to provide a service model delivering specialist assessment and management by an inter-disciplinary team where assessment, care planning and treatment occurs within GEM. This objective is being achieved through comprehensive geriatric assessment and management by a multi-disciplinary team with expertise in the care of older people. Patients are involved in setting their individual goals, and therapy is individualised and contextual. Stakeholders identified that this model of care is mostly provided five days a week and not seven.

**“*Multi-disciplinary approach provides quality client focused care and engagement that aims to improve/maintain independence*”**

The consultation process also identified that the GEM model of care facilitates patient flow and reduces length of stay in the acute setting, however efficiency is often reduced by waiting for third parties (e.g. Victorian Civil and Administrative Tribunal (VCAT) and Office of the Public Advocate (OPA)). Waiting times for discharge to Residential Aged Care Facilities also contributes to unnecessary delays in discharge, along with a lack of, or a waiting list for, home care packages and community services, particularly in regional areas.

Discharge planning was identified as a strength of GEM by many stakeholders, particularly discharge planning for those with complex needs. However, discharge planning was also identified as a weakness or area for improvement by other stakeholders. The TCP/HIP survey responses indicated that discharge planning is done well by GEM services, particularly complex discharge planning. Comments indicated that GEM services involve stakeholders, including patients, families and GPs, in the discharge planning process. However, the same TCP/HIP survey responses also identified improvements to be made in discharge planning processes, particularly for complex patients. Comments indicated that discharge planning could commence at an earlier stage of the patient journey and should consider involving community programs earlier in the discharge process. It was also suggested that more discharge destination options are needed to better support patients who have complex medical and/or mental health/behavioural issues in order to maintain their independence and safety in the community.

One of the key objectives of the GEM service is to improve the functioning of older people with multi-dimensional health needs, and the stakeholder consultation suggested that this objective is being achieved. Stakeholders identified that GEM care and management results in improved functional outcomes for patients, however there were questions around whether or not the Functional Improvement Measure (FIM) is the best outcome measurement tool. There were suggestions that alternative outcome measures, including longer term and more qualitative measures should be used to evaluate the quality of care provided. This should also measure social connectedness/isolation. Measures of the whole journey (“*e.g. total LOS e.g. total cost e.g. robbing Peter to pay Paul*”) and research examining longitudinal measures of GEM experience and outcomes of trajectory, were also suggested.

Other suggestions to improve the GEM model of care included investment in rapid response teams (Community/Emergency Department response team) and learning from international contemporary models such as the Swedish model – ESTHER.

**Workforce**

*Summary*

* The GEM workforce continues to provide specialist holistic care for older people and is extending the traditional scope of practice in nursing and allied health.
* The profile of volunteers and family members is becoming more recognised in GEM services to supplement direct care provision.
* Access to geriatricians and other specialists such as neurologists is important and new models such as telehealth are needed to improve access to specialist care.
* Staff wellbeing, engagement and safety are paramount to ensuring a positive patient experience of healthcare.

The increasing complexity of the GEM patient cohort requires a workforce skilled in the care of older people. Traditional roles are being expanded in both allied health and nursing disciplines with the introduction of Nurse Practitioners, Advanced Practice Nurses and Clinical Nurse Consultants. The assistant workforce (i.e. Allied Health Assistants and Assistants in Nursing) is expanding and plays a significant role in care delivery under the supervision of trained professionals. Stakeholders also suggested that new roles, such as an aged care navigator role, could be of value in future.

Volunteers were seen as a valuable supplement to the traditional workforce, and stakeholders reflected that a future GEM model of care may see greater involvement of families in helping care for their loved ones through increased involvement in care planning and supporting flexible models of care provision (e.g. in the home).

A key objective of the GEM service is to manage people who have complex and multiple medical, functional and often cognitive conditions requiring a Comprehensive Geriatric Assessment (CGA). The current GEM workforce is responding to the increasingly complex patient cohort, but at times access to required geriatricians and other specialists such as neuropsychologists can be a challenge, especially in regional areas. Suggestions from stakeholders to increase access included geriatric trainees and compulsory regional rotations for geriatricians, neurologists and other specialists. Telehealth was identified as a potential enabler to specialist geriatrician input. Undergraduate and post-graduate training pathways in regional areas was also suggested.

Access to allied health staff also varied, with both metropolitan and regional stakeholders identifying the role for increased allied health intensity. This was seen as a primary enabler for GEM to deliver a seven day a week service rather than the traditional five day a week service. Greater allied health intensity is also indicated to meet the greater complexity of patient needs and goals, not just to provide the status quo over more days. Stakeholders also identified challenges in providing backfill, particularly when allied health staff are on periods of leave. Review of nurse to patient ratios in GEM was also suggested as current ratios do not appear to be adequate.

***“Nursing ratios in GEM do not adequately reflect the level of care needed for GEM patients. GEM patients can have high nursing care needs (e.g. are dependent in mobility and PADLs (personal activities of daily living) and have high nursing needs such as intra-venous and wound management) which doesn’t allow time for nurses to support therapeutic programs on the ward outside allied health therapy times.”***

***“Allied Health leave cover is not covered and this causes slowed bed flow during all leave absences and is particularly exacerbated during periods of high unplanned leave.”***

The ageing population and the increasing complexities of patients accessing GEM are increasing both the demand for GEM services and the level of intervention and care needed to promote optimal outcomes. There is a perception that this increased demand has not been matched by growth in GEM places or funding per episode. In particular, stakeholders felt that there is a need to increase staffing levels and acknowledge the specialist skills that are now required in the GEM workforce. It was recognised that to remain viable, health services, within their funding envelopes, have needed to continually ‘do more with less’, and this may eventually come at the cost of an effective service model.

Stakeholders reflected that focussed education and training of the GEM workforce will continue to be required to upskill staff in understanding and managing conditions associated with ageing, such as dementia and delirium. There is a constant demand on health practitioners in sub-acute to manage patients with more acute health conditions and needs, and continually upskill in their knowledge of acute conditions.

Patients receiving care within GEM services have higher risk factors increasing the likelihood of harm during a hospital admission. As such, harm minimisation initiatives are a focus of GEM services, particularly in relation to reducing risk associated with falls, malnutrition, pressure care and delirium. When it came to supporting patients to leave hospital care, stakeholders noted that this ‘risk averse’ approach can become problematic, with health care providers being excessively cautious and concerned about their duty of care. Continued focus on patient ‘dignity of risk’ is important to promote patient self-determination and their rights to take reasonable risks.

Incidents of occupational violence, staff burnout and workload management are increasing at a rapid rate in all settings of health care, including Victorian GEM services. This, alongside an aging workforce, must be addressed to ensure that the GEM workforce is supported to deliver best care, and are recognised and rewarded for their important role in the care for older people.

**Interface with other Services**

*Summary*

* The efficiency of GEM to facilitate patient flow and reduce unnecessary length of stay in hospital settings is impacted by access to community services, including lack of access to GPs in regional areas.
* There is a lack of community services, particularly in regional areas, and long waits for third parties (such as VCAT and OPA) and community packages of care to facilitate progression of care.
* Despite the fact that there are some in-reach models, GEM is still viewed as a service setting rather than a model of care, and there could be better integration of the GEM service model across the care continuum.

Stakeholders identified an opportunity for GEM services, and the expertise of its multi-disciplinary team, to have a greater organisational profile and role in promoting timely patient care and pathway navigation across the continuum of care. If a GEM admission is indicated, stakeholders noted GEM’s role in reducing acute length of stay, however efficiency is constrained by a lack of, or long waiting lists for, community services for post discharge support. This is felt more keenly in regional areas.

Discharge planning was identified as both a strength and a weakness of GEM, with discharge often dependent on access to community services. Delayed discharge was thought to put patients at risk of deconditioning during longer hospital stays.

The increasing complexity of the GEM patient cohort (across physical, social and psychological domains), and subsequent increased need for escalation to VCAT and OPA, was seen as a significant factor leading to delays in discharge. A lack of timely access to residential care beds in some areas was also identified as having a negative impact on GEM patient discharge, particularly in some regional areas. Younger patients in GEM settings often face particular barriers, including managing interfaces with NDIS and access to age appropriate supports.

***“Access to services in the community prevents patients from being discharged in a more timely way, and delays to placement in Residential Aged Care Facilities means that access to GEM beds is slow”***

Jurisdictional issues were raised by stakeholders as a barrier to innovative models of care in GEM settings. As more GEM services are provided in patients’ primary place of residence (community or Residential Aged Care Facility), there will be a particular need to consider how Victorian funded models such as GEM can better interface with primary care, Commonwealth home care packages and other community based services. Rather than aim to create a GEM service that is all things to all people, an opportunity exists to consider how the GEM service can co-exist alongside other State, Commonwealth and locally funded programs designed to optimise the health and wellbeing of older people.

***“There are many community services available for patients post discharge however every service has its own eligibility, prioritisation, intake and referral process, which can be difficult for inpatient clinicians to keep abreast of and navigate. Some referral processes are also time intensive and burdensome, such as the My Aged Care referral process.”***

Raising the profile and awareness of GEM was suggested as a strategy to assist patient flow, seconding staff from acute services and increasing understanding of GEM program philosophy and model of care were identified as potential interventions.

### 4.4.2 Themes – Future GEM

**Innovations for generations**

*Summary*

* Innovative GEM models of care will be required to meet the different goals and expectations of the Baby Boomers, GenX and GenY cohorts.
* Leveraging existing and new technologies to facilitate access to specialist services, increase social connectedness and proactively maintain the health and quality of life for older people in their own homes would value add to future GEM service delivery.
* State-wide approaches to sharing of patient records, protocols and key performance indicators would enhance consistency of the future GEM model of care.

The Roundtable discussions focused on the needs of the different generations and the impact that the different goals and expectations of the Baby Boomer, GenX and GenY cohorts will have on future GEM services. Participants were separated into their own generations and asked what they would like GEM to look like by the time they needed it.

Innovations to enhance social stability, meaningful engagement and to deliver care outside of hospital walls will be required, with more of a focus on proactive and preventative models of care. Increasing health literacy, co-design and co-production of innovations would involve the community in designing the most appropriate person-centred models of care.

Shared care models, with geriatricians, mental health specialists and GPs with admitting rights, could be supported through increased use of telehealth and remote patient monitoring. Other shared care models such as the ortho-geriatric, onco-geriatric and cardio-geriatric models could be explored. Future GEM services could be delivered by mobile multi-disciplinary teams and in geriatric outpatient clinics that enable early assessment and intervention.

Purpose built and enriched environments, particularly dementia specific units with an upskilled workforce, should be part of the future GEM model of care.

***“Telehealth would also be a bigger part of this service, to enable all clients across regional services to access specialist input.”***

Upcoming generations will be increasingly technologically savvy and innovations in wearable devices, assistive devices, robotics, telehealth and social technology should be increasingly leveraged to support the health and wellness needs of future GEM patient cohorts. Default Information and Communication Technology (ICT) solutions need to change from a clinical focus to one that considers both a clinical and a social response to patient needs. Technology that connects to health, friends and enhanced lifestyle can assist reform.

Stakeholders identified that the current system is a collection of individual services all operating independently of one another that can lead to fragmented communication and a lack of continuity of care, both within and across different care providers. This increases risk and can lead to a poorer patient experience of care. The focus should be to create connected services and systems that promote integration of care.

State-wide approaches such as a state-wide electronic medical record system supported by state-wide protocols and new key performance indicators were suggested as potential reforms that would enhance future GEM models of care. Inter-sectorial approaches and multi-lingual systems that incentivise partnerships may assist to remove some of the current barriers and silos, facilitating a smooth trajectory through the service system.

**Evidence based best practice**

*Summary*

* There was limited evidence/data collected to support the overwhelming positive view of the value of GEM services.
* International models of care for older people can inform the future GEM model of care.
* Research should be undertaken to generate evidence and help inform future models of care.

Research to evaluate current models of care, identify changing consumer needs and patterns, and to provide an evidence base on which to further develop best practice in assessment and management of older people, is required to progress reform. Learning from international models of care for older people, particularly the Dutch small scale living and dementia/aged friendly communities, and the Swedish ESTHER model, should inform future GEM models.

Generating evidence to inform standardised guidelines and protocols should lead to development of GEM models of care that are safe, that increase dignity and decrease risk, and that provide advocacy and focus on recreation and contextual therapy. It will be important to integrate evidence based practice with lived experience.

Program measures and key performance indicators should take into account indirect care and should be aimed at keeping people at home for longer and meeting community expectations. The lack of uniquely Australian measurement tools and reliance on the FIM tool requires further investigation.

**Challenges for the future**

*Summary*

* Future models of care need to respond to the complexities of patients with a disability, delirium, dementia and bariatric syndromes.
* Future models of care also need to respond to those with challenging social circumstances, including our vulnerable patient groups, unstable housing and victims of domestic violence.
* Funding models need to be flexible to support both direct and indirect care needs of patients and to match changes in the GEM workforce.
* The need to address social isolation, social disadvantage, and younger patients with disability or conditions of ageing, will increasingly challenge traditional models of care.

Indirect care needs of patients experiencing social isolation, social disadvantage and homelessness are not well catered for in the current GEM service model. Addressing the needs of the “*lonely and the alone”* will be part of the challenge facing future GEM service provision, particularly when designing and expanding on GEM at Home models. Stakeholders perceived a current gap in appropriate models of care and environments for younger people with a disability, younger onset dementia and bariatric syndromes.

***“The complexity of patients through GEM, in regards to medical acuity, social complexity and Behaviours of Concern (BOC) has increased over the years which has placed a lot of pressure on the system and on length of stay. The average lengths of stay don’t adequately provide the time complex patients need in an inpatient setting. For example younger bariatric patients with significant functional decline never meet their average length of stay (ALOS).”***

Flexible funding models that support innovation and match value based healthcare are required. Funding models need to be informed by valid measures that identify and detail patient need and complexity, and support health services to invest in meeting these needs appropriately.

***“The model of care would be more flexible and adaptable to changing demographics and complexity. We would also see more GEM provided at home and have the flexibility to link in with community programs and conduct assessments both in hospital and off-site (ambulatory day model).”***

Flexible funding models that support innovation and match value based healthcare are required. Funding models need to be informed by valid measures that identify and detail patient need and complexity, and support health services to invest in meeting these needs appropriately.

Funding models need to recognise the increasing scope of practice for some professionals such as nursing and allied health, as well as the growing recognition of the assistant workforce. There is some growing literature on the benefits of volunteer programs that should also be explored to complement the work of the professional workforce.

There are also challenges in providing a seven day a week GEM service (particularly with current Enterprise Bargaining Agreements (EBAs)), and in attracting and retaining the skilled workforce of the future. Raising the profile of GEM and promoting the rewarding aspects of the service will lead to better patient outcomes and a happier, more joyful workforce.

# 5 Conclusion

The extensive stakeholder consultation process provided a wealth of valuable information to inform the evaluation of GEM. Results indicate that the four key objectives of the GEM service are currently being achieved. These are:

* To improve the functioning of older people with multi-dimensional health needs
* Manage people who have complex and multiple medical, functional and often cognitive conditions requiring a Comprehensive Geriatric Assessment (CGA)
* To provide a service model delivering specialist assessment and management by an inter-disciplinary team where care, all assessment and planning occurs within GEM
  + To provide the service model in a variety of settings, including in the patient’s own home

Whilst the four key objectives of GEM services are being met, there was support for strengthening the program further through leveraging its successes, and addressing its current and future challenges. GEM services were highly engaged throughout the consultation process, and expressed a keen interest in working collaboratively with the Department to further enhance the program.

At multiple points throughout the stakeholder consultation process, the voice of consumers and co-production of future GEM services was raised as a crucial element for successful future reform.

The stakeholder consultation process has achieved its aim and objectives by identifying achievements and gaps across the service system, and suggestions for future policy reform.

# 6 Recommendations for future policy reform

Feedback from the GEM stakeholder consultation identified that future DHHS policy direction must enable GEM funded services to:

Provide care flexibly in patients’ usual accommodation as a preference, while continuing to invest in purpose built environments for patients whom cannot be cared for outside of the hospital environment. Assessment and provision of support for carers will need to be considered when providing care in patients’ usual accommodation.

Evaluate and promote the effectiveness of models of care for older people, promoting and scaling innovative service platforms across the state.

Consider more robust outcome measures that are sensitive to the complexity of patient presentations, which will be paramount to support benchmarking across the sector and informed analysis of performance.

Support and develop the workforce of the future, acknowledging the changing patient cohort, and need for staff to retain and develop expertise in providing care for an increasingly acute and complex set of care needs. This should include further exploration of extended scope roles in allied health and nursing, and support for the growing assistant workforce. Consideration also needs to be given to initiatives that support staff wellbeing.

Develop a state-wide approach to supporting and developing the profile of volunteers and family members to supplement direct care provision.

Better interface with community services to reduce unnecessary delays to discharge within GEM programs. This should include consideration of how GEM funded programs can be delivered across the continuum of care alongside other programs in acute and the community.

Innovate rapidly, with fast adoption of new technological advances in health care monitoring and delivery for future generations of GEM consumers. Innovation should also be informed by emerging research in home based care, social isolation and best practice environments to meet the needs of our diverse older population.

# 7 Recommendations for Immediate Action

Establish a platform to support the identification of **existing innovation** within GEM settings of care to promote and scale this across the broader sector. This should include consideration of:

* Short-term ‘collaborative’ activities to address targeted issues – supported by experts in Improvement Science
* Longer-term regular opportunities for funding bodies, peak bodies, and providers of GEM services to meet and discuss trending issues and opportunities in the delivery of care for older people.

Re-engage with the sector to validate themes identified through the stakeholder consultation process and progress to co-design **the future model** of GEM for Victorians:

* Given the extensive investment made by the sector in the GEM stakeholder consultation discussion, it is recommended that this commence as soon as practicable to build on good will and engagement.
* Focus of the ‘Future of GEM’ design should take a transformational approach to address key challenges in the system, and enable the service to continue to deliver best care in a more flexible and responsive manner.
* Co-design of the future GEM model of care must include current and future GEM service consumers, their representative peak bodies, and key stakeholders at all stages

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