Regional Health & Aged Care Action Initiative

Addressing bed block in the Illawarra and Shoalhaven

Improving outcomes for older people

community INDUSTRY GROUP

Contact:

CEO: Nicky Sloan 0407 933 279
Consultant: Mark Sewell 0409 833 101

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1. Introduction

Community Industry Group (CI Group) is the peak body working for community services and organisations in Southern NSW. Established in 1993 and led for the past 12 years by CEO Nicky Sloan, CI Group supports community organisations, promotes expertise and innovation, fosters industry development and pursues social justice in the region.

CI Group provide a voice, influence and leadership for our not-for-profit members to ensure they feel heard, supported and informed in order to continue caring for the most vulnerable people in our society.

Southern NSW is one of the few regions in NSW which has a regional peak body. This makes it uniquely placed to deliver regional collaborative projects. As a generalist peak and non-service provider, CI Group has extensive experience in bringing together organisations from different sectors to work together to address regionally significant issues.

CI Group has a large member base across not-for-profit aged care services and has a history of industry, cross sector and intergovernmental coordination and facilitation. These collaborations have led to problem solving and service enhancements that benefit all stakeholders.

2. The context

The Illawarra / Shoalhaven region is located across the South East coast of New South Wales and encompasses the main communities of Shellharbour, Wollongong, Nowra and Kiama.

The region's economy has historically been centred around the manufacturing and mining industries, however now the health and social services industries are the largest sectors in the region. 14% of all employees in the Shoalhaven are employed in this sector, as well as 13.4 % in Wollongong and 13.1% in Shellharbour. These all exceed the state average of 11.6%. This change is driven by the decline in the heavy manufacturing sector and the rapidly ageing population. Over the next 20 years health care is expected to remain the fastest growing industry in the region.

The population of residents in the Illawarra region aged over 65 is already higher than the national average. The Illawarra's population is estimated to be 320,000 in 2023 with 20% (64,000) over 65, and 3% (8,100) over 85. Within 9 years it is expected that one in four people living in the region will be aged over 65.

The Illawarra Shoalhaven Local Health District (ISLHD) has hospitals at Bulli, Wollongong, Port Kembla and Shellharbour with more than 700 beds at 4 locations across the Illawarra. The Australian Institute of Health and Welfare (AIH&W) notes that 53% of all hospital stays are by people over 65 and the most prevalent cause for admission is an actual or suspected injury from a fall.

Aged Care services are privatised and diverse with over 2000 aged care beds across more than 30 locations in the broader region, as well as several thousand people receiving in-home care services. The largest operators are Warrigal, IRT, Uniting, Anglicare, Hammond Care, Marco Polo and Bluehaven. These are all not-for-profit, for-purpose entities.

The Community Home Support Program (CHSP) providers and Home Care Program (HCP) providers in the region vary in size and scope from small private start-up businesses to some of Australia's largest home care service providers.

3. The issue

Residential aged care occupancy levels in Australia was estimated at 87% as at 30 June 2022 (AIHW). Allowing for beds taken offline due to renovation or refurbishment, this indicates that at any point in time around 10% of beds should be available for occupation. This figure is significant – 10% of beds means 300 vacant residential aged care beds in the Illawarra.

Despite this, for more than two years it has been regularly reported that there are between 100 and 200 older people at any one time in the northern Illawarra public hospitals that are ready for discharge and formally approved for accommodation and care in a residential aged care home. This has a significant impact on the public health and hospital system in the region.

Current estimates are that it costs in excess of $3,000 per day to keep an older person in a hospital bed, compared to less than $500 per day for a residential aged care bed. In addition, hospitals are not able to offer the stimulating activities, opportunities to socialise, or outdoor recreation activities that are part of the residential aged care experience and which support both physical and mental health. Having older people 'blocking' hospital beds while they wait for appropriate aged care can lead to ambulance ramping, surgery delays, and poor health outcomes for the wider community.

From the older person's perspective, they cannot, or do not want to, secure a suitable aged care service for their needs. This leads to their transfer being delayed, sometimes indefinitely. Functional decline is a common side effect of hospitalisation. So often, for these older people caught in limbo between hospital and residential aged care, their health declines without adequate mobility and socialisation and they end up 'stuck' in hospital and 'blocking' a bed needed urgently for other people with acute hospitalisation needs.

It is estimated that half of people aged over 75 require help with activities of daily living after a hospitalisation, and this is certainly reflected in those who have extended hospital stays in the region. As their rehabilitation opportunities decline, their hope of being discharged and returning to their usual home deteriorates. Their own home environment may become assessed as unsuitable due to a lack of accessible modifications, unsupported unless family members can provide 8, 16 or 24/7 levels of support, unsafe if they would be living alone, or all three.

Many of these people have waited in a public hospital setting where the risks to their health, from a lack of mobility and exposure to infections from a clinical environment, have presented additional unnecessary risks to their health. Many are still waiting after more than 200 days past their discharge dates, and some have died waiting for appropriate aged care services.

4. The causes

The aged care system is undergoing generational reform as a result of decades of low levels of government investment, a public disdain and chronic ageism towards aged care across the community and a recent Royal Commission with many recommendations to improve the ailing system. Many, or even most, services are under financial stress after several years operating at a significant deficit, struggling to attract sufficient staff to operate their labour-intensive services and fearful of the government's compliance regime after being exposed to harsh non-compliance activities by the Aged Care Quality & safety Commission. As a result of these issues many providers across the Illawarra have paused expansion, reduced their actual utilisation levels or closed. Services have closed at Thirroul, North Wollongong and Warilla, or been sold off at Woonona, Wollongong, Unanderra, Warrawong and Berry. It has been reported in the public media that nearly 400 aged care beds have closed, or not opened, in the Illawarra Region in the last 3 years. Several large projects at Wollongong, West Wollongong and Fairy Meadow, that would have delivered several hundred new beds, have not progressed due to planning hurdles and there are now no new beds planned to be opened, with fears of more closures. The needs demographic continues to grow rapidly as the service supply side is in significant disruption and decline. With new funding levels and improved wages in 2023, aged care services may be able to respond to the need if they get coordinated planning assistance from this project.

From the patient's perspective the barriers to prompt discharge are also significant and locally are reported to include:

- lack of awareness of all the options available, including temporary respite in a residential aged care facility with return to home being supported through Commonwealth Home Support (CHSP) or Home Care Package services (where appropriate),
- fear of the unknown, especially around residential aged care accommodation and home care services,
- behavioural and psychological symptoms of dementia resulting in challenging behaviours that may prevent entry to a non-acute or sub-acute setting,
- ongoing complex medical management issues that require regular direct GP or hospital support,
- lack of understanding by the patient and their family about the quality and risk of the aged care services they are referred to,
- fear about the affordability and the financial assessments required to enter a full-time accommodation and care environment,
- financial barriers leading to fear of being discharged from a fully Medicare funded setting, and more.

While many of the causes are known or speculated upon, there has been no root-cause analysis completed to identify all causes and develop a wholistic program of initiatives to address each contributed factor. Equally, the current situation is dire, and action is required urgently to implement proven strategies to alleviate the situation whilst root-cause research is completed.

This whole unresolved scenario also creates an unacceptable risk to other people, of all ages across the community, who need public health and hospital services and find emergency departments clogged and admission to their public hospitals frustrated. Using a combination of research, immediately implementable solutions, and development of bespoke solutions to address identified

root-causes, this project seeks to address both ends of this vulnerable person transfer issue to create a systemic and sustainable solution.

5. Case Studies

These names have been changed to protect the identity of the person but these stories are told by close relatives of these people.

Case Study 1 – Rose

Rose is 92 and lives at home. She has had several visits to hospital in the last 5 years, due to falls, respiratory difficulties, suspected heart attacks and infected wounds, usually in her legs. During each admission she is terrified she will be transferred to a nursing home and makes it clear to everyone she is determined to go home. Before she could be discharged at the conclusion at her last visit, an OT assessed her home as needing modifications for her to safely live there, and an urgent ACAT assessment approved her needing a home care package for support. Whilst she waited for the home modifications and the personal care package, her children and grandchildren created a rostered 'circle of support' to provide all shopping, some meals, assistance with medical appointments, house cleaning, and her lawn mowing.

The modifications of a ramp to the front door were completed 4 months after her discharge from hospital. She could then walk out the front door to the driveway and letterbox with the aid of a walker. Up till then she needed 2 people to assist her down several stairs and the family feared she would suffer a fall when trying to go outside.

Her level 2 package was approved 6 months after her discharge and she is awaiting a provider. She has spoken to Feros Care and Warrigal, to deliver housecleaning, assistance with shopping and medical appointments, garden maintenance and podiatry (as she has sore legs and swollen feet making walking and shoe selection difficult).

Without comprehensive family support, Rose would be in a nursing home due to delays in the delivery of appropriate home modifications and personal care services.

Case Study 2 – Tom

Tom was 93 when he passed away in the geriatric ward at Wollongong hospital in October 2022. He was admitted a month before his death due to an uncontrollable infection in the skin on his legs. Through intensive medication and rehabilitation, he improved to the point where he was to be discharged back home. He was waiting for a week for his home to be assessed and, as there were

home modifications needed, he was also being assessed for residential aged respite care to enable him to be cared for until these were modifications were carried out. All of these assessments were required to be completed before he could be discharged.

Whilst waiting for another week for transfer, he became ill with fluid on his lungs and aspirated during the night. He passed away unexpectedly on the same day in the same hospital a few hours before his great grandson was born a few floors below. He didn't get to see him.

Case Study 3 – Helga

Helga was a proud and talented woman who lived in Wollongong in an IRT retirement village unit. She was 90 and proud that she had never stayed in hospital. She was admitted to hospital when her mild confusion became delirium, for investigation of a urinary tract infection. Medication reduced the infection and delirium after a week, but her condition declined quickly requiring rehabilitation to be able to return to independent walking and living alone in her unit. She wasn't able to start rehabilitation for another few weeks, so she eventually agreed, after many explanatory visits by the family, to accept a respite stay in a local aged care home. It took several weeks to arrange visits to two local homes as she wanted to assess them in case she ended up staying there permanently. After choosing one in the Warrigal group, she had another week or two, waiting for a bed to become available. In this period the family cleaned out her unit, deciding what she would take to the care home, and made it ready to sell in case she never returned to it. In the few days before her transfer to a respite care bed in an aged care home, her infection deteriorated quickly, and she passed away.

Case Study 4 – Penny

At 93 years of age, Penny had been living alone in the house that she and her husband had built 40 years ago. After years of caring for her husband, he had been admitted to full time residential care in a specialist memory support unit. Penny received support in the home through a Home Care Package.

A keen gardener, Penny had a fall outdoors one day which resulted in hospitalisation. Her injuries were relatively minor and she was making a good recovery, but because her family live some distance away it was decided that she would not return home, but would go into residential aged care.

However, the assessment failed to take into account that Penny is a valued part of a community within her street. Most of her neighbours do not go out to work, and they all visit and support Penny in many practical ways – such as mowing her lawn or taking her garbage bins out.

Unfortunately, there were no vacancies in the facility in which her husband was housed, and Penny is now living in a facility away from her spouse, and away from her local community network who are missing their friend and neighbour.

6. Previous Strategies

In the past few years there have been a number of partly successful regional strategies that have progressed the issue. These have included:

- Weekly interagency health and aged care collaboration meetings hosted by ISLHD
- Funding assistance by DOHAC/ISLHD re labour costs for fast-tracked entry assessment needs for all vacant beds.

This has resulted in some improved patient flow and entry to aged care but has been reliant on ad hoc good will by providers and, without formal coordination resources, has failed to be systemised and sustainable.

This 2023 project seeks to build on and formalise these good will attempts to address this wicked problem through a systemic facilitated collaboration of the relevant stakeholders coupled with some new short, medium and long term service interventions to directly improve the lives of older people who need aged care services appropriate to their needs. This will in turn enable acute public health services to be utilised for the needs of all people who need acute public hospital care from across the general public.

7. Project Overview

CI group is independent, experienced and ideally placed to facilitate stakeholders to implement an effective integrated set of 6 strategies that respond promptly and are sustainable in the long term.

1. Preparatory phase.

- Review effective models and find possible research partners.
- Engage key stakeholders and agree on a practical plan.

(This phase is well underway with several meetings of many interested parties through July and August).

2. Baseline the issue.

- Assess the detailed needs of the current and recent cohort of people approved for aged care but still in hospital especially the long-stay bed-block group.
- Assess the current actual capacity of the regional supply of aged care services and find any opportunities to maximise or expand their services to better meet the needs.
- Compare the patient needs and service supply baselines and make recommendations for a regional service supply response plan.

(Researchers have been engaged and are discussing how to best conduct this data collection).

3. Direct assistance.

- Establish a regional centralised online registry of current bed vacancies.
- Provide professional priority fast track transition assistance for those ready to relocate.

- Develop and deliver a volunteer ally scheme to offer to assist each person navigate the system towards the services they need with a trusted informed volunteer advisor.

(This would be a groundbreaking innovative cost-effective service that would address the individual reasons people find the whole health & aged care system confusing & resist prompt relocation).

4. Pilot.

- Lobby relevant decision makers to obtain the federal, state and local resources required to pilot these key essential service solutions.
- Implement a continuous improvement program to ensure ongoing analysis, identification and implementation of strategies to finesse the proposed solutions.

(The resources required aren't significant but will help the aged care system recover and older people in hospital transfer promptly to the services they need.

5. Expand.

- Provide specialist project advisory assistance, based on the research from item 2 above, to aged care services who want to:
    - develop in-house expertise to implement fast track hospital transition-to-aged-care programs to minimise their vacant bed days,
    - maximise their service offerings to fully utilise the staff skills, community trust and purpose built facilities they have to better meet the current need of people seeking aged care services,
    - assess all the opportunities to expand their accommodation and home care services to better meet need growth targets, and/or
    - implement innovative services such as joint health & aged care services eg MPS, to meet special needs such as dementia, mental health and rehabilitation.

6. Sustainable oversight.

- Establish an ongoing health and aged care collaborative taskforce comprising senior representatives from the key stakeholders including:
    - Department of Heath & Ageing (DOHA),
    - Illawarra Shoalhaven Local Health District (ISLHD),
    - Aged and Community Care Providers Association (ACCPA),
    - Coordinare – the Primary Health Network,
    - Community Industry Group (CI Group),

  to review and oversee improvement of strategies based on relevant research eg Melbourne Aged Care Collaborative (MARC), National Ageing Research Institute (NARI) etc. thus ensuring they continue to meet emerging, changing and growing needs in a regional aged care response strategy.

8. Immediate Implementation.

Baseline data scope of the problem

Professor Kathy Eager, formerly of the Australian Health Services Research Institute (AHSRI) been approached for the research phase of this project. Should funding be approved, Prof Eager will assess the needs and blockages of the 100 or 200 people currently in hospital awaiting discharge to aged services.

Professor Eagar has a long history of direct involvement in ISLHD hospital governance and research, as well as national aged care research and service models.

Paul Sadler, former CEO of Aged & Community Services Australia (ACSA) has been approached to review current service system supply issues. Paul brings an extensive range of experience from more than 35 years in the aged care sector.

Identifying Current Vacancies

Implementation of a regionally specific, real-time online register of current vacancies across the Illawarra/Shoalhaven. Will require coordination to obtain commitment from CEOs and senior leadership of local providers to contribute and keep data up to date as well as training for relevant staff of each organisation.

Promotional activities will then be implemented to ensure key personnel e.g. social workers, discharge coordinators are aware of the register and how to use it.

This initiative will not only address the bed-block concerns for NSW Health, but will also help address some of the issues identified by providers in the recent CI Group survey.

Older Person Allies Volunteer Project

Transition assistance and advocacy by expert volunteers to assist vulnerable people's transition to a suitable place to live and receive suitable care – whether this is in residential aged care or in the person's own home with support through the Commonwealth Home Support or Home Care Packages program.

A volunteer older person ally will minimise the risks of a prolonged hospital stay. The scheme could invite informed and aware volunteers such as aged care managers and professionals or family members who have navigated the system, to consider volunteering their time to assist a person blocked in a hospital bed to transfer. Their knowledge of the system may alleviate fear and improve access to relevant aged care services, as well as reduce fear and improve decision-making.

The development of the voluntary program will be informed by the successful Hospital to Home service in the UK which utilises volunteers to support the return home for older people. At first glance this appears to be a beneficial program with some good potential outcomes.

https://www.royalvoluntaryservice.org.uk/about-us/commissioned-services/supporting-your-recovery/home-from-hospital-service/

Addressing Workforce Constraints

Addressing workforce constraints will be key to the success of the collaborative project. The workforce shortage in the aged care sector is well documented, and creates increased obstacles to expeditious transfer of people from hospital care to home, supported by CHSP or HCP services, or to a residential aged care setting. .

In 2022, CI Group piloted the CareForce project, an industry-led collaboration to promote employment opportunities and careers in the care sector in the Illawarra and South Coast. This project addressed negative perceptions inhibiting job seekers from taking up opportunities in the Care Sector through:

- Promotion of employment opportunities through a multi-media campaign.
- Facilitation of interested and suitable job seekers into relevant jobs or training through the CareForce Hub.
- Directly linking job seekers with employers in the sector.
- Upskilling employers to implement best practice recruitment and retention strategies.

Between September 2021 and August 2022, CareForce delivered significant results, including:

- 447 employment outcomes, reported by six employers, from 1 January to 30 June 2022, 86% of the employment total were entry level participants new to the sector.
- Over 100 participants attended Employer Round Table workshops, receiving information and resources to support recruitment and retention of care work employees.
- Engaged with over 70 agencies and organisations on the NSW South Coast, including employers, ESPs, government agencies and registered training organisations (RTOs).
- Developed marketing resources to promote employment in the Care Sector, including video and photo stories featuring existing workers.
- Delivered multi-media campaigns targeting school leavers and youth and social media campaigns to showcase jobs and careers and raise the sector's profile.

Community Industry Group retains all of the rights to the CareForce program, and the resources, including the CareForce Hub which is currently deactivated but can be reinstated at short notice.

9. Investment required.

The resources to do this work will be located in the CI Group team at Port Kembla, report to the CI Group CEO and Board and remain independent of any one key stakeholder. The following resources would be required to deliver short, medium and long term actions.

- Project Advisor (part time) - to set up the project with relevant stakeholders and write submissions. (Note: CI Group has commenced this role without funding, by employing Mark Sewell as a consultant).

- Research Consultants (short term project) - to deliver the baseline data and problem scope.

  Professor Kathy Eagar is preparing a scope of research for both people in hospital and the service system they need. Paul Sadler Consultants is preparing a brief for research into the service system in the region.

- Project Manager (full time) – recruit and manage all the resources to deliver all the outcomes so that systemic improvements are made to the regional aged care system.
- Volunteers Coordinator – to develop and manage a team of approx 30 volunteer expert allies (sourced from experienced aged care managers & other professionals) to assist patient's achieve successful transfers to aged care.
- Project Officers (full time) – (years 2 &3) 2 positions to assist aged care providers to understand how to better maximise their residential and home care services towards hospital transfer patients and plan for expansion of their services to meet escalating demand.
- Project Officer – Workforce Development (Part Time) – to address workforce shortages that prevent the full utilisation of existing aged care services.
- Administrative Assistant (part time) – assist the team to deliver work efficiently.

While the projects are dependent on the outcome of the root cause analysis, the total cost is currently estimated to be $3,170,000 for the first three years.

10.Other Relevant Projects.

Joint health & aged care models.

Dr Rosemary Calder of Victoria University (VU) was recommended by ACCPA as the VIC state's academic expert in Multi Purpose integrated hospital and aged care services. She has been interviewed and is willing to be available to this project especially as it considers jointly operated health & aged care services, under state and federal funded partnerships.

Dementia Services Australia ARCTS

This federally funded 6 month project for Dementia Services Australia is about to commence supporting people living with dementia and their families to transition from Illawarra hospitals to residential care during 2023.

Program Director Marie Alford has agreed to meet, collaborate and ensure there is no duplication of efforts. On the contrary, collaboration will ensure the maximisation of both projects' aims.

Local workforce challenges by PWC

A PWC report in May 2023 reported the outcomes of a recent workshop of aged care operators and detailed the challenges and potential solutions to address the Illawarra Shoalhaven's aged care workforce challenges. This project seeks to appoint a workforce coordinator to assist aged care providers to implement these important strategies.

Preventing readmissions to hospital from aged care

In 2021-22, the Department of Health engaged HealthConsult to assess best practice multidisciplinary models of care to avoid preventable hospital admissions, emergency department (ED) presentations and/or readmissions (collectively referred to as 'avoidable hospitalisations') in residential aged care homes. Clinical and referral pathway management issues were identified.

Royal Commission recommendations re Health & aged care

Specific recommendations were made by the Aged Care Royal Commission (especially recommendations 66 – 71) regarding the need for a better and more effective interface between health and aged care. Some have been implemented but most are delayed. Many are about improved baseline and ongoing data capture and reporting to better understand the issues and the size of the challenges both service systems experience. Older people deserve to have both systems working well together for their benefit.

11.References/Further Information.

1. Background
2. Successful local regional strategies
3. Capital assistance
4. ARCTS
5. Multi Purpose Services. MPS
6. Care finder
7. Provider viability.
8. Collaboration models to consider
9. Aged care reform agenda
10. Department of Health Scoping study on models of health care in aged care
11. Royal Commission recommendations re health & aged care interface.

1. Background

Service profile - The region has a strong service profile of impressive aged care not-for-profit providers who have for many years provided a range of diverse and responsive services in response to the local community needs. These services have been strained by funding and accreditation issues over the last few years including:

- Warrigal various locations- closed down it's Warilla aged care centre in 2021.
- IRT various locations - did not open new Bulli aged care centre in 2020 and sold largest Wollongong home to Warrigal in 2021.
- Blue Haven (approved for sale in 2023 by Kiama Council)
- Uniting Care various locations
- Diggers Aged Care Corrimal
- Marco Polo - closed high care sections (acquired by IRT in 2023)
- Harbison Care Southern Highlands
- Multicultural Aged Care Illawarra (acquired by Warrigal in 2022)
- Christadelphian Aged Care Albion Park (acquired by Warrigal in 2019)
- Royal Freemasons Berry
- Catholic Aged Care Berkeley and Unanderra
- Anglicare Dapto
- Presbyterian Aged Care North Wollongong (closed down in 2019)
- Fresh Hope Care Thirroul (closed down in 2022)
- plus many others across the South Coast and Southern Tablelands beyond the scope of this project.

2. Successful local regional strategies

In Sept 2022 a facilitated workshop was held to tease out the main issues. The Illawarra Shoalhaven Aged Care Health Collaborative Workshop met at Fairy Meadow on September 16 2022 with four aged care operators (large and small services) and key managers assigned to address aged care and health care interface from ISLHD, and Coordinare Primary Health Network.

An aged care consultant (Paul Sadler) facilitated the workshop with five strategies developed as priority actions:

1. Digital health implementation to ensure seamless client records across hospital, GP and aged care – responsibility Coordinare PHN
2. Expand the Geriatric Flying Squad to ensure aged care can access expert health and medical advice prior and post hospital stays – responsibility ISLHD
3. Identify and coordinate GP support for people discharged to aged care from hospital to enable prompt and safe transfers and settlement assessments - responsibility Coordinare PHN.
4. Ensure the hospital discharge interface with aged care is useful and inclusive so that all the stakeholders including the hospital staff, aged care management, family members, GP and the patient are full engaged and agreeable to prompt transfers to a more suitable living environment - responsibility
5. Establish best practice management and suitable environments for the management of people with challenging behaviours of concern, whether from dementia or mental health causes - responsibility

3. Assistance.

The Aged Care Capital Assistance Program (ACCAP). This funding can be used to provide staff accommodation and aims to increase aged care services in thin market settings for people living in regional, rural and remote areas. Eligibility to apply and receive grant funding will be determined on a round-by-round basis and clarified through grant opportunity guidelines. The program is expected to open in 2023.

Federal Department of Health & Aged Care (DOHAC) funding

The DOHAC Dep Sec Michael Lye acknowledged to ACCPA on June 14 that there are regions with significant aged care bed losses and these are having a detrimental impact on the health and hospital systems in those regions. He cited the Structural Adjustment Fund that has assisted some services, and the new Market Adjustment Fund that may be able to assist services remain open. Access to this resource is by invitation only.

These resources are important. An example of this is the funding was granted in 2022 by the 100 bed Multicultural Aged Care Illawarra (MACI) aged care home at Warrawong that enabled it to secure Warrigal as a new merged operator to ensure the 100 beds continue.

These capital funds may be necessary to enable the existing beds in the Illawarra to continue via renovations, technology systems, project staff, etc. They may also be useful sources of funding for exisiting services to expand their services.

4. Acute to Residential Care Transition Service (ARCTS)

May 2023 Federally funded to Dementia Services Australia and hosted by Hammond Care

Supporting people living with dementia and their families to transition from hospital to residential care

Marie Alford, Bethany Kings & Jenny Summerton and the managers.

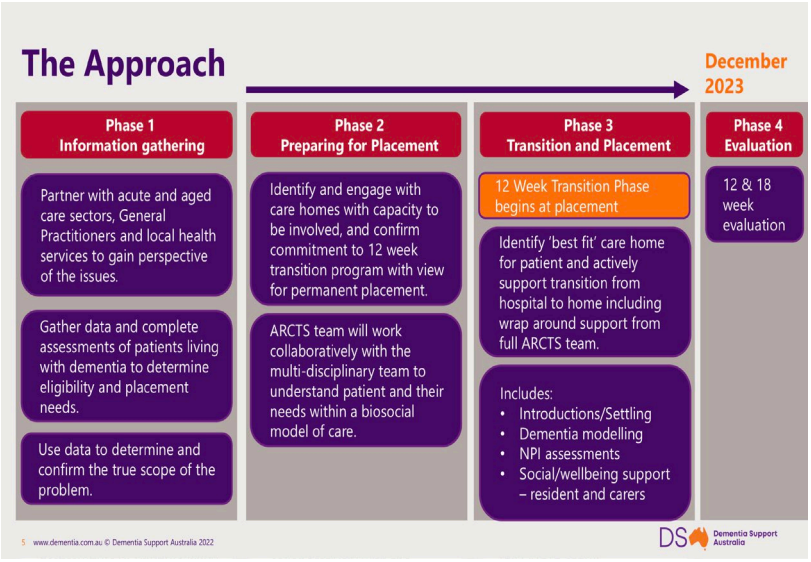
Head of Dementia Professional Services, DSA National Program Manager, DSA.

ARCTS is an exciting step towards building capacity between acute and aged care for better outcomes for people living with dementia, their families and those who provide care for them. Active partnership in the Illawarra Shoalhaven and Hobart regions with the local health services, General Practitioners, acute sector and residential aged care homes. ARCTS team will work with all involved to help find the right care home, prepare for and provide support during the transition and for up to 12 weeks after the transition to the care home.

To be eligible for the ARCTS Program, the person requiring support must:

- Be part of Illawarra Hospital Exit Block
- be currently admitted to an acute hospital setting; and
- have a diagnosis of dementia; and
- experience behaviours as a result of their dementia that impact

their care. Assessed by ACAT and approved for RACF placement; and to agree to receive DSA services.



5. Multi Purpose Services Model

Professor Rosemary Calder of the Australian Health Policy Collaboration at Victoria University (AHPC) was interviewed and shared her research

Sustaining health and aged care services in small rural communities. Multi-Purpose Services in Victoria: their strengths and vulnerabilities. Commissioned Report No. 2017-01. 2017.

The MPS model is a joint State and Commonwealth initiative designed to provide small rural communities with a 'cashed out' model of funding that amalgamates all services under one locally operated provider. This model is designed to:

- Ensure services meet the needs of the community
- Increase coordination, flexibility and innovative delivery of services; and
- Improve cost efficiency.

Through a history of development and operation over the past 20 years across rural and remote Australia, the MPS model has been shown to be successful in enabling integrated health, community and aged care services in small rural communities. Implementation of the model has effectively provided a health services solution to the the imminent closure of small rural hospitals and health services. The model has been praised for enabling the provision of health services relevant to the needs of diverse communities, with the capacity for those services to flex over time in order to meet changing community needs. The significant outcome of the model, prior to recent policy environment developments, has been the sustained provision in small rural communities of financially viable, comprehensive services with strong local community relevance and engagement.

6. Care-finder services

The government's important navigator service known as 'care finder' doesn't apply to people in hospital awaiting aged care.

People in hospital are not eligible to use the Federal Government's Department of Health and Aged Care's Care Finder service as a person needs to have no current carer or advocate and be in an unsafe environment to get access to the service. Older people in hospital awaiting aged care services are deemed to have carers, ie the staff, and be relatively safe, ie by being in hospital.

7. How are providers going?

The UTS Ageing Research Collaborative (UARC) consists of leading academics from multiple UTS Faculties conducting research in collaboration with industry leaders, health and aged-care providers,

and the government to address the obstacles to people ageing well in Australia and impact on complex problems in aged care and health care policy and practice.

UTS UARC current research re aged care sector challenges notes that with over 50% of providers making repeated financial losses there is no confidence to expand their services, or in many cases, continue to provide these essential services. With the recent changes to the funding system the worst losses are being sustained in regional areas, eg Illawarra, as funding supplements for services in rural and remote services are having a positive effect there, and services in metropolitan areas enjoy economic benefits of full market effects.

They note that whilst most aged care services will meet the 2023 deadline for 24/7 RNs, there are still 6000 more RNs needed to cover every minute of service with back up capability for leave and other absences. It is noted the NZ experience of nurses migrating to health care with the subsequent closure of 1100 aged care beds when ratios were imposed there, and the resultant transfer of residents to hospitals 'following the nurses'. UTS also notes the Home Support reforms due to in 2024 and 2025 where nearly a million CHSP clients will become part of the low level home care system that does not enjoy understandable federal access and finance policy yet.

https://www.uts.edu.au/uarc

8. Collaboration models to consider joining or replicating

The National Ageing Research Institute (NARI) is a national, independent medical research institute, which is highly respected across the aged care industry and research sector nationally and internationally. NARI brings together industry leaders, innovators, academic experts, and world-class educators who combine their expertise to influence and shape the agenda in ageing research and aged care. With a strong focus on translational research, they have made significant improvements to the lives of older Australians through research.

MARC (Melbourne Ageing Research Collaboration) is a unique consortium of 20 partners, bringing together hospitals, universities, aged care services, primary health, government and advocacy organisations. MARC aims to improve the lives of older people through rapid translation of research into policy and practice. They seek to improve aging-related knowledge, skills and understanding among researchers, the health and aged care workforce, policymakers and the general public to ultimately create long-lasting, systemic change. MARC's focus is on addressing key issues of importance to older people, their carers, health professionals and the wider community. Their four key themes are preventing falls, providing better dementia care, improving mental health and wellbeing, and enabling better end-of-life care.

9. Aged care reform roadmap causes service disruption

An update of the aged care reform timetable released by Minister Wells in June 2023 shows there have been a significant number of reforms to aged care so far and many more initiatives are to be

rolled out. Whilst these are largely accepted by all stakeholders as good things to do, they are putting pressure on service providers to reassess their capacity to provide their services. Some are closing, reducing or redeveloping their services, and few are confident to expand with so many unknown impacts on the sustainability of their services. For example Warrigal expanded its services rapidly over several decades by building new services at several locations across the Illawarra and Southern Highlands till 2019. Since then it has acquired services at Albion Park from Christadelphian Care, Canberra from BUPA, Wollongong from IRT, and Warrawong from MACI. Most of these suffered compliance sanctions and were at risk of closure. Whilst the acquisition rescue approach is commendable work and necessary to maintain essential service levels, it has diverted resources from expanding the service system to meet growing demand, towards just maintaining the existence of some exisiting services.

The current timetable of aged care reforms are welcomed but they lead to many complex changes across the whole system.

Completed Reforms:

October 2022

- New Residential Aged Care Funding Model (AN-ACC). Better alignment of funding with the cost of care delivery.
- Capability review of the Regulator commences.
- Specialisation verification framework visible for consumers.
- System changes to support carer referrals from My Aged Care to Carer Gateway and/or Dementia Australia.
- Publication of Food and Nutrition Report. Analysis of 12 months of data.
- Aged Care Financial Report. Annual reporting due.

November 2022

- Home Care urgent access to Assistive Technology. $25 million to address supply constraints and expanded access to assistive technology.
- Strengthened Food and Nutrition Reporting. Report through Quarterly Financial Report.
- Aged Care Quarterly Financial Report. Quarterly reporting due (including care minutes, food and nutrition).

December 2022

- Code of Conduct and Banning Orders. Commencement of strengthened safeguards for older people receiving aged care services.
- Serious Incident Response Scheme. Expanded to home services providing greater protections for older people.
- Strengthened Provider Governance. Commence improved governance systems of approved providers.
- Star Ratings. Residential care star ratings commence.
- My Aged Care face-to-face service roll out complete.

January 2023

- Aged Care Complaints Commissioner. Commissioner advertised to drive more timely resolution of complaints and improve complaint management processes.

- Care finders. Supports for highly vulnerable older people to access care commences.
- Capping administration and management charges in the Home Care Packages (HCP) program. Price capping commences.
- Interim Inspector-General of Aged Care commences.

March 2023

- Capability Review of the Regulator completed.
- Legislation to establish Inspector-General of Aged Care and supporting office introduced.

April 2023

- Strengthened Aged Care Quality Standards – pilot commencement. Aged Care Quality and Safety Commission commence pilot to test the draft Strengthened Aged Care Quality Standards with providers.
- Government Provider Management System. Commencement of a new provider portal and capability to preview Star Ratings prior to publication on My Aged Care.
- Additional Quality Indicators. Requires residential aged care providers to report on crucial areas of care to support quality improvement and better health outcomes for older people.

May 2023

- Complaints Commissioner in Aged Care Quality and Safety Commission commences.

Yet to be completed

June 2023

- Elder Care Support Program. Establishment of a new national service to provide face-to-face support to assist First Nations elders navigate and access aged care services (68 staff).

July 2023

- Aged care prudential regulator. Responsibility for financial monitoring will transfer from the department to the Aged Care Quality and Safety Commission, as part of the commissionexpanded role as the prudential regulator.
- Aged Care Volunteer Visitor Scheme. The Community Visitor Scheme is expanding and from 1 July 2023 will be renamed the Aged Care Volunteer Visitor Scheme.
- Food and Nutrition Advisory Support Unit – Staffed by specialists within the Aged Care Quality and Safety Commission and dietitian experts established.
- Funding Pay Increase for Aged Care Workers. 15 per cent award wages increase for many aged care workers.
- Office of the Inspector General of Aged Care and appointment of the acting Inspector-General. Establishment and commencement.
- Registered Nurses onsite 24/7. Requirement and supplement for 24/7 Registered Nurse coverage in residential aged care commences.
- Interim First Nations Aged Care Commissioner commences in first part of financial year.
- Integrated Care and Commissioning expands trial sites in thin markets, progressively from 4 to 10.

August 2023

- Food complaints and advice “hotline” established.

October 2023

- Enrolled Nurse Care Minutes delivered in residential aged care will be published with Star Ratings on the My Aged Care ‘Find a Provider’ Staffing pages.
- Care Minutes 200/40. Mandated care minutes required to be delivered by Registered Nurses, Enrolled Nurses and Personal Care Workers.
- Provider Operations reporting. Annual information submitted.

December 2023

- A Bill for a new rights-based Aged Care Act. Exposure draft.
- 24/7 Registered Nurse coverage in residential aged care will be published with Star Ratings on the My Aged Care ‘Find a Provider’ Staffing pages.
- Aged Care Digital Strategy and Aged Care Data Strategy. Publication.

January 2024

- Dollars Going to Care. Publication of residential providers financial information on My Aged Care.
- Residential, home care and transition care provider transparency. Published on My Aged Care.

March 2024

- Completion of the Home Care Workforce Support Program. Established in 2022 with the goal of approximately 13,000 new personal care workers recruited over past 2 years to support growth in Aged Care including In-Home Aged Care.

June 2024

- Residential aged care places assigned to people. Greater choice and control over which approved provider delivers their care.
- Elder Care Support Program. National service to provide face-to-face support to assist First Nations elders navigate and access aged care services (110 staff).

July 2024

- New Regulatory Model commences.
- Quality Standards commence.
- Commonwealth Home Support Program. 12-month grant extension.
- National Worker Screening for aged care commences.
- Accommodation Framework. Commencement of New National Aged Care Design Principles and Guidelines to create more home like environments which better meet the needs of residents.
- Single Assessment System commences.
- New rights-based Aged Care Act. Passage of the new Aged Care Act.

October 2024

- Care Minutes 215/44. Improve access to direct clinical care for older people in residential care.

April 2025

- Elder Care Support Program. Full establishment of a new national service to provide face-to-face support to assist First Nations elders with 250 staff across Australia.

July 2025

- Expansion of the National Aged Care Mandatory Quality Indicator Program to include enrolled nurses, allied health and lifestyle staffing measures in residential aged care and work to expand quality indicators to in-home aged care.
- English language and ongoing training requirements for Personal Care Workers commence.
- In-Home Aged Care Program. A seamless system of care with choice for older people.

10. Department of Health Scoping study on best practice multidisciplinary models of health care in residential aged care homes

In 2021-22, the Department of Health (the 'Department') engaged HealthConsult to assess best practice multidisciplinary models of care to avoid preventable hospital admissions, emergency department (ED) presentations and/or readmissions (collectively referred to as 'avoidable hospitalisations') in residential aged care homes.

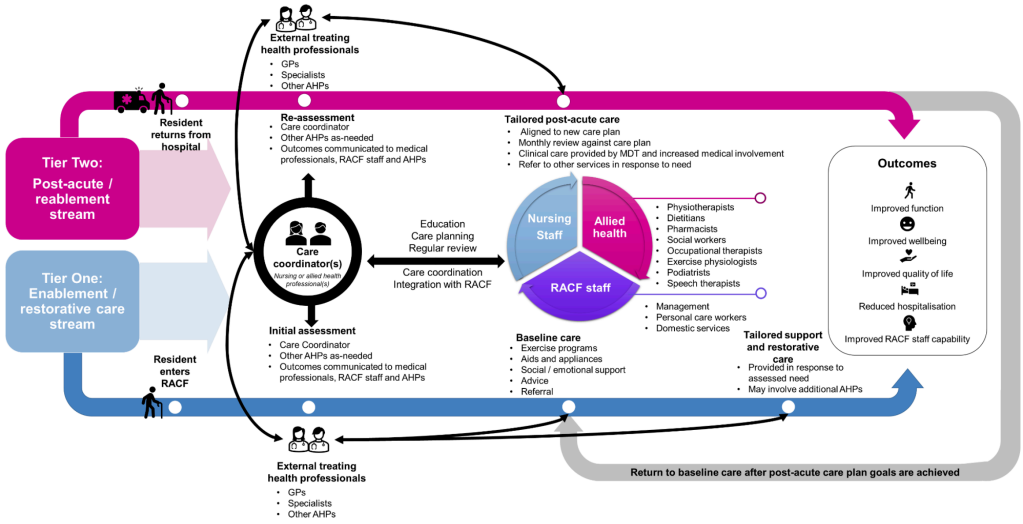
Proposed model of care

Figure 1 provides an overview of the model of care. Key characteristics of the proposed model include:

- a focus on addressing the top three drivers of avoidable hospitalisation in residential aged care homes:
- falls and fall-related injuries
- chronic respiratory disease, and
- chronic cardiovascular disease.
- providing care through a 'streamed' approach that includes:
- an 'enablement/restorative stream' that provides a base level of care from nurses, core allied health professionals (physiotherapists, dietitians, pharmacists and social workers) and other residential aged care staff (including personal care workers, lifestyle officers and other staff) that is focused on improving resident wellbeing by maintaining and improving function. The enablement/restorative stream would also provide additional care to support functional improvement, in response to the assessed need (including from occupational therapists, speech pathologists, podiatrists and exercise physiologists).
- a 'post-acute care stream' that seeks to address a gap in current care availability for residents after a hospital stay or ED presentation. The post-acute care stream would provide additional, tailored allied health interventions (in addition to baseline care) through a multidisciplinary approach to restore function and wellbeing.
- embedding a dedicated Care Coordinator role(s) within each residential aged care home that would lead the multidisciplinary team and be responsible for assessment and coordinating resources to respond to resident needs. The Care Coordinator would be a nurse or allied health professional skilled in aged care, provide a central point to integrate the multidisciplinary team with residential aged care home operations, and ensure effective coordination of the multidisciplinary team with other health professionals, such as GPs and specialists, to support an integrated approach to care.

- a focus on resident needs through assessment upon entry to residential care and regular monitoring and re-assessment against care goals by the multidisciplinary team.
- building the capacity of (clinical and non-clinical) residential aged care home staff through by integrating tightly with residential aged care homes operations and delivering additional support by delivering education, developing guidelines and conducting regular case review meetings.
- flexibility for the model to work successfully across different types of residential aged care homes settings and locations. The proposed model prescribes only those professions that are needed for it to succeed, and how members of the multidisciplinary team would work together to achieve its objectives. Residential aged care homes would engage members of the multidisciplinary team in a way that will work best for them (i.e., on an employed or contracted basis); could deliver services using Allied Health Assistants where appropriate (under the direction of an appropriately qualified allied health professional) and would be encouraged to use telehealth as a service delivery modality where appropriate.

Figure 1: Overview of the proposed model of care



AHP = allied health professional

MDT = multidisciplinary team

RACF = residential aged care home or facility

11. Royal Commission Recommendations re aged care / health care interface

Specific recommendations were made by the Aged Care Royal Commission (especially recommendations 66 – 71) regarding the need for a better and more effective interface between health and aged care. Some have been implemented but most are delayed and many are about improved data capture and reporting to better understand the issues and the size of the challenges.

Recommendations 27 - 29 refer to better info and support for consumers, specially the introduction of a 'care finders' service to be established.

Recommendation 66: Improving the transition between residential aged care and hospital care

The Australian and State and Territory Governments should:

a. by 1 July 2022, implement, and commence publicly reporting on compliance with, hospital discharge protocols that ensure that discharge to residential aged care from hospital should only occur once appropriate clinical handover and discharge summary (including medications list) has been provided to and acknowledged by the residential care service, and provided to the person being discharged

b. by 1 December 2021, require staff of aged care services, when calling

an ambulance for a resident, to provide the paramedics on arrival with an up-to-date summary of the resident's health status, including medications and advance care directives.

Recommendation 67: Improving data on the interaction between the health and aged care systems

The Australian Government and State and Territory Governments should improve the data available to monitor the interaction between the health and aged care systems and improve health and aged care planning and funding decisions.

In particular:

a. the Australian Government should implement an aged care identifier

by no later than 1 July 2022 in the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme Schedule datasets to allow regular public reporting on the number and type of medical and pharmaceutical services provided to people receiving aged care

b. by no later than 1 July 2023, all health National Minimum Data Sets reported to the Australian Institute of Health and Welfare (other than those relating to maternity, neonatal and paediatric care) should include an item identifying whether a person is receiving aged care services and the type of aged care the person is receiving

c. National Minimum Data Sets covering all State and Territory Government- funded health services should be implemented by no later than 1 July 2023

d. all governments should implement a legislative framework by no later than 1 July 2023 for health and aged care data to be directly linked, shared and analysed to understand the burden of disease of current and prospective people receiving aged care and their current and future health needs

e. the Australian Government should direct the Australian Institute of Health and Welfare to include data tabulated on the basis of aged care recipient status in any relevant health statistical publications, and make the de-identified data publicly available through the Australian Government's data portal data.gov.au.

Recommendation 68: Universal adoption by the aged care sector of digital technology and My Health Record

The Australian Government should require that, by 1 July 2022:

a. every approved provider of aged care delivering personal care or clinical care:

i. uses a digital care management system (including an electronic medication management system) meeting a standard set by the Australian Digital Health Agency and interoperable with My Health Record

ii. invites each person receiving aged care from the provider to consent to their care records being made accessible on My Health Record

iii. if the person consents, places that person's care records (including, at a minimum, the categories of information required to be communicated upon a clinical handover) on My Health Record

and keeps them up to date

b. the Australian Digital Health Agency immediately prioritises support for aged care providers to adopt My Health Record.

Recommendation 69: Clarification of roles and responsibilities for delivery of health care to people receiving aged care

1. By 31 December 2021, the Australian and State and Territory Governments should amend the National Health Reform Agreement to include an explicit statement of the respective roles and responsibilities of approved aged care providers and State and Territory health care providers to deliver health care to people receiving aged care, similar to the Applied Principles and 'tables of supports' for the National Disability Insurance Scheme, on the basis that, among other things:

a. allied health care should generally be provided by aged care providers

b. specialist services, including specialist palliative care and subacute rehabilitation, should be provided by State and Territory health care providers, even if these services involve allied health practitioners

c. less complex health conditions should be managed by aged care providers' staff, particularly nurses.

2. By 31 December 2021, the Australian Government should amend the Quality of Care Principles 2014 (Cth) to clarify the role and responsibilities of approved providers to deliver health care to people receiving aged care, including but not limited to their particular role and responsibilities to deliver allied health care, mental health care, and oral and dental health care.

Recommendation 70: Improved access to State and Territory health services by people receiving aged care

By 1 July 2022, the Australian and State and Territory Governments should amend the National Health Reform Agreement or any future health funding agreement to include explicit commitments by State and Territory Governments to provide:

a. access by people receiving aged care to State and Territory Government- funded health services, including palliative care services, on the basis of the same eligibility criteria that apply to residents of the relevant State and Territory more generally

b. clinically appropriate subacute rehabilitation for patients who:

i. are receiving residential aged care or personal aged care at home, or

ii. may need such aged care services if they do not receive rehabilitation,

as well as performance targets and reporting requirements on the provision of subacute rehabilitation care to people receiving aged care.

Recommendation 71: Ongoing consideration by the Health National Cabinet Reform Committee

The Health National Cabinet Reform Committee should require the Australian Health Ministers' Advisory Council to:

a. consider the full suite of the Royal Commission's recommendations related to the interface of the health care and aged care systems and report to the next meeting of the Committee

b. include a standing item in all future meetings of the Council on the aged care system and its interface with the health care system.