Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Moving Care & Support of Older Persons to Community

Dr Bhaskar Mandal (HOS Geriatrics Medicine, FSFHG)

Clinical Lead for Centre of Excellence for Geriatric Care (SMHS)

Clinical Lead for Older Person's Health Network (OPHN) Department of Health WA.

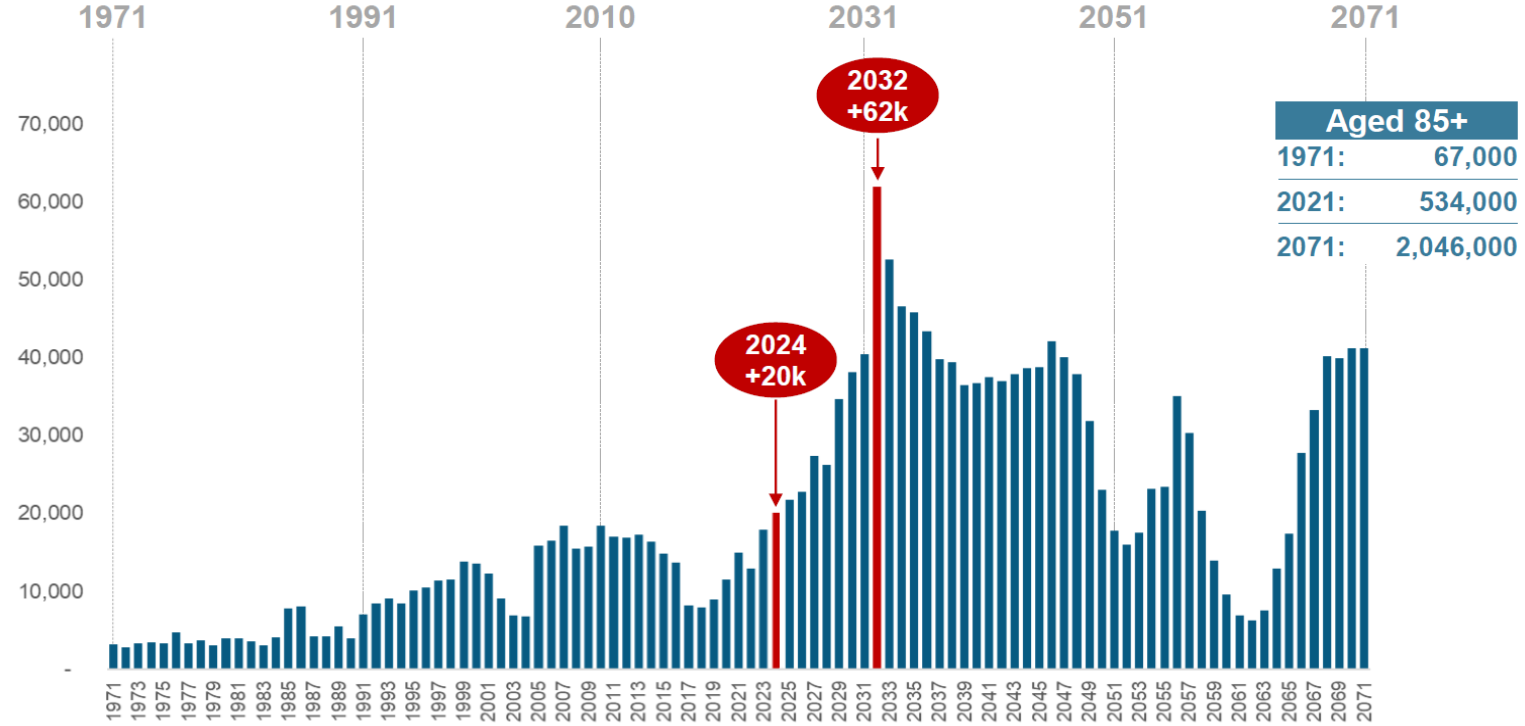
South Metropolitan Health Service respectfully acknowledges the past and present traditional owners of this land on which we are meeting, the Noongar people. It is a privilege to be standing on Noongar country.

We also acknowledge that the Aboriginal population in the South Metropolitan Health Service is diverse and includes Aboriginal people from many communities across Australia.

We also acknowledge the contributions of Aboriginal and non-Aboriginal Australians to the health and wellbeing of all people in this country we all live on and share together.

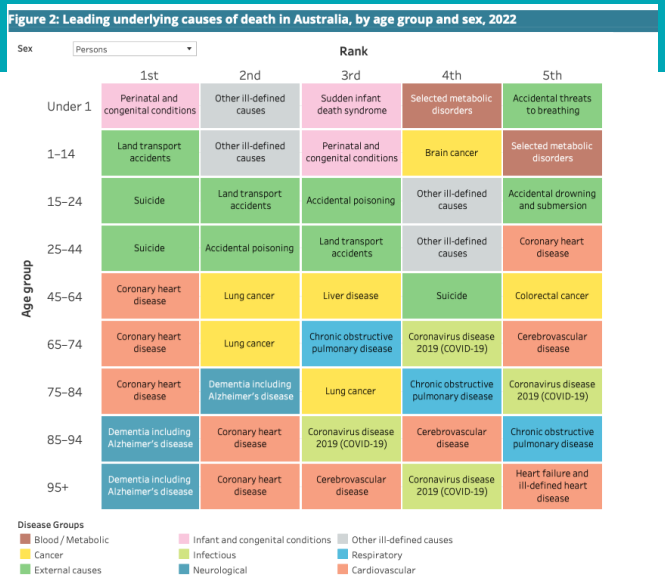
Older adult - demographics

The number of older adults is projected to grow at twice the rate of the general population with an associated increase in frailty and dementia

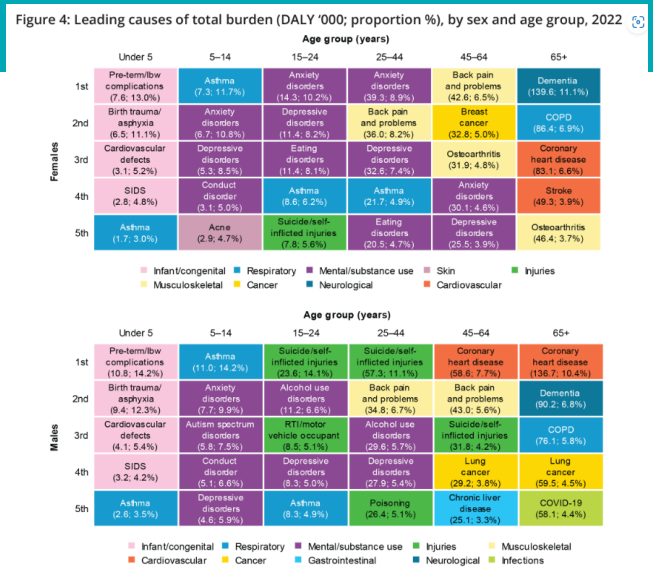


Net growth in the 85+ cohort for Australia, 1971-2071; Source: ABS Population Projections (med series) 2023

Burden of Disease & Leading cause of Death in Australia

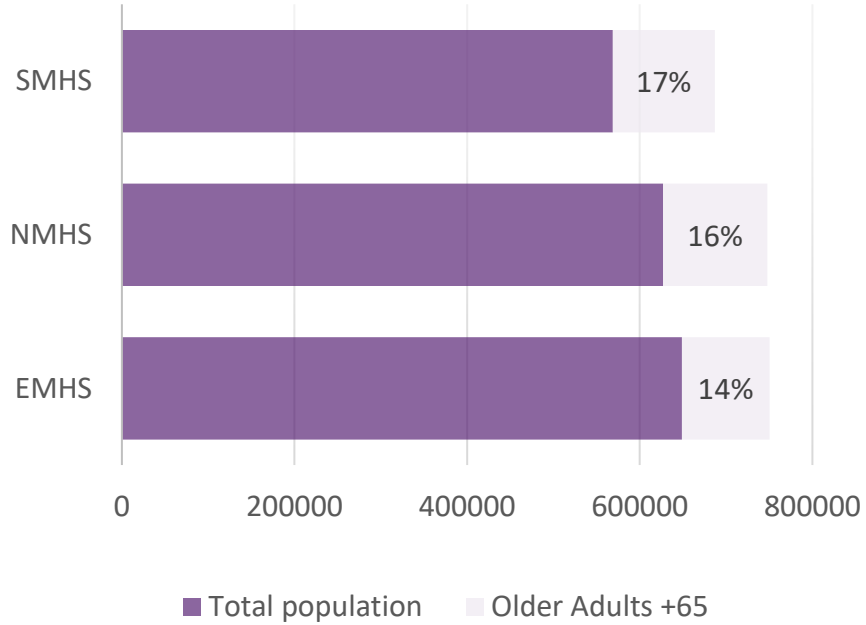


Source: Deaths in Australia, Leading causes of death - Australian Institute of Health and Welfare



Source: Australian Burden of Disease Study 2022, Summary - Australian Institute of Health and Welfare

Why the older adult is a priority right now

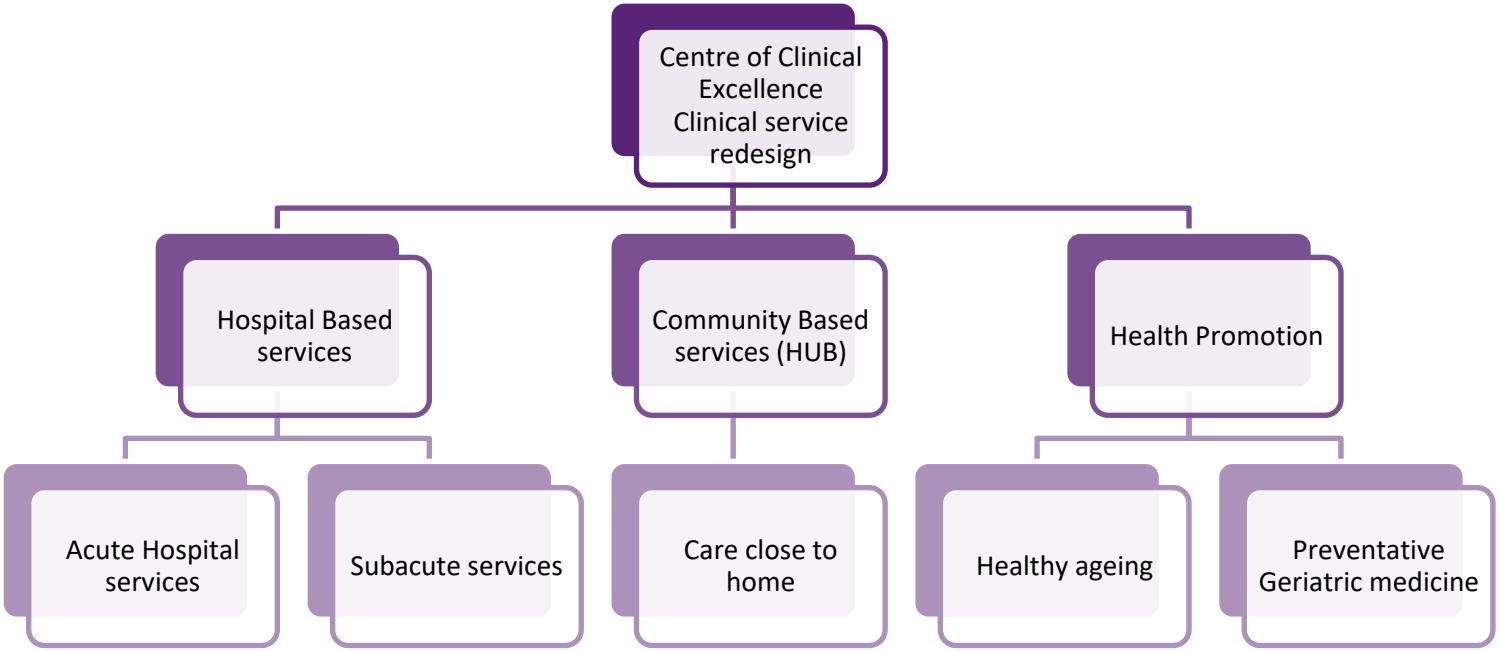


Source: Australian Bureau of Statistics 2021

- Across the metropolitan area, older adults make up between 14 and 17% of health service catchment populations.
- The older adult cohort represents only 17% of the total population, yet accounts for 23% of total Emergency Department (ED) presentations and 44% inpatient admissions.
- So far in 2024, ED attendances for patients 65+ account for 23% of activity but 32% of the time patients spend in EDs. This has increased from 27% in 2018.
- In 2022/23, over 50% of potentially preventable hospitalisations in East Metropolitan Health Service (EMHS), South Metropolitan Health Service (SMHS) and North Metropolitan Health Service (NMHS) were in patients aged over 60 with 42% in WA Country Health Service (WACHS).

Clinical Service Redefining & Development.

(Centre of Clinical Excellence) – Blue Print



Hospital Based Services – two sites based

Fiona Staley hospital (Quaternary Hospital)

Acute & Subspecialities in reach services

ACUTE MEDICAL GERIATRIC SERVICES-

- ED in reach service (GOLD – ED)
- ED falls Pathway

MEDICAL SUBSPECIALITIES GERIATRIC SERVICES

- Oncogeriatrics
- Cardio geriatrics
- Nephro Geriatrics / Respiratory /Haematology
- In reach services
- Palliative care

SUGICAL GERIATRIC SERVICES (PERIOPERATIVE)

- Orthogeriatric
- OASIS (Older Adult Surgical Inpatient services)
- Surgical Subspecialities Geriatric care – Vascular
- Burns service
- Colorectal / Upper GI

Cardiothoracic, Urology, Colorectal, Ears Nose and Throat (ENT), Plastics, Transplant

Transitional care – M8

Sub Acute Geriatric Medicine / Rehabilitation/ Enablement Care

Fremantle Hospital Perth

RATU (Rapid access & Treatment unit) –	**Rehabilitation services (in patient)**	Stroke / Parkinson's & Nuro rehabilitation
Post Surgical rehabilitation.	Orthogeriatric rehabilitation	Complex Medical Geriatric Rehabilitation 24 beds (will need another 24 beds to address demand)
Dementia / Delerium unit ?? At FH	7/7 Ambulatory care Geriatric HOT clinics (by passing ED)	**Outpatient Services - 20 plus clinics / week** **Geriatric & Subspeciality Geriatric services** **Advanced directive care clinic**
Early supported Discharge services (CHOICE)	**Palliative care.**	**Psychiatry for older adult.**

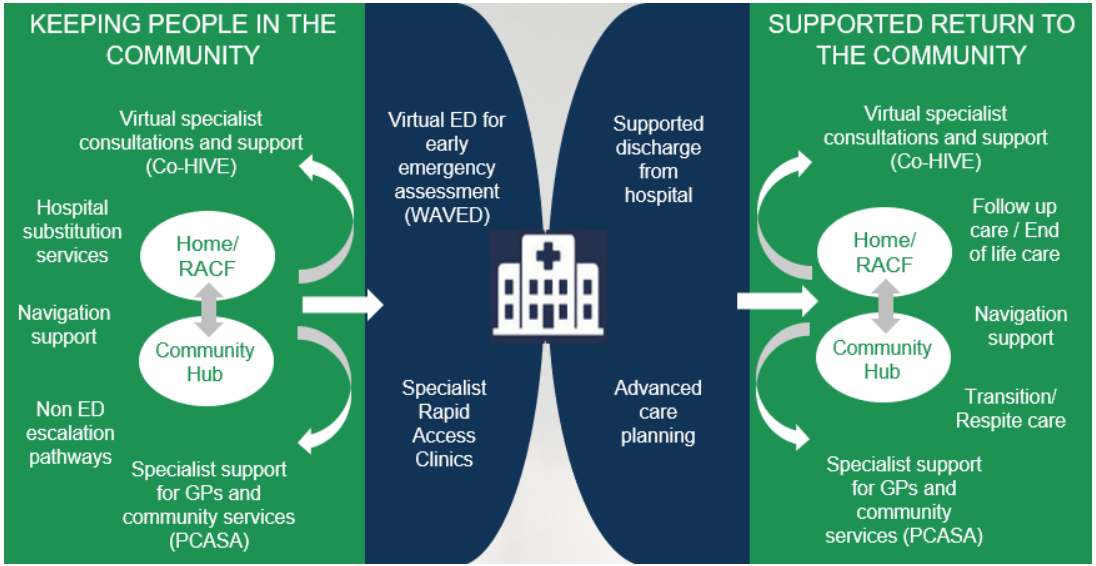
Community Based Services (Geriatric HUB) – (Philosophy & Brick & Mortar) Care close to home

Target State

- Establishment of Community Integrated Care (CIC) hubs for older adults, designed to increase access *in the community*.

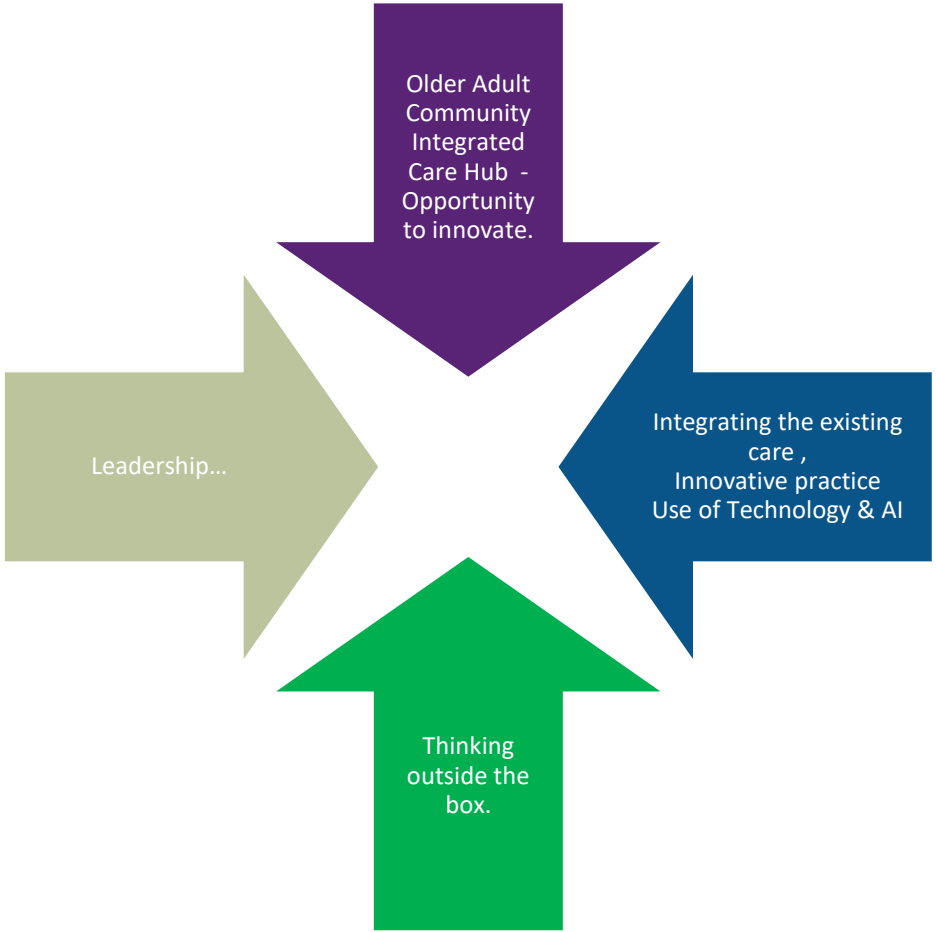
…first steps

- Implementation of the CIC Hubs will begin with leveraging existing services to initiate the transition of care away from hospitals.



Next Stage in Patient Care 2025/26 Geriatric Hub

Strategic Thinking & Planning
(Physical / Virtual / Philosophy)



Possible Model of HUB in SMHS – An integrated Service

Keeping Patients in Community

HOT clinics 7/7 access to Geriatricians (ambulatory)

Accessing Specialist knowledge (ASK)

Multidisciplinary team (MDT) clinics in community

Virtual Clinics in community / CO-HIVE

Specialist input in Residential Aged Care Facility (RACF)

Residential Care Line

Rehabilitation in the Home (RITH) / Hospital in the Home (HIH) / Connect

Community Aged Care Assessment Team (ACAT) process

Working with care Providers

Rapid access specialist clinics

Single point access

Hospital Care at SMHS

- Models of care in the hospital (CCE).
- Alternate Admission pathways.
- 7/7 Senior clinicians' input.
- Technology /Innovation
- Leadership
- Early supported discharge
- Hospital HOT clinics.
- Access to early specialist input including clinics.

Early supported Discharges

CHOICE

Rehabilitation in the Home (RITH)

Hospital in the Home (HITH)

Interim Hospitals Packages (IHP)

Fast Track Aged Care Assessment Team (ACAT) process

Community Transition Care Program

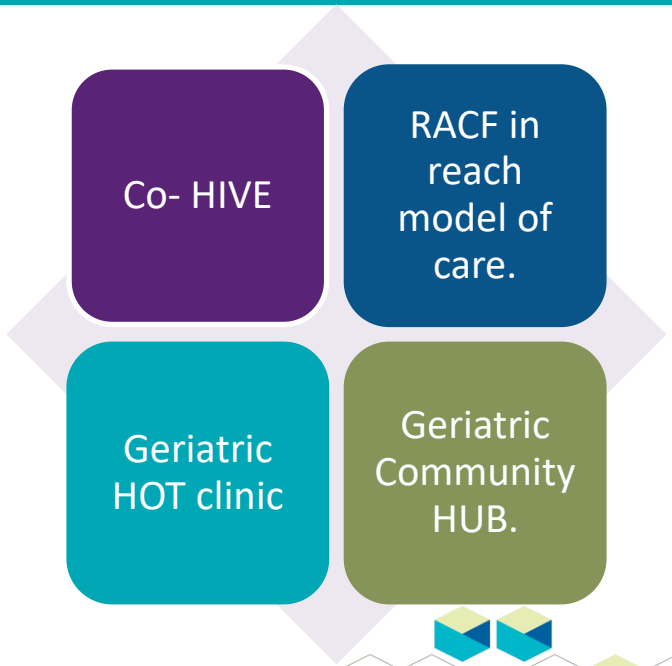
Residential Transition Care Program

Time to think beds

Supported discharge home waiting placement.

Involvement of Non-Government Organisation (NGO) & voluntary community services

Our Priorities over the next six months.



What is needed to make this a reality?

“If the only tool you have is a hammer , you tend to see every problem as nail”

In order to make this happen, we call for:

1.Commitment to implementing the principles set out above to deliver a high-quality person-centred care for older people.

2.Coordination and linkage of services to enable delivery of coherent and efficient services for people living in community.

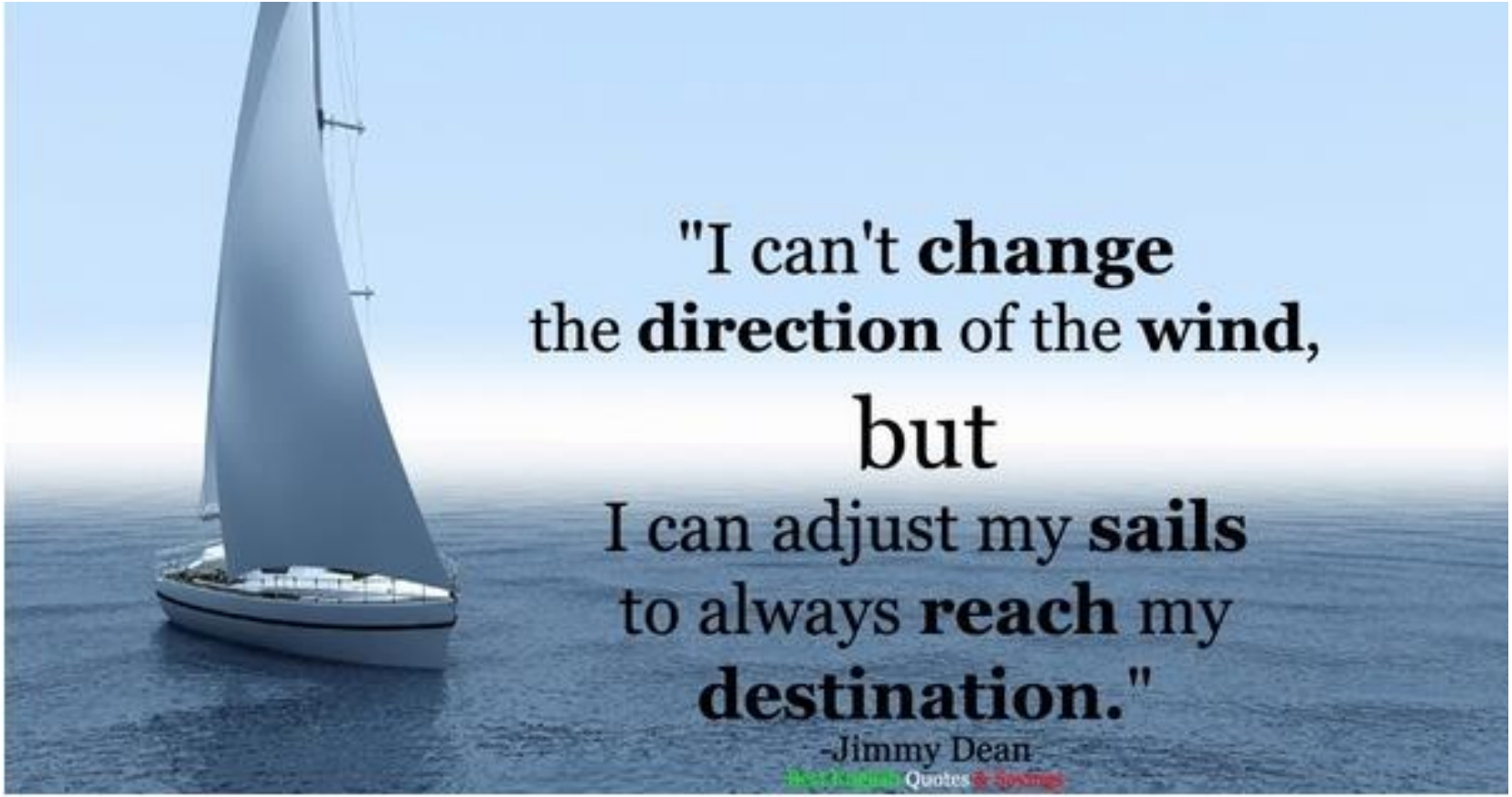
3.Sharing of good practice and avoid duplication and fragmentation of services.

4.Communication between providers so that proactive and reactive services are joined up.

5.Appropriate resources to be identified to ensure older person have clear, effective and sustainable alternatives to hospital admission where appropriate.

6.Investment in technology to ensure excellent communication between primary, secondary and community care.

7. Promoting Healthy aging.


"I can't change
the direction of the wind,
but
I can adjust my sails
to always reach my
destination."
-Jimmy Dean

Questions?

Like and follow **South Metropolitan Health Service** on **Facebook** and **Linkedin** to keep up with the latest news and information