Health Service Framework for Older People
2009-2016

Summary Document for
Allied and Scientific Health Workforce

* Please note this is a Summary Document only. For a complete version of the plan go to www.health.sa.gov.au/clinicalnetworks
Index

Overview .......................................................................................................................... 3
Planning better health services for older people ......................................................... 4
Planning Principles ....................................................................................................... 5
Service Delivery Enablers ............................................................................................ 5
  i. Supporting older people to take the best care of their health ................................. 5
  ii. Improved health promotion and primary care ...................................................... 6
The health service model for older people ................................................................. 6
Integrated services ....................................................................................................... 7
  i. Service locations .................................................................................................... 8
The team approach to providing older people’s health services ................................. 8
  i. Ambulatory and home based rehabilitative care .................................................... 9
  ii. Mobile support teams ......................................................................................... 9
  iii. Intervening in Emergency Department and Acute Medical Assessment Units ............................................................................................................................ 9
  iv. Transition care program and care awaiting placement ....................................... 10
  v. Research and Innovation .................................................................................... 10
Health workforce changes ......................................................................................... 10
Addressing the needs of specific populations ............................................................. 11
  Older people with dementia, delirium and cognitive impairment .......................... 11
  Meeting the needs of older people with mental health conditions ....................... 12
  Meeting the needs of older Aboriginal people ....................................................... 12
  Meeting the needs of people of culturally and linguistically diverse background .......................................................................................................................... 13
  Meeting the needs of older people in rural and remote areas ................................ 13
  Supporting carers ..................................................................................................... 14
  Palliative care services ............................................................................................ 14
  Working alongside other regionalised services ...................................................... 14
Key Initiatives and enablers of the Framework .......................................................... 15
Evaluating the outcomes of the Framework ................................................................ 16
  Statewide ................................................................................................................ 16
  Metropolitan specific ............................................................................................... 16
  Country specific ...................................................................................................... 16
Overview

The overall objectives of this Framework are to:

- maximise the period in which older people maintain good health and wellness
- compress the period in which they transition to ill-health, become frail and increasingly dependent on care
- deliver services and programs that keep older people out of hospitals and shift the balance of care toward care provided in the community
- deliver services that are integrated across the continuum of care and promote smooth transitions between the care settings that exists along that continuum
- position at the ‘right places’ along the continuum of care, the right types of services that specialise in care of older people in ways that ensure the sustainability and efficacy of those services
- reduce dependence on the health and aged sector over the long term and promote cost effective outcomes for SA Health.

The population of South Australia is ageing rapidly. South Australia has one of the highest proportions of older people in the nation, with one in six people over the age of 65. In 15 years, this rate will nearly double, as the “baby boomer” generation ages. The increase in the number of South Australians aged over 85 is expected to peak during 2010–2015 and is not expected to slow until 20202. Women are living longer than men with the number of women aged 80 years and over predicted to be almost double that of men in 2016. The population of older people across SA is scattered unevenly across SA and allocation of services for older people need to take account of this.

The risk of developing cancer, dementia and Parkinson’s disease or serious injury from falls also increases with age. When coupled with smoking and/or excess consumption of alcohol the risk is even higher.

The more chronic conditions an individual has, the greater the risk of serious illness and disability, injury from falls, reduced mobility, increased usage of health and community services (especially in the last two years of their life) and premature death. These conditions and the associated effects of polypharmacy affect an individual’s ability to stay active and retain their health and wellbeing.

South Australia’s Health Chronic Disease Action Plan describes the expanded and redesigned services that will be put in place to prevent and or manage avoidable chronic diseases. The Health Service Framework for Older People compliments this plan and includes specific services for older people with a range of chronic disease such as dementia.
Planning better health services for older people

This health planning approach values the importance of focusing on the transitions that older people will make as their health needs change. In this respect, phase changes such as ‘entering old age’, being diagnosed with a ‘age-related illness’ and those transitioning into an ‘end of life phase’ represent critical moments for rethinking the sorts of services, resources and intervention that are required, and just as importantly, where in the system these are best located or utilised.

In the early phase of the ageing process as older age approaches, a ‘window of opportunity’ is present to build health literacy and reinforce the foundations of healthy lifestyles. This can be achieved through eating and exercising well, taking advantage of a variety of disease prevention programs and services which aim to maintain and extend the healthy living well into later years. These programs and services are best located in the primary care sector.

For those older people who have just received a diagnosis of a chronic health condition, and may be experiencing the early stages of that illness, the goal is to provide the right programs and services that identify emerging health problems early and encourage the development of effective self-management skills. Again the best place for this to take place is in primary care settings.

The planning focus is directed toward the provision of flexible community-based care and support service responses that optimise functional and psychosocial independence to ensure that older people maintain the highest possible levels of independent living and social integration within their community.

The planning and delivery of appropriately targeted health care and support services to older people who are transitioning through areas of the hospital as their level of acuity changes are critical, as is the planning about what takes place outside hospitals (both before they are needed, and after they are used).

This requires integrated planning along the entire continuum of care including primary care, acute care, sub-acute, and across transitional, community and residential aged care settings. Across this continuum services will need to support and reinforce a wellness and self-management approach.

With these profiles in mind, older people will need varying service responses and differing supports to:

- stay well at home for as long as possible whilst adapting to age related changes with assistance as and when required
- have access to relevant, understandable, quality health information
- have timely access to primary health care services
- have timely access to health services for single acute episodes and or ongoing management of chronic conditions in the primary health care, ambulatory, out-of-hospital and in-hospital settings
- have timely access to interventional, rehabilitative, restorative and end of life care services as required.
The South Australian Government and SA Health have already begun the process of system-wide reform through the Generational Health Review and South Australia’s Health Care Plan.

These changes will ensure that older people have access to the best available health care in hospitals, health care centres, at ‘home’ and through an integrated team of primary care and specialist health practitioners and family/carers. The key directions outlined in the framework focus on:

- supporting older people to take the best care of their health
- strengthening partnerships across the in-hospital, community based and primary care sectors and residential and community aged care
- strengthening the preventative and restorative focus of health services to better meet needs of older people
- establishing coordinated specialist services to ensure high quality health care for older people with complex needs
- supporting informal care/carers.

**Planning Principles**

The reshaping of health services to meet the diverse health needs of older people reflects the following principles:

- healthy ageing and individual responsibility for health will be promoted and supported across the health system
- older people are central in the delivery of right care, at the right time by the right team and have the right to make their own decisions unless unable to do so
- maintenance of physical and cognitive function and prevention of functional decline are a priority across the care continuum
- services will assess and manage the diverse and complex needs of older people in suitable age friendly environments as close to home as possible
- communication and teamwork between health professionals, older people and carers will achieve coordinated, safe, quality and effective care including end of life care.

These principles have been adapted from relevant national and state policy directions and guidelines for the health care of older people.

**Service Delivery Enablers**

*i. Supporting older people to take the best care of their health*

An older person with a good health profile is usually the result of healthy genes, favourable socioeconomic, cultural and environmental circumstances, healthy lifestyles and good access to health care services. Good health for older people involves healthy ageing.
The wellbeing and social integration of older South Australians can be supported by:

- promoting the ‘health in all policies’ approach taken by the SA Strategic Plan
- implementation of the State Ageing Plan ‘Improving with Age’ in particular actions that strengthen healthy ageing
- promoting a positive image of older people in service planning and service delivery.

**ii. Improved health promotion and primary care**

Primary prevention strategies for older people are included in the SA Health Primary Prevention Plan. The foundations for healthy ageing are established early in life and continue throughout the lifespan.

This plan covers secondary and tertiary prevention, health promotion and early intervention strategies that help retain or regain the health and wellbeing of the older person consistent with their potential capacity. There is sound evidence that health is not fixed in childhood, small gains accumulated across the life span and preventative steps taken in middle age and older years can improve health and wellbeing.

The increasing prevalence of chronic diseases is linked to unhealthy lifestyles, particularly the consequences of under nutrition, obesity, smoking, alcohol and a lack of physical exercise. Exposure to ageism or elder abuse further threatens the health and wellbeing of older people. In addition, older people often find they have to cope with grief and loss associated with the death of life partners and others within their generation or community whilst contemplating their own mortality.

**The health service model for older people**

The integrated health service model described is person and family/carer centred. The service model spans the continuum of care and includes a specific focus on:

- promotion of healthy ageing and illness prevention
- early identification and management of lifestyle and age related risk factors
- effective management of chronic conditions and age related changes to enable people to remain at home for as long as possible consistent with their preferences
- promotion of advance care planning
- reducing unplanned admissions to hospitals
- timely comprehensive, interdisciplinary assessment and management of emergency and acute care and ongoing care needs
- appropriate restorative rehabilitation following illness or injury
- effective transition to community based aged care services for those requiring ongoing care
- end of life care that places an emphasis on quality of life, the relief of symptoms, support for family and the preservation of dignity at end of life.
SA Health will re-orientate services to improve health services for older South Australians. This means the health system will:

- promote mobility, independence and a positive outlook in older people
- support older people recover from illness and injury through restorative approaches
- provide specialised health services for those with complex health care needs.

As a result, older South Australians can expect that person-centred services will be delivered closer to home and be linked to appropriate community and aged care services as required. Effective partnerships between health and the community aged care sectors will support older people achieving:

- more healthy years of life
- enhanced function with reduced disability
- improved capacity for self care and self management of chronic diseases
- improved access to coordinated health services across the care continuum
- quality care, active symptom control and the preservation of dignity at end of life.

**Integrated services**

Effective collaboration across clinical settings and services, across disciplines and across the public and private sectors are hallmarks of system integration.

The key strategy of the Framework is the establishment of specialised interdisciplinary older people’s health care services that work across all care settings within a defined service catchment. This includes homes, residential care facilities, GP Plus Health Care Clinics, and the outpatient and inpatient areas (including rehabilitation services) of hospitals.

These regionalised older people’s health services will use a common model of care and approach to service delivery utilising an integrated interdisciplinary approach.

These regional teams will apply their collective specialist expertise, knowledge and skills at key points along the continuum of care and deliver a range of older people-specific services that will be integrated with, support and enhance those services provided by generalist, acute and primary health service partners.

As well as direct care they will also assume a system-wide leadership role in championing the redesign of specialised in-hospital and community services to better meet the needs of older people through:

- the piloting and evaluation of new and advanced practice roles
- service innovations, and
- building evidence to support best-practice models of care for older people in hospital settings, in community-based health centres and in residential settings.
Their wider brief is to improve, through a range of direct and indirect means, the health outcomes of older South Australians, influence patterns of service use, and build the capacity of others working within the system to provide care that better meets the needs of older South Australians.

**i. Service locations**

Three regional older people’s health services (Northern, Central and Southern) are planned for metropolitan Adelaide. The administrative centres of these three services will be located at the Modbury Hospital, The Queen Elizabeth Hospital and the Repatriation General Hospital. They will develop and maintain strong links with general practice, a wide range of health care services providing acute and chronic care and with residential care services and facilities within their catchment.

Seven regional older people’s health services are planned for country South Australia. These services will be developed at each of the four Country General Hospitals (Mt Gambier, Berri, Pt Lincoln and Whyalla), and at three key periurban centres (Barossa, Adelaide Hills and Southern Fleurieu).

The care of older Aboriginal people will be explored as the Pt Augusta Centre of Excellence in Aboriginal healthcare develops.

**The team approach to providing older people’s health services**

These interdisciplinary teams will have specialist knowledge and clinical expertise in the assessment and management of older people with complex, acute syndromes and chronic conditions. The interdisciplinary teams will include the following health professionals:

- geriatricians and advanced trainees
- aged care nurse practitioners and advanced practice nurses with mental health expertise
- allied health practitioners with geriatric and rehabilitation expertise
- social workers
- clinical psychologists and neuropsychologists
- clinical pharmacists.

These teams may also include, or have access to:

- General Practitioners with a special interest in care for older people
- rehabilitation specialists
- psychogeriatricians
- neurologists specialising in memory disorder.
i. Ambulatory and home based rehabilitative care
A proportion of older people gain little benefit from post acute rehabilitation and will require continuing supportive care in a residential care setting. In this instance the ongoing care plan, goals and discharge destination will be negotiated with that person, their caregivers and family.

Provision of rehabilitation services in the community is essential to ensure decreased hospital lengths of stay and enable older people to continue to rehabilitate in their own environments.

A flexible suite of ambulatory community based services with multiple access points will be available to older people, and will include day rehabilitation programs and rehabilitation in the home.

ii. Mobile support teams
Regional aged care services will provide mobile support teams that will:

- accept referrals from a community program or general practitioner
- operate across homes and residential care settings within their service catchment
- provide timely comprehensive physical and psychosocial health assessment of older people with a particular focus on older people at risk of an acute health crisis that requires hospitalisation
- undertake a range of screening and diagnostic investigations and clinical therapeutic interventions as needed, and
- negotiate and tailor a care plan and organise planned admissions in collaboration with the referrer and other primary care providers.

iii. Intervening in Emergency Department and Acute Medical Assessment Units
Regional Older People’s Health Services will position teams in the Emergency Departments and Acute Medical Assessment Units of major metropolitan hospitals and metropolitan general hospitals. They will screen all older people presenting to the Emergency Department to ensure early identification of the older person’s needs and identify appropriate strategies to improve outcomes.

Comprehensive assessment and restorative-focussed intervention will help to reduce unnecessary re-presentations to the emergency department, avoid inappropriate admission to hospital and reduce length of stay through early identification of co-morbidities such as pressure wounds, delirium and high falls risk.

The positioning of teams in all Emergency Departments and Acute Medical Assessment Units is a first order priority.
iv. Transition care program and care awaiting placement

Transition care services provide an effective alternative care option for supporting older people to maintain an independent lifestyle. These programs receive both State and Commonwealth funding to provide therapy, nursing support and/or personal care for short-term assistance following a hospital stay.

The current program supports approximately 1800 older people per year to access rehabilitation services and this will be expanded by an additional 171 Transition Care places over 2008–2011.

v. Research and Innovation

Each Regional Older People’s Health Service will be involved in research to improve health outcomes for older people. Working in conjunction with Universities and research foundations, SA Health will seek to increase focus on ageing research.

Health workforce changes

A skilled workforce is the foundation of an effective and responsive health system. SA Health will continue to invest in a workforce that delivers health services responsive to the needs of older people. New workforce arrangements and new ways of working together will be required to ensure high quality care for older people and to ensure health services are able to respond to the particular and diverse needs of older people.

They will include:

1. Working with Universities to develop and implement training and skill development programs that:
   • expand and extend the scope of practice of a range of disciplinary roles within the regional aged care teams to ensure that all roles are optimised and the capacity of interdisciplinary teams is sustainably enhanced over the long term
   • increase competence across the wider health workforce to recognise and eliminate ageism within the system, promote positive approaches to ageing, and to recognise and respond proactively to tipping points for older people at risk.
2. Support for clinical leaders in improving and expanding existing/future better practice service models.
3. Ensuring a suitable workforce is established and trained to meet these demands.
4. Exploring in collaboration with specialist and primary care service providers across community and aged care sectors:
   • the optimisation of all clinical roles and disciplinary contributions through the systematic development of new and emerging advanced practice roles
• improved ways of working with volunteers and carers to better meet needs of older people
• opportunities to expand and develop partnerships between teaching hospitals, teaching aged care centres of excellence, and relevant vocational and university partners.

The Australasian Faculty of Rehabilitation Medicine staffing formula suggests that the total ward-based staffing requirements for 254 inpatient beds is approximately 300 FTE of nursing, 32 FTE of physiotherapy 25 FTE of occupational therapy 15 FTE of social worker, 10 FTE of dietician and physician, and 0.5 FTE of speech pathology, clinical psychologist and neuropsychologists.

Additional FTE (particularly in the Emergency Department, mobile outreach, consultation, etc) will need to be determined through detailed service profiling and a comprehensive workforce strategy, developed as a component of work undertaken through the Statewide Geriatric Clinical Network.

Addressing the needs of specific populations

Older people with dementia, delirium and cognitive impairment

Anticipating and responding to the changing needs of people who experience deteriorating brain function from delirium and dementia and chronically progressive diseases like Parkinson’s remains a continuing challenge for the health and aged care system as a whole.

The anticipated growth in the rates of dementia is underscored by research from the Australian Institute of Health and Welfare, which reports that between 2003 and 2031, the number of people with dementia is projected to increase from 175,000 to 465,000; an overall increase of 166%.

SA Dementia Action Plan 2008–2011 has recently been developed by the South Australian Department of Families and Communities in consultation with SA Health. The Action Plan outlines a series of key actions and outcomes to be achieved across 5 priority areas aimed at improving health care for people with dementia and their families. The priority areas are: care and support, access and equity, information and education, research, and workforce and training.

Health and community services across South Australia will need to provide an integrated and collaborative response for the person with dementia, as their capacity for independence changes over time. As most people with dementia will continue living in their community, it is essential that health and community care service providers have the capacity to respond to the needs of these people. It is also important to strengthen support to carers to enable them to continue to care. Acknowledging the support that carers give to people with dementia is fundamentally important.
Meeting the needs of older people with mental health conditions

With an increasing ageing population, there will be greater demands on services to meet the needs of older people with pre-existing mental illnesses and those people who first develop mental illness later in life.

Older people who have a mental illness as a co-morbidity to other chronic conditions are less likely to achieve optimal management of their health. There is a need for an effective response to depression, the prevention of suicide and the underlying causes behind the social marginalisation of older people with mental illness.

Access to psychogeriatric advice will be available to the Older People’s Acute Assessment Services and Older People’s Acute Medical units through co-location in general hospitals with acute mental health units to facilitate consultation and liaison.

The SA Health Older Persons Mental Health Future Service Model outlines the key mental health issues for older people and the strategic priorities for older people’s mental health. It defines the scope and actions for future service delivery across South Australia.

Meeting the needs of older Aboriginal people

There is an ongoing challenge to ensure health services are responsive to the needs of Aboriginal and Torres Strait Islander peoples.

The numbers of older Aboriginal people is very small compared with the general population but their roles as elders are extremely important to Aboriginal and Torres Strait Islander societal wellbeing.

Many Aboriginal and Torres Strait Islander people have a lifespan that is up to 17 years shorter than other Australians. Whereas older people in the general population are considered to be over 65 years old, it is sometimes appropriate to plan and deliver services of this type to Aboriginal people as young as 50 years in order to ensure that they receive equitable services consistent with their needs.

SA Health will work in partnership with Aboriginal people (including elders) and key agencies to strengthen the health system’s ability to ensure respectful and culturally safe care to older Aboriginal people. This framework is aligned with the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013, SA Aboriginal Health Policy, South Australian Aboriginal Cultural Respect Framework and the SA Health Reconciliation Action Plan 2008–2010.

Implementation of an integrated person-centred service model will deliver in collaboration with Aboriginal people:

- health services for older people consistent with the Aboriginal Cultural Respect Framework principles
- culturally appropriate models of health care for older Aboriginal people aged 50 years and older that promote healthy ageing, self management and
access to general and specialist health care services (including grief and loss services) as close to home as possible

- partnerships with key agencies (Aboriginal Health Services and Aboriginal Community Controlled Organisations) that explore how the roles of traditional Aboriginal healers, elders and carers can be most effectively acknowledged and supported across the health care sector.

**Meeting the needs of people of culturally and linguistically diverse background**

The Framework recognises that older people come from a great variety of cultures and backgrounds. It is projected that by 2011, 20% of the South Australian population will consist of people of a culturally and linguistically diverse background.

Implementation of an integrated person-centred service model will deliver in collaboration with multicultural communities:

- cultural competence training across the mainstream health workforce to ensure services are able to provide an effective response to older people of culturally and linguistically diverse backgrounds
- improved access to general and specialist health services for older people culturally and linguistically diverse backgrounds
- effective and early use of the health care interpreter service by clinical staff.

**Meeting the needs of older people in rural and remote areas**

A key issue confronting people living in peri-urban, rural and remote areas is timely access to health and aged care services. The outcomes of further planning in Country Health SA will enhance the care provided to older people in country communities.

To ensure country services are able to respond to the particular needs of older people, Country Health SA will:

- establish formal links to metropolitan specialised health services for older people to increase availability of specialist visiting consultations and use of telemedicine
- systematically develop partnering relationships between metropolitan and country aged care services to ensure improved equity of access and outcomes for all older South Australians
- implement specialist programs to help their staff understand the special needs of older people who become ill
- establish systems to improve collaboration between health professionals to ensure older people get the right care, in the right place, at the right time, by the right care providers
- further develop dementia care services
• explore options to provide care as close to home as possible while regaining independence following acute illness or surgery.

**Supporting carers**

Partners, families, live-in carers, neighbours and friends play vital roles in assisting frail older people to live independently in their homes. This Framework recognises carers of older people as well as carers who are older. There is particular recognition of the invaluable contribution of ‘family carers’.

Carers often have knowledge about the health and well being circumstances of the older person and it is therefore vital they are included in care planning processes. This framework recognises that carers face significant difficulties in providing support to family members while confronting a range of complex circumstances including emotional, health and financial difficulties.

Implementation of integrated person-centred service model and collaboration with Carers SA, Council On The Ageing (COTA), SA Department for Families and Communities, Australian Government Department of Health and Ageing and the aged and community care sector will deliver:

• a workforce that understands the ‘carer role’ and its associated challenges, responds effectively to carer needs and works together with them in providing quality care for older people
• supported carers able to deliver the care needed by the older person
• improved identification of the carer throughout the health system

**Palliative care services**

Much of the end of life care of older South Australians will be provided by those services that have had a continuing role in their care. Palliative care services support the work of all those who provide end of life care. Wherever the symptom control or psychosocial support needs of older South Australians exceeds the skills, capacity or resources of their usual care providers, palliative care services will be available to ensure high quality end of life care remains in place for all people regardless of age, diagnosis or setting of care.

*Palliative Care Services Plan 2009–2016* sets out in more detail the role of specialist providers of palliative care and their relationship to aged care services and other providers of end of life care.

**Working alongside other regionalised services**

Each of the Regionalised Older People’s Health Services set out in this Framework shares the same service catchment with a number of other regionalised services including palliative care. For both of these services, key tasks related to population-based service-level planning, and outcomes evaluation overlap, suggesting a need for shared planning and analysis and high levels of inter-service collaboration and open lines of communication. Formal service-level arrangements, close working relationships and well designed
referral pathways will need to be in place to ensure continuity of care for older people at end of life and the coordination of service contributions by the teams working across the same hospital, community and residential care settings.

Key Initiatives and enablers of the Framework

Statewide initiatives
1.1 Establishing a statewide geriatric clinical network.
1.2 Strengthening primary health services to better meet the needs of older people.
1.3 Using a shared model of care and common approach to service delivery.
1.4 Rolling out an ‘Informed Choices Program’ across the state.

Service level redesign initiatives
2.1 Establishing three metropolitan and seven country regional older people’s health services.
2.2 Configuring Older People’s Assessment and Management units in each Metropolitan and Country General Hospital.
2.3 Establishing Older Persons Acute Assessment Services in each Major Metropolitan Hospital and in all Major and General Hospital Emergency Department.
2.4 Developing community-based rapid response capacity across each regional older people’s health services catchment.
2.5 Greater integration between regional older people’s health services and transitional care programs including new governance and support arrangements.

Collaborative enablers
3.1 Establish an SA Health for Older People Interface Group.
3.2 Strengthening service partnering arrangements across the state.

Workforce initiatives and enablers
4.1 Developing a statewide older people’s health services workforce strategy.
4.2 Growing the established workforce.
4.3 Exploring and using new and emerging roles.
4.4 Proliferating advanced practice roles.

Quality, data, reporting initiatives
5.1 Developing capacity to report on the quality and outcomes of care of all older people.
5.2 Implementing a statewide quality program.
5.3 Establishing a statewide reporting cycle.
5.4 Putting in place IT solutions & support.

Research and education initiatives
6.1 Establishing a statewide population-based aged care research collaborative.
6.2 Using a statewide approach to education, training support and practice development.
Evaluating the outcomes of the Framework

Will occur at key points across the life of the Framework and include:
> the ongoing piloting and adaptation of system and service-level reforms and innovations
> a 2012 midpoint report, and
> a new statewide strategic plan for 2017 and beyond.

The anticipated program of work required in 2008-09 includes the following areas:

Statewide
- The establishment of the statewide clinical leadership framework for older people’s health service provision (Statewide Geriatric Clinical Network).
- Establish SA Health for Older People Interface Group to continue collaboration between health, community and aged care sectors.
- Develop a detailed specialist workforce profile and implement a range of workforce initiatives that recruit and develop specialist older people’s health practitioners.

Metropolitan specific
- The formation of the 2 Level 6 services in CNAHS and 1 for the SAHS catchment. This will require bringing together the separate teams currently located in different hospitals and services in the community to form regionalised services.
- Develop processes needed to enable clinicians to work across multiple care facilities including the provision of acute assessment and management capacity in each Metropolitan Hospital Emergency Department.
- Systematically extend early assessment and intervention capacity beyond the Emergency Department into community settings with a rapid response capacity focussing on older people at risk of hospitalisation.
- Establishment of Acute Assessment and Management units in the general hospitals within the service catchment of each Level 6 service.

Country specific
- Development of Acute Assessment and Management units in country Level 4 sites.
- A workforce development strategy that focuses on the development of aged care specific or blended nurse practitioner roles across the Level 4 older people’s health services in country SA.