CHAPTER 7

TRANSITIONAL CARE

> *There [needs to] be a better integration of aged care and the acute sector to achieve a continuum of care interface to provide the most appropriate and cost effective care.*[1]

7.1 This chapter discusses the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

7.2 Evidence to the inquiry emphasised the importance of effective Government initiatives at the acute-aged care interface to improve the health and independence of older people who experience a hospital stay, and increase the likelihood of older people returning home rather than entering residential aged care.[2] The Australian Medical Association illustrated the problem in graphic terms:

> Thousands of Australians are trapped in the wrong environment for the type of care they need. There are many people in hospital who no longer need acute care, but are unable to care for themselves at home and cannot access appropriate residential or community care. Similarly, there are people in nursing homes who should be in hospital, and people in the community who ought to be in either hospital to treat particular conditions, or in aged care homes.[3]

Introduction

7.3 In February 2001, Commonwealth and State/Territory Health Ministers agreed to jointly examine the acute-aged care interface through collaborative work progressed by the all-jurisdiction Care of Older Australians Working Group (COAWG) under the Australian Health Ministers' Advisory Council. Since then COAWG has completed a work program, including a national census of older people in public hospitals, a stocktake of innovative service delivery models at the acute-aged care interface and a mapping exercise of service provision for older people in the hospital and aged care sectors.

7.4 In 2003-04, COAWG developed a National Action Plan for Improving the Care of Older People Across the Acute-Aged Care Continuum, covering the period 2004-2008. Transition care is an important area addressed in the National Action Plan.

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1 *Submission* 166, p.17 (CHA).

2 The acute-aged care interface refers to the transition of frail older people from hospitals to home or residential aged care.

3 *Submission* 129, p.8 (AMA).

Commonwealth Government initiatives

7.5 The Commonwealth Government has introduced a number of initiatives to assist frail older people following a hospital episode. These include the Transition Care Program, the Pathways Home Program and the Aged Care Innovative Pool. Through these initiatives, the Government aims to work with the States and Territories to assist older people in making a smooth transition from hospital to home or other long-term care arrangements.

7.6 The need for more flexible care arrangements was highlighted by the Review of Pricing Arrangements in Residential Aged Care (the Hogan Review).

> In the main, the current planning arrangements for the release of new aged care places are not able to respond as flexibly as is desirable for the development of new care approaches or to encourage innovation in service delivery. This has been addressed to an extent by the introduction of the Innovative Pool of flexible care places, which has trialled services linked to the acute care-aged care interface, the disability-aged care interface and dementia care. These opportunities should be enhanced.[4]

Transition Care Program

7.7 The Commonwealth in the 2004-05 Budget announced the establishment of a national Transition Care Program to assist older people after a hospital stay. The Government has committed to expanding the Transition Care Program to 2000 flexible aged care places by 2006-07. In the 2005-06 Budget, the Government announced that that it will allocate 1500 places by the end of 2005-06.[5]

7.8 Under the program, transition care is provided for older people with low level rehabilitation and support to improve their independence and confidence after a hospital stay. It will also allow older people and their families time to determine whether they can return home with additional support from community care services or need to consider the level of care provided by an aged care home. Transition care is provided in either a residential or community setting. It is estimated that the average period of care will be 8 weeks, meaning that when fully established in 2007 the Program will assist up to 13 000 older Australians each year.[6]

7.9 Recent amendments to the *Aged Care Act 1997* also provide that in cases where residents of aged care homes temporarily leave the facility for transition care, their places will be kept in the facility until their return.[7]

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4 Hogan WP, *Review of Pricing Arrangements in Residential Aged Care, Final Report*, Canberra 2004, p.277.

5 *Portfolio Budget Statements 2005-06*, Health and Ageing Portfolio, p.83.

6 *Submission* 191, pp.61-62 (DoHA).

7 *Aged Care Amendment (Transition Care and Assets Testing) Act 2005.*

Pathways Home Program

7.10 The Commonwealth funds the Pathways Home Program under the 2003-08 Australian Health Care Agreements. The Program provides one-off capital and infrastructure funding of $253 million over five years to assist States and Territories to expand their provision of step down and rehabilitation care.

7.11 The Minister for Health and Ageing, as at July 2004, has approved a range of projects across New South Wales, Victoria, Queensland, Western Australia, South Australia, Tasmania and the ACT, with a total value of $249 million. The Department of Health and Ageing (DoHA) stated that individually and in combination, these projects will substantially improve the number and quality of rehabilitation and stepdown services that patients will be able to access. All the projects were designed by the States and Territories to ensure that they meet local needs, and the States and Territories will meet the ongoing recurrent costs of their projects.[8]

Innovative Pool

7.12 The Aged Care Innovative Pool, established in 2001-02, is a national pool of flexible care places available for allocation to innovative services outside of the Aged Care Approvals Round. This Pool allows the Commonwealth Government, in partnership with other stakeholders, to allocate places to services that will pilot the provision of aged care services in new ways and via new models of partnership and collaboration.

7.13 Projects that are approved under the Innovative Pool have clear client eligibility criteria, controlled methods of service delivery and are time-limited. Evaluation is an integral element of all projects involving alternative service models.

7.14 Under the Innovative Pool, the Commonwealth and State and Territory Governments provided funding for Innovative Care Rehabilitation Services (ICRS) pilots in 2001-02 and 2002-03. The Commonwealth provided funding for short term personal and nursing care and the State/Territory government provided funding for intensive rehabilitation support for these pilots. In 2001-02 nine ICRS pilots were approved, with a total of 341 places and in 2002-03 a further three ICRS pilots were approved with 52 places.

7.15 In 2003-04, Intermittent Care Services were a focus of the Innovative Pool. The target area of Intermittent Care Services is a broad category focussing on short-term interventions for older people who require additional support to remain in, or return to, their own homes (and avoid entry to residential aged care or hospital) when they experience a change in circumstance or care needs. It is intended to be similar in operation to the short-term, post-hospital rehabilitation category in the 2002-03 ICRS pilots but wider in scope, particularly in terms of the eligible client group it addresses and the services that can be provided. The services to be provided to clients could

8 *Submission* 191, p.62 (DoHA).

include a range of assessment, rehabilitation, treatment, guidance and case management services, intended to determine what the most appropriate long term care arrangement is for the client, and equipping them as well as possible to benefit from that arrangement. In 2003-04, six ICRS pilots were approved, with a total of 396 places.[9]

Effectiveness of programs

7.16 Submissions generally supported these Commonwealth transitional care initiatives although some concerns were raised, especially in relation to the scope of the programs. Catholic Health Australia characterised the programs as 'fragmented' and argued that 'these disparate arrangements will not be sufficient in the medium to longer-term' to meet the needs of the elderly.[10] The Queensland Government also noted that the Commonwealth, in creating special programs, has further fragmented the system and made it more difficult for clients, service providers, and health professional 'to find the right care in the right place at the right time'.[11] The Government also commented that while these programs operate at the health and aged care interface they do not resolve the 'key problems' of the shortages of residential aged care beds or the need for high support care packages in the community.[12]

7.17 The Tasmanian Government, while welcoming the Transition Care Program, noted that it will impose 'rigorous reporting requirements around the utilisation of any approved places and a requirement for some level of State contribution'. The Government also argued that the Pathways Home Program is 'restrictive' in its permitted application of funds.

> The investment must be in step-down and rehabilitation services, with a strong emphasis toward capital expenditure on new infrastructure or refurbishment of existing infrastructure. As a consequence, innovative proposals for Tasmania targeting local needs cannot be met with funds under this program.[13]

7.18 Submissions emphasised that transitional programs need to be developed in partnership with the different levels of government and non-government community agencies with input from district health services and divisions of general practice to ensure a consistent integrated approach.[14]

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9 *Submission* 191, p.63 (DoHA).

10 *Submission* 166, p.16 (CHA).

11 *Submission* 193, p.22 (Queensland Government).

12 *Submission* 193, p.3 (Queensland Government).

13 *Submission* 200, p.9 (Tasmanian Government).

14 See, for example, *Submission* 116, p.8 (Blue Care).

State Government and other initiatives

7.19 The States have implemented a number of initiatives to assist with the transition of the elderly from acute hospital settings to aged care settings or back to the community. These initiatives often involve partnerships with hospitals and service providers. The examples referred to below do not cover all programs but are illustrative of a range of initiatives currently undertaken. Initiatives in the private sector have also been undertaken.

7.20 NSW Health has developed a special program, called ComPacks, to provide assisted discharge and post-discharge care to selected in-patients at risk of unnecessarily protracted hospital stays because of high community support needs. Under the pilot program, case managers work with multidisciplinary hospital and community health teams prior to a patient's discharge to identify the patient's in-home care needs and put in place customised community care packages comprising services which will allow the person to return home safely with the support they require.[15]

7.21 Submissions commented on the effectiveness of this pilot. ACOSS argued that results of this program to date have been 'very successful' and ACOSS urged the Commonwealth to support such initiatives more widely.[16] Aged and Community Services (ACS) of NSW & ACT also commented that the program 'could potentially be used to facilitate the more effective discharge of older people from hospital to residential care facilities'.[17]

7.22 In Victoria, the Government funds a number of initiatives including a well-developed sub-acute service system that includes both an inpatient and community focus – with a particular focus on rehabilitation services and inpatient geriatric evaluation and management services. The Government also has developed a targeted Interim Care Program that provides temporary support and active management of older patients who have completed their acute or sub-acute episode of care, have been recently assessed by an Aged Care Assessment Service and recommended for residential aged care, and are suitable for immediate placement in a residential care facility if a place were available.[18]

7.23 One submission noted that the Victorian Government has been 'particularly pro-active' in developing and funding initiatives in the area of transitional care.[19] COTA National Seniors noted that an evaluation of the Interim Care Program found

15 *Submission* 202, p.24 (DADHC/NSW Health).

16 *Submission* 172, p.6 (ACOSS). See also *Committee Hansard* 11.3.05, p.48 (NCOSS).

17 *Submission* 170, p.19 (ACS of NSW & ACT). See also *Submission* 204, p.22 (NCOSS).

18 *Submission* 180, p.13 (Victorian Government).

19 *Submission* 66, p.4 (ANF - Victorian Branch).

that increasing numbers of older people were able to return home following rehabilitation with increased physical functioning and an improved quality of life.[20]

7.24 In South Australia, the Acute Transition Alliance (ATA) pilot program is a partnership between the State and Commonwealth Governments, public hospitals and aged care providers. The program provides short term community support services and rehabilitation either in a person's own home or temporarily in an aged care facility to improve the physical functioning of older people following a hospital stay. Another program, City Views, provides a residential transition care facility offering specialised rehabilitation and care services to support recovery and provide transition pathways into the aged care system which aims to reduce hospital stays and improve outcomes for older people awaiting residential placement. ACS SA & NT argued that both programs have produced 'excellent outcomes in terms of both benefits to consumers and the hospital system'.[21]

7.25 Another program in South Australia, GP Homelink, is a short-term, community based health crisis intervention program aimed at avoiding older persons' admission to public hospitals. The program works in conjunction with GPs and public hospitals to provide external assistance and support to older people who would otherwise be admitted to hospital. The Hogan Review commented that this project is a 'most useful pilot study' to aid the elderly and 'has much potential for helping the elderly stay in their own homes'.[22]

7.26 Submissions noted that there is a continuing need to provide incentives to take these various pilots programs and convert them into mainstream services especially where the programs have demonstrated service improvement and enhanced systems efficiency.[23]

7.27 Private sector initiatives were also noted during the inquiry. The Village Life model provides a form of 'transitional care' between independent living and low care nursing. Village Life Ltd, which is a listed public company, provides managed rental accommodation for low income retirees not currently provided for in retirement village facilities, mainly because of financial barriers. Residents pay rent equal to the standard single age pension plus rent assistance and are provided with a furnished unit and daily living assistance in areas such as shopping and meal preparation, home maintenance and heavy laundry. Village Life aims to provide quality lifestyle options with the aim of delaying entry into aged care facilities by approximately five years. At

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20 *Submission* 174, p.17 (COTA National Seniors).

21 *Submission* 125, pp.12-13 (ACS SA & NT). See also *Submission* 174, p.17 (COTA National Seniors); *Committee Hansard* 22.2.05, pp.5-6 (ACS SA & NT).

22 Hogan Review, p.257.

23 See, for example, *Submission* 74, p.15 (ANHECA).

present there are 4000 residents in 70 villages throughout Australia. The average age of residents is about 75 years.[24]

7.28 Some criticisms of the model were made. One witness noted that it did not provide for continuity of care, especially once an elderly person's care needs increased and that the model would be difficult to apply in situations where elderly residents developed dementia.[25]

Issues

7.29 A number of issues were raised in relation to the acute-aged care interface and these are discussed below.

Discharge planning

7.30 Evidence indicates that for older people early discharge from acute settings back into the community or to residential care can be very difficult unless there is adequate follow-up and access to significant formal and informal support including short and long-term residential and/or community care.[26]

7.31 Evidence indicated that discharge planning needs to be significantly improved. The Royal District Nursing Service (RDNS) argued that the quality of discharge planning in the acute sector is 'erratic' and frequently fails to recognise the needs and issues faced by clients on their return to their homes. This often leads to distress for clients and their families and even readmission to acute care, an event that may have been avoided with better planning and communication between the acute and community services.[27]

7.32 NCOSS also noted that it appears to be assumed by hospitals that because community care services exist, there will be adequate supports for people returning home, despite the fact that community care was never intended to respond to the needs of people with sub-acute needs and is not designed as a quick response solution to early discharge.[28]

7.33 UnitingCare Australia also commented that:

> The inadequacy of effective discharge planning for older people leaving hospital and the lack of timely and effective multi-disciplinary intervention in the post-acute phase places a huge burden on the acute hospital system, the residential and community care sectors and, most importantly, on older

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24 *Committee Hansard* 18.3.05, pp.23-32 (Village Life).

25 *Committee Hansard* 11.3.05, pp.30-31 (The Benevolent Society).

26 *Submissions* 150, p.23 (VAHEC); 204, p.22 (NCOSS); 79, pp.13-14 (CPSA).

27 *Submission* 51, p.4 (RDNS).

28 *Submission* 204, p.22 (NCOSS).

> people and their carers. This burden is exacerbated where people have multiple vulnerabilities, or are isolated from supportive communities.[29]

7.34 Submissions noted that planning for discharge should be coordinated across a range of medical, allied health and community care professionals and involve the older person, their families and carers.[30] ACOSS noted that 'evidence to date is that this rarely occurs in ways that provide security and comfort to the older person, seamless service provision and optimal health and emotional outcomes'.[31]

7.35 The RDNS commented that standardising and formalising of referral protocols between the acute and community sectors may offer some means of addressing this issue and would be an initial step in future developments such as the electronic exchange of information.[32]

7.36 COTA National Seniors stated that post discharge community care services are inadequately resourced and poorly planned. COTA argued that the Commonwealth, in conjunction with the States, should develop a national framework for discharge planning and the provision of post acute and convalescent services and facilities, including those in the community – 'they could ensure that adequate discharge, post acute, convalescent and rehabilitation support services back up acute hospital services and facilities. Finally, they could ensure that hospital patient discharge remains a medical decision, not a financial one'.[33]

Common assessment processes

7.37 Submissions argued that common assessment procedures for patients need to be implemented across the various health sectors.[34]

7.38 The Australian Nursing Homes & Extended Care Association (ANHECA) argued that there is significant scope to improve communication between the acute and residential sectors through the adoption of advanced IT systems and the integration of other health-specific IT systems to assist in the communication channels between the two sectors.

7.39 The Association argued that it is essential, that a patient being transferred from acute to residential care have information forwarded at the time of transfer, detailing a recommended medication regime, any diagnostic results, and any suggested treatment regime that needs to be applied in the future. Similarly, a resident

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29 *Submission* 57, p.15 (UnitingCare Australia).

30 *Submission* 203, p.19 (NSW Aged Care Alliance).

31 *Submission* 172, p.6 (ACOSS).

32 *Submission* 51, p.4 (RDNS).

33 *Committee Hansard* 27.4.05, p.31 (COTA National Seniors).

34 *Submission* 61, p.12 (Melbourne Citymission).

being transferred from the residential to the acute sector should have information forwarded to the hospital at the time of transfer providing the patients' medical problems and supplying an up-to-date copy of the resident's medical history to avoid unnecessary duplication of patient information on presentation to the hospital.[35]

7.40 This Committee' s report *Healing our Hospitals* noted that there is increasing recognition across the health sector of the potential benefits of electronic health records in improving efficiency, safety and quality of care over paper-based systems.[36] At the national level the Commonwealth has been working with the States to develop Health*Connect*, a national health information network, which is expected to lead to integrated patient records across the health sector. The recent June 2005 Council of Australian Governments (COAG) Meeting noted that the health system could be improved by accelerating work on a national electronic health records system.[37]

Rehabilitation

7.41 Submissions argued that rehabilitation services for people leaving hospital need to be expanded. The Australian Nursing Federation (ANF) commented that rehabilitation is an essential part of the transition process. Rehabilitation incorporates the skills of a multidisciplinary team such as nurses, medical specialists and allied health professionals. The ANF noted that rehabilitation of older people following an acute health episode requires expert knowledge and care, and any program needs to factor in the resources needed to employ professionals in the field.[38]

7.42 The NSW Aged Care Alliance stated that geriatric rehabilitation is 'essential' at the interface between acute in-patient care and the next phase, whether it be transitional care, home or residential care. The Alliance also suggested that geriatric rehabilitation facilities should be available for those older people living in the community who have developed disabilities, which may be remediable without admission to the acute hospital system.[39]

Lack of residential aged care places

7.43 Submissions noted that the effectiveness of transition strategies depends on a number of complementary strategies, including the provision of an adequate supply of residential aged care places.

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35 *Submission* 74, pp.14-15 (ANHECA).

36 Senate Community Affairs References Committee, *Healing our Hospitals*, December 2000, p.176.

37 COAG, *Communique*, 3.6.05.

38 *Submission* 201, p.27 (ANF). See also *Submission* 170, p.18 (ACS of NSW & ACT).

39 *Submission* 203, p.19 (NSW Aged Care Alliance).

7.44 The Victorian Government stated that:

> The lack of available residential aged care beds, especially high care places, puts extreme pressure on available hospital beds. The effectiveness of transition arrangements for the elderly from acute hospital settings to aged care settings will depend upon the provision of more high care places.[40]

7.45 In the 2004-05 Budget, the Commonwealth provided $58.4 million over four years to increase the aged care provision ratio from 100 operational places for every 1000 people aged 70 years or over, to 108 operational places. The balance within the provision ratio was also re-weighted to double the proportion of places provided in the community (from 10 to 20 places). The proportion of places provided as high level residential care remained the same – at 40 places for every 1000 people aged 70 years or over. The 2004-05 Budget provided for an estimated 27 900 new aged care places to be allocated over the next three years, including 13 030 in 2004. In the 2005-06 Budget it was announced that a further 11 426 new aged care places will be released in 2005, including 5274 residential places, 4352 CACPs and 1800 flexible care places.[41]

7.46 In a joint submission from the Department of Ageing, Disability & Home Care (DADHC) and NSW Health it was noted that while the Commonwealth increased its allocation of residential aged care beds to the States in the 2004 Budget, the inadequate growth in funded residential aged care places and the considerable lag time between residential aged care beds being approved and becoming operational poses problems. At the same time, the demand for assessments of older people for aged care places has been increasing – 'put simply, there are insufficient aged care places to meet the demand'.[42]

7.47 The Committee questioned DoHA as to why the Government continues to fund low-care places in residential aged care where there is relatively less demand compared with the high level of demand for high care places. The Department argued that the policy of ageing in place 'means that you enter as low care and then you become high care'.[43] The Committee questioned this argument noting that while more aged people are using CACPs or HACC services, when they enter residential aged care they are increasing entering as high care residents.

7.48 The Department provided data that shows that of those that entered permanent residential aged care in 2002-03, 61 per cent of admissions were at the high care level and 38 per cent were at the low care level. The Department stated that not all people entering residential aged care at the low care level become high care residents. Of those that enter care at the low care level, 65 per cent move to high care and 35 per

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40 *Submission* 180, p.12 (Victorian Government).

41 *PBS 2005-06*, Health and Ageing Portfolio, p.83.

42 *Submission* 202, pp.22-23 (DADHC/NSW Health).

43 *Committee Hansard* 11.2.05, p.77 (DoHA).

cent are discharged while still at the low care level. Of those who do move to high care, the average period in low care is 35 months.[44]

Co-ordinated approach

7.49 Evidence suggests that transitional care needs a more coordinated and strategic policy and funding commitment to meet future needs. DoHA noted that the acute-aged care interface is one of a number of areas where Commonwealth funded and State/Territory funded programs intersect and acknowledged that 'there are significant opportunities for the Australian Government and States and Territories to work together to ensure better outcomes for older people faced with this transition'.[45]

7.50 The recent June 2005 COAG Meeting acknowledged that the elderly face problems at the interfaces of different parts of the health system and recognised that the health system could be improved by:

- simplifying access to care services for the elderly and people leaving hospital;
- helping public patients in hospital waiting for nursing home places; and
- improving the integration of the health care system.[46]

COAG agreed that senior officials would consider these ways of improving the health system and report back to it in December 2005 with a plan of action to progress these reforms.

7.51 Submissions noted that progress towards a continuum of care for older people requires strategies for the integration of primary care, community care, health promotion, rehabilitation, acute care, sub-acute care and residential care.[47]

7.52 State Governments and departments commented that the division of Commonwealth-State responsibilities in the areas of aged care and health poses difficulties in implementing effective transitional care programs. The Queensland Government argued that arrangements for these programs remain 'fundamentally flawed' – 'for many years there have been significant disputes between the two levels of government over the interface between acute and residential care'.[48]

7.53 DADHC/NSW Health noted that the Commonwealth needs to focus on fundamental reforms at the health and aged care interface and adopt a 'whole-systems' approach.

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44 *Submission* 191, Supplementary Information, 26.5.05 (DoHA).

45 *Submission* 191, p.61 (DoHA).

46 COAG, *Communique*, 3.6.05.

47 *Submissions* 173, p.9 (ACSA); 150, p.23 (VAHEC). See also *Committee Hansard* 23.2.05, pp.3-4 (Centre for Research into Aged Care Services).

48 *Submission* 193, p.22 (Queensland Government).

> What is required is an effective whole-systems approach to health and aged care…The progression in program and service integration across acute care, residential care and community care for older people has been slow and generally services and funding arrangements still remain inevitably fragmented, complex and inflexible.
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> …[without change] the challenge to manage growth in demand efficiently, service duplication and gaps, and ensuring older people have access to services in the right place and at the right time will continue. The cost shifting between jurisdictions, and the requirement to focus resources on managing program complexities, will also continue.[49]

7.54 The Hogan Review also commented generally on the duplication and overlap in the delivery of services to the aged.

> Where programs are intertwined to the extent that health and aged care services are, it is essential that significant effort is expended on minimising overlap and duplication, providing a single point of access for consumers and maximising coordination and communication.[50]

7.55 The review argued that enhanced service delivery is needed and noted that the following broad principles should be followed, including:

- improvements to lines of communication with the States;
- further development of, and support for, joint pilot programs such as the Acute Transition Alliance and flexible funding options; and
- further consideration and development of joint Commonwealth-State Government programs, where the Commonwealth contributes funding to a greater or lesser extent and the State delivers the program.[51]

Conclusion

7.56 A number of initiatives have been undertaken at the Commonwealth and State levels towards improving the effectiveness of current arrangements for the transition of older people from hospital settings to aged care settings or back to the community. While these initiatives are welcome, evidence suggests that a more co-ordinated approach needs to be adopted between different levels of government to address a system that remains fragmented and ill-equiped to meet the transitional care needs of the elderly now and into the future.

7.57 Evidence suggests that in a number of areas from discharge planning, assessment procedures and rehabilitation services significant improvements are needed. The effectiveness of transitional programs also depends on a number of complementary strategies, including the provision of an adequate supply of residential

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49 *Submission* 202, pp.21-22 (DADHC/NSW Health).

50 Hogan Review, p.260.

51 Hogan Review, p.261.

aged care places. Both Commonwealth and State and Territory Governments need to work together collaboratively towards the implementation of a system that delivers a continuum of care providing the most appropriate and cost effective care across the acute-aged care interface.

Recommendation 48

7.58 That the Commonwealth and the States and Territories improve coordination in the development and implementation of transitional care programs, and that the development of programs include input from the community sector and health professionals.

Recommendation 49

7.59 That the results of innovative pilot programs funded by the Commonwealth and the States and Territories be widely disseminated and that mechanisms be developed to coordinate information about these pilots across jurisdictions so that innovative models of transitional care can be more readily developed based on these models.

Recommendation 50

7.60 That, the Commonwealth, in conjunction with the States and Territories, develop a national framework for geriatric assessment and discharge planning and the provision of post-acute and convalescent services and facilities, including community services; and that discharge planning be coordinated across a range of medical, allied health and community care professions and involve the patient, their family and carers in the development of these plans.

Recommendation 51

7.61 That common assessment procedures for patients be implemented across the various health sectors so that medical records and diagnostic results can be easily transferred across these sectors.

Senator Gavin Marshall
Chair
June 2005