Clinical issues in aged care: Managing the interface between acute, subacute, community and residential care

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Abstract

Although there is considerable evidence for the use of geriatric assessment and rehabilitation in many clinical settings, there exists relatively poor access in various regions of Australia. There has been considerable growth of community support services to assist in personal care of older people. Unfortunately, a lack of uniform assessment has hindered prioritization of clients, with the resultant need, and delivery, of post-acute hospital care services. In addition, there has been considerable progress in the clinical management of the age dependent disabling problems, such as dementia, osteoporosis, incontinence and falls, but the appropriate mix of funding between primary, secondary and tertiary interventions has not been determined. The health care needs of older people in residential care have been totally neglected, placing the sector at considerable risk. There need to be a fundamental rethink in managing the interface between acute, subacute, community and residential care.

The science underlying the modern practice of aged care is complex and rapidly developing. Early reports of the benefits of geriatric medicine and rehabilitation, were followed eventually by convincing evidence of this approach (Warren 1946). In 1984, a randomised trial of the effectiveness of a geriatric evaluation unit was reported (Rubenstein et al 1984). Patients who had been assigned to the geriatric unit had lower mortality, were less likely to have spent any time in a nursing home during the follow-up period and had greater improvement in functional status and morale (Rubenstein et al 1984). Since then, other studies have been performed and a systematic review and meta-analysis has confirmed the benefits of inpatient geriatric assessment and rehabilitation with a reduction in death at 6 months, odds ratio (OR) of 0.65 [0.46, 0.91], with decreased rates of institutionalisation, and improved physical and cognitive function (Stuck et al 1993). The use of the multidisciplinary team may have benefits in other specific settings. Organised inpatient stroke unit care has also shown benefits, with a reduction in death or institutionalisation, OR 0.76 [0.65, 0.90] and inpatient rehabilitation of older patients with proximal femoral fractures has demonstrated a trend for benefits, OR of death and deterioration in function of 0.92 [0.82, 1.02] ((Stroke Unit Trialists' Collaboration 2001; Cameron et al 2001).

The extension of this rehabilitative approach into community and maintenance programs has been argued (Criddle and Flicker 2001). At present many older people are in receipt of support services to assist them to remain in their own homes, mainly through the Home and Community Care Program (HACC). They are auspiced by a large number of community organisations often with less defined health professional links, especially for medical and allied health staff. Thus, it has been more difficult for these services to access specialist assessment and rehabilitation services for their clients to decrease their degree of disability. Also, stringent rules have largely prevented the use of these services to assist the discharge of older people from hospital. This, and the need to discharge increasing numbers of older people with complex acute and rehabilitation needs, has resulted in the proliferation of post acute care services from hospital (Howe 2002). Unfortunately, the potential needs of, and response of HACC clients to rehabilitation has not been quantified, although some pilot attempts have

commenced. Also, most rehabilitation programs have rightly focused on issues to do with mobility, with a relative neglect of upper limb function, both from neurological and musculoskeletal causes. Potentially the benefits from rehabilitation of upper limb function might result in increased quality of life as well as decreased disability.

It should not be thought that advances in interventions in the medicine of old age have only resulted from the more efficient use of the multidisciplinary team. Dementia, the commonest diagnosis made by the aged care teams has been found to be ameliorated by pharmacological strategies and by psychosocial interventions (LoGiudice et al 1995; Flicker 1999; Opie et al 1999). Pharmacological strategies have resulted from insights from basic science which have taken almost 30 years to bring to clinical use (Davies and Moloney 1976). The pathophysiology of Alzheimer's disease continues to be elucidated and efforts are constantly being made to utilise these advances in clinical trials. The immunisation of amyloid beta was reported to have benefits in a mouse model of Alzheimers Disease, but early human trials have been marred by recent reports of meningoencephalitis (Schenk et al 1999). Unfortunately, in a chronic condition which is both heterogenous in its clinical course and difficult to stage, clinical studies may lag many years behind these basic science advances.

The management of osteoporosis is another common, strongly age-dependent, condition that has benefited by pharmacological (eg bisphosphonate and SERM treatments) and non-pharmacological strategies. Striking a balance between the use of pharmacological, individual lifestyle and population approaches is difficult, but a recent Australian attempt has been made (Sambrook et al 2002). There are now several interventions that have been demonstrated to reduce the risk of falls. Multidisciplinary, multifactorial, health/environmental risk factor screening/intervention programmes, reduce falls in unselected community dwelling older people, OR 0.73, [0.63 to 0.86], and for older people with a history of falling OR 0.79, [0.67 to 0.94] (Gillespie et al 2001). Other effective fall reduction strategies include muscle strengthening and balance retraining, Tai Chi, home hazard assessment and modification, and withdrawal of psychotropic medication (Gillespie et al). Similarly, simple proven interventions are available to treat the common embarrassing problem of urinary incontinence in older women (Hay-Smith et al 2001; Berghmans et al 2000).

Summarising the above, there is substantial evidence that there are simple, evidence-based interventions for the common age dependent problems of dementia, falls, immobility and incontinence in older people. The evidence for these relatively simple strategies is as strong as any branch of medicine. There is no scientific basis for the nihilistic attitudes often adopted by health professionals in dealing with older people. It is inexplicable that there is so little access to these evidence-based approaches.

A deliberate attempt has been made to focus on the clearly age dependent diseases and conditions, although advances in the common cardiovascular and neoplastic diseases also bring about benefits to people of advanced age. Decreases in premature mortality from these conditions have resulted in the increased prevalence of the neurodegenerative disorders and musculoskeletal disorders. This has now resulted in the commonest causes of years of life due to disability in women to be osteoarthritis and dementia (Victorian Department of Human Services 1999). By their nature the management of individuals with these chronic neurodegenerative and musculoskeletal conditions requires co-ordination of pharmacological, allied health and support services. The balance between support for these elements is difficult to rationally allocate, even if the processes were not largely based on historical and political factors.

The provision of these services for aged care medicine occurs in primary care, acute inpatient, sub acute hospital, specialist outpatients services and residential care. Each has separate funding models and resource constraints as discussed by Howe (Howe 2002). Suffice to say, secure funding for the major interventions, based on evidence, has been difficult to achieve. One of the basic tenets of aged care medicine has been to direct interventions at improving the quality of life rather than quantity but the amount of resources required for the last few years of life is difficult to justify. Unfortunately it is often difficult to estimate when this last phase of life does occur.

These issues are particularly problematic for people in residential care. It is now clear that older people housed in residential care are the sickest and frailest of people with severe or profound disability in Australia. There are approximately 480,000 Australians over the age of 65 years with severe or profound disability, of which 154,000 people live in cared-for accommodation, chiefly Commonwealth subsidised aged care facilities. Even within this group the older people in residential care are older, frailer and more likely to be women (Gibson et al 1999). An illustration of the potential health care needs is gained from a study of 952 high level and 667 low level residents across three states of Australia (Flicker et al 2001). Over a six month period 388 falls were recorded in

low level care and 643 falls in high level care, in 26% of these women yielded an average fall rate of 1.5 per year. Only 16% of high level care residents and 55% of low level care residents scored within the normal range on a simple test of cognitive function. Neuroleptics were used in 10% of hostel residents and 25% of nursing home residents, benzodiazepines in 33% and 27% of residents, respectively, and antidepressants in 30% and 32%, respectively. In this study vitamin D deficiency, which was widespread, was found to be an independent risk factor for falls after adjusting for other associated factors which included neuroleptic use, cognitive function, "wandering" status and walking ability. Despite the obvious health needs, the lack of clear guidelines and organisation of health services in this setting has been of concern to many bodies including the Australian Society for Geriatric Medicine which has released a position statement on methods to promote a higher quality of health care in residential care (ASGM 2001).

The major issue commonly raised concerning the interface between acute care and residential care is the access to residential care by patients who are admitted to acute care services and cannot be discharged anywhere else but to a residential care facility in which they were not previously housed. There is no accepted benchmark as to how long this time period should be, nor exactly how much pressure can be legitimately applied to the patients and their families to expedite this change in residence. In contrast, there is much less emphasis on the unmet acute and chronic health care needs of the residential care population. The admission of older people from residential care to acute care often occurs outside office hours for life threatening complications of chronic conditions and is characterised by complaints of poor communication from both sectors. The establishment of models of partnership between the sectors, including general practice, and defining the parameters of best practice is sorely needed.

There have been several incidents in residential care over the last few years which have portrayed the standard of health care in a negative light. These incidents are a major risk to providers of residential care and can force the closure of these facilities. These problems appear to be relatively unpredictable and it is not yet clear how they can be guarded against. It is not surprising that the quality of aged care in residential care has been difficult to estimate as it is similarly difficult to estimate in acute care. The assessment of quality of health care in the acute and sub-acute sectors has largely depended on a few key clinical indicators and may not represent the overall quality of service provided. Within the relatively poorly resourced residential care sector the approach to quality determination is even more rudimentary.

A fundamental rethink of the approach to the coordination of health care for older people is required across all the disparate settings that these services are provided. This is particularly required in residential care where continuing problems have not been addressed by Government policies. It is surprising that in a sector as important as this, in both funding and population terms, that so little attempt has been placed on these aspects. In many parts of the acute and sub-acute sectors a systematic approach to the health problems of older people has produced tangible benefits. A similar multidisciplinary approach is now required for residential care.

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