Geriatric medicine services in Australia and New Zealand provide care to older adults in metropolitan and rural areas. There is considerable heterogeneity in the services that are currently available.

**Key Points**

1. A significant proportion of people admitted to general hospitals in Australia and New Zealand are older than 65 years.

2. Geriatric medicine services in general hospitals are provided across the spectrum of emergency, acute and subacute care. They are also important for outpatient consultations, post-discharge care and interface with the community.

3. Hospitalisation poses particular, inherent risks to older adults. Prevention of unnecessary hospital admission and reduction in length of hospital stay are important to minimise iatrogenic harm. However, hospitalisation should not be denied to older people when it is needed. Hospital environments and systems of care should be responsive to these vulnerable patients and designed to mitigate their risks.

4. The revised National Safety and Quality Health Service (NSQHS) standards were released in 2017. They provide a framework for quality improvement for all health services. Many parts are particularly relevant to geriatric medicine service provision.

5. Not all older patients can be cared for primarily by a geriatrician or on a geriatric medicine ward. Systems of care that deliver geriatric expertise across the broader hospital population, such as geriatric consultation and liaison teams, are important. Educational programs that increase the body of geriatric knowledge among other specialists, nursing and allied health staff are also essential.

6. At times, patients younger than 65 can have complex needs and frailty and would benefit from geriatric medicine expertise. A geriatric service within hospitals that accepts referrals based on a number of factors and not simply chronological age can be important to ensuring equity of high quality care.

7. There are varying levels of evidence for different models of geriatric care across inpatient settings. Care can be provided in emergency departments, acute wards and subacute wards. Models of care include geriatric-led care, shared care and geriatric consultation-liaison services.

8. Post-discharge and hospital-avoidance schemes are core components of many geriatric services. Transition care, for example, is integral to post-discharge services in many hospitals. There is evidence for Hospital in the Home in avoiding unnecessary admissions and for post-discharge care. Hospital in the Nursing Home and Geriatric Evaluation and Management (GEM) at Home are other ventures showing promise.

9. Older adults use a significant proportion of the hospital beds in smaller and regional hospitals, in the same way they do in larger or metropolitan hospitals. Smaller hospitals may not have the capacity for a full range of geriatric services. However, a commitment to providing some specialist geriatric medicine input, and incorporating the principles of geriatric care hospital-wide, is likely to provide better and more effective care.
10. Telemedicine is showing some promise in delivering high quality specialist geriatric care to people in rural and remote areas.

This Position Statement represents the views of the Australian and New Zealand Society for Geriatric Medicine and was approved by the Council on 2 September 2019. This paper is a revision by Professor Ruth Hubbard and Dr Sarah Fox. It follows a previous review by Professor Len Gray and Dr Alison Cutler (2009) of the original written by Professor Len Gray and Dr Mike Dorevitch (1993)

Background Paper

1. Introduction

1.1 Demographics

1.1.1 General demographics

Adults over the age of 65 years currently account for approximately 15% of the Australian population [1], which is equivalent to 3.7 million people. The Australian population continues to grow and improvements in life expectancy coupled with lower fertility rates mean that the proportion of Australians who are older than 65 is expected to increase. It is predicted that by 2056 there will be 8.7 million older Australians, accounting for 22% of the population. The proportion of the oldest old (aged ≥85 years) is also expected to increase. [2]

New Zealand Government data shows that the proportion of the older (>65 years), older-old (>80 years) and oldest-old (>95 years) are all steadily increasing, explained by increasing life expectancies and smaller families. It is projected that 22% of the New Zealand population will be older than 65 years in 2036. [3]

1.1.2 Demographics of Hospital Use by Older Australians

Most older people in Australia and New Zealand are well and high-functioning, and self-report to be in good health. [4]. However, many chronic health conditions increase with chronological age. Ageing is also associated with frailty, with functional and cognitive decline and increased vulnerability to adverse outcomes [5]. As such, older people in Australia and New Zealand require a disproportionate amount of hospital services. In Australia, a 2017 report by the Australian Institute of Health and Welfare identified 701 public hospitals with 61000 beds [6]. Within these hospitals, people aged 65 and over accounted for 41% of admissions and 48% of patient days. In addition, the increase in hospital bed utilisation by this age group exceeds their rate of growth [7]. New Zealand Government data show that older people use 42% of health services despite accounting for 15% of the population. [8]

1.1.3 Demographics of Geriatric Service Provision in Australian and New Zealand Hospitals

The last formal survey of inpatient geriatric services in Australia was conducted in 2001, with results published in 2007. This survey provided insights into the large amount of variability in the geriatric services available throughout the country, with differences found state by state and between regional and metropolitan centres. Such a survey can help in setting geriatric service priorities at a national, state and local level. As such it would be worthwhile to repeat such a survey in the future. [9]

1.2 Need for Geriatric Medicine Care

The health needs of frail older people are often complex. Models of hospital care that are designed to manage a single problem often fare poorly when faced with patients with multiple problems and functional limitations. At times, complex and frail older patients, trying to navigate hospital and healthcare systems, may inappropriately be considered too difficult or complex. However, it is important to acknowledge that the fault here lies with the model of care and the systems in place, rather than with the individual. [10] The way that hospitals are structured and care is organised can result in significant improvements in the care of older people, with regards to managing illness, improving disability and maximising independence at discharge. Hospitalisation can have particular risks for older patients and well-organised systems of care can help to mitigate these
risks. Hospitals with dedicated teams and environments for older patients have the potential to provide more efficient, cost-effective and streamlined care.

Compared to younger patients, patients aged over 65 years have a higher prevalence of geriatric syndromes, such as falls, functional decline, delirium and malnutrition. [11-13] Functional decline can happen early in hospitalisation, and in one study was found to occur within two days. [14] [15]. There is evidence that Comprehensive Geriatric Assessment (CGA), a multidisciplinary, multidimensional assessment and management tool, can mitigate some of this functional decline and reduce the incidence of other geriatric syndromes impacting upon a patient during the hospitalisation. [16-19]

There is a real need to prevent unnecessary hospital admissions for this vulnerable group of people. In so doing, exposure to the many common complications of hospitalisation can also be reduced. Programs that explore alternatives to inpatient care, such as Hospital in the Home, are important parts of this effort. However, admission to hospital is sometimes the safest and most effective way to provide acute and subacute care to this patient group and as such, a mentality that opposes hospitalisation at any cost should be resisted. Rather, when hospitalisation is indicated, older adults should expect to receive treatment in hospitals that are respectful of, and responsive to, their particular needs. Furthermore, hospitals that design age-appropriate systems of care can expect greater efficiency as well as improved patient outcomes.

1.3 National Safety and Quality Health Service (NSQHS) Standards

The National Safety and Quality Health Service (NSQHS) Standards have been developed to reduce potential harm to people accessing healthcare in Australia. They comprise eight separate standards that form a framework for health services. Within these eight standards, the Comprehensive Care Standard is particularly relevant to reducing the risks of hospitalisation that older people face. Within this particular standard are specific frameworks such as:
- Preventing falls and harm from falls
- Preventing and managing pressure injuries
- Nutrition and hydration
- Preventing delirium and managing cognitive impairment

These are particularly relevant to the older person during a period of hospitalisation. They provide information relevant to the prevention and treatment of the various conditions, from an individual, ward-based and hospital-wide approach.

The documents also provide links to the relevant Clinical Care Standards including:
- Prevention and Treatment of Pressure Ulcers: Clinical practice guidelines [20]
- Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines 2009 [21]
- [22]

1.4 Organisation of Geriatric Care in Australia and New Zealand Hospitals

To understand how geriatric care is organised in general hospitals in Australia and New Zealand it helps to look in turn at:
- Acute Care
- Subacute Care
- Post-discharge care and community interface
- Outpatient clinics and community outreach services

2 Acute Care

Geriatric services for acutely hospitalised older people include:
- Inpatient specialist geriatric wards
- Geriatric consultation-liaison services
- Specialist geriatric liaison services or co-management services including
  - Perioperative care
  - Orthogeriatric care
  - Cardio-geriatric care
  - Geriatric Oncology care
- Geriatric services in Emergency Departments
- Hospital-wide programs to reduce the incidence of complications amongst acutely hospitalised older adults
- A geriatric focus of care, particularly in smaller and rural hospitals
Acutely unwell older people are vulnerable to rapid deterioration and require access to a hospital service that can quickly and effectively manage illness while minimising the risks of complication. The hospital environment, if not properly designed, can leave older patients feeling alone and without personal agency.

The appropriate design of hospital services for acutely hospitalised older patients, across the spectrum of care types, should include access to:
- A multidisciplinary geriatrician led team
- Comprehensive geriatric assessment of appropriate patients
- Ward design that is safe and respectful of older people
- A commitment to the ongoing professional development of people caring for older patients.

Ideally, a geriatric-focus should be taken early in the patient’s hospitalisation, to ensure the prompt identification and management of medical and psychosocial problems. For example, emerging studies of Comprehensive Geriatric Assessment delivered in the emergency department have suggested reduced admission to acute wards and the Intensive Care Unit, improved patient satisfaction and improved functional outcomes [23-25]. Likewise, Acute Care of Elders (ACE) wards, which provide geriatrician-led multidisciplinary care to acutely hospitalised older patients, are associated with improved outcomes. [26]

2.1 Specialist Geriatric Wards in the Acute Hospital Setting

Acute geriatric care units, sometimes referred to as ACE units, provide a geriatrician-led service of assessment, diagnosis and management for acutely hospitalised older adults. They generally differ from other medical wards, including general medical wards, in being staffed by doctors, nurses and allied health staff who specialise in geriatric care. They offer the multi-dimensional, multidisciplinary approach of a comprehensive geriatric assessment and are proactive at reducing complications of hospitalisation, such as functional decline and delirium, by taking early preventative measures. A systematic review and meta-analysis examined the effectiveness of acute geriatric units compared with standard care. It found a benefit in terms of reduced functional decline and increased likelihood of living at home upon discharge [27]. Another meta-analysis by the same group showed that these acute units can also improve the efficiency of care with shorter lengths of stay and lower hospital care costs [28].

A 2012 systematic review and meta-analysis compared the effectiveness of acute geriatric inpatient care, using all or a part of the ACE model, with usual acute care. It found that the ACE model was associated with fewer falls, less delirium, less functional decline, shorter length of stay, fewer discharges to a nursing home and more discharges home, and lower costs. It did not demonstrate a mortality benefit [26]. A reinterpretation of this data the following year attempted to elucidate the components of the Acute Care of Elders program that were most important for success. It suggested patient-centred care and function-focused programs were more important than early discharge planning and environmental preparedness [29].

2.2 Geriatric Consultation Liaison Services

Geriatric consultation liaison services involve a geriatrician assessing patients admitted under other teams and then providing advice and guidance. In addition to the management of the medical problem that precipitated hospitalisation, they can also evaluate other medical problems, advise on polypharmacy, make suggestions to reduce the potential complications of hospitalisation, provide risk assessment and planning for possible medical procedures or treatments and engage in discharge planning.

One landmark meta-analysis of a geriatric consultation liaison service demonstrated a reduction in mortality at six months and a trend to reduced mortality at 12 months. However, it failed to show a significant improvement in functional or cognitive status at 12 months or rates of hospital readmissions [30]. There was significant heterogeneity in the studies included in this early review, which made interpretation difficult. A 2013 systematic review and meta-analysis examined the efficacy of CGA offered in the form of a mobile interdisciplinary team to acutely hospitalised older patients. This review
found a reduction in mortality at 6 and 8 months but failed to show a significant improvement in functional status or readmission rate [31]. One of the key limiting factors in geriatric consultation services is that there is a large amount of inconsistency in how recommendations are implemented and followed up.

Newer models of consultation and liaison include a mobile interdisciplinary team providing care to patients geographically located on different hospital wards. These differ from the traditional consultation-liaison model in that they generally control and monitor how treatment recommendations are implemented and followed up and there is more clear ownership of care by the geriatric team. They typically include a geriatrician and a geriatric nurse specialist as well as allied health professionals and often provide CGA for appropriate patients. A prospective, matched cohort study of one such unit found that a Mobile ACE unit was associated with lower rates of adverse events, shorter hospital stay and improved patient satisfaction. A costing analysis suggested significantly reduced costs for the mobile ACE units when compared with usual care [32].

2.3 Specialist Geriatric Liaison and Co-management Services

The increasing numbers of older adults being cared for throughout the hospital have led some groups to work particularly closely with geriatricians to optimise patient care. This can take the form of shared-care, geriatrician-led care with other specialty input or other specialty-led care with geriatrician input.

2.3.1 Perioperative care

The number of older adults undergoing surgery is increasing. This group is known to have high rates of comorbidity and functional impairment. In particular, older surgical patients who are frail may be particularly vulnerable to poor surgical outcomes. [33]

A 2014 systematic review looked at the impact of pre-operative CGA for elective surgical patients. It found benefit with regards to post-operative outcomes including medical complications [26]. A 2017 systematic review examined whether CGA is cost effective in acute surgical patients, with secondary outcomes of measuring impact on function and mortality. This review suggested that hospitals that provide CGA to acute surgical inpatients would benefit in terms of cost effectiveness and could also expect to see improvements in functional decline and mortality [34].

The concept of “prehabilitation” is gaining increased interest. This refers to the optimisation of health, physical function and cognition prior to surgery. Interestingly, a trial suggested that a prehabilitation program consisting of physical reconditioning, nutritional optimisation and psychological support could improve post-surgical outcomes better than traditional rehabilitation [35, 36].

Pre-operative assessment, led by a geriatrician in conjunction with a multidisciplinary team, is a vital part of the surgical pathway. It is vital that perioperative assessment includes a discussion of treatment goals and expectations, particularly in patients who are complex and frail [37]. Important components of the pre-operative evaluation include:

- Goal setting and quality-of-life considerations
- Medication review
- Neurocognitive assessment
- Functional capacity
- Identification of frailty and geriatric syndromes

[38]

In the perioperative sphere, new service models are emerging which aim to provide multidisciplinary, coordinated and patient-focused care. Examples of these include Proactive Care of Older People undergoing Surgery and Perioperative Surgical Home (PSH) [39, 40].

2.3.2 Orthogeriatric care

Orthogeriatric care has developed in an attempt to minimise the complications faced by older patients admitted to hospital with fragility fractures, particularly neck-of-femur fractures. These units involve collaboration between orthopaedic surgeons and geriatricians, with the support of a multidisciplinary team. There
are three main models of care: shared care, orthopaedic-led care and geriatrician-led care.

A study in 2005 suggested that a multidisciplinary, orthogeriatric service for hip fracture patients could reduce medical complications and length of stay [41]. A 2005 randomised controlled trial (RCT) of daily multidisciplinary geriatric care in hip fracture patients suggested this care is associated with reduced in-hospital mortality and medical complications [42]. A case control study of orthogeriatric care in 2009 also suggested improved outcomes [43].

A 2014 systematic review and meta-analysis found that orthogeriatric care was associated with lower mortality compared to traditional surgical care as well as shorter length of stay. However, it was unable to clarify whether any of the three different models of care was superior. Furthermore, this analysis was not able to determine an effect on any of the other common outcomes such as delirium, falls, and functional decline [44]. Another systematic review and meta-analysis in 2013 found a trend in favour of orthogeriatric care with regards to mortality, but the studies were not large or numerous enough to show any statistically significant difference compared with usual care [45].

For a more extensive discussion of Orthogeriatrics, please refer to the ANZSGM Position Statement 5, titled “Orthogeriatric Care” [46].

2.3.3 Cardio-geriatric care

The majority of people with heart failure, managed in hospitals, involve older adults; a New Zealand study of patients admitted with heart failure in Waikato showed the mean age at admission was 71 years [47]. They experience high rates of morbidity, mortality and frequent readmissions. Cardio-geriatric care is care provided by both a cardiologist and a geriatrician, with the support of a multidisciplinary team. To date there are no randomised controlled trials of this concept. A team in Melbourne has recently published the results of a pre-post cohort study, which failed to show a reduction in readmission rates or length of stay. However, this may have been confounded by a higher rate of comorbidity in the cardio-geriatric group [48].

2.3.4 Geriatric oncology care

The management of cancer poses particular challenges in older patients. The traditional role of clinical oncology, with powerful chemotherapy and systemic therapies aimed at eradicating malignancies, is challenged when faced with frail older patients who have multiple comorbidities, functional impairments, complex social situations and cognitive impairment. There is evidence that CGA can be useful in predicting patients who are likely to experience poor outcomes such as poor chemotherapy tolerability, surgical complications, functional decline and mortality [49]. It is hoped that improved collaboration between geriatricians and clinical oncologists, and the involvement of a multidisciplinary team, may lead to superior outcomes in this population. Special interest groups have been established to support and disseminate research in this field (e.g. the Geriatric Oncology Group of the Clinical Oncology Society of Australia) A review in 2007 did suggest that CGA could predict morbidity and mortality in older cancer patients, which may help in planning treatment [50]. However, there are yet to be RCTs to evaluate whether CGA can improve outcomes or treatment tolerability in these patients.

2.4 Geriatric Services in Emergency Departments

The impact of the ageing population on overall hospital services has highlighted the importance of integrated models of geriatric care with strong links to the community sector. For example, hospital emergency departments see a disproportionate number of older people, who have complex medical problems and are at risk of functional decline and readmission. A number of interventions based on Geriatric Evaluation and Management (GEM) principles have been proposed. These include modification of physical environment and protocols for identification of common geriatric syndromes [51].

To date there has not been a randomised controlled trial of CGA within the
emergency department setting. A group in the United Kingdom did carry out a pre-post cohort study, which found that the introduction of this model was associated with a lower readmission rate but a longer length of stay [52].

Many different models of care have been developed to improve the ED/Community interface for older people. Sometimes models are continued locally due to their positive impact without results being disseminated in academic journals. This makes synthesis of findings and recommendations for practice more difficult. One successful model that has been described is the Geriatric Emergency Department Intervention (GEDI) program, which was initially developed at the Nambour General Hospital in Queensland. It has recently received research funding to expand across other Queensland hospitals. This program involves specialist geriatric nurses undertaking comprehensive geriatric assessment of adults aged over 70 years presenting to the emergency department. As well as reducing unnecessary admissions and aiming to improve function and quality of life upon discharge from the ED, the GEDI program allows for more streamlined transfer of care when patients do require admission to hospital, and reduces the length of time these patients are waiting in the emergency department [53].

A consensus position statement titled: The Management of Older Patients in the Emergency Department is available on the ANZSGM website. [54]

2.5 Hospital-wide programs to reduce the incidence of complications among acutely hospitalised older adults

Targeted protocols have been developed to address the risks of hospitalisation for older patients. These risks include falls, functional decline, pressure sores, new urinary incontinence and delirium.

Falls in hospital are a significant cause of morbidity for older people. There is evidence that multicomponent hospital-wide programs can reduce falls in hospitalised older adults [55, 56] and that exercise programs can reduce falls in subacute hospital settings. [56]

In 2009, the Australian Commission on Safety and Quality in Healthcare (ACSQA) published a document titled “Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals” [21]. This guideline sets out key components of a successful falls prevention strategy. A number of state-based and local programs have developed in response to these guidelines such as “Stay on Your Feet ®” and “Don’t Fall for It” [57]

Consultancy services have also targeted other geriatric syndromes. For example, the Hospital Elder Life Program, a multicomponent multidisciplinary intervention, has demonstrated success at reducing rates of delirium and functional decline in at-risk acutely hospitalised older patients [58]. Such a study has not yet been replicated in Australia. However, Eat Walk Engage is a multidisciplinary hospital-wide intervention that aims to combat the functional decline and other complications associated with acute hospitalisation on non-geriatric wards. This program is designed to take some of the important components of an Acute Care of Elders unit and apply it more widely to general medical wards [59]. The tenets of the Eat Walk Engage care model are early mobilisation, assistance with feeding and cognitive stimulation. Early audits suggest a benefit of this approach and a randomised controlled trial is currently underway [59].

2.6 A Geriatric Focus of Care on Non-Specialist-Geriatric Wards

The number of older adults presenting to hospital far exceeds the capacity for them all to be cared for by geriatricians. Furthermore, at times the most appropriate care for these older adults is under other specialists.

Holistic, multidisciplinary and patient-centred programs can take a geriatric model of care to patients who are not on Care of the Elderly wards nor who are being seen by geriatric consultancy services. Programs that address the multiple contributors to poor health in this population have strong face validity. However, a 2015 review of the evidence into the effectiveness of interdisciplinary care interventions on general medical
wards failed to show benefit of this approach [60].

3 Subacute Care

Subacute care is necessary to address restoration of functional independence, with attention to quality of life, amongst older patients. Many patients requiring subacute hospital care have experienced significant functional decline or other complication of acute hospitalisation. Sometimes, older people, particularly those who are frail, can present to hospital with a seemingly minor trigger that causes functional or social problems and these patients may be best managed by immediate admission to a subacute unit. The aim of these services is to utilise CGA to improve physical, cognitive and social functioning.

There are different types of subacute inpatient care including
- Geriatric Evaluation and Management units (GEMU)
- Geriatric rehabilitation units

A multidisciplinary and multidimensional approach is integral to the design of these units.

The effectiveness of geriatric assessment units providing comprehensive care to older people after resolution of acute illness has been widely studied. Two early systematic reviews and meta-analyses suggested benefit of GEMU. The first indicated a mortality benefit at 6 months [18]. The second review reported that GEMUs were associated with lower rates of institutionalisation [30] [61].

A 2010 systematic review and meta-analysis comparing GEMU to usual care included a total of seven studies and 4759 patients. A key component of all the GEMUs was involvement of a multidisciplinary team. GEMUs improved functional status at discharge and were associated with lower institutionalisation at one year. However, there was significant heterogeneity in the studies [17]. A further systematic review of geriatric rehabilitation units in the same year, found that patients who were admitted to these units had less functional decline, reduced likelihood of nursing home placement and lower mortality at the time of discharge and also at the end of follow-up, which ranged from time of discharge to twelve months afterwards [19].

4. Post-discharge Care, Admission Avoidance and Community Interface

Geriatric-specific programs can include
- Transitional care and supported discharge programs
- Hospital in the Nursing Home
- GEM at Home

Older patients also use non-age-specific post-acute care programs including:
- Hospital in the Home (HITH)
- Post-Acute Care Services (PACS)
- Community Based Rehabilitation Therapy (CBRT)

Early, individualised discharge planning is integral to meeting the needs of older adults after a period of inpatient care. In addition to clear and timely discharge summaries it is important that thought is given to what services people will require when they return to the community and ensuring that these are organised as much as possible prior to discharge. Clear communication is required between hospital staff and the community service providers who can help support patients with nursing care, domestic tasks, respite care, community integration and community-based rehabilitation.

4.1 Geriatric-Specific Programs

4.1.1 Transitional care and supported discharge programs

Transitional care programs are federally funded programs in Australia and New Zealand that provide ongoing support and multidisciplinary rehabilitation for people who have been in hospital and who have not returned to their baseline function and/or are at high risk of readmission to hospital. These programs are variously known as Transition Care, transitional care programs, supported discharge schemes, and intermediate care programs. These programs, which can be provided in a patient’s home or a residential setting, are usually only available to those over the age of 65 years. They are goal-oriented, patient-centred and time-limited.
A national report of the Transition Care program in Australia, released in 2008 and funded by the Australian federal and state governments, concluded that the Transition Care program reduced rehospitalisation and movement into residential aged care at six months [62].

An independent 2015 Australian review, in the form of a prospective cohort observational study, aimed to evaluate the cost-effectiveness of transitional care programs and their impact on readmission. It was not clear from this study whether transitional care was effective at reducing re-hospitalisation, and the costs associated with the program were high [63]. Another prospective cohort study in 2015 investigated outcomes from Transition Care in Australia, comparing cognitively intact patients with patients with cognitive impairment. It found no difference in the studied outcomes of readmission rates, institutionalisation rate and attainment of personal transitional care goals and concluded that older patients with cognitive impairment should not be excluded from these programs [64]. Similarly, in a prospective observational cohort study, Transition Care programs benefitted frail older people, and not just those who were fitter [65].

A New Zealand trial of supported discharge schemes demonstrated a reduction in length-of-stay and reduced time spent in hospital over a six-month period. It also demonstrated the program to be cost-effective. [66]

4.1.2 Hospital in the Nursing Home

Hospital in the Nursing Home (HINH) is a program concept currently employed by many hospitals and health service districts. HINH aims to prevent unnecessary hospital admissions among patients in residential aged care facilities through outreach services. There is some heterogeneity in models, with different emphases on reactive versus proactive care and emergency physician/geriatrician/nursing led teams. A 2016 review suggested that HINH could be effective at reducing ED presentations and hospital admissions. [67].

4.1.3 GEM at Home

GEM (Geriatric Evaluation and Management) at Home is an inpatient substitution program providing multidisciplinary post-acute geriatric rehabilitation in a patient's own home. It is currently being operated at a number of hospitals in Victoria. There are no specific studies that have examined the effectiveness of this model of care. However, it is strongly centred on the evidence-based principles of Geriatric Evaluation and Management Units, incorporating some of the features of early discharge programs. [18] [30]

4.2 Non-Geriatric-Specific Services

4.2.1 Hospital in the Home

Hospital in the Home is not specifically a geriatric service. There is no age restriction for patients, however a significant number of the people admitted to the HITH program are older people. Patients are considered to be inpatients of the hospital and remain under the care of the hospital doctor. This service is designed to provide acute medical care to people who are medically stable enough to be cared for at home with regular visits by a nurse or medical practitioner. A systematic review and meta-analysis of the evidence for Hospital in the Home, published in the Medical Journal of Australia in 2012, found that the program was associated with reductions in mortality, readmission rates and costs [68].

Two systematic reviews on the Cochrane database also investigated the value of Hospital in the Home. The first examined HITH for admission avoidance and found the program was associated with less movement to residential care and higher patient satisfaction [69]. The second Cochrane review explored early-discharge HITH and suggested that HITH could reduce total length of stay, be associated with higher patient satisfaction and result in less movement to residential facilities [69, 70].

5. Outpatient clinics and community outreach services

Outpatient geriatric services attached to general hospitals can include:
- Clinics: including geriatric assessment clinics, memory and cognition clinics, falls clinics and continence clinics
- Community Outreach Programs servicing patients in their own homes or in residential aged care facilities including Aged Care Assessment Team (ACAT) in Australia.

These services can support people to remain well and with optimal independence. At times, they may be able to reduce unnecessary admissions to hospital or, when hospitalisation is necessary, aid in a more streamlined and effective admission. While they have strong face validity in this regard and are well cemented as part of the fabric of geriatric services, their effectiveness has not been systematically investigated.

Close liaison between general hospitals and ACAT, which coordinate access to federally-funded community- or residential based aged care services, is also very important. Aged Care Assessment Teams work closely with geriatric services in hospitals.

6. Smaller and Regional Hospitals

Smaller and regional hospitals may not have the capacity to incorporate the full range of geriatric services. Furthermore, a specialist geriatrician may not be available. However, a large number of the people admitted to these hospitals will be older than 65: Thirty-six percent of the rural Australian population is older than 65 and in many rural and remote communities, the proportion of people in this age group exceeds that of metropolitan areas [71]. Therefore, hospitals in these areas will benefit from staff who are educated about common geriatric conditions and who can provide comprehensive geriatric assessment. Smaller hospitals will benefit from providing
- A multidimensional approach to patient care
- Access to subacute care that can provide rehabilitation and discharge planning
- Access to a specialist geriatrician either in person or by teleconferencing or videoconferencing
- Access to ACAT
- A collaborative relationship with community service providers including close contact with local residential aged care facilities.

6.1 Telehealth

Since July 2011, videoconferencing has been rebatable via Medicare in a bid to encourage doctors to utilise this means of providing care to people in rural areas. Geriatrics and psychiatry have been the two specialties with the highest uptake proportionate to in-person consultations [72]. By expanding telemedicine across Australia and New Zealand, people in rural and remote communities may have access to specialist care they would otherwise be denied by distance.

A prospective observational study of a geriatric telehealth service to rural hospitals in Queensland suggested that telemedicine is safe and cost-effective [73]. An earlier review had reached a similar conclusion. [74]. The factors associated with success of individual telemedicine services have also been explored and include having a vision for the program and ownership by both clinicians and management. Adaptability, with frequent review of the program, as well as having transparent economic value efficient processes and reliable equipment were other key factors identified in a review. [75]

7. Conclusion

Geriatric services in general hospitals need to be reflective of the current evidence for best practice. Across acute, subacute and post-discharge settings, geriatrician-led, multidisciplinary and patient-centred interventions can reduce rates of readmission to hospital and institutionalisation. Importantly, they can also reduce the incidence of common complications of hospitalisation such as falls, functional decline and delirium.

The number of older people in Australia and New Zealand is expected to increase significantly over the coming decades and the provision of geriatric services in Australian and New Zealand hospitals should be tailored to the expectations and needs of older adults. Patient satisfaction
is an important goal, alongside functional outcome measures and efficiency of care.

It is a challenge for which the community of geriatricians and other health professionals will need to collaborate closely with federal, state and local governments, as well as with local health districts and hospital networks, in order to provide the best possible in-hospital care for our older people.

8. References


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