

POLICY OPTIONS

Functional decline in community-dwelling older people and the Medicare 75+ Health Assessment

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Minimising residential care, maximising community living

Functional decline (FD) is the term used to describe the (often insidious) loss of physical, social and/or thinking capacity. It can impact on people living safely and independently in the community. FD is commonly associated with getting older, but it is not an inevitable consequence of ageing. FD can be prevented, or its manifestations reversed or minimized with early detection and appropriate, timely supports. Consumer co-research was a potent methodology used in this research to hear the voices of older people, their GPs and practice nurses. Older people had quite different views from their health care providers regarding the ageing process, its consequences, and possible solutions.

STUDY PURPOSE

- > Discover how well the 75+ HA provided in primary care settings by GPs and practice nurses matches research and best practice around the world
- > Explore older people's views about early signs of declining function, and the strategies they use to prevent or manage FD
- > Explore primary health practitioner views about the 75+ HA and how it is used
- > Gather consumer perspectives on how well the 75+ HA identifies and addresses their ageing-in-place needs.

Policy options

1. Retain the 75+ Health Assessment (HA)

- > Revise the current data items to include more comprehensive evidence-based assessments of health and social functioning domains. The 75+ HA should include data items that facilitate sensitive exploration of individual manifestations of early FD by the older person (with or without their family), and the GP and/or practice nurse. This will provide the most effective and feasible individual management strategies to deal with risks in the home environment, social circumstances, community functioning and decision-making, and caring responsibilities

- > Routinely offer the 75+ HA at least every two years to every person aged 75+
- > Ensure older people and their families are aware of, and can access, this valuable primary care opportunity for considering in a holistic manner, ageing in place
- > Make the 75+ HA more consumer-focused by explicitly recognizing and including older people's concerns, and the enablers that they perceive will support their successful ageing in place.
- > Follow up the 75+ HA with timely agreed actions that address older people's specific needs. These could be as inexpensive as facilitating their contact with local peer groups, or suggesting low cost alternatives to managing stressful situations (shopping online, or having groceries delivered, carpooling, having regular help in the garden).

2. Improve information exchange

General practitioners and practice nurses should be informed about:

- > The current evidence-base for the 75+ HA, including the key FD domains and constructs and recommended psychometrically-sound assessment tools
- > Person-centred care approaches to conducting the 75+ HA including recruitment; preparation; time and timing; location; confidentiality practices; and shared decision-making.

Older people should be informed about

- how to best use the 75+ HA to plan for ageing in place

3. Provide solutions, don't just tick boxes

- Planning for ageing in place often requires individualized solutions to specific problems. Older people should be engaged as problem-solving partners by their GP/ practice nurse, to ensure that workable solutions are found to issues raised in the 75+ HA. This will require not only follow-up to the 75+ HA, but it may also require engagement of multiple agencies / services, and sensitive communication to devise a plan.
- An accessible, relevant, current source of local support service information, including eligibility criteria and cost, is critical if older people are to age safely in place.

4. Prioritise further research and development of primary care HAs for older people

- > Determine if 75 years is the appropriate commencement for this intervention. The age at which this assessment commences could be younger, depending on individual need.
- > Develop and disseminate to GP practices a revised, evidence-based 75+ HA assessment tool with online links to validated assessment tools.
- > Develop and disseminate a consumer tool to assist older people and their families to plan for, and get the most out of, their 75+ HA
- > Validate the new tool developed from the perspectives of consumers who participated in this research: HIPFACTS. This is an acronym for the key issues that older people identified to

support them to age in place successfully (health; information; practical support; financial advice; physical and mental activity; company; transport; and safety).

- > Test the revised evidence-based 75+ HA for acceptability and outcome

Key findings

1. The 75+ HA needs to be updated in line with evidence-based practice

- > Many aspects of early FD are not currently addressed, yet could be, in the 75+ HA. In particular, many HIPFACTS elements are not addressed in the 75+ HA
- > A more evidence-based and consumer-focused 75+ HA could be effective in identifying, and addressing the broad spectrum of issues related to ageing safely in place
- > Not all issues related to safe ageing in place are health related, and GPs and practice nurses need to be comfortable with seeking advice from non-health professionals to understand and address all issues relevant to safe ageing in the community

2. Older people are clear about what support they need for the ageing in place they want

- > Older people demonstrated resilience, independence and adaptability in addressing ageing.
- > They want access to information and flexible, affordable community support services
- > Older people relate variably to their GP (not wanting/ needing to see their GP often; consulting multiple GPs for different reasons, not wanting to 'bother' their GP with 'small worries'; or regularly visiting the GP to manage health issues).

3. Health practitioners (HPs) like the 75+ HA

- > HPs generally believed that 75+ HA was a valuable opportunity to 'touch base' with older people to discuss issues often overlooked in routine consultations
- > Recruitment, conduct and follow-up to a 75+ HA varies, and could be more standardised
- > Scheduling the 75+ HA earlier in the life trajectory could support greater proactivity in making plans about ageing in place
- > Conducting the 75+HA in older peoples' homes is better than the GPs' rooms, as more efficient observations of living situations can be made, and more informal discussions held to identify sensitive issues about ageing in place
- > Engaging dentists, allied health, optometrists etc in 75+ HA and subsequent follow-up would provide a more comprehensive picture of health.

4. Older people like the 75+ HA but don't get all they could from it

- > The 75+ HA was perceived as a valuable opportunity to discuss health more holistically.
- > Older people are not sufficiently informed about the 75+ HA to see its value
- > The common lack of follow-up to the 75+ HA means that older people see little change as a result of it, and thus query its relevance to their lives.