

SENIORS HEALTH ROUNDTABLE  
11 May 2016

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REPORT AND RECOMMENDATIONS

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## ACKNOWLEDGEMENT

This report was commissioned by the Community Participation Group (CPG), Community Services Directorate (CSD), ACT Government. The findings, outcomes and recommendations contained in this report do not constitute agreement or endorsement from the ACT Government.

CPG, CSD hosted the Seniors Health Roundtable, on behalf of the former Minister for Veterans and Seniors, Dr Chris Bourke MLA.

CSD would like to acknowledge the contribution of ACT Health toward hosting the Seniors Health Roundtable.

The ACT Government would like to acknowledge the following organisations represented at the Seniors Health Roundtable:

- Health Care Consumers' Association of the ACT (HCCA);
- Canberra Multicultural Community Forum Inc;
- Partners in Culturally Appropriate Care (PICAC);
- ACT Human Rights Commission;
- Council on the Ageing ACT;
- ACT Retirement Village Residents Association Incorporated;
- A Gender Agenda;
- Ministerial Advisory Council on Ageing (MACA);
- ACT Veterans Advisory Council;
- ACT Totally and Permanently Incapacitated (TPI) Ex Servicemen and Women's Association;
- ACT Disability, Aged and Carer Advocacy Service (ADACAS);
- ACT Senior of the Year (2016);
- Australian Association of Gerontology;
- National Heart Foundation of Australia (ACT);
- Arthritis Australia;
- Communities @ Work;
- Capital Health Network;
- Women's Centre for Health Matters;
- Australian Red Cross;
- ACT Health, Health Improvement Branch;
- Palliative Care, ACT;
- National Seniors Association, Canberra South Branch;
- Lesbian, Gay, Bisexual, Transgender, Intersex and Queer Ministerial Advisory Council;
- Northside Community Services;
- AIDS Action Council;
- ACT Senior Woman of the Year (2016);
- Country Network;
- ACT Jewish Community;
- ACT Chinese Australian Association;
- Rehabilitation, Aged and Community Care Canberra Hospital and Health Services;
- Faculty of Health Disciplines of Nursing and Midwifery – University of Canberra;
- Just Better Care;
- ACT Hindu Community;
- Residents Committee, Goodwin Village;
- Returned and Services League of Australia (ACT Branch); and
- Capital Works, Design and Delivery, Territory and Municipal Services.

## BACKGROUND

The *ACT Active Ageing Framework 2015-2018* and associated *Action Plan* (the Framework) provide a coordinated approach to improving outcomes for seniors in the ACT.

The Framework contains 34 practical outcomes to be implemented over the three years life of the plan. The practical outcomes give expression to the Frameworks guiding principles, which have been based on the outcomes of local community consultations, the 2<sup>nd</sup> Older Persons Assembly in 2014 and contained within the *Checklist of Essential Features of Age-friendly Cities*, issued by the World Health Organisation.

## PURPOSE OF THE SENIORS HEALTH ROUNDTABLE

In consultation with ACT Health a Seniors Health Roundtable was held to provide qualitative recommendations regarding health provisions for seniors to the Minister for Ageing (now Minister for Veterans and Seniors).

## KEY TOPICS

The six key topics that formed part of the Seniors Health Roundtable proceedings were:

1. **Advocacy (health decision-making)**, led by Ms Fiona May, ACT Disability, Aged and Carer Advocacy Service (ADACAS) and ACT Ministerial Advisory Council on Ageing (MACA).
2. **Access to Health**, led by Mr Patrick Reid, MACA.
3. **Transitions in Care (continuity of care across services)**, led by Dr Susan Andrews, Health Care Consumers' Association (HCCA) of the ACT.
4. **End of Life Care Issues**, led by Ms Gayle Sweaney, Palliative Care ACT.
5. **Health Technologies (e Health)**, led by Professor Greg Tegart, 2016 ACT Senior of the Year.
6. **Health Promotion, Wellbeing and Healthy Living**, led by Mr Tony Stubbs, National Heart Foundation of Australia (ACT).

## RECOMMENDATIONS

The Roundtable made 42 recommendations for consideration by government. A summary of the recommendations is available on page 44.

## THE WORLD CAFE

The World Cafe is a whole group interaction methodology that focuses on conversations. This provided the delegates with the opportunity for collaborative dialogue, sharing knowledge and creating recommendations for action.

Each topic was hosted by a facilitator provided the delegates with background information to assist in the group discussion.

Nine topic hosts facilitated discussions in the World Cafe session with the following four questions directed to the delegates for each topic:

#### Advocacy (Health Decision-Making), Ms Fiona May, ADACAS and MACA

1. What is currently available that supports/enables advocacy and health decision making by older Canberrans?
2. What more could be done to enable access to advocacy and health decision making and whose responsibility is it to do this?
3. What might need to change to ensure that older people can provide feedback and make complaints about the health care experience that they have?
4. If older Canberrans were fully exercising their right to be involved in decision making about their care, what impact would that have on their experience and outcomes of health care?

#### Access to Health, Ms Jenny Mobbs, COTA ACT and Mr Patrick Reid, MACA

1. What is working to enable access to the widest range of health care in the ACT?
2. What more could be done to enable access to better health services and facilities in community, what can be done better and how?
3. If older Canberrans were fully exercising their right to access better health care services, what should be done – short term and longer term?
4. Whose responsibility is it to do this in each setting?

#### Transitions in Care (continuity of care across services), Ms Kerry Snell, HCCA of the ACT

1. Thinking about your own experience and the experience of people you know, what would you say is currently working in our system to enable safe transitions of care for consumers?
2. What more could be done to improve this?
3. What does the ideal state look like to you?
4. What are three things we can do to make a difference and improve transitions in care?

#### End of Life Care Issues, Ms Gayle Sweaney, Palliative Care ACT

1. Imagine you were unable to communicate your wishes regarding your health care and medical treatment...would your family and friends know your wishes?
2. What can we do to ensure a 'good death'?
3. Who needs to be involved?
4. What would a 'healthy' community look like if it was to support all stages of life?

#### Health Technologies (e-Health), Professor Greg Tegart, 2016 ACT Senior of the Year

1. What do you see as the significant areas to be covered in an ageing -in -place approach for older Canberrans?
2. How do you feel about your medical data being recorded electronically and possibly made available for analysis in a big data project?

3. Do you know anyone using telehealth or mHealth- if so have you any feedback on this approach to healthcare?
4. How can we ensure access to timely and reliable information on healthcare for older Canberrans?

Health Promotion, Wellbeing and Healthy Living, Ms Suzanne Eastwood, AIDS Action Council of the ACT

1. What is currently working in health promotion with Seniors?
2. What could be done better?
3. What would you want to see in health promotion with Seniors?
4. Who needs to be involved or who is responsible and what do they need to know?

## OUTCOMES FROM THE WORLD CAFE

### 1. Advocacy (Health Decision-Making), Ms Fiona May, ADACAS and MACA

#### 1.1 Introduction

Ms Fiona May opened the discussions on advocacy and health decision-making: her statement that decision-making is at the heart of being human resonated through all the discussions.

Ms May noted that decision-making can be difficult. Busy places like hospitals impose many competing priorities for staff, and we can be easily bamboozled by a combination of the location, our own illness and the emotional pressures around the situation. Additionally, she noted the possibility of impairment through ageing means that we are more likely to comply with the directions from staff rather than feeling able to make our own choices.

Therefore, Ms May focussed on empowerment in decision-making and the role of the advocate, either from within the family or externally, to put the patient at the centre of the decision-making process.

Ms May also focussed on forward planning for health and wellbeing matters, rather than waiting for them to arise.

#### 1.2 Summary of Table Discussions

Outlined below is a summary of the table discussions on the Advocacy (Health Decision-Making) topic:

- Everyone concerned must be aware of a patient's rights when decisions are being made. This includes the patient themselves, their family, doctors and all clinical staff.
- Professionals should inform themselves about who is making decisions within the family, and should not hesitate to engage in those conversations without fearing that they are 'opening a can of worms', or acting beyond the scope of their role.
- Some patients will be isolated and without family members who can advocate on their behalf. Other people's families may not be willing to act on the patient's own choices.

Therefore, it may be useful to have an independent advocate available for people who need the service.

- Advanced care plans need to be more easily accessible, broader in their scope and more frequently used. They should be as easily accessible and useful as free will kits.
- Refusing to allow people to make their own choices about their care is, and needs to be recognised as, a form of elder abuse.

### 1.3 Topic Questions

#### 1.3.1 What is currently available that supports/enables advocacy and health decision-making by older Canberrans?

A number of services are available to older Canberrans. They include the ADACAS, Carers ACT, COTA ACT, the Public Advocate, Advance Care Planning and the ACT Civil and Administrative Tribunal (ACAT).

There are also self-help, disease-specific, community service, religious and charitable organisations, trustee, guardian and family groups, health care consumers' organisations and palliative care providers in the ACT.

All of these services are valued by older Canberrans, but delegates were critical of the extent of 'siloing' of such services, and they called for a more holistic approach.

One initiative that was praised by delegates was the Carers Association Information Packs for families.

Many delegates expressed disappointment about My Aged Care. They saw it as potentially valuable but felt that it needed to be better integrated with local systems. They noted that GPs and pharmacies are major sources of information and advice.

**Recommendation 1:** *Delegates recommended that the various services work more closely together and jointly evaluate the outcomes of their activities in order to improve services for the aged.*

#### 1.3.2 What more could be done to enable access to advocacy and health decision-making and whose responsibility is it to do this?

Ideally, individuals should be empowered to make their own decisions, and advocacy should not be thought of as a substitute for decision-making.

Consequently, if the 'advocate' is able to inform and support the individual to make their own decisions and stop short of actual advocacy, that is the 'gold standard'.

Older Canberrans must be aware of the availability of advocacy services and what they offer well before they need to avail themselves of such services. Unfortunately, many individuals do not encounter advocacy services until they are in crisis, at which time their capacity to benefit may have become compromised.

It is therefore important to educate the entire population about the right to make decisions about one's health, and to inform them about advocacy services, their right to be assigned an advocate and how to access such services.

It is particularly important to conduct education programs and training for guardians and younger persons supporting older people.

It is essential that information be expressed clearly and concisely, in community languages, and in culturally appropriate ways. Different cultural conceptions of people's rights need to be addressed and educational programs must address cultural barriers to 'speaking up'.

In making decisions, individuals need to know what is 'out there', and the delegates noted that service providers are not always in a good position to advertise their services because they have tight budgets and may be reticent to divert scarce human and financial resources away from service delivery to promotional activities.

**Recommendation 2:** *Delegates recommended that advocacy services be advertised more widely, to the whole community.*

Some service providers do not know how to access health decision-making or advocacy services and delegates felt that, as the GP is the 'information hub' in primary care, it was important to ensure that GPs and nurse practitioners were well informed so that they could, in turn, inform patients. However, delegates saw this as a challenge for doctors who now spend less time with patients. In fact, the changing nature of GP practice was a recurring theme throughout the afternoon.

Many individuals know little about advanced care plans and would not know where to find advanced care forms. It was suggested that these could be made as available as free will kits and it was recommended that education programs should be conducted about the use of advanced care plans and enduring powers of attorney. Such programs need to reach the elderly and their families. GPs should be aware of and discuss such plans with the family so that the family knows what to do should a crisis occur.

**Recommendation 3:** *Delegates recommended that free advanced care plans be made available and that accompanying education programs be conducted about the use of advanced care plans and enduring powers of attorney.*

Delegates discussed the need to have ongoing conversations about health wishes and noted that it was important to build relationships with trusted peers.

Many lone elders need support in their decisions and it was important that advocates be independent and see their role as supporting the aged person in their decision-making.

Families do not always advocate for the wishes of the elder. They may exercise control over information and prevent the individual from speaking on their own behalf. Families can bully the older person and elder abuse is a significant issue.

**Recommendation 4:** *Delegates recommended that elder abuse should be a reportable offence.*

Residential care issues are sometimes handled badly by family because the family members may have conflicts of interest. In such cases, it would be better to have in place an enduring power of attorney that names an advocate. Otherwise, an independent advisor/advocate

should be appointed. Professionals need to check that a proper decision-making process has been undertaken and that the elders are aware of their rights.

**Recommendation 5:** *Delegates recommended funding be made available for independent advocates.*

Similarly, in hospitals, the patient's family and children are often the main advocates, and there was some support for the idea that social workers could advocate on the patient's behalf. However, delegates noted that, with current resourcing levels, such services are not readily available.

Volunteers, perhaps sourced from veterans' organisations, could offer a range of services, from helping the patient to attend appointments and engage in community activities through to providing information that would assist the person in self-advocacy and managing end-of-life issues. Volunteers could potentially also act as advocates themselves.

Residential care facilities need to take a holistic approach. Aged people in residential care are often treated only as 'old' and the connections are not made regarding other issues such as depression or anxiety.

An idea that gained some support was the creation of a 'one stop advocacy shop' in hospitals and aged care facilities.

People with dementia were seen as particularly vulnerable. They are often isolated, lack family support and have diminishing decision-making capacity.

**Recommendation 6:** *Delegates recommended that people with dementia be provided with advocates at Territory expense.*

Action on many of these matters requires resources. Delegates saw this as a significant challenge, but one that must be addressed.

### 1.3.3 What might need to change to ensure that older people can provide feedback and make complaints about the health care experience that they have?

Older people often feel isolated when involved in the health care system. They feel that they are not fully informed about their condition or treatment options, not given enough time to express themselves and not consulted in a meaningful way. Consequently, they may not fully understand their condition or the treatment or be aware of treatment options.

Furthermore, the very elderly are often timid, shy and compliant. There is a power imbalance. If they do not want the treatment offered by medical staff, they may be afraid to speak up because they fear that they will be ignored and possibly left waiting.

Oversight is needed to make sure that the patient is heard and that their treatment decisions are respected and, where possible and appropriate, carried out.

**Recommendation 7:** *Delegates recommended that advocacy services be made available when requested.*

Patients need to feel confident that they can provide robust feedback. Feedback mechanisms should be made clear. There should be follow-up and complainants should have no fear that they will suffer for having complained.

Health systems should encourage, welcome and seek feedback. They should put in place systems to follow-up on that feedback, respond actively and see the feedback as a positive opportunity to improve the services they provide.

#### 1.3.4 If older Canberrans were fully exercising their right to be involved in decision-making about their care, what impact would that have on their experience and outcomes of health care?

Older Canberrans would be prepared ahead of time with appropriate knowledge of their rights and how to exercise them.

They would be given accurate information about their condition and about treatment options so that they could make informed decisions about the medical treatment they want. For instance, different people would have different preferences regarding the choice between pain relief and lucidity or between extending life and discontinuing 'futile' treatment.

They would probably have expressed their desires in enduring powers of attorney, advanced care plans and wills. Consequently, they would feel empowered, relaxed and confident that their wishes would be respected.

Their carers would be aware of their wishes and the system would ensure that those wishes were carried out to the greatest extent possible.

Older Canberrans want to age with dignity, and involvement in decision-making is essential to that.

#### 1.4 Recommendations

Delegates recommended that:

1. various services work more closely together and jointly evaluate the outcomes of their activities in order to improve services for the aged;
2. advocacy services be advertised more widely, to the whole community;
3. free advanced care plans be made available and that an accompanying education program be conducted about the use of advanced care plans and enduring powers of attorney;
4. elder abuse should be a reportable offence;
5. funding be made available for independent advocates;
6. people with dementia be provided with advocates at Territory expense; and
7. advocacy services be made available when requested.

#### 1.5 Four priority areas:

Delegates suggested that the ACT Government should also consider the following priorities when considering their recommendations:

- Services should work more closely together and jointly evaluate the outcomes of their activities in order to improve services for the aged.
- Free advanced care plans should be made available and education programs should be conducted about the use of advanced care plans and enduring powers of attorney.
- Advocacy services should be funded and advertised more widely, to the whole community.
- People with dementia should be provided with advocates at Territory expense.

## 2. Access to Health Care Services, Ms Jenny Mobbs, COTA ACT and Mr Patrick Reid, MACA

### 2.1 Introduction

Mr Patrick Reid's discussion urged delegates to acknowledge the fact that we are part of an ageing society, and that it is important to create a community that recognises and responds to those needs, including a health care system that is easy to navigate, that reflects the reality of our population and offers equity of care to everyone regardless of where they receive that care.

In this country Australians' value the principles of universal care, and Mr Reid suggests that we need an integrated health and aged care system where our own planning can be factored into the decision-making processes.

### 2.2 Summary of Table Discussions

Outlined below is a summary of the table discussions on the Access to Health Care Services topic:

- Education, information and health literacy are the key to accessing appropriate services. There is a need for face-to-face information among peer groups, but also currently there is no one-stop-shop for information regarding health and ageing.
- Patients may be assessed for services and know what they need. However, individuals may struggle to put all the information together and create a coherent action plan for themselves. This is particularly important when providers and resources may range across the Federal, ACT and private systems.
- Staff must be respectful of a range of different cultural values including the people from culturally and linguistically diverse backgrounds (CALD) and lesbian, gay, bisexual, transgender, queer, questioning and intersex communities (LGBTQI), and also recognise older people's differing social beliefs around matters like privacy. There needs to be more specific gerontology training for carers.
- A GP is not always the right person to help navigate access to the health care system. It is presumed that people will see a single doctor when in fact they are likely to see a range of doctors in the same practice for very limited periods of time. The centralised GP model is seen as commoditised and cost-based in a way that is unhelpful for older people with multiple health and social issues.
- Aggregated record keeping across a number of different health services would be helpful, as currently happens at the Belconnen Health Co-op.

- eHealth is not currently meeting people's needs regarding advanced care, health transitions and complex care. It should follow patients through their care cycle and include advanced care plans, medical privacy details and other useful ancillary information about the patient.
- Ageing in itself is not an illness, and health care also goes beyond a narrowly applied government health filter. It can include planning, physical activity and social support networks. Health impact statements could be useful in considering development and planning issues for example.
- In a society where family and neighbourhood structures are less connected than they used to be, we need better straightforward information for the whole community about what happens when you age and how your life might change.
- Do we hear the voice of the ageing as strongly as we hear the voice of children or the disability sector? Consumers need a strong voice.

## 2.3 TOPIC QUESTIONS

### 2.3.1 What is working to enable access to the widest range of health care in the ACT?

Delegates praised some of the current healthcare services. In particular, the walk-in centres, the hospitals' cardiac emergency care system, new health cooperatives and the 24-hour access to dialysis services for older people.

The Walk-in Centres are seen as a big success and delegates noted that having the Walk-in Centres reduces the load on the emergency department. Patients can go there for injections and wound care. Delegates did, however, note that parking is poor at the Belconnen Walk-in Centre.

Delegates noted that Canberra Hospital offers dementia training for all staff, which is important especially considering the lack of gerontologists and inadequate gerontology education in current Australian medical training institutions. They also noted that aged care nurses outside hospitals are the lowest paid.

**Recommendation 8:** *Delegates recommended improved gerontology training in Australian medical schools.*

Palliative care services were rated as satisfactory, with patients able to access services in less than one month.

Delegates expressed an overall sense of satisfaction with hospital access, after care and other agencies, tempered with concerns that are detailed in response to the next question.

Vietnam Veterans were seen as a model in addressing discrimination, isolation and social health issues, providing access to clinical services, connecting people within the community and helping people to remain active in social groups.

### 2.3.2 What more could be done to enable access to better health services and facilities in community, what can be done better and how?

It can be difficult to physically access outpatient clinics but, more importantly, too many older people present at the ED who should not be there. We need to divert them. However,

triage nurses are reluctant to turn people away, so they wait. The delegates discussed allocating a separate area for the elderly but expressed reservations about painting the elderly as 'different'.

Delegates agreed strongly that dementia patients, in particular, should not be at the hospital. Hospitals are not designed to meet their needs. Consequently, their needs are not being met and hospitals are forced to divert scarce resources away from other services.

**Recommendation 9:** *Delegates recommended that people with dementia be treated outside the hospital system.*

Independent living unit staff are not allowed to assist if a resident falls, and must call for an ambulance officer to assist them. This may be driven by legislative requirements or fear of liability. If so, those issues need to be addressed by the government, the industry and insurance companies.

**Recommendation 10:** *Delegates recommended that residential care facilities cease sending residents to Emergency for minor matters. This should be addressed by the government, with the residential care and insurance industries at the table.*

A major objective should be for the elderly to stay at home for as long as possible. However, in rural communities, home care may not be a viable option, forcing people into institutional care.

Social health care and in-home care after leaving hospital are very important. Patients, carers and family are often not consulted about the transition to post-hospital care or the inter-dependent logistics of transport, care and support. Home-based palliative care would be good, but it is not available due to the lack of staff.

**Recommendation 11:** *Delegates recommended the provision of home care to assist with the transition from hospital, provide advocacy and help the patient to establish social networks.*

Services must be flexible and recognise that some older people are 'set in their ways'. For example, some individuals reject Meals on Wheels because they eat a hot meal in the evening rather than at lunchtime. Care needs to be individualised - Meals on Wheels could look into offering a menu from which the person could choose.

Information and access are essential. There needs to be a single point of access on the phone, a physical one-stop-shop where the person can talk to a person and an interactive web resource. It is complicated and hard for the average Australian to understand the health system, but much harder for migrants, and this must be taken into account in the design of the information services.

Health literacy in some cultures is poor and, in many cases, information is incorrect.

Mandated interpreter use and its funding have helped and there are twelve languages which are readily available. However, delegates reported that some GPs and specialists are refusing to use the free interpreters. Doctors also need to understand that cultural context is important. Simple translation is not culturally appropriate for some medical issues.

**Recommendation 12:** *Delegates recommended that GPs receive training on how to make best use of interpreters.*

Outreach is needed to reach the very socially isolated. As the National Disability Insurance Scheme (NDIS) seems to have this, it might be a good model.

There was strong criticism of My Aged Care. A forty-to-fifty minute wait on the phone is common. The people who man the lines are not always sufficiently knowledgeable or qualified to tailor the package to the vulnerable individual.

**Recommendation 13:** *Delegates recommended that My Aged Care be re-crafted to be more user friendly or abolished.*

Housing ACT was criticised for being ill-equipped to support older people. Security, location and transport are all issues that need to be addressed specifically with older people in mind.

There is too much 'red tape'. The current aged care assessment and application for entry to nursing homes requires the completion of the 32-page form. This is challenging, frightening, intimidating and often requires an advocate. Delegates posed the question: Have we created a system that requires assistance to navigate? If so, it is too complex and should be simplified.

**Recommendation 14:** *Delegates recommended that care and residence application processes be simplified and made more accessible.*

Cost can affect access, and it is important to have access to bulk billing. There is an increasing number of GPs who will not bulk bill or are accepting new patients. The cost of pharmaceuticals is another barrier. Patients forego medication and carers forego their own care in order to pay for the aged person's treatment.

**Recommendation 15:** *Delegates recommended that the Safety Net for all individuals should be at the single rate.*

Delegates noted that, in relation to accessing services the expression is: 'we go where people are', the practice is: 'people should come to where we are'.

Getting to services can be problematic. For example pharmacy deliveries would be helpful. Delegates noted that many ideas were being floated, but needed to be tested.

**Recommendation 16:** *Delegates recommended that, as a general rule, new ideas should be piloted, noting that this could involve community organisations and Territory, State and Federal governments.*

Delegates noted there was some feeling that the government's attitude towards pain relief was based on non-medical factors rather than on medical evidence. Additionally delegates noted that may affect the care available to older people.

### 2.3.3 If older Canberrans were fully exercising their right to access better health care services, what should be done – short term and longer term?

It is important not to confuse health with ageing. As people age, changes happen but these are not necessarily health issues. For example, it may not be necessary to eat as much as at

a younger age to maintain a healthy weight. Many things that affect health are outside the ambit of what ACT Health can control. But the government has a role: health outcomes can also be achieved by building liveable, age-friendly suburbs and providing government services at or near home.

The links between social aspects of life and ageing are not well understood by some GPs who therefore do not know whom to refer to when issues are not purely medical. Community and voluntary services need to take the initiative here.

Community health nurses and community health centres were praised, in particular the community development health worker at Gungahlin who engages with the community about their needs. Delegates would like to see increased funding cuts reversed.

**Recommendation 17:** *Delegates recommended that Aged Care Centres be multidisciplinary one-stop-shops, employing healthcare and exercise specialists, focused on preventative activities and the provision of timely care.*

Money is important, but, for government, the primary need is to plan, provide information, assist individuals to self-manage, overcome glitches and eliminate breakdowns at the transition points. Self-management requires information and this is addressed in more detail under Health Promotion.

Delegates felt that GPs are under too much pressure. They recommended having a health navigator or concierge to support aged people and relieve some of that pressure on GPs, especially when managing the transition between levels of medical care.

**Recommendation 18:** *Delegates recommended having a health navigator or concierge to support aged people to manage the transition between levels of medical care.*

Delegates commented that it appeared to be particularly expensive to provide services in the ACT, but it was not clear why that was the case.

#### 2.3.4. Whose responsibility is it to do this in each setting?

Hospitals can be very difficult and confronting for elderly people, especially when they are unaccustomed to the ED and if they are not accompanied by a carer. Volunteers are needed for the ED, to assist people to navigate the system.

There is a children's ED and delegates asked why not have an elder's ED as well. They raised the question as to whether this reflected the value placed on elders by our society.

**Recommendation 19:** *Delegates recommended that hospital volunteers be recruited to assist people to navigate the system.*

For those who live alone, it is important to have a backup system, for neighbours to check on their welfare, backed up by volunteers.

Hospitals should build teams around a geriatrician in EDs to support with aged patients.

**Recommendation 20:** *Delegates recommended that hospitals build a geriatric-centred ED team, using the paediatric model.*

GPs should be linked-in as soon as the patient enters the ED and should be involved in discharge planning.

Delegates would like there to be one health record no matter which service a patient was utilising or accessing.

**Recommendation 21:** *Delegates recommended that each individual have a single health record.*

Delegates called on health providers to look at the whole person, not just the issue the patient was presenting with.

## 2.4 Recommendations

Delegates recommended:

8. improved gerontology training in Australian medical schools;
9. that people with dementia be treated outside the hospital system;
10. that residential care facilities cease sending residents to Emergency for minor matters. This should be addressed by the government, with the residential care and insurance industries at the table;
11. the provision of home care to assist with the transition from hospital, provide advocacy and help the patient to establish social networks;
12. that GPs receive training on how to make best use of interpreters;
13. that My Aged Care be re-crafted or abolished;
14. that care and residence application processes be simplified and made more accessible;
15. that the Safety Net for all individuals should be at the single rate;
16. that, as a general rule, new ideas should be piloted, noting that this could involve community organisations and Territory, State and Federal governments;
17. that Aged Care Centres be multidisciplinary one-stop-shops, employing healthcare and exercise specialists, focused on preventative activities and the provision of timely care;
18. having a health navigator or concierge to support aged people to manage the transition between levels of medical care;
19. that hospital volunteers be recruited to assist people to navigate the system;
20. that hospitals build a geriatrician-centered ED team, using the paediatric model; and
21. that each individual have a single health record.

## 2.5 Four priority areas:

Delegates suggested that the ACT Government should also consider the following priorities when considering their recommendations:

- Triage for people with dementia needs to be re-thought to reduce the number of people with dementia for whom hospital treatment is inappropriate.
- Residential care facilities must cease sending residents to ED for minor matters. This should be addressed by the government, with the residential care and insurance industries at the table.

- Navigators' services should be available at all stages of health care.
- Gerontology needs to be treated seriously as a standard part of the medical curriculum and hospitals should build geriatrician-centered ED teams based on the paediatric model.

### 3. Transitions in Care (continuity of care across services)

Dr Sue Andrews and Ms Kerry Snell, HCCA of the ACT

#### 3.1 Introduction

Dr Sue Andrews discussed the importance of ensuring continuity of care across a number of services. Where healthcare is increasingly fragmented, people can slip through the cracks unless the focus is on developing good systems and good communication with everyone concerned.

Good health literacy is also vital to ensure that everyone knows what each other is talking about and that in turn may prevent unnecessary transfers between aged care and emergency wards.

#### 3.2 Summary of Table Discussions

Outlined below is a summary of the table discussions on the Transitions in Care topic:

- Consumers need 'to understand and to be understood'. This may mean that interpreters are required for people from CALD backgrounds, and also suggests an important role for eHealth which it does not currently fill.
- Consumers may require help with their advanced care plans, and a dedicated month for information and action could be useful.
- Information is crucially important: 'You need to know what's actually available before you can access the services'.
- If patients are left their own resources, it may be difficult to ensure that their rehabilitation needs are met.
- A navigator role that operates beyond discharge could be useful as a means of ensuring that consumers have someone with whom they are very familiar and trust to help them access continuing care. This might be a medical practice role or operating out of the hospital system and with detailed oversight.
- Expectations on GPs for paperwork and gate-keeping are not always appropriate or useful. Governments may need to be better educated about how modern GP practices function to understand that the fee-for-service model often prevents doctors from fully engaging with ongoing care.
- The navigator role already happens informally for a number of CALD communities where there are language barriers, but needs to be formalised across the community to include people who might struggle with it for a variety of other reasons.

### 3.3 Topic Questions

#### 3.3.1 Thinking about your own experience and the experience of people you know, what would you say is currently working in our system to enable safe transitions of care for consumers?

Delegates expressed satisfaction with a number of services, including access to GPs, bulk billing through the national health scheme and the new clinics that offer bulk billing. They praised the oncology service at Canberra hospital, the walk-in services and ED. They also noted that the nursing staff at Canberra hospital were very attuned to the needs of veterans.

Delegates also praised access points and after hours services as well as the National Doctor Service.

It was commented that some of the emergency services work extremely well. For example, calling 000 for an Ambulance normally achieves a quick response, immediate care and decision-making on the spot. With the right advice, this can also contribute to preventative care.

Another example was the transition between the Canberra Hospital ED and Eye Clinic.

Delegates praised the volunteers at Canberra Hospital.

They also noted that there are services available to navigate people through these challenges, for example the Dementia Behaviour Management Advisory Services (DBMAS) assisting people entering dementia. Those individuals are not always aware of the services that are available.

Navigators provide an excellent service helping people to using health services in the ACT. Social workers, too, can help people to navigate the system.

Delegates said that there was good communication within the health service to facilitate continuity of care, combined with a collaborative approach at the time of discharge, which led to a smooth transition. However, this applied mainly to wards that focused on the elderly, but did not occur in all wards. Delegates considered it important to set up a health pathway (continuity of care access services) on discharge and to not accept an ad hoc approach.

The health worker should be trained in that pathway and adopt a holistic approach to advanced care programming when transitioning patients.

Palliative care was 'good if you can get it' but it can be difficult to gain admission.

The comment was made that independent women sometimes choose to go to retirement villages like Goodwin Homes because they get transitioned to higher care in a streamlined way.

#### 3.1.2. What more could be done to improve this?

Ideally, delegates would like to see good communication between all the health systems and a phone number to contact when in need of help. Many older people would prefer that or a walk-in counter rather than having to rely on online services.

Delegates note the importance of a multifaceted, holistic approach to discharge planning and it was suggested that hospital to home to community planning is handled much better in Europe. Detailed planning takes time and people to coordinate – acute care workers do not have the time. It is also complex, requiring Social Workers, Geriatricians, GPs or a psychologist. More staff need to be trained in discharge planning and particular attention must be paid to the risk of medication errors when entering and exiting hospitals.

**Recommendation 22:** *Delegates recommended that there be an aged care registered nurse in EDs who would also be involved in patient discharge.*

People want an integrated care system— to ‘tell their story once’. This raises confidentiality issues when transitioning – a lot of personal information is required and the elderly often do not like giving it. An eHealth system could help but issues with that are discussed under the Health Technologies heading. There are also difficulties with transferring medical e-records from hospital to hospital.

The need for communication during transition was a recurring theme, as was the need to improve the quality of communication currently available.

Upon leaving hospital, three things are needed: follow-up within 48 hours, self-management support, and connectivity to community-based support. These must be organised before leaving.

**Recommendation 23:** *Delegates recommended the provision of home services, including hairdressers and podiatrists, as well as pharmaceutical deliveries, for the housebound elderly.*

Delegates noted that it takes a long time to organise equipment and arrange external assistance.

Loneliness is a major issue for the elderly, whose families are often scattered, and social issues include difficulty in meeting people within a similar age group. Delegates would like these issues incorporated into discharge planning.

**Recommendation 24:** *Delegates recommended that social isolation be addressed as an issue in discharge planning.*

Delegates supported the right to die at home and note that the transition needs to be timely in order to meet the wishes of the patient.

**Recommendation 25:** *Delegates recommended the appointment of an advocate for over 85 year olds when leaving hospital.*

There was discussion about pathology collection points. Solutions discussed included being able to have pathology performed locally or to have better access to public transport, Cab Charges or community buses in order to get to pathology collection points. Delegates

considered it strange that social and medical transport are funded by different government agencies.

**Recommendation 26:** *Delegates recommended the provision of transport services to pathology collection points.*

### 3.1.3. What does the ideal state look like to you?

Delegates expressed support for the Rapid Assessment of the Deteriorating and At-Risk program (RADAR) identifies patients at risk before discharge and follows through after discharge.

Delegates would like older people to have access to support through a navigator, event manager or coordinator who understands their personal situation and who could support them throughout their health journey, almost a 'life health coach'. This would be a dedicated role and not subject to the pressures to which hospital social workers are exposed to.

There would be a seamless eHealth system in which all clinicians would record information thoroughly, share it with relevant colleagues and make it accessible to consumers.

Hospital staff would assess people for care in the patient's home.

### 3.1.4 How could transitions in care services improve?

Services would be integrated so that patients have to tell their stories only once.

Where possible, services would be co-located.

Systems to support transition, including ensuring that medication issues are addressed as patients enter and leave each stage.

Where possible, services would support people to return to their homes and put in place all that the individual needs to take care of their physical and emotional health and to prevent isolation, especially for those who are living alone.

## 3.2 Recommendations

Delegates recommended:

- 22.** that there be an aged care registered nurse in EDs who would also be involved in patient discharge;
- 23.** the provision of home services, including hairdressers and podiatrists, as well as pharmaceutical deliveries, for the housebound elderly.
- 24.** that social isolation be addressed as an issue in discharge planning;
- 25.** the appointment of an advocate for over 85 year olds when leaving hospital; and
- 26.** the provision of transport services to pathology collection points.

### 3.3 Four priority areas:

- EDs should have an aged care registered nurse who would also be involved in patient discharge.
- Social isolation should be addressed as an issue in all discharge planning.

- An advocate should be appointed for over 85 year olds when leaving hospital.
- The ACT Government should provide transport services to pathology collection points.

#### 4. End of Life Care Issues, Ms Gayle Sweaney, Palliative Care ACT

##### 4.1 Introduction

Ms Gale Sweaney from Palliative Care ACT opened the conversation on what she called 'the D Word' – death, and how we die these days.

Almost everyone would prefer to die at home, and that is a right. Unfortunately, it happens much less than we would prefer, and often without the dignity we would wish for.

Ms Sweaney encouraged us to have open discussions about how we can have a good death.

##### 4.2 Summary of Table Discussions

Outlined below is a summary of the table discussions on the

- Only three people in the room had an ACP. The plan should be far more widely available and could be attached to eHealth records. In the ACT, families do not have an automatic legal right to exercise a person's wishes unless the person has signed an advanced care plan.
- The process of making an ACP can seem arduous and may require assistance for some people. It could also require a mediator if there is dissent or confusion within the family about how someone's wishes can be carried out.
- Respite care is vitally important for both patients and their families. Palliative care also needs to include everyday life care, such as showering, cooking, cleaning, as well as health care.
- Health professionals need to be empowered to have conversations about death and dying. They can sometimes feel that those discussions are contrary to their role and message, but these discussions are vital in respecting patient rights.
- Awareness can be spread by engaging with the media about death, by holding 'death café' conversations and using social media to make death a familiar topic and break down the cultural taboo.

##### 4.3 Topic Questions

###### 4.3.1 Imagine you were unable to communicate your wishes regarding your health care and medical treatment...would your family and friends know your wishes?

It is important to plan in advance, write it down and tell people about it. There was considerable discussion about the extent to which family has the right to override plans and whether an EPA can be used to override such plans. The issue of complexity of planning, in general, was noted.

Medical staff, family and possibly carers each have a role in responding to or changing End-of-Life Care. Delegates recommended writing yourself a letter, taking it with you and keep it current, no more than twelve months old.

**Recommendation 27:** *Delegates recommended a program to educate the public about EPA and ACP, and what is required of them.*

It is important that end of life care be delivered in a culturally appropriate manner and that GPs respect patients' choices, which could involve cultural and religious considerations. The delegates discussed the concept of a death café - a roundtable about death and dying.

Delegates discussed broadening sex education to cover the whole of life from conception through to death. It should cover what to expect at the end of life, as it is important for the community and clinicians to better understand palliative care. The concept of 'suiciding successfully' also came up on a number of occasions.

It is important to ensure that staff maintain a focus on patients' end-of-life wishes, but delegates noted that it is a huge 'achilles heel' for many seniors, even hospital to hospital communication is poor.

**Recommendation 28:** *Delegates recommended that the eHealth system automatically prompt hospital electronic systems about patients' End-of-Life Plans.*

Families may need on-the-spot counselling and it is important to ensure that relatives and staff understand their responsibilities. Families from Culturally and Linguistically Diverse backgrounds may require interpreters.

Expansion of palliative care services and workforce development are as important as End-of-life planning is complex. There should be national guidelines. Delegates noted that NSW and ACT practices are not compatible. Delegates suggested a simple one-page form kept on a widely available eHealth system, or the form could be kept in hard copy by the patient.

**Recommendation 29:** *Delegates recommended incorporating a simple one-page end-of-life form into the patient's eHealth record.*

Patients should be able to demand what they want. It is not up to staff to decide. We need boundaries and limits for staff.

Some delegates suggested that these issues should be discussed from 18 years of age onward. Others preferred that it start much younger.

#### 4.3.2. What can we do to ensure a 'good death'?

In addressing the question of what a community would look like if it supported all stages of life, delegates talked about 'normalising' death. They discussed having better ways to record the wishes of patients, a universal electronic health record, and confidence that the individual's wishes would be fulfilled. They talked about raising the topic and planning as early as possible, the need for more research into best practices, the continuity of palliative care services and family education around the ACP.

The Public Trustee has an end-of-life week to publicise issues and delegates felt that this could be built on to raise public awareness of many of the issues discussed this afternoon.

**Recommendation 30:** *Delegates recommended a month-long concentrated advertising campaign to promote the Public Trustee's end-of-life week and raise public awareness of end-of-life issues.*

The dying have the right to choose between avoiding pain and suffering or accepting pain and suffering in order to remain lucid. The decision may affect how long their death is prolonged.

**Recommendation 31:** *Delegates recommended that patients' preferences around pain relief be respected.*

There is currently confusion regarding the legalities around death. The goal of medical staff is to 'save' the person, but this may go against the person's wishes.

**Recommendation 32:** *Delegates recommended that the ACT enact legislation to support euthanasia.*

Many people prefer to die within their community in a familiar place surrounded by family and friends, rather than the 'medical' model. They may also wish to avail themselves of cultural services. The point was made that 80 per cent of people want to die at home but only 20 per cent are able to do so. In the ACT, there is no support if the dying person elects to stay at home, except for those in aged care facilities.

**Recommendation 33:** *Delegates recommended the development of policies and practices that will help people to die at home.*

People need to be aware of their right to choose and, in order to exercise that right, they need to plan well beforehand and document their wishes.

Delegates repeatedly raised the issue of respite for carers.

#### 4.3.3 Who needs to be involved?

Wills, and Powers of Attorney, end-of-life and ACP should all be completed well before they are required. Individuals may need some assistance in this, as the forms and booklets are not easy to complete.

Various people are involved in an individual's death, most notably family, carers and friends. This is especially true for those who elect to die at home. Everyone needs to be prepared, to understand their roles and to respect the wishes of the dying person.

If the family cannot cope or provide adequate support, there will be issues around palliative care and a possible move to a hospice may be required.

The GP, hospital staff, home nurses and advocates all have important roles.

Delegates noted that it is useful to 'scale down' and gradually minimise household items. Pets can be important to older people and their welfare must be seriously addressed.

#### 4.3.4 What would a 'healthy' community look like if it was to support all stages of life?

This question was not discussed by any of the groups.

### 4.4 Recommendations

Delegates recommended:

**27.** a program to educate the public about EPA and ACP, and what is required of them;

28. that the eHealth system automatically prompt hospital electronic systems about patients' end-of-life plans;
29. incorporating a simple one-page end-of-life form into the patient's eHealth record;
30. a month-long concentrated advertising campaign to promote the Public Trustee's end-of-life week and raise public awareness of end-of-life issues;
31. that patients' preferences around pain relief be respected;
32. that the ACT enact legislation to support euthanasia; and
33. the development of policies and practices that will help people to die at home.

#### 4.5 Four priority areas:

1. ACT Health should develop a program to educate the public about enduring EPA and ACP.
2. The eHealth system, which should incorporate a simple one-page end-of-life form, should automatically prompt hospital electronic systems about patients' end-of-life plans.
3. ACT Health should support a month-long concentrated advertising campaign to promote the Public Trustee's end-of-life week and raise public awareness of end-of-life issues.
4. The ACT should enact legislation to support euthanasia.

## 5. Health Technologies (eHealth), Professor Greg Tegart, 2016 ACT Senior of the Year

### 5.1 Introduction

Professor Greg Tegart believes that technology is a friend to older people in managing the ageing and health care process.

Technology can assist with safety and security, can monitor medication usage and safety, provide advice and enhance participation in life.

Ideally the process can include apps and diagnostic computer programs that turn ageing into a self-directed process. However, the uptake on eHealth programs has been quite slow. What are we missing in terms of getting people on board?

### 5.2 Summary of Table Discussions

Outlined below is a summary of the table discussions on the

- Comparatively little is being done in Canberra with eHealth and there is little recognition that it encompasses more than just medical records. We need education and awareness about how much it can assist people to age in place. Uptake among GPs is also patchy and dependent on their willingness to get involved.
- Many older people remain concerned about privacy issues and personal information. It is important to acknowledge these as genuine concerns. If eHealth is to be accepted across the spectrum we need extensive information and education to raise awareness about how it can work for them.
- Concerns also exist over existing digitally held medical records. Delegates are worried

about who owned their records in a commercial medical practice. If the practice is sold, who retains ownership of the records and how will they be used? What rights do people have over their records and how can they be accessed?

- Fitbits and similar devices are becoming increasingly popular and could be a useful diagnostic tool if they were integrated into eHealth programs to create broader and more useful health records. Existing computer clubs and e-learning programs for older people might be used to teach them how to access their records.
- eHealth could also have benefits for preventative care, and the information could be used by broad-based data analysis. Consent would be crucial to the process.
- Education and consent are key to the success of all the eHealth measures discussed. Processes need to be explained clearly and consent obtained to ensure people feel entirely comfortable about the process.

### 5.3 Topic Questions

#### 5.3.1. What do you see as the significant areas to be covered in an aging -in -place approach for older Canberrans?

For an eHealth system to work well, it must be a single, national system. The states currently record patient information differently and the data is not readily transferrable.

All relevant recorded information, whether from the GP, hospital or other health professionals must be available anywhere in Australia on the same system.

Bar codes on wristbands in hospital are a good idea and could be linked to the eHealth system.

A significant positive for some delegates was the possibility to have their end-of-life plans on the system and easily accessed by acute care and medical staff.

IT security is an issue. Delegates expressed concern that others could access and use health information and that it could be hacked.

The response to MyHealth was largely positive. It could support the use of assistive technologies and be used for monitoring for ageing in place, as well as assisting carer support. However, delegates expressed concern that home monitoring devices and integrated technology-based solutions for aged care services could be expensive.

Furthermore, MyHealth monitoring devices could cause more isolation by replacing people contact.

Health apps were seen as having great potential and their uses could extend beyond the obvious. For example, delegates noted that it would be possible to remotely monitor whether a person was using their hot water jug in order to check that they were drinking tea regularly. However, quality assurance would be an issue. For apps, who will approve, license or certify that they are legitimate, effective and beneficial. Furthermore, for those who are less IT-literate, it may be difficult to find the apps.

Delegates considered it important to get health professionals to adopt and recommend eHealth and mHealth.

### 5.3.2. How do you feel about your medical data being recorded electronically and possibly made available for analysis in a big data project?

The idea of having a big data service available to researchers nationwide received some support, but only if anonymity could be guaranteed. Trust was the major issue – it was noted that Iceland and UK hospitals have sold data.

Some migrants, especially those from police states, are particularly concerned about how their information will be used. They have experienced government misuse of personal data. They feared that data could be hacked and they worried about how it might be used. They were particularly concerned about how insurance providers might use their data.

Delegates had privacy concerns over who would have access to information and whether, at some future time, access might be broadened and they would have no say in this. On the other side, what happens if you change your mind about your data being available?

They worried about data being used for purposes other than health. For example, might medical data be passed to the RTA and people lose their driver's licence?

The current eHealth system just adds a layer of administrative complexity. It also involves too much paperwork.

Some groups have cultural mores that make sharing of health matters unacceptable.

Most of the above discussion was around privacy and the use of data. Another major issue was whether the data, once collected, could be trusted. Information needs to follow the patient. Data must be up-to-date, accurate and complete. Records including medical and pharmaceutical, would have to be updated constantly by all relevant service providers. This requires that all users be sufficiently IT-literate, and that they communicate in a mutually comprehensible manner.

Privacy issues mean that each user would have a level of access appropriate to their needs.

GPs involvement is critical to the success of eHealth. They have not yet been given adequate incentive to participate.

Although not related to 'big data', an example of using eHealth was that acute care services sometimes ignore things such as the diabetes bracelet. This could be countered by putting such information into the eHealth record.

### 5.3.3. Do you know anyone using telehealth or mHealth- if so have you any feedback on this approach to healthcare?

Few delegates have had personal experience with tele-medicine or mHealth and most discussion focused on eHealth.

The current eHealth system received considerable criticism. It was described as complex, confusing and inaccessible for the user, medical staff and allied health workers, and not well understood by the public in general.

**Recommendation 34:** *Delegates recommended that eHealth be simplified and made user-friendly. This would improve take-up.*

It should support safe and appropriate care but, to do so, information needs to follow the patient. Among other things, that requires that health records be saved in the cloud, which worries many people. The issue will need to be addressed and people will need to be convinced that they can trust the system.

**Recommendation 35:** *Delegates recommended that privacy and security issues be addressed so that people will be confident in having their data on the system.*

Consumers do not trust the rebranded My Health Record, the design of which was done without appropriate or effective consultation.

Certain groups of people, such as mental health clients, people with HIV AIDS and possibly some religious groups, may have particular concerns about having their medical data on such a system. Some delegates suggested that individuals should be given the right to opt out.

Delegates were confident that the data collected by an eHealth system could provide a good evidence basis for health planning, even with some opt-outs. Delegates were not fully confident that the government could actually guarantee that their data would actually be, or would remain, de-identified.

**Recommendation 36:** *Delegates recommended that de-identified eHealth data be used for health planning.*

#### 5.3.4. [How can we ensure access to timely and reliable information on healthcare for older Canberrans?](#)

Health literacy across all cultural groups is necessary for good health care.

Information can be spread in many ways and it is important to take into account ways older Australians prefer to receive their information.

It is sometimes hard to know what services exist. For example, there may be a booklet but its existence may be unknown. Government departments, seniors clubs and sports clubs are often a good place to display such booklets, pamphlets and brochures about available services and programs for older Canberrans.

**Recommendation 37:** *Delegates recommended that information be imparted in as many community languages as possible, in plain jargon-free language.*

Interpreters are hard to obtain and, in close-knit communities, privacy, gender and cultural issues may render face-to-face translation unsuitable.

Network-based systems can be used, but websites must be navigable, accessible and easy to use for the non-expert, and apps must be simple. The 'digital divide' remains an issue.

There must be incentives for GPs to use eHealth. eHealth and GPs' business systems do not interact. Also, GPs do not want extensive pathology information from acute systems transferred onto their office systems. Delegates want their information to follow them, be accessible to relevant medical and allied services and remain secure.

## 5.4 Recommendations

Delegates recommended:

- 34.** that eHealth be simplified and made user-friendly. This would improve take-up;
- 35.** that privacy and security issues be addressed so that people will be confident in having all their data on the system;
- 36.** that de-identified eHealth data be used to assist with future health planning; and
- 37.** that information be imparted in as many community languages as possible, in plain jargon-free language.

## 5.5 Four priority areas:

1. eHealth should be simplified and made user-friendly in order to improve up take.
2. Privacy and security issues should be addressed so that people will be confident in having their data on the system.
3. eHealth data could be used to assist with future health planning, providing it is de-identified.
4. Health information should be imparted in as many community languages as possible, in plain jargon-free language.

## 6. Health Promotion, Wellbeing and Healthy Living

Mr Tony Stubbs, Heart Foundation ACT and Ms Suzanne Eastwood, AIDS Action Council of the ACT

### 6.1 Introduction

Mr Tony Stubbs from the Heart Foundation used the relatively high number of heart attacks, vascular disease and strokes to illustrate his point that we need both mobility and activity programs and also policy settings to reflect the positive effects that activity can have on health wellbeing and, consequently, health costs.

Activity builds bone density, reduces stroke risk, and improves mental and social wellbeing as well as physical fitness.

Mr Stubbs suggested that we need a comprehensive physical activity strategy in the ACT that considers mobility, access and recreational needs. This might include age-friendly suburbs and age-friendly physical activity programs for retirement villages.

### 6.2 Summary of Table Discussions

Outlined below is a summary of the table discussions on the

- Health literacy is vital to ensure people are active and full participants in both preventative and ongoing health care.
- Age-friendly infrastructure is vital. This includes easily accessible streets and footpaths, effective lighting and safe exercise spaces. Access to gardens and community spaces was also a priority for many and a 'playground for the elderly' to facilitate exercise and physical activity was suggested.
- People from culturally and linguistically diverse backgrounds and older people with

special needs must be understood and respected in regard to appropriate activity.

- There is a need for much more easily accessible information about how to get involved in physical activities. COTA provides an information line that might help, but it is difficult to find out what is available, including other life services, especially if people are house-bound.
- Service providers should not presume that information about physical exercise and other services is always accessible via digital devices: some older people are keen users of these devices while others do not use them at all.
- It is vital for aged care residential services to provide genuine active care: delegates felt 'They should lose their licences if they don't'.

### 6.3 Topic Questions

#### 6.3.1 What is currently working in health promotion with Seniors?

Delegates praised a number of current health promotion services, including Heart Moves, the ACT Health Services Directory, the Find a Health Service smart phone app that links to the National Health Services Directory, the Health Directory 24/7 phone service, the local *Contact* directory and the recently released Activation Framework.

They also noted that Monash, Kaleen, Ainslie and Weston suburbs were being made 'age-friendly'.

Delegates praised Access Canberra. It has well-trained staff and they are backed by a good database. People can use Access Canberra to obtain information and locate services, and staff refer people to relevant services.

The implementation of health stations around Canberra received considerable support, but delegates felt that people need to be encouraged to use Canberra's open spaces. They noted that is important to place facilities where they are accessible and to maintain them.

#### 6.3.2 What could be done better?

Health promotion needs to be at the top of the agenda and exercise must be a priority.

Community groups need to be strengthened and halls, community centers and community spaces could be used more effectively to promote a sense of continuity and ownership by the community.

Aged people should have better access to public facilities such swimming pools. Pool space is time-controlled and people with arthritis have limited access to use the pools in a beneficial way. Programs targeting chronic illnesses could be delivered at such public facilities. For example, physiotherapists could run courses at public swimming pools.

Government agencies should collaborate in this area.

**Recommendation 38:** *Delegates suggested that aged people should have better access to public facilities such as swimming pools and that programs targeting chronic illnesses be delivered there.*

Delegates noted that 'wearing out' is not the same as being ill and preventive programs can effectively address the former. There is too much effort being put into repairing rather than preventing. The Weston Creek Health Centre was praised for its focus on activity rather than treatment.

On the other hand, some illness is psychological in origin and compounded by lack of confidence and self-worth. This can apply in particular to those who have lost a partner. The recently widowed should be seen as a group that should be targeted.

### 6.3.3. What would you want to see in health promotion with Seniors?

It is essential to use a variety of well-targeted communication methods and strategies, social marketing and specific campaigns.

However, 'health promotion' activities can also be understood more broadly than communication strategies. For example, attractive and accessible infrastructure that supports and invites activity can also be seen as promoting health. Examples raised by delegates include well-maintained and wider foot paths with better crossings, suitable for walking groups.

**Recommendation 39:** *Delegates recommended that the government promotes the development of attractive and accessible infrastructure that supports and invites activity.*

Delegates suggested 'playgrounds' and exercise areas for seniors, although not necessarily for their exclusive use, as they would prefer to encourage mixed use and mixed age groups.

**Recommendation 40:** *Delegates recommended 'playgrounds' that encourage exercise and cater for all age groups.*

Safety was an issue. For example, delegates commented on the danger of sharing walking paths with cyclists and the lack of venues available for walking on level ground. They noted the need to factor into planning the cost of these improvements.

Delegates would like to see more Commonwealth gardens and plantings around suburbs. These should be accessible to the disabled, for example by including raised garden beds.

Noting the sense of self-satisfaction that can come from gardening, they suggested assistance in maintaining their own garden.

In an ideal world, delegates would like to see a health promotion television program, an aged care services page in the Northside and Southside Chronicle, more training and awareness of the needs of different groups, including the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer communities and culturally and linguistically diverse groups, assisted transport and government assistance for carers to take people out.

Delegates noted that some seniors do not use smart phones or other digital devices. For them, finding out what is happening is an issue, more so for those who are housebound. It can be difficult to find a hairdresser or a podiatrist or somewhere to exercise.

**Recommendation 41:** *Delegates recommended that health information and advice that meets the needs of our diverse population be provided and accessible over a range of media.*

Some social activities are available only to club members. Delegates recommended that organisations and clubs initially invite people to attend and participate in community activities before having to decide whether to join. ‘Try before you buy.’

**Recommendation 42:** *Delegates recommended that organisations and clubs invite people to participate in community activities before having to commit to join.*

#### 6.3.4. Who needs to be involved or who is responsible and what do they need to know?

Health promotion should be seen in its broadest context. Planners need to design suburbs, transport systems and facilities in ways that encourage physical activity and social interaction in safe spaces.

Health promotion organisations and agencies need to take account of the particular needs of the aged, the particular difficulties they face, the ways in which they prefer to communicate and social isolation.

The aged are not a homogeneous group. Communications must be deliberately and effectively targeted and recognise cultural differences, not just around appropriate communication methods but around the appropriateness of particular activities.

It is important to respect people’s choices. Some elderly people do not want to exercise and there should be activities that meet their needs as well.

Seniors clubs could have a much larger role but they need more government assistance than they currently receive.

#### 6.2 Recommendations

Delegates recommended:

- 38.** that aged people should have better access to public facilities such as swimming pools and that programs targeting chronic illnesses be delivered there.
- 39.** that the government promotes the development of attractive and accessible infrastructure that supports and invites activity
- 40.** establish ‘playgrounds’ that encourage exercise and cater for all age groups
- 41.** that health information and advice that meets the needs of our diverse population be provided and accessible over a range of media.
- 42.** that organisations and clubs invite people to participate in community activities before having to commit to join.

#### 6.3 Four priority areas:

- 1. Aged people  
should have better access to public facilities such as swimming pools and programs targeting chronic illnesses should be delivered there.
- 2. The  
government should promote the development of attractive and accessible infrastructure that supports and invites activity, including ‘playgrounds’ that encourage exercise and cater for all age groups.

3. Health information and advice that meets the needs of our diverse population should be provided and accessible through a range of media.
4. Organisations and clubs should invite people to participate in community activities before having to commit to join.

## PRIORITY AREAS FROM THE WORLD CAFE

### Advocacy (Health Decision-Making) - Four priority areas:

1. Services should work more closely together and jointly evaluate the outcomes of their activities in order to improve services for the aged.
2. Free advanced care plans should be made available and education programs should be conducted about the use of advanced care plans and enduring powers of attorney.
3. Advocacy services should be funded and advertised more widely, to the whole community.
4. People with dementia should be provided with advocates at Territory expense.

### Access to Health - Four priority areas:

1. Triage for people with dementia needs to be re-thought to reduce the number of people with dementia whom hospital treatment is inappropriate.
2. Residential care facilities must cease sending residents to Emergency for minor matters. This should be addressed by the government, with the residential care and insurance industries at the table.
3. Navigators' services should be available at all stages of health care.
4. Gerontology needs to be treated seriously as a standard part of the medical curriculum and hospitals should build geriatrician-centered ED teams based on the paediatric model.

### Transitions in Care (continuity of care across services) - Four priority areas:

1. EDs should have an aged care registered nurse who would also be involved in patient discharge.
2. Social isolation should be addressed as an issue in discharge planning.
3. An advocate should be appointed for over 85 year olds when leaving hospital.
4. The ACT Government should provide transport services to pathology collection points.

### End of Life Care Issues - Four priority areas:

1. ACT Health should develop a program to educate the public about enduring powers of attorney and advanced care plans.
2. The eHealth system, should incorporate a simple one-page end-of-life form and should automatically prompt hospital electronic systems about patients' end-of-life plans.

3. ACT Health should support a month-long concentrated advertising campaign to promote the Public Trustee's end-of-life week and raise public awareness of end-of-life issues.
4. The ACT should enact legislation to support euthanasia.

#### Health Technologies (e-Health) - Four priority areas:

1. eHealth should be simplified and made user-friendly in order to improve take-up.
2. Privacy and security issues should be addressed so that people will be confident in having their data on the system.
3. eHealth data could be used to assist future health planning, providing it is de-identified.
4. Health information should be imparted in as many community languages as possible, in plain jargon-free language.

#### Health Promotion, Wellbeing and Healthy Living - Four priority areas:

1. Aged people should have better access to public facilities such as swimming pools and programs targeting chronic illnesses should be delivered there.
2. The government should promote the development of attractive and accessible infrastructure that supports and invites activity, including 'playgrounds' that encourage exercise and cater for all age groups.
3. Health information and advice that meets the needs of our diverse population should be provided and be accessible through a range media mechanisms.
4. Organisations and clubs should invite people to participate in community activities before having to commit to join.

## SUMMARY OF RECOMMENDATIONS

1. Services work more closely together and jointly evaluate the outcomes of their activities in order to improve services for the aged.
2. Advocacy services be advertised more widely, to the whole community.
3. Free Advanced Care Plans (ACP) be made available and that an accompanying education program be conducted about the use of ACP and Enduring Powers of Attorney (EPA).
4. Elder abuse should be a reportable offence.
5. Funding for independent advocates.
6. People with dementia to be provided with advocates at the Territory's expense.
7. Advocacy services be made available when requested.
8. Improved gerontology training be provided in Australian medical schools.
9. People with dementia to be treated outside the hospital system.
10. Residential care facilities cease sending residents to Emergency Department (ED) for minor matters.
11. Provision of home care be provided to assist with the transition from hospital, provide advocacy and help the patient to establish social networks.
12. General Practitioners (GPs) to receive training on how to make best use of interpreters.
13. My Aged Care to be re-crafted or abolished.
14. Care and residence application processes be simplified and made more accessible.
15. The Safety Net for all individuals should be at the single rate.
16. As a general rule, new ideas should be piloted, noting that this could involve community organisations, Territory, State and Federal governments.
17. Aged Care Centers to be multidisciplinary one-stop-shops, employing healthcare and exercise specialists, focused on preventative activities and the provision of timely care.
18. Having a health navigator or concierge to support aged people to manage the transition between levels of medical care.
19. Hospital volunteers to be recruited to assist people to navigate the system.
20. Hospitals build a geriatrician-centered ED team, using the paediatric model.
21. Each individual to have a single health record.
22. Aged Care, Registered Nurses to be in ED who would also be involved in patient discharge.
23. Provision of home services to be provided, including hairdressers and podiatrists, as well as pharmaceutical deliveries, for the housebound elderly.
24. Social isolation be addressed as an issue in discharge planning.
25. Appointment of an advocate to be provided for over 85 year olds when leaving hospital.
26. Provision of transport services to be provided to pathology collection points.

27. Implement a program to educate the public about EPA and ACP, and what is required of them.
28. The eHealth system to automatically prompt hospital electronic systems about patients' end-of-life plans.
29. Incorporate a simple one-page end-of-life form into the patient's eHealth record.
30. Develop a month-long concentrated advertising campaign to promote the Public Trustee's end-of-life week and raise public awareness of end-of-life issues.
31. Patients' preferences around pain relief should be respected.
32. The ACT enact legislation to support euthanasia.
33. Support the development of policies and practices that will help people to die at home.
34. eHealth to be simplified and made user-friendly.
35. Privacy and security issues to be addressed so that people will be confident in having their data on the system.
36. De-identified eHealth data to be used for health planning.
37. Information to be imparted in as many community languages as possible, in plain jargon-free language.
38. Ensure aged people have better access to public facilities such as swimming pools and that programs targeting chronic illnesses be delivered there.
39. Promote the development of attractive and accessible infrastructure that supports and invites activity.
40. Develop 'playgrounds' that encourage exercise and cater for all age groups.
41. Health information and advice that meets the needs of our diverse population be provided and accessible over a range of media.
42. Organisations and clubs be encouraged to invite people to participate in community activities before having to commit to join.