The impact of cognitive impairment on health care costs

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The financial impact dementia has on individuals, and the community is not well established. In Australia, Aged Care Assessment Teams (ACATs) provide multidisciplinary assessments for the elderly, assisting with the appropriate utilisation of services and residential care. Health care costs associated with cognitive impairment in this frail elderly group has not previously been studied.

A random sample of 100 persons was selected from referrals to North West Hospital ACAT, of which 78 persons participated. Each person underwent extensive cognitive assessment and were classified as dementia or cognitive impairment using ICD10 criteria. At one year utilisation of community services, hospital and residential care were determined for each person. Out of pocket (OOP) costs and Government and agency (Govt) costs were calculated using cost figures available. All prices are in Australian currency.

The mean annual cost per person was $29,436. Of those referred to an Aged Care Assessment Team, the mean annual cost per person with cognitive impairment was almost twice the cost of one without cognitive impairment. The difference lies largely in the cost of residential care. Inpatient care also accounts for a large proportion of costs in both groups. Cognitive impairment has a great impact on subsequent health care costs of clients seen by an Aged Care Assessment Team.

Implementation of continuing care guidelines in hospital patients


A 6 month prospective study was undertaken to evaluate the role of a specialist team (2 nurse practitioners under consultant supervision) in implementing continuing care guidelines in hospitalised patients with complex disability. The team was responsible for assessing for and facilitating access to continuing health care throughout the hospital and across the hospital community interface on a non age-related basis. It had access to 6 inpatient beds and a budget to purchase health care after discharge for 7 days. Patients with complex needs were referred to the team if their continuing health care needs could not be assessed, improved or provided for within mainstream practice.

Of the 93 patients included in the study, 34 (37%) were from geriatrics wards and 59 (63%) from other specialties, notably orthopaedics. Of the 59 patients from other specialties, 26 (44%) had been inappropriately referred (no continuing health care needs) and 24 (41%) appropriate patients had not been referred by the ward teams because of inadequate assessments.

It was possible to facilitate discharge and continuing care provision in 35 patients without transfer to dedicated beds. Thirty two patients were transferred for further assessment and management (median length of stay 17 days). Three (9%) patients died, 20 (63%) were discharged home and 6 (19%) were discharged to institutional care. Three patients had to be transferred to acute care. An improvement was seen in psychosocial measures and a high level of satisfaction with support and post-discharge arrangements was reported by 81% patients, 78% carers and 81% general practitioners involved in the study.

Specialist assessment and input, using a team approach, facilitate effective implementation of continuing care guidelines, especially in patients in specialities other than geriatric medicine.