Propositions under consideration by Counsel Assisting: response

Department of Health and Human Services

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Introduction

The Department of Health and Human Services (the department) welcomes the opportunity to respond to *Propositions under consideration by Counsel Assisting the Royal Commission into Aged Care Quality and Safety*.

These responses supplement information provided to the Royal Commission in the Victorian Government submission, and previous evidence provided by Terry Symonds, Deputy Secretary Health and Wellbeing through witness statement dated 13 November 2019 and at during oral evidence presented at the Canberra public hearing on 13 December 2019.

As highlighted in previous evidence, the department has a dual perspective on the topic of the health and aged care interface, playing key roles as system steward of the Victorian public health system, and as the system manager of Victorian Government public sector residential aged care services.

The department welcomes collaborative processes to develop a nationally consistent model for healthcare delivery in aged care. The department notes that building the clinical capacity of the aged care workforce and addressing underlying systemic aged care issues must be considered alongside strategies to leverage the health system to support older Australians to age well.

Responses to propositions

Primary health care funding models [proposition CH1]

The Australian Government should work with the aged care sector, professional and consumer groups to introduce a new funding model to improve access to and quality of primary health care services for people living in residential aged care, or who require high levels of care at home. The funding model should:

a. incentivise practitioners or organisations to deliver more proactive and preventative primary care and coordinate more effectively with other practitioners, facilities and families;

b. promote access to a greater range of health practitioners, and ensure flexibility in who can deliver services to better address service gaps; and

c. promote innovation (including investment in technologies) and quality care outcomes for people in aged care.

The model might include a mix of risk adjusted base funding paid on the basis of enrolment, fee for service for non-standard attendances, and payments contingent on achievement against performance indicators.

In consideration of future funding models, aged care residents should retain the ability to choose their general practitioner and GPs should have the ability to elect to take part in the new model or not.

The department supports the proposed changes to the primary health care funding model.

This is likely to be a longer term solution, with other measures needed to support improved access and higher quality primary care in residential aged care settings in the short term.

Commonwealth funded Primary Health Networks have a central role in planning and commissioning primary care services. There are opportunities for these networks to lead and support actions to maximise current arrangements to benefit aged care recipients as well as play a role in developing new funding models.

RACGP accreditation requirements [proposition CH2]

The Royal Australian College of General Practitioners should amend their accreditation standards to allow general practices which practise exclusively in providing primary health care to aged care recipients in RACFs and in their own homes to be accredited, thereby leading GPs in those practices to be eligible to claim payments designed to incentivise GPs to provide primary health care to aged care recipients under the Practice Incentive Program - Aged Care Access Incentive.

Specifically, the amendments would involve the following standards not operating in relation to mobile general practices of this kind:

a. Standard GP2.1: continuous and comprehensive care so as to permit such practices to specialise in providing care exclusively to the demographic of older Australians in RACFs; and

b. Standard GP5.2: practice equipment.

The department supports this proposition. Incentivising GPs to engage with older people is integral for healthy ageing. It is important to encourage GPs to continue to care for patients as they age and change care arrangements.

The department encourages broader opportunities to increase the provision of high quality, primary care services (including but not limited to GPs) for aged care, including policy and funding adjustments such as:

- adjustments to the MBS to improve primary care utilisation (including other specialist support for older people);
- exploring alternative funding models that facilitate multidisciplinary approaches.

Other system and practice improvements that will support GP engagement include:

- streamlining access to a resident's clinical file;
- ensuring that staff with clinical knowledge of the resident participate in health assessments;
- having appropriate equipment and facilities in residential aged care services to support the clinical care of residents.

Physical infrastructure and staffing support [proposition CH3]

The Quality of Care Principles 2014 (and any subsequent instrument) should include a requirement for approved providers of residential aged care to provide a room with sufficient lighting and privacy for consultations (which could be the resident's room), access to necessary equipment, and the necessary levels of clinical support staff to visiting primary health practitioners to ensure residents have timely and quality access to primary health care services. Visiting health practitioners may also include non-primary health care practitioners, such as geriatricians.

The department supports this proposition. Improving engagement by primary care practitioners in residential aged care settings is critical. Visiting primary care practitioners have identified physical infrastructure and staffing support as two key barriers to engagement.

A key component of this proposition will be ensuring access to suitably skilled staff within the aged care system on both the arrival and departure of visiting primary care practitioners, and for follow up health care activities.

This supports quality of clinical handover and improves the quality of information transfer for both the staff, visiting clinician and the resident and their family, which should improve outcomes for the resident.

Requirement to make arrangements with primary health care practitioner/s [proposition CH4]

The Australian Government should amend the Quality of Care Principles 2014 to require that:

(a) residential aged care providers and providers of high level home care (aged care providers) are to offer to the people to whom they are providing aged care (aged care recipients) to make arrangements with general practitioners or nurse practitioners to provide primary health care to them; and

(b) in the event that an aged care recipient has not arranged for their own primary health care practitioner within a reasonable time, the aged care provider is to arrange for a practitioner on the aged care recipient's behalf.

Aged care providers are to enter into a documented arrangement between the provider, each aged care recipient (or their authorised representative), and their primary health care practitioner, stipulating the roles and responsibilities of the aged care provider and of the health care practitioner with respect to primary health care of the aged care recipient. This may, for example, take the form of a service contract or memorandum of understanding.

As for proposition CH1, aged care recipients should retain the ability to choose their general practitioner, and general practitioners should have the ability to elect to provide this service or not.

The department agrees there is a need to ensure that aged care recipients have timely access to appropriate primary health care.

The department supports the amendments to the Quality of Care Principles and considers that this is a role that providers should already be playing at intake and through the development and review of care plans.

However, there are reservations about mandating memorandums of understanding or service contracts. Such a measure will place a further administrative burden on all parties, and as such has the potential to disincentivise engagement of primary health practitioners with the aged care sector.

Consideration must also be given to the potential conflict of interest for practitioners entering such an agreement – there are times when a practitioner must advocate for their patient with the aged care provider. The proposed contract may be perceived to affect this important advocacy role.

In addition, such a prescriptive approach may not be ultimately required in light of other systemic reforms and practice improvements that the Royal Commission is considering, including:

- increasing the clinical capacity of the aged care sector;
- national agreement about roles and responsibilities;
- appropriate funding and incentives for primary health provision;
- practice improvements such as enhanced clinical handover;
- ongoing, regular assessment of aged care recipients to determine whether primary health arrangements are satisfactory.

Increasing numbers of nurse practitioners [proposition CH5]

The Australian and State and Territory Governments should introduce measures to increase the available workforce of Nurse Practitioners in the aged care system, including by establishing/expanding a Nurse Practitioner scholarships program, with return of service obligations. [Note: return of service obligations requires further consideration by the Commission.]

The department supports increased engagement of the Nurse Practitioner workforce in the aged care sector. Nurse Practitioners can support improved outcomes in aged care, especially where primary care provision is thin in rural and regional areas.

While the department welcomes efforts to promote Nurse Practitioner career pathways, addressing funding barriers to these roles in aged care should be the priority for action, including:

- improving access to additional MBS items and rates for services provided by Nurse Practitioners;
- financial incentives for employers to provide the mandated three years of supervision and mentorship required before registered nurses can apply for endorsement as a Nurse Practitioner. For smaller aged care providers seeking to develop Nurse Practitioner models of care, resourcing for this requirement can be a significant barrier.
- consideration of the limitations imposed by the existing Aged Care Funding Instrument, which does not incentivise the use Nurse Practitioners to their full potential and often leads to duplication of services. As an example, a diagnosis made by a Nurse Practitioner is not renumerated in the same way as one made by a GP, so a facility may not authorise treatment directives made by the Nurse Practitioners (in favour of the same directive made by a GP).

Responsive funding for comprehensive health assessments [proposition CH6]

The Medicare Benefits Schedule (MBS) items 224, 225, 226, 227, 701, 703, 705 and 707 should be revised to support comprehensive health assessment and team care arrangements on entry to aged care and then every 6 months or as needed. They could also be amended to allow nurse practitioners to carry out health assessments in particular circumstances.

The department supports this proposition, noting it needs to be part of a multifaceted approach that considers options to improve access to cross-sector clinical expertise.

A comprehensive health assessment is significant to an older person's health, safety and quality of life outcomes, providing a holistic approach to assessing an older person's complex medical, social and care needs.

This assessment is integral in identifying the key areas where primary healthcare providers will need to be engaged to support attainment of the person's goals. Developing and enacting a care plan based on the assessment will also be essential to support the older person, their family and staff to meet the goals and adjust at reassessment.

A skilled and competent workforce in aged care that can act on the outcomes of these assessments is key to the success of this proposal.

Multi-disciplinary outreach health services [proposition CH7]

The Australian and state and territory governments should agree on the introduction and funding of Local Hospital Network led outreach health services for people in residential aged care services or receiving high-level home care.

These should be accessible for all older people in residential aged care services or high-level home care, based on clinical need, and involve:

• Multi-disciplinary teams, including NPs, allied health practitioners (speech pathologists, occupational therapists, physiotherapists), and pharmacists.

• Access to a core group of relevant specialists, including geriatricians, psycho-geriatricians and palliative care specialists.

• Embedded escalation to other specialists (endocrinologists, cardiologists, infectious disease specialists, wound specialists etc), who are already salaried within the hospital and assigned to the model for part of their work.

• Use of telehealth and other advances in technology where appropriate (such as mobile xray and CT capability (when viable)).

• 24/7 on-call services to residential aged care residents and their families and to residential aged care facilities (i.e. any of these groups can call the service)

• Proactive care through 'rounds' at facilities.

The key features of the model to include:

• holistic, person-centred multi-disciplinary care;

• triaging of need in line with clinical need and advanced directives;

• advice for and upskilling of residential aged care providers and high-level home care providers;

• hospital avoidance wherever appropriate;

• providing services in a person's place of habitation wherever possible, building on hospital in the home initiatives; and

• easily accessed through a phone call direct to the service

• information sharing with the residential aged care service and with the resident's relevant primary health care providers

These services should be explicitly funded through the National Health Reform Agreement. The determination of funding should take into account the cost benefit to the states and territories of hospital avoidance achieved by these programs.

There should be sufficient flexibility in funding to implement these services according to different models of care designed to meet the needs of the local population and other service infrastructure.

The department supports this proposition, and welcomes the opportunity it provides to strengthen existing Victorian models.

Bringing care to the older person through outreach health services can support better health outcomes for the individual. As noted to the Royal Commission, Victoria has several initiatives in place to support aged care residents to receive appropriate specialist and emergency care, notably the Residential In Reach (RIR) program.

To improve healthcare outcomes for people in aged care, system improvements must also focus on upskilling and incentivising the aged care workforce to deliver foundational healthcare. It is important that expanded outreach programs support aged care providers to build their own clinical capacity, complement the non-tertiary care delivered by the provider, and do not disengage GPs. In brief, multi-disciplinary outreach health services should be complementary to a skilled clinical workforce within the aged care system, not a replacement.

Key primary care and aged care functions - for example, escalation to specialists and proactive rounds at facilities – are best performed by skilled clinicians with a continued relationship with the aged care recipient.

The department agrees with the need for sufficient flexibility in funding arrangements to enable local variation in models of care, with services able to develop approaches that best meet the needs of the local population. In Victoria, RIR models vary across health services, linking to the existing availability of specialists, access to service infrastructure, and the need profile of the local community.

It is important that design of models of care at the local level also reflect likely demand for outreach services. For instance, in most areas it is unlikely that demand will be sufficient to support funding of 24/7 on-call services. Most specialist services are chiefly available on a more targeted basis, with a high cost associated with extending availability outside of standard hours.

The Victorian Government operates the Nurse on Call service and the Personal Alert Victoria system to provide additional support to older Victorians, their carers and families outside of standard hours. In genuine emergencies, aged care residents should continue to access ambulance transport and emergency department support.

Consideration is required in the design of funding levels for a new or expanded outreach program. While a successful outreach program (coupled with other improvements in health capacity and capability within the aged care system) should reduce avoidable hospital presentations, there should be careful assessment of the likely scale of potential improvements within each community.

From the department's experience, new or expanded programs should be funded at (or very close to) the true cost of delivery for that program. If not funded adequately, health services are likely to either reduce the volume of services available to aged care residents through the program, or reduce the number of older people that are supported through the program.

Following targeted analysis of potential flow-on benefits of a new or expanded program to the wider health system, any potential funding adjustments should not be made at the program level, as this could result in the outcomes of this positive proposition not being achieved.

Enhancing the Rural Health Outreach Fund to improve access to medical specialists [proposition CH8]

Funding available under the Rural Health Outreach Fund should be increased, and the objectives of the Fund amended to include delivery of medical specialist services in aged care services in regional, rural and remote Australia.

The department supports this proposition, welcoming efforts to increase access to medical specialists in rural and regional areas. Programs to increase the number of medical specialists (including geriatricians) in rural and regional areas would complement this proposition.

Other areas to build on and learn from include:

- The Commonwealth supported specialist training program could prioritise training positions in aged care in rural and regional locations for Commonwealth funding.
- Outreach services could include opportunities for education and training. Encouraging specialist medical colleges to accredit outreach services as part of specialist training would ensure that new specialists and specialists-in-training are exposed to these models of service delivery.
- A national model could be based on the Victorian Geriatric Medicine Training Program. This program has significantly increased the number of geriatric trainees in Victoria.

Incentivising specialists to provide a minimum level of services in residential aged care [proposition CH9]

The Australian Government should introduce incentives to encourage medical specialists in core disciplines (for example, geriatricians, psycho-geriatricians, palliative care specialists, and rehabilitation specialists) to provide a minimum level of services in residential aged care services.

This could be achieved either through differential rebates contingent on achieving minimum levels of service delivery or service incentive payment akin to the general practitioner payments under the Practice Incentive Program (PIP).

The department supports a coordinated interdisciplinary approach to managing health care for people in residential aged care.

As feedback from specialists indicates, there are both financial and non-financial barriers to their engagement in residential aged care. Consideration could also be given to broader incentive packages and other initiatives to address non-financial barriers.

For example, a multi-pronged response could include:

- access to GP support and appropriate clinical (including nursing and allied health) staff within aged care facilities;
- incentives for delivery in rural locations;
- incentives for specialists-in-training to receive exposure to aged care services. Early and ongoing exposure has been effective in other disciplines and access to junior doctors also incentivises senior doctors/specialists to maintain outpatient clinics and rural services.

Other ways to enhance service provision are through access to other health services, including nurse practitioners, clinical nurse specialist services, and increased access to allied health services.

Explicit commitment to provide access to state/territory health services [proposition CH10]

Any future Commonwealth-state/territory health funding agreements should include an explicit commitment by state and territory governments to provide access by aged care residents to state/territory funded services, including palliative care services, on the same eligibility criteria that apply to residents of the relevant state and territory more generally.

The department supports this proposition. The department is committed to providing access to specialist health services for all older people, regardless of their place of residence.

There should be no instances in which aged care recipients have difficulty accessing state funded services. From a departmental perspective, there should be no barrier to emphasising this strong commitment through a national agreement.

Palliative care outreach services [proposition CH11]

Commonwealth, state and territory governments should agree on a model or range of models for palliative care outreach programs to residential aged care facilities, which deliver specialist palliative care services to residents and upskill facility staff to deliver more effective general palliative care.

These services should be explicitly funded through the National Health Reform Agreement.

There should be sufficient flexibility in funding to implement these services according to different models of care designed to meet the needs of the local population and other service infrastructure.

[Note: this may be rolled into the aged care health outreach model outlined above in proposition CH7.]

The department supports national agreement on core components of a palliative care outreach model, noting that palliative care should not only be viewed as a specialist service.

The Commonwealth Comprehensive Palliative Care in Aged Care Measure may be a useful vehicle to test and refine potential components.

Advance care directives [proposition CH12]

The Australian Government should provide education and encouragement to all aged care providers to assist residents who want to put in place an advance care directive (including an indication of the person's preferred place of care at each anticipated future stage of health status) or equivalent to do so.

This could be achieved in the current aged care system by amending Standard 2 of the Aged Care Quality Standards (ongoing assessment and planning with consumers) to require providers to assist residents to do so.

The department welcomes this proposition, noting that improving advance care planning will require ongoing training and education, and monitoring of quality.

This proposition could be strengthened if it explicitly provided for advance care planning processes to be triggered when an aged care assessment was completed. This would mean an advance care plan would inform care discussions early, rather than after decisions have been made about treatment and care options.

A complementary focus on completing advance care directives early in the community would further strengthen this proposition. Ideally people begin to discuss these before they enter residential aged care. Leaving it until entry may mean they have already lost some decision-making capacity or ability to communicate their preferences.

Requirements relating to hospital discharge to residential aged care [proposition CH13]

The National Health Reform Agreement should include a requirement for hospital discharge protocols to be developed and implemented to ensure that discharge to residential aged care should only occur once a discharge summary (including medications list) has been provided to and acknowledged by the residential care service.

The department supports the intent of this proposition to improve seamless transition of care for older Australians following a hospital episode. However, it is important to consider handover as a process rather than focusing on a policy requirement around the discharge summary itself.

Transfers of care, particularly across settings, pose high risks for residents, thus the quality of the clinical handover is vital. The provision of relevant medical and functional information is a joint responsibility between all the parties involved in arranging the transfer, conveying the resident and those receiving the resident into their care. There must be appropriate clinical staff within the aged care setting to receive and act on the discharge planning.

The department notes unintended consequences that may arise from the proposition as currently framed given the focus on completion rather than the person and their health. A requirement to ensure discharge only occurs once the discharge summary is provided could lead to:

- older people staying longer than necessary for their health in hospital because paperwork has not been completed;
- brief discharge summaries rushed through to allow a transfer to take place.

Requirements for subacute rehabilitation [proposition CH14]

The National Health Reform Agreement should include sub-acute rehabilitation reporting requirements with respect to states and territories to encourage the provision of appropriate periods of subacute rehabilitation after hospitalisation to patients over 65 years, particularly those who are living in a residential aged care facility or receiving a home care package.

The State, Territories and Australian Governments should discuss establishing performance targets in this regard, with funding tied to this requirement.

Where appropriate, and particularly where a patient has cognitive impairment, hospitals should be funded through the National Health Reform Agreement to deliver subacute rehabilitation to the resident's residential aged care facility (for example through a hospital in the home service).

The department welcomes a focus on the provision of rehabilitation for older people, supporting a stronger emphasis on reporting of performance in this area.

However, there are potential unintended consequences associated with setting performance targets, particularly if not informed by targeted research and planning. Access to services, including length of service provision, should be based on clinical need and judgement rather than a performance target.

While performance targets can be problematic, as noted above the department supports in principle further reporting of performance against rehabilitation provision. Existing reporting processes may capture sufficient information to support this proposition.

However, reporting must not distract from ensuring the focus is on identifying the healthcare that an older person needs and wants and whether they received that care, rather than ensuring a certain proportion of aged care recipients receive sub-acute rehabilitation.

If the policy objective is to maximise function, the development of functional activity plans that are tailored to the resident or care recipient's needs could be the performance target. The plans could be developed by sub-acute clinicians and implemented by residential aged care services. Short term targeted rehabilitation activity would continue to be reported via the relevant program's performance measures.

Requirements relating to transfer to hospital from residential aged care [proposition CH15]

The Quality of Care Principles 2014 (and any subsequent instrument) should include a requirement to the effect that when calling an ambulance for a resident, aged care services should provide the paramedics on arrival with an up-to-date summary of the resident's health status, including medications and advance care directives. [Note: this will require amendments to the Aged Care Act 1997 (Cth) and subordinate legislation to address secrecy provisions in Division 62-1, which relate to the protection of person information of a person to whom the approve provider provides aged care services.]

The department supports this propositions, welcoming improvements in the effectiveness of clinical communication with patients, carers and families, and between clinicians and multidisciplinary teams.

Consideration should also be given to improving communication with non-emergency transport providers, as these services are also frequently used by residential aged care clients.

Care coordinators [proposition CH17]

Older people with high care needs should have a designated care coordinator responsible for managing their various health and aged care needs, both within the current system and in any future system. The role of the care coordinator is to:

a. ensure that the resident is accessing appropriate health care at an appropriate time

b. ensure that any health care plan is being implemented

c. liaise with general practitioners

d. liaise with the new outreach service (Proposition CH7)

e. liaise with family and the rest of the residential aged care facility

The care coordinator should be a registered health practitioner, should be chosen by the aged care recipient (or their authorised representative), and may for example be:

a. someone employed by the relevant aged care provider;

b. the aged care recipient's primary health care practitioner, or someone employed in their practice;

c. a nurse practitioner;

d. someone who is part of an outreach service (Proposition CH7);

e. someone employed by an independent entity commissioned by government.

The department supports the intent of this proposition, agreeing that all aged care recipients require care coordination to drive a seamless experience across the health and aged care systems. With regards to the potential location of the care coordinator, the department believes this role should be firmly embedded in the aged care system.

Aged care providers play a key coordination role in engaging primary health and broader multidisciplinary health care teams. The role of the care coordinator, as articulated in this proposition, is what would be considered foundational, day-to-day care for an aged care recipient. This should be delivered by a suitably qualified and senior staff member of the aged care facility. This may be a registered health practitioner (most likely a nurse) but could also be performed by an allied health worker.

While it is important to respect choice and control for older people, there are concerns the proposition as it stands may allow aged care services to abdicate their responsibilities in this area. Further, reliance on care coordinators not embedded within aged care services may add a layer of administration in care delivery and may further complicate an already complex system.

The default expectation (particularly in residential care contexts) should be that the aged care provider performs the care coordination role. This role needs to be a clear expectation and factored into Commonwealth funding of aged care services. Further thought could be given as to how to improve the delivery of care coordination within aged care through training and development.

The department notes that many of the responsibilities outlined in the proposition are already the responsibility of the provider as detailed the *Quality of Care Principles 2014*, particularly in Standard 2: Ongoing assessment and planning with consumers, and Standard 3: Personal care and clinical care. However, there could be an opportunity to make this more explicit. Monitoring of compliance with these standards, with an appropriately skilled clinical workforce, may be sufficient meet the intent of this proposition.

Finally, we note that while the proposed role of the care coordinator as articulated in the proposition is generally sound, depending on the nature of the outreach service being provided to the resident, it may be more appropriate for liaison to occur with the general practitioner. From a health system perspective, specialist engagement (such as geriatricians) typically is coordinated through a general practitioner. This helps to ensure coordinated care planning and ongoing oversight of health care needs.

Greater clarity on the role and responsibility of residential aged care provider to deliver health care [proposition CH18]

The Quality of Care Principles 2014 (and any subsequent instrument) should be amended to provide greater clarity on the role and responsibility of residential aged care providers to deliver health care to residents. The extent and parameters of their role should be the subject of clear agreement between the Commonwealth and state and territory governments, having regard to other propositions in this document (particularly Proposition CH7).

The clarification of the role of aged care providers may involve the imposition on aged care providers of obligations to make arrangements with aged care recipients and health care practitioners (proposition CH4) and to ensure the designation of a care co-ordinator for each care recipient (proposition CH16).

The department supports this proposition. As previously stated, clarity of roles is critical for the delivery of high-quality clinical care. Consideration should also be given to consider how these principles can be enforced with health outcomes for people in residential aged care measured and monitored.

This proposition could be strengthened by nationally agreed and consistent roles and responsibilities across residential aged care, primary care and health services so that there are clearly articulated consistent expectations across all services, providers and people accessing services.

Collection and publication of use of state/territory funded health services [proposition CH19]

The Commonwealth, in any future health funding agreement with states and territories, should require states to collect and publish data on use of state and territory funded health services by aged care recipients to inform policy monitoring and design.

The data should include the following categories of data (at the local hospital network level, or more refined level if practicable):

• use of palliative care services

• use of Local Hospital Network-led multidisciplinary outreach services

• ambulance call outs

• emergency department presentations

• hospital separations and lengths of stay

• performance on compliance with clinical handover requirements (to conform to standardised requirements under propositions CH13 and 15).

The department supports this proposition. Data capture and publication is critical to driving continuing improvement. As already evidenced by this Royal Commission, there are existing opportunities for data matching and data analysis that can support policy monitoring and design. For example, the recent Australian Institute of Health and Welfare (AIHW) analysis commissioned by the Royal Commission is very welcome.

As a general observation, administrative data collection issues are less prevalent in administrative data that is clearly linked to a purpose for collection or linked to incentives.

The department agrees that there are many opportunities to better leverage and link existing data to support policy initiatives around different aged cohorts. However, there are a several issues for further consideration relevant to details in the general proposition.

First, the intent of this proposition could be better articulated. Palliative care, hospital separations, multidisciplinary teams and clinical handover data appear to be health system indicators. However, references to emergency department presentations and ambulance call out data, in this context, seem to speak to the performance of the aged care system.

Further work is required to assess which system would be the most appropriate source of data for each item. The department's view is that where possible, it is preferable that aged care data and regulatory processes are used to report on the performance of the aged care system. Improving aged care data collections to enable this should be considered.

While health system data such as ambulance call outs and emergency department presentations may be useful indicators of the performance of the aged care system, these must be very carefully considered. It is critical to note that the measure design, and the response of the regulator to reported results, has the potential to drive perverse behaviour impacting quality of care. For example, a potential unintended consequence could be facilities avoiding calling ambulances for residents when they are needed.

The department also foresees some challenges in developing benchmarks and reporting data against several of the items referenced in the proposition.

Particularly, whether a hospital stay would be expected to be longer or shorter will be a complex consideration. It is suggested that further research is required to enable development of meaningful benchmarks in this area.

The department also suggests that 'aged care recipient' should be clearly defined. While information relating to the usual place of residence is currently used as a proxy for 'residential aged care', Victoria does not currently collect data on home care package or Commonwealth Home Support Program (CHSP) status. As such, this proposition has the potential to necessitate changes in Victorian data collections.

Given CHSP recipients are not considered aged care recipients under the *Aged Care Act 1997,* there is a need to clarify whether CHSP is in scope. CHSP services provide a range of entry level supports on a short term and

longer term basis, depending on the needs and circumstances of the person. Further research would be required to enable the making of comparison across this cohort. There may also be issues in categorising lower level home care package recipients with those on high care packages.

The department proposes refining the proposition to only include residential aged care participants in the first instance, with indicators related to 'high care' home care package recipients included at a later stage and linked to a clear policy rationale.

Further thought could also be given to the implementation timing of this proposition, if progressed. It may be optimal to implemented new reporting in the final stages of Royal Commission reform rollout so that it accurately captures the changed landscape. Reporting requirements that are not developed alongside policy objectives may result in in health services changing behaviour to respond to data that does not, in fact, measure the intended outcome.

Finally, the department considers that it would be appropriate for jurisdictions to report this information to a Commonwealth body such as the AIHW, so that a consistent report can be published. There may also be opportunities for the AIHW to undertake data linkage projects as they have done with MBS data. This could include undertaking data linkage with other Commonwealth held data, such as home care packages and CHSP. This may provide more useful information depending on the policy intent.

Requirement for aged care providers to adopt care management systems [proposition CH20]

The Australian Government should amend the Quality of Care Principles 2014 to require all aged care providers to comply with the following requirements by 1 July 2023:

(a) all aged care providers must have a digital care management system

(b) the care management system must be interoperable with My Health Record

(c) all aged care recipients must be invited to consent to their care records being made accessible on My Health Record

(d) if an aged care recipient consents, the aged care provider must:

(i) place the aged care recipient's care records on My Health Record, and

(ii) in the event of any material change in that information, place updated information on My Health Record.

At a minimum, the care records to be placed in My Health Record under subparagraph (d) must include the categories of information required to be communicated upon a clinical handover (which are to be developed in accordance with proposition CH15).

The department supports this proposition, acknowledging there are opportunities for improvement in data management systems across both the health and aged care systems.

Consideration must be given to assessing the resources and timeframes required to enable sector readiness, particularly for small providers. There are technical, time and cost considerations that are attached to any change to data management systems, with funding likely to be required to support upgrades.

Conclusion

An older person's care must be coordinated and integrated, delivered by a highly skilled aged care workforce, where risks are understood and well managed. This must be a combined effort across the health and aged care systems.

As previous presented to the Royal Commission, a definition of health care includes:

- Management of self-care needs – daily care routines and practices that promote health and wellbeing, such as brushing your teeth, eating a balanced diet and exercise

- Preventative and population-based healthcare needs –health needs common to all or most older people - dental care, regular check-ups with a general practitioner (GP).
- Primary healthcare needs, including chronic disease management – this could also include specialised nursing care and allied health interventions.
- Specialist healthcare needs – referred by primary care clinicians, often to support the specialist management of a single disease process.
- Acute healthcare needs – this may occur when there is a sudden critical escalation in an older person's condition requiring a hospital admission or for specialist management of chronic conditions such as dialysis or admitted rehabilitation.

While responsibility for the provision of care will differ across these health-related needs, the department believes facilitating access to healthcare is the core responsibility of the aged care system.

This should occur through aged care providers proactively:

- Providing day-to-day care – including management of self-care needs and preventative healthcare required by an older person. As much as possible, this would include care to meet particular diagnoses, such as screening and proactive assessment for clinical risks and expected health conditions, administering medicine and changing catheters where clinically appropriate.
- Facilitating access to care through managing regular GP visits and relationships with primary health providers – this would largely include access to Commonwealth funded primary health providers but may also include access to state funded specialist or acute health care such as specialist palliative care.
- Escalating care to primary healthcare or acute care as required – including contacting triple zero (000) in an emergency.

The department is committed to finding solutions to improve the interface between the health and aged care systems. Best care is achieved when primary health care, acute health care and the aged care system work seamlessly together in pursuit of common goals set for, and by, the older person.

It is critically important that the aged care system's capacity is bolstered to deliver foundational healthcare to aged care recipients, with changes to healthcare systems configured to complement and support these reforms.

As previously articulated, there are four critical enabling actions that the department believes are needed to drive a clear model of healthcare provision for aged care recipients:

1. Ensuring an adequate clinical workforce (in aged care);
2. Robust health assessment of all aged care system entrants;
3. Strengthened clinical governance settings; and
4. Secondary consultation and engagement with specialist services.

The first three actions are linked to the aged care system. The fourth enabling action must be progressed in context of supporting reforms covering the first three items.

While the department recognises the overall intent informing the propositions, there is a need to ensure a multi-faceted approach to improving the provision of health care for aged care recipients, with a complementary focus on changes needed within the aged care system to support better engagement with the health system.

Again, we thank the Royal Commission for providing the opportunity to comment on these propositions. The department welcomes any future opportunities to discuss these or any other propositions to improve the interface between the health and aged care systems.