Royal Commission into Aged Care Quality and Safety

CANBERRA HEARING: PROPOSITIONS UNDER CONSIDERATION BY COUNSEL ASSISTING

The first six propositions are directed to improving access to primary health care services (particularly general practitioners, nurse practitioners and primary care nurses) for people in residential aged care.

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.

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*.

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.

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.

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.]*

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 next six propositions are directed to improving identification of individual needs for and access to high quality specialist, secondary and tertiary (sub-acute and acute) health care services for older people, outside hospital wherever possible.

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 x-ray 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.

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.

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).

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.

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.]

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 next three propositions are directed to improving transfers of older people in residential aged care to and from hospital, including the improvement of ambulance transfers, rehabilitation and transition care.

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.

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).

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 next two propositions are directed to achieving more effective and clearer interfaces between the health and aged care systems

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.

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 final two propositions are directed to improving data collection, communication and planning.

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).

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).