SA Health submission to the

Royal Commission into Aged Care Quality and Safety

In response to

Melbourne Hearing 4 propositions

July, 2020

Government of South Australia

SA Health

Introduction

SA Health acknowledges that the needs of older people will vary depending on where they feature on the spectrum of ageing, from independence, to living at home with supports at varying levels, to the extreme end of the spectrum, 24-hour residential aged care facility (RACF) care at the peri-end of life stage.

There is a need for a shift in the aged care paradigm to investment in preventative care and reablement of older people, to maximise the time that they can remain in their homes, stay connected and vital in their communities and delay the need for 24-hour care. This will not only benefit older people but will also have a positive effect on the acute health care system.

In proposing programs and recommendations to build an equitable aged care system, critical consideration of their feasibility in rural and remote communities will be needed, as these areas have ongoing difficulty in recruitment and retention of health workforce. Incentives should recognise geographic location, necessary investment and the challenges associated with providing services in these areas.

Beyond funding mechanisms that are assessed on provision of service, assessment should be based on and evaluated primarily through measures of resident health and wellbeing, in addition to system-wide outcomes of reduced avoidable hospital admissions and emergency department presentations.

SA Health is supportive of an integrated approach to aged care, a system that has resident outcomes at the forefront of its aims, person centred, informed and equitable regardless of their place of residence.

SA Health respectfully provides the following responses to the Melbourne hearing 4 propositions for consideration of the Royal Commission.

Mental Health

General comments

In considering the mental health propositions, there is a general observation that they have been devised to respond to anxiety and depression in older people as a pathology, rather than a whole of person approach that includes consideration of preventative models.

In doing so, the propositions describe a highly specialised treatment model, which relies on psychiatrist and psychologist care rather than a multidisciplinary, layered approach that provides a level of care that is responsive to the care needs of individuals, including a preventative approach.

The propositions do not appear to recognise the needs of older people with chronic and enduring mental illness, such as treatment resistant schizophrenia, bipolar disorder or personality disorders. This cohort of people is often forgotten and rejected by the residential aged care system due to the often challenging nature of their presentation. Many live in boarding houses or are homeless, and as a result, are very vulnerable and at risk. Any changes to mental health provision in aged care needs a focus on the needs of this population and consideration of how to best provide quality care.

The current psychiatric workforce is unlikely to be able to respond to an approach that directs older people with mild depression and anxiety to a psychiatrist. It would place unnecessary increased demand on the system, and may mean that these highly specialised services are not available for those with more complex conditions.

General Practitioners (GPs) play a vital role in the everyday care of older people with a mental health condition. There is a risk that mandatory referrals to a psychiatrist would deskill GPs in the provision of mental health care and would create a siloed model of care that places the responsibility for mental health care solely with psychiatrists and psychologists.

As part of a preventative approach, consideration should be given to a research based population health approach to understand the triggers for anxiety and depression as people transition from community living to RACFs.

Proposition M1: Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care

SA Health agrees with this proposition and supports an increase in the number of services accessed through GP prepared mental health plans. However, SA Health advises against the inclusion of a cap on services as this may be problematic for people living with enduring mental illness who need long-term psychological support.

Proposition M2: Fund mental health assessments and mental health treatment plans by a psychiatrist for Australians living in residential aged care

SA Health agrees that all residents in RACFs should have the same access to service provision by psychiatrists as those living in the community.

To ensure a resident's mental health is cared for, in addition to their physical care, an initial mental health assessment should be undertaken by a GP as part of the resident's care plan. Regular revision and assessment of the resident's care plan outcomes should be mandated (as proposed in proposition M7) to ensure approved providers are delivering all aspects of the resident's care plan. It should be noted that not all RACF residents need to be assessed, or have a mental health treatment plan prepared by a psychiatrist.

The proposition to expand MBS funding for provision of this service by psychiatrists to RACF residents is welcomed but it should not replace the ability of, and MBS funding for, GPs to prepare mental health treatment plans. GPs as primary health providers should maintain competency and skills in the provision of mental health care.

Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care

SA Health agrees with this proposition, but disagrees with the arbitrary cap placed on such service provision. There are some older people living with enduring mental illness, such as bipolar disorder, who will require long-term psychological support.

Proposition M4: Incentivise psychiatrists and psychologists to attend residential aged care facilities

SA Health agrees with this proposition.

Incentives should be based on assessable patient outcomes that are in line with their mental health plan and demonstrate an improvement in the person's wellbeing, rather than just reflecting services

provided. SA Health welcomes further funding for psychologists and psychiatrists training, targeting this demographic. SA Health agrees that the proposition should be extended to people at home accessing high level home care services. However, this should not be at a cost to residents of RACFs, especially those in the regional and remote areas. If the package was to include high level home care recipients, the incentives should be higher for provision of these services to regional and remote areas or incentivised in a way that also ensures provision of services to residents in regional and remote areas, especially those residing in RACFs.

In South Australia there is a maldistribution of workforce between metropolitan and regional and remote areas. In some smaller communities there is the longer-term challenge of recruiting an ongoing local GP. Most specialty services in regional and remote areas are provided by the metropolitan-based workforce. Any incentive program will need to be sufficient to attract practitioners to provide services in regional and remote areas, on a regular basis and within a multidisciplinary model.

It is noted that the Commonwealth Government introduced a Workforce Incentive Program in early 2020 to facilitate the delivery of eligible primary health care services in regional, rural or remote areas that have difficulty attracting and retaining doctors. While it is too early to gauge the effectiveness of this program, its principles support the development of GPs leading multidisciplinary teams to provide primary health services.

Proposition M5: Increase outreach services by state and territory government older person's mental health services to Australians accessing aged care services

SA Health agrees with this proposition.

SA Health's older person's mental health services currently have specific teams that provide outreach to RACFs to support the care of older people with behavioural and psychological symptoms of dementia and enduring mental illness. These have been embedded in all metropolitan local health networks, with one regional wide service for country South Australia.

Services are provided to both public and private RACFs with an aim to build capacity for the care of people with behavioural and psychological symptoms of dementia and / or enduring mental illness. This is achieved through providing both structured and unstructured training to staff in RACFs. For example, where a referral is made for behaviours of concern relating to a resident, SA Health staff may provide specific in person training relating to the management of those behaviours. Alternatively, more generalised training may be provided to all staff in the RACF on topics such as recognising responsive behaviours to pain.

Through capacity building in RACFs the objective is to avoid unnecessary hospital presentations and admissions and support discharge from acute care to residential care. The effectiveness of these services will be monitored over time.

SA Health welcomes the creation of a funding stream under the National Health Reform Agreement for the provision of outreach services which would offer the opportunity to further expand these much needed services. An agreed National Standard Framework would ensure greater consistency and service access across all jurisdictions.

Proposition M6: Increase mental health training for personal care workers

SA Health agrees with this proposition, but suggests that training should be expanded beyond personal care workers to all people working in RACFs to ensure a cohesive and supportive culture is established.

By way of example to this approach, at SA Health's Northgate House staff members at all levels, including hotel services staff, interact with residents on a regular basis and so are provided with training that supports a facility-wide person-centered approach to care. This includes management of actual or potential aggression training which teaches management and intervention techniques to de-escalate behaviours of concern in a safe manner. It is suggested that training such as this be implemented in RACF, and that consideration be given to mandatory standardised training to ensure consistency across all jurisdictions, and the best care of patients with enduring mental illness and dementia.

Proposition M7: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents

SA Health supports this proposition.

The effort to improve the mental health of residents needs to include consideration of issues such as quality of life, understanding the impact of transitions, meaningful engagement, grief and loss, cultural factors within a RACF and understanding the impact on the loss of life roles. The measurement of mental health of residents should take into account mental wellness as well as service provided to residents e.g. the measure of psychological distress could be used as a baseline to measure transition into aged care.

The Productivity Commission's final report into mental health is expected to be tabled by the Commonwealth Government in the coming months. Recommendations from this report are likely to include options for mental health service governance, and it is respectfully suggested that the Royal Commission may wish to consider these recommendations in relation to the mental health service needs of people receiving aged care services.

Proposition M8: The Australian Government should inquire into the potential contribution of the mental health peer workforce in addressing access to mental health services in aged care

SA Health supports this proposition.

Each of the three metropolitan local health networks in South Australia has older person's mental health community teams, which provide specialist services for people with dementia and enduring mental illness. In addition, rapid access teams have been established in each of the metropolitan local health networks, along with a single service for all of regional South Australia to provide in-reach to RACFs to support the care of people with dementia and enduring mental illness. This service aims to build capacity in mainstream RACFs.

Peer workforces are important in a system of care provided to people with mental illness and should be considered along a continuum of care that provides the most appropriate care to meet the needs of an individual. Consideration should be given to the expertise and skills that can be provided by a peer workforce in the context of residential aged care. Support offered by peer workforces should be utilised to complement care provided by specialist mental health services and should not be a replacement for the level of care and expertise offered by specialist clinicians.

Peer workers and carer consultants connect with people using empathy. Peer and carer consultant work includes instilling hope and support through treatment, identifying strengths and coping strategies, regaining independence, achieving goals, being active, social and involved in the community. It also provides support in accessing resources, programs, services and treatments.

A number of carer consultants, consumer consultants, peer specialist and project officer roles currently exist in mental health services across South Australia and one metropolitan local health network has a specific older person's carer consultant role. This role has been in place for less than 12 months and covers hospital psychogeriatric services and not RACFs.

SA Health's *Mental Health Services Plan 2020-2025* proposes the following in relation to improving on South Australia's current lived experience workforce:

- A professionalised peer workforce is supported to grow and expand in a strategic and consistent way.
- Consistent selection criteria are developed and used to recruit and select peer workers.
- Induction programs provide peer workers with the knowledge they need to operate effectively.
- Career pathways provide opportunities for career advancement and appropriate levels of remuneration.
- Roles are defined consistently across South Australia.
- Clear guidelines provide advice to senior staff on the supervision requirements for peer workers.

To facilitate this, the SA Lived Experience Workforce Taskforce has been established to progress the role of the peer workforce in South Australia, to support the implementation of the *Mental Health Strategic Plan 2017-2022* and the *Mental Health Services Plan 2020-2025*.

The role of the taskforce is to develop a co-designed state-wide Lived Experience Workforce Framework to support the further development and delivery of peer lived experience roles within SA psychosocial and clinical mental health services.

This builds on work undertaken in 2014 to evaluate the Lived Experience Workforce Program at the Central Adelaide Local Health Network in its rehabilitation and acute inpatient units. It was found that the Lived Experience Workforce, made up of peer specialists and carer consultants, assisted consumers and carers to develop skills and strategies to support them, or the person they care for, on their recovery journey while providing hope that it is possible to live a meaningful life in spite of having a mental illness. Clinical staff also benefited as the peer workers challenged their intrinsic beliefs and assumptions of people with mental illness.

Clinicians working alongside peer workers were assisted in their practice to move toward the concept of personal recovery.

One of the outcomes identified in the *Mental Health Services Plan 2020-2025* is for clinicians and peer workers to support consumers to identify personal goals, make decisions about their health, and to exercise choice and control. Training to assist staff, including clinicians and peer workers will be available to support the decision-making capacity of consumers.

The plan will be evaluated progressively over its first three years to monitor the implementation and outcomes achieved, with a final evaluation report at the end of the plan's five year period. Measures of success of clinicians and peer workers supporting consumers to identify personal goals, make decisions about their health and to exercise choice and control will include:

- Assessing and measuring effective care and support from the consumer's and carer's perspectives using the Your Experience of Service (YES) survey and Carer Experience of Service (CES) survey.
- Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs, including cultural and linguistic needs (YES survey).
- Proportion of people receiving services who report their individual needs and values were respected and incorporated into their care (YES survey).
- Evidence of an improvement in people's ability to manage their day to day needs and actively participate in their chosen community using the National Outcomes and Casemix Collection (NOCC).
- Proportion of people receiving services reporting they had opportunities for family and carers to be involved in their care if they wanted (YES survey).
- Rate of care plan reviews completed every 90 days (or sooner), in partnership with the consumer.
- All consumers will have access to a peer.

Oral Health

Proposition D1: Fund public dental services to provide outreach services to Australians accessing aged care services in their place of residence

SA Health supports the intent of the proposition as it is in the interest of older Australians to ensure a proactive approach to dental care than responding only in emergency situations. It is well documented that poor dental health and disease can impact on an older person's quality of life.

The current National Partnership Agreement on Public Dental Services has recently been extended until 30 June 2021. However, proposition D1 proposes a national partnership agreement to fund public dental services to provide outreach services to aged care recipients in their place of residence, which may be in the community or in RACFs, if they are unable to travel to receive public dental services.

South Australia has a finite public dental workforce therefore, to establish an outreach service as described would require participation of private dental providers for the provision of the service. There are currently limited South Australian based private providers providing outreach dental services. There have been no discussions with the Australian Dental Association to determine whether such an outreach service could be viable in South Australia through the support of private providers.

As outlined under proposition M4 there is a maldistribution of health workforce in South Australia between metropolitan and regional and remote areas. This includes the dental workforce. Any proposal to provide dental services on an outreach basis will need to provide incentives at a sufficient level to ensure coverage to regional and remote areas. It is noted that other than orthotists / prosthetists, the general dental workforce is not included under the Commonwealth Government's Workforce Incentive Program. Inclusion of the dental workforce under this program may work towards ensuring that dental services are available to those residing in the regional and remote areas.

The removal of professional boundaries for the dental workforce may assist in public dental services to provide services on an outreach basis. Dental therapists are restricted to a scope of practice that only involves treatment to children and adolescents. The expansion of their scope of practice to include adults could allow greater coverage to dental services in regional and remote areas.

The provision of outreach services by public dental services would require a sustainable funding instrument to support the outcomes, which may go beyond the scope of a national partnership agreement. To establish an outreach service would incur additional administration, set-up and portable equipment costs for private providers. Many may not wish to participate in such a scheme governed by a partnership agreement where uncertainty exists on whether the agreement will continue beyond its expiry date. Further, dental providers will be required to ensure that infection control measures are in place when providing dental services, and this may not always be practicable in a community setting.

An alternate model may be for the Commonwealth Government to establish an ongoing older persons' dental scheme, similar to the Child Dental Benefit Scheme, which may be more likely to incentivise the private dental sector to set up specific outreach dental services. Under the Child Dental Benefit Scheme a monetary amount is provided ($1,000 over two calendar years) for basic dental services including check-ups, x-rays, cleaning, fissure sealing, fillings, root canals and extractions. Such a scheme may be more effective in attracting private dental practitioners to providing aged care services for older Australians in a community setting.

Proposition D2: Increase oral health care training for personal care workers

SA Health supports the intent of this proposition.

Regular attendance to oral health hygiene can assist in minimising the impact of oral health diseases and it is appropriate for personal care workers to have a basis understanding of oral health care.

SA Health would recommend that daily oral health care checks should be a work-ready skill for all care providers engaged in the daily care of RACF residents, and considered as an ongoing competency for providing fundamental care. As such, SA Health would recommend the extension of oral health care training to nurses.

The role of personal care workers and nurses should encompass basic hygiene checks and advice on how to maintain healthy teeth, with any treatment required referred to a dental professional.

The training should be delivered under an agreed framework led by the Commonwealth Government to ensure consistent core competencies.

Proposition D3: Greater clarity on the role and responsibilities of residential aged care providers to maintain the oral health of residents

SA Health supports this proposition.

The most effective model of oral health care includes the following four key oral health processes:

- oral health assessment;
- oral health care planning;
- assistance with daily oral hygiene; and
- referral for, and provision of, dental treatment.

Evidence shows diminished impact on oral health if one or more of these processes are not in place. Embedding of oral health care planning and daily oral hygiene within residents' mandated fundamental care is a low cost infection control intervention and hospital avoidance strategy.

The interface across aged care, health and primary care is the subject of a schedule in the newly signed National Health Reform Agreement. This schedule aims to outline roles and responsibilities along with governance structures to identify and respond to emerging system issues and a platform for national data sharing.

Proposition D4: Fund services delivered by oral hygienists and dental and oral health therapists in residential aged care facilities

This proposition is supported in principle. However, it needs to be considered as part of proposition D1 i.e. as part of an integrated service and not with a separate line of funding.

In South Australia there may be limited workforce capacity to provide such services in RACFs. It is likely that these services will need to be provided by the private sector, and so funding should be set at a level that will attract private providers. A limited workforce capacity may also result in waiting lists.

As outlined in proposition D1, the delivery of services by dental therapists in RACFs is precluded by their scope of practice set by the Dental Board of Australia. The Board limits dental therapist services to children and adolescents. The expansion of their scope of practice to include adults would assist in providing dental services in RACFs, particularly in regional and remote areas.

Oral health assessments are included in existing Aged Care Assessment Team (ACAT) assessments, however dental referral, ongoing oral health care planning and outcomes are not routinely monitored.

The Medicare health assessment for people aged 75 years should classify oral health and dentition assessment as a mandated requirement; it is currently classified as optional.

Allied Health

General comments

In metropolitan areas, multidisciplinary services are generally available, however safeguards for the quality of services and their ability to meet the needs of the client should be incorporated in to funding and/or safeguarding systems.

In regional areas, workforce maldistribution limits access to many allied health disciplines. This has been the subject of the recent national Rural Health Commissioners work, current National Disability Insurance Scheme (NDIS) thin market projects and the redesigned Primary Health Workforce Incentive Program.

In this context, allied health professionals can become increasingly isolated and limited access to clinical supervisions and governance can lead to increased risks for both clinicians and clients. Efforts to grow this workforce and create the needed supports will require collaboration across sectors.

The Long Term Health Reform priorities for the new National Health Reform Agreement 2020-25 include commitments to consider joint planning and funding for services and the development of innovative and flexible funding models to support the needs of local populations. SA Health is committed to working with partners in community and primary care service delivery to prioritise prevention, and help people manage their health across their lifetime.

Proposition A5: New allied health funding for aged care

Funding that is built into a shared cost base may enable allied health professionals to provide services as part of a multidisciplinary, integrated team.

There are concerns however, that having two funding mechanisms adds complexity and there is a potential risk for consumers to fall through the gaps between the two funding mechanisms and not receive minimum or adequate services.

The model may not be possible in rural and remote communities as there are too few private allied health providers to meet needs, and those working in the public sector do not have Medicare provider numbers and so are not eligible to provide MBS services.

Rural and remote communities rely on sole GP practices that may choose not to become a registered primary care practice. Some recipients of Home Care Packages choose not to engage with a regular GP and so it would be beneficial to consider funding mechanisms that facilitate access through clinics and the health system for clinical and assessment needs.

Brokering access to multiple providers may get problematic for facilities and how that service is captured in the client record – access to client records may be complex and could lead to care fragmentation and high levels of complexity.

The list of allied health services need to be the same for both funding mechanisms as the clients may need frequent and episodic services at different times. This would also enable flexibility with client needs and clinical requirements.

This proposition proposes that allied health services are divided into frequent and episodic services. Frequent versus episodic service needs to be defined, and at what point a frequent service becomes episodic, and vice versa.

Service plans should be regularly reviewed, and a decision made on who has responsibility for managing the overarching plan. Consideration should also be given where an individual may have two competing reviews and care plans developed e.g. aged care system and primary health system.

The overlap with the NDIS needs to be considered and documented as clients move into residential aged care facilities.

Access to all disciplines may not be possible in rural and remote settings therefore telehealth access may need to be considered.

Allied health professionals use allied health assistants for delegated care e.g. podiatry nail care services, and this should be retained in the aged care setting.

There is potential for over and under-servicing where multiple service providers are involved, as well as care straying from what the resident has requested.

There may be sustainability and management oversight costs to ensuring that quality and safety of services, especially if they are delivered by a mixture of in-house and brokered services. Therefore this needs to be considered in the proposed model.

A cap or limit on allied health services needs to be based on consumer needs at the time, and not on discipline. There should be some flexibility to allow for genuine tailored care e.g. for rehabilitation consumers, who may need to be seen daily and then visits reduced, a capped system might make it difficult to tailor suitable care on a needs basis.

There should not be different approved limits for people in residential aged care compared with people accessing level 3 and 4 home care packages. The location of care should not make a difference; it should be based entirely on consumer need and choice.

Determining a recipient's allied health needs should be based on a multi-disciplinary assessment and review to identify their care needs and ensure that services are consumer directed. Regular reviews should be documented and this should be managed by the RACF service provider in collaboration with the GP where possible. Referrals for additional services should also be possible through nursing staff and allied health practitioners to allow for consumer needs to be met flexibly and avoid everything having to be directed through the GP.

Service providers that are arranging care will need to ensure that all contracts and legislative requirements are in place to ensure the quality and accountability of the provider being used for a brokered service.

The review and assessment of the resident needs to occur at regular intervals. Provision of allied health services provided should be measured against evidenced-based practice guidelines. Consumer care outcomes should be measured to ensure that they are relevant to comprehensive multidisciplinary care and relevant to allied health.

The level of funding used for allied health services should be monitored through the funding mechanism.

Telehealth is imperative to support service provision, especially for those in a rural and remote setting. There are not enough locally based service providers located in rural settings to meet demand. Telehealth and remote support for other staff on the ground will optimise the care options that can be wrapped around to the consumer.

Access to the service should be built into the ACAT process so that those that most require allied health access, dependent on their care needs, can access a level of support regardless of the package level.

Alternate draft proposition: The Australian Government implement a new primary care model for aged care recipients by 2022

The general principle of a new primary care model for aged care recipients is supported. However, the viability of this model in rural and remote areas is questioned.

This model should be considered within the context of broader considerations of the role of aged care providers in providing primary health care services. A number of issues need to be considered in the context of the model.

Firstly, an adequate GP workforce for the residential aged care sector is critical to optimise the medical outcomes of older people. There remains a maldistribution of workforce and access to specialist care outside of metropolitan centres is difficult.

There are significant recruitment and retention issues for GPs across rural and remote areas in South Australia. Many GP practices in these areas are sole practices that are already overburdened, and so there may not be the scope or willingness to become aged care accredited.

Consideration also needs to be given to continuity of care arrangements e.g. how can this model provide for people to continue to access their regular GP if they choose to, even when moving locations e.g. moving from home to a RACF.

The accreditation criteria should include some awareness of the aged care system such as how to access respite and behaviour supports such as the Dementia Behaviour Management Advisory Service, and training in common issues for older people i.e. skin integrity, falls management, palliative care, medication management, constipation and cognitive issues to ensure that the response is fit for purpose.

The proposal that people with an ACAT assessment enrol with an accredited practice must be streamlined and not fragmented or create barriers for people who do not have, or cannot get access to, a local GP in a timely way. There must be flexibility to work without a GP where this may not be possible.

An ACAT assessment cannot be taken to assume someone is actually accessing aged care services, so the scope needs to be clearly defined i.e. is it to target aged care recipients or people eligible to receive aged care. ACAT eligibility only covers care under the *Aged Care Act 1997* (Cwlth) and not all aged care services, with the majority of eligibility approvals for the Commonwealth Home Support Program currently assessed by the Regional Assessment Services (RAS). The RAS should also be include so that people on the Commonwealth Home Support Program can also be included if they wish.

Mandatory acceptance of eligible clients presents risks in rural and remote areas where workforce recruitment is an issue. In this instance a practice may under deliver on outcomes across all clients due to a lack of capacity. To mitigate this, support needs to be given to recruitment and retention initiatives to grow the allied health workforce.

Performance indicators should include preventable presentations to emergency departments, admissions to hospital.

A capitation payment for practices presents opportunities for flexible and needs based service delivery however risks a 'cherry picking' approach. To mitigate this risk, robust outcomes including client reported and goal based outcomes should form part of practice reporting.

The capitation payment will need to be sufficient to cover a group who can be high users. The financial incentives to the GPs also have to be at a level that provides sufficient incentive to participate in these arrangements. Recent programs involving capitated models such as the Commonwealth's healthcare homes program had limited uptake in some areas. The capitation payment needs to be sufficient to provide an incentive to provide care to more complex clients.

Also, it is not clear these capitation payments would necessarily encourage hospital avoidance through primary health services. The scale and implementation of such a model should also be considered to ensure it is impactful and targeted towards high need communities.

Establishing cooperative arrangements to provide after-hours access to primary health care is supported. This is an area that has a particular impact on the public health system, including ambulance attendance, because of a current lack of primary health care access after- hours.

The concept of an aged care plan is supported however, needs to be considered in the context of other care plans / service plans that a person may have around their aged care needs as assessment by RAS / ACAT and implemented by relevant service providers.

Technological solutions need to be invested to ensure that the aged care plan can be a collaborative document that is developed and reviewed by the consumer, their service provider and the GP, and any other service providers involved in the care plan. It needs to be based on consumer need, available and preferred services to meet goals, and a shared understanding of who is undertaking which function and which funding steam it can be drawn from. If there are multiple care plans that are not integrated, the consumer runs the risk of either falling between the cracks, as each provider thinks the other is managing the process, or that a person will be over-serviced with all parties delivering everything multiple times.

One of the current issues in South Australia is having access to the relevant services within the person's package. SA Health continues to support the non-acute ongoing age related community nursing needs of a number of aged care recipients who have exceeded their package capacity. In putting this initiative in place the Commonwealth Government needs to consider how these primary care and aged care needs are met – either through Medicare or through the aged care system.

In addition to the aged care plan, or as part of it, consideration should be given to the development of action plans for people at high risk of deterioration. If these action plans are loaded into the My Health Record it would assist ambulance services, locums and any other healthcare providers working together in supporting these individuals.

During my appearance before the Royal Commission on 17 July 2020, I referred to an alternate model for the provision of aged care services. This model is an extension of the new primary care model for older persons and puts the person at the centre of tailored care and service provision to ensure that their lives are lived to the fullest. I respectfully provide further details on this model as follows.

All Australians currently receiving services in our aged care system have lived rich, complex and amazing lives. Behind every face is an experience of childhood, the maelstrom of adolescence, the transition into adulthood with first love, buying a house the establishment of careers and the launching of family. These life narratives continue as children grow, families move, economies turn around them, health issues come and go and eventually the children move away and life settles into retirement.

Throughout this life narrative, each and every one of us are sketching the words for ourselves. Of course, circumstances will often dictate some directions, but it is we ourselves who decide on our response to how our lives unfold. Yet for many Australians who are in the aged care system, particularly the very old and very frail who are essentially in their “peri-end-of-life” phase, our ability to be ‘the authors of the last chapter of our life narrative’ is diminished. Like any narrative, the last chapter is critically important. In life, our end-of-life phase is of upmost significance. So much so that it is rarely talked about or discussed in the modern culture.

The manner in which the peri-end-of-life phase plays out for most Australians is extraordinarily disempowering. The older Australian is subject to a complex array of services if they are to remain independent and in control of their lives. Moreover, those services are usually provided by numerous different organisations, all with different business models and economic incentives, rarely well connected to each other and all subject to confusing and complex bureaucratic obligations and criteria. The older Australian often needs to access significant primary care services from their GP, multiple pharmaceuticals from a chemist, various allied health services for physical and possibly psychological challenges, and support for activities of daily living and community supports to maintain a participation in their social life. In addition, from time to time they will require a short-term acute intervention resulting from deteriorating health. It is in this phase of life people use more hospital care than the rest of their life.

Each and every one of these actors is motivated to behave in different ways.

> The GP is motivated by a 10 minute fee-for-service business model. Everything about the general practice business environment is motivated by a fast flow of patients through the clinic to receive rapid intervention, advice and possibly referral. For the most part, a GP who wants to extend his/her care to support family members; arrange remote monitoring of an at risk patient; and/or converse with an aged care provider to advise them how to best respond to a particular health issue, is not remunerated. These are things that GPs do in spite of the prevailing economic incentives.
> Pharmacy is essentially a retail business model supported by some supplementary regulation and dispensing fees. While they are remunerated for medication reviews, an ongoing dialogue with referring clinicians is not recognised or remunerated.
> Aged care providers operate in a complex environment across three major service paradigms: common home support program for minor home support services; Commonwealth aged care packages for moderate to high care clients at home, and, residential aged care. While these all provide varying levels of support for activities of daily living and social care they do not look to address the person in the context of the situation in life; their home, the involvement of family and the fact that they are approaching the end of their life.

Very old Australians are one of the most complex patient groups in our society. They are very high users of the acute health care system and frequent users of all primary care services. This underscores the intersection of these consumers' quality-of-life and quality of healthcare. In the current systems this is left to chance. The older Australian relies on GPs, pharmacists, aged care providers and acute care providers to somehow seamlessly coordinate their care around their unique circumstances to give meaning to a last chapter of their life narrative for which they wish to be author.

The current funding incentives, particularly for general practice and acute care, have served Australia well over many decades, and in many ways remain fit for purpose for responding to simple episodic healthcare issues. However, for the cohort such as the one being addressed by this Royal Commission a radical change in the economic incentives for the provision of quality care needs to be adopted.

We need to create organisations which are incentivised to respond to the comprehensive range of issues that older persons are negotiating in their lives to truly position them at the centre of the decision-making process. Recognising the frequent use of all primary care services and acute care services by this cohort of patients it is likely that there are sufficient funds in the existing system to achieve significantly improved outcomes. However, in the current system, these financial resources are distributed across the aforementioned actors all operating under different economic incentives, none of which promote the optimisation of a comprehensive system of care around the older person.

It is suggested that bringing these financial resources together into one stream to a *Specialist Primary Aged Care Provider* that is uniquely charged with the task of optimising the care of older patients (excluding all other patient cohorts), will ensure that the end-of-life journey for older Australians is better supported, coordinated and person centred.

For older people living in the community the in-scope service systems should include general practice, psychology and other allied health disciplines, aged care, and low complexity acute care (home hospital and home nursing). The model would also include some provision for substitution of hospital-based outpatient care for example geriatrics, cardiology, respiratory, medicines (and others). Bringing the resources typically used by very old elderly patients into one funding package, likely to be a stratified capitation approach, and holding the *Specialist Primary Aged Care Provider* organisations accountable for a defined set of outcomes would allow these organisations to continue to optimise the outcomes and the experience of the older person.

As a suggestion, these outcomes might include: ensuring the older person is in control of their health and life plan (possibly expressed by the documentation of a life plan including an advance care directive); lower anxiety particularly relating to end-of-life decisions; increase family comfort and involvement in end-of-life issues; increase their quality of life (as measured per SF 36 or the like) and reduce inappropriate hospitalisation.

In the development of this model it is important that the functions of the *Specialist Primary Aged Care Provider* team are not (at least initially) subcontracted. It is important that all the components of the team operate together in a truly integrated way that optimises around the needs of the older person. In this way the continuity of care and the coordination of care is built into the business processes rather than putting effort into coordinators of the care of different actors. But more importantly, the restriction on subcontracting prevents existing organisations accessing resources to provide services to these clients within their existing business models, thereby failing to radically reorientate their business processes to meet the needs of these clients specifically.

When GPs, are asked "would you be surprised if patient X died in the next 12 months" if they answered "yes", evidence indicates that it is 70% likely that the patient will die in the next two years. This indicates that GPs are intuitively aware of their patients last two years of life. However, in the existing fee-for-service paradigm they are not incentivised to have the long, often difficult and complex conversation that allows the patient to be informed and prepare for this final chapter.

The GP, as one of our most trusted professionals, needs to be provided the opportunity to have this enormously significant conversation with patients. Whether it's a patient with end-stage respiratory disease, renal disease, cardiac disease or recurring cancer treatments, the GP is usually quite familiar with the end-of-life trajectory that the patient is likely to experience. A failure to have this discussion with the patient, thereby enabling them to be informed to the degree that the GP is, is not desirable. This end-of-life discussion should be supported with appropriate psychological (or other counselling disciplines) support for the patient and possibly the family.

In the elderly patients I have talked to, their decisions and quality-of-life was significantly dependent on alleviating the concern of their children. It follows therefore that in helping the older person navigate their own end-of-life journey, it may well be necessary to support families coming to terms with the end-of-life phase of the parents and helping them navigate a good death and not a death characterised by lack of awareness, anxiety, surprise and frustration.

Good deaths are entirely possible for people who have achieved closure of the many of their life concerns, and have had the opportunity to come to terms with the journey ahead and ensure that their final chapter of a life narrative is as they wish it to be.

The proposed *Specialist Primary Aged Care Provider* organisations should be well placed to provide healthcare components reaching into RACFs. While I believe that residential aged care should only be for patients whose care is so complex that it cannot be provided as they wish in their home, the provision of the healthcare components of the patient's life should continue to be optimised aligned with the patient's wishes.

Where the person lives in a RACF, clearly the activities of daily living and hotel services should be provided by the residential aged care service. The *Specialist Primary Aged Care Provider* organisation would provide the ongoing monitoring of the patient's wishes and provide a level of independent quality assurance of the RACF. It would be assumed that the RACF would provide a level of nursing care necessary to monitor the resident's well-being for their ongoing health care. Quality-of-life outcomes would be monitored and responded to by the *Specialist Primary Aged Care Provider* organisation.

The following examples of the application of an alternative model of aged care are provided for the Royal Commission’s information.

A clinic in the community is established incorporating several GPs who have sub-specialised in aged care. The clinics include the GPs, a psychologist, various allied health professionals, a pharmacist, visiting dermatologist, respiratory physician, cardiologist, nephrologist and an oncologist. These specialists are available to receive video consultations with the GPs at any time including during the consultation with the patient. The clinic also is a registered aged care provider incorporating Commonwealth home support packages and aged care packages. The clinic includes a team of well-trained nurses and nurse practitioners who are equipped to provide acute care in the home. The clinic also has a small bus able to pick patients up and bring them to the clinic recognising that transport is a critical barrier for elderly patients accessing primary care. The clinic also has an adequately resourced technology capability supporting the function of communication, logistics for visiting and communications as well as remote monitoring of patients.

Scenario one – community care

The remote monitoring capability detects that patient Smith has low oxygen saturation levels overnight. The clinical monitoring software detects the patient's oxygen saturation is low and alerts the aged care worker visiting next morning to check with the nurse before attending the patient's home to assist with showering and morning activities. The nurse asks the attending carer to check with the patient to see how they are feeling, if they are short of breath, or whether they have a cough producing phlegm. As a carer attends the patient in the morning to assist with showering, she confirms the patient is developing a cough and advises the nurse. The nurse makes time to attend the patient and do a general reassuring health check and review the patient's cough.

Noting the productive nature of the cough and the potential emerging chest infection she calls the patient's GP (who is an employee of the clinic) who prescribes antibiotics and in this case, knowing the patient's history and vulnerability to chest infections requires it to be intravenous. This is because we know this patient is expecting the birth of a great-grandchild and it is his aspiration to see the great-grandchild before he dies. The family are communicated with as per the patient's wishes, the nurse returns with the necessary equipment to put in place IV antibiotics. Monitoring is increased and aged care visits are scheduled three times per day. The patient is comforted by the rapid response and nature of the treatment. A hospital admission and ambulance carry is avoided. The family are reassured that the system is responding not only to the health needs of their loved one but also the aspirations to see the great-grandchild.

Scenario two – RACF care

Patient Jones is a resident in a RACF receiving care from the same clinic described above. On routine monitoring it is observed that the patient's temperature has increased by half a degree. This is detected through a monitoring apparatus in the patient's bed. A nurse schedules a visit to the RACF to review the patient having conferred with the nurse in situ at the RACF. Patient Jones is showing signs of a urinary tract infection in that she is less steady on her feet and feels a little confused. The nurse arranges an urgent urinalysis and responds with in situ IV antibiotics. While in the RACF, the nurse reviews the charts of the RACF and notes that the patient has not been eating well recently and this is not documented appropriately nor has the RACF advised the treating clinic as per the protocol documented in the patient's notes. This is advised to the patient's GP who follows up with the RACF management.

Current general practice vs the alternative model of care

Current general practice

General Practice is characterised by highly trained GP working on a fee for service basis. All clinic processes are designed to accommodate ten minute patient encounters. This includes software documentation, patient registration at front desk, billing processes, and importantly the clinical consultation. The patient waits in the waiting room which is usually comfortable enough to wait ten to fifteen minutes. The patient doesn’t know other patents in the waiting room and the ambience of the waiting room is utilitarian. In some cases laboratory and treatment rooms are available. Consultation with the clinician is usually brief and the patient feels, and expects to be in and out of the consult within five to fifteen minutes.

The patient subsequently needs to travel to an allied health professional or chemist. The patient needs to find their own way to or from the clinic (for elderly patients this can be very difficult). The patient may have deferred the trip to the GP because of the inconvenience to family member to arrange transport. The patient may be referred to a specialist in which case they are provided with a letter of referral however, it is the patient’s obligation to arrange the outpatient consult (when that patient attend the outpatient consult a repeat of many of the tests radiology and pathology may be required).

There is no communication with the aged care provider regarding the outcome of any consultation or referrals. In the context of a five to fifteen minute consultation with the GP, that patient does not remain fully informed and may even be confused about the outcome of the GP's advice.

Optimal healthcare under the alternative model

Acknowledging that patients find it difficult to travel to a clinic, which is a barrier and concern for them, the clinic arranges a bus to pick patients up that require this assistance. Patients attend at regular intervals such that they coordinate with seeing similar patients in the waiting room on every occasion they visit. The receptionist at the clinic is as much a concierge as s/he is a receptionist, ensuring that patients know each other's names and are fully engaged while waiting for the clinician interventions. The waiting area itself is more like a café providing the right ambience for social engagement acknowledging that patients in this age group are often isolated in their homes. The décor is reminiscent of Adelaide in the 50s and 60s.

The consultation with the GP is routinely half an hour (slow medicine) acknowledging that patients process information more slowly and possibly the nature of discussions are more profound. Allied health and psychology services are in situ in the clinic and the patient's usual treating allied health professionals are available for a follow up consultation. During the consultation, where the GP might require a specialist assessment, the GP can simply call the specialist by videoconference and can discuss the patient, while the patient is with the GP. This gives the patient the confidence that a specialist assessment has taken place and provides a continuing transfer of knowledge to the GP. This not only saves the outpatient occasion of service but also a significant inconvenience to the patient.

The results of the consultation are entered into the patient management software which is communicated to the patient's individual aged care provider personnel (who are a part of the clinic) and the nursing team. Any follow up care or observations are automatically entered in to the continuing checklist for the visiting nurses and aged care workers and advised the family are advised through a shared portal that the family can access (assuming patient consent). The patient is at the clinic for an extended period of time which encompasses a social outing along with a clinical treatment and ensures that business processes have provided an entirely joined up communication between specialist, GP's, allied health, treating nursing team and aged care workers. This is all centred around the patient's life plan with the aim for ensuring that the patient's last chapter of their life narrative is one for which they are the author.

Glossary of Terms

ACAT	Aged Care Assessment Team
GP	General Practitioner
MBS	Medicare Benefits Schedule
NDIS	National Disability Insurance Scheme
RACF	Residential Aged Care Facility
RAS	Residential Assessment Service

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