Royal Commission into Aged Care Quality and Safety
Queensland Health submission in response to draft propositions on mental, oral and allied health care

Draft Propositions on mental, oral and allied health care

Introduction

Queensland is expected to experience a population growth of 43 per cent to the cohort aged 65 and older in the period 2016 to 2026. Consistent with the Queensland Government's *Healthy Ageing* strategy, Queensland Health aims to support older person's health by:

- promoting health and wellbeing through prevention strategies,
- maintaining independence and restoration of function,
- delivering connected and person-centred care, and
- promoting self-determination and choice.

Queensland Health acknowledges that healthy ageing involves physical and cognitive decline. While this decline is expected, investment in health promotion and prevention enables older people to stay in good health for longer, living and ageing well with choice. Focusing investment on prevention and restoring function will positively benefit older people while minimising the financial impact to the health system.

Queensland Health favours a systems approach that integrates health and other support services. Reform should focus on existing clinical skills and governance, providing accessible care that is flexible and responsive to consumer need.

Queensland Health aims to support funding mechanisms that support self-determination and choice. This is critical for regional and remote areas in Queensland where there are thin markets and limited options for consumers' choice of mental, dental and allied health services. Telehealth is a valuable mechanism for reaching populations in rural and remote settings and any proposed funding mechanisms and incentives need to leverage and capitalise on advancements in technology.

Mental Health

Queensland Health supports improving access to services and promoting mental health, which represents a positive shift to integrating mental health services in aged care settings.

Queenslanders are living longer and living with increasing complexity including complex mental health needs. Over time, Queensland's Older Persons' Community Mental Health Services (OPCMHS) will be challenged to scale the staffing and service models to meet the additional demand, particularly in regional and rural Queensland where service gaps already exist.

Several of the propositions recommend strategies to increase the volume of assessments and mental health services to people living in residential aged care facilities (RACFs) with mental health disorders. For example, propositions 1 and 2 which promote the development of mental health treatment plans by GPs and psychiatrists. This may lead to increased identification of mental health disorders, requiring ongoing management by specialist services. An increase in such activity could lead to increased demand on public mental health services. Appropriately incentivising private services and specialists is considered likely to reduce the demand on already stretched public mental health services.

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

The Australian Government should immediately remove the barriers to use of existing Medicare Benefits Schedule (MBS) items by people living in residential aged care facilities, by allowing general practitioners to prepare mental health treatment plans for residents on the same basis as people living in the community.

1. This proposition proposes to remove the existing barrier for people living in residential aged care, and allow them to access mental health treatment plans prepared by a general practitioner (through the MBS funded Better Access Initiative) on the same basis as people living in the community. This would also allow people living in residential aged care to access mental health services (named psychological services in the MBS) pursuant to a treatment plan.
2. Consideration should also be given to whether the services accessed through a mental health treatment plan prepared by a general practitioner (10 psychological services annually) should be increased for people living in residential aged care. One option might be to raise the limit to 15 psychological sessions each six months, which would equate to once a fortnight (see Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care).
3. This proposition should also be considered alongside Proposition M2 (Fund mental health assessments and treatment plans prepared by a psychiatrist for Australians living in residential aged care).
4. It is noted that mental health issues, particularly depression and anxiety, can coexist with cognitive decline and dementia. Consideration should be given to ensuring that access to MBS mental health items is available to older people, irrespective of whether they are also accessing dementia or cognitive impairment related services. This applies to other draft propositions set out in this section.

Queensland Health Response: Supported

Barriers which prevent aged care residents from accessing Medicare Benefits Schedule (MBS) items that would otherwise ensure their equitable access to mental health treatment planning by a GP should be immediately removed.

Care provided under a 'Commonwealth subsidised residential aged care place' includes various care components that are distinct from health care. Care is generally provided by a personal care worker, with limited access to a registered nurse. The current subsidy system falsely assumes, and is funded on the basis that, that an aged care residential service can adequately assess, treat, and directly support the mental health needs of residents. Some people in residential aged care may therefore miss out on mental health services due to their accommodation and general care arrangements. Residents should not be excluded from the MBS mental health treatment plan initiative or from accessing other MBS mental health items.

Increasing the number of psychological sessions that can be provided to older persons residing in a residential aged care facility (via a mental health treatment plan prepared by a GP) per year would be invaluable in promoting residents' mental health, restoring function and preventing decline.

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

By 1 January 2022 the Australian Government should create new MBS items for:

- **a comprehensive mental health assessment, including preparation of a residential aged care mental health treatment plan, by a psychiatrist within a month of a person entering residential care**
- **a review by a psychiatrist (at three monthly intervals, or more frequently in exigent circumstances) of a comprehensive mental health assessment and residential aged care mental health treatment plan.**

5. The Royal Commission has heard evidence that entry into residential aged care may contribute to mental health issues. Evidence has also been given at previous hearings of the Royal Commission about the importance of assessment and care planning for people entering residential care.
6. Psychiatrists are currently funded to perform assessments and develop mental health management plans for people living in the community. These MBS-funded psychiatrist assessments are not available to people living in residential aged care and receiving an Australian Government subsidy for their care. This proposition would allow people living in residential aged care to access mental health services through a comparable plan.
7. The MBS items for psychiatric assessments and management plans are also subject to strict location requirements and usually must be delivered at the psychiatrist's consulting rooms. Travel may be difficult for people accessing aged care services. Proposition M4: Incentivise psychiatrists and psychologists to attend residential aged care facilities, set out below, is intended to operate in conjunction with this proposition so as to encourage practitioners to attend people's place of residence.
8. In relation to this proposition and Proposition M1 (Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care), it is proposed that residents would only require (and therefore should only be eligible for) a mental health assessment and plan prepared by either a general practitioner or a psychiatrist. Consideration should be given to whether, if this proposition is implemented, there is still a need for MBS funding for mental health treatment plans prepared by General Practitioners for Australians living in residential aged care (Proposition M1).
9. Finally, consideration should be given to whether approved providers of residential aged care services should be required to ensure that residents have an opportunity to receive an initial mental health assessment within a set timeframe after entering residential aged care (whether undertaken by a general practitioner or a psychiatrist) and periodic reviews. Consideration should also be given to how any such requirement could be evaluated or enforced (see Proposition M7: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents).

Queensland Health Response: **Supported.**

Individuals should have equitable access to MBS-funded psychiatric assessments and treatment plans regardless of whether the person resides in a RACF or their own home.

An initial assessment should be undertaken within one month of a person entering a RACF, with ongoing quarterly (MBS funded) reviews. If new MBS items are introduced, they should not be limited to individuals newly entering residential aged care but should apply to all persons residing in residential aged care following referral from a GP.

MBS location requirements, which stipulate that care must ordinarily be delivered at the psychiatrist's consulting rooms, should be removed. Requiring attendance at a consulting medical practitioner's usual place of work (in rooms) is not keeping pace with advancements in technology. COVID-19 has demonstrated that the provision of good quality care is not predicated on physical attendance in a consultation room. Ensuring psychiatrists are funded to visit patients in RACFs or to undertake telehealth consultations would remove access barriers for those aged care residents with mobility issues and those who would ordinarily require a carer to accompany them to appointments.

It should be noted that residents are likely to only require (and therefore should only be eligible for) a mental health assessment and plan prepared by either a GP or a psychiatrist. A GP may have a pre-existing relationship with a resident and, if mental health issues are identified that require specialist psychiatric intervention, a GP can refer that individual to a psychiatrist. GP prepared plans are likely to offer primary care alternatives and facilitate connected care. GPs, particularly those in regional areas, are often more accessible and are able to write plans immediately.

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

By 1 January 2022 the Australian Government should create a new MBS item for psychologists providing services pursuant to a mental health treatment plan to Australians living in residential aged care, with up to fifteen services in a six month period, and benefits commensurate with the Australian Psychological Society National Schedule of Recommended Fees.

10. This proposition addresses services provided by psychologists pursuant to a mental health treatment plan prepared by either a general practitioner or a psychiatrist (see Proposition M1 and Proposition M2).
11. Despite there being a high prevalence of mental health issues among older people in residential aged care, recent research indicates that less than 1% of those people receive any kind of psychosocial treatment for a mental health condition. A recent study found:
    a. psychologists are less likely to be employed by residential aged care facilities compared with other service providers (including diversional therapists, pastoral care workers and occupational therapists)
    b. there are more referrals made to GPs, pastoral care workers and geriatricians than psychologists for people who displayed depression and anxiety symptoms residents are more likely to be referred for medication than psychological treatment.
12. Psychologists are able to receive MBS rebates for providing psychological services through the Chronic Disease Management Program and the Better Access Initiative. However, these services are limited for people receiving Australian Government subsidies for residential aged care (up to 5 provided under the Chronic Disease Management program).
13. In addition, the subsidies that are provided are significantly lower than the fees recommended by the Australian Psychological Society. This may mean that psychologists will charge a gap fee, which can affect the access to these services for older people in both residential aged care and home care. This proposition is intended to remove this discrepancy in payment to psychologists.
14. While this proposition is directed to funding for individual sessions, consideration could also be given to whether this should include funding for group sessions (see, for example, MBS item 80020 which pays benefits for the concurrent treatment of six to ten patients).

Queensland Health Response: Supported

Queensland Health supports this proposition and considers it would benefit aged care residents for the following reasons:

1. Improved access to psychological services is likely to result in better mental health outcomes and wellbeing for residents.
2. Residents would not have to use their limited number of Chronic Disease Management Program consultations on psychological services and could use them for other allied health services, as required.
3. Improved access to psychological services is necessary to accommodate an increase in the number of residents who require psychosocial intervention to support their mental health.
4. Facilities may be more likely to employ a psychologist if there is an appropriate funding mechanism available.
5. Residents may be less likely to be prescribed medications if they have access to a psychologist, as they provide drug-free interventions.

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

By 1 January 2022 the Australian Government should establish an access incentive payment scheme with stepped payments for:

- **psychiatrists carrying out more than 50/100/150/200 weighted comprehensive mental health assessments or reviews in residential aged care facilities annually**
- **psychologists carrying out more than 500/1000/1500 weighted services in residential aged care facilities annually.**

Services provided (other than through telehealth) in residential aged care facilities located in outer regional or remote areas should have a weighting to reflect the higher costs of service provision in these areas.

15. People accessing aged care services may have reduced mobility, and it may be difficult for them to travel to access mental health (and other health) care services. In view of these challenges, mental health services may often need to be provided in an older person's place of residence.
16. One option for increasing the provision of psychological and psychiatric services in residential aged care facilities is through providing funding incentives.
17. This proposition is modelled on the General Practitioner Practice Incentive Payment (PIP), which encourages general practitioners to provide services in residential aged care facilities. The PIP supplements the MBS 'fee-for-service' payment model. The incentive payment is made directly to a general practitioner upon meeting the eligibility criteria.
18. Consideration should be given to whether the thresholds set out in this draft proposition would provide an adequate incentive, or whether they should be lower. Consideration should also be given to whether this proposition should extend to the provision of services at the residence of people accessing high-level home care services.
19. Finally, we note that consideration could be given to whether there is a need for additional training for psychologists and psychiatrists providing services to people accessing aged care services.

Queensland Health Response: Supported

Additional incentives should be introduced to enable person-centred mental health treatment.

Appropriately incentivising the completion of weighted mental health assessments in residential aged care (modelled on the PIP), may lead to an increase in the involvement of private sector psychiatrists in the management of aged care residents. Currently, this does not routinely occur and such a change would arguably improve access to providers and increase resident choice of provider.

Queensland Health supports a 'no wrong door' experience for older Queenslanders as they transition between the public health system, aged care services and community-based support services. More flexible options are required to address lack of mobility or issues associated with travel, and other matters such as care integration, continuity of care and person-centred care. Telehealth services should be considered for inclusion, as an alternative, particularly for older people residing in rural and remote areas where there is a lack of service providers.

A review of the thresholds set out in this draft proposition should be undertaken to ensure they provide an adequate incentive to practitioners, including where a person is in receipt of high-level home care services and requires the practitioner to attend at the person's residence.

Queensland Health considers there would be merit in additional training being made available for psychologists and psychiatrists who provide services to people accessing aged care services.

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

By 1 January 2022 the Australian, state and territory governments should create a funding stream under the National Health Reform Agreement to fund outreach services by state and territory government older person's mental health services at the residence of Australians accessing aged care services.

20. Each jurisdiction (state and territory) provides mental health services for older people (OPMHS). These multi-disciplinary services are generally provided to older people living with severe mental illness (that is, people over 65 years, or Aboriginal and Torres Strait Islander people who are over 50 years).
21. There is no standard framework for the delivery of OPMHS. Eligibility, participating specialists, and the information available to the public varies across jurisdictions. In particular, the extent to which these services offer out-reach services to residential aged care facilities varies across and within jurisdictions. There does not appear to be any data on the extent to which these services are provided to people living in residential aged care. It is unclear whether these services, even if they are available to people living in residential aged care, are provided as needed.
22. These specialist services should be available to people accessing aged care services across Australia, and there should be a level of consistency in terms of eligibility and access. One of the propositions tested in the Canberra Hearing was whether there should be multi-disciplinary outreach health services for people living in residential aged care or accessing high-level home care (Proposition CH7). Consideration should be given to whether OPMHS should form part of these multi-disciplinary outreach services.

Queensland Health Response: **Supported, in principle.**

In Queensland, the Older Persons Community Mental Health Service (OPCMHS) is responsible for the provision of comprehensive, multidisciplinary community mental health assessment and treatment services for older people with severe and complex mental illness who are living in the community. Older Queenslanders residing in their own home or in a RACF may access care from an OPCMHS, however, it is not funded or resourced to deliver care for 'high prevalence disorders' like depression and anxiety.

Queensland Health supports, in principle, the proposition to provide outreach mental health services to Australians accessing residential aged care services. Two potential models of delivery for mental health outreach are discussed. Whilst acknowledging that a gap presently exists between the level of community mental health services being delivered to older persons and the level of services required, Queensland Health prefers the first model which contemplates delivery via existing OPCMHS. This model would utilise existing service frameworks, patient data platforms, Mental Health Act infrastructure, current governance structures and a skilled multidisciplinary workforce. Utilisation of this model would, of course, necessitate further investment.

The second model contemplates the inclusion of mental health clinicians and specialists in new multi-disciplinary outreach health services for people living in RACF or accessing high-level home care (Proposition CH7). There are complexities with this model, specifically where specialists could be required to work outside existing service frameworks. Additionally, issues with the management of patient data and platforms, infrastructure and governance may eventuate. Implementation of this model may also require specific guidance on when and how the existing OPCMHS interfaces with the mental health specialists and clinicians working in the new outreach services. Unintended outcomes that may arise from this model include:

- unnecessary duplication of assessments;
- confusion amongst referrers, resulting in delays in the provision of care, and poor response to mental health deterioration; and
- increase in transfer of care points and associated impacts.

Proposition M6: Increase mental health training for personal care workers.

Training for personal care workers should include training on addressing loneliness and disengagement, and on recognising the symptoms of mental illness that require referral for further evaluation and treatment.

23. The Royal Commission has heard evidence that personal care workers do not receive sufficient mental health training, including regarding suicide prevention.
24. Consideration should be given both to initial training needs (including components of Certificate III qualifications), and the need for ongoing training. Consideration should also be given to whether ongoing training, if recommended, should be mandated and whether approved providers should be responsible for ensuring it occurs.
25. It may also be important to clearly articulate what is expected of personal care workers with respect to mental health, including identifying symptoms of depression, and working with people living with advanced dementia.

Queensland Health Response: **Supported**

Mental health training should be a mandatory education requirement to achieve certification to work within aged care settings. This would benefit not only the care recipient but also improve the resilience and capability of personal care workers. There is an opportunity for mental health training to be extended to all service providers in an aged care setting, including allied health.

Queensland Health welcomes wider discussions with the Commonwealth on the development of a nationally consistent framework for qualifications and professional standards for the aged care workforce.

Specific considerations for mental health awareness and training might include:

- improving overall mental health literacy and wellbeing (including addressing loneliness and disengagement);
- the identification and management of mental health conditions for Australians aged over 65, including an awareness of the psychosocial changes that transpire during older age which may be precipitated by a person's entry to a RACF (including recognising the symptoms of mental illness that require referral for further evaluation and treatment);
- behavioural and psychological symptoms of dementia.

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

The *Quality of Care Principles 2014* (Cth) and any subsequent instrument should include an explicit and measurable requirement to maintain the mental health of residents.

26. Under Standard 3(3)(d) of the *Quality of Care Principles 2014* (Cth) an approved provider must demonstrate that "deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner". This standard does not require approved providers to ensure that Australians accessing their aged care services have an ongoing mental health care plan in place.
27. In view of the high rates of mental health conditions among people in residential aged care, including depression and anxiety, there is a need to ensure that maintaining the mental health of residents is core business for residential aged care providers. One way of ensuring this is to introduce an explicit and measurable requirement that approved providers maintain the mental health of residents.
28. Consideration should be given to how the maintenance of mental health of residents could be measured or assessed. One option is measuring rates of mental illness, such as depression or anxiety. Another is measuring the services provided to residents.
29. Consideration should also be given to whether there could be a performance indicator relating to mental health, and whether this should be voluntary or mandated. Under the National Aged Care Mandatory Quality Indicator Program, there are performance indicators for pressure injuries, use of physical restraint and unplanned weight loss. Two further indicators for medication management and falls are being developed.

Queensland Health Response: **Supported.**

There should be greater clarity as to the role and responsibilities of residential aged care providers in relation to mental health outcomes, not only in relation to maintenance and prevention of decline, but also the promotion of mental health and wellbeing of residents.

As highlighted in hearings conducted by this Royal Commission, the current wording of the *Quality of Care Principles 2014 (Cth)* is not prescriptive and is open to interpretation. Not all RACFs will necessarily respond to a standard, in the provision of their service offering, in the same way.

If the introduction of a scheme which ensures RACF residents have an ongoing mental health care plan (as outlined in Propositions M1 and M2) forms part of the *Quality of Care Principles 2014 (Cth),* this should be monitored as part of the accreditation and compliance process.

Queensland Health recognises that an explicit and measurable instrument to assess the mental health of residents in an RACF would require collaboration between private non-government and public sector aged care providers, and the Commonwealth and State Governments. Queensland Health supports such collaboration.

Proposition M8: Peer workforce

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.

i. The Productivity Commission has noted that gaps in mental health services for older people are partly caused by a shortfall in the workforce providing State and Territory community mobile services to older people
ii. Consideration should be given to using the mental health peer workforce as a potential resource for providing companionship and trained support to people receiving aged care.

The Productivity Commission has recently proposed a draft recommendation to strengthen the peer workforce by professionalising it. Further, the National Mental Health Commission has indicated it will develop guidelines for peer workers by 2021. Consideration should be given to whether this move towards professionalising the peer workforce might allow for one means of increasing mental health support in aged care.

Queensland Health Response: **Supported.**

In Queensland Health, the peer workforce includes both consumer and carer peers. An examination of employment arrangements across Queensland Health's public mental health services identified significant variation in employment of the peer workforce across the state, including considerable differences in responsibilities, training opportunities, pay scales and naming conventions.

The Peer Workforce Support and Development Framework (the Framework) was developed to address these issues and ensure the peer workforce was adequately supported. The Framework seeks to professionalise the mental health peer workforce and ensure appropriate support and recognition is provided to people working in that profession. It outlines the scope of practice and defines key functions and activities for the peer workforce and what activities can be undertaken by a peer worker at various levels. Queensland Health released the Framework in 2019. www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf

There are clear benefits in professionalising the peer workforce through provision of training and development opportunities, defining the scope of practice for peer support workers, and developing outcomes to assess how that intervention is contributing to patient-centred care, experience and safety.

The peer workforce is not a substitute for workforce shortfalls in mental health and should only be considered an adjunct to specialist mental health services.

Oral Health

Actions that may be taken to increase the responsibility of RACFs to maintain the oral health of residents are strongly supported. Ensuring the provision of appropriate and effective oral health care, especially daily oral health care, is considered likely to increase overall health outcomes for older people, particularly those in aged care settings. Queensland Health notes the evidence received by this Royal Commission that:

- the delivery of daily oral health care to people in aged care settings is primarily the role of personal care workers, and should form part of their activities of daily living routine;
- increased oral health literacy among personal care workers is needed.

Providing outreach dental services to aged care recipients in their place of residence (in the community or in a RACF) presents a range of challenges. Given the dispersed population in regional and remote Queensland, any funding mechanism needs to address equity of access issues for people located in these areas.

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

The Australian and state and territory governments should enter into a new National Partnership Agreement to begin no later than 1 January 2022 to fund public dental services to provide outreach services to aged care recipients in their place of residence (either in the community or in residential care facilities) if they are unable to travel to receive public dental services.

Under the Agreement the Australian government should pay 50% of the Dental Weighted Activity Unit (DWAU) cost of services provided, up to a cap of each jurisdiction's aged care recipient share of $120 million in 2021-22. The national total should be indexed annually for price movements and increases in the eligible population.

30. The reduced mobility of older people may make it difficult to transport them to service providers. In view of these challenges, dental services may often need to be provided in an older person's place of residence.
31. Some private dentists and some state dental services currently provide outreach services to residential aged care facilities, but these outreach services are limited.
32. One option for improving access to dental services for Australians accessing residential aged care and high-level home care services is to fund public health dental services to provide outreach services in an individual's place of residence.
33. As almost half of all aged care residents have their accommodation costs subsidised by the Government due to an inability to pay (based on income and assets test), more than half are likely to be eligible for state-funded public dental services. Public dental services tend to be subject to waiting lists which prioritise people based on how urgently they need treatment.
34. It is proposed that increased funding be provided through joint contributions by state and territory governments on the one hand and the Australian government on the other (50% each).
35. The National Partnership Agreement on Public Dental Services is a mechanism through which older persons outreach dental funding could be established. That Agreement is about to expire, and is currently being renegotiated.
36. The DWAU is the measurement used for performance indicators (accountability for funding) under the Agreement. It measures the number and service intensity of dental services provided. The DWAU is calculated using Australian Dental Association three digit item codes and a weighting for those items.
37. Under this proposition, funding would be provided to public dental services, who could then either directly provide the service or outsource to private providers. This would allow for a systematic approach to service provision, with the state public dental services managing the dental care of older Australians.
38. The waitlist associated with public adult dental services should not affect this older person's outreach service, because it would be provided through a separate funding stream.
39. Consideration should be given to who should be able to access these outreach services, and how any requirement that an individual be unable to travel could be established.

Queensland Health Response: Supported, in principle.

The scope of services that can be provided within a place of residence are limited. Dental practitioners require a range a specialised equipment to provide high quality and safe dental care. If attending upon someone in their home, dental care would be limited to basic procedures that can be provided using a small number of disposable dental instruments such as an examination (check-up), oral hygiene instruction and fluoride varnish application. An identified need for more comprehensive dental treatment would require a patient's transportation to a dental facility.

With access to additional equipment, it may also be possible for some patients to have dentures repaired or new dentures constructed. Overall, however, provision of dental care in a person's home would be an inefficient and high cost model, albeit it would allow regular check-ups to be conducted for people for whom travel is difficult.

There are also significant challenges to providing dental care on-site at RACFs. Appropriate in-house visiting dental infrastructure would enable a greater scope of dental treatment to be performed on-site. Telehealth and mobile dental equipment may enable provision of simple fillings, prevention procedures and the like. A number of public and private dental providers already offer services in some RACFs and there are existing models of care that, with appropriate investment, could be applied to other facilities.

National Partnership Agreement (NPA)

The proposed NPA could greatly benefit aged care recipients by increasing services provided, as well as enabling greater accountability in addressing the needs of this high-risk group. In recent years the various NPAs for public dental services have had a positive impact on the ability of public dental patients to access timely care.

The activity-based approach of the NPAs has been relatively successful in addressing adult public dental waiting lists, but this funding model will have limitations for delivering more services to aged care residents. Most general waiting list patients can travel to dental clinics so NPA funding has been used to quickly ramp up services with additional public dental capacity and vouchers to allow patients to attend private dentists.

For aged care residents the proposed NPA funding model will have significant limitations. A suitable funding model needs to take into consideration:

- higher costs per Dental Weighted Activity Unit (DWAU) related to the logistical complexities of delivering care at a place of residence including travel, setting up equipment, administration of appointments, communication with other care providers, complex patient medical histories, complex consent requirements and unpredictable patient availability.
- investment in infrastructure, such as telehealth and mobile dental equipment, to ensure the provision of safe, high quality care.
- professional development for dental practitioners to enable them to deliver appropriate care in an aged care environment.
- time to scale up, establish and/or sustain public and private outreach services to expand the capacity of this segment of the dental services market.

As with the current NPA, there is the potential for public dental services to partner with the private sector to increase outreach services. Relevant considerations include:

- A fee structure that provides adequate incentives for private providers to enter this segment of the market, which is difficult to enter due to the challenge of delivering mobile outreach dental services. Only a limited number of private providers currently offer these types of services.
- A funding model that encourages private providers to deliver appropriate care to aged care residents – an entirely activity-based model creates the risk of over-servicing, which could put frail patients at risk and waste funding.

A potential barrier to implementation of a NPA for aged care outreach services is that, unlike the current NPA, the proposed NPA would only fund 50% cost of services provided for the DWAU, up to a cap of each jurisdiction's aged care recipient share of $120 million in 2021-22. A new NPA that is based on a cost-shared model of 50% between State and Territories and the Commonwealth would mean that if Queensland received its usual share of Commonwealth funding, this would equate to 20% of $120 million or $24 million per annum. An additional investment of $24 million would be required by the Queensland Government

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

Training for personal care workers should include training on providing routine oral health care and on recognising the symptoms of oral disease that require referral for evaluation and treatment by a dental professional.

40. The Royal Commission has heard evidence that the delivery of daily oral health care to older people in aged care settings is primarily the role of personal care workers, and should form part of their activities of daily living routine (i.e. showering, dressing, personal hygiene). The Royal Commission has also heard evidence that increased oral health literacy among personal care workers is needed.
41. Common entry-level qualifications for personal care workers are Certificate III in Individual Support (Ageing) and Certificate IV in Ageing Support. There are no mandatory units in either course that explicitly cover oral health care.
42. There are no requirements for approved providers to ensure their staff have professional development training in oral care (see Proposition D3). However, there are some oral health training programs available to aged care providers and their staff.
43. Consideration should be given both to initial training needs (including components of Certificate III qualifications), and the need for ongoing training. Consideration should also be given to whether ongoing training, if recommended, should be mandated and whether approved providers should be responsible for ensuring it occurs.
44. The Royal Commission has heard evidence that the high turn-over rate among staff working in residential aged care facilities may limit the utility of one-off oral health training.
45. It may also be important to clearly articulate what is expected of personal care workers with respect to oral health care (see Proposition D3: Clarify the responsibility of residential aged care providers for maintaining the oral health of their residents).

Queensland Health Response: Supported.

The delivery of oral health services by dental practitioners is important, however, it is daily oral health care that has the greatest impact on the oral hygiene of aged care recipients. Appropriate preventive routines mitigate the risk of dental problems and the need for dental treatment and will improve the health and wellbeing of older Australians. Queensland Health agrees that personal care workers should be trained in routine oral health care and to recognise the symptoms of oral disease that require referral for evaluation and treatment by a dental professional.

Training for personal care workers should take into consideration:

- the considerable demands on personal care workers and how oral health care can be integrated into their daily routines in a sustainable way;
- requirements and/or incentives for personal care workers to undertake training;
- professional development opportunities for personal care workers;
- clinical practice guidelines related to oral health for personal care workers;
- referral pathways to dental practitioners to escalate identified issues.

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

The *Quality of Care Principles 2014* (Cth) and any subsequent instrument should include an explicit and measurable requirement that residential aged care providers maintain the oral health of residents.

46. Item 2.7 in Part 2 of Schedule 1 to the Quality of Care Principles 2014 (Cth) provides that residential aged care providers are required, for all care recipients who need it, to make arrangements for dental health practitioners (among other practitioners) "to visit care recipients, whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients, or are made direct with a health practitioner".
47. The standards themselves make no reference to oral care. There is one reference in the guidance material for the standards to providers ensuring consumers' oral health care preferences are reflected in care and service plans.
48. This proposition (D3) is directed at ensuring that residential aged care providers are held responsible for the oral health of their residents.
49. Expected outcome 2.15 of the former Accreditation Standards explicitly required that residential aged care providers ensure that "Care recipients' oral and dental health is maintained". However, the Royal Commission has heard evidence that the old standards were also insufficient in ensuring evidence-based oral care.
50. One way of ensuring that oral care is core business for residential aged care providers is to introduce an explicit and measurable requirement that approved providers maintain the oral health of residents.
51. Consideration should be given to how the maintenance of oral health of residents could be measured or assessed. One option is measuring particular outcomes, another is measuring the oral health services provided to residents.

Queensland Health Response: Supported, in principle

Queensland Health agrees that there should be an explicit and measurable requirement that residential aged care providers maintain the oral health of residents.

It would be ideal to have an outcome measure for this purpose, such as a plaque index to record the oral hygiene of residents. However, it may be more practical to measure services provided, such as compliance with daily oral hygiene protocols or frequency of periodic examinations (check-ups) by a dental practitioner.

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

The Australian government should establish a new mechanism to fund organisations to supply oral hygienists and dental and oral health therapists to residential aged care facilities to carry out regular oral health assessments and personal care worker education in oral hygiene.

52. The Royal Commission has heard evidence about the importance of oral health assessments for older Australians, particularly those living in residential aged care. There is currently no requirement for a formal oral health assessment to be conducted as part of the aged care assessment conducted by a local assessor from ACAT.
53. Ongoing and basic dental services can be provided by oral hygienists and/or dental and oral health therapists in a residential aged care facility with very little in the way of specialised equipment. These services include oral examinations, scale clean and polish, extractions and restorations (not endodontic or prosthodontic).
54. This proposition (D4) suggests that funding be provided to dental and oral health organisations through a national dental scheme to provide ongoing services to residential aged care facilities. In the alternative, funding could be provided directly to residential aged care providers to engage dental health practitioners. Another alternative is that funding could be provided to the public dental services proposed in Proposition D1 to provide these oral hygienists and dental and oral health services.
55. Other mechanisms for funding could include: an MBS item for oral health assessments for Australians aged over 75 years, inclusion of oral health assessment in the ACAT process (with an appropriate referral pathway), or mandatory oral health assessments upon entry to residential aged care.
56. However, these mechanisms would not necessarily provide ongoing oversight of oral health needs by qualified practitioners, and would not contribute to increasing the oral health capability and processes of residential aged care facilities.
57. Consideration should be given to the interaction between this proposition and Proposition D3 (Greater clarity on the role and responsibilities of residential aged care providers to maintain the oral health of residents).

Queensland Health Response: Support, in principle.

Oral hygienists and dental and oral health therapists are well suited to providing care in RACFs, however, consideration should be given to implementing a funding mechanism that provides RACFs and dental providers with more flexibility around how they deliver services.

In relation to the types of dental providers, ongoing and basic dental services provided by hygienists and/or therapists would certainly benefit patients but may not be the most cost-effective approach, nor cover the scope of services required by aged care residents. For example, a significant proportion of residents are likely to have dentures which are most efficiently managed by dental prosthetists. Alternatively, some residents with more complex health and/or dental needs may require a dentist.

Consideration should be given to recognition of the use of telehealth as a cost-effective tool to support oral hygienists and dental and oral health therapists in RACFs, linking them with dentists based at a dental clinic.

Proposed funding models or mechanisms recommended by the Royal Commission should enable facilities and dental providers to enter into financially and clinically sustainable models of care delivering high quality and safe care.

Allied Health

The propositions relevant to allied health services, regarding redesigning aged care programs to focus on maintaining and restoring function, independence and wellbeing, are supported. Queensland Health supports the introduction of a designated care coordinator (proposition CH17) noting this does not reflect the broad range of allied health professionals who could be considered eligible for such a position. Not all allied health professionals are registered, some are self-regulated whereby each professions' accreditation process is managed by their professional association, similar to functions provided by the Australian Health Practitioner Regulation Agency (AHPRA). For example, social workers, who would suit a designated care coordinator role, belong to a self-regulated profession that is not registered with AHPRA.

The suggestion that ratios be used to provide allied health staff should only be considered as a costing tool. Determining an appropriate ratio of allied health staff to patients in an aged care setting, to provide high quality and safe care, is problematic due to the diversity of allied health services and patient needs. Each allied health profession brings a different skillset to patient care. Ratios would need to be considered for each allied health profession.

Applying a ratio of allied health supply (e.g. minutes of service provision) to allied health service demand (e.g. per patient) may have unintended consequences and may result in limitations and restrictions in the types, as well as delivery, of services that are provided. There may also be unintended impacts on the quality of allied health services that are provided due to a focus on outputs rather than outcomes.

Queensland Health considered propositions A1 to A4 as alternatives. Based on these alternatives Queensland Health's preferred funding proposition is A3. In the event that the Royal Commission recommends implementation of a combination of the propositions, Queensland Health prefers weighting towards proposition A3.

Proposition A5 was considered separately as a hybrid that included features from propositions A1 to A4. It was considered with regard to draft proposition CH21 – a new primary care model for aged care recipients, which is understood to be foundational to proposition A5.

Proposition A1: Increase funding for allied health services through a new MBS benefit structure for Australians accessing aged care services.

By 1 January 2022, the Australian Government should implement a new MBS benefit structure for allied health services provided under an "Aged Care Plan" to aged care recipients.

The level of MBS benefit for allied health services provided under Aged Care Plans should be raised to a level that removes the current disincentive to provide MBS services and the need for service providers to charge large gaps.

58. With respect to MBS funding for allied health, under the Chronic Disease Management package, medical practitioners can refer people with chronic conditions for subsidised allied health services under a management plan. People with a management plan can access five MBS-funded allied health services in a calendar year.
59. The draft proposition relating to a new model of primary health care developed following the Canberra Hearing is that a new primary care model be implemented in which general practices could apply to become accredited aged care practices. People with an ACAT assessment could enrol with an accredited practice, which would receive an annual capitation payment for each enrolled person's level of assessed need. Accredited practices would also be required to prepare an 'Aged Care Plan' for each enrolled person, which would include referrals for allied health services.
60. Under this proposition (Proposition A1), new MBS items would fund allied health services provided pursuant to an 'Aged Care Plan' to older Australians enrolled with an accredited general practice.
61. It is proposed that there would still be a cap or limit on allied health services and that Government should set this limit based on clinical advice. For example, it might be that physiotherapy and psychology should be available weekly, podiatry monthly, while diabetes education or dieticians should be available only quarterly, and audiometry annually. Consideration should also be given to whether there should be different approved limits for people in residential aged care compared with people accessing aged care in the community.
62. This proposition (Proposition A1) still operates within the traditional fee for service model of the MBS, which pays for direct one-on-one treatment activities between the allied health professional and older person. It would not reimburse allied health professionals for work they undertook to support family members and aged care staff.
63. This proposition also relies on general practitioners identifying allied health needs and making appropriate referrals. Consideration could be given to alternative ways in which residents' allied health care needs could be identified.
64. Consideration should also be given to the need for allied health services to be provided at an individual's place of residence, and to the possibility of allied health.

Queensland Health Response: Supported, in principle

While the MBS is a useful mechanism for funding allied health professionals to provide services to aged care recipients, this funding model does not represent value to the broader system. It offers limited value to individual aged care recipients who are likely to have changing needs over time, and not all allied health professions attract Medicare rebates. The model does not allow for facility-level programs for prevention of functional and cognitive decline, nor does it embed a reablement approach to care.

Some allied health professions are more likely to provide individual patient consultations (e.g. podiatry) whereas other allied health professions would provide both individual and system/facility level interventions (e.g. physiotherapy, developing falls prevention program for all residents and providing individualised treatment). Some allied health professions would have greatest impact at system/facility level (e.g. dietitians for optimal nutrition and the prevention of malnutrition through facility menu planning).

This funding model does not support building capacity of RACF staff and relies on clinical judgment by a GP to understand what allied health services would benefit the patient through an Aged Care Plan.

Proposition A2: Fund accredited aged care general practices to provide a comprehensive range of allied health services to patients.

By 1 January 2022, the Australian Government should fund aged care general practices to provide a comprehensive range of allied health services to patients.

65. Proposition A2 also relates to the proposed new model for primary care (see the draft proposition set out at the end of this document).
66. Under this proposition, the risk-adjusted capitation payment made to accredited general practices to cover primary care services would be increased to cover the provision of allied health services. For example, a practice with an enrolled aged care recipient requiring three hours of physiotherapy per week would receive $30,000 per year. This would require accredited general practices to employ or engage allied health professionals to provide services. This model would not necessarily embed allied health services in residential aged care facilities.
67. Consideration would need to be given to how feasible it would be to develop a price schedule. Consideration should also be given to how accredited general practices could be held accountable for ensuring services are delivered.
68. Finally, consideration would need to be given to the provision of services at an individual's place of residence.

Queensland Health Response: Supported, in principle

The proposed funding model relies on an accredited general practice servicing a geographic area and understanding the allied health needs of individual patients.

This model does not provide for facility-level programs for prevention of functional and cognitive decline (e.g. diversional therapy) and does not embed a reablement approach to care. This model does not provide choice for older people as services will be delivered by whoever the practice engages.

If this model were adopted, consideration needs to be given to the accountability framework for delivering against the capitation payment for non-GP services. It should not be assumed that GPs have the knowledge and/or ability to measure the quality of allied health services provided.

Delivery of services to care recipients in their own residence will need to account for the differences between metropolitan and regional and remote areas. The use of telehealth and associated technologies should to be considered for these areas.

Proposition A3: Fund aged care providers to deliver a comprehensive range of allied health services to people receiving aged care.

By 1 January 2022, the Australian Government should fund aged care providers to deliver a comprehensive range of allied health services to people receiving aged care.

69. This proposition, and Proposition A4 (the Australian Government should fund multidisciplinary allied health organisations to deliver a comprehensive range of allied health services to people accessing aged care) are both directed at creating a funding mechanism that facilitates more holistic allied health care, allowing for a broader range of service provision beyond one-on-one treatment.
70. Allied health professionals may be able to provide beneficial services beyond treatment for individual care, such as building the expertise of aged care staff (both in residential an home care) through training, advice and improvement initiatives. In addition, older people with complex needs may not be well served by short assessments and treatments by different service providers. For this reason, there may be benefits in ensuring that any proposed funding model be directed at embedding allied health services within aged care facilities.
71. Under this proposition (Proposition A3), aged care providers would receive additional funding to deliver a full range of allied health services to residents. This could be provided pursuant to an 'Aged Care Plan' (see the draft proposition for a new primary health model, set out below). Consideration could be given to alternative ways in which residents' allied health care needs could be identified. Aged care providers could choose whether to contact allied health practitioners or organisations, and/or employ in-house allied health professionals.
72. The proposed Australian National Aged Care Classification (AN-ACC) system could be expanded to add subclasses reflecting the allied health care needs of different groups.
73. Consideration should also be given to how approved providers could be held accountable for the delivery of adequate and appropriate allied health services.
74. Finally, consideration should be given to whether this approach to funding could contribute to a divide between the health system and the aged care system, on the basis that the community allied health care system would not extend to residential aged care and a separate system for funding allied health care in residential aged care result. This approach would not necessarily embed allied health services in residential aged care facilities at all times – their presence could still be episodic depending on the resident profile. Lastly, there may be an economy of scale issue for smaller residential aged care providers, particularly those in rural and remote locations.

Queensland Health Response: **Supported**

This proposition is preferred over the other propositions because it:

- provides a more holistic approach that has broader benefits to RACFs as well as individual clients and their families;
- promotes a more person-centred approach that focuses on lifestyle and quality of life rather than a medical model of service delivery and treatment.

This model provides for flexible use of allied health input across RACFs and doesn't preclude the facility contracting external allied health organisations or State-operated services to deliver appropriate care.

As this proposition is premised on a well-considered Aged Care Plan (the Plan), the design of the Plan is critical as is ensuring it is not based solely on deficits but includes reablement plans/goals, similar to NDIS plans, to ensure that adequate supports are funded to meet residents' own lifestyle goals.

Providing funding into the aged care system to providers would need to be implemented so that a range of allied health services could be included in individual Plans (e.g. podiatry), or to providers at a facility level (e.g. dietetics).

Proposition A4: Fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to people accessing aged care.

By 1 January 2022, the Australian Government should fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to people accessing aged care.

75. The Royal Commission has heard about the need for holistic care, multi-disciplinary team assessment and restorative care. Positive outcomes for frail older people through comprehensive geriatric assessment by multi-disciplinary teams have been well established in the geriatric literature for several decades.
76. Under this proposition, capitation funding would be provided directly to organisations that provide multi-disciplinary allied health services. State based multi-disciplinary hospital-led outreach services could also seek funding for this more preventative and primary care in addition to sub-acute care.
77. Consideration would need to be given to which organisations could qualify for this funding, and whether there would be adequate supply of such services (or whether there would need to be an interim arrangement). Consideration would also need to be given to how referral to these services could occur.
78. Finally, consideration would need to be given to how organisations receiving this funding could be held accountable for the delivery of services and health outcomes.

Queensland Health Response: Supported, in principle

This proposition relies on the existence of a viable market for allied health services and is particularly problematic for regional and remote areas. The model depends on having a large enough population to have the necessary range of allied health services available.

Where there is market failure in regional/rural areas, there would be greater risk that public allied health services will be the provider of last resort thus stretching existing small services that are required to respond to needs that are spread across a large catchment.

State-operated services could potentially end up competing with primary health care providers, rather than complementing services.

Proposition A5: New allied health funding for aged care

By 1 July 2022, the Australian Government should implement a new funding model to support the delivery of allied health care to aged care recipients.

Two funding mechanisms should be used to achieve a sustainable funding model to support high-quality allied health for aged care:

1. **Fund residential aged care and home care providers to deliver 'frequent and ongoing' allied health services; and**
2. **Increase funding for 'infrequent or episodic' allied health services through a new MBS benefit structure for people accessing aged care services under an 'Aged Care Plan'.**

Permanent aged care residents and people accessing level 3 and 4 home care packages should be eligible for allied health services under the new funding model.

The levels of funding for allied health services should be raised to a level that removes the current disincentive to provide MBS services and the need for service providers to charge fees that result in large gap payments by patients.

The table below outlines the proposed distribution of allied health services by setting and type of care:

Aged care setting	Type of allied health care	
	Frequent and ongoing: *Podiatry, occupational therapy, speech pathology, maintenance physiotherapy, dietetics*	Infrequent or episodic: *Psychology, rehabilitative physiotherapy, audiometry, optometry, rehabilitative physiotherapy*
Home care (level 3 & 4)	Need assessed as part of aged care entry assessment. Aged care provider funded to deliver assessed level of care.	Referred by primary care practice. Provided by allied health professionals reimbursed through Medicare Benefits Schedule.
Residential care	Need assessed as part of aged care entry assessment. Funding built into shared cost base; services provided by professionals remunerated by the aged care provider (either employees or contractors).	Referred by primary care practice in collaboration with the aged care provider. Provided by allied health professionals reimbursed through Medicare Benefits Schedule.

79. This proposition is directed at creating two new funding mechanisms to facilitate more holistic allied health care for aged care recipients, allowing for a broader range of service provision beyond one-on-one treatment. It seeks to promote continuity of care by funding providers directly to support frequent and ongoing allied health needs, while also taking advantage of the benefits of the fee-for-service model for infrequent or episodic allied health care.
80. The first aspect of the proposition relates to allied health services care recipients are likely to need on a 'frequent and ongoing' basis, including:
    a. Podiatry
    b. Occupational therapy
    c. Speech pathology
    d. Maintenance physiotherapy
    e. Dietetics
81. It is proposed that providers of residential and home care services (with respect to level 3 and 4 home care packages) will be responsible for and funded for the provision of frequent and ongoing allied health services.

82. This approach may support allied health professionals to provide beneficial services beyond treatment for individual care, such as building the expertise of aged care staff (both in residential and home care) through training, advice and improvement initiatives. In addition, older people with complex needs may not be well served by short assessments and treatments by different service providers.11
83. Under this aspect of the proposition, providers would receive additional funding to support the delivery of these services.
84. The second aspect of this proposition relates to allied health services needed on an 'infrequent or episodic' basis, including:
    a. Psychology
    b. Rehabilitative physiotherapy
    c. Audiometry
    d. Optometry
85. With respect to current MBS funding for allied health, under the Chronic Disease Management package, medical practitioners can refer people with chronic conditions for subsidised allied health services under a management plan. People with a management plan can access five MBS-funded allied health services in a calendar year.
86. This proposition suggests new MBS items for 'infrequent or episodic' allied health care for aged care recipients. Older people enrolled with an accredited aged care general practice would be eligible for this MBS funding.
87. Under this proposition, the referral pathway for people to access MBS funded allied health services would depend on the type of aged care received:
    a. aged care recipients living in the community would be referred by a primary care
    b. practice;
    c. aged care residents would be referred by a primary care practice in collaboration with the aged care provider.
88. It is proposed that there would still be a cap or limit on allied health services funding under the MBS and that Government should set this limit based on clinical advice. For example, it might be that rehabilitative physiotherapy should be available weekly, psychology monthly, and optometry and audiometry annually.
89. Consideration should also be given to whether there should be different approved limits for people in residential aged care compared with people accessing level 3 and 4 home care packages.
90. Approved providers of residential and home care (with respect to level 3 and 4 home care packages) would be responsible for arranging attendance by allied health practitioners to provide episodic or infrequent allied health care.
91. Aged care providers could choose whether to contract allied health practitioners or organisations and/or employ in-house allied health professionals to cover any or all of the allied health services identified.
92. Consideration should be given to:
    a. which allied health services should be defined as 'frequent and ongoing' and which 'infrequent and episodic' in an aged care context
    b. how care recipients' allied health care needs could be identified
    c. how approved providers could be held accountable for the identification of need for allied health services and/or the delivery of adequate and appropriate allied health services.
    d. the impact of this recommendation for smaller scale aged care providers and providers in regional, rural and remote Australia
    e. the need for allied health services to be provided at an individual's place of residence, and to the possibility of allied health services being delivered via telehealth, particularly in rural and remote areas
    f. access to allied health by people receiving level 1 or 2 home care packages.

Queensland Health Response: Supported, in principle

Funding aged care service providers to provide frequent and ongoing allied health services would increase the connection between those allied health professionals and residents, enabling such

professionals to undertake comprehensive assessments and shape residents' care plans. It would also support capacity building and education of RACF staff.

Limiting an individuals' eligibility for allied health services creates a barrier to access. Requiring enrolment with an accredited aged care general practice as a pre-condition to access services assumes there to be a relationship with a GP and also relies on the skills of that GP to assess the need for, and benefit of, allied health services.

The Chronic Disease Management Package relied on the existence of a management plan and this has proven to be a barrier to individual's accessing appropriate allied health services. A similar model that requires an Aged Care Plan and referral by an accredited aged care general practice would need to overcome these limitations. The use of screening or assessment tools to determine the allied health services required may address some of the limitations, however, individualised assessment by allied health professionals would deliver more holistic and person-centred allied health care.

Additional funding should be allocated for the provision of infrequent or episodic allied health services. Queensland Health considers the list of applicable professions should be expanded to include social work, orthotics and audiology, the latter either in addition to or instead of audiometry.

Careful consideration of funding caps would be required. Queenslanders are living longer and with increasing complexity and levels of chronic disease. To ensure person-centred services, limits should be considered for each allied health profession independently. Capping of limits should be based on clinical criteria and deliver equity for people in RACFs and those receiving level 3 or 4 home care packages.

Funding for allied health services should also be provided for people accessing level 3 or 4 home care packages while in respite. There is often a need for allied health treatment during a period of respite to prevent functional decline, thus maximising the resident's chance of returning home.

Proposition CH21: the Australian Government implement a new primary care model for aged care recipients by 2022

93. Under this new primary care model, general practices apply to the government to become accredited aged care practices.
94. This model could have the following features:
    a. The initial accreditation criteria might simply be RACGP accreditation, participation in after hours cooperative arrangements and utilisation of My Health Record, but over time these could be strengthened to include features such as formal relationships with geriatricians and other specialists, or attainment of geriatric medicine or gerontology qualifications by GPs or other practice staff.
    b. People with an ACAT assessment can enrol with an accredited practice.
    c. The practice would receive an annual capitation payment according to an enrolled person's level of assessed need.
    d. In return for the capitation payment the practice agrees to meet the primary medical care needs of the person for the year, including cooperative arrangements to provide after-hours care if required.
    e. Practices can agree with people and their aged care providers on how care will be provided, including use of telehealth services, use of nurse practitioners, and so on.
    f. Practices must agree to accept any person who wishes to register with them (subject to geography).
    g. The capitation payment will be reduced by the value of benefits paid when an enrolled person sees a GP in another practice.
95. Practices will be held to account against a range of performance indicators, including immunisation rates and prescribing rates. They will be required to use My Health Record in conjunction with aged care providers, and required to initiate and take part in regular medication management reviews.

96. Practices will be required to prepare an “Aged Care Plan” (in collaboration with a geriatrician and the aged care provider if there is one) for each enrolled person, which includes referrals for appropriate allied health services and dentistry.