Submission on Aged Care Program Redesign: Services for the Future Consultation paper 1 (Dec 2019) by Royal Commissions into Aged Care Quality and Safety

Clinical Associate Professor John Cullen
Senior Specialist Geriatric Medicine, Concord Hospital, NSW
Clinical Director - Aged Care / Rehabilitation / General Medicine / Chronic and Ambulatory Care / General Practice - Sydney Local Health District:
T: [redacted]
E: [redacted]@health.nsw.gov.au

Professor Vasi Naganathan
Professor of Geriatric Medicine, Centre for Education and Research on Ageing
Academic Faculty of Medicine and Health, University of Sydney
Consultant Geriatrician, Geriatric Medicine, Concord Hospital
T: [redacted]
E: [redacted]@sydney.edu.au

We wish to comment on the Aged Care Program Redesign: Services for the Future Consultation paper 1 (Dec 2019) by Royal Commissions into Aged Care Quality and Safety.

In our submission we would like to give our view on:

a. some of the principles that should guide the design of aged care services
b. our view on how we see Aged Health services fitting in with the proposed structure
c. specific answers to some of the questions asked in page 23-26 of the consultation paper

We are of course available to have further discussions about what we have submitted and are happy to direct the commission to other people we know who have expertise that you might find helpful

Who we are? (Our Credentials)

We are Consultant Geriatricians working in the public health sector in the Inner West of Sydney. Our practice spans inpatient acute care, inpatient rehabilitation, dementia assessment and management, outpatient clinic, community practice, rural setting and residential aged care settings. We have over 34 years (JC) and 20 years (VN) experience working in our local area. In addition to our roles as clinicians, one of us (VN) is a Professor of Geriatric Medicine at the Centre of Education and Research on Ageing at the University of Sydney, and the other (JC) has over 30 years' experience as a clinical manager and stream director of the local Aged Care Health services that includes Community based services, ACAT teams and outreach services to Residential Care Facilities. VN is a senior council member of the Australian and New Zealand Society of Geriatric Medicine (ANZSGM) and JC has been actively involved with the organisation for years. We have both been heavily involved in the training of Geriatricians in Sydney and VN at a National level.

Principles

We agree with the consultation paper's Principles and Fundamental changes discussion. One of the fundamental things to understand is that the reason older people require aged care is because of health problems rather than because of simply getting older. A key reality is that most older people who require access to intensive support services do so because of disabilities which arise from acute and chronic medical conditions (including conditions affecting cognition). Dependency and need for support is not an inevitable consequence of ageing.

This explains why we feel strongly the new design of the aged are system has to interface well with health systems (as has been stated) but in addition we think some aspects of the aged care system proposed in the consultation paper should be provided by the community and residential care arm of local Health district Geriatric Medicine/Aged Health Services. These services have multidisciplinary teams that include Geriatricians, nurses, allied health staff (physiotherapist and OTs in particular) and social workers who are the best people to comprehensively assess the health of older people and help manage their health problems. They also are best placed to be able to access the expertise of people and services within the health system such as pharmacists and other medical specialists. They have established links with General partitioners in their local health districts

We agree strongly that comprehensive assessment by experienced clinicians who possess a multidisciplinary skill set is the pivotal step in approval for access to more intensive home support and accommodation services (p8 of the paper). We agree a single comprehensive assessment service should have coverage of a defined region. We further argue that assessment should be independent of potential service providers, removing potential conflicts of interest. We believe that the assessment must be more than a check list comparing the care needs of the older person at a particular point in time with the eligibility criteria of various service providers. The assessment must be based on an understanding of the aetiology, prognosis and potential to treat conditions and restore function. This requires that the clinicians undertaking the assessment are highly skilled, grounded in a strong clinical structure and that they have access to pertinent information and skilled clinicians of other disciplines.

If expertise in managing complex health problems, disability, rehabilitation needs and social circumstances is accepted as one of the keys to helping older people achieve better quality of life then these teams can play a crucial role in the following aspects of the proposed age care design described in the consultation paper:

a. Perform the comprehensive assessment required for eligibility for intensive service streams as health and functional problems that are potentially reversible are often the reason why older people require assistance from aged care services (this is the role of current State health embedded ACAT teams. In general, this role is fulfilled to a high level.)
b. Identify people who would benefit from rehabilitation or restorative care and be able to provide some of these services (when it needs to be intensive and/or complicated)
c. pro-actively helping people access the care they need and case manage people till a plan has been put in place that has addressed their medical problems as best as possible, community services/ residential care services have been successfully accessed and restorative care program has been completed – we think that the community arm of our Aged Health Services should be providing the face – face support to help people through the aged care system
d. Provide outreach multidisciplinary service to help residential care facilities with the health care of older people

How Geriatric Medicine/Aged Health services would fit in with the proposed structure

Background to the people we see and Geriatric Medicine/Aged Health services

Our patients within both hospital and community settings are characterised by considerable age, frailty, multimorbidity (acute and chronic illnesses) and polypharmacy. They have high rates of cognitive impairment and dementia, restricted mobility and social isolation. Many are financially disadvantaged. Many need extensive home supports. Some are transitioning to Residential Aged Care. The health and general care needs of many of those in Residential Aged Care are extensive, complex and variably well met by the facilities and primary medical care. Most of our inpatients are admitted through Emergency Departments.

We work as part of the Local Health District's Aged Health service. The service is large and multidisciplinary. It spans hospital, ambulatory care, community and Residential care settings of care delivery. We provide direct care and consultative advice.

The Aged Care Assessment Service with responsibility for our local population is embedded within the Aged Health service. We have worked with the local ACAT for the entire period of our practice as Consultant Geriatricians.

In the discussions around the work of the Royal Commission we feel that the current role and potential role of Geriatric Medicine/Aged Health services has not been fully appreciated. Aged Health services have ACAT teams as a core component of their services. ACAT clinicians have the clinical skills and multi-disciplinary expertise to assess eligibility for more intensive service streams including need for rehabilitation and restorative care. There was a time when ACAT teams were provided resources to case manage people through the aged care system until they got the services they needed. During this period our ACAT teams would meet regularly with the Community Aged Care providers. Our clients and families benefited from these well-established links between ACAT teams and aged care providers. We regret that directions of the Aged Care program central managers have now prevented the ACAT assessment from extending to short term case management or care navigation. When the ACAT teams role were diminished to simply assessing for eligibility for aged care services as opposed to also trying to improve the health of our clients and helping people navigate the system many services, including ours, "fought", to maintain some of our ability to help people through the system. We did this by funding and establishing up smaller services that could take on some of the case management/helping people navigate through the aged care system role. The problem is that these team can only take on the most difficult and complex cases (where the need seem greatest) so that they are not overwhelmed with the large number of people who could potentially benefit from this help. This is an unmet need.

Geriatric Medicine/Aged Health services have also included teams that have been able to provide rehabilitation at home with the expertise of Geriatricians, physiotherapists and occupational therapist. At our service we have an established home-based rehabilitation program. More recently many Geriatric Medicine/Aged Health services, including our own, have established outreach services to residential care facilities with the aims of providing better health care to older people in residential care and trying to manage health problems in "their homes" rather than in hospital (hospital in the home). Many of our services work closely with the old age psychiatry teams to help with the management of the behavioural problems associated with dementia.

The specific Roles Geriatric Medicine/Aged Health services should take on in the proposed aged care system

1. Assessing eligibility for intensive service streams (currently done by regional ACAT teams embedded in the Aged Health service, but under threat of being "privatised")
2. Provide the support to older people and their families to understand the system and the services and care they need by providing information and face-face support (this used to be a renewed function of ACAT teams). Many of our services try to still do this to a limited extent

3. Take a lead in assessing rehabilitation and restorative care needs of older people living at home and case manage people through their rehabilitation/restorative care program – this needs to be done by skilled clinicians in services with multidisciplinary expertise (Geriatric Medicine/Aged Health services would run some home-based programs and day hospital rehabilitation programs but aged care providers would also run their own such programs)
4. Some of the proposed increase in nursing and allied health services should be provided through Geriatric Medicine/ Aged Health services to address the health needs of the older people living in the community and in residential care
5. Providing medical, nursing and allied health expertise to residential care facilities (many Geriatric Medicine/ Aged Health services have already established well developed outreach services)

Why we think these proposed roles should be undertaken by Geriatric Medicine/Aged Health services rather than Aged Care Providers

If there is one thing, we have learnt over the years is that many of our older patients' health problems, functional problems and social problems are complex. It requires multidisciplinary expertise and time to formulate and implement plans that improves the quality of life of our patients and their families. We can do this because the "business model" of our teams are not based fundamentally on the number of people we see. The funding model for Aged Care Providers on the other hand has to be a model based on the number of people seen. This is not an incentive to sort out complex health, functional and social problems. It takes time to do this properly and time to help people navigate through the health system.

Having said that, ACATs in NSW operate efficiently with high rates of compliance with ACAT KPI timeframes. Time to completion of an ACAT assessment is not a factor the unacceptable delays to access a Home Care package.

Geriatric Medicine/Aged Health services have the advantage of having all the expertise under "one-roof". In our service we have Geriatricians, Old Age Psychiatrists, nurse practitioners, physiotherapists, occupational therapists and dieticians. We have access to other medical specialists (including palliative care) and pharmacists. Aged Care providers are able to have skilled nurses and allied health as part of their regular staff but have traditionally not had Geriatricians or Old Age Psychiatrists as part of their teams. Some have called upon their services on "pay for time basis" but usually for case discussion rather than face to face assessment.

Aged care providers are not part of the health system they do find it more difficult to access hospital based services or to help people access hospital based expertise.

We conducted a study to understand more about the links people seeking to access intensive support services have with the health system. In our Local Health District 90% of those referred for ACAT assessment had contact with the Health service in the six months prior to referral for assessment. Approximately 45% of those referred are inpatients at the time of assessment. Referrals of inpatients are only accepted when access to TACP is sought or when transfer to Residential Aged Care is required to enable discharge from hospital. Inpatients who seek access to

Home Care Packages are not accepted for assessment in the inpatient setting, but are considered community referrals and are seen subsequent to discharge.

Referrals from inpatient settings can pose challenges. Time pressures and an imperfect understanding of the interplay of diagnoses, prognoses, relevant time frames and management options, by some medical subspecialists, family members and even ACAT clinicians can leave older patients vulnerable to inappropriate decisions regarding their future care and living arrangements. ACAT clinicians can find it difficult to withstand pressures from the inpatient system to make expedient decisions. To mitigate this risk we require that all Public Hospital inpatients within our health service who are referred for consideration by ACAT undergo Geriatric Medicine consultation before the referral to ACAT proceeds. An external aged care provider is going to struggle in the hospital setting and there is a danger of delays or even worse decisions made that are not in the interest of our patients.

The embedding of ACAT within State Geriatric Medicine /Aged Health services has had an important secondary benefits of facilitating the establishment of outreach Geriatrician services between regional areas, and assisting flows for older inpatients. While the latter may not be a priority of the Department of Ageing, it is a matter of importance to older inpatients (whose admissions should not be prolonged longer than is medically necessary), and Commonwealth and State Departments of Health.

The decision of the Minister for Aged Care and Senior Australians to place ACAT functions out to competitive tender, with new providers to commence by March 2021, will dismantle clinically important and highly functional relationships. It will threaten the quality of assessments and distance the Aged Care program from Aged Health services, to the detriment of consumers, the Aged Care Program and Aged Health services. We urge that this decision be reviewed.

Have Geriatric Medicine/Aged Health services the Resources to take on these roles?

It would be fair to say that as ACAT roles have been diminished over time the ability of Aged Health services to take on the roles described above has varied across the country. Many of the large well-established Aged Health services have argued successfully for more resources and have established some of the models of care to take on some of the tasks discussed above. We feel strongly that ACAT should remain linked clinically and organisationally to State Aged Health services and they would need more resources if they are going to take on the case management role and the face-face support to help people navigate through the health system. Geriatric Medicine/ Aged Health services will also need to continue to grow in response to ageing demographically and the growing demands for Geriatric Medicine input into the care of patients under the care of many disciplines. We recognise that Geriatric Medicine/ Aged Health services are better developed in some regions that other. Different models will be required for regional services.

There would need to be more discussion about the resources implications if our services were to increase their ability to provide rehabilitation/restorative care to community living older people and outreach services to residential care but many of our services have already good examples of these models of care.

If Geriatric Medicine/Aged Health services take on more of these roles, then we think it is mandatory for them to show how they have established good links with the aged providers and residential care providers. Again, there are good examples around the country of how this can be done.

Answers to specific questions

1. What are your views on the principles for a new system, set out on page 4 of this paper?

We agree with the list of principles on page 4.

2. How could we ensure that any redesign of the aged care system makes it simpler for older people to find and receive the care and supports that they need?

3. What is the best model for delivery of the services at the entry point to the aged care system—considering the importance of the first contact that older people have with the system? This includes looking at services provided by phone and website as well as face-to-face services

We agree strongly that comprehensive assessment by experienced clinicians who possess a multidisciplinary skill set should be the central step in approval for access to more intensive home support and accommodation services (p8 of the paper). We agree a single comprehensive assessment service should have coverage of a defined region. The Regional Assessment Service model which has multiple organisations delivering RAS assessments within the same geographical area has been problematic. Locally we have seen differences in performances and inconsistencies of practices between the different RAS providers. We further argue that assessment should be independent of potential service providers, removing potential conflicts of interest.

We contend that these principles are fulfilled by the existing ACAT network, and that the embedding of ACAT within public Geriatric Medicine/Aged Health services is critical to the successful conduct of the assessment function.

We agree that the key principle that older people and their families need face-face help to navigate through the aged system. People often require services from the aged system because there has been a change in their health, function and/or social circumstances. We think the ACAT teams (if they remain based in state Geriatric medicine/ Aged Health services) are the best people to help people access and navigate the aged care system. They can help people make informed choices about what services they want to access. It has not made sense to us that the ACAT teams do a thorough assessment of the needs of an older person, but it is now not in their "brief" to then help people with the next important stage of accessing the care that they need. As you would know from your work many people are left to "fend for themselves".

5. *Investment stream.*

• *What are the most important aged care interventions for people experiencing a crisis or sudden change in their circumstances?*

The key is a proper skilled assessment by the Geriatric medicine community teams. Sometimes they key is to sort out health problems. Other times it is a social or family problem required the input of an external person. Our approach to crisis and sudden change in circumstances is to do a comprehensive assessment and then work out whose input from within our team would be most useful (Nurses, Geriatricians, Old Age Psychiatrists, allied health, social worker, other specialists) and/or services from aged care providers. In this ideal world our community team would "case manage" people to make sure they have been able to access this help and monitor the situation. Through good Geriatric Medicine a proportion will achieve improved function, negating or postponing their need to access intensive support services. As Geriatricians, working with a multidisciplinary clinical team, we have been able to divert many patients referred to us from pathways leading towards Residential care to more independent living arrangements.

What evidence is available on how these interventions prevent or delay a move to higher level packaged care or permanent residential aged care (or support older peoples' wellbeing, health and functioning)? Are there specific interventions that need increased funding? Are there new or innovative approaches that should be recommended for inclusion in this stream?

Part of the reason we think our community teams has a role in assessing the rehabilitation/restorative care needs of older people is there it requires expertise to work out what is likely to help and what isn't. There is good evidence for some type of rehabilitation programs for specific problems but there is also no evidence for other interventions. For example there is good evidence that home based exercise programs with a balance and strength component can prevent falls in older people at risk of falling but there is no evidence that generally increasing physical activity will prevent or delay moving to higher level of care or residential care because it usually major health and functional problems that are driver for this. This is not to say that increasing physical activity and social activity are not important – they do enhance quality of life.

7. *Specialist and in reach services. How could the aged care and health systems work together to deliver care which better meets the complex health needs of older people, including dementia care as well as palliative and end of life care? What are the best models for these forms of care?*

The assessment of the problems and formulation of management plans should be done by the community Geriatric medicine teams (the multidisciplinary teams – not a medical only model) in consultation with patient's family and GPs. The Geriatric medicine/ Aged Health community teams have expertise in Dementia care as well as palliative care but also are able to access expertise within the health system.

They then need to work closely with the Aged Care system (community and residential care). The Aged Care system should have ready access to the expertise of the Geriatric medicine

multidisciplinary teams. If provided with the resources, it is in our opinion, not so difficult to improve the links between aged care and the health system. It has to be done at a local level.

• *What would be required to support in reach of multidisciplinary health teams from the health system in the care of older people with high needs? What other services could be used (24/7 on-call services, embedded escalation to specialists, access to relevant ageing specialists, telehealth or other technological advances)?*

As one example, we have developed an outreach team (medical and nursing) which assists with the provision of clinical care to residents of local Aged Care Facilities within the Facilities (we note a reference to this model on p15 of the discussion paper). The service operates 7 days for extended hours. We have plans to extend its intake/triage/ advice function to 24/7 operation. We are utilising TeleHealth technology to assist with clinical care. Our service also operates a special unit for older people with challenging behaviours in the context of cognitive impairment.

The service is unified by the electronic Medical Record, a streamlined intake system, and a single management structure. Funding is by a mixture of State and Australian Government sources. We see our target population as being all older people with the characteristics defined above in our health district hospitals or living in the local health district catchment, as well as the carers of that cohort, and more healthier older people who need to access preventative and healthy lifestyle programs. This service is mirrored in other LHDs.

• *What is needed to ensure greater uptake of in reach health services (such as specialist palliative care) and aged care specific services (such as Severe Behaviour Response Teams and Dementia Behaviour Management Advisory Services)*

Differing models will be required in metropolitan and regional areas. For the former, residential aged care outreach services provided by public health services should be the structure to which externally funded services such as those mentioned are linked. Such arrangements will support the provision of comprehensive clinical care. We support consolidation rather than fragmentation of service structures. Our experience is that since DBMAS services were centralized and detached from the rest of the health service, the worth of the advice provided by DBMAS has diminished, and coordination of interventions has reduced. Our local RACF Outreach service (which has been developed by our Geriatric Medicine / Aged Health service) provides residents access to health intervention not otherwise available through primary care or by facility carers. The service has achieved highly functioning connections with a range of local subspeciality medical and surgical services, including Old Age Psychiatry, Palliative Care, Vascular surgery, Dermatology, Plastic surgery, wound management and Hospital in the Home, with others being engaged. The service has an average daily occupancy of over 200. Videoconferencing and other technologies (Virtual Health service model) can increase capacity and range of resources. We agree that much more needs to be done to ensure that the health needs of RACF residents are better met. We contend that additional resources should be applied to existing effective operational models rather than to the creation of new, disconnected structures. This is a responsibility of both State Health and Commonwealth jurisdictions.