AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA

AMA submission to the Department of Health: Future reform – an integrated care at home program to support older Australians

The following submission refers to the discussion paper, *an integrated care at home program*, which is available here.

Section 2: reform context

2.3 Reforms to date

Comments
We would welcome your views and feedback on the February 2017 *(Increasing Choice)* reforms.

Increasing consumer choice in aged care services is important to ensure older people have flexibility and control over their own lives. However, support is still needed to help them make these choices. A consumer has up to 84 days to enter into a home care agreement and if they surpass this timeframe, their home care package will expire and they will need to reapply[1]. We have heard from stakeholders in the sector that it is usually taking a long time for consumers to choose a home care agreement, and some do not choose one at all. Letters are sent to the consumer at around 35 days to remind them to enter into a home care agreement. Letters can be easily lost and there should be multiple avenues to follow up with a consumer, such as a phone call. Further, AMA members have consulted with individual aged care providers to understand the waiting times consumers were experiencing, and providers reported that they were not receiving any referrals. This was also reflected in several media reports[2], and Leading Aged Services Australia (LASA)'s *My aged care home care provider survey* – where 50 per cent of providers reported a decline in the number of packages received, and there were also common comments on low numbers in activated home care packages, and increased consumer confusion with the new correspondence processes[3].

It appears from the evidence above that there is a gap in the referral system that is resulting in huge delays for older people to receive care. The Government must ensure that consumers are provided with appropriate levels of support to make decisions about their home care package,

[1] https://www.youtube.com/watch?v=PQtsUgeLVWI&feature=youtu.be
[2] http://www.australianageingagenda.com.au/2017/05/19/confusion-reigns-new-aged-care-queue/
[3] https://lasa.asn.au/wp-content/uploads/2017/06/Home-Care-Reforms-Info-Series-13-FINAL.pdf

and there should be further research into why home care packages are expiring before being activated. Support should be given through an aged care facilitator who has in depth knowledge on the aged care system, and available services in their area. Facilitators could be employed by Primary Health Networks.

Consumers are only provided with choice to a certain extent. A consumer can only choose one provider to access all their aged care services. However, it is likely that some providers are better at some kinds of services than others. For example, a provider may be succeeding in transport and personal assistance services, but have limited provisions for nursing or medical care. The AMA agrees with the *Aged Care Roadmap* in that consumers should be able to choose different services from more than one provider.

Section 3: what type of care at home program do we want in the future?

3.1 Policy objectives

Question
Are there any other key policy objectives that should be considered in a future care at home program?

The proportion of Australians 65 years of age and over is predicted to increase to 18 per cent by 2026[4], and the health care needs of older people are increasing in complexity, with a prediction that 900,000 Australians will have dementia by 2050 (342,800 as at 2015)[5]. However, the aged care system in its current state is not ready for these changes. The Government must ensure that the sector has the capacity and capability to provide quality care for this growing, more complex, ageing population.

In the policy objectives outlined in the discussion paper provided, there is no mention of access to quality medical care. There is a growing preference for older people to seek aged care services from their own home rather than transferring to a Residential Aged Care Facility (RACF), and it is predicted that 80 per cent of aged care services will be community-based by 2050[6]. Further, the majority of Australians want to die in their own home[7] and this will only increase with an increasing population. The policy objectives should include access to quality medical care with a focus on palliative care, and a streamlined link to a consumers' usual GP, who should remain the coordinator of medical care.

The future care at home program should also have objectives in place that highlight the need for an appropriate aged care workforce. There has been a decreasing trend in the proportion of registered and enrolled nurses in the aged care workforce[8]. This decline needs to be reversed to

[4]https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12_2016/2015-16_report-on-the-operation-of-the-aged-care-act-1997.pdf
[5] http://www.aihw.gov.au/dementia/
[6] Mavromaras et al (2016) *The aged care workforce, 2016.* Department of Health. p68.
[7] Foreman et al (2006) *Factors predictive of preferred place of death in the general population of South Australia*, Palliative Medicine, vol. 20, no. 4, pp. 447-453.
[8] Mavromaras et al (2016) *The aged care workforce, 2016.* Department of Health. p70

ensure home care consumers are provided with timely and appropriate clinical care. This is critical to the success of the aged care system.

Further, aged care workers need to be appropriately skilled and trained in aged care. Only half (51 per cent) of community care workers in 2016 had a Certificate III in Home and Community Care[9]. It has been reported to the AMA that many aged care staff do not have appropriate training to properly handle the major issues facing the elderly, such as palliative care, behavioural conditions, falls prevention, pressure sore prevention, and pain management. Some of our members are concerned that aged care staff are requesting sedation of residents so they are easier to handle without considering other options first.

The AMA suggests a review of the relevant certificates for aged care to ensure the appropriate treatment of older people. The Government should also include a policy objective for *an appropriate and well-trained aged care workforce that has the capability and capacity to deliver quality care.*

As mentioned in sections two and four, consumers are experiencing significant waiting times for home care, which is impacting on their health. Related to the objective that *delivers high quality support and services to those who need it, when they need it*, the objective should also outline that high quality support and services should be delivered efficiently within a reasonable timeframe according to the consumer's needs.

We are pleased to see that *encourage innovation and increased use of technology* is a policy objective (**see section 6.1.2**). Aged care services need significant uptake of contemporary and interoperable IT systems to achieve quality information management systems. The AMA is supportive of the My Health Record (soon to be opt out), which has significant potential to improve the aged care system. We need to ensure there is interoperability between the Aged Care Gateway, the My Health Record, and the service providers' access to consumers' health information, provided they can meet any privacy and security requirements. Technology also has the potential to improve consumer health, as discussed in **section 6.1.2.**

Page 10 of the discussion paper outlines that "future reforms will need to be funded from within the existing aged care budget envelope". The aged care system is already underfunded, so this is simply unrealistic due to the rapidly growing older population, and the aging 'baby boomer' population approaching the age range for aged care. As significant reform is underway in the aged care system, now is the time to invest in aged care in order to produce the foundations of higher quality system. There is considerable evidence that keeping older people out of hospitals by providing quality care at home (and in RACFs) significantly reduces health costs[10,11], so investment into aged care now will result in savings in the future. Only so much can be achieved through reshaping an existing system.

[9] Mavromaras et al (2016) *The aged care workforce, 2016.* Department of Health. p79
[10] Swerissen, H and Duckett, S (2014) *Dying Well,* Grattan Insititute, Melbourne
[11] http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/07/PCA019_Economic-Research-Sheet_2a_Home-Based-Care.pdf

Section 4: reform options

4.2 An integrated assessment model

Question
What do you believe could be done to improve the current assessment arrangements, including addressing variations or different practices between programs or care types (e.g. residential care, home care and flexible care)?

Currently, Aged Care Assessment Team (ACAT) waiting times are too long. The My Aged Care Gateway was supposed to streamline access to needed services for consumers, but instead it has complicated access by requiring all consumers to undergo either a Regional Assessment Service (RAS) or ACAT assessment in order to access support services. An assessment bottleneck has been created and is causing delay in elderly consumers' access to support and medical care.

Although there are 'first clinical contact' timeframe guidelines (High urgency: 2 calendar days, medium: 3–4 calendar days, and low: 15–36 calendar days[12]), our members are reporting delays longer than these outlined periods. While 47.8% of respondents in the 2015 AMA Member Aged Care Survey reported a wait for initial assessment by ACAT was less than one month, 38.8% had to wait 1-3 months. States who had the longest ACAT waiting times were New South Wales, South Australia and Queensland. The current aged care assessment arrangements fall short on efficiency and responsiveness to the care needs of older people.

The My Aged Care website is easy to navigate for most consumers. However, the number of complaints from AMA members and consumers about the administrative process of the My Aged Care System is extremely high. Complaints include:

- Over a week to inform a consumer they were ineligible for home support required to redress their infected wound and that their application required further processing. This process was a stream of back and forth phone calls between the consumer, the referring doctor, and the My Aged Care call centre.
- The lack of communication in the new My Aged Care HACC application process and increased administrative burden on doctors and practice staff.
- Waiting times on the My Aged Care contact centre of 90 minutes for a referral.
- Several website malfunctions.
- The My Aged Care contact centre not following up with a consumer's doctor when an attempted call to the consumer has had no response.
- The contact centre failed to act on information supplied on the application form about a hearing-impaired consumer unable to answer phone calls.

For the My Aged Care system to work properly, it must be simple and efficient. Reports from our members indicate this is not the case, and previously simple processes have become complex and time consuming, leaving consumers in need of urgent care left at home waiting. The AMA welcomes the Department of Health's recent changes to My Aged Care where health

[12] Department of Social Services (2015) *My Aged Care Guidance for Assessors*.

professionals are able to follow up on consumers' assessment processes[13] and we hope this change will help to improve consumers' access to care. The Gateway must be interoperable with clinical software, the My Health Record, and service provider software system to ensure effective and efficient information management pathways.

4.3.1 New higher level home care package | 4.3.2 Changing the current mix of home care packaged

Questions
Would you support the introduction of a new higher package level or other changes to the current package levels?
If so, how might these reforms be funded within the existing aged care funding envelope?

Further information is required to fully understand the impacts of introducing a higher home care package level for more complex care needs, such as the level of demand for this package, and what services would be included. However, one can assume that consumers in this level have very limited ability to carry out everyday tasks themselves. This would include bed- or walkerframe-bound individuals, and those needing access to palliative care. Although home care is the preferred method of care for Australians, and home care results in significant savings compared to Residential Aged Care Facilities (RACFs) or hospital care, there are also challenges that need to be considered when developing guidelines around this higher care package.

Consumers in this higher package level may require 24/7 care from multiple staff skilled in different disciplines. It may also put additional pressure on family members and informal carers. Currently, it is difficult for carers to access respite care quickly, as an ACAT assessment is required to receive respite care services[14]. The demand for respite care will be more frequent with the introduction of a higher package level, so it will be important for more efficient pathways to exist.

The Government must ensure that there are clear pathways to primary care services to ensure home-bound consumers can access the same medical care as others. This includes coordinating care between the aged care provider, the consumer's regular GP (including through the Health Care Homes program if implemented), and medical deputising services. If the proposed changes to restrict access to the after-hours Medical Deputising Services Medicare item numbers[15] are implemented, this will further impact on consumers' access to medical care.

As previously mentioned, consumers' accessing this higher level package are likely to be in need of palliative care services. In this case, there should be a legislative requirement for all consumers to have an Advanced Care Directive within a broader advanced care plan. This will ensure that the entire care team (including informal carers and family) is aware of the consumer's preferences for care. The advance care plan should be made available on the consumer's My

[13] https://agedcare.health.gov.au/programs/my-aged-care/health-professionals-overview-of-changes-to-improve-access-to-patient-information
[14] Department of Health and Ageing (2013) *Home care packages program guidelines*. p 81
[15] Medicare Benefits Schedule Review Taskforce (2017) *Preliminary report for consultation – urgent after-hours primary care services funded through the MBS.*

Health Record. This is especially important for the higher care level packages, however should be considered for all other levels as well.

Funding the higher home care package

Reducing the number of residential care places released in order to support a higher level package would minimise consumer choice and would result in a sector that is not market-driven, but is instead still heavily controlled and restricted by the Government. Reducing the release of residential care places would contradict the *Aged Care Roadmap*'s view to reduce unnecessary regulation and increase consumer choice. However, demand for RACFs is likely to decrease naturally in the future, as the majority of Australians prefer to stay in their own home to receive care, so some funding will arise from this.

It is important that there is investment in both RACFS and home care to reduce the likelihood of an older person being transferred to an Emergency Department (ED). Hospitals are not an ideal environment for older people. Consumers in EDs have a higher risk of contracting an infection and the older population are more susceptible as their immune systems are often compromised[16]. Further, they are more likely to have decreased cognitive impairment[17], which can result in anxiety and disorientation, and can increase the risk of injuries when attempting to mobilise unaided in a confused state[18]. Residents in RACFs are usually on multiple medications and there is an increased risk of incorrect dosage at the wrong time in a busy ED environment[19]. Our members believe that there is sometimes a tendency for hospitals to refer a consumer to a RACF before considering other, more preferable, options such as providing care at home.

There is emerging evidence to suggest that community-based care for the last three months of an individual's life is significantly cheaper than if they were to die in hospital (approximately $6,000 compared to an average hospital admission cost of $19,000 per consumer)[20] . These substantial savings, coupled with the ability to respect a person's choice in their place of death, argues that more funds should be invested in providing good quality palliative care and other aged care services in the home. Preventing people from being admitted to hospital will balance out, if not save, the costs of investing in a higher home care package.

In order to reduce the costs of this higher care package level, there should be a particular focus on preventive care. This would include exercise and social programs, and education around implementing a healthy lifestyle. Committing to reducing polypharmacy would also prevent falls and cognitive decline. Maintaining continuity of care with the consumer's GP will also ensure that healthy lifestyle choices are maintained, and complex health conditions are identified early. Investing in health prevention and promotion will reduce the number of consumers requiring high level home care packages.

16 Avci, M. et al. (2012) Hospital acquired infections (HAI) in the elderly: comparison with the younger patients, Archives of gerontology and geriatrics, vol. 54, no. 1, pp. 247.

17 Deary, I.J et al (2009), Age-associated cognitive decline, British Medical Bulletin, vol. 92, no. 1, pp. 135-152.

18 Baumgarten, M et al. (2006) Pressure ulcers among elderly patients early in the hospital stay, The journals of gerontology. Series A, Biological sciences and medical sciences, vol. 61, no. 7, pp. 749.

[19] Rothschild, J. (2010) *Medication errors recovered by emergency department pharmacists*, Ann Emerg Med*,* vol. 55, no. 6, pp. 513-521.

[20] Swerissen, H and Duckett, S (2014) *Dying Well,* Grattan Insititute, Melbourne

4.4.1 Changing the current mix of individualized and block funding

Question
Which types of services might be best suited to different funding models, and why?

Keeping in line with the *Aged Care Roadmap*'s vision to increase consumer choice, individualised funding should be the main funding model for aged care services. A model of entire block-funding to a provider may result in rationed care, and care may not be tailored to an individuals' needs. However, individualised care does not completely replace the need for block funding and there needs to be an appropriate balance between the two. Block funding should be reserved for services that are not frequently available in an area.

For example, rural aged care services remain limited in choice and rely on Government-funded aged care services, as for-profit providers are increasing only in major cities[21]. A consumer-driven model may not be as effective in rural areas for this reason, and in turn affect the rate of aged care services in rural areas, further reducing the amount of choice and resulting in the absence of some services.

As outlined on page 15 of the discussion paper, people with rare conditions or specialised needs who face significant costs for care would be disadvantaged if they rely solely on their individualised funding as these services will not be common.

Block funding could be used for aspects of aged care that indirectly benefit the consumer. This includes:

- Fixed costs of running a business, such as
    - Building rent
    - Maintaining staffing levels
    - Purchasing equipment
    - Staff education and training
    - Administrative costs for the attraction of volunteers.
- Services for consumers, such as
    - Transport
    - Community activities
    - Installing safety infrastructure (e.g. ramps, shower bars).

[21] Baldwin, R. et al (2015) *Residential Aged Care Policy in Australia – Are We Learning from Evidence?*, Australian Journal of Public Administration, vol. 74, no. 2, pp. 128-141.

4.5.1 Refocussing assessment and referral for services

Questions
Should consumers receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed?
If so, what considerations need to be taken into account with this approach?

Short-term intensive interventions are required for some consumers seeking at-home support. This would help to reduce the number of complaints our members have made regarding the waiting times for consumers to receive care when urgently needed.

In a situation where a consumer requires short-term intensive interventions, they should see their preferred GP. Once the GP has considered the nature of the intervention required, they should be able to refer their consumer directly to the short-term support service using the services list on the My Aged Care website as a reference. If required, an ACAT assessment could then occur during (if the consumer is able) the provision of the intensive support, or shortly after the support has ceased.

There needs to be clear expectations and guidelines on what services are provided for short-term intensive restorative/reablement interventions to ensure funding is directed to the consumers who need it.

Question
How could a wellness and independence focus be better embedded throughout the various stages of the consumer journey (i.e. from initial contact with My Aged Care through to service delivery)?

Refer to page 16 of the discussion paper

Australia's ageing population will become more IT-literate in the future. To prepare for this, it would be useful for consumers to have a social platform or forum in which they can talk to other consumers about the best avenues for seeking support. This would increase a sense of community and would allow increased knowledge of the system to increase consumers' independence. This forum could be monitored by My Aged Care, were My Aged Care staff could engage with consumers and provide information on navigating the aged care system.

4.6.1 Ensuring that services are responsive to consumer needs and maximise independence

Questions
How do we ensure that funding is being used effectively to maximise a person's ability to live in the community and to delay entry to residential care for as long as possible?
For example, should funding be targeted to services or activities where there is a stronger connection with care and/or independent living? Are there examples of current services or activities that you believe should not be funded by government?

Refer to pages 16 - 17 of the discussion paper

Consultation with consumers is essential to develop policies and processes that reflect their needs and requirements for living independently. Data collection and monitoring through a consumer survey would allow the Government, particularly Primary Health Networks, to determine whether services are supporting their population's ability to remain independent and active in their community.

Question
How do we maximise the flexibility of care and support so that the diverse needs of older people, including those with disability, are met?

Refer to pages 16 - 17 of the discussion paper

The healthcare needs of people at any age change over time. Currently, in order to move up and down between the home care package levels (from levels 1 or 2 to 3 or 4), another ACAT assessment is required[22]. The significant waiting times consumers are experiencing for an ACAT assessment, coupled with the restriction of the release of home care packages means that moving between different levels is not flexible. The ACAT assessment process should be efficient enough that reassessment is not a long process. The Government should consider remodelling the system that determines the number of packages released so it is more driven by demand, so consumers are not left without the required level of care, and are able to switch between levels without disadvantaging others.

4.6.2 Accessing services under different programs

Question
Under the current program arrangements, does allowing some consumers to access both programs promote inequity, particularly if other consumers have to wait for a home care package?

Refer to page 17 of the discussion paper

Due to the program's current nature, the number of home care packages and Commonwealth Home Support Programs (CHSPs) are restricted by the Government. This means that a consumer's ability to access both programs limits other's access to a program. There should be avenues to reassess an individuals' home care package to ensure they are receiving an appropriate package level for their needs. As mentioned in the previous questions, the ACAT assessment process should be fast and efficient enough for this to occur. Further, if the proposed short-term intensive

[22] Department of Health and Ageing (2013) *Home care packages program guidelines*. p 24

interventions outlined in page 16 of the discussion paper is introduced, this may negate the need for a consumer to access an additional program.

4.8.1 Supporting specific population groups

Question
How can we make the care at home system work better for specific population groups, particularly those whose needs are not best met through current CDC models and administrative arrangements?

Refer to page 19 of the discussion paper

Culturally and Linguistically Diverse (CALD) individuals

Australia has seen a rise in the number of migrants. In 2013, 32 per cent of the Australian population (5.8 million people) were born overseas[23]. Projections for 2021 suggest that the older population will comprise 30 per cent of people born in a country other than Australia[24]. This presents a major challenge to incorporate different cultures into aged care, and communicate with individuals who may have low levels of English literacy.

In the case of Aboriginal and Torres-Strait Islander populations, it is important to ensure aged care providers are culturally aware and informed, similar to the cultural understanding seen in the Aboriginal Community-controlled Health Service. This will ensure smooth transition between the health system and the aged care provider.

Our members have recently highlighted the communication difficulties both with CALD staff and residents of RACFs, and more awareness of the services and training available to staff is required if CALD residents are to receive equitable aged care. This also applies to home aged care providers. The benefits of ensuring home care providers hire carers who speak their clients' language should be explored.

One method of better supporting CALD individuals in aged care is for food services to provide meals from different cultures. One member describes how this improved the health of their patient:

I have looked after an Eritrean insulin dependent diabetic who cannot speak English. His weight and diabetic control (and hence his insulin dosage) were proving very difficult to control. He hated the food, picked a few things to eat whenever he felt the need, could not communicate at all with the staff and the nearest Eritrean community members lived many miles from the RACF. Once he started having visits from the Eritrean community (when they learned of his isolation) on a weekly roster organised by his community, his diabetes and weight suddenly stabilised, as well as his happiness. I subsequently found out that despite the rule that you cannot bring cooked food into the RACF, the community had been feeding him with delicious Eritrean cuisine in the privacy of his own room.

[23] Australian Bureau of Statistics (2013) *Characteristics of Recent Migrants* [online http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6250.0/ accessed 23/11/2016]]
[24] Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*

We suggest that Primary Health Networks (PHNs) conduct research into which CALD communities are in their area so they can tailor training, and the availability of CALD-related services (such as food and CALD community-based activities), based on their local communities. PHNs could also present their results in forums to share innovations with other PHNs.

4.8.2 Supporting informed choice for consumers who may require additional support

Question
What additional supports could be considered to ensure that people with diverse needs can access services and make informed choices and exercise control over their care?

Refer to page 19 of the discussion paper

The more information available to a consumer, the more choice they have in obtaining a service that is preferable to them. Currently, not all service providers reveal the costs of a service. My Aged Care should ensure that aged care providers are listing their costs for a service to improve informed choice for consumers.

There could also be a review/rating system on My Aged Care that allows consumers to rate a service provider on their different services available. This would mean that consumers could easily see whether providers excel in services that are important to them. This would also encourage providers to improve on areas that are rated poorly, and would produce a basis for networking with other providers to gather insight on methods of improvement.

4.10 Other suggestions for reform

Question
Do you have other suggestions for care at home reform, or views on how changes might be progressively introduced or sequenced?

Refer to page 20 of the discussion paper

No comment

Section 5. Major structural reform

5.2 What would be needed to give effect to these structural reforms?

Question
Are there other structural reforms that could be pursued in the longer-term?

Refer to page 21 of the discussion paper

No comment

Section 6. Broader aged care reform

6.1.1 Informal carers

Question
How might we better recognise and support informal carers of older people through future care at home reforms?

Refer to page 22 of the discussion paper

Pressure on informal carers will only increase with an increase Australia's older population. Currently, approval for respite care depends on a formal ACAT assessment. As previously mentioned there is significant difficulty in accessing an ACAT assessments, meaning it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the consumer to hospital in order to give the carer some relief. This causes great distress for consumers and their carers and increases the risk of delivering respite care that is inappropriate both in timing and in the nature of the care given. Admitting the consumer is also expensive and further overpopulates the public hospital system.

A streamlined process is required to improve access to respite care for people who have not yet been assessed by an ACAT or who have not yet entered the aged care system. GPs who work in aged care know their patient's circumstances and requirements. In these circumstances, access to respite care could be streamlined by allowing GPs to approve respite care for older people in much the same way a doctor determines that a hospital admission is necessary.

Caring for an older person can be stressful and it is important that the carer is also taking care of themselves. The use of Day Respite Centres can improve wellbeing and socialisation through group activities, and provides a break for the carer[25,26]. However, research suggests Day Respite Centres are under-utlised by carers because they believe it will result in negative outcomes for the consumer[27,28]. The AMA suggests further investment into the availability of Day Respite Centres, and campaigning to promote the benefits of Day Respite Centres from both a carer and consumer perspective. Again, this short-term respite care should not require an ACAT assessment, and could be streamlined through the consumers' GP.

There should be a public campaign to support and recruit more volunteers to further reduce the pressure on informal carers.

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[25] Stirling, C.M et al. (2014), *Why carers use adult day respite: a mixed method case study*, BMC health services research, vol. 14, no. 1, pp. 245.
26 Phillipson, L. & Jones, S.C. (2012), *Use of day centers for respite by help-seeking caregivers of individuals with dementia*, Journal of gerontological nursing, vol. 38, no. 4, pp. 24.
[27] Stirling, C.M et al. (2014), *Why carers use adult day respite: a mixed method case study*, BMC health services research, vol. 14, no. 1, pp. 245.
28 Phillipson, L. & Jones, S.C. (2012), *Use of day centers for respite by help-seeking caregivers of individuals with dementia*, Journal of gerontological nursing, vol. 38, no. 4, pp. 24.

6.1.2 Technology and innovation

Question
How can we best encourage innovation and technology in supporting older Australians to remain living at home?

Refer to page 22 of the discussion paper

Embracing Information and Communication Technology (ICT) potentially has huge benefits for the aged care sector. It can increase communication between healthcare (and other service) providers, reduce administrative burden, and assist to improve the health and independence of older people. For example, telehealth consultations allow health professionals to be more available to provide advice to the consumers' nurse or carer. Further, there are health monitoring machines that allow a consumer to measure their own blood pressure or blood glucose levels[29], where data is transferred to a practice and reviewed by a nurse or GP each day, increasing the likelihood of their health professional identifying and responding to a health issue quickly. Introducing ICT into the aged care sector also has benefits for the Government because the data collected, provided that privacy and security conditions are met, can be used to identify and monitor the issues in aged care to inform policy to improve safety and quality in aged care.

Communication technology also has the potential to reduce the risk of adverse health issues such as polypharmacy. Polypharmacy (the use of multiple (five or more) medicines) can cause cognitive impairment, delirium, frailty, increase the chance of falls, and mortality to name a few. Polypharmacy is an issue that occurs nation-wide, with reports of 20-30 per cent of hospital admissions over the age of 65 being medication-related[30]. Aged care providers require improved ICT systems that are interoperable with the My Health Record, namely its Medication Management feature, to ensure medical health professionals have the tools in place to access all relevant medical information with all relevant stakeholders to prevent the risk of adverse reactions to using multiple medications.

However, the aged care sector is not typically ICT-literate and this creates a barrier to a more efficient aged care system. To encourage innovation and technology in the aged care sector, the Government needs to provide useful guidelines and frameworks that assist aged care providers in embracing ICT. The Government could also provide incentives for aged care providers, like the Practice Incentive Program for medical practices[31], to improve and update their ICT systems. Education and training grants would also be useful to ensure staff are ICT-literate.

Question
What are the existing barriers, and how could they be overcome?

Refer to page 22 of the discussion paper

The aged care sector is currently not capable of fully embracing technology. The *Aged Care Technology Benchmark Survey* conducted by the Aged Care Industry Information Technology Council (ACIITC) found that Australia's aged care providers' management systems and provisions

[29] http://www.racgp.org.au/digital-business-kit/remote-monitoring-devices/
[30] Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions.* Pharmacological Research. 116: p27-35.
[31] https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program

of care have low levels of technology readiness[32]. A study on community aged care services reported that falls and medication incidents were the highest prevalence in community aged care settings[33]. This kind of data is rare in the aged care sector as reporting incidents are usually not easily done, with reasons such as a lack of time, training and education and feedback to staff who reported the incident. For aged care providers to embrace technology in their day-to-day work, they need education and training to improve their ICT literacy. Further, in order to make sense of data collected to enable proper analysis, there needs to be a nationally consistent guideline for what kinds of data are collected, and the definition of each data.

Approved service providers need to keep the consumers' GP informed in what medical services are being provided, the date services will commence and when they will be reviewed. One concept worth considering is a Medicare Benefits Schedule (MBS) item for phone consultations with a nurse or carer from a home care service to incentivise doctors to be on call after hours. This could in turn increase the number of doctors who make themselves available out of normal business hours and reduce costs in comparison to reimbursing a GP physically-attended consultation. In addition, the care of consumers' regular GP would avoid unnecessary referrals to the ED and the associated triage issues. Carers could initiate a pre-arranged appointment with the consumers' GP for non-threatening situations such as wound reviews and dermatological conditions.

6.1.3 Rural and Remote areas

Question
How can we address the unique challenges associated with service delivery in rural and remote areas?

Refer to page 22 of the discussion paper

As previously mentioned, Rural aged care services remain limited in choice and rely on Government-based aged care facilities, as for-profit providers are increasing only in major cities[34]. There is a lack of services in rural areas, which is coupled with a shortage of medical practitioners. This is due to the lack of funding to support the recruitment and retention of doctors and health professionals, and the limited availability of education and training facilities in rural and remote areas. Funding is also required to address that rural doctors are finding it difficult to find locum relief to maintain their Continuing Professional Development (CPD) points and find a work-life balance[35].

Older Australians should have access to aged care services in their own community instead of moving to a neighbouring town that is potentially hundreds of kilometers away from their home. Providing access to more remote communities would reduce the cost and travel times for families and friends to visit, thus improving the wellbeing of the resident. Further, the GP-patient

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[32] Aged Care Industry Information Technology Council (ACIITC) (2017) *A Technology Roadmap for the Australian Aged Care Sector*. p 21.
[33] Tariq, A. et al (2015), *A Descriptive Analysis of Incidents Reported by Community Aged Care Workers*, Western Journal of Nursing Research, vol. 37, no. 7, pp. 859-876.
[34] Baldwin, R. et al (2015) *Residential Aged Care Policy in Australia – Are We Learning from Evidence?*, Australian Journal of Public Administration,vol. 74, no. 2, pp. 128-141.
[35] Australian Medical Association (2016) *AMA Rural Health Issues Survey Report – Rural Doctors have their say*.

relationship is undermined when the patient has to move from their community and as a result disrupts continuity of care. The familiarity a GP has with their patient, coupled with knowing the patients' history is essential to providing quality of care and may reduce the prevalence of referring patients to the ED. To ensure rural and remote areas are not left behind in this consumer-driven system, the Government should invest in aged care for rural and remote areas.

As evident from above, providing aged care services represents a unique and challenging issue for Australia from both a funding and availability perspective. Embracing technology in rural areas has the potential to allow older people to stay in their homes for longer. For example, through the use of remote monitoring as described in section 6.1.2. Currently, remote monitoring is not covered by Medicare[36] but should be considered for rural and remote areas. Telehealth communication can also assist with reducing unnecessary travel time to rural and remote consumers. Although technology is a useful tool for rural and remote areas in particular, we must ensure that it does not completely replace face to face contact, which may exacerbate social isolation.

6.1.4 Regulation

Question
How can we further reduce regulation to allow for innovation while ensuring that essential safeguards remain in place?

Refer to page 23 of the discussion paper

The aged care sector is heavily regulated and is currently going through significant reform[37], so it is difficult for the sector to keep track of all relevant legislation, policies and guidelines. The accreditation standards however give vague indications to home care providers on how to achieve adequate care. Regulations and standards in the aged care sector needs to be flexible to allow and foster innovation and quality in the sector, but need to be rigid where medical care is involved in order to protect the consumers' health. We hope to see standards refined through the development of a single set of aged care quality standards.

In the development of a new single set of aged care quality standards, it is imperative that medical access is included as a Home Care Common Standard. As previously mentioned, the majority of Australians want to die in their own home[38], and Australia's ageing population is growing and experiences more complex and multiple medical disorders.

Currently, our members report that the process to access palliative care is slow and unresponsive. Access to palliative care needs to be included in the Standards, outlining that consumers need to be provided with the opportunity to access end of life care, and get the support required to produce advanced care plans. This will provide consumers with good quality patient-centred care that is a collaboration between the consumer and the health care team. Although this care should be facilitated and coordinated by their medical practitioner, home care staff should have clear

[36] http://www9.health.gov.au/mbs/search.cfm?q=remote+monitoring&Submit=&sopt=S
[37] https://agedcare.health.gov.au/aged-care-reform
[38] Foreman et al (2006) *Factors predictive of preferred place of death in the general population of South Australia*, Palliative Medicine, vol. 20, no. 4, pp. 447-453.

referral pathways in place for consumers to access palliative care services, along with additional training for carers and staff in palliative care.

6.1.5 Aged care and health systems

Question
What are some examples of current gaps or duplication across the aged care and health systems, and how could these be addressed?

Refer to page 23 of the discussion paper

Older people are often burdened with complex and multiple medical disorders that warrant the regular attention of medical practitioners and quality nursing care, which in turn warrants consideration in the context of aged care reforms. Currently, the aged care system is heavily regulated and has multiple funding mechanisms. In the production of aged care at home reforms, it is important to ensure that medical professionals and aged care service providers have good quality communication systems in place to ensure there are no information gaps concerning the consumers' health. This includes links between the My Health Record, the potential future Health Care Homes model, and the integrated Home Care Packages model. As reforms, innovations, and new technologies are introduced into the aged care sector, new packages need to work seamlessly together, including interoperability with GP clinical software so GPs can monitor their patients in their home, and with home care services' software systems.

Any further comments?

Do you have any general comments or feedback?

The division of accountability

In order for the aged care system to evolve we must also consider that, like the broader health system, aged care impacts upon state, territory, and Federal Government. However, there is a lack of coordination between the levels of jurisdiction. Aged care is the purview of the Commonwealth but when a health complication arises, residents or home care consumers are often transferred to a hospital which is the responsibility of the State or Territory Government. This means that the States often bear a financial cost resulting from issues that arise in a Commonwealth-run aged care environment.

The federal government is both the regulator of, and an important source of revenue for, aged care providers[39]. Although regulated by the Federal Government, state and territory governments still play an important role in providing and funding aged care services[40]. There is no overarching body for the whole aged care sector. This can create confusion for aged care providers when working out who is ultimately responsible.

As part of significant reform currently underway, the Department of Health should re-introduce an Aged Care Commissioner. The aged care sector (both government and non-government

[39]Aged Care Financing Authority (2016) *Fourth report of the funding and financing of the aged care sector.* p2
[40]Community Affairs References Committee (2017) *Future of Australia's aged care* workforce. p17

funded) needs an overarching body that provides a clear, well-communicated, governance hierarchy implemented so aged care service providers are aware of their responsibilities, and who is responsible for them.

The Aged Care Commissioner should liaise closely with the Rural Health Commissioner to keep in touch with the unique issues facing older people in rural areas.

Contact

Hannah Wigley
Policy Adviser
Medical Practice Section

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