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 submission to the Department of Health – Streamlined Consumer Assessment for Aged Care

StreamlinedAgedCareAssessment@health.gov.au

Introduction

The AMA thanks the Department of Health for the opportunity to comment on a streamlined consumer assessment for aged care. The AMA's members as doctors interact with My Aged Care and aged care services in a diverse range of settings – such as in the older person's home, in the community, in a hospital, at the doctor's practice, and in residential aged care facilities (RACFs). Doctors, particularly general practitioners (GPs), refer their older patients to aged care services through My Aged Care. Specialists in the care of older people are also frequently involved in the assessment and management of older people across diverse settings. This gives AMA's members independent insight into the aged care system.

AMA members have identified several issues with My Aged Care in addition to those outlined in the discussion paper. AMA members find the current My Aged Care system to be a slow, bureaucratic, process to access aged care services, and completing assessments is difficult for professional staff. There is a consensus that many non-medical assessors having little or no health knowledge. This means that there is a wasted opportunity to improve the older person's health, only to deliver a service.

Doctors have a responsibility to facilitate coordination and continuity of care. Currently, many doctors feel they are not adequately engaged throughout the aged care assessment process. This creates inefficiencies through duplicate and incomplete information. Not involving the patient's usual doctor undermines the doctor's role in caring for their patient.

The aged care system can be difficult to navigate for older people, their families and carers, and planning for aged care services usually occurs in a time of crisis due to rapid deterioration in health[1]. For this reason, the AMA supports in principle the development of a streamlined assessment model. However, a streamlined model must involve an adequately resourced and qualified workforce, including clinicians, to deliver better health outcomes for older people. Properly resourced general practitioners (GPs) and timely specialist geriatric services are key components of the system.

[1] Aged Care Financing Authority (2018) *Understanding how consumers plan and finance aged care*. Page 32. [https://agedcare.health.gov.au/sites/default/files/documents/12_2018/acfa_consumer_finance_report_0.pdf]

1. Are the proposed design principles appropriate for a streamlined assessment model? Are there any other principles that you believe should be included?

The AMA generally supports the principles outlined in the discussion paper (page 6) however consider the following improvements can be made.

Firstly, the AMA argues that the design principles cannot be achieved without a health focus. The principle number four – *comprehensiveness* – should include the patient's usual doctor. Australia's health and aged care systems are fragmented, which leads to gaps in medical care for people living in aged care settings or receiving aged care services. An older person's GP is their primary carer for health issues and research shows that continuity of care (i.e. seeing a regular GP) is associated with better health outcomes and a reduction in health costs[2]. Currently, there is little to no involvement with the older person's usual GP when assessing need for aged care services. In addition, comprehensive geriatric assessment and management has been demonstrated to have many benefits for hospital inpatients[3].

The principle number seven – *Efficiency and effectiveness* – should emphasise *timely* assessment. Respondents (AMA members) of the 2017 AMA Aged Care Survey reported that the highest average waiting times for an initial ACAT assessment for their patients was one to three months[4]. The highest reported waiting times in 2012 and 2015 were less than one month. This indicates that waiting times may be increasing. There are also reports that some older people have been waiting up to 12 months for an ACAT assessment[5]. Further, as of September 2018 there were 126,732 people waiting for their approved home care package level that meets their assessed care needs[6]. Approval waiting times are over 12 months for most home care package levels[7]. While there have been recent announcements for additional packages[8], this is inadequate compared to a waiting list that continues to increase each quarter and will continue to increase with an ageing population.

Long waiting times for ACAT or RAS assessments, residential care places, and home care packages, creates significant risk to the patient's health and can increase avoidable and costly hospital transfers. Older people deserve better from the aged care system.

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[2] Barker, I Steventon, A, and Deeny, S (2017) *Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data.* BMJ. 356:j84

[3] Ellis, G et al (2017) *Comprehensive geriatric assessment for older adults admitted to hospital.* Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD006211. DOI: 10.1002/14651858.CD006211.pub3.

[4] 2017 AMA Aged Care Survey, page 24. [https://ama.com.au/article/2017-ama-aged-care-survey]

[5] Department of Health (2017) *Legislated Review of Aged Care 2017*. Page 139. [https://agedcare.health.gov.au/sites/default/files/documents/08_2017/legislated_review_of_aged_care_2017.pdf]

[6] Department of Health (2018) *Home care packages program: Data report first quarter 2018-19.* Page 11 [https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/HCP-Data-Report-2018%E2%80%9319-1st-Qtr%E2%80%93.pdf]

[7] Department of Health (2018) *Home care packages program: Data report first quarter 2018-19.* Page 14 [https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/HCP-Data-Report-2018%E2%80%9319-1st-Qtr%E2%80%93.pdf]

[8] Commonwealth of Australia (2018) *Mid-Year Economic and Fiscal Outlook 2018-19.* Page 11[https://www.budget.gov.au/2018-19/content/myefo/download/MYEFO_2018-19.pdf]

2. What issues need to be considered for assessment providers to manage intake and triage under a streamlined assessment model? (e.g. staff skills required of a triage function; consistency of operational processes; and resource implications)

Again, the effectiveness of the aged care assessment process can be improved by including the patient's usual GP in the entry/triage, assessment and decision-making process. GPs form long-term relationships with their patients. An older person's usual GP can bring holistic background knowledge of their patient and their current circumstances to the assessment process. This knowledge would ensure the person's assessment results in receiving the most appropriate care for them, be it in the community or RACF. It may also reduce the assessment time by reducing assessment duplication and the time it takes investigating medical information. In turn this may allow people to access services more quickly.

Current referral forms for GPs do not ask how urgently the assessment or services are required. An older person's usual GP has the skills and experience to be able to determine how urgent their older patient's needs are. This also provides an opportunity for My Aged Care to communicate that GPs can directly contact the service provider and carry out the ACAT/RAS assessment later if the services are required urgently. There was a lack of communication in the past regarding processes for when a patient requires urgent attention. Some GPs were unaware they could make a direct referral. For example, this information was on the Department of Health website but not on the My Aged Care website (where they would logically look for this information).

A recent study by Jukic and Temple (2018) highlighted that on average, recommended long-term care (RLTC) settings made by ACAT teams reasonably reflect the care needs of the assessed older people[9]. However, members have reported that their patients have received a different service (as a result of an ACAT assessment) to the one they have been originally referred for. This is a result of a lack of communication and undermines the doctor's role in caring for their patient. Assessors should not be overriding doctor referrals.

3. How can a streamlined assessment model enhance referrals and collaboration between health professionals, My Aged Care and a national assessment workforce?

The AMA has continuously called for interoperability between My Aged Care and clinical practice software systems. Current methods of referrals (i.e. the online form, by phone, or by fax) are administratively burdensome and many AMA members actively find alternative ways to refer aged care services to avoid My Aged Care (such as referring to the ACAT directly or referring to other community services).

As such, the AMA supports the Health Professional Referrals Project to integrate the My Aged Care referral form into GP clinical software. However, the project in its current form does not incorporate a feedback loop to update GPs on their patient's progress through the assessment stages, or when they begin receiving the services. All doctors can follow up on their patient's assessment progress by calling My Aged Care, but this is inefficient. Members

[9] Jukic, M and Temple, B (2018) *Recommended long term care settings following aged care assessments in Australia*. PLoS ONE. 13:11: e0204342, page 13

have reported waiting times as high as 90 minutes to reach a contact centre representative. Members have reported that the lack of feedback can result in significant risk to their patient's health. Examples include:

- The My Aged Care contact centre not following up with a patient's doctor when an attempted call to the patient had no response.
- Over a week to inform a patient 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 patient, the referring doctor, and the My Aged Care contact centre.

Doctors need to know whether their patient is receiving the services they have been referred to in a timely manner. Some older people, such as those with cognitive impairments, require a doctor or other person to request services on their behalf because they cannot do it themselves. Without a feedback loop to the doctor or other referrer, there is a risk that the older person will not be receiving the services they need. With a feedback loop, doctors can act if a delay puts the older person's health at risk.

The AMA calls for feedback loop capability within clinical software programs, in addition to the referral form being integrated within clinical software programs. This will reduce the administrative burden placed on GP practices and reduce the risk of harm if older people are not receiving the services they have been referred to.

4. How do you think the triage process should operate to expedite access to a single time-limited CHSP service? What are the risks and how could these be managed?

Single time-limited services are required for some older people seeking at-home support and fast-tracking some of these interventions is appropriate. This would help to reduce the number of complaints made regarding the waiting times for simple services.

On some occasions, such as for a service that is required urgently, it is appropriate that the older person would not access the services through their usual GP. However, the GP should be notified that their patient is accessing these time-limited services, and that GP input will be required upon completion of the service to assess whether further services are required.

In a situation where an older person requires time-limited intensive health 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 patient directly to the time-limited 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 patient is able) the provision of the intensive support, or shortly after the support has ceased. For this to occur, there needs to be clear expectations and guidelines communicated to GPs on what services are included under time-limited CHSP services.

There is a risk that, without an assessment, there is no information about the appropriateness or success of the CHSP service, and no subsequent action to address any longer-term needs if the service was not successful. This means that a service is provided in the *hope* that it

succeeds, instead of *making sure* it succeeds. AMA members report that RAS assessments on occasion have not documented that escalation to an ACAT assessment is required. The AMA suggests that the older person, their carer, or referring doctor, should be contacted prior to completion of the single-time limited CHSP service to determine whether a more comprehensive assessment is or is not required. AMA members report that for rapidly deteriorating older people, a RAS assessment merely delays a more comprehensive assessment that must be integrated with rehabilitation services appropriate for older people. This should not occur under time-limited CHSP services.

5. How can support plan reviews be better managed under a streamlined assessment model?

Again, an older person's usual GP should be involved in aged care assessments and this includes support plan reviews. GP input into support plan reviews should be adequately remunerated to compensate for the GP's services. Streamlined assessment must be integrated with appropriate intervention options, that include medical assessment and potential for reablement.

The older person's My Health Record could also be referred to, to check for updated medical information regarding the progress of the patient. For example, any new diagnoses, discharge letters, hospital admissions, or test results. See answer to question 7 for further comment on the My Health Record.

6. What qualification and competency requirements do you believe are needed for a national assessment workforce? What particular areas of assessment practice require clinical expertise and/or multidisciplinary team-based approaches?

An ideal assessment team would be integrated and multidisciplinary. Teams should include:

- Geriatricians
- Psycho-geriatricians or psychiatrists
- Specialist geriatric nurses or nurse practitioners
- Social workers
- Allied health professionals (such as occupational therapists, physiotherapists, psychologists, speech therapists)
- Administrative support staff

Ultimately, members of the multidisciplinary team chosen for each assessment should align with the older person's medical and social history.

AMA members report that the non-medical assessment workers often have no health knowledge and that the skills mix in assessment teams vary widely. Some assessment teams are integrated with regional geriatric teams while some are separate. Geriatricians should be included in assessment teams (and should form strong collaborative relationships with the older person's usual GP). In addition to the assessment team, the triage workforce should be trained with health knowledge so the appropriate assessment team can be identified.

7. What design features will enable assessment providers to operate an integrated workforce which is capable of delivering assessment for people across the full continuum of aged care needs?

My Aged Care should be interoperable with the My Health Record (MHR). This will help to reduce fragmentation between the health and aged care systems. Both the MHR and My Aged Care contain important information about the older person's care. It is essential that the people responsible for the care of that older person have the most complete information possible. Studies indicate that appropriate care placement and care quality improves with consideration of more detailed medical information[10,11].

The older person's privacy and security factors need to be carefully considered before these two systems become interoperable. Further, assessor access to an older person's MHR does not replace the involvement of their usual GP, geriatrician or other doctor. The consumer-controlled nature of the My Health Record may mean some Records are incomplete. This underscores the necessity of maintaining the involvement of the older person's usual GP to ensure a holistic overview of the older person's needs is obtained. Aged care IT systems need to be modern and the aged care workforce needs to improve their IT literacy for MHR interoperability to be successful.

8. What training and other initiatives should be considered to build the capability of the national assessment workforce?

The My Aged Care workforce must have a thorough knowledge of the aged care system and how the health system interacts with it. Distinguishing between these two systems can be confusing for older people and their carers. My Aged Care must be able to recognise when medical attention through the health system is required as opposed to through the more limited medical services under the aged care system.

The national assessment workforce must be able to effectively communicate and engage with culturally and linguistically diverse (CALD) older people, and older people from Aboriginal and Torres-Strait Islander (ATSI) populations. Australia has seen a rise in the number of migrants. In 2016, 35 per cent of the Australian population (6.8 million people) was born overseas[12]. Projections for 2021 suggest that the older population will comprise 30 per cent of people born in a country other than Australia[13]. In addition, the number of older people using aged care services that identify as ATSI is growing (but still underutilised in specific areas)[14].

[10] Meehan, R (2017) *Transitions from acute care to long-term care: evaluation of the continued access model.* Journal of Applied Gerontology. [https://journals.sagepub.com/doi/10.1177/0733464817723565]
[11] Jukic, M and Temple, B (2018) *Recommended long term care settings following aged care assessments in Australia*. PLoS ONE. 13:11: e0204342, page 15
[12] Australian Bureau of Statistics (2017) *Characteristics of Recent Migrants*. http://www.abs.gov.au/ausstats/abs@.nsf/mf/6250.0
[13] Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*
[14] Department of Health (2017) Factsheet: Aboriginal and Torres Strait Islander peoples' use of aged care services. [https://www.gen-agedcaredata.gov.au/www_aihwgen/media/2017-Factsheets/Aboriginal-and-Torres-Strait-Islander-peoples-use-of-aged-care-services-2017_3.pdf?ext=.pdf]

Approximately one per cent (residential) and two per cent (home care) of the direct aged care workforce identify as ATSI[15]. This presents a major challenge to incorporate different cultures into aged care and communicate with individuals who may have low levels of English literacy.

The AMA suggests that Primary Health Networks (PHNs) should determine a specific performance indicator relating to ageing CALD communities in their area. This indicator should measure the availability of CALD-related services and tailored training that reflects need in their local communities. PHNs could also present their results in forums to share innovations with other PHNs.

The prevalence of dementia is increasing significantly. At least 53 per cent of residents in RACFs have dementia[16], although this is probably underestimated[17]. This proportion will continue to grow over time, with projections reaching up to 1,100,890 people with dementia by 2056[18]. It is important that the My Aged Care workforce has dementia and behavioural change training with an aim to reduce the stigma and discrimination some people with dementia feel when interacting with others[19], and to ensure they are interacted with in a respectful and effective manner. Assessment workers need to be able to identify signs of dementia so the older person can receive the appropriate medical attention and aged care services.

9. What assurance mechanisms should be put in place for a national assessment workforce to ensure the achievement of quality assessment outcomes for senior Australians?

Key Performance Indicators (KPIs) should be developed for the assessment process. This could include short, medium, and long-term outcome measures such as the proportion of:

- older people on the assessment waiting list per year;
- assessments completed per year;
- assessments completed in a specified timeframe (in line with how urgently they require the assessment); and
- older people receiving aged care services within a specified timeframe (in line with how urgently they require the service);
- older people that have met (or are on the way to meet) their assessment outcomes (such as wellness and reablement).

The quality of assessments could also be measured including whether assessments are complete and are not duplicated, contain adequate medical assessment and information, and if the older person or their representative is satisfied with the assessment process. A set of Standards need to be developed for this to occur.

[15] Department of Health (2016) *The Aged Care Workforce, 2016*. [https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/03_2017/nacwcs_final_report_290317.pdf]
[16] Australian Institute of Health and Welfare (2012) *Dementia in Australia*, p15.
[17] Dyer SM, et al (2018). *Diagnosis of dementia in residential aged care settings in Australia: An opportunity for improvements in quality of care?* Australas J Ageing.37(4):E155-E158
[18] Alzheimer's Australia (Now Dementia Australia) (2017) *Economic cost of dementia in Australia*. p6 [https://www.dementia.org.au/files/NATIONAL/documents/The-economic-cost-of-dementia-in-Australia-2016-to-2056.pdf]
[19] https://www.dementia.org.au/national/about-us/our-organisation/strategic-direction

The aged care workforce has issues recruiting and retaining workers[20] and the Department needs to ensure this does not happen with the national assessment workforce. There should be nationally consistent procedures and processes for assessment workforce recruitment and retainment, and appropriate and attractive remuneration to entice qualified workers.

10. What should be considered in the design of a streamlined assessment model and a national assessment workforce to achieve efficiency and deliver the best value for money?

There should be nationally standardised procedures and tools for the operation and evaluation of the streamlined assessment model. To do this, the model will require standardised IT, data collection, and reporting platforms which monitor and share information. The Department should also consider similar programs within Australia and around the world to improve the model.

Currently, the National Screening and Assessment Form (NSAF) is a major bureaucratic load to assessors. For example, the ACAT assessment form is 32 pages long. In contrast, approximately 30 years ago the form was one page that took approximately 10-15 minutes to complete. While a comprehensive assessment is important, it is also important that the form is the most efficient and effective it can be. The AMA understands the NSAF was recently reviewed in 2017[21], however AMA members still report the issue of bureaucratic load with the NSAF. The AMA suggests the Department further review the NSAF to reduce unnecessary collection of information and co-design with those who will be carrying out the assessment, while still addressing the level of detail that may be required by Government. ACAT assessors should be surveyed to determine whether the changes to the NSAF post-review have made the process more efficient and effective.

11. How should aged care assessment work for people in a hospital setting under a streamlined assessment model? What issues need to be considered?

The issues around timely discharge from a hospital are broader than just the assessment process. It concerns service availability. A streamlined assessment model will not be successful unless the following demand issues are resolved.

The various levels of health and aged care systems creates barriers to older people receiving the care that they need. While hospitals and hospital services are state-funded, aged care is funded by the Commonwealth. AMA members report that this fragmentation of responsibilities between the different jurisdictions means that, for example, if one service closes, it assumes another service will pick up the demand. This is not the case and a more integrated approach is required to ensure the movements of one jurisdiction does not negatively impact another.

[20] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy.* [https://agedcare.health.gov.au/sites/default/files/documents/09_2018/aged_care_workforce_strategy_report.pdf]

[21] Department of Health (2017) *Review of the National Screening and Assessment Form (NSAF)* [https://consultations.health.gov.au/aged-care-access-and-quality-acaq/review-of-the-nsaf/]

Reports from our members suggest there are not enough residential aged care places to meet the needs of older people being discharged from hospitals. However, in June 2018 the average occupancy rate was 90.3 per cent[22] and some future funding for residential aged care places was transferred to home care packages because there were additional funds that were not required to meet perceived demand[23,24]. Further, hospital data shows that 11.4 per 1000 patient days are taken up by patients waiting for an aged care place[25]. This discrepancy between reports at the coal-face and the government's perceived demand suggests that the systems used to determine supply of aged care places may require revisiting – or at least communication with the profession who feel an issue remains. This was also a recommendation from the *Aged Care Legislated Review*[26]. There is very limited public data available to determine supply and demand issues for aged care places, one reason being to protect the older person's privacy[27].

Service availability should reflect the care needs of the older population and promote healthy ageing. The *Aged Care Legislated Review* recommended to discontinue the aged care approvals round (ACAR) and instead have aged care places follow the older person[28]. This already occurs with home care packages. While this has the potential to reduce confusion for the older person and their carers if transitioning between home care packages and RACFs, it has not resolved issues with demand. As previously mentioned, there are over 126,732 people waiting for their approved home care package level that meets their assessed care needs[29].

In addition, if aged care places follow the older person, the government must ensure that places in rural, regional and remote (RRR) areas are still adequately available, and that sufficient information and assistance is provided to older people and their carers in accessing their aged care place.

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[22] Productivity Commission (2019) *Report on government services: Chapter 14: Aged care services*. Page14.6 https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/aged-care-services/rogs-2019-partf-chapter14.pdf

[23] Department of Health (2018) *Portfolio budget statements 2018-19: Budget related paper no. 1.9. Health portfolio.* Page 133 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2018-2019_Health_PBS_sup1/$File/2018-19_Health_PBS_1.00_Complete.pdf]

[24] Department of Health (2018) *Portfolio budget statements 2018-19: Budget related paper no. 1.9. Health portfolio. P*age 126 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2017-2018_Health_PBS_sup4/$File/2017-18_Health_PBS_Complete.pdf]

[25] Productivity Commission (2019) *Report on Government Services 2019:* Chapter 14. Page 14.17 https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/aged-care-services/rogs-2019-partf-chapter14.pdf

[26] Department of Health (2017) *Legislated Review of Aged Care 2017.*Page 8 [https://agedcare.health.gov.au/sites/default/files/documents/08_2017/legislated_review_of_aged_care_2017.pdf]

[27] Jukic, M and Temple, B (2018) *Recommended long term care settings following aged care assessments in Australia*. PLoS ONE. 13:11: e0204342, page 5

[28]Department of Health (2017) *Legislated Review of Aged Care 2017.*Page 8 [https://agedcare.health.gov.au/sites/default/files/documents/08_2017/legislated_review_of_aged_care_2017.pdf]

[29] Department of Health (2018) *Home care packages program: Data report first quarter 2018-19*. Page 11 [https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/HCP-Data-Report-2018%E2%80%9319-1st-Qtr%E2%80%93.pdf]

Assessments in hospitals are more complex than assessments in other settings because the older person has often experienced an acute illness that requires rehabilitation before the assessment can be made. An older person may require transition care before a more long-term assessment can be made. However, to access transition care, the older person must have an ACAT assessment[30]. This can result in duplication and inefficiencies within the system.

Hospitals need to be adequately equipped and resourced for older people in order to conduct a successful assessment process. This includes availability of geriatricians, needs assessment and management services. The medical workforce should be trained to be able to monitor and coordinate the interface between the health and aged care systems, including at local, State, and Federal levels. The availability of regional subacute services that provide inpatient assessment and rehabilitation has wide variability across Australia and there are no clear reporting systems for this information.

Hospitals already have clinical teams that are adequately qualified to carry out aged care assessments. Older people can spend a significant amount of time in hospital before they are allocated an aged care place, or have other arrangements made. Hospital clinical teams (which include geriatricians) know the patient and are well-equipped to treat any reversible cause of dysfunction or to refer the patient to the appropriate service.

12. How can a streamlined assessment model support timely, high quality assessments in remote Australia? What flexible assessment approaches would you support, and why?

Aged care in RRR Australia presents a unique set of challenges:

- People in RRR areas are more likely to be admitted to respite care (57 per cent vs 42 per cent for people living in major cities)[31].
- Older people living in remote areas have difficulties accessing a RAS or ACAT assessment in a reasonable timeframe[32].
- ATSI people sometimes require additional support to overcome cultural barriers they face when interacting with My Aged Care contact centre[33].
- Aged care services, including rehabilitation are limited in RRR areas[34].
- Internet accessibility to be able to navigate My Aged Care is limited[35].

[30] Department of Health (2018) *Transition Care Programme*. [https://agedcare.health.gov.au/programs-services/flexible-care/transition-care-programme]
[31] Australian Institute of Health and Welfare (2019) *Movement between hospital and residential aged care 2008-09*. Page 71 [https://www.aihw.gov.au/getmedia/7aa1f7f7-9290-4a4d-84b0-bd804bfe909f/15531.pdf.aspx?inline=true]
[32] Aged Care Financing Authority (2018) *Understanding how consumers plan and finance aged care*. Page 61. [https://agedcare.health.gov.au/sites/default/files/documents/12_2018/acfa_consumer_finance_report_0.pdf]
[33] Aged Care Financing Authority (2018) *Understanding how consumers plan and finance aged care*. Page 61. [https://agedcare.health.gov.au/sites/default/files/documents/12_2018/acfa_consumer_finance_report_0.pdf]
[34] Department of Health (2018) *Streamlined consumer assessment for aged care: discussion paper*. Page 15
[35] Park, S.(2017) *Digital Inequalities in Rural Australia: A Double Jeopardy of Remoteness and Social Exclusion.* Journal of Rural Studies, 54: p. 399-407.

- Aged care services can be more expensive in RRR areas due to a range of factors – including geographical distribution and lack of industry competition[36].

Assessment approaches in RRR areas need to be flexible and appropriately resourced to reflect challenges such as the above. The Department should work with local governments and consult Aged Care Master Plans or Strategic Directions/Plans to address local challenges. This includes ensuring there is an appropriate assessment workforce consisting of doctors, nurses and allied health professionals.

My Aged Care requires the older person to be computer-literate and have internet access, which is not the case for many older people living in RRR. Because internet access is limited, it is important that aged care system navigator services are also delivered in RRR areas. This could include services via telephone, and public information sessions, as a more practical delivery method. Aged care navigators could also be employed by rural hospitals to assist in the discharge of older patients and support them in navigating the aged care system.

There may be a requirement for properly resourced specialist Telehealth models to work in conjunction with local GPs.

13. How should wellness and reablement be further embedded in assessment practice under a streamlined assessment model? What strategies do you support and how should they be implemented?

The AMA supports a focus on healthy ageing in government policies and health practices. Consistent, quality training for the My Aged Care workforce across Australia is essential to ensure older people are receiving an equitable assessment.

Wellness (or wellbeing) is a relatively new concept with several definitions. It is also subjective to the individual. Research on wellness in older people is limited and older people were not considered in the development of commonly-used wellness models[37]. This makes a wellness approach to assessment difficult to implement and difficult to measure. The Department must ensure they conduct research into the best methods of implementing wellness models in the context of older people, and ensure these methods are clearly communicated to the assessment workforce.

Further, AMA members report there is little understanding (due to limited data) around the provision of rehabilitation (or reablement) in Australia. If there is limited provision of these services, a focus on reablement in the assessment process will be useless. The government should provide data on the availability of these services for older people to ensure there is an adequate supply that meets demand.

[36] Aged Care Financing Authority (2018) *Understanding how consumers plan and finance aged care*. Page 61. [https://agedcare.health.gov.au/sites/default/files/documents/12_2018/acfa_consumer_finance_report_0.pdf]
[37] Fullen, M (2019) *Defining Wellness in Older Adulthood: Toward a Comprehensive Framework*, Journal of Counseling & Development, vol. 97, no. 1, pp. 62-74.

A wellness and reablement approach needs good integration between the health and aged care systems. Doctors, in particular GPs, regularly incorporate preventive care and reablement (or rehabilitation) as part of providing holistic, long-term, health and medical care. GPs also provide the medical home for many older people; coordinating their complex care requirements, ensuring access to services and advocating on their behalf. It is imperative that older people have access to a regular GP and that an older person can access GP-referred services provided by other health professionals. The My Aged Care workforce should cooperate with GPs in developing programs to promote the optimal health of older people before impairment develops.

In addition to the older person's usual GP, the ACAT assessor should ensure access to allied health professional services that focus on wellness and reablement – this includes psychologists, physiotherapists, speech pathologists, dieticians, and podiatrists. Older people living in RACFs can also benefit from wellness and reablement strategies, however they have difficulty accessing allied health professional services.

Digital health and assistive technologies have the potential to significantly improve the aged care system through increased efficiency and coordination of care providers, and increased independence and health of older people. The use of assistive technologies could also be considered through the ACAT assessment. However, it is important that older people and their carers, and the My Aged Care workforce are adequately supported to use digital health and assistive technologies. This is crucial to the technology's effectiveness.

14. How can more effective and consistent linking services to vulnerable older people be delivered under a streamlined assessment model?

In principle, internal systems should be improved that allow for consistent assessment to translate to appropriate actions (i.e. evidence-based referrals to the correct services or interventions). The My Aged Care system should allow linking to appropriate local services. Systems should be comprehensive, allow easy navigation, evidence-based, suitable to the older person, and minimises the burden of navigating and contacting the services. Aged care navigators[38] should have an important role in ensuring effective and consistent linking services.

Integration is required with specialist geriatric services and the patients' GPs with easy user - friendly data sharing.

15. What do you believe are the key benefits, risks and mitigation strategies of a streamlined assessment model for aged care?

It is important to ensure that the new assessment workforce is independent from aged care providers. This will reduce the risk of conflicts of interest, or service providers potentially over-assessing the older person to receive more funds. AMA members have reported aged

[38] Department of Health (2018) *Better access to care – aged care system navigator*. http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2018-factsheet77.htm

care providers over-assessing older people under the aged care funding instrument (ACFI) to receive more funds for the RACF.

There are some concerns that 'streamlining' the assessment process will result in a deskilling of the assessment workforce. RAS assessors with fewer qualifications than their ACAT counterparts may be used more commonly as they conduct higher numbers of assessments at a lower cost. There needs to be a health focus within the assessment workforce for the benefit of the older person. Older people, under international law, have a right to the highest achievable level of health[39]. Australia's systems must adapt in order to uphold this human right.

The introduction of My Aged Care resulted in an assessment bottleneck that increased assessment waiting times. While a streamlined assessment model is supported in order to simplify the process, it is important that the government ensures the assessment workforce has enough staff with the appropriate training. It is also important that the workforce builds networks between, and has a thorough understanding of, the health and aged care systems to ensure older people are receiving the services they need (under either system). This should partially reduce the risk of non-consistent assessments.

It makes no sense to have streamlining of the assessment process if there are major downstream bottlenecks as currently exists with home care packages. It is important to ensure that all older people, after assessment, have adequate access to transition care, geriatric assessment and rehabilitation, and community reablement programs.

16. What implementation and transition issues will require consideration in the design of a streamlined consumer assessment model?

It will be important that health professionals, such as doctors, are adequately communicated to and engaged with throughout this process. This is particularly important throughout the development of the Health Professional Referrals Project. The AMA thanks the Department for its initial efforts of engagement for this project. Adequate communication and engagement now can prevent confusion and delays when the streamlined assessment process is implemented.

[39] Office of the United Nations High Commissioner for Human Rights and the World Health Organization. *Right to Health.* [https://www.ohchr.org/Documents/Publications/Factsheet31.pdf]

Conclusion

The AMA supports in principle a new framework for streamlined consumer assessment for aged care. The framework must be integrated with both the health and aged care systems at the various levels of jurisdiction. For the assessment framework to be successful, the government must ensure health and aged care services are in adequate supply to meet demand.

The new assessment process needs a health focus with an appropriate clinically-based workforce. It is important that the older person's usual GP can provide input into the assessment. Referrals via the GP's clinical software systems should have feedback loop functionality so they can ensure their patient is receiving the services in a timeframe that is appropriate to their needs. The AMA looks forward to further engaging with the Department throughout the Health Professional Referrals Project.

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Contact
Hannah Wigley
Policy Adviser
Medical Practice Section
hwigley@ama.com.au