LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

Draft recommendations from the Primary Health Reform Steering Group

LASA submission

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Submitted via email to: primaryhealthcarereform@health.gov.au

About LASA

Who We Are

LASA is the national association for all providers of age services across residential care, home care and retirement living/seniors housing.

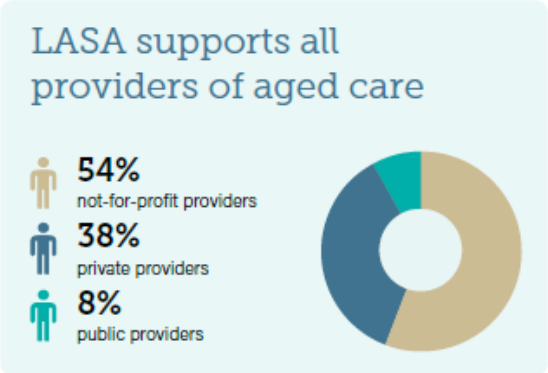
Our Purpose

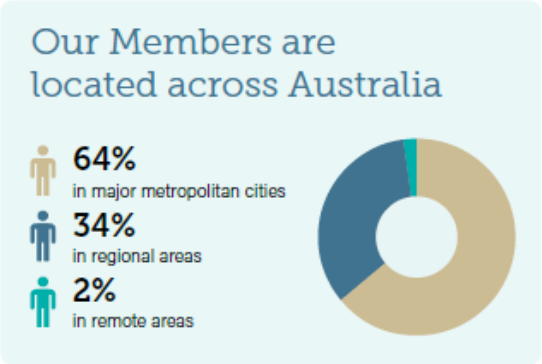
Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion—always.

Our Members

We represent providers of age services of all types and sizes located across Australia's metropolitan, regional and remote areas. We are dedicated to meeting the needs of LASA Members by providing

- a strong and influential voice leading the agenda on issues of importance;
- access to valuable and value-adding information, advice, services and support; and
- value for money by delivering our services and support efficiently and effectively.





Our Affiliates

LASA Affiliates are proud supporters of the critical role played by the age services industry in caring for older Australians. Their value-adding products and services help age services providers apply innovative solutions that improve the provision of efficient and quality care.

Our Strategic Objectives

1. Be the credible and authoritative voice of aged care representing the views of our Members for the benefit of older Australians.
2. Build sector capability and sustainability by delivering valued services and support to Members
3. Lead continuous improvement by promoting and celebrating excellence and innovation in age services
4. Deliver value for money for Members and Affiliates.
5. Be a high performing, respected and sustainable association that cares for our purpose, our Members and our people.

Thank you for giving LASA the opportunity to comment on the discussion paper/Primary Health Reform Steering Group draft recommendations on the Government's Primary Health Care 10 Year Plan. This submission focusses on specific issues pertaining to the delivery of primary health care in the context of aged care settings.

Key points

- It is not clear how the proposed recommendations will align with recommendations of the Royal Commission (RC) into Aged Care Quality and Safety to improve primary care for older Australians. The development of the Government's Primary Health Care 10 Year Plan should consider the RC recommendations and this should be discussed/reflected in more detailed in the discussion paper.
- Aged care residents can have more limited access to GP care, allied health services (including, oral health, mental health/psychological services), specialist services care and hospital care. The proposed actions to support integrated care should consider initiatives to improve residents' access to specialist and allied health services as part of multidisciplinary care.
- The Patient-Centred Medical Home (PCMH) can facilitate a partnership between individual patients, their usual treating GP and extended healthcare team, which enables better-targeted and effective coordination of clinical resources to meet patients' needs. The PCMH Model (which focuses on management of chronic illness) should be extended to include older people in RACFs. This will ensure older people in RACFs receive equitable access to primary healthcare.
- Ideally, a RACF clinical team member, a nurse, who is familiar with the condition and care needs of a resident should be available when that resident receives care from their regular GP or a GP team member visiting that resident. Additional funding should be considered for the employment of primary care nurses in RACFs to support GP care as part of initiatives to build workforce capability and sustainability.
- Implementation of a formalised agreement to strengthen partnership between general practice/GP and RACFs will improve residents' access to GP care. This should be supported and included as part of initiatives to implement single primary health care destination.
- System interoperability is a key issue in aged care. A targeted and well considered injection of digital enhancement funding to support system interoperability to the aged care sector (which will better connect primary health care workforce) should be considered to better support the delivery of best-practice multidisciplinary team care.
- Primary care providers (including GPs, NPs and allied health professionals) with their ability to identify disease at an early stage, their knowledge of the patient including their social contact and their capacity for ongoing chronic disease management, all have a role to play in prevention and early intervention. Initiatives such as support/incentive for advance training in aged care (especially dementia care) and funding for preventative health services should be supported. This will improve RACF residents' access to GPs, NPs and allied health professionals.
- The establishment of PHNs and LHNs provides an environment to support best practice clinical handover and transfer of care arrangements. PHNs and LHNS should have formal engagement protocols and some common membership in their respective governance structures, and work together in areas such as hospital avoidance, clarity in responsibility, minimisation of waiting lists, assisting with patients' transitions between sectors and, where relevant, into aged care.

Development of the draft recommendations

LASA supports the development of the Government's Primary Health Care 10 Year Plan which aims to achieve the Quadruple Aim of: improve the patient experience; improve the health of populations; improve the cost-efficiency of the health system; and improve the work life of health care providers. We are, however, disappointed to note that the aged care sector was not represented on the Steering Group tasked with developing the draft recommendations.

As a result, we believe some of the issues that are important to ensure older Australians, especially those living in residential aged care facilities (RACFs), receive adequate and timely primary health care, are not adequately reflected in the discussion paper/draft recommendations (this is despite page 57 of the discussion paper noting that targeted consultation includes 'older Australians with a focus on improved health care services for older Australians whether living in residential aged care or in the community').

Primary medical care for older persons includes management of chronic diseases and geriatric syndromes, acute episodic care, rehabilitation, preventative care, and palliative end-of-life care. While General Practitioners are the primary medical care providers for older people in the community, when attending to residents in RACFs they are supported by a multidisciplinary care team that can comprise nurses, allied health practitioners, and pharmacists and may also include specialist medical practitioners and nurse practitioners.

Currently, there are a number of systemic barriers that limit access to the health specialisations and services needed for the delivery of holistic care to older Australians that meets changing community expectations. The challenges of accessing health services are even more acute in rural and remote areas due to barriers associated with service constraints, skilled workforce shortages, and broader factors such as the additional costs associated with delivering care.

The issue is further exacerbated by the lack of interoperability between systems which means health providers often cannot exchange information effectively. This contributes to disjointed care, adverse events, inefficiencies and poor quality data.

LASA response

Building upon reform

On page 1 (Executive Summary) the discussion paper notes that "In 2009, the National Health and Hospitals Reform Commission identified and proposed several primary health care solutions to Australia's fragmented health care system. This included adoption of a Health Care Home model for general practice and Aboriginal Community Controlled Health Organisations (ACCHOs), and much closer integration between primary and acute care."

LASA acknowledges the benefits and that the Patient-Centred Medical Home (PCMH) can facilitate a partnership between individual patients, their usual treating GP and extended healthcare team, which enables better-targeted and effective coordination of clinical resources to meet patients' needs. However, older Australians living in RACFs were excluded from the Health Care Home Trial.

Considering that older Australians in the RACFs comprising of mostly older people with complex healthcare needs, we believe the PCMH Model (which focuses on management of chronic illness) should be extended to include older people in RACFs. This will ensure older people in RACFs receive equitable access to primary healthcare.

Integrated system

According to the Productivity Commission[1] and Royal Commission (RC) into Aged Care Quality and Safety[2] problems with the interface between the aged and health care systems are a key factor in preventing older Australians from receiving appropriate and seamless care.

It has also been noted[3] that when older Australians move into a RACF the healthcare system does not fully cater for their needs. Access to State-funded health services and/or Commonwealth-funded primary care or specialist services is often variable and residents of RACFs can have more limited access to GP care, allied health services (including, oral health, mental health/psychological services), specialist services care and hospital care.

While LASA supports Recommendation 1 which aims to support a coherent and flexible system of delivering care and preventative services, we believe the proposed actions should also cover initiatives to improve access to specialist and allied health services as part of multidisciplinary care team (as aged care faces greater barriers to accessing these services when compared to those living in the community), and this should align with RC Recommendations 58, 62 and 63, in particular.

Single primary health care destination

For frail elderly people living in RACFs, having access to quality and responsive GP care, is a priority. When access to GP care is inadequate (or fragmented), health outcomes are poorer and there are increased visits to hospital emergency departments (People in RACFs aged 65 years and above account for nearly 9% of hospital admissions, despite representing only 4% of this age group[4]). While GP service provision to RACFs has been increasing in the last decade, there is growing concern that they are inadequate to meet residents' current and future needs.

In the future there is an expectation that, with Government policy geared toward keeping people healthy and in the community for longer, residents of RACFs will largely comprise those with high acuity and complex health care needs. Consequently, the demand for GP care for people living in RACFs will likely increase, placing even greater demands on the time and clinical expertise of GPs that practice in RACFs.[5]

While LASA supports Recommendation 2 which aims at formalising and strengthening the relationship of individuals, families and carers with their chosen primary health care provider and practice, we also believe that with regard to GP care, access will improve when there is a formalised agreement between general practice/GPs and RACFs to strengthen their partnership. Both the general practice/GP and the RACF should mutually agree to, and clearly understand, their respective roles and responsibilities regarding the provision of clinical care and management of medical records.

To this end and to support Members to implement a formalised agreement with their local general practice/GP, LASA has developed two templates (supported by LASA Members and the RACGP) that could be adapted to suit local settings. These are:

- General practice and aged care collaboration MOU template; and

[1] Productivity Commission (2011) Caring for older Australians https://www.pc.gov.au/inquiries/completed/aged-care/report/aged-care-overview-booklet.pdf

[2] Royal Commission into aged care quality and safety: https://agedcare.royalcommission.gov.au/publications/final-report

[3] NACA (2019) Draft aged care/health interface position paper

[4] Reed, R.L. (2015) Models of GP services in aged care facilities AFP Vol.44, No.4, April 2015.

[5] Burgess et al (2015) General practice and residential aged care: A qualitative study of barriers to access to care and the role of remuneration. AMJ 2015; 8(5):161–169.

- Agreement for provision of medical services by general practitioner to residents of residential aged care facilities template.

LASA believes implementation of a formalised agreement to strengthen partnership between general practice/GP and RACFs to improve residents' access to GP care should be supported and included as part of actions under Recommendation 2.

Funding reform

LASA notes that Recommendation 3 is aimed at leveraging voluntary patient registration to bring together the components of funding reform to support providers to tailor care to meet the needs of their patients, delivering value based care and facilitating redirection of funding from secondary/tertiary care to primary care.

While LASA supports the intent of Recommendation 3 to leverage patient registration, it is not clear how funding will be redirected from secondary/tertiary care to primary care. It is also not clear how Recommendation 3 will align with recommendations of the RC to improve primary care for older Australians.

In its Final Report[6] the RC recommends the development of a new primary care model to encourage the provision of holistic, coordinated and proactive health care for the growing complexity of the needs of people receiving aged care (Recommendation 56). According to the RC, the new primary care model would have the following characteristics:

a. general practices may, if they choose, apply to the Australian Government to become accredited aged care general practices
b. the initial accreditation criteria would be:
    1. accreditation with the Royal Australian College of General Practitioners
    2. participation in after-hours cooperative arrangements, and
    3. use of My Health Record
c. over time, as aged care general practices mature, the accreditation requirements could be strengthened
d. each accredited aged care general practice would enrol people receiving residential care or personal care at home who choose to be enrolled with that practice
e. each accredited aged care general practice would receive an annual capitation payment for every enrolled person, based on the person's level of assessed need
f. an accredited aged care general practice would agree with each enrolled person and the person's aged care provider on how care will be provided, including by any use of telehealth services and nurse practitioners
g. the accredited aged care general practice would be required to:
    1. meet the primary health care needs of each enrolled older person (including through any cooperative arrangements with other general practices to provide after-hours care if required)
    2. use My Health Record in conjunction with aged care providers
    3. initiate and take part in regular medication management reviews
    4. prepare an 'Aged Care Plan' (in collaboration with a geriatrician and the aged care provider and others) for each enrolled person

[6]Royal Commission into aged care quality and safety: https://agedcare.royalcommission.gov.au/publications/final-report

5. accept any person who wishes to enrol with it (subject to geography) to avoid practices accepting only patients with less complex care needs, and

6. report on performance against a range of performance indicators, including immunisation rates and prescribing rates

h. the capitation payment would be reduced by the value of benefits paid when an enrolled person sees a general practitioner in another practice.

LASA believes it is important for the development of the Government's Primary Health Care 10 Year Plan to consider the RC recommendations to improve older Australians access to primary health care and this should have been discussed/reflected in Recommendation 3 (Commissioner Briggs of the RC considers that the new primary care model for older people using aged care should be adopted now as it is the only viable option to address older people's health access problems and will provide for better management of chronic and complex health conditions).

Supporting coordinated care

Care coordination between RACFs, primary care and acute health services influences quality care in RACFs and clinical handover is a core component that supports care coordination. Access to current health information and qualified RACF staff involved in the day-to-day care of residents is critical to a quality clinical handover.

With regard to GP care, ideally, a RACF clinical team member, a nurse, who is familiar with the condition and care needs of a resident should be available when that resident receives care from their regular GP or a GP team member visiting that resident. This will enable the GP to focus on assessment/treatment of that patient.

LASA acknowledges the need for a RACF clinical team member to support the GP in delivering care to residents which will improve the quality of health care. However, many RACFs (especially the smaller homes) are struggling to access nurses and having a nurse to support the GP in delivering care (taking the nurse away from attending to the larger resident cohort) is a tough ask especially when 54%[7] of aged care providers are operating at a loss. In this context, LASA believes that additional funding should be provided for the employment of primary care nurses in RACFs to support GP care and this should be reflected in Recommendation 10 which focusses on building workforce capability and sustainability.

Additionally, aged care recipients, their families and carers, often need to manage multiple intersections between health service providers, and across various different settings that could delay the necessary care sought for older Australians and negatively impact on their health outcomes.

LASA believes that Health Care Coordinators have the potential to improve residents' access to health care and hence improve health outcomes. To this end and as highlighted above, the Health Care Home Model (which employs Care Coordinators) should be extended to residents of RACFs to support coordinated care.

Digital infrastructure and system interoperability

Fundamental to ensuring seamless collaboration between medical practitioners (including hospitals), clinical pharmacists and aged care is streamlined access to clinical data. This data includes information that may be present on a patient's My Health Record as well as nursing progress notes, medication dispensing history and clinical observations.

[7] StewartBrown March 2021 https://www.stewartbrown.com.au/news-articles/26-aged-care

Digital data storage and secure remote access across all aged care providers will contribute to ensuring quality care and safe medication management. The pharmacists, GP and aged care sectors are however fragmented and include many small companies, or individual operators, who are unable to support the cost of introducing digital clinical and medication management systems.

A targeted and well considered injection of digital enhancement funding to the sector could provide relatively quick high value impact and this should be considered as part of Recommendation 15 which aims to better support delivery of best-practice multidisciplinary team care through clinical decision support mechanisms and a digital infrastructure that better connects the primary health care workforce. It is also not clear how Recommendation 15 aligns with RC recommendations to support digital health particularly Recommendations 56, 63, 68 and 109.

Additionally and with regard to the use of My Health Record (MHR), LASA is of the view that incentive similar to the PIP eHealth Incentive provided to general practices should be afforded to aged care providers and should be considered as part of Recommendation 15. This will encourage MHR adoption among aged care providers by July 2022 as recommended by the RC and supported by the Government.

Prevention and early intervention

Prevention and early intervention should be at the forefront of support services for older Australians. It means making day-to-day living easier, enabling older people to live full and meaningful lives by planning for the ageing process and preventing, delaying or managing crises.

Geriatric syndromes often require multidisciplinary care management, which is strength of primary care. This requires access to and coordination of appropriate and evidence-based medical and social interventions.[8]

Primary care providers (including GPs, NPs and allied health professionals) with their ability to identify disease at an early stage, their knowledge of the patient including their social contact and their capacity for ongoing chronic disease management, all have a role to play in prevention and early intervention. However, while MBS funding for care planning and team care can assist with coordination, access to GP care, NP care and allied health services often can be problematic.

In this context, LASA is of the view that Recommendation 7 which aims to ensure prevention occurs across the lifecycle should be expanded to include initiatives (such as support/incentive for advance training in aged care especially dementia care) to improve RACF residents' access to GPs, NPs and allied health professionals including funding for preventative health services.

Local approaches to deliver coordinated care

LASA notes that the draft document (Recommendation 5) recommends prioritising structural reform in rural and remote communities and to support a community-connected approach built around the strengths of rural and remote communities, where the community has equitable access to care and providers trust a system that supports and empowers delivery of high value care.

While LASA supports the intent of Recommendation 5, and considering that access to primary health care is an ongoing issue for many older Australians in RACFs, LASA believes that Recommendation 5 should be expanded to include aged care. This will ensure older Australians in RACFs receive equitable primary health care.

[8] Pond C.D. and Regan C. (2019) Improving the delivery of primary care for older people https://www.mja.com.au/journal/2019/211/2/improving-delivery-primary-care-older-people

The role of PHNs and LHNs

The establishment of PHNs and LHNs provides an environment to support best practice clinical handover and transfer of care arrangements. PHNs and LHNs need to ensure that primary, secondary and tertiary health care services engage and work together effectively around patient need.

LASA believes PHNs and LHNS should have formal engagement protocols and some common membership in their respective governance structures, and work together in areas such as hospital avoidance, clarity in responsibility, minimisation of waiting lists, assisting with patients' transitions between sectors and, where relevant, into aged care. In this regard, PHNs and LHNs should investigate with the residential and home care providers in their region on the best approach to integrate primary care, secondary and acute care with aged care at a system level, and this should have been reflected in Recommendation 5.

Implementation of the Government's Primary Health Care 10 Year Plan

LASA agrees with the draft document that the Government's Primary Health Care 10 Year Plan should ensure there is an Implementation Action Plan developed over the short, medium and long-term horizons. It should also ensure that consumers, communities, service providers and peak organisations (including aged care) are engaged throughout implementation, evaluation and refinement of primary health care reform.

A Strong voice and a helping hand

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