Australian General Practice Network

Delivering local health solutions through general practice

Australian General Practice Network submission to the Productivity Commission inquiry into caring for older Australians

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AGPN represents a network of 111 general practice networks as well as eight state based entities. More that 90 percent of general practitioners (GPs) and an increasing number of Practice Nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an accessible, high quality health system by delivering local health solutions through general practice.

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Introduction

The Australian General Practice Network (AGPN) welcomes the Productivity Commission's (the Commission's) commitment to taking a comprehensive approach to its inquiry into aged care and to considering the "full spectrum of care needs of older Australians" with "a system-wide perspective…[that] looks at the needs of older people in a holistic way, including at the interfaces of related policy areas."

We believe it is critical that any comprehensive approach to the quality, viability and future of Australia's aged care system consider the interface between the aged care system and the primary health care (PHC) system and the quality of care for older Australians that this supports. The interfaces between the aged care system, the primary health care (PHC) system and the hospital care system impact on the quality of care older Australians receive as well as on the performance and efficiency of each of these service sectors. Ensuring older Australians can access quality care in accordance with their needs through either community care or residential aged care requires integration of, and coordination across, the aged care, primary health care and acute care sectors.

AGPN believes that all Australians have a right to timely access to patient-centred well coordinated and comprehensive PHC. The provision of timely multidisciplinary PHC to older Australians is critical to ensuring optimal health, wellbeing and functioning as well as limiting acute episodes of chronic illness and reducing unnecessary hospitalisations and presentations to emergency departments.

This submission highlights barriers in the current aged and health care systems that frustrate the assurance of this right to all older Australians, and looks at opportunities to address and overcome these. In particular we focus on opportunities for system reforms to:

- support better access to quality primary health care services for residents of Residential Aged Care Facilities (RACFs)
- restore and prolong independence for older Australians
- support system efficiency through better integration of community care and PHC.

AGPN is an active member of the National Aged Care Alliance (NACA) and notes support for the NACA vision for care for older Australians, that has been provided to the Commission.

About the Australian General Practice Network (AGPN)

AGPN is the peak national body representing a network of 111 General Practice Networks (GPNs) across Australia, as well as eight state based organisations (collectively termed the Network.) Approximately 90 percent of GPs and an increasing number of practice nurses and allied health professionals are members of their local GPN. The Network plays a pivotal role in the delivery and organisation of primary care through general practice and broader primary care teams and aims to ensure all Australians can access a high quality health system.

The Network has a long history of active involvement in supporting the provision of quality PHC services to older Australians, including through the implementation of the now ceased Aged Care Panels (the Panels) initiative that supported PHC professionals and RACF providers and staff to work together to drive improvement in the timeliness and quality of care delivered to residents of these facilities.

Since 2008 Network members have also worked with local aged care facilities to identify and address unmet allied health care access needs through the Aged Care Access Initiative, whilst continuing to support local GPs in delivering quality care to older Australians. The Network has also implemented the Rural Palliative Care program for over seven years which has built the capacity of rural health care teams to deliver quality palliative care by strengthening local partnerships and driving service innovation. The strength of all of these programs is that they

deliver locally-relevant solutions in partnership with local stakeholders and through strong engagement with local primary health care professionals.

The Commonwealth has recently announced its intention to develop a national network of regional Primary Health Care Organisations (PHCOs, termed 'Medicare Locals' in the Federal Budget 2010-2011) to provide regional coordination of primary health care services, by building on the foundational infrastructure of the Network.

Primary health care for residents in RACFS

Older people in RACFs are the sickest and frailest subsection of an age group that has the highest rates of disability in the Australian population.(1) Appropriate quality health care must be provided within the context of a multidisciplinary team with collaboration between GPs, residential aged care staff, pharmacists, allied health professionals and specialist service providers. The provision of timely multidisciplinary PHC to residents of aged care facilities is critical to ensuring optimal health, wellbeing and functioning for residents as well as limiting acute episodes of chronic illness and reducing unnecessary hospital presentations and admissions.

Today's reality

There is substantial anecdotal evidence to attest that some RACFs are unable to regularly access timely GP and PHC services for their residents, leading to suboptimal care and, in some cases, avoidable hospitalisations. Limited access to PHC services can also impact on a resident's wellbeing, physical functionality, mental health and palliation.

Research undertaken by Catholic Health Australia (CHA) in 2010 on the interactions between Catholic aged care facilities and general practice, for example, found that of 90 survey respondents, close to one third reported no difficulty in accessing GPs to attend their residents, over half reported they were managing though it was an "ongoing struggle" to access services, and 15% reported the difficulty they experienced in accessing GPs sometimes compromised patient care.(2) Further, 57% of survey respondents reported that limitations in access to GP services occasionally resulted in transfers to emergency departments and 18% reported that such transfers occurred fairly frequently or regularly.

Access to allied health professionals for residents in RACFs is also, anecdotally, inconsistent and commonly limited and suboptimal. Further, limitations in RACF staffing and staff ratios, particularly in relation to registered nurses, can provide obstacles to the maintenance of care or therapy regimes, including timely access to prescribed medications, and to the timeliness in which a resident's need for additional care and intervention is identified.

AGPN members have also noted significant gaps in services, particularly allied health services, to support resident rehabilitation following a major health event, which may have prompted admission to the facilirty or require hospitalisation.

Channels to access primary health care for facility residents

Through the Medicare Benefits Schedule (MBS) the Government has committed to providing all Australians with access to subsidised primary health care services regardless of where they reside. In theory, all residents of RACFs are able to access subsidised GP services through the MBS. Low care residents are also able to access subsidised services for a limited number of

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[1] Royal Australian College of General Practitioners (2006) Medical Care of older persons in residential aged care facilities 4th edition. Melbourne, Australia.

[2] Catholic Health Australia (2010). Survey of access to general practice services in residential aged care. Canberra. Australia.

allied health professional services on referral from a GP through this channel. However, unlike those residing in the community, residents of aged care facilities are ineligible to access Medicare funded primary mental health care services. This is a serious policy anomaly that should be addressed. Low care patients may also have access to funded allied health services through the allied health component of the Aged Care Access Initiative discussed below. Under the Aged Care Act 1997 facility providers are responsible for ensuring access to required allied health care services for high care patients.

As further discussed below, there are barriers to timely access to GP and PHC professional services for residents common across the RACF sector. To help address this the Commonwealth Government introduced the Aged Care Access Initiative (ACAI). The ACAI consists of two key components. The first is directed at engaging more GPs in the provision of services in RACFs through an incentive payment system that pays GPs a set amount once they have claimed 60 MBS items for services provided in a RACF within a year, and a higher tiered incentive if they claim 140 MBS items for services provided in a RACF. The quantum of the incentive payments has been increased from 1 May 2010 and the Commonwealth has committed to investing $99 million over the next 5 years to supporting an increase in this financial incentive. (Notably, however, the range of MBS items that can be counted toward the service targets required to receive these incentive payments has recently been reduced as an outcome of a streamlining of MBS PHC items.)

The second component of the ACAI is intended to support better access to clinical care provided by AHPs. It funds GPNs to work with RACFs to identify local AHP service needs and establish local arrangements to address these (provided these services are not also covered by Medicare.)

Impact of, and, limitations in current initiatives

There is no available evidence about how effective the GP-focused component of the ACAI has been in increasing the number of GPs providing services to RACFs or improving overall GP access for RACF residents. Anecdotal evidence has suggested that whilst the incentive payments are taken up by some GPs these may primarily be those that were already providing services to these residents and that a relatively small proportion of GPs regularly provide services to residents in aged care facilities.

There has been some suggestions that the low impact of this initiative on increasing overall numbers of GPs providing services in RACFs is associated with the insufficiency of the incentive. If this is the case then the recent increase to the incentive may help address this barrier. However, there remain other concerns about the capacity of the incentive system to achieve the required service level for RACFs:

- The incentive is targeted against relatively low numbers of MBS subsidied services to residents in RACFs. The first tier incentive payment requires 60 services annually, which is equivalent to one service per month for 5 residents, a very small patient load.
- The incentive does not provide encouragement for those GPs providing high levels of services in RACFs to continue to do so. Often a very small number of GPs provide a large number of services to support the care of residents at any given facility and across the region. The incentive remains low on a per service basis for these GPs.
- The incentive can only be accessed by GPs working through an accredited practice. Data provided to AGPN by the Department of Health and Ageing on 31 July 2008 indicated that at that time approximately 11.5% of the GPs providing services in residential aged care were not connected with an accredited general practice and thus not eligible to access the ACAI. Approximately 30% of these GPs were estimated to work almost exclusively in aged care.
- The ACAI does not address any of the barriers outside insufficient remuneration, to timely GP access in RACFs. These barriers are outlined below.

Reports from GPNs implementing the allied health components of the ACAI model suggest this initiative is working effectively to provide better access to timely allied health services for RACF residents. Through the ACAI GPNs have been able to work in partnership to broker access to and deliver essential allied health services including preventative health measures such as falls prevention, lifestyle modification, exercise programs and improved self management of diabetes care. Both GPNs and facilities have commented that without ACAI programs these services would not have been provided.

For example, through the ACAI program GPNs have provided services for residents on both an individual and group basis to address mental health issues of grief, loss, depression and anxiety. In many facilities this has been the first time that these kinds of services have been provided, as low care residents are unable to access subsidised primary health care services through the MBS. GPNs providing mental health services through the ACAI have noted significant improvements in the overall health and well being of the facilities residents with, for example, health professionals noting the impact of these services on increased social interaction between residents and staff, and staff noting a decrease in aggressive behaviour from residents.

Funding limitations, however, impede the capacity of GPNs to support the provision of all necessary services through the ACAI, with budget constraints generally requiring GPNs to focus on addressing one particular health area or providing one or two specific allied health services. Program limitations also impede the capacity of GPNs and allied health workers to drive system improvement through the facility. ACAI funds cannot be used to provide education, training or capacity building services to facility staff, though there are many instances where this would benefit the quality of care. For example, many GPNs have noted the difficulties in attracting appropriate referrals from facility staff for mental health services as mental health and emotional wellbeing are not areas that the staff feel confident in assessing. This could be simply addressed through appropriate education and training that would then support better quality care and greater efficiency through appropriate referrals.

Further, this component of the ACAI is directed primarily at supporting access to allied health services for low care residents. Funding and brokering access to allied health services for high care residents is the responsibility of the facility. However, this does not guarantee timely access to required services. For example, a number of GPNs following consultation with local aged care facility providers have directed their local implementation of the ACAI initiative towards supporting better access to dental care for residents, by brokering access to dental assessment and in some cases treatment for low care residents in RACFs. Dental Staff visiting facilities and GPN staff have noted the inequity in providing access to this vital service to only low care residents, when many facilities are unable to effectively do so for high care residents due to workforce shortages of dentists and dental hygienists and limitations in getting dental staff to travel to provide assessments of residents in the facility.

Funding for the ACAI program is only guaranteed for the 2010-11 financial year, so the role of this program in supporting access for residents to allied health services may not continue beyond this point.

Additional barriers to better PHC access in RACFs

Despite these targeted initiatives there continue to be significant barriers limiting access to quality health care for older Australians who reside in RACFs. A key barrier to GP access remains in the opportunity cost – in terms of both remuneration and personal time- of accepting patients who are RACF residents. There is a wealth of anecdotal and informal information sources to attest that caring for this group of patients requires greater time investment and is less financially rewarding than clinic-based services. There is often insufficient remuneration to compensate for the time lost to travel and for time required to undertake tasks away from the patient interface to care for this high need group; GPs provide significant amounts of telephone advice and support for RACF staff which is disruptive to their

practice and unremunerated. This is anomalous when we consider that GPs can be remunerated under Enhanced Primary Care arrangements for case conferences with other providers with complex situations. Anecdotally, many GPs perceive an economic disincentive to provide RACFs services over clinic-based practice.

AGPN members advise that there are also a range of additional barriers to timely GP access for this population cohort, many associated with frustrations at the ability to provide quality comprehensive care for residents or with the 'time drain' associated with providing care in these facilities. These include:

- limited engagement of GPs and the extended primary health care team in planning the ongoing care for residents
- insufficient carer, enrolled nurse and registered nurse to resident ratios that can provide obstacles to the maintenance of care or therapy regimes instigated by the GP
- insufficient GP access to support from RACF staff to provide updated patient information, a common point of contact at the RACF for the GP and to accompany the GP as required in providing services to residents
- unnecessary delays in engaging GP services or unnecessary 'emergency' calls for GP services, associated with lack of appropriately skilled RACF staff who are capable of clinically assessing patients, administering medication changes and performing simple clinical procedures
- inappropriate or inadequate access to medical and treatment equipment and examination facilities which impedes practitioners ability to provide quality care in an environment that upholds a patient's right to privacy
- limitations in access to allied health professionals by the residents of the facility, which can frustrate efforts to meet care needs through multidisciplinary team work and to implement care plans comprehensively and consistently
- poor discharge planning and clinical handover systems between the acute sector and the facility which can require GPs to make clinical decisions on partial information
- lack of information and communication technology infrastructure which can result in a requirement to duplicate paper work or in incomplete records and avoidable GP visits for tasks that could potentially be completed electronically
- the requirement to complete both a medication order (chart) and PBS prescription to order PBS-listed medications for residents which is commonly perceived as task duplication and an inefficient use of practitioner time.

Access problems can be expected to intensify unless effective systems to broker GP access for RACFs are established. Older GPs provide the majority of RACF attendances and recent graduates are less likely to work in these environments, suggesting that as older GPs retire we will have a further shortage of GPs willing to attend these settings.

Barriers to quality use of medicines within RACFs

In addition to those noted above there are also a number of barriers that inhibit the timely and efficient provision of PBS-prescribed pharmaceuticals within RACFs, including the following factors:

- on discharge from hospital to a RACF, residents are often only provided with a medication supply sufficient to address their needs for 2-3 days which affects the therapeutic continuity. As a result residents may require a follow-up prescription before the GP has received information from the hospital about the current treatment plan. This can result in delayed provision of required medication, suboptimal care or necessitate urgent supply orders. At worst, it can result in relapse and readmission to hospital.

- limited access to pharmaceuticals outside of standard pharmacy business hours for residents of RACFs, which can limit residents' access to required therapeutic and palliative medicines, resulting in clinical deterioration due to delayed treatment, patient discomfort and avoidable hospital admissions. There is currently great diversity in the range of medications available onsite at RACFs for urgent implementation with many low care facilities not providing access to any medication in this manner or ensuring availability of nursing staff qualified to administer such medication.
- medication additions and deletions often occur on admission to hospital and at times medication changes are made without reference to previous medication history. To reduce the incidence of adverse events it is preferable for the medication chart to be updated at the time of discharge, however it is often impractical for a GP to attend an RACF for an unplanned and often out of hours visit to provide this service. There is an absence of appropriate systems for implementation and review of medication changes on the residents return to the RACF that consider these circumstances.

Provision of palliative and end of life care to residents of RACFs

Implementation of ageing in place models frequently means that residents, including those in low care places, spend that period of their lives where they require palliative care and end-of-life support, in an aged care facility. Ensuring quality care during this period of life requires that residents have timely access to holistic care that addresses, physical, psychological and spiritual needs. In the context of residents of aged care facilities this is likely to mean:

- timely access to comprehensive primary health care services, including services from a GP who is competent and confident in providing palliation and who is able to consult with a palliative care specialist in a timely manner as required
- timely access to palliative medicines, including 24 hour access to nursing staff able to administer medications
- a care team who works in accordance with well established referral pathways to support escalating care needs to be met
- RACF carers who are familiar with working in accordance with a palliative approach model and who have the time available to provide support and companionship to the individual
- timely access to specialist services on referral
- access to support to develop an advance care plan to promote care that accords with the individual's wishes.

Like access to GP and PHC services, there is inconsistent access to care that meets these requirements for residents in RACFs. This is in large part associated with common barriers to quality primary health care services for residents in RACFs including limitations in timely access to GP and PHC services and to medications, and staffing levels and ratios that restrict resident access to nursing staff able to make care assessments and administer palliative medicines.

In addition, despite a plethora of effective programs there remains limitations in the knowledge of aged care staff about working within a palliative approach, associated with a somewhat adhoc approach to who receives education in this approach. There also remains limitations in the confidence and competence of some GPs to provide palliative care, which may be frustrated by limited access to advice and support from a palliative care specialist. These limitations can negatively impact the quality of care and end of life experience of patients.

Advance care planning can support a patient nearing the end of their life to consider and plan with their health care team so that they receive the care they would prefer as they approach

death. Advance care planning supports patients to prepare for death and can prevent interventions to prolong life that are not wanted by the patient. Whilst some facilities have well established processes for supporting advance care planning as a result of participation in programs such as Respecting Patients Choices, this is far from universal, and many residents are not able to access support to develop a plan for their care wishes to be upheld. Further, when advance care plans are routinely developed in RACFs, GPs are often not consulted and there is no financial model to support their contribution, despite their role as a key stakeholder in patient management decisions.

In recognition of the value of advance care planning to patient-centred care the National Health and Hospital Reform Commission (NHHRC) has recommended that advance care planning be funded and implemented nationally, commencing with all RACFs. Whilst this would likely reduce unwanted hospitalisations and care interventions for residents, it also requires sufficient ratios of appropriately qualified RACF staff to ensure that residents dying in place receive sufficient palliation.

Toward better access to quality care in RACFs

Supporting local solutions to overcome barriers to accessing GP and PHC services and to drive quality improvement in care

To support better access for residents to PHC teams there is a need for a locally coordinated approach to work with local GPs, PHC professionals and RACFs to identify and address local barriers to access, to broker arrangements to ensure residents have timely access to comprehensive care, and to drive quality improvements in the care provided.

The Commonwealth has recently announced as part of their health reform agenda that that the Government will "provide funding for Medicare Locals from 2012-13 to increase access for older Australians to GP and primary health care [by]… administer[ing] a flexible funding pool to target gaps in primary health care services for aged care recipients."

AGPN strongly supports this proposed direction and recommends that PHCOs (Medicare Locals) are charged with, and resourced to, broker GP and allied health professional access for RACFs and to drive quality improvement in PHC, through the use of flexible funds to address local needs. PHCOs may facilitate GP access by supporting arrangements that overcome key barriers to GP visits to facilities or, particularly in areas of workforce shortage or where GP are required to travel substantial distance, by paying additional incentives to GPs. In the short term, this should not replace current MBS and ACAI incentive payment arrangements, however, the impact of the enhancements of the ACAI incentive should be comprehensively reviewed. Flexible funds could also be employed to drive quality improvement through locally-relevant solutions, for example, education for RACF to support greater identification of residents needs for primary mental health care support, or supporting greater PHC team collaboration by facilitating GP participation in a RACF's medication advisory committee (MAC.)

Key advantages of this approach include that:

- PHCOs will have well established networks with local GPs and PHC providers and are well positioned to engage these service providers
- PHCOs will have a comprehensive understanding of the needs of local PHC providers and the functioning of the local PHC system and are thus well positioned to work to negotiate models of service provision that suit local requirements
- the foundations of this approach are proven and effectively functioning through the ACAI program implemented by GPNs (the foundations on which PHCOs will be built) across the country

- there is precedent demonstrating the effectiveness of this approach. GPNs under the Panels commonly performed a brokering role with some GPNs continuing to do so without Commonwealth resources. For example, one GPN has facilitated the establishment of GP clinics in two local low care hostels, where regular clinics are run at a standard time and residents can book in to see the GP, in the company of a facility RN if required, as with GP clinics in community-based settings. Similarly the GPN has established standard times for GPs to do 'rounds' in a high care facility which ensures the GP is provided with sufficient support. AGPN suggests these approaches could be effectively established in many facilities.
- It provides flexible funds to address regional need so funds can be directed as they are best suited to enhance the quality of care.

The NHHRC has alternatively recommended funding RACF providers to make arrangements with PHC providers to provide care to residents. AGPN believes this approach would be less effective as RACFs do not commonly have well established networks with local PHC providers. There is also a risk that RACFs locally would 'compete' to access GP services, where as PHCOs would be able to seek to establish equitable arrangements with GPs across RACFs. Resourcing PHCOs to perform this role also negates the potential conflict between profit-making and delivery of quality care that RACF providers may face if funded for this purpose.

The recommended approach would build on and extend the current ACAI program implemented by GPNs to facilitate better access for residents to allied health providers. This program is currently funded to the end of the 2010-11 financial year. As noted above the Commonwealth has indicated an intention to fund Medicare Locals from 2012-13 to support better access for older Australians to GP and allied health services. There is therefore the potential of a year lag where no brokerage and support services are provided. This would not only limit the already suboptimal range of primary health care services available to RACF residents, but would also weaken the established relationships between key stakeholders which are so central to the continuing efficacy of these programs. If this were to occur the substantial resources required to develop strong partnerships would need to be reinvested in 2012-13. Alternatively it is recommended that an expanded version of the ACAI is continued until Medicare Locals are funded to perform this role.

Supporting more effective models of care

While not all clinical presentations require a team approach, chronic and complex conditions common in the frail elderly are frequently most effectively and efficiently managed through team care. Delivering timely access to comprehensive team care for residents of RACFs must be considered a fundamental aspect of their care.

In residential aged care settings the facilities nursing team and the resident's general practice team can be considered as comprising the core members of the primary health care team, and should work in conjunction with allied health professionals to meet the patient's care needs. It is imperative that systems are established to support this team to work together effectively and efficiently.

Ensuring that the RACF nursing team have sufficient time, including through appropriate staff numbers and ratios to actively engage in team care with the general practice and broader primary health care team is paramount and further discussed below. Funding arrangements should also enable the practice nurse to support the GP by providing patient care to residents. Practice nurses commonly perform key role in clinical care and care coordination within the practice setting that could also be performed in caring for patients in RACFs. For example, practice nurses may be able to provide clinical services such as ear syringing and wound repair using skin adhesives. This would enable the development of models of care that would most efficiently and effectively utilise the skills of the general practice team and, if associated with appropriate remuneration structures, would facilitate better resident access to PHC services.

The Commonwealth announced through the 2010-11 Federal Budget a new initiative intended to support greater employment of practice nurses in general practice through an alternate funding structure to support and incentivise the uptake of practice nurse services. New measures introduced to support practice nurses to deliver patient care should include, or be supplemented by, approaches that enable practice nurses to provide care to patients in RACFs without financial loss to the practice.

Exploring alternate funding models to make caring for facility residents more viable for GPs

The insufficiencies of the current fee for service arrangements to support RACF resident access to subsidised primary health care services have been highlighted above. The viability of alternative or additional funding models to remunerate PHC professionals for providing services in RACFs should be explored.

AGPN believes that, in general, a blended payment system including fee- for- service, pay-for –performance and capitation payments linked to patient registration with a general practice will best support the delivery of optimum care through the general practice setting. AGPN recommends that the viability of blended funding systems to support better access to comprehensive primary health care for residents in RACFs be explored. We note, however, that this will not negate the necessity of resourcing PHCOs to broker RACF access to primary health care services and to work in partnership with RACF providers and PHC providers to drive quality improvement of the care provided in these settings.

Greater focus on primary health care in service planning

The ability of the primary health care workforce to support residential aged care providers is significantly affected by the placement of new beds and facilities through the Aged Care Approvals Round (ACAR). The ACAR supports providers who demonstrate that they are able to meet the needs of the ageing population within their region. However AGPN's members advise that aged care places are too often provided in acknowledged areas of workforce shortage. This can frustrate efforts to provide an adequate level and mix of staff to meet the care needs of residents. The result can be understaffed facilities and compromised standards of care.

To help ensure the appropriate level of health care is available and accessible to support residential aged care providers, AGPN recommends that, if the ACAR system is to continue, the allocation of new beds and facilities through the ACAR include a requirement for planning for the availability of GPs and the PHC workforce. Potential providers should be required to work with their local PHCOs to plan for primary health care service delivery in the planning and development of ACAR submissions.

The assessment framework utilised in the ACAR, detailed through the ACAR Essential Guidelines , do not advise what is required of a provider to adequately address Section 14-2 (1)(c) of the *Aged Care Act 1997* which requires providers to demonstrate an "ability to provide the appropriate level of care." Providing further detail of the health care service standards which must be met to accord with the requirements of the Act in the Guidelines would help ensure that the capacity of services to meet health needs are thoroughly considered in the allocation of new beds.

Address communication, technology and infrastructure barriers that frustrate PHC professionals ability to provide quality and efficient service

Fundamental to enabling more efficient, timely and safe provision of PHC in RACFs is the widespread uptake of information and communication technologies that support shared electronic health records, electronic prescribing and the electronic transfer of clinical data. This would support:

- greater efficiency in care through the reduction in task duplication for GPs and PHC professionals
- greater quality and safety in care by enabling health practitioners to make care decisions on the basis of comprehensive and up-to-date information and decision support programs
- greater timeliness of care by enabling the GP to remotely access patient data and advise on care practices without the delay necessary in waiting for the GP to be able to attend the facility
- timeliness in provision of information provision about a resident's changed health status or medication requirements through electronic transfer of hospital discharge data to facilities and a patient's GP
- enhanced willingness for GPs to provide services for RACF residents due to a reduction in time wastage and enhanced opportunity to provide quality care.

Whilst both nationally-coordinated and regional initiatives are driving development in this space it is critical that this is prioritised and supported through financial support or funding incentives for the aged care sector to develop the infrastructure necessary to support shared electronic health records and electronic messaging as well as incentive programs to support electronic transfer of clinical data.

To further support the provision of primary health care in RACFs, AGPN recommends that funded measures are introduced that require and support RACFs to provide appropriate medical equipment, consultation facilities and patient record and medication management systems. This can be expected to help promote access to primary health care professionals by providing them with conditions that enable the delivery of appropriate on-site care. However given the current parlous financial position of many of Australia's RACFs, such a requirement cannot be imposed without adequate financial support.

Enhance medication management systems

To support greater efficiency in care and reduce duplication of effort, AGPN has continually advocated for the streamlining of medication charts and prescription orders, such that medication charts serve as prescriptions. Through the Fifth Community Pharmacy Agreement, the Commonwealth is supporting progress toward this outcome. AGPN applauds this development and recommends it is pursued as a priority.

To facilitate timely access to PBS medication for residents of RACFs and system efficiency, AGPN further recommends:

- the development of a standardised list of medications that are retained at RACFs throughout Australia for situations in which access to a pharmacy supply is not available and the urgent use of medication is required to prevent clinical deterioration or transfer to hospital, or provide symptom relief
- the development of mechanisms to support after hours access to pharmacy services in RACFs, in consultation with RACFs and pharmacists
- greater support for GPs providing services in RACFs to actively participate in Medication Advisory Committees (including regional networks) and to work through these committees to support quality improvement in medication management and administration systems for residents.

As noted above, by resourcing and empowering PHCOs to utilise flexible funds to enhance access to primary health care services, they can take the lead locally in coordinating the later two recommendations.

Address workforce shortages and suboptimal staff ratios in RACFs as a priority

As noted above insufficient staffing ratios and staff shortages in RACFs frustrate health practitioner's efforts to provide quality care and discourage health professionals from providing services to RACFs. They also impact on the quality of care and overall wellbeing of residents. The introduction of measures that support appropriate staffing ratios in RACFs and promote the sustainability, capacity and competency of the aged care workforce are critical first steps to address these barriers.

AGPN is aware of the parlous financial position of a large proportion of RACF providers. We advise that fundamental to addressing workforce challenges and ensuring the provision of quality primary health care for residents of aged care facilities is sufficient allocation of additional funds to RACFs targeted to ensure appropriate staff ratios and a staffing mix that provides for sufficient numbers of PHC professionals.

Funding arrangement for RACFs should be only one element of a comprehensive approach to professionalise the aged care workforce and support the sector to be regarded as a rewarding area within which to work. Such an approach must address pay inequities between nurses and carers working in aged care and those employed in other sectors and promote rewarding workplace experiences through appropriate education and training opportunities, an environment that enables meaningful engagement between residents and staff and which enables nurses to provide a quality of care they are proud of as an active member of the broader PHC team.

Facilitate access to quality palliative care in RACFs

Whilst some facilities and PHC teams work in regions with well established palliative care referral pathways and support for PHC professionals to provide quality palliative care through advice from palliative specialists this is not consistent across the country. AGPN recommends that PHCOs are resourced to work in partnership with local RACF providers and other stakeholders to ensure that suitable referral pathways for palliative patients are established and to enhance the capacity of RACF residents to access palliative care by ensuring GPs providing care in RACFs can access education and training in palliative care and advice from a palliative care specialist as required.

It is critical to ensure ongoing access to education and training in end of life care for all RACF staff providing direct client services.

AGPN recommends the national roll out of a residential aged care-specific training package for advance care planning and end-of-life care, that is sufficiently flexible to enable its use in all types of residential aged care settings and that is structured to ensure that advance care planning occurs in consultation with the resident's GP and PHC team who have a comprehensive understanding of the resident's care needs and a history of working to plan care with the resident. This package should be directed both at supporting staff to develop the skills to engage with residents in developing an advance care plan as well as encouraging executive and management staff to facilitate the culture change required to support the adoption of associated new work plans and systems.

To support advance care plans to be routinely offered to residents this package should be accompanied by an advance care planning document that can be utilised in all jurisdictions. To ensure the sustained implementation of advance care planning initiatives, consideration should be given to embedding the requirement to routinely and systematically offer residents opportunity to develop an advance care plan in the Aged Care Standards.

Key recommendations in summary

- PHCOs (Medicare Locals) should be charged with, and resourced to, broker GP and AHP access for RACFs, and drive quality improvement in primary health care provision in RACFs through the use of flexible funds to deliver local solutions

- New measures should be introduced to support practice nurses to deliver patient care include, or be supplemented by, approaches that enable practice nurses to provide care to patients in RACFs without financial loss to the practice
- An expanded version of the current ACAI program component directed at supporting better allied health access in RACFs should be continued until PHCOs are established and funded to perform this role
- The impact of the enhancements of the ACAI incentive payment system for GPs should be comprehensively reviewed
- The viability of alternate blended funding systems - that include fee-for service, capitation payments and pay-for-performance – to support better access to comprehensive primary health care for residents in RACFs should be explored
- The allocation of new beds and facilities through the ACAR should include a requirement for planning for the availability of GPs and the primary health care workforce
- The development of efficient and effective communication and record management systems in RACFs should be enabled through funding incentives for the aged care sector to develop the infrastructure necessary to support electronic transfer of prescriptions and shared electronic health records that can be accessed externally by GPs
- Funded measures should be introduced that require and support RACFs to provide appropriate medical equipment, consultation facilities and patient record and medication management systems
- The streamlining of medication charts and prescription orders should be pursued as a priority.
- A standardised list of medications that are retained at RACFs for situations in which access to a pharmacy supply is not available and the urgent use of medication is required, should be developed
- Measures should be introduced to support staffing ratios in RACFs that are more appropriate to residents' care needs, including sufficient allocation of additional funds to RACFs targeted to ensure appropriate staff ratios and a staffing mix that provides for sufficient numbers of primary health care professionals
- Pay inequities between nurses and carers working in aged care and those employed in other sectors should be addressed as a priority
- PHCOs should be resourced to work in partnership with local RACF providers and other stakeholders to ensure that suitable referral pathways for palliative patients are established and to enhance the capacity of RACF residents to access palliative care by ensuring GPs providing care in RACFs can access education and training in palliative care and advice from a palliative care specialist as required.
- The Commonwealth should fund the national roll-out of advance care planning initiatives in RACFs and encourage all aged care providers to employ staff trained in supporting residents to complete advance care plans in consultation with their health care team.

Caring for older Australians in the community

Currently aged care in Australia is predominantly community based and there are further trends in this direction. Most older Australians receiving aged care services in the community receive support through the Home and Community Care (HACC) program, additional community care packages funded through the Commonwealth, or Veterans' Home Care. These programs provide packages of care that include services to assist with everyday living activities, help with personal care, and provide access to health care (to varying extents.)

Better access to aged care assessments and community care packages

With the exception of HACC, access to government subsidised community care packages requires a referral following an aged care assessment from a specialised assessment team. In many regions older Australians experience lengthy delays to be assessed and to packages of community care recommended. This can place strain on individuals and their carers, may be associated with deterioration in physical or mental health and wellbeing, and can result in avoidable or premature admissions to hospitals and RACFs.

To ensure timely access to aged care assessment and community care services to support older Australians to live well in the community it is critical to increase the number and/or capacity of assessment teams and community care packages to that required to meet community needs. This demands substantial increases in investment in these services.

AGPN believes there is also opportunity to enhance the efficiency of assessment processes and timeliness of access to assessments through greater integration of assessment processes with PHC. GPs and practice nurses are often well placed to inform or to undertake assessments efficiently and in a timely manner due to their high level of knowledge of their patient and their patients current care needs built up over the course of their relationship with the patient. The current assessment system requires assessors who are not familiar with the patients to gather information that the patient's GP is likely to already have available.

The Commonwealth Government has announced as part of its health reform agenda that it will streamline the assessment process to ensure a common process using common criteria is applied across the country. As part of this streamlining process, AGPN recommends consideration is given to opportunities to enhance efficiency in assessments through greater integration of assessment processes with general practice, and to enhance timely access to assessment by enabling GPs and practice nurses to undertake assessments in some circumstances.

Greater system focus toward promoting and maintaining independence

A primary goal of the HACC and Veteran's Home Care programs, as well as of those such as EACG, EACH-D and CACP which provide more intensive and flexible packages of care, is to support older Australians to remain living independently in their own home and avoid premature institutionalisation. However, few community care packages have included interventions specifically directed to supporting individuals to optimise their functioning, reduce their needs for support and enhance their independence. As Lewin and Vandermeulen note: "they have tended to focus on supporting independent living by providing assistance for the daily living tasks that people are finding difficult."[3]

However there is an emerging body of evidence that highlights the benefits of prevention and health promotion initiatives to preserving functionality and independence, and of restorative care programs focused toward promoting independence. For example, Western Australian research has shown that older people referred for home care who receive a program focused specifically toward re-ablement achieve better personal and service outcomes than those referred to standard HACC services.[4] Encouragingly there is also a trend toward the provision of community care programs focused on reducing dependency.

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[3] G. Lewin and S. Vandermeulen (2009) 'A non-randomised controlled trial of the Home Independence Program (HIP) – an Australian restorative programme for older home care clients.' *Health and Social Care in the Community Journal* 8 (1): 91-99.

[4] *ibid.*

To support better health and wellbeing outcomes for older Australians and move toward promoting a more sustainable aged care system we need to support a greater health and aged care system focus on:

- delivering health promotion and prevention programs targeted at maintaining health, functionality and independence for older Australians
- home and community care programs specifically targeted to optimising an individual's functionality and reducing their need for support services, rather than solely responding to an individual's dependency needs.

A greater orientation of the health and aged care system towards promoting health, wellbeing and independence for older Australians will require:

- investment to support the delivery of locally-relevant health promotion, exercise and wellbeing programs for older Australians. If appropriately resourced the new regional coordination infrastructure provided by PHCOs provides a mechanism to drive a greater focus on prevention. By providing PHCOs with flexible funds to coordinate the regional implementation of evidence-based health promotion and exercise programs with proven effectiveness in promoting the health and wellbeing of older Australians and supporting older Australians to maintain and enhance their functionality, they would be able to implement programs best matched to the needs of their local communities. PHCOs would be required to demonstrate improved health outcomes for older Australians in their jurisdiction.
- a greater focus on restoring functionality amongst individuals receiving HACC services, which in turn requires greater flexibility in how funding for these services is provided, so that service providers are able to tailor care packages and interventions to meet the individual's needs and promote their independence. Flexibility also recognises that the quantum of care required varies from time to time depending on the clinical status of the person receiving care. To drive a focus on reducing dependency performance indicators for HACC service providers should consider reduction of dependence and restoration of functionality amongst service recipients.

  To enable a greater focus on re-enablement through more flexibly funded community care packages, the range of permissible services, particularly the range of allied health services that can be purchased, through these packages should be reconsidered to ensure these are best directed toward promoting independence.

Invest in related services to support the maintenance and restoration of independent living

Supporting the continuation of independent living for older Australians in the community and reducing the need for premature entry to residential care, hospitilasition and the extension of hospital stays, requires the expansion of sub-acute and restorative/rehabilitative care services. These services play a critical role in reducing the need for institutional care when an older Australian's care needs temporarily increase and supporting a return to independent living following hospitalisation. They are thus critical to supporting an individual to maintain and regain independence, whilst reducing the additional cost burden associated with hospital or residential aged care.

The Commonwealth has recently announced an increased investment in sub-acute beds, including to support the transition between acute and aged care for elderly Australians. AGPN recognises this as a promising step and notes the need for continual growth in investment in both sub-acute and restorative care services, and the need to ensure that a sufficient proportion of these services are focused toward addressing the needs of older patients, in order to sustainably meet the care needs of our ageing population.

Carers play a critical role in enabling older Australians to remain living independently within the community, including in conjunction with the support of community care services. Our aged care system is fundamentally reliant on the contribution of family carers and would be unsustainable without this contribution. As our population ages the necessary reliance on the contribution made by carers to the sustainability of our aged care system is expected to increase. Simultaneously the ageing of the population, increasing participation of women in the workforce and smaller family size is reducing the availability of informal carers to support older people living in the community.

More effective support to assist informal carers to maintain their caring role is vital. Supporting carers to continue to perform this critical role requires:

- timely access to affordable and quality respite services that cannot be guaranteed with the existing investment in respite services
- education and training services to carers them in performing their caring role
- financial support to help offset the cost of caring.

Supporting regional service planning and greater integration of community care and PHC services

The quality of care an older Australian receives in the community to maintain health, wellbeing and functioning, is an outcome of their access to, and the quality of, both community care and PHC services. Quality of care and system efficiency is optomised when the community care and PHC systems are well integrated and work together to provide a coordinated package of care for the individual.

There is a need to, and opportunity to, realise more effective and efficient service delivery by supporting better integration of these two service sectors at the local level. To support better integration PHCOs should be charged with working to ensure strong integration between general practice, community care access assessors, community care providers, sub-acute and acute services.

The Council of Australian Governments (COAG) has recently agreed to a Commonwealth take-over of funding and policy responsibility for aged care assessments and all community care packages (in practice this will only change current funding arrangements for HACC.) This is intended to support more streamlined and consistent approaches to assessment and service provision. However, there will remain a need to ensure that services provided under community care packages are regionally coordinated to ensure adequate provision of required services, and are well integrated at a service level, to reduce duplication and gaps in assessments of consumers and the provision of services. It is not clear whether the 'one-stop' shops for older Australians that the Commonwealth has announced to support older Australians to access services and "better integrate aged care with other parts of the health system" will be charged with a regional service planning role.

Regardless of how regional service planning and coordination functions for community aged care services are performed in the short term, there are potential benefits to better service integration and administrative efficiency for merging, over time, regional coordination functions for community care with those for PHC. This for example has been a policy direction pursued in Scotland. This option should be further explored.

Key recommendations – in summary

- The capacity of assessment teams and availability of community care packages should be increased through additional investment in these services, to ensure older Australian have timely access to required services
- Consideration should be given to opportunities to enhance efficiency in aged care assessments through greater integration of assessment processes with general practice,

and to enhance timely access to assessments by enabling GPs and practice nurses to undertake assessments in specified circumstances

- A greater focus on prevention for older people in the community should be taken by providing PHCOs with flexible funds to coordinate the regional implementation of evidence-based health promotion programs with proven effectiveness in promoting the health and wellbeing of older Australians and supporting older Australians to maintain and enhance their functionality
- A greater focus on restoring functionality amongst individuals receiving HACC services should be supported through more flexible funding arrangements and performance indicators and reporting requirements linked to reduction of dependence amongst service recipients.
- Guidelines for community care programs should be relaxed to enable the sort of services best suited to promoting an individual's independence to be provided in flexible models.
- Governments should continue to invest in sub-acute and restorative care services as a priority and ensure these are targeted toward meeting the needs of older Australians
- Governments should invest in supporting informal carers supporting older Australian to live in the community through a greater investment in respite service, education and training initiatives and enhanced financial support to help offset the cost of caring
- PHCOs should be charged with working to ensure strong integration between general practice, community care access assessors, community care providers, sub-acute and acute services
- The potential to support better service integration and administrative efficiency by merging, over time, regional coordination functions for community care with those for PHC should be explored.