24 January 2020

Royal Commission into Aged Care Quality and Safety
GPO Box 1151
Adelaide SA 5001

via email ACRCProgramDesign@royalcommission.gov.au

**AGED CARE PROGRAM REDESIGN: SERVICES FOR THE FUTURE**

The Australian Council of Deans of Health Sciences (ACDHS) welcomes the opportunity to comment on the Consultation Paper on the future design of the aged care system. ACDHS is the peak representative organisation for Australian universities that provide undergraduate education and research in allied health sciences.

ACDHS commends both the thoughtful recognition of various shortcomings of the current aged care system as well as the principles of a newly conceived system, set out of pages 4-5 on the Consultation Paper. Members have long emphasized the need for overall structural changes in the aged care system, to attend to the differing needs of older persons within the system, listening to their voices as well as the voices of their families and loved ones.

We are pleased that the Principles (page 4) are grounded in putting people at the centre of care, as well as highlighting choice as fundamental to a responsive system of aged care. Equity of access is a key concern and this too has been highlighted.

It is imperative to start from a position that sees ageing and aged care as a system of health and wellbeing, not a system for sick people, ie providing interventions when people get frail or sick. Redesigning the aged care system in Australia must involve a rethinking of values and expectations of growing older; how older adults can maintain productive engagement and life within communities; and, how conscious or unconscious age biases can negatively impact well-being in all contexts, including health care.

Education providers have a key role here, across university and TAFE sectors, to provide not only health care professionals but managers trained in healthy ageing principles as well as management of challenges in later life.

The ideal system is one therefore that allows equity and flexibility of pathways and is rooted in a new narrative around health promotion and disease prevention over the life course. In this regard an aged care system should not be seen in isolation of the broader narrative of healthy ageing. It should not exist in a vacuum.

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ACDHS's response is underpinned by the following, as fundamental to good design, one:

- That provides culturally competent and culturally safe care services that are determined by older people and their families/communities from diverse backgrounds.
- That provides professional education programs, to stream allied health and support services commensurate with the proposed design.
- That is equitable and sustainable with services that promote intrinsic capacity and reduce the burden on caregivers.
- That ensures that aged care is person-centred, focused on the needs of the older person rather than the structure of the service.
- That ensures that the aged care workforce is treated fairly, and receive the social status and respect it deserves.
- That ensures that Governments take overall responsibility for the stewardship of aged care systems.
- That supports older people to have a good death.
- That promotes age and dementia friendly environments.
- That addresses ageism.

The commentary that follows in our detailed response to the questions makes a number of observations and recommendations.

The Commission has made an excellent start on re-envisioning aged care in Australia. We as a major provider of training for a broad variety of relevant disciplines look forward to continued engagement with this process.

Please do not hesitate to contact the ACDHS Secretariat on (08) 8302 1187 or via email at secretariat@acdhs.edu.au to discuss any elements of the submission further.

Yours sincerely

Executive Officer

**Australian Council of Deans of Health Science**

*Attach: Responses to questions*

## RESPONSES TO SPECIFIC DESIGN QUESTIONS

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

We are pleased to see both the thoughtful enumeration of various shortcomings of the current aged care system as well as the principles of a newly conceived system, as set out on pages 4-5 of the Consultation Paper. Members have long emphasized the need for overall structural changes in the aged care system based on addressing the needs of the whole person and the context in which individuals want to access their care.

We note that the paper does not cover in any detail the Commission's work on:

- the role of older people in society and in our communities
- interactions between the aged care and health care systems;
- system stewardship
- provider governance, leadership and accountability;
- market development and delivery
- funding;
- workforce;
- Transition and implementation.

While we appreciate that this compartmentalized approach allows for focus on each topic, it is our contention that addressing the challenges and opportunities for system improvement should not be undertaken in a compartmentalized way. What is needed is an approach that recognizes the various actors and ultimately promotes a joined-up system.

***ACDHS recommends***

*That the design principles also include mechanisms:*

- *That provide culturally competent and culturally safe care services that are determined by older people and their families/communities from diverse backgrounds.*
- *That provide professional education programs, to stream allied health and support services commensurate with the proposed design.*
- *That is equitable and sustainable with services that promote intrinsic capacity and reduce the burden on caregivers.*
- *That ensure that aged care is person-centred, focused on the needs of the older person rather than the structure of the service.*
- *That ensure that the aged care workforce is treated fairly, and receive the social status and respect it deserves.*

- *That ensures that Governments take overall responsibility for the stewardship of aged care systems.*
- *That support older people to have a good death.*
- *That promotes age and dementia friendly environments.*
- *That addresses ageism.*

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

Face-to-face options to explain services to older adults and their families are mentioned in the discussion paper. However a clearer articulation of how the "entry level support" will help families to access targeted community-based services to maximise functioning for as long as possible, while simultaneously leading older persons and their families to consider forward planning options, is key.

Very often older adults are estranged from families, or families have a level of distress that can make decisions on future care difficult. It is important that the needs of older adults are recognised as requiring solutions in both medical and non-medical contexts. It is really important to ensure that when older people enter residential settings that the right level / setting is identified to match their needs and likely evolving needs at the outset.

Having an early triaging service which links older persons and families to a wide range of community services including referrals for allied health services is critical. This more holistic approach can better support older adults and their families to make informed choices about aged care and related services, affording older persons and their families greater control to decide what choices, what timetables and what potential outcomes best match their values and circumstances. Progression to higher care levels can be prevented if appropriate support is offered, and such support is most often more cost effective than institutional care options.

Finally, continuity of care is an important construct, and holistically conceived. Abrupt changes (in residence, in care providers, even in food, recreational activities, and sleep routines) are not a feature of a quality care system. Having control over not only services, but the manner in which they are constructed and delivered, reflects not only best practice standards internationally, but signals to the older person and their family that they are recognised as individuals with unique contexts, served by the system rather than being required to capitulate before it. This is particularly important in people with dementia who cannot communicate their needs effectively.

***ACDHS recommends***

- *The production of written information that is "Easy English" or "Aphasia friendly" - incorporating simple sentence structures, bolding of key words, diagrams and photographs etc.*
- *An interactive decision aid (ideally multilingual) that incorporates an understanding of the person*
- *Providing supports from health professionals such as social workers to manage potential anxiety and stress from the anticipation and implementation of changes in care systems, supports and environment.*

**Information, assessment and system navigation**

*Entry and Access*

The access point for services should be flexible ranging from a call centre that includes multilingual services, to face to face provided within community centres close to where older people live or community/religious organisations that older people are affiliated with.

Face-to-face services could be constructed as either in person (in major metropolitan areas) or via telehealth. A reconceptualization of the notion of "face-to-face" to encompass telehealth delivery systems fits well with the increasing sophistication of telehealth models, and their ability to deliver high-quality specialist services as needed in an efficient manner, irrespective of distance.

Benefits of a system navigator are many, provided they are independent of service providers and work in a person centred manner. The capacity for independence facilitates the building of trust that the care needs of clients becomes the driver of service recommendations.

*Residential Aged Care*

Once someone enters the aged care institutional care system, navigation should be a) face to face; b) include families at all stages; c) include regular reviews of how the older person is managing, to optimise care, minimise medications and medical procedures, and accommodates the wishes of the older person at all stages of care, including end-of-life care.

In summary, both at the entry to accessing aged care services or if moving to higher level needs care coordinators/system navigators would be a pivotal, game-changing innovation, particularly if that person is trained in healthy ageing and independent of a particular service provider**.** The benefits of independence and having a goal of maximal functioning and independence directly counters the prevailing, detrimental "deficit model" of increased funding in the face of increased dependence.

Further, at whatever point of access an older person enters the system, services must:

- be culturally and linguistically appropriate;
- include discussions about older people's wishes for type and delivery of services and the payment methods; and,
- be sufficiently resourced so that people do not experience unnecessary delays.

***ACDHS recommends***

- *Care coordinators come from various disciplinary backgrounds should as a minimum have specific training in both healthy ageing and best practice in methods to maintain physical and mental well-being in the face of disease or adverse circumstances.*
- *Ensuring system navigators for Aboriginal and Torres Strait Islander older peoples and for people from culturally and linguistically diverse backgrounds are trained in best practice cultural competency.*
- *Offering free interpretation services for CALD communities at all points of the system.*

**Entry-level support stream**

There has long been recognition of the value of assistive services to people living at home.[1] However, different people respond differently to even the suggestion of any level of home care, irrespective of financial position. For some people, any such provision of services diminishes their sense of independence. For those with early symptoms of cognitive decline, suspicion and paranoia that may be present can interfere with accessing high quality services. In these situations there is a need to determine if a person has capacity, make clear who decision makers are and then act in persons best interests. Further, ageing in place can lead to social isolation.

The more fundamental issue is how the services are presented in terms of what they offer; whether there is a sense of some continuity of current ways of living; whether providers are consistent and respectful of individuals. Important early supports vary, but those that can help ensure safety (e.g. a service to clean gutters vs older person falling off a ladder) and that leverage existing coping and strengths that enable the older person to remain motivated to live independently are most important.

Regardless, all persons should have access to information about community services, including the role of allied health professionals, in assessing the need for and access to appropriate support. Care co-ordinators/system navigators should be well-versed in ways in which unseen issues ie, inappropriate hearing aids, ill-fitting dentures can escalate into chronic issues but which can be addressed at an earlier stage, with good outcomes including avoidance of premature institutionalisation.

Increased awareness and access to allied health professionals is critical. At present, there are significant financial, gatekeeper and distance barriers that prevent timely access to allied health professionals who could significantly reduce premature institutionalisation and extend independent living. Older persons with multiple chronic diseases, such as cardiovascular disease, diabetes or chronic lung disease account for more than 70 per cent of our health system expenditure. Simultaneously lowering such barriers and expanding financial support to telehealth delivery systems could significantly improve outcomes for older adults, particularly in the maintenance of independence in the community[2]. Such independence and support for living within the community, and the framing of institutional care as a last but in many cases necessary resort, is the most important improvement that could be made in Australia's aged care system.

***ACDHS recommends***

- *That older people be supported to access health care, particularly in relation to chronic disease, via making available user- friendly digital health technologies.*

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[1] Living well at home: CHSP Good Practice Guide 2015, Commonwealth of Australia https://agedcare.health.gov.au/programs-services/commonwealth-home-support-programme/living-well-at-home-chsp-good-practice-guide, viewed 21/1/2020

[2]Home Monitoring of Chronic Disease for Aged Care: CSIRO Telehealth Trial Final Report May 2016, CSIRO https://www.csiro.au/en/Research/BF/Areas/Digital-health/Delivering-care-remotely/Home-monitoring, viewed 21/1/2020

**Investment stream**

Respite and restorative care, in the absence of support for both older persons and their carers in individual coping and emotional well-being, is a clear lack in the existing system. Teaching coping skills, self-care strategies and targeted environmental improvements have greater support as best practice than a day or number of days of respite. Respite is important, but if the entire context of the care-giver and care-recipient is not considered, it may actually be more stressful to each to return to a routine after such "respite." Thus, a collaborative approach utilising allied care professionals may have longer-term benefits for both care-giver and care-recipient than isolated respite provisions. Again, in terms of funding models, short vs longer-term solutions must be recognised, and the cost-savings as well as personal gains of increased time of care at home and living in the community require examination. In addition, physical and mental ill-health among carers is well-documented, is a significant cost and is another potentially-addressable point if the system is structured to a more holistic conceptualisation of "respite, reablement and restorative care."

Crisis management is another consideration, but in our opinion the approach advocated above, namely proactively providing skills and coping mechanisms, as well as environmental modifications and strategies for care-givers can avert many crises, and serve as a pro-active rather than a re-active solution to such issues.

Notwithstanding the above aged care interventions for people experiencing a crisis or sudden change in their circumstances includes: hospital care at home or nursing homes; old age psychiatry, geriatric or palliative care at home or nursing homes; the Dementia Behaviour Management Advisory Service (DBMAS[3]) at home or nursing homes; and emergency respite care. We recognise that providers may need additional training to meet the health or behavioural needs of its residents. This should be considered an investment, one that not only delivers benefit to older residents but supports a residential aged care facility to meet the National Aged Care Quality standards 5 and 7.

***ACDHS recommends***

- *Funding should be attached to additional needs. Those who require intensive and longer-term restorative and respite care for example should attract additional support.*
- *Investment in mechanisms that re-orient the quality of aged care services towards a model that recognises evidence-based early interventions, especially those that would reduce acute care episodes and improve the quality and safety of care provided.*
- *Future funding models recognise preventive, reablement and restorative care, including care provided by allied health.*

**Care stream**

The integrated stream concept is sound. Care can be provided irrespective of setting in such a model, and has many advantages, most notably within familiar contexts which provision of services in the home provides. Integrated care recognises the importance of delivery of services based on need regardless of where an older person is located.

Further, allied health professionals work to minimise facets of institutional care that hinder functionality: over-medication; unfamiliar, disorienting surroundings; lack of engaging, familiar activities, routines and stimulation. The concept of "short stay reablement" must be the focus, rather than a return to the option of "at home' versus "institutional" care. This would in the long run

[3] The Dementia Behaviour Management Advisory Service (DBMAS) is a national free service funded by the Australian Government. It is operated and administered by Dementia Support Australia (DSA).

save in cost,[4] as many conditions (delirium, falls, etc.) can be addressed with short term targeted care without permanent placement.

**Specialist and in reach services**

For care to be matched well to individual circumstances a range of services may need to be co-ordinated, or depending on the complexity of need, integrated by pooling resources from multiple systems. Trained to support healthy ageing, restoration and reablement, and qualified to recognise the likely progression of frailty, allied health professionals are ideally suited to work with and support other health practitioners in addressing the complexity of care needs of older persons.

Case manager or care coordinator models are needed for older people with complex care needs. To ensure greater uptake of in-reach health services adopting a 'care team' approach would see deployment of system navigators, case managers working in collaboration with allied health professionals facilitating knowledge sharing and improved planning processes.

Interprofessional teams could deliver such complex care, and be located in community care centres or private practice and provided as in-reach to residential aged care facilities. ACDHS member universities provide interprofessional education[5] (IPE) as an essential component of clinical training across a range of health science programs. One example of IPE in Australia is a six-bed student training ward (STW) which was established in 2010. The STW operates within a 26-bed general medical ward at Royal Perth Hospital. Final year students from medicine, nursing, occupational therapy, pharmacy, and physiotherapy undertake all ward duties as an interprofessional team. Facilitated group learning sessions and reflective practice complement profession-specific and generic tasks. Curtin University is the leading partner in this STW. Partners include four other Western Australian universities, Country Health Service, and Health Consumers Council, reinforcing the concept that collaboration across the health and education sectors is necessary for the implementation of large scale IPE projects. However, exposure to aged care facilities is limited in allied health professional placements offered by universities as often only "on call" private consultants are used in this capacity in residential facilities especially. (For example, a dietitian may consult on a menu but not provide services to individuals.) In this scenario, the limited supervision does not meet the accreditation requirements for professional placements and there is no incentive for private practitioners in any discipline to take university students and therefore current exposure to these settings is limited. (This is a similar situation with NDIS where most providers are privately employed in small or large businesses.)

***ACDHS recommends***

- *That Government invests in supporting collaborative approaches for educators and providers to embed interprofessional models of care.*
- *Investment in residential aged care facilities is required to ensure students have access to supervision, to gain relevant practice experience in these settings. This may include incentives for allied health professionals in private settings to facilitate student placements or incentives for the aged care provider to create suitable supervision environments.*

**Designing for diversity**

Funding needs to be equally distributed to older people from Aboriginal and Torres Strait Islander

[4] Pezzullo L, Streatfeild J, Hickson J, Teodorczuk A, Agar MR, Caplan GA. Economic impact of delirium in Australia: a cost of illness study. *BMJ Open*. 2019;9(9):e027514. Published 2019 Sep 17. doi:10.1136/bmjopen-2018-027514

[5] "Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care *UK, Centre for the Advancement of Interprofessional Education, 2002*

backgrounds and culturally and linguistically diverse backgrounds. Family carers of these populations share a higher care burden in navigating and accessing services and in providing care at home. Many Indigenous people are reluctant to seek care in their later years and many barriers currently exist that prevent Aboriginal people from seeking aged care. Yet there are examples of culturally sensitive programs delivering outcomes for Aboriginal and Torres Strait Island peoples. Booraja, a regional home care program specifically created for ageing Indigenous people in Eurobodalla and the recipient of Commonwealth funding won two awards for service excellence and innovation in 2019,[6] is one such example.

A system for care of *LGBTIQ,* Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse backgrounds should be predicated on the principles of co-design. As aforementioned there are some excellent examples of innovative practice delivering culturally responsive quality care to diverse populations.

Delivery of safe and inclusive services to people with diverse needs and life experiences is built into the Aged Care Quality Standards. Diversity is woven through the standards and underpinned by Standard 1 to value the identity, culture and diversity of each consumer and to deliver culturally safe care and services. The Aged Care Quality and Safety Commission assess aged care providers based on the quality of service experienced by service users.

We note the Aged Care Diversity Framework and the range of resources developed to support the Framework.[7] However, we recommend the development and implementation of specific programs and campaigns that assists providers to fully implement the Diversity Framework.

***ACDHS recommends***

- *Systems for addressing the unique needs of culturally diverse populations be based on co-design principles.*
- *That the Government invests in programs and campaigns that assist all providers of aged care in implementing the Aged Care Diversity Framework.*

**Financing aged care**

We argue that rather than the current 'deficit model' that provides payment for people with on-going illness and ailments, a social model to provide standard funding to meet individuals' needs, across the entire system of aged care, and additional funding if their needs require additional care or interventions be adopted. Funding should 'follow the individual', be person-centred and be subject to regular input from families.

We note the current trial of a new model of funding – the Australian National Aged Care Classification (AN-ACC). We acknowledge the AN-ACC model is an improvement on the ACFI. A system that incentivises people who experience increased pain, disability and frailty to gain additional funding does not support healthy ageing and potentially results in costly, unnecessary hospitalisations. Specific financial incentives for preventive, reablement and restorative care must be built into future funding of the system.

At the same time, a shift from block funding to a client-directed care model, with funding tailored to meet the individual's specific needs can have unintended consequences for older people who may find themselves unable to access the services they need. The findings to the Tune Review of the

[6] Illawarra Retirement Trust https://www.irt.org.au/about-irt/get-to-know-us/latest-news/irt-foundation-wins-national-award-for-indigenous-home-care-program/ viewed 21/1/2020

[7] Shared actions to support all diverse older people A guide for aged care providers (2019) Commonwealth Government

NDIS[8] where people with disability have reported poor experiences when working with NDIA staff, particularly with transparency, consistency and timeliness in decision-making provides lessons from which a future aged care system can learn.

***ACDHS recommends***

- *That future funding of the aged care supports a healthy ageing model.*
- *That financial incentives for preventive, reablement and restorative care be included in any future model*

**Quality regulation**

Oversight of all contexts of care, from home to hospital to institution, could be assisted if a review panel composed of lay persons, family members, and expert providers were an integral part of any accrediting and / or regulatory system. Moreover, moving to funding and support for positive rather than negative outcomes, to provide proactive versus reactive care solutions, and to make all efforts to have an older person age within their community would be key principles of such an approach.

Education providers have a key role here, across university and TAFE sectors, to provide not only health care professionals but managers trained in healthy ageing principles as well as management of challenges in later life. Further, ways of working together as a team, with fit for purpose models of care applies both to management as well as clinical care systems.

Redesigning the aged care system in Australia must involve a rethinking of values and expectation of growing older, how older adults can maintain productive engagement and life within communities, and how conscious or unconscious age biases can negatively impact well-being in all contexts, including health care.

The Commission has made an excellent start on re-envisioning aged care in Australia. We as a major provider of training for a broad variety of relevant disciplines look forward to continued engagement with this process.

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[8] Review of The National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing The NDIS Participant Service Guarantee (2019), Commonwealth Government