GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

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Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Sustainable Health Review – Public Submission from Amana Living Inc.

1. ***Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition***

   Access to specialist, medical assessment (e.g. GPs after hours) is a major issue for elderly clients living in the community and in aged care facilities. To achieve improved patient centred care and to avoid hospital admissions after hours, there should be:

   - Greater investment in Urgent Care Clinics (UCCs) that are located metro-wide and can provide assessment, treatment and referral to allied health services (radiology, pathology) and can transition potential emergency patients into appropriate community based services, by-passing Emergency Department (ED) presentations. Amana Living is trialling a hospital avoidance model with Apollo Health UCC in Cockburn, across two aged care facilities, to reduce hospital admissions. By establishing a collaborative working arrangement between the aged care facilities and the UCC, primary health staff who are engaged with treating older patients can also develop a holistic understanding of their health/care needs with better outcomes achieved for the patient;
   - Better promotion and expansion of (Blackwell) “The Collaborative” model across the primary health sector, which provides direct, 24 hours, 7 days a week access to GPs or Nurse Practitioners for primary health assessments and treatment. Amana Living is working in partnership with ‘The Collaborative’ to refer residents/clients who require medical attention, as an alternative to an ED presentation and potential hospital admission;
   - Options for GP’s to directly refer/admit patients to rehabilitation programs or other support programs (e.g. Rehabilitation in the Home - RITH). Often GPs are unable to initiate these services, which if utilised at an early stage may prevent further deterioration of the patient’s condition.

2. ***The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public***

- There are a range of current programs (broadly termed 'hospital avoidance and early discharge' programs), that could supplement or replace hospital based services, that can be delivered at a much lower cost in the home, or in an alternative residential setting (e.g.an aged care facility), and that should be expanded, such as:
  - Interim Hospital Packages (IHP)
  - Hospital in the Home (HITH)
  - RITH
  - Transition Care/Care Awaiting Placement (approximately 1% [11 out of 1,000 patient days] of hospital admissions nationally are awaiting residential aged care[1])
  - Short Term Restorative Care (STRC - Federal Government)

  Funding needs to be redirected towards expanding these community based health, allied health and aged care services, as they offer cost efficient alternatives to hospital based acute care;
- Opportunities exist to develop and increase community and partnership models particularly in the areas of sub-acute and non-acute care, rehabilitation, mental health and palliative care, which have the highest national average length of stay[2];
- Mental Health resources in the community are extremely stretched. There is a significant gap in the availability of community based mental health services and access to mental health expertise in WA. Hospitalisations occur because there is a lack of focus on early identification, intervention and prevention of high prevalence mood disorders in the elderly, and a lack of clinical services in the community to support patients to maintain their conditions in a stable manner. Improved management of mental health patients in the community will reduce acute episodes, often associated with longer periods of hospitalisations and thereby reduce the cost of acute care;
- There is a gap in medical outreach services that provide triage support for urgent medical assessments that should occur at home or in residential aged care (e.g. infectious diseases, gastro outbreaks). These usually result in ED presentations because of the need for urgent clinical assessment, treatment ((e.g. rehydration) and access to radiology and/or pathology services. An investment in the training of additional nurse practitioners that can be utilised for this purpose, may also reduce reliance on scarce GP resources after hours;
- There needs to be better access to specialised palliative care in the community via suitably trained GPs, nurse practitioners and specialist nurses. In WA, Silver Chain is the main community based palliative care provider. There should be a range of options available in the community with greater flexibility in service provision and more choice for the user.
- It should also be recognised that aged care facilities provide excellent palliative care and are a great resource to the community. Instead of palliation being provided in hospital (fourth highest length of stay as noted above), aged care facilities could be contracted by the Health Department to provide palliative care units, at their facilities;

[1] Australia's Hospitals 2015-16 ***at a glance*** Pg. 28

[2] Australia's Hospitals 2015-16 ***at a glance*** Pg. 18, Fig. 17

- A shortfall in the system is that patients who are too ill and palliative and cannot visit their GP, and if their GP does not do home visits, must rely on a locum doctor or community nurse to refer them on to relevant palliative care services.

3. *Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance*

The use of technology and digital innovations can assist and support the delivery and monitoring of patient centred care in the community. Noting that in 2015-16, the AIHW Australia's Hospitals 2015-16 *at a glance report*[3] stated that 6.4% (678,000) of admissions nationally were thought to be potentially preventable admissions, digital options should be explored for use within the health and aged care sectors, for example:

- Amana Living is involved with Telstra in trialling the use of tablets to monitor the care and safety of clients living with dementia, in their home. If successful, this technology will be more widely used for improved care interventions in the community. Could this be applicable for people suffering from chronic and complex health conditions that result in multiple presentations at ED? Could people with chronic health conditions, who are high users of acute care, be screened and subsidised for the provision of digital innovations that assist them to manage their health care needs better in the community and prevent hospital admissions?
- There is a smart phone app, "My Emergency Doctor", which allows access to an emergency Physician who can video conference with a patient in an urgent medical situation, to conduct an assessment, prescribe medication, treat and advise whether attendance at an ED is necessary. Services are charged directly to Medicare for residential aged care residents who have been referred to the My Emergency Doctor service. This direct contact, screening and assessment by a doctor potentially reduces unnecessary ED presentations. This app is also ideal for use in remote areas where access to a GP after hours is limited, often resulting in higher hospital presentations;
- The use of Telehealth should be promoted more widely. To encourage greater use of Telehealth, education, direct support, financial incentives and partnerships should be made available to potential users that would benefit from this technology;
- Mobile radiology units can potentially save admissions to ED for diagnostic purposes;
- There should be better sharing of digital hospital records with GPs (e.g. pathology, radiology, discharge summaries) when patients are transferred home, or to residential aged care facilities. This supports the maintenance of safe, quality care in the community. Lack of access to these records can result in medication and treatment errors, or duplicative procedures being performed (e.g. blood tests, x-rays). Although not a direct cost to the hospital, these additional procedures are a cost to the overall health system and they also subject patients to additional, possibly unnecessary and/or, invasive procedures.

[3] Australia's Hospitals 2015-16 ***at a glance,*** Pg. 28

4. *Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care*

- Duplication of care and the cost of care will be reduced and the quality of care improved through the development of more integrated, coordinated care models across the health and aged care sectors. This will rely of partnerships and agreements between all players particularly, Federal, State and Local Governments, public and private hospitals, GPs, allied health providers, aged care providers, health insurance providers etc. It will also require the breaking down of program boundaries and funding criteria (or restrictions). Amana Living is keen to work in partnership with WA Health Services to explore innovative models that achieve better integration and coordination across health and aged care and better outcomes for older people living at home and in residential aged care;
- An example of an integrated model that reduces hospital bed days is the $200m *Murdoch Health and Knowledge Precinct* which will include a 60 room Medihotel, a 150 places aged care facility, a medical super clinic, short stay accommodation and 175 residential apartments, with 30% zoned as affordable housing. The Medihotel is designed for patients that no longer need full-range hospital treatment, but can't return home. The overnight cost at the Medihotel is estimated to be less than $200 versus $1,800 plus in an acute hospital;
- Vacant ex-hospital sites, such as the Swan District Hospital, provide an opportunity for the development of integrated, coordinated care sites. Similar developments should be considered in each region adjoining a large public hospital facility;
- The transition care program has been operating in WA for many years, yet there are still elderly people 'in situ' in hospital awaiting entry into an aged care facility. This program may need to be expanded and options considered, in negotiation with the Federal government, for the allocation of a small number of 'care awaiting placement' beds at aged care facilities. These can be allocated to ACAT approved older people who are unable to return home due to their care needs and are awaiting a permanent residential aged care place. These places should be in addition to the allocation of 'permanent' aged care beds, be available on a temporary, short term basis (to allow for the flow through of ex-hospital patients) and be subsidised by the federal government, as occupants must be approved for residential aged care and therefore legitimately require a residential place.

5. *Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies*

- There needs to be improved funding for primary care through the Medicare Benefits Schedule so that GPs have incentives to take on complex care clients that require more time, a higher level of intervention and greater coordination of their physical, mental and psychological health and social/family well-being needs. Better management of these patients in the community will drive quality care, improve patient safety and minimise medical emergencies arising, for which acute care responses may be required;
- Access to more nurse practitioners to coordinate complex care clients in the community will also provide greater value, long term sustainability and support our limited, time constrained GP resources in WA;
- There should be more incentives to utilise nurse practitioners, such as, the introduction of more MBS options (currently there are only 4) and better reimbursement for services (nurse practitioners receive less than 50% of what a medical practitioner is reimbursed). The State Government can employ nurse practitioners to provide mobile, comprehensive, community based services.

6. *The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring*

- Often the lack of competencies to manage care in the community results in patients being re-admitted to hospital. An example of this is the safe and competent management of post-surgical wounds and stoma care. Community based clinical staff need more training and education in some areas of complex, post-acute care management.
- At present hospitals presume that all residential aged care facilities (RACFs) have nurses on duty 24/7, which is not always accurate. The HITH program should be extended to low care RACFs and/or to all RACFs after hours to support the early discharge of acute patients from hospital (e.g. stoma care, post op, chronic wound management);
- Patients are often discharged following an acute episode on the expectation that the residential aged care facility can provide sub-acute care - which they can't!
- There is a need for more for more psycho-geriatricians to address mental health issues with regards to acute psychiatric health care.

7. *Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system*.

- Carers and family members who look after older people at home, some with complex co-morbidities, dementia and mental health conditions, which can be further exacerbated by an acute care episode, require more support to manage post-acute care for the person at home. If the patient is non-ambulant, it presents further issues for the carer to get them to medical or allied health appointments. Support to the carer in providing follow up post-acute care in the community should be better resourced;
- There are 33,300 people living with dementia in WA and this is projected to triple to 69,000 by 2050. To support our clients with dementia, Amana Living introduced the McCusker Nurse program in 2011, which is generously funded by the McCusker Foundation and provided at no charge to the resident/client. Over 2,000 clients have been assisted by our two registered McCusker Nurses, who specialise exclusively in the care of people with dementia, providing education about dementia, information about services, tools and strategies to assist manage responsive behaviours and advice to staff about appropriate, responsive care interventions. The outcomes achieved by this program include:
    - Promoting quality care for people with dementia by ensuring the right interventions and care strategies are employed;
    - Maintaining older people with dementia at home for longer by supporting their carers;
    - Potentially reducing hospital presentations by preventing crisis situations from escalating.

  This program has received positive feedback from GPs. If funding was made available to expand and broaden the scope of this program (similar to the State funding made available for nurses to support Parkinson's patients in the community), it will enhance patient centred service delivery, better support and maintain people with dementia in the community and reduce reliance on comparatively more expensive acute care interventions.