



Cross-sector care simulation 2016

**Reform processes and the interface between disability services,
aged care and health**

November 2016

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1 Executive Summary

The Australian Healthcare and Hospitals Association's (AHHA) cross-sector care simulation held in Brisbane on 20 October 2016 tested policy initiatives at the interface between the disability, aged care, community and health sectors with the aim of developing recommendations to support greater integration and patient-centred care.

Recommendation 1: The Australian Government facilitates a meeting of governments and peak bodies representing the disability, aged care, community and health sectors to develop clear, defined and shared policy objectives for optimising care and outcomes for people requiring services across some or all of these domains.

Recommendation 2: Governments (Commonwealth, state, territory and local), health and welfare providers and other key stakeholders collaborate on: analysing the interactions between the Health Care Home trials, the aged care reforms and the National Disability Insurance Scheme; examining alternative systems of person-centred care used in other countries. These analyses are to be conducted with a view to: identifying shortfalls in the Australian approach; identifying policy and program alternatives to optimise the Australian consumer experience in navigating the disability, aged care, community and health sectors.

Recommendation 3: Governments and private fund holders jointly consider examples of funding-by-outcomes and funding for results schemes for application in Australia. Such schemes could involve the use of 'virtual bank accounts' for patients and their families as a mechanism for choosing their service mix from a predetermined total level of assistance. Current work by the International Consortium for Health Outcomes Measurement can inform this work. The most promising options in an Australian context should then be offered for sector and community consideration and input.

Recommendation 4: The Australian Government, in consultation with the states and territories, leads the establishment of better channels of cross-sector communication and cooperation among funders, consumers, providers and stakeholders. This is to be done with a view to implementing a formal mapping of the intersections between disability, aged care, community and health sectors, and between Commonwealth, state, territory and local governments, private sector and out-of-pocket sources of funding.

This mapping is to be done with a view to future cooperation on planning and co-design of a reformed, well-managed, coordinated and more flexible system to deliver the combination of services and care increasingly needed as a result of the rise of chronic diseases, disability and an ageing population.

Recommendation 5: Governments consider reforms to current funding arrangements and associated reporting mechanisms to encourage disability, aged care, community and health services to better identify and support complex care needs as early as possible.

Recommendation 6: All parties acting on Recommendations 1–5 and 7 use as a guiding principle that reforms are directed to the 'wellness' or 'wellbeing' of patients, in line with the World Health Organisation definition of health as 'A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.

Recommendation 7: All parties acting on Recommendations 1–6 use as guiding principles that, in addition to providing quality of life benefits to care recipients, reforms must also be cost-effective. Demonstrating both aspects may require data development initiatives covering met/unmet need for care, cost of services, and national economic benefits.

2 Overview

The Australian Healthcare and Hospitals Association's (AHHA) cross-sector care simulation held in Brisbane on 20 October 2016 tested policy initiatives at the interface between the disability, aged care, community and health sectors with the aim of developing recommendations to support greater integration and patient-centred care.

The simulation was based on the premise that the Australian healthcare and social welfare sectors are under-prepared to deal with rising rates of chronic disease, disability, and an ageing population. Government responses to these issues have included the establishment of programs such as the Health Care Home trials to be rolled-out across 10 Primary Health Network (PHN) regions, individual aged care funding packages and the National Disability Insurance Scheme (NDIS).

Although such innovations are welcome, care across the disability, aged care, community services and health sectors is fragmented in terms of service delivery and funding responsibilities. System changes are needed to ensure the delivery of comprehensive and integrated person-centred care, with appropriate communication and transitions between care providers.

Providing such care across the entirety of the patient journey will yield the best outcomes for patients, providers and systems, as well as generate system efficiency gains.

3 Simulation aims and structure

The simulation aimed to test policy initiatives at the interface between the disability, aged care, community and health sectors; with the aim of developing recommendations to support greater integration and person-centred care.

Three teams, each consisting of approximately 30 invited participants, were asked to work through three scenarios over the course of the simulation. The scenarios focused on:

1. Funding mechanisms, and timeliness and appropriate access for patients
2. Service delivery models and workforce issues
3. Technology to improve patient outcomes and developing a shared planning mechanism.

Wherever possible, participants were 'cast' in roles equating to their current employment within the Australian healthcare system (see Appendix 1 for participant roles).

Each team was assigned a discussion leader and rapporteur, and all participants received pre-reading material and specific role briefings.

Participants worked through the scenarios, seeking to answer the overarching research questions, while also being cognisant of their individual roles and role objectives.

Learning in a simulation occurs not only through what people say and offer as ideas, but through closely observing and reviewing the interactions between the participants. These interactions can expose potential gaps in processes and service provision, as well as unintended consequences.

4 Results

Details of the three scenarios, together with respective discussion points, suggested innovations, and hurdles and barriers, are available in Appendix 2.

5 Discussion

A substantial number of observations were made throughout the day in the discussion points, suggested innovations, and hurdles and barriers raised by participants (as set out in Appendix 2). It is readily apparent that this free flow of ideas, and the resulting interactions, covered a very wide range of subjects and viewpoints. Nevertheless, the following recurring themes were prominent:

- Shared purpose and values
- Person-centred care
- Funding by outcomes
- Competition to collaboration
- Early identification and prevention
- Outreach services
- ‘Wellness’ rather than health
- The role of system wranglers/navigators
- Financial justification

5.1 Shared purpose and values

Simulation participants generally agreed that as a community we need to place more value on older people and people with a disability. We need to have a shared purpose, and better definitions of what we actually want for people who may need services traditionally provided by permutations and combinations of the disability, aged care, community services and health sectors.

We also need to have better definitions of acceptable timelines and appropriate access, and in terms of accommodation, recognise the desire of most people to remain in their homes wherever possible.

Also raised was that politicians and governments often underestimate the willingness of the public to tolerate higher levels of taxation and other means of government revenue-raising if the clear pay-off is better healthcare and social welfare services for everyone.

Participants suggested goals such as reliable, evidence-based care, with no unwanted variation, that was coordinated and accessible.

Summary: Any reform of funding and care provision at the interface between the disability, aged care, community and health sectors needs to be guided by a clear, defined and shared purpose, and unambiguous definitions of what we as a community and as a nation are trying to achieve in terms of outcomes, timeliness and access.

5.2 Person-centred care

Person-centred care was a prominent theme in discussions on ways forward from the current disjointed system.

‘Think about the person, not the bed’ was one catch cry, in addition to ‘self-determination’, and ‘we have coordinators for body parts, but not for the whole person’. Other contributors to the discussion were concerned that individual ‘fund-holding’ (a feature of person-centred service models such as the NDIS) was not for everyone, although it empowers many.

Many participants were concerned that care systems should engage with each person’s unique needs, and that there was no single solution, no ‘one size fits all’. Diversity and differing system provision levels had to be respected and taken into account.

Many observers were concerned with 'patient activation'. More specifically, this is about patient motivation and behaviour change, some of which could come from programs designed to increase health and digital literacy in patients so that they could better navigate the various systems in deciding, in consultation with health and welfare professionals as necessary, the particular product or service mix that was best for them.

Equity was also raised. For example, inequities could result from location, with lack of available services close by—a flat rate of payment for a service may not go far in a very remote area compared with an urban area. Needs-based inequities may mean that, for example, a blanket payment might not meet basic needs for some, while resulting in 'cherry-picking' of services for others.

Similarly, person-centred care systems would have to take account of variable workforces around the country, and be based on enhanced relationships and understandings among the various healthcare and social welfare sectors.

Summary: Person-centred care was seen as the key to patients using services best suited to them at the level they needed, leading to less wastage and better patient outcomes. It was also seen as the key to taking account of individual circumstances, including factors such as remoteness, and differing availability of suitable staff and infrastructure.

5.3 Funding by outcomes

Funding being paid to care and service providers according to patient outcomes was seen as a corollary to person-centred care. It would lead to greater transparency, accountability and flexibility in where and how funds were spent, encourage the purchase of value-for-money options, and discourage the purchase of services by patients that were of questionable benefit to them for their particular circumstances. Greater flexibility in funding could also lead to greater innovation and capacity building in treatment and care regimes. Funding by outcomes was also seen as discouraging expensive funding micro-management.

Ideally, outcomes would have to be clinically reported as well as patient-reported.

To enable funding-by-outcomes, there would need to be a redistribution and loosening of the boundaries between Commonwealth, state, territory and local governments, and private financial flows. It might be prudent to establish 'virtual bank accounts' for patients and their families as a mechanism for choosing their service mix from a predetermined total level of assistance.

A culture change may be required among governments and some care and service providers. Most operate under long-standing service provision funding models that are not ideally suited to delivering person-centred outcomes funding.

Summary: Funding by outcomes was seen as a natural corollary to person-centred care. It has many potential benefits in terms of transparency, accountability and efficacy. But this would need wholesale sweeping changes to current funding systems, and attached accountability systems for public money. This suggests that outcomes funding is a solution for the medium to long term—stop-gap funding solutions may need to be implemented in the meantime.

5.4 Competition to collaboration

Simulation participants saw current disability, aged care and health and community services as often competing with each other, with each type of service often having specific and rigid limits as to what they could and could not do. This led to some patients 'falling through the cracks' and unable to get

suitable support at a reasonable cost, or getting too much of a service that they did not particularly want or need.

Competition was seen as reinforcing existing sector and funding stream 'silos'. 'We educate in silos, we work in silos, we don't get paid for collaborating and communicating, we only get paid for treating people' was one sentiment expressed.

Participants saw a loosening of the boundaries between service sectors and between funders, consumers, providers and stakeholders, as fundamental to effective reform. This would involve establishing better channels of cross-sector communication and cooperation, and a change of emphasis in healthcare training from a 'sole practitioner' to a 'team member' approach.

With a loosening of boundaries the various parties could then cooperate on better mapping of the intersection between health, disability and aged care, and between Commonwealth, state, territory and local governments, private sector and out-of-pocket sources of funding.

With a shared understanding of what was currently in place and what had to be achieved, the parties could cooperate on planning and co-design of a new, well-managed, coordinated and more flexible system to deliver the combination of services and care increasingly needed as a result of the rise of chronic diseases and disability, and the ageing of the population.

Simulation participants also observed that in collaborating on a new solution, all parties had to be cognisant of alignment with Commonwealth and state and territory legislation, industrial relations laws, enabling infrastructure such as the National Broadband Network and general community infrastructure. Changes to legislation would likely be required.

Summary: A move from competition and 'silos', to cooperation and breaking down of barriers, is essential to beginning the process of reform at the interface of the disability, aged care, community services and health sectors.

5.5 Early identification and prevention

'How do we find them earlier?' was a sentiment expressed repeatedly at the Simulation concerning people likely to have complex future care needs related to ageing, disability and chronic diseases.

Health practitioners and service providers strongly supported early detection of possible emerging health problems and implementation of prevention strategies as keys to avoiding larger health problems later.

The potential of funding Primary Health Networks to perform these functions was discussed, along with the potential of other sources of primary care such as after-hours drop-in centres, nurse walk-in centres, and telehealth e-consultation schemes.

Summary: Prevention and early identification activities were seen as having a large potential benefit in terms of mitigating health and welfare problems that could potentially be resource-intensive later if left undetected. Therefore prevention and early identification were seen as a vital component of any reform package or system catering for complex care needs related to aged care, disability and chronic disease.

5.6 Outreach services

Formal and systematic outreach services to residential aged care facilities from different sources such as GPs, hospitals, paramedics, psychologists and ambulance services could potentially detect

and/or treat problems before they became more serious, or needed hospital admission. Prevention strategies could be part of this service mix.

Summary: There was support for a broad set of outreach services to be provided within aged care settings on a regular and systematic basis to meet care needs and reduce hospital admissions.

5.7 'Wellness' rather than health

The intersection of aged care, disability and chronic disease encompasses more than 'traditional' concepts of health based on diseases and contributing conditions and symptoms. For example, two patients with identical conditions in terms of disease could have entirely different outcomes depending on whether they had supportive families willing to assist, or whether they were well-off financially or otherwise.

Simulation participants were therefore keen to see reforms directed to the 'wellness' or 'wellbeing' of patients, in line with the World Health Organisation definition of health as 'A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.

Other concepts mentioned were 'quality of life' and 'equity', that is ensuring that no matter their age, disability or illness, people were able to have the same experiences, the same sense of community and the same qualities of citizenship as anyone else in the community.

Summary: Successful services and care at the interface of the disability, aged care, community services and health sectors involves considering the full spectrum of physical, mental and social wellbeing rather than just diseases or health conditions alone.

5.8 The role of system wranglers/navigators

'System wranglers', also known as care coordinators, system navigators, nurse navigators, outcome facilitators and similar, are a response, some say a market response, to the complexity of the various care systems and funding streams available. These systems and streams can be notoriously difficult to navigate—both within and across.

In line with their general commitment to person-centred care, simulation participants favoured an empowerment model, where wranglers enabled patients and their families to make optimal choices for their care within their current circumstances. Wranglers also had a role in empowering and enabling providers to operate effectively across care systems.

Because 'one size does not fit all', some patients would likely benefit more from wrangler intervention than others. In addition there can be various levels of wrangling, from navigation and coordination up to 'going into bat and advocating'.

Participants also noted that wranglers could be associated with multiple points of entry into a care system or combinations of care systems, whether it be through Centrelink, primary care, a hospital or other facility. In this vein, there was general agreement that, currently, wranglers in Australia work in 'pockets'—they are not spread evenly throughout care systems and regions.

Participants raised the question of whether there was an economic justification for wranglers, also saying that it may only add another complexity to an already complex system. But there was general agreement that technology was of limited assistance in the absence of fully portable health records and flows of privacy-protected information between services, and no 'wrangler app' was available.

There was general agreement that those with previous experience of navigating the system(s) themselves were in the best position to 'wrangle' a good solution for others in need. There were also

suggestions that wrangling could be a role for Primary Health Networks, as long as the role was funded.

Simulation participants felt that raising patient visibility through having their information accessible across the patient journey was essential for an efficient and well-coordinated service and care mix in the future. Nevertheless, current information flows still need to be up to date to wrangle effectively, and that care systems should make it their business to learn from wrangler experience.

Summary: For some individuals, there is currently a need for system wranglers or care navigators, especially in the absence of development of a reformed system that better lends itself to well-coordinated technical solutions. Learning from the experiences of wranglers should be essential when developing new systems to cater for people accessing services at the interface of the disability, aged care, community services and health sectors.

5.9 Financial justification

Any future reformed system of care at the interface of the disability, aged care, community services and health sectors will need to be justified in terms of its economic benefit, while also acknowledging that the demand for this mix of services and for resources will inevitably rise with the ageing of the population.

On a per person basis however, one should not take the view that the solution is 'more money' alone, particularly if a reformed system results in cost savings and less waste. Simulation participants argued that a longer term view must be taken, as was done for the NDIS, because as with any wide-ranging reform, changeover costs will be initially high.

In terms of justification, appropriate data would be needed on the current costs of services provided and on current and projected future levels of met and unmet need.

Summary: Any reform of care services at the intersection of aged, disability and healthcare will need to have demonstrated economic benefits.

6 Tensions

A number of tensions ran through discussions in all three scenarios highlight complexities of the issues involved in the current reforms. These included:

Centralised versus local planning: The need to balance the centralised and local planning of services was a theme that emerged a number of times during the day. Overall, there was support for a system-wide changes and a centralised approach which would ensure all consumers had the same opportunities to access the care they needed. However, it was also noted that the nature of complex patients was that every person had a unique set of needs and that they all required individual solutions which also needed to take into account their local environment. This was seen as limiting the extent to which standardised and centralised approaches could be used effectively to meet individual consumers' needs. As one participant representing a primary health care organisation stated 'complex and wicked problems cannot be managed centrally'.

Privacy versus sharing information and data: Participants recognised that improved coordination of care across services and sectors required developing better ways of sharing data, including medical records and personal details. However, the need to respect consumers' privacy was also highlighted, particularly in relation to sensitive medical and personal details. Participants noted that the increased use of technology in sharing data created an increased risk of privacy breaches and that this highlighted the importance of ensuring that consumers maintained control over who could access their health data and that they were able to make informed choices about this issue.

Competition versus collaboration: Participants discussed the potential for consumers to benefit from increased competition in a number of areas of health, aged and disability care. A more market-based approach to the delivery of services was seen by many as having the potential to increase choice and provide more consumer-centred care. However, it was also noted that competition between providers could be a barrier to increased collaboration, which is another goal of the reforms. One example provided in relation to this was that hospitals and general practices may see themselves in competition to play a fund holder role for complex patients and therefore may not want to share information about these patients which would diminish their competitive advantage.

System navigators versus simplification: The need to support consumers (and/or carers and families) to take on additional responsibilities for coordinating and overseeing care was recognised and one solution discussed was to create a new 'health system wrangler' role. While participants acknowledged the potential benefits of this role for some groups of consumers it was seen as in tension with the competing goal of reducing the number of 'layers' within the health system and minimising the number of points of contact between services and health care providers. Some solutions suggested to resolve this tension were to restrict the use of 'health system wranglers' to those consumers who genuinely need them while ensuring other consumers receive the information and support they need without adding another 'layer' to the health system (for example through providing them with additional information about their options in a consumer-friendly format).

Empowering versus exploiting families and carers: The central role of families and carers was discussed by participants with many stating that they were an unrecognised and under-utilised resource within the health system and had the potential to play a greater role in supporting consumers to access the care they need. For example, some consumers stated that their families and carers knew more about their condition and needs than any of their service providers and that they would prefer their current carer to take on the role of a 'health system wrangler' rather than a third party. However, counter-balancing this was an awareness of the need to relieve families and

carers of some of their current burden of care and that the goal of the reforms should be to ensure that consumers can access the care they need without requiring family members to step into the service provider role. As one family carer put it “sometimes family members should be allowed to just be family.



7 Recommendations

For reforming care at the interface of the disability, aged care, community services and health sectors, the following recommendations to start the reformation journey arose/emerged from the simulation:

Recommendation 1: The Australian Government facilitates a meeting of governments and peak bodies representing the disability, aged care, community and health sectors to develop clear, defined and shared policy objectives for optimising care and outcomes for people requiring services across some or all of these domains.

Recommendation 2: Governments (Commonwealth, state, territory and local), health and welfare providers and other key stakeholders collaborate on: analysing the interactions between the Health Care Home trials, the aged care reforms and the National Disability Insurance Scheme; examining alternative systems of person-centred care used in other countries. These analyses are to be conducted with a view to: identifying shortfalls in the Australian approach; identifying policy and program alternatives to optimise the Australian consumer experience in navigating the disability, aged care, community and health sectors.

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This mapping is to be done with a view to future cooperation on planning and co-design of a reformed, well-managed, coordinated and more flexible system to deliver the combination of services and care increasingly needed as a result of the rise of chronic diseases, disability and an ageing population.

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Recommendation 6: All parties acting on Recommendations 1–5 and 7 use as a guiding principle that reforms are directed to the 'wellness' or 'wellbeing' of patients, in line with the World Health Organisation definition of health as 'A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.

Recommendation 7: All parties acting on Recommendations 1–6 use as guiding principles that, in addition to providing quality of life benefits to care recipients, reforms must also be cost-effective. Demonstrating both aspects may require data development initiatives covering met/unmet need for care, cost of services, and national economic benefits.

8 Appendix 1—Participant roles

Roles in each team included:

- Academic/researcher
 - Aged care advocate
 - Allied health provider
 - Commonwealth/State Department of Health
 - Community health service
 - Disability advocate
 - Disability service provider
 - E-health/health technology expert
 - General practitioner
 - Hospital and Health Service/Local Hospital Network
 - National Disability Insurance Agency
 - Nurse
 - Patient
 - Political staffer
 - Primary Health Network
 - Private health business
 - Residential aged care provider
 - Support worker
 - Workforce/training representative.
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9 Appendix 2—Detailed results by scenario

9.1 Scenario 1—Funding mechanisms; timeliness and access

Research questions

- How do funding mechanisms and differing fund holders impact upon the delivery of care?
- How do we define timeliness and appropriate access in terms of patient outcomes?

Policy initiative

The Commonwealth Government has released its 2017–18 Budget which includes provision of a \$1000 capitation payment per year for patients meeting eligibility criteria for a chronic disease or mental health package. This payment will be provided directly to individuals, and replaces all other payment forms and MBS items related to coordinated care.

Patient circumstances

A person with a mental health issue has an acute exacerbation of their paranoid delusions in May of 2018. They have accessed all the payments for their mental health package. The scenario will explore what happens next and which part of the system will help.

Discussion points raised

- Reforms to fund holders in healthcare will change healthcare and increase competition, but will be more reliant upon clients to navigate the system.
- Despite differing funding models changing behaviour, it doesn't necessarily address the lack of overall funds, workforce shortages, etc.
- We do have services, but not necessarily where needed—telehealth does not work with people with paranoid delusions, for example.
- Capitation model promotes minimalist approach as uncertainty in health means that you cannot predict the future. Need to reserve funds in case of exacerbation or deterioration.
- There is a risk that episodic payments may be required to top up capped payments.
- Innovations such as Health Care Homes make an organisation accountable. This is a potential game-changer as previously no-one was accountable for whole patient care.
- We are moving beyond a heavily regulated system to a trust-based system where organisations are being judged and need to be accountable—this is a big shift.
- Care must be person-centred—this will require a shift in clinician thinking.
- Collaboration is required between the person and their care team.
- Currently the healthcare environment is too provider-driven.
- 'Wellness' needs to be considered, not just physical health and illness.
- Siloing is an issue, and this is felt hardest by those with complex needs— these people have the most systems issues to navigate and may also be among the most vulnerable.
- Health literacy must be addressed.
- Care coordinators may be of benefit for some individuals.
- The influence that funding mechanisms drive behaviour.

Suggested innovations

- Many services delivered in acute care environments could be shifted with funds to the community setting to lower overall cost of care.
- Suggest developing an online e-market for services, to empower the client to make informed choices.

- Develop ways to flag/recognise those likely to fall through the funding gaps—early detection and intervention can lower overall costs.
- Use IT capacity to:
 - flag high users of services to provide additional support
 - avoid duplication
 - develop records
 - allow for connected monitoring (blood glucose levels, blood pressure, etc.) without need for face-to-face consultations
- Primary Health Networks have a role in coordination and communication in multidisciplinary teams.
- There is a role for local government in oversight of the social determinants of health and in developing healthy communities.
- Team-based care models that include the patient could be used for complex patients to avoid duplication and to improve collaboration and long-term planning.
- Patients to have a single point of interaction with the range of services available, not several.
- Quality and outcome measures evaluation must be included to minimise gaming and improve patient outcomes.

Hurdles and barriers

- Hospital funding is activity-based which fundamentally precludes shifting funding to the community.
 - Is \$1,000 enough? Is capitation even appropriate when patient needs vary? Blanket payments will result in cherry-picking and unmet need.
 - Currently our IT systems are not up to identifying those users most at risk of falling through the cracks.
 - Low levels of health literacy in complex systems
 - People with, for example, serious mental health problems, cannot make decisions involving complex systems.
 - Co-morbidities are often not reflected in current payment systems.
 - General practitioners may not always be aware of available services, therefore may not be the best care coordinator.
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9.2 Scenario 2—Service delivery models; workforce issues

Research questions

- How are patient outcomes affected by differing service delivery models?
- How do health and aged care workforce issues impact on the location and delivery of care?

Policy initiative

The State Government has announced that residential aged care facilities will no longer be required to have an on-site registered nurse 24 hours per day; and residential aged care facilities have advised that they intend to roster registered nurses only for 9 am – 5 pm shifts.

Patient circumstances

A resident has recently returned to their residential aged care facility after a short admission in their local hospital with recurrent urinary tract infections. The resident becomes unwell during the night with a raised temperature, dehydration and mild confusion. The resident's GP is unavailable at night and the on-site registered nurse is not due in until the morning, so an ambulance is called and the resident is returned to hospital.

Discussion points raised

- Important issues are access to care, decision support, information flow between providers, need for patient centred outcomes.
- Aged care is not supposed to replace people's access to healthcare. Many admissions are appropriate.
- Hospitals and aged care providers need to work together to reduce preventable hospitalisations.
- There should be pro-active mechanisms in place to enable prevention.
- Lack of appropriate funding/workforce means that optimal care is not always provided in an optimal location, reducing the quality of life of the resident. Negative stories emerge regularly about the low standard of care in some aged care facilities.
- Some hospitals 'shove' people into aged care or facilities for people with a disability rather than looking after people at home.
- Should it be aged care in the home or hospital in the home?
- State/federal government cost shifting.
- What is the cost of admission versus providing services to avoid admission? Do we know? There is very little research in this area around efficacy and costs of different models. Hospitals can potentially save money through well designed outreach programs, so what can we do to get them to consider them?
- Communication between aged care, acute care and primary care is disjointed, impacting patient care.
- What are the alternatives to taxpayer funding? If there are none, we will have more people in nursing homes/aged care.
- Create understanding through education, cheaply, on a national basis, delivered using modern communications technology.

Suggested innovations

- Utilise telehealth or an online consult so clients can be seen without leaving the premises or requiring home visits by a registered nurse, Practice Nurse or GP. This would also require client health information to be available online to allow access by relevant health care providers.

- On-call registered nurse at the residential aged care facility
- Aged care funding should be more like disability funding so that funding packages go to individuals rather than to services. This gives more flexibility and autonomy to consumers. Funding is currently not flexible.
- Hospitals having outreach or Hospital in the Home services to prevent expensive hospital admissions.
- Paramedic/ambulance outreach service.
- Community of practice, where general practitioners can have collective support and developing strategies to retain after-hour clinicians
- State-wide or national network of after-hours providers to solve problems and reduce hospital admissions.
- Set up a specific service that is used for nursing homes to prevent hospital admissions.
- Funding for aged care facilities based on quality markers.
- Workforce workarounds. Data exist to assess workforce shortage but maybe the focus should not be isolated to registered nurses, but instead should examine the possibility for a cheaper, more efficient workforce with additional roles for nurse practitioners to do care planning etc.
- General practitioner standing order, but this may also be associated with risks, utilising antibiotics when not needed may increase risk of anti-microbial resistance.
- Varying registered nurse hours, e.g. 4–11 pm shift would cover a greater amount of the night.
- The potential role of private health insurance in these circumstances.

Hurdles and barriers

- State/federal government cost shifting
 - There is no incentive for Aged Care Providers not to send people to ED.
 - There is a disconnect between research, what is happening on the ground and policymakers. There needs to be better research knowledge translation.
 - No organisation seems to take responsibility for patients' ongoing care/management including the hospital, aged care facility or primary health provider.
 - There is no consistent view of the totality of expected outcomes.
 - Too much time and money goes into accreditation in residential aged care facilities, taking away resources from patients.
 - Information is not transferred with the patient, e-health needs to be readily accessible across service sites and used.
 - Poor retention of staff in residential aged care facilities can impact on care provision.
 - Private health insurance funds are restricted in what they can do outside the hospital setting.
 - As a society older people are poorly valued resulting in inadequate investment in the care of older people and those with complex needs. Ageing of the population is often cast in negative terms, e.g. 'the ageing tsunami'.
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9.3 Scenario 3—Technology and patient outcomes; shared planning mechanism

Research questions

- How can technology be used better to improve patient outcomes?
- How do we develop a shared planning mechanism that delivers integrated service responses from multiple programs?

Policy initiative

It is proposed that a new support service be developed for those individuals/patients who access bundled payments including through the NDIS, Aged Care and Health Care Homes to assist in the allocation of funds. This support service would take the form of ‘system wranglers’, those who are familiar with the different requirements and providers of multiple support services. Their job would be to guide individuals/patients and assist them in making decisions, as well as facilitate developing greater health literacy and ability to navigate multiple systems.

Patient circumstances

A middle-aged patient/person with a partner and children, lives with multiple complex co-morbidities, including diabetes and hypertension. The patient has had a below-knee amputation as a complication of their diabetes and can no longer participate in employment.

Discussion points raised

- Shouldn't the systems adapt and coordinate and communicate and link up so that this role is not necessary?
- What do we do in the short term? Where do people get discharged to, where do they live, and who funds it?
- What can't we afford to lose? We should not throw out the baby with the bathwater in moving to individualised funding.
- We need a facility to ‘connect the dots’ so that the patient journey is much more seamless. Current systems rely on people putting their hands up rather than the system identifying them first.
- There was some debate about the need for a system wrangler due to potential duplication with the roles of other providers or increased complication.
- Nurse navigators have been used in Victoria, Department of Veteran's Affairs and have been a success. The Aboriginal Community Controlled Health Organisation model already assists clients to support continuity of care and breaking down barriers by assisting them with non-health issues such as housing and has Aboriginal Health workers who assist clients navigate the system.
- To some extent all providers have been taking on this role. There are staff with these skills who have been doing it as part of their role, is this duplication by identifying this as a separate job.
- Co-design is vital with discussion focussed on how people and providers can design system together, rather than what systems do to people.
- The community's perception is that a lot of money is spent in health. A lack of coordination in the system costs money.
- A person-centred approach is necessary, we need to find out what the patient needs to identify who and when a navigator role could/should help.
- Some concern about the term “wrangler”. Role goes from navigator through co-coordinator to the slightly more adversarial wrangler.
- The wrangler is not the solution to finite resources. They can't wrangle what's not there. Still need to consider overall funding and resourcing.

- There are apps available for smartphones and tablets devices that give all transport options to get from one place to another, complete with links to timetables, costs, and booking and payment facilities. It depends on information-sharing. With appropriate privacy safeguards this would be nice to have in aged/disability and complex health care.

Suggested innovations

- Loosen up the boundaries, but have clear accountability, and pay for outcomes.
 - Innovate across funding streams, enable services such as Primary Health Networks to step outside currently defined roles.
 - Primary Health Networks have a role in coordination across their area.
 - Online services which allows clients to pick and choose service providers.
 - Facilitated peer-to-peer support has some evidence in the research.
 - If a wrangler type role was introduced, they would need to work with clients with broader issues than just health.
 - Invest in skilling people to travel across sectors on behalf of patients.
 - Need mechanism to allow innovation, there are over 60 funding streams, but we have no means of innovating across settings to improve investment and value.
 - Current online records are about clinical management only and do not cover structural and social issues—they need to do so.
 - Social workers or others who are already filling these roles in narrower capacities could have their roles broadened. Many people will not need or want a wrangler.
 - A smart phone wrangler application could be developed to guide people through the system.
 - Where is a suitable place to locate wranglers? Some suggested situating them in general practice or appointing a point person to a multidisciplinary team in a private health insurer. But there needs to be multiple entry points eg. via social services, NGOs as many of the most needy won't be accessing quality general practice. Some thoughts in the group that hospitals could step up to provide this service. If linking up services is desired, why not base the wranglers at Centrelink or similar?
 - What should they do? No one-size fits all. It comes back to what the person needs or wants, their circumstances and location. Certain groups need a care co coordinator. It needs to be one-on-one with the client, with support provided across multiple services including health, disability, social services etc. Any wrangling role needs to be outcome based (someone even suggested calling them outcome facilitators).
 - There could be a role for the system wrangler in feeding back and improving communication between systems. Forging links and forming relationships so that, eventually, the role is not needed. The idea of system wranglers as “disruptors” to expose the gaps.
 - Possibly could fund the wrangler role with Health Care Homes funding.
 - Do some proper mapping, and planning and co-design, of the intersection of aged care, disability and healthcare services, across both Commonwealth and state and territory systems.
 - Fund the production of better statistics and data to support better mapping of what is happening at the intersection of aged care, disability and healthcare services.
 - Use of IT or telemedicine to deliver wrangler support in remote locations (or in other locations if it suits the client), develop smart phone application to enhance self-navigation.
 - There is a “workforce” of ageing, experienced consumers who could fill some of these roles, having navigated the system themselves. Using them could be an efficient approach.
 - Need to realise that people are at different stages of adjustment to their illness or disability. Might need soft access points, need to assess readiness and work with them.
 - Promoting and developing health and digital literacy among patients could be part of an approach to the problem.
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- If systems such as NDIS, social services, health etc. are linked up with a single system wrangler/navigator, who will hold the funds? Is there a role for virtual bank accounts?

Hurdles and barriers

- Not everyone is equal in their capacity to engage with the system.
- The only reason the NDIS got funded was because it made economic sense. But there is only a small 'market' for disability and aged care services, and it is not lucrative, hence it attracts limited private and public sector investment.
- Current use and access to e-health records is poor. E-health records need to house all of a client's health information in real time and be accessible and used by all relevant health providers to reduce the patient having to tell their story and to improve care provision. Although there has been poor uptake and use of My Health Records.
- Funding of a wrangler role would be difficult, as they will need to work with navigating across programs with different funders (federal and state).
- Currently there is poor communication between and across different settings and sectors.
- Social workers have undertaken this role for a long time, but funding is generally not provided for coordination, only for service delivery. Coordination roles disappear if people get individualised funding.
- The role of NDIS coordinators is more focused on outcomes of a funded package rather than individual services.
- Identifying those with the highest needs who would benefit most from wrangler type support. Need to make the service widely known through social services, advertising, etc. to reach those most at need.
- Equity of access would be challenging as those in regional, rural and remote areas may not have similar access to wranglers.



Australian Healthcare and Hospitals Association

Unit 8, 2 Phipps Close

Deakin ACT 2600

PO Box 78

Deakin West ACT 2600

P: 02 6162 0780

F: 02 6162 0779

E: admin@ahha.asn.au

W: ahha.asn.au



@AusHealthcare



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healthcare-&-hospitals-association

ABN: 49 008 528 470
