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AMA submission to the Department of Health – Specialist Dementia Care Units

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Background

The AMA thanks the Department of Health for the opportunity to comment on the establishment of the Specialist Dementia Care Units (SDCU) program. The AMA believes the Department of Health should also consult in depth with Dementia Australia and the relevant colleges, such as the Australian and New Zealand Society for Geriatric Medicine, the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australian College of General Practitioners, to ensure the program design achieves a high clinical standard.

With an ever increasing prevalence of dementia in Australia[1], the AMA understands the Government's push for the SDCU program. However, it should be noted that the SDCU program does not represent a holistic solution to the many issues surrounding dementia – rather it attempts to deal with one specific issue within the context of the wider problems with Australia's aged care system. It is also important to ensure that Residential Aged Care Facilities (RACFs) do not rely heavily on this program as a substitute for improving dementia management in usual RACF settings.

Reducing the need for SDCUs through aged care system reform

The quality of Australia's aged care system itself must be improved so that people living with dementia do not deteriorate to such severe levels of behavioural distress that they require specialist care units. The previous year has seen several inquiries into the quality of Australia's aged care system and has identified a number of recommendations. The AMA urges the government to act on these recommendations and invest in aged care reform now to build the foundations of higher quality aged care system.

[1] Australian Institute of Health and Welfare (2012) *Dementia in Australia*

The Government must ensure that the sector has the capacity and capability to provide quality care for Australia's growing, ageing population. In order to improve the quality of the aged care system, the following is required:

- The aged care system needs an overarching, independent, Aged Care Commissioner that provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system.
- Medical practitioners need to be recognised as part of the aged care workforce to ensure residents of aged care facilities are receiving quality care.
- Aged care needs funding for the recruitment and retention of registered nursing staff and carers, specifically trained in dealing with the issues that older people face, such as dementia.
- Access to Medicare-funded mental health services in RACFs that is already available to the rest of the population.
- The aged care sector needs a contemporary system that embraces information technology (IT) infrastructure for patient management.
- A contemporary IT system for medication management will reduce the risk of polypharmacy, and in turn reduce the likelihood of cognitive impairment, delirium, frailty, falls, and mortality in RACFs.
- There needs to be clear, specific, and confidential complaints referral pathways in each RACF so information on complaints processes are easily accessible to both residents and staff.

Many of these issues need to be reflected in specific Accreditation Standards that have a strong focus on health. In particular, an 'access to medical care' standard should be introduced.

Reducing the need for SDCUs through the RACF structure

A majority of residents in RACFs have dementia (53 per cent in 2009-10)[2]. In addition to SDCUs, all areas of RACFs should be physically designed[3] and operated in a manner that aims to prevent dementia residents deteriorating to high Behavioural and Psychological Symptoms of Dementia (BPSD) levels. This includes staff that are adequately trained in handling the symptoms of dementia. In particular, training to:

- improve methods of communication and social interaction with dementia patients[4]
- reduce the overuse of physical and chemical restraints (as identified under SDCU's service principles[5]),
- identify signs of undiagnosed pain and when medical attention from a GP or specialist is required,
- improve overall health by supplying nutritious meals and implementing adequate exercise programs[4],
- address mental health issues, and

[2] Australian Institute of Health and Welfare (2012) *Dementia in Australia*, p15
[3] https://www.dementia.org.au/files/20090200_Nat_QDC_QDC1PracResAgedCareFacAll.pdf p21-22
[4] https://www.dementia.org.au/files/20090200_Nat_QDC_QDC1PracResAgedCareFacAll.pdf
[5] Department of Health (2017) *Specialist Dementia Care Units Consultation Paper*, point 7, p25.

- increase support and awareness of the needs of Culturally and Linguistically Diverse (CALD) individuals.

This may also ensure that demand for SDCUs does not become unsustainable over time.

Implementing a high quality SDCU program

The consultation paper itself states that there is currently little research that supports SDCUs as an effective model to manage BPSD[6]. It would be more reasonable to initiate SDCU trials with extensive evaluation and review, rather than implement a full roll-out of a program that may not even be beneficial to the patient. Further, there should not be a maximum time limit that a patient can reside in a SDCU, as patients' health can either improve, worsen, or stay the same, at different rates. The length of stay should be determined by the patient's treating doctor.

To ensure the SDCU program runs at a high quality, the following aspects of the aged care system must improve.

My Aged Care (MAC)

The aged care system is complex[7] and can be confusing for consumers and service providers to navigate. MAC is supposed to be a 'one-stop-shop', with an aim to simplify access to aged care services. However, it has been complicated by requiring all consumers to undergo either a Regional Assessment Service (RAS) or Aged Care Assessment Team (ACAT) assessment in order to access support services. An assessment bottleneck has been created and is causing delay in elderly consumers' access to support and medical care. For example, 41.3 per cent of respondents in the 2017 AMA Member Aged Care Survey reported that their patients had to wait on average 1-3 months for initial assessment by ACAT[8].

The SDCU referral process is proposed to sit outside of MAC and the AMA understands that MAC will be able to assist individuals and their representatives with the SDCU referral process[9]. Regardless, it would be confusing for consumers and service providers to navigate an additional system to access the SDCU program. It would also undermine the reason why MAC was created in the first place. The Department of Health must urgently improve MAC and reduce ACAT waiting times. Without this, the proposed SDCU preliminary screening process[10] will only further delay care to those who urgently need it. The referral process should be included in the suggested initial SDCU trials to determine the most efficient referral method.

[6] Department of Health (2017) *Specialist Dementia Care Units Consultation Paper*, p47
[7] https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-and-aged-care-service-use
[8] To be published March 2018
[9] Department of Health (2017) *Specialist Dementia Care Units Consultation Paper*, p28
[10] Department of Health (2017) *Specialist Dementia Care Units Consultation Paper*, p30-31

The doctor's role in the SDCU program

The current aged care system does not adequately support medical practitioners visiting their patients residing in a RACF. The SDCU program should ensure that medical practitioners have sufficient access to their patients. Ways to facilitate access include:

- Interoperability between clinical software, MAC, My Health Record, and RACF software programs to increase communication and efficiency during the transition periods.
- MBS rebates that appropriately value the delivery of medical services to older Australians.
- Clinically-equipped doctor treatment rooms that enables patient privacy and an appropriate working environment.
- A sufficient number of well-trained registered nurses to ensure a reliable clinical handover.

In addition to being included in the SDCU program design, the above should be included in accreditation standards that appropriately reflect the need for medical care in RACFs.

It is proposed by the Department that General Practitioners (GPs) be heavily involved in the referral process for the SDCU program. To do this, GPs will need support from the government in forms of clear guidance around patient eligibility requirements, and remuneration for the time the referral process takes. There also needs to be safeguards against RACFs pressuring GPs and specialists to refer their patient to an SDCU in an attempt to get rid of a difficult resident. To reduce the likelihood of this occurring, the referring doctor needs to be the patient's usual doctor, where possible.

GPs already have a high administrative burden, especially as a result of the complex aged care system. Program referral systems must be organised in a way that does not compromise essential medical care. The AMA recommends the Department refer to the AMA's *10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors*[11], and also the *10 Minimum Standards for Medical Forms*[12] when considering referral and communication processes. As it is proposed that GPs and other specialists can refer their patients to the SDCU program, it is vital that the process be co-designed with these stakeholders to ensure that it aligns with practitioners' clinical workflows and appropriately remunerates them for the time involved. The AMA could assist with this as it represents both GPs and specialists.

There are several types of dementia, originating from different causes[13]. It is important that the definition of dementia for the purposes of eligibility of the program are clearly defined. This will help treating doctors understand whether their patient is appropriate for the program or not. For example, the document states that the person must have a 'primary dementia diagnosis', however 'primary dementia' is sometimes referred to as a category of dementia where the cause is not a different disease or condition (e.g. head injury)[14]. Upon further clarification with the Department, the definition of eligibility should instead state "dementia as the person's primary

[11] https://ama.com.au/article/10-minimum-standards-communication
[12] https://ama.com.au/article/10-minimum-standards-medical-forms
[13] https://www.dementia.org.au/about-dementia/types-of-dementia
[14] https://www.asha.org/Practice-Portal/Clinical-Topics/Dementia/#Primary_Versus_Secondary_Dementia

condition". The 'primary dementia diagnosis' definition could result in a person with tier 6 BPSD resulting from a head injury not being referred to the program.

The AMA urges the Department to consider the issues detailed above in the next stage of planning the SDCU program. The announcement is a welcome start, and does appear to draw heavily from recommendations made by specific providers. But much more needs to be done, in addition to this investment, to truly develop a comprehensive response to Australia's dementia challenge.

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