SUBMISSION

Allied Health Professions Australia

Royal Commission into Aged Care Quality and Safety

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Introduction

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to the Royal Commission into Aged Care Quality and Safety.

AHPA is the national peak body representing Australia's allied health professions. We have 20 allied health member associations and a further eight affiliate members with close links to allied health. The AHPA membership represents some 120,000 allied health professionals working across a wide range of settings and sectors. A significant proportion of those allied health professionals provide care to older Australians.

AHPA and its member associations are committed to ensuring that older Australians, regardless of their background, socioeconomic status or location, can access safe, evidence-based services to support wellness, reablement and maintenance of functionality. Allied health professionals assist with many conditions commonly experienced in older age, including chronic pain, communication difficulties, hearing and vision impairment, depression and anxiety, memory loss and cognitive impairment, mobility difficulties, nutritional deficits, and difficulty swallowing.

Allied health practitioners provide personalised care, focusing on individuals' functionality and independence, and helping to reduce avoidable hospital admissions. They can assist with reablement and supporting the older person to live well at home for as long as possible. In residential care, they can work with residents to identify their individual needs and to support staff to address those needs. They may also be involved in palliative and end-of-life care. Allied health care is an important means of ensuring the overall health and wellbeing of an older person, and of preventing hospitalisation and health deterioration. Unfortunately, access to care remains inconsistent and a low priority for both funders and aged care providers.

The AHPA response provides feedback to the Terms of Reference with a focus on allied health service delivery for consumers in residential aged care homes. Allied health service access remains a major issue for older Australians and despite significant work on aged care reforms, there remain real risks that there won't be better integration of allied health services. This would leave older people continuing to struggle with many of the issues being identified through the work of the Royal Commission.

It will be vital to ensure that Governments have a specific focus on ensuring that the allied health sector is actively involved in key work such as the implementation of funding reforms and the Australian Health Minister Advisory Council (AHMAC) project on the health/aged care interface, including in advisory and governance structures.

This submission has been developed in consultation with AHPA's allied health professional association members.

Key Recommendations

To address the current failures in aged care, AHPA argues that the following system-wide changes are required:

- **implement reforms to funding and service delivery models that address the allied health access issues older people experience in the community and in residential aged care homes**
- **create systems to improve the consistency and quality of services provided to people living in the community through programs such as the Commonwealth Home Support Programme and Community Home Packages.**
- **build the aged care workforce, both through education, and through aged care staffing profiles that ensure consistent access to services for aged care residents**
- **develop clinical governance mechanisms that ensure quality care and reflect best practice standards of care**
- **ensure better regulation and standards without unnecessary and costly duplication for allied health who work across sectors e.g. health/disability/aged care**
- **address funding disincentives within the aged care system that allow for cost-shifting and discourage a focus on preventative and reablement approaches**
- **ensure better involvement of the allied health sector in advisory and governance structures for government reform programs.**

Responses to the Terms of Reference

a. the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response;

Australia's population is ageing. With better in-home support, more people are ageing in place and entering residential aged care later in life. At the same time, the incidence of chronic disease is increasing and is now the leading cause of illness and disability in people over 65 years of age. The combination of an older population with the rise of chronic disease means that older Australians have greater healthcare needs that need to be met, whether they are delivered through in-home support frameworks or by residential aged care homes (RACH).

The transition to RACH is frequently triggered by a health event, which can include medical or cognitive decline. As a result, people entering RACH are not only older but are often frail and have complex care needs. They may also have specific needs relating to dementia management or palliative care. The move to residential care also frequently triggers mental ill-health as people deal with a loss of independence and potentially the loss of connections to their own community. It's worth noting that better preventive measures while people are at home are likely to reduce both hospitalisations and otherwise preventable moves into residential care.

Australian Institute of Health and Welfare (AIHW) data demonstrates the increasing age and health care needs in aged care residents.

- In 2017–18, 85% of people entering permanent residential aged care were aged 75+ years
- In June 2018, almost a third (31%) of people in permanent residential care had a 'high needs' care rating for all three ACFI care categories – activities of daily living, cognition and behaviour, and complex health care.
- The most common health conditions found in people in residential care are heart disease, stroke, arthritis, mental health and behavioural disorders, and dementia.

In addition, the most recent AIHW report on falls-related hospitalisation[i] demonstrates the strong and growing need for a focus on falls prevention in the community and in residential aged care. The report states:

> *In each year of the analysis, residents of residential aged care had considerably higher rates of fall-related injury than people falling in the home, and both sets of rates increased significantly over the study period. Age-standardised rates of fall-related injury cases for those aged 65 and over, occurring in the home, increased significantly between 2007–08 and 2016–17—for men, an increase of 3.9% per year (CI: 3.7%, 4.1%); for women, an increase of 2.7% per year (CI: 2.6%, 2.8%). However, rates of Falls that occurred in an aged care facility increased faster—men: 5.4% per year (CI: 5.0%, 5.7%); women: 3.3% per year (CI: 3.1%,*

3.5%). The faster annual increase in rates of falls for residents of residential aged care—and the widening difference in injury risk—suggest a continuing need for interventions designed for the aged care setting.

Despite strong evidence for the increasing age and healthcare needs of Australia's population, there are systemic failures in the aged care system with regards to healthcare provision, particularly as it relates to access to allied health care. For older people living in the community, these issues are less severe—they can access Medicare mental health funding, may be able to access flexible and self-directed care options via Community Home Support Packages and Home Care Packages, and can access both mainstream health and informal community support. However, for older people in residential aged care, service delivery is focused on support accommodation, and residents have limited to access to mainstream healthcare services and other forms of support.

Access to allied health in residential care

A number of previous inquiries into RACH[ii] have highlighted the import connection between access to allied health support and high-quality care. This is particularly the case for older people with complex needs such as those with dementia and those with complex behaviours. Older people (over 65 years) are among the highest risk groups for avoidable ill-health and hospitalisations. Access to allied health services in residential aged care can increase mobility, improve health through better diets, reduces falls risks, and offer more appropriate and effective strategies for managing challenging behaviours associated with dementia[iii]. The opposite has also been shown—where there is poor access to care, residents are more likely to suffer malnutrition, are more likely to experience repeated hospitalisation, and to be subject to restrictive practices such as over-medication.

Access to allied health services should be a priority in the residential aged care setting and seen as a direct contributor to high quality care, as well as a means of driving reductions in avoidable hospitalisations and other forms of avoidable health deterioration and loss of function. However, experience suggests that this is currently not the case and allied health services are extremely limited in many residential facilities. AHPA argues that this is largely a result of constraints imposed by our current assessment and funding models, as well as continuing uncertainty about the responsibility of aged care providers with regards to the health needs of residents and the intersection with other funding systems. This has been shown in previous inquiries, including the work of the University of Wollongong and the long-running Resource Utilisation Classification Study (RUCS), which have called out the need to ensure that funding assessments appropriately identify need and fund allied health services.

Where allied health practitioners are engaged by RACH, they are typically employed on a part-time or contract basis. In many cases, this limits their roles as well as their ability to deliver care to appropriate clinical standards. It also results in poorly coordinated care with service recommendations or follow-up interactions not being carried out by RACH due to lack of capacity between practitioner visits. There has also been a shift to large, multidisciplinary allied health practices providing contracted services to aged care facilities. A significant proportion of these are using relatively inexperienced, graduate staff, with limited skills and knowledge to deal with the specific needs of elderly residents. The current model of different health contractors servicing

facilities is often resulting in poorly coordinated/integrated care and recommendations not being carried out due to the lack of capacity within residential facilities (in terms of number, consistency, knowledge, attitudes and training of staff).

To address this issue, several areas of work are required.

Identifying care needs and ensuring consistent access for older people in residential care

AHPA strongly argues for the need to develop and mandate the use of a best practice needs identification and care planning assessment tool by RACH. This is one of the key recommendations of the RUCS review as part of its recommendations for a new aged care funding instrument. This is urgently needed as there is currently no assessment to determine the needs of new residents on entry to RACH. We note that it is current practice for Aged Care Assessment Teams to assess older people for ongoing care whilst in hospital but there is no equivalent process in RACH. Since there is often no allied health professional on site, there is often nobody able to identify specific needs that could be assisted by an allied health practitioner nor an awareness of what various allied health professions can offer. Best practice guidelines would support a more consistent process for identification of needs for, and access to, supports.

Allied health services provide an important mechanism for addressing independence and functionality in addition to clinical needs. Such a care planning tool must support the capacity for, and access to, appropriate allied health services. The allied health sector should be directly involved in the design, evaluation and implementation of such as care planning tool, so that access to important services is assured. Allied health practitioners should also be included as one of the groups, with appropriate clinical experience and understanding of individual care needs, approved to perform assessments. The assessment process should be performed independently of the facility receiving funding to avoid conflicts of interest. The development of such a tool will be an essential means of guiding care providers and of allowing families and older Australians to be confident that high quality, appropriate care is being provided.

Funding quality care in residential aged care homes

A key benefit of allied health interventions is maintaining and improving the health of aged care residents. However, the current system of aged care funding disincentivises investment in improving the health and independence of aged care residents by requiring downward adjustment of funding based on the improved level of functionality and care need. The proposal for a new aged care funding instrument has specifically identified the need to remove such disincentives for improving the health and wellbeing of aged care residents, allowing aged care homes to retain any difference between the level of funding the resident is assessed for and the actual cost of providing care to a resident that has benefited from reablement and restorative care.

Unfortunately, it is not clear that removing the disincentive in the funding model will be sufficient to improve quality and may need to be enhanced through additional funding aimed at investing in improving the health and wellbeing of the resident. The costs of reablement and restorative services as well as preventive care may not be covered by the potential difference in funding and care costs and may mean aged care providers do not choose to spend limited funds in this way. We also note

that there are a range of small improvements in function that can significantly impact the quality of life and wellbeing of residents while not significantly affecting the cost of providing care. This would mean that even under a new aged care funding instrument, key aspects of quality care would remain out of reach for many residents. We note in this context that the modelling for the new aged care funding instrument reflects existing use with significant gaps in access to allied health care.

Given these concerns, AHPA argues that it will be essential to specifically focus on the extent to which any funding reforms are able to cover the cost of best practice allied health care and what processes would need to be introduced to better integrate allied health care, noting that existing allied health services are typically contracted in.

Medicare and allied health care

One area of significant misunderstanding is the role of Medicare in providing access to allied health services for aged care residents. AHPA members report that RACHs frequently argue that they do not have sufficient funding to cover all allied health needs. Instead residents are told they must seek other funding, such as Medicare or paying private rates, for access to a range of allied health services, such as those relating to improving communication skills.

The ability to cost shift to health and other funding systems is a major issue and one that has been widely reported by allied health professionals and members of the community[iv]. AHPA argues that there is a disincentive to pay for allied health services out of aged care funding when other alternatives such as medications and medical treatments are funded through health and when the intersection with health is not clear. The utilisation of Medicare Chronic Disease Management item funding for assessment and other allied health services is a key example of health funding being used inappropriately to balance out gaps in aged care funding. This is particularly concerning as a significant focus for allied health work in aged care is working with staff to meet the needs of the person, something Medicare items are not designed for and which contravenes the guidelines for the items. For example, while a speech pathologist may initially work with the older person to assess their communication or swallowing needs, a major part of the intervention is then to work with residential care home staff to support adjustments to how they communicate with the person or with the food services and care teams to ensure the person has access to a safe and appropriate diet and support with eating.

The reliance on Medicare is not only inappropriate in terms of the intention of the items and the type of services provided in aged care homes. Rather, the inadequate nature of the items (which has been extensively discussed as part of the current Medicare Review[v]) massively limits the extent to which aged care residents are likely to access funded services. Funding under this program:

- is only available for five 20-minute consultations per year
- doesn't cover extended consultations, home visits or group sessions (other than diabetes education)
- doesn't cover non-face-to-face work outside of consultations
- provides no additional funding for travel and other costs associated with providing on-site care.

Current Medicare funding ignores the many extra (unpaid) hours that providers are required to spend either in preparation for sessions or follow up activities to fully support individuals. For example, if equipment is required to support an individual, then the administrative burden increases as additional paperwork is required to access the equipment and then often the provider is also required to assist with educating the individual, their family and carers regarding using such equipment and subsequent reviews are also required to ensure the equipment is appropriate. This 'extra' time needs to be funded as part of intervention for the allied health practitioner, however it is not currently claimable under a CDM plan.

A new funding model in residential aged care that supports reorientation of supports to a more person centred, active participation approach is required, in addition to access to the multidisciplinary allied health team and equipment needed to maintain this quality of life.

Allied health care in the community

The Home Care Package (HCP) program has significant potential to support people ageing in place, allowing flexible access to a wide range of services, based on the choices and care needs of the older person. By addressing the health and functional needs older people experience as they age, there are major opportunities to prevent or reduce falls, malnutrition and other trigger events that can lead to hospitalisation and a subsequent move into residential care. However, despite the potential of the program, and instances where it is working very effectively, AHPA and its members are concerned that there are a range of issues related to how the program is implemented that are limiting the effectiveness of the model.

A wide range of commentators have referred to the long waiting lists for home care packages, and there is significant evidence to suggest that the system is overly reliant on Community Home Support Packages as a stopgap measure while people wait for HCP funding. It is also evident that the same waiting list issues impact the ability to move from a lower level of HCP funding, to a higher-level package. Given the strong desire older people express to remain living in their own communities, and the cost effectiveness of keeping people at home, there must be greater investment by government in improving access to the HCP program.

However, AHPA argues that increased access alone will not be sufficient to address the missed opportunities that currently exist in terms of supporting older people to live and remain in the community. Reports from allied health providers working in the community suggest that there are significant issues in how the HCP program is being run by aged care providers. It appears that there is significant variation in knowledge about aged care services and the types of allied health services that can support older people and address functional or health needs at home. This is exacerbated by poor understanding among consumers about what a HCP can fund and their own role in driving the services that they receive. As a result, it is common to find that older people are primarily receiving cleaning and care services, rather than the sorts of preventative interventions that can help maintain and improve functionality. AHPA also understands that older people can have significant underspending of funds in their packages, suggesting a significant underutilisation of

supports that can improve the health and wellbeing of the person and work to address issues the older person is experiencing.

Case study

AHPA was provided an example of a 96-year old woman, who lives in her own home and currently receives a Level 2 package. In addition to receiving a Level 2 package, she has been assessed for and is currently on a waiting list for a Level 3 package due to reduced functionality arising from a number of injuries arising from falls within her home. While this woman is largely independent and needs only minimal support in the home, she continues to fall regularly, requiring ambulance assistance to get up after a fall and frequently requiring hospitalisation as a result.

On several occasions, the woman has spent some hours lying prone after a minor fall without being able to pull herself up. She has also had several more significant injuries including a broken shoulder as a result of falls in the home, spending significant time in hospital and in rehabilitation facilities while recovering from those falls. Given her age, the injuries from these falls are increasingly leading to a reduction in her overall functionality and ability to manage independently.

Despite the clear fall-related needs, the main forms of expenditure currently are fortnightly cleaning and gardening services, and a home monitoring system. While the aged care service provider is currently holding approximately $4000 in unspent funds, no programs have been introduced to address ongoing rehabilitation and reablement after the hospital-based services are finished and no falls prevention interventions have been offered. Falls continue to be the most significant concern for the older woman and her family and are considered the most likely risk of more significant injury and future hospitalisation.

AHPA argues that this is a clear example of the disconnect between a system where funding and coordination is being provided to an older person, and where there is the clear opportunity to provide proactive, preventive measures with funding already available. Instead, funds are being underutilised and the woman continues to be at high risk of permanent disability or worse arising from a fall. The health system is frequently carrying the cost of potentially avoidable injuries with significant costs arising from extended stays in hospital and rehabilitation services.

Perhaps most concerning to AHPA is that the aged care provider has clearly identified that falls are an issue and has provided photocopied literature from the Department of Health[vi] aimed at increasing understanding of falls prevention. The booklet makes no clear reference to the potential for allied health or other falls prevention programs that could be funded through the CHP and no offers were made to the older person by the coordinator to encourage them to take up such a program.

While this is only one example, it is one that is seen as fairly typical among those working in aged care. Despite Department of Health guidelines stating that older people “should not be limited to a

basic list of services. Home care providers have the ability to subcontract out services to meet your needs if they are not able to provide a specific service"[vii], most people are not accessing a well-designed, multidisciplinary set of services aimed at maintaining independence, and avoid hospitalisation and/or admission to residential aged care. This raises questions about the design of the current model, where an HCP provider is the fund holder and service provider, a situation that results in potential conflicts of interest.

AHPA argues that relatively simple measures could be introduced to address the current issues in the delivery of the HCP program:

1. Introduce a requirement for HCP providers to report on underutilisation of funds.
2. Develop a best practice needs assessment and care planning guide (similar to the one recommended for residential services) to guide HCP coordinators in putting in place services for older people.
3. Improve the quality of guidance materials for older people receiving HCP to ensure that they are supporting them in understanding and driving their own care needs.
4. Review current arrangements for service provision by HCP providers to determine whether conflicts of interest need to be addressed and to identify if there are administrative disincentives to using services not already contracted.

b. how best to deliver aged care services to:

i. people with disabilities residing in aged care facilities, including younger people

AHPA argues that no young person should be living in RACH. However, for many young people who have a severe disability and require constant high-level care, there is no alternative. Living in RACH is incredibly isolating experience for a young person and the current model of aged care provision does not adequately meet the needs of people living with a disability.

Whether a person is living with a developmental disability (e.g. cerebral palsy, intellectual disability, autism spectrum disorder) or acquired disability (e.g. brain injury, stroke, multiple sclerosis, motor neurone disease), appropriate levels of medical care and disability support must be made available. This includes services provided by health professionals who are appropriately trained to deal with the specific needs of the individual.

Access to multidisciplinary support, including allied health services, aids and equipment is an essential part of care for people with disability. The introduction of the National Disability Insurance Scheme (NDIS) means that disability assessments and supports provided in RACH may now be funded through the participant's NDIS Plan. However, this does not include training for aged care staff to implement disability supports.
People with disability should have full access to the NDIS, including the person-centred, goals-based approach to disability support, as well as service provision that complies with NDIS standards and accessible complaints processes.

NDIS is available to people living with disability from the ages 7– 65. For people over 65 years, the Continuity of Support Programme offers some support for people who continue to live in their own

home. However, for people over 65 who have a disability and are aged care residents there is not specific funding available for disability supports and services. This leads to a lack of access to required supports as RACH have insufficient funds to pay for allied health services. This issue needs to be addressed within a model of aged care service provision. The introduction of the new aged care standards reflects an increased awareness that older Australians have the same rights as other Australians, however until funding issues are addressed, we will see significantly different opportunities and levels of care and support available to people with disability receiving aged care rather than NDIS funding.

ii. the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services;

The increasing incidence of dementia, and the resulting increase in people with dementia entering residential care, means that RACH are dealing with resident cohorts that are much more complex and require significant behavioural support. The Royal Commission hearings have shown that there is currently a high dependence on chemical and physical restraints to manage patients with challenging behaviours. Better access to services provided by allied health professionals trained in behaviours support will help to avoid this dependence on external restraints and improve the quality of life for RACH residents with dementia. However, this will depend on a recognition that the use of allied health professionals and more appropriate means of managing difficult behaviours is more expensive and dependent on aged care funding while chemical restraints are funded through the Pharmaceutical Benefits Scheme (PBS) and both cheaper and easier for care homes to implement.

By providing increased funding for high quality care and by developing and implementing a best practice needs assessment and care planning tool, AHPA argues that significant improvements can be made to the health and wellbeing of older people with dementia.

Needs assessment

A best practice needs assessment for people entering residential aged care will be important to determine the specific needs of new residents and how these can be best addressed and funded. For people entering aged care due to dementia, this will be even more important to determine the stage and progress of dementia as well as the appropriate services and course of action for behaviour management.

Some symptoms and behaviours attributed to dementia may be a result of other undiagnosed issues, such as hearing or communication problems. A needs assessment will help to discern such issues, and the appropriate supports, and help to guide the delivery of person-centred care. Access to allied health professionals is important for communication support as well as any reablement or preventive strategies that may be put in place. Training for aged care staff directed by allied health professionals will also help to create an environment that increases engagement and reduces anxiety.

Communication/Environment

Disruptive and difficult behaviours may result from inadequate support for the person to express their needs and inadequate training for staff to respond to these issues. However, they are often attributed to dementia and managed using restraints rather than engagement.

Addressing unmet communication needs can reduce stress and time involved for staff dealing with such behaviours. They can also reduce feelings of isolation for the resident and significantly improve their quality of life. Allied health professionals can assist with identification of specific needs as well as recommending communication strategies, memory supports and assistive technologies. Good design of the surrounding physical environment can also help reduce anxiety in people with dementia.

Reablement

People with dementia do not routinely have access to allied health services for the purpose of reablement and rehabilitation. However, cognitive rehabilitation can be valuable in the early stages of dementia where new strategies can still be learnt. Allied health support for physical reablement is also important for greater mobility and pain management, which can reduce verbal and physical aggression.

There is currently no way to access funded allied health cognitive rehabilitation (e.g. occupational therapy and speech pathology) or preventive health services (e.g. dietetics and exercise physiology) services. RACHs are currently funded through a model based on dependence and care. By changing the focus of funding and recognising the significant opportunities for improved outcomes for older people with dementia, those older people will lead better and more dignified lives. In turn, residential staff will be better supported to work with people with complex needs and behaviours.

c. the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia, including:

i. in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and

More and more older Australians are seeking to remain living independently in their own home for as long as possible. As a result, demand for community-based aged care now far exceeds supply and there is increasing reliance on Commonwealth Home Support Package due to a long waiting list for Home Care Packages.

AHPA argues that there is enormous potential for preventative interventions that address the health needs of people as they get older. A significant portion of Australia's chronic disease burden could be prevented by addressing modifiable (i.e. lifestyle or behavioural) risk factors, reducing the disease burden and the cost of providing aged care services.

Preventive health programs and early intervention programs could significantly increase the potential for older Australians to remain living in their own homes longer, through improved strength and functionality and increased levels of wellness and wellbeing. Allied health professionals

are an essential part of the team that enables older people to function well physically, socially and emotionally and support them to live independently in the community. Allied health practitioners play a direct role through service provision and indirectly through education of older people and their informal carers.

The current consumer-directed nature of funding in the Home Care Package Program allows individual to use their funding as part of a proactive/preventive plan. However, this would require participants to be aware of the relevant services that may be available to them, understand how these services may be of benefit, and know how they could be incorporated into their care package.

ii. in remote, rural and regional Australia

Remote, rural and regional Australian communities have higher proportions of older people, have poorer health outcomes and shorter life expectancies, than those living in metropolitan areas. These issues are exacerbated by lower levels of private health insurance and capacity to self-fund care, more limited access to healthcare and a greater potential for social isolation. These factors place a significant demand on health and aged care services in these areas.

Despite the greater need for health professionals and aged care support, remote, rural and regional areas have an undersupply of qualified professionals and are likely to continue to face access issues while our health and aged care systems are not funding access to care. Some allied health disciplines don't exist in many remote areas. In other areas, professions such as optometry, occupational therapy, dietetics and podiatry are represented at a fraction of the rate of metropolitan areas.

The lack of funding certainty for many services act as an ongoing barrier to recruitment and retention of health professionals in rural and remote areas, with shortages in allied health professionals, as well as nursing and medical staff. These issues are exacerbated when it comes to finding professionals to work in aged care where the allied health workforce faces specific challenges including:

- a lack of funding for allied health positions at residential aged care homes and dependence on contracting in of allied health services
- limited scopes of practice for allied health practitioners providing services in aged care homes

AHPA argues that better access to allied health services in aged care in remote, rural and regional Australia will depend on:

- a national approach to increase numbers of allied health professionals in remote, rural and regional areas
- addressing workforce needs at the interface of rural health and aged care including education, training and clinical placements in the aged care setting
- better utilisation and expansion of practitioners' skills and knowledge through expanded scopes of practice and emerging roles such as the Rural Generalist Pathway for allied health

- a greater focus on multidisciplinary approaches across multiple sectors e.g. working across health, aged care, disability, community and education in rural and remote communities
- funding that allows telehealth to be used for allied health services and a collaborative approach to case management
- better utilisation of the allied health workforce for prevention, to support older people to stay at home and maintain their independence for longer.

d. what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe;

AHPA argues that there are a range of solutions to the current challenges experienced by our aged care system. The solutions proposed below would help ensure higher quality care and better outcomes for older people and improved conditions for those working in aged care.

Healthcare standards for aged care homes

Residential aged care providers are now assessed and monitored against the new Aged Care Quality Standards (as of 1 July 2019). These standards include a greater focus on outcomes for consumers instead of provider processes. However, although the Standards establish a minimum acceptable level of service for accreditation, they do not define or provide guidance on the delivery of high-quality care.

An important factor in the provision of aged care services is access to healthcare. There continues to be a lack of clear expectation for RACH to include health services in addition to (or as part of) the supported accommodation they offer. This has follow-on effects on management, operations and staffing at these facilities.

The introduction of a set of quality indicators may provide greater transparency and help consumers to compare different aged care services. There may also be a role for an approach to accreditation that provides information about whether a RACH has merely met or exceeded the expected standards and outcomes.

Although the Aged Care Act requires RACH to engage allied health professionals (e.g. speech pathologists, occupational therapists, podiatrists, physiotherapists) to provide services for residents, current regulatory mechanisms do not enforce this requirement. Clear descriptions of standards of care, including the types of allied health professionals with appropriate expertise and the expectation that these will be engaged, and requirements to monitor the use of allied health services for accreditation, would promote the availability of services provided.

Regular review of allied health service provision by aged care providers (e.g. type of service, frequency, uptake by residents, cases where an allied health service was recommended but not delivered) would also help the government understand provision of and gaps in allied health services.

Best practice needs assessment

Effective aged care delivers quality of life for care recipients, not just quality of care. It is important that care planning is based on an informed understanding of consumer needs in addition to consumer preferences. This requires a needs assessment to be undertaken by someone who is appropriately trained to see not only obvious needs, but areas for potential improvement, and understands the range of care providers who have the expertise to address those needs.

AHPA argues for the essential role of allied health practitioners in supporting the integration of new residents into a RACH, through their involvement in the needs assessment process and facilitating care planning that takes place as a result of that process. This includes the documenting the person's needs, the types of services that may be required to support or manage those needs, developing support/treatment strategies in conjunction with the RACH, documenting progress and reviewing strategies.

Professional standards for aged care workforce

High quality aged care services must include appropriate practitioner regulation. CHSP accreditation includes reviews of organisational systems for recording and monitoring staff, including qualifications, conduct and continuous development. Accreditation for RACH also includes checks of credentials or registrations of all allied health professionals, including contractors.

A number of allied health professions are regulated under the National Registration and Accreditation Scheme (NRAS) (e.g. psychology, physiotherapy, podiatry, occupational therapy) while other professions are self-regulated (e.g. dietetics, speech pathology, exercise physiology). For the self-regulated professions, mechanisms and processes analogous to those required by NRAS are in place to maintain high clinical, educational and ethical standards. These regulation methods provide a high degree of certainty about the clinical safety of practitioners, as well as the basis for any sanctions to be applied where clinicians are not providing high-quality care.

AHPA advises significant caution in overlaying additional requirements for allied health professionals. This is particularly important as many allied health professionals that provide services to aged care facilities are contracted in and may provide only limited services in aged care facilities. Adding significant extra layers of regulation, along with the accompanying time and financial impacts this has on providers, can act to reduce access to allied health services for older people. This effect has been seen most recently in the disability sector where the introduction of the new NDIS Quality and Safeguarding Framework, and the cost of achieving registration, is leading providers to opt-out.

Despite our caution, AHPA recognises the potential need for additional standards to be applied. If government determines this is necessary, AHPA strongly argues for alignment with the NDIS Quality and Safeguarding Framework through either an expansion of the scheme or a system of mutual recognition. We argue that the principles set out in the NDIS Framework provide a strong foundation for a consumer-focused approach, that encourages providers to strengthen their internal systems

and focus on providing high quality care and to seek continuous improvement in how they operate. Should the NDIS Framework not be used as the basis for any new regulatory standards for aged care, AHPA has strong concerns about the impact this will have on providers, particularly those working across multiple schemes, and the follow-on impact this will have on the availability of services for older people. This is particularly likely to impact regional, rural and remote allied health professionals.

As a final note, we argue that additional work should be done to develop identify if there is a need to develop capability frameworks and to introduce programs to support ongoing skilling up of the aged care workforce. This should include addressing the current lack of clinical placements available for students in allied health courses, supervision and mentoring of staff in aged care services, and other options to prepare future and current practitioners for the challenges of working with older people.

Consumer engagement

The new Aged Care Standards include a focus on consumers directing their own care, but most aged care recipients are not well informed enough, or don't have the capacity, to make decisions about their own care. Campaigns to increase health literacy, including the options available for healthcare (and specifically allied health services) in the aged care setting, should be implemented in conjunction with the sector. AHPA also argues for the important role of advocacy support roles and aged care navigators to ensure that older people with less capacity and less family support can still access high quality care.

Aged care recipients, whether at home or in residential care, must also have access to a central independent complaints body and process to address complaints from older people or their families and representatives.

e. how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters;

The challenge of providing genuinely person-centred care in an aged care setting is significant and depends on a range of factors.

Assessment

Assessment of individuals' needs can help tailor a specific healthcare plan, with preventive measures in place to maintain functionality and reduce the likely involvement of acute healthcare providers. A best practice needs identification tool will be key to determining what services aged care residents might need to provide person-centred healthcare in the aged care setting. Involvement of allied health professionals will be key to getting this right, with their knowledge and skills to identify needs that could be addressed by allied health services as well as an awareness of different supports the various professions can provide.

Health literacy

The new Aged Care Standards recognise that aged care residents should have a greater say in their own care. However, this assumes that aged care residents are informed healthcare consumers and have an adequate level of health literacy. AHPA argues that this cannot be assumed and that instead data shows that most people do not have sufficient health literacy to direct their own care. In 2006, less than one-quarter (22%) of people aged 60–74 had health literacy skills that were adequate or better (ABS). One of the most significant challenges older people face in terms of making choices about their own care, is a lack of understanding of the options available to them. As such it is essential to ensure that systems such as My Aged Care, and roles such as HCP coordinators are actively supporting improved health literacy and understanding of the aged care system.

It is also important to consider the aspirations older people may have for their life/lifestyle in aged care and raise expectations that they should have the opportunity to continue functioning to their own individual potential. The generation now entering aged care has a greater expectation on the quality and range of services, as well as the ability to maintain social activities and connections. Consumers must be educated, enabled and empowered in order for them to understand and participate in making decisions about their healthcare and aged cared planning.

Consumer education processes, and complaints processes, must be strengthened and information must be made accessible if recipients of aged care and their families are to understand their care options, make informed choices and be effectively engaged in the care process. It's also vital to recognise the important role of health professionals, particularly allied health professionals, in supporting older people in understanding the options available to them and in exercising choice and control about their care. Allied health professionals are experienced at working in a multidisciplinary team and are trained to work with the person to help them improve their own health and wellbeing. Increased access to allied health services will be an important foundation for improved health literacy.

Communication

People with communication issues or cognitive problems require support and/or advocates to ensure that they are engaged and that their voice is heard. There is a common misconception that people with communication difficulties do not have the capacity or competence to engage in decision-making processes about their own care. Even when someone cannot convey their opinions and preference through conventional means, or they have limited verbal capacity, this does not mean they do not have the mental capacity to provide input into the type of care and support they wish to have. Currently there is a very strong tendency to defer to family members or other representative if there are communication difficulties and this may not always reflect the individual needs and desires of the older person.

The ability of older people to express preferences and convey concerns is an important factor in ensuring that services provided are person-centred and of their choosing and should be prioritised. Speech pathologists are allied health professionals with expertise in the assessment and treatment of communication difficulties and have an important role in supporting older people to

communicate their needs. By ensuring that aged care providers have access to the right professional skillsets we can ensure that people are better able to access the care that they want and need and avoid some of the systemic failures that result when communication issues are not addressed.

Older people from culturally and linguistically diverse communities will also need additional support, and this will require targeted work to address issues around health and language literacy that are exacerbated for people from non-English speaking backgrounds. Augmentative and assistive technologies may be useful as communication aids both with people who have difficulty communicating verbally and those who may not be able to communicate their needs in English.

f. how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure;

AHPA argues that there are a range of opportunities that could be realised with appropriate reforms and investment in the aged care system.

Improved models of care

Current models of care do not address the needs of aged care residents with higher healthcare needs, complex behaviours and dementia. Healthcare is seen as something as something that is an acute need, delivered in healthcare facilities as required, rather than an ongoing responsibility of aged care facilities. Quality standards that apply to healthcare facilities, but not aged care facilities, are a reflection of this. Similarly, as outlined above, the community aged care system is not working effectively to realise opportunities to maintain and improve functionality and to prevent avoidable injury, illness and hospitalisation.

A new model of aged care must be developed that recognises the changing profile of older people entering residential aged care and that embeds proactive and preventive healthcare practices. To do it is essential to ensure that aged care homes provide access to allied health professionals for services that support wellness and reablement as well as mental health care. Changes to the aged care funding should support such a model and remove the need for RACH to rely on external funding for adequate allied health service provision. AHPA argues that it will be essential to develop more effective models for sharing of care responsibility between hospitals, primary care providers and aged care facilities. The current fragmented system is resulting in poorer outcomes for older people and greater cumulative costs to our taxpayer funded systems. This might involve not only strengthened access to allied health and other care, but also increased use of triage services and health care delivery in aged care homes.

Technology

Telehealth is often discussed in the context of rural health, where it can be used by individual clinicians to provide clinical services as well as team-based support for complex conditions. Telehealth has similar potential in aged care where it may improve collaboration between care

providers and access to care for older people who may be limited by mobility and health issues. Due to the number of comorbidities in many elderly people, aged care requires a collaborative, multidisciplinary approach, and telehealth may provide a mechanism to better connect general practitioners, medical specialists, allied health and acute healthcare providers through clinical discussions and case management.

For older people living at home, digital technologies are already being used to support home monitoring and ambient assisted living. It could also be used to improve connections to support services and social networks to reduce isolation and improve mental health. Unfortunately, Medicare does not currently fund telehealth for allied health services, although this has been recommended as part of the MBS Review.

The challenge with telehealth and digital health technologies is not the lack of possible applications. The key challenge is the ability to fund services and to support clinicians, aged care facilities and aged care residents to set up and access telehealth systems. For older people, many of whom have a low level of digital literacy or communication difficulties, the challenge of using telehealth applications, even those that are designed to protect them, can be far greater and is likely to rely on support within an aged care home.

With any consumer-based technologies, user-friendly devices or interfaces, an education program that focuses on the 'how to' as well as the likely benefits, and follow-up after implementation are essential. This is especially true for this older cohort. Funding for assistive technologies also currently fails to recognise that consumer education and follow-up are essential components for successful delivery and outcomes with such technologies.

Workforce

Allied health professionals represent a very small proportion of the aged care workforce, compared to nurses and personal care attendants. This is despite the increasing proportion of aged care residents that require the specialised care and support provided by the various allied health professions.

Investment in the aged care workforce is fundamental to improving the quality of lives of older people and preventing substandard care. In addition to direct funding for improved access to allied health services in aged care, the following areas need addressing/investment in order to improve future access to allied health and optimum outcomes for aged care recipients:

- perceptions of the requirement for skilled workers in aged care
- reduced scope of practice for some allied health professions working in aged care
- use of allied health assistants without appropriate supervision, training or direction by qualified allied health professionals
- lack of clinical placements in aged care facilities for students undertaking allied health courses
- lack of data collected and made publicly available regarding the allied health workforce and service provision.

g. any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.

No further comments.

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[i] https://www.aihw.gov.au/reports/injury/trends-in-hospitalised-injury-due-to-falls/formats

[ii] Compare for example the Oakden Report (see https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Reviews+and+consultation/Review+of+the+Oakden+Older+Persons+Mental+Health+Service/). See also https://theconversation.com/australias-aged-care-residents-are-very-sick-yet-the-government-doesnt-prioritise-medical-care-88690

[iii] See http://www.vifmcommuniques.org/wp-content/uploads/2017/12/Recommendations-for-Prevention-of-Injury.pdf.

[iv] https://agedcarecrisis.com/resources/allied-health-services-in-residential-aged-care

[v] See submissions made by AHPA to the MBS review at https://ahpa.com.au/advocacy/.

[vi] https://www1.health.gov.au/internet/main/publishing.nsf/Content/phd-pub-injury-dontfall-cnt.htm

[vii] https://agedcare.health.gov.au/programs/home-care/home-care-packages-program