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Guide Healthcare

Royal Commission into Aged Care Quality and Safety

FINAL REPORT

Allied Health Services in Residential Care

Written by

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Introduction

The much-awaited Final Report by the Royal Commission into Aged Care Quality and Safety was finally released on Monday 1st March. After 2 years and $92 million in spending, Commissioner Briggs and Commissioner Pagone put forward 148 recommendations. It was disappointing to read that out of these recommendations, there were 43 points of disagreement. Whilst not uncommon in these types of reports, in an industry which has struggled for unity and a clear path forward, the last thing we needed was differing opinions. Allied health in residential aged care was an area where the Commissioners failed to reach an agreed recommendation.

Whilst the report and recommendations are broad ranging, we've decided to focus on Recommendation 38 on allied health services into residential care. Allied health professionals of all scopes of practice have been beating on the door of change for more than a decade. Whilst the report provides some key recommendation, there's no doubt that more work still needs to be done in order to create the aged care system of the future, that is one that we can all be proud of.

Impression of the Allied Health Recommendations

We were pleased to see the general recognition that allied health should play an important role in preventing physical and cognitive decline, increasing physical capacity and mobility, reducing falls and injuries and in providing restorative short-term care in response to acute events. The recommendations recognise that allied health services, including physiotherapy, should not be limited by the narrow constraints of any funding tool. This has been the general consensus for years.

The recommendations bring allied health services closer in-line with the new aged care quality standards which mandate individualised programs, partnering with the consumer and providing "best-practice" treatments, among other things. This is extremely important as the competing objectives of ACFI and the Quality Standards consistently lead to an unbalance and sub-par service delivery.

It was interesting to read Item 3.11 of the Quality of Care Principles quoted in the report. This item, much like many of the sections in the report, remains wide open to different interpretations. We do however agree that as stated in the report, it is perverse that people are charged for services that may avoid or delay deterioration in their health; but, in theory, services are provided for free once they deteriorated. We would argue that these services are consistently not provided despite progressive disability, usually due to the limitations of ACFI and the current framework of aged care.

It was reassuring to see the recommendation of improved accountability on providers, particularly the "strict monitoring of the level of allied health services actually delivered". We see this as a great opportunity for providers to establish points of difference, based on the importance placed on the scope and service hours allocated to allied health. We've consistently advocated for allied health services to be viewed as a unique selling point for homes. Quality allied health service delivery has the potential to increase the confidence of next of kin, create better outcomes for residents, reduce injury rates and lower complaints. If delivered correctly, these services also place the home in a much stronger position to meet the Aged Care Quality Standards. The collection and review of data will no doubt lead to greater accountability and better industry benchmarks.

We are concerned about the consensus that the Australian National Aged Care Classification (AN-ACC) funding tool may "ensure increased and appropriate allied health delivery in the residential care setting". We question the Commissioners statement that it "may also encourage innovative models of care". History will tell us that if something isn't directly funded in aged care, it likely won't be prioritised. In a grossly underfunded system, this makes perfect sense. The application of item 3.11 of the Quality of Care Principles is a case in point. Whilst experts and peak allied health organisations fiercely highlight the shortfalls of the AN-ACC, we were surprised to read the commissioners spruiking it with such optimism.

The Differing Recommendations

Disunity between the Commissioners has no doubt created a missed opportunity. Having varying opinions increases the likelihood of delayed responses, which isn't what the aged care sector needs. In our opinion, ambiguity and the opportunity for "interpretation" is a huge problem in any piece of aged care legislation. As such, we foresee a number of issues in both sets of recommendations from the commission.

Commissioner Pagone's recommendation would:

require providers to have arrangements with allied health professionals to provide services to people receiving care as required by their assessment or care plan

Item 3.11 of Schedule 1 of the current Quality of Care Principles 2014 - requires approved providers to make available 'therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services' to all who need them, as long as the services are not 'long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma'. Without changing Item 3.11, we're concerned that this recommendation will have little impact on current practice. In our opinion, Commissioner Pagone's recommendation does not go far enough in specifying the requirements of providers.

Recommendation 38.d which would create increased accountability may help. However, we're left wondering what "provide services" as "required by their assessment or care plan" actually means. The lack of structured guidelines and seemingly nondescript recommendation isn't what the aged care industry needs.

Commissioner Briggs' recommendation would:

require approved providers to:

i. employ, or otherwise retain, at least one of each of the following allied health professionals: an oral health practitioner, a mental health practitioner, a podiatrist, a physiotherapist, an occupational therapist, a pharmacist, a speech pathologist, a dietitian, an exercise physiologist, and a music or art therapist

ii. ii. have arrangements with optometrists and audiologists to provide services as required to people receiving care

Commissioner Briggs considers that allied health in residential care services should be provided in multidisciplinary teams, and she identifies an exhaustive list of professionals who should make up this team. She also considers that aged care facilities must employ, or otherwise retain these practitioners so that older people actually receive the range of allied health services they need.

This is incredibly important. In the current aged care environment, the ACFI lens has created a lack of distinction between physiotherapists, occupational therapists, osteopaths and chiropractors. All have been reduced to massage specialists, in an industry with limited knowledge or recognition of the scope of allied health professions and their potential impact on residents. Creating on-site multidisciplinary teams would no-doubt improve outcomes for residents and ease the pressure on allied health and nursing staff who continue to struggle to complete tasks outside of their scope of practice.

Commissioner Briggs highlights that the existing laissez-faire arrangements have not worked, and few services have been delivered. We whole heartedly agree. As such, we believe their needs to be clearer guidelines as to the minimum expectation of service provision for each of the recommended allied health disciplines. The argument will no doubt centre around varying resident population groups and their individual needs, which could be a difficult challenge to overcome. After all, assessments and care plans and appropriate treatment options are open to interpretation.

What do we support?

If we had to simplify our impression of Commissioner Pagone vs Commissioner Briggs' recommendations, we would say that Commissioner Briggs has placed a higher value on allied health services and shows a greater insight into the importance of these services to older adults.

Commissioner Pagone's recommendation fails to significantly build on the existing legislature. The ambiguity of his recommendation means that current prioritising of certain allied health professionals will likely remain. This will mean that aged care residents continue to lack support in vital areas such as mental health. Ideally, we want a system which prioritises the use of a multidisciplinary team. Commissioner Pagone argues for flexibility in funding and control in the hands of providers. I'd prefer allied health funding to be incentivised and promoted.

Commissioner Briggs' recommendations create this priority and incentive. Whilst the AN-ACC moves funding away from an activity-based funding tool, which I support; in the case of allied health services there needs to be a financial incentive to provide these services. This is something Briggs recognised in the report, stating that an activity-based component increases service provision. Something she notes is "sorely lacking" in the current system.

In terms of physiotherapy, occupational therapy and exercise physiology, a simple physical therapy subsidy, which was an activity-based addition to the revised Aged Care Funding Instrument (R-ACFI), would likely achieve this outcome. This could be included as part of the existing AN-ACC. It's already been designed and costed and would be simple to implement. The physical therapy subsidy is not prescriptive, requires a focus on the individuals needs and preferences and requires consistent review to ensure effective service delivery. If the physical therapy subsidy isn't used as a basic framework, then more work needs to be done on what is to be included in the allied health funding, how it will be implemented and what monitoring mechanisms will be used.

Commissioner Briggs states that the capped base payment as part of her blended funding is "designed to cover the cost of establishing the ongoing engagement of allied health professionals as well as the costs of activities that are not easily captured by an activity-based funding model". She believes this model would "better support the ancillary benefits of having a multi-disciplinary team as part of the service, including increasing the capacity of other staff members, encouraging collaborations and case management between professionals, developing care plans, taking a holistic view of older people's health, and working with families and carers." If these outcomes are achieved, then we vote for Commissioner Briggs.

Commissioner Briggs also supports strict accountability measures for the use of allied health funding. They could include the use of clinical indicators and outcome measures to review progress and report the effects of allied health interventions. This recommendation was already included as part of the physical therapy subsidy outlined in the R-ACFI.

Importantly, what both commissioners could agree on was that "there should be more flexible arrangements for smaller providers, Aboriginal and Torres Strait Islander-specific services and services in regional, rural and remote areas". They also highlight the value that telehealth and an increased role for allied health assistants could play to achieve better outcomes for residents.

Conclusion

Aged care needs to be re-defined. Given the right supports, older adults have the ability to improve their physical function, psychosocial wellbeing, cognitive abilities and quality of life. We need to create a cultural shift away from providing passive care towards evidence-based treatments. And recognise that through multi-disciplinary teams, we can achieve more with our residents. As per Standard One in the Aged Care Quality Standards, we need to be better at putting the consumer at the heart of our decisions and work to create stronger partnerships with our residents. To achieve this, the system needs to change.

The Final Report recognises that allied health services have either been non-existent or implemented within a narrow framework. This needs to change. We would have liked a clearly defined path forward, which we don't believe has been achieved. However, there are many positives and avenues for exploration contained in recommendation 38.

We believe Commissioner Briggs has provided a more holistic framework for allied health in residential care. We now advocate for more clearly defined expectations for providers and the development of a funding tool which supports providers and incentivises allied health services. Our recommendation is to re-explore the physical therapy subsidy outlined in the R-ACFI as a viable addition to the AN-ACC. In its current form, the AN-ACC simply does not provide the springboard which allied health services need in residential care.

The one thing that is clear, is that there is still a significant amount of work that needs to be done in this space to ensure appropriate and effective allied health services for residents. We are more passionate than ever to drive change and be a part of this new system.


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