Exercise & Sports Science Australia submission

Royal Commission into Aged Care Quality and Safety

ADELAIDE HEARING 5 – DRAFT PROPOSITIONS

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1.0 About Exercise & Sports Science Australia

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing over 8,000 members, including university qualified Accredited Exercise Physiologists (AEP), Accredited Sports Scientists (ASpS), Accredited High-Performance Managers (AHPM) and Accredited Exercise Scientists (AES).

2.0 Exercise Physiology in Aged Care

There is compelling evidence that clinical exercise interventions, as delivered by AEPs provide a range of physical, mental and psychosocial benefits to older people, independent of age, disability or disease. Exercise interventions prescribed by AEPs can:

- improve cardiovascular fitness
- improve muscular strength and balance[i] [ii]
- decrease symptoms of depression, anxiety [iii]
- pain[iv] and
- when completed in a group setting, foster social connections and feelings of belonging[v].

AEPs are recognised allied health professionals who provide clinical exercise interventions aimed at primary and secondary prevention; managing sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness.

With a primary focus on improving health and functional independence, the AEP workforce is growing within the community based aged care sector where wellness, reablement and restorative care models are embraced. AEPs specialise in clinical exercise interventions for persons who may be at risk of developing, or who have clinically diagnosed medical conditions or injuries. Within residential aged care, AEP interventions remain largely underutilised. This can primarily be attributed to an Aged Care Funding Instrument (ACFI) which does not encourage wellness and reablement approaches or fund exercise physiology interventions.

3.0 Summary of Recommendations

ESSA recommends that:

1. Proposition A3 be considered as the most appropriate model for funding allied health services in aged care.

2. The funding model for Proposition A3 needs to:
    - fund access to exercise physiology in residential aged care
    - fund wellness, reablement and restorative interventions separately from a resident's ongoing care needs
    - reflect models outlined in the CHSP Manual 2018-19 under the service description for Allied Health and Therapy Services
    - introduce measures to ensure aged care service providers are subject to outcome measures relating to wellness, reablement and restorative care, with incentive to motivate and reward progress in these areas
    - stipulate that care planning and care coordination should be led by a clinical professional, employed within the residential facility
    - ensure that allied health services delivered within the aged care setting remain integrated with external health services accessed by the older person through the provision of dedicated funding for case discussion.

3. The Royal Commission explore how key elements of Proposition A3 could be applied across community-based care.

4. Elements of Proposition A4 be adopted alongside Proposition A3 to:
    - support access to allied health services in thin markets
    - cater for the diverse needs of residents
    - support client choice
    - provide access to specialised health services.

5. The Royal Commission needs to consider a more holistic approach to responding to mental health needs of aged care recipients by exploring the evidence supporting a range of allied health interventions, including exercise physiology.

4.0 ESSA's response to the Draft Proposals for Allied Health

Thank you for the opportunity to provide feedback into the Draft Propositions paper (the Propositions Paper). ESSA is pleased to see the Royal Commission consider how access to allied health could be improved for older people receiving aged care services.

Allied Health professionals offer specialised knowledge and skills and are an important means of ensuring the overall health and wellbeing of an older person. Appropriate access to allied health services, including exercise physiology can improve mobility, reduce falls risks, assist in the prevention and management of chronic conditions and provide humane and effective strategies for managing challenging behaviours.

ESSA maintains that improving access to allied health is a key step in improving the overall quality of care delivered within the aged care system.

It is ESSA's vision that all people receiving aged care services will have access to the same suite of allied health services regardless of the level of aged care they receive, or the environment in which they receive it. The amount of allied health care they receive needs to be based on assessed need and not influenced or restricted by funding caps. The funding model for allied health care needs to support a multidisciplinary team-based approach to care, making provision for case discussion and capacity building measures targeted at the older person, their family/carers and aged care staff. The funding model needs to support allied health professionals, including exercise physiologists, to work within their full scope of practice and adopt contemporary evidence-based practice.

ESSA advocates for an aged care system that promotes and supports access to contemporary evidenced based wellness, reablement and restorative approaches to facilitate the best possible health and wellness outcomes for older Australians. This improved system can be realised by mobilising the underutilised workforce of Accredited Exercise Physiologists and Accredited Sports Scientists, who are qualified to provide interventions that will improve the health, wellbeing, independence and quality of life of older persons in community-based and residential aged care environments.

The Draft Propositions

The Propositions Paper suggests four mechanisms by which funding for allied health care could be increased to facilitate increased access to allied health.

- **Proposition A1:** increase funding for allied health services through a new MBS benefit structure for Australians accessing aged care services.
- **Proposition A2:** fund general practices which have received an aged care accreditation to provide allied health services to their patients.
- **Proposition A3:** fund residential aged care providers to deliver a comprehensive range of allied health services to residents.
- **Proposition A4:** fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to Australians accessing aged care services.

It has been noted that some of these draft propositions are consistent with the Counsel Assisting's submission on Future Aged Care Program Redesign, whilst others propose very different approaches to funding allied health care in aged care.

It is important to reiterate to the Royal Commission that ESSA was supportive of many of the recommendations made in the Council Assisting's submission.

4.1 Proposition A1: increase funding for allied health services through a new MBS benefit structure for Australians accessing aged care services

Whilst ESSA would welcome an increase in MBS funded allied health services for older Australians, we are concerned that Proposition A1 caps funding which limits both access and health outcomes; does not provide funds for capacity building measures; and may not support a model of integrated care.

Proposition A1 describes a model similar to that used for MBS Chronic Disease Management Plans (CDMP). ESSA considers the current MBS cap of five allied health services per year under the CDMP to be far from adequate to achieve clinical outcomes. Many chronic conditions require at least two, possibly even three or four different health professions to provide care. An annual limit of five sessions means that Medicare support is barely adequate for an annual check-up and assessment,

let alone any provision for an intervention, especially where greater complexity or risk is demonstrated.

Data from the Australian Institute of Health and Welfare[vi] indicates that 70% of those aged 85 years and over have five or more chronic conditions. With such a high percentage of older Australians experiencing multiple chronic conditions, ESSA is concerned with how the Government would determine a capped figure that would be effective in meeting the diverse and complex needs of all older Australians.

ESSA is also concerned that Proposition A1 adopts the MBS traditional fee for service model, paying directly for one-on-one treatment activities between the allied health professional and the older person. This model does not support measures aimed at building the capacity of family members and aged care staff.

Finally, ESSA questions whether this model can achieve an integrated, multidisciplinary, team based approached to care. As noted earlier, this proposal is similar to that used for MBS Chronic Disease Management Plans. The Report on the Inquiry into Chronic Disease Prevention and Management (The Report) highlighted the following concerns in relation to this model:

> *The CDMPs are intended to help the GP assess and coordinate care for the patient across the spectrum of health care providers, however the allied health sector still feels that the integration between their providers and GPs is fragmented and that this funding does not cater for the required coordination between their sectors: The current model of funding, rather than promoting service integration and supporting team-based care, has created "professional silos", which results in medical and allied health professionals working independently of each other, leading to poor overall services and outcomes.*[vii]

The Report also highlighted numerous concerns raised by the Royal Australian College of General Practitioners (RACGP) in relation to the MBS CDMP model including:

- Lack of flexibility in tailoring plans that stem from MBS items.
- Excessive red tape.
- Referrals to allied health professionals that are complicated by the requirement to create team care arrangement plans.

- The weighting of the rebate payment is on creating the GP management plan, and not on the follow-up monitoring and outcome consultations, where the real outcomes and benefits from chronic disease management can be realised. [vii]

ESSA is concerned that similar issues will arise if GPs were to take the lead in the development of "Aged Care Plans".

4.2 Proposition A2: fund general practices which have received an aged care accreditation to provide allied health services to their patients.

ESSA is concerned that Proposition 2A will substantially increase the cost of aged care planning and care coordination but will not necessarily improve access and the quality of care provided to older Australians.

Proposition A2 significantly increases the care planning and care coordination roles of general practitioners. As mentioned in response to Proposition A1, the Inquiry into Chronic Disease Prevention and Management highlighted that GP led care coordination under the CDMP model is fragmented and often does not promote a team-based approach to care.

The Grattan Institute Report titled *Chronic failure in primary care* also highlights that GP led care coordination is usually limited to referral and exchange and is insufficient for people with highly complex and ongoing problems.

> *For a proportion of people with highly complex, ongoing problems, coordination by GPs is not sufficient. For these people, including those who are very frail and dying, responsibility for care needs to shift across providers as acute episodes occur. New problems (comorbidities) have to be addressed as they arise and a broader range of personal, social, and community supports have to be provided. Integrated relationships would see a number of practitioners working together as a team to treat patients. This would include joint involvement in developing treatment plans, joint monitoring of progress and jointly agreeing changes to treatment plans. General practitioners have difficulty establishing systems to identify and follow up people with chronic disease. They are often too busy with other clinical priorities to adopt an integrated approach to chronic disease. Under the current system, GPs are able to offer little in the way of self-management, systematic patient education or social and*

behavioural interventions to manage risks for chronic disease and support people with complex and ongoing conditions.[viii]

ESSA suggests that aged care plans, particularly those focused on the prevention and/or management of chronic conditions and reablement and restorative approaches should be developed in a partnership between the older person, their family/carers, their aged care provider and a multidisciplinary team. ESSA recommends that the older person's GP should play an integral role in the multidisciplinary team but does not necessarily need to lead the care coordination process. The number and type of health professionals involved in a client's treatment should be determined by the level of care needed, the type of outcome required, and client preferences. This approach aligns with the model successfully adopted by the Short-Term Restorative Care Program.

ESSA notes that Proposition A2 will see GPs take on an increased administrative burden with requirements introduced for them to either employ or outsource nursing or allied health professionals to deliver patients' aged care plans. ESSA would be interested to see how many GPs would be willing to take on this increased role, given many GPs report being overstretched in meeting their current practice requirements with all the regulatory requirements.

ESSA suggests there is a level of risk associated with implementing a model that assumes all GPs would be willing to take on increased responsibilities for such a large population group. ESSA is concerned that many GPs and corporate primary healthcare providers may decide not to become aged care accredited practices, which would impact an older person's access to allied health services in their local area and the achievement of best possible health outcomes.

4.3 Proposition A3: fund residential aged care providers to deliver a comprehensive range of allied health services to residents.

ESSA is supportive of Proposition A3. ESSA maintains that current issues relating to access to allied health in residential care stem from the current funding model – the Aged Care Funding Instrument (ACFI) which:

- rewards functional decline instead of encouraging wellness and reablement
- creates limitations on the type of allied health professionals an older person can access
- restricts allied health professionals from using contemporary evidenced-based practice.

This Proposition addresses many of the shortfalls in the ACFI by:

- suggesting an increase in funding for allied health within residential care
- providing access to a full range of allied health services
- suggesting a flexible funding model that will embed multidisciplinary allied health teams within residential aged care and support these teams to provide beneficial services beyond treatment for individual care, such as building the capacity of aged care staff through training advice and improvement initiatives.

ESSA is pleased to see that Proposition A3 would broaden the range of allied health services available to people in residential care. ESSA maintains that all people receiving aged care services should have access to the same suite of allied health services regardless of their level of care or their care environment. ESSA would like to see the inclusion of exercise physiology as part of a broadened range of allied health services that is mandated .

ESSA notes that exercise physiologists have shared case studies of people who received exercise physiology services under the Commonwealth Home Support Program, the Short-Term Restorative Care Program and/or the Home Care Package Program and were then denied exercise physiology when they eventually entered residential aged care. These older Australians have expressed disappointment and shock at not being able to access the continued health outcomes resulting from exercise physiology treatments as they transition into a higher level of care. One gentleman recently admitted into residential care, told his exercise physiologist that when he requested exercise physiology services, he was offered a range of alternative services that he neither wanted nor needed.

ESSA also supports the proposal to embed multidisciplinary allied health teams within residential aged care. We have talked about the value of this approach in previous submissions to the Royal Commission. Our workforce submission highlighted how exercise physiologists with a consistent presence in a residential care facility can coach aged care staff on engaging residents in physical activity, support aged care staff to identifying declines in function and wellbeing and report concerns to the allied health team, deliver onsite training on a range of topics (falls prevention, manual handling etc.), and introduce programs to support the health and wellbeing of aged care staff.
We also note that in addition to workforce benefits, a consistent allied health presence in residential care promotes continuity of care, enables ongoing monitoring of changes and declines health and wellbeing, fosters relationships of trust with residents (which boosts adherence to allied health

interventions) and creates an environment supportive of case discussion and a team based approach care.

ESSA suggests the following considerations will be critical to the success of Proposition A3:

1. Wellness, reablement and restorative interventions should be funded separately from a resident's ongoing care needs. This was a recommendation proposed by the Counsel Assisting and supported by ESSA. ESSA's Aged Care Program Redesign submission called for a dedicated funding stream for allied health services to ensure that access to valuable health interventions were not overlooked.

2. Funding should reflect models outlined in the CHSP Manual 2018-19 under the service description for Allied Health and Therapy Services. The CHSP promotes two models of care, ongoing services and restorative services:

    1) Ongoing Allied Health and Therapy services

    These services are of an ongoing or episodic nature, are delivered on an individual or group basis and provided at a low intensity or frequency, with a maintenance or preventative focus, for example regular podiatry for a client with diabetes and group exercise classes.

    2) Restorative Care services

    Service providers can deliver a time-limited, allied-health led approach to service delivery that focuses on older clients who can make a functional gain after a setback. These may be one to one or group services that are delivered on a short-term basis which are delivered by, or under the guidance of an allied health professional. Their goal will to be to increase the independence of clients. They will target people who can make a functional gain after a setback, who are at risk of a preventable injury, or who need other allied health led services to maintain independence.

3. Aged care service providers should be subject to outcome measures relating to wellness, reablement and restorative care, with incentive to motivate and reward progress in these areas. This recommendation was proposed by the Counsel Assisting and supported by ESSA. ESSA suggests that incentives may include block funding to assist with the delivery of health literacy programs, the purchase of equipment or to support subsidised wellness activities such as group-based exercise.

4. Care planning and care coordination should be led by a clinical professional, employed within the residential care facility. Experiences with the NDIS have highlighted the risks associated with unqualified persons preparing plans that influence access to clinical services. Care planning and coordination for allied health care should be developed in partnership with the older person, their family/carers, their aged care provider, a multidisciplinary allied health team and the older person's GP.

5. Care coordinators should ensure that allied health services delivered within the aged care setting remain integrated with external health services accessed by the older person. This will require clear channels for communication and dedicated funding for case discussion made available to both the aged care service and the external health services.

ESSA notes that Proposition A3 does not address access to allied health within the community setting.

ESSA advocates for a funding model that supports older people to experience a consistent process of assessment, care planning and accessing care, regardless of where they are in their aged care journey. ESSA suggests the Royal Commission explore how key elements of Proposition A3 could be applied across community-based care.

4.4 Proposition A4: fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to Australians accessing aged care service

ESSA is not supportive of multidisciplinary allied health organisations receiving a direct line of funding for the delivery of allied health services into aged care. In ESSA's experience these types of funding models involve a competitive tendering process where smaller businesses often do not have the resources to compete with larger more established organisations. The risk is that larger "super clinics" can monopolise the market, limiting consumer choice and reducing access to those residing in more isolated geographical locations.

We acknowledge that there will be circumstances where it may not be viable for a residential care facility to employ an onsite multidisciplinary team, as proposed Proposition A3. For example, it may be difficult for a smaller rural a remote service to recruit and maintain a permanent onsite

multidisciplinary team. ESSA suggests that in these types of circumstances a consistent team of external allied health professionals should be made available to the aged care recipients. Residential care facilities should be supported to subcontract external services to deliver in-reach allied health services and be engage in allied health professionals in telehealth where appropriate.

These types of funding models may also support residential care providers to be more flexible in meeting the diverse needs of residents (i.e. engaging an allied health professional who is bilingual or of a specific gender). It will also support arrangements whereby the aged care resident may express a preference to continue to consult with the allied health professional who supported them in the community.

In-reach teams should offer clear communication and direction, and where appropriate be funded to deliver capacity building activities to aged care recipients and staff and engage in case discussion with the facility and other relevant health professionals, as needed.

ESSA would welcome a funding model that supports the access to state-based hospital lead outreach services in residential care where gaps in specialised care occur (i.e. palliative care).

5.0 Draft propositions for Mental Health

ESSA would also like to take the opportunity to provide feedback on Draft Propositions for Mental Health. ESSA notes that the Draft Propositions for Mental Health primarily focus on providing interventions delivered by psychologists and psychiatrists.

ESSA respectfully encourages the Royal Commission to consider a more holistic approach to responding to mental health issues. Many allied health professionals, including exercise physiologists can work with older people to improve their mental wellbeing.

An AIWH snapshot of the people who were in permanent residential aged care on 30 June 2018 revealed that the majority of residents (86%) were diagnosed with at least one mental health or behavioural condition.[ix] Depression was identified as the most common mental health condition, with 49% of residents having a diagnosis of depression.[ix]

Beyond Blue suggests factors that can increase an older person's risk of developing anxiety or depression include:

- an increase in physical health problems/conditions e.g. heart disease, stroke, Alzheimer's disease
- chronic pain
- side-effects from medications
- loss associated with relationships, independence, work and income, self-worth, mobility and flexibility
- social isolation
- significant change in living arrangements e.g. moving from living independently to a care setting. [x]

It has been suggested that the experience of depression is relatively similar across the lifespan, although certain symptoms can be accentuated, and others suppressed in older people.[xi] For example, older people with depression typically report more physical symptoms compared to younger people with depression.[xi]

Beyond Blue maintains that physical exercise programs in residential settings have a wide range of physical and cognitive benefits and can reduce the symptoms of depression in older people.[xii]

The importance of including exercise as a cornerstone of effective mental health care has been well-established in clinical research. ESSA notes there is a growing body of evidence supporting the role of exercise in managing and preventing mental illness, as outlined below.

Mental health outcomes

- Decrease symptoms of depression, anxiety, stress and schizophrenia[xiii] [xiv] [xv] [xvi] [xvii]
- Decrease social isolation[xviii]
- Improve sleep quality [xix] [xx]
- Increase engagement with treatment and service utilisation [xxi] [xxii]
- Reduce cravings and withdrawal in substance use disorders (SUD) and alcohol addiction [xxiii] [xxiv] [xxv]
- Increase self-esteem [xxvi]
- Improve quality of life [xiii] [xxvii] [xxviii]

Further to this, recent evidence guides published by the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Commission of NSW recommend referral to, or engagement with dedicated allied-health professionals with expertise in exercise prescription, specifically an AEP, to promote improved health outcomes of people living with a mental illness.[xxix] To assist with appropriate referral to exercise physiology for mental health ESSA has developed Consensus Statement on the role of Accredited Exercise Physiologists within the Treatment of Mental Disorders.

6.0 Contact ESSA

Thank you for the opportunity to provide feedback into the Adelaide Hearings Draft Propositions for Allied Health.

Please contact our Policy and Advocacy Team on 07 3171 3335 or anna.harrington@essa.org.au for further detail or any questions regarding the content of this submission.

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