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Speech Pathology Australia

Speech Pathology Australia's Response to the The Royal Commission into Aged Care Quality and Safety

Draft Propositions regarding accessing mental, oral and allied health Adelaide Hearing 5

1 May 2020

The Speech Pathology Association of Australia Limited
ABN 17 008 393 440

Royal Commission
GPO Box 1151
Adelaide SA 5001

Dear Commissioners

Response to Adelaide Hearing 5: Draft Propositions for improving access to mental, oral and allied health

Speech Pathology Australia welcomes the opportunity to provide comment to the Royal Commission into Aged Care Quality and Safety (the Commission) propositions drafted for the Adelaide Hearing 5 (now deferred) for improving access to mental, oral and allied health. As you are aware, Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing more than 10,000 members. Speech Pathology Australia is also an active member of National Aged Care Alliance. Speech pathologists are university-trained allied health professionals with expertise in the diagnosis, assessment, and treatment of speech, language and communication disorders, and swallowing disabilities.

Speech Pathology Australia has outlined its position on how to improve the quality of life for older Australians, including improved access to allied health in previous submissions to the Commission:

i) April 2019: Response to Terms of Reference

ii) December 2019: Policy Issues related to workforce

iii) January 2020: Aged Care Program Redesign.

We thank the Commission for considering our previously articulated views and welcome the acknowledgement of these points within the current discussion paper for the Adelaide Hearing 5.

As we have also previously provided background information regarding communication disabilities and swallowing disorders and the role of speech pathologists working in the aged care sector, we feel it is unnecessary to repeat this information in this instance.

We hope the Commission finds our feedback and recommendations useful. If we can be of any further assistance or if you require additional information please contact Ms Kym Torresi, Senior Advisor, Aged Care at the Speech Pathology Australia National Office on 03 9642 4899 or agedcare@speechpathologyaustralia.org.au.

Yours faithfully

Mr Tim Kittel
National President

Speech Pathology Australia's feedback regarding the Commission's Draft Propositions for improving access to mental, oral and allied health

Speech Pathology Australia strongly supports the overarching principles proposed in Propositions CH7, CH18, CH17 and CH6. We will comment more explicitly around the proposed new primary care model for aged care recipients below. In noting the four initially outlined areas of inquiry on how to improve access to allied health, Speech Pathology Australia would strongly advocate that both increased funding, and more importantly *alternate* funding models are required to achieve real outcomes for older Australians. This alternate funding model should incorporate appropriate remuneration for the 1:1 mentoring, support, teaching of paid carers and family, for travel time for home based services, group staff training and organisational capacity building that is required to achieve effective outcomes.

Given the detailed advice contained in our previous submissions, we have now summarised those same points against the draft propositions.

Mental Health

Support for Propositions M1, M2, M3, M4, M5, M6, M7

- However, funding target and mechanism is limited, needs to enable and support multidisciplinary care. Increased access to psychologists and psychiatrists could best be achieved through outreach multidisciplinary teams

Speech Pathology Australia acknowledges that there is the need for far greater access to support for mental health for all older Australians, but particularly those living within residential aged care and therefore supports the proposed increased access to services such as psychologists, psychiatrists and older person's mental health services.

However, the current proposed funding mechanism for mental health risks creating ineffective and potentially detrimental silos. When considering the context of residential aged care and the specific needs of the cohort, appropriate outcomes are achieved when mental health services are included within a multidisciplinary team involving allied health. This proposed model does not recognise this breadth of contributions required to improve mental health status.

The proposed funding model here also raises some concerns that a 'mental health' service approach will be considered and adopted as being only about accessing a psychologist or psychiatrist once someone has become mentally unwell, rather than proactive approaches (e.g. that immediately look at adjustment support at the time of residential aged care admission given the known increased risk of developing depression at that time). Furthermore, the current terms of MBS funding could unintentionally limit appropriate case conferencing between allied health members and working jointly with other allied health, and access to group programs.

Speech Pathology Australia particularly raises the concern of barriers for older people living with communication disorders accessing 'talking based therapies' such as psychology. Studies have shown that up to 95 per cent of residents in residential aged care have some form of communication difficulty, including hearing loss[i]. Of those, many have significant difficulties with verbal expression and / or auditory comprehension due to underlying conditions (which may have precipitated their admission to aged care facilities) such as stroke or acquired brain injury (28.8 per cent of men and 17.8 per cent of women[ii] in residential aged care), or progressive neurological conditions such as Parkinson's disease or dementia (50 per cent of residents). The incidence of depression subsequent to changes in the ability to communicate is known to be high, for example the rate of depression in post stroke aphasia is 70 per

cent of people at 3 months and 62 per cent at 12 months (with 33 per cent showing a major depression at 12 months post onset).[iii]

Aphasia, as an example of a range of communication disorders, negatively impacts on social interaction, psychological wellbeing and quality of life.[iv] However, there is a current known lack of access to counselling and psychological services for people with aphasia[v], which goes beyond simply being due to funding mechanisms and limits.

Studies have shown that other health professionals do not understand the communication needs of people with aphasia to effectively assess low mood and depression.[vi] There is also a general need for further support and mentoring with psychologists for them to understand how they may include someone with a communication disorder within therapy – i.e. to fully implement customised communication strategies and aids within conversations that enable that person to participate in sessions to their maximum ability. This is best achieved when a speech pathologist and psychologist work together within a session to facilitate for this to occur with an individual. Current MBS funding terms do not allow for such dual billing of sessions.

Furthermore, psychology sessions alone do not address the underlying precipitating issues driving the depression in the first place – people with aphasia, for example, may benefit from speech therapy that enables greater social participation and interaction, and conversational partner training (staff, residents) that improves interaction and engagement in meaningful activities. Evidence based recommendations for this cohort currently recommend the application of a stepped model of psychological care that involves a range of strategies across a range of providers, but most notably must include speech pathologists prominently in those strategies[vii].

Without access to appropriate multidisciplinary care, environmental modification and carer training, there is a very real risk that this model will result in increased use of antidepressant medications in people with communication disorders. Studies have shown it is more common for people with aphasia to be placed on antidepressant medication rather than access behavioural therapies (such as engagement in meaningful activities that they can do) with the latter showing superior treatment effects[viii].

We therefore ask the Commission to reconsider the parameters of this section. Including speech pathology in MBS items under Mental Health Care Plans may be one way to address this but will still result in limitations in not being able to undertake necessary conversational partner training or conduct joint sessions between health professionals as needed. Additionally, this mode of funding may not encourage the residential aged care facility to engage with their own responsibilities in actions that may be needed to better address individual's mental health needs, e.g. staff accessing and implementing training strategies around how to support engagement of an individual with complex communication needs.

Speech Pathology Australia supports that greater access to psychologists and psychiatrists is critical but will be best achieved by combining access to these health professionals within an outreach multidisciplinary team that includes allied health and other health professionals such as Geriatricians and access to incentives for environmental modifications to support wellness and reablement.

Oral Health

Strong Support for Propositions D1, D2, D3, D4

Speech Pathology Australia strongly supports the introduction of appropriate access to public oral health services for all older Australians regardless of their location, and agrees with the presented arguments of the negative impacts that poor oral health can have on people's ability to speak, eat and socialise[ix]

Appropriate oral health care is also particularly critical for people living with swallowing difficulties, and can lessen the impacts of aspiration.

Allied Health

Speech Pathology Australia welcomes and acknowledges the strong support for allied health and the principles articulated in previous Speech Pathology Australia submissions including a focus on preventative health and wellness and reablement, and the need for comprehensive face to face assessment, outlined in the introduction of this section.

Comments relating to each of the propositions in this area will be set out individually below.

Do not support: **Proposition:** 'set staffing ratios and increase access to at least 22 minutes of allied health care per resident per day'

Speech Pathology Australia does not support Counsel Assisting's submission on 21 February 2020 for the Royal Commission to make a recommendation in terms of allied health "of at least 22 minutes of allied health care per resident per day". This statement alone will NOT achieve the stated aims the Commission has noted within the introduction for this section. This will be a simplistic proposition which:

- Will not accomplish a redesign of the system to achieve an appropriate model of care. Doing more of the same will not in itself lead to greater outcomes for older people
- Will not in itself ensure an appropriately skilled assessment of all needs occurs
- Does not ensure individualised needs are met. Whilst people with more complex needs may need far more than this for a time across a number of health professionals in order to get set up appropriately, there may well be others who do not need this quantity of servicing. There is potential for unmet need but also over servicing within such a model
- Will not in itself ensure the needed accountability and joint approach of residential aged care facilities to implementing allied health recommendations, thereby limiting the effectiveness and utility of this allied health input.

STRONGLY DO NOT Support: Proposition A1: Increase funding for allied health services through a new MBS benefit structure for Australians accessing aged care services.

Whilst increasing the level of funding for allied health access has merit, Speech Pathology Australia strongly disagrees with this proposed model in being able to achieve the stated aims of the Commission articulated within the introduction of the allied health section.

Significant key concerns re this model include:

- (60) A medical model of care would be enshrined within the system design when referrals to allied health are reliant on coming from GPs under the Aged Care Plan. This would not achieve the stated aims of the Commission in system redesign that incorporates a preventative / wellness / reablement approach.
- (63) GPs do not have sufficient background knowledge, or the time required for comprehensive assessment to identify all required allied health needs of an individual NOR identify what the care staff needs are (e.g. communication partner training needs of staff).
- (61) A cap or limit on allied health services – whilst potentially increased from the current totally inadequate 5 sessions a year across all of allied health – will not appropriately address individual needs and again lead to the type of substandard care that the Commission is looking to address. It is

inappropriate to set a standard frequency per discipline when the individual conditions being treated can vary so widely in their needs. For example a speech pathologist may need to see someone with an acute change to their swallowing status, and need to review this frequently throughout a single week to ensure safe oral intake and avoid complications / hospital admission, but may only need to review another person with a more chronic swallowing difficulty again in another month's time.

- (62) Payment only for one on one work and not reimbursing for education / mentoring of care staff and family members, for example, will not assist in achieving intended outcomes, and will not support the retention of allied health practitioners in this sector when they can not get paid for the work required. In addition, education and mentoring is an on-going process, and not just part of one-off staff training. This approach particularly does not recognize what may be needed to adequately support people living in residential aged care facilities.
- (64) Allied health services need to be able to be provided across a range of locations, but particularly within people's homes and communities, and residential facilities in order to achieve real quality of life outcomes. Any model of aged care redesign must appropriately include provision for this, which is not currently a feature of MBS funding.
- Outcomes for older people with more complex needs including acquired disability following stroke, neurological disease etc are best achieved within multidisciplinary care from a range of allied health. This will be most effective and efficient in a model that allows via its funding mechanism for joint sessions between different allied health professionals, and time for collaboration between these professionals which is not currently a feature of MBS funding.
- This funding model does not encourage accountability or 'ownership' of the role that residential aged care facilities and staff must play in achieving the goals of older people. A team-based approach is needed between aged care facilities and allied health and this external funding mechanism may not facilitate this to occur.

STRONGLY DO NOT Support: Proposition A2: Fund accredited aged care practices to provide a comprehensive range of allied health services to patients.

Speech Pathology Australia holds significant concerns regarding this proposition, many of which include points above relating to a likely medical model of care with care needs not always identified by GPs, or reablement goals or carer training not then supported by the GP practice to occur. Additionally, concerns would include:

- (65) The proposed new model of primary care has some disadvantages for older people, but primarily where someone by virtue of turning 65 and needing to access an ACAT for future planning and/or access to allied health may be forced to change from the GP they have had a long term relationship with. For example, many people at the time of a diagnosis of a neurodegenerative disease such as dementia may still be relatively independent but are encouraged to have an ACAT assessment to discuss future planning needs. They may well be dissuaded from doing this at this time if it means they must leave their GP because their current GP has chosen not to be accredited under this model.
- (66) There is insufficient detail in this model at this stage to understand how the level of patient need, and therefore funding level, would be determined. Would this be paid retrospectively when the allied health clinician has completed their discipline assessment and conducted the needed number of sessions? It is not feasible for the GP to determine the number of hours of speech pathology required to achieve goals in order to obtain required funding to employ that allied health professional. How will consistent and secure employment, supervision requirements and career progression for allied health professionals be factored into such a model?

- (67) Whilst a 'comprehensive' range of allied health services is proposed to be part of this model, it is of concern that disciplines that may have a lower rate of use may not be viewed by the GP practice as being something they wish to support. It is felt there is an inherent risk within this model that it will not appropriately support individualized reablement and care needs of older people.
- This model also does not encourage accountability or ownership of the aged care provider's role in the team providing health care to older people living in residential aged care.

Support: Proposition A3: Fund aged care providers to deliver a comprehensive range of allied health services to people receiving aged care

Speech Pathology Australia keenly welcomes the Commission's recognition of our position that good outcomes are achieved for older people when:

- (69) Holistic allied health care across a comprehensive range of allied health services is available
- (70) A funding mechanism exists that enables a "broader range of service provision beyond one on one treatment" given the beneficial role that allied health can play in "building the expertise of aged care staff through training, advice and improvement initiatives".
- (70) Allied health services can be embedded within aged care facilities to ensure this on the ground mentoring, relationship building with staff and embedding of the team based approach required between nursing, medical, personal care staff and allied health to achieve good outcomes.
- (73) Mechanisms are in place that monitor and ensure the delivery of adequate and appropriate range of allied health services.

However, our support for this model would be dependent on the following considerations:

- (71) Use of a GP generated Aged Care Plan to identify needs within the residential aged care facility may not reliably identify appropriate individual needs and is very unlikely to identify the wider staff and organizational needs. This would not be an appropriate means of assessment of need for this model.
- (72) The proposed AN-ACC classification system of funding care needs does NOT relate directly to all allied health needs of older people for wellness and reablement. This study was based on looking at *current* care times when determining funding levels for nursing / PCAs. Therefore, if *currently* there is no time available for staff to spend supporting the communication needs of a resident using a picture communication book – this does not equate to there not being a need or functional and psychological impacts from this difficulty.
- (74) Of major concern for speech pathologists, is that direct engagement of allied health staff by residential aged care on an individual basis may create additional economies of scale issues than those already identified in the paper in terms of access to appropriate providers to meet individual needs. Currently there are some facilities who do directly employ allied health – but this tends to generally be limited to physiotherapy or podiatry and not to other disciplines such as speech pathology, occupational therapy or dietetics. There is a risk with this model that it may not facilitate access to services most needed by the individual, but rather those most used across the facility.
- (74) Also of concern is that this model does not readily enable a seamless service system to be developed across home based care and residential aged care, as proposed in the Aged Care Program Redesign Paper of the Commission. Speech Pathology Australia's proposal regarding program redesign discussed a wrap around 'wellness and reablement' allied health service across

home based care and residential care that would enable continuity of service of allied health provision when someone moved into residential aged care.

Speech Pathology Australia believes that further modifications to this model would be required.

STRONGLY Support: Proposition A4: Fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to people accessing aged care.

Speech Pathology Australia strongly supports this model as having 'best fit' for the stated needs of:

- holistic care provided across a comprehensive multidisciplinary team within a person's own location as needed.
- access to the relevant expertise, supervision structures and career progression for allied health with the suggestion of embedding these within state-based multidisciplinary outreach services and ensuring an individualised approach for older people focussed on outcomes without being within a small business structure.
- enabling an approach that can provide continuity of allied health care from a subacute setting into residential aged care setting (e.g. post stroke then enters permanent care) or home-based care into residential aged care.
- enabling a range of interventions to be provided including staff training and organisational improvement initiatives.
- ensuring a separate funding stream for these allied health services to general care.

A further change to this model to look at *how* these teams are embedded within the residential aged care environment, and outcome accountability measures across the residential facility / outreach team partnership could achieve maximum benefits within the residential aged care sector.

One final comment would be to consider revising the wording within this proposition to be "fund multidisciplinary allied health *services*" as it has been noted that there is a degree of hesitancy in the sector around this proposition related to feeling this is referring to large consortium private "allied health *organisations*", with some previous negative experiences impacting perceptions.

Summary and recommendations

- There is a critical overarching need to ensure that all older people can access speech pathology services that appropriately and adequately address both their communication and swallowing needs.
- Speech Pathology Australia supports the combining of propositions A4, with some of the principles of A3 in relation to funding an alternate model of allied health service provision (including speech pathology) across the aged care sector.
- Outreach multidisciplinary allied health teams (including speech pathologists) which may be sited within existing infrastructure, such as hospital outreach teams, community health teams and other existing service providers, but allocated to specific residential care facilities in ratios according to need could ensure access to all allied health services as needed, and a partnership approach developed with the residential aged care service.
- The redesign of allied health service provision outlined above will significantly contribute to enhanced quality of life for older people and achieve the stated aims of the Royal Commission into Aged Care Quality and Safety.

Speech Pathology Australia commends the Commission for its foresight and appreciates the opportunity to contribute to this service redesign. If we can be of any further assistance or if you require additional information please contact Ms Kym Torresi, Senior Advisor, Aged Care at the Speech Pathology Australia National Office on 03 9642 4899 or agedcare@speechpathologyaustralia.org.au.

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