Statement of Dr Jennifer Anne Hewitt

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Address:	[redacted]
Date:	8th May 2020

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

2. The views I express in this statement are my own based on my education, training and experience. They are not intended to represent any views of my employers or any specific organisation.

3. This statement is provided in addition to my original Witness Statement, submitted 10th April 2020 and is in response to a subsequent request regarding my opinion on two documents provided to me by the office of the Royal Commission

   3.1. 20191220 – Canberra Hearing: Propositions under consideration by counsel assisting

   3.2. 20200311 - Adelaide Hearing 5 – Draft Propositions

4. The response provided to question 7 of my previously submitted Witness Statement will not be replicated in its entirety but is relevant so there may be some repetition. I have been requested to comment directly on the draft propositions relating to allied health (pages 12-16) of the "Consolidated Adelaide Hearing 5 Propositions" and the "Canberra Hearing: Propositions under consideration by counsel assisting".

   4.1 Regarding the Adelaide Hearing 5 propositions

   i. I strongly support the findings noted from Adelaide Hearing 4 regarding increasing the focus on preventative and early interventions and the equity of access to wellness reablement and rehabilitation services for all Australians. Current residential aged care funding precludes this.

   ii. I strongly support the recommendation to fund services on an assessed needs basis rather than from the individual's budget for ongoing care.

   iii. I strongly support a comprehensive care assessment being conducted for all individuals, however I believe that it could be conducted virtually if the person lives in rural, regional or remote Australia and does not have access to relevant allied health professionals required for their case. The current situation under COVID-19 and the consequent government restrictions have forced us to test this approach for some consumers in my current employ. We have been able to complete 1:1 reviews using a virtual platform when the consumer has either the digital literacy required themselves, lives with someone who has these skills, or has one of our own team visiting them as an essential service who can connect them to the relevant health care worker. Some allied health assessments are preferable to conduct face to face however, this solution is recommended where the individual will have difficulty accessing the service.

iv. I strongly agree that the emphasis on assessments should be on the principles listed, including: prioritising the person's quality of life and wellbeing, restoring or maintaining functioning and sustaining independence. I would add that these need to be determined with the person's own goals and needs as the focus and on the understanding that they are likely to change as the person moves through the phases of health common to ageing, these may include: maintenance (when all is well), crisis (if an acute health care need arises); restoration (recovering from an acute or long term health need); palliation and end of life. It is imperative that the person does not need to shift between providers and funding streams when these phases emerge, an integrated system where the funding relates to the individual not a package or program is recommended. Services and assessments should be funded to be face to face or virtual if accessibility is challenged.

v. I have witnessed a reduction in allied health professions employed in residential aged care first- hand. The Aged Care Funding Instrument has forced a "one size fits all" process by funding a few non-evidence-based interventions and removing the ability for allied health professionals to utilise their specialist skills. There is frankly little to be gained in conducting a person-centred, needs and goals- based assessment if it will not be possible to implement the recommendations. In my experience, at best, this results in allied health practitioners being frustrated by not being able to help the person with a best practice program, and at worst, being directed by the person's residential care facility to provide interventions that will maximise their funding, without any consideration for the needs and goals identified in the assessment. I have witnessed (but cannot quantify) a trend towards experienced therapists leaving the sector, and early career therapists turning over rapidly because of these issues.

vi. Regarding the calculation of at least 22 minutes of allied health provided to each resident per day, I would say that this may be difficult to provide for smaller facilities and some facilities in rural, regional and remote Australia. I have some reservations about the prescriptive sound of this proposal too, though have not seen the recommendation in detail. I strongly believe that funding and service provision should be on an assessed needs basis.

vii. Regarding the four propositions concerning improving access to primary allied health care by Australians receiving aged care services, I believe Propositions A1, A2 and A4 are likely to produce best outcomes for residents. Assessing needs and forming a person-centred plan is, in my opinion, more likely to be successfully achieved by the person, their representative (where needed), their Medical Practitioner and Allied Health team working together to integrate care. I believe that A3 may result in the same outcomes we have seen since the ACFI roll out in 2008, where Residential Aged Care Providers determine funding, there is a risk that the programs delivered may be prioritised to benefit the facility over the resident. Regarding high-level community care consumers, the fragmented nature of the package/program funding, long waiting periods for high care program access and complexity of accessing the system would also be best addressed by a combination of A1,2 and 4, in my opinion.

viii. To keep organisations, or practices accountable, a requirement should be made to measure and report on outcomes, including, but not limited to, consumer experience, health and wellness outcomes, ambulance call outs, avoidable hospitalisations, reduced lengths of stay, QALYs.

4.2 Regarding the Canberra Hearing: Propositions under consideration by counsel assisting

i. I strongly support Proposition CH1 in its entirety.

ii. I support CH 2 in principle but do not have extensive knowledge on this area.

iii. I fully support CH3 in its entirety and would extend this to include appropriate space and equipment for evidence based allied health assessment.

iv. I support CH 4 in its entirety.

v. I am unsure about CH 5 as I am unfamiliar with the nurse practitioner curriculum. I would stress that the nurse practitioners need to integrate care with allied health practitioners to avoid the current biomedical model of care continuing. My experience has been that when the assessments and management plans are devised without including allied health, the holisitic, evidence based and specialised services that can be provided with allied health are often omitted.

vi. I support CH6 and add that MBS items for allied health assessments and reviews be included in the MBS review.

vii. I celebrate and whole-heartedly support CH7 for both residential aged care and high-level community care consumers. I believe that both Local Health Networks and Primary Health Networks be included in this solution to avoid the potential for people to fall through the gaps when moving between primary and tertiary care.

viii. I strongly support CH8 and recommend that this be extended to include delivery of allied health services in rural, regional and remote Australia.

ix. I strongly support CH9.

x. I strongly support CH10.

xi. I strongly support CH11.

xii. I strongly support CH 12 and recommend that this be extended to include high level community care consumers.

xiii. I strongly support CH13 in its entirety. I have seen residents be transported home by their ageing relatives with no handover. I have even seen a resident arrive home by taxi, alone. Residents lose access to community transportation for all appointments once they move into facilities, resulting in severe access restrictions to many clinically indicated assessments and intervention services.

xiv. I strongly support CH14. There is no provision at present for subacute rehabilitation for residents of aged care. There are Transition Care (TC) Programs and Short Term Restorative Care (STRC) Programs for community dwellers but they are not consistently available and if someone is receiving Level 3 or 4 Home Care Package (HCP) Funding they are ineligible for these subacute rehabilitation packages.

xv. I strongly support CH 17 in its entirety.

xvi. I support CH18.

xvii. I strongly support CH 19.

xviii. I strongly support CH 20.

4.3 Additional Comments – an opportunity to further contribute?

I have been working with a dedicated team who are committed to transforming the way we care for our aged care community. Over the past 2 years, we have researched and planned for a proof of concept Systems Demonstrator that is entering the co-design stage. This program will draw together many of the propositions covered in the Adelaide and Canberra Hearings referred to above.

We are bringing together a local health network, primary health network, medical practitioners, allied health practitioners, consumer representatives, local government, funding bodies, peak bodies and researchers to partner with us (a not for profit community care provider, integratedliving Australia) to co-design an integrated, digitally supported, personal commissioning model of care that joins health and aged care at the individual level (proposition CH 7) through a centralised commissioning model. We are in discussion with a region we serve in rural Australia to conduct the Systems Demonstrator. Together we will design shared care protocols based on consumer needs and preferences including referral gateways, priority access to diagnostics, provision of hospital in the home with 24/7 specialist virtual care and wellness hubs that provide quick and easy access to a wide range of high impact services throughout the phases of health (CH 10, CH 11, CH12). This will be structured according to risk- based stratification in partnership with the consumer and an integrated team. This will include: a comprehensive assessment and establishment of a Personal Health Management Plan designed to support the person across the phases of health, long term; personal health managers (who will act like the Care Coordinators, Ch 17); integrated access to general practitioners, geriatricians, pharmacy, allied health, nursing, and the consumers with their representatives (by request) (CH 7). We plan to deploy a secure interoperative platform and digital infrastructure that integrates digital health records (CH 20). We will also ensure that outcomes are monitored and recorded under a robust integrated care quality performance framework, setting the benchmark for excellence and measuring health impact, financial impact, and social impact. We will evaluate:

- Quality of life
- Functional capacity
- Disease self- management
- Health literacy and engagement
- Avoidance of un-necessary hospitalisation
- Ambulance call outs
- Separations
- Escalation to higher level of care
- Cost effectiveness
- QALYs

We had commenced discussion with our stakeholders and were preparing a co-design event when the COVID-19 pandemic and ensuing restrictions developed. This will resume in the coming weeks/months. We would welcome representatives from the Royal Commission to collaborate with us to test this approach. The funding model researched and currently in focus for this project is a risk share capitation model that has been modelled over a 2-3 year period and demonstrated encouraging health, financial and social outcomes. My colleague Kylie Houlihan conducted this modelling and would be a valuable contributor to further Royal Commission funding discussions.