Royal Commission into Aged Care Quality and Safety

ADELAIDE HEARING 5 – DRAFT PROPOSITIONS

Adelaide Hearing 5 will inquire into how access to mental, oral and allied health care could be improved for Australians accessing aged care services, including through:

- increased funding and/or alternative funding models
- incentives for health care professionals to provide services at an individual's place of residence
- increased training for aged care workers
- clarifying responsibilities of approved providers and implementing performance measures or performance indicators.

This document sets out a series of draft propositions which have been developed by staff of the Royal Commission into Aged Care Quality and Safety (**Royal Commission**) to test in Adelaide Hearing 5. These draft propositions do not necessarily reflect the views of the Royal Commissioners.

The Canberra Hearing, held in December 2019, inquired into the interfaces between the aged care system and the health care system, including Commonwealth and state and territory programs. It examined whether older people, particularly those living in residential aged care, are able to access the health services they need as they age.

The Canberra Hearing did not examine mental, oral or allied health. However, some of the draft propositions that were tested in that hearing, or which have been developed following that hearing, would have an impact on the provision of these services to Australians accessing aged care services. In summary, those draft propositions concern, among other things:

- Multi-disciplinary outreach health services accessible to all Australians living in residential aged care or receiving high-level home care. Psycho-geriatricians and allied health practitioners should form part of these multi-disciplinary outreach services. [Proposition CH7]
- Greater clarity of the role and responsibility of residential aged care providers to deliver health care (including mental health care). [Proposition CH18]
- The introduction of a designated care coordinator for older Australians with high care needs. The care coordinator would be a registered health practitioner, engaged by the aged care provider, who would liaise with health care practitioners and services. [Proposition CH17]
- A new primary care model for aged care recipients in which general practices can apply to become accredited aged care practices (this draft proposition is set out at the conclusion of this document).
- Responsive funding for comprehensive health assessments for Australians accessing aged care, which are reviewed periodically. [Proposition CH6]

These draft propositions were the subject of evidence in the Canberra Hearing, and have been addressed in submissions which will be available on the Royal Commission's website. A copy of Counsel Assisting's submissions following the Canberra Hearing is **enclosed**.

In addition, Counsel Assisting made submissions relevant to mental, oral and allied health care at both Adelaide Hearing 3: the future of the aged care workforce and Adelaide Hearing 4: future aged care program re-design.

Mental health

Introduction

The high prevalence of mental health issues among people in residential aged care compared with the general community is well documented.[1] According to Australian Institute of Health and Welfare data (drawn from data held by the Aged Care Financing Authority) 45% of newly admitted aged care residents display symptoms of depression, along with 52% of all people in residential aged care.[2] Existing Aged Care Financing Instrument (ACFI) data shows that as at 30 June 2018, 49% of people in permanent residential aged care had a diagnosis of depression.[3]

The draft propositions set out in this section aim to improve the provision of mental health care to Australians accessing aged care services, particularly those living in residential aged care. In summary, these propositions are as follows:

- Proposition M1: Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care
- Proposition M2: Fund mental health assessments and mental health treatment plans by a psychiatrist for Australians living in residential aged care
- Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care
- Proposition M4: Incentivise psychiatrists and psychologists to attend residential aged care facilities
- Proposition M5: Increase outreach services by state and territory government older person's mental health services at the residences of Australians accessing aged care services
- Proposition M6: Increase mental health training for personal care workers
- Proposition M7: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents.

As set out earlier, draft propositions tested in the Canberra Hearing may also be relevant to improving mental health care for older Australians. These draft propositions are set out in the enclosed submissions, and an alternate draft proposition for a new model of primary care is set out at the end of this document.

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[1] Australian Institute of Health and Welfare, People's care needs in aged care, 2019, Australian Government, https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care, viewed 06 February 2020.

[2] Australian Institute of Health and Welfare, 2013, Depression in Residential Aged Care 2008-2012, Aged Care statistics series No. 39. CAT. No. AGE 73. Canberra: AIHW.

[3] Department of Health, People's care needs in aged care factsheet 2017-18, https://www.gen-agedcaredata.gov.au/www_aihwgen/media/2018-factsheets/People-s_care_needs_in_aged_care_factsheet_2017%e2%80%9318.pdf, viewed 5 February 2020.

Draft propositions specific to mental health

Proposition M1: Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care

The Australian Government should immediately remove the barriers to use of existing Medicare Benefits Schedule (MBS) items by people living in residential aged care facilities, by allowing general practitioners to prepare mental health treatment plans for residents on the same basis as people living in the community

1. This proposition proposes to remove the existing barrier for people living in residential aged care, and allow them to access mental health treatment plans prepared by a general practitioner (through the MBS funded Better Access Initiative) on the same basis as people living in the community.[4] This would also allow people living in residential aged care to access mental health services (named psychological services in the MBS) pursuant to a treatment plan.

2. Consideration should also be given to whether the services accessed through a mental health treatment plan prepared by a general practitioner (10 psychological services annually) should be increased for people living in residential aged care. One option might be to raise the limit to 15 psychological sessions each six months, which would equate to once a fortnight (see Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care).

3. This proposition should also be considered alongside Proposition M2 (Fund mental health assessments and treatment plans prepared by a psychiatrist for Australians living in residential aged care).

4. It is noted that mental health issues, particularly depression and anxiety, can coexist with cognitive decline and dementia. Consideration should be given to ensuring that access to MBS mental health items is available to older people, irrespective of whether they are also accessing dementia or cognitive impairment related services. This applies to other draft propositions set out in this section.

Proposition M2: Fund mental health assessments and mental health treatment plans by a psychiatrist for Australians living in residential aged care

By 1 January 2022 the Australian Government should create new MBS items for:

- **a comprehensive mental health assessment, including preparation of a residential aged care mental health treatment plan, by a psychiatrist within a month of a person entering residential care**
- **a review by a psychiatrist (at three monthly intervals, or more frequently in exigent circumstances) of a comprehensive mental health assessment and residential aged care mental health treatment plan.**

5. The Royal Commission has heard evidence that entry into residential aged care may contribute to mental health issues.[5] Evidence has also been given at previous hearings of

[4] MBSOnline Associated Note AN.0.56 for GP mental health treatment plans states that GPs should use a different item number (MBS 731 Chronic disease management) to contribute to care plans for residents of aged care facilities: An education guide from Services Australia says that GP mental health treatment plans are available to people living in the community or private in-patients. https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-better-access-mental-health-care-eligible-practitioners-and-allied-health/35591, viewed 10 March 2020.

[5] Transcript, Hearing, Sydney Hearing, Professor Henry Brodaty, 17 May 2019 at T1904.15-25; Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5161.30-45.

the Royal Commission about the importance of assessment and care planning for people entering residential care.[6]

6. Psychiatrists are currently funded to perform assessments and develop mental health management plans for people living in the community.[7] These MBS-funded psychiatrist assessments are not available to people living in residential aged care and receiving an Australian Government subsidy for their care.[8] This proposition would allow people living in residential aged care to access mental health services through a comparable plan.

7. The MBS items for psychiatric assessments and management plans are also subject to strict location requirements and usually must be delivered at the psychiatrist's consulting rooms.[9] Travel may be difficult for people accessing aged care services. Proposition M4: Incentivise psychiatrists and psychologists to attend residential aged care facilities, set out below, is intended to operate in conjunction with this proposition so as to encourage practitioners to attend people's place of residence.

8. In relation to this proposition and Proposition M1 (Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care), it is proposed that residents would only require (and therefore should only be eligible for) a mental health assessment and plan prepared by either a general practitioner or a psychiatrist. Consideration should be given to whether, if this proposition is implemented, there is still a need for MBS funding for mental health treatment plans prepared by General Practitioners for Australians living in residential aged care (Proposition M1).

9. Finally, consideration should be given to whether approved providers of residential aged care services should be required to ensure that residents have an opportunity to receive an initial mental health assessment within a set timeframe after entering residential aged care (whether undertaken by a general practitioner or a psychiatrist) and periodic reviews. Consideration should also be given to how any such requirement could be evaluated or enforced (see Proposition M7: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents).

Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care

By 1 January 2022 the Australian Government should create a new MBS item for psychologists providing services pursuant to a mental health treatment plan to Australians living in residential aged care, with up to fifteen services in a six month period, and benefits commensurate with the Australian Psychological Society National Schedule of Recommended Fees.

10. This proposition addresses services provided by psychologists pursuant to a mental health treatment plan prepared by either a general practitioner or a psychiatrist (see Proposition M1 and Proposition M2).

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[6] For example, Transcript, Sydney Hearing, Elizabeth Beattie, 14 May 2019 at T1619.27-29.

[7] Refer to MBS item number 291, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=291, accessed 5 February 2020.

[8] Royal Australian & New Zealand College of Psychiatrists, Supplementary submission to the MBS review taskforce of psychiatry services May 2018, https://www.ranzcp.org/files/resources/submissions/ranzcp-sub-to-supplementary-mbs-review-taskforce.aspx, accessed 5 February 2020.

[9] MBS item number 291 (for assessment and development of management plan) and item number 293 (for review of management plan) must be delivered at the psychiatrist's consulting rooms.

11. Despite there being a high prevalence of mental health issues among older people in residential aged care, recent research indicates that less than 1% of those people receive any kind of psychosocial treatment for a mental health condition.[10] A recent study found:

    a. psychologists are less likely to be employed by residential aged care facilities compared with other service providers (including diversional therapists, pastoral care workers and occupational therapists)

    b. there are more referrals made to GPs, pastoral care workers and geriatricians than psychologists for people who displayed depression and anxiety symptoms

    c. residents are more likely to be referred for medication than psychological treatment.[11]

12. Psychologists are able to receive MBS rebates for providing psychological services through the Chronic Disease Management Program and the Better Access Initiative. However, these services are limited for people receiving Australian Government subsidies for residential aged care (up to 5 provided under the Chronic Disease Management program).

13. In addition, the subsidies that are provided are significantly lower than the fees recommended by the Australian Psychological Society. This may mean that psychologists will charge a gap fee, which can affect the access to these services for older people in both residential aged care and home care. This proposition is intended to remove this discrepancy in payment to psychologists.

14. While this proposition is directed to funding for individual sessions, consideration could also be given to whether this should include funding for group sessions (see, for example, MBS item 80020 which pays benefits for the concurrent treatment of six to ten patients).

Proposition M4: Incentivise psychiatrists and psychologists to attend residential aged care facilities

By 1 January 2022 the Australian Government should establish an access incentive payment scheme with stepped payments for:

- **psychiatrists carrying out more than 50/100/150/200 weighted comprehensive mental health assessments or reviews in residential aged care facilities annually**
- **psychologists carrying out more than 500/1000/1500 weighted services in residential aged care facilities annually.**

Services provided (other than through telehealth) in residential aged care facilities located in outer regional or remote areas should have a weighting to reflect the higher costs of service provision in these areas.

15. People accessing aged care services may have reduced mobility, and it may be difficult for them to travel to access mental health (and other health) care services.[12] In view of these challenges, mental health services may often need to be provided in an older person's place of residence.

16. One option for increasing the provision of psychological and psychiatric services in residential aged care facilities is through providing funding incentives.

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[10] TE Davison et al., 'Brief on the role of psychologists in residential and home care services for older adults', *Australian Psychologist*, 2016, Vol 52, 6, pp 397-405.

[11] J Stargatt, SS Bhar, TE Davison, NA Pachana, L Mitchell, D Koder, C Hunter, C Doyle, Y Wells and E Helmes, 'The availability of psychological services for aged care residents in Australia: A survey of facility staff', *Australian Psychologist*, 2017, Vol 52, 6, pp 406-413.

[12] See for example Transcript, Canberra Hearing, Leonard Gray, 12 December 2019, T7493.41-45.

17. This proposition is modelled on the General Practitioner Practice Incentive Payment (**PIP**), which encourages general practitioners to provide services in residential aged care facilities.[13] The PIP supplements the MBS 'fee-for-service' payment model. The incentive payment is made directly to a general practitioner upon meeting the eligibility criteria.

18. Consideration should be given to whether the thresholds set out in this draft proposition would provide an adequate incentive, or whether they should be lower. Consideration should also be given to whether this proposition should extend to the provision of services at the residence of people accessing high-level home care services.

19. Finally, we note that consideration could be given to whether there is a need for additional training for psychologists and psychiatrists providing services to people accessing aged care services.

Proposition M5: Increase outreach services by state and territory government older person's mental health services to Australians accessing aged care services

By 1 January 2022 the Australian, state and territory governments should create a funding stream under the National Health Reform Agreement to fund outreach services by state and territory government older person's mental health services at the residence of Australians accessing aged care services.

20. Each jurisdiction (state and territory) provides mental health services for older people (**OPMHS**). These multi-disciplinary services are generally provided to older people living with severe mental illness (that is, people over 65 years, or Aboriginal and Torres Strait Islander people who are over 50 years).

21. There is no standard framework for the delivery of OPMHS. Eligibility, participating specialists, and the information available to the public varies across jurisdictions. In particular, the extent to which these services offer out-reach services to residential aged care facilities varies across and within jurisdictions.[14] There does not appear to be any data on the extent to which these services are provided to people living in residential aged care. It is unclear whether these services, even if they are available to people living in residential aged care, are provided as needed.

22. These specialist services should be available to people accessing aged care services across Australia, and there should be a level of consistency in terms of eligibility and access. One of the propositions tested in the Canberra Hearing was whether there should be multi-disciplinary outreach health services for people living in residential aged care or accessing high-level home care (Proposition CH7). Consideration should be given to whether OPMHS should form part of these multi-disciplinary outreach services.

[13] Services Australia, *Practice Incentives Program*, Australian Government, 2019, servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program, viewed 06 February 2020.

[14] See information provided by the state and territory government representatives and tendered in the Canberra Hearing. Only Queensland explicitly stated that their Older Person's Mental Health Services provide outreach services to people in residential aged care, providing individual assessment and ongoing treatment. See Exhibit 14-28, Canberra Hearing, Statement of Dr John Wakefield, WIT.0571.0001.0001 at 0040 [269].

Proposition M6: Increase mental health training for personal care workers

Training for personal care workers should include training on addressing loneliness and disengagement, and on recognising the symptoms of mental illness that require referral for further evaluation and treatment.

23. The Royal Commission has heard evidence that personal care workers do not receive sufficient mental health training, including regarding suicide prevention.[15]

24. Consideration should be given both to initial training needs (including components of Certificate III qualifications), and the need for ongoing training. Consideration should also be given to whether ongoing training, if recommended, should be mandated and whether approved providers should be responsible for ensuring it occurs.

25. It may also be important to clearly articulate what is expected of personal care workers with respect to mental health, including identifying symptoms of depression, and working with people living with advanced dementia.

Proposition M7: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents

The *Quality of Care Principles 2014* (Cth) and any subsequent instrument should include an explicit and measureable requirement to maintain the mental health of residents.

26. Under Standard 3(3)(d) of the *Quality of Care Principles 2014* (Cth) an approved provider must demonstrate that "deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner". This standard does not require approved providers to ensure that Australians accessing their aged care services have an ongoing mental health care plan in place.

27. In view of the high rates of mental health conditions among people in residential aged care, including depression and anxiety, there is a need to ensure that maintaining the mental health of residents is core business for residential aged care providers. One way of ensuring this is to introduce an explicit and measurable requirement that approved providers maintain the mental health of residents.

28. Consideration should be given to how the maintenance of mental health of residents could be measured or assessed. One option is measuring rates of mental illness, such as depression or anxiety. Another is measuring the services provided to residents.

29. Consideration should also be given to whether there could be a performance indicator relating to mental health, and whether this should be voluntary or mandated. Under the National Aged Care Mandatory Quality Indicator Program, there are performance indicators for pressure injuries, use of physical restraint and unplanned weight loss. Two further indicators for medication management and falls are being developed.

[15] See Exhibit 3-70, Sydney Hearing, Statement of Joseph Elias Ibrahim, WIT.0115.0001.0001 at 0021 [102], Exhibit 1-52, Adelaide Hearing 1, Statement of Melissa Coad, WIT.0018.0001.0001 at 0005 [32]; Exhibit 2-26, Adelaide Hearing 2, Statement of Sally Francis Warren, WIT.0082.0001.0001 at 0002 [14].

Oral health

Introduction

Poor oral health can have a significant impact on wellbeing, because it directly affects people's ability to speak, eat and socialise.[16] It can also contribute to serious health complications such as aspiration pneumonia, and lead to emergency care or death for the elderly.[17]

In 2016-17, Australians aged over 65 years had potentially preventable hospitalisations relating to dental conditions at a rate of 2.9 per 1,000 population.[18] This is the equivalent of 10,495 hospitalisations.

The Royal Commission has heard evidence about inadequate day to day oral health care provided in residential aged care facilities. In the Cairns Hearing, the Royal Commission heard evidence that many oral health problems of older people can be prevented with daily 'evidence-based' oral health care and timely referral to appropriate dental health practitioners.[19]

The draft propositions set out in this document aim to improve the provision of oral health care to Australians accessing aged care services, particularly those living in residential aged care facilities. In summary, these propositions are as follows:

- Proposition D1: Fund public dental services to provide outreach services to Australians accessing aged care services in their place of residence
- Proposition D2: Increase oral health care training for personal care workers
- Proposition D3: Greater clarity on the role and responsibilities of residential aged care providers to maintain the oral health of residents
- Proposition D4: Fund services delivered by oral hygienists and dental and oral health therapists in residential aged care facilities.

As set out earlier, draft propositions tested in the Canberra Hearing may also have an impact upon oral health care for older Australians. These draft propositions are set out in the enclosed submissions, and an alternate draft proposition for a new model of primary care is set out at the end of this document.

Draft propositions specific to oral health

Proposition D1: Fund public dental services to provide outreach services to Australians accessing aged care services in their place of residence

The Australian and state and territory governments should enter into a new National Partnership Agreement to begin no later than 1 January 2022 to fund public dental services to provide outreach services to aged care recipients in their place of residence (either in the community or in residential care facilities) if they are unable to travel to receive public dental services.

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[16] Australian Institute of Health and Welfare, Oral Health and Dental Care in Australia 2019 Introduction, https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction, viewed 6 February 2020.

[17] Exhibit 3-51, Sydney Hearing, Statement of Dr Peter Foltyn, WIT.0121.0001.0001 at 0004-0005 [28].

[18] Australian Institute of Health and Welfare, Oral Health and Dental Care in Australia 2019 Hospitalisations, https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations, viewed 6 February 2020.

[19] Exhibit 6-49, Cairns Hearing, Statement of Adrienne Lewis, WIT.0246.0001.0001 at 0005 [28].

Under the Agreement the Australian government should pay 50% of the Dental Weighted Activity Unit (DWAU) cost of services provided, up to a cap of each jurisdiction's aged care recipient share of $120 million in 2021-22.

The national total should be indexed annually for price movements and increases in the eligible population.

30. The reduced mobility of older people may make it difficult to transport them to service providers. In view of these challenges, dental services may often need to be provided in an older person's place of residence.

31. Some private dentists[20] and some state dental services[21] currently provide outreach services to residential aged care facilities, but these outreach services are limited.

32. One option for improving access to dental services for Australians accessing residential aged care and high-level home care services is to fund public health dental services to provide outreach services in an individual's place of residence.

33. As almost half of all aged care residents have their accommodation costs subsidised by the Government due to an inability to pay (based on income and assets test),[22] more than half are likely to be eligible for state-funded public dental services. Public dental services tend to be subject to waiting lists which prioritise people based on how urgently they need treatment.[23]

34. It is proposed that increased funding be provided through joint contributions by state and territory governments on the one hand and the Australian government on the other (50% each).

35. The National Partnership Agreement on Public Dental Services is a mechanism through which older persons outreach dental funding could be established. That Agreement is about to expire, and is currently being renegotiated.

36. The DWAU is the measurement used for performance indicators (accountability for funding) under the Agreement. It measures the number and service intensity of dental services provided. The DWAU is calculated using Australian Dental Association three digit item codes and a weighting for those items.

37. Under this proposition, funding would be provided to public dental services, who could then either directly provide the service or outsource to private providers. This would allow for a systematic approach to service provision, with the state public dental services managing the dental care of older Australians.

38. The waitlist associated with public adult dental services should not affect this older person's outreach service, because it would be provided through a separate funding stream.

39. Consideration should be given to who should be able to access these outreach services, and how any requirement that an individual be unable to travel could be established.

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[20] For example, Future Care Dental Group Pty Ltd and Mobile Dental Clinics Australia are privately owned companies which provide dental services directly to residents in aged care facilities.

[21] For example, the Victorian Government provides funding for Dental Health Service Victoria and the South Australian Government provides funding for SA Dental Health Services.

[22] Aged Care Financing Authority, *Sixth report on the Funding and Financing of the Aged Care Sector July 2018*, p.35.

[23] Australian Institute of Health and Welfare, A discussion of public dental waiting times information in Australia 2013-14 to 2016-17, p 2, https://www.aihw.gov.au/getmedia/df234a9a-5c47-4483-9cf7-15ce162d3461/aihw-den-230.pdf.aspx?inline=true, viewed 7 February 2020.

Proposition D2: Increase oral health care training for personal care workers

Training for personal care workers should include training on providing routine oral health care and on recognising the symptoms of oral disease that require referral for evaluation and treatment by a dental professional.

40. The Royal Commission has heard evidence that the delivery of daily oral health care to older people in aged care settings is primarily the role of personal care workers, and should form part of their activities of daily living routine (i.e. showering, dressing, personal hygiene).[24] The Royal Commission has also heard evidence that increased oral health literacy among personal care workers is needed.[25]

41. Common entry-level qualifications for personal care workers are Certificate III in Individual Support (Ageing) and Certificate IV in Ageing Support. There are no mandatory units in either course that explicitly cover oral health care.[26]

42. There are no requirements for approved providers to ensure their staff have professional development training in oral care (see Proposition D3). However, there are some oral health training programs available to aged care providers and their staff.[27]

43. Consideration should be given both to initial training needs (including components of Certificate III qualifications), and the need for ongoing training. Consideration should also be given to whether ongoing training, if recommended, should be mandated and whether approved providers should be responsible for ensuring it occurs.

44. The Royal Commission has heard evidence that the high turn-over rate among staff working in residential aged care facilities may limit the utility of one-off oral health training.[28]

45. It may also be important to clearly articulate what is expected of personal care workers with respect to oral health care (see Proposition D3: Clarify the responsibility of residential aged care providers for maintaining the oral health of their residents).

Proposition D3: Greater clarity on the role and responsibilities of residential aged care providers to maintain the oral health of residents

The *Quality of Care Principles 2014* (Cth) and any subsequent instrument should include an explicit and measureable requirement that residential aged care providers maintain the oral health of residents.

46. Item 2.7 in Part 2 of Schedule 1 to the *Quality of Care Principles 2014* (Cth) provides that residential aged care providers are required, for all care recipients who need it, to make arrangements for dental health practitioners (among other practitioners) “to visit care recipients, whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients, or are made direct with a health practitioner”.

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[24] Exhibit 6-49, Cairns Hearing, Statement of Adrienne Lewis, WIT.0246.0001.0001 at 0007 [36].
[25] Exhibit 6-49, Cairns Hearing, Statement of Adrienne Lewis, WIT.0246.0001.0001 at 0007 [36].
[26] My Skills, Certificate III in Individual Support (Ageing), Australian Government, https://www.myskills.gov.au/registeredtrainers/search?CourseCode=CHC33015, viewed 17 February 2020; My Skills, Certificate IV in Ageing Support, Australian Government, https://www.myskills.gov.au/courses/details?Code=CHC43015, viewed 17 February 2020
[27] Exhibit 6-49, Cairns Hearing, Statement of Dr Adrienne Lewis, WIT.0246.0001.0001 at 0009-0010 [51]-[52].
[28] See exhibit 6-49, Cairns Hearing, Statement of Dr Adrienne Lewis, WIT.0246.0001.0001 at 00010 [58] with respect to the Better Oral Health in Residential Care program.

47. The standards themselves make no reference to oral care. There is one reference in the guidance material for the standards to providers ensuring consumers' oral health care preferences are reflected in care and service plans.[29]

48. This proposition (D3) is directed at ensuring that residential aged care providers are held responsible for the oral health of their residents.

49. Expected outcome 2.15 of the former Accreditation Standards explicitly required that residential aged care providers ensure that "Care recipients' oral and dental health is maintained".[30] However, the Royal Commission has heard evidence that the old standards were also insufficient in ensuring evidence-based oral care.[31]

50. One way of ensuring that oral care is core business for residential aged care providers is to introduce an explicit and measurable requirement that approved providers maintain the oral health of residents.

51. Consideration should be given to how the maintenance of oral health of residents could be measured or assessed. One option is measuring particular outcomes, another is measuring the oral health services provided to residents.

Proposition D4: Fund services delivered by oral hygienists and dental and oral health therapists in residential aged care facilities

The Australian government should establish a new mechanism to fund organisations to supply oral hygienists and dental and oral health therapists to residential aged care facilities to carry out regular oral health assessments and personal care worker education in oral hygiene.

52. The Royal Commission has heard evidence about the importance of oral health assessments for older Australians, particularly those living in residential aged care.[32] There is currently no requirement for a formal oral health assessment to be conducted as part of the aged care assessment conducted by a local assessor from ACAT.[33]

53. Ongoing and basic dental services can be provided by oral hygienists and/or dental and oral health therapists in a residential aged care facility with very little in the way of specialised equipment. These services include oral examinations, scale clean and polish, extractions and restorations (not endodontic or prosthodontic).

54. This proposition (D4) suggests that funding be provided to dental and oral health organisations through a national dental scheme to provide ongoing services to residential aged care facilities. In the alternative, funding could be provided directly to residential aged care providers to engage dental health practitioners. Another alternative is that funding could be provided to the public dental services proposed in Proposition D1 to provide these oral hygienists and dental and oral health services.

55. Other mechanisms for funding could include: an MBS item for oral health assessments for Australians aged over 75 years, inclusion of oral health assessment in the ACAT process

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[29] Aged Care Quality and Safety Commission, Guidance and Resources for Providers to support the Aged Care Quality Standards, p 48, https://www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V8.pdf, viewed 17 February 2020.

[30] Aged Care Quality and Safety Commission, Accreditation Standards Fact Sheet, https://www.agedcarequality.gov.au/sites/default/files/media/accreditation_standards_fact_sheet_updated.pdf, viewed 17 February 2020.

[31] Exhibit 3-51, Sydney Hearing, Statement of Dr Peter Foltyn, WIT.0121.0001.0001 at 0006 [32]-[33]; Exhibit 6-49, Cairns Hearing, Statement of Dr Adrienne Lewis, WIT.0246.0001.0001 at 0007 [37].

[32] Exhibit 3-51, Sydney Hearing, Statement of Dr Peter Foltyn, WIT.0121.0001.0001 at 0013 [65].

[33] Exhibit 3-51, Sydney Hearing, Statement of Dr Peter Foltyn, WIT.0121.0001.0001 at 0013 [64].

(with an appropriate referral pathway), or mandatory oral health assessments upon entry to residential aged care.

56. However, these mechanisms would not necessarily provide ongoing oversight of oral health needs by qualified practitioners, and would not contribute to increasing the oral health capability and processes of residential aged care facilities.

57. Consideration should be given to the interaction between this proposition and Proposition D3 (Greater clarity on the role and responsibilities of residential aged care providers to maintain the oral health of residents).

Allied Health

Introduction

The Royal Commission has heard evidence about the importance of allied health services for Australians accessing aged care services.[34] The Royal Commission has also heard that allied health is a key contributor to maintaining quality of life and independence.[35]

In Adelaide Hearing 4 on future aged care program redesign, Counsel Assisting made a number of submissions relevant to allied health, including that:

- the redesigned aged care program should have an increased focus on preventative and early interventions with the aims of maintaining and restoring function, sustaining independence, and enhancing wellbeing[36]

- wellness, reablement and rehabilitation services (including occupational therapy and physiotherapy) should be available for all Australians accessing aged care services, and should not be funded from the individual's budget for ongoing care, but should be available based on assessed need[37]

- there should be a comprehensive care assessment which should be face-to-face, taking into account the person's living environment and other relevant circumstances, and be conducted with a strong emphasis on certain principles, including: prioritising the person's quality of life and wellbeing, restoring or maintaining functioning, and sustaining independence.[38]

The Royal Commission has heard evidence that Australians accessing aged care services have limited access to allied health care.[39] Research has shown that the number of allied health

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[34] See for example: Transcript, Canberra Hearing, Professor Leon Flicker, 12 December 2019 at T2044.26-34; Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3402.6-10; Transcript, Sydney Hearing, Jennifer Lawrence, 12 May 2019 at T1584.28-34; Transcript, Sydney Hearing, Professor Joseph Ibrahim, 16 May 2019 at T1807.5-7.

[35] See submissions in response to Aged Care Program Redesign Consultation Paper 1 – Program Design in Aged Care from: Allied Health Professions Australia; Australian Podiatry Association; Dietitians Association of Australia; Pharmaceutical Society of Australia; Occupational therapy academics, Flinders University; Speech Pathology Australia; Australian Physiotherapy Association; Audiology Australia.

[36] Submissions of Counsel Assisting, Adelaide Hearing 4: future aged care program re-design, 4 March 2020, p 4.

[37] Submissions of Counsel Assisting, Adelaide Hearing 4: future aged care program re-design, 4 March 2020, [47] and [217]-[218].

[38] Submissions of Counsel Assisting, Adelaide Hearing 4: future aged care program re-design, 4 March 2020, [193].

[39] See for example: Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3402.6-7; Transcript, Adelaide Hearing, Gerard John Hayes, 21 February 2019 at T573.9-11; Transcript, Sydney Hearing,

professional employed in the residential aged care workforce has reduced over time. As a proportion of direct care employees in the residential aged care workforce, allied health professionals and assistants decreased from 7.6% in 2003 to 4.0% in 2016.[40] Out of total staff working in residential aged care facilities in Australia, proportions of registered allied health professionals have reduced from 1.7% in 2012, to 1.1% in 2016.[41]

Counsel Assisting's submissions on the future of the aged care workforce made on 21 February 2020 included a submission that the Royal Commissioners should recommend that:

> An approved provider of a residential aged care facility should be required by law to have a minimum ratio of care staff to residents working at all times. The ratio should be set at the level that is necessary to provide high quality and safe care to the residents in its facility and should include at least 22 minutes of allied health care per resident per day.[42]

Some of the draft propositions set out in this section are consistent with Counsel Assisting's submissions, while others propose a different approach to funding allied health care in aged care. Staff of the Royal Commission are interested to hear views about these different approaches.

In addition, a draft proposition tested in the Canberra Hearing (Proposition CH7 – Multi-disciplinary outreach health services) was directed to provision of allied health service provision for those receiving acute and sub-acute care. The draft proposition for a new model of primary care, which is set out at the end of this document, has particular relevance to the draft propositions set out in this section.

The draft propositions set out in this section are concerned with improving access to primary allied health care by Australians receiving aged care services, particularly those living in residential aged care. These propositions suggest four mechanisms by which funding for allied health care could be increased to facilitate this improved access, in summary:

- 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.

These four propositions should be considered as alternatives, but it is possible that a combination could be recommended.

Professor Dimity Pond, 14 May 2019 at T1638.32-39; Transcript, Perth Hearing, Gaye Whitford, 26 June 2019 at T2518.12-15.

[40] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0010.

[41] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0009-0010.

[42] Submissions of Counsel Assisting, Adelaide Hearing 3: the future of the aged care workforce, 21 February 2019, RCD.0012.0061.0001 at 0034.

Draft propositions specific to allied health

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

By 1 January 2022, the Australian Government should implement a new MBS benefit structure for allied health services provided under an "Aged Care Plan" to aged care recipients.

The level of MBS benefit for allied health services provided under Aged Care Plans should be raised to a level that removes the current disincentive to provide MBS services and the need for service providers to charge large gaps.

58. With respect to MBS funding for allied health, under the Chronic Disease Management package, medical practitioners can refer people with chronic conditions for subsidised allied health services under a management plan.[43] People with a management plan can access five MBS-funded allied health services in a calendar year.[44]

59. The draft proposition relating to a new model of primary health care developed following the Canberra Hearing is that a new primary care model be implemented in which general practices could apply to become accredited aged care practices.[45] People with an ACAT assessment could enrol with an accredited practice, which would receive an annual capitation payment for each enrolled person's level of assessed need. Accredited practices would also be required to prepare an 'Aged Care Plan' for each enrolled person, which would include referrals for allied health services.

60. Under this proposition (Proposition A1), new MBS items would fund allied health services provided pursuant to an 'Aged Care Plan' to older Australians enrolled with an accredited general practice.

61. It is proposed that there would still be a cap or limit on allied health services and that Government should set this limit based on clinical advice. For example, it might be that physiotherapy and psychology should be available weekly, podiatry monthly, while diabetes education or dieticians should be available only quarterly, and audiometry annually. Consideration should also be given to whether there should be different approved limits for people in residential aged care compared with people accessing aged care in the community.

62. This proposition (Proposition A1) still operates within the traditional fee for service model of the MBS, which pays for direct one-on-one treatment activities between the allied health professional and older person. It would not reimburse allied health professionals for work they undertook to support family members and aged care staff.

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[43] Department of Health, *Chronic Disease Management (formerly Enhanced Primary Care or EPC) – GP services*, https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement, viewed 9 January 2019.

[44] Department of Health, *Chronic Disease Management – Provider Information Fact Sheet*, https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-factsheet-chronicdisease.htm, viewed 10 January 2019. A person with a diagnosis of type 2 diabetes can also access up to 8 additional group allied health services following assessment by a relevant allied health practitioner. See MBSOnline, *Medicare Benefits Schedule MN.9.1 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes – Eligible Patients*, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=MN.9.1, viewed 10 January 2019.

[45] This draft proposition is set out in more detail at the end of this document.

63. This proposition also relies on general practitioners identifying allied health needs and making appropriate referrals. Consideration could be given to alternative ways in which residents' allied health care needs could be identified.

64. Consideration should also be given to the need for allied health services to be provided at an individual's place of residence, and to the possibility of allied health services being delivered via telehealth, particularly in rural and remote areas.

Proposition A2: Fund accredited aged care general practices to provide a comprehensive range of allied health services to patients

By 1 January 2022, the Australian Government should fund aged care general practices to provide a comprehensive range of allied health services to patients.

65. Proposition A2 also relates to the proposed new model for primary care (see the draft proposition set out at the end of this document).

66. Under this proposition, the risk-adjusted capitation payment made to accredited general practices to cover primary care services would be increased to cover the provision of allied health services. For example, a practice with an enrolled aged care recipient requiring three hours of physiotherapy per week would receive $30,000 per year. This would require accredited general practices to employ or engage allied health professionals to provide services. This model would not necessarily embed allied health services in residential aged care facilities.

67. Consideration would need to be given to how feasible it would be to develop a price schedule. Consideration should also be given to how accredited general practices could be held accountable for ensuring services are delivered.

68. Finally, consideration would need to be given to the provision of services at an individual's place of residence.

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

By 1 January 2022, the Australian Government should fund aged care providers to deliver a comprehensive range of allied health services to people receiving aged care.

69. This proposition, and Proposition A4 (the Australian Government should fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to people accessing aged care) are both directed at creating a funding mechanism that facilitates more holistic allied health care, allowing for a broader range of service provision beyond one-on-one treatment.

70. Allied health professionals may be able to provide beneficial services beyond treatment for individual care, such as building the expertise of aged care staff (both in residential and home care) through training, advice and improvement initiatives.[46] In addition, older people with complex needs may not be well served by short assessments and treatments by different service providers.[47] For this reason, there may be benefits in ensuring that any proposed funding model be directed at embedding allied health services within aged care facilities.

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[46] Submission of Allied Health Professions Australia: Supplementary Submission – Aged Care Program Redesign, 24 January 2020, AWF.660.00081.0001 at 0001-0009; Submission of Dietitians Association of Australia, *Aged Care Program Redesign: Services for the Future*, 21 January 2020, AWF.660.00023.0001 at 0001_0004.

[47] See further: Allied Health Reference Group Submission to Medicare Benefits Schedule Review Taskforce, 2019, p 23.

71. Under this proposition (Proposition A3), aged care providers would receive additional funding to deliver a full range of allied health services to residents. This could be provided pursuant to an 'Aged Care Plan' (see the draft proposition for a new primary health model, set out below). Consideration could be given to alternative ways in which residents' allied health care needs could be identified. Aged care providers could choose whether to contact allied health practitioners or organisations, and/or employ in-house allied health professionals.

72. The proposed Australian National Aged Care Classification (AN-ACC) system could be expanded to add subclasses reflecting the allied health care needs of different groups.

73. Consideration should also be given to how approved providers could be held accountable for the delivery of adequate and appropriate allied health services.

74. Finally, consideration should be given to whether this approach to funding could contribute to a divide between the health system and the aged care system, on the basis that the community allied health care system would not extend to residential aged care and a separate system for funding allied health care in residential aged care result. This approach would not necessarily embed allied health services in residential aged care facilities at all times – their presence could still be episodic depending on the resident profile. Lastly, there may be an economy of scale issue for smaller residential aged care providers, particularly those in rural and remote locations.

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

By 1 January 2022, the Australian Government should fund multi-disciplinary allied health organisations to deliver a comprehensive range of allied health services to people accessing aged care.

75. The Royal Commission has heard about the need for holistic care, multi-disciplinary team assessment and restorative care.[48] Positive outcomes for frail older people through comprehensive geriatric assessment by multi-disciplinary teams have been well established in the geriatric literature for several decades.[49]

76. Under this proposition, capitation funding would be provided directly to organisations that provide multi-disciplinary allied health services. State based multi-disciplinary hospital-led outreach services could also seek funding for this more preventative and primary care in addition to sub-acute care.

77. Consideration would need to be given to which organisations could qualify for this funding, and whether there would be adequate supply of such services (or whether there would need to be an interim arrangement). Consideration would also need to be given to how referral to these services could occur.

78. Finally, consideration would need to be given to how organisations receiving this funding could be held accountable for the delivery of services and health outcomes.

Alternate draft proposition – a new primary care model

[48] See submissions in response to Aged Care Program Redesign consultation paper from: Allied Health Professions Australia; Australian Podiatry Association; Dietitians Association of Australia; Pharmaceutical Society of Australia; OT academics, Flinders University; Speech Pathology Australia; Australian Physiotherapy Association; Audiology Australia.

[49] Luker et al. (2019), 'The evidence for services to avoid or delay residential aged care admission: a systematic review', *BMC Geriatrics*, Vol 19, 1, pp 1-20.

Propositions CH1 and CH2 addressed in Counsel Assisting's submissions following the Canberra Hearing addressed primary health care funding models and RACGP accreditation requirements, respectively.

Having considered the evidence in, and submissions received in response to the Canberra Hearing, staff of the Royal Commission have developed the following draft proposition, which relates to a number of the draft propositions for mental, oral and allied health care set out earlier in this document.

Alternate draft proposition: the Australian Government implement a new primary care model for aged care recipients by 2022

Under this new primary care model, general practices apply to the government to become accredited aged care practices.

This model could have the following features:

- The initial accreditation criteria might simply be RACGP accreditation, participation in after-hours cooperative arrangements and utilisation of My Health Record, but over time these could be strengthened to include features such as formal relationships with geriatricians and other specialists, or attainment of geriatric medicine or gerontology qualifications by GPs or other practice staff.
- People with an ACAT assessment can enrol with an accredited practice.
- The practice would receive an annual capitation payment according to an enrolled person's level of assessed need.
- In return for the capitation payment the practice agrees to meet the primary medical care needs of the person for the year, including cooperative arrangements to provide after-hours care if required.
- Practices can agree with people and their aged care providers on how care will be provided, including use of telehealth services, use of nurse practitioners, and so on.
- Practices must agree to accept any person who wishes to register with them (subject to geography).
- The capitation payment will be reduced by the value of benefits paid when an enrolled person sees a GP in another practice.

Practices will be held to account against a range of performance indicators, including immunisation rates and prescribing rates. They will be required to use My Health Record in conjunction with aged care providers, and required to initiate and take part in regular medication management reviews.

Practices will be required to prepare an "Aged Care Plan" (in collaboration with a geriatrician and the aged care provider if there is one) for each enrolled person, which includes referrals for appropriate allied health services and dentistry.