Allied Health in Residential Aged Care

Introduction

The Royal Commission into Aged Care Quality and Safety will inquire into how mental health, oral health and allied health care could be improved for people accessing aged care services. This submission is in regards to allied health in residential aged care.

The Commission has proposed a two tier funding option for Allied Health services or care. This is greatly concerning as the Commission could have missed **warning signs** where this proposal may not be suitable.

Through personal experiences of having a family member in aged care, I have been aware that aged care providers could be ignoring their obligations in regards to providing allied health services to recipients.

Information provided in this submission is to assist the Royal Commission have an understanding of some of the issues relating to allied health in aged care and to examine obscure practices which have continued to be overlooked. Some of these relate to the proposal made by the Commission. Additionally it will assist to determine solutions or improvements that would be beneficial to recipients.

Allied Health Care or Services for Residential Aged Care Recipients

According to the Quality of Care Principles 2014[1] that sits under the Aged Care Act 1997[2], Australian Government-funded residential aged care providers are obligated to provide allied health care and services. These care and services are listed under Schedule 1. Please refer to the items listed in this Schedule to give you an overview of the care or services that must be provided. Part 3 of the Schedule relates to care that must be provided to recipients depending on their classification level, i.e. those under the high ADL domain category without an additional fee charged. Additional information is provided in the following document:

- Care and Services in Aged Care Homes – Information for Approved Providers[3]

Additionally the care and services specified in this Schedule must be provided in a way that complies with the Aged Care Quality Standards[4] set out in Schedule 2.

Improper use of government funds

It is very likely that there is inappropriate use or some form of 'double dipping' of government funds to provide the allied health services to residential aged care residents. It appears misleading information may be provided in some instances by aged care providers in accessing these services. Refer to the articles below to give you an overview of this issue:

- Allied Health Services in Residential Aged Care[5]
- Care and services in aged care homes [6]

[1] Quality of Care Principles 2014: https://www.legislation.gov.au/Details/F2020C00096
[2] Aged Care Act 1997: https://www.legislation.gov.au/Details/C2020C00164
[3] Care and services in aged care homes Information for approved providers: https://bit.ly/3gXU0E0
[4] Aged Care Quality Standards: https://www.agedcarequality.gov.au/providers/standards
[5] Allied Health Services in Residential Aged Care: https://bit.ly/32eIX52
[6] Care and services in aged care homes: https://www.agedcarecrisis.com/resources/care-and-services

I can personally substantiate this has been occurring through the aged care journey shared with a family member.

The family member lived in an aged care home and at the time I was considerably involved ensuring their needs were met or appropriate care was provided. Unfortunately I found care was inadequate and in my view the provider failed to provide care needed in line with the residential care and services set out under the Quality of Care Principles 2014. This would include Allied Health care or services. However during the experiences with the age care facility, it revealed far more than just inadequate care but also sinister behaviours.

At the time, the family member was required to be assessed by a speech therapist requested by a doctor. The aged care provider informed me that they were not responsible to pay for the speech pathologist to assess the family member and it is done through the CDM Chronic Disease Management CDM (formerly known as EPC) individual Allied Health Services under Medicare.[7] The facility also revealed that this is the option used for all the other residents in the home.

After researching the Aged Care Act and the Quality of Care Principles, I contacted the Aged Care Complaints Commissioner for more information and I was made aware that actually residential aged care providers were obligated to provide this service (at no charge) as specified under Schedule 1 for eligible recipient. This includes item 3.11 Therapy services.

> **Speech pathology services:** This is when I realised that they willfully misled me. Eventually after a complaint to the Aged Care Complaints Commissioner (now known as the Aged Care Quality and Safety Commission), the facility organised a speech pathologist to assess the family member at no charge. Since the family member had swallowing difficulties, consistencies of fluids and foods were altered to cater to his needs. Unfortunately the fluids were frequently of incorrect consistency and so the speech pathologist attended the facility to educate relevant staff.

I can add further that the facility was very insistent that I use the Medicare Allied Health option. During my communication with them and questioning in regards to this matter that the family member was a high care resident, and highlighting their responsibilities with providing this service, it become apparent that they would try any way they can to avoid providing this service or care. Even as far as the Director of Nursing boldly informing me that the facility contacts the doctor to inform them that a speech pathologist is needed, provides the form to the doctor who then completes it.

It seemed that this practice was widespread throughout the facility. As a result, the resident would then be charged $130.00 for this service of which Medicare gives a partial refund and the facility refunds the resident the rest.

It seems that was the last playing card they could use to convince me to use the Medicare option. Since the facility was involved with very suspicious practices, I did not accept that option either as I knew they could not be trusted and wished to have no involvement in encouraging this behaviour.

Besides this, it was concerning to learn that the facility was likely providing misleading information to other residents as well. I wondered how long this was occurring.

[7] Chronic Disease Management — allied health individual services: https://bit.ly/300XFty

Following this, I inspected the family member's Medicare claim records, it revealed that the CDM Allied Health was used to access podiatry services also. We were not aware of this and did not see a report by a podiatrist. This was even used despite the prior dilemma with the speech pathology concern. The family member though was entitled to podiatry care under Schedule 1 of the *Quality of Care Principles 2014* and there was no need to use the Medicare service to have access to this care. I was also astounded to learn that it was used for the purpose to cut the family member's nails, which is classified as basic personal grooming care.

After the family member passed away, I eventually had access to their general practitioner's (GP) medical file. The Medicare CDM Allied health form was not included in file and no report by the podiatrist. This was baffling as there wasn't visible evidence on how the claim was made initially. It is possible that the completed Medicare form was in the facilities' records as I did see they had forms there, (which they fax to GP's) but it would also not explain why the doctor did not have the podiatrist report. It may be included in the facility's file only and this would even be questionable.

The family member's prior Medicare documents may reveal more but unfortunately it would be very difficult to access these and so will never know what occurred in the background.

More than likely, this may be happening in other residential aged care facilities. Most likely there are cases that providers are not providing allied health care or services to residents who are entitled to this and residents forced in using the CDM Medicare Allied Health Service.

There may be some form of 'double dipping' of government funds to provide the allied health services to residential aged care residents. **The Royal Commission into Aged Care Quality and Safety should examine this closely.**

The Department of Health clearly states the following:

Medicare Eligibility and Aged Care Funding Classification

> *"Medicare-rebateable allied health services should not replace services that are expected to be provided to residents by the facility, as a requirement under the Aged Care Act 1997.*
>
> *Under this legislation, approved providers of residential aged care services are required to provide therapy services, such as recreational, speech therapy, podiatry, occupational therapy, and physiotherapy services, to certain residents (as defined by the resident's funding classification) at no additional cost."* [8]

They also emphasise the following:

> *"If residents are entitled to receive the allied health services noted above at no additional cost to themselves through the RACF, those residents should not routinely be referred for allied health services under Medicare."*

Refer to the Department of Health Chronic Disease Management page for additional details.

- Chronic Disease Management - Individual Allied Health Services Under Medicare - Residential Aged Care Facilities

[8] Chronic Disease Management - Individual Allied Health Services Under Medicare - Residential Aged Care Facilities https://bit.ly/2DzpdPe

Allied health professionals have likely raised the issue with various government agencies and Ministers. A letter dated 2017 in regards to Compliance to *Aged Care Act 1997* and impact on Medicare was addressed to MP Greg Hunt and Ken Wyatt.[9] It included the following:

> *"In essence, nursing homes are funded by the Federal Government to deliver "High Care" services to those aged patients in need. That high care status and associated government funding is intended to cover the nursing home requirements of basic care, accommodation as well as medical needs including podiatry and physio amongst others. Some allied health providers are also lodging enhanced primary care (EPC) payment requests via the Medicare system for services that should be provided under the aged care funding. This means that Medicare pays for the care direct to the allied health provider, and the nursing home keeps the proportion of the funding intended to cover this Allied Health. The allied health provider does not charge the nursing home for the allied health services. Effectively, the federal budget is double dipped to provide the care."*

I am unaware if the letter was actually sent to the Ministers and if a response to their concerns was provided.

In 2018, a summary[10] of an aged care/Medicare EPC forum was provided relating to questionable practices of bulk billing high care RACF (Residential Aged Care Facility) residents through Medicare.

Possible solutions for this issue were mentioned. Enquiries to Medicare to clarify the information were discussed.

In March 2018 a response[11] was received by the Enquiry Resolution, Health Support & Business Services Division, Australian Government Department of Human Services.

It included the following:

> *"Under the Aged Care Act 1997, approved providers of residential aged care services are required to provide therapy services, such as recreational, speech therapy, podiatry, occupational therapy, and physiotherapy services, to certain residents (as defined by the resident's funding classification) at no additional cost."*
>
> *"If an allied health provider is uncertain about whether a patient requires a service that should be provided by the RACF under the Aged Care Act 1997, rather than a service under Medicare, the allied health provider should obtain clarification from the RACF."*

Additionally an enquiry[12] was made to the Aged Care Quality Agency which provided the following response:

> *"Thank you for your enquiry. As the role of the Aged Care Quality Agency does not specifically cover funding for care recipients, I am unable to provide you with a definitive response to your query."*

[9] AGED CARE LTR TO GREG HUNT: https://bit.ly/3j0ZNKQ
[10] SUMMARY OF AGED CARE/MEDICARE EPC FORUM: https://bit.ly/3iWEZ7f
[11] 16.3.18 Medicare response: https://bit.ly/3eu3pBr
[12] SUMMARY OF AGED CARE/MEDICARE EPC FORUM: https://bit.ly/3iWEZ7f

Furthermore the following response was provided:

> *"However, the care and service to be provided for all care recipients who need them – fees may apply are specified in the Quality of Care Principles."*
>
> *"Please refer to Schedule 1—Care and services for residential care services, Part 3—Care and services—to be provided for all care recipients who need them—fees may apply; Item 3.11."*
>
> *NB:*
> *"Who need them – meaning with and assessed need Item 3.11 Therapy services such as podiatry refers to maintenance therapy and more intensive therapy on a temporary basis to allow CRs to reach a level of independence at which maintenance therapy will meet their needs; excludes intensive, long-term rehabilitation services."*

Sadly it wasn't an informative response by them. It is surprising that the Aged Care Quality Agency did not mention that fees would not apply to recipients if under a specific classification level. It is certainly stated under the *Quality of Care Principles 2014*.

Refer to links provided in this submission revealing more including an article[13] by a concerned Allied Health professional.

Coincidentally in April 2018, the Department of Health released a reminder in regards to Physiotherapy for aged care residents and responsibilities of providers.

It included the following:

> *Residential aged care providers are reminded of their responsibilities when providing physiotherapy services, and when fees can apply. Providers must provide rehabilitation support (including physiotherapy) to all care recipients who need it. Fees do not apply to rehabilitation support."* [14]

Is it evident then that the Department of Health was aware these issues were occurring? What has been done about it?

The following **submissions** provided to the **Royal Commission into Aged Care Quality and Safety** also **reveals** that these concerns in **residential aged care are very real.**

Allied Health Professions Australia – Published 21 February 2020[15] :

> *"frequent attempts by aged care providers to rely on Medicare Chronic Disease Management items to provide access to allied health services in an aged care facility."*
>
> ***Source:*** *https://agedcare.royalcommission.gov.au/system/files/submission/AWF.650.00059.0001.pdf*

[13] Footfiles article on RACF and Medicare issue: http://bit.ly/2tybcsP

[14] Department of Health Physiotherapy for aged care residents – provider responsibilities: https://bit.ly/3h9fgXx

[15] Allied Health Professions Australia – 21 February 2020: https://bit.ly/3esAXQc

Allied Health Professions Australia – Published 11 February 2020[16]

> *"Allied health interventions are inconsistently applied and are largely dependent on the beliefs and commitments of individual service providers. There are also misconceptions about the role of Medicare in providing access to allied health services for people in residential aged care. Residents are often advised that funding for allied health services is not available through the aged care home and they must use private or Medicare funding to access these services. This example of cost shifting to the health system is a significant problem."*
>
> ***Source:*** *https://agedcare.royalcommission.gov.au/system/files/submission/AWF.660.00081.0001.pdf*

Allied Health Professions Australia – Dated September 2019[17]

> *"One area of significant misunderstanding is the role of Medicare in providing access to allied health services for aged care residents. AHPA members report that RACHs frequently argue that they do not have sufficient funding to cover all allied health needs. Instead residents are told they must seek other funding, such as Medicare or paying private rates, for access to a range of allied health services, such as those relating to improving communication skills."*
>
> *"The ability to cost shift to health and other funding systems is a major issue and one that has been widely reported by allied health professionals and members of the communityiv. AHPA argues that there is a disincentive to pay for allied health services out of aged care funding when other alternatives such as medications and medical treatments are funded through health and when the intersection with health is not clear. The utilisation of Medicare Chronic Disease Management item funding for assessment and other allied health services is a key example of health funding being used inappropriately to balance out gaps in aged care funding. This is particularly concerning as a significant focus for allied health work in aged care is working with staff to meet the needs of the person, something Medicare items are not designed for and which contravenes the guidelines for the items. For example, while a speech pathologist may initially work with the older person to assess their communication or swallowing needs, a major part of the intervention is then to work with residential care home staff to support adjustments to how they communicate with the person or with the food services and care teams to ensure the person has access to a safe and appropriate diet and support with eating."*
>
> ***Source:*** *https://bit.ly/30fQ8aJ*

I completely agree with their findings. My experience also confirms their findings. These statements made by Allied Health Professions Australia cannot be ignored and would be beneficial to obtain further details by them in regards to this. Especially as it relates to the two tier funding option proposed by the Commission.

Other Allied Health networks such as Podiatry Western Australia may be able to share additional information in regards to this issue.

[16] Allied Health Professions Australia – 11 February 2020: https://bit.ly/3fspRfn

[17] Exhibit Submission Allied Health Professions Australia – Dated September 2019: https://bit.ly/30fQ8aJ

In April 2019, the Community Affairs References Committee published the final report - *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices*, and ensuring proper clinical and medical care standards are maintained and practiced. It noted the following:

> *"The Aged Care Taskforce also noted that there is significant confusion about what services should be funded by RACFs and what services must be privately funded by the care recipient."*[18]

What the Community Affairs References Committee noted relates to considerations made in the 'A Matter of Care Australia's Aged Care Workforce Strategy' - Report of the Aged Care Workforce Strategy Taskforce 2018.[19]

> *"Access to allied health functional services is further reduced because of limitations on the number and types of services that are subsidised through the MBS, the level of subsidy provided and the requirement for GP referral to access services. In residential aged care there is also confusion over what services should be funded by residential care providers and what services must be funded privately."*

The Aged Care Workforce Strategy Taskforce was aware of this issue, but what has been done about it since? Where did this concern lead?

Over the years there have been reports and articles relating to these types of practices.

There was a Victorian Civil and Administrative tribunal case[20] against versus Buehler Aged Care Pty Ltd, which is quite similar to the issues I have mentioned. The applicant for this case was an Attorney for her mother, a 96-year-old permanent resident in the aged care facility.

Recommendations were made by an Occupational Therapist for a wheelchair and a positioning package that would meet her mother's needs. Buehler Aged Care refused to pay for the items and was paid by the applicant of the case instead.

The Victorian Civil and Administrative tribunal ordered Buehler Aged Care to pay Jane Carroll the sum of $6,682.00 for the Broda Midline Wheelchair and positioning package as it was established that the aged care provider facility was required to provide the items at no charge due to a variety of factors, including the following ***Specified Care and Services for Residential Care*** under the *Quality of Care Principles 2014*.

[18] Community Affairs References Committee Final Report - Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised: https://bit.ly/2WfQ09M

[19] A matter of care - Australia's Aged Care Workforce Strategy Report of the Aged Care Workforce Strategy Taskforce https://bit.ly/2Wh4HJS

[20] Carroll v Buehler Aged Care Pty Ltd (Civil Claims) [2020] VCAT 84: https://jade.io/article/708207

Specified Care and Services for Residential Care

2.1 Daily living activities assistance
Personal assistance, including individual attention, individual supervision, and physical assistance with the following: …
(e) moving, walking, wheelchair use, and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other aids; …

2.5 Recreational therapy
Recreational activities suited to care recipients. Participation in the activities, and communal recreational equipment.

2.6 Rehabilitation support
Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a care recipients' ability to perform daily tasks for himself or herself, to assisting care recipients to obtain access to such programs.

3.4 Goods to assist recipients to move themselves
Crutches, quadrupled walkers, walking frames, walking sticks, and wheelchairs
Excludes motorised wheelchairs and customised aids.

3.5 Goods to assist staff to move care recipients

I can relate to this tribunal case as it also occurred to my family member at the aged care facility. It was determined that the wheelchair that was used by the family member was not suitable to meet their needs. In this case I also had organised a private Occupational Therapist (OT) to assess the family member for a suitable wheelchair.

Eventually, family purchased a wheelchair. Some funds were donated to purchase the chair by a Neurological Network. However though in this case too, the facility neglected their obligations. Since it would have been another battle to fight and the additional stress it would cause, the family decided not to pursue the matter further and that the wheelchair will then also be the property of the family member using it.

Additionally during this process it revealed that the facility was not using the chair air cushion for pressure care appropriately or ensure it was maintained. The Roho cushion was not pumped properly and also had to be pumped in a way that it can assist in preventing the family member from slipping or slouching. It should have also been locked in place, so it stays pumped in this way. An education session was organised with the provider of the wheelchair for staff members at facility in regards to this. They also showed the physiotherapist how many degrees the chair should be tilt for prevention too.

The family member was experiencing constant pressure or wound sores. This also confirms concerns mentioned in the Wounds Australia submission to the Royal Commission:

> *"Moreover, aged care employees should be educated regarding the function, use and maintenance of the equipment. For example, pressure relieving surfaces may not be functioning, air mattresses may be deflated or over inflated and the employee may be unaware or unsure of how to rectify the issue."* [21]

[21] Royal Commission into Aged Care Quality and Safety - Statement of Wounds Australia Submission: https://bit.ly/2Zut20O

In their submission, Wounds Australia noted that there needs to be regular maintenance schedule for pressure relieving equipment or support surfaces to be checked and monitored. Furthermore, it was vital to ensure that a clinician with appropriate knowledge is prescribing the pressure care equipment correctly and that aged care nurses also need a focus on those consumers who are unable to independently reposition themselves and those who sit in a chair, wheelchair, water chair for lengthy periods.

Eventually when the family member was moved to another facility, we were made aware by the new aged care provider that the air mattress that was used (purchased prior to admission) was not suitable. The prior aged care provider, the very same one that failed in so many ways to provide proper care, neglected to check the mattress and even provide a suitable alternative to meet their needs. Luckily the new aged care provided a suitable mattress. We found that wound care was excellent at this public aged care provider which was part of a state run hospital network and community services.

In 2017, there was an article[22] relating to the Medicare-funded mental health treatment approved by GPs under the Better Access Medicare program. The following was mentioned:

> *"Providers are required under the Quality of Care principles to provide high-care residents with certain allied health services, on the basis that they are funded via government aged care subsidies to provide these services. The thinking is that making the provider's care plan a precondition for Medicare-funded Chronic Disease Management services will help prevent double-funding. By making the provider the primary gatekeeper for Chronic Disease Management services, the department has placed aged care residents at the blunt end of its campaign for correct practice."*

These issues it seems, has become insignificant and appropriate changes are not made to the aged care system to address these concerns.

In December 2019, the Royal Commission into Aged Care Quality and Safety examined whether older people, particularly those living in residential aged care facilities, are able to access the health services they need as they age.[23]

I refer you to the transcript[24] of this hearing dated 13 December 2019, particular the comments made by Terry Symonds, Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, Victoria.

The counsel assisting highlighted that perhaps there's a lack of clarity in some ways about the responsibilities of various parties in providing healthcare to residents in residential aged care in particular and there is a greater need for clarity of the respective responsibilities of those charged with providing medical – healthcare to residents in aged care facilities.

[22] Corners cut on aged care: https://bit.ly/306rbhD
[23] Interfaces between the aged care and the health care systems: https://bit.ly/38XfLkz
[24] Canberra hearing 13 December 2019 - Interfaces between the aged care and the health care systems: https://bit.ly/3fvifJ3

Terry Symonds provided the following response to this:

> *"If I could cite the example of part 3 of the Quality of Care Principles attached to the Aged Care Act – that includes a fairly prescriptive list of healthcare services that should be provided, and I quote the heading at the top of the page of part 3 – to be provided for all care recipients who need them. And that includes for example nursing-services that include initial assessment and care planning, ongoing management and evaluation, establishment and supervision of a complex pain-management or palliative-care program, concession care and maintenance of tubes et cetera, and it goes on."*
>
> *"We believe that's a pretty good guide to the healthcare responsibilities that aged care providers have under the Act. But I would share with you that, when I raised this with a colleague who works for a private aged care provider during the week, they pointed out to me that there are words on the page that include services by nurses for example, acting within their scope of practice, and if they don't have sufficiently qualified nurses, they can't provide the services that are in here. They also pointed out the words "that services may include", not "must include", and so that – it occurs to me, that people are reading this page in different ways."*

He further stated:

> *"And we read this as a good guide to the services that should be provided, but private aged care providers might read this as an optional list."*

I agree that wording of Schedule 1 Specified care and services needs reviewing as well as further clarification of the care and services items listed. However, this cannot be used as an excuse for an aged care provider not providing the service. I direct you back to my family member's case and despite informing the aged care provider of their responsibilities under Schedule 1, it did not sway them to provide the care or service for the family member. **They blatantly ignored this.**

Michael De'Ath Director General, ACT Health Directorate also mentioned during the hearing that he supports the remarks made by Mr Symonds in relation to the importance of the wording and points of clarification and what he would probably refer to as some grey area and discretionary area that could be tidied up in the interests of residents.

However in light of this evidence it is important that you are aware in 2014, a document *'Care and Services in Aged Care Homes – Information for Approved Providers'*[25] was composed. This was additional guidance for each item under Schedule 1 - Specified care and services. The document has not been updated since and a separate consumer friendly document has not been produced for consumers or community members.

I am aware though that the Department of Health was planning to provide an updated version of this document. However, they have been slow in doing so. I am concerned that a consumer related document may not be composed with consultation by consumers or community members. Only they can spot gaps in the information provided. There are many items that I have spotted that need further clarification or additional information needed. If the Department of Health eventually published an updated version, I am not convinced it would be appropriate since in my view there may have been a lack of input by community.

[25] Care and services in aged care homes - Information for approved providers: https://bit.ly/3ez1dbH

I disagree with Mr Symonds (Deputy Secretary, Health and Wellbeing Division, Department of Health and Human Services, Victoria) that the healthcare responsibilities that aged care providers have under the Act is a 'pretty good guide'. It is a very poor guide and so is the '*Care and Services in Aged Care Homes – Information for Approved Providers'* document. You can understand this through the journey and many stories provided by consumers. Input by them is critical in getting it right as possible.

Monitoring funds and care

Facilities receive funds by the government as well as contributions from residents to provide allied health care and it seems it may be pocketed instead. This raises the concern that there is a lack of monitoring by the government on where funds are spent. If the Royal Commission into Aged Care Quality and Safety submission recommends more funding is given to aged care providers to provide allied health services, **it is paramount that they are monitored to ensure that the funds are actually spent on this.**

The quality monitoring commission should implement guidelines for quality officers in assessing or auditing the aged care provider to ensure appropriate practices are occurring.

In 2019, there was a consultation in regards to additional service fees in residential aged care.[26] The Department of Health was seeking feedback on a number of proposals designed to provide greater certainty, transparency, consumer choice and protection. What is ironic about this is as mentioned above, aged care providers may not even currently be providing care and services to recipients entitled under the aged care legislation (Quality of Care Principles 2014 Schedule 1 – Care and services for residential care services). Why then should there be a discussion about providers applying additional service fees in residential aged care?

Isn't it important to achieving consistent understanding of residential aged care responsibilities among providers or addressing this issue and to put mechanisms in place to ensure they do apply their responsibilities before moving on to this type of consultation?

Feedback for Royal Commission into Aged Care Quality and Safety Submission Draft Proposition – Allied Health

The proposition[27] suggests two funding mechanisms for allied health care:

- fund residential aged care and home care providers to deliver 'frequent and ongoing' allied health services; and
- increase funding for 'infrequent or episodic' allied health services through a new MBS benefit structure for people accessing aged care services.

This is not appropriate as it would encourage the practices mentioned in this submission.

[26] Additional service fees in residential aged care: https://bit.ly/3ewYbVz

[27] Royal Commission into Aged Care Quality and Safety Draft Proposition - Allied Health https://agedcare.royalcommission.gov.au/system/files/2020-07/RCD.9999.0343.0019_0.pdf

Any funding to residential aged care to deliver allied health services should be vigorously monitored to ensure that funding is actually spent on allied health. I mention 'vigorously' as in my view there has been poor monitoring of government funds towards aged care providers. It may be the main reason that there have been instances of some form of 'double dipping' and poor allied care to aged care recipients. It is baffling that a suggestion is even made to provide funds or even additional funding towards aged care providers when they may have been keeping the funding already provided to them to provide some allied health care.

Has the Commission or the Department of Health investigated this further? Because if this has been occurring, then shouldn't the providers pay back the money to the government? Instead the Commission is proposing to fund residential aged care providers despite evidence that they may not be using funds towards care.

Residential aged care is funded not only by Australian Government but also contributions are made from residents for providers to provide care and services. **Therefore the residents and taxpayers have a right to know where and how funds are spent!**

If you take in account the experience I have shared in this submission you can come to the conclusion that aged care providers may not be providing the bulk of the allied health services that are required to do so.

Increasing funding for allied health services through a new Medicare Benefits Schedule (MBS) benefit structure for people accessing aged care services will also encourage aged care providers to rely on this and pocket funds provided by the government. As mentioned in this submission most likely it will encourage providers to not provide allied health care or services to residents who are entitled to this and residents forced in using the new MBS benefit structure. This is occurring already with the existing Medicare Allied Health items.

The information provided in this submission should be alarm bells and suggest that the Royal Commission into Aged Care Quality and Safety proceed with caution in regards to the proposed two tier funding.

It is possible that a two tier funding may work but only if is monitored after it is implemented and changes made accordingly. I support some suggestions made in submissions made by Allied Health Professionals to the Commission.

Additional feedback

- Residents should have access to internal or external care coordinators to assist to coordinate allied health care and collaborate with allied health care professionals. To also ensure that Care coordinators would do what is best for the recipients and their care, not what the facility prefers. There should be no inappropriate influence by aged care providers
- There should be an interdisciplinary team based approach to allied health care
- Suitable education regards allied health, including maintenance and experienced staff members
- Have regular allied health care reviews and improvement of care and services
- Information or education for aged care providers in regards to providing allied health care or services as required under the Quality of Care Principles 2014. Scenarios or examples should be included.
- Appropriate information to residents as well as the community about Schedule 1 and their rights to allied health care. This should be done in consultation with community.
- Education and information sheets to be provided to Doctors regarding the rights of residents to have access to related Allied health care under Schedule 1 of the Quality of care Principles 2014. The aged care clinical guide is available from the Royal Australian College of General Practitioners (RACGP). What is missing is education in *Aged Care Act* and Quality of Care principles 2014 if GP's wish to work in the residential aged care industry. They should be knowledgeable in this area before providing care to residents as they do have a duty of care to their residents. They should be aware of the responsibilities of providers. An option is for RACGP to compose an aged care allied care clinical guide or informational sheets.
- GP's should be encouraged to notify the aged care regulator or Medicare if a resident is forced in using the Medicare funded CDM allied health services or if appropriate allied health care is not provided.

Oral Health in Residential Aged Care

There is limited access to oral or dental health services for residential aged care, residents. It is important that residents are aware of external services they can use. Public oral health services are available to aged care residents with physical disabilities, making it difficult for them to attend a dental service. The public domiciliary oral health services are a good example.

Sadly in all facilities my family member resided in there were no oral health considerations or referrals to oral health services. I organised an assessment using a public domiciliary oral health service to ensure that he had regular check-ups at facility.

Collaboration with the following oral health services would be beneficial to RACF's.

- **Westmead Centre for Oral Health (Westmead Hospital) - Special Care Dentistry**[28]
- **The Royal Dental Hospital of Melbourne - Domiciliary Oral Health Service**[29]
- **WA Government North Metropolitan Health Service (Dental Health - Aged Care Programme)**[30]

There may be oral health programs for residential aged care residents through Community Health Services. These initiatives may involve these services visiting the facilities and complete oral health education and screening for the residents. Referral pathways for families to find it easier to connect into their dental service or domiciliary service may be provided also. This includes information about how to access the Public Clinics as well. They could also assist with improving the aged care nurse's oral health screening and the addition of oral care plans – which include referral pathways.

An example of an initiative like this is the Link Health and Community (now owned by Latrobe Community Health Service) had a pilot run oral health service. The purpose of the program was to build capacity in residential aged care, inform management, train providers and share information to the families. Posters in all bathrooms were left with the referral pathways and domiciliary services. This pilot initiative has ended, however there is a need for ongoing work to sustain the knowledge and champion oral health in aged care. Government sponsorship and stewardship and access to oral care in nursing homes can improve greatly. Collaboration with these types of initiatives would be beneficial.

Mobile dental van services which can visit aged care homes are another valuable option to investigate. The Senior Smiles program[31] is another excellent model that could be implemented in residential aged care.

[28] Westmead Centre for Oral Health (Westmead Hospital) - Special Care Dentistry: https://bit.ly/2CBjl7Q
[29] The Royal Dental Hospital of Melbourne - Domiciliary Oral Health Service: https://bit.ly/2Cepkzm
[30] WA Government North Metropolitan Health Service (Dental Health - Aged Care Programme): https://bit.ly/309G036
[31] Senior Smiles program: https://bit.ly/3fxhWO0

Concluding points

The following ideas would be helpful:

- Educate RACF staff members in regards to oral health checks and appropriate referrals to be made to oral health services
- More involvement by GP's in regards to oral health
- Investigate a Medicare based Dental scheme for RACF recipients
- Increase dental workforce by supporting oral health students, Graduate students or postgraduate students to be part of initiatives for RACF services

It is time for the Royal Commission into Aged Care Quality and Safety to take the step to address these concerns!

I kindly ask the Commission to look at allied health in residential aged care closely and that my concerns and information I have provided are considered.