A New Program for In-Home Aged Care Discussion Paper

Submission by the

Australian Physiotherapy Association

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Executive Summary

The Australian Physiotherapy Association (APA) is pleased to provide feedback to the Department of Health and Aged Care (the Department) A New Program for In-Home Aged Care Discussion paper.

The APA believes that without comprehensive multidisciplinary clinical assessment and care planning the New Program for In Home Aged Care is unlikely to deliver is objectives to:

- provide people with timely access to the safe and high-quality services they need, so they can live at home for longer
- provide people with real choices about who provides their services and the types of services that they receive.

Assessment of need for domestic services such as cleaning and gardening requires basic screening as opposed to assessment of a person's difficulties with activities of daily living. Assessors conducting each type of assessment require vastly different skills. In many cases, an older person seeking support with domestic duties is experiencing functional decline as a result of an emerging clinical condition that should be assessed by a highly qualified health practitioner from a multidisciplinary team that includes allied health professionals such as a physiotherapist.

Ideally, assessment of the needs of the older person should be a two-step process – a general screening followed by a comprehensive health assessment by a multidisciplinary clinical team. For a streamlined, single assessment system to be successful, assessors must be qualified healthcare professionals who can appropriately assess the clinical need of older people and ensure their in-home care package is funded to cover the costs of the range services they need and choose to support them to remain functioning and independent in their homes. These services may include ongoing short or long term physiotherapy to maintain strength, balance and manage pain and other conditions associated with ageing.

The Royal Commission into Aged Care Quality and Safety made very clear findings about the importance of allied health provision in retaining and optimising physical and cognitive capacity in older people living at home, not least physiotherapy with its critical role in mobility, falls prevention, non-pharmacological pain management for various conditions including support for people living with dementia and incontinence.

In this paper, we have summarised some of the key points of the Royal Commission's *Final Report: Care, Dignity and Respect, Volume 1* to act as a checklist against which to evaluate any proposed new In-Home Aged Care program.

The APA has addressed the many questions posed in the discussion paper - A New Program for In-Home Aged Care. However, our recommendations centre on ensuring the new In-Home program delivers the recommendations of the Royal Commission to address an appalling lack of access to allied health services for people receiving government funded aged care services. The new home care program must provide older people with:

- comprehensive assessment of their needs by qualified, trained assessors
- appropriate funding of multidisciplinary allied health care
- monitoring of their progress, achievement of goals and outcomes, and
- flexibility and timely additional funding to address changing and unplanned care needs.

Accountability, transparency and reporting must be paramount in the system design. The packages must fund only the care needs of the older person whether they self-manage or engage a care planner. Care planning should be funded separately to avoid planning and administration fees reducing the amount of funds available for service provision.

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Recommended assessment pathway to ensure appropriate allied health service provision

Recommendation 1	Triage Ensure experienced health professional triages the recipient's needs and identifies the type of assessment required. The level of knowledge and skills required in the assessor are such that all opportunities to maintain physical function, optimise mobility and performance of activities of daily living within their existing home environment are identified.
Recommendation 2	Assessment Design a two-step process to allocation of allied health funding: 1. Identification of need for allied health in first stage of assessment (assessment tool). 2. Identification of level and scope (allied health practitioner assessment).
Recommendation 3	Assessor qualifications Require assessor workforce conducting comprehensive assessments is clinically qualified and includes allied health professionals such as physiotherapists.
Recommendation 4	Assessment tool Embed referral triggers into the individual assessment tool that flag when an allied health professional is required and inform the knowledge base of assessors.
Recommendation 6	Capability building Develop assessor capacity and knowledge on individual disciplines with guidance and training developed by allied health professions.

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Key findings of the Royal Commission into Aged Care Quality and Safety re: allied health and home care

Final Report: Care, Dignity and Respect, Volume 1

1. The lack of access to home care leads people to enter residential care when that is not their preference. People receiving aged care do not get access to services they need to maintain their function and health. There is a wealth of evidence on the importance of various allied health interventions in maintaining or enhancing people's mobility, dexterity, and cognitive function. However, only limited allied health is provided under the Commonwealth Home Support Programme or through Home Care Packages. (pg 25)
2. [Older people] should have access to a wide range of allied health services to maintain or improve their capacities and prevent deterioration as far as practicable. (pg 36)
3. People in aged care have limited access to services from allied health professionals. A survey found that in 2018–19, only 2% of Home Care Package funding was spent on allied health. Under the Commonwealth Home Support Programme in 2018–19, while 29% of people received services categorised as allied health and therapy services, more than half of the people received fewer than five allied health services per year. (pg 66)
4. Mobility is closely linked with people's health and their quality of life. However, we heard numerous examples of aged care providers not supporting people to maintain and improve their mobility—including limited access to allied health professionals critical to promoting mobility, such as physiotherapists. Poor mobility increases the risk of falls and fall-related injuries due to deconditioning and reduced muscle strength. (pg 70)
5. Reablement and rehabilitation need to be a central focus of aged care. We recommend that care at home should include the allied health care that an older person needs to restore their physical and mental health to the highest level possible—and to maintain it at that level for as long as possible—to maximise their independence and autonomy. (pg 101)

Recommendation 36:

From 1 July 2023, the System Governor should ensure care at home includes a level of allied health care appropriate to each person's needs.

2. From 1 July 2024, System Governor should:

a. ensure that the assessment process for eligibility for care at home identifies any allied health care that an older person needs to restore their physical and mental health to the highest level possible (and maintain it at that level for as long as possible) to maximise their independence and autonomy

b. ensure that the funding assigned to the older person following the assessment includes an amount to meet any identified need for allied health care, whether episodic or ongoing. This allocation must be spent on allied health care and be consistent with practice guidelines developed by the System Governor 234 Royal Commission into Aged Care Quality and Safety Final Report Volume 1

c. require the older person's lead home care provider to:

i. be responsible for ensuring that these services are delivered

ii. monitor the status of people receiving care and adjust the nature and intensity of the care provided to meet their needs

iii. seek a new aged care assessment if an increased need persists beyond three months

d. reimburse the provider for the cost of any additional allied health care needed by the older person through an adjusted Home Care Package, without the need for a new aged care assessment, for a period of up to three months, and undertake a new aged care assessment if the need for additional services persists beyond three months.

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A New Program for In-Home Aged Care | Part Two: Reform considerations: discussion paper questions

Managing Services across multiple providers - page 19

When someone chooses to use more than one provider to deliver their care: • Should a care partner be accountable for monitoring outcomes and changes in clinical and care needs, and ensuring the older Australian is receiving their services? How might this work?	It is critical to ensure clinical outcomes and the delivery of services are monitored. It makes sense that a care partner assumes this role. They must have the capability to: • work with multiple providers through partner agreements • respond to changes and coordination of multiple services • monitor the older person's ability to achieve the goals • facilitate interaction and integration between services • organise multiple providers and case conferencing • arrange funding to organise and pay providers attending case conferencing, and • ensure funding is appropriately spent to address identified need. Physiotherapists currently work both for home care providers and as subcontractors. This arrangement varies depending on the provider capacity to arrange their own employees and if the older person chooses to engage or maintain their own preferred physiotherapist. The APA supports the continued ability for this flexibility in service provider provision. A shared reporting system designed for user ease, timely referral, clear communication, assessments, goals, care planning and outcomes is essential to ensure smooth transition between providers and settings (in the event of hospitalisation, for example) and continuity of care. Outcome measurement may be based on clinical care standards, a small number of quality statements that describe the clinical care that a patient should be offered for a specific clinical condition addressing priority areas for quality improvement. The Hip Fracture Care Clinical Care Standard[1] is an example of a Standard that informs people what care should be offered by their healthcare system and helps them make informed treatment decisions in partnership with their clinician; assists clinicians to make decisions about appropriate care and health services to examine and improve performance and care provided. A consistent provider reporting template would assist in the monitoring of services by a care partner. Streamlining the arrangements for becoming a subcontractor for home care would create cost and time savings, i.e. applying the same registration process to care partners and providers. Conducting multidisciplinary assessments, case conferencing and sharing of information about the care of the older person and their requirements is important for consistency of care and responding to

	need. Historically, this has been difficult to facilitate but it should be an integral part of the new In -Home Aged Care Program. This could possibly be facilitated via a template for care planners to list all the involved providers that could be available and a shared reporting system for communication could be developed. One option is better utilisation of the My Health Record to allow multiple allied health and nursing to report and research clinical information. This would allow GP and other health care providers to be involved and included in clinical care. For example, when physiotherapists recognise changes in clinical need, they must have access to a user friendly and easy to navigate system that supports them to make time referrals via the care planner. This could be centrally managed by My Aged Care or through a care planner. Access to information such as discharge summaries from hospital for acute episodes must be streamlined to allow physiotherapists to increased service provision where needed – for example, post fall or functional decline due to illness surgery or hospital admission. .
If an older Australian chooses to use different providers to deliver different services, what should be the responsibilities of each provider to communicate with each other, and with the older Australians' care partner? How should these responsibilities differ for providers of different service types (for example domestic assistance vs nursing)?	Care partners must be able to provide a portal for information management. APA recognises the complexity of this task and that external supports may be required to manage client information sharing. The use of My Health Record is one option if providers are given access to the information and ability to upload information. One option is to use My Aged Care as a portal to manage information relating to service providers and contacts. Domestic care needs to be informed by clinical recommendations. For example, the amount of assistance recommended for a person having a shower may be a clinical recommendation that needs to be specified on person's care plan. Care partners could be responsible for determining care plans with input from allied health and nursing assessments. Tasks such as personal care and cleaning can be undertaken with clinical recommendations to say how much the client can participate in and what their functional goals are. An IT system that allowed for reporting and exporting of information to care plans sent to domestic and personal care staff would be optimal. The APA believes the regular reporting of allied health goals must be communicated to various service providers to ensure most appropriate delivery and provision of a range of domestic services to enhance the health and wellbeing of the older person and align to their clinical needs and goals. Oversight of different providers is also critical and should be supported within the reforms.

	Position descriptions must clearly outline the roles and qualifications required to deliver this fundamental role in the In-Home Program. Uniformity and standardisation of communication and information input, care plans and templates is important to ensure that all older people have access to the same standard of care and that expectations are clear to providers of services and care planners.
Should the older Australian be responsible for managing their own budget and ensuring they stay within their funding entitlements? How might this work?	The APA recognises that many older Australians are capable of managing their own budget. Clarity about the cost of providing services can inform the older person however cost should not be the only factor taken into consideration. The importance of comprehensive clinical assessment and education about health care are paramount to ensure care that encourages independence, such as physiotherapy, is prioritised. In these circumstances it may be of benefit for an amount of budget to be quarantined for physiotherapy assessment or if there was an additional contingency fund to allow the funding of short-term restorative services if a person required these in response to a decline in function or health event. An external guide would be helpful to assist people manage to their budget as some older Australians may be hesitant to spend their budget or may not understand their package and how it works. Understanding that the money is there to be spent to help them manage at home. Others may not understand the scope of practice or benefits of various types of allied health care such as physiotherapy. The initial assessment that includes clinical assessment can help to inform the older Australian to understand what services they may benefit from. There could also be certain funding allocated for supports such as cleaning, shopping and showering assistance and then certain funding specifically for therapy supports, which is dependent upon the older person's goals and clinical needs. It is important to include adequate funding for both core supports and capacity building supports.
What challenges might providers and older Australians face in coordinating services across multiple organisations? How might these challenges be overcome?	Providers are likely to be coordinating multiple services and organisations may be require additional resources to manage this, therefore increasing administration costs. The APA strongly believes that administration costs should continue to be funded separately and not be charged to the individual in home care package thereby reducing the funds available for care. Similar to private health insurance if the person is aware of the "limits" of each service covered then the provider and the older Australian could work within that budget. They may also then have the capacity to pay for additional services if they wanted to fund these themselves, maintaining the coordination role either themselves or as the provider. Service providers may provide information about the benefits of each type of service and evidence for effectiveness. If an older adult has a care partner involved they should be positioned to ensure that the funding is being spent as allocated. Each allied

	health profession identified as required should be funded separately for clarity in service provision and in monitoring/reporting of spend and outcomes.
Care partners for older Australians - page 20	
If an older Australian is using more than one provider, how can information and observations of care workers from different organisations be communicated to the care partner? – Does it matter where the care partner 'sits'?	Care workers need to be able to communicate freely and report risks to client and themselves. Information can be personal in nature and the ability to relay information to a care partner needs to be handled sensitively and in a response format. If the care partner is part of an organisation that also providers care then there could be a conflict of interest.
Should they sit with the provider delivering the highest risk services, sit with the provider selected by the older Australian, or alternatively, be independent of other providers?	Ideally they should be independent of other providers. However the APA recognises that in areas with decreased service providers, there may not be the option for care partners to sit separately to providers.
A care partner can support transitions in care and proactive responses to prevent crises. – What, and how, should a care manager be held accountable for this role?	Here there is use of two words – care partner and care manager and it is being understood that the intention of the author is that they are interchangeable. Transitions between care providers and responding to events needs to be handled in a timely manner. A care partner may be unaware of changes unless notified by the older person. They may be limited in the ability to flex up services in a short timeframe. Care managers may be required to support hospital discharge or coordinate short term restorative programs, organise GP appointments, call for nursing and allied health support. If these services are unavailable then the responsibility may fall to a care partner, which could be difficult especially where there are staff shortages or thin markets. High risk clients may require a different type of care manager with access to increased resources, The APA supports the role of a care planner who has a tertiary degree in a health discipline or social worker to enable the ability to follow up assessments and make appropriate referrals. Guidelines need to be developed to support the triaging of services in situations like transition between services. All providers of care need to have an escalation process and should be responsible for providing information in a timely manner to the care

	partner. The care partner should have a system for responding to escalations in care and onwards referral to appropriate practitioners.
What does successful care management look like? – What should a care partner's 'Key Performance Indicators' look like?	Care partner capability should include: • Understanding the person and their preferences • The level of family and social supports available • The person's goals – together with the recipient these are set using a SMART goal process with realistic means imbedded for measuring their achievement. • an understanding of clinical care vs domestic assistance (core supports vs capacity building for example, similar to NDIS) • ability to be contactable by providers of care and respond to requests to provider additional services and equipment. • not be over worked – is there a benchmark of how many clients a care partner can realistically service KPIs may be relate to: • evaluation of delivery of services against those identified and recommended by assessments • complaints, and • satisfaction surveys of the older Australians and providers of care.
What should the role of a care partner be in relation to ensuring services are meeting quality standards? How might this link to Quality Indicators for in-home aged care providers?	Standard 1, the person: Care partner understands the person and their preferences. Workforce is trained in culturally safe and trauma-informed care. The care partner facilitates access by older Australians to CALD resources, interpretation services, and has an understanding of the person's role in their community and family setting. Standard 2, the organisation: Care partners as a new role require new standards. The meeting of this standard would depend on the organisation with whom the care partner is employed Standard 3, care planning: How would a care partner interpret external assessments and coordinate the care required for an older person? The APA proposes that physiotherapists be able to recommend the amount and frequency of service to be provided with the ability to change these in relation to need. Where possible the physiotherapist referrals are timely and proactive. Accessing information for service providers is important and the care planner needs to be able to share information and coordinate services as part of the planning process. A centralised reporting tool where care plans can be shared and accessed by all those involved in the care. The use of My Health Record is one way of sharing the information. Access to My Health Record by the care planner can help them to communicate to service providers that can't access the system, for example communication difficulties can be shared with

	helpful tips for care staff to be able to work with a person. Practical information for domestic service providers and support workers will still require information related to the care plan. These people will also need to be able to communicate information back to the other providers and the care partner. Standard 4, environment: the care partner must be able to report unsafe environments or respond to reports from service providers. There may be situations where in home care is unsuitable or the older person cannot be supported at home. The care partner should be supported in this situation to facilitate alternative arrangements and coordinate with families and older persons. There must be clarity about how alerts such as environmental issues will be shared between service providers across all employment situations. Home care partners must work with service providers to select appropriate services that the recipient feels are safe to be delivered in their home. Standard 5, clinical care – a care partner must be educated to understand what types of clinical care are to be provided and monitor the outcome of interventions. Coordination of clinical care may require additional support. Standard 6, food and nutrition: Care planners can communicate with providers about food and nutrition issues. This will also be assisted by communication between allied health providers about access to food and nutrition e.g. ability to cut up food relates directly to dexterity. Physiotherapists work with dieticians to address frailty and restore function and maintain independence. Standard 7, residential care: care planner has a role to coordinate with residential care facility e.g. Coordination of services that were provided in the community that when a person goes into respite these services may be able to get information from the care planner. Ideally, My Health Record would also be used in residential care and used as the communication tool between providers.
A Funding Model that Supports Provider Viability and Offers Value for Money - page 22	
What key services and types of providers may require supplementary or additional grants?	Physiotherapists have been working in CHSP funded programs – these have provided physiotherapy through 1:1 Clinics and group exercise programs, as well as limited home visiting services. These have been supported by the block funding of CHSP services – If these are to be replaced by one system the APA supports a supplementary payment system to allow the ongoing provision of community based allied health services. The ability for a physiotherapist to provide an appropriate assessment and treatment requires the use of specialised equipment that may not be available in a person's home. Many people's homes are not suitable environments to perform specialised tests.

	Providing physiotherapy assessment and interventions frequently involves treatment of musculoskeletal or neurological issues requiring a plinth and specialised equipment. For occupational health and safety reasons, a physiotherapist may not be able to provide appropriate and safe care in a person's home. Other treatments – including management of vertigo or (BPPV), vestibular rehabilitation, women's and men's pelvic health management - require specialist physiotherapists and specialised equipment. The existence of financially supported group and clinical physiotherapy has the benefit of improving access to physiotherapy which can save money by the older person accessing treatments in a community centre – hence reducing the time that physiotherapists spend on the road. Group programs have evidence for efficacy based on the ability for a physiotherapist to provide care to more than one person as part of a tailored program – e.g. falls prevention, pain education, relaxation, tai chi, Pilates etc. that can contribute to an older person's wellbeing. The ability to meet and work in a group has social benefits that not only improve physical they also help with combating loneliness, depression and isolation. These groups require additional funding to client contribution to enable to servicing costs of running the facility, providing equipment, staffing the appropriate level and the additional costs of assessment and monitoring. Grant funding helps to set up and initiate the development of these community based programs – e.g. marketing, hire of venues maintaining these programs etc.
What are the positive and negative experiences providers have from current grant programs for in-home care, and the key learnings for future provision of grant funding?	There is a lot of lack of understanding of what services are available. People on a home care package may not know how to use or optimise this. Grant funded programs have been primarily set up following the day therapy service model, however these centres are not uniformly distributed throughout the rural and regional areas. Access to grant funding has been primarily granted to councils and aged care providers. This has limited the ability for private physiotherapists to access the funds to provide services in areas where CHSP programs are not available.
Which diverse groups may be at-risk from the shift to activity-based payments, both in remote areas and metropolitan areas, and what are the specific supports grants should address?	Grants need to support the recruitment retention and retaining of staff particularly in remote areas. Grants also can support training in manual handling, cultural awareness, trauma informed care, and maintaining quality and increasing access to technology, they can also provide incentives to invest in research and development of unique novel modalities and methods of service delivery – e.g. telehealth, use of assistive technology

	At risk groups such as those on low incomes, those with less family supports and those with a history of chronic disease or disability require additional support to engage in services. The supports the ongoing provision of services via grants.
What should be the reporting requirements of these grants?	• Number of clients registered • Size of service area • Types of aged care packages • Number of staff • Number of programs – groups e.g. number participating regularly
What are the fairest arrangements for reporting on grant performance, including options for the roll-over of funds across periods, or to other essential service delivery?	Services need to demonstrate their viability and how the grants are spent each year. Rolling over of funds could allow some investment in service review and innovation and training of new staff.
Support that meets assessed needs, but is responsive to changes over time – page 27	
Comment	Paragraph 1 – improved assessment would better match funding to needs. The APA supports an assessment tool that supports needs noting this is not a focus of this paper. The assessors should be a tertiary qualified health professional.
What are the benefits and limitations providers anticipate in distributing pooled funds: which services should see increased use, and which may be limited by workforce availability?	The APA supports the ability for older Australians to have flexible funding arrangements that allow for additional short-term services. The ability for providers to pool the flexible 25% of a package would enable the distribution of services that may be required by a group of clients – e.g. transport, bus tours, community events, attending groups or classes. There could be some limitations based on access to specific services based on the ability to provide them due to workforce or if the services were only nominated by a small number of people. The pooled funding may not be distributed evenly among package recipients. It is unclear how the pooled funding will be distributed if a package recipient changes package providers.
How should the flexible pool be set – is 25% of client budgets appropriate?	The proposed 25% is a substantial sum, most of which would be better spent on flexibility within individual packages. An effective In-Home package program would enable access to increased funding on an individual needs basis as assessed by a qualified healthcare professional. Therefore, the APA proposed 10% of client budget for pooled service is sufficient with the remaining 15% built into the individual packages themselves to enable timely responses or unforeseen changes in the older person's function.

What should be included in guidance for prioritising the use of the funds across clients?	The pooled funds should prioritise services that promote social and community engagement and enrichment activities with a focus on remaining active and promoting culturally appropriate services. Investing in education about healthy eating, keeping active as you age, planning for change and adapting to grief and loss as examples of appropriate programs.
Are there any unintended consequences of this type of payment model?	In the absence of a mandated specification for appropriate spend of pooled funds, there is a risk of provision of niche programs that do not service many clients or prioritise one group over another. Demonstration of benefit to the consumer would need to occur with promotion of these activities to all consumers so they are able to consider accessing programs.
Encouraging Innovation and Investment - page 29	
Comment	The APA has concerns that payments to providers for the provision of physiotherapy may not recognise the cost of high quality physiotherapy provided by specialised physiotherapists – the provider or consumer may choose to junior physiotherapists or allied health assistants to provide services to reduce costs – how can this be monitored?
How can innovation and investment in in-home aged care be fostered under the reforms?	Innovation in service delivery is often not translated from research to practice due to cost, lack of awareness, lack of investment and training and lack of industry dynamism. Improving links between research bodies and home care providers can improve service innovation. Investment in the support of student placement in home care clinical care may improve the uptake of new learning into the sector. Support for research programs and pilot programs requires sector wide engagement and investment. An example would be the roll out of the Sunbeam falls-prevention Program[2] to community and home care participants – this evidence based strength and balance program delivers on reduction of falls in elderly but requires intensity of attendance at group based exercise classes for 2 hour per week for 25 weeks. In order to support this program a participant would require transport and supports as well as the program requiring facilities to be provided. Investment in promoting the value of such programs is also required as the older person may need to be educated about the benefits and the commitment required. See also the APA's Option Paper, the Independence Falls Prevention At Home Program (Attachment A), and our proposed trial to demonstrate the efficacy of physiotherapy-led falls prevention at home. Access to telehealth and other forms of technology and AI may also be beneficial, however this type of service requires the older person

	to have a device and internet. This gives rise to the questions of how access to technology will be funded. Education about using technology would need to be included and costed in order for innovative technology to be used in people's homes.
How might we support innovative approaches to safely deliver higher levels of care at home?	People who require higher level of care fall broadly into two overlapping areas: 1. The older person with reduced physical capacity – might require use of equipment like lifting machines, specialised beds, wheelchairs, mobility scooters etc. pressure relieving seating and cushions, continence services, increased monitoring and attendance of allied health and carers who have specialised knowledge. These persons may be at risk in a home environment particularly where they are alone for long periods of time. Use of CCTV and other forms of monitoring may assist in safely managing their care. The distance a person lives from the care providers would also limit the ability to deliver higher levels of care in the home. 2. The older person with significant cognitive impairment such as memory difficulties or physical and psychological behaviours may be unpredictable and require specialised services. For those living with family or a carer, the ability to remain at home requires supports for the carers. On call provision of additional services may be helpful and access to support via telehealth for nursing and allied health may assist. Smartphone apps may monitor aspects of a person's health that could trigger certain referrals to predict and prevent deterioration in function or other issues such as weight loss, blood pressure or falls. 3. Lack of ability to communicate effectively a person's needs – increased uptake of new forms of communication assistance may help such as monitoring and access to communication devices.
How might we enable innovation in home care for providers working in congregate care settings?	People living in retirement villages are sometimes served by different home care providers – this does not promote economy of scale – however consumer choice can be reduced if home care providers also provide accommodation. Flexibility constrains investment in innovation as there is no one provider doing everything in the one place. Congregate care settings may require some support to provide services across different providers – e.g. if the physiotherapist is service 1-2 clients in a retirement village it may be of benefit economically to see more people in the one village but how do they access information about negotiating with multiple providers of home care services in the village.

How might we encourage innovations that increase the quality of care?	The department may invest more in education and awareness programs about in home care and how services can be provided, what an aged care package means and which service a person may spend their funds on. Quality of care is subjective and more investment needs to occur on how we measure and monitor quality to ensure providers invest in improving quality. See the APA's Option Paper, the Independence Falls Prevention At Home Program (Attachment A), and our proposed trial to demonstrate the efficacy of physiotherapy-led falls prevention at home.

References

[1] https://www.safetyandquality.gov.au/sites/default/files/migrated/Hip-Fracture-Care-Clinical-Care-Standard_tagged.pdf

[2] Hewitt J, Goodall S, Clemson L, Henwood T, Refshauge K. Progressive Resistance and Balance Training for Falls Prevention in Long-Term Residential Aged Care: A Cluster Randomized Trial of the Sunbeam Program. J Am Med Dir Assoc. 2018.

Conclusion

The physiotherapy profession is committed to delivering safe, evidence-based and high quality of care to older Australians. We look forward to working with the Commonwealth on future reform to ensure access to high quality, needs-based healthcare for all older Australians.

The APA is available to provide the Department further information to expand on our submission.

Australian Physiotherapy Association

The APA's vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 31,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.