Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Response to a new residential aged care funding model

Submission by the

Australian Physiotherapy Association

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Department of Health on the Australian National Aged Care Classification (AN-ACC).

Our profession is focused on maximising the quality of care for the ageing, and on achieving the best health outcomes at the lowest cost while maintaining an individual's right to safe and high quality care. Physiotherapy can improve the value of quality care in Residential Aged Care Facilities (RACFs), however the systems and structures of the current system make value difficult to achieve.

We recommend the Department of Health explore further mechanisms that will re-orient the quality of aged care services towards a model that allocates resources to evidence-based early interventions, especially those that would reduce acute care episodes and improve the quality and safety of care provided.

The proposed model provides no dedicated funding for preventive, reablement and restorative care, including care provided by physiotherapists. We recommend the AN-ACC includes an itemised incentive payment for preventive, restorative and reablement care, provided by highly qualified and skilled practitioners, including physiotherapists.

The AN-ACC cannot be a 'set and forget' model. The model must evolve to reflect best practice care. Consultation with the sector is imperative not only during roll out and implementation, but ongoing monitoring and evaluation to ensure sustainability.

We are seeking further information about how the Government plans to transition the sector to the proposed model. The key principle underpinning the transition must be that services must be able to continue and not be compromised. The funding model must be implemented in a way that ensures job sustainability for providers. Providers should not be financially disadvantaged during the transition period.

Physiotherapy can play a substantial role in keeping people well and in maximising their wellbeing and quality of life if they have a health or functional condition. This includes care planning as part of a multidisciplinary team.

Care delivery and planning that supports the early detection of changes in behaviour, and physical and cognitive decline is vital. Investing further in early detection of change will save money on complex care in the future. Physiotherapists have the skill and knowledge to thoroughly assess a person to change a resident's care plan.

By incorporating physiotherapy into the AN-ACC model of care planning there is opportunity to maximise value. The APA supports the annual care planning model proposed. Annual care planning will ensure that consumer needs are reviewed, and discussed at an appropriate interval. Physiotherapists must be recognised in their role as care planners *and* external assessors.

We believe that care planning must occur after the financial assessment. Current best practice approaches to care planning use a multidisciplinary approach, often using both staff expertise, allied health and medical expertise. This approach should be further encouraged.

The APA supports providing a best practice tool for care planning, provided its use is not mandatory. Residents have diverse needs, and true consumer-directed care requires a high level of flexibility in service provision.

The APA believe the proposed classifications system, including the thirteen classification groups is, overall, logical and appropriate for aged care assessments.

The assessment focuses on functional and physical capabilities as the drivers of costs but does not address other needs such as needs for meaningful activity, emotional or social support. We believe these elements of consumer directed care need to be more carefully considered in the proposed model.

We believe the current proposed triggers for funding reassessment are appropriate. Significant hospitalisation, significant change in mobility and change in overtime are all appropriate reassessment prompts.

We support additional research as the AN-ACC is rolled out to determine whether the reassessment remains appropriate. For example, it may become apparent that a fall or a 'near miss' fall is added as an additional category to prompt reassessment.

The APA does not support the introduction of reassessment charges, particularly in the early years of a new funding model.

The APA does not support reassessment being a requirement of the proposed funding model. Rather, providers should be able to access additional funding following investment in reablement and restorative care resulting in higher functioning residents.

As part of care delivery and planning, a sustainable workforce cannot be overlooked. While supporting the existing workforce is an integral part of aged care services, it is important that a strong and sustainable career pathway is implemented for the emerging workforce. This includes students and individuals who are new to working with older people.

We welcome an opportunity to meet with the Department of Health on behalf of the physiotherapy profession.

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Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Department of Health on behalf of the physiotherapy profession.

We recognise that a major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens, including the elderly in residential aged care facilities. We also recognise that with an ageing population in Australia, demand for services will increase, and it is important people are provided the most appropriate, and high quality and safe care as they age.

A funding model that rewards safe, high value, preventive, reablement, and restorative care, including physiotherapy service is vital to ensuring consumer needs are met.

Physiotherapy can improve the value in residential aged care in Australia

Physiotherapists play a substantial role working with and supporting the older person in maximising their health, wellbeing and quality of life as they age.

The physiotherapy profession has long been regarded as an important provider of services for older Australians. Physiotherapists provide highly skilled and safe services across the health care spectrum, including RACFs. It is important older people have access to physiotherapy care when and how they need it.

Physiotherapists work alongside and with the older person, their advocates and the workforce, to maximise independence, quality of life and dignity. The seemingly smallest and incremental change can positively affect the older person's physical, mental, emotional and social wellbeing. It is important these gains are acknowledged, and funding resources are allocated to support the adoption of high-value care options.

The majority of people entering aged care will have an active, progressive or advanced disease. The Resource Utilisation Classification Study (RUCS) has identified that the majority of residents are mild to severely frail. A physiotherapist's regular presence 'on the floor' with residents (and their families), and relationship with other residential care staff is vital to optimise mobility and functional ability for frail people.

Physiotherapists play a role in assisting in the management of fatigue, mobility, optimising comfort, and activities of daily living (including influences of cognitive impairment and responsive behaviours that are challenging), falls and falls prevention, pain, shortness of breath, exercise tolerance, oedema, incontinence, deconditioning, frailty, contractures, sleep and rest, skin integrity, and more in the RACF setting.

A core element of this scope is assessment of a person's capacity to move, and keep moving. The achievement of this is frequently multifactorial and can include implementing programmes into daily life to maximise function, and specific therapy prescription, including exercise and assistive technology, varying from basic aids to more complex and customised equipment. Physiotherapists build on an individual's strengths and address

impairments relating to activity and participation within the RACF and other relevant environments.

Physiotherapy services provided to older Australians are expected to increase over the next 10 years as baby boomers reach retirement age and experience changes in functional capacity that require physiotherapy intervention. It is expected an increasing number of physiotherapy practices will offer services related to aged care, including those in RACFs.

In Australia, the scope of practice of the physiotherapy profession is diverse and innovative. It is yet to be fully captured within the scope of services provided in RACFs.

Dementia

Currently 52% of individuals living in RACFs have a diagnosis of dementia[1]. Physiotherapists have the skills and knowledge to support and prescribe activities and exercises for individuals living with dementia.

Physiotherapists prescribe activities and exercises for individuals living with dementia, considering factors such as fluctuating cognition and mobility. For example, a physiotherapist may provide a person with dementia practical tailored approaches to improve motor symptoms such as weakness, gait, balance and functional decline.

Research shows that physiotherapy prescribed exercise delivered to individuals with dementia in RACFs have demonstrated significant improvements in cognition, agitation, mood, mobility and functional ability[2].

The value delivered by physiotherapists to support people with dementia is not only financial, but more importantly, invaluable in ensuring consumers experience improved mobility, balance, strength and functional ability directly contributing to enhanced quality of life.

Palliative Care

Palliative care is support that helps people live comfortably when living with a life-limiting or terminal illness[3].

Physiotherapists support people in palliative care, utilising a biopsychosocial approach in supporting individuals and their family for maximising quality of life. Physiotherapy for palliative care includes assessment; symptom management; optimising function; education and communication; prevention/minimisation of adverse consequences and psychological support.

Palliative care physiotherapy has been found to positively influence quality of life and perceived wellbeing in a range of palliative care populations, including those with cancer, neurological disorders, cardiopulmonary conditions and mental illness[4].

A systematic review found physiotherapy provided to those with life-limiting illnesses, resulted in higher satisfaction and quality of life ratings, improved mood and confidence, decreased musculoskeletal pain, improved mobility, and reduced fatigue and lymphoedema[4].

Physiotherapy provides valuable support to people with life-limiting illness to optimise their comfort, function and quality of life. While the financial benefits of physiotherapy intervention in palliative care remain largely unknown, we believe that personal comfort provided by physiotherapy is invaluable.

Falls

Falls are the leading cause of preventable deaths in residential aged care facilities and occur three times more often than in the community setting[5]. Consequences of falls are often traumatic, including reduced independence or injury and death[6].

Until recently, most research on falls was conducted in the community, with evidence showing that physiotherapy and exercise can improve the physical performance for older people and have a positive impact on preventing falls for older people in their homes[7]. This has resulted in inconsistent delivery of falls prevention activities in residential aged care facilities, and exercise being abandoned by some institutions[8].

Recent research conducted in Australia has shown that strength and balance exercise, delivered by a physiotherapist (with the support of activity officers), can reduce the incidence of falls from 1.45 falls per person years for usual care to 0.64 falls per person years in the exercise group. When both the acute and long term costs are considered, there is a cost saving of $670 per fall avoided[9].

Preventive, and reablement programs, which include falls prevention, delivered by physiotherapists have significant financial value to the health and aged care system.

Continence

Incontinence is a highly prevalent and costly issue within Australian RACFs. In 2008–09, the estimated total expenditure on incontinence was $1.6 billion, with the largest share spent within RACF at $1.3 billion[10]. Incontinence is a significant factor in decisions regarding admission to aged care homes, particularly high-care facilities, as indicative in 87 per cent of Aged Care Assessment Team (ACAT) assessments[11].

Patient-centred care through continence interventions can reduce or minimise functional decline and promote social continence and good bladder habits and strategies[12]. A physiotherapist is a key member of the RACF assessment and treatment team providing functional mobility and strengthening advice, supports through gait aids and improving bladder and bowel control through pelvic floor exercises.

While there is limited published research on the financial efficacy of active treatment for incontinence in RACF's, in other settings, physiotherapy led pelvic floor retraining is shown to be a low-cost therapy intervention, with few adverse effects[13]. Importantly, physiotherapy intervention that combines low-intensity exercise and incontinence care has been shown to significantly improve resident functional outcomes[14].

Recommendation 1.

We recommend the Department of Health explore further mechanisms that will re-orient the quality of aged care services towards a model that allocates resources to evidence-based

early/conservative interventions, especially those which would reduce acute care episodes and improve the quality and safety of care provided.

APA position on risks of the proposed Australian National Aged Care Classification

The APA welcomes the review of the existing model and acknowledges the risks and benefits of the AN-ACC.

The AN-ACC model provides an objective financial assessment of care needs and we support a funding assessment that is separate from care planning.

We support the inclusions of a base payment, followed by variable components (when applied appropriately) and adjustment payment.

We support the model being based on a consumer directed care platform and that where a consumer does not have the functional capacity to make decisions, appropriate delegation is made available to the next of kin.

Risks

We believe there are a number of risks associated with the AN-ACC model.

Reablement and restorative care

The model proposes no dedicated funding for preventive, reablement and restorative care, including care provided by physiotherapists.

Reablement care focuses on strategies that maintain or improve functional ability and independence, through maximising an individual's intrinsic capacity and the use of environmental modifiers[15]. Currently lacking in the Australian policy context is a true reablement focus and supporting best practice and quality outcomes for older Australians.

We acknowledge the AN-ACC model is an improvement on the ACFI, which contains a perverse incentive for people to experience greater pain, disability and frailty to gain additional funding. Appreciating that if an older person sees an improvement in functional capacity they will maintain their assessment funding, we believe it is an insufficient incentive in what is an increasingly acute and complex needs environment.

We are concerned that without a carved out financial incentive for preventive, reablement and restorative care, it will not occur. The model does not include any adequate direct incentive to work with the older person to improve their ability and quality of life.

It is acknowledged that the aged care workforce is under resourced. This directly impacts the capacity of a residential aged care facility to provide preventive, restorative and reablement care.

The AN-ACC reassessment study, presented in Report Two, confirms the current availability of reablement and restorative care is limited. Of the 775 residents who were

reassessed after 4-6 months, only 6 (0.8%) had participated in a structured reablement or restorative care program during that time period. We are concerned by the current limited availability of these services in residential aged care, and this may continue without a dedicated funding stream.

Reablement and restorative care should not be considered a 'nice to have' addition in the variable or fixed component of the funding model. Rather, it should be considered as an integral part of the proposal.

As highlighted earlier in the document, physiotherapists working to the full scope of their practice, which includes restorative and reablement care, provide not only financial value, but also value and improve life outcomes for the consumer.

In a consumer directed care model, where quality of life and wellbeing of a consumer are at the centre, funding for restorative and reablement care is vital. Genuine investment in restorative and reablement care represents value over time as well as the opportunity for the best consumer outcomes.

As the AN-ACC model does not stipulate how the fixed and variable costs are distributed or utilised by a residential aged care facility, there is a risk that consumer choice will be diminished and RACFs may prioritise spending on infrastructure or acute services.

Consumer education about the services and opportunities available is also vital to ensure consumers have choice over the services they receive.

Recommendation 2.

That the AN-ACC model includes an itemised incentive payment for preventive, restorative and reablement care, provided by highly qualified and skilled practitioners, including physiotherapists.

AN-ACC assessment vs care planning and service delivery

We appreciate that the AN-ACC is a funding assessment tool that can be completed by nurses, physiotherapists and occupational therapists. Highly trained, experienced and skilled assessors are required to determine supports required by an individual entering residential aged care.

Importantly, however, we want to ensure that physiotherapists also maintain their role as care planners and service providers within residential aged care facilities. The role of physiotherapists as care providers and a regular and familiar face to consumers cannot be underestimated. It is important that physiotherapists are able to maintain service provision and the therapeutic service delivery is not replaced by care assistants.

A clear delineation between the AN-ACC assessment and internal care provision is important for providers, consumers and their families.

The role of physiotherapists as a care provider and planner cannot be diminished by another physiotherapist who is an AN-ACC assessor. The movement of professionals and the distribution and availability of aged care service providers must be monitored as the AN-ACC model is implemented to prevent under resourcing.

Price

We believe that the payment model, which includes the base tariff, variable and adjustment payment are appropriate values of proportionality. However, we are conscious of how the price will be determined.

The experience of the National Disability Insurance Scheme (NDIS) shows the serious and systemic problems that arise when a price is set that does not cover the true cost of delivering a service. In the NDIS, inadequate prices have resulted in a number of organisations ceasing to provide services, and others struggling financially to cover funding shortfalls. It is critical that this does not occur with any new funding model for aged care.

As new aged care reforms emerge, the Aged Care Royal Commission is completed and systems evolve, the AN-ACC must remain dynamic in nature.

Recommendation 3.

The AN-ACC cannot be a 'set and forget' model. The model must evolve to reflect best practice care. Consultation with the sector is imperative not only during roll out and implementation, but ongoing monitoring and evaluation to ensure sustainability.

Appropriateness of the proposed classification system

The APA believes the proposed classifications system, including the thirteen classification groups is, overall, logical and appropriate for aged care assessments.

The assessment focuses on functional and physical capabilities as the drivers of costs but does not address other needs such as needs for meaningful activity, emotional or social support. We believe these elements of consumer directed care need to be more carefully considered in the proposed model.

Emotional and social supports are often individually focused, and the funding model needs to support care that allows staff, including physiotherapists, the opportunity to provide time and attention to residents and improve their quality of life.

The biopsychosocial skills of physiotherapists lend the profession to provide safe, high quality and consumer focused care.

As discussed earlier in the document, there is a risk that the funding model does not provide adequate incentive for prevention, restorative and reablement care.

Similarly, for the model to be effective, training for assessors must be appropriate. AN-ACC assessor training must include education on dementia, palliative care needs, as well a comprehensive understanding of what true consumer directed care entails.

Careful consideration must be given to the relationship between assessor decisions as well as care planning processes to ensure consumer needs are reflected. It is important a clear pathway exists for people who may fall between classes or require independent or secondary assessment if their functional capacity changes.

Reassessment triggers

We believe the current proposed triggers for funding reassessment are appropriate. Significant hospitalisation, significant change in mobility and change in overtime as all appropriate reassessment prompts.

However, we support additional research as the AN-ACC is rolled out to determine whether the reassessment remains appropriate. For example, it may become apparent that a fall or a 'near miss' fall is added as an additional category to prompt reassessment.

Furthermore, a 'significant change in mobility' in isolation may become a grey area to prompt reassessment, particularly as a change in mobility may be incremental rather than acute. Rather, complicating factors in conjunction with a change in mobility may be more sensitive in determining a change in care needs.

It is possible that an older person living in residential aged care may experience a clinical decline in function over a short period of time. This may trigger a care planning review, rather than a funding class assessment.

Residential aged care facilities need appropriate funding and staff, including physiotherapists, to ensure a care planning review can be undertaken at an appropriate time, without requiring a funding reassessment.

It will also be necessary to develop a suitable process for providers to disagree with the external assessment – potentially seeking reassessment if certain criteria are met.

There is no requirement in the new model for a re-assessment to be requested by a provider if the resident moves up the branching tree to a higher level of function. This is designed to provide an explicit incentive for high quality services to not be penalised with a lower funding classification. This was the initial sentiment surrounding the development of ACFI but we have increasingly seen government validators downgrade residents if their abilities have improved. We need further assurances by the government that this behaviour by AN-NAC assessors will not be repeated.

We believe the sentiment of facilities keeping a higher level of funding if a resident improves their functional capacity is not enough incentive to provide restorative care and reablement. AN-NAC does not address the same problem in ACFI that facilities will receive more funding if they 'allow' residents to functionally decline and then receive more funding.

We believe that there needs to be more work done to reward facilities that maintain and or improve residents' levels of independence and support our previous statements that residents require specific funding to support active restorative and reablement programs.

Reassessment charges

The APA does not support the introduction of reassessment charges, particularly in the early years of a new funding model.

Currently, many aged care facilities operate with limited profit margin, and organisations will likely face increased financial burden as they transition to a new funding model.

If the AN-ACC is effective as incentivising providers to provide maintenance, reablement and restorative care, there should be a natural progression away from reassessment, with providers not seeking to 'move up' categories to seek additional funding. Rather, care

planning should evolve as the older person changes in functional capacity and there is a change in consumer wishes.

Reassessment requirement

The APA does not support reassessment being a requirement of the proposed funding model.

Rather, providers should be able to access additional funding following investment in reablement and restorative care resulting in higher functioning residents.

If reassessment were to be part of the AN-ACC model, it would naturally reinforce the perverse incentive of functional decline.

Annual costing and supplements

We support an annual costing review to inform price. The price must be indexed annually, and an annual cost review must include careful monitoring and evaluation of utilisation and importantly, consumer outcomes.

A robust analysis of best practice service delivery cost is required to guide annual costing. Costing must reflect and support high value care, including restorative and reablement care, rather than minimal care focusing on pain management.

It is vital the annual costing is determined in consultation with the aged care sector. Experience with the NDIS has shown that if a costing is developed without sector-wide consultation, there is a risk that the price set will be lower than the market rate required to deliver high quality services. Importantly, a lower cost may also result in poor safety resulting in adverse outcomes for consumers.

To allow independent evaluation of AN-ACC we support de-identified data captured by AN-ACC to be made publically available.

The APA support the inclusion of the viability and homeless supplement. We believe in the delivery of equitable support for all Australians, regardless of vulnerability. We believe people who are homeless, live in rural and remote areas, or are from Aboriginal or Torres Strait Islander backgrounds have the right to equitable support, and an appropriately calculated supplement will support this.

Funding model transition and implementation

Effective change management will be instrumental in transitioning to a new funding model.

The key principle for decisions about the transition to the new model must be that services must be able to continue and not be compromised.

The funding model must be implemented in a way that ensures job sustainability for providers. Providers should not be financially disadvantaged during the transition period.

We believe that staff contracts must be maintained in the transition process. For example, if a physiotherapist is contracted for thirty hours to provide services under AFCI, the funding must be upheld during the transition period.

As the funding model is implemented it is important there is opportunity for regular feedback to provide monitoring and evaluation and incremental improvements as required. The transition requires effective communication to all aged care stakeholders, including the APA, the general public and to other allied health providers.

Should the two-year transition approach be taken, some further modelling should be made about the consequences of ACFI payments being frozen for existing residents during the transition period. This measure may adversely affect provider viability at a crucial time in the transition period for the sector. A gradual transition will allow greater opportunity for the workforce to adapt to shifting demands.

The use of external assessors needs to be well structured and moderated to ensure that the assessors are appropriately skilled, trained and understand the particular environmental and cultural contexts, histories and challenges of vulnerable people.

We seek further detailed information and planning about what the transition would actually involve to determine the best option.

Care delivery and planning

In Australia, physiotherapy is involved in a range of innovations that are yet to be fully captured within the AN-ACC, including in care delivery and planning.

Physiotherapy can play a substantial role in keeping people well and in maximising their wellbeing and quality of life if they have a health or functional condition. This includes care planning as part of a multidisciplinary team.

Care delivery and planning that supports the early detection of changes in behaviour, and physical and cognitive decline is vital. Investing further in early detection of change will save money on complex care in the future. Physiotherapists have the skill and knowledge to thoroughly assess a person to change a resident's care plan.

It is important care delivery, where appropriate, is provided by physiotherapists, rather than assistants and other health professionals to ensure safe, quality care is maintained. There is increasingly more RACFs choosing not to employ physiotherapists to undertake key areas of clinical management such as pain and mobility. This is placing residents at risk of poorer health, wellbeing and functional outcomes.

By incorporating physiotherapy into the AN-ACC model of care delivery and planning there is opportunity to maximise value, including health outcomes and high quality care.

The APA support the annual care planning model proposed. Annual care planning will ensure that consumer needs are reviewed, and discussed at an appropriate interval. Physiotherapists must be recognised in their role as care planners *and* external assessors.

As such, we believe that care planning must occur after the financial assessment. Current best practice approaches to care planning use a multidisciplinary approach, often using

both staff expertise, allied health and medical expertise. This approach should be further encouraged.

The APA supports providing a best practice tool for care planning, provided its use is not mandatory. Residents have diverse needs, and true consumer-directed care requires a high level of flexibility in service provision.

A best practice tool could be used as the basis for needs identification and care planning tailored to individuals and communities, and this tool should be co-designed with consumers, nursing, allied health and medical professionals to ensure a comprehensive multidisciplinary approach.

Information and communications platform

We believe the development of an information and communications platform would improve care delivery and planning. Such a digital platform, which may include an electronic health record, could, among other attributes, have a function for recording consumer behaviour, wellbeing and function. This platform would be able to collate patterns and behaviours with the potential to include a predictive element.

A sustainable workforce

As part of care delivery and planning, a sustainable workforce cannot be overlooked.

While supporting the existing workforce is an integral part of aged care services, it is important that a strong and sustainable career pathway is implemented for the emerging workforce. This includes students and individuals who are new to working with older people.

The market needs to fund and support career progression, including appropriate supervision and quality improvement for the workforce. A system that focuses on mentoring, maintaining excellence and advances and supporting a new generation of experts is critical for the aged care workforce.

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Response to AHSRIs Recommendations

The following section provides a response to a number of the Recommendations included in response to the RUCS. Please note, only Recommendations relevant to the physiotherapy profession are discussed.

Recommendation 5

That aggregate de-identified data captured in the AN-ACC assessment be released in the form of an annual public report on the needs of residents in the residential aged care sector.

The APA supports the collection of de-identified AN-ACC assessment data to improve transparency of the assessment process. Reporting will encourage accountability and reduce the likelihood of inappropriate assessment or classification.

The release of an annual public report should be followed by the opportunity for consultation with the sector to allow continuous improvement.

Recommendation 9

That a best practice needs identification and care planning assessment tool be developed for use by residential aged care facilities.

The APA supports the delivery of best practice and safe, high quality care in residential aged care facilities. We are particularly interested in supporting Government to develop the care planning tool for use by residential aged care facilities.

Physiotherapists play a vital role in care planning, considering the biopsychosocial components of an individual's care plan. Without engagement from a broad range of skilled services at the care planning stage, there is the risk an older person may miss out on the full scope of care services available.

A one off care assessment, conducted by a registered nurse employed by the RACF will not allow for a detailed, restorative and comprehensive approach. Rather, engagement of a broader multi-disciplinary team including physiotherapists at the care planning stage is vital for best practice care and ensuring consumer directed care needs are met.

Recommendation 19

That the Commonwealth, working through the Department of Health and the Aged Care Quality and Safety Commission, build strong accountability into the system to ensure that the adjustment payment be used for the intended purpose, not added to the bottom line and not contracted out to third party providers.

The APA *strongly opposes* the component of this Recommendation that prevents third party providers from receiving funding from the adjustment payment.

While in some larger residential aged care facilities, physiotherapists are employed on a permanent (full time or part time) basis, in many locations, physiotherapists are contractors who provide care for a set number of hours.

If the adjustment payment cannot be used by third party contractors there is a significant risk that older people will miss out on a range of care, including physiotherapy.

Contracted providers play an integral part of service provision for older people, and offer a familiar face when visiting a facility. Removing this service has the potential to be detrimental to the success of the AC-ACC funding model.

Recommendation 26

Irrespective of the broader organisational aspects, external assessment be undertaken by credentialed registered nurses, occupational therapists and physiotherapists who have experience in aged care, complete approved AN-ACC assessment training and comply with continuing professional development requirements.

The APA support external assessment be undertaken by a credentialed registered nurse, occupational therapist or physiotherapist who complete approved AN-ACC training. The APA believe that it is important the assessment is completed by a provider who is able to consider the older person in a broad context and take into account their biopsychosocial needs in addition to a mobility assessment. Physiotherapists are appropriately trained to successfully complete the assessment task.

Recommendation 28

That the Commonwealth work with peak bodies to develop and implement a change management strategy.

The APA welcomes the opportunity to be involved with the Government to implement a change management strategy as the AN-ACC is considered.

Recommendation 29

That Government commit to an ongoing aged care research and development agenda that builds on the work of the RUCS and that includes assessment, classification, costing and outcome studies.

The APA supports ongoing research and data collection developed in aged care that includes assessment, classification, costing and outcome studies.

We support research that is appropriately de-identified in thin markets and data that is made publically available to inform consumers and providers.

Recommendation 30

That a study equivalent to RUCS be undertaken in the community aged care sector with a view to expanding AN-ACC so that it includes aged care delivered in all settings.

The APA supports a similar review being undertaken in the community aged care sector.

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Definitions

The Resource Utilisation Classification Study (RUCS) reports released by the Australian Health Services Research Institute (AHSRI) include a number of definitions on care for people requiring support and they age. The APA has reviewed the definitions and we believe the following changes, in italics, can be made.

Frailty - A chronic condition acquired with ageing and associated with adverse outcomes, such as ADL impairment, falls, institutionalisation, and death. *Frailty can affect older and younger people and is not a reflection of chronological age.*

Reablement - Targeted, time-limited interventions that address functional loss, or that help the resident regain their confidence or capacity to resume activities – implemented by aged care facility staff.

We believe this definition of reablement is too narrow and does not reflect the full scope of restorative care, including care provided by physiotherapists.

Restorative care - Support for the provision of this type of care needs longer term consideration. It is similar to reablement but implemented by clinical staff such as allied health and medical clinicians, possibly externally based. Requirements for restorative care would be externally assessed and based on sound, objective criteria involving accredited providers.

We believe that restorative care requires immediate, rather than longer term consideration. Restorative care is a key component of ageing, ensuring that individuals are supported to reach their full capacity. We do not believe restorative care providers should be externally based, rather they should be integrated into the standard care available to residents in residential aged care facilities.

Residential aged care - Personal and/or nursing care that is provided to a person in a residential aged care service. In addition to care, the person is also provided with accommodation that includes meals, cleaning services, furniture and equipment. The residential aged care service must meet certain building standards and appropriate staffing in supplying the provision of that care and accommodation.

We believe this definition should not just be limited to personal and/or nursing care. Support, care, health and therapeutic services, including physiotherapy are also a key component of residential aged care.

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Australian Physiotherapy Association

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

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 26,500 members who conduct more than 23 million consultations each year.

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.

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