Unleashing the Potential of our Health Workforce

Scope of Practice Review

Occupational Therapy Australia submission

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Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide a submission to the Scope of Practice Review. OTA is the professional association and peak representative body for occupational therapists (OTs) in Australia. There are over 27,000 registered OTs working across the government, non-government, private and community sectors in Australia[1]. OTs are allied health professionals (AHPs) whose role is to enable their clients to engage in meaningful and productive activities.

One of OTA's core aims is to develop and maintain excellence across the scope of professional OT practice. OTA recognises that OT practice in Australia continues to expand and seeks to support and encourage appropriate innovation through a broad definition of scope of practice. This submission details the current barriers preventing OTs from practicing to their full scope and offers recommendations to enable the efficient and effective utilisation of OTs, and enhancements to the quality of primary health services in Australia.

Effective use of occupational therapists in primary care

There is growing synergy between the OT profession and primary health care services, due to the increasing focus on preventative health and social determinants of health, and the growth in person-centred, holistic care, health promotion and prevention, disease self-management, and overall quality of life[2].

OTs have a key understanding of the significant impact that roles, habits, and routines have on health and wellness outcomes. They also focus on a person's meaningful engagement in occupations, which is relevant and vital to their participation in individual, family, and community life, and health outcomes.

OTs are well placed to work to address the major health issues facing Australia's population now and into the future, which place pressure on the primary health system, and contribute significantly to healthcare costs. These include chronic disease, aging and age-related conditions disability, and mental illness.

OTs can contribute significantly to the work done in interprofessional primary care teams, and by individual medical practitioners, to reduce pressures on the primary health system by:

- maximising independence and participation in daily life by recovering and improving function, and development of skills for daily living;
- minimising the risk of crisis situations, such as unplanned hospital admissions; and
- overcoming the barriers to engaging with services such as social prescribing.

[1] Occupational Therapy Board of Australia (Australian Health Practitioner Regulation Agency), 2022; https://www.occupationaltherapyboard.gov.au/News/Annual-report.aspx

[2] Halle, Ashley D., et al. "Occupational therapy and primary care: Updates and trends." *The American Journal of Occupational Therapy* 72.3 (2018): 7203090010p1-7203090010p6

Key Issues

Historically, the OT profession has been linked to rehabilitation settings, facilitating recovery from and adaptation to injury, illness or disease (including chronic diseases). However, the OT scope of practice has broadened considerably in recent decades, to now encompass diverse areas including disability, mental health, preventative health and many other areas, as outlined later in this submission. OTs practicing in Australia today have a broad scope of practice that comprises a wide range of therapeutic skills and interventions that support and empower people to live healthy and meaningful lives.

Current health trends of increasing chronic disease, an ageing population, and increasing rates of mental illness will see additional pressure placed on the primary health system into the future. OTs are well positioned to provide direct and team-based health interventions to help with prevention and treatment of health conditions, and maximise people's participation in society, including education, employment and many other facets of life, which can indirectly impact health outcomes. There is significant opportunity to better utilise the OT skill set and scope of practice within primary health settings to provide cost effective and person centred health care, with the added benefit of reducing reliance on GPs to manage a person's overall health and wellbeing.

The key barriers to the uptake of OT services in primary health are linked to *insufficient reimbursement* and *low recognition* of the scope and availability of OT services. Currently, the uptake of OT services is limited by service design, including limited range and availability of Medicare rebated services. Additionally, the scope of OT practice is not well understood by some commissioners of health services and individual clinicians, leading to their exclusion, or low utilisation, in certain settings. Medicare rebates for occupational therapists are also set at rates well below the true cost of service provision, creating issues for OTs providing services, and add additional costs for consumers when they are required to pay a gap fee.

This submission sets out the current scope of OT practice in Australia, the key barriers to utilising OTs to their full scope, and possible enablers to unlock their potential.

Key solutions and enablers

OTA recommends a range of strategies and approaches to better enable the utilisation of OT services in primary health systems:

- Education and guidance of key referrers (i.e. GPs) to understand the scope of OT practice and encourage uptake of OT services, including the role of mental health OTs.
- Inclusion of OTs in the design and commissioning of services, to ensure they utilise full scope of OT practice, and enable person centred and holistic approaches.
- Increase to the Medicare rebates for OT services so they reflect the true cost of service provision, including the introduction of rebates for travel costs for home and community appointments, in recognition that best practice OT approaches enable assessment and treatment of clients in natural settings (i.e. their home, workplace or community).
- Support via Primary Health Networks to support supervision of new graduates, and training on primary health systems and referral pathways, and connection building across primary health networks and general practice.
- Enhancement of Medicare Chronic Disease Management (CDM) rules to enable 10 sessions, higher rates, longer appointments (with a long consultation rebate), and support for a wider range of conditions which contribute to or are frequently

experienced alongside chronic disease including obesity, chronic pain, and falls prevention.

- Development and trial of blended or block-funded primary care funding models for OT services and other allied health services as recommended by the Primary Health Reform Steering Group.
- Support for increased uses of multidisciplinary practice through block funded and commissioned health programs.
- Support for the adoption of cross-discipline referral pathways including AHP to GP/specialist/primary care program) and from AHP to AHP, within Medicare funding arrangements.

Occupational therapy practice in the Australian context

The World Federation of Occupational Therapy (WFOT) (2012), defines occupational therapy as:

> *"…a client-centred health profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement."*

Occupational therapists in Australia therefore:

- work with individuals throughout the lifespan, with families and circles of support, organisations, groups, communities or populations,
- work across a wide variety of institutional, community-based, organisational, educational, policy, industry and research settings, and
- share the common construct of person (client, group, or population), environment (physical, social, cultural, virtual, political, sensory and temporal contexts) and occupation (work and productivity, leisure and play, social participation and self-care).

The Occupational Therapy Board of Australia (2012) defines practice as:

> *"Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession. "*

Individuals who practice in Australia as an occupational therapist must be registered with the regulatory body, the Occupational Therapy Board of Australia, under the auspices of the Australian Health Practitioner Regulation Agency (AHPRA)

Unless registered, the title of occupational therapist cannot be used. The scope of occupational therapy practice is defined in the Health Practitioner Regulation National Law but is not protected and remains in the public domain. The Australian Minimum Competency Standards for New Graduate Occupational Therapists (2018), the WFOT Minimum Standards for the Education of Occupational Therapists (2016) and the Occupational Therapy Australia Code of Ethics (2014) embrace the core focus of occupation and set out the fundamental constructs and context of contemporary occupational therapy practice in Australia. These form the foundation for OT scope of practice.

Defining scope of practice in occupational therapy

OTA's Occupational Therapy Scope of Practice Framework (2017) articulates a strong and clear position of what the occupational therapy scope of practice is in Australia, now and into the future.

Scope of practice can be defined as the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within a profession are educated,

competent and authorised to perform[3]. Scope of practice is set by professional standards such as professional education and training, competency standards, codes of ethics, conduct and practice. Full scope of practice is attained with experience, appropriate supervision, and engagement in professional development. It does not necessarily reflect only those areas and skills which are taught at pre-registration level.

Scopes of practice are usually written in general terms and include statements of purpose, definitions of the profession, and descriptions of domains of practice. Scopes of practice do not usually provide lists of treatment modalities, because this risks defining practice too narrowly, and may not either reflect the range of current practice or allow the profession to grow and develop. Determining whether a practice is within scope is an exercise of professional judgment. Each individual professional is responsible for considering the purpose of their occupational therapy practice, whether it fits the definition of the profession and is within the domains of practice.

Evidence-based practice is a key element of best practice and it is expected that occupational therapists use professional reasoning to integrate information from their professional expertise, research evidence, the client's values and circumstances, and practice context, when making decisions.

OTA has defined what it considers to be core, extended and advanced scopes of practice for OTs, as outlined in the table below.

Definitions of scope of occupational therapy practice

Title	Definition	Skills and qualifications	Practice examples (non-exhaustive list)
Core	A broad range of activities within the context of core scope of practice. These activities are typically progressively developed with experience, continued professional development and supervision.	Minimum entry level competencies e.g.: • Academic qualification in occupational therapy from a WFOT approved provider • Career experience • Continued professional development and supervision	• Assessment and intervention to enable individuals, groups or communities to meet every day needs in self-care, leisure and productivity • Assessment and modification of occupation/s to enable engagement by individuals, groups and communities • Assessment and modification of environment/s where occupations take place
Advanced	Specific activities within the context of advanced practice that may be undertaken by more advanced professionals, which	• Additional training • Enhanced competency • Practice verification • Internal credentialing by an employer	• Complex driver assessment • Complex seating prescription • Complex pain management interventions (e.g.

[3] Occupational Therapy Australia (2017) Position Paper: Occupational Therapy Scope of Practice Framework (online) < https://otaus.com.au/publicassets/725829df-2503-e911-a2c2-b75c2fd918c5)>

	are not typically performed by entry level graduates/ those entering new areas of practice. These activities are typically a natural extension of the core scope of the profession (e.g. greater autonomy in complex professional decision making or practice in high risk or highly skilled areas of practice).	• Professional supervision and/or monitoring • Teaching and research activities, to maintain professional practice standards	physical agent modalities) • Specific mental health interventions requiring additional training • Research and evaluation • OT education and academia • Policy/advocacy
Extended	Performing tasks beyond the current scope of the profession and/or traditionally associated with another profession	• Further advanced training • May also require legislative or regulatory change to enact in practice	• Prescribing rights from a medication formulary • Requesting diagnostic procedures such as an x-rays

Delegation of scope of practice

From time to time, OTs may delegate tasks that are within their scope of practice to an identified professional, including allied health assistants (AHAs) and occupational therapy students. An OT may delegate specific tasks or request that another person carry out elements of occupational therapy practice as directed by a responsible occupational therapist within an appropriate governance framework. This is governed by the OTA Code of Conduct[4] which provides guidance on the correct approach including that a practitioner take:

> *"reasonable steps to ensure that any person to whom a practitioner delegates, refers or hands over has the qualifications and/or experience and/or knowledge and/or skills to provide the care required understanding that, although a delegating practitioner will not be accountable for the decisions and actions of those to whom they delegate, the delegating practitioner remains responsible for the overall management of the patient or client and for the decision to delegate, and always communicating sufficient information about the patient or client and the treatment needed to enable the continuing care of the patient or client".*

This delegation can be advantageous as it can enable an OT to continue to practice to the top of their scope of practice, while overseeing delegation of core elements of work to other professionals, where appropriate. This can enable a sense of satisfaction for the clinician, and better utilise specialised skills and experience within the health system. It can also, in certain circumstances, enable better access to OT services and supports in challenging settings, for example, in remote and rural areas, with supports such as telehealth, with an

[4] Occupational Therapy Australia (2019), Code Of Conduct (online) < https://otaus.com.au/publicassets/20e58804-25fb-eb11-943f-005056be13b5>

AHA delivering certain tasks under direction and supervision, at a remote or regional location.

However, substitution of roles and activities undertaken by appropriately qualified OTs to staff lacking in experience and training, and without appropriate supervision, compromises client care and creates risk for both the provider, and the patient. OTA has also been advocating strongly on the concerns about scope creep in certain settings, for example the aged care system and NDIS, to raise awareness of the risks of unqualified/inappropriately qualified non-OT practitioners being involved in functional assessments, assessments for Assistive Technology and Home Modifications, and delivery of interventions that require the skills and qualifications of an occupational therapist.

The breadth of OT practice

OTs deliver a broad range of clinically informed, therapeutic interventions to assist clients to maximise their participation in occupations that are meaningful to them, including activities of daily living, employment, physical activity, social and community settings and many more.

OTs commonly undertake core training via their academic study and then pursue further specialisation in areas of interest via further on the job training (under clinical supervision) academic study, placements, specialised employment, and continuous professional development.

Their role can encompass many facets and can include (but is not limited to):

- Assessment of functional capacity (physical, neurological and psychological)
- Prescribing approaches, aides, equipment, and modifications to enable independence in the home, community or other setting, including:
    - Environmental modifications (including sensory modifications and home modifications
    - Assistive Technology (including equipment that supports completion of activities of daily living, mobility devices, workplace modifications and vehicle modifications)
- Therapeutic interventions to build capacity and increase participation and independence in areas such as:
    - Occupational rehabilitation
    - Mental Health
    - Neurology and Acquired Brain Injury
    - Pain management
    - Hand therapy
    - Autism
    - Disability (including psychosocial, cognitive and physical disability)
    - Injury rehabilitation (including Cardiac injury)
    - Older persons (including aged care needs)
    - Palliative care
    - Paediatrics
    - Sexuality and Intimacy
- Chronic Disease Management (CDM)
- Preventative health
- Community health
- Leadership and management
- Occupational justice
- Academic and further research

Spotlight: Mental Health skillset within occupational therapy

OTs are a core part of the Australian mental health workforce. OTs specialising in mental health work across the spectrum of mental illness, providing early intervention, prevention, and treatment services to people with mild, moderate and severe mental health conditions. They deliver clinical, evidence-based services to people with relatively common mental health conditions such as anxiety disorders, as well as more severe conditions which require targeted interventions, such as psychosis and trauma-related disorders.

OTs working in mental health can work with individuals to support them to identify and successfully engage in the everyday activities they find meaningful. They draw on, and are trained in, occupational therapy specific tools and approaches as well as structured psychological techniques. They are skilled in delivering capacity-based interventions that can assist a person with psychosocial disability to overcome barriers and access treatment, employment, housing and other identified personal goals.

Occupational therapists assist individuals to:
- Develop skills to live independently
- Deal with stress and emotions
- Link in with the community
- Cope with grief and loss
- Manage self esteem
- Develop communication skills
- Structure daily life

OT mental health services are delivered across a wide range of settings, including in acute and rehabilitation primary care services, aged care, schools, private practice and government funded schemes such as NDIS, workers' compensation and motor vehicle accident schemes.

Occupational therapists bring a unique occupational focus, addressing the activities and occupations that are important and meaningful to a person's daily life. They are particularly effective at assisting people with mental illness to improve vocational and educational outcomes[5].

OTs can obtain OTA Mental Health Endorsement[6], which provides recognition of the additional knowledge, skills and experience of OTs focusing their scope of practice on mental health. Attainment of the OTA Mental Health Endorsement enables OTs to deliver services under the Medicare Better Access Scheme.

The endorsement program sets a high standard for the OT profession and provides an important signal to practitioners, funders, and users of OT services about what the profession considers the foundation for safe and effective practice.

In the primary health system, OT's are able to practice within a limited scope under the Medicare Better Access Scheme, and there is limited awareness by referring GPs, and consumers, about the role that OTs can play in providing mental health interventions. There is also limited understanding of the role and efficacy of mental heath OTs in mental health systems, leaving a workforce of skilled and effective practitioners underutilised.

[5] Kirsh, Bonnie, et al. "Occupational therapy interventions in mental health: A literature review in search of evidence." *Occupational Therapy in Mental Health* 35.2 (2019): 109-156.
[6] OTA (2023), online< https://otaus.com.au/membership/ota-member-programs/mental-health-endorsement>

Occupational therapy practice settings

OTs deliver services in a variety of settings across Australia. Data from 2021 shows that OTs are most highly represented in private practice settings, predominantly in group practice.

Setting	Percentage
Hospitals	15.5%
Group private practice	11.2%
Community health care services	11.1%
Disability service	10.1%
Solo private practice	9.1%
Other private practice	5.4%
Community mental health services	5.2%
Residential aged care service	4.4%
Outpatient service	4.3%
Rehabilitation/physical development service	3.0%
Other government department/agency	2.3%
School	2.0%
Tertiary education/academic	1.7%
Home services	0.9%
Other/Not stated	12.7%

Source: Health Workforce Data Tool – National Health Workforce Data Set

The importance of practicing at full scope

OTA recently undertook a workforce survey of OTs practising in Australia, and received over 2200 responses, including over 500 responses from OTs working in remote and regional settings. It found that scope of practice is a key factor that influences an OT's sense of professional satisfaction and can impact their decisions about remaining as a service provider. Only 68% of respondents agreed that they were able to work to their full scope of practice.

The survey results showed that maintaining breadth of practice is important for OTs, and they value the ability to work across their scope utilising all their professional skills with a variety of clients and enjoy career progression over time.

Being unable to practice at top of scope can create feelings of stress, burnout, frustration and other negative feelings and experiences, which can impact an OTs personal and professional satisfaction, and risk their underutilisation or even exit from the profession. However conversely, working mostly at top of scope without appropriate supports or downtime can also create stress and burnout. It's clear that OTs value and are sustained by the ability to practice to their top of scope, and also across their full scope.

Barriers that prevent full scope of OT practice

OTA has identified a number of key barriers that are impacting OT's ability to work within their full scope. The major factor impacting OTs utilising their full scope of practice in primary health is the limited scope of current funding schemes, particularly Medicare. OTs are currently supported to provide rebated treatments and supports under Medicare under four programs:

- Chronic Disease Management (CDM),
- Better Access (Mental Health) (BAMH),
- Eating Disorders, and
- Complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) and Eligible Disability Services.

The current Medicare rules around the number of funded annual sessions and the scope of services that can be supported, are too prescriptive in some cases. Additionally Medicare rebates are well below market rates, and result in the charging of a gap fee, which disincentivises uptake of these services, or provider decisions to offer subsidised service delivery, which impacts provider viability. Key Medicare issues are discussed below.

Medicare - Chronic Disease Management

OTs are particularly skilled at working to create changes in lifestyle and promote client disease self-management.

> *"…occupational therapy is uniquely situated to be an integral part of the chronic disease management team, including in primary care. Given the profession's specialized education (e.g., mental and physical health, management, and advocacy) and skills in functional assessments, activity analysis, skill development, problem-solving barriers, environmental assessments, adaptation, compensation, and remediation, occupational therapy practitioners are well equipped to support clients in managing their (chronic conditions)[7]."*

OTs can assess a client's current knowledge, willingness, and ability to engage in health management and maintenance, alongside other health-promoting occupations within the client's life, while taking into account habits, roles, and routines to optimise quality of life, and provide interventions that target barriers and support action.

Under Medicare, OTs can provide some limited supports and services for chronic conditions under item M3 – Allied Health Services for Chronic Disease Management (CDM). However, barriers exist in delivering full scope of services, including;

- the annual service limit of five sessions,
- limited duration of assessment and treatment items, and
- rebates that are funded well below the true cost of services.

OTA members report that the scope and volume of CDM services are not currently adequate to meet patient needs, or create beneficial health outcomes, and that many clients would benefit from a maximum of 10 sessions annually to assist with building client report and trust and embedding interventions.

Additionally, Medicare CDM funding limits 5 sessions annually across all allied health disciplines, with a maximum of 4 sessions with any one profession. In practice, clients pursue physiotherapy, podiatry and chiropractic services, which are shorter in duration, and

[7] Leland, Natalie E., et al. "Occupational therapy and management of multiple chronic conditions in the context of health care reform." *The American Journal of Occupational Therapy* 71.1 (2017): 7101090010p1-7101090010p6.

cost less to provide, resulting in a smaller gap fee to the client. A standard OT appointment has a longer duration, due to the need to conduct a thorough client assessment, and the resulting higher cost acts as a disincentive to some clients, due to the larger gap fee.

While CDM does enable case conferencing between professions, a single case conference between the GP and another professional can use up 3 of the 5 CDM items it a single day, further reducing a client's access to individual sessions with an AHP. Medicare rules only allow for a claim for a case conference if a GP initiated it and is present, which OTA understands rarely occurs in practice. This is a barrier to enabling AHPs to independently case conference and coordinate care.

The Medicare fees payable under CDM are also well below market rates, and impact delivery of care. OTs have described that, under CDM, they have received referrals for home visits to clients (often recipients of the Aged Pension or Disability Support Pension) in their home environment, to perform a home and safety assessment. This particular type of assessment typically takes a minimum of 45 minutes, not including travel time or cost (which are not reimbursed under Medicare), and other non face-to face services that are directly related to the requested assessment (i.e. report writing, equipment and home modification assessment and prescription processes, liaison with other clinical team members or family/carers). Under Medicare, they can only receive a rebate of $58.00 for a session. This funding rate is not representative of the true cost of these services (when compared to private practice rates of around $220 per hour, and the hourly rate of $193.33 payable under NDIS), leading to additional unfunded time spent by the clinician if they are to provide a full and comprehensive service. Some OTs report they are unwilling to charge any gap fee for pension recipients on ethical grounds, to enable service access, which impacts overall business costs.

It is noted that the definition of chronic conditions does not include several conditions that have significant impacts on the client, and which OTs have scope to provide assistance with, including chronic pain and obesity (which are usually seen as risk factors for chronic disease, and do not qualify for an CDM plan).

Medicare - Mental Health services under the Better Access Scheme

OTs who hold OTA Mental Health Endorsement can deliver focussed psychological therapies under the Medicare Better Access Scheme. The scope of services that trained mental health OTs are able to deliver however, extends well beyond the delivery of the focussed psychological therapies under the Better Access Scheme, and includes:

- assessment to develop goals and inform interventions;
- capacity building interventions, including support regarding socialisation, activities of daily living, accessing housing, employment, and other key areas of life that contribute to personal wellbeing;
- risk management;
- specialised services for child and adolescents;
- sensory modification;
- parenting interventions, among others.

For example, mental health OTs working in community mental health settings may support clients by completing cognitive assessments, delivering cognitive therapies, sensory strategies and group programs, and support the client to develop socio-emotional and communication skills, and pursue employment if appropriate.

The table on the next page provides a snapshot of the variation of scope of services that OTs are funded to support under a range of schemes, in relation to mental health.

Snapshot of government funded mental health occupational therapy services

Funding scheme	Medicare	DVA	NDIS	State compensation schemes
GP referral required	Yes	Yes	N/A	Scheme specific
Endorsements required	OTA Mental Health Endorsement	Medicare Provider Number	Not specified	Scheme specific
Scope of OT mental health services supported	• Focused Psychological Strategies Services by Allied Health Providers (Better Access to Mental Health (BAMH) Program) • Eating disorder treatment and management plan program.	Limited focussed psychological therapies	Capacity building therapeutic intervention, including strategies focussed on psychosocial, cognitive, sensory and other aspects of psychosocial disability.	Various, depending on scheme. Some schemes such as RTW SA and WorkSafe Victoria have specific item codes for OT mental health treatment, enabling both assessment and treatment.
Out of scope	Capacity building interventions	• Specific trauma related psychological therapies • Capacity building interventions	Focussed psychological therapies	

There are significant limitations in the level of access to the Better Access Scheme which impacts OT scope of practice and client outcomes. The current cap of 10 sessions annually with an AHP is not sufficient for some clients needing fortnightly or more regular mental health therapies. In the case of children and adolescents, the change in rules to enable up to 2 sessions to be for parents/carers without a child present effectively results in the child only attending 4 sessions, before they must return to the GP to "unlock" a further 4 sessions.

An OT reports "that means having barely been able to establish a good working relationship before asking them to do something that is incredibly difficult and embarrassing for them" (i.e. return to the GP). OTs have the skills to work with a client to assess if they require additional treatment. However, Medicare requires the person to return to their GP after 6 sessions to establish if further supports are required. It would be preferable for the clinician treating the client to make an informed decision on whether the client requires the additional 4 sessions (up to a maximum of 10 in a year).

There is a general lack of awareness of the role of Mental Health OTs in delivering Medicare Better Access services, both by referring GPs and consumers, which is a major barrier in the uptake of these services.

Medicare - Aged care

OTs provide a range of preventative and clinical interventions to support people as they age and reduce the impact of age-related changes on function and wellbeing. OTs have a key role in helping people age safely and in place (at home) wherever possible. OTs focus on reablement and implement strategies to ensure that age related impacts are managed. When funded to deliver their full scope of services in the community, OTs can assist to increase independence and reduce the need for higher care settings, and when utilised in residential and community care settings, they can directly support aged care providers in meeting and maintaining compliance and service quality.

Currently the design of the Australian aged care system, and limitations on Medicare funded services, impacts delivery of the full scope of OT services to older persons. Funding for allied health services in residential aged care settings is insufficient to meet individual resident needs and it not being utilised by aged care providers, limiting OT scope of practice. There is a need to better define the scope of practice that OTs are funded to provide under Medicare, to ensure that residents in aged care facilities can access OT services. There is also an identified need for better multidisciplinary approaches in residential aged care.

Systemic design and funding issues in the aged care sector have hindered OT clinical practice and eroded the understanding and profile of OT professionals, and comprehensive multidisciplinary approaches. There is varied understanding and utilisation of OTs by residential aged care providers. Those with in-house OTs may employ them using aged care funding, meaning these clinicians are unlikely to be registered with Medicare and thus be unable to deliver additional services under this scheme that could benefit clients (such as CDM and BAMH). Those providers who employ contractors outside of their organisation are more likely to have OTs that are registered to deliver Medicare services (however it is noted that gap payments are likely to be prohibitive) but may not be involved with clients on more than a one-off, or episodic basis. This creates inequality and inefficiency in service delivery, and both approaches have limitations meaning OTs are much less likely to work to their full scope.

While it is noted that the design of the aged care system is currently under review through federal reforms, it is important that this Scope of Practice Review considers how scope of practice for primary health care services are constrained and impacted through the aged care system, leaving older people without access to enabling and necessary health care.

Medicare funded programs are not designed to support restorative or reablement approaches to ageing. Instead, they are designed to support reactive models of care once an injury or condition has developed. Medicare CDM plans are highly restrictive for aged care OT and limited funding of up to 4 sessions means OTs are unable to deliver ongoing and comprehensive care to older people. There is also lack of clarity on who is the appropriate funder for services delivered in community or residential aged care settings.

Currently the language within Schedule 1 Part 3 of the Aged Care Quality of Care Principles states that therapy services delivered to residents of residential aged care are to be funded by the aged care provider with no additional fees for the provision of care charged to the resident. This makes it unclear if Medicare services that require a gap fee payment are to be covered by the provider or the resident. This ambiguity is resulting in limited engagement of Medicare funded services. Limited GP access for residential aged care residents also impacts the ability to obtain a referral for these services. In home settings, Home Care Packages and Commonwealth Home Support Program are often constrained by budgetary issues and as a result, extensive or full OT services may not be funded within the budget. This is particularly true for rural and remote clients where travel costs are extensive and need to be paid from the package funding.

Other funding schemes

While not within the direct scope of primary health, it is noted that other schemes such as DVA, NDIS and compensation schemes have interaction with primary health settings through referral pathways. These also have limitations which impact scope of practice which should be considered because they contribute to the factors impacting the broader OT workforce, many of which service across Medicare, other funding schemes, and into private practice.

Fee for service funding mechanisms (including NDIS and state insurance boards) can sometimes act as a barrier to AHPs working to their full scope of practice. This hindrance often stems from funding bodies prescribing and/or imposing restrictions on the quantity and intensity of assessments and therapeutic interventions provided to individuals (similarly to the limitations under Medicare). The level of service offered to an individual is often applied arbitrarily by the funding body based on the “strategy” to be applied (e.g. provision of a new wheelchair), rather than being tailored to the individual's specific occupational performance issues or functional goals.

Lack of awareness of the OT scope of practice also impacts GPs awareness or willingness ot provide referrals to OTs for clients they see under DVA.

Funding scheme specialisation

The large range of variance between funding schemes presents an additional barrier that affects scope of practice for OTs. The wide variance in schemes, and their eligibility rules (for both practitioners and clients to access), varying payment and administrative and reporting structures, and wide variance in the type of services supported, means that practitioners must familiarise themselves with a specific individual scheme to deliver services. This requires unfunded time to build understanding and familiarity and leads to some providers building and then maintaining service delivery within a single funding scheme, due to the real and perceived opportunity cost of working within any additional schemes. For example, under NDIS, some OTs only offer Functional Capacity Assessments, despite being skilled in other areas, due to difficulties with navigating other areas within a complex NDIS.

While some OTs report they are happy to wok across schemes, many report that it is unsustainable if in sole practice, due to the significant time and administrative pressures. Operating within one scheme’s specific structure leads to loss of scope for some clinicians. It

also reduces the potential for a client to utilise the same provider across schemes if they happened to need supports in more than one area. Better harmonisation of schemes, including any regulatory frameworks, would create incentives to practice more readily across schemes.

Other systemic barriers

Some other broader systemic factors are also impacting scope of practice through direct and indirect means and are included below for information.

Market changes

Reforms like the introduction of the NDIS and growth in private health insurance offerings have contributed to the marketisation of health and allied health services. This has resulted in the evolution of some flat service delivery structures which do not enable effective clinical structures to support staff and their clients and reducing scope of practice. This is a marked shift away from more traditional public health structures which comprised established clinical structures, and hierarchies, enabling career progression, supervision of junior staff, and a more varied scope of practice.

Referral pathways

While noting that there are shortcomings in the scope of services funded under Medicare and issues with GP referral being required in some cases, GPs are well placed to be the main referrer to AHP and other services (due to the frequency with which they see patients, and the existence of bulk billing incentives). However OTA members report that GPs are currently not utilising available referrals. GPs often will work with a single issue in an appointment as their time is limited, and this is a significant barrier to realising quality and appropriate referrals. GPs also report that the changing processes of referral and being unclear about the services OTs and other AHPs offer also impacts their willingness to refer.

While recent reforms have supported access to engage AHPs in primary care settings and clinics through the Workforce Incentive Program (WIP), barriers still exist in achieving referral to services and promoting collaborative care that best utilises OT's scope of practice.

It is noted that the barrier of effective GP referrals could be overcome through increased awareness of the role and scope of OT practice. Referral pathways could also be enhanced by enabling cross referrals from AHPs to other AHPs, and from AHPs to other medical professionals (e.g. an OT working with a client with a neurological condition, who would benefit from a consult with a neurologist, but the client must visit their GP for a referral as an OT cannot supply this).

Greater incentivisation of GPs would also improve the access to services across a range of health professionals. GPs have embraced the Medicare rebates of the Better Access Scheme, but few other referral pathways offer incentivisation for referrals to other components of health care provision for GPs.

Impacts of staff and resource shortages in public health settings

Changes in practice within the public health sector and moves toward privatised practice models (especially within the NDIS) has contributed to a shortage of qualified OTs. Lower levels of remuneration and less flexible work options also act as disincentives for experienced clinicians.

This places pressure on staff working in public health settings, via higher workloads, restrictions on the work that can be done, and reduced access to senior staff for support and supervision. Due to constriction in services, OTs are limited in the scope of interventions they can provide and cannot respond to a patient's entire range of needs, in a holistic manner which is in line with their training and ethical approach.

Similarly, reduced resources, workforce shortages and high service demand in public systems also mean that issues like bed blocking and extensive surgery wait lists, and a resultant focus on expedited discharges have narrowed scope of OT services, meaning that

OTs can't provide a full assessment of patient need, and provision of therapy or intervention that could prevent future hospital admission (despite having the clinical expertise).

For example, the scenario of an older person having a fall in their home and being admitted to hospital with a minor injury can show how an OT is not utilised to full scope due to systemic factors. If the person has been deemed by medical staff to be functioning at the same level as they were prior to admission, they may not see an OT due to the emphasis and demand in other areas, and may be discharged without review. Alternatively, they may be provided with high level advice regarding falls reduction strategies, but no additional assessment for fall risk, or support to reduce fall hazards. In this context, an OT would not be supported to exercise a wider scope of practice, including to undertake a more comprehensive assessment, or provide more in depth recommendations (for example, a home assessment, to see the home environment and assess further fall risk, or prescribe a personal alarm) that are likely to benefit the person and reduce the risk of further falls, major injury and hospital readmission.

Changes in Primary Health Network scope

Primary Health Networks (PHNs) are a key connection point in the primary care system and play an important role in enhancing the access and quality of primary care. OTs report varying levels of support provided by different PHNs for AHPs, which appears to signal a shift in their model of care, away from health care connectivity, towards commissioning of services. There is a perception that PHNs can take a greater leadership role in in educating and connecting primary care practices, and providing skills and training for clinicians, to benefit the sector and support GPs to make good referrals and work alongside AHPs.

Limitations on scope in remote and regional settings

Geographic location creates disparities in access to continued education and training opportunities for OTs, impacting their ability to develop their scope of practice. This is particularly related to in-person opportunities such as courses, workshops, and conferences, (but also to online options), based on location, with rural and remote areas facing the most challenges.

There are several factors contributing to the limited access to quality continued education to enable AHPs to work to the full extent of their scope of practice in these areas:

- Shortage of Experienced AHPs - Regional areas often lack experienced AHPs who can provide in-person supervision or facilitate CPD activities, especially in complex areas of practice.
- High travel costs – costs associated with traveling to attend continued education and training programs in more metropolitan areas can be prohibitively expensive for rural/remote AHPs.
- Disruption to clinical work - AHPs from these areas also face the challenge of balancing their clinical work commitments with the need to attend in-person training, which may require extended travel times.
- Supply-demand imbalance - in regional and remote areas, the demand for allied health services often outweighs supply, which may lead employers and private practitioners to prioritise service delivery over attending (or presenting) educational events. Furthermore, these workforce shortages may lead to the prioritisation of service delivery through a narrower scope of services being offered by some providers, in an attempt to provide a base level of service, rather than no service at all.
- Digital resources - online opportunities can partially mitigate issues with access to CPD and supervision. However, many rural and remote areas in Australia have unreliable digital infrastructure, hindering reliable access to online training and supervision.

Additionally, certain topics and therapeutic practices require hands-on training or in-person instruction for a higher quality of training.

Case study: Integrated primary care approaches to falls prevention

Falls are a common cause of injury in Australians over 65 years of age, with a third of people living in the community and aged over 65 experiencing a fall each year. Fall related injuries can be serious, and in 10 -20% of cases, result in a fracture, with is a significant source of morbidity and mortality[8] and an independent predictor of admission to a nursing home[9].

A recent review of falls literature found that taking measures to reduce fall hazards around the home lowers the overall rate of falls by 26%[10]. Measures included decluttering and reducing trip hazards (via means such as eliminating clutter, poor lighting and unguarded stairs). Other approaches such as supplying appropriate glasses, shoes and falls education, were not as effective.

OTs are particularly skilled in assessing home environments for falls risks and prescribing approaches to reduce fall hazards. Aged care advocates and leading OT academics have recognised the potential for GPs to work with AHPs, including OTs, to reduce fall risks and assist people to age safely in place.

GPs are in an ideal position to promote falls prevention and healthy ageing, through assessment of fall risk, and referral to AHPs to provide fall hazard reduction strategies.

Models of care have been proposed that would see the inclusion of falls prevention in the Medicare Enhanced Care Plans via CDM, to enable an OT to conduct an environmental assessment and work with the client to recue fall hazards.

To enable this, some key factors would need to be addressed:

- GP education and awareness on the OT scope of practice and role in falls prevention

- Changes to Medicare Chronic Disease Management (CDM) rules and guidance

- Increase to the current Medicare rebate rate to provide adequate remuneration (including travel costs to visit the client in the home) and avoid the need for the client to pay a gap fee (as many aged care clients are pension recipients). Under Medicare, OTs are only be reimbursed $58.00 for a session, significantly below private practice OT hourly rates of up to $220 an hour and well below the NDIS funding rate of $193.33, which remunerates for similar work conducting environmental assessments.

- Integration with other existing programs and services to realise efficiencies and referral existing pathways.

[8] Moreland, Briana, Ramakrishna Kakara, and Ankita Henry. "Trends in nonfatal falls and fall-related injuries among adults aged≥ 65 years—United States, 2012–2018." *Morbidity and Mortality Weekly Report* 69.27 (2020): 875

[9] Mackenzie, Lynette, Lindy Clemson, and Christopher Roberts. "Occupational therapists partnering with general practitioners to prevent falls: Seizing opportunities in primary health care." *Australian Occupational Therapy Journal* 60.1 (2013): 66-70.

[10] Clemson L, Stark S, Pighills AC, Fairhall NJ, Lamb SE, Ali J, Sherrington C. Environmental interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2023, Issue 3. Art. No.: CD013258.DOI: 10.1002/14651858.CD013258.pub2.

Enablers that unlock the full scope of OT practice

Access to OTs in communities and at affordable levels can deliver life changing outcomes for people, across a range of life areas including achievement of personal goals, independence, increased wellbeing, and better outcomes in physical and psychological health. There are a range of enablers that will support OTs to practice within their full scope of practice and enhance health outcomes for Australian consumers.

Funding arrangements

There are significant opportunities to enhance the services funded under Medicare to better utilise the skill and capabilities of OTs, as discussed in the previous section. Government could explore expanded Medicare items to include these, or development and trial of blended or block-funded primary care funding models for OT services and other allied health services as recommended by the Primary Health Reform Steering Group, to unlock access to OT services. A range of additional supports and programs are discussed below, that have the potential to enhance the primary health system and better utilise OTs.

Social prescribing

Social prescribing is the practice where primary health professionals have the resources and infrastructure to link patients with non-medical services, or even social groups, in a bid to address the social determinants contributing to poor health (both physical and mental). There is increasing recognition by GPs and medical specialists of the role and benefits of social prescribing.

Groups that may benefit most from social prescribing include people whose wellbeing is affected by complex social needs, who are isolated or lonely, living with long-term physical or mental health conditions, those who attend primary or secondary health care frequently, injured workers, people with psychosocial needs and people who are carers.

At its simplest, a GP may suggest a patient join a local running group to enjoy the benefits of exercise and interaction. However, social prescribing when associated with people who have complex needs requires a specialist approach such as that of an OT.

Social prescribing is a core part of OT practice. OTs are well qualified to take a lead role in social prescribing, particularly in complex cases, because of their dual focus on people's engagement with their social and physical environment, and enabling successful participation in occupations (activities). For social prescribing to work successfully, the specialised nature of this work (as with any complex client/provider relationship) must be recognised, and funding and processes developed to support this. For example, GP training could help to identify more complex situations where the client would benefit from specialist social prescribing by an OT, with the associated referral infrastructure introduced under Medicare.

The design of any proposed program would need to consider and support provision for key stages in service delivery, including initial assessment of the person and their environment and supports, review of available community supports, prescription and linking to supports, and client follow up.

Utilisation of OTs in Public health

There is scope for better provision of funding and support to enable OTs to deliver public health, preventative health and wellbeing services to identified populations, through the introduction new item codes and referral pathways. Services OTs could offer within their scope of practice include assessment, education, and preventative health advice (e.g. smoking, lifestyle issues), around various chronic health conditions and public health matters.

Pain management

OTs with advanced scope of practice can deliver services for pain management strategies and interventions (non-pharmacological). Inclusion of chronic pain conditions under the CDM criteria, or introduction of specific Medicare items for pain management, would enable OTs and other AHPs with pain management expertise to provide assistance in physical and psychological strategies to support a person living with chronic pain, and reduce reliance on GPs to manage pain.

Dementia care

The COPE program (Care Of People with dementia in their Environments) is an evidence based occupational therapy and nursing program for people living with dementia in the community (and their families). This program is recommended to be delivered to a client across ten sessions and is within the OT scope of practice. Initiatives like these can complement aged care funding and services available in the community and ultimately ensure cost savings through prevention of functional decline and delayed entry into residential care. However the current CDM program does not support this type of program delivery, due to the constraints outlined above.

Prevention of pressure injuries

OTs can collaborate with nursing teams, community groups, GPs and other providers to help prevent and manage pressure injuries. Currently in the community, it is commonplace for a referral for OT to be actioned only once a pressure injury is active, which is not best practice, and can have negative consequence on the person with a pressure injury, as well as being incredibly from an economic perspective. It is more appropriate to focus efforts on pressure injury prevention strategies, which is within OT scope to deliver, while maintaining funding for OTs to also be involved should a pressure injury develop and require management. OTs already have a well-defined scope and role within the provision of pressure injury prevention supports (e.g. through the appropriate provision of Assistive Technology). There is scope for this to be supported through broader block funding or Medicare rebated items.

Unlocking OT value through Primary Health Networks

Primary Health Networks can offer value to unlock better health connectivity, professional development, referral pathways and consequently patient outcomes. PHNs have previously auspiced better connections between primary care clinics and allied health workforces, by offering information, training and resources to AHP's working in primary care settings, and referring GPs.

PHN have a unique place-based role that could see a greater role in place-based sector supports and better utilisation of AHP's scope of practice via:

- supporting supervision of students of various allied health professions in primary care (currently there is a lack of trainees/students in this setting due to lack of incentives, PHNs could offer funding for this),
- offering interprofessional learning and collaboration for students/new graduates,
- supporting interdisciplinary meetings, networks and discussion, and
- information sharing across professions.

Enablement of referrals and diagnostics

OTA's position is that the ability to refer for diagnostic imaging may be appropriate in certain circumstances for an OT, however it is noted that OTA classifies this ability as an *extended scope of practice,* that would require the OT to need to have undertaken additional skills training and competencies to utilise appropriately.

Additional diagnostic testing could be utilised by OTs in specialised upper limb settings, such as hand therapy, through the referral for x-rays. Legislation governing x-ray referral is state based, and in Queensland, physiotherapists are able to order x-rays.

There are a number of services or specialists requiring referral from a GP, that could be more readily (and appropriately) accessed were OTs able to refer directly to them. Some examples (non-exhaustive) include:

- Referral to a specialised Paediatric Rehabilitation Service (public tertiary service providing outpatient clinics and community clinics depending on the state/territory). Currently the referral pathway is via GP in some states, while in other states referrals are accepted from AHPs (however a GP review prior to the appointment is required).
- Referral to a neurologist for additional assessment or treatment. For example, while an OT can assess for spasticity, if they opined that a client may benefit from pharmacological management of their spasticity (such as Botox), unless the person was still engaged with a neurologist, then the OT could not refer directly to a neurologist for an opinion. Instead, they would have to recommend that the person revisit their GP for an up-to-date referral to a neurologist, delaying possible treatment.
- Referral to a Cognitive Dementia and Memory Service (CDAMS), when an OT has identified potential early cognitive changes in a person they are working with, or they have expressed concerns about memory loss. Currently this can only be done by a GP. OTs working with a person (who meets the criteria for referral) should be able to initiate this referral and ultimately work alongside the CDAMS service and the results of their assessment to build and deliver tailored interventions.

Consistency across compensation schemes

Consistency of approaches across various compensation schemes would enable AHPs and OTs to build familiarity and move between schemes with less opportunity cost, enabling more flexible movement across the workforce, and a better client experience.

There are opportunities to better utilise OT's full scope in state and territory compensation schemes, particularly in the areas of consistent functional capacity assessments, issuing certificates of capacity, and driving modifications.

Occupational therapists play a vital role in the successful rehabilitation and return of injured workers to work. Occupational therapists are trained in the assessment and management of physical and mental injury, including functional capacity, work ergonomics, and biopsychosocial factors. Occupational therapists are well placed to provide assessments determine an individual's capacity to work, and issue evidence of this via certificates of capacity, that can be utilised by employers and workplace injury and insurance regulators.

The use of OTs to provide functional capacity assessments is inconsistent across various state and territory compensation schemes, leading some OTs to specialise in certain areas, and others to opt not to service certain client cohorts, limiting their scope of practice.

Currently, the majority of federal, state and territory injury compensations schemes require a certificate of capacity issued by a general practitioner or nurse practitioner in certain cases. Enabling OTs to assess and issue certification of capacity to work would reduce red tape and improve efficiencies within these schemes by removing the requirement for injured workers to visit a medical or nurse practitioner to certify their capacity (reducing demand on GPs). OTA understands that ACT is considering legislative change to enable independent assessors (i.e. not GPs) to deliver significant occupational impact assessments, which would enable an OT to provide a certificate of capacity.

In the area of driving, in some schemes, OTs can recommend vehicle modifications to enable a person to drive independently. However in other schemes, this must be recommended by a GP (who typically takes the recommendation of the OT).

There is also high degree of variance in the discipline-specific occupational therapy assessments and therapeutic interventions that can be funded across other schemes, including DVA and the NDIS.

Multidisciplinary Practice

The Review has sought feedback on to identify *examples of where conditions have enabled multi-disciplinary teams to thrive and consistently work at the top of their scope of practice.*

OTs are a vital part of multidisciplinary teams (MDTs), particularly in occupational rehabilitation, chronic disease management and aged care settings. OTs are particularly skilled at working with a client to identify goals and aspirations, which is important to consider in holistic, person-centred care planning, rather than approaches that focus solely on a health condition or disease.

The key factors that underpin successful approaches to MDT include:

- Processes, culture and funding that supports coordinated care planning.
- Uncapped and unrestricted referral pathways from medical and AHPs, and other community services.
- Person-centred approaches
- Uncapped and unrestricted funding (that enables the team to provide holistic services) and funding that supports assessments, case conferencing, and case review, and reporting, in addition to therapeutic appointments.
- Services funded/provided based on consumer feedback and need.
- Diverse mix of medical and AHPs.
- Leadership that values and drives MDT, and collegiate cultures.

There are currently a range of barriers and enablers to effecting good MDT practice which are discussed below.

Inadequate funding in current schemes

Limited or inadequate funding to support MDT approaches are the primary barrier to their effective use in primary health. Block funding approaches typically enable better MDT approaches as they enable commissioning of services. The design of Medicare items does not support effective MDT. While some Medicare items enable case conferencing, (e.g. under the CDM program) the uptake of this is low and this uses up the patient's capped sessions, reducing access to therapies and treatment. There is one exception whereby OTs have reported that the Medicare Eating Disorders Services program is more collaborative, via a collaborative care plan process and greater opportunity for a multidisciplinary team to work together.

Lack of other financial incentives

Current incentives to enable recruitment and retention of AHPs in general practices are not realising their full potential, with OTA members reporting they see a disconnect between the GPs and nurse practitioners, and AHPs who practice in the same location. While GPs may refer to the AHPs located within the practice for services, there is no linked service provision or team arrangements across professions such as that which would occur routinely in for example a hospital or community health setting.

Low awareness of OT scope

There is also low awareness of the OT scope of practice and clinical capabilities among the health and disability sector workforce, impacting referrals and/or requests for assessments or specific types of interventions.

Limited skills and experience

Limitations on university coursework and student placements makes it difficult for new OTs to develop foundational skills for interprofessional practice and work-based exposure to multidisciplinary teams and practice is limited by funding restrictions.

Contact

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