Occupational Therapy AUSTRALIA

Department of Health and Aged Care

A New Program for In-Home Aged Care

Occupational Therapy Australia submission

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Executive Summary

Occupational therapy services are fundamental to any Support at Home program as they enable independence, prevent functional decline, increase quality of life and reduce care needs. Occupational therapy is key to enabling older Australians to remain at home longer.

Occupational therapists work with older people with age-related conditions such as poor balance and coordination, memory loss and confusion, and vision and hearing loss, which lead to changes in their ability to participate in the meaningful activities of everyday life. Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and assessment of environment and safety risks including home modifications.

For these services to be effective, they need to be appropriately identified through an effective assessment tool, and properly funded to allow occupational therapists to provide the full range of treatments and supports to get the best outcome for clients.

Assessment is the entry point for consumers and requires skilled assessors and rigorous methods. An assessment pathway that prioritises access to restorative care through services like occupational therapy is central to its success. Therefore, it is crucial that there are processes in place to support the accurate and timely identification of occupational therapy needs by non-clinician assessors.

Clinical services provided by occupational therapists must be comprehensively funded. To meet best practice and evidence-based standards, occupational therapists require funding to complete all aspects of their client work. Funding needs to be flexible enough to accommodate the wide range of consumer needs, and easily accessible to all services working with the consumer. Unit prices should also accurately reflect the value of the work provided by occupational therapists and be competitive.

Equipment and home modifications that require the specialist knowledge and expertise of occupational therapists require timely and comprehensive funding to be most effective. With robust funding and infrastructure in place, occupational therapists can use technology to achieve innovative and consumer focussed results that will facilitate positive and healthy ageing experiences for older people.

Greater emphasis on allied health input must be prioritised in the development of the Support at Home Program. OTA welcomes all opportunities to collaborate with the Department to ensure the value of allied health professionals like occupational therapists are embedded into the future model.

Occupational Therapy and Aged Care

In June 2020 there were 4.2 million Australians aged 65 and over, making up 16% of the total Australian population. By 2066, it is projected that older people will make up between 21% and 23% of the total population (AIHW, 2021). The vast majority (around 80%) of Australians over 55 want to live in the community as they age, and the average cost of community care for older Australians who receive assistance is $15,525 compared to $66,512 for those in residential care (AHURi, 2019).

Occupational therapists have a critical role in providing services across the health system, supporting people affected by physical, intellectual, acute, and chronic conditions, and mental health issues. Occupational therapists work in a diverse range of practice settings including acute hospitals, rehabilitation settings, private practice, aged care facilities, community, primary health and in the home.

OTA is the professional association and peak representative body for occupational therapists in Australia. There are about 27,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to engage in meaningful and productive activities.

Assessment – identifying care needs

Assessment tool

OTA welcomes steps taken to ensure that older Australians receive an assessment that will accurately identify needs and funding. However, OTA has been unable to obtain a clear picture of what the proposed assessment tool and classification system looks like, despite some involvement in the consultation process with the Department of Health.

OTA is concerned that the tool may lack the detail necessary to comprehensively assess and identify allied health needs. This is especially relevant should the assessment be conducted by non-clinicians who will need to rely on the assessment tool to accurately identify the needs of the individual and the requisite services to address those needs.

To support the effective use of the assessment tool by non-clinician assessors, we recommend supplementary resources coupled with a rigorous training program. For example, the assessor may require further training or resources to understand best practice care pathways for complex care needs like dementia, pressure risk or continence. Complex clients and circumstances must be accounted for specifically, as they often require increased services or inter-disciplinary approaches. Clinical advisory panels can offer support to non-clinician assessors across the full continuum of the Support at Home Program, from triage/assessment through to plan reviews or for referrals that evolve to require a clinical perspective.

OTA welcomes further testing and validating of the assessment tool, but we believe that without these additional measures in place, the current tool will fail to accurately identify allied health needs. It is also imperative that validation is done comprehensively and in a real-world environment that includes clients with complex needs. We encourage the

department to consult closely with occupational therapists in planning and implementation of the assessment trial, and in the validation of the results.

Assessment Pathways

Assessment of need should ideally start at the point of referral intake to ensure the correct assessment approach and skills are applied. Triaging referrals to identify any social, health or wellbeing complexities can determine the need for a clinician led initial assessment. This approach, as per the Aged Care Assessment Team structure, would allow the initial assessment to be conducted in a way that would:

- ensure early and accurate identification of clinical needs
- allow clinician assessors to begin the process of immediately addressing identified clinical needs i.e. early prescription of basic aids or advice on safety or environment
- ensure accurate identification and referral to allied health services for comprehensive assessments and timely delivery of best practice multidisciplinary approaches
- support the early identification of restorative opportunities and early access to allied health to address factors that directly influence an older person's positive ageing.

Support Plans

OTA considers triage and initial assessments as the first stage of needs assessment and classification. These steps, particularly if administered by a non-clinician assessor, should not be relied on to comprehensively determine the occupational therapy needs of an individual. Nor should they form the basis upon which funding classification for occupational therapy is determined. Assessment of clinical need must be done directly by an occupational therapist. Only once a comprehensive assessment conducted by an occupational therapist is done can the care plan needs, and funding classification, be accurately finalised.

Occupational therapists take a holistic approach to their initial home-based assessments of older people. This often results in the identification of a different range of needs than originally noted by an aged care assessor. By fixing the services and funding classification in the support plan at initial assessment, before a comprehensive assessment is conducted, occupational therapists are limited in their ability to work with the older person to prioritise and address their needs. It also creates unnecessary delays and administrative burdens should reassessments or other measures be required to update care plans. Delays to receiving occupational therapy services can also lead to functional decline and increase the risk of adverse events like falls and pressure injuries, many of which can result in greater burden of care and costs, and reduced quality of life.

A pathway that includes a comprehensive assessment conducted by an occupational therapist will support the correct identification of older people into restorative or continuing care pathways. It will allow occupational therapists to work with the older person, their clinical peers and the care services supporting the older person, to accurately tailor and adjust the care plan to deliver restorative and preventative measures. It allows for clinicians to focus on supporting individuals to gain independence and capability before any care services are finalised and implemented. By directly delivering services that work against functional decline, the program will meet the ageing in place wishes of older people and

reduce the risk of ‘overservicing’ or dependency on services. This approach has the potential to generate longer term financial savings for government.

Service Delivery

The range of services provided by occupational therapists are varied. From assessment of functional performance through to prescription of assistive technology and home modifications, these services are all provided to facilitate engagement in meaningful daily occupations. Currently, Commonwealth Home Support Programme (CHSP) funding fails to acknowledge the full range of services provided by community based occupational therapists by only funding face-to-face work. This places pressure on occupational therapists to work in a way that undermines best practice and quality care.

To allow occupational therapists to work to their full scope of practice, the Support at Home program must acknowledge and fund all the services and clinical work that is required to achieve a client’s goal. This is consistent with other funding schemes across government. Funding must ensure that clinicians are able to deliver:

- Direct Case Discussions and planning with other treating therapists
- Clinical work that is non face-to-face (for example, drafting of home modification diagrams, reports, research for the prescription of aids and equipment, development of carer education materials)
- Education provided to paid and family carers to achieve client goals
- Local and regional travel as required

Multi-disciplinary and complex care provision

Occupational therapy practice is embedded in evidence and best practice models of care. This often involves a multidisciplinary approach to service provision. The current CHSP model allows for clinicians to work collaboratively and provides the flexibility for cross referral. The ability to bring in other clinicians in a timely manner supports a collaborative and comprehensive approach that elicits best outcomes. It also ensures that as clinical needs are identified, services can be sourced and delivered. This feature of the CHSP model is one that must be reinforced within the incoming Support at Home Program if we are truly aiming to achieve a shared care approach to positive ageing.

The CHSP model allows for the flexibility for occupational therapists to work with complex clients at a pace and in a way that supports the individual’s needs. Many older people are living with complex health, social, housing, and financial situations that can complicate service delivery. Often the need to build a strong relationship with the consumer is the priority and must be achieved before any therapeutic input can commence. This acknowledgement of the different service requirements of complex clients appears to be lacking in the proposed model. The services, range of inputs and time required for these complex clients must be considered when determining classification of need and funding at assessment.

If these complex clients are not accurately identified, there is a risk of clinical input being delayed, consumers becoming further isolated from services, reduced health and welfare outcomes and in the longer term, greater care burden and cost. An example of how

interdisciplinary coordinated care improved the quality of life, health outcomes and reduced service costs of a consumer with complex needs can be found in **Attachment 1**.

Central to the successful delivery of multidisciplinary approaches is a robust clinical records system. The current My Aged Care portal lacks the features required to support timely and effective sharing of clinical records. It is not fit for purpose, particularly given the intention for consumers to select their service providers from a range of sources, some of which may be sole or independent traders. The new system should support access by a range of providers and services and broader operability. Clinical record systems serve not only as a method of information exchange and care coordination but can also act as a repository for quality data, helping to streamline governance requirements for aged care services.

Care Partners

The role of the care partner requires further definition and scoping. Central to their role is the provision of information and advice that supports consumers to navigate the aged care system, particularly when making decisions about care. Care partners can be the gateway to receiving the right supports at the right time and hold an important role in advocating for additional supports, funding, or resources. Their input should range from intermediate and brief interactions through to ongoing and intensive involvement.

Care partners must have a defined scope of practice and set of specific skills and experience to optimally deliver this role. Clinical experience and skills would support the needs of consumers who have a complex social or health situation. Clinicians like occupational therapists may also be best placed to support timely needs identification and onward referral for specialist external support services like mental health support and dementia care. For consumers whose circumstances are less complex and more stable, non-clinician care partners may be appropriate with clinical advisory panels, as mentioned earlier, available to support clinical reasoning. Aged care training for non-clinician care partners is a requirement that should also be considered. Additionally, registration should also be required as per the governance and code of conduct changes planned for the sector.

Irrespective of who delivers the care partnership role, care partners should be independent from the service providers. This will ensure greater transparency and a stronger consumer focus. Independence from providers allows care partners to deliver an impartial review of services against the standards, creating an additional method of quality assurance.

Funding Model – supports viability and value for money

Funding types

Funding options must ensure occupational therapists can deliver services to best meet the needs of complex clients. Complex clients often require additional services to coordinate care, additional time to build clinical relationships and rapport, or shared care delivery across multi-disciplinary teams. For these reasons, additional care planning input is needed. A combination of funding options, including block and episodic funding, may offer the flexibility required to support these complex care scenarios.

Allied Health Professional funding

OTA welcomes the plans to have dedicated funding available to support the delivery of allied health services like occupational therapy. This funding must not be at risk of being used to cover other care or service needs. It must be used to provide the services identified by the comprehensive clinical assessment of each allied health professional involved and not pooled.

Funding must also facilitate the important collaboration between occupational therapists and allied health assistants (AHAs). AHAs allow occupational therapists to focus on their clinical remit and support the delivery of clinical interventions, thus enhancing the capacity of the occupational therapy workforce. In acknowledging the different but interrelated professional scopes of practice held by occupational therapists and AHAs, separate funding for each role is required.

OTA also welcomes the proposal to deliver funding in quarterly intervals. This would ensure that clinicians and consumers are able to monitor funding allocations and plan accordingly. The payment system required for the future Support at Home Program must accommodate the various ways providers will work within the sector. The ability for sole trader providers to operate within the proposed program is a welcome feature and must be closely considered when looking at the payment model.

The price for allied health services, like occupational therapists, must accurately reflect the market rate. While the unit prices shared within the discussion paper reflect the current CHSP unit prices, these are not aligned with the price for occupational therapy input in other sectors. Failure to address this reflects a diminished importance of the work done by aged care clinicians like occupational therapists and will exacerbate workforce shortages already being experienced. With the significant harmonisation work underway across the aged care, disability and veterans' sectors, we call for this work to extend beyond governance and address harmonisation of pricing.

Flexible funding administration

The proposed 25% flexible funding has the potential to offer the flexibility needed to support the care of complex clients if administered correctly. The language used in the discussion paper indicates that pooled funds will be held and administered by providers but fails to define this any further. Given the likely increased input of sole traders in the future program, and the possibility that some consumers may operate with multiple providers under a self-management model, it is imperative that the department consider these factors as they plan for the administration of the proposed 25% pooled funds.

Given the intention for the program to allow individuals to administer their own budgets, flexible funding ideally should sit within the consumer's budget. This would allow the full range of services involved in care to work with the consumer and coordinate how this money is best used. For those who require care partners or care management, this process would also involve them.

The competing needs of individual services, and differing perspectives on care priorities, may further complicate the administration of these funds. Guidelines must support both the consumer and their service providers to fully understand how these funds can be accessed

and assist in the prioritisation of need. There must be transparency and coordination, and this may require a central independent administrator who isn't involved in delivering services to the consumer.

Administration of these funds by a provider already delivering services creates the potential for conflict of interest. It also hinders external services to access these funds. This has been the experience of many occupational therapists working within the home care package (HCP) program. HCP providers are often the gatekeepers to a consumer's package funds, deciding the terms upon which an occupational therapist can work with an older person. This might take the form pre-determining the focus of occupational therapy intervention or capping the number of hours available for occupational therapy input prior to assessment. Many clinicians choose not to take these clients on under such restrictive terms. The future program is at risk of perpetuating this situation if it doesn't adopt an independent approach to funding administration.

Goods, Assistive Technology, Equipment and Home Modifications

As with the dedicated funding for allied health services, OTA welcomes the commitment from the Department to have dedicated funding for assistive technologies and home modifications. We also welcome early discussions that consider the use of loan or pooled equipment programs to support immediate, short-term access to assistive technologies. This approach has been successfully used by many programs across Australia and is crucial when supporting clients with urgent needs, including wound management or degenerative conditions.

OTA has presented to the Department concerns with the current GEAT2Go program, and the lack of clear guidance to occupational therapists on home modifications in the current CHSP manual. The future assistive technology and home modification programs must ensure that occupational therapists can:

- Prescribe a range of equipment and home modification solutions to their consumers and not be limited by stock availability or selection
- Operate efficiently and not be hindered by significant administrative burden, poor communication, or system complications
- Be funded to work with GEAT and home modifications suppliers and experts to achieve best outcomes
- Be supported by allied health assistants to improve efficacy and reach
- Work collaboratively with non-clinical peers to ensure the safety and independence of the consumer is optimised through prescription.

Funding

GEAT and home modification funding has been a significant limiting factor under the current aged care models. CHSP funding allocations have been inadequate, further hindered by excessive administration costs, and inconsistently delivered across the jurisdictions. The lack of guidelines around use of HCP funds for GEAT and home modifications have resulted in inconsistent access to these funds. Occupational therapists are often required to seek third party funds from various sources to support the purchase of equipment or home

modifications. This can be a complicated and time-consuming process and ultimately limits the capacity of the occupational therapy workforce to deliver clinical care.

The future Support at Home program must offer funding to support the timely availability of prescribed equipment and modifications. Funding for this process must consider all aspects of occupational therapy process required to achieve a successful equipment and home modification outcome. Accurate clinical data is essential in mapping the hours and funding required to realistically achieve successful outcomes.

Member feedback to OTA has found that the time required to prescribe equipment varies, dependent on a range of factors. The complexity of equipment, availability of products, travel time, funding application requirements, and the complexity of the consumer's health, all contribute to the time required for an occupational therapist to complete a thorough assessment and successful prescription of equipment for a consumer.

Often complex equipment is the best and only way a consumer's health, care and wellbeing needs can be addressed. These items can present a significant upfront cost but inevitably provide longer term cost and wellbeing benefits. One such example of this can be found in the case study presented in **Attachment 2**.

OTA member data on home modifications indicate that low-cost modifications like grabrails, access handrails, step or threshold ramps can require a minimum of 12 hours of clinical input. This includes time for the initial assessment, technical drawings, gathering quotations, funding applications, post modification reviews and outcome measures, and travel. More complex modifications like level access bathrooms, kitchen modifications, access modifications including multiple platform ramps or lifts, require a minimum of 20 hours.

Authorised prescribers like occupational therapists must be able to access sufficient funds to process the prescribed assistive technology or home modifications as promptly as possible. The pathway for occupational therapists to request additional funds or resources to support increased assistive technology or home modifications needs must also be considered. This process must allow clinicians to present their requests and have them reviewed by clinical experts, as is seen in other funding schemes. This will reduce complications and delays in the long run. The clinical advisor panel proposed earlier could assist in the review of non-standard or increased funding requests.

Encouraging innovation and investment

Occupational therapists are increasingly using digital and SMART technologies with older people living in the community with innovative assisted living solutions becoming more readily available on the open market. These technologies support consumers to take carriage of their own care, increase their capacity, support their safety, monitor their health and improve social engagement. They are also effective in supporting consumers who are geographically or physically isolated, allowing for telehealth or digital interventions when in-person services are limited.

Using these solutions with older people not only has the potential to improve their lived experience but can reduce the need for in-person care. With limitations on funding and workforce, these solutions offer a sustainable and cost-effective approach to community aged care.

Collaborating with experts and suppliers, occupational therapists are best placed to support the integration of these technologies to ensure client centred, tailored solutions. GEAT and home modifications funding streams must be structured and adequately resourced to facilitate the prescription of these innovative approaches by occupational therapists.

Contact

OTA would welcome further consultation, particularly in areas that specifically impact occupational therapy and allied health practice. For further information please contact:
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Attachment 1 – Case Study 1

70 year old woman living with husband

This case study demonstrates how occupational therapy involvement delivers:

- Benefits of long-term relationship building with complex client
- Assessment of assistive technology needs and arrangement of funding
- Benefits of interdisciplinary coordinated care
- Improved the quality of life and health outcomes
- Reduced service costs

Background

Long standing pressure injury issues (feet and bottom) with regular nursing supports (3 times a week).

Reported to OT feeling housebound waiting for services and increasing depression over time.

Client was dismissive of her own ability to reduce risk factors and would frequently cancel allied health appointments.

Following engagement with OT

- client allowed dietetics (wound healing) and physio involvement (falls risk prevention and mobility input for pressure injury prevention).
- Pressure injury preventative equipment was beyond CHSP funding allocation ($1000). Approvals sought for additional funds and then client agreed to self-fund new seating/positioning.
- Ongoing trial and error, education, self-monitoring and coaching with OT around prevention and reducing risk factors.
- Many missed/cancelled appointments as client not well or 'not sure'.
- After approximately 6 months OT was able to arrange new seating for client (low cost item $1200).
- Pressure injury healed and nursing services were no longer indicated (attended GP to review feet).
- Client returned to outings and social time with friends 3 times a week.

Attachment 2 – Case Study 2

65 year old man living with two young adult sons. New to CHSP post hospital admission

This case study demonstrates how OT involvement delivers:

- Relationship building to determine complex client needs
- Assessment of assistive technology needs and arrangement of funding
- Benefits of interdisciplinary coordinated care
- Improved the quality of life and health outcomes
- Reduced service costs

Background

Receiving 3 weekly to daily nursing support visits (varied with fluctuations in needs) that involved 1-2 nurses for minimum 60 minutes a visit. Support exceeded CHSP funding levels and was being provided by state health funding.

Referral to OT due to pressure injury risk and safety concerns around manual handling of large oedematous legs by nursing staff. Referral reported client as a ‘non-compliant’, obese, alcoholic who slept in his car for unknown reasons.

Following engagement with OT

Home visits were short but allowed OT to establish basic rapport and understand barriers to accepting care, reasons for sleeping in car, motivating factors and goals.

Extensive non face-to-face clinical time required to source appropriate equipment to meet assessed needs. Assessment supported a focus on electrically operated bed to meet range of assessed factors and improve overall quality of life.

Current bed was assessed as inadequate and standard domestic bed was assessed as not suitable to support:

- safe and independent transfers
- address pressure injury risk
- support optimal sleeping positions for lymphoedema management and comfort
- ensure safe working load
- support safe manual handling for nursing care needs
- facilitate sleep hygiene strategies to improve sleep

Once bed was installed

- Client reported improved sleep (up to 4 hours at a time. Previously 1-2 hours a night)
- Able to transfer in and out of bed (no longer sleeping in car)
- Able to position self for elevation of legs (to manage oedema) and breathing comfort

Follow up call with client one month later revealed

- Nursing reduced to twice week and transferred to CHSP funding
- Oedema in legs improved significantly
- More mobile and active
- Full night’s sleep every night
- Reduced back pain

The cost of the bed and mattress was $6838. This exceeded CHSP limits of $1000. OT agreed a plan with the client for them to self-fund $2000 with remaining funds sourced from a state government donation fund.

OT home visit time was approximately 90 minutes with out of home follow up (contact with suppliers to source appropriate bed/mattress for weight, communication with all stakeholders to gather info, report writing and funding options research) approximately 360 minutes with additional travel and follow up time.

Routine nursing input prior to prescription of bed (i.e. 3 times a week 1-2 nurses at 60 minute intervals for 4 months) was minimum 2880 minutes, not considering occasions when client required increased nursing support (every second day or daily).