Value of Allied Health in Residential Aged Care

Allied Health Professions Australia

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This submission has been developed in consultation with AHPA's allied health association members.

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Summary

Consumer access to allied health's broad range of critical services has long been limited by inadequate funding and service delivery structures for residential aged care. Despite a two-year Royal Commission and with significant reform underway, the issue of poor access to needs-based allied health care in the residential setting remains largely unaddressed.

The Australian Royal Commission into Aged Care Quality and Safety (the Royal Commission) found many people in residential aged care did not have sufficient access to allied health services and recommended increasing access with a number of mechanisms (recommendations 37, 38, 58, 61, 69, 70, 72). The Royal Commission Final Report stated:

> "Allied health should become an intrinsic part of residential care."[1]

The Australian Government response to the Final Report of the Royal Commission however gave qualified 'in-principle' support to the key recommendations regarding allied health.

There remains insufficient funding levels and inadequate funding mechanisms to reduce the morbidity, mortality and quality of life impacts highlighted by the Royal Commission.

The new Australian National Aged Care Classification (AN-ACC) funding tool, which is based on existing practice and the limitations of the current inept Aged Care Funding Instrument (ACFI), is not in itself the solution.

> AN-ACC does not assess for clinical need but rather for basic care costs and will continue to leave consumers with inadequate care.

In addition to directly contributing to poor outcomes for older Australians, this also contributes to a lack of understanding within the sector of the benefit of allied health services when utilised to their full scope of practice.

Allied health is integral to high quality care in the residential aged care setting and not an optional extra. Allied health professionals prevent, diagnose and manage a range of conditions and illnesses. As part of multi-disciplinary teams, they:

- Reduce emergency department admissions and preventable hospitalisations (for example via early assessment and management of chronic conditions, falls risks, dysphagia).
- Save lives (for example, through dietary and swallowing interventions, psychological management and falls prevention)
- Improve quality of life (for example, addressing pain, psychological and behavioural symptoms, communication, hearing loss and mobility)

A clear plan with articulated timelines needs to be urgently developed to ensure access to allied health services according to clinical need within residential aged care settings.

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[1] https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf

Introduction

Allied health scope of practice

Allied health professionals are university qualified health professionals with specific expertise in preventing, diagnosing and managing a range of conditions and illnesses. There are a diverse range of professions covering a wide range of consumer needs represented within allied health in aged care.

With its broad scope of practice, allied health aims to maximise independence, quality of life and dignity in older people in residential aged care. Allied health best practice is based on holistic, multi-disciplinary team approaches to meet physical, emotional and psycho-social needs of individuals as they age.

> In many cases allied health interventions can reduce or remove the need for medical interventions.

Allied health professionals work alongside, support and train advocates, formal and informal carers, other health providers and aged care workers in techniques, approaches and the use of aids to improve health and wellness outcomes. For example, this can include:

- demonstrating correct manual handling techniques
- advising families and workers in how to support older people with swallowing and communication difficulties
- diagnosing the causes triggering behavioural responses in those living with dementia, and
- treating depression or other mental health conditions.

The professionals within the sector provide insight and expertise to contribute to good clinical governance systems within aged care.

Allied health workforce

With more than 200,000 professionals, allied health is Australia's second largest health workforce.

The allied health workforce is counted alongside nurses and personal care workers (PCWs) as part of the Direct Care workforce in residential aged care, defined as providing care directly to care recipients as a core component of their work.

According to the Department of Health, there are about 13,600 allied workers in residential aged care (including allied health assistants), making up about 6.5% of the RAC direct care workforce.[2]

However, in terms of fulltime equivalents (FTEs), the proportion is 4.5% (due to allied health workers being more likely than others to work part-time).

Most of the staff employed on an agency or subcontractor basis are allied health professionals. Allied health staff are more likely to be part-time than nurses and PCWs. They are also the most likely to be non-permanent.

The allied health workforce in aged care is currently characterised by a predominantly part time agency/contractor workforce often providing services within individual disciplines.

It is noted that there continues to be gaps in data on the aged care allied health workforce and that the impact of employment uncertainty due to COVID-19 impacts and ongoing reform has not been quantified.

Spending on allied health

Many Australians, especially older people, live with chronic conditions. Only 4% of current health spending on chronic conditions is on allied health.[3]

Allied health professionals deliver just 1% of individual care time in Residential Aged Care Facilities (RACFs) - equating to eight inadequate minutes per day.[4]

Currently, the broad range of allied health services are underutilised and poorly integrated into funding and service delivery structures for residential aged care.

Reliance on MBS Chronic Disease Management Items to address the needs of those in residential aged care contributes to this piecemeal approach. These items do not support continuity of care and integrated multidisciplinary care, nor do they support the time for collaboration with relatives, facility staff and processes which are integral to care.

The Royal Commission identified the current lack of access to allied health in aged care and the subsequent impact of this on quality care in setting out several recommendations to be undertaken to ensure equitable access to services needed by all older adults.

"'The royal commission found that access to allied health was insufficient in both residential and in-home care, and that increased levels of allied health are crucial to maintaining capacity and preventing deterioration of health.'"[5]

Its Final Report (pg 67) stated: "People receiving aged care have limited access to services from allied health professionals, including dietitians, exercise physiologists, mental health workers, occupational therapists, physiotherapists, podiatrists, psychologists, speech pathologists and

[2] Department of Health, 2020 Aged Care Workforce Census Report.
[3] Productivity Commission, *Innovations in care for chronic health conditions* (March 2021), p3
[4] Eagar K et al. How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, AHSRI, University of Wollongong; 2019. https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf
[5] Committee for Economic Development of Australia, *Duty of Care: Meeting the Aged Care Workforce Challenge* (2021), p16

specialist oral and dental health professionals. Allied Health Professions Australia stated that 'allied health service provision in aged care is predominantly not a matter of an aged care / health interface but an integral part of aged care'. We agree."

Excepting Recommendation 61 and the introduction of the temporary Better Access Initiative for mental health allied health access there are no clear actions or timelines in the government response to these allied health recommendations.

The response to Recommendation 38 to ensure allied health access in residential aged care is particularly concerning: relying on the introduction of the AN-ACC tool of itself will not lead to increased access to allied health. The other recommendations of the RUCS review have not been accepted, namely comprehensive clinical assessment and minimum care time for allied health. No additional funding has been provided in forward estimates of the Federal Budget for this measure and the Support at Home Program will not provide increased access for those living in residential aged care. Most other recommendations have been deferred to needing consultation between State and Territory governments – with no clear timelines or plans to do so.

TABLE 1

Key Royal Commission recommendations on allied health service provision in RAC

Royal Commission Recommendation	Government Response	Planned Government Response
#37 new aged care program to include access to aids and equipment and provides integrated and high quality care based on assessed needs including 'allied health care'	Accepted	"reforms to residential aged care funding, quality and safety and new Aged Care Act will address this recommendation"
#38: residential aged care to include allied health	Accepted "in principle"	"design of the AN-ACC funding tool and new support at home program"
#58 Multidisciplinary Outreach services including allied health practitioners	Accepted "in principle"	"needs to be progressed in consultation with the state and territory governments" "Residential Aged Care Quality and Safety – improving access to primary care and other health services"
#61 short term changes to MBS to improve access to medical and	Accepted	Better Access Initiative commenced on 30 Nov 2020 until June 2022

allied health (psych, OT and social work)		
#67 improving data on interaction between health and aged care	Accepted	"this will need to be progressed in consultation with State and Territory governments"
#69 clarification of roles and responsibilities for delivery of health care: "allied health should generally be provided by aged care providers"	Accepted	"this will need to be progressed in consultation with State and Territory governments"
#70 improved access to health services including palliative care and clinically appropriate subacute rehabilitation	Accepted	"this will need to be progressed in consultation with State and Territory governments"
#72 Equity for people with disability receiving aged care	Subject to further consideration	Work between DoH, DSS and NDIA, completed by end of 2022

Australian National Aged Care Classification (AN-ACC)

Access to allied health services has been heavily rationed due to overall funding levels and the limitations in the Aged Care Funding Instrument (ACFI). This remains a concern for allied health professionals with the development of the AN-ACC based on existing practice and a funding instrument that failed to appropriately identify and fund allied health service.

AN-ACC does not assess for clinical need but rather for basic care costs.

The Resource and Utilisation and Classification Study recommended "that a best practice needs identification and care planning assessment tool be developed for use by residential aged care facilities" as it is widely accepted and acknowledged that the AN-ACC is a funding classification tool only and not for use as a clinical care planning tool.*[6]

"This will ensure that RACF management have access to a tool that will support them in building a care plan with the right AHP case mix to meet the client's needs. It also addresses the key issue identified by the 2011 Productivity Commission, namely that the largely unregulated aged care sector provided an incentive to aged care providers to replace higher paid and skilled clinicians

[6] AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations The Resource Utilisation and Classification Study: Report 6

with lower paid and semi-skilled personal care workers which works directly at eroding the capacity and capability of the residential aged care workforce and quality of care."[7]

The need for a full individual clinical assessment, preferably by a multidisciplinary, team occur upon admission to aged care – seems to have been overlooked.

Additional funding is needed to provide the appropriately trained allied health staff to perform these assessments. Appropriate assessment, multidisciplinary team planning will provide the optimal care program and planning for residents in aged care facilities. The investment at this stage and when care needs change will result in fewer hospital admissions or adverse events, resulting in a cost saving for the health care sector.

It is clear that insufficient funding levels are not in themselves blocking access to allied health, but also inadequate funding mechanisms to enable allied health including the new funding tool.

Allied health is integral to safe, good quality care. The sector has significant concerns that allied health continues to be seen as an optional extra.

The case for more allied health services in residential aged care

Allied health reduces emergency department presentations and potentially preventable hospitalisations

A systemic review of preventing presentations of older people to emergency departments found that presentations to the emergency department (ED) are increasing at a rate that exceeds population growth.*[8]

As age increases the likelihood of admission into the hospital when a person presents to the emergency department also increases, with hospitalisation rates in older people two to four times higher than rates in younger adults.

There is growing evidence high quality allied health care can avoid potentially preventable hospitalisations (PPH) of older people. PPHs are hospitalisations that may have been avoided with provision of appropriate preventative health interventions and early disease management in primary care to prevent the condition or the hospitalisation.[9]

There are 22 conditions for which hospitalisation is considered potentially preventable across three broad categories: vaccine preventable conditions; acute conditions; and chronic conditions. These are conditions that may be preventable through behaviour modification and lifestyle change, but can also be managed effectively through timely and clinically necessary care to prevent deterioration and hospitalisation.
A report developed for Services for Australian Rural and Remote Allied Health on allied health interventions targeting type II diabetes, osteoarthritis and post-stroke populations highlighted a

[7] Summary of Final Report Vol. 1 – Aged Care Royal Commission, 2018, p 129
[8] Kellermann AL: Crisis in the emergency department. N Engl J Med. 2006, 355 (13): 1300-1303. 10.1056/NEJMp068194
[9] AIHW (2019) Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017– 18 https://www.aihw.gov.au/reports/primary-health-care/potentially-preventablehospitalisations/contents/overview 3 ACSQHC (2017) A guide to potentially preventable hospitalisations indicator in Australia https://www.safetyandquality.gov.au/wp-content/uploads/2017/03/A-guide-to-the-potentially-preventablehospitalisations-indicator-in-Australia.pdf

considerable number of adverse health outcomes were avoided when patients are treated by allied health professionals.

> The report highlighted significant potential annual savings for the implementation of individual allied health interventions ranging from $5.1 million to $77.9 million per intervention.[10]

Research commissioned by the Royal Commission lists the reasons for hospitalisation of residents in aged care facilities, many of which could have been avoided with sufficient access to allied health services. For example, 18.4% of all hospitalisations of residents were a result of falls and injury, and 11.9% were due to circulatory issues.[11]

In New South Wales the largest contributing factor to potentially preventable hospitalisations relating to chronic conditions in rural and metropolitan districts was found to be a lack of access to allied health services.[12]

Early intervention upon entry to residential is key to reducing the number of emergency department presentations and PPHs. Research has found that within 90 days of residential aged care entry, 18% of individuals had unplanned hospitalisations and 22.6% had ED presentations. Several predictors, including modifiable factors, were identified at the time of care entry. This is an actionable period for targeting individuals at risk of hospitalisations. Early assessment by multi-disciplinary teams that include allied health are key.[13]

It is supported by people receiving aged care and their advocates

From Older Persons Advocacy Network, The National Aged Care Advocacy Program 2020-2021: Raising the voice of people accessing aged care (2021):

The top five presenting issues in advocacy casework in Assessment Services included service availability influencing assessment outcomes. The top five presenting issues in advocacy casework in Residential Care included care planning and quality of care. Concerns around quality of care included access to health and wellbeing services (p49).

'Inadequate care planning has been identified as an underlying issue in many advocacy cases relating to quality of care.' (p49)

'The Aged Care Quality Standards (Standard 2) stipulate that assessment and care planning should focus on optimising health and wellbeing in accordance with the resident's needs, goals and preferences. Despite this quality directive, OPAN members have been involved in numerous residential care cases where care plans have been inaccurate and have not been reflective of the individual's care needs. In some circumstances, OPAN members have even seen care plans that appear to be describing a completely different person to the resident they are supporting.' (p49)

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[10] https://www.sarrah.org.au/images/impact-report-091015.pdf

[11] Royal Commission into Aged Care Quality and Safety, Hospitalisations in Australian Aged Care: 2014/15-2018/19. 2021.

[12] Longman, J., et al., What could prevent chronic condition admissions assessed as preventable in rural and metropolitan contexts? An analysis of clinicians' perspectives from the DaPPHne study. PLOS ONE, 2021. 16(1): p. e0244313

[13] Inacio, M. C., Jorissen, R. N., Wesselingh, S., Sluggett, J. K., Whitehead, C., Maddison, I., ... & Crotty, M. (2021). Predictors of hospitalisations and emergency department presentations shortly after entering a residential aged care facility in Australia: a retrospective cohort study. *BMJ open*, *11*(11), e057247

Over 2020-21 advocates have requested care plan reviews and associated assessments (including assessments from relevant health professionals). (p49)

'Security of tenure cases have frequently involved residents experiencing behaviours associated with either a cognitive and/or mental health condition. In many cases, the aged care staff are not equipped with the knowledge or skill to respond to these behaviours in an appropriate manner.' (p54)

Consistency with Productivity Commission findings on successful health innovations

What distinguishes successful innovations from other interventions includes the fact that the former:

- consider people's needs and preferences, and offering comprehensive support
- empower health workers to make full use of their skills in delivering care
- build sustainable collaborative relationships between people as well as organisations
- improve the flow of information between different parts of the health system
- make the most of existing funding structures and embracing innovative approaches to funding.[14]

The Productivity Commission report provides an example of Tasmania's Community Rapid Response Service (ComRRS), which provides home-based care or care in a residential aged care facility for people at risk of a hospital visit.

The service covers a range of conditions often treated at hospitals, including acute injury or illness (such as falls or influenza), deterioration of chronic conditions (such as heart failure or diabetes), infections, nutritional deficiencies and palliative care.

A nurse practitioner, community nurses, the person's usual GP and other health professionals, such as physiotherapists and occupational therapists, all plan care together with the consumer.

ComRRS cost about $840 000 over a 10-month period. Usual care would have cost about $2.2 million, suggesting savings of close to $1.4 million.

Innovative Reablement and wellness are integral to allied health and recognised in the Royal Commission.

"Australian Royal Commission into Aged Care Quality and Safety investigating innovative models of care advocated a 'wellness and reablement approach in residential aged care, where people are assisted to regain functional capacity and improve independence through innovative models of care including exercise, activities of daily living (ADL) retraining, and behavioural interventions."[15]

Reducing complaints and meeting standards

[14] Productivity Commission, Innovations in care for chronic health conditions (March 2021), p5
[15] Dyer S, van den Berg M, Barnett K, Brown A, Johnstone G, Layer K, et al. Review of innovative models of aged care: report prepared for the Royal Commission into Aged Care Quality and Safety. 2019.

In the July-September 2021 quarter there were 1517 complaints made about residential aged care. The top 10 complaints were about medication administration and management (217), personnel number sufficiency (210), personal and oral hygiene (209), falls prevention and post fall management (142), representative/family consultation (141), lack of consultation/communication (129), change of clinical status/deterioration (127), personnel behaviour/conduct (103), constipation and continence management (98) and quality and variety of food and catering (97).

A number of these categories – in particular falls preventions and post fall management, constipation, continence, adequate staff support, quality of variety of food and catering - can be improved through expanding enabling the scope of allied health practice in this setting.

All of the aged care Quality Standards and Quality Indicators can be met through allied health intervention and joint working including falls, nutrition, pressure management and hospitalisations.

> Employing allied health professionals to work to full scope in RACFs directly ensures QI compliance and achievement of quality outcomes.

Table 2

ROLE OF ALLIED HEALTH IN MANAGING KEY CONDITIONS AFFECTING OLDER PEOPLE IN RESIDENTIAL AGED CARE

Dementia

Affects **54%** | **132,000** people | **$1.7 billion** dementia (2018-19)

- Exercise reduces risk and helps delay cognitive decline and maintain physical health
- Communication impairment increases distress and misdiagnosis
- Unmanaged hearing loss may account for up to 9% of preventable dementia cases worldwide

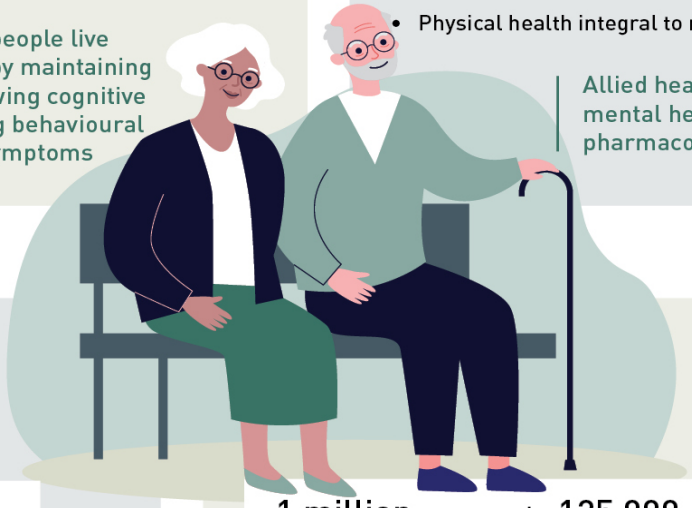
Allied health helps people live well with dementia by maintaining physical health, slowing cognitive decline and reducing behavioural and psychological symptoms

Mental health

87% have at least one mental health or behavioural condition | **50%** have depression

- In first three months in RACFs, 20%-31% receive psychotropic medications
- Non-pharmacological management via mental health clinicians and prescribed exercise limit psychotropic medicine
- Communication disability increases risk and decreases likelihood of needs being met
- Physical health integral to mental health

Allied health improves mental health and reduces pharmacological management



Malnutrition

22%-50% of older people affected

- Food and nutrition one of four key concerns of Royal Commission
- Malnutrition increases risk for all disease burden
- Professional dietary intervention ensures adequate nutrient intake
- Difficulties with swallowing without intervention significantly increases risk of weight loss

Allied health ensures nutritional needs of older people are met, improving overall health

Falls

1 million Australians aged over 65 fall each year | **125,000** hospitalisations annually | Leading cause of preventable death in RACFs

- Poor nutrition, difficulty communicating, hearing loss, lack of supervision or unmet care needs, and lack of strength, balance and mobility increase risk of falls
- Mobility is a key determinant of overall health
- Falls occur 3 times more in RACFs than in community
- Allied health led strength and balance programs reduce falls by 55%
- Dietary intervention reduces falls by 11%
- Hearing loss is associated with significantly increased odds of falling in older adults

Allied health interventions and prescribed exercise reduce falls and saves lives

Allied health's critical role in addressing key conditions

The allied health sector is diverse and encompasses a broad range of practice. For the purposes of this paper, examination of its impact in the prevention and management of four key areas of disease burden– mental health, dementia, falls and malnutrition – follows.

Mental health

According to the National Mental Health Commission (2016), the cost of mental illness in Australia equates to approximately $4000 per person, or $60 billion to the nation.

People living in residential aged care are at higher risk of poor mental health than those living in the community. Many mental health conditions, such as dementia, depression and anxiety, are more prevalent for older adults in residential aged care settings when compared to community-dwelling older adults.

At 30 June 2019, the majority (87%) of older people in residential aged care in Australia were identified with at least one mental health or behavioural condition and half had a diagnosis of depression.[16]

An Australian study found that symptoms of depression anhedonia and anergia were associated with almost a threefold increased risk of mortality in older adults living in RACFs.[17]

Allied health care can improve mental health and reduce pharmacological management

Despite an increase in awareness of depression and anxiety for older people in residential aged care, research indicates that access to psychological services is poor. For example, an Australian study found that residents were rarely referred to psychologists or to psychological treatments. Barriers to access include low availability of psychologists, lack of government funding for such access, and limited staff training in detecting depression and anxiety.[18]

Non-pharmacological psychological and behavioural management strategies are important for limiting the prescribing of psychotropic medicines for older people in residential care. Australian studies have demonstrated that dispensing of psychotropic medicines to older Australians increases markedly soon after entry into care. During their first three months in residential care, 20-21% of residents had received an antipsychotic, 28%-41% received antidepressant, and 22-31% of residents had received benzodiazepines.[19]

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[16] Older Australians: Health – selected conditions: Mental health. https://www.aihw.gov.au/reports/older-people/older-australians/contents/3-health/3b-health-selected-conditions#Mental%20health

[17] Greenfield, L., Mathews, S., & Toukhsati, S. R. (2021). Anhedonia and anergia predict mortality in older Australians living in residential aged care.Aging & mental health, 1-9

[18] Stargatt, J et al. (2017). The availability of psychological services for aged care residents in Australia: A survey of facility staff. Australian Psychologist, 52(6), 406-413

[19] Harrison, S. L et al, (2020). The dispensing of psychotropic medicines to older people before and after they enter residential aged care.*Medical Journal of Australia*, *212*(7), 309-313; Westbury JL,Gee P, Ling T, et al. RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities. *Med J Aust* 2018; 208: 398–403.

Since December 2020, limited Medicare-subsidised mental health services have been available to residents in aged care facilities. A relatively low percentage of older people, however, receive Medicare-subsidised mental health-specific services compared with younger people.[20]

The role of allied health providers in reducing depression and anxiety, managing and treating pain, improving mobility and function, and enhancing quality of life, has not been properly recognised and incorporated in mental health and suicide prevention strategies.

This is clear in the finding that people experiencing mental illnesses are more likely to develop physical illness and tend to die earlier than the general population.[21]

Dementia

Dementia is the leading cause of disease burden in Australians aged 75 and over. About 43% of the overall dementia burden in 2018 could have been avoided if exposure to six modifiable risk factors for dementia was avoided or reduced to the lowest level possible. (obesity, physical inactivity, tobacco smoking, high blood pressure in midlife, high blood plasma glucose levels and impaired kidney function). Additionally, hearing loss and loss of social participation have been identified as key potentially modifiable risk factors for dementia.[22]

More than half of people living in permanent residential aged care have dementia. Depression and mood disorders (47%) and a range of arthritic disorders (45%) were the most common co-existing medical conditions among people with dementia living in permanent residential aged care. (p13)

Allied Health can deliver interventions to slow the rate of cognitive decline

Allied health services are key to living well with dementia, as prescribed in the Clinical Practice Guidelines and Principles of Care for People with Dementia,[23] which state:

> "The provision of allied health services to maintain or enhance cognitive and physical function for people with dementia should be effectively embedded into aged care policy. This could be done, for example, by increasing funding allowances to access such services, and by promoting access to and increasing availability of such services."

Early access to allied health to maintain physical function, strength and mobility is important for all, including those living with dementia to slow the rate of cognitive decline. Interventions to ensure appropriate nutrition with a healthy balanced diet, cognitive stimulation and social participation are all recommended areas for reducing risk of cognitive decline[24] that allied health can contribute advice on, particularly when co-morbidities co-exist.

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[20] AIHW (2021a). Older Australians: Health – service use: Mental health. https://www.aihw.gov.au/reports/older-people/older-australians/contents/health/health-service-use#Allied%20health

[21] AIHW report, *Physical Health of People with Mental Illness* (July 2020)

[22] Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. Lancet. 2020 Aug 8;396(10248):413-446. doi: 10.1016/S0140-6736(20)30367-6.

[23] https://cdpc.sydney.edu.au/wp-content/uploads/2019/06/Dementia-Guideline-Recommendations-WEB-version.pdf

[24] https://apps.who.int/iris/bitstream/handle/10665/312180/9789241550543-eng.pdf?ua=1

Allied health can maintain physical health of people living with dementia

Physical health can often be overlooked in those living with dementia and its role in delaying cognitive decline unrecognised. Physical inactivity is a modifiable risk factor for dementia[25] and the World Health Organization recommends physical activity interventions for adults with normal cognition and with mild cognitive impairment, to reduce the risk of cognitive decline.[26]

Dementia affects balance, coordination and gait are affected as dementia progresses.[27] Along with changes to visual perception and dual-tasking ability, physical symptoms dementia can lead to falls, fractures and hospitalisation. People living with dementia have a high risk of poor outcomes during hospitalisation[28] including malnutrition, functional decline, delirium, falls and fractures.[29]

Managing the physical symptoms of dementia early is crucial.

Physical exercise can improve strength, balance, mobility and endurance in people with cognitive impairment and dementia.[30]Physical exercise can also reduce behavioural and psychological symptoms of dementia and reduce cognitive decline.[31]

Allied Health can provide interventions that make a difference in the lives of people with dementia and their carers

Whilst allied health can provide interventions to manage the impacts of a range of physical, communication, cognitive, social, behavioural impacts of dementia and subsequently lessen morbidity and hospital admission, increased care and resource needs, allied health has not been effectively used with people with dementia.

In 2018–19, $3.0 billion of health and aged care spending was directly attributable to dementia. Spending on residential aged care services accounts for the largest share of dementia spending (56% or $1.7 billion). Spending on allied health comprises considerably less than 3%. Expenditure on out of hospital medical services, which are defined as 'general practice, diagnostic imaging, specialist, allied health and pathology services as well as pharmaceuticals' is $99.2 million, or 3.3% of total directly related health and aged care spending.

There is a growing body of evidence demonstrating the effectiveness of allied health, enablement, and assistive technologies in rehabilitation for people with dementia post-

[25] Livingston G, Sommerlad A, Orgeta V, Costafreda SG, Huntley J, Ames D, Ballard C, Banerjee S, Burns A, Cohen-Mansfield J, Cooper C. Dementia prevention, intervention, and care. The Lancet. 2017 Dec 16;390(10113):2673-734]
[26] WHO guidelines 2019
[27] Suttanon P et al. Balance and mobility dysfunction and falls risk in older people with mild to moderate Alzheimer disease. American journal of physical medicine & rehabilitation. 2012 Jan 1;91(1):12-23
[28] Tropea J et al. Poorer outcomes and greater healthcare costs for hospitalised older people with dementia and delirium: a retrospective cohort study. International journal of geriatric psychiatry. 2017 May;32(5):539-47
[29] Fogg C, Griffiths P, Meredith P, Bridges J. Hospital outcomes of older people with cognitive impairment: An integrative review. International journal of geriatric psychiatry. 2018 Sep;33(9):1177- 97.
[30] Lam et al (2018) Physical exercise improves strength, balance, mobility, and endurance in people with cognitive impairment and dementia: a systematic review. Journal of Physiotherapy 64: 4–15
[31] Chun-Kit Law, Freddy MH Lam, Raymond CK Chung, Marco YC Pang, Physical exercise attenuates cognitive decline and reduces behavioural problems in people with mild cognitive impairment and dementia: a systematic review, Journal of Physiotherapy, Volume 66, Issue 1, 2020,Pages 9-18

diagnosis. [32] According to the Deeble Institute report *Reablement interventions for community dwelling people living with dementia:*

> "Reablement interventions for people with dementia are not widely implemented in Australia [citations omitted]. As a consequence of the limited availability of services or funding, not all people who need it can access high quality allied health support after a diagnosis of dementia (Royal Commission into Aged Care Quality and Safety, 2021). This is regardless of the evidence described in reviews of research studies [citations omitted] that support the use of allied health interventions in maintaining or enhancing a person physical or cognitive function. This means that people with dementia do not get access to services that help maintain or enhance their function and health."

The Royal Commission has made several recommendations to support people with dementia to access care that addresses their needs and values (recommendations No 3, No 35, No 36). Central to these recommendations is the concept that aged care should adopt a reablement and rehabilitative approach.

Furthermore, allied health plays a role in supporting carers manage the needs of people with dementia throughout the disease trajectory. Difficulties with communication are common and distressing features of dementia which impact the person and contribute to carer stress and burden and can be better addressed with communication partner training and compensatory strategies.[33]

Allied health interventions have been demonstrated to manage the behavioural and psychological symptoms of dementia, including via delivery of music.[34]

Falls

Falls are the leading cause of preventable death in older people in Australia with 1 million people aged over 65 falling each year resulting in 125,000 hospitalisations each year.

Risk factors for falls include reduced strength, balance and mobility; malnutrition; impaired vision, communication difficulties and hearing loss.

There is evidence that a multi-factorial falls prevention interventions provided through a multi-disciplinary approach significantly reduced falls and the number of recurrent fallers in RACFs.[35]

[3232] Dr Miia Rahja and Adjunct Associate Professor Rebecca Haddock, Deeble Institute for Health Policy Research Issues Brief No. 42, *Reablement interventions for community dwelling people living with dementia* (17 June 2021)

[33] Smith ER et al (2011). Memory and concentration support in dementia research-based strategies for caregivers. *International Psychogeriatrics*, 23 (2), 256-263. https://doi.org/10.1017/S1041610210001845

[34] Baker FA, Bloska J, Braat S, et al. HOMESIDE: home-based family caregiver-delivered music and reading interventions for people living with dementia: protocol of a randomised controlled trial. BMJ Open 2019;9:e031332. doi:10.1136/ bmjopen-2019-031332

[35] Vlaeyen, Ellen & Coussement, Joke & Leysens, Greet & Elst, Elisa & Delbaere, Kim & Cambier, Dirk & Denhaerynck, Kris & Dejaeger, Eddy & Boonen, S. & Milisen, Koen. (2013). Characteristics and Effectiveness of Fall Prevention Programs in Nursing Homes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. European Geriatric Medicine. 4. S54. 10.1016/j.eurger.2013.07.177.

> The Sunbeam Program trial demonstrated a 55% reduction in falls by older people in residential aged care who participated in the prescribed mobility program with a projected cost saving of $120 million per year for the Australian health economy.[36]

Economic analysis synthesising key clinical research (including the Sunbeam Program) and comparing the benefits they deliver with estimates of the cost of delivering the treatments was conducted by the Nous Group. Comparison of the cost of a prescribed falls prevention program compared to the cost of not undertaking the program, resulting in a fall, was conducted. The cost benefit of the aforementioned falls prevention programs equalled $1320 per falls episode.[37]

Nutrition also plays a role in falls prevention. A recent Australian study that increased residential aged care recipient intakes of dietary calcium and protein intakes through dairy foods, found that this dietary intervention compared to control was associated with a significantly reduced the risk of all fracture types (33% lower), hip fractures (46% lower) and falls (11% lower).[38]

Hearing loss has been shown to be associated with a significantly increased likelihood of falling in older adults.[39]

Dementia is an independent risk factor for falls and for serious injury such as head injury or hip fracture from falls. However, research shows people with dementia had longer lengths of stay in hospital (LOS), except for people with dementia with hip fractures. This population had less in-hospital rehabilitation than people without dementia and shorter LOS, an average of seven days.[40] Despite evidence that people living with dementia can benefit from rehabilitation if they already live in residential aged care they are often denied the chance.[41]

Malnutrition

Older Australians often face nutritional challenges, particularly malnutrition, which adversely impacts on their overall health and quality of life. In residential care, Australian studies have identified a prevalence of malnutrition from 22% up to 50%.[42] This results in considerable costs for the aged care sector and broader healthcare system.
Food and nutrition in residential aged care was singled out as one of four concerns requiring immediate attention as part of the Royal Commission.

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Allied health addresses malnutrition

Food and nutrition in residential aged care was singled out as one of four concerns requiring immediate attention as part of the Royal Commission into Aged Care Quality and Safety. Accredited Practising Dietitians (APDs) play a critical role in improving access to nutritious and appealing food, identifying and treating malnutrition and managing other nutritional concerns among older people in residential aged care and those receiving in-home services.[43]

Dietary interventions can improve malnutrition, wound healing, and reduce the risk of falls and fractures.[44] A systematic review identified that nutrition interventions in aged care offer clinical benefit as they help to improve weight, function and nutritional status.[45]
This review highlighted that food-based interventions and oral nutrition supplements have low costs of implementation.
A recent Australian study that increased residential aged care recipient intakes of dietary calcium and protein intakes through dairy foods was associated with a significantly reduced the risk of all fracture types (33% lower), hip fractures (46% lower) and falls (11% lower).[46]

Dysphagia (difficulties with swallowing) affects between 40%– 60% of people living in residential aged care, and significantly increases the risk of malnutrition and poor functional outcomes in older individuals when appropriate intervention is not in place.[47] Dysphagia also increases the risk of choking which is the second highest cause of preventable death in residential aged care.[48]

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