Silverchain submission

Aged Care Rules 2024: Draft Rules Service List

17 October 2024

silverchain

Acknowledgement of Country

Silverchain respectfully acknowledges the Traditional Custodians of the lands on which we work and live. We acknowledge Elders both past and present, whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future leaders and reconciliation within Australia.

Our Innovate Reconciliation Action Plan artwork was created by artist, Charmaine Mumbulla from Mumbulla Creative. The artwork is crafted from many individual pieces and is layered to tell the Silverchain story, including our increased commitment and efforts towards healing, reconciliation, and social justice.

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Contacts

For more information, please contact:

Bronwyn Perry
Executive Director, Strategic Communications
bronwyn.perry@silverchain.org.au

Dr Ronelle Hutchinson
Head of Policy & Advocacy
ronelle.hutchinson@silverchain.org.au
policy@silverchain.org.au

Executive Summary

As pioneers and innovators of community and home-based care for more than a century, Silverchain Group welcomes the opportunity to provide comment on the Draft Rules: Service List for the *Aged Care Bill 2024* (Bill). We provide a range of health and aged care services to 140,000 people each year. Many of our 5,900 employees provide care to 33,000 older people through Home Care Packages (HCPs) and the Commonwealth Home Support Program (CHSP).

We have read the Draft Rules in conjunction with information provided by the Department of Health in the Support at Home (SaH) Handbook and as such, provide comment on the Draft Rules in respect to how the Department expects these to be implemented in practice.

The Service List offers the range of services that older people need to remain independent in their homes and communities.

It is pleasing to see the inclusion of **psychology** as an allied health therapy service in the Service List. The prevalence of depression in older people living at home is high and until now, aged care providers have not been able to provide services funded through the Commonwealth to support their mental health.

As a home care specific provider, everyday thousands of our employees are privileged to be invited into our client's homes. We do this without judgement and focus on the delivery of the best care possible for each client. We welcome the addition of service items that are specific to providing care related to addressing **hoarding and squalor**. We have clients whose home environments are characterised by hoarding and squalor. This adds a layer of complexity and intensity of services to the provision of aged care to individuals living in their own homes. We welcome the addition of service items that are specific to providing care related to addressing hoarding and squalor.

The Assistive Technology and Home Modifications List was not released alongside the Rules or the SaH Handbook and as such, it is unclear if **consumables relating to continence** would be included in this list and which service type this would fall into (and thus, the client contribution that would be expected).

We note that the Rules have a provision for services specific to residential aged care homes that relate to nursing activities that include "advance care planning, palliative care and end-of-life care." This is needed for SaH services also. **Advanced care planning** is critical for people who have been diagnosed with a life limiting condition, but it is also a critical conversation to begin having with older people and their families well ahead of end-of-life. The inclusion of a Service List item for advanced care planning in the Rules for SaH incentivises providers to begin having these conversations with older people well in advance of them needing palliative or end-of-life care. The National Palliative Care Plan has a priority (priority 4.4) to ensure that "Funding mechanisms, including existing Medicare Benefit Schedule item numbers, facilitate advance care planning and care coordination across all settings". We think that the provision of a service item related to advanced care planning within the home care setting is important to help achieve this priority.

We note that the Rules have a provision for services specific to residential aged care homes that relate to dementia and cognition management and include the development of an individual therapy and support program. It is estimated that by 2050, there will be a doubling of the number of people living with dementia. Most of these people will want and need to live in their own homes as their condition progresses. The Strengthened Standards have a strong focus on providers identifying and appropriately responding to the needs of older people living with dementia and as such, it is expected that home care providers will support the older person and their families in developing plans for management of any behavioural and psychological symptoms of dementia while the person remains living at home and in the community. The addition of a relevant item for **dementia and cognitive management** for the SaH program

offers older people and providers the reassurance that living with dementia in the community is not only 'accepted' but can be encouraged and managed safely with the right plans in place.

There are some aspects of the Rules that may lead to unintended consequences.

We predict that the Service List and associated contributions regime will drive choices by consumers based on financial factors rather than evidence-based needs. We are concerned that the services listed in the Service List have differing requirements for contributions. We anticipate that this will have unintended consequences and drive consumer-decision making in ways that do not support the best possible outcomes and lead to inefficient use of aged care resources.

Under the Nursing items, it defines clinical care matters as those following "the assessment, treatment and monitoring of medically diagnosed clinical conditions". It is our experience that often, older people have health concerns that have not yet been medically diagnosed and as such clinical care and support are still needed while awaiting a medical diagnosis. A good example of this might be an older client with bowel incontinence who is undergoing investigations to determine if this is a symptom of bowel cancer. We would still need to provide continence care to this person while they await a medical diagnosis.

We note under 'Cultural Support' that there will be a capped hourly fee for translation services including for "translation of information into the individual's chosen language". Our understanding is that these services will require a co-contribution from older people. While it is important to recognise the real costs associated with the provision of culturally appropriate services, including translation services, there is also an equity issue to be considered in relation to imposing a co-contribution for these services from older people with these needs. Consideration might be given to addressing the funding for these services through another mechanism – such as a loading or additional percentage of care management fees for people from CALD backgrounds who require translation services.

We understand that there will be a cap of 52 hours per year for domestic cleaning services. The collapsing of 'general house cleaning' under the same grouping as 'domestic assistance' will make it difficult for providers and clients to determine how many hours have been used for that service only on an annual basis.

We understand there will be a cap of 18 hours per year for gardening. The collapsing of 'gardening' under the same grouping as 'home maintenance and repairs' will make it difficult for providers and clients to determine how many hours have been used for that service only on an annual basis. It is important to acknowledge that demand for gardening services is likely to be seasonal, and the allocation of budget associated with gardening should not be equally split into quarters for SaH.

Allied Health is a critical service to support people to remain independent and age in place but access will be restricted under the Draft Rules.

We currently employ hundreds of allied health professionals across Australia in a variety of our health and aged care services, including in specific allied health profession clinical roles as well as in care coordination and navigator type roles.

The definition in the Rules of an allied health practitioner states that they an "allied health professional means a person who is registered under the National Law in an allied health profession". However, it is important to recognise that some allied health professions self-regulate to the same standards as the Australian Health Practitioners Regulation Agency (AHPRA). For example, practitioners offering the service items of speech pathology and dietetics and nutrition may be regulated through their professional bodies under the National Alliance of Self Regulating Health Professions scheme.

We agree with the range of allied health services listed in the Service List are those that can provide evidence-based benefits to older people. The SaH Handbook indicates that eligibility for

access to these allied health services however will only be available after the individual has accessed allied health through MBS rebatable chronic disease management (CDM) or Mental Health plans. We see a number of problems with this and believe the requirement will reduce access to appropriate and beneficial services for older people living at home. The same requirement of use of CDM items is not in place for people accessing allied health who live in residential aged care homes.

We recommend:

- That there be no further delay in the release of all subordinate legislation to the sector.
- The inclusion of psychology as an allied health service be retained in the final Service List.
- That there be a service item related to social support for housing alternatives for people living in dwellings characterised by hoarding and squalor.
- Clarification is needed about the inclusion and funding of incontinence consumables.
- That the Service List includes an item for the development of advanced care plans for people receiving care in their homes.
- That the Service List includes an item for the development of dementia and cognition management plans for people receiving care in their homes.
- That the definition of allied health includes practitioners working in self-regulated allied health professions.
- That consideration be given to an alternative method of payment for translation services that does not impose a co-contribution to older people who need that service.
- That the requirement for older people to have used all MBS Chronic Disease Management or Mental Health items prior to accessing allied health services through Support at Home be removed.
- That consideration be given to the risk that individuals will forego needed, and beneficial services to minimise any co-contribution.
- The language relating to nursing clinical care relating to “the assessment, treatment and monitoring of medically diagnosed clinical conditions” be refined to recognise that clinical care needs to address symptoms even if a medical diagnosis has not been received yet.
- That general house cleaning be a service type on its own and not include the other items under ‘domestic assistance’.
- That gardening be a service type on its own and not include the other items under ‘home maintenance and repairs’.

1. About Silverchain and this submission

For 130 years Silverchain has provided high-quality, in-home health and aged care services to multiple generations of Australians. As a not for profit, we employ more than 5,900 people, including nurses, doctors, allied health, care experts, and a dedicated research and innovation division, operating as Silverchain, RDNS Silverchain and KinCare.

Our ambition is to create a better home-care system for all Australians.

Our team provides a range of health and aged care services to more than 140,000 people each year. We specialise in home and community-based care because we believe that people should have, and prefer to have, their care in or close to their homes. Our services comprise complex and acute nursing; hospital in the home; specialist community palliative care; independence services and support at home, allied health services; digital enabled care and remote monitoring; and chronic and complex disease management.

We are accredited against both health and aged care standards nationally. We are recognised as a rural and remote aged care provider through the Department of Health and Aged Care specialist verification for aged care framework.

We currently provide home aged care services to 33,000 people across Australia through Home Care Packages and the Commonwealth Home Support Program.

We have a productive and positive relationship with the Commonwealth departments and agencies. We currently serve on the Department of Health and Age Care's Support at Home Sector Reference Group to advise on the implementation of the Support at Home program reforms and on the Australian Commission for Quality and Safety in Health Care's Aged Care Advisory Group.

We have provided this submission to our colleagues in the Support at Home section of the Department for their visibility.

We have also provided this to the Senate Community Affairs Legislative Committee currently conducting an inquiry into the Aged Care Act 2024 (Provisions) to support their deliberations.

2. Services to support independence

The Service List offers the range of services that older people need to remain independent in their homes and communities

The sector has welcomed the detail released of the subordinate legislation for the Aged Care Act 2024. Efforts to reform services have been hamstrung by a lack of information to date, and providers have been waiting for sufficient detail to begin reforming services in earnest. As such, the publication of the Rules: Service List is very welcomed and we encourage the Department to finalise these as soon as possible lest the Department becomes subject to caretaker conventions in early 2025, resulting in a significant delay of the information we need to reform services both to meet the legislation but also to align with the new Strengthened Standards and SaH program.

We have read the Draft Rules in conjunction with the SaH Handbook to form a view about if the Rules are sufficient to enable a successful transition of services to SaH for older people to remain independent in their own homes and communities.

There are several significant inclusions in the Bill that we wish to make comment on.

We recommend:

- That there be no further delay in the release of subordinate legislation to the sector.
- The inclusion of psychology as an allied health service be retained in the final Service List.
- That there be a service item related to social support for housing alternatives for people living in dwellings characterised by hoarding and squalor.
- Clarification is needed about the inclusion and funding of incontinence consumables.
- That the Service List includes an item for the development of advanced care plans for people receiving care in their homes.
- That the Service List includes an item for the development of dementia and cognition management for people receiving care in their homes.

2.1 Mental health services

We welcome the inclusion of psychology as an allied health therapy service in the Service List. We know that:

- Depression is highly prevalent in older people living at home in the community and receiving aged care supports at home. Half of older people receiving aged care services at home experience symptoms of depression[1].
- The Royal Commission into Aged Care Quality and Safety concluded that the needs of older Australians with mental health conditions are not adequately addressed in aged care[2].
- This vulnerable population is also at increased risk of suicide, anxiety, and loneliness[3].
- Depression in older people is preventable and treatable[4].
- Aged care workers can, with appropriate training, support the mental health of older people[5].

Governments across Australia have commitments to improving mental health through the National Mental Health and Suicide Prevention Plan. Mental health is a national health priority and it is timely that it is considered as part of holistic aged care services in Australia.

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[1] Wang J et al. Mental health disorders in home care elders. *Geriatr Nurs*. 2016;37:44-60.
[2] Royal Commission into Aged Care Quality and Safety. Final Report; 2021.
[3] Wang et al, 2016.
[4] Wang et al, 2016.
[5] Davison TE et al. Knowledge of late-life depression: an empirical investigation of aged care staff. *Aging Ment Health*. 2009;13:577-86.

Importantly, the Strengthened Standards include explicit mention of the mental health of older people and the responsibilities of providers to identify and respond to mental health decline.

The inclusion of psychology in the Service List provides an avenue for providers to support older people living at home to identify and treat depression and anxiety (in particular) and to meet the Strengthened Standards in the new regulatory scheme.

Silverchain has been working on innovations in mental health care for older people and we are currently undertaking a clinical trial of the Enhanced Management of home-based Elders with Depression (EMBED) program. EMBED is an innovative and evidence-based model of care that aims to facilitate early detection and use of evidence-based treatment of depression in older Australians who receive home aged care. It has been developed by Silverchain with the underpinning technology developed in partnership with Swinburne University of Technology (and supported by funding from Aged Care Research and Industry Innovation Australia). EMBED has undergone an initial proof of concept trial and is now progressing to a clinical trial.

We believe that for older Australians to benefit from the inclusion of psychology in the Service List, then the requirement for the exhaustion of Medicare-subsidised mental health items before being eligible for these therapies in SaH needs to be removed[6]. Please see our commentary and recommendations under Section 4 of this submission.

2.2 Hoarding and Squalor

As a home care specific provider, everyday thousands of our care team members are privileged to be invited into our client's homes. We do this without judgement and focus on the delivery of the best care possible for each client. However, we have clients whose home environments are characterised by hoarding and squalor. This adds a layer of complexity and intensity of services to the provision of aged care to individuals living in these dwellings. We welcome the addition of service items that are specific to providing care related to addressing hoarding and squalor. We think the Service List could be improved by the addition of social supports associated with securing alternative accommodation in the event that the dwelling is not, or cannot be made to be, habitable for the older person. We do not anticipate that many older people will need this service through SaH, but for those who do, access to this type of service will be life changing.

2.3 Continence consumables

The AT-HM List was not released alongside the Rules or the SaH Handbook and as such, it is unclear if consumables relating to continence would be included in this list and which service type this would fall into (and thus, the client contribution that would be expected).

Silverchain operates the Continence Management and Advice Service (CMAS) in Western Australia where we provide a community-based continence service providing management and advice on long-term bladder and bowel incontinence to people living at home and those in high level residential care. Continence products play a vital role in high quality continence management, helping individuals to maintain dignity, comfort and independence and the management of skin integrity problems and infections associated with incontinence.

2.4 Advanced care planning services

We note that the Rules have a provision for services specific to residential aged care homes that relate to nursing activities that include "advance care planning, palliative care and end-of-life care."

This is needed for SaH services also. The introduction of a short-term end-of-life pathway is an important improvement that will benefit countless older people and their families and make the choice to die at home a reality in Australia. We believe it will enable generalist palliative care to be provided in people's homes.

[6] This requirement is listed in the SaH Handbook (not in the Rules themselves).

Advanced care planning is critical for people who have been diagnosed with a life limiting condition, but it is also a critical conversation to begin having with older people and their families well ahead of end-of-life. The inclusion of a Service List item for advanced care planning in the Rules for SaH incentivises providers to begin having these conversations with older people well in advance of them needing palliative or end-of-life care. The National Palliative Care Plan has a priority (priority 4.4) to ensure that "Funding mechanisms, including existing Medicare Benefit Schedule item numbers, facilitate advance care planning and care coordination across all settings". We think that the provision of a service item related to advanced care planning within the home care setting is important to help achieve this priority.

2.5 Dementia and cognition management services

We note that the Rules have provision for services specific to residential aged care homes that relate to dementia and cognition management and include the development of an individual therapy and support program designed and carried out to (i) prevent or manage a particular condition of behaviour; and (ii) enhance the individual's quality of life; and (iii) enhance care for the individual and include ongoing support (including specific encouragement) to motivate or enable the individual to take part in general activities of the residential care home.

It is estimated that by 2050, there will be a doubling of the number of people living with dementia. Most of these people will need to live in their homes in the community while their conditions progress. The Strengthened Standards have a strong focus on providers identifying and appropriately responding to the needs of older people living with dementia and as such, it is expected that home care providers will support the older person and their families in developing plans for management of any behavioural and psychological symptoms of dementia while the person remains living at home and in the community. The addition of a relevant item for dementia and cognitive management for the SaH program offers older people and providers the reassurance that living with dementia in the community is not only 'accepted' but can be encouraged and managed safely with the right plans in place.

3. Unintended consequences of the Service List

There are aspects of the Rules that we anticipate will lead to unintended consequences.

3.1 Preferences for services without co-contributions.

We predict that the Service List and associated contributions regime will drive choices by consumers based on financial factors rather than evidence-based needs. We believe this will have unintended consequences and drive consumer-decision making in ways that do not support the best possible outcomes and lead to inefficient use of aged care resources.

For example, personal care in a category that attracts a co-contribution however clinical care will not attract a co-contribution. We can foresee a client choosing to reduce the number of hours of personal care they receive (in order to reduce the amount they need to pay out of pocket) which will have flow on impacts to the use of clinical resources. Personal care workers play an important role in monitoring the health and wellbeing of people living in their own homes and escalating concerns to clinical colleagues. It is commonplace that a personal care worker will identify a skin integrity issue for an older person first and then escalate to ensure that a nurse can provide wound care.

We note under 'Cultural Support' that there will be a capped hourly fee for translation services including for "translation of information into the individual's chosen language". Our understanding is that these services will require a co-contribution from older people. While it is important to recognise the real costs to providers associated with the provision of culturally appropriate services, including translation services, there is also an equity issue to be considered in relation to imposing a co-contribution for these services from older people with these needs. Consideration might be given to addressing the funding for these services through another mechanism – such as a loading or additional percentage of care management fees for people from CALD backgrounds who require translation services. If a client chooses to forego these services due to the co-contribution, then their ability to participate in decision making about their care and their informed consent could be compromised.

We recommend:

- That consideration be given to the risk that individuals will forego needed and beneficial services to minimise any co-contribution.
- That consideration be given to an alternative method of payment for translation services that does not impose a co-contribution to older people who need that service.
- The language relating to nursing clinical care for "the assessment, treatment and monitoring of medically diagnosed clinical conditions" needs to be refined to recognise that clinical care needs to address symptoms even if a medical diagnosis has not been received yet.
- That general house cleaning be a service type on its own and not include the other items under 'domestic assistance'.
- That gardening be a service type on its own and not include the other items under 'home maintenance and repairs'.

3.2 Medical diagnoses as a 'gateway' for nursing services

Under the Nursing items, it defines clinical care matters as those following "the assessment, treatment and monitoring of medically diagnosed clinical conditions". It is our experience that often, older people have health concerns that have not yet been medically diagnosed and as such clinical care and support are still needed whilst awaiting a medical diagnosis. A good example of this might be an older client with bowel incontinence who is undergoing investigations to determine if this is a symptom of bowel cancer. We would still need to provide continence care to this person whilst they await diagnosis.

We think some refinements to the language are needed to avoid any unintended consequences of not being able to provide clinical care to a person whilst they await a medical diagnosis for a condition.

3.3 Caps for domestic cleaning and gardening

We understand that there will be a cap of 52 hours per year for domestic cleaning services. The collapsing of 'general house cleaning' under the same grouping as 'domestic assistance' will make it difficult for providers and clients to determine how many hours have been used for that specific service only on an annual basis. The Service List could be improved for more effective implementation if general house cleaning was a service type on its own.

We understand there will be a cap of 18 hours per year for gardening. The collapsing of 'gardening' under the same grouping as 'home maintenance and repairs' will make it difficult for providers and clients to determine how many hours have been used for that service only on an annual basis.

It is important to acknowledge that demand for gardening services is likely to be seasonal, and the allocation of budget associated with gardening should not be equally split into quarters for SaH. We can reasonably predict that demand and use of gardening services will occur in the spring months of the year with minimal spend throughout the remainder of the year. The Service List could be improved for more effective implementation if gardening was a service type on its own.

4. Allied health access

Allied health is a critical service to support people to remain independent and age in place but access will be restricted under the Draft Rules.

We currently employ hundreds of allied health practitioners across Australia in a variety of our health and aged care services, including in specific allied health clinical roles (listed below) as well as in care coordination and navigator type roles:

- Occupational Therapists
- Physiotherapists
- Therapy assistants
- Social Workers
- Podiatrists
- Spiritual Care Workers
- Psychologists
- Pharmacists
- Dieticians
- Speech pathologists

We recommend:

- That the definition of allied health include practitioners working in self-regulated allied health professions.
- That the requirement for older people to have used all MBS Chronic Disease Management or Mental Health items prior to accessing allied health services through Support at Home be removed.

Our employees work in multidisciplinary care teams with nursing and medical colleagues to support clients to improve their health, wellbeing and independence. Importantly, our allied health practitioners work mostly in people's own homes. It is important that they are supported to work to their highest level and broadest scope of practice due to the relative professional isolation at point of care.

The definition in the Rules of an allied health practitioner states that they an "*allied health professional* means a person who is registered under the National Law in an allied health profession". However, it is important to recognise that some allied health professions self-regulate to the same standards as the Australian Health Practitioners Regulation Agency (AHPRA). For example, practitioners offering the service items of speech pathology and dietetics and nutrition may be regulated through their professional bodies under the National Alliance of Self Regulating Health Professions scheme.

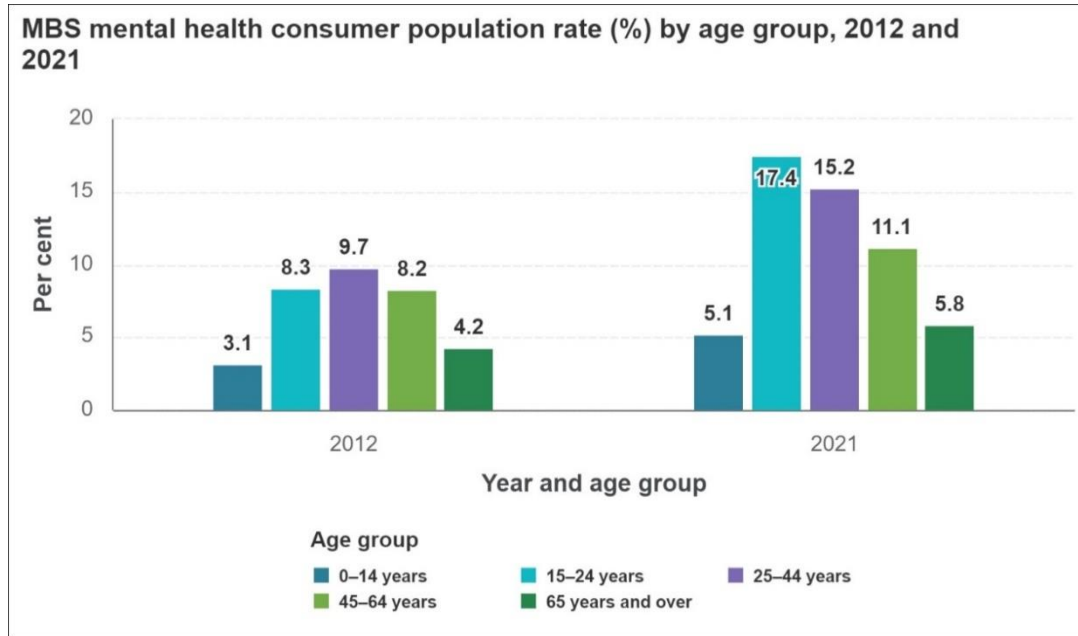
4.1 Barriers to accessing MBS CDM items

We agree with the range of allied health services listed in the Service List are those that can provide evidence-based benefits to older people. The SaH Handbook indicates that eligibility for access to these allied health services however will only be available after the individual has accessed allied health through MBS rebatable chronic disease management (CDM) or Mental Health plans. We see a number of problems with this and believe the requirement will reduce access to appropriate and beneficial services for older people living at home:

- CDM Plans offer a limit of five subsidies allied health sessions annually. Mental Health Plans offer up to ten consultations. For many older people, this number is insufficient to meet their needs to regain or remain independent.
- CDM Plans currently have limited uptake by older people living in the community. Whilst the rate of use of CDM Plans does increase with age, there remains a large proportion of older Australians who do not access allied health through their General Practice CDM Plans but who may benefit from allied health offered through SaH. For GP Mental Health Plans, we see

a reduction in update as people get older (see Figure 1) with only 6.2% to 5.8% of the population of people aged 65 accessing the rebated services[7].

Figure 1 MBS Mental health consumer population rate by age group 2012-2021. AIHW, 2024



- CDM allied health services attract a considerable client payment contribution. Private practice allied health practitioners are able to set their own fees, but often use large scale government funded service limits (such as the NDIS) as a basis for their rates as there is an opportunity cost for servicing clients outside of that funding scheme. For example, the upper limited of fees for an hour consultation with a speech pathologist through the NDIS is $193.99 (ex GST)[8] however the MBS rebate is $70.95 for the standard rebate for this item[9] - leaving the client with an out-of-pocket cost of at least $123 for the hour of care if accessing a private practice that charges at the NDIS capped rate.
- Most allied health in private practice do not do home visits.
- There are workforce shortages of almost every allied health profession in Australia. Many private allied health practices operating waiting lists. Older people can not be guaranteed to access the allied health they need under a CDM Plan within a timely manner.
- Access to CDM Plans and allied health services are dependent on the person's General Practitioner (GP) initiating the Plan. There are a range of barriers to uptake of CDM Plans by GPs[10].
- The same requirement of use of CDM items is not in place for people accessing allied health living in residential aged care homes.

Conclusion

We hope that the Department finds our feedback of assistance in refining the Draft Rules ahead of enactment. We would be pleased to provide further detail if you would find elaboration on our commentary or recommendations of value.

[7] See AIHW, 2024 Australia's health 2024: data insights: Use of Medicare services and pharmaceuticals by mental health patients in Australia over the last - Australian Institute of Health and Welfare (aihw.gov.au)
[8] See NDIS Pricing Guide 2024 NDIS Pricing Arrangements and Price Limits 2024-25 v1.3.pdf
[9] See Item 10970 | Medicare Benefits Schedule (health.gov.au)
[10] See Holden L, Williams ID, Patterson E, Smith JW, Scuffham PA, Cheung L, Chambers R, Golenko XA, Weare R. Uptake of Medicare chronic disease management incentives - a study into service providers' perspectives. Aust Fam Physician. 2012 Dec;41(12):973-7.

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