Inquiry into Rural Health Services in Tasmania

Objective: To inquire into and report on health outcomes and access to community health and hospital services for Tasmanians living in rural and remote Tasmania

Thank you for the opportunity to respond to the Inquiry into Rural Health Services in Tasmania.

Response from Discipline Leads Occupational Therapy, Tasmanian Health Service. Representing THS occupational therapy services state-wide with the exclusions of State-Wide Mental Health Services and Community Rehabilitation Unit (in the south).

Kerri Roberts, North

Christy Dorward, South

Lucie Bramich, North-West

Background Information

Occupational Therapy Services, THS

Occupational therapists (OTs) recognise that engaging in activities promotes health and well-being. Occupational therapists therefore promote health and wellbeing by enabling people to participate in everyday activities. Activities of everyday life include self-care (often referred to as activities of daily living – ADLs), work, leisure, rest, and play. Occupational Therapy provides interventions to address the person's body structures and function, modifying the activity (occupation), and/or modifying the environment.

Occupational Therapy Australia Scope of Practice Framework details the work of occupational therapists.

Occupational therapists in the Tasmanian Health Service (THS)

- Work with people directly in their homes and communities to maintain or improve their function and independence; to self-manage their own health; to assist people to remain living at home; and to prevent people from presenting to hospital.
- Improve quality of life and participation in everyday activities by working with people within the goals, contexts, and environments that are most suited to them i.e. "the most appropriate setting"
- Prepare people to leave hospital to return to their homes safely, sustainably and at optimal functional levels; and assist people's recovery or maintenance of function to enable people to stay at home, stay connected and participate in their communities.

Occupational therapists support innovative community models that provide post-acute follow up services at home, hospital avoidance services, re-enablement in the home, rehabilitation in the home, self-management strategies, complex care coordination at home, carer education/training/support and high acuity acute-on-chronic management at home.

Our HealthCare Future commits to better community care. Our response (imbedded) shows the alignment of occupational therapy services with the goals of Our Healthcare Future.

Our Healthcare Future - Occupation

The primary goal of occupational therapy is to **'enable people to participate in the activities of everyday life'** (World Federation of Occupational Therapy). Occupational therapists are well qualified to address 'a person's quality of life and participation in everyday activities' (p14 'Our Healthcare Future').

Occupational therapy provides care for patients in 'the most appropriate setting' (p17).

Best Practice

Research by Newcastle University (UK) has demonstrated that:

There is a predictable pattern to loss of function.

Instrumental ADLs indicate the first sign of functional decline. This includes daily activities such as shopping, managing stairs, and housework. Loss of independence in personal ADLs such as dressing, bathing, and toileting occurs later.

Interventions commenced in the first stages of functional decline can slow further decline in function or improve function. Hence reduce the need for support services and hospitalisation.

Interventions commenced at the later stages of functional decline are passive and compensatory – for example, provision of care to assist with showering – and do little to reduce health care costs associated with hospitalisation and support services.

Referral to occupational therapy often occurs when personal ADLs have declined (reflecting resource constraints) and the person is at high risk of falls and pressure injury. These late referrals result in a missed opportunity to reduce decline and reduce reliance on healthcare services.

There is good evidence of the cost effectiveness and value of occupational therapy in achieving better health outcomes. Difficulties in performing ADLs ('ADL disability') are independent risk factors for presentation to hospital emergency departments, admission and re-admission to hospitals, and increased morbidity and mortality.

Improving ADL abilities can decrease the risk of emergency department presentations, hospital admission, readmission, and mortality.

In a USA economic review (2016) of over 1 million cases in over 7000 hospitals, occupational therapy was the only spending category (out of 19 professional disciplines) that had a statistically significant association with lower hospital readmission rates. The researchers surmised this is because occupational therapy addresses both the clinical and social determinants of health.

For more information on occupational therapy in cost effective best practice, see Improving Lives, Saving Money

International examples of innovative approaches within communities where occupational therapy is key

1. Discharge to Assess – 'Home First' - prompt post-acute follow up in the community for recovery & transition support

   https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model

2. Integrated care systems – 7 day/week integrated multi-disciplinary community services incorporating admissions avoidance, care management and community rehabilitation services

https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf

3. Working with paramedics - Early intervention vehicles – 'EIVs' - paramedics & OTs responding to non-life-threatening calls (e.g. falls & frailty)

   https://aace.org.uk/initiatives/falls-early-intervention-vehicle-eiv/

   https://www.westsuffolkccg.nhs.uk/successful-rapid-intervention-vehicle-scheme-supports-more-than-900-patients-to-stay-at-home/

4. Functional frailty assessment services

   https://emj.bmj.com/content/37/11/714

   https://stpsupport.nice.org.uk/frailty/index.html

The Problem

There are inadequate numbers of occupational therapists in Tasmania compared with the rest of Australia. Please see our response to the *2040 Health Workforce Plan* (imbedded below)

Tasmania's Occupational Therapy headcount of professionals is 52.8 per 100,000. This is significantly lower than the national average of 73.8 per 100,000.

Health Workforce 2040_THS OT .pdf

The impact of insufficient funding includes:

- People of Tasmania have limited access to occupational therapy services
- Reduced scope of practice – services are often focused at the high point of acute care, rather than early intervention.

There is a focus on acute care and hospital beds. Whilst this work is important, we recommend an investment of additional resources to realign service delivery to enable:

- more care in the local community, in particular the home
- earlier intervention, in particular with instrumental ADLs as the precursor to functional decline
- time invested early to enable people to change their health behaviours rather than focus on the consequences of poor health behaviours

Key Discussion Points

Availability & Timeliness

We offer hub & spoke models of service delivery to regional & rural areas.

This is because it is too difficult to attract experienced occupational therapists (OTs), with small amounts of funding or FTE, to live and work outside of regional centres.

The hub and spoke model is an enabler for best practice service delivery.

There are wait lists for all community services; in some areas, the wait is up to one year.

Referrals are triaged based on clinical priority, not on geographical location. This means the people in most need get the service first. We aim to work within the clinical indicated time frames for the highest priority referrals – these tend to be based on risks such as falls, and reduced capacity for basic ADLs e.g. toileting.

There is no capacity to deliver services to regional towns on a routine or systematic basis (e.g. every week) where there is no clinical indicator to do so. This upsets some regional and rural communities who would like regular visits by OTs.

If an urgent referral is received for a regional or rural site, other less urgent referrals will also be attended to on the same day, to maximise our time in the area and reduce travel. OTs stay overnight in local communities when required.

Occupational therapy services are best delivered in the home environment.

This takes time, and results in slower "throughput" of people on our waiting lists. Many OT services are therefore reduced to single interventions only to achieve more rapid throughput.

For sustainable improvements in health and wellbeing, the focus needs to shift to enable reasonable intervention response times, acknowledging that although throughput of people is less when undertaking services in the home, there are longer term health and cost benefits.

Occupational therapists use telehealth daily to deliver services; this does not replace the necessity of undertaking visits to the home.

As most services are provided in people's homes, there is less visibility of occupational therapy in regional and rural communities. Many local service providers have little to no knowledge of our presence unless OT contacts them as part of the person's support network.

In 2019-2020, for example, 49% of all people seen by community OT in northern Tasmania lived outside of the Launceston area.

The primary reasons for referral are usually associated with ADL difficulties, home safety, functional decline and falls risk. There is so much more that OT can offer, but there are limitations on scope due to time (staff numbers). Referrals can be made by any member of the community, provided they fit the service scope.

Barriers

Inadequate baseline OT FTE in public services results in long wait lists, limited intervention time, narrow service scope and missed opportunities for sustainable health benefits

There is a lack of direct consultation and representation by THS occupational therapy in strategic directions and decisions that (should) involve occupational therapy, especially when it comes to core OT business of primary health and community care.

There is a lack of knowledge and awareness of the value and full scope of occupational therapy. For example: pain management services frequently cite the need for physiotherapy and psychology services, but don't recognise that OT is essential in making sustainable change by embedding pain management strategies into everyday life (e.g. making a bed, unpacking the groceries, carrying an infant)

Tasmania is too small to satisfactorily deliver de-centralised services.

Significant challenges are faced by OT in regional and rural areas trying to work alongside other private & NGO services with various funding sources and small FTE, geographical disparity, travel limitations and different interpretations of funding guidelines and processes.

The result is a complicated and fragmented system: books are opened then closed, providers "run out" of sessions and refer unfinished business back to public services, people are deemed too complex and referred back to public services, unrealistic expectations are set and then need to be re-dressed by public services.

Some services duplicate or are super-imposed on public OT at unnecessary cost and confusion for the consumer. We have many examples. Economies of scale could be achieved through pooled funding, which also serves to attract and support the workforce.

Barriers to integrated, seamless services across all regional and rural areas could be reduced by aligning governance of Allied Health services within the regions, thereby aligning systems and processes. Two services currently operate outside THS Allied Health governance structures: the community rehabilitation unit (CRU - south) and primary health north.

We question the value of ongoing investment in district hospitals in the status quo, or as step-down services for acute. We would like to see some or all of the facilities re-purposed, perhaps to multi-purpose day services, aged care facilities, or allied health rehabilitation hubs.

There is growing sentiment within Tasmania that allied health should work more in generalist roles. We recommend this approach be considered with caution.

Generalist roles mean that clients do not get access to the best practice service that they have a right to.

Whilst the value of generalist pathways and skill sharing is acknowledged, this also comes with complexities and risk. This risk can be reduced via hub and spoke model where the 'spoke' OT has access to 'hub' OTs with high level skills and knowledge in specific areas. For example, a generalist OT working rurally in one day may be expected to see clients at end stage neuromuscular degeneration, post orthopaedic surgery, and dementia. Each of these clients should have access to assessment and interventions that are evidence based and current.

OTs already work as generalists in many roles, especially in the community sector. This is at the expense of profession-based competencies and the capacity to stay abreast of evidence in so many areas of practice.

OTs feel that their profession specific skills can be eroded in rural practice without close links to profession specific networks and advanced training.

Skill-sharing can also be problematic; "scope creep" occurs by other professions where there is a lack of direct OT services, who are ill-equipped to understand the nuances of occupational therapy practice frameworks and the benefits of OT service provision *delivered by OTs* in our hospitals and communities.

There is suggestion that public services should employ more Allied Health Assistants in rural areas; again, this needs to be explored more fully.

The requirement that Allied Health Assistants (AHAs) report to Allied Health Professionals is not consistently understood or applied in Tasmania. Allied Health Assistants do not replace the need for Allied Health Professionals, rather, they augment Allied Health services.

It has been mooted in some Tasmanian health circles to employ AHAs without the relevant corresponding Allied Health professionals to oversee, delegate, and monitor work.

Occupational therapists are a highly skilled and cost-effective workforce operating across health and social care services. When resourced properly, occupational therapists improve lives and save money.

For more information, see Urgent-Care-report-ILSM-2015.pdf (rcot.co.uk)