

Beyond Sunbeam

- Best practice exercise for older adults
- New opportunities as the aged care system reforms

HUR Webinar November 2022
Dr Jennie Hewitt (Physiotherapist)



Outline

- Residential Aged Care Funding - ACFI - vs AN-ACC
- Barriers and facilitators as AN-ACC is rolled out
- Transitioning AH services
 - Using evidence to challenge the services funded until October 2022 and provide alternatives
 - Demonstrating how similar services could be used for other resident (not in pain)
 - Broadening allied health service provision to include the MD services recommended in the AC Royal Commission
- It's up to us AHP and peak bodies to promote best practice allied health in aged care
- DISCUSSION



The role of allied health in residential aged care under the Aged Care Funding Instrument (ACFI)

Physiotherapists/OT/EP were funded to perform the following:

- Initial assessments
- Manual handling directives (mobility and transfers)
- Delivery of funded interventions
- Scheduled reviews
- Falls prevention/ reviews



ACFI - funded AH interventions

- pain management



▶ Physio/EP/OT

▶ Massage or TENS (EPA) for pain relief:

▶ CHC4a = 20 mins/ week

▶ CHC4b = 4 x 20 mins/ week

ACFI vs AN-ACC

ACFI:

There was no direct funding for contemporary pain management, falls prevention, restorative care or rehabilitation

Interventions funded under CHC4a and 4b are not evidence based for pain management, there is no other setting that advocates Passive therapies or 4 x per week Rx for life.....

AN-ACC:

Allied Health have an opportunity to deliver person centered, goal orientated, best practice clinical care and finally utilize their expertise.

Australian National Aged Care Classification (AN-ACC)

Commenced October 1, 2022

AN-ACC key elements

There are 3 main elements under the AN-ACC funding model:

1. resident assessments will be completed by an independent [AN-ACC assessor](#) instead of residential aged care workers
2. the AN-ACC subsidy paid to providers has 3 components – fixed, variable, and a one-off entry payment. The characteristics of a residential aged care home, such as location or specialisation, determines a fixed amount of funding, and the variable funding component is determined by an independent assessment of a resident's care needs
3. annual pricing and model review, informed by independent analysis from the [Independent Health and Aged Care Pricing Authority](#) (IHACPA) based on costing studies and other available aged care sector data.

Increased funding - reduced administration, no prescribed AH services.....

AN-ACC funding results

- The average funding per bed day is expected to be approximately \$225* compared to an expected 2021–22 average funding per bed day under ACFI (including viability and homeless supplements) of approximately \$192.
- Under AN-ACC, more equitable care funding is provided to regional, remote, First Nations and homeless facilities recognising their additional care costs (on average):
 - Standard (MMM 5): \$233* under AN-ACC compared to \$182 under ACFI
 - Standard (MMM 6 and 7): \$290* under AN-ACC compared to \$207 under ACFI
 - Specialised Homeless: \$303* under AN-ACC compared to \$227 under ACFI.

* This figure is based on analysis of facilities that have had their shadow assessments completed. It is also representative of shadow assessment data up to 18 March 2022 and may change as further assessments are completed.

AN-ACC compared to ACFI funding



ACCPA
NATIONAL
CONFERENCE

12-14 October 2022
Adelaide Convention Centre

Aged & Community Care Providers Association

IT'S UP
TO US!

Why are we not yet dancing in the streets?



Care minutes - an ACRC recommendation

What are the care minute targets?

Consistent with the Royal Commission recommendations, from 1 October 2023, the initial care minute requirements will be set at a sector wide average of 200 minutes per day, including a minimum of 40 minutes of registered time. This will be based on care provided by registered nurses, enrolled nurses and personal care workers. Funding will be provided from 1 October 2022 (the commencement of AN-ACC) in recognition that it may take some time for providers to attract and retain staff.

The Government's policy is that, from 1 October 2024, the care minute requirements will increase to a sector wide average of 215 minutes per day, including a minimum of 44 minutes of registered nurse time.

- AN-ACC does not mandate or regulate allied health services
- Aged care providers can choose how they spend their daily rates
- Most are currently struggling to meet mandated minutes for RNs and Care Service Workers
- Without rules around AH some providers are ceasing AH interventions and shifting to AHA instead



Best practice allied health:

Targeted exercise is the **most evidence-based** allied health intervention for:

- ✓ Chronic Pain (with education and reassurance)
- ✓ Frailty (with adequate nutrition)
- ✓ Hip and Knee OA
- ✓ Bone health
- ✓ Falls prevention
- ✓ Restorative care and reablement
- ✓ Neurological conditions



How does AN-ACC improve access to allied health services and what incentives are there for providers to invest in allied health services?

The AN-ACC care funding model removes the incentives within the ACFI to deliver specific allied health treatments, such as massages for pain management, that may not necessarily be the most clinically appropriate or effective for a resident. AN-ACC does not link specific treatments to funding. It allows residential aged care facilities and allied health professionals to provide the treatments that are most beneficial to the resident consistent with their individual care plan (for example, treating pain through a rehabilitation program which may include exercises).

The AN-ACC funding model is underpinned by an explicit incentive for high quality care with a focus on restorative care and reablement. Consistent with Royal Commission recommendations, if the capability of a resident improves, there is no requirement for reassessment and potential reassignment to a lower payment class.

<https://www.health.gov.au/sites/default/files/documents/2022/10/how-allied-health-care-is-supported-under-an-acc-what-impact-will-an-acc-have-on-allied-health-services.pdf>

Allied health professionals play an important part in the restorative care of senior Australians.

Providers are required under legislation to make available allied health services to residents who need them



Implementing evidence based allied health in the aged care setting.

An example:

The Sunbeam Trial demonstrated that evidence-based exercise in residential aged care works:

- ✓ for falls prevention (55% reduction in falls rate)
- ✓ restoration and reablement (increase in physical performance $P = 0.019$)
- ✓ for people with a CI (50% reduction in falls rate for those with moderate CI)
- ✓ is cost effective (\$463 per person for the 6-month group program)

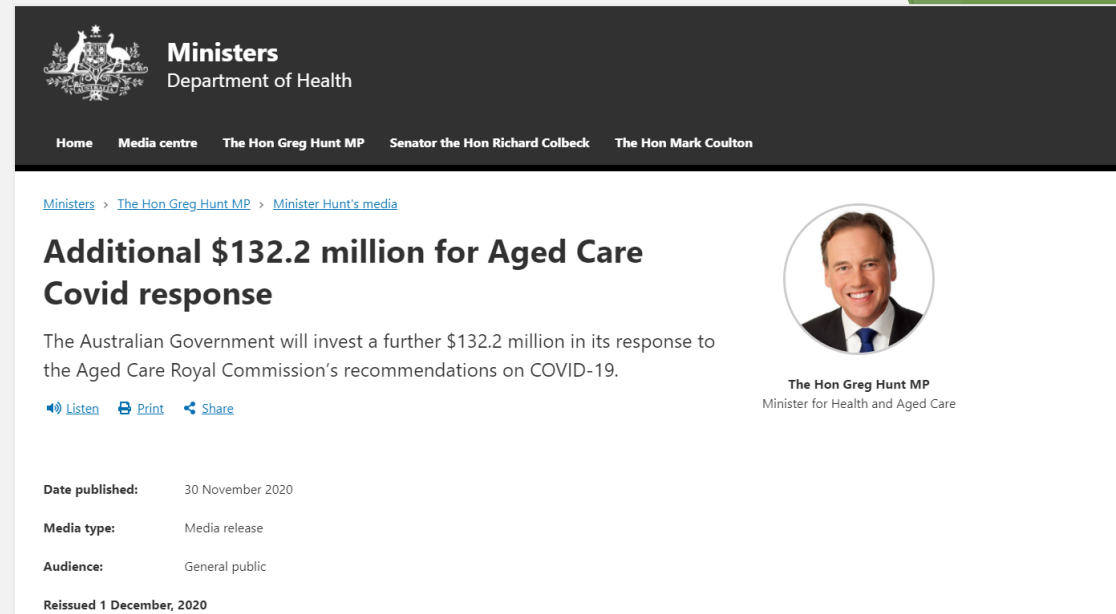
These are all key recommendations from the Australian Aged Care Royal Commission



How has this study been used?

2021/22

- AH Group therapy program
- Sunbeam Protocol with or without gym
- 1:4 AHP:residents
- 6 months
- Evaluation underway now



Ministers
Department of Health

Home Media centre The Hon Greg Hunt MP Senator the Hon Richard Colbeck The Hon Mark Coulton

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Additional \$132.2 million for Aged Care Covid response

The Australian Government will invest a further \$132.2 million in its response to the Aged Care Royal Commission's recommendations on COVID-19.

[Listen](#) [Print](#) [Share](#)

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Reissued 1 December, 2020

The Hon Greg Hunt MP
Minister for Health and Aged Care



Allied health professional instructional video for group therapy in Residential Aged Care Facilities | Australian Government Department of Health

Introduction. Hi, I'm Jennie Hewitt, physiotherapist, Member of the Australian Physiotherapy Association and one of the authors of the Sunbeam Program – a successful exercise program that resulted in increased physical performance and reduced falls in residents of aged care.

www.health.gov.au

Evidence for targeted exercise versus passive treatments for older adults

AMERICAN COLLEGE OF RHEUMATOLOGY
Empowering Rheumatology Professionals

Arthritis & Rheumatology
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DOI: 10.1093/rh/rkz412
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2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee

Sharon L. Kolasinski,¹ Tuhina Neogi,² Marc C. Hochberg,³ Carol Oatis,⁴ Gordon Guyatt,⁵ Joel Block,⁶ Leigh Callahan,⁷ Cindy Copenhaver,⁸ Carole Dodge,⁹ David Felson,² Kathleen Gellier,¹⁰ William F. Harvey,¹¹ Gillian Hawker,¹² Edward Herzog,¹³ C. Kent Kwok,¹⁴ Amanda E. Nelson,¹⁵ Jonathan Samuels,¹⁶ Carla Scanzello,¹⁷ Daniel White,¹⁸ Barton Wise,¹⁹ Roy D. Altman,¹⁴ Dana DiRenzo,¹⁴ Joann Fontanarosa,²⁰ Gina Girard,²⁰ Mariko Ishimori,²¹ Devyani Misra,²² Amit Aakash Shah,²² Anna K. Shmagel,²³ Louise M. Thoma,² Marat Turgunbaev,²² Amy S. Turner,²² and James Reston²³

Guidelines and recommendations developed and/or endorsed by the American College of Rheumatology (ACR) are intended to provide guidance for patterns of practice and not to dictate the care of a particular patient. The ACR considers adherence to the recommendations within this guideline to be voluntary, with the ultimate determination regarding their application to be made by the clinician in light of each patient's individual circumstances. Guidelines and recommendations are intended to promote beneficial or desirable outcomes, but cannot guarantee any specific outcome. Guidelines and recommendations developed and endorsed by the ACR are subject to periodic revision, as warranted by the evolution of medical knowledge, technology, and practice. ACR recommendations are not intended to dictate payment or insurance decisions. These recommendations cannot adequately convey all uncertainties and nuances of patient care.

The American College of Rheumatology is an independent, professional, medical and scientific society that does not guarantee, warrant, or endorse any commercial product or service.

Objective. To develop an evidence-based guideline for the comprehensive management of osteoarthritis (OA) as a collaboration between the American College of Rheumatology (ACR) and the Arthritis Foundation, updating the 2012 ACR recommendations for the management of hand, hip, and knee OA.

Methods. We identified clinically relevant population, intervention, comparator, outcomes questions and critical outcomes in OA. A Literature Review Team performed a systematic literature review to summarize evidence supporting the benefits and harms of available educational, behavioral, psychosocial, physical, mind-body, and pharmacologic therapies for OA. Grading of Recommendations Assessment, Development and Evaluation methodology was used to rate the quality of the evidence. A Voting Panel, including rheumatologists, an internist, physical and occupational therapists, and patients, achieved consensus on the recommendations.

Results. Based on the available evidence, either strong or conditional recommendations were made for or against the approaches evaluated. Strong recommendations were made for exercise, weight loss in patients with knee and/or hip OA who are overweight or obese, self-efficacy and self-management programs, tai chi, cane use, hand orthoses for first carpometacarpal (CMC) joint OA, tibiofemoral bracing for tibiofemoral knee OA, topical nonsteroidal antiinflammatory drugs (NSAIDs) for knee OA, oral NSAIDs, and intraarticular glucocorticoid injections for knee OA. Conditional recommendations were made for balance exercises, yoga, cognitive behavioral therapy, kinesiotaping for first CMC OA, orthoses for hand joints other than the first CMC joint, patellofemoral bracing for patellofemoral knee OA, acupuncture, thermal modalities, radiofrequency ablation for knee OA, topical NSAIDs, intraarticular steroid injections and chondroitin sulfate for hand OA, topical capsaicin for knee OA, acetaminophen, duloxetine, and tramadol.

Conclusion. This guideline provides direction for clinicians and patients making treatment decisions for the management of OA. Clinicians and patients should engage in shared decision-making that accounts for patients' values, preferences, and comorbidities. These recommendations should not be used to limit or deny access to therapies.

thebmj

BMJ 2015;350:h532 doi: 10.1136/bmj.h532 (Published 12 February 2015)

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CLINICAL REVIEW

Management of chronic pain in older adults

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Chronic pain is one of the most common conditions encountered by healthcare professionals, particularly among older (≥65 years) patients.¹ Pain is associated with substantial disability from reduced mobility, avoidance of activity, falls, depression and anxiety, sleep impairment, and isolation.^{2,3} Its negative effects extend beyond the patient, to disrupt both family and social relationships. Chronic pain poses a significant economic burden on society. Prevalence rates for pain are expected to increase as populations continue to age—by 2035 an estimated one quarter of the population in the European Union will be 65 or older—thereby increasing the public health impact of pain. Healthcare providers, irrespective of specialty, should develop competencies to assess and manage chronic pain in their older patients. In this review we summarize recent evidence on the assessment and management of pain in older patients. Evidence is taken from systematic reviews, meta-analyses, individual trials, and clinical guidelines.

What is chronic pain and how is it caused?

Although no universally accepted definition exists for chronic pain, it is often defined as pain that persists beyond the expected time of healing (typically 12 weeks) and may or may not be associated with an identifiable cause or actual tissue damage.^{4,5} Musculoskeletal disorders are common in later life, and increasingly common are painful neuropathies from diabetes, herpes zoster, chemotherapy, and surgery. Other types of pain are also prevalent among older adults, including pain due to cancer as well as cancer treatments.^{6,7} Pain is also common in the advanced stages of many chronic diseases, including congestive heart failure, end stage renal disease, and chronic obstructive pulmonary disease.⁸ Furthermore, millions of joint repair and replacement surgeries are performed annually, and an important minority of patients undergoing these procedures report chronic pain despite surgery.⁹ Finally, vertebral compression fractures are highly prevalent and cause substantial pain and discomfort, particularly among older women.¹⁰ Box 1 lists other common diseases where pain is a major symptom.

Who gets it?

Chronic pain in later life is a worldwide problem nationwide survey of older adults (n=7601) in the US.¹¹ 52.8% reported experiencing bothersome pain in 1 month.¹² Similar findings have been reported in a study conducted in Europe, Asia, and Australia.¹³⁻¹⁵ Risk factors for chronic pain include advancing age, female sex, lower socioeconomic educational level, obesity, tobacco use, history of 1 of a physically strenuous job, childhood trauma, or anxiety.

Factors predicting poor outcomes (that is, higher disability, depression) among people with chronic pain include higher levels of pain severity and disability, long pain history, multiple pain sites, history of anxiety or depression, maladaptive coping strategies (for example, worry and low social support) at the time of diagnosis. In older adults (n=40) with musculoskeletal pain, the assessed at the initial clinical encounter—degree of pain from pain, pain in multiple body sites, and duration of pain—predicted lack of patient improvement at 6 months.¹⁶ General practitioners predict this outcome judgment alone.¹⁷ Simple risk stratification approaches could help to tailor care.

How are older patients with chronic pain assessed?

A comprehensive pain assessment can increase the likelihood of identifying a specific diagnosis for the pain. It is important to consider the patient's history, physical examination, and laboratory tests to identify the cause of the pain. The assessment should include a history of the pain, its location, its intensity, its duration, and its impact on the patient's life. The assessment should also include a physical examination, including a detailed history of the pain, its location, its intensity, its duration, and its impact on the patient's life. The assessment should also include a physical examination, including a detailed history of the pain, its location, its intensity, its duration, and its impact on the patient's life.

Consensus statement

2018 Consensus statement on exercise therapy and physical interventions (orthoses, taping and manual therapy) to treat patellofemoral pain: recommendations from the 5th International Patellofemoral Pain Research Retreat, Gold Coast, Australia, 2017

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ABSTRACT

Patellofemoral pain affects a large proportion of the population, from adolescents to older adults, and carries a substantial personal and societal burden. An international group of scientists and clinicians meets biennially at the International Patellofemoral Research Retreat to share research findings related to patellofemoral pain conditions and develop consensus statements using best practice methods. This consensus statement, from the 5th International Patellofemoral Research Retreat held in Australia in July 2017, focuses on exercise therapy and physical interventions (eg, orthoses, taping and manual therapy) for patellofemoral pain. Literature searches were conducted to identify new systematic reviews and randomised controlled trials (RCTs) published since the 2016 Consensus Statement. The methodological quality of included systematic reviews and RCTs was graded using AMSTAR and PEDro, respectively. Evidence-based statements were developed from included papers and presented to a panel of 41 patellofemoral pain experts for consensus discussion and voting. Recommendations from the expert panel support the use of exercise therapy (especially the combination of hip-focused and knee-focused exercises), combined interventions and foot orthoses to improve pain and/or function in people with patellofemoral pain. The use of patellofemoral, knee or lumbar mobilisations in isolation, or electrophysical agents, is not recommended. There is uncertainty regarding the use of patellar taping/bracing, acupuncture/dry needling, manual soft tissue techniques, blood flow restriction training and gait retraining in patients with patellofemoral pain. In 2017, we launched the International Patellofemoral Research Network (iPFNRN) to consolidate and grow our patellofemoral research community,

INTRODUCTION

Patellofemoral pain is a common, chronic musculoskeletal condition, presenting as pain around or behind the patella during patellofemoral joint loading activities (eg, squatting, stair ambulation and running).¹ Patellofemoral pain has an annual prevalence of approximately 23% of adults and 29% of adolescents in the general population and affects almost 36% of professional cyclists.² Patellofemoral pain tends to persist in about 50% of people,^{3,4} in some cases for up to 20 years.⁵ Pain and symptoms associated with patellofemoral pain limit participation in daily and occupational tasks and reduce levels of physical activity.^{6,7} Importantly, patellofemoral pain may precede the onset of patellofemoral osteoarthritis,^{8,9} which has no cure.

International Patellofemoral Research Retreat

Every 2 years, scientists and clinicians who are active researchers in the field of patellofemoral pain meet at the International Patellofemoral Research Retreat. The aims of the Retreat are to: (1) share the latest patellofemoral pain research developments; (2) discuss the literature to formulate consensus statements to disseminate knowledge; and (3) develop a future research agenda for patellofemoral pain. The 6th International Patellofemoral Research Retreat will be held in Milwaukee, Wisconsin, USA, in October 2019.

In 2017, the International Patellofemoral Research Network (iPFNRN) was launched, bringing together past and present Retreat participants into a cohesive, collaborative network of patellofemoral pain researchers from around the world. We also launched the iPFNRN website (www.ipfmrn.org), a platform to share news on upcoming Retreats, recruit new members to the research community,



Physical Activity for Pain Prevention

Pain, especially chronic pain, remains an important medical and socioeconomic problem affecting populations from childhood to the elderly and is responsible for a significant proportion of healthcare resource utilization worldwide [9,15,16,19]. Chronic musculoskeletal pain conditions such as low back and neck pain are the most prevalent and the most costly in terms of daily and work related disability [4,15].

literature provides robust evidence that, in general populations, physical activity and exercises have id economic as well as health benefits due to their impact on the musculoskeletal, cardiovascular, central nervous system [7,22]. Conversely, insufficient physical activity is detrimental to health and been identified as a risk factor for noncommunicable diseases (including chronic pain) [20] and the leading risk factor for global mortality [8,14]. Although physical inactivity was initially considered a characteristic of older populations, it is common in all ages [10].

Physical activity has been defined by the World Health Organization (WHO) as “any bodily movement fueled by skeletal muscles that requires energy expenditure” [26]. Exercise is defined as “planned, structured, and repetitive bodily movements that are performed to improve or maintain one or more aspects of physical fitness” [26]. Multiple guidelines advocate physical activity and exercise as active treatment interventions to reduce pain and fatigue, and improve patients’ function in a wide range of chronic pain conditions including chronic neck pain, osteoarthritis, headache, fibromyalgia, chronic low back pain [13]. Regular physical activity and exercise may help in the prevention of pain. A recent systematic review found moderate-quality evidence supporting the effectiveness of an exercise program for reducing the risk of a new episode of neck pain [5]. There is also evidence that exercise (combined with education) reduces the risk of an episode of low back pain [25]. Indeed, patients with acute or sub-acute pain might be an important target group for intervention aiming to prevent a large individual and economic impact.

healthcare providers, recommending physical activity is known to reduce pain intensity and disability as well as provide a range of other benefits including improvements in strength, flexibility, and mood [18]. Physical activities and exercises may also be considered as a valuable mental health promotion strategy in reducing the risk of developing mental health disorders, which are frequently associated to chronic pain [2,6,21].

when prescribing physical activity health care providers should [3,7,24]:

Copyright 2020 International Association for the Study of Pain. All rights reserved. brings together scientists, clinicians, healthcare providers, and policymakers to unite and support the study of pain and translate that knowledge into improved relief worldwide.



There is strong level 1 evidence for targeted exercise for rehabilitation, re-ablement and falls prevention in older age



Sherrington et al. *International Journal of Behavioral Nutrition and Physical Activity* (2020) 17:144
<https://doi.org/10.1186/s12966-020-01041-3>

International Journal of Behavioral
Nutrition and Physical Activity

REVIEW

Open Access



Evidence on physical activity and falls prevention for people aged 65+ years: systematic review to inform the WHO guidelines on physical activity and sedentary behaviour

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World Health Organization 2020 guidelines on physical activity and sedentary behaviour

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ABSTRACT

Objectives To describe new WHO 2020 guidelines on physical activity and sedentary behaviour.

Methods The guidelines were developed in accordance with WHO protocols. An expert Guideline Development Group reviewed evidence to assess associations between physical activity and sedentary behaviour for an agreed set of health outcomes and population groups. The assessment used and systematically updated recent relevant systematic reviews; new primary reviews addressed additional health outcomes or

INTRODUCTION

In 2018, the World Health Assembly (WHA) approved a new *Global Action Plan on Physical Activity (GAPPA) 2018–2030* and adopted a new voluntary global target to reduce global levels of physical inactivity in adults and adolescents by 15% by 2030. As part of the WHA Resolution (WHA71.6), Member States requested that WHO update the 2010 Global Recommendations on Physical Activity for Health.²

Global and national guidelines on physical



Key messages - best practice exercise for MSK pain management

Exercise and exercise therapies, regardless of their form, are recommended in the management of patients with chronic pain.

The following approaches should be used to improve adherence to exercise:

- **supervised exercise sessions**
- **individualised exercises in group settings**
- **addition of supplementary material**
- **provision of a combined group and home exercise programme.**



Scottish Intercollegiate Guidelines Network (SIGN). Management of chronic pain. Edinburgh: SIGN; 2013. (SIGN publication no. 136). [December 2013, 2019]. Available from URL: <http://www.sign.ac.uk>

Transitioning to a new model

- ▶ **Recommendation: Step 1** - Redesign the approach for those already receiving AH and deemed as requiring pain management

Offer evidence based **exercise focussed pain management*** for those in chronic pain, 1:1, 1:2 or small groups

***Individually prescribed by an AHP using best practice recommendations and taking diagnoses, co-morbidities and goals into consideration**



Transitioning to the new model

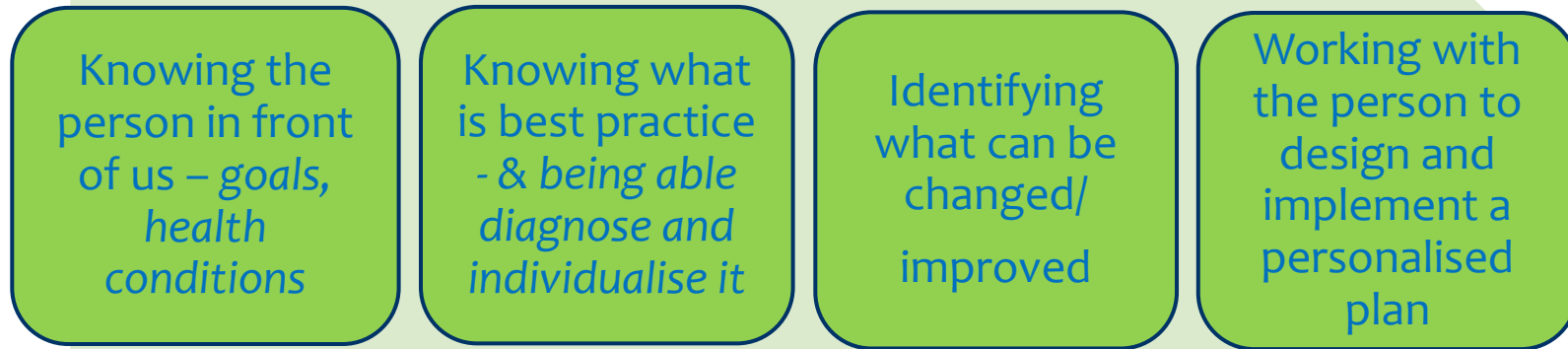
Under ACFI only those with chronic pain were offered Allied Health

- ▶ **STEP 2** - Offer evidence based AH services using the skill set of existing AH staff to those previously ineligible for AH services
- ▶ Recommendation:
- ▶ Offer evidence based* restoration, reablement, rehabilitation for those without pain too

***Individually prescribed by an AHP using best practice recommendations and taking diagnoses, co-morbidities and goals into consideration**



Confidently prescribing best practice exercise starts here:



Exercise is like medicine.....

Type

Dosage

Frequency



all matter...

and will vary according to diagnoses, co-morbidities and goals

Effective exercise is:




- Prescribed using scientific principles matched to diagnoses and accommodating co-morbidities
- Specifically targeted to address impairments
- Individualised
- Progressive
- Performed at a moderate to hard intensity to achieve outcomes
- Safer and more effective when supervised by allied health professionals
- Adherence increases with group classes with a social component, ease of access and morning timeslots

Getting the prescription right for: falls prevention in RACF:

TYPE: High challenge balance & PRT if deconditioned

DOSE: 2-3 sets, 10 – 15 reps
RPE 12 – 14

FREQ: 2 hours per week for 6 months
then maintenance



6		
7	Very, very light	How you feel when lying in bed or sitting in a chair relaxed. Little or no effort.
8		
9	Very light	
10		Target range: How you should feel with exercise or activity.
11	Fairly light	
12		
13	Somewhat hard	
14		
15	Hard	
16		How you felt with the hardest work you have ever done. Don't work this hard!
17	Very hard	
18	Very, very hard	
19	Very, very hard	
20	Maximum exertion	



Getting the prescription right for: frailty:

TYPE: Progressive resistance training
and/or power training

DOSE: 2-3 sets, 8-10 reps
80% of 1 RM or RPE 15-18

FREQ: 2-3 x weekly



BORG SCALE OF PERCEIVED EXERTION

Borg G. Psychophysical bases of perceived exertion. Med Sci Sports Exerc. 1982; 14:377-381.

6		How you feel when lying in bed or sitting in a chair relaxed. Little or no effort.
7	Very, very light	
8		
9	Very light	Target range: How you should feel with exercise or activity.
10		
11	Fairly light	
12		
13	Somewhat hard	
14		How you felt with the hardest work you have ever done.
15	Hard	
16		
17	Very hard	
18		Don't work this hard!
19	Very, very hard	
20	Maximum exertion	

<https://aci.health.nsw.gov.au/projects/resistance-training/guide-for-physiotherapists-and-exercise-physiologists>

Combine exercises for best outcomes

People living with frailty often have concurrent deficits in balance or endurance. Exercise addressing these areas is often indicated in this population but will not result in the strength gains achieved with resistance training, so should be used in combination with resistance training and not as a substitute.

Progressive resistance training for people living with frailty



Proven to be safe and effective in hospital, community and residential care settings.



Supervised programs achieve better outcomes.



Machines, free weights, bodyweight and isometric exercise are all effective if at appropriate intensity.



Gains made from resistance training are not maintained once training stops, therefore people living with frailty and sarcopenia should be encouraged to permanently incorporate resistance training into their lives.



Getting the prescription right and scaling:

EG: Set up a circuit - AHP Prescribed 1:1 dosage, in a group setting



EG: 1:1 AHP Prescribed exercise - in a group environment



Real life example - changing lives



Transitioning to the new model

Under ACFI only those with chronic pain were offered Allied Health

- ▶ **Recommended STEP 3** - Extend AH services to include those disciplines not usually included in RAC but recommended by the ACRC

Recommendation 38: Residential aged care to include allied health care

To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the System Governor should, by no later than 1 July 2024:

- a. require providers to have arrangements with allied health professionals to provide services to people receiving care as required by their assessment or care plan

Commissioner Pagone

- b. require approved providers to:

- i. employ, or otherwise retain, at least one of each of the following allied health professionals: an oral health practitioner, a mental health practitioner, a podiatrist, a physiotherapist, an occupational therapist, a pharmacist, a speech pathologist, a dietitian, an exercise physiologist, and a music or art therapist

Commissioner Briggs

- ii. have arrangements with optometrists and audiologists to provide services as required to people receiving care

► Current Challenges

- Reduction in hours for allied health staff during the transition from ACFI to AN-ACC
- Residents who are used to massage may not consent to change
- Culture change in facilities - families/colleagues beliefs about older age and pain
- AH workforce confidence in these methods after 15 years of ACFI



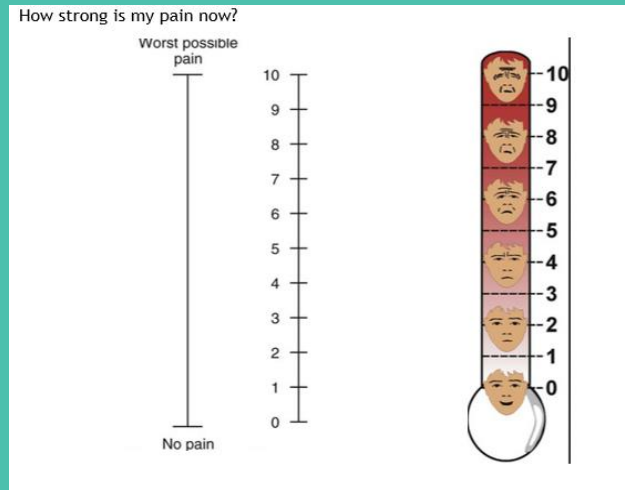
Eg; Whiddon Group exercise

- * **CHC4b** Individually assessed and prescribed exercises 1:1 by allied health professional
- * Exercise dosage tailored to residents' diagnoses & comorbidities & goals
- * Option to start exercises 1:1 then progress to small groups ≤ 6 2 x weekly



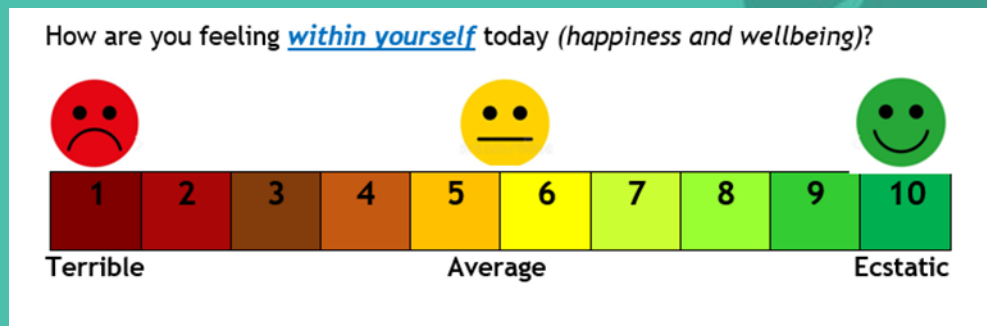
Pilot outcomes (28 residents):

1. PAIN



Mean PAIN (0-10 VAS)	Baseline	Follow up
RACF 1	2	0.75
RACF 2	2.5	0.3
RACF 3	5.6	3.2

2. GENERAL WELLBEING



Mean MOOD (0-10)	Baseline	Follow up
RACF 1	6	8
RACF 2	5	8
RACF 3	6	6

Whiddon Case Study

BILL (name changed)

- He used to have bad pain on waking every day in his neck and shoulders
- He had poor balance and was a frequent faller
- He saw results quite quickly - after only 6 weeks
- His balance is much better and he is very stable when he walks
- He has no more pain! And is determined to continue

“This program makes me think about what would have happened if I could have had it earlier. I would be much more mobile and pain free”



Potential enablers as aged care system reforms

1. New Quality Standards

Where funding allocation is unclear - ACQ&SC is very clear

New Standard 1-

ADL - % of care recipients who experience a decline in ADLs

2. ?Recommendations from DOH Allied Health Group Therapy Program



← Problems

Solutions →

Enablers

Sunbeam and Beyond - Practical Workshops for AHP

- * 4-hour interactive workshops, designed and facilitated by Dr Jennie Hewitt
- * Assessment and prescription of exercise for:
 - * Falls Prevention
 - * Pain Management
 - * Multi-morbidities
 - * Frailty
 - * Improving bone health
- * Practice running group and individual exercises using HUR Equipment and portable resistance bands and free weights.
- * Principles taught are transferrable across different aged care settings



AH Exercise4life-Sunbeam & Beyond

WORKSHOP 1 Melbourne

When: Saturday December 3rd, 2022

0900-1300

Where: Europa on Alma, Bolton Clarke St Kilda.

More information: email jennie-hewitt@bigpond.com

Tickets: \$235 available at

<https://www.eventbrite.com/e/exercise4life-sunbeam-and-beyond-tickets-444942112837>

DISCUSSION

2023 Workshops

Sydney February 4th, 2023

Brisbane February 25th, 2023

Perth March 3rd, 2023 TBC

Adelaide TBC

Expressions of interest - email:

jennie-hewitt@bigpond.com or tuire@huraustralia.com.au

