Submission template

Discussion paper:

Future reform – an integrated care at home program to support older Australians

Submissions close on 21 August 2017

Instructions:

- Save a copy of this template to your computer.
- It is recommended that you read the relevant pages in the discussion paper prior to responding.
- You do not need to respond to all of the questions posed in the discussion paper.
- The numbering of the questions in the template corresponds to the numbering in the discussion paper.
- Please keep your answers concise and relevant to the topic being addressed.
- Upload your completed submission on the Consultation Hub. Alternatively, if you are experiencing difficulties uploading, you can email your submission to: agedcarereformenquiries@health.gov.au

Thank you for your interest in participating in our consultation.

Tell us about you

What is your full name?

First name   Debra

Last name   Anderson

What is your organisation's name (if applicable)?

Seniors Collaborative Action Project

What stakeholder category/categories do you most identify with?

☐ Commonwealth Home Support Program[1] service provider	☐ Peak body – consumer
☐ Home Care Package service provider	☐ Peak body – carers
☐ Flexible care provider	☐ Peak body – provider
☐ Residential aged care service provider	☐ Seniors membership association
☐ Aged care worker	☐ Professional organisation
☐ Volunteer	☐ Disability support organisation
	☐ Financial services organisation
☐ Regional Assessment Service	☐ Union
☐ Aged Care Assessment Team/Service	
	☐ Local government
☐ Consumer	☐ State government
☐ Carer or representative	☐ Federal government
☐ Advocacy organisation	
	☒ Other Sector Support & Development - Collaborative Project

Where does your organisation operate (if applicable)? Otherwise, where do you live?

☐ NSW	☒ SA
☐ ACT	☐ WA
☐ Vic	☐ NT
☐ Qld	☐ Tas
☐ Nationally	

*May we have your permission to publish parts of your response that are **not** personally identifiable?*

☒ Yes, publish all of my response

☐ No, do not publish any part of my response

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[1] Includes Home and Community Care Providers in Western Australia

Section 2. Reform context

2.3 Reforms to date

Comments

We would welcome your views and feedback on the February 2017 *(Increasing Choice)* reforms.

A survey of 100 South Australian service providers regarding Stage 1 was conducted in April-May 2017 by the SA Collaborative Projects with the following key points being raised:

Whilst the majority of respondents indicated that they understood the National Prioritisation process for Stage 1, some comments indicated that the MAC Contact Centre does not have the same level of understanding.   Also the lack of information regarding waiting times was frustrating for both service providers and consumers, and there was a perception that there are less packages being allocated in SA.

The new system has not addressed the perennial problem of a lack of level 3 and 4 packages.
"There are not enough L3 and L4 packages available so clients are forced to go to up to 4 organisations to get services under CHSP to service their needs, eg a client has personal care from Dom Care, social support from Wesley Care , cleaning from the council, respite from ECH, dementia support from AASA."

Consumer confusion regarding the assessment, approval and allocation process was cited a number of times.

"The lack of information about waiting times is creating great unrest, particularly amongst older people and their carers. The lack of transparency in the process also is frustrating. Clients new to the system do not understand why they have to wait and why they can't be told where they are on the waiting list."

Respondents indicated that they need advice from the Department of Health particularly regarding the use of CHSP as a gap filling measure. A large number of clients were being advised to utilise CHSP services in the interim period between approval and allocation of a HCP. Service providers expressed concern at the impact on the long term CHSP capacity to fill these gaps.

On a positive note, the majority of respondents indicated that their organisation has the workforce capacity and flexibility to respond to market demand.

The majority of respondents indicated that they were dissatisfied with the number of HCP referrals they had received since 27th February with a number stating *"We have yet to receive one referral"*. Again there was acknowledgement that it is *"Still early days."*

Respondents provided a range of specific examples about service providers and consumer experience with Stage 1.
A number of examples demonstrated consumer confusion regarding the process and frustration with the length of time it takes to receive a service.

"Most of our clients are now so confused about who has called them, not knowing who to contact to get services and end up just giving up and going without any services, resulting in extreme carer stress and increased vulnerability of clients that don't have carers. I have been informed by QEH of carers who are presenting to outpatients exhausted and desperate."

Ongoing issues with MAC were cited in particular regarding inconsistency with initial screening and eligibility assessment.

Again there were examples of clients using CHSP to fill gaps whilst waiting for an allocation of a package, and also in preference to accepting a Package due to the cost.

"Many clients are not taking up HCP due to confusion, being overwhelmed and financial implications, instead CHSP is being accessed because affordable, and because volunteer supported, is flexible to client need rather than imposed for specific time periods."

Refer to page 6 of the discussion paper

Section 3. What type of care at home program do we want in the future?

3.1 Policy objectives

Question
Are there any other key policy objectives that should be considered in a future care at home program?

Refer to page 9 of the discussion paper

The role of informal carers in supporting and advocating for their person, needs to be recognised in the objectives.

The objectives need to recognise the entry point of the system as being short term or 'ad hoc' type services.

These 'ad-hoc' services can be:

- *the key to extending independence*
- *easy for clients to ask for especially when accessing help for the first time*
- *provide an opportunity for re-ablement*

Section 4. Reform options

4.2 An integrated assessment model

Question
What do you believe could be done to improve the current assessment arrangements, including addressing variations or different practices between programs or care types (e.g. residential care, home care and flexible care)?

Refer to page 12 of the discussion paper

Getting the assessment process right is integral to the success of the aged care system. It is the way all service providers and carers and family members understand what supports are needed and why they

are needed. There is support from service providers in the SCAP region for a single assessment service that combines both RAS and ACAT. A single service would likely be less confusing for consumers, be faster and ensure they enter the system at the right level. A skilled assessment workforce with access to multi-disciplinary professionals is essential to effectively assess the needs of consumers and avoid multiple assessments.

This need for better training also applies to MAC call centre staff as this is where the assessment process seems to be failing as MAC staff are not trained adequately to refer appropriately to RAS or ACAT.

As a single service would require a change to the Aged Care Act, and which may or may not not be necessary depending on other reforms, there was also support for the current dual service to continue on condition that there are sufficient resources available to ensure the two services work very closely together, which currently is not the case. Another key issue that needs to be addressed is improving transparency of the ITC system as currently RAS and ACAT assessors cannot access all of the information than MAC contact staff can access which is not conducive to effective assessment or service delivery.

The assessment services under the new integrated system need to focus on quality not outputs as it currently does. Also, the fee for service arrangement currently has assessments in regional and remote areas valued at the same price as for metropolitan areas, which is unrealistic and unviable for the obvious reason that it costs more to deliver any type of service in these areas due to distances that need to be travelled.

4.3.1 New higher level home care package │ 4.3.2 Changing the current mix of home care packages

Questions
Would you support the introduction of a new higher package level or other changes to the current package levels?
If so, how might these reforms be funded within the existing aged care funding envelope?

Refer to pages 12 – 14 of the discussion paper

There is a need for a level 5 package to prevent premature entry into residential care, and to enable more Australians to achieve their wish of dying at home rather than in hospital or in a nursing home.

However, it is questionable as to whether this could be achieved within the existing aged care funding envelope as it is quite apparent that the current aged care funding formula is not effective in predicting demand for aged care services. This is evidenced by the number of consumers assessed and waiting for higher level packages, and 'topping up' lower level packages with CHSP services while they wait. When even this level of service proves inadequate, consumers are prematurely entering residential care which contradicts the objectives of the system. A re-ablement focus, particularly at entry level, will likely have some impact on this, however it will not fully address the obvious current gap between supply and demand. There needs to be an anaylsis of why this is the case. Ideally the aged care system should be funded as is the NDIS and based on assessed need and uncapped supply. If this is not possible then a more effective formula for continued growth needs to be developed.

4.4.1 Changing the current mix of individualised and block funding

Question
Which types of services might be best suited to different funding models, and why?

Refer to pages 14 – 15 of the discussion paper

Service providers in the SCAP region strongly believe there is a need for a mixed funding model for the new integrated program. The following principles would dictate if a service type is to be block funded:

- *Short term and episodic services that have a focus on re-ablement.*
- *Services with significant infrastructure and/or capital elements and costs and /or social capital value, such as home maintenance and modifications, centre based services, including overnight respite accommodation and group social support, transport and volunteer services.*
- *Pilot stages of new and innovative services (reduces financial risk for providers).*
- *Service availability in areas (rural and remote) where there is little or no competition between service providers.*
- *Service availability for people with special needs (eg CALD, LGBTIQ, homeless, mental health, disability) where there is little or no competition between service providers.*

There was also support for ongoing block funded Sector Support and Development to assist with re-positioning of the CHSP sector to compete in a market-based environment.

Individualised funding should be made available for services that are based on the assessed needs and goals of the consumer and carer and could include: nursing, personal care, domestic assistance, home maintenance, respite care, meals and allied health services.

Question
What would be the impact on consumers and providers of moving to more individualised funding?

Refer to pages 14 – 15 of the discussion paper

HCP providers report that many consumers find confusing the various elements of individualised funding, namely exit fees, admin fees, hourly rates, etc therefore an extra 'support coordination' service will need to be available.

Individuals who require more than one service type should be able to purchase their services from as many service providers as they need/choose. This could lead to the creation of new business opportunities in regions as there would be no brokerage commission applied as there currently is with HCP's where the entire value of the package goes to only one provider who has to broker to another if they don't provide that service type.

Question
Are there other ways of funding particular services or assisting consumers with lower care or support needs, e.g. a combination of individualised funding and block funding, vouchers etc.?

Refer to pages 14 – 15 of the discussion paper

There should be multiple entry points for access to services depending on the type and length of service required.

To this end, there are a number of current CHSP service types that <u>should not</u> require an assessment and should be able to be accessed directly through a service provider, with an assessment only undertaken in the future if a consumer's needs change or they require ongoing services. These include:

- *Transport*
- *Some home maintenance services, eg gutter cleaning, window cleaning, 'spring' cleaning*
- *Group social support*

These 'entry level 'ad hoc' services can be:

- *the key to extending independence*
- *easy for clients to ask for especially when accessing help for the first time*
- *provide an opportunity for re-ablement*

Many CHSP consumers access only a single service for many years, eg once a year gutter clean or a social support group. These consumers do not comprehend the need for an invasive assessment and many are likely to reject it and therefore 'go without' which could result in negative outcomes for their well-being.

In the case of group social support, contacting MAC is a barrier to participation, and in the SCAP region this has been exacerbated by a number of consumers being rejected as ineligible for social support by the MAC contact centre as this is the only service type they are seeking and they are independent in other aspects of their lives. There is ample evidence that social isolation has significant negative health impacts, particularly on older people. Therefore there should be a focus at every opportunity of the aged care system to ensure that consumers have an opportunity to be socially connected or re-connected with their community. A consumer should be able to directly approach a group social support service provider and participate without an assessment in the first instance. Once connected with a service provider, they are more likely to seek or be referred to seek other service types should they need them in the future as their needs change.

4.5.1 Refocussing assessment and referral for services

> **Questions**
> Should consumers receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed?
> If so, what considerations need to be taken into account with this approach?

Refer to page 16 of the discussion paper

Service providers in the SCAP region generally support the notion that consumers should receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed. However it also needs to be recognised that "some people will not get better" and there needs to be a way of identifying this before subjecting consumers to a program that will not achieve the desired restorative outcomes.

Question
How could a wellness and independence focus be better embedded throughout the various stages of the consumer journey (i.e. from initial contact with My Aged Care through to service delivery)?

Refer to page 16 of the discussion paper

Service providers in the SCAP region support the WA model that the assessment determines what a consumer can do rather than what they can't do. This reablement approach needs to be explained when a consumer first contacts MAC, and be reiterated by all parties so that consumers understand what they are committing themselves to when they seek subsidised support.

Once a relationship has been established with a RAS or ACAT assessor, phone or skype reviews would be possible in some cases to monitor how the plan is progressing, which would be more cost effective than a face-to-face review.

MAC call centre staff, RAS and ACAT assessors and service providers will need to receive appropriate training in this area as many service providers in the past have taken the approach of "what can we do for you?" rather than "what can you do for yourself?". Also, in the past, many consumers have developed unrealistic expectations of the services they are 'entitled' to receive as a result of inaccurate information received from the MAC call centre or RAS assessor.

Also, currently the ITC infrastructure does not have the capacity to provide all of the information that service providers need in order to deliver services that achieve a wellness and independence focus.

4.6.1 Ensuring that services are responsive to consumer needs and maximise independence

Questions
How do we ensure that funding is being used effectively to maximise a person's ability to live in the community and to delay entry to residential care for as long as possible?   For example, should funding be targeted to services or activities where there is a stronger connection with care and/or independent living? Are there examples of current services or activities that you believe should not be funded by government?

Refer to pages 16 - 17 of the discussion paper

A similar mandate as used by the NDIS, ie "the NDIS will pay for the reasonable and necessary supports that a participant needs to enjoy an ordinary life." Could be applied to aged care as "the Care at Home Program will pay for the reasonable and necessary supports that a participant needs to maintain independence as they age."

The definition of 'reasonable and necessary' should be developed in consultation with consumers and service providers.

There should be a focus on wellness. A person with good mental health will likely have better all round health.

Question
How do we maximise the flexibility of care and support so that the diverse needs of older people, including those with disability, are met?

Refer to pages 16 - 17 of the discussion paper

Service providers are funded to deliver outputs against clearly defined service types. These funded outputs may not necessarily match local consumer demand nor be relevant to a consumer's support plan.

Service providers need to have more flexibility to offer genuine choice to consumers to better meet their goals. Freeing up of CHSP service type funding restrictions will enable this.

Short term case management should be a service type that is available for CHSP consumers.

4.6.2 Accessing services under different programs

Question
Under the current program arrangements, does allowing some consumers to access both programs promote inequity, particularly if other consumers have to wait for a home care package?

Refer to page 17 of the discussion paper

When a HCP consumer also utilises CHSP they are using services that could otherwise be provided to an entry level consumer who may only need that service to maintain independence. This is inequitable as CHSP is designed for entry level needs.

If a service provider has the capacity to provide services for a HCP recipient it should only be for a short term basis.

Episodic supports should be included in the package as they are likely to be predictable.

Questions
Until an integrated care at home program is introduced, is there a need to more clearly define or limit the circumstances in which a person receiving services through a home care package can access additional support through the CHSP? If so, how might this be achieved?

Refer to page 17 of the discussion paper

The survey of 100 South Australian service providers regarding Stage 1 that was conducted in April-May 2017 by the SA Collaborative Projects found that significant proportion of respondents (70.37%) indicated that "My organisation needs more advice from DoH about the protocols for providing CHSP services to clients who are waiting for HCP's."

This demonstrates that more consultation with the sector is required to more clearly define or limit the circumstances in which a person receiving services through a home care package can access additional support through the CHSP.

4.8.1 Supporting specific population groups

> **Question**
> How can we make the care at home system work better for specific population groups, particularly those whose needs are not best met through current CDC models and administrative arrangements?

Refer to page 19 of the discussion paper

Block funded programs are likely to be the most effective way of delivering services to some population groups, eg some ATSI and CALD communities, remote communities, and people wo are homeless or at risk of homelessness.

4.8.2 Supporting informed choice for consumers who may require additional support

> **Question**
> What additional supports could be considered to ensure that people with diverse needs can access services and make informed choices and exercise control over their care?

Refer to page 19 of the discussion paper

To better support people with diverse needs, the SCAP region support ACSA's concept of providing additional supports such as:

- *Independent advocacy services*
- *Peer networks*
- *'System navigators' to support goal development and to identify suitable providers*
- *'System wranglers' to work across systems and services*
- *Short term case management should be available for CHSP consumers*

4.10 Other suggestions for reform

> **Question**
> Do you have other suggestions for care at home reform, or views on how changes might be progressively introduced or sequenced?

Refer to page 20 of the discussion paper

There needs to be more support for service providers and assessors to learn how to use the system. It has been up to providers and RAS to work it out for themselves in SA. Also any system updates have been interpreted differently by different providers. The sector in SA has used the Collaborative Projects (funded through Sector Support and Development) to facilitate information exchange and problem solving at a regional level.

Further consultation with the sector needs to be undertaken regarding sequencing. The NDIS roll out involving staged piloting and implementation appears to have been effective, especially as it has allowed for a number of changes and improvements to take place prior to full scheme roll out.

The NDIS roll out will have an impact on the aged care system. There is confusion about the Continuity of Care program amongst consumers and service providers which also needs to be considere

Section 5. Major structural reform

5.2 What would be needed to give effect to these structural reforms?

Question
Are there other structural reforms that could be pursued in the longer-term?

Refer to page 21 of the discussion paper

A single integrated system comprising Aged Care, NDIS and Carer Support working effectively with the health system.

Section 6. Broader aged care reform

6.1.1 Informal carers

Question
How might we better recognise and support informal carers of older people through future care at home reforms?

Refer to page 22 of the discussion paper

Carers have been forgotten in the current system. They need to be more of a focus in the new integrated system.

Currently a carer cannot register with MAC if they are under 65.

RAS assessors do not have the skill set to consider the role of the carer or to include the carer in the assessment process, and assessors need to give consideration to how much is expected of each carer when conducting assessments or making recommendations.

Currently there is confusion about the process for accessing emergency respite for both CHSP and HCP consumers.

Both CHSP and Home Care Packages are programs that focus on the client (>65 in need of support) and not the carer. Carers need a program that focuses on their own needs. As such, flexible respite, which is for the carer and not the client, should be taken out of CHSP and packages and put in a stand-alone Carer Support Program.

Carers should be recognised for their role in supporting or advocating for their family member or friend. There should be formal recognition of this role in the new integrated program that ensures they are able to participate in the relationship with MAC, assessments, determining level of package required, delivery decisions, etc. Decisions that will impact on the person they care for, the carer and the rest of the family.

An holistic family approach to support has been proven to have greater success then when either the client or the carer are excluded.

6.1.2 Technology and innovation

Question
How can we best encourage innovation and technology in supporting older Australians to remain living at home?

Refer to page 22 of the discussion paper

Introduce Government incentives to provide opportunities for the marketplace to respond to need.

> **Question**
> What are the existing barriers, and how could they be overcome?

Refer to page 22 of the discussion paper

Whilst a large number of older people are open to the use of information technology, many of the older cohort have not been convinced of the benefits having not experienced it in their working lives and therefore would need to be convinced otherwise through a public education campaign and increased availability and access to training at a local level. Cost would be another barrier with many unable to afford ITC devices. Whilst some could use funding from their package to cover this, it would likely be at the expense of another support or service which could be detrimental to their well-being.

6.1.3 Rural and Remote areas

> **Question**
> How can we address the unique challenges associated with service delivery in rural and remote areas?

Refer to page 22 of the discussion paper

> **Question**
> What other service delivery and funding models could we consider for providing care at home services to consumers living in rural and remote areas, including examples of innovative local community models?

Refer to page 22 of the discussion paper

The NDIS model which allows self-managed participants to purchase services from whomever they choose rather than an approved or registered provider may address this, however this model does come with risks.

Technology and Innovation has a role to play in better servicing rural and remote areas.

6.1.4 Regulation

> **Question**
> How can we further reduce regulation to allow for innovation while ensuring that essential safeguards remain in place?

Refer to page 23 of the discussion paper

Consultation with the sector required to address this

6.1.5 Aged care and health systems

> **Question**
> What are some examples of current gaps or duplication across the aged care and health systems, and how could these be addressed?

Refer to page 23 of the discussion paper

The issue of the aged care and health systems not working together needs to be addressed through a strategic review and planning process involving both sectors and supported by training and development for the existing workforce in both. It also needs to be addressed during education and training at entry level for both sectors so that new entrants to the work force understand how the sectors best work together for the benefit of consumers and to maximise resources.

Any further comments?

Other comments

Do you have any general comments or feedback?

Co-payments

Service providers in the SCAP region support the view that consumers should contribute towards the cost of a service if they can afford to.

However means testing arrangements should not be extended to entry level consumers requiring small amounts of services, as the cost of doing this would likely far outweigh the small amount of revenue that would be collected. The level of co-payment for CHSP services needs to be determined through implementation of a fair and transparent process. If fees are considered too high by consumers they will either attempt to do it themselves or go without a service to the detriment of their well-being.

Means testing for residential care and home care package recipients includes both income and assets, however in farming areas consideration needs to be given to the wider ramifications of including assets such as farms in the assessment process where they are jointly owned by a number of family members or held in trust.