EACH Package Delivery: An improved delivery model

I am writing to express my concerns and offer practical solutions with respect to the utilization of the EACH package allocated to my elderly mother. Please understand that the analytical approach taken in this letter is not reflected in my commitment to caring for my mother. I want the best possible care for her; consequently I hope sometime in the future I will be able to expand for you on the way we do things in our family, both historically and currently.

Context

- My mother will be 92 in November. She has no dementia but is ACAS assessed High Care as she is wheelchair bound and frail. She lives with my husband and I in outer metropolitan melbourne in a house we bought to accommodate her care.
- My mother is a DVA Gold Card War Widow who lived independently until early 2008. Until January 2010 we accessed home help and residential respite with DVA support.
- In January 2010 after the intervention of her wonderful neurologist and the help of a hospital social worker we were allocated an EACH package.

Concerns

Please note: I am not singling out our provider, rather the system and the application of the legislation.

- Mum was classified as high care in January 2009 at which time we were NOT fully informed about EACH packages and the way they operated.
- Having been allocated the EACH package I have serious concerns about the method of delivery of this package. Both financially and at a personal level.

Financial

- As I see it
  - Package value ($118.37/day) $43,205
  - Funds we can spend* - 75% of the Package $32,409

  *(refer CDC PACS trial information)
  - Of this $32,409 services must be accessed using an agency & rule of thumb is work is charged at 50% mark-up on the rates actually paid
  - This means in real terms of worker hourly payments we receive hours amounting to
    32409 / 2 = $16,204 of hours service
  - Simple sum 16,204 / 43,205 = 38%.

In round figures we are only receiving services to the value of 38% of the EACH package

- It also appears there is no requirement for Approved Providers to allocate the entire package value to my mother's requirements. Indeed I have been told that if someone else has higher needs, as decided by the "professionals" employed by the Approve Provider, then we should feel it is appropriate that others should receive a "top-up' from those with "lesser" needs. I find this an interesting concept when Nursing Homes who operate for profit receive all of the allocation for their High Care residents.
- Irritatingly the Provider never wants to talk about budgets and financial management of our Package but feels it is fine to ask for a co-payment on top of their 25% cut for administration, unwanted case management and a minimalist approach to the management of cost effective service delivery

Conceptual

- I have concerns about the language that is consistently used within the "Care Industry" and addressing this is very important as we are not the recipients of charity. Current practice seems to involve language that suggests clients are "disadvantaged" or "not able to manage their own affairs" rather than people who need increased services to manage an increased workload and need for 24/7 commitment.

- I am also concerned that the Approved Provider, through whom we currently must accept delivery of the package, appears not to understand that my mother's utilization of an EACH package (ie remain living in her home) is contingent my ability to sustain this level of commitment to care for her.
- I am offended with compulsory requirement of case mangers, who feel they have the right to interview my mother, for whom I hold all powers of attorney, about her care goals. DVA does not do this; they talk about service provision.
- Case managers feel that it is acceptable to audit our household (over and above OH&S issues) with respect to the care we provide. DVA did not do this and no-one audits parenting skills with respect to the receipt funding such as the baby bonus or child care funding.
- The irony is that the Providers enforced financial constraints mean mum & my major goal of 'no more residential respite' is not achievable.

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Solution

Please do not think that this solution came quickly. It took months of feeling frustrated that I could not put my finger on which bit upset us the most and also annoyed me as a tertiary qualified retired manager. Was it

- the lack of understanding that mum living at home is contingent on me being able to sustain this commitment and thus it is the carer who needs support?
- Or the total lack of information and complete reluctance to discuss this generous Package in terms of effective financial management?
- Or enforced case management that displays a lack respect and understanding of the capabilities and skills of the major stakeholders ie the primary carer and recipient of the package?

Eventually it was the lack of financial transparency that allowed me to see significant parallels with the Financial Services Industry and the current airing of public and government concerns. From this parallel and the proven effectiveness of Self Managed Superannuation Funds (SMSFs), I would like to present my straightforward solution for real Consumer Directed Care for motivated Package recipients.

THE SELF MANAGED PROVIDER (SMP)

Advantages

- requires no change in legislation,
- I believe it addresses so easily the concerns expressed by package recipients/carers and their cry for Consumer Directed Care

- **significantly increases available funding for real service delivery by a staggering 52%, that is from a current 38% to 90%**

- increases flexibility for care provision
- potentially increases reporting detail on package management to the government
- leaves open the option for those recipients who feel they need the support of larger providers with their case management services.
- Respects the skills of Package recipients and their committed carers
- These increases in real service delivery means that EACH packages can become a truly effective way of managing the elderly that would even allow primary carers to remain in the paid workforce rather than receive a carers allowance of $13,742 pa, (income & asset tested)

How does the model work?

My husband and I have a Self Managed Superannuation Fund (SMSF). We pay a specialised company to provide information and services, including set-up & statuary reporting requirements. There were original set-up costs and ongoing administration costs – but not 25%. We make our own informed decisions, have flexibility and are in control of all administration costs apart from legislated payments.
When I read the Aged Care Act I see no reason why this same model will not work for motivated carers to be SMPs (refer proposed steps Appendix 1). They will need to engage the services of a suitably specialised

business management company just as we use the suitably specialised company to help with our SMSF but likely only at a single digit % cost of the package. My current guesstimates are generous.

Gains

- Many of the advantages are described above. The new DOHA CDC models and research projects (PACS) are well-meaning but suffer from a conflict of interest by association with the current major Industry Providers. Consequently I personally am concerned in the preliminary work associated with the funding submission for these research projects. Proposed models are still full of administration fees for the Industry. My model is not one that I would expect to be put forward by the Industry Providers as they may stand to lose significant funding dollars.
- Some reverse sums using my SMP model negates the need for the current CDC model and the new "funding" packages because SMP is the real consumer model with large financial gains for the consumer and real value for the government's funding dollar.

Package of	$43,205
Overheads of	$4,448

Available funds for real services in this model 38757 / 43205 = 90%

- This model is also more easily able to accommodate adjustments associated with wage rate improvements for service providers (this is a low paid, female dominated workforce where workers are not paid penalty rates unless they work a 38 hour week)
- It also allows package recipients/primary carers to directly manage services in the home and more effectively manage worker's through real time multitasking.

Please refer to attached Appendix 2 to see the financial differences of the 3 different models as I attempt to achieve that "no more residential respite" goal for mum

1. Current CDC model via Industry Provider
2. SMP model using agency Service providers
3. True SMP model

Only the true SMP model allows mum and I to achieve our goal and still allows me the carer to achieve what the industry sees as the minimum expected accepted standard of

- 15 hours per week respite for 52-9=43 weeks
- 9 weeks of residential respite care equivalent (24 hours care equivalent)

In fact the SMP model allows more respite time to be taken as the SMP model comes in around $10,000 under the package allocation. What's more we can take this respite in whatever way we choose as we are no longer locked into the allocated "9 weeks only" of available residential respite bed allocation. The extra money may also need to be allocated to other needs such as aids or community nurses.

Where to from here?

My research model is cost effective. For our specific family a company set up as a SMP test case would contain all the experience a current Provider approval would require. I am seeking support to persue this from Government ministers. I am keen to meet with, and report to, relevant stakeholders to achieve this outcome. Apart from minor out of pocket expenses all other research costs are covered by the effective utilization of the EACH package.

I believe this is a model that will go a long way to addressing the real concerns of many packaged care recipients and their carers without compromising the quality of existing care or pressuring those who do not seek extra autonomy. I look would be keen to discuss this with the Commission at a convenient time.

Appendix 1

Proposed Steps (to be refined but with little change in concept)

1. Become informed of the Aged Care Act requirements for in-home age care provision and the requirements to be an Approved Provider for this in-home situation (much of the Act relates to Industry based residential care and its more complex requirements)
2. Set up a company with the specific purpose of providing care through a Package. This is done by employing a suitable business management company who also provide ongoing accounting reporting services.
3. Prepare documentation and reporting on the Key Personnel of the SMP company ie carers and interested parties with respect to the package recipient.
4. Make application to become an (Self Managed) Approved Provider as per the official application document
5. Once approved request that the Package be transferred to this company.

   Note: This process will need to be reviewed once the SMP system is established in the wider community. I'm sure an acceptable solution to annual package application rounds can be found
6. Once allocated the SMP either engages in-home services through agencies &/or takes out insurance and employs service providers directly.
7. Utilization of forms allows the recording of care plans and other important care related recording requirements
8. Funds are managed with accounts, wages, superannuation etc paid by the allocated SMP person (carer or one of the other directors) in a similar way to existing larger providers using the company bank account. It is worth remembering that a single package of $43,205 is not that much different in magnitude to a household budget.
9. Provide company reports and statuary reporting as required by DOHA and prepared by registered practitioners from 2 above.

Appendix 2

Model utilizes an Aim of; **9 weeks** **full 24 hrs respite in home**
43 weeks **15 hrs per week respite, 5 on weekend**

			industry provider model	**SMP using agency**	**SMP direct employed model**	
	A					
	43 weeks of 15hours per week respite			rates	time	time and 1/2
	day respite option	flat rate		$ 36.30	$ 19.00	$ 28.50
	10 hrs week	10		$ 363.00	$ 190.00	
	5 hours week end	5		$ 181.50		$ 142.50
	total day respite		as for agency	$ 544.50		$ 332.50
A	52 - 9 weeks	43 weeks	**$ 23,413.50**	**$ 23,413.50**		**$ 14,297.50**
	B					
	9 weeks of 24 hour care					
	24 hrs	24 hr rate		$ 350.00	$ 196.00	
	week	7 days	as for agency	$ 2,450.00	$ 1,372.00	
B		9 weeks	**$ 22,050.00**	**$ 22,050.00**	**$12,348.00**	
	care total costs = A + B		**$ 45,918.50**	**$ 45,463.50**	**$26,645.50**	
	less DVA @ $36x28	$ 1,008.00	$ (1,008.00)	$ (1,008.00)	$ (1,008.00)	
	co-payment fees billed to us $2,241					
	continence aids		$ 1,600.00	$ 1,600.00	$ 1,600.00	
	Overheads					
	management costs		**$ 10,796.00**			
	super payments @ 10%				$ 2,664.00	
	company costs	1			$ 320.00	form company $600 then $200pa,
	statutory audit guesstimate	2			$ 1,000.00	say over 5 yrs
	worker insurance costs	3			$ 300.00	
	secretary costs, paper, printing, phone etc	4		$ 200.00	$ 200.00	
	Total overheads for SMP				**$ 4484**	
	total cost of care		**$ 57,306.50**	**$ 46,555.50**	**$32,021.50**	

Agency ates	agency	workers paid
flat hourly	$ 36.30	$ 19.00
public holiday	$ 54.45	$ 36.00
10hr sleepover	$ 190.00	
24hr shift	$ 350.00	$ 196.00