North West Region – CACP/ EACH/D / ACAS Forum
Submission for
Productivity Commission Inquiry into Aged Care 2010

The CACP/EACH/ACAS Forum was formed to facilitate effective communication between ACAS and Commonwealth funded package providers across the Northern and Western metropolitan regions of Melbourne. The forum is convened by the North West Aged Care Assessment Service, and includes the five Aged Care Assessment Services (ACASs) across the Northern and Western metropolitan regions of Melbourne, and all service providers in these regions providing Commonwealth funded packages of care; e.g. Community Aged Care Packages (CACPs), Extended Aged Care at Home packages (EACH) and Extended Aged Care at Home packages- Dementia (EACH-D).

The forum provides these stakeholders an opportunity to meet regularly, in order to discuss issues around the effective provision of Commonwealth funded supports for older people.

The Forum group would like to make this submission to highlight the following areas:

Impact of full-cost recovery for package clients in receipt of HACC funded services:

- Delivered meal costs to clients changes from $6 -$7 per meal to up to $17 per meal – i.e. $119 for seven delivered meals per week - which is paid by the package provider once clients commence receiving packaged care. There is no alternative to the Council's Meals on Wheels if a daily fresh meal is required.

- Personal care charges (i.e. assistance with showering and dressing) for clients changes from $3.80 per hour at the HACC subsidized rate to $35 per hour ($68 per hour for weekends and public holidays) which is paid by the package provider.

- Home Care (i.e. cleaning and shopping) fees changes from $4.50 per hour to $35 per hour once on a package which is paid by the package provider.

- Care at home is the preference for most elderly people, but the funding for packaged care (CACP, EACH and EACH-D), as well as all other community based services, needs to be substantial and flexible enough to truly meet the increasing care needs for people wanting to remain living at home, and to avoid hospitalization wherever possible.

- The erosion of the purchasing power of packages over time has led to a situation where many clients are reluctant to move from HACC services. This is due to the package providers' inability to match or exceed the current service level and provide case-management within their funding restraints. From 1995 to 2005 CACP subsidy had increased by 27.2% while ordinary full-time adult earnings increased by 64.3% (ACCV CACP Issues Paper).

Considerations/Recommendations:

- Separation of case management from service provision
- Need for review of community service costs by all 3 levels of government in a joint approach to aim to address what has become an untenable situation for clients living in the community who need both services and case-management.

Inequitable access to services amongst package clients

- Planned Activity Group (PAG) – While Community Aged Care Packages clients are now able to access Planned Activity Groups at the HACC subsidized rate to stay connected with the community, a significant barrier remains for EACH and EACH-D package clients to maintain their social inclusion. The acceptance by a client of such 'high level' packages often renders the client ineligible to continue attending the group of which they are a member or be denied access to engaging in appropriate social activities in a supportive environment. The subsequent fall out is that clients who are eligible for 'high level' packages may decline or defer acceptance of a package and miss out on the suite of services that could otherwise be harnessed to assist with their care at home.

- The accessibility of diverse PAG's is fundamental in the provision of social activities to elderly Victorians. Notwithstanding, the alternative is in home respite in the client's house. This is an "eggs in one basket" for the Package Provider, lacks the social connection and diversity for the client and increases the work load whilst reducing the social support of informal carers.

- Aids & Equipment Program (A&EP) & Continence Aids Payment Scheme (CAPS) – Despite the decreased level of independence often encountered by clients receiving either a EACH or EACH-D package, they have only access to funding for a limited range of aids under A&EP and no access to CAPS funding at all. Their package funding is often spent for purchase of essential aids at the expense of provision of their care.

  EG: The new payment arrangement with CAPS (whereby the funding is deposited directly into clients' bank account) may create problems

for clients receive the actual continence aids for the instance where particular clients may prefer to spend the funding for non-continence related items or they may have difficulties in managing their own finance.

While studies have shown that appropriate modifications to a person's home environment will fundamentally increase their ability to remain living in their own home, the A&EP appears to be under funded with long waiting lists. Not having access to the right equipment or home modifications in a timely manner diminishes the capacity for the person to be supported in the community and increases the chances of the person being prematurely admitted to residential care.

- Inequitable access to community nursing services such as Royal District Nursing Service also exists for EACH and EACH-D package clients. While CACP clients are able to access nursing services at the subsidized HACC rate of $3 per visit, fees charged for EACH and EACH-D clients increases substantially to close to $100 for the hourly rate.

Considerations/Recommendations:

- Eligibility for EACH & EACH-D clients to access funding for aids via A&EP and CAPS needs to be reviewed. These clients may require the provision of a wider range of aids due to their higher care needs and are disadvantaged under the current eligibility criteria.

  EG: Payment arrangement with CAPS needs to be reviewed with the consideration of possibly returning to the former CAAS arrangement. Funding level for A&EP needs to be reviewed considering its current long waiting list.

- Eligibility for EACH & EACH-D clients to access HACC funded nursing services needs to be reviewed given the importance of nursing care for maintaining these clients at home in general.

Challenges for community package providers

- The level of support provided through a CACP is insufficient to sustain many people in the community, but these CACP clients may not have care needs at such a high level to warrant an EACH or EACH D package. The increasing care requirements of CACP clients present a challenge to CACP providers. The current three tiered system and associated guidelines restrict clients with a combination of service needs to a CACP. Improved funding of case-management at a lower entry point may avoid hospital admission, entry into permanent residential care or progression to more intensive services.

- An example of a client with history of:
    - Psychoses & depression/Mood affective disorder
    - Phobic & anxiety disorder
    - Chronic lower respiratory diseases
    - Heart disease
    - Osteoporosis
    - TIA's, Fracture tibia

  The management / support issues required for this client include transport (shopping / CADL's) / social engagement & family connectedness/ personal care, liaison with mental health outreach. Regular services include, home care, Meals on wheels, community access transport & carer assistance, support regarding medication compliance/monitoring. Direct care hours per month from services 33+ hours. Care Manager facilitation on average 2-3+ hours / week & home visit 1-2x / month. This client would not substantiate the criteria for a higher level package, but clearly the support required is way above a CACP package.

- Another category is those clients who are aged and frail who have no family or informal supports. They present with a high level of service needs, due to their social isolation, which often exceed that a CACP can provide.

- The difference between CACPs service delivery and EACH service delivery is too great with no middle ground provided. Being on a CACP can disadvantage clients who were previously able to access HACC services, and there are many examples where service provision is reduced through them being on a CACP due to the full-cost incurred for accessing HACC services. Another concern is that there is limited scope to discharge clients from packages. Clients can improve with good case management and become more stable. As their care needs may become stable and manageable with mainstream HACC services and that there is little need for case management, these client, only when they are willing to, may be discharged from packaged care back to the HACC services system following thorough discussion with the case manager. These are, however, a very small proportion of clients receiving packaged care and similar clients may otherwise remain on a package for many years with little or no requirement for case-management.

- To promote independence package providers require a more flexible process for securing packages with clients. There needs to be care plans with goals developed with the client, and where improvement is possible

the package can be ceased. Short term case-management should be a service which can be allocated to short term crisis situations.

- Generally the package numbers are insufficient with unacceptably long waiting times (up to 12 months plus in some areas in Victoria), and at the same time there is growing demand for EACH and EACH D level of support. The number of clients waitlisted on infoXchange (website for managing eWaitlist of services) for packaged care remain at a high level and, for the instances of the EACH and EACH-D packages, even exceed the number of currently allocated and operating packages in the Northern and Western Melbourne metropolitan region (Appendices 1 & 2).

  There also appears to be inequitable access to packages between different regions, e.g. generally shorter waiting time involved with packaged care in the Eastern metropolitan region than the Northern and Western region. Such long waiting lists have created immense difficulties for service providers in our region in regards to identifying the most suitable candidates for their packages program as well as an enormous administrative burden for both package providers and ACAS. The above issue is further compounded by the extra resources often spent on updating client information on the website which has proven to be a difficult process as these clients remain on the waiting list for a long time and some may fail to inform changes in their circumstances. Providers and ACAS have also met with additional financial commitments as annual subscriptions to infoXchange for utilizing this service and fee payments for functionality and system enhancements.

- Clients should contribute if they can afford to do so, however the burden of negotiating the cost directly by providers often reflects on the acceptance of a package. The concept of no financial issue limiting access to services is not routinely practiced by all services, and lack of consistency of approach to this between different package providers adds to the difficulty of addressing it.

- In regard to a client fee or contribution, affordability should drive what the client pays at all levels of care and care types. The mismatch between subsidies for HACC services and the formula for the client contribution for CACP often means the client would be disadvantaged by moving to a CACP.

Considerations/Recommendations:

- A tiered funding structure may more adequately meet the needs of the clients receiving packaged care at different levels of care needs and promotes ongoing continuity of care.

- Eligibility criteria for packages in relation to the level of care of residential aged care otherwise required by client needs to be reviewed. A person may require an intensive level of support in the community but may otherwise only qualify for low level of care in a residential setting. Criteria for funding should better address the complexity of multiple aged related disease and the psycho-social implications involved.

- The number of allocated places for packaged care needs to be reviewed with consideration for an increase in allocation. The variation of waiting time between regions also needs to be taken into consideration for the above. There ought to be additional financial support available to package providers and ACAS for acknowledging the resources they are spending for operating and maintaining the waiting list.

- The option of a means test process attended by an outside source such as Centrelink may be useful to assist determining client fees contribution.

Provision of culturally appropriate aged care services

- Case Management is an essential component in Packaged Care services (CACP, EACH & EACH-D), and it is especially important for people coming from CALD background who require a high level of assistance to understand and navigate the service system.

- Even though the value of CACP packages is diminishing, due to limited funding and various constraints, CALD clients are often willing to drop their HACC services and accept CACP since they will then have a Case Manager who supports their special needs, provides assistance to them and may either speak their language or use an interpreter for communicating with them. They are willing to drop some of the direct service hours in order to have flexible services co-ordinated by the Case Manager.

- However, currently the availability of culturally appropriate aged care services is much less than the demand. For example, in the Northern region, there are only 16 Chinese specific CACP packages, but there is a waiting list for 22 eligible clients. The waiting time is estimated to be over 2 years. A similar situation exists for Italian clients in the Northern and Western regions as the number of clients on the CACP and EACH waiting list doubles the number of packages allocated on an ongoing basis.

Considerations/Recommendations:

- Since case management service is an essential component for the CALD community, either the places of packaged care should be increased for the CALD community or local Councils may need to be provided with the resources to purchase case management service from ethno-specific service providers.

- The first option provides culturally appropriate services for CALD client which is an efficient and effective way of aged care service provision.

- The second option can be used as a transitional care arrangement, i.e. for those who are currently HACC clients and their needs may not be going up to packaged care, but would greatly benefit from case management. It also encourages continuity of care for these HACC clients as they may not have to change their direct care staff and routine of service provisions (e.g. service delivery days and payment methods, etc.) when the major scope of their needs can still be maintained in that service delivery system

Veterans and their spouses, widows and widowers

- The Department of Veterans' Affairs (DVA) appears to have the interpretation that home care and health services, including house cleaning, shopping assistance, community nursing and allied health services usually funded by DVA to eligible members within the Veterans' community, will instead be funded by the EACH or EACH-D package providers as per Schedule 2 to the EACH and EACH-D Payment Agreement once these clients commence to receive care via an EACH or EACH-D package. This limits their available choices of home support and health services and often precludes them from appropriate level of access to these services due to the funding constraint involved with service provision under EACH and EACH-D packages.

Considerations/Recommendations:

- Veterans' community clients are disadvantaged in regards to accessing normally eligible services via DVA if they are receiving care under an EACH or EACH-D package. There needs to be a review of the eligibility criteria for service provision by DVA and DoHA in a joint approach to ensure these clients have access to appropriate level of services.

Pressures on hospitals and impact on community-based services

- The significant expansion of the aged care market particularly in Community Care is incongruent with the centralized nature in the delivery of health care to older Victorians. The push to support the elderly in their own homes through the provision of Community Care Service such as Community Aged Care Packages (CACP), Extended Aged Care at Home Packages (EACH) and EACH Dementia (EACH D) has not been supported by growth or diversity of community clinical services. The pinnacle of access for older Victorians to medical services remains with in the public hospital system. This medical paradigm destabilizes the foundation of the community model particularly for older Victorians in most need of clinical support as it funnels them out of the community into a medical stream.

- The increasing prevalence of dementia and chronic illness reflect the changing face of disease among the elderly and their need for clinical services. There is an increasing demand for General Practitioners, Registered Nurses and Allied Health Professionals to provide services to the aged in the community. Waiting times to access these health professionals is also growing. Therefore, the capacity of health professionals to provide clinical services to clients in their own home is diminishing. Given the very nature of the aged person's disease such as a chronic illness or dementia and the diminishing number of informal carers to provide support, availability of treatment for the client in their own home is paramount to their ongoing health and ability to sustain living within the community.

- For many elderly Victorians access to the appropriate clinical services is an ambulance ride to the Accident & Emergency Department of their local public hospital. This of course does not guarantee assistance. Due often to the chronic nature of the elderly patients' illness, once reviewed in the Accident & Emergency Department of an acute hospital they are often sent home by taxi regardless of the time of day or night or the situation at home which lead to their presentation. Despite the possible involvement of a case manager for clients who receive packaged care, staff at the Accident & Emergency Department may not be aware of the situation and often fail to engage the case manager during the discharge process. Whilst many hospitals provide outreach programs into the community they may have restrained access due to client diagnosis and the flow on effect of limited long term social and clinical support in the community.

- The advent of a hospital admission does not necessarily provide a smooth transition to eventual discharge. Often the elderly are discharged home with out correspondence to the necessary support systems whether social or medical. This can lead to discharges where elderly patients are sent home without keys to access the house, no fresh food in the house or access to finances to purchase food items and a lack of social and medical follow up. Many older Australians struggle in such circumstances, and teeter on the brink of being funneled back into the medical system from where they came.

- The following list examples where the lack of community clinical services impacts on the aged to remain supported at home:-
    - Waiting times of up to 3 to 4 days to visit a GP where the client is known and the client history is maintained.

    - Ever reducing numbers of GPs undertaking home visits

    - Little access to sub-acute geriatric or rehabilitation wards from the community. Often elderly clients must deteriorate medically to a point where access to these wards is only possible via an acute hospital admission through the Accident and Emergency Department.

    - Nursing services require lead in times of around a week to assess a client with a further wait time to commence services

    - Lack in home physiotherapy, for assessing and treating both acute and chronic condition

    - Long waiting times of up to 3 or 4 months involved with accessing community occupational therapy for visiting clients who may require urgent environmental and functional assessment due to temporary or progressive decline in their independence

    - Elderly clients with Private Health Insurance are often left financially challenged and without an overarching management plan and facilitator when accessing rehabilitation through private hospitals and their private health fund.

- HACC Assessment Officers often pick up clients who do not qualify for transitional care or post-acute care and take on the role of ‘short term ‘case managers’ although they are not employed in a case management capacity. This places significant pressure on the HACC system and the community care sector as a whole.

Considerations/Recommendations:

- There is need for a "rapid response" approach for clients who need immediate intervention from a case-manager to address urgent needs, but who do not otherwise qualify for short-term programs such as TCP, Post Acute Care, HITH, etc. Many people are waiting for 12 months or more for a package in the northern and western metropolitan region, and this is unacceptable particularly for clients who have already been identified by ACAS as requiring packaged care.

- Better identification process of clients receiving package care and communication with case managers is required within the acute health section.

Dementia Care

- EACH Dementia packages has developed a model of care that recognizes the additional demands of a person with dementia. The inequity exists for low care clients with dementia and behaviours or impairment that requires higher level of services in the community. The anomaly of only offering high care packages for people with behavioural concerns related to dementia needs to be removed.

Considerations/Recommendations:

- Additional subsidies for assisting care needs relating to behaviours should be available across all types of packaged care by introducing a dementia care supplement for CACPs.

Mental Health

- There are increasing numbers of people being referred for packaged care who have a mental illness diagnosis or dual diagnosis of mental illness and a physical chronic disease. Older people with a mental illness are some of the most vulnerable in our society. Carers and care staff require specialist skills to manage and care for this group of people. Packages of care should be tailored to meet their needs, staffed by appropriately skilled care staff with the aim to encourage independence and quality of life.

- These clients are also generally disconnected from formal medical mental health support and they have fragmented ongoing access to mental heath support with the general option available for support being limited to Aged Psychiatric Assessment & Treatment Teams (APATT) which is limited in

access for community clients after initial assessment, and provides limited ongoing support. Increase support services should exist that provide specialised and accessible mental health support within the community to an aged population. GP management is not a satisfactory fall-back point.

Workforce Issues

- The predictions by most demographers are consistent in the need for ensuring access to appropriately skilled staff to meet demands from all areas of the aged care sector. There is a need to address workforce issues with difficulty recruiting appropriately trained direct care staff for package clients. Funding for packages does not allow for this group of vital "coal-face" workers to be paid appropriately for their important work, and therefore it is hard to attract suitable staff. It is also becoming more difficult to attract Case-Manager staff, and the high turn-over of staff and the "casualization"of the community-based workforce places additional strain on the capacity to provide continuity of care for clients. The move to national registration of professional disciplines involved in aged care is encouraging. Apart from the existing mandatory minimum qualification requirements applicable to HACC care workers, all workers in aged care should be required to meet qualification standards and requirements for professional registration.

Considerations/Recommendations:

- Ongoing education needs to be encouraged to maintain registration. Education courses and teachers need to be accredited to specified standards. Currently there is significant variation in the level required for qualification.

Indigenous Australians

- It is important to support the needs of ATSI people but at the same time ensure that through information and education there are reasonable expectations as to what support level can be provided, and for there not to be an inequitable approach to what is available to support people at home.

- Current application of existing flexible care options (packages eg. CACP) to facilitate support to indigenous clients can be successful where there are key contacts/roles to support the package facilitator and the client eg. HACC Aboriginal Liaison Officers.

- Flexibility of package provision is paramount to success, but the supports required do not generally fit the same model of support services as for generic aged care packages.

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Consumer Directed Care (CDC) Packages

- Consumer Directed Care is an important approach which promotes consumer choice but there needs to be consideration of what is considered appropriate for expenditure, and what resources and authority are available for overseeing these packages.

- Working differently with Brokerage Agencies - clients are more likely to not use a set roster for accessing services from agencies, but want to request services only as needed. This will increase the strain on the agencies and may lead to increase in fees. Agencies will require training to address the changes.

- Increase in time spent by case manager in relation to putting used hours on diaries when rostered hours changes weekly instead of decreasing case management time.

- Clients choosing to employ their own staff will require training around recruitment issues such as Work Cover and Superannuation.

- Supports need to be put in place to support those carers directly employed by clients to prevent exploitation.

- As there has been no need for Case Managers to agree to services and discuss the Care Plan, there is little to encourage clients and family carers to make themselves available for Case Managers to visit. Some clients and family carers may have the impression of the Case Managers 'checking up' on them about their ability to manage or may even mis-interpret the Case Managers' visits as intrusive. Boundaries should be established regarding administering CDC packages and the roles of the Case Managers in regards to developing and monitoring of the Care Plan should be clarified.

Considerations/Recommendations:

- There is need for provision of training and support to Case Managers on CDC model in regards to the operational issues and approaches.

- There is need for establishing guidelines for CDC so that agencies have a framework or model to adopt.