The Adult Services Community Aged Care Program (CACP) provides Commonwealth funded packaged care assistance in the form of case management and coordinated services to elderly clients with complex care needs living in independent accommodation in the community. Our services cover the Northern and Western metropolitan regions of Melbourne. We provide our services to the special needs groups of 'socially and financially disadvantaged' and 'homeless' care recipients. We provide care to those who may not otherwise receive services from mainstream providers. Our care recipients have histories of homelessness, mental health issues, substance abuse, acquired brain injury and challenging behaviours. Our program has a total of 184 Community Aged Care Packages at any one time.

We wish to highlight the following issues for consideration by the Productivity Commission. These issues are considered by our service to have the most significant impact in relation to all aspects of service delivery to our clientele.

Funding

The annual incremental increases in base funding for packaged care is insufficient to meet the most basic needs of providing services to clients in general, but more so to those who have specials needs.

As stated above, our clients are socially and financially disadvantaged, and some are from the homeless special needs group. This clientele generally do not have the capacity to financially contribute to the cost of their own care. Other service providers can charge up to 17.5% of the base pension as fee for service. In the case of our client group, however, we are unable to charge more than one dollar per day as a fee for service as our clients are unable to contribute any more. Some clients cannot even contribute at all. Unlike residential care, packaged care does not get a Commonwealth supplement in the instance that clients are unable to pay a fee for service.

Charging CACP providers for full cost when accessing HACC funded services such as meals disadvantages clients and diminishes the capacity of a package in some cases where it is disadvantageous to the client to move from HACC to a CACP. Clients may pay up to $7.00 per meal under HACC, but CACP providers are charged up to $17.00 per meal for a client. EACH and EACHD do not have to pay for clients' meals (except enteral feeding, which is subsidised anyhow). At a minimum, CACP should be able to provide meals to a client at the HACC rate. The clients are at the same level of care (generally low level) but require case management due to complex care needs. The issue of double dipping due to arbitrary segregation (State versus Commonwealth funding) only disadvantages the clients.

Funding for packages is tied to whether the client qualifies for a certain type of care (HACC, community packaged care, or residential care) regardless of whether they have a special need as defined in the Aged Care Act. The funding is very regimented and compartmentalised into things like home care, personal care, meals, and shopping assistance. It does not take into account that many clients from the special needs groups do not have family, community and/or careers to assist them. In fact, the package providers end up being the clients' community. The clients see the providers as their connection to the outside world and their main resource. Psychosocial support and behavioural issues can often be a large part of the care required. Funding, in our view, should take into consideration the special needs of the client as well as the level of care they need.

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Case study:

Jenny (not her real name) is 85 years old. She lives in public housing on an elderly persons estate. She has no family to speak of. She only has her cat, which she adores. Jenny has multiple medical conditions, including mental health issues, which require attendance to various clinics. Jenny's refrigerator has also recently broken down. Her refrigerator is essential, as she needs it to not only store food but to keep her insulin as well. It was about 10yrs old and she can't afford to replace it. Jenny's care plan involves attendance thrice weekly for personal care, weekly homecare and shopping with transport and support to attend her numerous medical appointments along with medication monitoring and/or prompting. She requires complex case management to make sure that all her physical and mental health needs are met. This can add up to in excess of 10hours of service provision per week. She doesn't qualify for EACH. She exists on the base rate of pension. Jenny requires double the average number of service hours per week (5 hours per week is the average according to the last census). She can't afford to replace her fridge, which is broken down, she can't afford to repay a loan for a fridge and she doesn't like going to other services, because she is embarrassed and doesn't like asking for emergency relief. CACP purchased a fridge for Jenny and loans it to her to use for as long as she needs it.

The aged care or support needed by many people who fall into the homeless or disadvantaged category is not just simply "HACC, CACPs or Residential Care," but a much broader mix of housing and support. Services such as industrial cleans, in cases of hoarding and/or squalor, are often required for the elderly yet there is no viable funding source to obtain this money. Services required by the client often refuse to attend the property because of the OHS risk posed by the hoarding and/or squalor and yet the client still needs services. Pest control to eliminate bed bugs, cockroaches or mice is also an often needed service in community packaged care, and again, no funding is available to support these much needed services. The aged care standards acquit a process that discourages unique and innovative approaches. It encourages one size fits all.

Therefore, the *REAL NEEDS* of our client group are not covered by instrumental care costs such as personal care and domestic support. Instead, people may require complex case management, shelter, whitegoods and clothing. This is the real cost of providing services to our special needs group.

<u>Considerations/Recommendations:</u>

- *A funding instrument similar to the ACFI implemented in community care to enable funding to be aligned to clients' needs rather than the type of care they qualify for.*

- *CACP clients entitled to HACC subsidy for pre-packaged Meals and/or Meals returned to the client/carer/family as their responsibility. This would be in line with the current responsibilities in EACH/EACHD (with the exception of enteral feeding).*

- *Separate case management for the provision of service delivery. Fund it separately and appropriately. Recognise that service provision is not just limited to hours of personal care, home care, and the like.*

- *The issuing of a commonwealth subsidy, as it is established in Residential Care, should the client be unable to contribute to the cost of their care provided by CACP/EACH/EACHD.*

- *Link funding to the real cost of providing services.*

Access to Existing Services to Assist Disadvantaged and Homeless Elderly Clients

Services and clients have general access issues to Assistance with Care and Housing for the Aged (ACHA) program. The program does not have universal coverage. It only funds the worker. It doesn't fund what the client may need (i.e. funding for a bed, pest control, cleaning up squalor and or hoarding). It also doesn't fund transport or physical assistance for people to relocate. This client group relocates often due to the temporary nature of some shelter options. The Salvation Army often has to cover these kinds of costs for a CACP client since funds from other sources, such as ACHA, cannot assist.

Considerations/Recommendations:

Fund ACHA programs appropriately and make the program universally accessible irregardless of the location, so that disadvantaged and homeless clients can access these kinds of services.

Mental Health

It is not uncommon for disadvantaged and/or homeless aged clients to have mental health issues in addition to physical health issues. These clients are amongst some of the most vulnerable in the community. Too many barriers are placed in the way of approved providers in the name of scarce resources that a client aged between 55 and 64 yrs of age cannot gain mental health support unless they have a GP. Moreover, quite a few clients do not have GPs and do not want them. The local area mental health service advises that, because the client is on an aged care package, they should be seen by an aged psychiatric service such as APATT because they don't have the resources. APATT, on the other hand, advises that because the client is under the age of 65, support cannot be provided due to lack of resources and funding.

Considerations/Recommendations:

Make mental health everyone's business. If a client is already in the aged system, by being a packaged care recipient, make it compulsory for the Aged Psychiatric Services such as APATT to accept referrals. Limited resources are an issue for everyone. Access to services such as mental health services should be a right for all people.

Consumer Directed Care Packages

The Salvation Army's support of older homeless or disadvantaged clients is very attuned to working flexibly with clients in a very person centered approach. The reality is that for some people with their cognitive issues arising from dementias, brain injury, substance and/ or mental health problems, the extent of "control" that can be given to people (especially if the goal is to keep people independent and to facilitate their choice to remain in the community) needs to be carefully considered. Simply attempting to transfer ideas from disability sectors or other jurisdictions such as the new Continence Assistance Payment Scheme (CAPS) or various interpretations of Consumer Directed Care do not translate well. For some clients, the role of a worker or advocate to control, support resources and/or finances for a client is critical in order to keep other aspects of their life intact. It was helpful that the Commonwealth listened to this issue when it decided to make a provision in the new CAPS for representatives or interested organisations to be the recipient of an individual's CAPS funds.

Aged care is significantly different to disability. Not all people "will get better" or become more skilled or independent. They will just need long-term on-going (and increasing) support until they die. This is the nature of being old and possibly suffering from degenerative conditions. Blindly transferring policies from the disability sector into Aged Care without consultation with approved providers will not work well for the clients.

Considerations/Recommendations:

Liaise with Approved Providers on the ground before making policy changes on how packaged care or any aged care is funded and provided. Make sure you liaise with special needs providers, not just mainstream providers. Remember to consider the varying cognitive capacity levels of clients with acquired brain injury, dementia, substance use, mental health issues, intellectual disability, and any combination of these conditions. Remember also that some clients do not have carers, families or other community supports when considering significant changes in how funds are allocated for care.

Access to Aged Care Assessment Services (ACAS) by " The Younger Than Old" Clients of Packaged Care

There appears to be reluctance by some ACAS services to assess people in the 50-65yr old aged group as eligible for services for various types of aged care, even though the clients already may use such care.

Case study:

Deena (not her real name) is 64years old and has been a recipient of a CACP for at least 6 years. She has a permanent independent Guardian appointed, as she is unable to make appropriate lifestyle and medical decisions for herself. Her health conditions include degenerative conditions such as chronic obstructive pulmonary disease, and she has a cancerous leg which will never heal. Her condition deteriorated over the last 6 months to such an extent that she is unable to walk or transfer without aide. She was found on the floor one morning after a fall. She has been in hospital for about 6 weeks. She wants to go into permanent residential aged care, her Case Manager and her Guardian agree that she cannot live at home on her own anymore. The local ACAS service refuses to accept her referral for an assessment for residential care because she is under the age of 65. She is 64. They declared that the ACAS guidelines state that DHS must be consulted as an option prior to assessing for residential aged care as the client is under age. All her supports in the community agree that she should be in a high level residential care setting, and sending her to anything other than a residential facility would be doing the client a large disservice.

After following up with DHS and their incapacity to provide alternative appropriate accommodation, we were able to convince the local ACAS to assess this client. She was eventually approved for high-level residential aged care. The amount of time and effort put into getting the approval for care could have been much better spent providing care to the numerous clients on our waitlist (352 as viewed on 21/07/2010) who are without care. Some ACAS services appear to limit their services purely on the client's age, and follow their guidelines to the letter, without considering the many other issues that impact on the client.

Considerations/Recommendations:

Train ACAS services and clinicians to consider the 'whole' person when dealing with referrals, and not just the numerical age of the client. The guidelines are just that – "guidelines" – so use common sense to assess the needs of the 'whole' client. A client's age is only ***one*** *factor that determines their care needs. Fund the ACAS appropriately.*

Better Resource Allocation and Planning- Find an Alternative to The Aged Care Approval Rounds (ACAR)

A more efficient means to achieve rational planning and resource allocation to communities and groups of individuals with these needs requires a better way than the ACAR, with reams of writing in the competitive bidding process. Across the sector, the resources acquitted to ACAR processes that do not succeed come at the very real cost of allocating those same resources to quality support and care..

Considerations/Recommendations:

Approved providers must go through quality reporting at a minimum every three years. Resource and allocation planning could be tied to quality reporting. Local primary care partnerships (PCP) and ACAS could work with representatives from Quality Reporting to gain access to the level of need in a region, the available approved providers, and any special needs of the clients, and then ask for expressions of interest to gain further packages. In this manner, vast amounts of resources on what is essentially an "essay writing competition" would not need to be spent on trying to gain more packages, and the money could be better used to provide care. The Quality Reporting Team, PCP and the ACAS, would have a very good understanding of the capacity of the local approved providers.