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Submission to the Productivity Commission
Emailed to: agedcare@pc.gov.au

Dear Commission,

RE: INNOVATION IN COMMUNITY CARE BROKERAGE BUSINESS MODELS AND INDEPENDENCE PROGRAM SERVICE DELIVERY

Care Assess (Care Assessment Consultants Pty Ltd) is a Tasmanian state-wide private health care organisation specialising in assessment and coordination of HACC programs and brokering of service provision in the aged care community sector.

At the invitation of Michael Woods and Robert Fitzgerald (Commissioners) at the Hobart public hearing on 24 March 2011 in response to the Productivity Commission's draft report, *Caring for Older Australians* (the Report), I have put together this submission to the Commission outlining the business model of our organisation and describing our current programs. At the hearing I made brief remarks describing the innovative brokerage model of our private health care organisation and some of the leading programs we coordinate. Our Home-based Independence Program was described to the Commission to serve as an example of the type of model and program that Care Assess has adopted, which seems to embody much of the shift that the draft report is recommending within the Aged Care Sector broadly.

The Report notes that "changes to the aged care system over the past decade or so have improved the range and quality of care and support available to older Australians." (p. XXI) The Federal Government's Home and Community Care (HACC) funding is an example of one of these changes that has evidently resulted in improvements in the community care sector in Tasmania. However the Report notes that "fundamental reform is required to overcome the delays, discontinuities, constraints and shortages that currently exist, and to respond to future challenges." (p. XXI)

HACC services in Tasmania are an example of where an increase in delays has been the result of an increasing number of HACC eligible home care clients in Tasmania receiving services on an on-going basis. This issue further results in the long-term home care client's increased dependence on these services, adding further to the problem of an increased projected demand for these services and consequent financial strain that will be placed on our Health Budget in the future.

Within this context, Care Assess is an organisation that began in the last decade or so by addressing some of these issues by a redesigned business model and a number of redesigned HACC programs based on innovative service delivery specifically tailored to our local context. In the spirit of the Report's recommendations, these programs have been "redesigned around people's wellbeing and delivered in ways that respect their dignity and support their independence." (p. XXI)

Our Post-Acute Program (PAP) and Home-based Independence Program (HHIP) are two examples of programs that should serve the Productivity Commission to highlight sustainable and effective models that help shift the focus of aged care from hospitals and residential care to:

- effective and efficient primary health care in the home (community care)
- better self-management of health conditions within the community
- prevention of chronic conditions
- a wellness approach and supporting independence

Our business profile

Commencing operation as a specialist assessment agency in southern Tasmania in 1999, Care Assess has grown considerably over the past decade to a state-wide organisation with satellite sites in the North (Launceston) and North West (Devonport), employing a multi-disciplinary team of 30 highly skilled professionals across Tasmania, and centralising all administration to our corporate office in the South (Rosny Park). Our team currently combines a mix of disciplines including nursing, mental health, occupational therapy and exercise physiology to conduct assessments and deliver programs.

As a private health care organisation, Care Assess offers a client centred service focussed principally on comprehensive assessment of client needs, referral to appropriate service providers, and coordination of that service delivery. We offer a suite of services that integrate assessment, care planning, referral and re-assessment to ensure a high standard of care and support for the client. We collaborate in an extensive range of networks, ensuring appropriate referral patterns and further service development in response to changing client needs, shifting care recipient's services as necessary.

We now have a well demonstrated history of excellence in brokered and co-ordinated service delivery and innovation in the community care sector. All of our programs are linked together and staff work collaboratively in multi-disciplinary teams to ensure services remain goal orientated and flexible towards the client's changing needs.

Through the provision of quality care, all of our services were established with the aim of maintaining and improving upon the quality of life for clients at home in order to prevent inappropriate admission or re-admission to hospital or residential care while at the same time also preventing unnecessary on-going assistance and supports.

Our brokerage model

Care Assess' business model brokerages government and non-government service providers by specialising in assessment and coordination of care for clients, outsourcing all service-provision to support workers contracted to our organisation. This operational model of independent assessment and coordination complies with the National HACC guidelines which highlight the need for separating assessment and service provision to ensure best practice.

The model allows services to be delivered more efficiently because, by specialising in coordination and out-sourcing service provision, Care Assess is able to deliver more cost-effective, flexible and timely programs across the State. Clearly separating assessment and services also encourages healthy competition between service providers and thus can encourage improvements in efficiency for the benefit of clients in the community.

The model also allows for care that is flexible and adaptable to client's changing needs over time. Care Assess draws from a wide pool of skills and many service providers to undertake identified tasks and services, and has the ability to research the best skill mix available for each care situation in order to ensure client access to services are tailored to meet their assessed needs.

Quality assurance is a key function of Care Assess as an intermediary organisation brokering funding to those who provide the care. The model of care ensures best practice by enforcing that only quality accredited service providers are used for the provision of care. Care Assess' program managers hold regular meetings with service providers to discuss Care Assess' expected standards of care and levels of training from their service providers. Annual Memorandums of Understanding are in place with each brokered service provider, outlining additional requirements.

An added advantage of the model is the priority it gives for our organisation to work more directly with the strategic directions and plans of Government. As an intermediate organisation brokering the funding of Government for the care delivered by service providers, our focus can be given to developing a more collaborative partnership with the initiatives of the Department and developing the level of transparency required by employing effective reporting mechanisms.

Our programs

Care Assess currently coordinate a mix of service types. These include a HACC Home-based Independence Program, a HACC Post-Acute Program, Veteran Home Care and a HACC Home Care Program. We also conduct Comprehensive Health Assessments and Care Planning for people in the community of behalf of General Practitioners, including Mental Health Care plans.

The service types within these programs include domestic help, personal care assistance, in home respite and some gardening and shopping assistance. The Home Independence

program also has a exercise component and this is implemented by our exercise physiologists.

All of our programs aim to support and where possible enhance the independence of clients within their homes and community environment. All of our programs also adopt a wellness focus, in the firm belief that our clients deserve to enjoy a happy and healthy life in their own homes for as long as possible.

In this submission, I will describe two of our most innovative HACC programs highly relevant to the Productivity Commission's enquiry into Aged Care in the community sector, our Home-based Independence program, and our Post-Acute program, with greater concentration given to our Home-based Independence program.

Our Home-based Independence program (HHIP)

Program description

Our HACC Home-Based Independence Program (HHIP) was officially launched by our Premier, the then Minister for Health and Human Services, Hon Lara Giddings MHA (8 November 2007) because she recognised the distinctively innovative approach adopted in this program within our business model.

HHIP is a 12 week program aiming to maintain or improve eligible client's functional independence and thus reduce or limit the need for basic support services such as on-going home care.

The program is for HACC eligible people (over 60 years of age) who are living in the community with on-going health concerns (such as a chronic condition or a functional disability/difficulty) who have been unable to maintain or regain their independence at home and who are motivated to work with health professionals to improve their quality of life and independence. A key indicator is that a client is experiencing difficulties with Activities of Daily Living (ADL) but is still functioning at a low to moderate level.

Tailored to client's assessed needs and goals, the program focuses on their overall health and wellbeing. Employing a multi-disciplinary team approach to coordination of support services, the program includes strategies to reduce risk and falls, awareness and understanding of the use of medications, introducing and encouraging the use of aids to assist activities of daily living, assistance with chronic disease management and encouragement in daily living activity programs to enhance socialisation.

The need

The primary focus of Home and Community Care (HACC), as described in the *Home and Community Care Act 1985* and the Government's *Community Care Review,* is to provide basic maintenance and support services to the target population to allow them to live independently in their own homes and reduce the likelihood of unnecessary or premature admission into long-term residential care.

Care Assess established HHIP to address two significant needs:

1. Extensive waiting lists for home care services by eligible HACC clients in all Tasmanian regions meant that many clients were unable to access assistance in most areas due to both a significant number of clients remaining on the home care program for extended periods, and also to the growing overall number of clients requiring the service. The HHIP program recognised the need to better manage the demand for home care services.

2. With the State's health costs already increasing, Tasmania's rapidly ageing population (with an increasingly high proportion of people aged 65 years and over) is projected to place the State's health budget under even greater strain because older people have a greater need for health services and their needs are more likely to be related to chronic diseases.

Our paradigm

Care Assess recognised the potential to explore approaches which better retain or improve client's independence and self efficacy thereby minimizing the impact of functional decline on the person's capacity to live at home and participate in everyday social interactions.

Care Assess established HHIP upon the belief that the provision of *some* services to *many* clients (even at very low levels of service) is more effective than providing *more* services to *fewer* clients. It is Care Assess' belief that an independence promoting model of service delivery provides the optimum opportunity to target clients who will receive the greatest benefit and provide a highly cost effective service.

Historically it has been recognised that the previous HACC paradigm of service delivery may have assumed dependence or constant decline. Services commonly were at risk of substituting client's own efforts to look after themselves rather than improving their capacity to care for themselves.

HHIP moves from a dependency model of care to an "independence or enabling model of care". The intent of the model is to create a shift from "we will do everything *for* you" to encourage autonomy, motivation and client-driven development but reinforce support if and where there is needed ("we work *with* you"). It achieves improved outcomes for clients by maximising the individual's capacity to self care through provision of supports that boost self confidence and well being.

The program utilises a multidisciplinary team approach offering a home-based early intervention service which focuses on optimising functioning, preventing or delaying further decline, promoting healthy aging, providing support and encouraging self management.

How it works

The HHIP service model aims to maintain or improve the client's functional independence and in so doing reduce or limit the need for on-going home care services. Promoting good health and a healthy lifestyle by encouraging individual participation in community activities and prevention of illness and injury are prominent features within this model. The program

focuses on motivation, preventative strategies, education, and self-regulation. Clients take ownership of their health management and goal setting.

By providing a short-term, home-based early intervention service involving a multi-disciplinary team approach, the program provides individual clients with skills and equipment that will enable them to continue living in their own homes as independently as possible.

While a "coaching" model encourages clients in the self management of their chronic medical conditions, the HHIP program expands on this to a model that addresses functional dependence by assisting clients to regain their independence at home.

By increasing the independence of clients, the program reduces their need for basic support services. In this way it helps reduce Tasmania's demand for HACC home care services, and indirectly reduces the costly burden on the State's services managing chronic conditions.

Target clients

HHIP is designed to target older individuals when they are first referred for home services or request an increase in basic services. The client must be motivated to regain independence by participating in the program and this will form part of a client contract.

Referrals are received from GPs, community centres, hospitals and self referrals. Target clients include people who are being referred for the first time or who are being referred because of a change in level of need or because of a precipitating incident such as a fall.

Eligible admission to the program is based on the following criteria:

- Over 60 years of age
- Low to moderate functional needs
- Requests for personal care and domestic assistance
- Eligible for Home and Community Care assistance
- Must be highly motivated and consent to participating in a program that promotes independence and that provides service for no longer than a 3 month period (Dementia and high needs groups excluded)

Assessment and Coordination

As highlighted, Care Assess specialises in assessment and coordination of care and brokerages services to providers whose support workers give care under our coordination and in line with our care plans. The team has extensive and expert assessment skills and goal orientated care planning skills utilising targeted evidence-based interventions.

In keeping with this approach, Care Assess' HHIP program is coordinated by a multidisciplinary team approach including assessment. The coordination team comprises:

- Manager, responsible for the program
- Registered Nurse, Occupational Therapist, and Exercise Physiologist.

The coordination team will also involve where appropriate Dieticians (mostly accessed through CDM items - formerly, EPC), skilled RNs for specific consultations, Falls Prevention Clinic, Equipment, Red Cross Transport and the client's GP. An integral part of this model of service delivery is keeping the GP informed as to the community care needs and services delivered to the client.

Service delivery is undertaken primarily in the client's home and uses a varied approach to improving overall health and independence. A comprehensive multi-dimensional assessment (including functional capacity) is conducted on the first visit by a member of Care Assess' team. A case conference on admission with a family member, a team member (co-ordinator) and client would result in an agreed Care Plan being developed. This Care Plan will be compiled in part to assist the client to take ownership of both short and long-term goals, aiming towards the client's progress to independence. It is also an instrumental tool for coordination in enabling Care Assess to communicate with service providers and ensure support workers provide support, assistance and care according to the needs and goals of the client.

A key aspect of this service delivery model is the establishment of measurable and client-driven goals. Also, the model remains flexible to tailoring those goals throughout the program as these goals are identified, clarified and developed. Initial short-term goals are adapted and new and long-term goals are progressively developed.

A family member is encouraged to be present at the initial assessment to ensure their support to the client. Whilst the client may be motivated to engage in the project, the family may be reluctant to allow a parent to take any risks. Family/carer support is crucial for client's success. In parallel to this need, safety for the client will always be of paramount importance throughout the project.

After this Care Assess will visit the client for the initial set up, allow for regular phone contact with client and revisit only if required. The multidisciplinary team then meets throughout each client's program to discuss the client's progress and suggest further interventions to enhance client's independence.

Our aim is to involve GP's to encourage and support the client to participate in the program to bring significant benefits to the overall model. We aim to devise our Care Plans in collaboration with the client's GP, although our program has not yet arrived at this aim. A major role in working with GPs to complete Care Plans for clients with chronic diseases is utilising the Chronic Disease Management items (formerly EPC items), whereby clients can receive five free (or reduced cost) allied health services per year which are used to implement appropriate lifestyle changes. This includes access to a wide range of services including podiatry, dietetics, physiotherapy, occupational therapy, exercise physiology, psychology, audiology, diabetes education, speech pathology, osteopathy, and Aboriginal Health Workers.

Accessing these services becomes part of the team approach to providing clients with support and education in techniques to increase their skills in regaining their independence. Accessing prompt allied health services from private providers through the CDM items

provides more readily available support to a client with declining functional ability. This allows the clients to avoid the long waiting times from Government allied health services.

Challenges

One of the significant challenges of this model is that each support worker from each service provider must be educated by Care Assess regarding the program objectives, and requested to work with our coordinator to utilise the client's devised care plan, which is kept in the client's home. Regular communication with the co-ordinator and support workers must be maintained to ensure the client's goals are being maintained.

Objectives

The objectives of the program are to:

- Develop and demonstrate new/different ways of approaching personal care and daily activities that have become more difficult, to enable people to manage activities without the need for assistance
- Introduce strategies to reduce the risk of falls both in and outside the home and safely promote confidence with managing day to day tasks especially after a fall or illness
- Improve the quality of life by increasing independence and autonomy
- Prevent or delay further functional decline and promote healthy aging
- Increase the awareness and understanding of the use of medications and provide alternatives to managing medications. A Pharmacy review by a qualified Pharmacist may be recommended.
- Introduce and encourage the use of aids to assist in ADLs
- Assist clients to self manage chronic diseases
- Encourage activity programs to enhance socialisation
- Provide encouragement and an appropriate home based exercise program which aims to increase overall physical activity levels
- Gain family support for the promotion of independence

Client Goals

Short-term goals include:

- Clients identifying their own goals in their safe, supportive environment (Home)
- Clients take ownership of these goals
- Steps identified to implement change
- Simplifying techniques for personal care and domestic assistance - e.g. upright vacuum cleaners, Velcro instead of buttons, showering techniques to ensure safety etc.
- Trialling personal and household equipment aids

Long-term goals include:

- Exercises to help regain strength and balance
- Increased level of physical activity

- Education to self manage chronic diseases, supplying necessary background information to meet their desired goals and consequently increasing their success in achieving their goals
- Accessing information on community resources and programs

Program Costing

Clients may access the program for a maximum of three months, but may complete the program in less than three months depending on progress. Over this period program costs are calculated and separated into the assessment plus coordination component and the brokerage service delivery component per client program over a three month period, including:

Assessment and Coordination component costs may include:

- Client home visit for Comprehensive Health Assessment and functional assessment, case conferencing and Care Planning
- Documenting Care Plans to access Enhanced Primary Care Items
- Visit to GP
- Meetings within Care Assess multi-disciplinary team fortnightly
- Organising brokered service providers
- Phone support to client
- Database reporting
- Development of tools

Brokered service provider component costs may include:

- Domestic assistants - 5.5hrs
- Personal care - 11hrs
- Allied health including exercise -5 hours

While costs have increased over time due to rising service provision expenses, the maximum cost per client in total is estimated to be currently $2,200 for each program delivery. This includes the assessment and coordination component and brokered service delivery component. Where clients leave the program prior to completion of the 3 month period, costs are reduced and made available for other clients. All clinical nursing costs remain outside this program.

HACC fee guidelines apply to clients receiving this program and HACC fee contributions are used for service delivery. Hire of equipment or cost of purchasing equipment and transport costs remain the responsibility of the client.

Client evaluation

Clients are reassessed as they exit the program to determine if their needs have been met and where necessary strategies will be developed for those clients with on-going support needs. A functional assessment is completed again for evaluation purposes at the end of the client's program. A key factor in the evaluation is the determination of measurable

outcomes against client goals in the initial Care Plan. The evaluation uses a HACC tool that scores the clients progress towards independence against these measurable indicators.

A client feedback survey is sent to each client one or two weeks after completing the program to monitor satisfaction with the program. The survey instrument looks at whether clients were ready to be discharged, had achieved the goals they had set, whether the program did help them regain their independence and whether the program was appropriate to their needs. Clients are also surveyed as to whether they would recommend the program to others.

Our HACC Post-Acute Program (PAP)

Complimentary to our Home-based Independence Program, Care Assess also provides post-acute services for the HACC eligible clients. Our Post-Acute Program (PAP) is a state-wide program designed to provide short-term, higher level packages of care in the home. PAP offers up to six weeks of post hospital home care in accordance with the client's assessed needs. PAP is a program designed for clients who have suffered an acute episode and at discharge from hospital need services greater than the basic HACC home support and assistance in order to regain their independence at home.

In this program, our co-ordinators visit the client whilst in hospital and in collaboration with the hospital staff organise care for the client on discharge. This care may include:

- Personal care
- Domestic assistance
- Respite care
- Shopping assistance
- Nursing care to monitor aspects of client's care

Following exit from our program, any clients requiring on-going care are referred to an appropriate service provider. Early statistical information within our organisation taken over a 4-months period demonstrated that in southern Tasmania 85% of clients receiving services through our Post-Acute Program did not required on-going care after the finalisation of the program.

PAP reduces the burden on over-extended mainstream health services, such as rehabilitation services for clients with higher level needs eligible for transitional care packages. PAP clients receive short-term use of extra services designed to enable them to be discharged from hospital with assistance to recover to their best level of independence. Accordingly, it decreases the change of unnecessary re-admission into the hospital system, and reduces the likelihood that they will unnecessarily begin to receive on-going HACC funded home care services, with the adverse effect of increasing their dependence on support services, rather than enable their growth towards independence.

Conclusion

In Tasmania, Care Assess is an organisation leading the way with an effective community care brokerage business model and with innovation in independence program service

delivery in the community sector. Having begun a little over a decade ago as a reliable and professional nursing and assessment service, our HACC programs such as our Home-based Independence Program (HHIP) and our Post-Acute Program (PAP) were among the first of their kind in Australia and certainly have many unique aspects that make these service models distinctive examples for the Productivity Commission in its enquiry into Aged Care across Australia and in formulating its final Report.

Final remarks

Care Assess also wish to highlight to the Productivity Commission that the success of our organisation is due in large part to the funding initiative and support shown by Tasmania's Department of Health and Human Services towards the early strategic and pioneering work of Merryl Lane (one of the founding Directors of Care Assess) who was instrumental in developing our programs and model, and who has an on-going role in moulding these programs.

In *Tasmania's Health Plan*, and *Primary Health Services Plan*, our Government has committed to supporting the management of chronic conditions in the community sector. Care Assess believe that our State Government should be commended, not only for the direction they have taken in shifting the provision of primary care as it relates to basic community services to outside the Department and Hospital system and into the Community Sector by funding independent organisations including private and non-for-profits, but also in particular for recognising and supporting the innovative model that Care Assess has developed and our effective and strategic service delivery programs that we have implemented with their funding.

Finally, I invite the Productivity Commission to contact me to request any further information if any items of interest that would assist in the preparation of your important and final Report are not covered in this submission.

Yours sincerely,

Joe Towns, CEO | **Care Assess**