SUBMISSION

Commonwealth Home Support Programme

30 June 2014

Background

The Victorian Healthcare Association (VHA) is the peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health service, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

Introduction

The Commonwealth Home Support Programme (CHSP) discussion paper (the discussion paper) was released in May and outlines the Commonwealth Government's plans for the basic level of support for older Australians living at home.

VHA members provide more than 45% of the current HACC program in Victoria, and will be significant service providers of the CHSP. As existing and future stakeholders, Victorian health services are integral to the delivery of home and community-based care. The links between the acute, aged care and primary and community health sectors are strong in Victoria, facilitating shared approaches to service provision and planning and a connected system that benefits consumers. The VHA views these established links between providers to be fundamental to the strength of the health and aged care system in Victoria.

The VHA has consulted broadly within its membership in formulating this response and welcomes the opportunity to provide feedback to the consultation.

The VHA agrees to this submission being treated as a public document, and the information contained within being cited in the final report.

Consultation Questions

1. Are there any other key directions that you consider should be pursued in the development of the Commonwealth Home Support Programme from July 2015?

The discussion paper's key directions and vision that will underpin the CHSP are broadly appropriate and clearly represent how the Department of Social Services (DSS) intends to direct the system. The VHA supports the proposed key directions, however would like to suggest a number of additional areas that could be integrated into the existing directions.

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Equity should be included as a key direction for the CHSP. Provided a consumer meets the assessment eligibility criteria, there should be no barriers to them accessing services, particularly for those from culturally and linguistically diverse (CALD) backgrounds, those living in social disadvantage, those living in rural or remote regions and those with complex conditions.

The VHA recognises that consumers with special needs are covered in the discussion paper, but suggests that defining which special needs are appropriate to receive further support potentially restricts access to those outside of the defined groups. The discussion paper should include an underlying principle of 'removing obstacles to care' for any and all potential consumers, regardless of whether they fit within the list of special needs groups defined in legislation.

While the CHSP should be organised in a way that gives consumers and carers clarity and confidence, it is important to recognise that service providers should be of a high quality and supported by a robust strategic framework. The VHA suggests that the CHSP should have as a guiding tenet the provision of high quality services, accessible to all Australians in need. The CHSP key directions should also underscore the importance of a robust and properly resourced aged care sector to deliver them.

Consumer independence and control should be included, as it underpins the philosophy of consumer directed care. The intention is that the funding model will eventually move to an individual controlled budget, and it is appropriate that the underpinning directions are in line with this. In addition to the introduction of consumer independence and control as a CHSP direction, the VHA supports the adoption and use of the National Aged Care Alliance's working definition of consumer directed care:

> *"Consumer directed care empowers the consumer to have more control over their own life. It focuses on the person's life goals and strengths, and provides services and support (including aged care, disability and health services) to achieve them. The person makes choices and/or manages the services they access, to the extent they can and wish to do so, including who will deliver the services and when. Where there is a carer, their needs are also acknowledged and considered. CDC incorporates many of the principles of person-centered care, while putting the consumer in charge of decisions about their care."*

2. How should restorative care be implemented in the new programme?

Restorative care should be available to any consumer as a time-limited function that takes place before a long-term care plan begins. It is important that the consumer's level of function is assessed pre- and post-restorative care intervention, so that an objective view of their needs and the success of the intervention is available.

The VHA notes that the concept of restored function is relative and differs from person to person. Any criteria that determine the appropriateness of restorative care and the measures of success should be sufficiently flexible to allow a subjective analysis of the consumer's potential for improvement.

If the short-term intervention results in a reduced reliance on support in the long-term, it is preferable that more consumers are able to access a restorative care program.

The discussion paper should clearly delineate the intended use of the terms 'wellness', 'reablement' and 'restorative care'. Wellness and reablement being defining principles that should be adhered to in each outcome grouping; and restorative care being a program that is time-limited, with the goal to improve functional capacity and independence before the implementation of on-going support. Wellness as a principle should include a strong emphasis on a holistic approach to improving independence and self-sufficiency, including recognition of the importance of prevention and early intervention.

3. Are these proposed client eligibility criteria appropriate? Should the eligibility criteria specify the level of functional limitation?

The VHA considers the description of a consumer having "difficulty performing activities of daily living" to be an appropriate specification of eligibility, as opposed to defining levels of functional limitation. The inclusion of functional limitation as its own criterion poses the risk that the root causes of the limitation may be missed in subsequent assessments, it may also preclude some people from contacting My Aged Care in the initial instance.

It is important that eligibility criteria are broad enough to ensure all appropriate consumers are able to access the lower levels of care and do not end up increasing demand on the more intensive care packages at the middle and higher levels.

4. Are the circumstances for direct referral from screening to service provision appropriate?

The VHA agrees that direct referral is appropriate when clinical needs require immediate care and support. It is important that direct referrals are guided by a clear framework that also takes into account any requests from either consumers or carers, provided criteria do not indicate a face-to-face assessment is required.

Irrespective of the reason a direct referral is deemed appropriate, a follow up assessment should always be offered and pursued to ensure that the consumer's full range of needs have been identified and met.

5. Are there particular service types that it would be appropriate to access without face to face assessment?

The CHSP is intended to provide services in line with a consumer's needs. With this in mind, the VHA believes it is inappropriate to set up the direct referral system around the use of service types, as opposed to each consumer's needs.

With this in mind, there are a number of circumstances where direct referral to a service provider would be appropriate. When the My Aged Care phone assessment results in a recommendation that the consumer is living independently and is able to self-manage without additional supports, then a direct referral to allied health or community nursing services may be appropriate. This is contingent on there being no co-morbidities or social issues identified in the initial screening.

6. Are there any other specific triggers that would mean an older person would require a face to face assessment?

The VHA suggests that the assessment criteria include provisions that identify areas of significant risk to potential consumers These might include dementia; carer stress or illness; homelessness risk; identified falls risk; social isolation; family breakdown and other agreed measures of specific or special need, such as low proficiency in English. Consumer or carer requests for a face-to-face assessment must also be viewed as a trigger.

The assessment process and criteria used by My Aged Care must be robust and sophisticated enough to correctly identify consumers in need of an expedited assessment. Weighting should be applied to high need consumers to ensure they can access care efficiently and help them remain independent and in control of their circumstances.

Greater clarity is required regarding the process for service providers when a consumer's needs are reassessed to be higher than the assessment provided by the RAO. Many providers of HACC and community aged care rely on an in-depth internal assessment and referral when developing a consumer's care plan. This process often yields a deeper understanding of the consumer's social context, health needs and other complexities, which then leads to an integrated care plan.

Other measures of consumer need should be incorporated into the assessment framework, including: social context; clinical factors; geographic location; local availability of support services; and where possible, the degree of social isolation. It is in the best interests of both the consumer and the CHSP that as many consumers as possible are referred to a face-to-face assessment, to ensure appropriate referrals are initiated, risk is reduced, and future costs are contained.

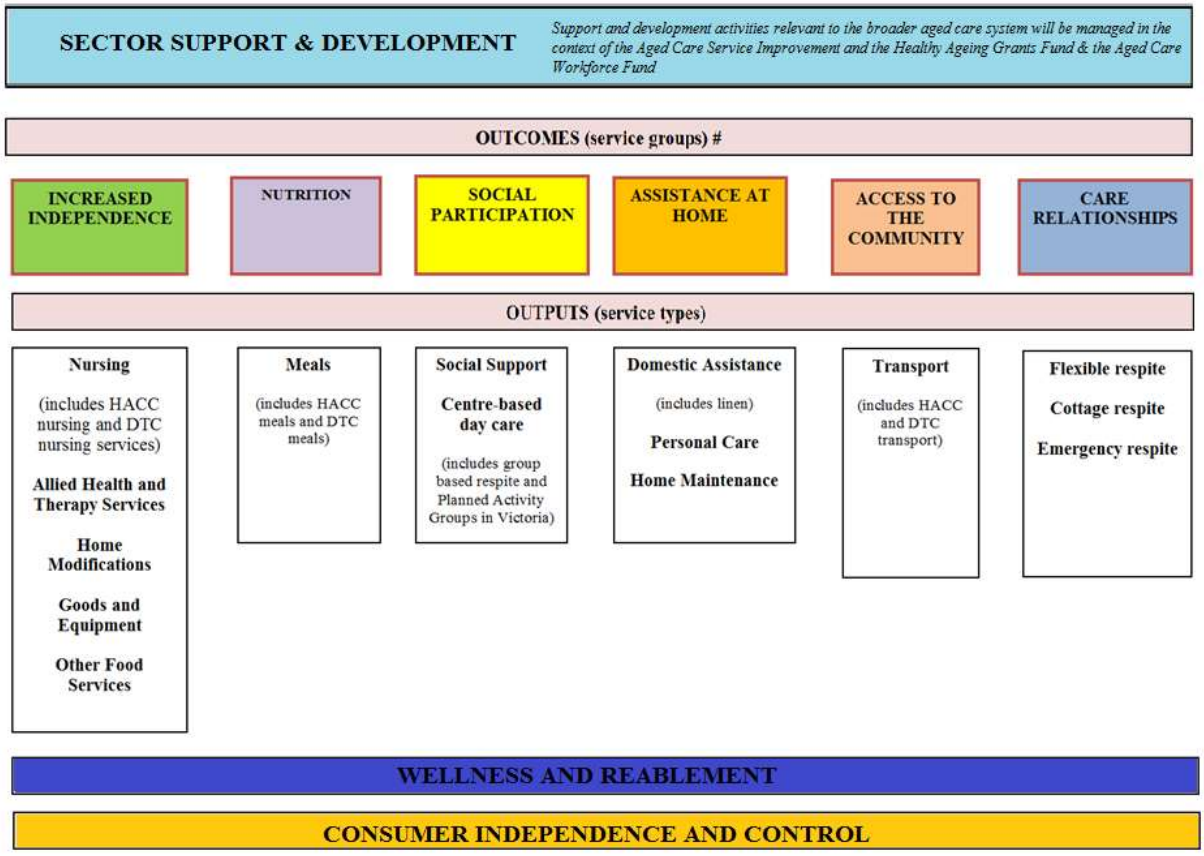
7. Are there better ways to group outcomes?

The VHA supports the outcome groupings, however suggests a number of modifications to the way that the programme is visualised.

Sector support and development is ongoing work and is not related to consumer or carer outcomes, and should be represented as ongoing work; wellness and reablement, and consumer independence and control are defining principles and underline all programme outputs, and should be represented as core values inherent throughout the all outputs within the CHSP.

The VHA notes that the 'Nutrition' outcome group is potentially misleading. By separating meals services from other functional assistance outcome groups, the discussion paper indicates that a lack

of independence with meal preparation and shopping is a discrete issue, rather than the result of other functional limitations that may need addressing.



8. Are there specific transition issues to consider?

The implementation timeline is particularly short, given the lack of concrete detail available to health services to assist them with planning their transition to the CHSP. Capacity building work with service providers would be appropriate and will ensure a smoother transition post-July 2015.

The current intake and assessment model is based on a methodology that is broadly understood and accepted in the community. The move to a telephone-based single point of assessment represents a significant change. The My Aged Care model assumes a degree of technological capacity and health literacy in the target age group. While this approach may be appropriate for the majority of the target population, consumers with complex needs and those from CALD backgrounds may find this a difficult system to navigate.

The VHA notes that a successful uptake of the CHSP will rely heavily on public awareness and understanding of the changes, and ensuring that existing service providers and stakeholders are sufficiently engaged and able to direct consumers to the correct assessment portal.

There is not currently a clearly defined model to guide service providers through the transition. Much of the focus has been on ensuring the assessment and referral systems are operational, however it is crucial that service providers are included in DSS's transition arrangements. Infrastructure, particularly IT, within service providers is variable and many of the CHSP goals risk being undermined if service providers are unable to link the centralised consumer management system with their own internal IT systems.

The VHA recognises that the gradual shift towards consumer directed care, and eventually consumer managed budgets, mirrors similar reforms across the health, aged and social service systems. However, notes that this shift in focus brings with it a number of explicit risks. The current HACC, primary health and social service systems in Victoria feature excellent communication and collaboration between service providers. The change to packaged care, and eventually consumer controlled budgets, without a clear transition plan for service providers may result in poor consumer outcomes.

To counter this, the VHA suggests that successful existing models be included where possible. The transition to the CHSP must be guided by a transparent timetable of achievable goals and outcomes that service providers can work towards, ensuring that they are in a position to receive referrals and provide care seamlessly by the implementation date of 1 July, 2015.

9. How are supports for carers (other than respite services) best offered? For example, should these be separate to or part of the Commonwealth Home Support Programme?

Carers are an essential element of the aged care system and their needs must be adequately addressed by the CHSP. Apart from the inclusion in the eligibility criteria, the discussion paper fails to set out a clear vision for how carers will be supported. 'Clients' and 'older people' are regularly referred to, however the discussion paper fails to sufficiently explain how the individual needs of carers will be provided for.

Ensuring that carers' health and wellbeing is maintained as long as possible is crucial in terms of keeping consumers independent and living at home and in their communities for as long as is appropriate. Therefore the VHA recommends that carers' needs be clearly delineated from those of the care recipient. Tying carer support to a consumer's outcome groupings reduces the focus on the carer's needs, which in turn may result in an increase of carer stress and related carer co-morbidities.

The VHA notes that specific carer legislation is not cited in the discussion paper. The Victorian *Carers Recognition Act 2012* formally recognises and values the role of carers and the importance of care relationships in the Victorian community. The Act also specifies obligations for state government agencies, local councils, and other organisations that interact with people in care relationships. The Commonwealth *Carer Recognition Act 2010*, also recognises and values the role of carers, as well as setting out obligations for commonwealth public service agencies and associated providers. Both pieces of legislation are important in framing expectations of support for carers, but references to these obligations are missing from the discussion paper.

While difficult to quantify, the work that carers undertake can reasonably be described as the foundation of the Australian community aged care system. It is imperative that their needs are accounted for and that they are able to access care and support in their own right. The eligibility criteria indicate5 that this is the intention, however further detail is required.

10. What capacity building resources are needed to assist with the sector's transition to the Commonwealth Home Support Programme?

Capacity building as a concept in the discussion paper is dealt with as though it is a consideration limited only to the transition period. Under the current HACC system, service providers undertake ongoing capacity building activities within their communities and with local stakeholders to ensure all support elements within the community are aware of consumer needs and the current requirements of the health system. The VHA is concerned that this on-going capacity building will cease to be funded under the CHSP.

DSS should ensure communication to service providers is clear and consistent, setting out their expectations of service providers through the transition period. DSS must ensure that both service providers and the community are engaged and informed through the use of clear and open communication at all times.

11. How should the current Assistance with Care and Housing for the Aged Program be positioned into the future?

The VHA suggests that the Assistance with Care and Housing for the Aged (ACHA) Program remain separate to the CHSP, given that its consumer group is generally at risk of homelessness and of higher complexity, but that it should retain close ties to My Aged Care. The needs of ACHA consumers are complex, and are best managed directly by service providers, rather than via the linear model described in the discussion paper.

A potential design would tie the ACHA to the Linking Service as both systems are based on an assertive outreach model which would then allow for an assessment and referral into the CHSP if appropriate for eligible consumers.

12. Are there any other issues that need to be considered in transitioning functions from the current HACC Service Group Two to My Aged Care?

Case-management and client care-coordination are important elements of HACC service provision and the withdrawal of funding for these services will impact on the consumer outcomes. The VHA questions the appropriateness of case-management and client care-coordination functions being carried out by My Aged Care, when these services are intensely personal and reliant on consumer-service provider relationships. The assumption that My Aged Care will be able to efficiently provide

care-coordination on behalf of each service provider risks underestimating the diversity of scope and suite of programs that Victorian health services offer.

Many service providers in Victoria operate from an integrated care perspective, where various elements of primary health, mental health, social support and preventive healthcare are combined within the single organisation to allow a consumer to receive a comprehensive and linked care plan. The VHA is concerned that the model proposed by the discussion paper will undermine the integrated care approach to the detriment of consumer outcomes.

There are a number of smaller programs within HACC that provide specific services to consumers with more complex needs. An example is the Linkages Program and the care-coordination, case-management for planning and funding for in-home supports that it provides.

The VHA is concerned that consumers requiring direct case-management and care-coordination will be forced onto Home Care Packages due to the support offered by My Aged Care being insufficient to their needs. As outlined below, the VHA is not confident that the case-management and care-coordination services to be delivered by My Aged Care will have sufficient insight into consumer needs and the services and programs available from local service providers. For these more targeted programs it is suggested that existing consumers be grand-parented under existing arrangements, and that consideration be given to the continuation of the case-management and care-coordination functions at service provider level beyond 2015.

In addition to the grand-parenting of existing consumers, the case-management and care-coordination functions should be retained within the Linkages Program to allow these important functions to remain funded and available to eligible consumers.

Other Issues

Terminology

The VHA notes that the definition of the term ‘basic’, used throughout the discussion paper is unclear, as the programme can offer both short-term intensive care, and ongoing clinical and reablement care.

The term ‘basic’ lacks the appropriate nuance needed to accurately assess a consumer’s level of need and then develop a care plan. Further work is required to set out the concept of ‘basic’ care, as it will have a direct impact on whether a potential consumer is eligible as having needs “that do not exceed a basic support programme.”

It is important to define the CHSP as the ‘first tier’ of the aged care system and the discussion paper should aim to reflect this.

System Fragmentation

The VHA is concerned that the Victorian HACC system will experience fragmentation as a result of the transition to the CHSP. While the funding model offers contestability in a select number of areas, the long-term intention is to introduce individual budgets. In addition to the funding changes, the CHSP will

introduce new service providers to each region, many of whom have no existing relationship with consumers or current service providers.

The introduction of new service providers and the eventual implementation of individual budgets risks undermining links between existing service providers and other stakeholders. This risk can be reduced by ensuring that an appropriate organisation is tasked with local planning and integration of service providers and related stakeholders from across the health, aged care and social support systems.

Population Health Planning

The VHA is concerned that the CHSP lacks an effective local planning function that is able to analyse population health data and ensure that service providers in the region are appropriately targeted at local needs. While it is assumed that the RAO will have a degree of insight into the service provider profiles locally, it is unclear which body will have responsibility for collecting and analysing population health data and measuring the success of the CHSP.

Any local population health planning process undertaken through the CHSP must be integrated with existing state level processes to avoid contradictory outcomes and duplication.

CHSP Evaluation

The discussion paper does not detail the process for evaluating the success of the CHSP. Data from both My Aged Care and service providers should be collected and analysed to inform future changes to the CHSP. An evaluation process should be outlined as early as possible.

Volunteer Policy

The discussion paper notes the role of volunteers within the current HACC system, as well as recognising that these activities are currently supported by HACC non-output funding. The discussion paper does not, however, indicate how the input of volunteers will be managed in the CHSP. While the time and work offered by volunteers is provided at no cost to the funder, there are significant costs to the service provider associated with training, accreditation and management of volunteers that will now be unfunded.

This as a risk to the fabric of the HACC system in Victoria and may have a direct long-term impact on service providers that will now have to bear the costs associated with these unfunded activities.

Consumer Assessment

The VHA has a number of concerns about the lack of detail regarding the assessment protocols proposed in the discussion paper. The performance and efficiency of the CHSP relies on correct assessments and referrals by both the My Aged Care and RAO staff at each point of contact.

The discussion paper does not detail the protocol for reassessments, including expected lengths of time for reassessment of consumer need, triggers for reassessment within that period, or the party responsible for undertaking reassessments.

DSS must clearly outline their expectations for service providers when inaccurate assessments are made, including the protocols for reassessment by both service providers and RAOs, the assessment tool that service providers should use, and the process for delivering high levels of care when consumers' needs are reassessed.

Referrals to Service Providers

The discussion paper does not set out how consumer referrals to service providers will be managed equitably and transparently.

It is imperative that service providers and consumers have complete confidence in the RAO, and that consumers are referred to service providers in a way that ensures their needs are best met, and that complex consumers are fairly distributed across the service system.

It is important to recognise that many HACC providers will have to manage referrals from My Aged Care and their local public hospital at the same time. The discussion paper does not outline how service providers should manage this. The links and interface between health services and aged care providers should be recognised, and that hospital discharge staff should be able to access My Aged Care on behalf of their patient to ensure expedited referrals to a RAO is in place.

Complex Consumers

There is little detail about how consumers with lower levels of English proficiency will navigate the initial contact with My Aged Care. As discussed above, the ability of the consumer to accurately describe their level of need will largely determine how efficiently they will progress through the system. The VHA is aware of service providers that work with a consumer group, 80 per cent of whom do not speak English. The cost of translation for these consumers is partially funded, with the remainder supported by the service provider. The VHA is concerned that this level of support may not be maintained by other service providers that lack the experience and dedication to working with complex and CALD consumers, particularly if the funding mechanism does not recognise the added cost of working with these people.

Complexity also increases as consumers age, with those over 80 years of age with multiple health and/or psychosocial needs or dementia requiring additional time, support and resourcing, something that is not recognised in the discussion paper.

DSS must clarify how the CHSP's consumer assessment and service provision will manage the needs of complex consumers and those with low English language proficiency.

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Consumer Management Systems

There is a significant degree of variation within the sector in regards to IT capacity, particularly consumer management systems (CMS). Many Victorian health services operate a CMS that does not easily allow access to consumer records at an aggregate level, making it difficult to analyse and review data. Reporting systems for different government departments operate in parallel, often with dual entries required for a single consumer.

The VHA understands that a significant degree of work has been undertaken to ensure that the My Aged Care CMS can handle the demands of the CHSP, in terms of both consumer referrals and consumer record management. While it is important that the My Aged Care CMS operates efficiently, it is equally important that the CMS is able to interact with the systems used by service providers.

The VHA recommends that, subject to relevant privacy legislation, DSS ensure that service providers are able to access and manage consumer records in a way that does not require duplication. Doing so will ensure data quality is consistent and maintained at a high level, and will aid future evaluations of the CHSP.

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