COMMONWEALTH HOME SUPPORT PROGRAM

VHA Submission
Commonwealth Home Support Programme

17 April 2015

Background

A holistic approach to meeting the needs of older people must include recognition that the overwhelming majority of aged care consumers also currently receive, have received or will receive services from the health system. Those in residential care, receiving a home care package, or receiving Commonwealth Home Support Programme (CHSP) services will commonly receive health services within aged care programs, and outside of these programs at GPs, community health organisations, and public hospitals. It is also common for consumers to transition from health settings into aged care programs and vice versa.

The impacts of changes and reforms in the aged care system immediately affect the operation and service delivery of the primary, acute, community, and preventative health sectors. Reform implementation should always seek to ensure that policy development in one sector does not lead to unintended consequences in another. The extent of avoidable utilisation of health services in addition to, or as a replacement for, aged care programs which purport to meet the holistic needs of consumers can be seen as a marker of performance of the aged care system.

Service models must be designed to ensure that people receive care and support in the most appropriate settings, are supported to transition between service settings, and are able to receive services from multiple systems at one time in an integrated way that minimises duplication. Doing so can both better meet consumer preferences and save governments and individuals money.

As the peak body representing the public healthcare sector in Victoria the Victorian Healthcare Association (VHA) is keen to work with the Department of Social Series (DSS) to ensure the CHSP can meet the needs of its target cohort and does not result in unintended consequences to the Australia's healthcare system.

The VHA membership includes public hospitals, rural and regional health services, community health organisations, residential aged care facilities and Medicare Locals. In addition to a core commitment to advocate for a successful aged/health interface, the VHA also represents the public sector providers who provide services through the Home and Community Care (HACC) program, Day Therapy Centre (DTC) program, the National Respite for Carers Program (NRCP), and the Assistance with Care and Housing for the Aged (ACHA) program. In fact public sector providers make up 45% of HACC services in Victoria.

Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians from the perspective of its members.

Victorian Healthcare Association Ltd / ABN 54 004 228 111
Level 6, 136 Exhibition Street Melbourne Victoria 3000 T / 03 9094 7777 F / 03 9094 7788 E / vha@vha.org.au

vha.org.au

Victorian Healthcare Association

Submission Document

This submission has been prepared to respond to the CHSP draft Programme Manual (the Manual), Fees Policy Consultation Paper (the Fees Policy), and draft Good Practice Guide for Restorative Care Approaches (the Guide), and is set out in the following structure:

- Policy Design Comments Impacting on the Manual and Fees Policy
- CHSP Program Manual
  - General Comments
  - Challenges and Opportunities
  - Support for Providers
- National Fees Policy Consultation Paper
  - General Comments
  - Safeguard Arrangements
  - Barriers and Opportunities
  - Current Rates
- Good Practice Guide for Restorative Approaches
  - General Comments
  - Barriers and Opportunities

A: Policy Design Comments Impacting on the Manual and Fees Policy

Accessible Information

The VHA supports the accessible and readable language used across the three consultation documents, and acknowledges the consultative approach of DSS in the drafting process. However**,** **i**nformation must also be made available to consumers of the CHSP in accessible formats. There is currently a lack of information about these changes in languages other than English or accessible formats for those with vision impairments. The VHA supports the position in the National Aged Care Alliance (NACA) submission that these resources must be developed as part of the effective implementation of the CHSP.

Integrated Care in a Fragmented System

Many service providers in Victoria operate from an integrated care perspective, where various elements of primary health, mental health, social support, aged care, Alcohol and Other Drugs (AOD) services and preventive healthcare are combined within the single organisation to allow a consumer to receive a comprehensive and linked care plan. 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 in their local service providers. The assumption that My Aged Care will be able to efficiently provide care coordination on behalf of each service provider ignores the diversity of scope and suite of programs available. The VHA is concerned that the model proposed in the Manual undermines this integrated approach to the detriment of consumer outcomes.

Equity of Access: Challenges

The guidelines refer to equity of access; however there are no directions for how vulnerable groups will be ensured access. The core principle of equity of access should have a much stronger presence in the drafting of both the Manual and the Fees Policy. This principle needs to be matched with specific policy design measures to ensure that the CHSP continues to address the needs of all of the members of the target population. The VHA is concerned that a number of policy design elements of the current drafts of the Manual and Fees Policy are not consistent with this principle. These include:

- *Growth funding via fees*

The feedback provided here should be read in the context of the decision to reduce the CHSP growth fund from 6% to 3.5% per year due to the expectation that fees collected will generate 15% of the overall CHSP program and that fees collected by CHSP providers are to be utilised to expand service offerings and increase occasions of service.

The VHA is concerned that allocating growth via the collection of fees moves away from a principle of equity of access and may lead to a system in which more services are provided to areas in which consumers are more able to pay fees. The VHA is also concerned that areas with lower socio-economic status catchments will not be able to collect adequate fees and will not be able to match service growth to service demand. If not complemented with a strong service planning approach and alternate arrangements for lower socio-economic areas, this approach may mean that the needs of more disadvantaged and vulnerable communities are not met. This in turn may then place the burden of service provision unduly on the health systems and lead to poorer outcomes for consumers.

Allocation approaches and service planning need to reflect the needs of target populations across geographic catchments. The VHA is also concerned that the CHSP lacks an effective local planning function that can analyse population health data and ensure that service providers in the region are appropriately targeted at local needs.

- *Access for complex consumers*

It is imperative that consumers are referred to service providers in a way that ensures their needs are best met.

Although My Aged Care referrals will include a client prioritisation rating and a capacity for consumers to report urgent requirement of services, the referral process as currently envisaged does not have any safeguards to prevent service providers from only taking referrals for consumers with needs that are easier and more cost effective to meet. This may mean that complex consumers may wait substantially longer to receive services, have fewer choices than other consumers, or may not be able to find a required service. In a such a system it is likely that the public and not-for-profit sectors will be left to manage the bulk of complex consumers with more cost intensive needs without sustainable financial support.

- *Language services*

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 progress through the CHSP.

The VHA is aware of service providers that work within communities and target groups in which up to 80% of consumers do not speak English. The cost of translation for these consumers is partially funded, with the remainder supported by the service providers. The VHA is concerned that this level of care and support may not be equally maintained by other service providers that lack the experience and dedication to work with complex and CALD consumers, particularly if the funding mechanism does not recognise the added cost of working with these consumers.

> *"Almost 100% of the consumers on our waiting list for OT services require a translator; these are costs that we just can't continue to absorb."*
> **– Manager of Community Services at a Community Health Organisation**

- *Mandatory Fees for the CHSP cohort*

The VHA is concerned that the fees policy may not represent the cohort of likely users of CHSP services. It appears to be based on the assumption that the majority of service users are partial or non-pensioners and able to pay fees with only a minority requiring the hardship provisions.

However, the current reality is that a large proportion of those who can afford to pay fees choose to access private services and those that currently access HACC are frequently not able to pay the level of fees illustrated in the attached schedule. This means that a majority of consumers may need to utilise the hardship provisions.

Designing a system in which a majority of consumers are utilising hardship arrangements stigmatises the consumer and potentially creates a barrier to service access. This is particularly true of the many community health organisations that provide services specifically to lower socio-economic catchments and diverse groups.

The fee structure should be designed in a manner that accurately reflects the service user cohort, so that hardship provisions are only needed by a small proportion of consumers.

> *"Approximately 80% of our consumers currently have their fees waived due to financial hardship, an evaluation of their living environment and social determinants of health."*
> **- Divisional Director Primary Care from a Community Health Organisation**

Equity of Access: Solutions

In order to address the concerns outlined above the VHA recommends that DSS consider the following approaches:

- *Service Planning*

In the longer term My Aged Care be responsible for collecting information about ability to pay, setting fees, recording information about fees paid, implementing fee caps, and collecting fees. These fees can then be redistributed across providers to reflect planning priorities and community need rather than providing perverse incentives for growth of service provision in areas where there may be less need but a greater ability to pay.

- *Specialist Services*

The VHA notes that some service providers focus on delivering service to a cohort of diverse, complex or vulnerable consumers who will, in the large majority, be approved for hardship. This may include homelessness CHSP services, services focused solely on some rural/remote communities, services focused on delivering care in public housing settings, or community health organisations that were established to provide services to disadvantaged areas and vulnerable cohorts with complex needs.

These services should be able to apply for status as a 'specialist provider' and could have the following arrangements:

- A blanket fee waiver option for those providers who specifically target lower socio-economic communities where they can demonstrate that their client base is collectively covered under the hardship guidelines.
- An alternate funding model to ensure that the additional costs of providing services to these cohorts, including funding for specific services such as translators and case management, to ensure that the needs of their communities are met.
- Until My Aged Care is in a position to redistribute fee revenue in a way that matches service planning best practice, an alternate approach to distribution of growth funding is applied to ensure that funding reflects the needs of communities rather than the consumers of specialist providers' ability to pay fees.

- *Complex and vulnerable consumers*

A supplement incentive structure similar to that operating in residential aged care that currently mandates minimum rates of supported residents and provides additional funding to those providers that exceed 40% supported resident rates. This structure could set:

- Mandated rates, based on the demographics of the catchment area, of complex/diverse/vulnerable/supported consumers to apply all service providers; and
- Target rates of complex/diverse/vulnerable/supported consumers that are matched to an incentive in the form of a higher funding rate.

People with Disability

The VHA is concerned that people who acquire a disability after the aged of 65 have not been considered within the Manual. A clear vision and system for those over 65 with a disability requiring services is needed.

Estimates vary, but a substantial percentage of those under 65 currently receiving disability services through HACC are not anticipated to be eligible for a NDIS plan. The arrangements for transition and for ongoing funding and service provision to this cohort are urgently needed.

Page 8 of the Manual states "DSS determines that other circumstances justify the delivery of services to the younger person", and more detail on this is required, particularly regarding how it relates to those under 65 in need of palliative care or who have early onset dementia.

Monitoring and Evaluation

The operation of the CHSP should be closely monitored and evaluated, to ensure a continuous improvement approach to reform implementation. This process should seek to monitor:

- Any increase/decrease in workload on service providers as part of the Manual
- Impact of fees on consumers, specifically the discontinuation of required services and the rate at which consumers decline services due to cost.
- The rate at which consumers access similar services via alternative programs/funding streams due to a real or perceived inability to pay fees, particularly the public health system including preventable acute presentations. That is, the frequency with which health service funding and services are utilised in situations where a CHSP service response would be more appropriate.
- The geography of fee collection and hardship determinations, with consideration of the local socio-economic background of older locals to identify any inequity across areas with high numbers of hardship consumers.
- The movement of consumers from CHSP to Home Care packages.

B: CHSP Programme Manual

B:1 CHSP Programme Manual: General Comments

Basic Support

The stated intent of the CHSP is to provide a 'basic' level of support as the entry level or 'first tier' of an end-to-end aged care system. The VHA supports the creation of such a program and the Manual's description of the CHSP's core purpose. However, there is significant concern that this approach overlooks the significant benefits that the provision of CHSP level services – as a 'top up' to a home care package or as a short-term intensive program – can have for both the consumer and for the sustainability of the aged and health systems by keeping people safely at home for longer.

The CHSP should continue to allow consumers to access higher-intensity services where this is the most appropriate service offering for that individual, where it can prevent unnecessary entry into residential care or avoidable admissions into acute care.

Assessment

The VHA has a number of concerns about the lack of detail regarding the assessment protocols proposed in the Manual. The performance and efficiency of the CHSP is reliant on correct and appropriate assessment and referrals by the My Aged Care and Regional Assessment Service staff at each point of contact.

- *Inaccurate assessment and referral process*

The Manual does not detail the protocol for service providers who, upon receiving a referral from My Aged Care / Regional Assessment Services, find that the consumer's needs are beyond the assessed level. The VHA requests that DSS clarify how inaccurate consumer assessments will be managed, both by service providers and Regional Assessment Services.

- *Monitoring and reassessing needs*

Clarity is also needed around the process for monitoring and reassessment of consumer need. With the removal of assessment, care coordination and case management from CHSP providers, many consumers may only have access to one service provider staff member and if they are provided domestic assistance, for example, they will require considerable guidance as to when to refer back to the My Aged Care / Regional Assessment Service.

- *Care planning*

Clarity is required around the development of the service plan and how this fits with meeting client directed goals, motivations and aspirations. If the service plan is to sit centrally, it should be made clearer who is responsible for the formal review, updating and providing a copy to the client as required under the current home care standards.

Referrals

- *My Aged Care*

It is recommended that My Aged Care link with the National Deaths Index to ensure referrals to service providers do not lead to providers accepting referrals for or contacting the deceased whose families are subsequently contacted.

- *Referrals from the Health System*

Currently it is common for referrals to come directly from GPs and hospitals who have extensive knowledge of the consumer's experience. Service providers have existing relationships with GPs and hospitals and changing this practice to include a My Aged Care / Regional Assessment Service assessment process will require significant communication and change management efforts.

The VHA recommends that the links and interface between health services and aged care providers be explicitly recognised in the Manual, and that hospital discharge staff be guaranteed access to My Aged Care on behalf of their patient to ensure expedited referral to a Regional Assessment Service is in place.

GPs and relevant hospital staff should be able to contact My Aged Care and register a consumer for a client record on behalf of the consumer. This process should be made as simple and timely as possible as consumers transitioning from hospitals are generally of a high clinical priority and no delays to discharge planning should result from the My Aged Care registration and assessment process.

It should also be noted that currently post-acute programs exist to ensure consumers have access to interim services upon discharge while they wait for an assessment, which can take weeks. Services must be made immediately available to consumers to ensure they are safe in their homes upon discharge while they wait for an My Aged Care / Regional Assessment Service assessment and the commencement of CHSP service provision.

Additionally, in the case of hospital transfers the CHSP service provision and fee policies must be flexible to ensure that those leaving hospital, who do not require ongoing case management, can access the significant services they require in the short term and are able to return to lower level CHSP services in the longer term.

- *Referrals between providers*

The Manual reads as though only My Aged Care / Regional Assessment Service will be able to make referrals for service provision, and that this system does not allow direct referrals between services. This would act as an unnecessary delay and barrier to access; it would also lead to duplication for both the consumer and for My Aged Care / Regional Assessment Service.

> *"For example, our OT may be referred to see a client and while they are completing their service specific assessment note that a Physio for balance assessment and speech for swallowing would be beneficial. If the client agrees, currently the OT can make a referral and our other HACC allied health services can be involved immediately. In the draft CHSP Manual it seems that before any other HACC allied health discipline can get involved, the My Aged Care and Regional Assessment Service would have to do another assessment and recommend the services become involved. This seems like a lot of duplication for the client and the Regional Assessment Service /My Aged Care. I think it would be better if the CHSP provider could update the client record on My Aged Care to say that the client has agreed and consented to another referral."*
> – ***Community Allied Health Manager from a Regional Health Service***

Sub-Programme & Service Types

- *Carer Programmes*

The Manual indicates that carer programmes will no longer form part of the CHSP. However, more clarity is required for transition arrangements for these services where they are currently being delivered through programs that will be consolidated into the CHSP.

- *Advocacy*

HACC Advocacy is no longer included in the CHSP, however the transition arrangements for the existing program and the future of CHSP consumer and policy advocacy need to be made transparent.

- *Allied Health and other Therapies*

Exercise physiology needs to be included on page 12 as it is on page 31.

- *Assistance with Care and Housing*

The VHA supports the decision to leave this program as a separate sub-programme. Providers that currently deliver services to the homeless and those at risk of homelessness have highlighted the need for assessment to continue as an ongoing process by the service provider who has (or who develops over time) a relationship with the consumer.

> *"In our experience in working with homeless people assessment needs to be an ongoing process and there is need to revisit service users' needs at regular intervals as the process of disclosure may happen over time. This is particularly the case for people have experienced trauma and need additional support.*
> **– Policy Manager at a Community Health Organisation**

A flexible service response that supports both in-reach and outreach and which links consumers into the service system is also required, as people who are homeless and/or have complex needs are at risk of being lost out of the service system if this is not retained.

The Manual should also clarify that those consumers aged 50–65 who are homeless or at risk of homelessness are eligible for all CHSP services, not just the ACHA stream.

- *Sector Support & Development*

This section of the Manual is currently blank and the VHA notes the importance of these activities, the need for consultation and the short implementation time frames currently facing DSS. Clarity is urgently sought on the future of existing support and development activities.

Case Study

Multiple providers have indicated that the case study on page 3 of the Manual is far too simplistic and that the client described has needs that are not identified or responded to in the example response.

"The client has memory issues and is only eating three days per week. The care needs of the client were not adequately assessed or addressed with the correct service provision; what about the following considerations:

- *Investigating the memory loss as a result of malnutrition/dehydration and/or dementia, delirium, polypharmacy, infection e.g. Urinary Tract Infection*
- *Meals on Wheels three days per week but no strategies around assisting the client to remember to eat*
- *Personal Care Attendant to monitor the client's weight loss/gain*
- *If the client forgets to eat, they are most likely also not taking their medications, what about those tablets that should be taken with food – resulting in gastric upset. What other daily personal activities are being forgotten e.g. doctors' appointments?*
- *Cooking of meals at other times – are they at risk of leaving the gas on, do they understand how to raise an alert in an emergency?*
- *Is the client at risk of people taking advantage of them due to their cognitive impairment?*
- *Services that should also be considered include General Practitioner, Allied Health Occupational Therapist, Dietetics, Speech Pathology, Shower assessment, Possibly Nursing for medication management, Social Support at meal times, weekly weights via a PCA.*
- *Does the client have a licence/vehicle, is she safe to drive – what transport needs may she require?"*

- Staff member at a Regional Health Service

B:2 CHSP Programme Manual: Identify any key challenges you might face in implementing the responsibilities outlined for CHSP providers.

Grandfathering Arrangements

The VHA supports the grandfathering of existing consumers and their current rates of service provision. The Manual, however, provides very limited information on the management of the grandfathered consumers into the future. The VHA recommends that DSS prepare a transition plan that outlines how providers are to manage these consumers.

Additionally, the VHA supports clarification of grandfathering arrangements, as requested in the NACA submission for the following specific categories of existing consumers:

- Living in residential care who currently access day therapy centres;
- Currently receiving more than a 'basic' level of support (particularly where consumers are either financially unable or refuse to migrate due to costs onto the home care program);
- Accessing current HACC services at a level akin to a Home Care package because there is no appropriate level of home care package available in their area;
- On a lower level home care package who are "topping up" their services from the CHSP programmes because the package at their assessed level of need is not currently available in their area; and
- Currently being managed under HACC case management services.

Assessment functions

The Manual outlines assessment functions to be undertaken by CHSP providers. This includes 'service level assessment activities such as work, health and safety' and 'on-going monitoring of the client, the home environment; and appropriateness of service arrangements'. The VHA requests that substantially greater detail and clarification be given to outline exactly what activities providers are expected to undertake. The VHA also notes that in removing assessment as a funded service type, the level of expected assessment activity may become difficult to meet.

Given that CHSP consumers are expected to engage multiple service providers the issue of duplication of this work, inconsistency in reporting findings and overlap of responsibility are all of concern. The selection of a 'core provider' to oversee these assessment, monitoring and referral tasks would ensure that these activities are undertaken and are not duplicated by multiple providers.

Volunteer Policy

The Manual sets out the responsibilities of providers in regards to police checks, OHS and other requirements in utilising volunteers in their CHSP service provision.

The Manual does not, however recognise the crucial role volunteers play in the provision of CHSP services, or indicate how the input of volunteers will be managed in the CHSP. While the time and work offered by volunteers is technically provided at no cost to the funder, there are significant costs to the service provider associated with training, accreditation and management of volunteers that in the Manual will now be unfunded.

The VHA sees this as a significant risk to the fabric of the existing HACC system in Victoria and is concerned about the long-term impact to service providers that will now have to bear the costs associated with these unfunded activities.

B:3 CHSP Programme Manual: Identify any support which you, as a provider, might appreciate, to meet your requirements as a CHSP service provider.

Interacting with My Aged Care

The transition to My Aged Care will require staff training, infrastructure updates and considerable administration time entering information into the client record that in effect duplicates the provider's

own more detailed records. These cost imposts have not been recognised and need to be supported during the transition.

Infrastructure, particularly IT, in service providers is variable and funding is required for staff time taken to train assessors in the use of the My Aged Care Client record and national assessment framework, as well as for equipment needed to access the portal, particularly for outreach.

The new assessment and referral system requires all assessments to be done 'on line' in a consumer's home. This means that what is currently a majority paper-based system will be transferred to laptop and iPad technology. The costs associated with the mandatory purchasing of hardware needs to be funded to ensure it is not a burdensome cost impost – particularly for not-for-profit and public providers.

It is also anticipated that many providers will end up supporting consumers to interact with My Aged Care and this time burden has not been acknowledged or funded.

DSS contact and Support

The VHA recommends that specific support contacts be allocated to geographic catchments and contact details given to all providers in the catchment. Particularly in the transition period, this will allow providers to have a consistent point of communication with DSS allowing them to have their questions and queries responded to in a timely and consistent manner.

C: CHSP National Fees Policy Consultation Paper

C:1 CHSP Fees Policy: General Comments

'Minimum' Rates

VHA supports the discretion given to a provider to charge less than the rates set out in the fee schedule. If there is any intent to remove this flexibility then substantially more work would need to be undertaken to examine the appropriateness of these rates to ensure that no unintended consequences – such as cost shifting to the broader community and health systems – would apply.

The VHA recommends that the word 'minimum' be removed from the fee schedule, as in practice the hardship provisions allow providers to make decisions to reduce fees or to waive them entirely. It is recommended that these be labelled 'Suggested' or 'Indicative' Rates.

The VHA also recommends that a caveat be included that these rates should not exceed the cost of service provision to align the arrangements with the 'standard' fee arrangements.

Standard Fees

The Fees policy indicates that providers will set 'standard' fees for non-pensioners that will be up to the full cost of the service. It is not clear whether the definition of 'cost of service' includes a rate of return.

The VHA also believes the terminology of 'standard' is potentially misleading and should be replaced.

Service Occasion

The VHA supports a fee for service occasion, rather than an hourly rate as this would reflect the diversity of need and the principle of equity of access for consumers.

> *"Last week one of our OTs had to take a client to Melbourne for a meeting with a wheelchair supplier to get some wheelchair modifications completed. This process meant that the client was with the OT for six hours and technically receiving OT intervention for this time. I don't think it is appropriate to expect a client to pay upwards of $60 in fees if we are using the hourly rate. As well as the difficulties administrating the charge for part hour fees I think it could impact some consumers that are more complex and therefore require more time to manage a situation."*
> **- Community Allied Health Manager from a Rural Health Service**

The VHA recommends that an option to charge a single fee for multiple services delivered in a single service occasion ought to apply to encourage consumers to access multiple services in a convenient, integrated and cost-effective ways where appropriate.

Service Frequency

The rates should also reflect likely frequency of service provision. Those services that tend to be delivered at a greater frequency should have a lower rate. For example, it can be assumed that someone will need multiple showers in a week, therefore personal care should have a lower rate, or a weekly rate attached to it. Gardening however, may happen every fortnight or month and a slightly higher once off fee may be more appropriate.

Fee Cap

While it is understood that a high rate of fees is intended to act as a trigger to transition to the Home Care Package program, the VHA is concerned that this may lead to unintended consequences.

The rates outlined for full and part pensioners may exclude or discourage consumers from accessing CHSP services and instead relying on other healthcare services, including community health and acute services. The flow-on consequences need to be considered and the risks to health services mitigated.

Alternatively, these consumers may stop accessing the services they require, which may lead to avoidable admission to residential care or unnecessary and costly presentations at emergency departments.

Community health organisations currently providing HACC services to culturally diverse communities have indicated that without such a cap there is a significant risk of consumers no longer accessing the services they require, potentially not admitting to the financial hardship caused by paying high rates of fees, or going without other necessities in order to pay fees, such as turning off their heating/cooling or cutting meals from their diets.

A fee cap is recommended to protect those whose needs are best met through the CHSP, but who may not be able to pay high rates of fees that their multiple service activities will attract.

Victorian Healthcare Association

For example, many nursing services have consumers who require medication assistance twice daily; the fees associated for pensioners are between $198–300 a month and for part-pensioners $640–960 per month.

The VHA understands the administrative difficulties associated with implementing a fee cap, but in the context of a long-term shift to a single home care system, suggests that:

- In the short term, a suggested weekly cap is included in the fee policy; and
- In the medium to longer term, fee information and pensioner status be captured by My Aged Care and that a fee cap and formal reassessment trigger be included in My Aged Care functionality.

Transport

The transport consumer fees are clearly designed to reflect the increased cost of provided transport over longer distances. However, the distance-based approach to setting transport fees contravenes the equal right of those living in rural and remote locations to access the services they require in their own communities.

Services providing crucial services to those in regional, rural and remote communities (particularly in areas where poor or non-existent public transport systems make CHSP transport services their only option) must be supported to remain financially sustainable. It is proposed that funding of transport to providers be based on a distance model to ensure that the additional costs (of both provided services in a person's home where they live in a remote location and the provision of transport as a service type) faced by providers servicing populations in rural and regional settings are met.

However, consumers who live in rural and remote locations have the same right to access services as someone living in a metro location does and this should be reflected in the application of a flat transport fee structure. In fact, those in rural areas where there are no alternate public transport options rely more heavily on aged care transport and should not be presented with disincentives or barriers to using CHSP transport services.

Other comments on the fee schedule:

- The VHA supports the decision not to include the Assistance with Care and Housing for the Aged (ACHA) within the fees policy.
- A distinction between individual social support and group social support should be recognised with the introduction of reduced fees for group support.
- A distinction between face-to-face service provision and telephone-based service provision should be applied, with the introduction of a reduced fee for any telephone-based services.
- The part-pensioner fee for nursing services is $32 per hour; this seems inconsistent with the rest of the fee schedule and VHA recommends this be brought into alignment with the rest of the schedule at $12 to prevent unintended demand for these services through the broader health system, or an increase in avoidable emergency department presentations.
- The in-home respite fee should be service-based not hourly, as this will move people into centre-based respite options which do not reflect consumer preferences.
- A nationally consistent fee for allied health groups, e.g. short-term education and exercise groups, that is substantially less than the proposed allied health rate should be included.

C:2 CHSP Fees Policy: Are there any additional safeguard arrangements that should apply for client financial hardship?

Further Guidance

The VHA recommends the development of further guidance for consumers and providers on the hardship arrangements and tools for applying these. This may include factsheets for both consumer and providers and an indicative hardship calculator tool.

There is no methodological guidance for service providers to determine how much a consumer experiencing hardship could reasonably afford to pay. The VHA recommends that further guidance is included to avoid inequity for consumers across service providers.

A formal process for the use of hardship provisions to reduce or waive fees should include a mechanism for linking consumers with social workers or like services that can support with resolving financial issues where appropriate.

Contributing Factors

Broader information should be provided on contributing factors for considering financial hardship than the current example of 'high pharmaceutical costs'. This may include:

- Consumers co-contributing to a significant home modification.
- Other high expenses such as utilities, child care costs, transport costs, specialist care costs, and special food requirements with high costs.

C:3 CHSP Fees Policy: What barriers or opportunities do you see in applying the proposed fee policy and standard fee schedule?

Assessing Applicable Fees

The VHA supports distinguishing fees for pensioners, however recommends that categorising a consumer should be the role of My Aged Care not service providers. There is no funding to support the additional administrative burden this represents for providers.

Notifying Consumers of Fees Prior to Commencement of Services

Nursing services are sometimes used to provide a rapid response to referrals that enable a consumer to avoid a hospital presentation. However, consumers are not always able to be contacted prior to a service commencing. There needs to be exceptions where this requirement to allow these urgent services to continue.

Collection of Fees

The collection of fees will become more complex for many providers who currently charge a single fee rate, particularly in situations where multiple services are provided in a single interaction. In the short term, this will require additional resources to manage invoices and payments. As identified above, the VHA recommends that in the longer term, responsibility for collecting fees shifts to the My Aged Care to allow the implementation of a fee cap and the allocation of growth funding according to geographic needs-based service planning rather than a client's ability to pay.

Victorian Healthcare Association

Fees as a Trigger for Home Care

The policy assumes that those with increasing service needs can simply access a Home Care Package. However, there are substantial wait times for packages in many areas and they tend to be unavailable at short notice. Safeguard arrangements for those waiting for a Home Care Package should be introduced that cap their fees so they do not have to pay beyond the Home Care Package fees in the interim.

The higher use of CHSP services and increasing fees are established in the policy as a trigger for a Home Care Package, however this ignores that many of the high-end users of HACC services require short-term episodic care. Such consumers are better served by the intensive short-term interventions that can currently be provided through the HACC system as they can respond to their changing needs. Additionally, this episodic service approach is more sustainable than prematurely forcing a consumer onto a permanent and higher-level package intervention.

C:4 CHSP Fees Policy: Do you currently charge more than the rates proposed in the fees schedule attached to the consultation paper?

The majority of public health services and community health organisations currently charge significantly less than the fees indicated on the schedule. The Manual sets out thresholds that are significantly lower than current rates in Victoria. The proposed arrangements would see people of lower incomes paying fees which are significantly higher than current rates.

As outlined above, the VHA has concerns about the indicated fees posing a potential barrier to access and the corresponding burden on other public health services including avoidable emergency room presentations.

D: CHSP Good Practice Guide for Restorative Care Approaches (incorporating Wellness and Reablement)

D:1 CHSP Good Practice Guide: General Comments

The VHA supports the general direction, intent and tone of the Good Practice Guide, as it reflects the current philosophy and approach of the Victorian system and in particular the Victorian Active Service Model (ASM).

The VHA notes that the current performance of many Victorian service providers is already beyond the approach described in the Guide and would like to see the tenor of the document indicate that it is an expected minimum rather than a prescribed maximum. This would draw the document in line with the national commitment to ensure that the CHSP lifts national practice to the highest level of current practice and does not reduce the efficiency and efficacy of current practice of those providers that currently excel in restorative care.

The VHA also notes the Guide's focus on the WA service model and suggests that there is also room to highlight more of the Victorian service system strengths in wellness and reablement approaches, which are widely recognised.

Victorian Healthcare Association

Coordinating Appointments

The VHA considers that the description of support planning on page 23 of the Guide has been simplified. For those consumers with multiple appointments the coordination of these appointments becomes important and currently the practice in many Victorian health services is to provide coordinated appointments to make service systems as simple to use and understandable as possible for consumers. The loss of the coordination role in this part of the system is problematic for people who need to access a range of service providers and this section of the guide glosses over this issue.

D:2 CHSP Good Practice Guide: What barriers or opportunities do you see in implementing these approaches?

Holistic Care Approaches

The implementation of a wellness and reablement approach relies on the successful integration of the aged care system with health, allied health, and other core service systems. The implementation of such an approach should be seen as an opportunity to embed effective interfaces between these systems, and continue to strengthen partnership approaches between relevant organisations. In jurisdictions that already have strong partnership approaches the implementation of the guide should not seek to replicate or replace this system.

Open and frequent communication between My Aged Care /Regional Assessment Service and service providers will be crucial to implementing a wellness and reablement approach and short-term restorative care. The separation of assessment and service provision could potentially act as a barrier to this communication and it is imperative that feedback is timely and accurate to ensure that changes are recorded and care plans updated.

Complex consumers

Barriers including cultural, language, housing, and complexity can affect the time required to plan approaches and deliver services aimed at reablement. It is imperative that additional assistance is provided to support consumers with complexity or additional barriers to access restorative care.

While complexities and complex needs are identified under assessment and support planning, there is no definition or guidance as to what will constitute such needs or result in such an assessment. The VHA requests clarity of this definition, as this may have a significant impact on access and outcomes for a significant proportion of the public sector client group.

For further information, please contact:

Nina Bowes
Manager, Aged Care
nina.bowes@vha.org.au
(03) 9094 7777