Department of Health

Challenges and opportunities in delivering aged care services in remote regions

Final Report
February 2016
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Executive summary

Introduction

KPMG was engaged by the Department of Health (the Department) to undertake qualitative research into the challenges and opportunities faced by aged care service providers delivering aged care services to clients in remote regions. This research was based on site visits and interviews with 17 remote aged services located in New South Wales (NSW), Queensland (QLD), Western Australia (WA), South Australia (SA), and the Northern Territory (NT). For each site, KPMG prepared a case study presenting the challenges experienced in supporting remote aged care clients and their impacts on both the service and consumers.

This report presents a thematic analysis of the challenges, service delivery barriers, identified impacts and lessons learnt, including local innovations identified across the 17 case studies. It aims to inform the Department's development of strategies and policy options to foster improved service delivery and sustainability across aged care services in remote Australia. A number of the challenges and issues identified in this report align with findings documented across recent literature.1

The following section provides a high level summary of the key findings and themes from the 17 case studies. The key challenges and issues identified in each domain are explored further in Section 2 of this report. A range of policy considerations for the Department to address these challenges are included in Section 3 of this report.

Key findings / themes

The domains of enquiry and key insights in each domain were:

- **Service management type** examined the organisation's corporate and management structure. The remote aged care providers consulted varied in size, structure and remoteness. Notably, larger providers and those located in less remote locations reported they were better able to respond to the challenges of remote aged care delivery due to more extensive internal resources, as well as ability to recruit the required workforce. In comparison, small providers were particularly vulnerable to loss of clients and were nervous about the impact of competitive consumer driven environments (Increasing Choice and the National Disability Insurance Scheme, (NDIS)) on their financial viability, particularly with high operating costs and limited revenue. Small community controlled providers appear to have stronger community linkages and ownership, but often lacked networking opportunities for support and innovation.

- **Entry and screening** examined systems and processes for accessing aged care services. Providers identified interactions with My Aged Care as a challenge for many consumers, especially Indigenous people. Providers are allocating unfunded time to support this process. Notably, a large proportion of providers believe there are people in their communities who would benefit from aged care services, but whose needs they are currently unable to meet.

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1 Examples include:
- Aged and Community Services Australia. Issues facing aged care services in rural and remote Australia (2013).
Executive summary

Key findings / themes (continued)

- **Eligibility and assessment** examined systems and processes for assessing consumers. Challenges encountered included poor access to Regional Assessment Services (RAS) and Aged Care Assessment Teams (ACATs) in some locations, leading to delays in assessments. Many providers commence service provision immediately on referral / presentation; however due to the level of client need and community expectations about immediate care, much of this support is unfunded. However this may partly be an issue of educating providers about existing provisions which enable urgent service provision prior to RAS / ACAT assessment.

Indigenous consumers again experience a range of cultural barriers impeding their interactions with assessment services, requiring providers to support these interactions. Providers are seeking alternative arrangements to the current My Aged Care notification letters, particularly for Indigenous consumers.

The My Aged Care Service Finder tool also concerned some providers as it provides misleading information on service availability, particularly for new assessors who are unfamiliar with the market.

- **Service delivery** examined challenges including costs of service delivery, managing the implications of client choice, and impacts of recent aged care reforms. Providers consulted consistently presented the view that current funding models are not appropriate to the remote aged care context. Key issues reported included a perceived lack of flexibility to respond to the complex and varied needs of remote aged care consumers, and funding models that do not address the significant costs of remote service provision.

There is a common lack of access to allied health and nursing staff due to the isolation and challenges recruiting qualified staff, indicating there is little rehabilitation focus to the services provided. Providers instead prioritise delivering meals, respite, social activities and transport as core services. These are often centre-based rather than in the client's home.

Aged care providers are also required to provide a range of unfunded services and supports to respond to the needs of their community and to fill broader service gaps derived from their remoteness. Providers are seeking new service and funding models which are better matched to the remote aged care context and the needs and circumstances of their clients.

- **Workforce** considered the challenges associated with the availability and maintenance of a skilled workforce. Providers face significant challenges in the recruitment, retention and professional development of their staff, and in particular management, nursing and allied health staff. Access to affordable, quality and secure housing is a significant barrier to recruitment, with some providers opting to subsidise or manage suitable housing stock to incentivise employment. While some providers have identified development of a local workforce as a priority, training is expensive to access.

Providers also face a range of challenges in employing Indigenous staff due to often low skill levels, differing attitudes to work and absenteeism. The larger providers had greater access to experienced management and service staff than smaller providers and were better able to offset higher costs of recruitment within the broader organisation.
Executive summary

Key findings / themes (continued)

- **Funding and finance** examined the appropriateness of funding models and payment and claiming systems and processes. Providers were consistent in their view that current funding for remote aged care service provision is insufficient, with the majority operating services making a loss. Significantly higher operating costs together with revenue challenges are driving these losses. Providers are therefore heavily reliant on the remote viability supplement to maintain operations.

  Difficulties in obtaining consumer contributions and provision of unfunded services, both prior to and post-assessment, are also placing pressure on the financial viability of many providers. Small remote aged care services are vulnerable to changes in clients and funding due to their small size. In particular, they lack the economies of scale to effectively support service delivery, particularly with covering high fixed costs.

  Shifts towards individualised funding models and portability of services, together with recent Aged Care Funding Instrument (ACFI) changes have increased their sense of vulnerability. This limits their capacity to invest in staff, training, equipment and infrastructure.

- **Quality and regulation** examined the appropriateness of quality review processes and the impact of regulatory requirements. The majority of providers see quality as a priority and reported they have few challenges in meeting these requirements. Some smaller providers reported experiencing challenges with adhering to multiple sets of standards, but this was not the case for those that were National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) or Multi Purpose Service (MPS) providers. A few reported a need for accreditation assessors to better understand Indigenous and the remote aged care context.

- **Reporting** examined challenges associated with funder reporting requirements, systems and processes. Providers reported few concerns relating to reporting requirements. However a small number of small providers have had difficulties, often linked to high levels of staff turnover as well as a lack of staffing resources to direct to reporting requirements. Where reporting was not a matter of concern, services often received administrative support from a centralised team within the organisation.

- **Facilities and infrastructure** explored the suitability of service infrastructure and challenges associated with making capital improvements. Providers have a range of high infrastructure requirements and costs. Providers believe current funding models do not adequately recognise these costs nor address capital maintenance and replacements needs. Difficulties collecting Refundable Accommodation Deposits (RADs) as well as the Basic Daily Fee (BDF) are contributing to these funding pressures.

  It was also apparent that some providers would benefit from further information about access to funding streams available to support capital investments. However, where capital grant programs are available, workforce capability and capacity limitations can mean providers struggle to prepare a successful application.
1. Introduction

1.1 Project context

Over ten per cent of Australians aged 65 and over live in outer regional, remote and very remote locations, while 1.5 per cent live in remote and very remote locations. Indigenous peoples form a significant proportion of the population in remote and very remote locations. Australians living in rural and remote areas tend to have poorer health outcomes than other Australians, with shorter life span, higher levels of disease and injury, and poorer access to services including aged care.

It is essential that older Australians in rural and remote areas have access to aged care services that support them to remain in their own homes and/or access supports during their last years of life. However, as outlined by the Department, a number of challenges have been identified that impede the provision of services in remote areas including:

- Workforce
- Service costs
- Provider viability
- Timely access to quality and culturally appropriate care
- Limited service availability, scope and diversity, particularly for more complex care
- Aged infrastructure
- Administration
- Community relationships
- Cultural attitudes and beliefs, particularly amongst Aboriginal and Torres Strait islander communities, which can impact both care seeking and delivery behaviours
- Seasonal climatic impacts

As a result of these challenges, there are a number of initiatives and supports available to improve the sustainability of aged care service delivery in remote regions. These include the:

- Viability supplement to support residential aged care and Home Care Package (HCP) providers
- Flexible funding via the MPS model
- NATSIFACP.

However, despite these initiatives, challenges persist in developing robust, sustainable aged care services in remote areas, that meet the individual needs of older Australians within the framework of the aged care reform process. Through this project, the Department is seeking to identify and more fully understand the issues impacting service delivery and access for consumers and to identify policy options for improving the sustainability, viability and quality of remote aged care providers.

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1. Introduction

1.2 Project purpose, scope and approach

Project purpose and scope

The purpose of this project is to research and evidence the challenges experienced by service providers in delivering aged care services in remote and very remote regions. This will assist the Department to further consider strategies or policy options that encourage greater sustainability, improved service provider viability and delivery of quality aged care services.

The scope of the project includes providers who deliver services to Indigenous and non-Indigenous Australians, and providers who deliver services funded under both mainstream and flexible aged care programs across residential and home settings.

Project approach

The Department identified 17 remote aged care service providers across five states and territories, each operating in remote and very remote regions (classified as regions 6 and 7 under the Modified Monash Model (MMM)). The providers deliver a range of aged care services including Commonwealth Home Support Programme (CHSP, operating as Home and Community Care in Western Australia), Home Care Packages, residential aged care (RAC), Multi Purpose Services (MPS) or via the NATSIFACP.

KPMG undertook site visits to the remote aged care services to interview a range of staff (e.g. executive, service management and service delivery staff) and Board members (where appropriate). Following the site visits, KPMG prepared one case study per provider outlining the challenges and innovations identified by stakeholders under the nine domains of enquiry.

The domains of enquiry, as agreed with the Department, were:

- **Service Management Type** - The organisation’s corporate and management structure
- **Entry and Screening** – Systems and processes for accessing aged care services
- **Eligibility and Assessment** – Systems and processes for assessing consumers
- **Service Delivery** – Challenges with service delivery including costs, choice and the impact of recent aged care reforms
- **Workforce** – Challenges associated with the availability and maintenance of a skilled workforce
- **Funding and Finance** – The appropriateness of funding models and payment and claiming systems and processes
- **Quality and Regulation** – The appropriateness of quality review processes and the impact of regulatory requirements
- **Reporting** – Challenges associated with funder reporting requirements, systems and processes
- **Facilities and Infrastructure** – The suitability of service infrastructure and challenges associated with making capital improvements.

The project was undertaken between October and early December 2017.
2. Key findings from the case studies

2.1 Service management

The service management type domain of enquiry examined the organisation's corporate and management structure.

Key issues and challenges identified

Remoteness

The 17 remote aged care services providers profiled were located in New South Wales (four providers), Northern Territory (four providers), Queensland (three providers), South Australia (three providers) and Western Australia (three providers). Service locations varied by remoteness, with one classified as MMM 5, six as MMM 6, and 10 as MMM 7. The review team noted a marked difference between MMM 6 and MMM 7 locations, with the latter being significantly more remote and hence more challenging for delivering aged care.

Size and structure

The size, structure and ownership of remote providers varies considerably. These differences have implications for the financial viability of operations. The providers consulted included six incorporated entities, four public companies, three local government entities, two local government statutory authorities, one state government statutory authority and one state government other incorporated entity. Eleven entities were registered charities. The largest entity held 1,295 residential beds and 399 HCPs at 30 June 2016, while the smallest entity held no residential beds and delivered six HCPs.

Most significantly, 10 of the 17 providers in the remote and very remote locations were part of a larger organisation such as a local government, state health service or larger aged care provider. These larger organisations were able to provide head office supports in areas including corporate services (e.g. finance, human resources and ICT), management, quality, regulatory compliance and contract compliance. This was also the case with recruiting more skilled staff such as service management, nursing and allied health professionals using financial incentives. Due to access to these supports, larger aged care providers who have services in remote regions were generally better equipped in dealing with a number of the aged care domains examined.

Organisations that do have head office support have also indicated that distance from the actual service location can inhibit a detailed understanding of on-the-ground issues and proactive recruitment approaches. Some providers – particularly MPS and local government entities – benefited from shared resources such as tradesmen within the local community, enabling the service to avoid costs of flying them in for repairs and maintenance work.
2. Key findings from the case studies

2.1 Service management

Size and structure (continued)

By contrast, many smaller providers lack economies of scale and scope of services found in urban areas. They particularly experienced challenges meeting corporate governance, quality and accreditation requirements. These providers, mainly located in MMM 7 areas, were also more likely to experience difficulties both recruiting and managing their workforce, as well as providing a full range of client services, including more basic services such as personal and domestic care as well as more advanced services such as nursing and allied health care.

Smaller providers tended to have an advantage in terms of community engagement, given many are community controlled organisations. However, their remote location often meant these providers lack a network to draw on for experience, resources, advice and specialist skills.
2. Key findings from the case studies

2.2 Entry and screening

The entry and screening domain examined challenges associated with systems and processes for accessing aged care services. This focused on consumers identifying and entering the aged care system through My Aged Care.

Key issues and challenges identified

Appropriateness of the My Aged Care platforms

There was a general consensus that My Aged Care is challenging to engage, use and navigate for many consumers in remote areas, both Indigenous and non-Indigenous. Consequently, providers invest significant unfunded time to case manage clients through the My Aged Care process. For the providers consulted, it often begins with poor understanding in the general community about how Australia’s aged care system works, what entry pathways are, and how referrals work. Several providers reported they rarely use their portal, lacking the time and knowledge to update service information and access client records. There appears to be a heavy reliance on health services such as general practitioners (GPs), hospitals, clinics and Aboriginal Medical Services (AMS’) to identify and refer aged care consumers.

For non-Indigenous consumers, My Aged Care challenges included a lack of familiarity in using online and telephone based services, and a level of distrust about providing personal information over the phone or internet. Consumers from a culturally and linguistically diverse (CALD) background also faced language and cultural barriers, as well as a lack of IT literacy and accessibility which inhibits access.

My Aged Care may be OK for you or I, but it is extremely difficult for the elderly to navigate, as well as those who are time poor.

As a result of these barriers, many providers believe that there are people in their communities who would benefit from aged care services, who have either declined or delayed accessing care.

It was noted by some providers that interactions with My Aged Care had somewhat improved, in relation to changes made to consumer representation and consent processes.

Coordination support and services required prior to assessment

The majority of providers consulted reported providing considerable unfunded assistance to community members, particularly Indigenous and CALD consumers, either managing interactions with My Aged Care on their behalf or supporting them to complete the process.

Without that support, people simply wouldn’t access services. They don’t have computers. They don’t have a permanent phone number. They’re not confident talking to a stranger on the phone. So we support them through the process to make sure that they can access the services that they need.

This support includes identifying consumers who would benefit from services and educating them about their options, provision of computers and telephones for interacting with My Aged Care and translating or explaining questions. These unfunded services are essential to assist the community but take time away from direct care.

Dealing with My Aged Care over the phone [for screening and a referral to an assessor] is a nightmare for us. It really needs a qualified interpreter on the phone... I can’t talk on behalf of the client or their family... The whole thing takes up more time than you’d think.

Many providers also begin service provision during this process to ensure a consumer’s needs are sufficiently met, despite this activity being a largely unfunded exercise.
2. Key findings from the case studies

2.2 Entry and screening

Cultural issues and barriers
For many Indigenous consumers, the barriers to access are significant and include:

- Access to telephones, computers and reliable internet
- Language barriers including a lack of translation services, plus low literacy and numeracy levels
- A lack of records and identification information such as a birth certificate, known birthdate, Medicare numbers and a home address, making both registration and follow up communications challenging
- Ashamed to admit that the family can no longer care for the older person
- The fear of losing family carer support payment
- Cultural issues and barriers including a mistrust of government services and a reluctance to answer personal questions from a stranger
- Regular movement across their community, visiting country or other communities, meaning they are not available for every My Aged Care interaction and can be difficult to locate.

Notably, it appeared that some providers were unaware of the new provisions introduced by My Aged Care, such as authority to represent consumers and ability to make a referral on behalf of a consumer who is unable to access a telephone, suggesting further education about these options may be warranted.

One provider recounted instances when Indigenous consumers ended a call to My Aged Care when asked during screening whether they were 65 years or older. More broadly service providers identified there to be notable absence of cultural awareness by staff at the My Aged Care contact centre which inhibits progression through the access process.
2. Key findings from the case studies

2.3 Eligibility and assessment

The **eligibility and assessment** domain examined challenges associated with eligibility criteria and systems and processes for assessing consumer, including assessment agencies.

**Key issues and challenges identified**

**Accessibility of RAS and ACAT services**

The case studies indicate that ACAT and RAS practice, experience and understanding of remote aged care as well as Indigenous consumers are highly variable across the country.

Many communities experience infrequent visits from both the RAS and ACAT due to prohibitive costs, with some assessments taking up to 12 to 16 months to be completed. One provider reported the visiting assessor model does not work for highly remote communities with transient populations, and the regional ACAT had only visited once in the past three years. Given these difficulties, the flexibility of the NATSIFACP model, which does not require an ACAT assessment, was seen as better suited to remote settings with fewer administrative and cultural barriers to care.

Other providers reported that RAS and ACAT services will not visit their community, and assessments are undertaken by teleconference or videoconference (regardless of the complexity), relying on support from the service provider. These practices appear to be limited to certain assessment teams or jurisdictions.

Support by providers can include facilitating bookings, transporting clients and attending the assessment, providing information, translation support, and cultural advice specific to the consumer and their community. This is unfunded, time consuming work and places an additional burden on an often strained workforce in these regions. Providers estimated that it requires up to one day of unfunded time per client.

We've had to drive clients out to [the ACAT] for an assessment because the ACATs refuse to complete one in person.

One provider reported that it has an arrangement with its respective ACAT (located approximately 1000 kilometres away) under which the provider conducts the assessment onsite and submits the assessment to the ACAT for its review and approval. The provider employs an allied health professional who previously worked as an ACAT assessor; however this work is unfunded and completed on top of normal duties.

**Cultural issues and barriers**

Providers reported a lack of cultural competency and understanding of the remote context amongst some RAS and ACAT staff. As a result, providers are required to provide a significant level of support to consumers (as previously specified) and to the assessment workforce about local culture, customs and geography.

When conducting assessments, providers flagged particular cultural issues and barriers for many Indigenous consumers. Some consumers will refuse assessments due to a mistrust of government services or because they are embarrassed by the questions. Indigenous consumers can be reluctant to talk about their needs, particularly with a stranger, limiting the ability to conduct a holistic assessment. Some are unable to understand questions and lack the confidence to answer questions or challenge assumptions. These barriers increase the risk of inappropriate service recommendations or that consumers miss out on services altogether.

We'll make a referral to My Aged Care and then later find out that they've [the client] declined the assessment because they didn't understand or didn't feel comfortable speaking with the assessor.
2.3 Eligibility and assessment

Cultural issues and barriers (continued)
Providers reported the presence of their staff, who are known to the consumer, can facilitate communications including discussion of their home, supports and needs (beyond what may fit into the assessment framework or assessor's experience and understanding).

Notification letters
Another significant access barrier for people in remote communities is the requirement for the consumer to enter into a home care agreement with a relevant service provider within 56 days of receipt of an approval letter. Providers reported notification letters sent directly to Indigenous consumers are often not received or read. This may be due to failure to collect mail, wet season causing irregular mail delivery, multiple family members with the same surname, multiple families with similar names, and disregard for government correspondence. The consumers therefore fail to acknowledge the letter and hence fail to activate their HCP.

Issues with notification letters were also identified by providers working with non-Indigenous clients, who reported that clients do not know how to action their letter or being unable to do so due to personal circumstances:

There was a lady who was non-verbal and physically impaired but fine cognitively. When she received a letter she was not able to do anything about it. Unless she was checked on by us, she would never have been able to respond. Other communication channels are needed.

The providers consulted consistently reported they feel a need to regularly monitor My Aged Care, as most consumers are unlikely to receive notification letters informing them of an allocation. Providers are seeking a better notification process to ensure they are aware of outcomes of the assessment process including when the client is allocated a HCP, and thus are able to better support consumers through this stage.

Some providers commence care prior to receiving assessment, despite this being unfunded to avoid social inequity and to protect services reputation.

We still provide the care without the referral, otherwise they'd have nothing. But the funding isn't provided until after the assessment and the client is referred.

My Aged Care Service Finder tool
The Service Finder tool on the My Aged Care website was also identified as a concern. This tool lists service providers by postcodes. In many rural and remote locations, postcodes can cover a significant area including multiple towns and hence give misleading information about the availability of services within a location, particularly for new assessors unfamiliar to the local market. Furthermore, it appears that some service providers are listing postcodes where they do not currently have clients in the hope of winning new clients but lack a genuine willingness to make the investment required to develop a presence in that community.
2. Key findings from the case studies

2.4 Service delivery

The service delivery domain examined challenges with service delivery including costs, choice and the impact of recent aged care reforms.

Key issues and challenges identified

Providers consulted consistently presented the view that the standard aged care program and funding models are not appropriate to the remote aged care context. Key issues from their perspective included a perceived lack of flexibility to respond to the complex and varied needs of remote aged care consumers, and funding models that do not address the significant costs of remote service provision. As a result, providers are needing to balance their individual clients' needs with the viability of their service and their capacity to respond to existing clients as well as unmet needs. These issues are further explored in the following discussion.

Service priorities

The providers consulted provided feedback about service priorities and gaps for their remote communities. Notably, many communities lack local residential, transition, short term restorative and/or sub-acute care services. Providers also described often blurred lines between CHSP and HCP with many limited in their capacity to provide in-home support due to the travel implications or the unsuitability of their clients' home environment for the provision of care.

Most providers identified meals as a key service that is prioritised over other tasks. Meals are considered to be important due to the high proportion of economically disadvantaged clients who have poor access to affordable and nutritious food. Meals may be delivered at a day care centre, a client's home or other community locations (particularly for clients who often move around their community).

The concept of consumer directed care is not relevant to Aboriginal people. They just want to know that the provider will give them a meal.

Some raised concerns that the costs of ingredients (a large, variable cost) are not covered under CHSP and HCPs. While providers commonly seek a consumer co-payment of $8 to $10 for food, these contributions are often difficult to collect due to clients' lack of income. The providers therefore end up covering a lot of the food costs, which are significantly higher than in metropolitan areas.

Respite care is also considered a key service, especially where there is little or no access to residential care nor informal support such as family members. Permanent residential care is often not consumers' preference as it involves travelling away from community, is socially isolating and can cause distress to the client and their family. Respite care is valued as a break for both consumers and carers, with providers noting that even short stays can result in improvements to consumers' health and wellbeing (e.g. weight gain, review and adjustment of medications). However, a number of providers considered that there is insufficient access to respite care due to a lack of funding and appropriate accommodation.

Social activities and transport services are also commonly offered. While these can be time consuming to deliver due to the large distances travelled, supporting social inclusion and connection to country for indigenous clients are seen as priorities. Providers flagged concerns about constraints on funding to support these activities; for example enabling a client to visit her husband who was living in a residential facility in another town or providing travel escort to a wheelchair bound client being transported to Darwin for hospital treatment to provide assistance and emotional support.
2. Key findings from the case studies

2.4 Service delivery

**Service priorities (continued)**

Given there are Patient Travel Subsidy schemes, this could be considered a funding limitations of either the health or aged care systems.

*One client's home was so poorly maintained, she had a pigeon infestation and a crumbling roof. We knew she needed support with cleaning, but all we could do is provide transport because it was a safety issue for our staff.*

Many CHSP and HCP providers offer little or no personal care and domestic support in remote regions. This was particularly the case for Indigenous clients, for whom the home environment is often poorly suited to these services.

Barriers include a large number of family members in the home, lack of private spaces (e.g. for personal care), and lack of clean and functioning basic facilities (e.g. bathroom, toilet, kitchen and / or laundry). In some instances, safety of both the consumer and the provider's staff visiting their home is a concern. As a result, many providers provide centre-based services for meals, laundry, social activities and personal care. Similarly, many do not offer domestic assistance due to either the scale of work required or because families are not comfortable with this service.

Some providers identified that they would like to expand their current service offering but viewed it as too risky under current funding models, as a critical mass of clients is required to sustain the additional workforce required and attracting qualified workers is problematic. Others noted the eligibility criteria for certain programs limits their ability to apply to provide additional services, such as the requirement to provide 10 or more beds to apply for Short Term Restorative Care places.

These approaches demonstrate the need for an alternative approach to remote care that is adapted to priorities and circumstances.

**Service gaps**

A lack of nursing and allied health services is a key gap for many communities, particularly MMM 7 locations. The inability to attract and retain these staff in remote locations indicates there is little rehabilitation and capacity building focus to the services provided. Insufficient funding in HCP budgets to pay for travel and accommodation for professionals, even when sharing the costs between clients, also inhibits providers to outsource allied health services.

Palliative care was also noted as a gap by several providers.

Unsurprisingly, access to residential care close to a consumer's home was a concern, especially in very remote communities. As noted, most are reluctant to leave their community, and in remote locations were unable to sell their home in order to fund their care. However many of the small, remote providers lack the capacity to deliver this level of care due to workforce constraints as well as a lack of facilities and funding.

**Unfunded services and barriers to efficient provision of care**

It is common for remote aged care providers to provide a range of unfunded services and supports. For example, providers reported that it is common for Indigenous consumers to present or be referred in crisis, and to be in urgent need of support but lack the funds to pay for private services. Where providers lack staff to drive clients to town, a monthly taxi account can equate to $1000 of unbudgeted expenditure.
2. Key findings from the case studies

2.4 Service delivery

Unfunded services and barriers to efficient provision of care (continued)

Given the importance for providers of maintaining positive relationships with the communities and expectation that care will be available immediately, providers are commencing services straight away without waiting for assessment and care allocation processes to be completed. This has an impact on cost to the service but providers in these regions will not decline care to a member of their community as it destabilises relationships and community structures. For clients with urgent needs, it may be the case that this is an education issue given provisions enabling providers to begin urgent service provision prior to assessment.

Clients in remote communities do not understand or know what is permitted under the aged care services they are approved for, and in particular have no awareness of the different aged care programs and their rules. It is therefore common for family members to drop a client off for respite when they are seeking a break or the consumers wellbeing has declined. Similarly, providers will often also support family members who present with a client.

Notably, there appears to be poor awareness of provisions to obtain Departmental approval for emergency care, and hence providers are not recovering their costs for this care.

Many providers also utilise HCPs on goods and equipment for clients’ home, such as air-conditioning, refrigerators and beds, in the absence of alternative funded supports. These are required to support clients through the extreme heat of summer in many remote parts of Australia and are often significantly more expensive than in metropolitan areas.

Service delivery can also be considerably challenged by external influences, such as weather, equipment and availability of staff and may halt or significantly affect the services available on any given day.

*There’s no back up option in remote communities. Our freezer broke down today in a remote service and that’ll impact our meal service for the entire week.*

Lack of funding for case management under CHSP was also raised, given the extensive and currently unfunded support needed for many clients across the continuum of care. This can include time for locating, organising, transporting and educating consumers, managing income, and negotiating with family. Due to these needs, there is little difference between CHSP and HCP recipients in terms of case management needs.

Cultural issues and barriers

Providers also identified a range of additional cultural issues which impact the efficient provision of care, as discussed in the following section.

There was strong and consistent feedback that Indigenous consumers have a range of complex needs and cultural practices which require time to address. Noting that cultural attitudes and practices vary from community to community, examples include:

- Residential occupancy may be influenced by customs prohibiting Indigenous people of the opposite sex from occupying the same residence. Providers also need to recruit both male and female staff to offer clients personal care from a staff member of the same sex. However, it is often difficult to recruit male staff, who perceive aged care to be a female occupation.
2. Key findings from the case studies

2.4 Service delivery

Cultural issues and barriers (continued)

- Fears relating to occupying a room where someone has died impacts on bed occupancy. There can be delays in new residents entering a facility, due to the need and time taken to organise 'smoking' of the room. One provider also noted fears about 'payback' practices following a death can impede the recruitment of Indigenous staff.

- Some Indigenous consumers are highly transient and will move both within their community (e.g. between family houses or community locations such as the local river) as well as between communities. For example, a provider reported it is common for their Indigenous clients to present at its facilities throughout the Kimberley, which can place additional pressures on the small teams staffing those facilities. Other providers reported providing brokerage services for transient clients travelling outside of their jurisdiction to enable continuity of care.

> We have one guy who had a HCP in Katherine but was in Darwin for a few months so we brokered through another provider in Darwin so he could keep getting his meals.

- For many Indigenous people in remote communities consulted, providers reported that the idea of an individualised budget was 'not relevant' to the needs of local people as they tended to have a more communal approach to resourcing and the satisfaction of needs.

> All of our clients need case management. It's the reality... Because it's individualised, people just don't know what their options are or where to go to.

- Further to this, it is common for Indigenous clients or their families to frequently discharge or cancel services due to family movements or a desire to avoid co-payments (basic daily fee). Families may also cancel co-payments without notifying the service provider. Many providers have experienced aggressive and verbally abusive family members who have been denied access to their elder's aged care pension. In some communities, these behaviours have increased due to the Cashless Debit Card Trial, as some family members access non-quarantined money through their elders. These behaviours can result in additional case management and administration time caused by managing discharge and readmission processes, and can also lead to irregularities in income for providers operating on thin margins.

- The majority of service providers in MMM 6 and MMM 7 regions struggle to collect the basic daily fee and are unable to secure RADs for many non-Indigenous as well as Indigenous clients.

Support services

Access to essential support services, especially primary health care, is a key challenge for remote aged care providers and their clients. Many reported GPs and other primary health care providers will not visit residential aged care facilities, including those employed by local hospitals or health services. Similarly, many have found Indigenous medical services will not service non-Indigenous residents, despite some towns having no private GP services.

Similarly, several flagged communication and information sharing with local hospitals as being limited, and have occasions where clients are discharged with notice and discharge summaries not provided.
2. Key findings from the case studies

2.4 Service delivery

Support services (continued)

A small number of providers identified limited access to the Dementia Behaviour Management Advisory Service (DBMAS) as a constraint on their ability to support clients with dementia and challenging behaviours. The lack of other providers commenting on this service may indicate a lack of awareness, but this assumption would require further testing.

Multi Purpose Services

Only one provider of the group consulted operates a Multi Purpose Service (MPS). This service had a number of benefits including strong management, governance, quality and reporting capabilities, as well as access to clinical staff and services.

However, the MPS was needing to balance its responsibilities in providing acute health care services with its aged care services, with aged care residents seen as potential threats to the wellbeing of acute patients and a burden to staff. Management's preference was for a permanent, dedicated aged care facility to be built. Management were also of the view the MPS was absorbing a range of costs relating to aged care services use of infrastructure, equipment and workforce.
2. Key findings from the case studies

2.5 Workforce

The workforce domain examined challenges associated with the availability of a skilled workforce and the ongoing retention of staff.

Key issues and challenges identified

Attraction, retention and professional development

Workforce attraction, retention and professional development is an ongoing challenge for all the remote aged care providers that participated in this research. The remote context means the local workforce supply is extremely limited, providers face difficulties in recruiting and retaining non-locals, and incur high employment costs. While incentives can make positions more attractive, other employers such as hospitals and mining typically offer higher salaries and often attract skilled staff away from the aged care providers.

People don't work in aged care for the money. They do it because they love it and want to help people.

Providers usually need to recruit skilled staff such as service managers and nursing staff from outside the community, and are incurring significant expense in attracting candidates (see Section 2.6 Funding and Finance for further discussion). Due to professional and social isolation (which can contribute to mental health issues), as well as the challenges of the work, turnover rates are high, which in turn contribute to service disruptions, lost productivity and additional recruitment and induction expenses. Revenue insecurity can also be a problem, with providers unwilling to recruit extra staff due to a lack of certainty about income, especially for those operating under Increasing Choice.

Access to affordable, quality and secure housing is another significant barrier, with some providers electing to subsidise and even manage suitable housing stock to address this issue.

I am currently living in a caravan on a friend's property, but they're going to sell the property at the end of the year. I've looked around town and the only places for me to stay are $300 per week, which is not possible on my salary so I'm going to have to leave the community.

Furthermore, recruitment to address vacancies can be difficult and often takes long periods of time (e.g. 3 months) to complete. Some providers reported being in a permanent recruitment cycle.

Providers also commented on difficulties and high costs encountered in developing and training their workforce. Some reported administrative services as their primary gap, with limited resources (workers and funding) to dedicate to day-to-day administration of their organisation. Many communities do not have a TAFE and staff undergoing training such as a Certificate III Aged Care may need to travel over an hour for training. Providers sending staff to another city incur high costs relating to the training course, travel, accommodation and backfill. Providers with high turnover also experience high training costs due to the need to induct staff to organisational policies and procedures.

We can't afford to spend over $1000 for a staff member to attend one day of training in Adelaide. If we do, we certainly can't send all the staff that should go. Staff usually only get to go to training once per year.

Some providers have invested in their own training material; one has created an online training tool to enable staff to access on demand training that is more relevant and cost effective.

While most providers offer incentives to attract staff external to the community (see discussion under Section 2.6 Funding and Finance), several have recognised the importance of recruiting and developing locals who are more likely to remain in their community and job.
2. Key findings from the case studies

2.5 Workforce

Key roles

The service manager is a critical role for remote aged care services. This is a 'jack-of-all-trades' position overseeing service delivery teams and often includes an active role in service delivery, case management quality, reporting, governance and in some cases board support. Many providers target registered nurses for this position to ensure access to this skillset.

Access to nursing and allied health professionals is another significant challenge. In fact, many service providers reported having little or no access to nursing and allied health professionals.

A lack of nursing staff in particular is preventing some remote providers from offering more complex care such as Level 3 and 4 HCPs as well as residential aged care. As a result, clients typically either need to leave the community, go without, or access health services for this care.

To have more Level 3 clients would be an issue for us... But to have Level 4 would be impossible right now... Even if the housing and living conditions enabled us to get access, we simply can't offer more hours of care from our staff.

Many remote services sponsor overseas-trained RNs to work for the service on a Temporary Skill Shortage visa (formerly the Temporary Work (Skilled) Visa (subclass 457)). This was described as an expensive and onerous process, involving a three month processing period with no guarantee the person would ultimately agree to come, with last minute withdrawals common. Once staff gain permanent residency, it is common for them to leave to work elsewhere. Other providers have been able to recruit staff from travelling backpackers, who can make a positive contribution to the organisation but are short term only.

The majority of providers consulted are unable to access allied health professionals at all, or may only do so at significant cost. Several noted they had previously been able to receive support from state health services, but are now being charged significant brokerage fees at rates comparable to private sector providers, meaning this care was no longer affordable. A couple of providers are using telehealth combined with 'fly-in, fly out' (FIFO) models, but can only offer occasional onsite services.

One provider is attempting to establish a close relationship with a health service to effectively 'share' the time and cost of bringing health professionals to community. This was suggested as a way of promoting the sustainability of aged care services in remote communities and enhancing access to specialist medical services.

Providers also reported that a lack of familiarity among its staff, as well as a lack of Aged Care Funding Instrument (ACFI) specialists, had led to challenges with claiming. Several have had to refund ACFI funding to government due to over-claiming and others suspect under-claiming has been an issue. Several had resorted to engaging ACFI consultants, particularly due to over-claiming.

Care workers, cooks and drivers typically form the core client services team, many providers, especially those with high Indigenous populations, employ Indigenous people in these positions. However, many are still working to obtain a basic qualification such as a Certificate II Aged Care.

Maintenance and repair services are usually purchased from local or FIFO tradesmen, despite costs being significantly higher than urban settings. One provider commented that the cost of tradespeople is typically 30 percent greater compared to metropolitan areas.
2. Key findings from the case studies

2.5 Workforce

Key roles cont.

Agency staff are typically only used in exceptional circumstances, such as the service manager going on leave and no internal staff are available to cover them, as costs are too prohibitive. As one provider noted, agency staff are significantly more expensive than local staff and yet do not lead to long-term staffing options or support continuity of care.

Cultural issues and barriers

Providers recognised the importance of engaging Indigenous staff wherever possible and the benefits for their clients, community and the provider itself. In particular, Indigenous staff bring community relationships and an understanding of the local culture, language and individual community members. However, providers also identified a range of issues and challenges relating to this part of their workforce:

• Indigenous staff often have English as a second language and poor numeracy and literacy skills.

• Some Indigenous staff may only support particular Indigenous clients (e.g. members of the same gender and/or clan group) and will not undertake certain tasks (e.g. personal or domestic care) due to cultural practices or gender bias. One provider described how Indigenous staff will not care for dying clients due to a fear about payback from family members if they are the last person to be with an elder when they pass away. This fear may prevent locals from applying for a job and has caused others to quit due to the anxiety they experienced.

• Staff may be employed because they hold basic qualifications such as a valid driver’s licence, which are uncommon in some communities.

• Police checks can also be a barrier to employment. One provider is in the process of applying for funding under the Indigenous Advancement Strategy to open a small bakery in the community which would allow the aged care service to purchase meals from the bakery which clients or their families could collect. It would also limit the impact of the requirement for a police check on service delivery as it would be delivered from a separate premises.

• Indigenous people in remote communities are often employed with government subsidies such as the National Jobs Creation Package (NJCP) wage subsidy and the Northern Territory Jobs Package (NTJP). While the associated subsidies are valuable, some staff will exit the position once their welfare obligations have been met.

• Basic tasks can take more time with some Indigenous residents due to language barriers and cultural barriers. One provider reported having higher staffing ratios in remote sites (1:2 and 1:3 compared with 1:6 in urban settings) to address this issue.

The most significant issue relating to Indigenous employees relates to absenteeism. Providers noted that a frequent issue is non-attendance by Indigenous staff for scheduled shifts without notification. This may be due to ‘sorry business’, community events, travel to country or another community, family disputes etc.

Absenteeism places pressure on other staff – often the service manager – to cover the duties of the missing staff, and thus reducing time available for other tasks. One provider reported that when staff attendance is poor, the Service Coordinator or Team Leader has to ‘act-down’ from their role in order to maintain a minimum level of service. Absenteeism also impacts attendance at training and the time taken to complete this.
2. Key findings from the case studies

2.5 Workforce

Differences between small and large providers

Some larger services provide administrative and financial support to their remote services. These remote services were notable in having more experienced management staff than many of the small providers. They also had access to senior management within their organisations as well as staff who could backfill positions when key personnel such as service managers were attending training or were on leave. Several providers have benefited from recruitment of experienced CEOs or managers who have been able to strengthen governance, improve rostering and professional development practices, stabilise the workforce, reduce operating losses and improve the overall service viability.

Finally, a key issue impacting all organisations – and particularly the small and / or very remote providers – was their inability to expand their services even when they were aware of unmet need in their community. The challenges in recruiting skilled and qualified staff together with the high costs of doing so means that a critical mass of new clients is required before they can recruit an additional worker due to the high costs. Likewise, many are prevented from employing staff in support roles such as administration, quality, community liaison and business development. One provider reported labour costs accounted for roughly 75 per cent of the service’s total annual expenditure.

Portability of HCPs

The shifts towards portable funding was also recognised as a risk to workforce sustainability and flexibility. In particular, fluctuations in client numbers could influence the provider’s ability to recruit a pool of labour, particularly with staff requiring certainty of hours to relocate to remote communities. Similarly, providers identified logistical issues of rostering staff where funding certainty is removed.
2. Key findings from the case studies

2.6 Funding and finance

The funding and finance domain examined the appropriateness of funding models and payment and claiming systems and processes.

Key issues and challenges identified

A large number of providers consulted reported operating some or all of their remote aged care services at a deficit. Services are heavily reliant on the remote viability supplement to maintain operations due to the considerably higher costs associated with remote service delivery. However, there was a strong view put forward by most providers that this supplement together with standard aged care funding is inadequate in addressing the full costs of remote service delivery.

Remote aged care operating costs

While there was some evidence of inefficient practices as well as over-servicing of clients, providers were unanimous in pointing to very high operating costs and their impact on delivering services in remote communities, particularly:

- Employment cost – attracting and retaining staff through higher than standard salaries and incentives such as additional leave and subsidies for housing, transport and professional development
- Induction and training costs, exacerbated by frequent staff turnover
- Brokerage costs, e.g. for allied health care
- Agency staff costs including for travel and accommodation
- Food and other consumable costs: *I pay as much per month in these three small facilities in food costs including the cost of transportation of that food as I did at a 240 bed facility in the metropolitan area*
- Service delivery costs, such as double staffing of shifts for safety reasons, extra time required for service delivery (e.g. locating clients, processing clients, waiting for clients), residential service vacancies due to transience or waiting to complete a smoking ceremony
- Higher utility and infrastructure costs, including tradesmen or safeguards for service delivery during wet season such as purchase and maintenance of large fridges for storing produce and generators for ensuring power supply. One provider reported being unable to construct new facilities without government grants due to operating losses and the considerable costs. For example, this provider installed two new industrial washing machines for a cost of $60,000 made possible through a grant
- Inability to collect co-payments basic daily fee (BDF) and RADs, as well as families who frequently cancel co-payments without notifying the service provider. The majority of service providers struggle to collect the basic daily fee and are unable to secure RADs for Indigenous and non-Indigenous clients
- Over-servicing / provision of unfunded services (see Section 2.4 Service Delivery for further discussion). Aside from supporting vulnerable people, they see this as essential to maintaining the community’s trust. However, the flexibility to provide care that does not have a direct funding mechanism is significantly limited under individualised funding models.

Some providers operating as smaller very remote residential care services emphasised the inadequacy of the remote service viability supplement, particularly in the context of small bed remote residential care facilities which had high overhead costs. Often larger providers, or those operating within a government agency, are able to subsidise the aged care service with revenue from other areas of their organisation.
2. Key findings from the case studies

2.6 Funding and finance

Individualised funding
Some providers also considered individualised funding and the portability of HCPs as a threat to their viability. Although many providers reported only beginning to notice a shift in their local provider landscape, they expect the introduction of the Increasing Choice and NDIS will bring competition to their local area. Given many small providers operate on the cusp of viability and struggle to cover high fixed operating costs, any shift in client numbers was reported as a threat to their viability.

Service use goes down when people move out of community, go to residential care or pass away. If we lost four or five packages, it would be increasingly difficult to maintain the building and we would have to rethink our employment arrangements. It hasn’t been an issue, but it could be with such a small population.

Some providers were also concerned that they may end up being responsible for clients with more complex needs (particularly those with behavioural issues) who other providers will be deterred to service due to their more challenging and costly service requirements. As a result, several cited concerns about the future shift to individualised and portable CHSP funding, and having guaranteed income to meet core overheads.

Concerns were also raised that some clients and family members see individualised funds as an account that cash can be drawn from, leading to elder abuse and abuse of provider staff.

A small number of providers appear to lack the capacity to manage individual client budgets and allocate HCP services to these accordingly.

You spend more time working through their [the consumers'] budgets with them than you do putting data into e-tools… They [the consumers] can’t get help with budgeting from family so it’s down to me to try and run them through it.

ACFI changes
A number of RAC providers noted the 2017 ACFI changes have resulted in lower scores (e.g. in Complex Health Care domain) and hence funding, with no option for offsetting the drop in income from resident charges. These providers are engaging external ACFI consultants to ensure they word their assessments appropriately, although this comes at a cost.

As noted already, several providers have had issues with ACFI downgrades and refunds, while others were concerned that they were underclaiming. Concerns were raised that the ACFI model does not adequately recognise the significant amount of time staff spend managing client and family behaviours, particularly those with complex needs.

Capital replacement costs
Given the operating losses, many providers raised concerns that they are unable to fund capital replacement costs. Consequently, most are reliant on capital grant programs to enable work such as infrastructure upgrades or expansions. Other than uncertainty about their capacity to secure such grants, providers also noted there is some, albeit relatively limited, cost in preparing applications and reporting on grant implementation.
2. Key findings from the case studies

2.6 Funding and finance

Funding flexibility

One provider commented about a lack of flexibility to re-allocate underspends in one program to another (e.g. from CHSP to residential care). As a result, the provider is encouraging prospective clients to enrol in the underspent program; this raises the risk that clients are serviced through programs where funding exists rather than those that best suit their needs.

The funding for people receiving a Level 4 HCP, who almost require residential care but do not want to enter residential care, was deemed to be insufficient by some providers. It was suggested the use of a flexible funding pool, which could be used to top up services if required would improve services available to clients, and perhaps allow the client to stay at home for longer, or avoid residential care.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)

Providers funded under NATSIFACP were able to use their block funding to supplement other revenue sources. Furthermore, given some of the standard aged care system requirements such as My Aged Care engagement were avoided and reduced reporting requirements the providers had reduced administrative burden.

Nonetheless, providers identified some restrictions on how NATSIFACP funding can be used, requiring other revenue sources to be utilised. For example, one provider stated:

_The NATSIFACP funding prioritises residential care, not centre-based home and community care services, and so that type of resourcing just isn’t available to us for upgrades to infrastructure or the purchase of more suitable vehicles._
2. Key findings from the case studies

2.7 Quality and regulation

The regulation and quality domain examined the appropriateness of quality review processes and the impact of regulatory requirements.

**Key issues and challenges identified**

The majority of providers consulted had minor or no issues in addressing the regulatory and quality requirements of aged care, and most acknowledge it is a priority for their organisation. Some providers reported experiencing challenges with adhering to multiple sets of standards across aged care and health and disability interfaces. However, providers of NATSIFACP and MPS were able to somewhat offset this complexity with the reduced level of regulatory requirements compared to providers of mainstream residential aged care services.

Services belonging to larger (multi-service) organisations were much better able to manage regulatory and quality requirements due to the support provided by their central office. These included state health and local government operated services as well as large not for profit providers.

A small cohort of providers, mainly small community controlled services, encountered challenges in meeting accreditation standards, with one provider in particular having significant difficulties. Key issues have been a failure to maintain appropriate records and establish all required policies and procedures. Difficulties in interpreting standards, particularly amongst staff for whom English is a second language, were also reported. As a consequence, one provider has been working to simplify processes for adhering to the standards within a plain English manual, accompanied by staff-user training.

Challenges with meeting accreditation requirements also appear to be more common for organisations with high turnover rates amongst the senior management responsible for leading quality improvement efforts. Likewise, where requirements are addressed by a single role (e.g. service manager), turnover in these positions can have a large impact due to the time taken and difficulties encountered in recruiting replacement staff.

Furthermore, new staff take time to familiarise themselves with the organisations policies and procedures, particularly those new to aged care. For example, one service provider recounted a situation where their Acting Director of Nursing experienced a quality audit on their first day at the service.

It is apparent that addressing regulatory and quality requirements requires time and resourcing. The staffing costs associated with this work needs to be recognised as a core operational requirement that must be addressed regardless of the size of the provider and its client base. Where providers were able to receive support through the Department’s Service Development Assistance Panel (SDAP), they were able to make immediate improvements.

Some providers expressed concern that they did not know who their contact at the Department was, as this contact was perceived to be constantly changing, and were concerned they had insufficient contact. They felt that this made it challenging to establish a relationship, which they saw as a valuable connection to assist in improving service delivery and maintain currency of knowledge of legislation and reforms.
2. Key findings from the case studies

2.7 Quality and regulation

Understanding of the remote context

Some of the providers also identified a range of more minor frustrations with experiences they felt demonstrated a lack of flexibility and understanding of the remote context by some accreditors. Examples cited included:

- Timeframes provided to resolve areas of non-compliance. For example, one aged care manager remarked:

  We got a non-compliance because of the condition of some of our chairs. We were given 12 weeks to get new ones, which is extraordinarily difficult due to transportation costs and delivery timeframes. We could only show them the purchase order but the chairs weren’t able to be delivered in that timeframe.

- A provider whose client spends the dry season at the river and delivers his meals there. The provider was marked down because meals were left in the shade rather than a fridge, as no fridge was available.

- An aged care facility had built a fire pit for residents to sit around as they were used to this custom. The provider was required to cover over the fire pit due to safety reasons. Residents now leave the facility to sit around a fire, which the provider considers to be a greater risk given issues in the community.

- Meal menus must be reviewed by a dietician; however most remote locations are too small to sustain this role.

When providers had quality reviewers visit who had previous experience in a remote aged care setting, they experienced a more balanced and contextual application of the standards.

To support this capacity building, one provider requires all reviewers to complete a cultural induction before entering any of its remote sites.

We have the accreditors, and indeed, all staff and visitors, do an induction before they go to the service. The induction varies according to the protocols of each community but consists of staff being introduced to the community and its culture by local staff to promote culturally respectful and safe care.
2. Key findings from the case studies

2.8 Reporting

The reporting domain examined challenges associated with funder reporting requirements, systems and processes.

**Key issues and challenges identified**

The majority of providers experienced few challenges in meeting reporting requirements, particularly when provided with back office / quality assurance support from head office. Providers operating under block funding arrangements also reported simpler reporting requirements and hence associated administrative burden.

As with the regulation and quality domain, however, several small providers have encountered difficulties with maintaining records of services delivered. In particular, turnover in staff and an absence of clear policies and procedures has impacted smaller provider’s ability to meet reporting requirements. Some providers reported having to backdate payments because previous staff failed to complete claiming or adjust DEX counts because service delivery accounting was not completed for months at a time.

Other providers reported experiencing greater challenges with corporate governance reporting requirements. One example cited was of an elderly resident that goes ‘walk-about’ twice a week. The service believes her to be safe within the community, but the service manager is obligated to lodge a formal report on her absence.

Staff absenteeism and low levels of literacy amongst staff also influence reporting. Some providers expressed having little time available to complete reporting, because their service manager has to take on general duties when staff are absent and prioritise providing care services to clients. This delays completion or influences quality of reporting, particularly with maintenance of care plans. Other services have invested in improving staff competency in this area by providing ongoing training on how to effectively monitor and report on program outcomes.

A few providers did note ACFI reporting is complex for staff who may have limited English and / or literacy skills, and hence this work is undertaken by more experienced staff such as the service manager.

The ACFI paperwork is too complex for the local staff to assist with so it all falls to the service manager and me [the aged care services manager]. So when a new service manager starts, I educate them about the ACFI process and provide ongoing support while they gradually gain their independence. I still review all the ACFI packs that come through, even when the service manager has aged care experience because usually there is an educative process to make sure that they have maximised their claim.

Comments relating to reporting systems included:

- A key frustration is a lack of interoperability between the My Aged Care and Medicare. This is reported to result in duplication of data entry across systems.
- Using Auskey to access IT systems is an onerous process that includes a lengthy installation process and limits on how many devices it can be used on, restricting access to provider laptops enabling staff to access systems while on the road.
- It is difficult to make adjustments to CHSP data errors entered into the Data Exchange (DEX).
- Slow and unreliable internet connections can be frustrating and lead to frequent work disruptions.
2. Key findings from the case studies

2.9 Facilities and infrastructure

The facilities and infrastructure domain examined the suitability of service infrastructure and challenges associated with making capital improvements.

Key issues and challenges identified

Climatic requirements and costs

Remote aged care providers incur significant facility and infrastructure costs related to their location. The community environment and location – especially for services located in northern Australia – means that services require additional infrastructure such as four wheel drive vehicles (e.g. for accessing clients during the wet season, which may also require modifications following purchase).

One service provider noted they previously lacked funding to purchase a four wheel drive, and had to rely on support from other organisations to access clients who live out of community. A number of providers also noted the importance of client transport services (e.g. client transport to a community from an outstation, client transport for centre based services, and client transport for connection to country).

Other equipment needs can include large storage areas, large refrigerators and freezers to keep substantial food stocks during the wet season, and generators to ensure electricity supply. During emergency situations, providers may need to fly stocks to the community to ensure food supply, incurring very significant costs (for example, chartering a plane due to unusable roads).

These equipment requirements involve significant additional purchase, operating and maintenance costs due to their remote location (e.g. locations where a technician needs to be flown to the community and provided accommodation in addition to the service costs). There can also be significant delays in repairing broken equipment or facilities due to distance, which impact on service delivery. For example, the air-conditioning recently broke down in one remote community and when staff contacted the tradesperson who installed the air-conditioning, they quoted $22,000 including travel, and demanded full payment before attending the site. Fortunately, the service manager contacted 'a mate of a mate' who was a local electrician who could fix it up for $2000.

Similarly another provider reported:

In one community, the sprinkler system required urgent repairs. If the local tradespeople had the skills required, it might only cost us about $17,000. But because the sprinkler system requires specialist tradespeople, we need to fly them in and accommodate them. So if return trips are required, we estimate that it could cost us up to $150,000.

Day centres and residential facilities

Given the CHSP and HCP models tend towards centre based care, many providers have invested in these facilities. However, day centres and residential care facilities often lack amenities such as gardens (which are expensive to maintain in many climates), shade and protection against rain as well as extreme weather events. Many facilities also need to invest in security such as fences to protect against community vandalism and violence.
2. Key findings from the case studies

2.9 Facilities and infrastructure

Capital replacement concerns

The combination of high operating costs, revenue constraints, funding limitations and uncertainties associated with individualised funding means providers are reliant on grant programs to address their infrastructure requirements. However providers perceived these programs to be inadequate to address capital maintenance and replacements needs.

One provider identified the current size of their residential facility as a constraint on service viability. Currently the service is too small to be viable, but the provider is unable to fund its expansion despite believing there is unmet demand in the community for its services. The provider also raised concerns that current residential care funding is insufficient to address asset depreciation and replace the infrastructure at the end of its useful life.

Where capital grants were available, workforce capability and capacity limited providers’ ability to complete successful applications. Their inability to fund replacement of key infrastructure from core aged care funding is a critical concern.

Other issues

A further difficulty for some providers is negotiating long term leases from traditional owners and land councils. This insecurity of tenure can lead to a lack of infrastructure investment.

Larger providers, especially those operated by local councils and state health services, subsidise infrastructure and maintenance services.

Some providers, particularly those located in tropical regions of Australia, experience greater insurance costs associated with being located in areas prone to extreme weather conditions. For example, one provider described cyclone proofing buildings and completing ongoing maintenance to redress weather related damage and deterioration, at a significant cost to the organisation.
3. Policy options for the Department’s consideration

3.1 Considerations for future policy

Policy considerations
Considerations for the Department in addressing the challenges faced by remote aged care providers in their communities include:

Entry and screening considerations
1. Development of a marketing campaign or roadshow to educate remote aged care providers more extensively about how existing programs and processes operate (if they are to be maintained). Include awareness of:
   a. The Appointment of a Representative option, its associated benefits and requirements
   b. Existing Department provisions that enable clients with an urgent need to receive interim services prior to an assessment
   c. The new process that enables providers to make a referral on behalf of consumers who have limited access to phone or internet in rural and remote settings.

   Also consider roadshows or communication strategies specific to rural and remote for future changes or enhancements (delivered by the Department or else the service provider if appropriate to the prevailing funding model).

2. Funding remote aged care providers or other relevant agencies to support My Aged Care engagement for consumers in their community. This is due to the importance of having on-the-ground support with community linkages and an understanding of local language and cultural requirements. Due to potential for conflict of interest, it may be preferable for this role to be allocated to an independent advocate where this capability exists within the community. This support may be funded as part of a holistic funding model or on a fee-for-service/ activity basis.

3. Reviewing the RAS and ACAT model, to consider amalgamation of these into a single service model, especially in rural and remote areas. The review should include consideration of assessment methods suitable to remote locations, utilisation of tele- and video-conferencing and face-to-face methods, frequency of visitation schedules, the role of service providers, key performance indicators (KPIs, e.g. relating to time allocated to completing an assessment post referral), costs and funding models. Core competencies including cultural awareness should also be considered.

4. Noting current work to enhance My Aged Care, survey contact centre staff to assess cultural competence and awareness of the remote aged care context, with a view to providing further education to staff as required.

5. Reviewing and updating My Aged Care call centre scripts and processes to reflect any revisions to the consumer support process and to improve identification of Indigenous consumers at commencement of the call.

6. Redesigning the My Aged Care Service Finder tool to better identify services in discrete communities, their current capabilities including the number of clients by service type, and their capacity to take on new clients.
3. Policy options for the Department's consideration

3.1 Considerations for future policy

Eligibility and assessment considerations

7. Funding remote aged care providers or other relevant agencies to support RAS and ACAT assessments for consumers in their community. While aligned to Consideration 2, this support would be a further step along the continuum of care and would aim to ensure the assessment process is appropriately coordinated, culturally appropriate and efficiently undertaken.

8. Reviewing the consumer notification process and where relevant establishing methods appropriate for remote consumers, particularly Indigenous and Culturally and Linguistically Diverse people. Options include ensuring a remote aged care provider or other advocate authorised by the consumer is notified of the outcomes of the assessment and when a service (e.g. HCP) is allocated. These actions may be undertaken in alignment with Consideration 1 (improved awareness of the existing options for authorising a representative) and 2 (funding support for consumers through the screening process).

Service delivery considerations

9. Establishing a new, flexible aged care model for remote services that considers needs along the continuum of care. Provider feedback was clear and consistent in stating that national aged care programs such as CHSP, HCP and residential care are not well suited to the remote context in their current design. Options for consideration include:

a. At a minimum, replace CHSP and HCP with a single remote community care model addressing consumers' key aged care needs for remaining in the community. As well as the continuation of existing core activities (meals, day centre, respite, social activities, transport, nursing care) alongside personal and domestic support, this should include funding for case management.

b. One option is to establish NATSIFACP as the core model for all remote services, replacing the traditional programs. However, provider feedback suggests revisions to this program's funding model would be required to better address remote operating costs.

c. An alternative option would be to design a new flexible remote aged care model that combines block funding to meet core operating costs including management, governance, infrastructure and equipment with individualised funding packages based on client need.

d. An ambitious option would be to implement a remote aged care funding model based on Medicare payments to GPs. It would be important to avoid current limitations of this model and investigate the applicability of blended payment model using capitation and fee-for-service arrangements (e.g. similar to Health Care Homes). However, controls would be required to ensure available funding is targeted responsibly.
3. Policy options for the Department's consideration

3.1 Considerations for future policy

Workforce considerations
10. Developing remote workforce attraction and retention programs modelled on the health workforce. These may be targeted at key workers such as service managers, especially those with a nursing qualification. Options include subsidies targeted to particular areas such as housing, transport, professional development and / or wages, or reaching employment milestones such as two years of continuous employment.

   a. Consider programs to develop the Indigenous aged care workforce, that build base skills (e.g. literacy, numeracy, driver’s licence) as well as aged care skills (e.g. Cert III or IV level requirements, quality and accreditation based requirements).

   b. Consider the role of online training where appropriate to the cultural context of the staff being targeted, as well as appropriate access to reliable internet services.

11. Consider funding visiting nursing and allied health services to very remote communities, similar to existing visiting medical practitioner programs.

Funding and finance considerations
12. At a minimum, increasing funding to meet the costs of remote aged care delivery, either through an improved viability supplement that recognises distinctions in remoteness (e.g. linked to the MMM scale) or a new funding model / program (as per Consideration 9 Establishing a new, flexible aged care model for remote services that considers needs along the continuum of care).

13. Revisiting and if necessary updating the Government’s review of remote aged care infrastructure requirements across Australia to determine the level of short, medium and long term risk to service viability due to inability to fund the maintenance and replacement of existing stock. It is anticipated this review would also inform planning for the Government’s infrastructure grants program.

14. Implementing processes to ensure remote aged care providers are notified by Centrelink when pension payments relating to the basic daily fee are cancelled.

Regulations and quality considerations
15. Expanding assistance to build the capacity of small, remote aged care providers in delivering sustainable, high quality services.

16. Assessing and if necessary, providing education to improve the cultural awareness and understanding of the remote aged care context of accreditation assessors.

Reporting considerations
Noting current investments in improving interoperability issues between My Aged Care and Medicare payment systems, and previously stipulated considerations regarding catering for higher operating costs and workforce retention issues, no further policy options for the Government in addressing the reporting challenges faced by remote aged care providers and their communities have been identified.

Facilities and infrastructure considerations
- See Consideration 9. Establish a new, flexible aged care model for remote services that considers needs along the continuum of care.
- See Consideration 13. Review remote aged care infrastructure requirements across Australia to determine the level of short, medium and long term risk to service viability due to inability to fund the maintenance and replacement of existing stock.
Appendices

A. Structured interview guide

**Rationale:** To collect qualitative evidence which documents the key issues, challenges and impacts in relation to the service's experience across all applicable aged care programs;[1] to identify barriers and challenges to service delivery that Government can influence or better support; and to identify any lessons learnt or innovations applied that might improve service delivery or inform Government support for providers of aged care in remote regions.

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>PROMPTS / ISSUES FOR CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE BACKGROUND</td>
<td>The incorporation/entity type of the service provider and the service, and how this may support the governance and operations of the service; the corporate and management structure of the service and the nature of its relationship to the service provider; the programs delivered and the type and extent of services provided.</td>
</tr>
<tr>
<td>ENTRY AND SCREENING</td>
<td>Barriers to accessing aged care services in the region; challenges with entry and screening processes and their impacts on the operations of the service; the accessibility of My Aged Care and challenges with its use and interface.</td>
</tr>
<tr>
<td>ELIGIBILITY AND ASSESSMENT</td>
<td>Challenges with assessment processes, including frequency of assessments and other issues; implications of assessment processes and practices for your service and workforce; the cultural appropriateness of assessments; challenges with and barriers to effective referral. Where no issues/challenges exist, understand why and what makes model work.</td>
</tr>
</tbody>
</table>

[1] Be that the Commonwealth Home Support Program, Home Care Packages, Transition Care, Residential Aged Care, Flexible Aged Care Program, or Short-Term Restorative Care Program.
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<tbody>
<tr>
<td>SERVICE DELIVERY</td>
<td>The impact of aged care reforms on the administration, operations and sustainability of service delivery, including:</td>
</tr>
<tr>
<td></td>
<td>• The service’s experience with ACFI and its appropriateness as a funding allocation tool for remote services, including whether there are any particular costs components of ACFI that the provider is not able to deliver or receive funding for.</td>
</tr>
<tr>
<td></td>
<td>• Increased costs and other overheads associated with delivering aged care (consider all programs), including factors affecting the ability of the service to offer access to cultural, leisure and social activities of interest to consumers.</td>
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<tr>
<td></td>
<td>• The impacts on the service of recent increasing choice reforms, including the national queue and potential for increased competition in the region.</td>
</tr>
<tr>
<td></td>
<td>• The availability and quality of service alternatives in the region and the impacts on consumers of limited choice, and the impacts on consumers where limited choice exists.</td>
</tr>
<tr>
<td></td>
<td>• The impact on service delivery for HCP providers of changes since February 2017.</td>
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<tr>
<td></td>
<td>Administrative issues around claims, payments and supplements and their impact on service delivery, including:</td>
</tr>
<tr>
<td></td>
<td>• Information management systems: issues concerning the effective use of My Aged Care (barriers including internet access, computer literacy and access to computers); challenges to the effective implementation of management systems; access to technical support.</td>
</tr>
<tr>
<td></td>
<td>• Claiming: implications for the service of differing systems across aged care services and programs; issues with the frequency of claims; use of supplements and hardship payments; issues with collecting payments and implications for financial management.</td>
</tr>
<tr>
<td></td>
<td>Identify local solutions and systems (where applicable) that providers in these regions have adopted to support their service provision and operation.</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>WORKFORCE</td>
<td>Retention and recruitment of workforce; education; size, age and quality of the workforce pool; availability of appropriately skilled persons; rates of staff turnover and drivers for this; difficulties rostering staff and managing absences; costs associated with managing workforce in these regions (does it differ from other regions); staff development activities; access to appropriate training; use of volunteers.</td>
</tr>
<tr>
<td>FUNDING AND FINANCE</td>
<td>Type and flexibility of funding model; appropriateness of funding model and financial impacts on the service; equity of funding across programs; relevance and applicability of the Aged Care Approval Round and grants (including impacts on workforce to apply); evidence of the higher cost of service inputs, including labour, capital items and consumables; population size and its impact on service viability; impact of differing payment and claiming systems across the aged care programs; cost of delivering aged care services and whether funding models sufficiently account for this.</td>
</tr>
<tr>
<td>QUALITY AND REGULATION</td>
<td>Anything about funder quality and regulation that impacts on your organisation and its operations; understand challenges (if any) in complying with regulatory requirements (in relation to health and personal care, care recipient lifestyle, occupational health and safety, employment and workplace relations, or regarding the physical environment and safe systems); impacts on workforce and challenges of compliance with differing standards across aged care programs with different requirements and reporting systems; challenges with corporate regulatory requirements, including with regards to governance and compliance (if there are challenges why); aged care reforms and the impacts of recent system changes; Australian Aged Care Quality Agency visits and their impact on the service and workforce; the cultural appropriateness of Agency assessments; how the service measures quality, knowledge and participation in the National Quality Indicator Program for Residential Aged Care Facilities.</td>
</tr>
</tbody>
</table>

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### A. Structured interview guide

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<tbody>
<tr>
<td>REPORTING</td>
<td>Anything about funder reporting that impacts on your organisation and its operations; challenges with any funder reporting requirements and reporting systems/processes; challenges with reporting against differing standards across aged care programs with different requirements.</td>
</tr>
<tr>
<td>FACILITIES AND INFRASTRUCTURE</td>
<td>The age, longevity and appropriateness of facilities and infrastructure; impacts on accessibility, privacy and comfort; implications for asset management and maintenance; barriers to service delivery; impacts on workforce; issues with application processes for capital and infrastructure.</td>
</tr>
</tbody>
</table>

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### B. Key findings by case study

#### Service management type

<table>
<thead>
<tr>
<th>Case study</th>
<th>Key Findings</th>
</tr>
</thead>
</table>
| A          | The service provider is a large not-for-profit organisation.  
|            | The service receives corporate services support from the provider's central office, including assistance with management, quality, finance, human resourcing and reporting.                                                                                                                                             |
| B          | The Council has historically struggled to meet local government standards for corporate governance and management.  
|            | The Council operates a matrix management structure, whereby aged care Team Leaders report to the Community Services Manager and to a local Area Manager with oversight of the delivery of all Council services within a particular geography.  
|            | Team Leaders receive local operational support for infrastructure and assets, while the administration associated with the provision of aged care services is handled by the Community Services Manager and a central finance team. |
| C          | The service is a not-for-profit organisation that works across Queensland including in a number of discrete Indigenous communities.  
|            | The service responded to a request from the Department of Health to assume control over home care and residential aged care service delivery in three remote communities.  
|            | Delivery of aged care services across the three sites is viewed as financially unsustainable long term.  
|            | Staff noted that providing services across very remote sites long term is financially unsustainable with each site currently operating at a deficit.                                                                                                            |
| D          | The service provider is a not-for-profit provider of health and community services across the Northern Territory. In the case study town, the service provider operates three residential aged care facilities and community care services under HCP and CHSP.                                                                                       |
| E          | Aged care programmes receive a range of corporate services from corporate headquarters. Programmes are also integrated with the service provider's primary and secondary health services.  
|            | The Service Coordinator indicated that the level of administrative support provided centrally by the organisation has historically been poor.  
|            | There is no aged care committee on the corporation's board, despite this being an action in its strategic plan.                                                                                                                                                                                                 |
| F          | The service provider operates under the governance of a Board of Directors. Day-to-day operations are led by the Chief Executive Officer and a team of four managers.                                                                                                                                                                    |
| G          | Aged care programmes are supported by the full range of corporate, human and financial resources available to the state organisation and are integrated with the broader network of health and allied services.                                                                                                  |
| H          | The service is a community-controlled Indigenous Corporation, not auspiced by any parent organisation or agency. It receives no shared services from a larger corporate partner and is responsible for its own governance, administration and management.                                                                                       |
## Appendices

### B. Key findings by case study

#### Service management type

<table>
<thead>
<tr>
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</table>
| I          | - The service provider is a local government authority, responsible for the provision of local government services to local community including aged care services.  
- The local government authority provides back office support to the aged care service and access to local tradespeople. |
| J          | - The organisation provides a range of community services across Queensland including community aged care services in remote communities.  
- The organisation provides considerable back office support to its services with dedicated and experienced aged care staff. |
| K          | - The service provider is a not for profit public company, delivering aged, family and community, alcohol and drug services.  
- The service's central administrative office is collocated with the organisation's residential aged care and community aged care facilities. Corporate functions including finance, staff services (HR), IT and asset management, business development and governance, and building maintenance. |
| L          | - The service provider is a local government authority, operating a co-located hostel and nursing home.  
- A new Multipurpose Service providing inpatient beds, an emergency treatment bay and community and allied health spaces will be completed in May 2019. |
| M          | - The service is operated by a local government authority. It delivers residential aged care (RAC) services only, as one of two RAC facilities in the case study community (the other being operated by the District Health Service.)  
- Management of the Hostel is not seen as Council's core business, therefore Council is in the process of implementing a more autonomous management structure for the Hostel.  
- The Hostel doesn't provide dementia care as the facility is not secure enough, nor palliative care as it is unable to attract qualified staff. |
| N          | - The service receives a range of administrative and shared services support from Council administration: including back-office accounting, support with staff recruitment and training, business and strategic planning capability, and regular infrastructure repairs and maintenance.  
- Community engagement processes at the local service level are weakened by the absence of any dedicated local membership or advisory committee. |
| O          | - The service provider is governed by a Board of Directors. Day-to-day operations are overseen by the Chief Executive Office and management staff. |
| P          | - The service provider is an autonomous, incorporated Association under the NSW Act. It is one of three aged care providers in the area, and the only local provider of CHSP. The provider has service coverage across most local Indigenous families. |
| Q          | - The service provider is part of a large Local health District (LHD) operated by the State, and is managed by the local Multipurpose Service (MPS). It is the only local provider of HCP clients, site residents have access to other aged care services in nearby towns. |
## B. Key findings by case study

### Entry and Screening

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>- Indigenous consumers experience significant barriers to interacting with My Aged Care, requiring staff to facilitate this unfunded activity.</td>
</tr>
</tbody>
</table>
| B          | - Operating in smaller communities allows local staff to liaise with the clinic and easily identify older people who require services.  
  - The Council is susceptible to competition from NDIS providers in future and has limited visibility over the cost of their services.  
  - My Aged Care contact centre’s lack of remote area knowledge contributes to delays in registration processes and increased provider workload.  
  - Use of the Appointment of a Representative form has improved entry processes for consumers, but is an additional unfunded service. |
| C          | - The service manager coordinates the entry and screening process on behalf of clients, further unfunded services provided by the service.  
  - Older people are often reluctant to access care out of fear that family members will lose welfare support.  
  - Older people within the community may be missing out on services if they have not been identified by the clinic or aged care service.  
  - The My Aged Care screening process is viewed as culturally inappropriate due to contact centre staff lack of knowledge about the remote setting and aged care eligibility for Indigenous people. |
| D          | - Generally, consumers in town are directed by their GP, or self-refer to My Aged Care and then contact the service provider directly to access services.  
  - Consumers at very remote sites are usually directed to the service provider by their local health clinic and the service provider then assists the consumer to navigate My Aged Care to access services. Although assistance can take several hours to a day per client the service see it as part of their role.  
  - Some consumers may be missing out on services as they are not engaged with any services to identify them for aged care support.  
  - Indigenous consumers often require translation services during screening, taking staff away from funded care delivery. The service provider noted financial recognition of the cost to deliver the services would improve service accessibility for consumers and financial viability for the service. |
| E          | - Older people in the community may be missing out on aged care services due to cultural and system barriers.  
  - The introduction of My Aged Care and market competition have made it more difficult to identify older people who are currently receiving or require services.  
  - The service provider coordinates the entry and screening process on behalf of clients as they often delay access or decline services.  
  - Management and staff were resolute in their view that My Aged Care is unsuited to the remote aged care setting.  
  - Indigenous people feel displaced in residential facilities – so often decline or delay access. |
| F          | - The most significant barrier to service entry is lack of community awareness about accessing aged care services. As a result, the service spent considerable time undertaking informal community education.  
  - The provider regularly assists consumers to access My Aged Care. |
## Appendixes

### B. Key findings by case study

#### Entry and screening

<table>
<thead>
<tr>
<th>Case Study</th>
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</tr>
</thead>
</table>
| G          | - Older people in the community have limited access to aged care services.  
- Increased market competition from both aged care disability providers is viewed positively, however the service provider remains cautious that complex clients may not be catered for by not-for-profit providers entering the market.  
- My Aged Care needs to improve the identification of discrete remote communities on the service finder and improve the contact centre’s knowledge of remote, to effectively support the remote context.  
- Due to limited proficiency in English, IT literacy and a distrust of third parties, staff submit referrals and assist consumers throughout the screening process. |
| H          | - Older people in the community with low to moderate care needs have good access to aged care services, but lack access to higher levels of service to enable them to remain in community longer as their needs change.  
- Aged care screening processes prior to entry are considered to be challenging and unsuited to the remote circumstances and cultural context in which the community’s older people live. The service provides a high level of support during this phase to obtain the consent of clients and carers and to manage communications between them and My Aged Care. |
| I          | - The service provider invests considerable time identifying older people in their community who require services and assisting them to navigate My Aged Care. |
| J          | - The Service Manager case manages consumers to navigate My Aged Care to overcome language barriers, literacy issues and unfamiliarity and trepidation about dealing with government agencies. |
| K          | - The service reported that Indigenous consumers often do not have reliable access to telephones, computers and the internet. This lack of access—compounded by low levels of literacy—means service staff need to provide unfunded assistance to help consumers navigate My Aged Care.  
- Letter notification by HCP is seen as an issue. The service proactively engages with consumers and monitors My Aged Care when they have been assessed. |
| L          | - The service provider offers places based primarily on order of need.  
- My Aged Care system is seen as a barrier for consumers in the region. |
| M          | - Referrals to the Hostel are primarily from the Hospital Coordinator at the local MPS, and the Hostel’s own RN through her personal connections formed in a part-time role she holds with another organisation.  
- Staff do not find My Aged Care particularly user-friendly; of note, they find it lacking in detail.  
- MPS receives referrals before the Hostel, impacting on its viability. |
| N          | - The My Aged Care registration and screening process is frustrating for the service because of convoluted consent processes.  
- Referrals for clients in remote communities are complicated by the lack of community knowledge and cultural awareness of contact centre staff.  
- Clients require a significant amount of care coordination during the screening and assessment process. |
## B. Key findings by case study

### Entry and screening

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| O          | - Clients are usually identified in the community through the various services offered by the provider. There is minimal need for the service to use My Aged Care.  
- Clients do not use My Aged Care due to a lack of relevance, IT access, low literacy levels and language barriers. |
| P          | - Entry to CHSP is via community connection, rather than through more formal avenues.  
- The service was not aware of any consumers using My Aged Care; they viewed this as being redundant in their community as their consumer group has low digital literacy. The service manages these interactions with My Aged Care on behalf of the consumer. |
| Q          | - The provider delivers HCPs to six consumers locally; demand for services (both in terms of numbers of people, and level of care requirements) has remained steady for some time.  
- There have been no service entrants since the My Aged Care reforms, and the service was therefore unable to comment on the impact of these reforms on entry and screening.  
- Due to low literacy levels and poor internet availability, consumers are unable to access My Aged Care without assistance from the service or MPS. However, consumers are fearful that the service or the MPS would exert control over their care and put them into a residential facility. The provider is working to address this misconception. |
## B. Key findings by case study

### Eligibility and assessment

<table>
<thead>
<tr>
<th>Case Study</th>
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</tr>
</thead>
</table>
| A          | - The service reported variability in completeness of ACAT assessments. There have been cases where the severity and complexity of a consumer's needs have been understated. In some instances, some Indigenous consumers have been allocated a HCP despite requiring residential services within a short period of time. This was not the case for RAS.  
- The service identified the use of letters to communicate with Indigenous consumers as a major problem and leads to the loss of a HCP. The service frequently initiates service delivery while waiting for HACC services to be approved or a HCP to be allocated, due to community expectations and individual client needs. These service costs are unable to be recovered.  
- The service’s view is that the distinct aged care service and programme types lack flexibility and would prefer a single flexible care programme with an appropriate funding model.  
- The community has an expectation that elders will receive care irrespective of whether they have been assessed or not. |
| B          | - The service provider coordinates the screening and assessment process, an unfunded exercise.  
- Unfunded services are usually provided to clients prior to approval.  
- Assessment timeframes vary across communities depending on their remoteness and geography, with timeframes of over four weeks and assessments completed both over the phone and face-to-face.  
- Staff attend assessments to bridge language and cultural barriers during assessment, particularly to support the RAS. |
| C          | - Staff actively manage the assessment process despite it being a lengthy and unfunded process. This service further strains the services viability.  
- Regional Assessment Service (RAS) and Aged Care Assessment Teams (ACAT) are provided with support to understand the local context and cultural practices which may be relevant to an assessment or services required.  
- Client transience and lack of proof of identity require additional support by staff to manage. |
| D          | - The service provider is confident in its ability to assist consumers to access services, as senior staff members have significant experience in the industry and are familiar with existing systems (e.g. My Aged Care). |
| E          | - The service provider’s involvement during the assessment process is limited due to staffing shortages.  
- Staff and management have a tenuous relationship with the assessment workforce and find it challenging to get assessment teams to visit regularly.  
- Many clients, unable to receive culturally appropriate support opt-out during the booking process, only to have to recommence the process at a later date.  
- Service recommendations are sometimes inappropriate because of communication barriers between assessors and clients.  
- The service provider would prefer assessments to be managed by service to remove administrative and cultural barriers. |
| F          | - While there have been some delays in clients being assessed, the service generally thought the services provided by the local ACAT and RAS teams are adequate.  
- The service expressed concern about ‘a letter’ being the method of notification of assessment and assignment, with their consumers not knowing what to do with the letter. |
## B. Key findings by case study

### Eligibility and assessment

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| G          | - The service supports clients through the screening and assessment processes and in some cases attend assessments which is a time and cost to the service but prioritises hospital clients due to a shortage of auxiliary staff.  
- The state organisation also operates the Aged Care Assessment Team (ACAT) so the service benefits from established linkages.  
- Although not always considered appropriate, assessments are completed by video-conference to ensure timeliness of assessment.  
- Staff raised broader concerns about the Regional Assessment Service (RAS) business model and the incentive to increase frequency of assessments and limited information provided about service requirements (factors also applicable to the urban context).  
- The postcode based design of the service finder system is regarded as presenting a distorted picture of the service landscape to clients. |
| H          | - Communication between My Aged Care and the consumer is problematic, and is a time-intensive exercise for the service provider to remain informed about the consumer’s progression through the system.  
- There is frustration with the waiting period for a consumer to be formally referred to the service after assessment, and the service has typically responded by initiating provision of the service, despite not being funded to do so. However this may be an education issue.  
- There is some reluctance to initiate a reassessment of Level 2 HCP clients, whom the service believes will be assessed as either requiring a lower level of service (less funding) or else a higher level of service that may stretch the service’s capacity to support them. |
| I          | - The 56 day timeframe to accept a HCP acts as a barrier to accessing care as many consumers do not receive their approval letter.  
- If the service provider does not intervene, Aged Care Assessment Teams (ACAT) can determine that a client is ineligible for services, due to insufficient consideration of their social circumstances related to living in a remote community.  
- The service provider invests significant time in coordinating clients through a Regional Assessment Service (RAS) assessment because assessments are only available over-the-phone. |
| J          | - Strong aged care expertise in the head office and working relationships with the Aged Care Assessment Team (ACAT) and Regional Assessment Service (RAS) teams support the Service Manager to navigate eligibility and assessment criteria (for example the ACAT team will call ahead before deeming an applicant to be ineligible for services).  
- The requirement for a consumer to receive and approve a HCP allocation within 56 days is not feasible in the context of remote communities and occasionally resulted in an older person missing out on funded services.  
- A clear barrier to timely service access is literacy and language limitations, and notification through a letter. |
| K          | - Management reported that the organisation has well established relationships with regional Aged Care Assessment Teams (ACAT) and Regional Assessment Service (RAS) teams.  
- Communicating with Indigenous consumers by letter was identified as a major issue. Management stated that the majority of its Indigenous consumers will ignore or destroy unopened letters. Staff therefore proactively engages these consumers and assists them to read the letters, however this activity is unfunded. The service did not identify these issues as impacting non-Indigenous consumers. |
### B. Key findings by case study

#### Eligibility and assessment

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| L          | - The Director of Nursing supports consumers through the My Aged Care process, including accessing an assessment.  
- Management did not identify any challenges with the aged care assessment process; they attributed this to their good relationship with the Aged Care Assessment Team (ACAT) assessor in the region.  
- The means test assessment is seen as difficult and time consuming, and is often incorrectly completed by the consumer. |
| M          | - The Hostel management staff did not identify any challenges with the aged care assessment process; they attributed this to their relationship-based referral pathways. |
| N          | - The service commences care while waiting for a client to be assessed, but is unfunded for this activity.  
- The Regional Assessment Service (RAS) required support from the service when setting up their assessment service in the community, given their lack of community knowledge and limited cultural awareness.  
- Completing an assessment can be challenging due to language barriers. Staff are frequently needed at an assessment to bridge these barriers.  
- On average support provided equates to one day unfunded time per client during the entry, screening and assessment processes. |
| O          | - The Aged Care Assessment Team (ACAT) assessor rarely visits the region to undertake assessments. Assessments are being performed by the service's physiotherapist and are unfunded.  
- Advising clients of assessment outcomes by letter doesn't work when clients are unable to read it, don't own a letterbox or are nomadic. This method of notification lacks relevance in this community.  
- The service noted general entry and assessment processes aren't designed for very remote communities. |
| P          | - Service provider staff commented that no eligible individuals requiring aged care services are currently missing out.  
- They are not aware of how referrals to their organisation are made.  
- The service noted that they are responsible for identifying the need for an assessment and often arrange for the ACAT team to undertake the assessment. The Regional Assessment Service (RAS) process was not well known; as a result, no specific issues were identified.  
- The service provides unfunded services such as informal needs assessment conversations. |
| Q          | - Consumers have not been re-assessed in recent times as their needs have remained constant.  
- Historically the service has found it challenging to arrange Aged Care Assessment Teams (ACAT) when consumers are in hospital as these consumers are considered a low priority.  
- The service is providing unfunded assistance with assessment and re-assessment and navigation of My Aged Care 'because it's the right thing to do'. |
### B. Key findings by case study

#### Service delivery:

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<tr>
<th>Case Study</th>
<th>Key Findings</th>
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</table>
| A          | • Client transience and family interventions can lead to inconsistent service usage and income, resulting in additional administrative tasks.  
           | • Clients are often referred to the provider in crisis and require immediate care. Delays relating to My Aged Care and Aged Care Assessment Team (ACAT) processes can mean this care is unfunded.  
           | • HCP recipients have little understanding of the structure and limitations of their packages, and will request services that cannot be delivered or do not fit within the individualised budget of their package. |
| B          | • Older people in the case study community with low to moderate care needs have good access to aged care services, however the variety and level of service offered is significantly influenced by the remote environment.  
           | • Client transience, costs of delivering service, cultural barriers, housing conditions and staffing all impact service delivery.  
           | • The level of service provided to clients of CHSP and Level 2 HCPs is largely indistinguishable. HCP clients tend to be underserviced.  
           | • Clients requiring more intensive care must travel or move permanently to a regional centre. |
| C          | • Infrastructure and staffing issues limit the intensity of services offered to clients in the community.  
           | • Clients with higher care needs must relocate to other communities to access higher levels of care, or else are over-serviced by the provider.  
           | • Delay in package upgrades has led to over-servicing of clients awaiting a higher level package.  
           | • The service receives little information when clients are discharged from regional hospitals, impacting on continuity of care.  
           | • Aged care reforms have created financial issues with clients waiting for higher level home care packages or the allocation of a package.  
           | • Provider supportive of HCPs ability to accommodate transient clients but noted administratively it added considerable workload and low levels of literacy made individualised budgets conversations difficult with clients. |
| D          | • Respite care has a critical role in meeting the care needs of Indigenous clients in very remote areas where there is no access to residential aged care and limited access to formal and informal supports. Permanent residential care is not the preference of these clients.  
           | • Visits by allied health professionals are infrequent, thus impacting the quality of service available to people in very remote areas.  
           | • Clients waiting for HCP level upgrades receive additional services through CHSP to maintain the service provider's reputation in the community.  
           | • Brokering services enables continuity of services for transient clients.  
           | • The service provider utilises a mix of CHSP and NATSIFACP to deliver appropriate levels of care to remote clients.  
           | • The service provider noted that NATSIFACP provided a more flexible funding model than HCP for the delivery of care for remote clients.  
           | • Delivering HCP on a consumer directed care basis in locations with low literacy added complexity in meeting administrative requirements such as individual budgets.  
           | • To deliver culturally appropriate care the service provides cultural awareness training every six months. At one site signage is in the local language which staff are encouraged to learn. |
B. Key findings by case study

### Service delivery

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<tr>
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</table>
| E          | - Indigenous people in the community access care from multiple providers as the service provider has gaps in its service offering. This level of service is controlled by staffing and facilities available.  
- Increasing choice and the National Disability Insurance Scheme (NDIS) are likely to increase competition in the HCP market, for which the service provider is currently not an approved provider.  
- Lower occupancy across programmes impacts the financial viability of the service.  
- The service provides unfunded support to CHSP clients with case and financial management and access to other support services.  
- Service provision is also impacted by the culture of reciprocity and ICE addiction, gambling and the introduction of government welfare management policies which have exacerbated financial pressures on clients.  
- The service provider is over-servicing clients as they do not want to move to facilities that do not provide culturally appropriate care. |
| F          | - The service does not experience significant challenges in delivering their services.  
- The service notes that since the HCP reforms commenced in February increased competition has impacted the service.  
- The district Hospital doesn’t offer palliative care services, as a result the service provides unfunded palliative care through its respite facilities. |
| G          | - Being part of the broader health and hospital network operated by the state, the provider is regarded by staff and management to be a high quality service.  
- Providing services in the home can be problematic due to the level of poverty and homelessness in town. Some houses are seen as a safety issues for staff.  
- Providing longer term support for the community’s ageing population will become problematic as the community’s care needs become too complex for the service provider’s low care facilities.  
- In the absence of family in town and a reluctance by clients to accept care, the service provides a greater level of case management than might otherwise be expected.  
- HCP portability will potentially impact viability, given the need to maintain minimum volumes to account for high fixed operating costs. |
| H          | - Case management and planning to determine the requirements of clients is challenging, given the difficulty of communicating service level concepts and the culturally sensitive nature of personal and domestic care matters.  
- There is little to differentiate CHSP and HCP service levels, which has led to some underservicing of HCP clients and/or a tendency to over-service CHSP clients. |
| I          | - There is insufficient funding available within HCPs to deliver services which meet the specific needs of Aboriginal and Torres Strait Islander peoples in remote areas particularly in relation to providing social support and allied health services, because of the cost of travel and accommodation for allied health professionals.  
- Older people in the community often miss out on receiving higher levels of care because they are reluctant to relocate to a larger regional centre to access residential care.  
- Individualised HCP budgets are seen to have potential for financial abuse. |
B. Key findings by case study

Service delivery:

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| J          | - The service provider has successfully trialed the use of tele-health to overcome the prohibitive cost of delivering allied health services in their remote communities.  
- Staff work closely with the local health service to enable the delivery of all HCP levels.  
- The service indicated that some additional flexibility in the programme guidelines would ensure its service offering meets the specific needs of the local Aboriginal and Torres Strait Islander people.  
- Case managing processes on behalf of the consumer requires a significant amount of unfunded time. |
| K          | - The service faces challenges in accessing GP services for residential clients due to a lack of appropriate services locally, and a refusal on the part of the local Aboriginal Medical Service and District Hospital to provide visiting services.  
- Most HACC and HCP clients serviced do not have telephones and are unaccustomed to attending planned meetings or appointments. The service's care workers dedicate a significant amount of time to locating these clients.  
- There are homes that the service will not send staff to unless they are working in groups due to safety concerns. |
| L          | - Due to the remoteness of the service accessing some rehabilitation services is challenging and costly to the service. Currently some services can only be accessed in the nearest regional centre 300kms away. |
| M          | - The Hostel currently houses 13 residents, including 12 permanent and one respite consumer. No consumers are of Indigenous descent. More than 40 percent of residents are fully supported.  
- The Hostel has noticed the extent of the Aged Care Funding Instrument (ACFI) indexation freeze, and finds ACFI complex.  
- Residents have access to the full range of health-focused support services, including allied health and GP services. However, there are no transport services available for residents' offsite medical appointments. |
| N          | - Older people in the community with low to moderate care needs have good access to aged care services, however the variety and intensity of services delivered is limited by staffing and resourcing constraints.  
- Providing services in a clients home can be problematic due to overcrowding and cultural sensitivities.  
- Community remoteness adds significant expenses when delivering services, particularly in the wet season.  
- CHSP clients are being over serviced as wait times for eligible HCPs inhibit referrals.  
- The only differentiation between HCP and CHSP is the intensity of services delivered.  
- Case management is provided to all clients, irrespective of programme type, with ensuing costs borne by the service. |
### B. Key findings by case study

#### Service delivery

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| O          | - Service delivery is impacted by the significant distances between communities and the extreme remoteness of the area. The service provides the best care they can for clients despite these barriers.  
- The service identified a need in the community for respite and palliative care facilities.  
- The service suggest an integrated service delivery model is the most efficient and cost effective for remote communities. |
| P          | - The service considers there is greater demand for their services, particularly transport, than they are currently able to provide.  
- The service noted that their relationship with consumers often involves their family members, and this can present challenges. |
| Q          | - The LHD stated consumer directed care was challenging to deliver, due to practical limitations of being in a remote location (i.e. internet connectivity) and unique cultural expectations.  
- Service intends to exit aged care service delivery in the future. |
## B. Key findings by case study

### Workforce

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| A          | • Although recruiting and retaining a suitable workforce is a challenge the service is currently adequately staffed.  
• A lack of suitable and affordable housing can make attracting and retaining staff difficult and the service provides some subsidised housing for key staff.  
• Absenteeism amongst the service’s Indigenous employees is a challenge for the service. |
| B          | • The aged care workforce is under-qualified and unable to provide the required level of care for Level 2 HCP clients needing personal care and domestic support. A mix of factors, namely the gender assignment of roles, lack of aged care related training, and the absence of a foundation for mainstream learning, limit the contribution that can be made by the service’s local Indigenous staff.  
• The service’s ability to recruit is impeded by the requirement for staff to have a valid driver’s license, and by the high cost of providing accommodation to staff from outside the community.  
• Gaps in the availability of allied health workers and for qualified nurses present an additional challenge for clients with complex needs. |
| C          | • Staffing poses a significant challenge to the financial viability of service delivery, accounting for 75 per cent of expenditure.  
• Absenteeism related to social and cultural obligations makes rostering a challenge.  
• Accessing qualified staff within local communities is difficult and expensive.  
• The service relies on external agency staff to support skill shortages and bridge cultural barriers related to local staff delivering care to people they are related to. This puts pressure on HCP budgets and service viability.  
• An adaptation of the Certificate III for those with English as a second language would improve workforce capacity. |
| D          | • Workforce was the biggest issue facing the service provider in terms of its ability to deliver aged care services with the reliance on overtime, agency and casual staff significantly increasing the costs of service delivery.  
• The recruitment and retention of registered nurses is challenging, with the service sponsoring overseas trained RNs to fill the recruitment gap.  
• The service provider uses a fly-in fly-out model for non-local staff at its very remote services as it had been very difficult to recruit non-local people who were willing to relocate to very remote areas due to social isolation and poor living conditions.  
• Absenteeism is high amongst Indigenous staff therefore the service provider encourages them to work in areas other than delivery of care.  
• The service provider has invested in an online training tool which allows new staff members to access training on an as needed basis. |
| E          | • The cost of accredited training is prohibitive and none of the CHSP staff are therefore currently studying for a certificate level qualification.  
• Qualification and skill levels at the residential service are high, with all six permanent staff qualified to either a Certificate III or IV level.  
• Care staff at the residential service were dissatisfied because of the service provider’s inability to recruit auxiliary staff, much of their time is spent undertaking lower skilled tasks as opposed to personal care and social support.  
• Access to qualified health professionals such as nurses and allied health is limited, despite aged care’s integration with medical services. |
### B. Key findings by case study

#### Workforce

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| **F**      | The service stated that the lower pay rates in the aged care sector pose challenges in recruiting and retaining staff however the service currently have a full complement of staff.  
- The service can not offer HCP staff job security due to potential client portability.  
- The service identified training as a significant challenge, to address this it flies trainers in to minimise costs and maximise access for staff. |
| **G**      | Access to affordable and quality accommodation in the community is regarded as a major impediment to the recruitment of qualified staff from outside the community.  
- Difficulty recruiting qualified staff has had a material impact on both residential and home care services, with residential services in particular lacking sufficient coverage from qualified nurses.  
- Shortages of staff present several challenges for the service, in terms of its ability to provide a high and consistent level of care, the costs incurred during the recruitment process; and costs incurred by needing to back-fill positions with temporary staff.  
- The state organisation provides a range of online training modules however sending staff to Adelaide for further training has travel cost implications as well as backfilling costs. |
| **H**      | The qualification and skill level of available staff is considered by the Service Manager to be the greatest constraint on the quality and level of service provided.  
- Options to provide increased levels of care (by tasking the Service Manager or using package funds to contract the clinic) do exist, but are not scale-able to multiple clients.  
- Staffing limitations will impact the service in the future, the service would like to recruit a qualified team leader from outside the community but accommodation and travel entitlements prohibit it. |
| **I**      | The recruitment and retention of an appropriately qualified service manager with adequate experience to manage a standalone service was considered the key workforce challenge facing the service.  
- Irregular attendance of available staff was also a significant challenge to service delivery. |
| **J**      | Despite paying the Service Manager a modest remote allowance and providing onsite housing, the recruitment and retention of an appropriately qualified Service Manager was highlighted as a challenge.  
- Poor work attendance by local staff was considered a challenge although manageable in the context of service delivery to the local Indigenous population.  
- When the Service Manager is away the service is run by the cook and local staff, with daily calls from the Aged Care Service Manager.  
- A barrier to completion of Certificate II by care workers is the TAFE’s minimum attendance requirements.  
- The cost of delivering training to staff is higher in remote communities with trainers flown into community. |
| **K**      | The service has a strong focus on the retention and development of staff – this has begun to pay dividends with reductions in turnover and high numbers of staff completing qualifications.  
- The service competes with mining companies and state government agencies that offer better pay and conditions, and attracting and retaining staff remains an on-going challenge.  
- Indigenous recruitment is difficult and inter-generational welfare dependency is perceived to be an entrenched problem. Management also reported that absenteeism is a major issue with Indigenous staff.
### B. Key findings by case study

#### Workforce

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| **L**      | - All employees are employed under a Council award, although these differ by facility.  
- Staff turnover is high, for example there have been five RNs in the last 12 months. This has resulted in needing to use agency staff, which incurs 12 percent higher fee.  
- The major workforce challenges are associated with recruitment of adequately skilled staff and workforce training. |
| **M**      | - The Hostel is soon to implement a new management structure whereby all functions related to the Hostel will be carried out on premises. The intention of this is to build the Hostel’s independence.  
- The major workforce challenges are associated with recruitment of adequately skilled staff and workforce training.  
- Lack of qualified staff impacts on their ability to deliver certain types of care. |
| **N**      | - Challenges associated with the service’s workforce are a significant limiting factor on its ability to deliver a full suite of services, particularly under the HCP programme and for those clients who require a higher level of service. While personal care and domestic cleaning is occasionally provided, the limited number of staff hours available are typically used for meals and laundry services only.  
- The need to recruit staff locally is an on-going task for the Team Leader, who must regularly source, screen, interview and induct staff for only short periods of employment. |
| **O**      | - Attracting and retaining a qualified workforce is an ongoing struggle and a large cost to the service.  
- The service report around one-third of staff develop mental illness due to isolation and boredom. A lack of activities and close confinement has lead to conflict between staff.  
- Staff perform roles and functions above and beyond their funded position. |
| **P**      | - The service identified workforce gaps in administration, and data entry / reporting specifically.  
- The organisation also described challenges they face due to low levels of language and computer literacy, and that their workforce is not supported by on-the-job or formal qualifications. |
| **Q**      | - Recruitment of permanent, adequately qualified and trained staff was raised as a major challenge by the LHD.  
- Management stated community expectations that the service would be available at all hours, and the consequent impacts on staff working overtime, was a threat to their financial sustainability. |
### B. Key findings by case study

#### Funding and finance

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<tr>
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</table>
| A          | - The service runs at an operating loss and is subsidised by revenue delivered from other areas of the provider. The service is provided as part of the service provider’s social mission.  
- Current funding arrangements do not take account of the additional expense related to provision of services in remote areas.  
- The service reports that the viability supplement does not cover the funding shortfall.  
- The service relies on grant funding to offset major capital costs and supplement on-going service provision.  
- ACFI payments for the behaviour domain are seen as inadequate for remote providers.  
- Management flagged concerns that delivery of services under a consumer directed care model significantly increases funding uncertainty while also working with high operating costs, clients exits and a small number of clients. |
| B          | - The financial position of aged care services delivered by the provider is unclear, but it is likely the service’s are in deficit. The financial impact of unpaid viability supplements and the extent to which the service is reliant on these payments is therefore unknown. According to service management, the service is cross-subsidised by the Council in order to remain viable.  
- The provider has no understanding of the cost implications of over-servicing CHSP clients, and does not charge HCP clients for some services.  
- Client contributions for food are not always received, while the service is not receiving viability supplement payments for several clients. |
| C          | - Funding is insufficient to support the delivery of aged care in remote communities, and risk the service provider moving out of residential care.  
- Small facilities lack the economies of scale to remain financially viable.  
- Portability of packages has created viability issues for the service.  
- Administering client contributions is problematic and places a burden on the service.  
- The Aged Care Services Manager noted costs incurred to run 10 bed facility in remote regions is comparable to a 60 bed facility in a metropolitan area.  
- Changes to the Aged Care Funding Instrument (ACFI) has lowered funding, compounding financial viability issues. |
| D          | - The recent changes to Aged Care Funding Instrument (ACFI) has reduced funding compounding the difficulties to cover higher costs in remote areas.  
- The service relies on full occupancy to make residential aged care services financially viable.  
- For the smaller very remote residential care services, the CEO emphasised the inadequacy of the remote service viability supplement, particularly in the context of small bed remote residential care facilities which had high overhead costs.  
- Last year the service wrote off $100,000 in unpaid debts, some attributed to the cancellation of Centre pay deductions. |
B. Key findings by case study

**Funding and finance**

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| E          | - Aged care services at the organisation are in deficit and require cross-subsidisation from other areas of the organisation. Fixed costs for senior staff and infrastructure are high, and these are effectively subsidised by other areas of the corporation.  
- Various services are provided that are either unfunded or else insufficiently funded to maintain current service levels. Examples include: client transport services, case management for CHSP clients, fire-wood collection, and the need for staff travel-escorts. (This can equate to $1,000 per month of unbudgeted expenditure).  
- The service provider does not charge additional fees to its CHSP clients given client poverty levels and community expectations.  
- The Service Coordinator, responsible for implementation of aged care programmes, lacks visibility over levels of income and expenditure, making day-to-day service planning difficult. |
| F          | - A flexible funding model would assist in topping up services if required.  
- The service have been able to deliver their services within their allocated funds. However, they noted cost pressures in some areas due to funding changes, such as to the Aged Care Funding Instrument (ACFI) and to HCP.  
- The service deem funding for Level 4 clients insufficient and have suggested the use of a flexible funding pool, to top up services and assist the client remain at home.  
- The service charge a basic daily fee to clients in receipt of a HCP.  
- The service suggested a re-allocation of the viability supplement according to their remoteness or at a minimum a travel supplement. |
| G          | - Aged care services are in deficit and are sustained only by in-direct subsidies paid by the service provider. High fixed workforce and infrastructure costs are the main cost drivers at the service. Cost of a tradesman can be 30 percent higher for a remote service.  
- Shortfalls in the cost of delivering services are not adequately covered by the service levy charged by the service provider (at 15 percent for service administration and an additional 20 percent for case management for HCP clients) nor the viability supplement paid for HCP clients, nor the client co-contribution charged.  
- Underspends in CHSP and HCP budgets can be attributed to limited choice of services available.  
- HCP viability supplement is regarded as insufficient to make up the funding gap of high fixed costs. |
| H          | - The cost of over servicing some CHSP clients is being borne by the service. Meanwhile some HCP clients have consistently under-spent their allocation.  
- HCP funding is considered to lack flexibility under certain conditions, for example with regards to the use of un-spent funds, exemptions for food goods and around case-management of transient clients.  
- Given the level of service provided under the two programmes (HCP and CHSP) is so similar, the value of administering two separate programmes is questioned by the Service Manager. |
| I          | - The service is heavily reliant on the remote viability supplement to maintain operations due to the considerably higher costs associated with remote service delivery (an additional 40 percent for food, fuel at $2 per litre and storage during the wet season).  
- The service is concerned about a shift to portable CHSP funding as portable HCP funding is impacting service viability in terms of their ability to meet fixed overheads. |
### B. Key findings by case study

#### Funding and finance

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<tr>
<td>J</td>
<td>• The service emphasised the value of the remote viability supplement in maintaining the viability of its remote services, particularly in the context of portable HCP funding, limited capacity for differentiated pricing and low levels of client contributions.</td>
</tr>
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</table>
| K          | • Management reported that the residential service operates at a loss due to a lack of scale and an inability to obtain refundable accommodation deposits (RADs) from its residents.  
• The service believes that there is unmet demand in the community for both residential and community based services, but the organisation does not have the funds nor operating margins it would require to expand and meet this need.  
• The service generally has few issues with claiming; however claims for a Level 4 client are outstanding for over 13 months.  
• Management broadly happy with Aged Care Funding Instrument (ACFI) but finds it complex and challenging. |
| L          | • The service has historically operated to budget, with some deficits and surpluses over the years.  
• Management stated that existing supplements and funding is inadequate to cover the higher costs associated with operating a remote aged care facility, particularly because of the higher costs associated with food, labour and freight.  
• Lack of qualified ACFI assessors to ensure assessment and funding is up to date.  
• The service has not noticed the impact of the Aged Care Funding Instrument (ACFI) indexation freeze, specifically, although the indexation freeze on Complex Health Care, specifically pain management, has been an issue. |
| M          | • The Hostel operates at a significant deficit (>600k in 2016-17, equivalent to approximately 50 percent of Council’s revenue base). They attributed this to the much higher cost of consumables in remote areas.  
• The Hostel felt that the RAC viability supplement was not high enough to cover their increased operational costs.  
• Council is considering ceasing the delivery of aged care services. |
| N          | • The service is financially viable, but is reliant on workforce wage subsidies from the NT Jobs Package as well as cost savings through the use of shared services from Council administration, which off-set high transaction costs for goods and services.  
• Inflexibility with CHSP and HCP programmes means various costs are borne by the service, including travel-escorts for clients; the cost of case management for CHSP clients and the cost of food delivered under the meals service. |
### B. Key findings by case study

**Funding and finance**

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</table>
| O          | - Services are delivered at a much higher cost than an equivalent service in a metropolitan or regional area, impacting on the quantity of services clients can receive within the current funding.  
- The residential aged care facility has run at a loss over the past few years, having a significant impact on the service finances. In just the first three months of the year it is already $44,000 in deficit. The provider stressed emphatically that the extreme remoteness of the region is the significant contributing factor to high operating costs of its aged care services.  
- The provider does not charge the aged care service an overhead, as such the 'real' losses would be roughly 10 per cent higher.  
- The services are concerned the transition of HACC to CHSP may result in services being reduced to fit in an expected lower budget.  
- The service noted that remote loading is the same regardless of the remoteness of the community.  
- The service have considered the continued viability of providing aged care services in the region. |
| P          | - The service reported their current funding arrangements (quarterly block funding) works well for them.  
- In order to cover operating costs, they have sought to diversify funding sources to include tax deductible donations and income from advisory, cultural and other activities. |
| Q          | - Costs related to the operations of the service more broadly, such as staff, and stock and equipment, present a challenge to the financial sustainability of aged care service delivery by the service.  
- Delivery of unfunded services has significant impacts on the financial viability of the service. |
## Appendices

### B. Key findings by case study

#### Quality and regulation

<table>
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<tbody>
<tr>
<td>A</td>
<td>The values and attitudes implicit in the Accreditation procedures and the Standards are not representative of the values held by the residents and consumers in remote communities.</td>
</tr>
<tr>
<td>B</td>
<td>Management and accountability were historically issues due to significant staff turnover at the senior management level and an absence of clear policies and procedures. The Quality Review process and consultancy assistance through the Service Development Assistance Panel (SDAP) have supported improvements to the provider’s quality and reporting procedures.</td>
</tr>
<tr>
<td>C</td>
<td>Australian Aged Care Quality Agency (Agency) reviewers often exercise insufficient flexibility in applying Quality Standards to the remote context. The organisation provides mandatory cultural induction training for all staff and visitors, including Agency staff, to improve their capacity to work in the remote setting. The service has been subject to a high level of scrutiny by the Agency, resulting in significant cost to the service and disruption to staff and clients.</td>
</tr>
<tr>
<td>D</td>
<td>The service employs three full time staff members to assist its services in meeting the relevant quality standards and reporting requirements. The Aged Care Services Manager emphasised the need for the accreditors to take into account the context of remote service delivery to ensure the fair and consistent application to the standards. Aged Care Services Manager is supportive of a single set of aged care standards, as ensuring compliance across different standards adds additional complexity for services. The Residential Care Manager highlighted the difficulty of unannounced site visits with high staff turnover and frequent use of agency staff.</td>
</tr>
<tr>
<td>E</td>
<td>The service provider benefits from corporate safeguards and structures that contribute to quality of care. Quality is a priority for staff, who invest significant unfunded time to adhere to standards. Complying with some quality standards can be challenging given training deficiencies and inability to recruit appropriately qualified staff. Quality reviewers are reportedly too stringent in applying standards in remote settings.</td>
</tr>
<tr>
<td>F</td>
<td>The service have passed all accreditation and quality reviews, however reported some issues with these processes. Leadership changes in the organisation has led to seven visits over the last two years. The service believes unannounced visits are a strain on remote services, you need to drop everything to assist the assessor, which has significant flow on effects on care delivery to clients during visits.</td>
</tr>
<tr>
<td>G</td>
<td>The service provider benefits from rigorous corporate governance, quality standards and quality review practices, including corporate IT and infrastructure support, mandatory corporate training and health and safety procedures. The service has had minimal issues with passing external quality review processes and maintains its own internal processes for monitoring and assessment of standards.</td>
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<tr>
<td>H</td>
<td>The quality review process conducted by the Australian Aged Care Quality Agency is regarded as unnecessarily onerous and conducted without a contextual appreciation of the service. Interpreted standards for risk management and corporate governance are regarded as unrealistic.</td>
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</table>
### B. Key findings by case study

#### Quality and regulation

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<tr>
<td>I</td>
<td>- The service felt that the accreditation process was relevant to remote services, provided that accreditors exercised a degree of pragmatism to the realities of remote service delivery in their application of the Home Care Common Standards.</td>
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<tr>
<td>J</td>
<td>- The service emphasized the importance of having at least one quality reviewer with experience working in the remote context to ensure they could apply the Standards appropriately to remote service delivery.</td>
</tr>
<tr>
<td>K</td>
<td>- Management reported the accreditation assessors that have visited have a good understanding of the remote delivery context.</td>
</tr>
</tbody>
</table>
| L          | - The service recalled generally positive experiences with the Australian Aged Care Quality Agency (Agency), and found that existing internal audit and process improvement program makes the accreditation process straightforward.  
  - However, risk management and compliance activities are time consuming and detract from patient care.  
  - Lack of ability to network in remote communities to aid ongoing support and innovation. |
| M          | - The provider noted that meeting business, legislative and corporate requirements can be a significant challenge. In particular, the Hostel finds it difficult to maintain compliance with changing regulatory and administrative requirements.  
  - The Hostel recalled generally positive experiences with the Australian Aged Care Quality Agency (Agency), but they did note that the Agency’s visits require a significant amount of preparation and that they can distract from resident care. |
| N          | - Some quality standards are regarded as unrealistic and inappropriate to the remote context.  
  - Visiting a remote community and having an understanding of the service environment supports reviewers to properly evaluate service delivery in the community.  
  - The service operates largely independently but benefits from Council corporate governance and quality safeguards. |
| O          | - Meeting staff training requirements has been an ongoing struggle due to general availability of training, the need to back-fill staff if they leave the community to attend training, and high cost of sending staff out of the community to attend.  
  - The service experienced some difficulties in obtaining police checks for all Board members.  
  - The service noted that some quality standards do not consider cultural factors and are not culturally or remote appropriate. |
| P          | - The service recalled positive experiences with the Australian Aged Care Quality Agency (Agency); they viewed their interactions with the Agency as allowing them to maintain a high standard of operations and service delivery.  
  - The service stated that they experience challenges in developing relationships with their contact within the Department. |
| Q          | - The provider commented they had positive experiences with the Australian Aged Care Quality Agency (Agency) visits, in that the Agency had been able to assist them in implementing improved processes for delivering HCP services. |
### B. Key findings by case study

#### Reporting

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Reporting was not viewed as a major issue, due to overarching support and assistance provided by the service provider’s central office.</td>
</tr>
<tr>
<td>B</td>
<td>E-tools used for CHSP and HCP reporting are viewed positively, however staff turnover has caused challenges with reporting accuracy.</td>
</tr>
<tr>
<td></td>
<td>Auskey is viewed as an onerous tool for accessing IT systems. The provider is exploring Vanguard as an alternative mechanism.</td>
</tr>
<tr>
<td></td>
<td>Issues with HCP claiming required the service to backdate payments to 2008.</td>
</tr>
<tr>
<td>C</td>
<td>The service has invested resources to develop a reporting system robust enough to withstand workforce issues.</td>
</tr>
<tr>
<td></td>
<td>Lack of interoperability between My Aged Care and Medicare systems has caused frustration due to duplicate data entry.</td>
</tr>
<tr>
<td></td>
<td>ACFI paperwork is too complex for local staff so service manager needs to complete it.</td>
</tr>
<tr>
<td>D</td>
<td>Management did not identify any particular challenge meeting reporting requirements as they employ dedicated staff responsible for reviewing all documentation for ongoing compliance across its facilities.</td>
</tr>
<tr>
<td>E</td>
<td>The service provider leverages off support from corporate services to complete reporting requirements.</td>
</tr>
<tr>
<td></td>
<td>The absence of linkages between service provider and government platforms creates a barrier to effective CHSP data management and reporting.</td>
</tr>
<tr>
<td>F</td>
<td>The operation of the aged care service is well supported by the Board.</td>
</tr>
<tr>
<td></td>
<td>Reporting and claiming requirements are well managed as a result of the governance of management, with no challenges currently experienced in these processes.</td>
</tr>
<tr>
<td>G</td>
<td>The service has invested considerable corporate resources to develop robust reporting systems to ensure accurate and timely financial and performance reporting.</td>
</tr>
<tr>
<td></td>
<td>The service is able to leverage corporate services to upload data in Commonwealth systems.</td>
</tr>
<tr>
<td></td>
<td>The service provider has had issues with HCP being end-dated by the My Aged Care system however the issues were resolved by manually updating the system.</td>
</tr>
<tr>
<td>H</td>
<td>The service experiences few challenges adhering to funder reporting requirements and considers their use of E-tools to be effective.</td>
</tr>
<tr>
<td></td>
<td>Corporate governance reporting requirements, rather than aged care requirements per se, are a greater challenge for the organisation.</td>
</tr>
<tr>
<td>I</td>
<td>Meeting reporting deadlines is difficult for the service as the service manager is often responsible for reporting requirements due to low levels of capacity among local staff but is often occupied with service delivery due to irregular staff attendance.</td>
</tr>
<tr>
<td>J</td>
<td>The service did not identify any particular challenges meeting reporting requirements as service staff were closely supported by head office, who had a dedicated and experienced aged care team to assist with reporting.</td>
</tr>
<tr>
<td>K</td>
<td>Service reporting and acquittal processes for aged care services are reasonable and do not present any major issues. However management expressed frustration with frequency of changes to reporting formats and content.</td>
</tr>
</tbody>
</table>
### Appendices

#### B. Key findings by case study

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>The service provider finds reporting time-consuming but does not experience major challenges with reporting.</td>
</tr>
<tr>
<td>M</td>
<td>The Hostel does not experience major challenges with reporting, although they had experienced difficulty lodging their financial reporting in the past, predominantly due to difficult-to-follow instructions and the slow website.</td>
</tr>
<tr>
<td>N</td>
<td>Programme reporting and acquittal processes are viewed positively. The service is supported with extensive back office support from the Council.</td>
</tr>
<tr>
<td></td>
<td>Staffing availability and skills can limit the service's ability to use My Aged Care.</td>
</tr>
<tr>
<td>O</td>
<td>Aged care services receive significant head office support, hence they have no issues in meeting their reporting requirements.</td>
</tr>
<tr>
<td>P</td>
<td>The service experiences challenges in prioritizing their reporting requirements above their service delivery requirements.</td>
</tr>
<tr>
<td></td>
<td>They found AUSkey to be an impediment to their efficient reporting, but relayed positive experiences with using DEX, which they attributed largely to support that had been provided by Aged &amp; Community Services Australia (ACSA).</td>
</tr>
<tr>
<td>Q</td>
<td>The service did not express any concerns about the process of collating statistics and reporting through to the Department due to the support provided from the regional administrative office.</td>
</tr>
<tr>
<td></td>
<td>However, it was their view that there was insufficient clarity around reporting requirements, which had, at one point, resulted in them being behind in meeting their requirements.</td>
</tr>
</tbody>
</table>
### B. Key findings by case study

#### Facilities and infrastructure

<table>
<thead>
<tr>
<th>Case Study</th>
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</table>
| A | - The service incurs additional cost related to cyclone proofing and related maintenance costs. The site also has additional fencing for security purposes following a spate of break-ins.  
- Due to intermittent access to the internet the service is unable to run their standard electronic care management software and instead utilise paper files. |
| B | - Facilities and infrastructure in the community have historically not been maintained or improved, but thanks to a recent capital grant from the Department, the service has received upgrades to kitchen, shower and toilets, that will enable the service to improve its respite service.  
- The service’s 4WD vehicle has high ground-clearance, making it unsuitable as a means of transport for social support activities, including a pick-up and drop off service for the centre.  
- Mobile phone and Wi-Fi internet services are unreliable and intermittent. |
| C | - A lack of dedicated staff housing means staff occupy housing that could otherwise be used by a community member.  
- Attempts to develop infrastructure within the community have been futile due to council approval processes.  
- Costs and availability of tradespeople inhibit maintenance of facilities. |
| D | - Although the cost of maintenance in town was noted to be only slightly higher than in metropolitan areas, the cost of maintenance for the very remote sites is noted to be significantly higher due to the cost of flying in and accommodating trades people. |
| E | - A programme of responsive repairs and maintenance is carried out at the residential facility, however no provisions are in place for future capital upgrades.  
- A feasibility study regarding a proposed expansion of the facility was prepared with funding from the Department in 2015. Although identifying the benefits of the proposed expansion, the service provider has to date been unable to finance the project.  
- There is no centre based care provided for the service’s CHSP clients. |
| F | - All service facilities have been purpose-built. The aged care facility requires refurbishment to be in line with resident/family expectations. |
| G | - Residential care services are limited. The hospital only has four funded places and management were of the view that the proximity of aged care residents with complex needs to acute care patients at the hospital was concerning and restricted the number of places to three.  
- Hospital management suggested that the best long-term solution to this problem would be the construction of a dedicated residential aged care facility in town, as has already been achieved for the community’s Indigenous population. |
| H | - The Service Manager has no concerns regarding the cyclical upkeep of the building, which is maintained by the Council.  
- The facility has no ramps for easy wheelchair access, no garden or shaded outdoor area, and most furnishings need replacement.  
- Applications for capital grants for works on ramps and toilets have to date been unsuccessful. |
## B. Key findings by case study

### Facilities and infrastructure

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>There are considerable logistical challenges and higher costs of maintaining appropriate infrastructure in remote areas.</td>
</tr>
<tr>
<td>J</td>
<td>The primary risk to service delivery identified was the potential for the service provider to lose its service site which is currently subject to receivership proceedings. Cost of maintenance is significantly higher in remote locations, with fly in fly out tradespeople.</td>
</tr>
<tr>
<td>K</td>
<td>The service incurs additional cost related to cyclone proofing and related maintenance costs. Management indicated that current residential care funding is insufficient to address asset depreciation and replace the infrastructure at the end of its useful life. Slow internet speeds hinder the service’s ability to install more advanced care management software, but the organization has limited needs for such capability.</td>
</tr>
<tr>
<td>L</td>
<td>The NSW Government has committed to building a Multipurpose Service (MPS) co-located adjacent to the existing facility. As part of the build, there will be an extension to and renovation of the existing facilities. Both the MPS and changes to the current facility are expected to be completed in May 2019.</td>
</tr>
<tr>
<td>M</td>
<td>The Hostel is a purpose-built RAC facility, which is only about 10 years old. Both residents and their families are very happy, both with the facility and the level of care that consumers receive. Council assists the Hostel with asset maintenance and repairs, including gardening.</td>
</tr>
<tr>
<td>N</td>
<td>The service’s community care centre has a commercial kitchen and a dedicated ablution block, with a separate laundry and with toilets and showers equipped for use by people with a disability. The care centre is well-maintained by the Council, but is used to accommodate and store food in large commercial freezers during the wet season and has in recent years been broken into for this reason (with the loss and spoiling of foods).</td>
</tr>
<tr>
<td>O</td>
<td>The aged care facility is not fit-for-purpose and not appropriate for the level of care and services required by the residents. New infrastructure and equipment and maintenance are a significant cost due to the extreme remote location (e.g. the installation of two new industrial washing machines cost $60,000).</td>
</tr>
<tr>
<td>P</td>
<td>The service rents the current facility from the Project Manager, and they aspire to purchase the building in the future. The service does not consider their current facilities to support the safety of their workers and assets, such as vehicles.</td>
</tr>
<tr>
<td>Q</td>
<td>Nursing staff funded to deliver HCP services do so within the consumers’ homes and, as such, did not raise any impacts of the facilities and infrastructure on their ability to deliver quality services. The LHD did not raise any concerns with the adequacy of the service’s facilities and infrastructure. Rather, both management and nursing staff felt fortunate that such a high quality facility existed in such a remote location. Poor internet availability impacts the service’s ability to access My Aged Care.</td>
</tr>
</tbody>
</table>
Disclaimer

This report has been prepared as outlined in the Scope Section. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this report are based on a qualitative study and the reported results reflect the perceptions of the stakeholders consulted but only to the extent of the sample surveyed, and the data provided including publicly available information. These stakeholders include the Board members, management and staff of 17 remote aged care service providers. Any projection to the wider management and personnel is subject to the level of bias in the method of sample selection. KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by and the information and documentation provided by the stakeholders consulted as part of the process.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form. The findings in this report have been formed on the above basis.

Third Party Reliance

This report has been prepared at the request of the Department of Health in accordance with the terms of KPMG’s contract dated 6 October 2017. Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party’s sole responsibility.