Submission Template
Increasing Choice in Home Care – Stage 1
Discussion Paper

Please upload completed submissions by **5pm, Tuesday 27 October 2015** to engage.dss.gov.au

**Instructions for completing the Submission Template**

- Download and save a copy of the template to your computer.
- You do not need to respond to all of the questions.
- Please keep your answers concise and relevant to the topic being addressed.

**Name (first name and surname):** Anthea McGuigan on behalf of WACHS regional services

**Name of organisation:** WA Country Health Service (WACHS)

**Stakeholder Category:** Service provider

**State/Territory:** WA

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**NOTE:** Submission is in two parts:

1. In relation to HCP services in the southern part of WA which has higher population density and greater involvement of private providers (response to specific questions)
2. In relation to HCP services in the Kimberley region where clients live in remote Aboriginal communities (separate section under Other comments).

As will be noted the issues impacting on consumer choice and service access are vastly different.
General questions (see section 4 of the Discussion Paper)

**Question a)** Overall, what do you believe will be the impact of the proposed changes in Stage 1 on consumers and providers?

In areas with a healthy market it will provide greater choice and possibly better value to consumers. In areas with a poor supply of providers it could lead to increased costs/decreased services for consumers. Importantly it does assume an informed consumer, so service offerings and fees will have to be very clear, and provided in a consistent format by all providers, including the cost of admin and coordination components.

Without extensive consumer education there will be confusion – this has already been evident over the past 5 months – for families as well as consumers.

The impact on many providers will be loss of guaranteed funding for organisational infrastructure, especially those fixed costs that are required to maintain service systems.

**Question b)** What type of information and support will consumers and providers require in moving to the new arrangements?

Effectiveness of this approach assumes a healthy market and informed consumer, so service offerings and fees will have to be very clear, and provided in a consistent format by all providers, including the cost of admin and coordination components. Possibly need to use something like the comparison statements provided by health insurance funds.

**Question c)** What additional information and support will the assessment workforce require in the lead up to February 2017?

The exact tools for undertaking assessments, expected timeframes/prioritisation frameworks, mechanisms for approval/delegation/submission. Working knowledge of MyAgedCare consumer and provider interfaces.

Specific questions (see identified sections of the Discussion Paper)

**Question at 3.2.1** Your feedback is sought on the proposed national approach for making packages available to consumers based on individual needs. This would replace the current system of planning and allocating home care places to providers at the regional level.

This is a very positive initiative, but obviously it still relies on the consumer being able to identify a suitable provider before the funds are released. There should be some provision for alternative use of funds (i.e. items/services from non-approved providers) in areas where there are no approved providers. Otherwise there will still be inequity built into the system for people in rural and remote areas, just as there is in the current distribution of Medicare funds. There is potential for an over-provision of packages in well-serviced urban areas.
In many rural areas of WA there are no choices due to the non-viability of providing home care and/or residential services. As the sole provider of MPS in WA, WACHS is frequently the only choice available; and in these cases I would be choice between using WACHS or not receiving a service. As some towns are quite remote (for example in Midwest and Goldfields, as well as Kimberley and Pilbara) the infrastructure costs associated with establishing, maintaining and delivering these services to small populations is possibly going to be a deterrent to new providers; and possibly make the viability of existing services even more precarious.

**Question at 3.2.5** Where there is a limited number of home care packages available, what factors do you believe should be taken into account in prioritising consumers to access a package?

- Current safety of consumer/carer,
- Ability to access alternative support without resorting to admission to the local hospital
- carer burden/stress, hospital avoidance,
- facilitation of hospital discharge,
- whether the consumer has the capacity to pay for services for non-approved providers if these are available.

**Question at 3.2.6 (first question)** Feedback is sought on whether there should be a specified timeframe for the consumer to commence care once they are notified that a package has been assigned to them, and if so, what types of circumstances might extend this period.

Preference would be for no specified timeframe. However, if one is applied, there should be contact with the consumer prior to the end of this timeframe to identify any barriers to taking up a package, e.g. lack of suitable providers, problems with illness, unable to engage with process. Support should be provided to address these barriers – perhaps package-funded social worker support, for example. Over time it should be possible to develop an understanding of these factors, and the supports that consumers use during the time between approval and activation.

**Question at 3.2.6 (second question)** The Department is seeking feedback on how interim care arrangements should be addressed from February 2017 where the consumer’s approved level of package is not available. For example, where a consumer has been approved as eligible for a specific package level, should My Aged Care assign a package to the consumer at a lower level as an interim arrangement?

Yes, but the arrangement should be reviewed after a period of time. The difficulty for consumers in receiving packages at lower levels is they invariably still require the care. Prior to CDC providers could cross-subsidise these clients thus enabling them to receive the appropriate level of care. Of major concern will be those consumers who do not informal care support; and do not have the financial ability to pay for top-up services. This has the potential to lead to consumers being at increased risks of detrimental outcomes, including risk of falls, which will inevitably require hospital admission. This is a serious concern in rural WA where clients frequently face acute admissions because there is no other solution when the appropriate care levels are not available. WACHS experience is that many of these clients end up in Care Awaiting Placement because of the lack of options available to them. This is a very significant issue across rural WA, especially in the regions.
Question at 3.3.2.1 Feedback is sought on the proposed approach to the treatment of unspent funds when a consumer moves to another home care provider.

Transfer of unspent funds to the new provider is appropriate. Any penalties or admin fees associated with transfer should be minimal, regulated and transparent to the consumer.

Question at 3.3.2.2 Feedback is sought on whether there is a preferred approach for the treatment of unspent funds when a consumer leaves subsidised home care.

Commonwealth funds should be returned to the Commonwealth for reallocation within the program. Consumer funds should be returned to the consumer or his/her estate. This should be based on actual funds received from the consumer rather than a formula.

Question at 3.3.3 What types of circumstances might need to be considered in developing the approach and legal framework for dealing with unspent funds? For example, should there be different considerations where there is a deceased estate?

Feedback is also sought on what might be reasonable timeframes for providers to action the transfer of unspent funds.

If the person is deceased the unspent consumer contribution should be returned to the consumer's estate. This is appropriately respectful to carers and families, who may themselves have incurred significant financial and personal costs caring for the person who is deceased.

The timeframe could align with the timeframe for refund of residual accommodation deposits in residential care.

Question at 3.5.2 How might the criteria relating to the assessment of approved providers (Section 8-3 of the Aged Care Act 1997 and the Approved Provider Principles 2014) be adjusted to better reflect expectations around the suitability of an organisation to provide aged care?

Feedback is also sought on the other proposed changes to approved provider arrangements, particularly those affecting residential and flexible care providers.

Supported, as per discussion document

A centralised register of Key Personnel should be developed to enable organisations to access information pertaining to KPs when they move from organisation to organisation. Ideally, it should be a credentialing system such as the one used in hospitals for medical practitioners.

Other comments

General comments or feedback on other issues

- There needs to be consideration of how these principles will apply when the only available
providers is an MPS, which may or not have capacity to provide the necessary services, or in remote areas where there are no approved providers or MPS (please see below for specific responses pertaining to remote communities)

- If appropriate care is not possible in the consumer's current location, could relocation assistance be part of a package?
- Provider fee structures need to be very transparent and provided in a way that makes comparison between providers easy for consumers.
- It is not acceptable for admin and care coordination to be lumped under one category. Providers should clearly identify what funds are being used for each component.
- Arrangements when a consumer is admitted to hospital? Currently package providers continue to be paid for 4 weeks while a person is in hospital, but the person receives no benefit from this and is also subject to any relevant inpatient expenses – if this is to continue then that funding should remain with the consumer to fund unexpected expenses potentially related to hospitalisation.
- Commitment to communication by MAC is welcomed but how will this occur? Needs to take account of hearing, eyesight, language and communication difficulties of this cohort, as well as technological challenges in some locations. Should note that not all older people in rural areas are technologically skilled – it's not an issue for the ones with families, but not for those who are alone.

Comments specifically pertaining to the delivery of Home Care Packages in remote Aboriginal communities in the Kimberley by Kimberley Aged & Community Services (KACS) which is the Home Care Package service of WACHS Kimberley.

- **FIXED COSTS AND INFRASTRUCTURE:** There needs to be a guaranteed minimum funding to providers to assist them maintain essential infrastructure (especially those costs that are fixed). Infrastructure costs for an organisation delivering remote community services are high due to additional costs associated with staff wages; location costs; and especially travel costs (our submission to ACFA detailed these additional costs)
- **ECONOMY OF SCALE AND THE 2017 CHANGES:** To enable our services to be viable we need to be able to fund sufficient staff to manage and deliver the services. This is of particular concern in regard to the proposed 2017 changes to HCP funding. If the funding is not coming directly to our department we will not be able to demonstrate that we can afford our FTE subsequently we will have to reduce the number of staff employed which then means that even if the clients engage our service we will not have the staff to take on case management roles. This is a circular situation as without the clients we will not have the staff to deliver services; and therefore won’t be able to respond promptly to client needs.
- **SERVICE DEVELOPMENT:** As the area we cover is the remote Aboriginal communities in the Kimberley it is necessary that if clients are to have access to any services that these are provided locally. In order to achieve this KACS has for over 20 years worked in partnership with remote Aboriginal Communities to support and assist the larger Aboriginal Communities to develop and sustain their Community Care Services. Currently KACS works in partnership with 12 communities in the Kimberley. The communities employ the local Aboriginal people to provide hands on Community Care Services. KACS provides all funding (HACC, HCP and NJCP), does the client assessments and care plans, training,
quality reporting, financial reporting, and when required direct hands on client care. The costs of doing this service development are part of the overall KACS administration costs, with CDC this is now much more difficult to fund and sustain. Working with the communities to provide services in this way ensures that the services the clients receive are culturally safe, provided by people who can speak their Aboriginal language and who know and understand the importance of country and family for the clients. While in some ways it may be easier to deliver services in a fly in fly out model this would not enable services to be culturally safe nor sustainable in the longer term. The change to the funding in 2017 will result in greater uncertainty regarding the funding that can be used to support the community care services which will put this partnership model of working which has been very successful into jeopardy.

- POOLED FUNDING FOR HCPs: Prior to CDC we used the total pool of HCP funding to support all of the clients based on their needs at the time. So those with less needs basically had less services and case management and those with very high needs had services as appropriate to keep them at home. This is now not possible. In addition through pooled funding we were able to spread the travel costs (as above) so that those clients living in the most difficult and expensive communities had equal access to services as those people closer to towns. With CDC this is no longer possible so the 16 clients we currently have on HCP 2 packages who are waiting for a HCP 4 package to become available are not having the level of service they require. In addition those clients in the most difficult to access communities are disadvantaged as the number of case management visits and other supports to them has been reduced to what they can afford. 2 of the clients in Kalumburu for example are expected to have deficits of up to $10,000 this financial year. Obviously this is not sustainable for our organisation so we will be looking at how we can further reduce their services. There is no indication that the proposed model post Feb 2017 will be any different in supporting these clients – instead of packages being rationed by provider they will be rationed by allocation to the client; in this way our 16 Level 2 clients waiting for Level 4s would still be in the same position.

- EQUIPMENT: If the funding is to sit with the client then it will be more difficult to purchase equipment etc that clients need to remain at home. The administration required to obtain the funds will be increased and therefore the cost of the equipment overall will be increased.

- PAYMENT OF THE FUNDS: There is concern regarding how funds will be allocated to clients and how they / family member can access these funds and the potential risk that this may pose for some clients (which is the same nationally).

- CULTURAL CONSIDERATIONS: For the Kimberley Aboriginal Elders remaining at home is critical to their well-being which is centred in obligation to their family, culture, community and country. If they are not able to remain at home then the alternative is placement in residential care usually hundreds of kms away. Our service works to keep these elderly people in their country for as long as is possible. Without adequate support from their HCP package to provide the Community Care Services, equipment, and the case management they need this will not be achieved. This will be a greatly increased risk if our service is not able to continue to the change in funding model.

- FLEXIBLE ABORIGINAL PACKAGES: KACS has previously requested that its HCP packages are changed to Flexible Aboriginal Packages as 100% of our clients are from remote Aboriginal communities in the Kimberley. Unfortunately these have not been
available to KACS. These packages have the potential to overcome many of the disadvantages to clients that have occurred due to the CDC.