Australian Government
Department of Social Services

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.

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Stakeholder Category: Peak Body

State/Territory: VIC

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(Please note: In this submission the word "Aboriginal" refers to both Aboriginal and Torres Strait Islander People. Direct reference to Torres Strait Islander people and the word "Indigenous" have been used where these are part of a title or direct quote.)

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) was established in 1996. VACCHO is the peak Aboriginal health body representing Aboriginal community controlled health organisations (ACCHOs) in Victoria. The role of VACCHO is to build the capacity of these members and to advocate for issues on their behalf. Capacity is built amongst members through strengthening support networks, increasing workforce development opportunities and through leadership on particular health areas. Advocacy is carried out with a range of private, community and government agencies, at state and national levels, on all issues related to Aboriginal health.

Nationally, VACCHO represents the community controlled Health sector through its affiliation and membership on the board of the National Aboriginal Community Controlled health Organisation (NACCHO). State and Federal Governments formally recognise VACCHO as the peak representative organisation on Aboriginal health in Victoria. VACCHO's vision is that Aboriginal people will have a high quality of health and wellbeing, enabling individuals and communities to reach their full potential in life. This will be achieved through the philosophy of community control.

VACCHO and our members welcome the opportunity to respond to the "Increasing Choice in Home Care – Stage 1 Discussion paper" developed by the Department of Social Services (DSS). VACCHO agrees that "it is important that as people age, they have choice about their care."[i] This submission responds directly to questions in the DSS template, with emphasis on equitable access to Home Care by Aboriginal people, and those factors necessary to enable Aboriginal people to exercise informed choice and control over the care they receive.

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?

The intention of Stage 1 is to progress the goals of the Aged care reform in relation to increasing consumer choice and consumer control for all Australians. There are a number of issues which need to be addressed to ensure that changes outlined for Stage 1 does not reduce Aboriginal consumers' capacity to exercise choice and control over the care they receive. These issues include:

- **Enablement of informed choice**: for Aboriginal communities this requires consumer information and information dissemination mechanisms tailored to the diverse needs of Aboriginal peoples. The Caring for Older Australians report noted:

> "The challenges in providing services to this group are compounded by their heterogeneous nature…In addition, there are marked differences in attitudes, cultural identification and needs, between Indigenous people living in many urban centres and those living in rural and remote locations. Like other special needs groups, a 'one size fits all' approach is not appropriate"[ii]
>
> (Productivity Commission 2011)

Consequently there is a need for investigation to establish which information formats and dissemination processes will be most effective in reaching Aboriginal communities, and there is also a need for translated information for those communities where English is not a first language. To date, there have been no Aboriginal- specific information campaigns targeting Aboriginal people or Aboriginal service providers, and no evidence to indicate that the information of Aboriginal service providers or the communities they serve have had their information needs met by accessing the *My Aged Care* (MAC) website or call centre.

- **Availability of a range of appropriate service options so 'real choice' is possible**. The Commonwealth is to be commended for streamlining processes to achieve Approved Provider Status by organisations providing Commonwealth Home Support Program (CHSP)/Home and Community Care (HACC in Victoria) or packages funded through the Aboriginal Flexible Funding. This measure is necessary but not sufficient to ensure diversity of service providers and service options. Development and/or reorientation of business systems required to ensure viability under an 'individualised'/marketised' funding model is a major financial impost for small specialist providers of aged care services such as Aboriginal community controlled services. These service providers play a vital role in ensuring availability of real choice of services to small, dispersed and culturally distinctive communities as well as communities in regional, rural and socially disadvantaged areas. In some instances, the demise of these service providers will deprive communities of their only available service provider, or at very least, their only culturally safe service provider and there will be no competitive pressure on mainstream providers to adopt culturally safe service models/practices to meet the needs of these communities.
- **Culturally safe assessment processes which provide an accurate picture of care needs of**

individual clients – Allocation of home care packages on the basis of client need, proposed as part of the Stage 1 changes, increases the importance of client assessment to the equitable allocation of funded aged care supports. Cultural safety of assessment processes has a major impact on Aboriginal peoples' use of aged care assessment services. The Productivity Commission Report on Government Services (2015) provides data that shows the comparative under-usage of aged care assessment services by the non-Aboriginal population and Aboriginal populations in Victoria and nationally[iii]. MAC Customer Solutions Specialist (CSS) staff who provide eligibility screening, do not have mandatory training in cultural safety. In addition, Home Care Package comprehensive assessment provided by Aged Care Assessment Teams (ACAT) have been shown to produce variable outcomes across jurisdictions – i.e. older people with similar needs, receiving very different levels of support resources[iv]. In Victoria, for Aboriginal people, outcomes of comprehensive assessment is often influenced by local ACAT willingness to form working relationships with Aboriginal community controlled organisations to provide workers with cultural expertise who can participate in the assessment process. The current assessment variability and lack of cultural safety, when combined with the increased reliance of assessment as an allocative mechanism for aged care services is likely to further disadvantage Aboriginal peoples' access to necessary aged care services, unless targeted strategies to ensure cultural appropriateness of assessment tools and cultural safety of the assessment process are developed, implemented and outcomes monitored.

- **Failure to address systemic barriers to access experienced by Aboriginal people and other groups designated as having 'special needs" by the Aged Care Act (1997**). The "Increasing Choice in Home Care – Stage 1 discussion paper" notes that the current system of Home Care Package which imposes specific conditions of allocation to prioritise access to special needs groups is ineffective and will be removed. By comparison the new system makes no attempt to address systemic barriers to aged care services experienced by Aboriginal and Torres Strait Islanders and other designated 'special needs' groups. The criteria developed to assess and prioritise individual need for allocation of packages must take into consideration these systemic barriers to enable equitable access to members of special needs groups.
- **Clear criteria for prioritisation of "need" and transparent process for ranking those criteria and for progression of clients up the 'priority list'.** As implied above there is no indication as to the criteria which will be used to define or prioritise client need. The other issue which is yet to be addressed is a clear and transparent process for tracking the progression/'re-prioritisation of clients on the waiting list. For example, if a client has been assessed as eligible for a Level 3 Package, but is a 'low' priority in relation to other clients assessed as eligible for a Level 3 Package, what process will be used to progress them on the waiting list for Level 3 packages? Without a clear process of progression, a 'low priority' client may be forced to rely on a deterioration in health before they can be prioritised as a 'high' priority for receiving a package. Similarly if the health of a client who already has a package deteriorates and they need a package at a higher level that which they currently occupy, how would they be prioritised, in relation to other clients experiencing a similar level of need, but who do not currently occupy a package?

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

As noted above there is a need for information, and information dissemination mechanisms tailored to the diverse needs of Aboriginal communities and service providers. As there has not been a tailored communication strategy in relation to the Aged Care Reforms in general (including My Aged Care and the National Gateway), or more specifically, about Consumer Directed Care (CDC) or proposed Stage 1 changes, information is required in relation all of these issues:

- For community members, this should include, but not be limited to, information on their rights, entitlements and responsibilities as a consumer under CDC, including their right to independent advocacy, as well as changes proposed under Stage 1 (i.e. portability of CDC packages and changes to the way in which packages will be allocated directly to consumers). In addition, there must be information which clearly explains the prioritisation process that will be used for the allocation of packages to clients, particularly if this process allows for 'low priority' client to be 'overtaken in the queue' by a client whose needs are assessed as being of higher priority. There must also be information which differentiates between CDC packages and packages funded through Aboriginal Flexible funding (some of the providers accessed by Aboriginal people may be managing both CDC and 'Flexible' funded packages)
- For Aboriginal providers of aged care, this should include but not be limited to: clear information about the application process for Approved Provider status, business systems and reporting responsibilities (to Government and to clients) under CDC, sources of support which can be accessed to assist them in transitioning to CDC and information materials which can be used to explain aged care reforms to clients.
- For Aboriginal Community Controlled Organisations' boards of management – clear information about the nature and scope of aged care reform and changes to business systems and service offerings that will be required to enable their organisation to operate sustainably in the new funding environment and in the context of Aged Care reform, so that they can make informed decisions about the strategic direction their organisation will take

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

Government will need to develop a framework and clear criteria for prioritisation of client need, and definitions of client vulnerability aligned with the National Screening and Assessment Form. The assessment workforce (including *My Aged Care staff* involved in client screening) will require training to ensure common understanding and consistent application of these criteria

In addition, workforce will require training in relation to information and computer technology, particularly as it relates to interaction with My Aged Care referral and feedback processes, as well as reporting processes to ensure that criteria and assessment processes are consistently applied across jurisdictions and clients with similar level of need receive a similar level of subsidised supports.

Finally, as noted above, there is a pressing need for mandatory cultural safety training for assessors.

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.

As indicated above, there is a very real risk that current lack of culturally appropriate assessment processes and culturally safe assessment practice will negatively impact on Aboriginal clients' access to aged care supports and services which they need. In the absence of culturally safe practice, assessors will not necessarily get an accurate measure of the needs of Aboriginal clients. Implementation of a national approach for making packages available to consumers based on individual needs will amplify this impact. Consequently there is need for:

- A cultural safety strategy for aged care assessment which should include but not be limited to mandatory cultural safety training for all staff involved in assessment and screening (including My Aged Care CSS staff, Regional Assessment Service (RAS) staff, ACAT staff)
- Mandatory requirement for inclusion of cultural expertise in assessment of Aboriginal people. This expertise could be provided by Aboriginal employees of assessment agencies (ACAT, MAC CSS, Aboriginal organisations that are RAS consortium partners) or through partnership/fee for service arrangements with Aboriginal community controlled organisations
- Ongoing monitoring of the impact of changes to the assessment process and national approach to package allocation on the number and distribution of Aboriginal people receiving Home Care Packages at each of the four package levels.

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?

As noted above, Aboriginal people and other groups designated as having 'special needs' under the Aged Care Act (1997) experience systemic barriers to accessing Aged Care services. Consequently, membership of one or more 'special needs' groups as defined by the Aged Care Act (1997) should be included as a criteria for priority access. In addition the following should be taken into account

Complexity of physical and social/emotional and mental health needs should be taken into account in the prioritisation of access.

Prioritisation of access should take into account the complexity of family structure and carer obligations of the client. Feedback from VACCHO Members note the frequent complexity of carer responsibilities in Aboriginal communities. An older person in need of aged care supports may themselves have carer responsibilities for several family members, with different care needs, i.e.:

- Aged care related needs
- Care needs related to disability
- Care needs related to mental health
- Care needs related to dependence on alcohol or substance abuse
- Care of dependant grandchildren

Socio economic disadvantage should also be taken into account in the prioritisation of subsidised aged care support.

Geographical location of consumer in relation to available supports should also be taken into account e.g. for Aboriginal clients, is there an ACCO nearby that may be currently providing supports.

Client literacy including health literacy must be taken into account as this will impact on client capacity to interact with the aged care system as an informed consumer, or to exert (informed) choice and control. The following case example illustrates this:

"I spoke with ACAS today about an Elder who had been approved for a Level 1-2 package … and they required him to call up various package providers to determine if he was able to get a package. He is illiterate, so all the letters and the need to call was lost with this client. Realistically, he will never move forward in the queue as he can't and won't pursue this".

(Aborigines Advancement League 26/10/15)

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.

VACCHO members who expressed an opinion on this topic indicated that there should not be a specified timeframe to commence care once notified that they have been assigned a package, because of the large number of legitimate circumstances which can prevent clients commencing care (e.g. family circumstances, health and geographic impediments to accessing care).

If a specific timeframe for the commencement of care is introduced, the following should be considered as extenuating circumstances to enable suspension of the time limit:

- Transient clients: many Aboriginal organisations service highly mobile and transient populations. Transience should not be used as rationale to deny clients the opportunity to access a support package.
- Provider refusal: there are a range of circumstances which make clients more expensive to service, for example, complexity of client health need and geographic access/rurality, Aged care providers have 'right of refusal' if asked to manage a client whom they consider difficult (or too expensive) to service. Where service has not commenced within the specified timeframe, individual client circumstances must be examined to ensure that they have not been denied service on the basis of complexity of service need or expense of service provision.
- Market failure/thin markets: Clients must not be penalised for living in socially disadvantaged or small dispersed communities, where there may be a paucity of (appropriate) aged care service providers willing to take on the management of their package
- Unstable housing or homelessness should not be a barrier. VACCHO Members cite examples of having worked with clients to get stable accommodation and advocated for this based on the fact the consumer will be getting necessary supports to maintain their housing, financial requirements

etc.

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?

This question highlights a need for clear and transparent framework for determining the relative prioritisation of clients at different assessed levels of care, and process for 'progression of priority' (i.e. what procedures/rules govern the way that clients 'progress in the queue'?)

Where the level of package required by the client is not available, VACCHO Members' feedback favours provision of assigning a package at a lower level, as an interim arrangement. This is on the proviso that there is a clear and transparent mechanism for ensuring that the client is subsequently 'progressed in the queue' for a package of the level to which they were originally assigned on the basis of their assessed support needs. It has also been suggested that a client who has 'interim' support i.e. a package at level lower than that for which they have been approved should be 'progressed in the queue' towards a package appropriate to their needs, ahead of 'new' clients (i.e. if a level 4 package becomes available, should this be allocated to the person currently receiving interim level 3 supports, ahead of another newly assessed client who is eligible for a level 4 package, who is currently receiving no support).

There are a range of additional questions which must also be considered, for example

- Should a client approved for a higher level of package, where a specific package is not available, take priority over other clients approved for that band level (e.g. should a client approved for a level 4 package, be allowed, as an interim measure to occupy a level 3 package in preference to other clients assessed as 'high priority' to receive a level 3 package?).
- At present, some clients are able to access block funded CHSP (HACC in Victoria) as an interim measure. How will basic supports of this type be provided with the CHSP/HACC program is integrated into a single Home Care Program underpinned by an individualised funding model?
- If a provider is maintaining a consumer on a lower level package until another higher level becomes available, duty of care will require the provider to bear the costs of providing services appropriate to client needs. Will there be an opportunity for reimbursement of funds expended to maintain the client's health when they should have a higher dollar value package?

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.

Members providing feedback have broad support for the principle that Elders should be able to move their package to a service that provides the level of support and care that suits them without fear of loss, however, there must be acknowledgement that there may be administrative costs to the client's current provider associated with transfer of the client's package to the client's new provider, and an

administration fee which accurately reflects this cost could be legitimately levied from unspent funds. The following should be considered in determining this fee:

Time & effort taken by the original provider to transfer information, care plans etc. to the new provider.

Client requirements/requests for transitional supports or advocacy with the new provider

Aboriginal providers have experienced situations where an Aboriginal client transfers their package to a mainstream provider, and that mainstream provider has subsequently requested information and advice on culturally safe service provision. Aboriginal providers must be able to recoup the cost of time and other resources allocated to this purpose.

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.

It should be noted that many Aboriginal Community Controlled Organisations which manage/provide home care packages have explicit 'no fees' policies or 'no fees' practice in response to widespread social disadvantage in Aboriginal communities.

Where client contributions are being collected, feedback on this issue of unspent funds was in favour of returning any/all client contribution to the client or their family. Remaining funds should be retained by the approved provider. The following scenario illustrates legitimate costs that can be incurred by providers in relation to clients who has left subsidised home care:

"We have a consumer who has gone in to residential respite & is awaiting a permanent bed. Whilst the person is in respite the package was used to clean out their old premises, take away all rubbish, give it an end of lease clean etc. Staff are still visiting and assisting with the transition. Staff also have to cancel all services etc."

(Gippsland and East Gippsland Aboriginal Cooperative 19/10/15).

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.

Feedback to VACCHO suggests a need to balance the needs of consumers and providers. It must be acknowledged that families may rely on return of unspent funds contributed by their deceased family member to assist with funeral and other costs, however, lived experience of service providers is that accounts often do not come in for services provided for 1-2 months after they have been delivered

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.

Once again, VACCHO commends the Government on streamlining the process to make it easier for current HACC/CHSP providers to become approved providers. Of the 22 Aboriginal community controlled providers of HACC/CHSP in Victoria, only four are currently approved providers of home care packages. Reduction of red tape associated with the approved provider application process will enhance the capacity of this group to continue providing specialised, culturally appropriate services to older Aboriginal Victorians. Adjustment of the Approved Provider Principles should focus on providers' demonstrated capacity to provide high quality aged care appropriate to client need, and organisational factors such as sound governance, risk management and commitment to continuous quality improvement. Applicants should be permitted to use current accreditation status in relevant and/or related areas to demonstrate capacity in relation to provision of aged care services. For example, Aboriginal community controlled health organisations in Victoria which currently offer HACC, mostly function as cooperatives offering a range of services across different sectors. Consequently these organisations, on average, fulfil the requirements of six to seven accreditation frameworks. These may include but not be limited to:

- Community Care Common Standards/ HACC accreditation
- Organisational accreditation (e.g. QIP or ISO accreditation)
- Accreditation of their primary health care service/medical clinic (e.g. AGPAL/RACGP accreditation)
- Accreditation for the purposes Victorian Department of Health and Human Services (DHHS) Registration (DHS One)

The high standards (financial, governance and service related) required in order for ACCHOs to meet all of these accreditation standards should be taken into account in their assessment for approved provider status.

In addition, streamlining of the 'opt in process' will need to consider that Aboriginal providers funded through Aboriginal Flexible Funding are not governed by the framework provided by the Aged Care Act (1997). For the new 'streamlined' opt in process to benefit this group of providers, the Approved Provider Process will need to take into account the different accreditation standards under which they currently operate.

Other comments

General comments or feedback on other issues

[i] Department of Social Services (September 2015) *Increasing Choice in Home Care- Stage 1 Discussion Paper* Australian Government p4

[ii] Productivity Commission 2011, Caring for Older Australians: Overview, Report No. 53,
Final Inquiry Report, Canberra

[iii] Productivity Commission (2015) Report on Government Services 2015

[iv] National Aged Care Alliance (January 2014) Assessment and the Aged Care Services System Paper downloaded 17/10/2015 URL: http://www.naca.asn.au/Publications/Assessment%20&%20The%20Aged%20Care%20Service%20System%20Paper.pdf