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The National Aged Care Alliance advice on phase one development of Consumer Directed Care (CDC) Home Care Packages

Introduction

This paper provides advice to Government on the implementation of the *Living Longer. Living Better.* (LLLB) aged care reform initiatives which introduce two new levels of Home Care Packages and requires all new packages allocated in the 2012-13 Aged Care Approvals Round (ACAR) to be offered as consumer directed. This advice relates primarily to the immediate tasks required to ensure the ACAR can proceed in a timely way including development of:

- the key design elements of the Home Care Packages and consumer directed care (CDC); and
- sufficient information for providers seeking to apply for packages in the ACAR.

In this paper the term consumer is inclusive of the family or informal carer.

Consumer Directed Care (CDC)

The importance of a long term vision

The fundamental aim of the LLLB reform is to create a consumer led and directed aged care service system. In its first year LLLB introduces a number of new CDC Home Care Packages moving to all packages, new and existing, being CDC by 2015. In the longer term the reforms will design and introduce CDC in residential care. Moving to a CDC based system is a fundamental and significant shift from how services operate currently and how consumers experience the service system.

For the implementation of CDC to be effective, any short term action needs to be taken with an understanding of the longer term vision balanced with operational practicalities.

The Government needs to be aware that CDC and consumer assessed level of need must be properly resourced.

The National Aged Care Alliance (the Alliance) *Leading The Way – Our Vision for Support and Care for Older Australians* sets an overall vision for aged care and related service systems. CDC needs to work within that context.

Specifically CDC should:

- Empower and provide choice for an older person to continue to manage their own life. This will be different for every individual with some requiring or wanting assistance and others choosing to manage on their own.
- Be offered within a restorative or reablement framework to ensure the consumer is as independent as possible, potentially reducing the need for ongoing and/or higher levels of service delivery.
- Enhance the contribution that support arrangements make to improving well-being and quality of life for consumers and their carers.

- Acknowledge an older persons right or entitlement to individualised services and support that will assist them.
- Enable the consumer to move seamlessly between higher and lower levels of support without requiring intrusive and major reassessment.
- Increase health literacy by providing the older person and their carer with the information, time and support required to make informed decisions about how to use their resource allocation to achieve reasonable goals.

A strong and financially sustainable aged care system will be funded appropriately to deliver the services consumers want and need. Consumers will determine what the services are, with advice from the service providers who will have the flexibility to purchase or provide them. The aged care workforce will be educated, supported and appropriately remunerated to deliver consumer led care.

The introduction of CDC Home Care Packages is the first step in a system wide transformation. Resources will be needed to support consumers to take full advantage of the increased control and flexibility, and for aged care providers to make the cultural and operational changes to offer CDC. This may include increased advocacy services for consumers and one off system development grants for providers.

The Alliance recommends Government undertake implementation of all reform initiatives in a way that achieves a long term vision for CDC.

The Alliance recommends Government identify and provide the resources and support required to shift the aged care system from its current operating environment to an effective CDC model of delivery.

Design elements

CDC packages will have the following design and operational elements:

- an individualised and transparent budget;
- a control and decision making framework; and
- an ongoing management and communication approach.

Each design element is explored in more detail in this paper, including identifying where further consideration is required in developing the program guidelines.

1. An individualised and transparent budget

- ◊ The Packages will operate on the basis of an individualised and transparent budget replacing the current model of cross subsidisation and resource pooling.
- ◊ The total of the budget will be defined by the package level (i.e. A – D) which will be fully disclosed to the consumer.
- ◊ Consumers will be made aware of their individual budget and receive a regular statement of income (Government subsidy plus the consumer fees) and expenditure. In some cases, service costs may only be able to be reported after provision has occurred (i.e. actual cost as opposed to a scheduled cost) particularly in rural and remote areas.

- The approved provider (AP) will manage and administer the budget on behalf of the consumer (i.e. no cashing out) in a transparent manner meeting quality and accountability requirements.
- The consumer elects the level of control they have over the package from no active direction through to full direction.

It should be understood the move to an individualised transparent budget will stop the current practice of cross subsidisation used by providers to:

- enable more people to be supported than the number of packages available;
- support shared care where more than one consumer lives in the same house and pools their resources; and/or
- provide a higher level of service than package funding allows to consumers with higher needs levels.

This change in operating approach will increase transparency for consumers.

In order for this approach to operate effectively there is a need for a cost of care study to be undertaken to ensure income (Government funding and consumer co-contributions) covers the cost of service provision for an individual consumer.

However there are short term issues that will occur prior to the completion of the cost of care study which will need to be addressed.

Issues for further consideration in program guideline development

In developing the more detailed program guidelines the following issues about individualised budgets will need to be further explored:

(Note: special circumstances need to be considered for rural and remote locations that provide service)

Transparency

The budget needs to be transparent. The Working Group identified two possible approaches to achieve transparency:

- Budget with component parts such as:
  - *Administration* – the costs of meeting Australian Government quality and accountability requirements such as: insurance and government reporting, CDC administrative overheads including staff and IT, developing statements and other consumer communication, establishing contracts with (other) providers and the setting up and cancellation of appointments.
  - *Core advisory and management services* – the costs of initial assessment, periodic review, case co-ordination or management or provision of support to the consumer who has elected to manage it themselves.

  Both of these elements should be related to the agreed level of control being exercised by the consumer, the complexity of the arrangements (e.g. purchasing from multiple providers may be more expensive to administer) and ensuring the AP can appropriately support and inform consumer decisions.

- *Service and support provision and/or purchasing* – the costs of direct service provision. This will not support cashing out or direct payment of funds to consumers.

There will need to be clear and agreed definitions of what costs are included in each component. In developing the definitions for the program guidelines it would be worth reviewing existing definitions (for example those in the HACC MDS or Government acquittal requirements) with which providers are already familiar, and amending as required to support CDC.

There will at least initially, be variations in the amounts of funding allocated to various budget elements by different providers due either to regional variations or to supporting people with special needs (e.g. homeless, people with disabilities or CALD consumers). The allocations will also be dependent on the level of control and self management that a consumer chooses.

The Working Group discussed introducing an overall cap on the amount allocated for administration. Members of the Working Group had differing views about how feasible or desirable such a cap would be given the:

- regional and model variations which exist and drive the cost of service delivery;
- desire to maximise funds available for service provision and purchase; and
- need for adequate consumer protections.

An alternative to a set fee or cap would be the creation of guidelines and/or benchmarking of cost allocations. This would give greater flexibility to APs while providing consumers with some measure for determining whether their fees and charges are fair and reasonable.

Consideration and development of the approach to a cap on administration should be the responsibility of the Aged Care Financing Authority (ACFA).

◊ Unit costing approach

Rather than dividing the package into component parts providers could adopt a unit cost approach which creates a transparent price for the services delivered. This approach is quite commonly used in disability services.

Establishment and ongoing costs

The AP incurs costs from the moment they start to interact with a consumer in assessment and package planning. These costs are not currently recognised within package funding but are a legitimate cost including IT, administrative and risk management systems that need to be incorporated.

2. A control and decision making framework

◊ A purpose statement which outlines why the package is being provided (e.g. to maintain me at home as independently as possible) will be developed to support the decision making process. The statement will include examples of the types of services and support that can be provided, as well as any exclusion/s for which the funding is not to be used.

◊ The consumer will determine, in consultation with the AP the:

- goals (that meet the purpose of the package for the individual);
- services and support to purchase which support the goals;

- » provider/s who will provide the services and support. This is substantially different to current practice where there is generally only one organisation involved. In the CDC model consumers can elect, where there is a choice, to purchase services from providers other than the one administering the budget; and
- » amount of control they will exercise over package management.

◊ The package will be signed off between the consumer and AP with clear documentation of the elements for which the provider and consumer are responsible.

◊ The AP will discuss with the consumer the package and deliver the agreed services in an environment of least restriction, giving due regard to workforce safety, budgetary constraints, duty of care and regulatory obligations.

◊ Consumers will be given information and sufficient time to make informed decisions.

3. Ongoing management and communication

◊ There will be ongoing communication between the consumer, AP and aged care workers to identify and address any issues that occur as they happen.

◊ The AP will have a communication system in place that supports feedback and reporting to and from consumers and workers which enables the provider to proactively manage any risks. This will include ensuring appropriate arrangements for feedback are in place with any service the AP has contracted on behalf of the consumer.

◊ Negotiation/renegotiation will occur when there is a change in circumstances (initiated by either the consumer or the provider) and/or as the consumer and AP have agreed.

◊ The AP will operate in an environment of least restriction, giving due regard to workforce safety and availability, budgetary constraints, duty of care and regulatory obligations in meeting the consumers goals and support/service purchase decisions.

◊ The AP will provide a formal and regular reassessment/package negotiation. In a truly consumer led service system this would (and should) only occur at the clients behest with monitoring/feedback systems enabling providers to proactively manage risks and adjust the package as required. However, given the various quality, legal and contractual obligations placed upon service providers there will be a need to maintain the practice of regular (the timing could vary based on the support level of the client but should occur annually at a minimum) formal reassessment. The cost of doing this would be included in the individual package budget.

The Alliance recommends the above elements be adopted for the introduction of CDC Home Care Packages commencing with those advertised and allocated in the 2012-13 ACAR.

The Alliance recommends ACFA be charged with undertaking a comprehensive, open and transparent cost of care study to ensure adequate funding for the delivery of CDC Home Care Packages. This study needs to take into account those with special needs including cultural diversity, homelessness, LGTBI, disability, mental health, rural and remote locations.

A key element of the study involves ensuring an appropriate level of flexibility for the AP and the consumer. The study needs to ensure a strong and financially sustainable aged care system that is appropriately funded and meets the cost of service provision.

Home care package scoping

The LLLB reforms introduce two new package levels - (A) which is below a CACPs package and (C) between a CACPs and an EACH.

There are a number of elements to be considered to successfully introduce these two new levels:

1. Terminology

The current packages have names which can be shortened into acronyms. In the LLLB documentation the packages are referred to as A, B, C, and D. Numbers provide a universal language that cross cultural and language divides.

They are more easily understood and should therefore be adopted for the package terminology.

The Alliance recommends the packages are labelled numerically (1, 2, 3 and 4).

2. Use of the individualised budget

Consumers will need some information about what and how their budget can be spent. There are two basic ways to provide such information:

- by inclusion – listing everything for which the funding can be used; or
- by exclusion – listing only those items/services for which the funding cannot be used.

The current packages are defined using an inclusion approach. This means in most cases providers will only offer the services listed even where another, more appropriate, response could be made to meet an individual need.

To be truly consumer led there needs to flexibility and creativity in the system. It would be almost impossible to create a fully inclusive list without limiting the thinking of both the consumer and any provider involved (as it does now).

The Alliance recommends package scope is set by exclusion - e.g. packages cannot be used for providing permanent accommodation or major home modifications.

The purpose statement (refer page 4 of A Control and Decision Making Framework) would set the context for establishing the goals and determining the supports and services required. Decision making principles (together with a list of exclusions) should be developed to assist in the definition of purchases that are justifiable with Government funding.

Accountability to Government for purchases would be a mixture of:

- alignment of purchases with the consumers goal/s; and
- clearly articulated evidence of how any unusual purchase supports the consumer goal/s.

Providers could still report expenditure against service categories (potentially the existing EACH package headings) to provide data. This will be important, at least in the short term, for monitoring and evaluation of both CDC and package levels.

Within the exclusion based approach it will be important to clarify the interface issues with the current HACC program (becoming the Home Support Program incorporating HACC, NRCP, Day Therapy Centres and ACHA programs in 2015). Consumers on a CACPs can generally still access the nursing services provided by HACC (where there is availability) but nursing is included within the package for EACH consumers. Arrangements also vary from state to state with the package funds required to pay (full cost) for HACC services accessed in some instances. This needs to be addressed now that both programs are under Commonwealth Government control.

There needs to be a clear statement on the access package consumers can and should have to HACC/Home Support Program funded services, premised on what the consumer needs to achieve their care needs. This is also important to maintain the real value of lower level packages. For a D/EACH consumer it should continue to be provided through the package as it is now.

Any package level should include the ability to use resources for the provision or purchase of nursing or allied health assessment or specialist services or the provision of aids or equipment.

For packages A, B/CACPs and C it should be able to be provided or purchased through package funds and/or accessed from the HACC/Home Support Program as appropriate and available[1].

The Alliance recommends at all package levels, funds can be utilised to provide or purchase nursing, allied health or other specialist services as well as aids and equipment.

The Alliance recommends consumers on a package continue to be eligible to access nursing, allied health or other specialist services through the HACC program (and its successor the Home Support Program). Guidelines in both programs need to clearly state the eligibility of package clients for these services.

It is worth noting consumers with the financial means may also choose to purchase services over and above what it provided to them through any of the package levels.

Implementing the exclusion approach

The *Aged Care Act 1997* sets the direction and requirements which govern the delivery of services to older people. It is supported by Guidelines but in any uncertain situation the provisions of the Act prevail.

To give full effect to the exclusion approach there should be legislative change that embeds the CDC service delivery philosophy and ensures the necessary cultural shift occurs.

However the following practical considerations need to be addressed for the new packages to be operational by 1 July 2013:

- there is limited time to draft and pass necessary legislative change; and
- with only a small number of CDC packages being made available there would be an administrative and financial impost if providers had differing legislative requirements requiring them to run parallel package systems.

[1] This should be reviewed against the outcomes from the Specified Care and Services Review to ensure the longer term objective of streamlining funding, assessment etc between community and residential care services.

To overcome these issues the Department of Health and Ageing (DoHA) has proposed a guideline based approach to defining and creating an exclusions package scope.

The current Community Care Subsidy Principles – 12.5(2) *"Community care for a person is also constituted by providing any of the following kinds of care:* ***…(m) other services required to maintain the person at home***" enables the exclusion approach to be applied with the Guidelines clarifying and supporting the required cultural change. In addition it enables all packages to operate under the same legislative framework and supports providers who may choose to move all packages to a CDC model ahead of the 2015 deadline.

The Working Group has discussed this approach. While it does not see it as the ideal it would support this if there are sufficient guarantees that it would not result in minimising the choice and flexibility provided to consumers.

To ensure such guarantees are in place the Alliance believes the Aged Care Act needs to be amended to include a statement of intent on the purpose and operation of CDC, thereby, strengthening the effectiveness of the Guidelines and clearly set future directions. More substantial legislative change must occur prior to the whole system operating within a CDC framework in 2015.

The Alliance agrees in the short term the exclusion basis for package scope may be best managed through the existing legislative framework and clear supporting guidelines. The Alliance recommends (at least) a statement of intent is included in existing legislation.

The Alliance recommends in the longer term, prior to the whole system shift to a CDC framework in 2015, there is more far reaching legislative change to embed CDC and promote cultural change within the Home Care Package system.

Assessment process

Eligibility for Home Care Packages is assessed by the Aged Care Assessment Teams (ACAT). The consumer is assessed as needing either a CACP or EACH package. If a person is eligible for an EACH package they are also eligible to receive a CACP.

The assessment process needs to be considered in light of the introduction of the new A and C level packages as well as the new dementia supplement and the supplement for veterans who have an accepted eligible mental health condition.[2]

Ideally the assessment process for home care and support will be streamlined and operate in such a way that there is only one major assessment of the consumers needs and changes in circumstances and requirements (with access to more or less services) being managed by the consumer and the AP. The LLLB package proposes the creation of an ACFI style assessment across the entire system to enable this to occur.

While the Alliance believes there may be other appropriate assessment models to achieve this it is strongly supportive of the principle of an integrated and streamlined approach that better supports the consumer. It is acknowledged this will take time to be developed and an interim arrangement needs to be established.

[2] A separate dementia supplement working group will be formed by DoHA to determine the specifics, including assessment requirements, of the supplement. A consultation process will also need to be established to support the introduction of the new supplement for veterans who have an accepted eligible mental health condition.

There are different options for how such an interim assessment arrangement could occur:

- assessment could be required for any package level and/or to move between (either up or down) the levels;
- packages could be 'broad banded' so one assessment is required for access to either a level A or B package and another assessment required to move from a B package to either a C or D package; or
- broad banding could be extended to group package levels A, B and C together (requiring one assessment) and a separate assessment required to move to a level D package.

Given it will be important to see how the introduction of A and C packages impact on demand and delivery it would be sensible to adopt a broad band approach grouping together assessment for A and B packages with another assessment required to move to C and D packages.

This maintains two ACAT assessment points which should have the added benefit of limiting increased demands on generally under resourced ACATs.

There needs to be transparent decision making criteria and a process to inform movement within the bands to ensure allocation does not only occur on the basis of availability and providers have flexibility within each range to address individual needs. Some form of validation of package expenditure will be required and this should be further considered during the development of the program guidelines.

Assessment for packages now is not time limited and this practice should be continued.

The Alliance recommends as an interim measure, a broad banding approach is applied to assessment for Home Care Packages with an assessment required to access levels A and B and another assessment required to move up to access package levels C and D.

The Alliance recommends assessments are not time limited.

Allocation principles

The LLLB reforms will introduce a significant increase in the overall number of Home Care Packages over its ten year implementation. However the number of packages introduced in the early years is relatively small. It will be important to get the most beneficial outcome from the introduction of packages in every year, particularly as the introduction of CDC is one of the key system improvements for consumers balancing an overall increase in the fees and charges they are required to pay for aged care services.

Allocation of the packages should be based on principles which deliver the best value for consumers:

- level A and C packages should be allocated in numbers that create a critical mass for efficiency and effectiveness of individual APs;
- APs need to be able to demonstrate they can, and are ready to, operate individual and transparent budgeting for each consumer and to undertake consumer led care planning;
- APs should have a track record in delivering services which focus on consumer needs and active participation; and

- some priority should be given to allocation of packages for 'special needs' consumers to organisations with demonstrated strategies for servicing the specified target group. This is important to ensure the CDC Home Care Package model works for all consumers.

The Alliance recommends the adoption of the above principles/criteria for the allocation of CDC Home Care Packages in the 2012-13 ACAR.

Additional consideration could be given to providing level A and C packages to APs who already provide CACPs and EACH to facilitate consumers being able to move between package levels. Alternately allocations of A, B, C and D packages could be made to a new provider who can meet the above criteria.

Budgetary decisions have already been made about the number of packages in each level for the 2012-13 ACAR with more level A packages available than level C.

There is concern that level A packages are of very limited value and will create interface and confusion issues between Home Care Packages and the new Home Support Program (replacing the HACC Program) with consumers likely to be reluctant to take up a more expensive package over continued and similar levels of HACC service provision. The greatest demand will be for level C packages as there has long been a gap between the existing CACPs and EACH/D packages.

The Alliance strongly recommends Government reconsider the creation and allocation, of a level A package and directs that funding to the delivery of more level C packages.

If Government is unable to make this critical and sensible change to the reform package there will need to be a strategy to manage the demand/supply mismatch. It is therefore suggested the ACAR planning process reviews the requirements for the new level A and C packages and offers places according to local requirements. This strategy would include enabling a number of level A packages to be merged to create, and be offered as, a level C package.

The Alliance recommends if level A packages go ahead, then local ACAR planning processes determine respective allocations of A and C packages and have the capacity to merge a number of level A packages to create and offer more level C packages.

The issue of mismatch between demand and supply will ultimately only be fully addressed when the current artificial supply ratios are replaced by an entitlement based system.

The Alliance recommends Government replace the current artificial supply ratios with an entitlement based aged care system.

Moving to a CDC system

Converting to CDC before the 2015 deadline

The LLLB package requires all new and existing packages to be provided on a CDC basis by July 2015. APs should be given the opportunity to convert their existing packages before 2015 if they are ready to operate on a CDC basis (as outlined in this paper).

This will allow a more streamlined approach for providers as well as providing a better indication of the interest in, and uptake of, CDC to assist in embedding this fundamental system wide change.

It should be noted if a consumer elects to leave full control of the package with the AP that is still their choice. Packages where the consumer makes this choice should still be designated as a CDC package as long as it was offered in line with the program guidelines (including meeting transparent budget and reporting requirements).

The Alliance recommends Government encourage and support APs who choose to convert existing packages to CDC ahead of the July 2015 deadline.

Significant cultural change

The fundamental shift the introduction of CDC will make in the aged care service system should not be underestimated.

It will be critically important resources and supports are put in place to:

- assist organisations transition to the new system;
- enable staff to be trained and supported in delivering CDC; and
- ensure consumers are equipped to take full advantage of the opportunities it presents for better quality of care and life.

Consumers may require additional advocacy support and the Alliance acknowledges the LLLB package includes an expansion of such services as well as extension of the Community Visitors Scheme into home care services. There may also be a need for additional funding to support consumers through training or development.

Providers may also require one off funding to support system development and/or training requirements for staff.

The Alliance recommends the adoption of a change management approach, including the identification and provision of resources and supports – for consumers, workers and aged care providers, to effectively establish and embed a CDC service system.

Fees and charges

It is proposed consumers pay a percentage of their pension (or equivalent income) for the package they receive. The package levels vary considerably with a level D package delivering many more hours than a level A package. Consumers should not be paying the same amount for such different service levels.

The fees and charges regime needs to be considered to ensure it is fair, transparent and equitable for consumers while ensuring sufficient funds to providers to deliver the required services.

Conclusion

This advice relates primarily to the introduction of CDC Home Care Packages in the 2012-13 ACAR but in developing this advice some longer term requirements became evident. Its focus is on ensuring an approach to CDC that supports the long term reform goals and providing sufficient information to enable APs to apply for these packages.

In summary the Alliance recommends:

1. Government undertake implementation of all reform initiatives in a way that achieves a long term vision for CDC.
2. Government identify and provide the resources and support required to shift the aged care system from its current operating environment to an effective CDC model of delivery.
3. The above elements be adopted for the introduction of CDC Home Care Packages commencing with those advertised and allocated in the 2012-13 ACAR.
4. ACFA be charged with undertaking a comprehensive, open and transparent cost of care study to ensure adequate funding for the delivery of CDC Home Care Packages. This study needs to take into account those with special needs including cultural diversity, homelessness, LGTBI, disability, mental health, rural and remote locations.
   A key element of the study involves ensuring an appropriate level of flexibility for the AP and the consumer. The study needs to ensure a strong and financially sustainable aged care system that is appropriately funded and meets the cost of service provision.
5. The packages are labelled numerically (1, 2, 3 and 4).
6. Package scope is set by exclusion - e.g. packages cannot be used for providing permanent accommodation or major home modifications.
7. At all package levels, funds can be utilised to provide or purchase nursing, allied health or other specialist services as well as aids and equipment.
8. Consumers on a package continue to be eligible to access nursing, allied health or other specialist services through the HACC program (and its successor the Home Support Program). Guidelines in both programs need to clearly state the eligibility of package clients for these services.
9. In the short term the exclusion basis for package scope may be best managed through the existing legislative framework and clear supporting guidelines. The Alliance recommends (at least) a statement of intent is included in existing legislation.
10. In the longer term, prior to the whole system shift to a CDC framework in 2015, there is more far reaching legislative change to embed CDC and promote cultural change within the Home Care Package system.
11. As an interim measure, a broad banding approach is applied to assessment for Home Care Packages with an assessment required to access levels A and B and another assessment required to move up to access package levels C and D.
12. Assessments are not time limited.
13. The adoption of the above principles/criteria for the allocation of CDC Home Care Packages in the 2012-13 ACAR.
14. Government reconsider the creation and allocation, of a level A package and directs that funding to the delivery of more level C packages.
15. If level A packages go ahead, then local ACAR planning processes determine respective allocations of A and C packages and have the capacity to merge a number of level A packages to create and offer more level C packages.

16. Government replace the current artificial supply ratios with an entitlement based aged care system.
17. Government encourage and support APs who choose to convert existing packages to CDC ahead of the July 2015 deadline.
18. The adoption of a change management approach, including the identification and provision of resources and supports – for consumers, workers and aged care providers, to effectively establish and embed a CDC service system.

The Alliances CDC Home Packages Working Group will continue to work with Government on phase two implementation including the development of:

- more detailed information for the Home Care Packages program, including CDC (e.g. assessment and eligibility issues);
- program guidelines including further exploration of issues identified in this paper, interface issues and requirements with the HACC/Home Support Program and the ACAT/Gateway developments;
- communication materials;
- resources to support consumers, providers and aged care workers in a consumer led environment; and
- an evaluation approach and process.

The National Aged Care Alliance is the representative body of peak national organisations in aged care including consumer groups, providers, unions and professionals.

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