national
AGED CARE alliance

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COMMONWEALTH HOME SUPPORT PROGRAMME (CHSP) CONSULTATION ON CHSP PROGRAMME MANUAL, CHSP NATIONAL FEES POLICY AND GOOD PRACTICE GUIDE FOR RESTORATIVE CARE APPROACHES

Background

The National Aged Care Alliance (the Alliance) welcomes the opportunity to respond to the Department of Social Services (the Department) consultation on the Commonwealth Home Support Programme (CHSP)'s key documents:

- CHSP Programme Manual for Providers;
- CHSP National Fee Policy Consultation Paper; and
- Good Practice Guide for Restorative Care Approaches (incorporating wellness and reablement).

This short response builds on the Alliance's advice of September 2013 '*Commonwealth Home Support Program – Design Paper'* and our June 2014 '*Response to the Key Directions for the CHSP Discussion Paper'*[1]. The Alliance notes a number of its members will make comprehensive submissions to the consultation on matters affecting their constituency and proposes that this submission will focus on the key issues affecting the broader sector.

The Alliance would like to thank the Department for its co-production approach to developing the CHSP through its consultation with the sector. We welcome that the Manual and Fees Policy is largely in line with the Alliance recommendations stemming from this co-production and note our appreciation for the opportunity for input through the Alliance consultation mechanisms with the Department. We offer our ongoing support to the co-production approach over the coming 12 months as the Department implements the Programme should the Department choose to extend the term of the CHSP Advisory Group.

We note our appreciation of Minister Fifield's view that a future aged care reform should be the consolidation of the current Home Care Packages Programme and the CHSP into a single, integrated community care programme, funded via a mix of individualised funding and block funding[2]. We reaffirm the Alliance supports this direction and we would welcome the opportunity to commence discussions about this reform at the earliest appropriate time. In the context of the 1 July changes we note the continued disparity of fees between the two Programmes and recommend that regardless of any merging of the Programmes the pathway towards price parity between the two Programmes be commenced within the context of the five year review or earlier.

1 Available from www.naca.asn.au

2 Senator the Hon. Mitch Fifield 11 November 2014 'The Economics of Aged Care: Speech to the Committee for Economic Development Australia (CEDA)', Four Seasons Sydney.

Available from: http://mitchfifield.dss.gov.au/speeches/the-economics-of-aged-care

The Alliance notes that Home and Community Care (HACC) services in Victoria will form part of the CHSP at a yet to be announced time frame. HACC services in Western Australia have not yet agreed to form part of the CHSP. In both states services from the Assistance with Care and Housing for the Aged (ACHA) Day Therapy Centres Programme (DTC) and National Respite for Carers Programme (NRCP) will commence within the CHSP on 1 July 2015.

Transition Plan

The Alliance would like to reaffirm its view that the CHSP would benefit from a dedicated, publicly available transition plan ('plan') that addresses a number of areas that we feel are not sufficiently covered by any of these three documents. Some elements of the below proposed discussion plan may also be included in the Manual, however greater detail is required and this may be more appropriately addressed with the plan.

The elements that should be included within a CHSP transition plan are:

Grandfathered consumers

The Alliance supports the notion of grandfathering consumers receiving existing services and introducing the new eligibility criteria for new consumers or consumers receiving new services. However we feel the draft Manual provides insufficient information for providers in managing these grandfathered consumers into the future and would benefit from greater information being included within a plan.

The Alliance believes there are a number of specific categories of consumers where further information about their circumstances should be discussed within the Manual, including consumers:

- living in residential care who currently access day therapy centres;
- currently receiving more than a 'basic' level of support (particularly where consumers are either financially unable or refuse to migrate due to costs onto the Home Care Programme);
- accessing current HACC services at a level akin to a home care package because there is no appropriate level of home care package available in their area[3];
- on a lower level home care package who are 'topping up' their services from the Programme because the package at their assessed level of need is not currently available in their area; and
- currently being managed under HACC case management services.

The language to discuss grandfathering of existing consumers (pg47) has led to some confusion as to whether existing consumers of previous Programmes (HACC, DTC, ACHA, NRCP) who are eligible under CHSP will be grandfathered, or if the intention is only to ensure continuity of service for those who may no longer meet the CHSP eligibility criteria. This presents critical differences when considering the service level of some consumers that would no longer be possible under the new Manual. The Alliance supports the grandfathering of all existing consumers to receive their current services.

3 Note the Alliance discussed its view in greater detail regarding HACC consumers as part of our response to the Key Directions document in Question 3.

Further, we note that the Manual does not state a guaranteed period of time the grandfathering arrangements will be available which may lead to confusion within the sector as to whether this is a permanent or temporary arrangement for existing consumers. Nor is there clarity whether grandfathering continues for existing consumers where their needs change (potentially resulting in either new services or changing levels of existing services).

Training and education in wellness and reablement

The Alliance notes the experiences of Western Australia and Victoria in embedding a reablement and wellness approach within their HACC services. A key success of these experiences has been the comprehensive training and education for HACC workers in the principles and practices of reablement. The Alliance believes that a workforce development strategy must be articulated to support the roll out of wellness, reablement and restorative care across the sector. Such a strategy should include training in cross cultural competencies and the use of interpreters. This strategy should be supported by a Commonwealth funded Programme to train the existing workforce to deliver upon the Programme's goals. The Alliance also notes the importance of working to update qualifications that may be received by new or potential staff to include the wellness and reablement agenda, coupled with actively ensuring RTO's appropriately embed practical changes in their delivery of the qualifications.

Culturally appropriate and accessible consumer information

The Alliance reaffirms its view that information should be made available to consumers in an accessible format. Currently there is a lack of information about these changes available in a diversity of languages or in an accessible format for people with vision impairment. It is necessary for the effective implementation of the new Programme that such resources be developed.

Reporting

The Alliance welcomes the introduction of a new reporting system through DSS Data Exchange and the Department's indication of willingness to consult with the Alliance about this implementation. The Alliance however notes that such a consultation should involve more than just its provider members.

Urgent detail around the information technology requirements and the specific reporting requirements is needed to build the necessary systems. The Alliance recommends this be an area of priority in the coming weeks and months prior to the 1 July or the 1 November milestones.

Transition arrangement for specific areas of the Programme

The current Manual does not sufficiently provide information about some components of the Programme. The Alliance believes these Programme users and providers will benefit from specific transition arrangements being clearly articulated in the plan. These areas include:

- *Carer Programmes* that may no longer form part of CHSP but were previously within one of the Programmes being consolidated;
- *HACC advocacy* which requires greater clarity around the transitional arrangements for the continuation of existing system and policy advocacy until such time as the review into the Aged Care Advocacy Programme is finalised; and

- *Sector support and development* arrangements for CHSP users, providers and workforce. Intensive support is required as part of the transition and an indication of the future support to be provided under the Programme would be of benefit.

Monitoring

The Alliance believes it is important that the implementation of the CHSP and its associated changes are monitored and reported on. This is an issue not only to monitor the impact on providers and consumers within the aged care sector, but to also identify any flow on impact to other Programmes such as the state health and hospital system. The Alliance would encourage the Department to develop strategies to monitor:

- any increase/decrease workload on service providers as part of the new Manual;
- impact of fees on consumers, specifically the discontinuation of required services and the rate at which consumers decline services due to cost;
- the rate at which consumers do not commence services generally, or particular types of services, because of the new Fees Policy;
- the fee levels actually charged by providers;
- the rate at which consumers access similar services via alternative programmes/funding streams due to a real or perceived inability to pay fees, particularly the public health system including preventable acute presentations;
- the geography of fee collection and hardship determinations, with consideration of the local socio-economic background of older consumers to identify any inequity across areas with high numbers of hardship consumers. Particular attention should be paid to the impact on rural/small towns and remote areas (including Aboriginal communities);
- the consistency with which hardship was approved;
- the rate at which hardship was not approved but consumers did not pay the fee required of them; and
- the movement of consumers from CHSP to Home Care packages.

Any introduction of monitoring mechanisms should not unnecessarily increase administration or red tape on aged care providers. Consideration should be given to utilising data from My Aged Care to prepare this information where possible. The Alliance through the CHSP Advisory Group is prepared to co-produce such reporting mechanisms to ensure consideration of the provider burden is included in any such discussion.

The Alliance notes the concern amongst its members that any introduction of fees must not have the perverse impact of altering the HACC system to remove opportunities for Australians to volunteer. While there is no indication the current proposal would lead to such an occurrence, the Alliance encourages the Department to monitor volunteer participation in the Programme to ensure no unintended consequences occur.

The monitoring reports developed should be reviewed in a co-production fashion between stakeholders such as the Alliance and the Department.

Compliance with changes

The Alliance is concerned there is not enough time for effective culture change within the sector once the final Manual has been released and the specific requirements of the programme are finalised. The Alliance notes its appreciation for the shift to November 2015, but recommends that the Department make a public directive to the Quality Agency and its reviewers that no 'fail' score will be provided on matters relating to these changes until June 2016. This is particularly important in the area of fee collection, where preparing some consumers for new fee levels may take some time.

Older consumers who aquire a disability

The Alliance remains concerned that the CHSP does not sufficiently indicate the pathway for people who acquire a disability over the age of 65 (nor is it clear that the changes adequately address people with younger onset dementia where some have traditionally been supported under the HACC Programme). We believe it is necessary and important for the Department to articulate the transition for how people over the age of 65 (over 50 years for Indigenous Australians) with a disability will continue to have their care needs met.

The National Health and Hospitals Reform Agreement, along with the design of the National Disability Insurance Scheme (NDIS) and the CHSP, have left concern within the sector that there is a group of people who may not be serviced by any Programme. As discussed later this includes, in particular, older Australians with vision impairment.

Consumers who are ineligible for CHSP may continue to need disability services (provided by a specialist disability provider) that due to their age they will not be able to access from the NDIS. Similarly, a person over 65 years may have higher needs than can be provided through a Home Care package. With the design of these aged care reforms it remains a concern to the Alliance that there will be no support for people with a disability who fall outside these aged care Programmes.

The Alliance would also urge the Government to consider the needs of older Australians with blindness and vision impairment and consider whether current services both within and outside of CHSP are of sufficient support to adequately assist this cohort of consumers.

CHSP Programme Manual

The Alliance supports the consolidation of the four Manuals into one document and appreciates the easy to read style of the Manual.

There remains however a number of areas where greater clarification of the provider responsibilities is needed in the Manual:

- Greater clarity around the tasks included within a 'service level assessment' is needed. In particular, what information do they need to collect that is not provided by the Gateway screening and Regional Assessment Services (RAS) assessment through the referral information from My Aged Care? Given the removal of assessment funding for providers, information collected by the provider should be kept to an absolute minimum.

- Consumers may access services from multiple providers. The Manual states that service delivery under CHSP should not exceed that of services available under a Level 1 Home Care package. However there is no expectation set under the Manual about the role of providers in monitoring this usage level, nor any indication of whether this will form part of any compliance audit. The Alliance believes with the introduction of My Aged Care this responsibility should sit with My Aged Care or the RAS.
- The current NRCP Programme includes a small sub-programme of dedicated respite funding for carers in the workforce or training to re-enter the workforce. The Alliance is concerned by the Manual not indicating this Programme will continue.
- The meals food type does not implement the Meals Review Working Group recommendation of the development of a national standard on nutrition quality. The Alliance urges the Department to announce a pathway to develop and implement nutritional standards within 12 months of the Programme's commencement.
- There is a concern amongst some members of the Alliance that the Manual examples do not sufficiently showcase the role of Allied Health professionals to demonstrate the multiplicity of consumer needs and potential interventions. The Alliance would support greater inclusion of a wider diversity of Allied Health professionals in line with the CHSP wellness and reablement objectives.
- The Manual should be updated to include a definition of what constitutes 'complex needs' as referred to under the assessment and support planning discussion. Clarity is important as this may have an impact on access and outcomes for a significant portion of CHSP consumers.
- The Manual does not sufficiently discuss capital works for service types such as transport. Currently it is unclear if Programme funds can be used to contribute towards the purchase of a bus or car (see capital works on pg13). If the intention is to continue a Capital Grant Programme for CHSP, this should be mentioned within the Manual.
- The Alliance encourages the Department to reflect a genuine commitment to special needs groups within the Manual and policy. Recognition of the disadvantage faced by these groups, information about culturally competent environments and need for care coordination of these consumers should be included. The Alliance would like to see additional resources provided to allow free access to interpreter services and translation of all relevant consumer documentation. A targeted communication strategy for special needs groups about the CHSP should be developed.
- The Alliance would encourage the Department to make it clear within the Manual that provider assessment functions may be conducted over the phone (pg52). While the reference to assessments being conducted face-to-face is contained within the RAS, the silence on this issue within the functions of a provider (s3.4.3) has led to some confusion.
- In addition the Alliance notes the lack of explanatory case studies of how people with blindness or low vision or cognitive impairment are envisaged to access CHSP, nor are there case studies focused on mental health. The Alliance would recommend the inclusion of such case studies within the Manual to show how the Department anticipates such groups being included within the CHSP.

Interface between CHSP and other Programmes

The Alliance notes its dismay that the Department has not taken on board its recommendation to allow CHSP services up to equivalent of a Level 2 package. The Alliance remains of the firm view that benchmarking against a Level 1 will not allow the flexibility in delivering services that is required to maintain care levels. The Alliance reaffirms its view that the Department should review the value and success of Level 1 packages and include within the review their interactions with CHSP.

The Alliance is particularly concerned that Level 1 and 2 package recipients should be able to continue to access transportation services under the CHSP. The Alliance proposes that an exemption to the interaction between the Level 1 and 2 packages and the CHSP for the sub-type of transport be provided.

Missing service types / new fee structure

The Alliance notes there are a number of key services that should have their own scheduled fee including:

- *Wound management* – wound management and chronic wound management often involves a daily visit of a registered nurse (RN or EN), with considerable cost of consumables. The Alliance notes that the cost effective management of wound care impacts not only the financial viability of the CHSP but, where consumers refuse care due to costs, this has a negative impact on the state health budget. The Alliance notes the ongoing discussion within the sector about the appropriateness of wound care being delivered through the HACC Programme (rather than a comprehensive community nursing Programme). The Alliance believes a wound management fee that recognises the need for registered nursing care should be set distinct from nursing care and factoring these considerations into its calculation.

- *Group Social Support* – the Alliance notes the Fees Schedule is missing a different fee for group social support and feels that the rate for individual social support would not be an appropriate level.

- *Social Support (telephone or volunteer programs)* – the Alliance notes that a fee for telephone social support should be distinct from in person social support. Further we note that volunteer Programmes should also be distinct in the Fees Schedule. The Alliance believes consideration for a new fee (if any were to be charged) should be provided for volunteer or telephone social support Programmes.

- *Reablement Support* – the Alliance notes the concern amongst some members that delivery of reablement services, working one on one with returning a consumer to doing their own household duties, may not be within the skill of some workforce members across a range of service types, while the sector is increasing the skills around reablement across its workforce. This may be particularly true in areas such as home maintenance and domestic assistance. The Alliance notes the skill of 'Other Food Services' is largely a one-to-one reablement service. Accordingly we would propose amending and broadening this service type to 'Reablement Support', noting that the 20% of service delivery outside contracted services should be sufficient to cover this transition need. Alternatively the definitions with a broad range of service types would need to be updated to include wellness and reablement explanations within their context.

- *Day Therapy Centres* – In some states a day therapy centre will deliver Allied Health, Social Support, a meal and transportation as part of their service delivery. The Alliance feels that the current fee structure would inappropriately impose 4 costs in this delivery of service which should be one rate.
- *Multiple service types in one delivered activity* – Similar to day therapy centres, the Alliance believes providers should be encouraged to deliver services in an innovative manner that responds to the needs of their consumers in their particular area. We are concerned that this may be hindered by only having a component based fee in the delivery of these services. Accordingly, we would encourage the Department to consider a solution whereby either a bundled component fee was set or where a maximum over all fee would be charged for any one activity, no matter how many individual service type components were included.

Additional sub-service types

There are a number of additional sub-service types that the Alliance feels would benefit from specific mention within the guidelines. In addition the Alliance would seek to ensure that service data is collected at this sub-service type level and that aggregated reporting is available:

Allied Health (pg31)

If the Allied Health service type were to include a list of types of Allied Health professionals, the Alliance notes there are some professionals not included in the current draft including:

- Orientation and Mobility specialists.
- Dietitians (Accredited Practising Dietitians).
- As a rule all Allied Health professionals who are members of professional groups that are regulated under the national law through the Australian Health Practitioner Regulation Authority, self regulating through accreditation schemes through professional colleges or self regulating professions should be included[4].
- The Alliance proposes that following the updating of the professions on page 31, the list of professions on page 12 should be updated to match all Allied Health professions included to avoid confusion. Alternatively specific professions could be removed on page 12 and simply a reference to page 31 included.

Goods and Equipment (major purchases)

There is a wide range of assistive technologies that enable 'the consumer to perform tasks they would otherwise be unable to do or promote the older person's safety and independence' (pg32). The draft guidelines correctly identify some of these. However there are diverse support, mobility, communication and other aids that range from those that are cheap and require no customisation, to those that are expensive and must be tailored to the individual user. The Alliance is concerned that the current guidelines and Fees Schedule will cater for one end of that continuum, and do little to address the other.

We are also concerned about the lack of clarity regarding existing state aids and equipment programmes continuing to provide their current coverage for older Australians.

4 See Attachment One - National Aged Care Alliance (June 2013) 'Pre-costing report on the Specified Care and Services Review', Canberra. Available from: http://www.naca.asn.au/Publications/NACA%20Pre-Costing%20Progress%20Report%20on%20the%20Specified%20Care%20and%20Services%20ReviewFINAL.pdf

As currently drafted, the guidelines may disadvantage particular consumer groups whose aids are more expensive. It may also discourage innovation, particularly in technological solutions that may be higher in capital cost, but which may have a longer life, or provide better consumer outcomes, including avoided future costs in other care settings, such as acute hospital or disability services.

The Alliance recommends that the fee guidelines, and the service type description, be revised to ensure that the full range of assistive technologies are appropriately supported. We would welcome the opportunity to work on implementation in this area through our CHSP Advisory Group.

Service type definitions

There are a number of definitions used within the Manual that the Alliance believes can be improved upon in order to ensure greater understanding of and compliance with the Manual, including:

- The Alliance welcomes the policy intent to move towards activity based funding, however the Alliance is concerned about the impact on some activities. In particular the cost of interpreter services beyond the initial intake process puts culturally and linguistically diverse consumers at a disadvantage. In addition the Alliance would urge the Department to consider whether volunteer management has been sufficiently funded in its funding model.
- The primary and secondary objective of the Meals service type (pg20) would suggest that the 'service type description' needs to be updated to include reference to the social support element of a meal contained within the secondary objective. The Alliance believes this to be important to ensure the continued variety of service delivery models across Australia to suit the local needs.
- There are a number of unintended scopes of practice issues due to the wording of the 'service type definitions'. As a principle, the Alliance believes the CHSP should not impose more onerous restrictions on a particular profession than their own regulated or self-regulated rules generate. Accordingly, reference to duties performed under the 'Nursing', 'Allied Health' and 'Personal Care' functions should be reviewed with the following in mind:
    - Nursing's professional scope of practice permits the delegation of nursing-related activities to other care workers (however named). The current wording of nursing services within the 'service type description' (pg30) does not recognise that nursing-related tasks can be delegated to other workers. Greater clarity of how this delegated care model would work under CHSP is required. The Alliance notes that a number of today's delegated activities to a personal care worker may not be able to continue under the draft definition of nursing or personal care.
    - The exclusion of 'post-acute care' from the nursing service needs greater clarification. The Alliance would propose this be worded to indicate exclusion where only post-acute care is required. In situations where consumers have other non-post acute needs for their wellness and reablement, but were not previously on the Programme, these consumers should not be required to wait until after a post-acute period.

- Allied Health services should reference the scope of practice of their particular regulated or self-regulating body to ensure national consistency. In some instances this permits activities being undertaken by assistant Allied Health professionals or other less qualified staff.
- Personal Care – the current service type definition indicates personal care workers will be permitted to undertake 'medication monitoring' however does not indicate if they can 'assist with self-administration from dose administration aids and report failure to take medicines'. The Alliance supports the view that decisions about medicines and monitoring of medication must occur under an appropriately qualified professional; accordingly we would recommend that reference to 'medicine monitoring' be removed from the personal care service type. However once those decisions are made, assistance with self-administration from dose administration aids and reporting of failure to take medicines may be performed by a personal care worker, who has received the appropriate training. Given the quantum of service delivered under CHSP the Alliance believes this is an important issue to ensure workforce viability into the future.

CHSP National Fees Policy

The Alliance notes the decision to reduce the CHSP growth fund from 6% per year, to 3.5% per year on the basis that the National Fees Policy would, within 3 years, generate 15% of the overall CHSP Fees Policy. We also note the advice of the Department during the most recent roadshows that fees will be used by providers to expand their Programme beyond the contracted number of occasions of service. The Alliance notes its concern that this approach could result in Programme growth only in the geographical areas where fees are continually paid. Accordingly, those socio-economic geographical areas where hardship applications have a high approval rate could over time create a significant disparity in services. Consideration of how to ensure equity where larger than average hardship approvals are occurring should be given, particularly given that many of these consumers may also have complex needs resulting in higher service delivery costs.

The Alliance also notes that neither the Manual nor the Fees Policy adequately addresses the issue of whether a carer of a consumer receiving transport services may be included within counting of heads for funding acquittal purposes. Further it is unclear if the carer will be charged a fee if they accompany the consumer on the service. The Alliance believes the carer should not be charged a fee for transportation where their presence is required to assist the person for whom they care.

'Fee' or 'Care Contribution'

The Alliance has had much discussion about the interpretation by consumers of a 'contribution towards their care' and a 'fee'. The Alliance believes the Department should give significant consideration to altering its language from fees to 'care contributions', which in our view more accurately represents what these consumer payments are.

If the Department continues to utilise fee terminology, the Alliance would suggest that the term 'standard fee' incorrectly implies the same fee across the country. The Alliance would suggest a change to 'Service Fee', 'Part-Discounted Fee' and 'Full-Pensioner Fee'. The Alliance urges a removal of the term 'minimum' in the schedule.

The Fees Policy makes it unclear if services are to be discontinued should payments not be received from consumer fees where hardship has not been approved.

The role of providers in assessing appropriate fees for consumers

The Alliance supports the 3-tier structure of the fees but reaffirms its view that the provider should not be liable for assessing this information. As the Department is aware funding for assessment has been removed and there has been no indication that further compensation for the administrative hours setting up a consumer will be received.

The Alliance notes roughly 550,000 consumers are currently within the CHSP, each of which will need to be assessed by providers in order to determine their fee level. Once determined providers will then need to work with individual consumers to migrate them onto paying these fees. Such a process should be as quick and painless as possible for providers given that Government has shifted the fee assessment component for these providers from the My Aged Care system to providers.

The Alliance reaffirms its view that such information should be included in the referral information from My Aged Care (talking to Dept. of Human Service systems). The Alliance understands this is not technologically feasible for 1 July launch and understands that the temporary solution to reduce burden on providers is that the supplying of a 'pension card' or a 'commonwealth seniors health care card' by the consumer to a provider will be sufficient.

However, the current wording is being interpreted as the provider is responsible for assessing the income level of consumer. The Alliance would suggest this be reworded to make it clear that the provider will only need to access Centrelink Confirmation eServices (CCeS) where the consumer believes their income levels are of eligible amounts but do not have their card available during intake.

The Alliance notes that no analysis was made available on the number of older Australians that were expected to fall within the 'Service Fee', 'Part-Discounted Fee' and 'Full-Pensioner Fee' categories. The Alliance notes the recent changes to eligibility of the Commonwealth Health Care Card and recommends that the Department monitor the eligibility of consumers within these categories to ensure appropriate access equity is maintained in the future.

Rate of return

The current Fees Policy indicates that a provider will set the 'standard' fee rate for non pensioner/ part-pensioner consumers. The Alliance wishes to draw attention to the fact there is a lack of guidance of whether this fee may include a rate of return component in calculating the cost of the service.

Exempting certain services, service types or classes of people from paying a fee

The Alliance notes there are a range of situations where it may be most appropriate for the hardship policy to provide automatic exemptions.

Service providers rightly have a range of service delivery methods for similar service types. In some cases services are delivered largely by a volunteer base. The Alliance recognises that while there is still a cost to delivering these services that cost may not be at the rate of the prescribed fee. The Alliance finds it particularly concerning that 'friendly visiting' schemes funded under the CHSP will incur an hourly fee, while those same volunteer low cost programmes under the Community Visitors Scheme will not.

This is also true of services that have been delivered by telephone. The Alliance proposes that the Fees Schedule permit a provider to charge a discounted fee where the standard fee is greater than the cost of delivering the service.

There may also need to be consideration of the appropriateness of charging the same contribution for a service delivered by tele-health (e.g. phone) as it is for an in person visit. Currently there is no flexibility around such delivery within the Fees Schedule.

The Alliance also recognises that some service providers focus on delivering services to a cohort of consumers who in the large majority will be approved for hardship. This may include homelessness CHSP services, services focused solely on some rural/remote communities, services focused on delivering care in public housing settings and services that are delivered to Aboriginal and Torres Strait Islander populations. The Alliance feels it may be appropriate for the Fees Schedule to include a clause that allows a provider to seek a blanket exemption where they can demonstrate their consumer base is collectively covered under the hardship guidelines.

The Alliance supports the suggestion that consumers who are homeless should be exempt from paying fees, while recognising that non-specialist providers may require greater guidance on who meets the criteria of being defined as homeless.

Proposed changes to Fees Schedule

The Alliance is broadly happy with the fees indicated however would like to propose the following amendments to the Fees Schedule:

Aids and Equipment

The Alliance notes that the current wording of the $500 limit has confused some parts of the sector as to how many items may be purchased by a consumer per year. We reaffirm our position that this should be $1000 not $500. The Alliance believes the contribution from the CHSP towards a Programme should take a similar approach to home modification where the Programme sets a limit on the amount of Programme funds that can be contributed towards a project in a single year, but does not set a limit on the total project (thus leaving opportunities for alternative funding to make up the difference). Accordingly we would propose the language to be 'Programme funds may contribute up to $1000 for a single consumer in a financial year'.

The Alliance also proposes that the approach used by home modifications is also adopted in Aids and Equipment by setting the fee at a percentage of the cost of the item (50% Pensioner, 75% part-pensioner, 100% self funded retiree).

Finally the Alliance notes the new Manual does not make clear in which service type enteral feeding equipment and consumables should be assigned.

Meals

The Alliance supports the position of Australian Meals on Wheels on moving from a set amount for each meal to an equitable percentage of the cost of the meal (excluding food components). This will ensure that where meals can be delivered for a cost to consumer at $5, they continue to do so, but also recognise that some meals may cost consumers $15. We would support using the 50% Pensioner, 75% part-pensioner, 100% self funded retiree used in home modifications and proposed for Aids and Equipment.

The Fees Schedule should also be updated to make clear if the meals fee is for a whole day or per meal. If the above percentage approach is taken, the Alliance notes this will resolve its concern that the current schedule does not distinguish between a 'meal' and a 'snack' in terms of the value contributed. A commitment to equitable pricing on cultural or therapeutic requirements in meals should be included within the Fees Schedule. Those needing such foods should not be paying significantly more contributions.

Transport

The Alliance would like to see consistency in travel bandwidths between those proposed for group and individual transportation. We support the Australian Community Transport Association's call for the introduction of a 1-10km fee bandwidth.

Part-pensioner nursing fee amount

The Alliance is unclear of the methodology used to charge $32 for part pensioners accessing nursing services. The Alliance is concerned that the part pensioner fees for these services could be too high for some consumers.

Payment plan options for short term intensive restorative care

The Alliance supports the definition of basic services including the delivery of short term intensive services. However the Alliance notes that the delivery of multiple services per week in the short term may be unaffordable for some consumers to pay as they use the services. The Alliance recommends the Fees Policy specifically state allowances for providers to accommodate fees being paid over a longer period of time in a payment plan style arrangement for these types of intensive services.

The Alliance also notes that people with chronic conditions may continue to access the CHSP. This may lead to unreasonable total consumer fees on a short term yet ongoing basis or in some case a medium-long term ongoing basis. This is particularly of concern for transporting consumers with chronic conditions to medical appointments.

Future reform

The Alliance notes the Manual's requirement that providers must make their Fees Schedule publicly available from 1 July 2015. The Alliance feels that this information should in the future be published on My Aged Care and would encourage the Department to commence development work necessary to facilitate this publication.

Fee hardship guidance

To facilitate the consistent assessment of hardship across the country, the Alliance believes greater guidance is needed to be provided by the Department on the expectations and methodology for a fees hardship assessment. While some providers will develop their own tools or use third party system that will provide these tools, other providers will benefit from the development of fact sheets and FAQs about hardship (and fees generally) for consumers; a checklist of things to consider and possibly an electronic calculator that can determine if hardship is to be approved.

The Alliance also notes the lack of clarity within the sector whether or not grandfathered consumers will be subject to the new Fees Policy and encourages the Department to make this policy decision more explicit within both the Manual and the Fees Policy.

Good Practice Guide for Restorative Care Approaches

The Alliance is broadly supportive of the Good Practice Guide and appreciates the effort put in by the Department to developing this Guide. The Alliance offers these limited comments on the draft provided:

- The Alliance notes the concerns amongst some members that it is not clear and upfront that the Good Practice Guide is not an enforceable part of a provider contract like the Programme guidelines. A clear statement should be included in on the front cover.
- There is a need for an explicit strategy/plan by the Department to create restorative care services across Australia. Currently Allied Health and Day Therapy Centres are not available in all areas (especially in regional / rural / remote areas). The Alliance would support achieving this goal through a targeting of the initial years' growth funding.
- The Alliance believes the list of disciplines in the Good Practice Guide (pg9/10) should be clearly marked as illustrative examples only and that they are not a prescriptive list. However there are some professions we think should be included in the list:
    - Dietitians (Accredited Practising Dietitians) - are already employed under HACC services and this will need to be expanded as part of delivering a wellness approach.
    - Orientation and Mobility specialists - blindness and low vision can often cause people to lose confidence and impact their ability to get around safely. Orientation and Mobility Specialists are highly trained and skilled to ensure they can assist individuals to learn to move about as safely as possible, including through the use of a white cane (including a support cane if there are additional needs). Orientation and Mobility Specialists will assess both the individuals' needs and the environments they wish to travel in to ensure any potential risks are identified and reduced.
    - All Allied Health professionals who are members of professional groups are regulated under the national law through the Australian Health Practitioner Regulation Authority, self regulating through accreditation schemes through professional colleges or self regulating professions[5].
- The Alliance notes that reference to 'sports physiology' in the Good Practice Guide is incorrect (pg44); there is no recognised Allied Health profession of this name. The correct Allied Health term and profession is 'exercise physiology'.
- The Good Practice Guide should acknowledge the significant cultural change within the sector that a move to restorative care will have. It is recommended that all staff, from the My Aged Care team to support workers on the ground, should receive a Commonwealth funded training Programme on reablement and wellness for staff with existing qualifications (as discussed in the above section on a transition plan).
- In Chapter 1 of the Good Practice Guide it states reablement will be embedded throughout the support continuum, and that support will be consumer led, however this doesn't really shine through from Chapter 2 onwards. If reablement is embedded there should be more emphasis placed on support being delivered in line with consumer goals and preferences. The language within the Manual continues to be reflective of the outgoing HACC system and is too prescriptive.

5 See Attachment One of NACA's Pre-Costing Report on Specified Care and Services Review

- The case study on page 30 of the Good Practice Guide titled 'Robert' indicates that a home maintenance worker will deliver restorative care services. We note our previous discussion about the development of a 'reablement service' service type. This example has sparked much concern amongst providers who sub-contract to home maintenance staff that are unskilled in restorative care and unable to facilitate restorative care approaches under some state laws.
- In the case study on page 34 of the Good Practice Guide, there is a lack of reference to assistive technologies, which are an important component of referral outcomes for people with low vision. The Alliance suggests an additional bullet point be added referring to the assessment and provision of a low vision assistive technology, such as a magnifier, accessible mobile phone, or computer screen reader.
- The Good Practice Guide should reinforce that reablement services should be based on assessment and intervention provided by suitably qualified persons. For example nutrition reablement should be directed by an Accredited Practising Dietitian, but service delivery might be provided by someone with certificate III or IV with practical skills in food preparation, and applied knowledge of nutrition, special diet preparation, budgeting, food hygiene etc. Knowledge of food legislation and food safety only would not be adequate.
- An acknowledgement that culture, language, housing or complexity may affect the time taken for the planning and delivery of reablement services should be included.

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