# Aged Care Legislated Review

***Submissions close 5pm, 4 December 2016***

## Instructions:

- Save a copy of this template to your computer.
- Populate Section 1 with your details.
- If you would like to respond to a specific criteria please use Section 2 of the template.
- If you would like to provide general comments please use Section 3 of the template.
- Upload your completed submission on the Consultation Hub. Alternatively, if you are experiencing difficulties uploading, you can email your submission to agedcarelegislatedreview@health.gov.au

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**Thank you for your interest.**

# 1. Tell us about you

1.1 What is your full name?

**First name** **Dianne**

**Last name** **Couch**

1.2 What stakeholder category do you **most i**dentify with?

**Non-government organisation – community health**

1.3 Are you providing a submission as an individual (go to question 1.4) or on behalf of an organisation (go to question 1.5)?

**On behalf of an organisation**

1.4 Do you identify with any special needs groups?

People from culturally and linguistically diverse (CALD) backgrounds

1.5 What is your organisation's name?

**COHEALTH**

1.6 Which category does your organisation **most** identify with?

**Community Health**

1.7 Do we have your permission to publish parts of your response that are not personally identifiable?

☒Yes, publish all parts of my response except my name and email address

☐No, do not publish any part of my response

## 2. Response to Criteria in the Legislation

cohealth welcomes the opportunity to respond to the Department of Health Consultation on the Aged Care Legislated Review.

***About cohealth***

*cohealth's Vision: Improve health and wellbeing for all and tackle inequality, in partnership with people and the communities they live in.*

cohealth is a large community health organisation with an operating revenue of over $60m and more than 850 staff, delivering services from over 40 sites across 14 local government areas in northern and western metropolitan Melbourne. cohealth also delivers a number of state-wide programs.

More than 110,000 people receive over half a million GP, dental, allied health, mental health, counseling, disability and community support services from cohealth each year and benefit from its extensive networks across a range of sectors.

cohealth is not a provider of residential aged care services. Its primary engagement with the aged care sector is through the delivery of a range of Commonwealth Health Support Programs (including physiotherapy, podiatry, occupational therapy, dietitians and other allied health practitioners), ethno-specific supports, homelessness services (including the Assistance with Care and Housing for the Aged program), supports for older people residing in public housing, and delivery of a range of Planned Activity Groups (PAGs) for aged and frail people and people with dementia.

cohealth is an award-winning organisation known for its work in building community capacity and providing high quality health and community services, particularly to culturally diverse communities. Its clients come from many different backgrounds and speak 85 community languages. cohealth acknowledges it works on Aboriginal land and pays respects to Elders past and present.

cohealth chooses to focus its efforts on supporting people with greatest need and poorest health. Health in this context means understanding the whole person, their environment and their social and economic relationships. Its core principles, articulated in the Strategic Plan 2015-18, include human rights, co-design and a social model of health.

A key capability of cohealth is service assessment/coordination and navigation, and finding the "right door" for people seeking services. To achieve this outcome cohealth combines integrated care with individual and systemic planning, and client, partner and community collaboration. cohealth recognizes partnership delivers opportunities for innovation and a stronger voice for equity and system reform.

These approaches are central for cohealth because those who access our services often experience the poorest health outcomes due to the complexity of their health and wellbeing needs. They experience significant difficulties accessing complex systems, and are often marginalized from mainstream settings that are poorly geared to responding to the circumstances that add to their vulnerability.

cohealth invests extensively in building relationships with these individuals and groups, by seeking to better understand their needs and working with them to co-design programmatic, organisational and system responses that better respond to those needs.

It is within this organisational context that we respond to a selection of the Consultation's response criteria, being those that are most relevant to our experience and the experience of people who access our services.

## 2.1 Whether unmet demand for residential and home care places has been reduced

*Refer to Section 4(2)(a) in the Act*

In this context, unmet demand means:

- a person who needs aged care services is unable to access the service they are eligible for e.g. a person with an Aged Care Assessment Team / Service (ACAT or ACAS ) approval for residential care is unable to find an available place; or
- a person who needs home care services is able to access care, but not the level of care they need e.g. the person is eligible for a level 4 package but can only access a level 2 package.

No comment.

## 2.2 Whether the number and mix of places for residential care and home care should continue to be controlled

*Refer to Section 4(2)(b) in the Act*

In this context:

- the number and mix of packages and places refers to the number and location of residential aged care places and the number and level of home care packages allocated by Government ; and
- controlled means the process by which the government sets the number of residential care places or home care packages available.

No comment.

## 2.3 Whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model

*Refer to Section 4(2)(c) in the Act*

In this context:

- a supply driven model refers to the current system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages;
- a consumer demand driven model refers to a model where once a consumer is assessed as needing care, they will receive appropriate funding, and can choose services from a provider of their choice and also choose how, where and what services will be delivered.

2.3.1 cohealth is committed to consumer-driven models of care, underpinned by a co-design approach that enables staff and consumers (or other service users) to design, construct and deliver services, products, programs, places, spaces and care pathways, together in partnership.

2.3.2 Central to cohealth's co-design approach are strategies to empower consumers to exercise choice and control in relation to the types of services received, how they are designed and delivered, and who delivers them.

2.3.3 cohealth welcomes and strongly supports the intent of the *Aged Care Roadmap* to promote consumer choice, but retains concerns that many aspects of the current system design inhibit consumer choice and control, especially for the vulnerable and marginalised communities with whom cohealth works.

2.3.4 The current model assumes a level of individual agency - language and other literacy skills, ability to navigate complex systems, understanding of available options, and capacity to self-advocate that is often compromised within cohealth's consumer base.

2.3.5 Resources to support individuals' access and system navigation are very limited or non-existent, except in limited circumstances, and many elements of system design inhibit organisational attempts to support vulnerable consumers' engagement with it.

2.3.6 A consumer-demand driven model and a consumer-directed care model are not interchangeable concepts. Consumers do not identify their support needs according to funding streams or assessment processes.

2.3.7 cohealth operates within a social model of health and engages with its consumers to provide goal-directed care plans designed to deliver wrap around, integrated models of care that facilitate care coordination and aim to dissolve funding and programmatic silos.

2.3.8 cohealth's approach is built around often long-standing relationships with consumers, particularly those with multiple and complex needs. These relationships frequently involve face-to-face engagement, relationships of trust, and coordination of care involving multiple providers.

2.3.9 The current model inhibits goal-directed care planning in a number of ways:

- Business processes are highly linear, formulaic, transactional and narrow in scope;
- There is limited time, opportunity and resources to facilitate care planning at a provider level, or to connect the delivery of specific service to a person's;
- Privacy constraints limit collaboration between services and sectors and disrupt well-established referral protocols that enable warm referrals and follow-up to ensure access barriers for vulnerable client are addressed and overcome;
- The MAC system does not integrate with the multitude of other client management systems operating across cohealth, including those also operating at a national level (PCEHR, NDIS, carer gateway);

- The MAC system's assessment and referral process requirements are lengthy, onerous and complicated, and inhibit opportunistic engagement to address urgent presenting need, or to facilitate timely referral to local services (such as a PAG for example);
- Although the RAS/ACAS complete a comprehensive assessment that could form the basis of a client-centred goal directed care plan, the service provider only receives a referral plan creating a disconnect in available information that needs to be duplicated or is otherwise lost from the goal directed care planning process.

2.3.10 cohealth recommends system improvements to facilitate consumer goal-directed care planning including through more transparent and simplified referral processes, MAC portal access, and information sharing.

2.3.11 cohealth recommends that comprehensive assessment information be made available to the service provider subject to all of the usual confidentiality and privacy provisions, to support the development goal directed care plans and enable consumer choice and control.

2.3.12 cohealth recommends improved system supports for vulnerable, marginalised and disadvantaged older people with multiple and complex needs to facilitate their system access and capacity to exercise choice and control.

2.3.13 cohealth recommends a more nuanced approach to MAC assessment and referral to facilitate opportunistic engagement with presenting need and more streamlined referral to and engagement with lower level supports.

## 2.4 The effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services

*Refer to Section 4(2)(d) in the Act*

In this context:

- means testing arrangements means the assessment process where:
  - the capacity of a person to contribute to their care or accommodation is assessed (their assessable income and assets are determined); and
  - the contribution that they should make to their care or accommodation is decided (their means or income tested care fee, and any accommodation payment or contribution is determined).

No comment.

## 2.5 The effectiveness of arrangements for regulating prices for aged care accommodation

*Refer to Section 4(2)(e) in the Act*

In this context:

- regulating prices for aged care accommodation means the legislation that controls how a residential aged care provider advertises their accommodation prices.

No comment.

## 2.6 The effectiveness of arrangements for protecting equity of access to aged care services for different population groups

*Refer to Section 4(2)(f) in the Act*

In this context equity of access means that regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need.

In this context different population groups could include:

- people from Aboriginal and/or Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations);
- parents separated from their children by forced adoption or removal; and / or
- people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities.

2.6.1 cohealth prioritises access and focuses its attention on people who experience the poorest health and wellbeing, typically those who also experience a range of barriers to accessing health services and systems. Health in this context means understanding the whole person, their environment and their social and economic relationships.

2.6.2 Priority groups and communities targeted by cohealth include people with disability and carers; Aboriginal and Torres Strait Islander peoples; people from culturally and linguistically diverse backgrounds including refugees and asylum seekers; families and young people at risk; older people with complex needs; GLBTI people; women experiencing family violence; and people with histories of chronic disease, mental illness, homelessness, alcohol and drug use, incarceration, and poverty.

2.6.3 Equity of access for these groups has always been a concern and remains so. By their very nature, these groups experience a range of access barriers. They are frequently marginalised from mainstream service settings, have lower education and literacy levels, low English proficiency, and lower uptake of technology and web-based platforms.

2.6.4 CALD and ATSI groups have historically been under-represented in HACC services. Organisations like cohealth have invested significantly to improve access for these groups through a range of mechanisms supporting culturally responsive practice, engaging people and communities where they are, ensuring capacity to opportunistically engage when people present, and on ensuring 'wrap-around', 'one-stop', 'no-wrong-door' approaches to service delivery.

2.6.5 cohealth is concerned that many aspects of the MAC service system create barriers for significant sections of the community who have a limited understanding of the health and aged care system, and the changes occurring within them.

2.6.6 The MAC portal creates an immediate barrier for many people as a web-based platform, only available in English. Many consumers are unclear about the changed access arrangements and report being frustrated having to engage with a system they find confusing and ambiguous.

2.6.7 MAC assessment and referral systems are detailed, multi-faceted and onerous. For consumers with low English proficiency; complex needs; backgrounds of trauma; cognitive and auditory disabilities and

memory impairment, the registration and assessment process undertaken by phone and with strangers, can be particularly challenging.

2.6.8 Based on previous experience, cohealth anticipates a proportion will choose to opt out of the new system and instead rely on family and other supports until they reach crisis point.

2.6.9 Delayed engagement with the system until crisis point will have a number of flow-on effects. For individuals it will mean lesser capacity to plan for active ageing and ageing in place. Lesser focus on early intervention and preventative measures will mean people will be more likely to present at emergency departments and require residential aged care earlier than they might otherwise have required, with all of the quality of life and increased system costs these outcomes deliver.

2.6.10 cohealth has established systems to encourage and support people with their initial MAC registration but is unable to ensure necessary supports, including interpreters, are available at subsequent RAS assessments, which cannot be scheduled. Referrals into the system cannot be tracked to ensure their success, or to ensure services are integrated with other care and supports the person may be receiving.

2.6.11 Services such as cohealth have limited resources, and few provided through the MAC systems itself, to support its diverse and vulnerable client base to engage with the new system and its multiple gatekeeping points, each involving a different agency that consumers frequently fail to differentiate.

2.6.12 cohealth is concerned that these detailed and onerous RAS assessments are frequently undertaken by staff lacking in clinical skills, and result in referrals that undermine clinicians specialist skills.

2.6.13 Where a consumer is known to a provider and care is being provided in the context of an integrated consumer-directed care plan, the MAC system should support the continuation of this plan and facilitate the consumer-clinician relationship throughout the assessment and referral process.

2.6.14 cohealth is a provider of the Assistance with Care and Housing for the Aged program (ACHA) specifically targeting older people experiencing homelessness and insecure housing. ACHA enables assertive outreach and coordination of supports to ensure this at-risk cohort is able to engage with the aged care system and access the services and supports to which they are entitled.

2.6.15 cohealth also has two part-time Access and Support staff offering ethno-specific support to communities. Similar to the ACHA role, these support staff provide a crucial bridge between members of CALD and ATSI communities and the aged care system. Limited to geographic catchments not recognised by communities, these roles are in high demand and have become pivotal in facilitator peoples' registration into the system.

2.6.16 The allocation of Access and Support staff to particular communities appears arbitrary. In cohealth's case, it's workers support Aboriginal and Chinese communities, in an organisational catchment with ageing communities across 85 language groups. Access and Support staff allocations were not reviewed as part of the most recent growth funding round.

2.6.17 cohealth recommends a number of system changes to improve access and equity for vulnerable groups including:

- expansion of ACHA functions to generalist roles supporting other cohorts access to the aged care registration and assessment system;
- review of Access and Support staff funding allocations to ensure their availability matches current demographic distributions of CALD and ATSI groups, as well as projected growth in different locations;
- increased emphasis on face-to-face assessment at pre-determined times that facilitate supported and/or joint assessments by providers known to and trusted by the consumer, and draw upon provider clinical expertise; and
- increased utilisation of interpreters and translated materials to support all CALD engagement with the MAC system as required.

## 2.7 The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers

*Refer to Section 4(2)(g) in the Act*

In this context aged care workers could include:

- paid direct-care workers including: nurses  personal care or community care workers; and allied health professionals such as physiotherapists and occupational therapists; and
- paid non-direct care workers including: managers who work in administration or ancillary workers who provide catering, cleaning, laundry maintenance and gardening.

2.7.1 As expressed in the previous section, cohealth is concerned that the primary means of assessing consumers' eligibility for various services, and making referrals initially occurs via a phone screening assessment. The MAC screeningassessor does not know the person, and supports are not provided to the person to help them understand the process or the range of options available to them.

2.7.2 These systemic limitations are further compounded by limitations within the screening phone assessor's knowledge or skill set – including limited use of interpreters when required, reported low cultural competence, and lack of knowledge or consideration of the person's other health and wellbeing needs or current supports. Although we understand improvements in this arena have taken place during the MAC implementation period, we continue to have concerns for the most vulnerable and least capable clients.

2.7.3 Whilst the assessment of need and eligibility for people with more complex care requirements are streamed towards ACAT/ACAS teams, it is still the case that RAS teams are screening for and making clinical assessments about people's allied health needs. The RAS teams are missing critical referrals in this process particularly for people with chronic disease. Early intervention in chronic disease is critical in assisting people to manage their health condition more successfully and for longer.

2.7.4 cohealth is concerned that these RAS assessments and referrals have the potential to de-professionalise the role of skilled clinicians who should be more centrally involved in working with individuals to determine their most appropriate course of care.

2.7.5 As outlined in the earlier section, cohealth recommends system changes to enable the more central involvement of clinicians already involved in a person's care with assessment, goal-directed care planning, and review processes to ensure system and service quality is maintained, continuity of care, and enhanced capacity for integrated care.

## 2.8 The effectiveness of arrangements for protecting refundable deposits and accommodation bonds

*Refer to Section 4(2)(h) in the Act*

In this context:

- arrangements for protecting refundable deposits and accommodation bonds means the operation of the Aged Care Accommodation Bond Guarantee Scheme .

No comment.

## 2.9 The effectiveness of arrangements for facilitating access to aged care services

*Refer to Section 4(2)(i) in the Act*

In this context access to aged care services means:

- how aged care information is accessed; and
- how consumers access aged care services through the aged care assessment process .

2.9.1 As has been detailed elsewhere in this submission, consumers report the new aged care registration and assessment process to be complex and onerous.

2.9.2 cohealth held a focus group discussion with its consumer advisory groups in June 2016 about MAC and aged care reforms. Comments and themes are reported in section 3 below. Overall, consumers report finding the process confusing, burdensome and frustrating. They report:

- inability to differentiate between stages of the process;
- repetition in providing their details to multiple strangers;
- poor understanding about why they cannot simply book an appointment with somebody at the front counter of the service they have always attended or have been directed to be another community member;
- added complexity in accessing simple services;
- poor communication about next stages in the process; and
- occasional anger at being contacted about services they have not requested or do not want.

2.9.3 It is understood that the aged care system was primarily designed to facilitate choice for people entering residential aged care and their capacity to compare costs across various providers. The later addition of non-residential services, including access to allied health and other stand-alone programs such as ACHA, raise questions about the system's fitness for these wider purposes. cohealth works to ensure timely access to appointments and where needed a coordinated approach to chronic disease particularly for vulnerable community groups. At present the aged care system has not been designed to provide this level of access or service response.

2.9.4 Information provided by the Commonwealth about the new service has been in generally short supply. Although limited resources (posters, magnets) were initially available, these supplies disappeared very quickly with high demand, and later supplies were rationed. All materials were only available in English.

2.9.5 cohealth has produced materials at its own expense to support consumers' understanding of the new system. Resources have been produced in English, Arabic, Greek, Italian, Mandarin, Persian, Somali, and Vietnamese consistent with the main language groups in cohealth's catchment.

2.9.6 The provision of a 1800 number to initiate registration with MAC assumes capacity that may not exist within marginalised, vulnerable and disadvantaged communities. cohealth's commitment to encouraging and facilitating people's initial registration carries a number of implications.

2.9.7 The addition of a web form for practitioners was a welcome later addition, and in the context of a service seeking to promote integrated care planning, provides a useful tool to support some aspects of that approach.

2.9.8 The transition to MAC is a significant service system change. Other such changes have frequently involved a period of transition and additional resourcing to support the transition. In this instance transition has been decided at late notice i.e. CHSP referrals direct from other health professionals and limited resources have been provided. cohealth has internally resourced a HACC -> CHSP transition project. This approach would be beyond many other organisations.

2.9.9 The resources required to support registration are not available as part of transition arrangements and therefore become absorbed costs for the agency. These resources include allocation of appropriately trained staff time as well as physical spaces and ICT infrastructure conducive to the registration process.

2.9.10 Where a client consents to or requests cohealth support to participate in the RAS assessment process, the inability to schedule the follow-up phone call or to provide necessary consents means it is impossible to facilitate that support.

2.9.11 With call-backs being scheduled at the convenience of the RAS call centre team, rather than the person, consumers report being ill-prepared at the time of the call, especially given the length and depth of the assessment, and this model is further complicated for people who are homeless and itinerant, insecurely housed, and accessing outreach services such as ACHA. Messages are not left and if people are not available on two occasions they drop out of the system.

2.9.12 Rather than simplifying and streamlining consumer access, the assessment process is often more complex for simple referral requests than it needs to be (for example a person who wishes to attend the same PAG group as a peer), and prevents opportunistic engagement with consumers at the point they request a service – a significant system limitation when working with groups of people frequently regarded as difficult to engage.

2.9.13 As discussed elsewhere, there is poor visibility within the system once a referral is made, as to where the referral goes, and whether it is fulfilled. Under the previous system in Victoria, significant investment was made for well over a decade to develop sophisticated referral protocols through Primary Care Partnership Service Coordination and Active Service Model initiatives. These arrangements included confirmation of referral receipt; whether the referral had been accepted or refused and whether a service was in place; and notification of service closure. Poor system visibility inhibits effective care planning and integration across programs and systems.

2.9.14 cohealth recommends that these well-developed system improvements be retained through increased system visibility and communication within the MAC user interface, subject all of the usual client privacy and confidentiality requirements.

2.9.15 Integrated care planning is further inhibited by the MAC system's incompatibility with GP, state-funded and Commonwealth program client management systems. Interoperability issues add to clinician resource constraints, inaccuracies in double handled transcriptions, and lost time as information is manually added into multiple systems. Poor integration with financial systems further adds to organisational absorbed costs.

2.9.16 Concern has been expressed that once a referral has been made by the RAS to a local service provider where there is limited capacity to deliver a service, that consumers may sit on a waiting list for extended periods of time. It is not clear in these instances, or where a person is unhappy with a referral or service supplied, what process exists to support a referral to an alternative.

2.9.17 cohealth welcomes the temporary arrangements allowing internal agency referrals without the need to refer people back to the RAS for a new assessment and referral. Currently due to expire in mid-2017, cohealth recommends that this arrangement be extended, and consistent with other recommendations, be expanded to enable clinicians to more actively assess and refer clients delivering streamlined, simpler and more timely response to need.

# 3. Other comments

In June 2016, cohealth held a focus group discussion with cohealth consumer advisory committee members. Key themes emerging from the discussion included:

- A strong reaction of surprise to HACC changes - there was no awareness that changes are coming.
- Participants felt the changes would create barriers, obstacles and an increased reliance on carers and support people.
- The role of the carer, advocate or intermediary received a lot of attention throughout the session. Attention was directed to those who have different levels of support (family, carers, service provider), and competence (language, Internet access/skill, confidence-agency, disabilities) and how the changes add another level of complexity.
- The benefits of centrally stored and client accessible health records and the increased ability to shop around for services was not strongly valued or recognised as a significant advantage.
- There was a high degree of scepticism about the changes, thinking the system would be bad (worse than now), and that their needs would not be met.
- Participants felt the changes were about cost cutting and looking at people as a number. They were surprised that there had been no advertisements or other PR to alert older and vulnerable service users and expressed a lot of fear and disappointment with MAC portal and 1800 number.
- Difficult for many users to understand the different roles of cohealth and MAC.
- 'Empathy mapping' of the older person included references to fear, confusion, loss, loneliness, isolation, frustration, complexity, fear of change, fear about language comprehension, expectation that a support person is involved, preference for the human (face to face) touch.
- Additional support for those seeking services, including warm 'assisted' referrals may be necessary for a proportion of the traditional cohealth /community health client cohort. Participants preferred to be able to attend cohealth where they will be able to see people face to face, with an interpreter, and who will help to alleviate their concerns, fear, anger, frustration of talking or working with people on the computer or via the phone.
- Participants expected that cohealth will advocate on their behalf as carers and users to access better services. They were concerned that this capacity would be lost in the future.
- Participants were interested to take a leadership role in helping to promote the changes to others within their networks. They recognised that others would benefit from more information.

Among the ideas and recommendations proposed by the group:

- Age-related triggers for MAC registration;
- Ensure authentication procedures for support person are clear and easy, and that support people are included at every step;
- More guidance for older people on what path to take in certain circumstances (GP, hospital, MAC, 000) to alleviate confusion;
- Support to ensure customer service and community engagement staff have good knowledge of the system and can provide necessary supports to consumers;
- Recognising that proximity builds trust and confidence, and knowing what to expect before calling also builds confidence;
- Ensure availability of interpreters for 1800 and RAS, including language auto-detect software;
- Increased marketing and promotion, particularly in accessible forms for CALD and people with a disability.