COTA AUSTRALIA RESPONSE TO AGED CARE ROYAL COMMISSION HOME CARE HEARING 31 AUGUST – 4 SEPTEMBER 2020

DRAFT PROPOSITIONS

Proposition HC1. More care at home to meet the preferences of older people wanting to age in place (transition proposition)

COTA Australia **fully supports** this proposition, particularly:

- immediate allocation of home care packages and new entrants waiting no longer than 30 days once assessed
- allowing access to the Commonwealth Home Support Programme for people using a home care package for social support services (group and individual), centre-based respite services, transport services and meals during the 3-year transition to an integrated Care at Home combined program.

COTA Australia **recommends** that the Aged Care Royal Commission (ACRC) stipulate a time frame for the full and complete implementation of an unrationed, demand-driven home support and care program. We submit it should be no more than 3 years.

Proposition HC2. More funding for care at home to meet assessed needs

COTA Australia **supports** part of this proposition and **does not support** other parts, as detailed below.

We support the overall direction proposed. That is development of the four separate funding categories outlined: social support, enabling care, respite care and care at home. Further we support the proposal that under 'care at home' the assessment will allocate service hours of care into further categories with the Assessor to determine a quantum of hours for the consumer to identify how to use those hours within the allocated category. We note that Government will develop a price schedule of hourly rates within those assessed hours of care.

However, we propose three variations to the detail of where how the model might operate:

1. We believe that '**care management**' should be a fifth top level of allocated funding and should not be subsumed underneath the 'care at home' category. Such a category is necessary to ensure that consumers have the structural support and ability to be independent of their service provider and be allocated hours, or quantum of funding for this based on a specific assessment for this service:
    - We note that need for 'care management' exists for services delivered in categories other than 'care at home' in particular for some consumers to implement services from enabling care and respite care.
    - We submit that the function of 'Care management' (which is traditionally referred to as 'case management') is different to 'care **coordination**' (where activities such as staff rostering should be accommodated within the administrative costs of delivering that

service). Care Managers may also be referred to as facilitators, 'concierges', or customer service staff.

- Further we note 'care management' provides similar functions to elements of the ACRC's envisaged 'care finder' functions and we submit there are benefits for consumers (particularly for vulnerable clients) that one organisation/staff member can provide their early care finding needs and follow through to supporting them to independently implement services to meet their care needs with their provider.
- We submit that 'care management' should be a separately funded activity but recognise some consumers may choose to bundle these services to the same organisation which delivers their service. However, the system should not be designed to structurally prevents 'care management' being independence, that should be the consumer choice. Accordingly, 'care management' should be separate to the 'care at home' allocation.
- The reason it is critical that the 'care management' service is independent of providers and part of a broad and holistic service delivery approach that enables consumer access and choice, is that there is a significant power imbalance between consumers and providers. This will continue to exist even if all the ACRC recommendations are implemented. It is intrinsic the consumer situation. Current provider culture is either that "they know best" and the consumer should have to follow that; or that they have services they can provide, whether or not the consumer needs and wants them, and that's what they will prescribe. That has been a consumer compliant for decades. This is not to say that consumers will not benefit from professional advice on services to meet their needs. They will. But that advice needs to not be conflicted by loyalty to a provider. It must be guided by the consumer's best interests. This very closely parallels the problem of conflicts of interest in the provision of financial advice to which the Financial Services royal Commission gave significant attention.

2. We believe that '**personal care'** should be included with the 'living supports' subcategory and not with 'clinical, enabling and therapeutic care'.
    - Grouping all activities that support daily living provides the consumer with more control and flexibility in achieving daily living goals. Consumers need some autonomy to choose how they are supported in their activities of daily living and it is feasible that the same worker would deliver a range of supports. For example, a consumer may want their worker to provide support with showering, preparing a meal and vacuuming the house in one visit. The next visit they may want a different combination of some of those and other tasks because of their needs that day. Splitting domestic assistance and personal care into different "streams" creates additional and unnecessary complexity for the consumer. Additionally, having different workers increases the likelihood of these interactions becoming transactions rather than building a care relationship, and increases other risks. Further, we believe there is benefit for workers, which can provide greater job satisfaction and job security. We see many examples of service providers delivering service with the same workers across domestic assistance and personal care for continuity and better consumer outcomes. These providers have higher levels of worker satisfaction as they have been able to guarantee hours of employment and either train workers to Certificate III or IV qualification or attract workers with this level of qualifications.

3. While supportive of the general move towards 'care at home' allocation by hours, we note that some flexible funding (i.e. money allocated for consumer usage) should be permitted as part of the consumer package. Such examples may include provision of taxis or Ubers where other transport services are not available to secure transportation

Further to the propositions we **recommend** that Home Care design allow for a consumer to choose multiple providers each of which is responsible for the quality of their own service delivery (i.e. no requirement for one approved provider over the top being effectively responsible for the others).

COTA is **concerned** by the proposal that assessments identify when a person is no longer safe at home, even if they receive the maximum care available under the program. The implications of this proposal need to be fully canvassed and explored. In this circumstance, does the consumer have the choice to remain at home? How is safety determined? How are the choices and decision-making capacity of the consumer incorporated in the process? How are the civil and human rights of the consumer protected and enabled? What would be a right of review and appeal?

Proposition HC3. Changes to consumer directed care

COTA Australia **is very concerned by the** lack of detail in this really important proposition and believes further information and discussion is required to develop a full understanding and assessment of what Counsel is proposing here and whether with further development we could support this overall direction, or whether we would oppose it, as we need to express in regard to some apparent key elements of this proposition, as discussed below.

COTA **strenuously opposes** the element of this proposition that we take to mean the removal of 'self-management' as a valid option for a consumer to choose in the new care at home world.

- We draw attention to COTA Australia's "Increasing Self-Management in Home Care 'Responsibilities Checklist" on pages 32-39 of the Provider's Implementation Guide (COT.1111.1111.0021). This approach considers both care and administrative functions and provides for identification of which functions will be 'managed by the consumer', 'managed in a shared fashion between consumer and provider' or 'managed by the provider'. Should a consumer manage any function or share in the management of any item, COTA submits that this is a form of 'self-management' that should be encouraged by the Royal Commission.
- We note that most older Australians today receive 'provider managed' care, without consumer choice, notwithstanding the official policy of consumer directed care. For them a shift to 'shared management' would be an improvement, if it was genuine. We note that the power imbalance is such that real sharing is problematic in many contexts, especially as there are no robust current mechanisms for addressing where this does not occur.
- We recognise that this is a one-line statement with no detail defining self-management or shared management (or mention of provider managed) or the process of assessing need. However, taken at face value this proposition would be a step backwards, disempowering aged care consumers, creating greater dependency and lack of choice and control, which consumers have sort to achieve for decades.
- This proposal or statement implies that consumers do not have the capacity to make valid, sound, autonomous decisions about their care needs. It alters the power balance of decision making and care planning, disempowering consumers. The Home Care provider should enable, inform and support the consumer's care decisions and actions. The notion of 'shared 'care management endorses the probability of paternalistic control by providers.
- We note that the cognitive profile of consumers who require support and care at home is widely diverse and very different to the profile in residential care where greater support from providers is generally required.

- COTA is deeply **concerned** about the recent decrease in the number of home care providers indicating they do not offer self-management, which we believe is an indication of their inability to change their culture from a 'command and control' to a 'customer services and human rights' based service. The Royal Commission has regularly highlighted the need for culture change in aged care services. We submit that requiring there be self-management options will lead to a greater 'customer service' focus and the process of collaborating with consumers about their care, improve quality of life outcomes for consumers.
- There is increasing evidence that self-management is effective and achieves optimal outcomes for consumers. Whilst self-management can work well in residential care, it should be the guiding framework for Home Care. Where professionals collaborate with consumers, enabling and informing them to make their own care decisions, then the best outcomes are achieved.
- As presented in our submission to the ACRC on aged care design, the role of case managers (care finders), independent of providers is critical to a successful home care service. Consumers who self-manage will receive optimal outcomes when a customer-centric collaborator is 'on their side' and is not conflicted by provider preference. It will ensure that competitive market forces that have led to poor provider practice do not occur in the future.

As discussed above whilst we support consumer choice regarding how annual hours of care are used, COTA **recommends** that Home Care should have the flexibility to enable services that are not based on service hours but the use of some funds to solve individual needs. For example, not all transport can be delivered from the social support funded service providers, and at times that option costs far more than readily available alternatives. For example, in some circumstances, clients will need a taxi to get to important medical appointments.

COTA agrees that Home Care funding should be used for aged care purposes only, but we note that the proposition has not defined "aged care purposes".

- We **recommend** the ACRC develop a stronger understanding of this principle and develop solutions to mitigate when this does not occur.
- We note that the Department of Health's "Operational Manual" for Home Care Packages dated March 2020 contains a list of Inclusions and Exclusions of categories of items that can or cannot be funded from an HCP. It would be helpful for the ACRC to clarify if this is what it is referring to , or if it proposes changes to those Inclusions and Exclusions? The Manual is (available at: https://www.health.gov.au/sites/default/files/documents/2020/03/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.pdf).
- COTA **strongly recommends** that that the definition of 'aged care' purpose must include provisions to support mental health and wellbeing.
- COTA also **strongly recommends** that atypical solutions that work for individual consumers must be permitted within guidelines for meeting aged care purposes (e.g. funding a first language subscription service for a socially isolated CALD pensioner).
- A human rights-based approach to aged care must mean that consumers have the right to make choices in home care about who and how care is delivered. Unfortunately, a human rights approach and principles has not guided the development or operations of the Home Care program to date.

Proposition HC4. Pricing that accounts for the administration activities of home care providers

COTA Australia **supports** this proposition.

We strongly support the inclusion of administrative activities into unit pricing.

We recommend that the costs associated with workers rostering and resources, often referred to as 'care coordination', should be included as the fifth element of administrative activities in this proposition. Such costs should be clearly identified as NOT a cost or function of care/case management.

Proposition HC5. Responsibility for co-ordination of care in the new program

COTA Australia **does not support** this proposition as it is currently written.

As previously stated, Case/Care management must be independent from providers and have a broader aged care system role than Care at Home services. The role engages, advises and supports consumers to make informed decisions about their care, including their choice of providers, types of services and care setting. We support the view that coordination of care is a distinct responsibility, but it must be independent and part of design of the broader aged care system.

We recognise that, currently, many consumers choose to receive their services from one provider. However others do not. Some who only have one provider would prefer to be able to have choice and flexibility, but their provider will not agree to this. It is fundamentally important that consumers have the capacity to determine the services they receive, have a range of services to choose from, and are not unduly influenced or compelled to receive their care from only one provider. In a future transformed system that is demand driven and not rationed, consumers should have more choices in developing their care plan and options. Independent case/care managers will support this. Consumers should also be able to make decisions about the retention of their case/care manager once they are receiving care from a provider or providers.

Consumers constantly report to us their belief that, in the current system, care coordinators recommend services that are in the interest of their employer and not them. The inherent conflict of interest, demonstrated in current practices, when a case coordinator is employed by a provider, cannot be resolved. This includes where the case coordinator 'commissions' or 'contracts' or 'purchases' the services from a pre-set list of subcontractors due to the current legal obligations that 'approved providers' who hold package funds must verify the quality of their subcontractors.

We also note the qualification of 'case manager' could be added to the recognised relevant qualifications or experience. The ACRC may wish to discuss this further with the Case Management Society Of Australia & New Zealand & Affiliates (CMSA) who provide qualifications and certifications of case managers today https://www.cmsa.org.au/certification/apply-now-to-be-certified

Proposition HC6. Transition to the new program

Proposition HC6(a) A suitably trained and skilled workforce

COTA Australia **supports** this proposition.

We **recommend** the ACRC, in the development of workforce proposals:

- consult with and be advised by workforce specialists to determine whether unqualified or differently qualified workers can be employed whilst obtaining the Certificate IV qualification, under supervision of an appropriately qualified person, as part of a transition arrangement. This may be a way to address current worker shortages.
- ensures that migration pathways to source workers are not adversely impacted by the requirement for a Certificate IV qualification. Increased migration numbers targeted for Aged Care may require pathways to qualification to be included in order to attract the necessary number of workers.
- seeks the harmonisation of competencies, skills and qualifications across both the aged care and disability systems to maximise employment opportunities. Consideration of a joint 'disability and aged care' qualification (with relevant specialities) should be considered.
- be aware that some services provided as part of home care (e.g. a handyman engaged to make an outdoors area safe for a consumer) do not require workers to have a Certificate IV minimum qualification.

Proposition HC6(b) Suitable employment and engagement arrangements for home care workers

COTA Australia **does not support** this proposition as written.

Aged Care consumers must be able to access local, personalised, remunerated support people who may not provide services to anyone other than that individual, just like under the NDIS Quality and Safety Framework. We support the registration of home care workers and requirements for all approved providers to use registered workers, but this does not have to be at the expense of curtailing consumer service choices outside this registered system.

We **recommend** that, in the development of proposals for home care worker employment and engagement arrangements, the ACRC:

- incorporate 'single service' organisations who provide low risk services and can operate across multiple systems (e.g. cleaning company which works for disability, aged care and private businesses). This may be an innovative solution to addressing workforce shortages. Health care services, such as nursing and palliative care, are regulated by their AHPRA qualifications and may be more appropriately regulated for aged care.
- fully investigate the NDIS Quality and Safety Framework as a mode for worker registration in aged care. (See https://www.ndiscommission.gov.au/participants/national-approach-safety-and-quality). This would inform the development of aged care worker registration that includes:
    - a process of registering all providers but incorporating the right of consumers to use unregistered providers.

- compliance with a Code of Conduct for both registered and unregistered providers. (See https://www.ndiscommission.gov.au/providers/ndis-code-conduct). This is in addition to Standards that only registered providers comply with.
- development of a worker screening database linked to registration for both aged care and disability services. Providers need to make sure that all workers are not on this database. Consumers can request workers have a screening check to ensure compliance. The database should clearly demonstrate evidence of their qualifications (e.g. manual handling, Cert IV etc). National worker screening would occur in all jurisdictions with workers required to have consistent checks over time. Once screened, checked and registered, workers can be employed by both Aged Care and Disability.
- a complaints mechanism being established that provides enough protection for a consumer, where they provide informed consent to opt-out of the more robust quality accreditation standards. Complaints about unregistered providers can still be made to the Aged Care Quality and Safety Commission.
- further information about worker screening for self-managed consumers, see (https://www.ndiscommission.gov.au/participants/worker-screening-self-managed-participants) and unregistered provider, see (https://www.ndiscommission.gov.au/providers/unregistered-providers).

COTA is **concerned** by the proposal that providers should be required to deliver a set percentage of their care hours through the care workers they employ. Whilst understanding and supporting the need for improved worker conditions, particularly reducing casualisation, this proposal does not address workforce issues in remote and regional areas where subcontracting arrangements are necessary due very limited numbers of services being available across large geographical distances. More detail is required to fully articulate how services can be provided to all consumers, regardless of location and circumstances, whilst improving worker conditions. For example, provision of medication management in 15 minute intervals in a retirement village or co-located housing model is often achievable, whereas provision of the same service in non-co-located living arrangements, such as living in your lifetime home, may require 30 minutes minimums.

Proposition HC6(c) Quality regulation

Proposition HC 6(c)(i) Certification prior to delivering services
Proposition HC6(c)(ii) Continuing certification
Proposition HC6(c)(iii) Assessment of home care certification
Proposition HC6(c)(iv) Publication of annual report

COTA Australia **supports** these propositions regarding certification.

We support the provider approval and service approval certification stages, particularly endorsing the proposal that 'service' approval should be given at category of services level. (i.e. a provider who is approved for cleaning, may not be approved for nursing).

We also endorse the timeline for the graduated reporting system to be implemented by 1 July 2022.

We **recommend** that certification include:

- greater clarity on the relationship between service types and the Aged Care Quality Standards to enable the appropriate level of regulations to apply to the risk profile of services. Low risk services (which should face lower levels of regulatory burden) may attract a broader pool of workers.
- Increased recognition, understanding and response to consumer experience. A feature missing from the envisaged design is not merely aggregated consumer experience reports to the regulator, but publicly available consumer reviews to inform older people making service decisions. The issues of information about Consumer Experience, Reviews and Quality of Life was more fulsomely discussed in our research https://www.cota.org.au/publication/project-report-measuring-quality-and-consumer-choice-in-aged-care/
- organisational annual reports, informing the graduated reporting system, include 'quality of life' indices related to outcomes and not simply quality of care metrics. This could be implemented in Stage 2 of the implementation timeframe.
- organisational annual reports, informing the graduated reporting system, provide a clear consistent measure of the proportion of funds received for aged care, that have been used to deliver "direct services" in aged care. Where an entity's annual report covers multiple 'approved providers' then the individual approved provider's proportion of direct care funding must be reported individually. Mere inclusion of profit and loss statements will not provide this level of transparency. Nor will it ensure equitable comparisons between organisations of a different structure (e.g. Not for Profit vs Publicly listed private providers, single legal entities with multiple Aged Care providers vs single Aged Care providers)

Proposition HC6(d) Safeguards for older people receiving home care services

COTA Australia **partly supports** this proposition.

The compulsory recognition of "advocacy organisations" must go beyond the regulator. It must include the Assessors, care finders, My Aged Care and providers. Current regulations of aged care too easily permit these services to ignore the involvement of a consumers' chosen advocate.

We **recommend** that a legislative mandate be included for 'care finders' to ensure their recognition by the future functions currently performed by My Aged Care, Assessors and Service Providers.

We are supportive of the principle of the proposition but argue for more information and detail.

Proposition HC6(e) Systemic indicators of health and well-being

COTA Australia **supports** this proposition.

We strongly endorse Quality of Life indicators at the system level, however as discussed above note that such a measure should also be adopted at the operational and individual provider level.

We **recommend** that the ACRC should mandate the automatic and continuous reporting of the underlying data that devises health and wellbeing metrics, to ensure real time understanding of the system and individual providers at a given time.

Proposition HC6(f). System management and coverage

COTA **seeks further clarity** about this proposition.

It is not clear what is meant by the words "providers capable of providing the full range of home care services".

Does it mean to imply that only 'one-stop-shop' providers that deliver all services should be included in the market in the future, or does the ACRC intend it to mean that the mix and profile of a variety of providers (either single service or multi-service) available in the system delivers the full range of services?

We recommend that this statement should be consistent with market analysis, investment and development capability in the provision of the mix and profile of a variety of providers (either single service or multi-service) that delivers the full range of services.

Proposition HC7. Duty on home care providers to provide high quality and safe care

COTA Australia **supports** this proposition.

However, as discussed above, we argue that provision should be made to allow consumers to engage specialists, or multiple providers directly (with or without the support of their care/case manager). Providers should only be responsible for the care they deliver. In the current system, the number of subcontractors available to consumers is restricted by providers.

Proposition HC8. Carers Leave

COTA Australia **supports** this proposition to enable work-place entitlements to care arrangements.

Proposition HC9. Minimum staff contact time for home care

COTA Australia **supports** this proposition.

We **recommend** that the proposition should be modified to include the needs and environmental setting of the care delivery. For example, a 15-minute medication dispensing or check, in a co-located environment such as a retirement village, may be appropriate (given the likelihood of similar service delivery in the same location). This compares with minimum staff contact time for a consumer living in their own home in the community which should be a 30-minute minimum.

Proposition HC10. An enablement approach to care in the home and community

COTA Australia **supports** this proposition. However, we believe it should be a much higher priority in the redesign of aged care than is implied by it being the last proposition. As has been demonstrated where this approach has been fully trialled it has had a major positive impact for both consumers and for the efficiency and effectiveness of the system.

We **recommend** that an enablement approach to care in the home and community should be a **required** initial step in the assessment process, and should include:

- a strong focus on self-management, empowering consumers to make informed decisions about their support and care and to be as involved as possible in managing that support
- requirements on care/case managers/finders to incorporate enablement in their practice as a first principle of their approach.