St. Laurence

Helping People Help Themselves

30 July 2010

Caring for Older Australians Inquiry
Productivity Commission
GPO Box 1428
CANBERRA ACT 2601

Dear Commissioner Wood and Commissioner Fitzgerald,

SUBMISSION FROM ST LAURENCE COMMUNITY SERVICES INC TO PRODUCTIVITY COMMISSION INQUIRY – CARING FOR OLDER AUSTRALIANS

St Laurence Community Services Inc (herein after referred to as St Laurence) is a not-for-profit, community-based organisation that has been providing care to the Victorian regions of Barwon, South West and the Grampians for over 50 years. St Laurence has Public Benevolent Institution status. It has a workforce of 540 employees of which 260 are employed in delivering residential or in-home services to people whom are ageing and their families.

ST LAURENCE'S AGED AND COMMUNITY CARE SERVICES

St Laurence currently provides 455 Packages of Care across the continuum from Home and Community Care Linkages, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and EACH Dementia. The purpose of these packages is to maintain people in their place of choice for as long as possible.

St Laurence Retirement Village, based at Lara, offers low cost Retirement Living in a rural setting on the outskirts of Geelong. The Park is set on 42 acres of parkland offering security and peace of mind and consists of fully self contained accommodation in 93 units and 22 apartments

The organisation operates a Day Therapy Centre co-located with the Retirement Village and Residential Care facility. St Laurence currently provides 101 Residential beds – Age in Place and anticipates opening a 19 bed purpose built dementia specific wing in November 2010.

St Laurence provides for dementia specific respite in a home environment under National Respite for Carers Program ('NRCP'), supports three community based facilities two coastal and one forest retreat to support transition of care for recipients and their carers to introduce the concept of supported "holidays" or breaks and provides Day Programs for people living with dementia

In 2010 206 volunteers worked alongside the paid workforce to assist St Laurence provide a range of high quality, person-centred services that seek to meet the needs of each person seeking support from the organisation's Aged and Community Care Division. Records indicate that during the 2009-10 period over 1,000 people received some level of support or assistance.

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RESPONSES TO CARING FOR OLDER AUSTRALIAN INQUIRY

There are many interesting questions posed under the terms of reference for the Productivity Inquiry into Aged Care. In this submission St Laurence will seek to provide a perspective on many of them after consultation with staff, families, care recipients and industry peak body workshops.

PACKAGED CARE

Access to Community Packaged Care in Australia is inconsistent. Dependant on which state, region or town you live in, the experience of an assessment through the Aged Care Assessment Service (ACAS) to time spent on a waiting list differs. The ACAS guidelines are loose, requiring interpretation as to how to apply the eligibility criteria for each level of care. The result of an ACAS assessment is entirely dependant on the course of communication undertaken over one and a half hours by an independent assessor (stranger) and the subjective application of the guidelines to allocate entitlement to access care. Major inconsistencies are evident across regions and a gate keeper mentality can be seen. Victoria's e-waitlist system has been the only consistency in the process, allowing ACAS to list potential recipients in an orderly fashion for providers to have equal access to information.

- Inflexibility of numbers of packages based on floored formulae are made available for Community Aged Care Packages('CACPs'), Extended Aged Care at Home ('EACH') and Extended Aged Care at Home Dementia ('EACHD'). One region may have 300 people waiting for a particular package with a 12 month minimum wait alongside a region with no waiting list and unfilled packages. Again this partly reflects the application of the eligibility criteria and the potential for ACAS to gate keep access to waitlists.
- Waiting lists are far too long due to the lack of number of packages in some regions. This can result in a higher percentage of aged care recipients being admitted to hospital and aged care facilities prematurely where they still could be managed at home.
- Wait time for recipients to be allocated a package is causing a huge stress on the recipient/ carer and when a package is allocated, the service provider ends up with a recipient with higher needs than initially assessed and an inadequate level of packaged care than the could have been earlier. Evidence of increasing complexities of care with reduced potential for impact of packaged care on the management of either capacity building or recipient decline when introduced later in the recipient's life journey.
- The Australian community is now about to enter the baby boomer era. Recipients will become more informed about access to service, with increased capacity to provide copayments and hold providers to greater account, demanding their right to service. This may mean that Consumer Directed Care funding will become more popular and this funding will need to be less restrictive and more recipient directed or Baby Boomers may demand access to support and services as their predecessors have enjoyed which would not be sustainable.
- CACPs should be more flexible, perhaps on a funding sliding scale where the higher the needs of the recipients the greater the access to brokerage support allocated to their package based on assessed need. If this was to happen it would reflect a more realistic support of decline in the community and close the gap between a CACPs package and an EACH package. At this point the gap is large and unrealistic.
- Dependant on type of support some low needs recipients may also be prematurely accessing residential care. For example the full cost recovery for Meals on Wheels via HACC leaves very little brokerage on a CACP for critical services e.g. personal care.
- The cost of transport for our rural and isolated recipients to access services outside of main townships is prohibitive limiting access to both baseline and specialist services.

- Minimum shifts have now gone from 15 minutes to 30 minutes and some service providers will not provide direct care under one hour. This is not recipient centred at all. St Laurence reports that recipients feel that most regulations are moving away from facilitating recipient centred care and closer to acquittal of funds.

POTENTIAL SOLUTIONS

- One assessment with seamless transition through age in place, in community and funding allocated based on need.
- Accommodation separated from needs assessment to facilitate care provision in recipient's place of choice.
- Asset assessment exclusive of accommodation to establish capacity for copayment towards care.
- Providers allocated packages across the needs spectrum (CACPs →EACHD) to facilitate continuity of care provision.
- Education packs for people over 65 years to navigate the complete Aged Care service spectrum before they need it.
- A range of service providers to provide diversity and facilitate choice.
- A non competitive tender process allocating all eligible providers Aged Care Provider Status if standards of care can be met.
- A central register of eligible providers
- Funding to follow the individual with choice of provider
- Access to regular respite reduces the risk of carer "burn out" from burden of care increasing longevity of community based care.

CONSUMER DIRECTED CARE

The sector is working towards understanding Consumer Directed Care. The sector is concerned about management of the many risks for which it often stands accountable for as funded services or approved provider entities. The accountability for some compliance risks is not just back to primary funding authorities such as government departments and their attendant regulatory structures some of the accountability sits in other areas of regulation such as Occupational Health and Safety.

- A service organisation may be in compliance breach or remain accountable if things go wrong even if a care recipient has taken an action that generated the risk. This leaves providers with layers of compliance and accountability that can leave them bound and limit their ability to greater flexibility or provide consumers with greater control.
- Therefore rights and responsibilities need to be properly understood by consumers and renegotiated between service providers and consumers in light of these risks. Both parties need to understand the need to seek a balance between consumer wishes and consumer safety.
- CDC will drive a redefining of Case Management as a role and the need for administration when recipients start to purchase administration, recruitment, service finding, crisis case management etc.
- Understanding how CDC has worked in the disability sector (eg Individual Support Packages in Victoria) and the expectations of disability recipients will become increasingly important as these recipients age and transition to service provided under the umbrella of aged community care. At the same time this is also an enormous opportunity to improve the Ageing-Disability interface.
- CDC, together with a potential de-regulated systems which attaches the funding to the recipient, not the provider raises need to consider how cross region movements of

recipients are managed if this is an issue at all (or indeed a solution to a longstanding issue.

- De-regulation carries a risk that small organisation might lose market share In recognition of the fact that one size does not fit all, the loss of small players could lead to the loss of small boutique services with eventual shrinkage of the supply market and less choice.
- We need to ensure that the discussion and consideration about potential deregulation approaches will allow for the attachment of funding to the recipient, not the provider focus on outcomes or hours of "care".
- Recognise which problems those for with the providers and the system as a whole.
- In Community Care the potential is there that a poorly handled transition to a more de-regulated approach will be about the loss of valuable human and organisation capital and knowledge and capacity which has been built over the years.
- "Transformational reform" requires an overhaul of funding incremental model to really support it.
- Veterans tend to stand alongside the existing structure under the HACC and Commonwealth funded streams of packaged care. There is no real integration of eligible veterans to be provided services collaboratively. Veterans rely on information from the industry to choose which stream of service they prefer.
- Is there a possible risk of a "black market" economy or race to the bottom? Would the conditions be created for this if recipients hired their families "hired" a friend or neighbour? How would a government support its own policies on industrial relations, taxation, OH&S under such circumstances?
- What is the place for a user pay approach in CDC? It already exists in the straight fee for service market. What does a blended approach look like?

POTENTIAL SOLUTIONS

- There are working examples of CDC happening in the. The success of these can be acknowledged, understood and shared.
- A different approach and model is to fund both CDC and a potential de-regulated model. Government will need to consult further with service providers about how to do it, and sustain the important human and organisation capital that already underpins high quality support and care.

INDEPENDENT LIVING UNITS – RETIREMENT VILLAGE

Building regulations

At present the Australian Standard 1428 for wheelchair users (not frail aged requiring full assistance) applies .There are risks if the BCA 9C code was applied to Class 1 (Domestic dwellings) in retirement villages or ILUs. This would be very costly.

Accreditation:

At present there is a voluntary accreditation program. It would be undesirable to replace this with the same quality reporting scheme which is used in residential aged care scheme

Other regulations:

As retirement villages increasingly offer care, they are more likely to be regarded as a work environment as well as a living environment and therefore become more exposed to OH&S regulation.

Financial and affordability access issues:

Some retirement villages (e.g. some NFPs) will have charged less than market value as an ingoing. Hence capital uplift is counterbalanced by the initial low entry price.

However, there is a question of how people can change place of residence if they wish to change their place of residence (eg don't like retirement living, unhappy with the circumstances as that village, or simply choose to geographically relocate. In escalating property markets, lack of share in capital gain/ uplift can make it difficult to find other villages or housing if prices for these have floated with market movements.

There is a lack of creation of retirement living options for people without the financial means.

It is also apparent that after paying maintenance fees, middle class poor in retirement living find it difficult to meet other living costs

POTENTIAL SOLUTIONS

- Retirement living is a solution for the broader aged car sector as it is currently provided.
- There is a movement towards building appropriate accommodation and delivering care into it (certainly evidenced overseas). The concept of Service Integrated Housing.
- Dwellings could be built to a certain standard (eg AS 1428) with a capacity to upgrade to certain 9C features (especially bathrooms and access) with a substantial Aids and Equipment program funded by government to support this.
- Retirement villages are already subject to consumer protections and a complaints framework. Aged care regulation for what is primarily accommodation is unnecessary. Each care service has an appropriate framework already (in-so-far as services funded by government). Again the separation of meeting functional and cognitive needs and accommodation needs.
- It serves Victoria well to keep the **Retirement Villages Act** based in State legislation as other states have legislation which is far more prescriptive about how financial allocations and accounts must be managed for maintenance and capital upgrades.
- Extend the National Rental Affordability Scheme or similar to retirement living settings – not just an incentive model but a subsidy model. This should be considered by government as an important social investment for an Ageing Australia.
- Set a ratio for villages (e.g. like concessional resident ratios) so that new developments are required to have a proportion of dwellings operated as affordable accommodation.
- It would seem that the Commonwealth Government has a proportionately reduced role to sponsor accommodation for concessional/assisted residents in low care residential care as low care assumes a reduced proportion of residential population). Could some of the funding be transferred to sponsor low income group/ low asset base group in retirement living.

  At the same time use a local planning mechanism attached to a regional allocation funding pool from the Commonwealth to achieve a balanced transfer. Adding to this approach - in the same way that aged care funding already pays for people's living costs, it would be also reasonable to supplement people's living costs in retirement villages where there is demonstrated need.

RESIDENTIAL FACILITY CARE

- Regulation versus Resident choice and dignity of risk. The requirements to meet regulatory compliance are at times at odds with the Residents dignity of risk in making individual choices.
- There is a concern that compliant residential facilities are over audited. St Laurence residential facility has experienced spot auditing within short time frames of achieving full compliance. This adds stress to facilities and wastes the valuable resource of Department of Health and Ageing staff.
- Some Departmental Auditors take a disciplinary approach to facilities when discussing the audit process which again adds to the burden of regulatory compliance and is unnecessary.

- There is a distinct lack of requirement to provide staff skill mix to meet increasing complex care needs. Not only is there a lack of requirement there is also a lack of funding to facilitate this. Lack of funding to support increased skill mix to support changing complexities of care including end of life care i.e Pastoral Care.
- Aged care is struggling to attract Division 1 Registered Nurses to the workforce. The capacity to transition young, inexperienced nurses into facility based care to support transitional succession planning is greatly limited due to the sole leadership role Division 1 nurses are funded to take. Residential care tight funding models and Awards diminish the potential for experienced nurses to buddy with inexperienced nurses to nurture workforce development.
- The lack of focus on maintaining or increasing functional capacity once residential based care provided. Anticipation people will deteriorate. July 2010 a resident of St Laurence slipped breaking his hip. Within 7 days of experiencing surgical intervention the resident was returned to the facility without any offer of rehabilitation services, transitional care or allied health support. This resident was reported to have become confused, which is to be expected and therefore the acute sector indicated the resident did not have the potential to rehabilitate. At the expense of St Laurence facility this resident is now accessing private rehabilitation as the once low care resident post surgery now meets high care eligibility under the Aged Care Funding Instrument ('ACFI'). The resident is rehabilitating and improving his mobility with a noted reduction in his level of confusion.

POTENTIAL SOLUTIONS

- Consideration of the requirement to provide a higher level of skill mix to meet an increasingly complex work load in residential care, through funded models attached to needs assessment.
- An understanding that Active Ageing with programs to support functional and cognitive capacity and social inclusion are valid in residential care. Residential care can provide more than end of life care.

WORK FORCE

Ensuring that there will be skilled aged care workers to provide the necessary support for our growing aged population is a challenge for the industry

- Aged care providers and their employees, have a responsibility to ensure that people are attracted to, and remain in, the aged care workforce.
- The impact of the ageing population on labour utilisation will be significant. These global trends will have wide-ranging implications; saving behaviours, asset returns, international capital flows, and the supply of labour are all likely to be affected. It will be important to continue with policy reforms to improve labour force participation and productivity to address these challenges.
- The demand for aged care services is expected to increase significantly over the next 30 years. The provision of these services is dependent on the availability of sufficient workers with the necessary skills.
- The scope of practice clarifies the accountabilities, roles, and functions that qualified Staff are educated and competent to perform as well as the limitations under which services may be provided, these can become outdated as practice evolves in response to changes such as the growth of knowledge, advances in technology, the evolving scopes of practice of other health care providers, and health care system changes. The roles for providers are clearly identified within their legislated scope of practice; however we need to think outside the box in working with other providers of community care to expand our current scope of practice to "spread the load" between Staff
- Certificate III in Aged Care and Certificate IV in Aged Care should also provide focus on the significance of the home service setting as opposed to the current model of residential focus, with the following comments:

- Practical, hands on skills in personal care training are essential - the competency units outlined for both Certificate III and Certificate IV level do not appear to give enough emphasis on the manual skills training and techniques needed to be able to actually undertake personal care tasks in an unsupervised or variable setting.
- Training in medication assistance/supervision needs to be consistent with legal and program guidelines and job responsibilities. i.e. Assisting with self medication by a client and Assisting with medication from a dose administration system that does not require or allow exercise of discretion in any aspect.
- Pre and co requisites need to be removed from competency units so that there are no disincentives to trainees undertaking qualifications or doing individual competency units as skills gap training.
- There needs to be enough flexibility in the core and elective choices for Certificate IV, to allow it to be effective as both an entry level for direct care work, as well as to accommodate the more senior roles in direct care and entry into service co-ordination and administration, that provide for work variety and career advancement, for those who have already done a Certificate III.
- CHCICS301A module, "provide support to meet personal needs" – requires that trainers are clear that trainees must learn physical, hands on, personal care skills in this unit.
- The modules of competency-based study listed below are offered as electives:
    - CHCCS305A Assist clients with medication
    - HLTFS207B Follow basic food safety practices
    - HLTFA301B Apply first aid

  St Laurence considers that these three modules ought to be compulsory.
- Aged care has not attracted new graduates and this includes Day Therapy Centres. However, once people arrive at working in aged care – they find it very rewarding. The sector and government need to become attuned to promoting aged care careers.

POTENTIAL SOLUTIONS

- Supporting workforce development across cultural domains to ensure community care is being provided by communities for their communities. Effectively matching carers to recipients has been evidenced to improve the outcomes for the recipient
- A suggested model of service delivery is an holistic approach by developing a skilled workforce of multi-disciplinary teams providing specialist response services across the state. The teams could comprise Community Care Workers, Occupational Therapists, Speech and Language Pathologists, Nurses and other necessary Health Professionals working with teams of Specialist Staff such as Dementia Specific Advisors, Neuropsychologists and General Practitioners and Specialists.
- This collaborative practice approach would also reduce time in the hospital, improve housing stability and improve the retention of aged people to remain in their homes, especially among people who are high service users.
- Welfare checks by phone for those that can cope with this, instead of using scarce resources and sending staff out to check in person.
- The argument in support of increased pay for aged-care staff is that they do an important and essential job for which they should be better remunerated. With the government controlling funding to aged-care services, a pay claim can be met only if funding rules are changed and government funding increased. Without these changes, there is little money in the kitty for better pay resulting in less workforce in an already stretched system.

DAY THERAPY CENTRES

The role of day therapy programs operating in Victoria provides affordable longer term allied health services to maintain older people's physical functionality. However, it is apparent that

these comprehensive and well structured programs delivered from community-based Day Therapy Centres ('DTCs') are all too often not considered to be a component of an integrated aged care service system..

- DTCs play an important role in assisting older people to transition to other services rather supporting or delaying the transition
- Social work is underrepresented. Rehabilitation and restorative work involves a blend of physical/ functional therapy work with sensitive motivational input. The psychological approach is of key importance among frail older people with multiple and complex health needs. This approach is essential to supporting people to make decisions and adaptive changes. It combines well with short-term case-management interventions. DTCs provide very good mental health services. If you don't deal with this then physical and functional therapy interventions aren't as effective.
- There are very concrete cost savings that DTCs can and do achieve for the community and taxpayer. DTCs can improve independence or slow decline. Very concrete outcomes of this is a reduced need for more intensive care services, or even by way of some programs such as continence retraining and bladder strengthening programs, the need for continence aids.
- Practical examples of DTC services include:

  Individual therapy - Physiotherapy, Occupational Therapy, Speech Therapy, Counselling,

  Group therapy - cooking groups for older men and men's sheds, stroke groups, upper limb function group, falls and balance, continence retraining and bladder strengthening programs, Parkinson's and movement disorders, strength training, community access and public transport and walking, Physio-chi, communication groups, social support, depression, grief, bereavement, emotional and mental health international support, access to equipment from local community, Short term case management, Referrals and collaborate with other services and GP's
- There are essentially three groups within DTCs
  1. People who will recover lost independence or functions,
  2. People who will be able to "stay the course"
  3. People who will need some support to psychologically adjust and adapt their living to declining function or health.

  Therefore, in contrast to Community Rehabilitation Centres, Community Health Centres and HACC Allied Health which are relatively short term in their engagement with recipients, DTC recipients are frequently characterised by and still able to benefit by the slow stream approach. This enables the building of relationship which complements the psychological approach.

  This long term approach is of itself a foundation for longevity for some people
- DTCs are also different from other service types as being both programs and centres of excellence in older person's wellbeing, independence and adaption to degenerative health processes. This expertise is a work force strength.
- DTCs are not designed to create service dependence but achieve the right milieu and balance of professional and peer support to give people time and encouragement to stay their course, be it transitioning to the next level of care, re-engaging with the wider community, mainstream, programs or both.
- Specialists in chronic and complex support, co-morbidity and frailty.
- When other services say "there's nothing more we can do after eight sessions" – recipients are scoped for discharge, DTCs will continue to work with their recipients
- The paradox of constant rhetoric to address an ageing population by promoting "active ageing", independence and capacity building – but who is being funded to do it?

- DTCs have not collected data to provide evidence on the impact on reducing acute admissions as a result of falls and balances sessions, cardiopulmonary rehab or capacity building program delivery. Likewise the DTCS are unable to directly evidence the impact on delay in premature admission to residential care as a direct result of access to DTCs. This however should not be overlooked.
- Rationalisation of distribution of DTCs with a planned strategy to address the profound gaps in access.
- There has been long term policy indecision with: no growth, no strategic approach, no innovation funding, increased accountability, no security of continuity, centres generally paying for their infrastructure costs above and beyond with both poorly indexed funding and what can be collected through limited recipient fees not supporting increasing costs of service provision. This is achieved by transferring resources out of other programs.
- Demand for DTCs is increasing. Waiting lists are expanding. St Laurence has a six week waiting list to access Physiotherapy support and exceeds the key performance indicators funded annually.
- The National Hospitals and Health Reform Commission almost completely ignored prevention, health promotion, wellbeing in older people, yet DTCs can help keep people out of hospitals – an expressed policy goal of government.
- DTCs statistics are constantly submitted with no feedback to the sector or community
- Ongoing research is needed to see if programs are as effective as they could be and how they might need to improve. Currently student placements offer the most opportunity to assess the impact of service provided in St Laurence DTC.
- Allied Health Professionals and the much valued Allied Health Assistant workforce are critically important with an ageing population. Like the rest of aged care there is the need to competitively remunerate as there is competition from acute care, sub-acute care and private practice sectors.
- The DTC target group is often not a well group. Some people are frail and will require long term support *in situ* in the community. Yet both community and government seem to somehow be very afraid that people may not get better, become more frail and deteriorate. Not all older people will get better. Coping with frailty is a poorly understood area. It is time to promote greater acceptance of this part of the human condition.
- Day Therapy Centres welcome accountability and quality improvement if it is meaningful, appropriate to resourcing and the program, and truly intended to assist growth, development and service/consumer improvement.
- In spite of their lack of funding and strategic attention, DTCs have at least benefitted from low regulation approach and have been allowed to be flexible and innovative – within funding

POTENTIAL SOLUTIONS

- In the Victorian context, a minimum of one DTC per municipality would seem to provide a reasonable basis for access
- With an ageing population we need to re-evaluate and re-visit "maintenance" approaches and reframe well-being goals to include "a well managed decline".
- Government to pay attention to the long term value of investing in a campaign to promote working in the aged care sector.
- The potential with incentive funding to work with older people as peers and volunteers in running and supporting programs and groups. This needs to balance against the reality that not all people have the energy to make such a commitment. Also practical support to enable people to contribute in this way such as transport or defrayment of costs (Community Volunteer Grants Scheme).

CONCLUSION

Overall the fragmentation of the aged care system with a requirement for multiple assessments, involvement of multiple providers and enormous waiting lists to access resources renders services ineffective. Unless delivered in a timely and efficient manner the service is redundant. Currently the potential recipients are subjected to an inefficient, ineffective model of care, if they have managed to negotiate the service system to reach an assessment. Simply adding a campaign for consumer directed care and direct funding would appear to be an exercise in shifting the responsibility and accountability of an industry struggling to sustain quality in care.

The reality is that an ageing population is going to place greater strain on a system of care that cannot meet current need. The system needs to change and people need early interventions if the ageing process is to embrace an active ageing model. User pays service models would certainly introduce more capacity to source resources however the workforce required to support an increased demand is not evolving.

Future age care policy environments will need to continue to consider the implications of a basic eligibility of any person to access care based accommodation based on assessed need rather than individual choice – a difficult policy position for ageing Australian from the baby boomer generation to accept. Governments and consumers also need to understand that to be most effective, care based on assessed need must be implemented at the time of assessment not 6–12 months later. Decline in people ageing can be marked and rapid without appropriate interventions and the impact on informal, unpaid carers can be detrimental to the carer's health as well.

St Laurence believes one of the greatest benefits that could emerge from the Inquiry is recognition and the development of a proposed framework from which governments and service providers can come to terms with the necessity to achieve a balance between recipient choice and provider regulatory compliance.

St Laurence welcomes the opportunity to participate in the Inquiry Caring for Older Australians. Change is necessary if a sustainable service industry is going to provide a valuable continuum of Aged Care moving forward.

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