Submission to the Aged Care Royal Commission

Aged Care Redesign: Services for the Future

Consultation Paper 1

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Made by:

Research Analytics and People & Culture Solutions

MyCDC ™

My CDC™ – A partnership between Research Analytics and PEOPLE & CULTURE SOLUTIONS

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Our Perspective

About Us

This submission is prepared by Mark Sheldon-Stemm and Marcia Baron. We thank the Commission for providing this opportunity to make our submission.

Research Analytics is headed by Principal Mark Sheldon-Stemm. Mark brings over 20 years CEO/CFO experience in health aged care services in metro, rural and remote settings. Since 2015 he has worked in the development of new aged care systems with supporting business & financial systems; including MyCDC for both community and residential Aged Care.

In 2018, Mark was commission by the Department of Health and the Minister for Aged Care to undertake analysis and provide a report on how Consumer Directed Care will work in Residential Aged Care. He currently conducts workshops for Leading Aged Care Services Australia (LASA) on Consumer Directed Care (MyCDC), with over 2,500 staff trained in this area; and in helping organisations meet the Aged Care Standards.

People & Culture Solutions was co-founded by Director Marcia Baron. P&CS is a boutique HRM consultancy servicing the community services sector. An Affiliate of LASA, P&CS provides expertise in multiple areas including service mode design; organisational culture; HR, IR and ER services and workforce planning and development. The P&CS team works with a wide range of aged care, disability, training and other organisations; with Directors and Associates having considerable practical leadership experience in this sector.

Marcia also has extensive experience working with both service providers and individual consumers in the National Disability Insurance Scheme (NDIS); and designed the first independent HR service delivering people and culture support to NDIS participants who self-manage their supports. This service, "MyTeam"; is a trademarked service package delivered by P&CS to NDIS participants who self-manage their support teams.

About our model of Consumer Directed Care in Aged Services: MyCDC ™

We have provided more detail of MyCDC as an appendix, in case it is of interest to the Commission. An overview of its key aspects follows below, to provide the context to our inputs and comments on the Consultation Paper. MyCDC has been piloted and is now operating in several organisations.

MyCDC is a researched model of care and service; that puts relationships & consumer choice at the heart of services. It "puts people at the centre", and is where:

- The focus shifts from a task-based culture & practice to a relationship-based culture. This empowers consumers & families to be true partners in their care & service; & enables staff to build deeper relationships with consumers & families, delivering better outcomes for all parties.
- The locus of control shifts, with the consumer co-designing their care & service plan with staff through discussions/negotiations about what they want, how and delivered by whom – whilst maintaining the quality & level of personal care.

- Staff learn to interact differently with consumers, to get to know what matters most to them. Asking what they want, how they want to go about it; talking to not about them; listening actively; and always thinking about acting in a way that will benefit the consumer.
- Continuity of care & service also has continuity of care/service staff members.
- Core clinical care needs are in accordance with assessment and clinical governance requirements; and lifestyle services provided around preferences & choices of the consumer, within a respectful & safe environment.
- Care and services are provided within a relationship focus not a task focus.
- Plans, funding and costs are all transparent.

Organisations who have implemented MyCDC have found:

- Staff, consumers & families involved, are very happy with the changes. Complaints are reduced, with higher satisfaction with outcomes. People feel more consulted, and that the staff are genuinely trying to meet their wishes. There is an increase in compliments.
- Consumers say they have more involvement in both care & service plans. There is more trust & respect; with staff forming closer bonds with consumers. Staff are noting the benefits of these better relationships, with increased happiness of consumers and family.
- No major changes with rosters, more about how, when & what people do. Minimal additional hours for MyCDC coordinators but this is really needed especially at start.
- Staff were very concerned about additional work but are more relaxed when they realized it's just a *different way to work; not more work.*
- Consumers are not asking for anything elaborate, or for anything that would jeopardize their health or wellbeing or regularly changing their minds. The key to meeting any challenges is being open about why something can't happen, what other options or alternatives are available; and negotiating an agreeable outcome. Staff training & on the ground leadership support is a key to this outcome.
- One of the biggest challenges is changing culture & thinking. This needs ongoing reinforcement so that cultural change & practice change become embedded. You cannot underestimate the need to make consumers, families and staff comfortable with this service model, and this takes planning, support, time and on the ground leadership.
- MyCDC is a good model & culture that can be flexibly implemented to suit each organization.

This service model is our core area of operation and expertise in Residential Aged Care; however, we also have considerable experience in home-based care in aged and disability services, so understand the need for service systems integration.

This model is operational in a number of aged care facilities throughout Australia with reference sites available for consultation on how the model has changed their culture and practices and the outcomes for the elderly.

Our inputs to the Consultation are therefore focused on these aspects of the proposal. We make no comment or only minor comments in areas where we feel we have less expertise to offer.

Inputs to the Design Questions

1. Principles for a new system

We designed MyCDC because of our experiences in seeing services provided to older people in a way that did not provide for them to exercise their rights of choice, or to have their preferences and goals respected and supported. Whilst this has improved considerably in home / community based services we believe that residential aged care remains institutionalised – its structures, leadership, staff, practices operate in a task completion mode; with little if any real flexibility and choice; which cotton-wools and effectively infantilises residents so that after a short time they lose their ability to express their wishes.

Take for example the standard tea-time at a residential care facility (RAC). The tea lady automatically pours coffee for Jim and tea for Janet without asking, because she knows "that's' what they like". Whilst that may seem like a real personalised approach; is it respecting the right of the older person to have and express a choice? Outside RAC people *sometimes* have tea, *sometimes* have coffee, *sometimes* have something else? If that person was still living in their own home, wouldn't they have the choice to make the drink they *actually* wanted? Haven't they earned that right, wherever they live?

Residents/consumers have become so institutionalised and disempowered that they line up for meals so that staff don't come and tell them that they have to eat now – whether they feel like dinner at 5pm or not. Perhaps this explains the high level of depression amongst residents in aged care settings. Many people living in residential care facilities did not plan to be there and don't want to be there. System redesign needs to respond to this point.

We believe that services that truly put people at the centre; respects, rights, choices, people's own decisions about what gives them quality of life and dignity; is provided in an environment of respectful and collaborative relationships – ***must*** be at the centre of the service system re-design and ***must*** cross the boundaries of where the service is provided.

Model redesign must include a de-institutionalisation of service in residential settings and become a model of communal living with individual choices, preferences and wishes being met – i.e. move from "the person fitting the system" to "the system fitting the person" and providing them with the opportunity to live the last years of their life, the way they want to.

These are the underpinning principles of both MyCDC (the model, design and the actual service delivery implementation) and the Paper, and we wholly endorse them. (We do just suggest that "good death" be reworded to say "die in a manner in accordance with their wishes, without pain or anxiety and with dignity.)

Further, with any system redesign there must be no diminution of the accessibility, quality, affordability and sustainability of the system. Enhancing service user empowerment must not be allowed to reduce the accountability for duty of care by service providers; however, regulators will need to understand that risk management must take account of reasonable support of choices; and the rights of older people to make those reasonable choices.

2. System design and navigation; user control

The Paper notes on page 6 that "We want a system that would allow older people to enter any stream and be supported to build their own bundle of supports and care". It goes on to say that once the person has established social supports and their needs increase; personal, nursing, allied health and respite services can be added to their continuing social supports even if they enter permanent residential care.

MyCDC within residential care allows for people to make and live out their independent lifestyle choices within a communal setting and the security of 24 hour on call support if and as needed. Given this, we support this statement but add that in our view ALL services provided in the community should be able to continue – i.e. the same staff as well as the same or increasing level of support – as well as the service.

That is, when a person moves from their community home (whatever that may be, e.g. home alone, with family etc.) their care and services plan and providers should be able to be retained if the person wants it and it is possible from the service provider. Community providers build a great knowledge of and respectful, trusted relationship with their clients. They know what their client likes, and how they like things done.

When most people currently move into residential care for short term or permanency; they are suddenly surrounded by unfamiliar environments, timetables, routines, rules and people. They may not be able to adequately explain their wishes and preferences to these new people. Familiar faces that know them and that they trust would help them settle into these unfamiliar surrounds and support them continuing to live the way they want and receive care and services in the manner they wish.

This is discussed further in section 6, Care Stream; however .the notion of "my care and service AND my care and service PROVIDERS come with me wherever I live" also links with the underpinning principles of the system and how it is accessed. We have combined our comments around access, navigation, information and informed choice into section 3, Information, Assessment and System Navigation, to avoid duplication.

3. Information, assessment and system navigation

We believe that the central tenet of the system should be a single-entry point. There should not be multiple and repetitive layers of process. MyGov and MyAgedCare have gone some way towards this but there are potentially opportunities to further strengthen and streamline approaches.

Getting information and planning ahead can be difficult, as assistance is often sought without an understanding of the aged system. This can be because the older person is unwilling to countenance support services or, as in around 70% of cases, there is an emergency or crisis leading to an urgent need for services. The system must be appropriately responsive to both planned and urgent information and intake.

Therefore, we see that there should be two pathways to access services.

Pathway 1: - non urgent need

- Services are referred for assessment based on the elderly person's requirement for assistance;
- An assessment is made on the requirements and services;
- Services are allocated based on the need and assessment.

This process should take no longer than 3 to 4 weeks; with services progressively allocated to the elderly person within this period.

Pathway 2: - urgent need

- An assessment is made of the services required;
- Services are allocated based on the assessment;
- In the case residential care or the need for 24-hour care at home then a system is set up (see below) to assist the elderly person and their families/representatives to navigate and acquire the services.

This process should take no longer than 1 to 2 weeks; with services provided based on availability and funding.

Service access and navigation processes primarily relate to two groups: the elderly person themselves; and their family and/or other representative. Family and representatives could access information via websites, personal visits and/or phone calls to potential service providers, social media, or the GP clinic caring for their relative.

2016 census data noted that whilst 90% of people aged under 54 used the internet, this dropped to 80% for people 55-64 and less than 60% for those over 65. So, some older people (or the families of those aged in their mid - 80's+) will not be connected or comfortable accessing information primarily or at all, from the internet.

This means that whilst a lot of information can be made available via the internet, it also needs to be presented in a variety of ways – especially for older people on their own.

Generally, the older person would be in contact with their GP clinic; and we believe this could be a good place for centralising easily accessible information about service options.

*We propose a system which we call **The Service Broker Model**.*

GP clinics are independent of the aged care system and can provide both the elderly person and their family/representatives with information and assistance in finding suitable services.

This would be an additional service offered by GP's and should be resourced accordingly. It need not be the GP themselves. In this model we recommend a Service Broker be part of the GP clinic (practice) and that their role is to provide this assistance. The entry point therefore becomes the person's local GP with the support of their general practice.

The information required about service options may be provided by:

- Personal face to face discussion with the elderly and their GP/GP staff (Service Broker);
- Written information on the services available in their local area;
- Follow up meetings with possible service providers.

The Service Broker would provide the following services:

- A mentoring and information service to work with the elderly and their families/representatives to source the right services that meet their needs
- This mentoring service will work with possible service providers, so the elderly persons needs are met, and they have sufficient information to make informed choices
- Liaison with the GP to ensure information and options are suitable and independent.

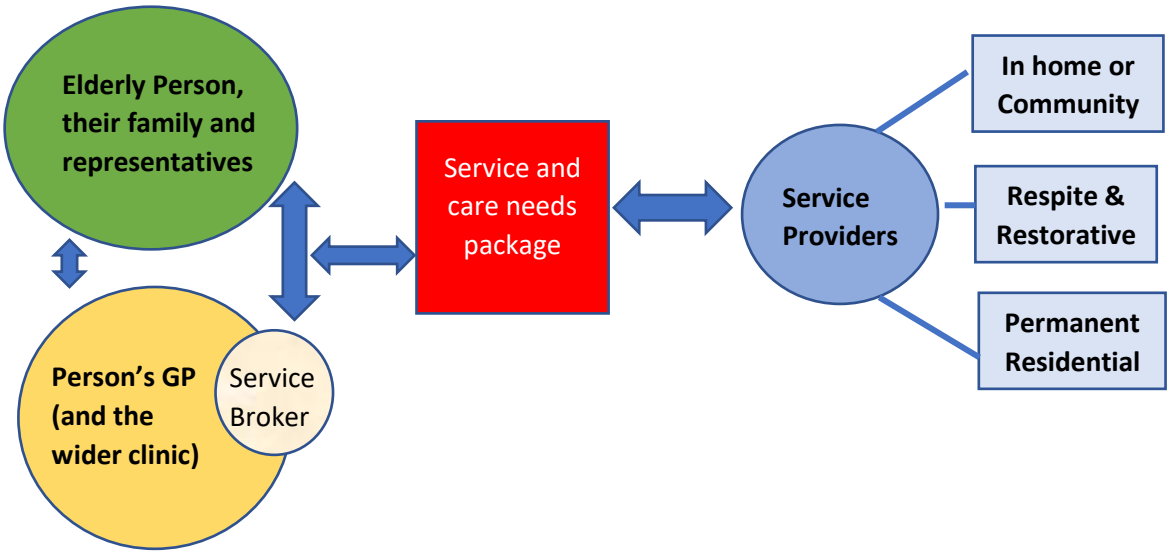
Face to face services will allow for a greater understanding of services available to meet the needs of the person; as it better facilitates questioning.

Once the elderly person choses a service provider then the Broker would make the connection and ensure the start-up of the services commenced smoothly and in line with the elderly person's wishes. The person will continue to see their GP while receiving services and this will allow for any changes in the service requirements to be addressed.

The Broker would then only be re-engaged if the GP advised of a change in condition and there is a need for services to be varied; where the process of information, selection and organisation would recur.

In the case where service changes are required, and service providers need to be considered then the Broker would be re-engaged to assist the person and their families/representatives access these services.

Graphic of The Service Broker Model



This system would be like that which operates in the finance sector with mortgage brokers. However, these need to be independent of any service provider, so their advice is not biased to one service provider or another (nor should they be operated by a side company of a service provider as is currently the case with some assessor organisations).

In terms of who bears the cost of the Broker this would be negotiated between the parties. Currently there are several Brokers operating in aged care who find a placement for clients and the elderly person and/or their families pay for this service. However, the current practice is open to bias in favour of some service providers and independence is required for this to work.

It would be possible to allocate the role(s) based on demographics and GP Clinics in an area could share the use of a Broker. The resourcing could be easily calculated based on historical data of the numbers of the elderly in a region who need to access services. This could range from 10 people a week to a 100. These figures could be easily be obtained through current demand statistics collected.

This model aligns to the health and wellbeing of the elderly person as their GP is the first to be consulted on health and other services required for daily living. The GP clinics also have a strong connection to allied health services and can coordinate these services for elderly clients (which they currently do across all their patients).

The only drawback to the model is a greater reliance on GP Clinics; and whether some of the rural and remote areas would have the resources would need to be investigated. This could be said of any model, as many areas struggle to have sufficient available GP's.

4. Entry Level Support Stream

Terminology. The Paper notes on page 1 that: *"While the system may be seen as providing a continuum of care as a person's needs increase; older people do not necessarily move through the system in a linear fashion. Some people may only ever receive one type of service, whilst others may progress from one service directly to the highest form of care – residential care".*

We agree – and our research has also found that around 70% of people entering residential care do so directly as a result of crisis or emergency either from a health episode or breakdown of supports. We therefore suggest that the term "entry level" conflicts with the statement above; and can be seen by older people as quite negative and implying that they are now on an inevitable path to residential care. We suggest consideration of a new terminology, for example "community living support services".

We feel that it is not possible to answer some questions; such as "what are the most important early supports for people in their homes and communities? The answer, we believe, is "whatever that person says it is".

For some, having someone to take them to their beloved bowling or bridge club will stave off depression and keep them mobile; for another it might be someone helping with their veggie patch so that they don't have a fall; and for others it might be helping them prepare their meals because cooking is everything to them. For others it is more practical, personal care than social and mental health support.

This is a critical point as it goes to one of the principles of the new model design – supporting the person to make their own choices and living their life their way.

The interactions between the person, their GP and Service Broker should determine what a person needs most and how it ought to be provided.

We support a stronger investment in preventive and restorative health for older people. In 2002 a Chronic Disease Self-management trial carried out by Tandara Lodge Community showed a reduction by 50% in people accessing health services.

The participants became healthier and more able to manage their conditions themselves, reducing demands on the acute and chronic health care systems – and improving mental and physical wellbeing due to the sense of control.

Social isolation and depression are significant issues facing older people. Increasing investment in upstream community-based programs that provide increased visiting of, community access, mobility and social integration (including with cultural and personal interest relevance) would undoubtedly have a positive impact on the need for higher cost personal and health care downstream.

We are familiar with the range of funding mechanisms employed to date and in the past for people needing aged care. Each of the bulk / aggregated program funding and fixed annual budgets have pros and cons. Rather than assess these, we propose a bigger change.

The ability for services to match the needs of a person receiving them has been shown through the operation of the Home Care Package program to suit the person directing the service. Having been involved in services under bulk funding and individualised funding it is clear the service and the cost of these services are best directed by the person rather than the service provider.

The NDIS is reforming how people who have both service and accommodation support needs have the ability to choose their service and accommodation providers and pay for those services themselves.

Rather than being tied to the service provider who managed the accommodation, clients can now take their accommodation funds to a range of options and purchase their services from another provider. They can self-manage their funds and engage their own support workers.

There is argument that this model should be translated to older people needing support. This would see an assessment of the supports sought and required and a funding amount allocated. The person can then choose where they live and what services they want. If living at home they use accommodation support funds for the aids, modifications and assistive technology that will keep them there; and then purchase in services from their chosen provider.

They, with support from the Service Broker, work out how the money is spent. If able, they manage their funds and workers themselves or with family.

If they want to live in a communal setting, they pay the accommodation fee for 24 hour supports and other base costs to the residential provider. They then select what other services they want and purchase them from the residential provider (if offered) or from an external provider, perhaps the same people they have used when living at home. This includes items such as meals, community access and other activities; and developing to include nursing and allied health care.

Residential providers will have to accept external people coming in and design protocols that are not prohibitive for people to do this; but at the same time do not make residential providers professionally accountable for those external workers.

This approach also increases the transparency of funding. We believe that this must be a fundamental principal of any future funding arrangements.

For example, even though home support packages must now show a rolled up fee inclusive of care coordination, there is still ample evidence of people with maximum packages around $65,000 pa only being able to obtain around 12 hours of personal care a week (meaning they pay around $100 per hour yet receive very little if any case management. Perhaps another tack is decoupling care coordination/case management from care provision to prevent clients being loaded with such high costs of indirect service.)

This is effectively forcing people into residential care as families and friends cannot match the gaps needed to support someone with complex physical needs or dementia. Residential care is much more expensive for the government than a system that works more actively to keep people within their own home.

The Transport Accident Commission (TAC) in Victoria has undertaken some very positive work in partnership with Deakin University in building in assistive technology into peoples' homes. Many of their clients have families and want to stay living together, regardless of required supports arising from their acquired disability. The TAC has found that overall this investment reduces costs as in many cases the only alternative is full time care staff.

We encourage the Commission to draw from these and other examples of service system reforms already undertaken, which arguably have strong parallels with aged care.

5. Investment Stream

Again, we would suggest a change in terminology of this component of the model before it enters the public arena. The name does seem to infer that anyone not in this stream is not worth investing in, which is clearly not the case with the proposed new model. Perhaps a title that reflects the preventive, restorative and respite nature of the service stream would be more fitting.

We have noted earlier our belief that increased investment in community-based generic/mass services that increase social interaction, mental and physical activity for older people will prove beneficial. In addition, we believe there is sufficient evidence to show that early intervention (e.g. intensive gym/physio classes once someone has had a fall; intensive memory and cognitive activities once someone is diagnosed with early stages of dementia) will prevent or slow down the advancement of frailty and with that, reduce the demands for care and service.

Hospital discharge planners generally only integrate with aged care service providers when it is a new referral to the service – if someone is returning home but already has a care package, or is returning to a residential service then it is left to the client, family and service to get service plans altered as might be required.

If there was a new stream introduced that allowed for older people living at home to have short stays in a communal centre with a focus on restoration of health and function; intensive social, physical and cognitive programs – then this would help people stay at home longer. This would also provide an opportunity for assessment of ongoing capacity and whether assistive technology would be applicable. As people progress their restoration, they may return to their usual living place and come to the centre as "outpatients".

These centres could also be used for respite – it could revitalise the older person whilst giving the carers a break; benefiting all parties. Too often people enter residential aged care when their family carers are away and have such a negative experience that it perjures any thought of permanent residential care in the future.

People living in residential care could either have a spell in one of these restorative centres if they have an episode that requires such rehab; attend there as an "outpatient", or the program could be brought to the residence and provided in concert with existing staff.

The health system in areas seems to facilitate the notion that reduced physical and mental functioning is an inevitability and this notion needs to be removed from both the professional services and the general public.

We recommend that this new, high energy, positive focussed restorative service be seen as effectively rehabilitative health care and be operated and funded as part of the health care system. However, oversight will be needed to ensure that older people are treated with the same intensiveness as young people who require rehab following injury or illness and are not discharged from the program too early.

6. Care Stream

We have described the key facets of MyCDC in our introduction and provide a more detailed coverage in our appendix; and we would be happy to discuss this in more detail with the Commission. We strongly believe that this model will go a long way to providing a reoriented service that is based on meeting the needs, preferences and choices of the older person.

When this is combined with the Service Broker model and the new "restorative/rehab" service, we see this as a comprehensive model. Fundamentally we believe that a person should have the same access and response to and from services regardless of where they live. A move to a funding system more like the NDIS removes the "hold" that bricks and mortar services have over people.

We understand that more non-permanent residency and/or service provision (arising from clients shifting their services as their needs shift) provides difficulty for government and service providers as costs and revenues can be inconsistent and mis-matched; and staffing potentially an increasing challenge with people working across multiple services. However, the Commission has a stated aim of a full redevelopment of the system not a tinkering; and if the model is right then solutions can be found. The NDIS in Australia and Accident Compensation Corporation (ACC) in New Zealand are just two examples where the funds move with the person who uses the service and care.

Services available and availability to older people (most whom in current times have made lifelong contributions to general society through taxes, raising families without government funded family benefit payments, and volunteering their time and expertise) should not depend on whether they live in their own home, a private shared home arrangement or residential aged care.

The MyCDC model also works in community settings. As noted earlier we feel the shift to a funding and service management arrangement more like the NDIS will further improve services.

All providers may also need support to ensure they are living a consumer directed care principles in their services, regardless of location.

7. Specialist In-Reach Services

Our experience suggests that many residential aged care services are not active enough in engaging partners who would be effective in providing the restorative / rehab services discussed earlier, or in providing comprehensive and appropriate palliative care when their residents are dying of any cause. Perhaps training in meeting these requirements (now more clearly defined in the Aged Care Standards) would be a good support to improvements in this area.

Also, if the client held the service funds rather than the residential provider, they and/or their families could bring these services in as needed. We support the notion of "reasonable and necessary" as applied in the NDIS.

Our proposed intensive restorative centres would fit very well into the desire for an increased uptake of health services.

8. Designing for diversity

As noted, our experience is that assistive technology is used considerably less for older people than for younger people needing similar supports. This is not equitable, and there are many opportunities for expanding its application. Perhaps Cooperative Research Centres (CRC) funding could be targeted in coming years to applications that provide more automated supports (such as the use of robot technology) that enable people of any age who would otherwise need 1-2 care staff for simple mobility, to remain in independent living for longer or for ever.

Telehealth and assistive technology may be of particular benefit in regional and rural areas where staff are in small numbers and distances of travel make providing regular service both difficult and costly.

Diversity could also mean different types of accommodation. Uniting Connections has a program of home sharing; where in exchange for being a companion and keeping an eye out for an older person otherwise living alone; a younger person has free rent. They are not the carer, but a reliable adult presence providing confidence.

With the significant growth in single person households amongst the elderly, this could be a good alternative option. Another option is smaller shared houses where older people needing some supports and socialisation could live in a shared house. As it is for NDIS clients, funds could be used separately by each person for their personal care or leveraged for common services needed such as shopping, cleaning and transport.

9. Financing Aged Care

As noted earlier our focus is on service and care systems. We do however note that there are a range of options, each with pros and cons, that are no doubt being considered in addition to the current funding models.

Whilst we understand the very real challenges associated with funding, we encourage the Commission to focus first and foremost of designing the service for the future, and then working out the funding options.

Previous system changes have got bogged down in "who pays and how much" questions during this stage, and the end result has been very messy, inequitable and inefficient systems designed by funding concerns rather what is appropriate and required; and what will make the biggest positive differences to our citizens and communities.

We make these comments, so the focus is on the system driving funding rather than funding driving the system.

As part of this focus, we have found a major requirement for any system to work is financial transparency. No matter what funding system is employed the flow of funds must be transparent to all parties. People should know what funds are available, the cost of services and supplies so they can make the decisions about how these funds can be best used to suit their needs.

A comment from the royal commission interim report reflects the need for funding transparency. "The aged care system also lacks transparency. The aged care sector behaves like an industry, but this masks the fact that 80 per cent of its funding comes directly from Government coffers".

Without funding transparency any system will fail to provide choice and decision making.

The MyCDC model has achieved this in home and residential care with real benefits for the elderly person, their families/representatives and service providers.

10. Quality Regulation

We believe quality in aged care should be driven through the empowerment of the elderly person and their families/representatives. We have been able to achieve this through the introduction of MyCDC. Results show the quality of services improve, as does the ability for the elderly to direct services which suit them and allows them to live the life they choose.

The role of a regulatory system is therefore one of monitoring the services to ensure there are systems and processes in place which affords the elderly person and their families/representatives the ability to exercise this empowerment.

As mentioned previously this requires a cultural change amongst service providers and not all are willing to make these changes. Any service that does not operate in this way should not be providing services to the elderly.

In the previous aged care standards, there was a great emphasis on ensuring clinical care was of a high quality and the person in care was being treated with best practice. Unfortunately, there have been a number of cases where the clinical care and the regulatory management were well short of community standards and expectations.

The new aged care standards have taken a different focus with the emphasis on choice, control and dignity. However, clinical care is still required to be at best practice level.

Therefore, we would recommend there are three streams to the regulatory process going forward:

- Consumer experience, satisfaction and control;
- Clinical governance; and
- Corporate governance.

The approach to these three areas would be different.

Consumer experience, satisfaction and control:

The approach here would be one of interviews with the elderly person and their families/representatives and a series of audits based on the systems and processes services use to ensure choice, control and dignity is provided.

The checks performed by the regulators require a focus on human interaction and an ability to establish if the daily lives of people accessing care (whether at home or in residential care) is one where they are directing the services.

The checks in this area should be conducted by people who have the personal skills and the ability to connect and engage with the elderly person in care and their family/representative.

Clinical governance:

The approach for this stream is more technical with a focus on ensuring the clinical practices meet the standards required for best practice.

These checks should be conducted by people who have appropriate clinical skills and measured against a set of standards accordingly.

Corporate governance:

This stream requires skills in areas of governance, finance and systems. Again, these are more technical and are designed to ensure the service provider has a structure in place that covers risk, compliance, financial operations and a governing body that is suitable for the role.

These checks should be conducted by people with governance, business and financial background and the demonstrated ability to establish if the organising is well run.

The current monitoring of regulation by the Aged Care Safety and Quality Commission (ACSQC) is conducted across these streams. The staff of the commission are fundamentally clinically based. They do not have the necessary skills across all three streams to establish whether the service provider is meeting all the requirements. This comment is not a mark of any disrespect to the current assessors but merely reflects their backgrounds and it could not be expected any one person could conduct across all these streams.

We believe that the 3-stream approach matching specific skills and function will enhance positive regulatory outcomes in aged care.

We believe that the Aged Care Standards (which amongst other things require providers to demonstrate that their clients believe they are getting adequate choice) should be met across all service providers and in terms of all three streams, regardless of the location of the service or the complexity of need of the service and care recipient.

Summary of Key Points

The key points of our submission can be summarised as follows:

- The aged care system needs a total revamp; not a tweak at the edges.
- The redesign must come before best endeavours are re-shaped by funding concerns and the benefits of redesign lost.
- There needs to be a seamless, single entry point.
- Service providers must be allowed to go with the client, even if their accommodation arrangements change.
- Funds should go with the client, not accommodation and/or service providers. There is much in the NDIS model that could answer the questions of the Commission.
- Funding transparency should exist across all services.
- New accommodation options should be considered.
- A service brokerage model should also be considered.
- Restorative / rehab centres should be created as a logical extension to the health service, to optimise the independence and health of older people.
- The system also needs a fundamental cultural change to put the care recipient at the centre of planning and delivery; provide real choice and actively support the person to live they life they choose.

  This can be provided through programs such as MyCDC. Should the Commission wish to know more about this program we would be happy to discuss.

Appendix 1 – The MyCDC ™© Model

My Life, My Choices, MyCDC
The Service of the Future

Consumer Directed Choices in Residential Aged Care

Empowering people to live the life they choose

PEOPLE & CULTURE SOLUTIONS

MyCDC™

PEOPLE & CULTURE SOLUTIONS in partnership with RESEARCH ANALYTICS ©

What is MyCDC?

A researched and piloted model of care that puts relationships & consumer choice at the heart of services:

- Where the focus shifts from a task-based culture & practice to a relationship-based culture. This empowers consumers & families to be true partners in their care & service; & enables staff to build deeper relationships with consumers & families, delivering better outcomes for all parties.
- Where the locus of control shifts, with the consumer co-designing their care & service plan with staff through discussions/negotiations about what they want, how and delivered by whom – whilst maintaining the quality & level of personal care.
- Where staff learn to interact differently with consumers, to get to know what matters most to them. Asking what they want, how they want to go about it; talking to not about them; listening actively; and always thinking about acting in a way that will benefit the consumer.
- Where continuity of care & service also has continuity of care/service staff members.
- Where core clinical care needs are in accordance with assessment, and lifestyle services provided around preferences & choices of the consumer, within a respectful & safe environment.

The new Standards require a shift in culture & service provision - MyCDC is a model that can help deliver these changes.

The MyCDC Principles

- Regular, open, honest dialogue; active listening; respect for individual choice & preferences, and appropriate consideration of risk acceptance/management is the basis of the relationship.
- Consumers & family develop the goals they wish to achieve whilst living at the facility. This starts pre-entry, with an assessment being made by both consumer & facility as to the compatibility prior to intake. Once set, goals are regularly revisited in open discussions with staff to ensure they are being met & are effective. Goals may change over time.
- Consumers can make choices within both the clinical care & lifestyle services, to meet their goals. Plans are co-designed, with working openly to explain why & find agreeable alternatives where some or all choices may not be able to be accommodated.
- Goals & funding available are openly discussed, with clarity as to how/if the funding meets the goals. If choices exceed the available funds, the choice may be negotiated to fit the funds or the consumer may agree an additional fee for that service. There is financial clarity and accountability to the consumer/family; with monthly statements & open discussion.
- Risks are managed within a framework of appropriate levels of duty of care, clinical needs, OH&S & the understanding that the consumer lives in a shared space; but also supports consumers to exercise choice & independence. A problem-solving approach, including the consumer/reps, is taken to reduce risk & support consumers to live the way they choose, as far as possible.
- As the locus of control shifts; the relationship model shifts the culture from task/service provided to services selected.

3

Why consider MyCDC – Benefits & Outcomes

For consumers & families

- Better able to live within their preferences & choices
- Higher feeling of involvement, being informed & in control
- Improved mood / happiness, social engagement, participation
- Improved relationships with staff

For workforce

- Higher levels of empowerment & flexibility
- Improved job satisfaction; work is more enriching with stronger teamwork
- Improved relationships with consumers, families & other staff
- Happier staff; leading to better outcomes and increased retention

For organisation

- Can become seen as Provider of Choice – for consumers & staff (competitive edge)
- Increased happiness, satisfaction, attraction & retention of consumers & staff
- Meet Standards, compliance, regulator & financial accountability requirements
- The ability to charge for extra services based on the financial model

4

The MyCDC Model Key Components

Engagement Model

- With consumers, family, workforce & organisation / Board
- Develops concepts of future vision vs what we have now
- Finds out what consumers want, staff ideas; opens communication
- Starts the cultural change process
- Drives ongoing monitoring of outcomes; & goal reviews

Service Model

- What services are required to meet consumer needs, goals & choices
- Co-design with consumer both the clinical & the consumer directed goal care & service plans
- How the workforce is organised to provide these services
- Includes work on:
  - roles, rostering for continuity of care/care team
  - recording, reporting, reviews, communication & feedback

Financial Model

- Understanding the core / common 24 hour service, accommodation & clinical costs
- Aligning the budget with the MyCDC service model
- Understanding the funds available for choices
- Funds allocation negotiation
- Financial recording & reporting

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The MyCDC Engagement model – Key components

- Consumers and families; staff / workforce; organisation / board / management
  - Information sessions: the new standards, talking about MyCDC – why and what could be the changes
  - Getting input on current levels of engagement; what they might want to be different in services
  - Engagements starts prior to residency/service; to assess needs, plan goals, align expectations
  - Pre and post pilot surveys; continuous feedback loops
  - Building relationships; setting goals and agreeing service plan
- Workforce
  - Consultation, planning, communications, pilot working group, pre and post pilot surveys
  - Sharing information, getting ideas on changes and how they might work
  - Considering rosters, roles, shift times – trialing and managing change
  - Training in choice and shifting from task to service & relationship focus; support, mentoring
- Management / Board: Planning and discussions on what needs to change with:
  - KPI's, targets, measures, recording and reporting; quality systems; policies & procedures; HR instruments
  - Governance systems and focus; compliance systems; financial transparency and reporting; staffing and budgeting

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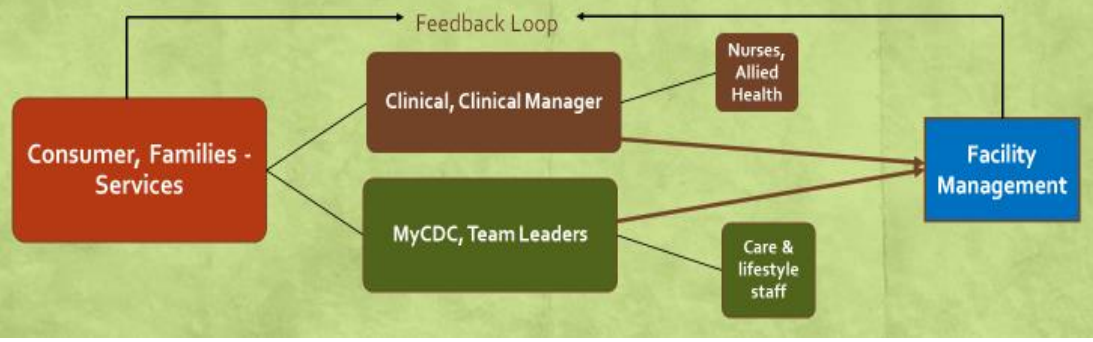
The MyCDC Service model – Key components

- Focus – consumer directs the services as they do in home care settings; *co-design both Clinical Care Plan and Services/Goals Plan*
- Relationship focus not task focus
- Clinical Service Plan: ACAT, assessed needs to maintain health & wellbeing; monitored by clinical governance and quality systems
- Consumer Goal Directed Service Plan: what the consumer wants to do; and how they want those services provided (what, when, with and by whom)
- Continuity of care & service as well as care provider/s & service provider/s. Teams of staff.
- May see a change in roles of some staff and/or times of service, care, activities (not prescriptive, different for each organization)
- MyCDC team leaders may be created (has worked well in pilots)
- Staff training, mentoring, support; clear, regular communication to keep everyone on the same page
- Setting and evaluating pilot measures, targets, indicators or success / outcomes
- Records, evidence, reports – what evidence do we need; how do we gather it? How do we know and demonstrate we are providing choice?
- HR and operational practice, policies, compliance review
- Revisit KPI's, measures, targets, systems, governance (what are the priorities and focus)
- Ongoing feedback loops ensure services are in alignment with wishes, preferences and goals of consumer/family

7

Possible staffing structure – what worked in pilots

- Senior care staff members take up MYCDC Team Leader (TL) role (1 to 10-15 consumers)
  - Given responsibility and time for the goal directed service plan – creation, monitoring & follow up, updating, recording
  - Coordinate & liaise with consumer, families/reps, other staff (clinical, activities, care, management)
- Clinical Manager takes responsibility for Clinical care plans, clinical staff (nursing, allied health etc) & liaison with MyCDCTL
- There is a degree of multitasking by staff; performing a range of roles to meet consumer goals; Ongoing diary of goals/wishes/preferences and constant feedback loop enables continued review and adjustment of services



8

The MyCDC Financial model – Key components

- Supports providers to develop a financial model to provide accountability of funding under the MyCDC model and individualised funding through ACFI & consumer contribution. This allows charges to be set, monitored, reviewed and reported as the service develops. Includes:
  - Developing the budget in a CDC cost format (costs of staff, services; incomes and charges) to reflect operations
  - Benchmarking and review of income and costs
  - Application of model into Turnpoint Software to track and report including on per consumer basis
- Providers work out how they cost, package & present finances. Aim is transparency of funding available against costs of:
  - Providing a 24 hour at call support service
  - Nursing care, clinical care, provision of ADL's
  - Meals, housekeeping, supplies
  - Group activities & therapies
- What can then be negotiated with consumer as part of the service plan is how much funding remains; and how they would like to spend it. If costs exceed available funds, then services or additional costs are negotiated.
- Monthly statements are provided to consumer/families showing funds available and how funds are being spent
- A model of financial sustainability through knowledge of income and costs

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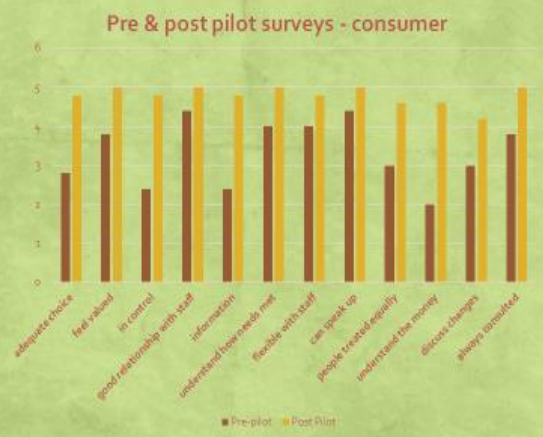
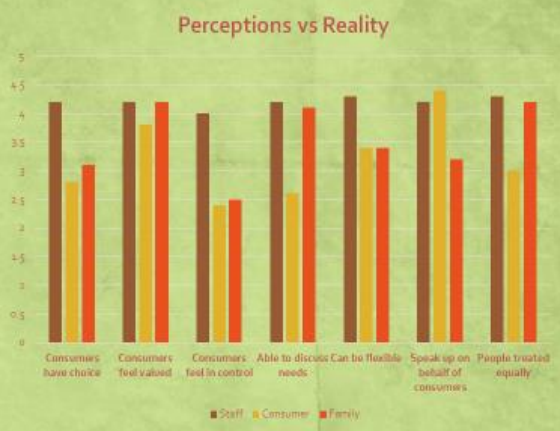
MyCDC pilot sites – survey findings





Legend: Likert scale where 1 = strongly disagree and 5 = strongly agree

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Key feedback from pilot facilities

- Staff, consumers & families involved, are very happy with the changes. Complaints are reduced, with higher satisfaction with outcomes. People feel more consulted, and that the staff are genuinely trying to meet their wishes. There is an increase in compliments.
- Consumers say they have more involvement in both care & service plans. There is more trust & respect; with staff forming closer bonds with consumers. Staff are noting the benefits of these better relationships.
- No major changes with rosters, more about how, when & what people do. Minimal additional hours for MyCDC coordinators but this is really needed especially at start. Some challenges with continuity of care staff, but this could be helped with better forward planning.
- Staff were very concerned about additional work but are more relaxed when realised it's a different way to work; not more work.
- Consumers are not asking for anything elaborate, for anything that would jeopardise their health or wellbeing or regularly changing their minds. Key to meeting any challenges is being open about why something can't happen, options available; and negotiating an agreeable outcome. Staff training & on the ground leadership support is a key to this outcome.
- One of the biggest challenges is changing culture & thinking. Need resources on the ground to reinforce new ways of thinking & behaving, so that cultural change & practice change become embedded as the norm. Takes time to embed a new culture.
- Cannot underestimate the need to also bring consumers on the journey; get on board. Must sell the changes right to get consumers, families and staff comfortable and this takes planning, support, time and on the ground leadership.
- Need to make changes; MyCDC is a good core model (& culture) that you can flexibly implement for your population
- Some challenges with breaking down activities to cost model – is being simplified. Concerned that not much funds available for choices.

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Some examples from pilot facilities

- Staff learning how to reframe discussions around what people want. Staff have to spend time, probe & listen to what consumer used to do, enjoys, makes them happy etc. Need to de-institutionalise consumers & staff from what can be inflexible existing routines around activities, meals etc.
- In the pilot, staff started to get better at spending time with consumers and getting better at following up and following through on actions agreed with consumers, because of the stronger bond.
- Some things consumers wanted:
  - Pets – now have 2 kittens
  - A longer shower with time on their own – renegotiated care plan and this has been provided
  - A monthly social BBQ where they could join in the cooking - implemented
  - To iron their own clothes themselves – checked for safety and where person safe, allowed
  - To go for a walk before breakfast – renegotiated care plan and provided
  - To be able to walk again. Consumer could not, however provider worked with them on "where did they want to walk to" and have now factored that into a program of more outings in a wheelchair
- Important to redevelop tools including for intake, measurement of performance/outcomes, reporting. Ideas include consumer focus groups, quarterly independent review & report.

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The MyCDC Implementation Road Map

Future Vision: My Life, My Choices; MyCDC	Service & Cultural Change	MyCDC Pilot Planning	MyCDC pilot Implementation	Review & next steps	MyCDC finance model
Future vision / options Key staff Workshop • The case for change; what choice looks like • Envisioning your future; what you want your service to be • Considering other practice ideas, & feedback from CDC pilots • Cultural & practice change • MyCDC – overview model components; what a pilot would involve	**MyCDC Service Model Key Staff Workshop** • Changing culture, thinking, & practice; learnings from pilots • MyCDC Model in detail: • Engagement processes with consumers, staff, families, management • Co-design of service and care plans • Service & Care provision models • Staff roles, rosters • Change management • Practice, systems, records and documents change • Financial management aspects of My CDC • Next steps	**Setting Up Pilot** • Organisation leadership & staff commitment • Agree the process, fees & timeframes; contract • Workforce planning workshop with key staff • Pilot site & staff considered & selected • Objectives; outcome measure; milestones; evaluation tools and processes established • Pilot Steering Group • Engagement, surveys, communications • Staff training • Software & training for pilot (optional)	**Steps & Stages** • Staff feedback • Plan & implement service & care delivery • Staff roles, team leaders, teams • Rosters for continuity of care & carer • Communications • Service/choice plans • Key staff support, mini-coaching • Identify document & process areas for change incl: intake, HR, policies, evidence, measures, targets, risk management, evidence, records, reports • Change management • Progress reports	**Outcomes & Learnings** • Post –pilot surveys & discussions, inputs from consumers, family, staff. • Information review e.g.: complaints; consumer choices; feedback; observations; records • Analysis of financial impacts • Analysis of staffing, HR, IR impacts (if any) • Analysis of compliance & accreditation impacts • Analysis, report & recommendations • Ongoing supports needed if continue • Decision: continuance, expansion, cease	**Full consultant support** • Developing the budget in MyCDC format • Understanding costs – what is bundled, fixed & what is left for individual choice • Benchmarking & review of costs & income • Tracking services provided • Using TurnPoint Software (at cost) to track & report per consumer (optional) • Developing & providing individualised finance reports for consumers • MyCDC finance expert support during the process

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Change and Culture – Impacts to Stakeholders

- Implementing MyCDC is a journey of operational & cultural change
- It changes the way people think, behave, act – what they focus on
- A new culture generally takes around 2 years to embed
- It provides the opportunity to revisit & reset organizational values & behaviours; in line with the new operating approaches
- Changing what we do and how we do it is not easy, it requires:
  - A planned, open and clear process for consultation, communication & decision making
  - Understanding fear, loss – paint the picture
  - A clear plan for future directions, with timelines for actions
  - Engagement with and buy in from all key stakeholder groups
  - Leadership, reinforcement, openness, clarity of expectations
  - Review, measurement
  - Communication, communication, communication

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The MyCDC Service model - Summary

- Focus – consumer directs the services as they do in home care settings
- Relationship focus not task focus – work out what can be flexible in care and services
- Clinical Service Plan: ACAT, assessed needs to maintain health & wellbeing
- Consumer Goal directed service plan: what the consumer wants to do; and how they want those services provided (what, when, with and by whom)
- Continuity of care & service as well as care provider/s & service provider/s. Teams of staff – work out who does what.
- May see a change in roles of some staff and/or times of service, care, activities
- MyCDC team leaders may be created (has worked well in pilots)
- Staff training, mentoring, support is important – open dialogue; culture of trust
- HR and operational practice, policies, compliance review
- Records, evidence, reports – what evidence do we need; how do we gather it? How do we know and demonstrate we are providing choice?
- Revisit Unit/organization KPI's, measures, targets, systems, governance (what are the priorities and focus)

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