Developments that support innovations in Aged Care – How Consumer Directed Care will work in Residential Care

Report prepared by Research Analytics

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**** The information contained in this report is based on the CDC models developed by Research Analytics. The models have been trialled in a number of aged care facilities to assess their suitability for conducting a CDC service. The models are designed to be generic in nature and therefore applicable across a range of aged care facilities. The data supplied for this report has been collected during trials or from other residential aged care providers. The information in this report demonstrates the applicability of CDC to those who have agreed to share their data. Any third party should make their own assessment of the data. The detail workings of the financial model has not been included in this report. Funding for the trials was provided by the aged care provider involved in the trial.**

Developments that support innovations in Aged Care – Consumer Directed Care in Residential Care:
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Introduction:

The introduction of Consumer Directed Care (CDC) into the Commonwealth government funded Home Care Package program in July 2015 applied the first principle of consumer power of choice over their services. The shift of the licence to consumers in February 2017 further cemented the control of care in consumer's hands.

In July 2015, consumers were granted the right to choose applicable services within packaged allocated funds. This was followed in February 2017 by empowering consumers with the choice of who provided these services. The ability to choose providers and acquire individual control of their care service has shown early signs of benefiting consumers in the cost of services and the method in which they are delivered.

The introduction of CDC into Home Care Packages has changed the way home care providers operate.

These changes to Home Care Packages pave the way for the introduction of CDC into residential care. This is a natural progression in line with the Aged Care Road Map released in April 2015 by the then Minister for Social Services – the Honourable Mitch Fifield.

A decisive point included in the Aged Care Road Map is that the aged care system will be one of "predominantly individualised funding that follows the consumer" (Aged Care Road Map, April 2015, P9).

A report undertaken by KPMG into CDC in residential care, was released by the Department of Social Services in July 2014. In the executive summary the report concluded that:

"Currently, there is no single 'CDC model' for residential care that could be implemented. It is suggested that reorientation to a CDC approach be considered as a process to be developed over time, rather than a specific 'model' to be implemented"(Applicability of Consumer Directed Care principles in residential aged care home, KPMG, 2014, p4).

Based on the conclusions of the KPMG report, and having developed several models for CDC in Home Care, Research Analytics (RA) turned its attention to developing a CDC model for residential care.

In early 2016 RA conducted a series of workshops on the operation of CDC in residential care where a model of CDC was presented. As a result of the workshops, a residential care provider undertook trials of CDC in their residential aged care facilities.

The CDC model was trialled in 2016 at two facilities. Based on the outcome of these trials the model was further refined and trialled again in 2017 at one of the facilities used in the first trial. Funding for the trials was provided by the aged care provider involved in the trial.

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Executive Summary:

This report provides information about the outcome of these trials (research) and how the CDC model has been successfully applied.

The research methodology and results are detailed in this report. The first series of trials used a number of different elements in shaping services and how they affected funding on an individualised basis.

In essence, the research was a cost of care study to determine how the cost of services could be individualised to each resident. All costs were validated as part of this research.

The research was also validated in terms of the mixture of residents and their need for services. Residents with a high level of cognitive impairment were engaged in the trials and the results reflected how they and their families responded to CDC.

The initial trials used models developed by Research Analytics and were conducted over a six month period from mid to late 2016. An action research approach was considered to be the most suitable method to facilitate the nature of change required e.g. change is intuitive, and the process involves and empowers key stakeholders in decisions about those changes.

Further to these initial trials, another trial was conducted over a six-month period in 2017 at one of the aged care facilities involved in the first trial.

During the initial trials it became evident that the current structure of residential care provides barriers to a workable model of CDC. Clearly, a more effective approach was required for principles of CDC to work.

Research Analytics identified that three major components were necessary for CDC introduction and its ongoing application. These became conceptual models.

During the trials, this made it easy for residents, staff and the organisation to understand and apply CDC in a residential setting. These models formed the basis of the CDC system developed by RA.

The 3 conceptual models developed and trialled were:

- **Engagement** – Where residents (families/representatives) were consulted on their goals and the services they required to meet these goals. This provided choice on what, how and when these services were delivered;
- **Service** – How the workforce was organised to provide the services based on the goals set by the residents (families/representatives); and

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- **Financial** – Setting the cost of the services, providing a system where residents (families/representatives) are charged for these services and the provider's accountability of funding.

Central to the success of these models is the requirement of providers to provide feedback:

1. To the residents (families/representatives) on achieving the specific goals set by them.
2. In ongoing discussion regarding the costs of services, as agreed.
3. Demonstrating their accountability for individual funding.

The outcomes of the research from applying these models were:

- Residents (families/representatives) had increased choice and control;
- Residents (families/representatives) were able to see what they were paying for and evaluate value for money;
- The aged care provider had a system for charging services; and
- The aged care provider could account for funds and supply consumers with transparency of funding.

The engagement and services models are not dissimilar to that of the Home Care system where individualised services meet the goals of consumers.

The financial model was new and required extensive testing to develop a system that could account for funds on an individual basis. Detailed in this report is how the financial model operates and its transferability to other residential aged care operation.

As the financial model was being applied it became evident that there had to be a separation of accommodation and care costs. The initial research combined care and accommodation income and costs. However, this skewed the results and could not be applied across a range of different aged care facilities. Therefore, the financial model accounts for care services only and omits accommodation.

Finally, the operation of the CDC model in residential care, as applied in the second trial, was conducted within the following parameters:

- An engagement process that promoted transparency about costs and services based on available funds. The aim was that each resident (family/representative) would fully understand the services, the cost of these services and how the funds were being spent, based on their choices. This first phase took time to explore resident goals e.g. what was essential to them, what they really valued and were willing to pay;
- The allocation of specific staff to work closely with each resident to ensure the goals and needs of the residents were being met. This included discussing funds available in regard to their choices;

- This personalised approach placed residents (families/representatives) in control of the services they required;
- The provision of a service that supported residents after hours. This was a standard charge across all residents in the facility;
- Allocation of clinical and essential living services to residents based on their need for these services. Residents were charged according to these requirements;
- Funding available for residents (families/representatives) to expend on other services (choices);
- A software and financial system that tracked services (as required) to provide funding accountability; and
- Monthly statements showing funds available and the charges for services provided.

Conclusion:

As detailed in this report the research carried out by Research Analytics has shown the model developed for CDC in residential aged care provides:

- Genuine choice for residents (families/representatives);
- An affordable service for residents (families/representatives);
- A sustainable financial system for residential aged care providers;
- Improved outcomes for residents (families/representatives) and staff; and
- An affordable model for government funding.

Over a period of time, and as identified by Research Analytics, the model will be further refined and developed to meet the needs of different communities. The model presented is not a "one size fits all". The diversity of Australian culture will drive further refinements. It has a series of variables that can be tailored to an individual residential aged care provider. It is a model that has been proven to operate successfully.

Furthermore, Research Analytics found that the CDC models trialled pointed to the importance of effective and educated leadership. Individual managers need to be the champions of change and make CDC 'real'. Leadership was a key element determining the success or failure in the trials. Effective leadership cannot be overemphasized in successfully implementing CDC into residential care.

Finally, it is important to point out that CDC in residential care has implications for the new single standards to be applied to Home and Residential aged care in 2019. These include a choice for consumers in services and the manner in which these are provided.

The conclusion from the research is that while this works in home care it is unsustainable in residential aged care under the current system.

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Without accounting for individual funding, an aged care provider is unlikely to be able to meet this standard in residential aged care. This resourcing issue can only be met with a thorough and dedicated financial system that responds effectively to expectations instigated by consumer choice.

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Outline of the objectives and scope of the report:

Description of the report:

This report provides a series of models for operating Consumer Directed Care (CDC) within a residential aged care facility.

It also provides practical examples of the application of the financial model for CDC in residential aged care. The data for the examples used in the financial models has been supplied by current aged care providers.

The models developed for providing services under CDC including:

- The model of engagement:
    - The manner in which the engagement model operates to provide genuine choice of services; and
    - How these choices are then reflected in the daily services and meeting resident's goals.
- The model of services:
    - What services are available?
    - How the services are planned to meet resident's goals; and
    - How these services are organised, categorised and the basis of calculating their usage.
- The model for financing services under CDC:
    - What charges are applicable and what services are provided for these charges? This includes choices available for residents for other services;
    - The affordability of services for residents in a CDC model;
    - The sustainability of CDC for the aged care provider; and
    - What is included and excluded in a CDC model.

The report demonstrates that the models are applicable across a range of aged care providers and achieves transparency in funding, affordability by residents and a sustainable service for aged care providers and the government.

The validation of the models was made through a series of trials. The methodology and approach to the trials is detailed in the report.

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The report provides examples of a series of residential operations. There are seven examples developed as “working models”.

- A small rural aged care facility with 30 beds operating as a standalone facility;
- An aged care facility with 40 beds operating as a standalone facility;
- A rural aged care facility with 60 beds operating as a standalone facility;
- A regional aged care facility with 75 beds operating as a standalone facility;
- A metropolitan aged care facility with 110 beds operating as a standalone facility; and
- A large multi-site aged care provider with a mixture of facilities with varying bed numbers and locations. Two of the facilities are included as part of the examples.
    - One site with 70 beds
    - One site with 110 beds

The examples use the financial model to demonstrate the suitability of CDC to all stakeholders.

The funding currently provided for residential care is sourced from two areas (government and residents). The question of how applicable is this to operating CDC in residential care is outlined.

The report provides an assessment of the current funding model and discusses an alternative funding model.

The report also discusses the benefits of CDC operating in residential care where residents are afforded the same choice as those accessing home care.

Finally, the report formulates a discussion on the possible timing of the introduction of CDC into residential care.

Principles of Consumer Directed Care (CDC) in residential aged care:

Consumer Directed Care (CDC) is an approach where the resident (their family/representative) is consulted about their individual service (care) plan and associated costs. They are given choice about how they wish to have their services provided and how to spend the funds available. As with CDC in Home Care, the services are directed by the resident or their families/representative so their goals and needs are met in accordance with their wishes and within the resources available to them.

CDC provides transparency about the cost of service with residents as the recognised consumer of the service. This results in residents (and their families/representatives) being informed about how much money the Government provides for specific care services as well as their own contribution and the breakdown of the charges applicable to the service.

The Principles of Implementing CDC:
The principles by which CDC is carried out in a residential setting are similar to that of Home Care with some variations.

- CDC in residential care is based on the normalisation model. This model is designed to provide the living experience of someone in residential care. The service is to mirror (as much as possible) everyday life in the community. It is to be normal;
- Each resident (and/or their family/representative) are provided with their clinical care needs as they have been assessed and agreed upon;
- Each resident (and/or their family/representative) develop the goals they wish to achieve while living at the facility. This includes areas of their social, emotional and physical needs;
- A frank and open discussion is held with the each resident (and/or their family/representative), prior to the commencement of the service, (and then again over the period of the first couple of months) about the funding available for the service and how the costs of services align to the funds available;
- The goals and funding are reviewed on a regular basis in a feedback system for each resident (and/or their family/representative) to ensure the goals are being met and funding is available to meet these goals;
- Resident (and/or their family/representative) have the ability to make adjustments and/or seek more individualised services to meet these goals;
- Each resident (and/or their family/representative) is able to make choices within the clinical and care services as well as lifestyle activities to meet their goals;
- Financial information is provided each month on funds available; and
- As each resident (and/or their family/representative) have control of their services the relationship with them (and/or their family/representative) changes from a service provided to services selected.

This is a change in the focus, mindset and power structures

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Detailed description of the approach and methodology used and the data that formed the basis of the analysis

Background

In 2016, the provider commissioned Research Analytics to undertake research to trial a new service model in Residential aged care (RAC). The new model of service was Consumer Directed Care or CDC. The impetus for this was underpinned by a change in Government policy. CDC heralds a major paradigm shift in the way aged care is provided and funded. It also signals a distinct move towards a user controlled system.

The Trials

Trials were undertaken at two of their aged care facilities.

This initial trial included 17 residents located between the two sites. A further 16 residents acted as a control group at the two sites. The trials were conducted over a period of 6 months.

The method used was a small model trial. This type of trial allowed for a greater level of understanding of how CDC operated. The scale was such that time could be spent with residents to properly understand the effects of CDC and how it could be operated.

The approach and methodology used comprised of:

- An action research methodology was adopted as it is iterative and facilitates change. Importantly, it involved those most affected by the change in the change process.
- A customised financial model was provided. It was based on trial sites financial data. It enabled managers to have a concrete financial model of CDC. It showed the level of resources available under current funding.
- A key theme of the research was site managers and their staff would be as hands on as possible to imbed any CDC change. Hence a Train the Trainer approach was adopted and relevant training materials provided.
- A critical component of CDC is the process of engagement with the resident/representative (as the Consumer).
- Staff recorded times spent with residents on different services so an accurate costing of services could be provided, on an individual basis (this was a manual process).
- Financial information was fed back to the facility managers during the Trial indicating the amount of individual resident funds and how much they had spent. This allowed the facility managers to have a conversation with the residents about how they wish to spend their money.
- Surveys were taken pre and post-Trial with residents (families/representatives) and staff to gauge the changes in attitudes and perception as a result of the trials.

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- There was a control group of residents at each site who were not involved in the trial and these were surveyed pre and post-Trial.
- Based on the feedback and results of the surveys the trial has led to a number of improvements. This is in services and relationships between residents and staff. This is attributable to the manner in which the trial has been conducted and applying all of the CDC principles.

** - Comments on the Surveys used:
The surveys were developed from a template that is commonly used to measure resident satisfaction with services (refer Chart 4 – page 52). The emphasis was changed to ask about choice and control rather than satisfaction with the service. The surveys were not pre tested as it was felt they presented a similar format and style as other surveys carried out as part of the feedback process conducted on a regular basis.

The surveys have since been used in subsequent trials and validated in terms of the understanding of the questions and their ability to reply in an informed manner (replies from residents are consist with the early trials).

The surveys are focused on the control and choice by residents. This is not a measure of the quality of care but rather how they felt they were in control of the care provided and whether they could direct that care.

While the trials were from a section of each facility the spread of resident conditions were such that they covered a series of low care to high care needs including a number with serve cognitive impairment. The range of Aged Care Funding Instruments (ACFI) for the initial trials ranged from $111 per day to $211 per day. A total of 65% of residents had an ACFI higher than $163 per day.

The second trial (in 2017) involved the same methodology with some of the same residents (eight) involved in the first trial at one of the aged care facilities. Again, the condition of the residents in the second set of trials range from medium to high care.

There was no control group included in the second trial as the models of engagement, service and financial were outcomes of the first trial. This second trial focused on being able to refine the models so that all aspects of CDC could be applied to the satisfaction of the residents involved. The outcome of the surveys, at the conclusion of the trial, indicated the trial was successful in providing resident satisfaction across all aspects of the models (refer Table No 19 – page 58).

During the second trial a full facility CDC model was developed that allocated levels of clinical and core services to every resident and the projected rosters to provide CDC across the whole facility. This part of the trial further validated the models use and the ability to deliver a CDC model on a facility basis. This validation related to individual resident

affordability, staffing levels and availability and the financial sustainability of the aged care facility.

Data that formed the basis of the analysis:

The data collected consisted of:

- Results of pre and post surveys with residents, families/representatives and staff;
- Times spent on provided nursing, assisted daily living and lifestyle services for each resident in the trials;
- Individual interviews with residents, families, representatives, management and staff during and at the conclusion of the trials;
- Individual service plans
- The financial data for each aged care facility including:
    - Annual budgets for the facilities
    - Staff rosters
    - Staff pay rates (EBA details)
    - Individual Aged Care Funding Instrument (ACFI) levels
    - Individual resident contributions

The above data was used to as the information for each of the models to test their validity for use in CDC in residential care.

Summary of trials in CDC:

The approach and methodology was designed so that it provided a feedback loop as the research was in progress. Several changes were made to engagement, service and financial models as the first set of trials were in progress. Again with the second trial adjustments were made to find the right fit.

The question of the size of the trials and the validity of the data can be relied upon for the following reasons:

- The level of acuity and conditions were representative of the general population of aged care residents as determined by the level of ACFI funding for the residents;
- The times taken to provide individualised services matched the level of acuity and condition that related to the particular individual resident;
- The results of the surveys from both residents (family/representative) showed a significant increase in their satisfaction of the service where goals were met; and
- Due to the size of the trials a greater personal approach could be applied to find out what was working and what was not.

The results of the resident surveys, pre and post-Trial, supported evidence that the current service model (non CDC) does not provide the type of choices that residents require once they are given control of the services.

There were four major outcomes from the initial trials:

1 That CDC in residential care does not operate within the current service model offered by aged care providers.
2 The new service model requires flexibility to meet the needs of the resident (as directed by them) and at the same time allow the care provider to operate sustainably.
3 An engagement tool needed to be developed to gain the knowledge and understanding of CDC by the resident and their families.
4 The service and financial models (and associated tools) needed to be refined to provide better clarity for all stakeholders.

Leading on from these initial trials the 2017 trial applied the learnings from the first trials and fully tested the service, engagement and financial models so they could become operational across a whole facility. Some of these residents were also involved in the first trial. There was no control group in the second trial.

The statistical analysis from the first trial indicated that while there were some improvements made in the way residents perceived services the current model of services did not provide choices. The second trial used the newly developed service model to deliver services in accordance with CDC principles and provide genuine choice.

*** - refer appendix 2 for detailed information on the tools and processes used in the trials.

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Methodology used to analyse the data

The methodology used to analyse the data included:

- Results of pre and post surveys with residents, families/representatives and staff;
    - The scores were based on a Likert scale from strongly disagree (rating of 1) to strongly agree (rating of 5).
    - These scores were entered for each category (resident, family, representative, staff) against each of the questions.
    - The scores were aggregated and an average score was calculated per question and then an average across the different categories
    - The pre and post averages were compared to determine if the trials had changed the answer to the same questions in each category.
    - An excel spreadsheet was used to analyse this data.
- Times spent on provided nursing, assisted daily living and lifestyle services for each resident in the trials;
    - These times were fed into an excel spreadsheet against each resident for each day. Monthly calculations were made for each resident to determine their use of the services. The times were then averaged against each type of service.
- Individual interviews with residents, families, representatives, management and staff during and at the conclusion of the trials;
    - This was data collected from interviews and detailed in reports on the trials.
- Individual service plans;
    - These were developed for each resident using a standard goal directed template.
- The financial data for each aged care facility including:
    - Annual budgets for the facilities
    - Staff rosters
    - Staff pay rates (EBA details)
    - Individual Aged Care Funding Instrument (ACFI) levels
    - Individual resident contributions
        - All of this data was fed into the financial model developed in an Excel spreadsheet.

All of the data was entered manually during the period of the trials. Initially an Excel spreadsheet was used to produce individual statements each month. The software application was developed during the second trial and used for entering the individual services and producing budgets and statements for each resident.

*** - refer appendix 3 for detailed information on the methodology used to analyse the data.

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How CDC operates in the residential care setting

- **The Engagement Model**
- **The Service Model**
- **The Financial Model**

The Engagement Model

The engagement model involves the engagement with residents (family/representative) and the staff within the organisation.

The engagement model with residents (family/representative) is based on consulting them on the goals and services they required to meet their needs. This provides choice on how and when these services were delivered.

The research also provided insights into how this engagement operated.

The first set of trials involved residents that had been in the facility for some period of time. The staff also included members who had been employed at the facilities for a number of years.

When the trials began it took a number of months, and many conversations with residents (family/representative), before the idea that they had choice in services was seen as an option for them.

Initially, there was a lack of understanding on what was meant by choice and many residents (family/representative) were not familiar with the idea that they could ask for what they wanted.

It was concluded that this was due to a type of "institutionalisation" by the residents (family/representative). The idea that choices could be made was foreign to them as they had adjusted to the routine and regimentation of the services.

Interviews during the trials found that many residents (family/representative) expressed a level of powerlessness in determining their service. However, they spoke highly of the staff but found the system had taken away their choice.

Therefore, the result of engaging with the residents (family/representative) initially started with some resistance before they fully understood what was available to them.

On the other hand, there were several new arrivals during the trials. In these cases the engagement was much easier and they availed themselves of choices from the beginning.

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The similar resistance was found with staff. Staff were task oriented and had a set routine to achieve these tasks in a set time frame.

It also took staff some time before they understood that the task had to be tied to the goals and needs of the residents (family/representative). Adapting to meet the choices was initially difficult. This was demonstrated in one of the first trials sites where changes were not made to meet the goals and needs of the residents and the CDC model did not operate as it should have.

Therefore, the main engagement with staff was to educate them in how CDC operates and what changes are required in order to apply a CDC system.

In many cases it was found that staff adapted. However, there were cases where staff could not adapt and they struggled with the changes. Further education and mentoring was provided to these staff.

*** - refer appendix 4 for detailed information on the process used to engage with both residents (family/representative) and staff.

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The Service Model

Services available to residents as part of their plan

The service model is used in the engagement model in providing the basis of what services are required to meet the goals and needs of the residents (families/representatives).

The model is how the workforce is organised to meet the goals of the residents (families/representatives). The model is also based on a normalisation process which matches the resident's experience with lives prior to taking up residency in the care facility.

The service model.

The service model for CDC is one operated by senior care staff members who are allocated a number of residents to be their main contact (in the trials it was 1 senior care staff member per 8 to 9 residents). These senior care staff are then responsible for the services so the goals of each resident are met to the satisfaction of the resident (family/representative). They also liaise with families/representatives, other care staff, nursing staff and management to undertake their role.

Below is one form of structure for the organisation to undertake CDC (this was the structure developed during the research which has proved to be successful):

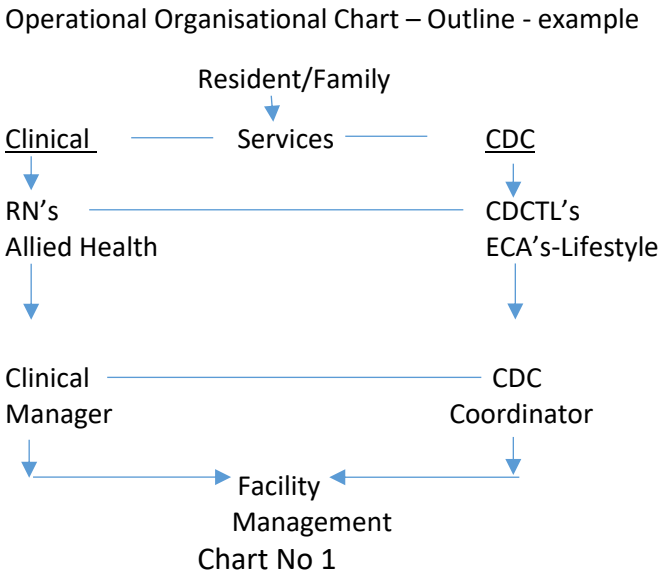

Chart No 1

Under this service model the CDCTL's (CDC Team Leaders) operate the service to meet the individual resident's goals and coordinate services with others within the structure.

The service model involves a level of multitasking by staff. Staff perform a series of roles that will meet the goals set by residents.

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As a result of this the model it was found to be a more efficient model which resulted in less time in segregated duties and handling issues of complaint or concern.

It is understood that this model is currently being employed by a number of residential aged care providers to increase the connection with residents, meet their goals and needs as part of what is often referred to as a "person centred" approach to care services.

The difficulty with this model ("person centred" approach) is twofold:

- Firstly, it does not alter the relationship between the provider and the residents (families/representatives) and there is the issue of the resident feeling powerless and open to retribution; and
- Secondly, the model is not financially sustainable and often suffers from an inability to meet residents goals based on available resources.

Service Planning:

The CDC service model produces two service plans:

- Clinical service plan; and
- Resident goal directed service plan

The clinical service plan covers the areas of clinical care required by residents to maintain their physical health and wellbeing (a wellness model). This is in place in the current model of residential care. In some cases it is the only service plan. The plan and its application are maintained by the clinical staff.

The resident goal directed service plan is the one developed during the engagement process. This details all of the resident's goals and how they (family/representative) wish to have their services provided. This service plan is used on a daily basis by the CDCTL's to monitor the achievement of the goals and to make any changes required.

This plan is maintained by CDCTL's and notes are recorded on the progress of the individual plans.

Rostering of Services:

The rostering of services is split into three parts:

- The roster for providing a service for after hours (normally afternoon and night shift);
- The roster for clinical care and core living services; and
- The roster for other services to meet the residents (families/representatives) goals.

The difference between these rosters is further explained in the financial model. This form of rostering was used in the second trial and found to be effective in meeting all of the

clinical, core living and other services that met the goals of residents (families/representatives).

Software has been developed to cater for this type of split in rosters.

Summary of Service Model:

The service model has a level of flexibility in terms of the overall structure to be operated. This similar to other processes in CDC where the residential aged care provider has the ability to set up a structure in a way that suits the residents and the environment.

Again, this is similar to the operation of home care where the service model is planned and delivered so as to meets the goals and needs of the client.

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The Financial Model

What charges are applicable for the services and what services are provided for these charges? This includes choices available for residents for other services;

The financial model is aligned to the service model and used in the engagement model when communicating the charges for services and determining areas residents (families/representatives) wish to spend their funds.

It should be noted that the financial model only includes amounts relating to care, lifestyle and clinical services. The cost of accommodation is not included.

There are five components to the financial model which makes up the charges for each resident for the services they receive.

1 A charge for the after-hours support service. This is a daily rate applicable to each resident and is not based on need but available resources to provide this coverage of qualified staff.
2 A charge for the core clinical and care (assisted living) services as calculated during the initial month of receiving services (referred to as core services). This amount is converted to a daily amount and added to the After Hours service cost for a band of 4 levels.
3 Direct expenses for purchase of required medical and living aids.
4 Charges relating to services over and above the after-hours and core clinical and care services.
5 Charges which are over and above funds available. These are additional amounts the residents (families/representatives) may wish to pay for services over and above the general funding available.

** It should be noted that each of the components of these charges are "within" the current care subsidy provided and the services equate to those included in the Quality of Care Principles. Any charges above the care subsidy or the resident's contribution are included as part of charges over and above meeting the Quality of Care Principles.

A charge for the After Hours support service.

This charge is calculated per resident for the afternoon and night shift staff on duty who provide the coverage for after-hours services.

The calculation is across the 7 days covering the cost of allowances, penalties, oncosts, overheads and margins.

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The rate per day will vary between aged care providers based on the level and type of staffing across these periods. Aged care providers will need to ensure suitably qualified staff are on duty and also provide a competitive rate.

Residents (families/representatives) will assess this charge based on other competitors providing the service and their perceived value for money.

Aged care providers will also be able to determine (using the model) how much they allocate to this service and what may be attributable to core or other services.

A charge for the core clinical and care (assisted living) services to meet the resident's needs (core services)

As per stage two of the engagement model residents are assessed in terms of their use of core services. A matrix tool has been developed to guide the assessment of these services and to categorise services into four levels.

*** - refer appendix 5 for the core services matrix.

The matrix is designed to allocate core services on an equitable basis across all residents within a facility. The tool has demonstrated that it provides an accurate assessment and one that residents (families/representatives) find easy to understand and relate to the charges made.

The charges included in this service are:

- All nursing services;
- The care services that meet the core daily living needs of each resident;
- The cost of the CDC Team Leaders who provide the focus on meeting the resident's goals and also provide core services; and
- The cost of overheads and margin as part of the pricing.

The matrix is an individual facility model that can be varied by each aged care provider.

The recording of these services is only taken when the initial service begins or when there is a change in the conditions or circumstances of the resident (suggested period of recording is between 2 to 4 weeks).

The calculation is not hard and fast and again can be varied by an aged care provider. The model allows these times to be adapted for a different mix of residents within a facility.

Direct expenses for purchase of required medical and living aids.

This the cost of medical and incontinence aids that are attributable for an individual resident.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

Charges relating to services over and above the After Hours and core clinical and care services.

These are charges for services based on the choices residents (family/representative) make on the remaining funds available.

These relates to meeting the goals of the residents (family/representative).

This charge is accounted for in the statement of funds. CDC provides accountability on funding and charges so the process is transparent to the residents (families/representatives) and based on the agreement reached.

Further details and examples of how these and other charges operate are shown in the report under practical examples of CDC in residential care.

Any charges that are over and above funds available

Where the goals of the residents (families/representatives) are beyond the funds available then this involves the discussion outlined in stages one and three of the engagement model.

A resident (family/representative) will decide if additional funds are required for activities and other services they wish to access.

During the trials it was found that a number of residents, and in some cases their families, wished to purchase a higher level of service. This was discussed and negotiated on an individual basis.

Funding accountability

The funds available and the charges for services are documented in a monthly statement provided to the resident (family/representative). This is the same format as is currently required under the Home Care system for CDC. In home care, it is legislated that the provider has to agree with the client, an individualised budget.

The basis for calculating usage of Services – as part of the Service Plan

The services available to residents are part of their service plan:

The services included in the After Hours and core services charges include:

Item	After Hours and Core clinical and care services(assisted living services)
	Administration
	Toiletry goods
	Emergency assistance
	Daily living activities assistance – Basic Daily Needs
	Emotional support
	Treatments and procedures
	Support for care recipients with cognitive impairment
	Goods to assist care recipients to move themselves
	Goods to assist staff to move care recipients
	Goods to assist with toileting and incontinence management
	Nursing services

Table No 1

** This list has been taken from the Quality of Care Principles as listed in the current Aged Care legislation.

The services that are then included in the direct charges to residents, based on their goals include:

Item	Services which are Chosen by resident and charged accordingly
	Meals and refreshments
	Care recipient social activities
	Cleaning services
	Laundry services
	Daily living activities assistance – Additional needs
	Recreational therapy
	Rehabilitation support
	Assistance in obtaining health practitioner services
	Assistance in obtaining access to specialised therapy services
	Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services
	Other services as required to meet the goals of residents

Table no 2

** This list has been taken from the Quality of Care Principles as listed in the current Aged Care legislation.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

The above service charges are recorded for each resident in accordance with the service model and became part of the statement showing income and costs.

Tracking:

In the research the tracking of services were initially completed manually (pen and paper). The manual recording provided a consistent capture of times of services. However, there were areas where the recording was considered not accurate and allowances were made for this in the analysis of the charges for each resident.

The recording demonstrated the following in regard to services:

- The daily times for core services were consistent from day to day;
- This was due to the routine carried out by either nursing or care staff;
- After a period it was determined that the core services did not need to continue to be recorded (unless a resident's condition changed) and the residents (families/representatives) were satisfied with the basis of these charges;
- Recording of other services continued (lifestyle, activities, rehabilitation, etc.) so an accurate picture of services was produced on an ongoing basis; and
- In the medium to long term manual recording was not efficient or effective.

Software is now available to record services under the new format.

The software is Turnpoint Care. This is a cloud based system and is being used by many Home Care providers for all of their rostering, invoices and tracking of services.

This software is modified to allow for:

- Recording of services as part of the core services;
- Recording of services that are part of meeting the resident's goals;
- Producing a real time tracking of income and services costs for each resident;
- Producing budgets for residents based on the services and goals selected;
- Producing monthly statements of income and services costs per resident;
- Rostering of staff to meet CDC format and services; and
- Provides a services plan that meets the goals of residents.

The use of technology for CDC in residential care is an important part of tracking and fully accounting for funds. Other software is likely to be developed in the future, but Turnpoint Care is currently the only software that is applicable to CDC in residential care.

Method of Charging:

A series of charge out rates have been produced based on the operation of an aged care provider.

Based on the research there were four levels of core services developed. They are calculated using the core service matrix (refer appendix 5 for the matrix).

** An Example – indication of the charge format (practical working models are included later in this report)

Category (level)	Rates per day for the After Hours service	Rates per day for the core services	Total Rates per day for these services
1	$62.85	$30.50	$93.35
2	$62.85	$60.25	$123.10
3	$62.85	$76.20	$139.05
4	$62.85	$90.50	$153.35

Table No 3

Service	Rate/Hour
General Assistance	$42.00
Allied Health	$95.50
Activities - Group	$4.20
Activities - Individual	$42.00
Medical – living aids	As per usage
Living Expenses	Rate/Day
Meals/Food	$33
Housekeeping (Laundry/Cleaning)	$14

Table No 4

These tables demonstrate the charge rates for services. This type of charge layout will allow potential residents (families/representatives) to compare different care facilities on price and services offered in the future.

It also allows the aged care provider to price their service, provide residents (families/representatives) with information on price and compete with other services.

What is included and excluded in a CDC model

The initial research took an approach of including all aspects of the services offered by an aged care provider.

This research demonstrated a number of anomalies between care and accommodation income and costs. Depending on the form of funding obtained some residents had a greater capacity to pay for service than others.

The funding for residential care is split between:

- Accommodation payment;
- Payment for care services; and
- Payment for general living expenses

In each of these areas there are a number of payments made by either the resident and/or the government.

In the case of accommodation payments they are made by the resident in the form of Residential Accommodation Deposits (RAD's), Daily Accommodation Payments (DAP's) or Daily Accommodation Contribution (DAC's)

In the case where residents are unable to make payments for accommodation then the government makes a contribution as a daily supplement.

Payment for care services is a combination of government funds (Aged Care Funding Instrument- ACFI) and possibly each resident. The level of a resident's contribution in this area is subject to a means test.

Payment for general living expenses is made by the resident. The resident contribution is set at 85% of the single adult pension.

The outcome of the research was that accommodation and care/living funding should be separated.

The model of the Commonwealth government Home Care services (Home Care Packages – HCP's) was then adopted as the framework for how CDC should be operated in residential aged care. In Home Care the services cover the needs and goals for the clients to remain in their own home, independent and include housekeeping, personal care, transport and meals, etc.

It was felt that it should also apply to residential aged care occupants as well.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

Service included in the CDC residential care model (income and charges):

The services that were classified as being part of the income and charges for CDC were:

- Income (resident's funds to be used to provide services)
    - Government Funds from ACFI
    - Resident daily contribution (85% of the pension)
    - Resident payments for any additional services required to be purchased
- Charged services
    - Assisted living services
    - Lifestyle and recreational services
    - Enablement services
    - Clinical care
    - Medical expenses
    - Meals
    - Cleaning/Laundry services

** As per tables No 1 & 2 shown in the "The basis for calculating usage of services" section of this report (p22).

Also included in the charge out rates is the cost of general administration and a margin for providing the service.

Service excluded in the CDC residential care model (income and costs):

The services that were considered not to be included as being part of the income and charges for CDC were:

- Income (income from resident to pay for accommodation)
    - Government Funds for accommodation supplements
    - Payments from residents in the form of – RAD's, DAP's, DAC's
- Costs
    - Depreciation/Rent
    - Maintenance and insurance related to buildings
    - Labour costs for maintenance
    - Utilities

Summary of included and excluded in the CDC residential care model:

As set out in the executive summary and CDC principles the above follows the normalisation model of services and is in alignment with how Home Care is currently delivered. It is also in line with other forms of aged accommodation where accommodation and care services are provided separately – i.e. retirement villages and independent living units.

Providing genuine choice of services to meet residents' goals

The concept of choice

Choice is often raised as one of the areas that may prove difficult in providing CDC in residential care. However, our research found that choice is a matter of empowerment of the resident (family/representative) to be able to make decisions on the type and time of the services. While there may be limited choices (due to the condition of the resident or available resourcing), the research found that the exercising of choice provided significant benefits to residents.

Choices made

Choice for each resident is maintained at all levels of the service. This choice commences prior to the person taking up residency, in the early stages of occupancy and during their stay. The choices as part of the service include:

- Clinical Care:
    - The resident (family/representative) are able to choose the services that meet their needs in this area;
    - They are able to choose the timing of these services;
    - They are also able to refuse the services (as sometimes may occur) based on their preferences; and
    - They are able to choose staff they feel they have a greater connection with.

The choices made are gathered through the process of the engagement and form the basis for their goals in this area.

** The research found little or no evidence that residents refused clinical care or made choices which would endanger their wellbeing. In all cases we found residents (families/representatives) understood the importance of maintaining their health and wellbeing.

- Core Care (Assisted Living) services:
    - The resident (families/representatives) are able to choose the services that meet their needs in this area;
    - They are able to choose the timing of these services;
    - They are able to exercise their choice in the manner in which the service is provided; and
    - They are also able to refuse the services (as sometimes may occur) based on their preferences; and
    - They are able to choose staff they feel they have a greater connection with.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

The choices made were gathered through the process of the engagement and was based on their goals in this area.

** The research found little or no evidence that residents refused these services or the staff used. There was extensive staff training prior to the trials and staff fully understood their performance was based on the satisfaction of the resident (family/representative).

In the research there were cases where staff lifted their performance in their roles as relationships changed. This is evidenced by the feedback from residents.

- Other services – further assistance with daily living, lifestyle, enablement services, meals, housekeeping service:
    - These areas provided residents (families/representatives) with how they wished to live their day to day lives;
    - These services are individualised to match the goals set and were carried out within the available resources;
    - Where further resources are required residents (families/representatives) have the choice to make further contributions towards meeting services.
    - Some of these services are provided by outside professionals or contractors.

** The research showed the goals set by individual residents varied greatly and the CDCTL's role was to put actions in place that would meet these goals. Initially, some residents goals were extensive and outside of their available resources. As a result they modified these to accommodate what they could afford. After some time the residents (families/representatives) goals became routine and were able to be met through the services.

Summary:

Providing genuine choice is an important part of the engagement model and how the services are presented to residents (families/representatives). The opportunity for residents to be able to exercise choice is maintained at all levels and in a vast majority of cases residents (families/representatives) exercised these choices in a rational and considered manner.

However, it is understood that a number of residents do not have the capability to choose (due to their condition) and also have no family/representative. In these cases they rely upon Public Trustees, Guardianship Boards or appointed Advocates to make these choices for them.

It is important that residential aged care providers ensure the choices made for these residents is in accordance with their rights and maintain their health and wellbeing (both mental and physical).

The affordability of services for residents in a CDC model

The affordability of services for residents is dependent on three factors:

- The cost (price) of providing after-hours support services;
- The cost (price) of providing the core services to maintain health and wellbeing; and
- The cost (price) of providing other services that will achieve the goals set by the resident.

Based on the model of providing after-hours services and the 4 levels of core services the affordability for each level depends on the level of funding. This will vary from resident to resident, but is based on their requirement for services. Included in the examples are a set of charges for the different types of residential services and the funds available to residents (family/representative) across the 4 levels in the funding.

The tables in the examples indicates the amount of funds each resident (level) would have each day for other services including – Lifestyle, Other Assisted Daily Living Services, Meals and Housekeeping, etc. The amounts vary for each level. This is mainly due to the fact that the current Aged Care Funding Instrument (ACFI) does not directly correlate with the services residents require or choose.

The research showed that AFCI is not necessarily directly aligned to the actual services. The ACFI instrument is "skewed" in the way it determines funding.

The summary table (no 5 page 32) shows the amount that a resident would have on a daily basis, for purchasing other services.

Affordability of the service

Under CDC any affordability will be determined by the residents (families/representatives) and how the aged care providers sets their charges.

In the early stages of the operation of CDC the charges and affordability is likely to be similar to the current level offered by aged care providers.

Residents currently receive services that meet their needs as part of the aged care standards applicable to residential care. It is a fundamental requirement for each resident to have no unmet needs.

The difference with CDC is that these needs are met in accordance with the goals and wishes of the resident (family/representative) and within their individual available funding.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

In the future the charges are likely to change to become more competitive. This is the current experience with the Home Care packages. Many of the more expensive providers have lost market share while those who operate a quality services, at competitive rates, have gained market share.

The question of affordability under the CDC model and the current arrangements is the ability to individualise services and charges. The current arrangements in residential care allow a "pooling" of funds which are then directed by the aged care provider. The CDC model changes this arrangement and provides accountability of funds. In home care, the funds are accountable at an individual client level and not able to be used as part of pooling arrangement.

It is expected that as a result of CDC in residential care there will be a series of innovative models developed by aged care providers. This will be to the advantage of the residents (families/representatives) and these aged care providers.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

Practical examples of CDC in residential care:

This report provides practical examples of CDC in residential care, the services received by residents, the method of charging resident services and how choice is fully available to residents. The examples include:

- Seven working models, based on data provided by current aged care providers;
- Detailed financial modelling to demonstrate how CDC operates financially; and
- The affordability for residents and financially sustainable operations for aged care providers and the government.

The modelling operates utilising four pieces of information from an aged care provider:

- Their yearly budget showing detailed income and expenditure.
- The rostering of staff.
- The rates payable to staff (either through the award or an EBA).
- The ACFI rates for each resident (and any care supplements payable).

This information is fed into the model to produce the charge out rates. The model is flexible in the way rostered shifts and costs are allocated and aged care providers are able to allocate costs in any number of combinations.

The information is provided in the format of Tables 3 and 4 (p24) as well as information about the financial return for the aged care facility.

As the data has been provided by a range of current aged care providers the data is considered representative of the industry. The facilities are located in different states with different cost structures, EBA's and operations. The information has been used in confidence.

The data used in each of these examples are from the organisations 2016/17 financial year results.

It should be noted that the calculations in the model are shown in dollars and cents per category. These examples have been rounded to the dollar for reporting purposes.

*** - refer appendix 6 for detailed information on each example.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

Summary of charges for the examples

The summary below (table no 5) shows variations from provider to provider with the differences in rates attributable to:

- The scale of the operation.
- The percentage of residents at the different levels.
- The level of AFCI funding available.
- The manner in which shifts are arranged with different levels of qualified staff. E.g. the smaller facilities often run with an RN on night on call.
- The pay rates for different staff, either under the award or an EBA.
- The level of overheads carried by the facility. A range of charges are applicable with many smaller facilities outsourcing some functions.
- The expected rate of returns for the facilities. In these examples the rate of returns ranged from a margin of 5 to 10%.

Amounts remaining after initial charges per day				
	Level 1	Level 2	Level 3	Level 4
30 Bed Rural - Standalone	$71	$91	$117	$101
40 Bed Rural - Standalone	$77	$101	$127	$116
60 Bed Rural - Standalone	$65	$88	$106	$109
75 Bed Regional - Standalone	$66	$97	$112	$116
110 Bed Metro - Standalone	$76	$107	$120	$123
70 Bed - Multisite	$73	$90	$119	$109
110 Bed - Multisite	$67	$98	$111	$127

Table No 5

It is important that the figures are not seen as some form of comparison of the performance of the operation of each facility. Rather, under CDC they are viewed as to whether they are reasonable charges for residents. At the same time CDC has to provide a return for the aged care provider so they remain viable and are able to provide the service.

A further comment needs to be made in respect to the EBITDA for each example. The EBITDA is affected by the level of depreciation charged. These examples include a range of buildings of different ages. Some have a low depreciation charge as the buildings are older and attract a smaller charge. Others have newer buildings which attract a higher charge for depreciation.

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

Summary of charges across each facility

Summary of CDC Charges to residents and Returns to aged care providers – per day (unless otherwise stated)									
	Levels	**After Hours Charge**	**Core Service**	**Available funds**	**Hourly Rates - General**	**Meals**	**House Keeping**	**EBITDA per resident per year**	**Average ACFI**
30 Bed Rural – Standalone	1	$71.92	$38.35	$71	$40.72	$34	$13	$9,146	$187
	2		$61.34	$91					
	3		$72.85	$117					
	4		$120.72	$101					
40 Bed Rural – Standalone	1	$53.96	$30.73	$77	$40.78	$35	$12	$8,197	$168
	2		$49.93	$101					
	3		$61.46	$127					
	4		$104.64	$116					
60 Bed Rural – Standalone	1	$72.82	$24.08	$65	$42.58	$27	$21	$13,081	$159
	2		$44.16	$88					
	3		$64.18	$106					
	4		$92.70	$109					
75 Bed Regional – Standalone	1	$64.91	$31.27	$66	$41.50	$41	$13	$10,978	$168
	2		$42.97	$97					
	3		$66.32	$112					
	4		$93.82	$116					
110 Bed Metro – Standalone	1	$60.60	$24.68	$76	$43.66	$35	$19	$15,650	$182
	2		$37.03	$107					
	3		$62.44	$120					
	4		$90.49	$123					
70 Bed – Multisite	1	$66.46	$22.09	$73	$46.92	$44	$15	$11,067	$182
	2		$48.62	$90					
	3		$57.45	$119					
	4		$98.53	$109					
110 Bed – Multisite	1	$73.70	$20.74	$67	$44.05	$35	$18	$9,201	$188
	2		$33.20	$98					
	3		$58.10	$111					
	4		$73.23	$127					

Table No 6

The sustainability of the CDC model for aged care providers

The examples indicate the charges and the returns for aged care providers.

Under CDC the sustainability of the aged care provider will depend upon three factors:

- The ability for the aged care provider to apply the three models of CDC and provide genuine choice to resident (family/representative);
- The services offered are provided to the satisfaction of the resident (family/representative); and
- The prices charged provide value for money to the resident (family/representative) compared to other forms of care services available.

Each of the facilities showed a positive Earnings Before Income Tax Deprecation and Amortisation (EBITDA). These ranged from $8,197 to $16,650 per annum.

The sustainability of aged care providers is important in places where they are the only provider of aged care services (rural and remote locations).

However, other forms of care services are likely to be developed which incorporate smaller residential care models which are a combination of accommodation and care services.

The introduction of CDC to residential care is also likely to provide an avenue for newer forms of services which meet the needs of the consumers.

The introduction of CDC into residential care will require the provider to produce a budget which is different to the current system used. Setting prices and costs will be similar to what is required of Home Care providers where they calculate their charge rates for direct services, administration and other fees. The software developed for CDC in residential care also alleviates any additional administration burden that would be placed on providers.

The model developed for calculating charges has been used across these trials and the calculation of charges on Table 6 page 34 of this report. These prices are not difficult to calculate and would not impose an additional administration burden on the provider.

It was also found that prices for introducing choice were not unreasonable and are based on the cost of providing services.

The other observation in reviewing the EBITDA's of these facilities and the operation of CDC is the returns to aged care providers for their accommodation. Due to a number of factors some of the aged care providers lose money on their accommodation. Their income from RAD interest, DAP's, DAC's and Supported supplements is often insufficient to meet the cost of servicing the accommodation.

This comment has no real bearing on the operation of CDC in residential care, other than it affects the overall sustainability of some aged care providers where they are unable to match accommodation income and costs.

The funding model applicable to Consumer Directed Care

A discussion of the funding model applicable to providing CDC in residential care, including an assessment of the current funding model and discussion of alternate funding models that may support improved transparency for both residents and provider.

The funding model has implications for the level of subsidy paid by the Commonwealth government. This has been emphasised by the adoption of CDC in home care. Home care funds, which were previously used in their entirety (the old CACP program), are now underutilised under the Home care CDC system. This is evidenced by an amount of unspent funds being held by home care providers which has to be returned to the Commonwealth once the client has ceased services.

The introduction of CDC into residential care could be viewed in a similar manner. The funding will no longer be that of the aged care provider's but to individual residents (with funds held on their behalf by the provider). This is likely to change the dynamics of what level of funding is required. However, due to the nature of residential care the likelihood of underutilised funds may be less.

Also, the discussion below should be read in an environment where consumers are the ones who have control of the funds. They then make choices based on receiving services they perceive as value for money. Therefore, the discussion is not about what the level of funding is but rather what is the level of funding utilised by the consumers?

Funding Model applicable to CDC in residential care

The use of ACFI as a funding tool for CDC:

The current funding model for residential care is a matrix of amounts based on an assessment. The current level of subsides for residential care are:

Basic Subsidy Rates

Daily ACFI subsidy rates*

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	$0.00	$0.00	$0.00
Low	$36.65	$8.37	$16.37

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Medium	$79.80	$17.36	$46.62
High	$110.55	$36.19	$67.32

***** Department of Health notice on subsidies dated – Aged Care Subsidies and Supplements New Rates of Payment from March 2018**

The weighted average of ACFI for the practical examples shown in Table 6 (p33) is equal to $177.62 per resident per day. Based on information provided in the Aged Care Financing Authority Fifth report on the Funding and Financing of the Aged Care Sector - July 2017.

The average ACFI rates in 2016/17 have been stated as:

"The latest Departmental ACFI monitoring report is based on data to the end of January 2017. It shows that claims peaked in the lead up to 1 July 2016 when the first stage of changes took effect, and flattened in subsequent months. Claim amounts started to rise again in November and December 2016 prior to the second stage of changes taking effect on 1 January 2017, after which claim amounts decreased again.

The January report shows that the average ACFI subsidy per resident per day for the year to date was $172.56. If this rate of real growth continues for the remainder of 2016-17, annual real growth will be 1.9 per cent. This is slightly higher than the budget projection (1.7 per cent real growth), but significantly lower than the reported 5.2 per cent real growth in 2015-16". (Aged Care Financing Authority Fifth report on the Funding and Financing of the Aged Care Sector - July 2017, p136).

Although there was no increase in the ACFI rates for the 2017/18 financial year the rates applicable to the research and those used in the practical examples of this report reflect an amount close to the industry average.

While the ACFI instrument does not reflect the needs and goals of residents it is a classification that can be used for the operation of CDC in residential care.

The practical examples show that the higher the rate of ACFI the more funds a resident has available. As Table No 5 (p.32) shows the amounts left after the after-hours and core services charges for the lower levels (level 1 and 2) have less funds available.

Therefore, while AFCI can be used for CDC in residential care it requires some adjustment to provide a more equitable base.

An alternative form of funding residential care for CDC:

The alternative to ACFI is to view the current structure of Home Care subsidies and how these could be aligned to residential care under CDC.

The current funding model for Home Care packages is a range of levels funded per day based on the assessed level of need. The current rates for 2017/18 for Home Care packages are:

Home Care Subsidy Rates

Home Care Package Level	Subsidy Rate
Level 1	$22.35
Level 2	$40.65
Level 3	$89.37
Level 4	$135.87

Home Care Supplements

Dementia and Cognition and Veterans' Supplement

Home Care Package Level	Amount of Supplement
Level 1	$2.24
Level 2	$4.07
Level 3	$8.94
Level 4	$13.59

***** Department of Health notice on subsidies dated – Aged Care Subsidies and Supplements New Rates of Payment from March 2018**

In accordance with the Aged Care Road Map any model of funding should be allocated to the consumer for their direction in services. This provides a seamless process for consumers to choose the type of service most applicable to their needs.

As the current list of daily subsidy rates stands they would not be sufficient to provide services within a residential setting.

Acknowledging the difference between Home Care and Residential Care is the security of providing 24 hour 7 day a week services then any subsidy rate should reflect the costs of providing this type of service.

The average subsidy rate during the first set of trials was $165.72 (table No 11, p53) with ranges from $111 to $211 per day. While the lower subsidy rates were within the range of level 4 in Home Care a majority were in excess of this rate (82% of the residents above this level).

In the Tune Legislative Review a suggestion is made that a level 5 be considered for Home Care. “A level 5 home care package should be introduced to support people with high care needs to stay at home longer” (Legislative Review of Aged Care 2017, p8).

Also mentioned in the “Future reform – an integrated care at home program to support older Australians” (Discussion paper – Department of Health – July 2017) the need is:

“To support consumers with higher care needs to remain living at home, a new home care package level (higher than the current level 4) could be introduced.

Assuming that the average cost for the care of people in residential aged care is an appropriate reference point, the package could be priced up to $60,000 per annum (noting that the average level of Australian Government payments for permanent residents in aged care homes was $63,400 per resident in 2015-16).

While preliminary consultations have indicated support for a higher level package, as an alternative to residential care for some consumers, a key issue is how such packages would be funded.

For instance, making available 5,000 new packages at an average cost of $60,000 per annum would cost an additional $300 million per annum. One option would be to reduce the number of residential care places released in the future in order to fund new home care packages at a higher level. This would mean lowering the current residential care planning ratio and increasing the home care planning ratio” (page 12-13).

The above comment about lowering the places allocated for residential care and increasing home care is at odds with the concept of CDC and the seamless system of aged care as set out in the Aged Care Road Map.

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If consumers who are assessed for care were provided with a level of funding required to meet their needs then this funding would be portable as they may choose to use it at home or enter a residential facility. Therefore, any funding based on assessed level of needs and including a level 5 could be calculated in the following manner:

Care Package Level	Subsidy Rate
Level 1	$22.35
Level 2	$40.65
Level 3	$89.37
Level 4	$135.87
Level 5	$170.50

Table No 7

The system could operate in the following manner:

1 A consumer is assessed at the level of need to support their health and wellbeing.
2 This amount is available for them to access services on a CDC basis either at home or within an approved residential facility.
3 In the case they choose to enter a residential facility then their needs are further assessed on the level of 1 to 4 as set out in this report (residential levels).
4 These residential levels would have a supplement applied to them to cater for providing the 24 hour 7 day a week service (this is the point of difference between being at home or within a facility).
5 It would be suggested that consumers who were assessed at level 3 on the Care Package Level and above would access residential care due to their needs. ***
6 A table of the supplements could then be devised to cater for the consumer who wished to or needed to enter residential care (due to their condition and/or circumstances).

Supplement Rate Calculation

Care Package Level	Subsidy Rate	Supplement Rate	Supplement Rate	Supplement Rate	Supplement Rate
	Residential Levels	1	2	3	4
Level 1	$22.35	$0.00	$0.00	$0.00	$0.00
Level 2	$40.65	$0.00	$0.00	$0.00	$0.00
Level 3	$89.37	$22.63	$0.00	$0.00	$0.00
Level 4	$135.87	$0.00	$19.62	$57.13	$78.13
Level 5	$170.50	$0.00	$0.00	$22.50	$43.50

Table No 8

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Total Funded Rates

Care Package Level	Subsidy Rate	Supplement Rate	Supplement Rate	Supplement Rate	Supplement Rate
	Residential Levels	1	2	3	4
Level 1	$22.35	$0.00	$0.00	$0.00	$0.00
Level 2	$40.65	$0.00	$0.00	$0.00	$0.00
Level 3	$89.37	$112.00	$0.00	$0.00	$0.00
Level 4	$135.87	$135.87	$155.49	$193.00	$214.00
Level 5	$170.50	$170.50	$170.50	$193.00	$214.00

Table No 9

The above form of funding will allow the following to occur:

- The allocation of funded places based on the financial constraints of funding aged care;
- A degree of certainty in funding for places as currently occurs with the Home Care system;
- The aged care provider would be required to make the assessment within a care facility and justify the category for a resident, or the assessment it could be made independently prior to the resident entering and then reassessed if required;
- Whilst this may produce some higher levels of subsidy the subsidy is no longer going to the aged care provider but the resident.

This last point is important in the movement to CDC. The funds are made available for consumers to use in a CDC environment where the aged care providers will have to fully account for the funds and will only be able to charge consumers for the services agreed to and provided.

If consumers do not want a service or finds it too expensive then they have other options available to them for the use of their funding.

Summary:

In the initial stages it is likely prices for different providers may be similar which will leave the consumer with little to compare. However, as has occurred with the home care, consumers are shopping around and finding providers who offer a competitive rate and a quality service. Those home care providers who were charging between 35 to 50 percent administration fees have struggled to attract new clients because of their pricing levels under the new CDC system.

The same is likely to occur in residential care as the change takes place and other forms of services are developed which better meet consumer needs.

Possible Transition of CDC into Residential Care:

There are two factors to consider as to when the transition of CDC could occur in residential care.

- The introduction of a CDC funding accountability; and
- The movement of funds to the control of the consumer.

In the case of Home Care Packages the transition period was phased in from 2013. All packages had to be delivered on a CDC basis on 1 July 2015 (as per the changes to the Aged Care Act) and the movement of licences to the consumer in February 2017.

This gave the home care providers time to develop and adjust their systems for the changes.

The other factor to consider is that in July 2020 the current Commonwealth Home Support Program (CHSP) is due to be redeveloped in line with the other parts of the aged care system. In line with the Aged Care Road Map this should then provide an opportunity for one aged care system to operate from Home Support to Home Care to Residential Care.

On this basis when would it be timely for CDC to be introduced into residential care?

Consideration has to be given to the allocation of licences in any Aged Care Approval Rounds (ACAR) between now and when changes are made.

In the case of Home Care Packages the last ACAR round for allocation was the 2015-16 year which was the last one before the funds were allocated to consumers (deregulation). This was a year before the change.

In the case of residential care, if the 2018 ACAR round was to be the last round, then the possible timing of the introduction of CDC and the funds moving to consumers could be:

- Accounting for funds on a CDC basis - July 2020
- Funds moved to consumers - July 2022

This time period would allow aged care providers to prepare well before the changes were made.

The above is only put forward as a matter for discussion the possible transition. The advantage of setting a transition timetable is it provides a clear timeline and target for both consumers and aged care providers to work towards.

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Appendices:

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

Appendix 1:

Material Referenced in the Report and Terminology:

Materials referenced:

- Aged Care Road Map – Department of Social Security – April 2015 – website - https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap
- Applicability of Consumer Directed Care principles in residential aged care home – July 2014 – KPMG Consulting. Released by the Department of Social Security – website - https://agedcare.health.gov.au/ageing-and-aged-care-aged-care-reform-home-care-packages-reform/applicability-of-consumer-directed-care-principles-in-residential-aged-care-homes-final-report
- Aged Care Financing Authority Fifth report on the Funding and Financing of the Aged Care Sector - July 2017 – Department of Health – website - https://agedcare.health.gov.au/reform/aged-care-financing-authority/2017-report-on-the-funding-and-financing-of-the-aged-care-industry
- Tune, D, Legislated Review of Aged Care 2017 - Department of Health – website - https://agedcare.health.gov.au/reform/aged-care-legislated-review
- Future reform – an integrated care at home program to support older Australians" - Discussion paper – Department of Health – July 2017 – website - https://agedcare.health.gov.au/reform/future-care-at-home-reform
- Quality of Care Principles – Aged Care Act (1997) – website- https://www.legislation.gov.au/Details/F2014L00830
- Schedule of Fees and Charges for Residential and Home Care – Department of Health – March 2018 – website - https://agedcare.health.gov.au/aged-care-funding/aged-care-fees-and-charges

Terminology:

The report uses a number of aged care specific terminologies. In each case the Acronym used has been detailed to prior to its use. For further details on these specific terminologies refer to My Aged Care at the website: - https://www.myagedcare.gov.au/glossary

The report also uses a short form of residential aged care providers in referring to them as – aged care providers.

Appendix 2:

Detailed description of the approach and methodology used:

Details of the Methodology used:

The first set of trials:

The timeline set out for the trial:

CDC Trial - Timelines

Program for Trial - Months 1 to 6	**Time for each part**
Discovery phase - gather information/workshop	1 week
Establish Project Committee	Part of 1st Week
Development of the model for CDC	2 weeks
Development of Objectives, measures, milestones, feedback, workbook	1 week
Selection of residents for trial	Part of development of objectives
Surveys	1 week
Training of staff at facility	2 week
Preparation of residents, families and staff	At the same time as training
Sign off by residents, families, staff & management	3 weeks
Commence Trial	After 10 weeks
Monitoring during first 4 weeks	4 weeks
First review period	2 months after commencing
Monthly reports	
Committee meetings to determine progress and response	
Trial continues with monthly reporting	months 3 - 6
End of Trial with analysis of effect on people, systems and processes	
Decisions made on method of CDC to be used	2 weeks
Decide on Transition Phase/timing/method	Upon conclusion

Trial Information:

1 A number of tools were developed for the trial

- Spreadsheet/CDC financial model (USB/Excel spreadsheet).
- CDC Training materials:
  - CDC Master Training Manual.
  - CDC Train the Trainer Handbook (for Managers).
  - CDC Training Handbook for Staff.
- Resident Agreement
- Resident Letter
- Resident/representative and staff surveys

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- A “Frequently Asked Questions” (FAQ pack)
- The Recording tools
- Surveys for the following at the commencement of the Trial:
    - Residents directly involved in the trial at each site
    - Residents who were not involved in the trial (control group): and
    - Staff
- Surveys for the following at the end of the Trial:
    - Residents directly involved in the trial at each site
    - Residents who were not involved in the trial (control group):and
    - Staff

2 Data Collection

The study to collect data from the sites commenced on 20 June 2016 through until October 2016.

3 Data Collection Forms

The initial data collection form was designed intentionally to be simple so staff would not be “put off” by the extra documentation. While other data areas were proposed at the initial training (e.g. behaviours) it was felt that too many categories in the beginning would overly complicate the documentation process for staff.

4 Surveys

The initial surveys were undertaken and data was compiled for each group involved.

The collection of the data for all groups was meaningful.

At the end of the trials another set of surveys were completed for each group and the differences in the responses from the pre to post Trial were measured.

5 Implementing the Trial

As part of the trial there were a series of reviews to monitor its progress and make any necessary changes. The purpose of site reviews were.

- ✓ Evaluate each site’s progress since the trial commenced
- ✓ Consult and obtain feedback from the managers
- ✓ Consult and obtain feedback from Residents and/or their family/representative.
- ✓ Consult and obtain feedback from staff
- ✓ Evaluate the effectiveness of the methodology.

The outcome of the trials and the continual review process provided valuable feedback.

Outcomes:

- Both sites were conscientious in their co-operation in the collection of data.
- The trials tested the financial model. The data collected over both sites demonstrated that the financial model worked and accounted for funds.
- Both trial sites experienced varying degrees of difficulty with regard to staff compliance with CDC tracking documentation.
- The manual tracking of activities was onerous in some instances.
- Despite documentation gaps, there was sufficient data in Clinical and Assisted Daily Living support to establish accurate costing and eliminate further tracking in this area.
- It is considered that an initial 2 to 4 week of recording these services would be sufficient for an accurate costing to be determined for each resident.
- The trials also informed further changes to be made to the model to adapt it further to CDC e.g. break down of services, the production of statements and accountability of funds.
- Trial residents across both sites expressed general satisfaction with the overall quality of services.
- Trial residents expressed a high appreciation for staff, however identified that not all staff performed equally or were suited to their role in aged care.
- All interviews with residents and representatives demonstrated the high degree of disempowerment experienced by Consumers (residents and their families or representatives) when entering residential aged care. This is seen as a result of the current system of service provision (institutional care).
- The results of the surveys from residents showed a marked increase in their awareness of services, costs and a better relationship with staff.
- The control groups showed some improvement in services (due to some "spill over" in staff behaviour) but were significantly lower than the groups in the main CDC group.
- Overall the objectives of the trial were met.
- A financial model was further developed during the trial to provide accurate information.
- A new service model was developed which provide genuine choice to residents.
- A new engagement model was developed which provided the steps necessary to properly engage residents, their families/representatives and staff.

However, these first trials indicated that the current service model in residential care is not applicable to CDC as it does not provide choice to residents.

As a result of this lack of genuine choice being provided a second trial was initiated in 2017 using the newly developed models.

The next trial:

The next trial took place between June and November 2017. The newly developed models were used to provide CDC in residential care in a different format and arrangement.

The main objective of the trial was to develop a working model which could then be rolled out to the remainder of the facility.

Methodology

This trial used these new models:

- Engagement:
    - A goal seeking service plan was used to gather the individual goals for each resident.
    - These formed part of the new service plan implemented to meet these goals.
    - The engagement process ensured these goals were being met.
    - The individual financial information was discussed with each resident and this information was aligned to their goals.
- Service:
    - Dedicated care staff were appointed to lead the project and work with residents (and families/representatives) to gather their goals and ensure these were implemented.
    - There was a greater emphasis on the goals and seeking genuine choice for residents.
    - Staff were further trained on CDC and how the new service model operated.
- Financial:
    - The model was changed to provide a set of services that were included as part of the cost of services and allowed residents to spend their funds in the manner they wished.
    - The amount of charges were tracked and resident's goals matched the funds available.

The services were tracked manually using an updated tool for the initial month to classify services and their use on an individual resident basis.

This information was used to provide the financial information to each resident on the spending of their funds.

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The outcome of the second trial:

Based on the feedback and results of the surveys the trial has led to a number of improvements. This is in services and relationships between residents and staff. This is attributable to the manner in which the trial has been conducted and applying all of the CDC principles.

It was important that measureable outcomes were able to be achieved. The other aspect of the trial was to make the introduction of CDC into residential care a cost benefit for all stakeholders. This led to a number of outcomes.

- Improved relationships with the residents and their families – this is supported by the feedback at the end of the trial.
- Improved staff satisfaction from those involved in the trial. The greater autonomy and ability to connect with the residents and their families produced a greater commitment and innovation in service. Again evidenced by feedback from the trial.
- The marked reduction in complaints from residents and their families as a result of the trial. The summary of responses before and after the trial:
  - Feedback concerning residents in the trial consisted of Jan-Jul 2017: 9 complaints- mostly around staff attitude, care needs and food. Compliments – Nil.
  - Feedback from Jul-Dec 2017: nil complaints and 17 compliments- mostly around activities provided, choice and food and staff attitude.
- The development of a financial model that allows four core elements:
  - Being transparent and accountable for funding.
  - Providing information on the services provided and the cost of these.
  - The ability to work with the resident and their families on what funds are available to meet their goals.
  - The feeling by the resident and their families that they are financially in control of their funds and can make choices with independence.
- The CDC model can be operated within Budget parameters based on available income (staffing and resources).
- There was no change in Clinical Indicators (CI), even though there was a marked deterioration in the condition of some of the residents during the trial.
- The development of the operational model that can be transferred to other facilities.
- The education materials and other insights gained in operating the CDC model of care services. All of these are transferrable.

- Surveys with residents showed a marked increase in their satisfaction with the service and an understanding of how CDC operated.

Recording Tools:

- **First Trial**

Health Services:	Date:	Time In	Time Out	Time In	Time Out	Time In	Time Out
Nursing	Medication:						
	Wounds:						
	Pain Management:						
	Specialised Nursing:						
	Unplanned Events:						
Assisted	Showering:						
Living Services	Bathroom:						
	General Assistance:						
	Unplanned Events:						
Enablement:	Physiotherapy:						
	Occupational Therapy:						
	Speech Assistance:						
	Other Services:						
Activities:	Individual:						
	Group:						
	Social:						
Cleaning :	Services:						
Catering:	Services:						
Volunteering:							

Chart No 2

- **Second Trial**

Activity	Units per day												
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Nursing													
Medication	1												
General Nursing	1												
Specialised Nursing	1												
Unplanned events	1												
ADL's													
Showering	3												
Bathroom	2												
General Assistance	2												
Unplanned events	1												
Enablement													
Physio	0												
OT	0												
Speech	0												
Podiatry	0												
Other Enablement	1												
Individualised Services													
Activities													
One on One	1												
Group	1												
Catering													
Food Preferences													
Cleaning Preferences													
Cleaning type													

Chart No 3

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- **Survey Questions:**

Questions	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
You feel you are given adequate choice for all of your needs	☐	☐	☐	☐	☐
You feel valued	☐	☐	☐	☐	☐
You feel that you are in control of the care and other services provided	☐	☐	☐	☐	☐
You feel that you have a good relationship with the staff	☐	☐	☐	☐	☐
You are given the information to make informed choices	☐	☐	☐	☐	☐
You feel you understand the way your needs are met and why	☐	☐	☐	☐	☐
You find you can be flexible with staff and they consider your needs	☐	☐	☐	☐	☐
You feel that you can speak up on any matter	☐	☐	☐	☐	☐
People are treated equally	☐	☐	☐	☐	☐
You understand the resources needed to meet your needs and where the money goes	☐	☐	☐	☐	☐
When things change you are able to discuss these beforehand	☐	☐	☐	☐	☐
You are always consulted on all of your needs	☐	☐	☐	☐	☐

Chart No 4

Appendix 3:

Methodology used to analyse data:

The results of the first trials, in terms of times spent on different function, are shown in the table below (excluded due to privacy):

Summary of Services Measured during Trials - minutes per day			
Service Combined	Average Times	Highest	Lowest
Medication:			
Wounds:			
Pain Management:			
Specialised Nursing:			
Unplanned Events- Nursing:			
Showering:			
Bathroom Assistance:			
General Assistance:			
Unplanned Events - ADL's:			
Enablement:			
Lifestyle:			
Individual:			
Group:			
Social:			

Table No 10

This shows the average times spent in these service areas. Other data collected has been randomly tested against these times and has been shown to be within range of the above.

Points to be made in regard to the trials:

- The average times spent, per day, per resident was across all residents in the trials;
- The highest minutes per day were not all attributable to the same residents;
- The residents in the trials were a mixture of low, medium and high care residents; and
- A number of residents had some form of dementia.

- The matrix of the funding provided to each of these residents in the initial trial was:

Summary Table of ACFI - Rate per day (2016/17)		
Rate	No of Residents on the trial	Percentage
$111	1	6%
$114	1	6%
$120	1	6%
$139	1	6%
$154	1	6%
$161	1	6%
$163	3	18%
$173	1	6%
$181	4	24%
$211	3	18%
Total	17	
Average ACFI	$165.72	

Table No 11

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- Statistical Analysis from the trials:

The ability to carry out an analysis is limited to the responses from the residents' pre and post-trial. In the initial set of trials the following were scores were record for residents on the Likert scale as indicated earlier in the report:

First Trials	Trial & Control Group – Pre Trial			
Questions	Trial	StdDev	Control	StdDev
Adequate Choice	4.00	1.10	3.38	0.89
Feel Valued	3.86	0.89	3.75	1.00
In Control	3.71	0.75	3.00	0.45
Good Relationship - staff	4.29	0.41	4.25	0.00
Information - about Choices	3.57	0.41	3.63	0.89
Understand how needs met	4.00	0.89	4.00	0.00
Flexible with staff	3.86	0.82	3.75	1.79
Can Speak Up	4.00	1.10	4.00	0.45
People treated equally	3.43	1.10	4.13	0.55
Understand the money	3.14	0.98	3.25	0.84
Discuss changes	3.71	0.98	3.38	0.84
Always consulted	3.71	0.52	4.00	1.10

Table No 12

First Trials	Changes - Trial Group - Averages		
Questions	Pre Trial	Post Trial	% change
Adequate Choice	4.00	4.00	0%
Feel Valued	3.86	4.00	4%
In Control	3.71	4.17	12%
Good Relationship - staff	4.29	4.83	13%
Information - about Choices	3.57	3.83	7%
Understand how needs met	4.00	4.00	0%
Flexible with staff	3.86	4.33	12%
Can Speak Up	4.00	4.00	0%
People treated equally	3.43	4.00	17%
Understand the money	3.14	4.17	33%
Discuss changes	3.71	3.17	-15%
Always consulted	3.71	3.67	-1%

Table No 13

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First Trials	Changes - Control Group - Averages		
Questions	Pre Trial	Post Trial	% change
Adequate Choice	3.38	3.60	7%
Feel Valued	3.75	3.00	-20%
In Control	3.00	3.80	27%
Good Relationship - staff	4.25	4.00	-6%
Information - about Choices	3.63	3.60	-1%
Understand how needs met	4.00	4.00	0%
Flexible with staff	3.75	3.20	-15%
Can Speak Up	4.00	4.20	5%
People treated equally	4.13	3.60	-13%
Understand the money	3.25	3.20	-2%
Discuss changes	3.38	2.80	-17%
Always consulted	4.00	3.20	-20%

Table No 14

t-Test: Two-Sample Assuming Unequal Variances **Pre Analysis - First Trial**		
	Trial Group	*Control Group*
Mean	3.773333333	3.71
Variance	0.091678788	0.151218182
Observations	12	12
Hypothesized Mean Difference	0	
Df	21	
t Stat	0.445155682	
P(T<=t) one-tail	0.330381014	
t Critical one-tail	1.720742903	
P(T<=t) two-tail	0.660762027	
t Critical two-tail	2.079613845	

Table No 15

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t-Test: Two-Sample Assuming Unequal Variances		
Post Analysis - First Trial		
	Trial Group	*Control Group*
Mean	4.013888889	3.516666667
Variance	0.153829966	0.192424242
Observations	12	12
Hypothesized Mean Difference	0	
Df	22	
t Stat	2.927140864	
P(T<=t) one-tail	0.003901573	
t Critical one-tail	1.717144374	
P(T<=t) two-tail	0.007803146	
t Critical two-tail	2.073873068	

Table No 16

The above results are an indication of the first trials being carried out without changing the model of services, as indicated earlier in the report.

The second trial in 2017 changed the model of services and did not use a control group. The following statistics indicate the changes in the responses to the questions pre and post-trial.

Second Trial results		
Questions	Pre Trial Average Scores	Standard Deviation
Adequate Choice	2.80	1.10
Feel Valued	3.80	1.30
In Control	2.40	1.52
Good Relationship - staff	4.40	0.89
Information - about Choices	3.60	1.34
Understand how needs met	4.00	1.41
Flexible with staff	4.00	0.71
Can Speak Up	4.40	0.89
People treated equally	3.00	1.00
Understand the money	2.00	0.00
Discuss changes	3.00	0.71
Always consulted	3.80	1.30

Table No 17

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Second Trial results		
Questions	Post Trial Average Scores	Standard Deviation
Adequate Choice	4.80	0.45
Feel Valued	5.00	0.00
In Control	4.80	0.45
Good Relationship - staff	5.00	0.00
Information - about Choices	4.80	0.45
Understand how needs met	5.00	0.00
Flexible with staff	4.80	0.45
Can Speak Up	5.00	0.00
People treated equally	4.60	0.55
Understand the money	4.60	0.55
Discuss changes	4.20	0.45
Always consulted	5.00	0.00

Table No 18

Second Trial results			
Changes - Averages			
Questions	Pre Trial	Post Trial	% change
Adequate Choice	2.80	4.80	71%
Feel Valued	3.80	5.00	32%
In Control	2.40	4.80	100%
Good Relationship - staff	4.40	5.00	14%
Information - about Choices	3.60	4.80	33%
Understand how needs met	4.00	5.00	25%
Flexible with staff	4.00	4.80	20%
Can Speak Up	4.40	5.00	14%
People treated equally	3.00	4.60	53%
Understand the money	2.00	4.60	130%
Discuss changes	3.00	4.20	40%
Always consulted	3.80	5.00	32%

Table No 19

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Appendix 4:

Engagement Model – detailed process:

The engagement model includes components for residents (and their families/representatives) and for staff. Both of these components are important for CDC to be successfully undertaken. The engagement model centres on the goals to be set by the residents (family/representative) and the funding available. The engagement is about how to match these two components – service and finances.

Residents (families/representatives):

A stage approached has been found to be the most successful method of introducing CDC to residents (and their families/representatives). There are four stages in engagement:

1 The first stage is prior to the resident taking their place in the aged care facility. This involves the following:
   a. The first part is to establish what the initial goals of the potential resident are and what they (or their family/representative) see as their expectation of the service and how they wish to have services provided. These provide a base line for future discussions.
   b. Following on from this (normally a period of separation from the first contact and point a), an estimate of the likely funds to be provided by the Government for the care (currently the Aged Care Funding Instrument – ACFI).
   c. Added to this are the resident's contribution.
   d. Based on this assessment an initial estimate of the services to be provided as part of the standard core services.
   e. The cost of this assessment plus the After Hours charge is calculated.
   f. This will then leave an estimate of funds available for use by the resident for services.
   g. It is important at this stage to openly discuss what is included in the standard service for the After Hours, the core services and the other funds available.
   h. It is also important at this stage that a clear understanding is established between the resident (their family/representative) and the aged care provider of what the services will be and the cost of these services.
   i. It is made clear that the first month of occupancy will provide further refinement of the needs and how the resident (their family/representative) wish to have their goals met.

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j. Where the goals of the resident (their family/representative) are beyond the funds available then a discussion takes place to establish if additional funds can be provided for these services (additional services).
k. This discussion should take place before taking up occupancy and then again in stage two once there is a clearer picture of what the goals and needs are of the resident.

2 The second stage of engagement is when the resident takes their place. During the first month a detailed assessment is made of the base services required to meet all of the resident's core clinical and assisted living needs. Based on this assessment (recording of times spent one designated areas) the next stage is revisited the goals, the funding to ensure there is a match of funds and services.

a. In the trials and research we found that it took at least one month for a new resident to familiarise themselves with the service and to be able to clearly articulate their goals and wishes.

3 This stage is updating the goals of the resident. These goals are again matched with funds available and flexibility in being able to deliver services to meet these goals.

a. As part of this engagement the aged care provider may wish to provide a "menu" of services. However, in the trials we found it was more about allowing the residents (their families/representatives) to choose the type of service and how they wished to have these provided.
b. Initially, many residents had an extensive list of goals and part of this engagement was to assist them to prioritize them. This occurred as a result of some goals not being able to be met with the resources available.
c. As the engagement is progressed and relationships develop with the resident (family/representative) the goals will reflect their priority and enabled the service to be delivered within resources available.
d. Normally at this stage the residents (their families/representatives) were able to make informed decisions that allowed them to choose, have control and independence on the goals selected.

4 The final stage is the continual review of goals and matching these with resources. This is achieved by:

a. The ongoing monitoring to ensure individual goals are being met.
b. The monthly review of the funds available and the use of these funds in meeting the goals.

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c. In the research we often found that residents (families/representatives) will review and change their goals based on funds as they fully understand what is possible.

The other issues to note from this engagement model:

- Where there are existing residents they are likely to take at least two to three months to understand what it means to be able to choose services. This is the result of the "routine" of not having choices before;
- However, once there is a recognition that residents (families/representatives) have control they will begin to exercise it;
- It is also unrealistic to offer choice and setting goals expectations without the inclusion of funds available. This was clear during the trials as residents (their families/representatives) fully understood their goals were within their "means". It is not sustainable for any service to provide an "unlimited" resources;
- The engagement model allows the discussion about additional services that the resident may require and in many cases are willing to pay for. The model therefore develops a "healthy" relationship between the residents (families/representatives) and the aged care provider as there are no "grey" areas of service provision;

In the case where a resident's condition changes then the engagement model is revisited and the stages are worked through again so they reflect the needs and wishes of the residents (families/representatives).

Staff:

A staged approached is also required for staff. There are three stages of staff engagement.

1 The first stage is a series of training on what CDC means and how to engage with residents (families/representatives). There is an emphasis on the changes in the dynamics of the services they provide.

2 This stage involved "on the job" training of staff to perform their roles in a manner that matched the goals set by residents (families/representatives). This engagement included:
   a. The designation of certain staff to act as the main contact with the residents (families/representatives) and to assist with setting the goals and ensuring they are met (CDCTL's).
   b. These designated staff are allocated time to spend with each residents (families/representatives) on a regular basis to set, monitor and review individual goals.
   c. Some staff are allocated this role while others perform the more routine tasks as required by the goals set.

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3 The third stage is “reinforcing” with staff with updated training sessions on how to operate under CDC.

As a result of the use of this engagement model a number of outcomes can be expected:

- The staff engaged in the role as the main contact will gain a greater level of satisfaction from their role;
- Residents (families/representatives) will feel they have a contact that will listen and act to ensure their goals are being met;
- Other staff will begin to engage with residents (family/representative) in a different manner and will be more attuned to resident’s needs; and
- Some staff will be unable to make the transition and there is likely to be a level of staff turnover.

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Appendix 5:

Financial Model – detailed information:

The tool is referred to Core Services Matrix:

The Core Services Matrix

	Core Services Matrix	Level 1	Level 2	Level 3	Level 4
	Score	3	6	9	12
	Nursing				
1	Medication				
2	General Nursing				
3	Specialised Nursing				
4	Unplanned Assistance				
	ADL's				
1	Showering				
2	Bathroom Assistance				
3	Daily Living Assistance				
4	Family Assistance				
	Possible scores	24	48	72	96
	Ranges	0-24	25-48	49-72	73-96
	Times - daily minutes				
	Core Services Matrix	Level 1	Level 2	Level 3	Level 4
	Score	3	6	9	12
	Nursing				
1	Medication	5<	3-5	5-7.5	>7.5 +
2	General Nursing	3<	3-5	5-7.5	>7.5 +
3	Specialised Nursing	3<	3-5	5-7.5	>7.5 +
4	Unplanned events	3<	3-5	5-7.5	>7.5 +
	ADL's				
1	Showering	5<	5-9	9-12	>12 +
2	Bathroom Assistance	5<	5-9	9-12	>12 +
3	Daily Living Assistance	5<	5-9	9-12	>12 +
4	Family Assistance	5<	5-9	9-12	>12 +

Table No 20

Appendix 6:

Examples of how CDC is applied to different care facilities:

A small rural aged care facility with 30 beds operating as a standalone facility

Summary of CDC Charges to residents – Total use of funds for services				
Per Month – All Funds expended				
Facility Type: 30 bed stand alone				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	20%	35%	25%	20%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,998	$5,310	$6,462	$7,426
Total	$5,503	$6,816	$7,968	$8,931
Charges				
After Hours charge	$2,188	$2,188	$2,188	$2,188
Core Services	$1,167	$1,866	$2,216	$3,672
Purchased Services	$669	$1,246	$2,038	$1,484
Meal Services	$1,020	$1,020	$1,020	$1,020
Housekeeping	$407	$407	$407	$407
Medical – living aids	$49	$78	$93	$154
Total	$5,498	$6,804	$7,962	$8,924

Table No 21

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 30 bed stand alone				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	20%	35%	25%	20%
Income - resident				
Total residents funds	$5,503	$6,816	$7,968	$8,931
Charges				
After Hours Services	$2,188	$2,188	$2,188	$2,188
Core Services	$1,167	$1,866	$2,216	$3,672
Subtotal funds spent	$3,354	$4,054	$4,404	$5,860
Total – Available per month	$2,149	$2,762	$3,564	$3,071
Available per day	$71	$91	$117	$101

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Table No 22

	Facility Type: 30 bed stand alone		
Category (level)	Rates per day for the After Hours Service	Rates per day for the core services	Total Rates per day for these services
1	$71.92	$38.35	$110.27
2	$71.92	$61.34	$133.26
3	$71.92	$72.85	$144.77
4	$71.92	$120.72	$192.63

Table No 23

Service	Rate/Hour
General Assistance	$40.72
Allied Health	$88.83
Activities - Group	$4.47
Activities - Individual	$44.73
Living Expenses	Rate/Day
Medical – living aids	As per usage
Meals/Food	$34
Housekeeping (Laundry/Cleaning)	$13

Table No 24

EBITDA	
Per Resident per annum	$9,146

Table No 25

The above amounts indicate that residents of all levels are able to be provided with the services required to meet their needs and goals. The level of funds available after the After Hours and Core Services charge vary between each level of resident.

The amount of funding for this service includes a viability supplement available for a care facility of this type.

A 40 bed rural facility – standalone

Summary of CDC Charges to residents- total use of funds				
Per Month - all funds expended				
Facility Type: 40 bed standalone - rural				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	20%	35%	25%	20%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,417	$4,729	$5,881	$6,845
Total	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours Services	$1,642	$1,642	$1,642	$1,642
Core Services	$935	$1,519	$1,870	$3,183
Purchased Services	$876	$1,576	$2,362	$1,956
Meal Services	$1,058	$1,058	$1,058	$1,058
Housekeeping	$369	$369	$369	$369
Medical – living aids	$42	$68	$84	$143
Total	$4,921	$6,231	$7,384	$8,351

Table No 26

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 40 bed standalone - rural				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	20%	35%	25%	20%
Income - resident				
Total residents funds	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours Services	$1,642	$1,642	$1,642	$1,642
Core Services	$935	$1,519	$1,870	$3,183
Subtotal funds spent	$2,576	$3,160	$3,511	$4,825
Total - Available	$2,346	$3,075	$3,876	$3,526
Available per day	$77	$101	$127	$116

Table No 27

	Facility Type: 40 bed standalone - rural		
Category (level)	Rates per day for the After Hours service	Rates per day for the core purchased services	Total Rates per day for these services
1	$53.96	$30.73	$84.69
2	$53.96	$49.93	$103.89
3	$53.96	$61.46	$115.42
4	$53.96	$104.64	$158.60

Table No 28

Service	Rate/Hour
General Assistance	$40.78
Allied Health	$88.95
Activities - Group	$4.48
Activities - Individual	$44.79
Living Expenses	Rate/Day
Medical – living aids	As per Usage
Meals/Food	$35
Housekeeping (Laundry/Cleaning)	$12

Table No 29

EBITDA	
Per Resident per annum	$8,197

Table No 30

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A 60 bed rural facility – standalone

Summary of CDC Charges to residents- total use of funds				
Per Month - all funds expended				
Facility Type: 60 bed standalone - rural				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	30%	35%	20%	15%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,417	$4,729	$5,881	$6,845
Total	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours Support	$2,215	$2,215	$2,215	$2,215
Core Services	$732	$1,343	$1,952	$2,820
Purchased Services	$446	$1,094	$1,584	$1,603
Meal Services	$835	$835	$835	$835
Housekeeping	$630	$630	$630	$630
Medical – living aids	$65	$119	$173	$250
Total	$4,923	$6,236	$7,389	$8,352

Table No 31

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 60 bed standalone - rural				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	30%	35%	20%	15%
Income - resident				
Total residents funds	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours Support	$2,215	$2,215	$2,215	$2,215
Core Services	$732	$1,343	$1,952	$2,820
Subtotal funds spent	$2,948	$3,558	$4,168	$5,035
Total - Available	$1,975	$2,677	$3,219	$3,316
Available per day	$65	$88	$106	$109

Table No 32

	Facility Type: 60 bed standalone - rural		
Category (level)	Rates per day for the After Hours service	Rates per day for the core services	Total Rates per day for these services
1	$72.82	$24.08	$96.89
2	$72.82	$44.16	$116.98
3	$72.82	$64.18	$137.00
4	$72.82	$92.70	$165.52

Table No 33

Service	Rate/Hour
General Assistance	$42.58
Allied Health	$92.89
Activities - Group	$4.68
Activities - Individual	$46.77
Living Expenses	Rate/Day
Medical – living aids	As per usage
Meals/Food	$27
Housekeeping (Laundry/Cleaning)	$21

Table No 34

EBITDA	
Per Resident per annum	$13,081

Table No 35

The preparation of this Report was funded by the Australian Government through the Dementia and Aged Care Services Fund.

A regional aged care facility with approximately 75 beds operating as a standalone facility

Summary of CDC Charges to residents- total use of funds				
Per Month - all funds expended				
Facility Type: 75 bed standalone - regional				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	20%	35%	25%	20%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,417	$4,729	$5,881	$6,845
Total	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$1,975	$1,975	$1,975	$1,975
Core Services	$951	$1,307	$2,017	$2,854
Purchased Services	$296	$1,231	$1,622	$1,690
Meal Services	$1,241	$1,241	$1,241	$1,241
Housekeeping	$390	$390	$390	$390
Medical – living aids	$67	$92	$142	$202
Total	$4,920	$6,236	$7,387	$8,351

Table No 36

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 75 bed standalone - regional				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	20%	35%	25%	20%
Income - resident				
Total residents funds	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$1,975	$1,975	$1,975	$1,975
Core Services	$951	$1,307	$2,017	$2,854
Subtotal funds spent	$2,926	$3,282	$3,992	$4,828
Total - Available	$1,997	$2,953	$3,395	$3,522
Available per day	$66	$97	$112	$116

Table No 37

	Facility Type: 75 bed standalone - regional		
Category (level)	Rates per day for the After Hours service	Rates per day for the core services	Total Rates per day for these services
1	$64.91	$31.27	$96.18
2	$64.91	$42.97	$107.88
3	$64.91	$66.32	$131.23
4	$64.91	$93.82	$158.73

Table No 38

Service	Rate/Hour
General Assistance	$41.50
Allied Health	$90.52
Activities - Group	$4.56
Activities - Individual	$45.58
Living Expenses	Rate/Day
Medical – living aids	As per usage
Meals/Food	$41
Housekeeping (Laundry/Cleaning)	$13

Table No 39

EBITDA	
Per Resident per annum	$10,978

Table No 40

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A metropolitan aged care facility with approximately 110 beds operating as a standalone facility

Summary of CDC Charges to residents- total use of funds				
Per Month - all funds expended				
Facility Type: 110 bed standalone - metro				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	10%	25%	35%	30%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,417	$4,729	$5,881	$6,845
Total	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$1,843	$1,843	$1,843	$1,843
Core Services	$751	$1,126	$1,899	$2,753
Purchased Services	$622	$1,528	$1,841	$1,881
Meal Services	$1,061	$1,061	$1,061	$1,061
Housekeeping	$584	$584	$584	$584
Medical – living aids	$62	$93	$157	$228
Total	$4,923	$6,236	$7,387	$8,351

Table No 41

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 110 bed standalone - metro				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	10%	25%	35%	30%
Income - resident				
Total residents funds	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$1,843	$1,843	$1,843	$1,843
Core Services	$751	$1,126	$1,899	$2,753
Subtotal funds spent	$2,594	$2,970	$3,743	$4,596
Total - Available	$2,328	$3,265	$3,644	$3,755
Available per day	$76	$107	$120	$123

Developments that support innovations in Aged Care – Consumer Directed Care in Residential Care:
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Table No 42

	Facility Type: 110 bed standalone - metro		
Category (level)	Rates per day for the After Hours service	Rates per day for the core services	Total Rates per day for these services
1	$60.60	$24.68	$85.28
2	$60.60	$37.03	$97.62
3	$60.60	$62.44	$123.04
4	$60.60	$90.49	$151.08

Table No 43

Service	Rate/Hour
General Assistance	$43.66
Allied Health	$95.24
Activities - Group	$4.80
Activities - Individual	$47.96
Living Expenses	Rate/Day
Medical – living aids	As per usage
Meals/Food	$35
Housekeeping (Laundry/Cleaning)	$19

Table No 44

EBITDA	
Per Resident per annum	$15,650

Table No 45

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A large mutli-site aged care provider with a mixture of facilities with varying bed numbers and locations

Summary of CDC Charges to residents- total use of funds				
Per Month - all funds expended				
Facility Type: 70 bed multi-site				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	4%	34%	38%	24%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,417	$4,729	$5,881	$6,845
Total	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$2,022	$2,022	$2,022	$2,022
Core Services	$672	$1,479	$1,748	$2,997
Purchased Services	$392	$850	$1,716	$1,354
Meal Services	$1,337	$1,337	$1,337	$1,337
Housekeeping	$461	$461	$461	$461
Medical – living aids	$40	$88	$104	$178
Total	$4,923	$6,236	$7,386	$8,349

Table No 46

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 70 bed multi-site				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	4%	34%	38%	24%
Income - resident				
Total residents funds	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$2,022	$2,022	$2,022	$2,022
Core Services	$672	$1,479	$1,748	$2,997
Subtotal funds spent	$2,694	$3,501	$3,769	$5,019
Total - Available	$2,229	$2,734	$3,618	$3,331
Available per day	$73	$90	$119	$109

Table No 47

	Facility Type: 70 bed multi-site		
Category (level)	Rates per day for the After Hours service	Rates per day for the core services	Total Rates per day for these services
1	$66.46	$22.09	$88.56
2	$66.46	$48.62	$115.08
3	$66.46	$57.45	$123.91
4	$66.46	$98.53	$165.00

Table No 48

Service	Rate/Hour
General Assistance	$46.92
Allied Health	$102.35
Activities - Group	$5.15
Activities - Individual	$51.54
Living Expenses	Rate/Day
Medical – living aids	As per usage
Meals/Food	$44
Housekeeping (Laundry/Cleaning)	$15

Table No 49

EBITDA	
Per Resident per annum	$11,067

Table No 50

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Summary of CDC Charges to residents- total use of funds				
Per Month - all funds expended				
Facility Type: 110 bed multi-site				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	10%	15%	35%	40%
Income - resident				
Resident Contribution	$1,506	$1,506	$1,506	$1,506
Commonwealth Subsidy	$3,417	$4,729	$5,881	$6,845
Total	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$2,242	$2,242	$2,242	$2,242
Core Services	$631	$1,010	$1,768	$2,228
Purchased Services	$394	$1,290	$1,609	$2,065
Meal Services	$1,068	$1,068	$1,068	$1,068
Housekeeping	$534	$534	$534	$534
Medical – living aids	$67	$107	$188	$237
Total	$4,937	$6,252	$7,409	$8,374

Table No 51

Summary of Funds remaining after set charges				
Per Month				
Facility Type: 110 bed multi-site				
	Level 1	Level 2	Level 3	Level 4
ACFI Levels	LLH	MLH	HHM	HHH
Percentage within facility	10%	15%	35%	40%
Income - resident				
Total residents funds	$4,923	$6,235	$7,387	$8,351
Charges				
After Hours	$2,242	$2,242	$2,242	$2,242
Core Services	$631	$1,010	$1,768	$2,228
Subtotal funds spent	$2,873	$3,252	$4,010	$4,470
Total - Available	$2,050	$2,983	$3,377	$3,881
Available per day	$67	$98	$111	$127

Table No 52

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	Facility Type: 110 bed multi-site		
Category (level)	Rates per day for the After Hours service	Rates per day for the core services	Total Rates per day for these services
1	$73.70	$20.74	$94.45
2	$73.70	$33.20	$106.90
3	$73.70	$58.10	$131.81
4	$73.70	$73.23	$146.94

Table No 53

Service	Rate/Hour
General Assistance	$44.05
Allied Health	$96.10
Activities - Group	$4.84
Activities - Individual	$48.39
Living Expenses	Rate/Day
Medical – living aids	As per usage
Meals/Food	$35
Housekeeping (Laundry/Cleaning)	$18

Table No 54

EBITDA	
Per Resident per annum	$9,201

Table No 55

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