aspex consulting

DAREBIN CITY COUNCIL, MERRI-BEK CITY COUNCIL, CITY OF WHITTLESEA

Rethinking Care Management

Stage 1 Report - Issues and Opportunities

October 2024

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LIST OF ABBREVIATIONS

ACQSC	Aged Care Quality and Safety Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADL	Activity of Daily Living
AI	Artificial intelligence
CALD	Culturally and linguistically diverse
CHSP	Commonwealth Home Support Programme
DHAC	Department of Health and Aged Care
FTE	Full-time equivalent
GP	General Practitioner
HCP	Home Care Packages
IHACPA	Independent Health and Aged Care Pricing Authority
PCG	Project Control Group
OH&S	Occupational Health and Safety
RAS	Regional Assessment Service

ACKNOWLEDGEMENT

Supported by the Australian Government Department of Health and Aged Care. Although funding for this Rethinking Care Management project has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government.

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1. Purpose and Context

1.1. PURPOSE

The City of Whittlesea, Darebin City Council and Merri-Bek Council have commissioned Aspex Consulting to codesign an extended CHSP **care management model**. This project aims to define what an extended entry level CHSP care management model may look like. Since CHSP will transition to Support at Home no earlier than 1 July 2027, this provides a lead time for the CHSP sector to anticipate and be prepared for care management directions. Through this project, the three local governments are seeking to review care management practice and how this may align with the care management directions for the Support at Home Program.

1.2. CONTEXT

Role of CHSP

The Commonwealth Home Support Programme (CHSP) provides entry-level services to support older Australians 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) living independently in their homes and communities. It also provides respite services to give carers a break (DHAC, 2024). Based on a person's needs, CHSP services can be *short term, episodic* (where services can be put in place to improve function or capacity), or *ongoing* (DHAC, 2024a). The programme places a strong focus on activities that support independence and social connectedness and take into account each person's individual goals and choices, with the core objectives of:

- Helping people live as independently as possible;
- Focusing on working with people, rather than doing things for them; and
- Giving a small amount of help to a large number of people (DHAC 2024b).

There are some key policy developments over the last five years that are relevant for this project's focus on care management and its relevance for CHSP service providers in the transition to the Support at Home programme. These are briefly summarised below.

Royal Commisison into Aged Care Quality and Safety

The recommendations arising from the 2021 Royal Commisison into Aged Care Quality and Safety have had a substantial influence on subsequent policy directions. The Royal Commission recommended as its first recommendation, that a new Aged Care Act be introduced and that it should be based on the following paramount considerations:

- Ensuring the safety, health and wellbeing of people receiving aged care;
- Putting older people first so that their preferences and needs drive the delivery of care.

The Royal Commisison into Aged Care Quality and Safety also identified that ***care management*** should feature as an important enabler of improved quality and safety for aged care, including for home support services.

> The day-to-day coordination of care through **care management** can be essential to achieving good outcomes in aged care. It is especially important for people who have complex needs or needs that require multiple or intensive responses. We recommend that approved providers should assign a care manager to people receiving aged care (unless a person is receiving home care and has been assessed as not needing care management). **Care management** should be scaled to match the complexity of the older person's needs (emphasis added) (Royal Commission into Aged Care Quality and Safety, 2021:98).

Strengthened Aged Care Standards

The final draft proposed standards for aged care, Strengthenend Aged Care Standards, were released in November 2023 and have reiterated the importance of person-cented care.

> Outcome 1.1 - The provider understands that the safety, health, wellbeing and quality of life of older people is the primary consideration in the delivery of care and services (DHAC 2023:6).

Support at Home Program handbook

The Support at Home Program handbook released in October 2024, sets out expectations for care management as part of the proposed Support at Home Program.

> All Support at Home participants will have access to care management, which supports participants to get the best outcomes from their aged care services) (DHAC 2024c:41).

The following elements are proposed for care management in the Support at Home Program handbook:

- Care planning
- Service coordination
- Monitoring, review and evaluation
- Support and education (DHAC 2024c:41).

The scope of services covered by the Support at Home program handbook include the Home Care Packages Program and Short-Term Restorative Care (STRC) Program, to support preparation for transitioning to new arrangements by July 2025. The handbook does not include CHSP services, which are not scheduled to transition to new arrangements until July 2027 at the earliest. However, the handbook does state that "CHSP providers will be covered by the new Aged Care Act from 1 July 2025: (DHAC 2024c:7).

Care management in the current CHSP context

CHSP service providers are currently undertaking a range of person-centred care planning, review and coordination activities which have similar components to those defined for care management.

These activities are embedded as part of CHSP service delivery and typical activities of CHSP person-centred care planning, review and coordination include:

- Service specific assessment which builds on information in the Support Plan. It draws on considerations related to service delivery preferences, scheduling and the client's current situation, strengths, needs and goals.
- Service specific care plan in partnership with client based on client goals and what they want to see achieved.
- Ongoing review when there is a change of circumstance/s with an expectation of an annual review if no change. This relies on a team-based approach (Case Manager and direct care staff).
- Referral back to My Aged Care or other organisations (such as primary care or mental health services) if required.

In the context of CHSP, currently there is no specific funding allocated for care planning, coordination and review activities – that is, care management activities. Rather, the care planning, review and coordination activities are included within the existing unit price for CHSP service provision.

Policy implications for current project

In summary, current policy settings indicate:

- Person-centred care is a core recommendation of the 2021 Royal Commission into Aged Care Quality and Safety.
- Care management is intended to be a key service component for Support at Home services to plan, review and coordinate services for older people receiving in home services
- The Support at Home programme handbook specifies expectations for care management, but at this stage, the focus is only on those services transitioning to the new programme by July 2025, Home Care Packages Programme and Short-Term Restorative Care (STRC) Programme.
- In the interim, there is no specific policy clarity about the care management expectations for CHSP service providers that will be required from July 2027, the earliest date at which CHSP will transition to the Support at Home programme.

Given this evolving policy context, the current project seeks to develop approaches for enhancing CHSP care planning, review and coordination practices in line with the contemporary thinking on care management requirements in the lead up to the new Support at Home Program.

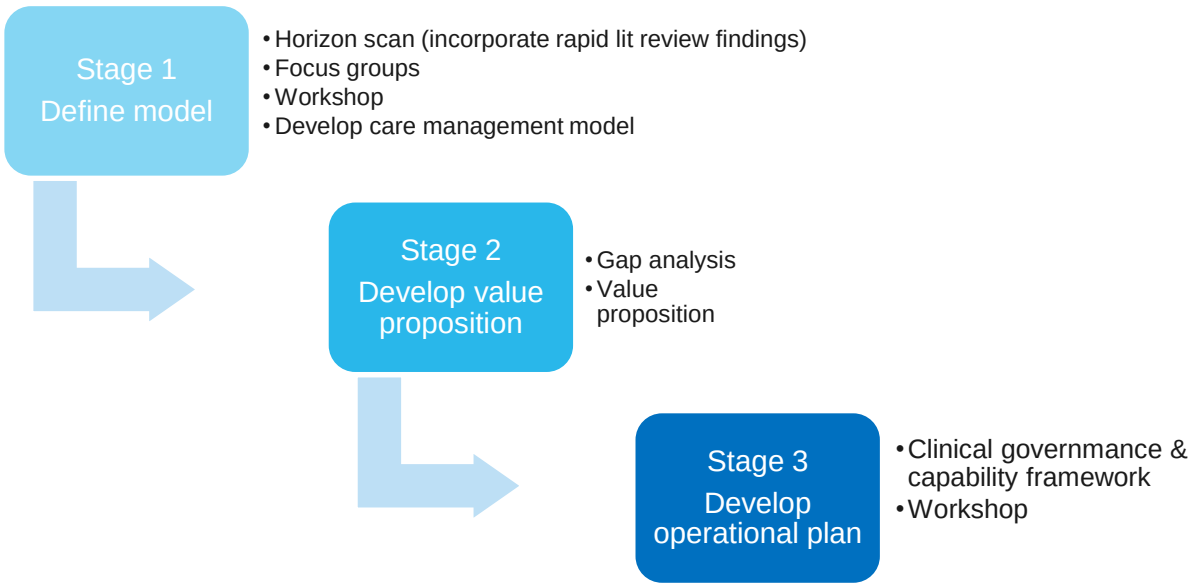
1.3. APPROACH

The project is in three stages:

- Stage 1. Define model
- Stage 2. Develop value proposition
- Stage 3. Develop operational plan.

The components of each stage are summarised in Figure 1-1.

Figure 1-1: Overview of project stages



Consistent with the workplan, the Stage 1 of the project has involved the following steps:

- Undertake close liaison with three local governments: Darebin, Merri-bek and Whittlesea;
- Undertake a current state description of the existing CHSP care management models;
- Develop options for an enhanced model considering a horizon scan (rapid literature review) from the concurrent project (Rethinking Personal Care), additional policy review and focus groups with subject matter experts who can advise on the proposed care management directions that are currently under consideration (by the Commonwealth Government);
- Define an extended entry level CHSP care management model that can operate within a multi-provider environment (in readiness for the Support at Home Programme directions);
- Facilitate a workshop with the Project Control Group (PCG) to explore a future state and explore the pros and cons of CHSP care management model enhancements;
- Based on the workshop findings, develop a concise 6-to-8-page report that summarises the extended care management model.

This current report represents the concise report that summarises the workshop findings. Separate stand-alone documents have been developed as part of the Re-thinking Personal Care project and are available as companion documents to this report, namely:

- Rapid Literature Review
- Re-thinking Personal Care Service Model.

In Stage 2 of the project, a more detailed gap analysis will be undertaken, and a value proposition will be developed. Stage 3 will involve the development of an operational plan, inclusive of a clinical governance framework and capability framework.

1.4. TERMINOLOGY

The term ‘home support worker’ is used in this report to refer to a worker who provides personal care CHSP services. It is acknowledged that different terms are used by different service providers and some use the term ‘community support worker’.

2. Current state

This chapter provides a summary of the rapid literature review report relevant to care management as well as supplementary policy analysis.

2.1. LITERATURE REVIEW FINDINGS

2.1.1. Clinical Governance

The Royal Commission into Aged Care Safety and Quality emphasised that inappropriate clinical supervision and inappropriate personal care practice can present a serious risk to the health and safety of people receiving aged care (Royal Commission into Aged Care Quality and Safety 2021:392)

The Australian Commission on Safety and Quality in Health Care sets out a definition of clinical governance in its National Model Clinical Governance Framework as follows:

- Governance, leadership and culture;
- Patient safety and quality improvement systems;
- Clinical performance and effectiveness;
- Safe environment for the delivery of care; and
- Partnering with consumers (ACSQHC 2017).

The Australian Aged Care Quality and Safety Commission defines clinical governance as follows:

> Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support safe, quality clinical care and good clinical outcomes for each consumer (ACQSC 2019a).

In a 2023 review of the key requirements for clinical governance as it applies to home care services, M. Tan acknowledges that the core elements are the same as identified by the Aged Care Quality and Safety Commission, namely: leadership and culture, consumer partnerships, communication and relationships, monitoring and reporting, effective workforce, and organisational systems (Tan 2023).

In broad terms, Tan (2023) comments that the Strengthening Aged Care Standards represent a clinical governance framework. She emphasises that Standard 5 recognises that effective clinical governance relies on ‘systems and processes from Standards 1-7’.

2.1.2. Wellness and re-ablement

A core focus of the current CHSP model is that service providers should follow a wellness and reablement approach to delivering services. This means that providers should aim to facilitate as far

as possible client autonomy and independence by focusing on clients' strengths and goals (DHAC 2024a).

The approach shifts the focus from client deficits to strengths. This is based on evidence that there is a greater potential for older people to retain capacity for activities of daily living through such strength-based approaches that promote independence and reduce the rate of functional decline.

Although no process guidelines exist for the implementation of care management in CHSP, there is an expectation in the CHSP programme manual that providers implement systems and processes to embed wellness and reablement in their approach to service planning and service delivery (DHAC 2024a). The text box below provides definitions of wellness and reablement.

DEFINITIONS OF WELLNESS AND REABLEMENT (DHAC 2024a)

Wellness

A wellness approach involves the assessment, planning and delivery of support that builds on individuals' strengths, capabilities, and goals. It encourages actions that promote independence in tasks of daily living, and reduce risks associated with living independently at home.

The wellness approach involves assessment, planning and delivery of supports that builds on a person's strengths and capacity to encourage independence. Whereas reablement involves time-limited interventions to address specific goals to adapt to functional loss and/or ability to resume activities.

Reablement

Reablement services are short-term or time-limited interventions that target a person's specific goal or desired outcome. This approach to service delivery allows clients to address a specific barrier to independence, adapt to functional loss, regain confidence and enhance their capability to resume activities.

The principles and practices relevant for wellness and reablement are described in *A Good Practice Guide* which was published by the Commonwealth Government in 2015 (Department of Social Services: 2015:3). It is clear that the Good Practice Guide is based on person-centred care principles and working *with* clients – not *for* them – to support their independence and autonomy, and to support clients to ahieve goals that are meaningful to them. The Guide makes clear that this includes reviewing goals as clients' needs and circumstances change over time.

> "A wellness approach means listening to what the client wants to do, looking at what they can do (their abilities) and focuses on regaining or retaining their level of function and minimising the impact of any functional loss so that they can continue to manage their day to day life. It supports clients to be independent in their homes and to continue to actively participate in their communities for as long as they wish to do so" (Department of Social Services 2015:3).

> "Communication with a client from the point of intake onwards will need to reflect that services are person-centred and will change according to a person's needs through a process of ongoing review" (Department of Social Services, 2015:22)

This approach is underpinned by the principles of wellness and reablement, listed below in the text box, that were published by the Commonwealth Government in 2021 (Department of Health 2021:9). The principles emphasise the importance of *regular reviews* of client needs and consider how clients' support needs may change over time.

CHSP TOOL – PRINCIPLES OF WELLNESS AND REABLEMENT

- Promote Independence – people value their independence; loss of independence can have a devastating effect, particularly for older people who may find it more difficult to regain
- Identify clients' goals – a person's independence requires more than just services to help them remain in their home and maintain their current capacity. Service delivery should focus on supporting the client to actively work towards their goals and improved independence wherever possible
- Consider physical and psychological needs – independence is not limited to physical function; it includes both social and psychological function
- Encourage client participation – being an active participant, rather than a passive recipient of services, is an important part of being physically and emotionally healthy. Service delivery should focus on assisting a person to complete tasks, not taking over tasks that a person can do for themselves
- Focus on strengths - the focus should be on what a person can do, rather than what they can't. Wherever possible, services should aim to retain, regain, or learn skills rather than creating dependencies
- Support clients to reach their potential – help clients to maintain and extend their activities in line with their capabilities
- Individualised support – service delivery should be individualised and suited to the goals, aspirations and needs of the individual.
- Regular review – client assessment should be ongoing, not one-off. It should focus on progress towards client goals and consider the support and duration of services required to meet these goals.

The CHSP Programme Manual further reinforces the requirements for service providers in implementing a wellness and re-ablement approach. As with the principles listed above, the CHSP programme manual emaphises that providers are required to "monitor changes in client needs and regularly review support services" (DHAC 2024a).

CHSP PROGRAMME MANUAL – REQUIREMENTS FOR PROVIDERS FOR WELLNESS AND REABLEMENT

As part of applying a wellness and reablement approach to service delivery, CHSP providers are required to:

- Ensure services focus on helping clients to achieve their agreed goals as outlined in the client's support plan.

  - My Aged Care Assessors develop the support plan with the client to accurately reflect the client's needs and goals.
  - The client's support plan is saved to the client record on My Aged Care and can be viewed by the client's provider.
- Apply a 'doing with' approach across service delivery.
- Offer time-limited interventions where appropriate.
- Monitor changes in client needs and regularly review support services.
- Comply with wellness and reablement reporting requirements
- Have an implementation plan outlining their approach to embedding wellness and reablement in service delivery.

There is a key role for care planning to ensure that wellness and reablement principles can be put into practice. The Hume Whittlesea Primary Care Partnership developed a resource to promote person-centred goal setting and care planning for CHSP providers (Pascale et al. 2021). The guide outlines the key elements of service specific goal setting and care planning for CHSP providers. This guide emphasised that "care plans should be 'living documents' that are reviewed and updated regularly to ensure they remain relevant and useful" (Pascale et al. 2021).

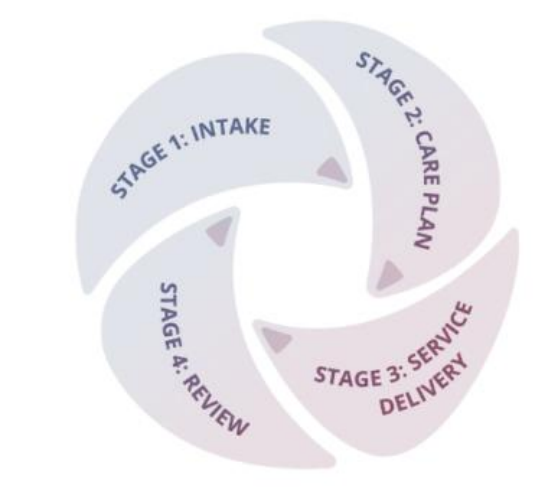
SERVICE SPECIFIC GOAL SETTING AND CARE PLANNING FOR CHSP PROVIDERS

Care plans should be updated regularly, including:

- recording when actions are completed
- utilising monitoring and feedback to keep the plan up to date and relevant
- updating the care plan to reflect the client's changing needs, priorities and circumstances. This may include setting new goals, modifying existing goals and/or identifying new actions to support goal achievement
- completing formal reviews of the care plan periodically (at least once a year) and at the end of an episode of care.

The Commonwealth Government's publication, A practical guide for embedding wellness and reablement into service delivery, sets out four stages for embedding wellness and reablement approaches into CHSP delivery (see text below) (Department of Health 2021). Following the intake stage, which involves client's RAS assessment and **support plan**, the second stage is the care planning stage. This involves working in partnership with the client to develop a care plan that outlines ***how*** the services/support will be delivered over the specified time period, ***how*** the client will be involved and ***how*** the support worker will help the client achieve their goals. Service delivery is the third stage, in line with the care plan. The fourth stage is review of the client needs and the service relevance, which should be regularly undertaken.

A PRACTICAL GUIDE FOR EMBEDDING WELLNESS AND REABLEMENT INTO SERVICE Delivery (Department Of Health 2021)



- **Intake** - when reviewing incoming referrals, it is important that a CHSP providers' intake team/officer reviews the outcomes of a client's RAS assessment and **support plan**
- **Care plan** – The CHSP providers' care co-ordinator/facilitator is primarily the person who develops the client's care plan. They should use the **support plan** to work in partnership with the client to identify strategies and solutions to achieve the client's goals. In partnership with the client, the CHSP care co-ordinator/facilitator should develop a care plan that outlines ***how*** the services/support will be delivered over the specified time period, ***how*** the client will be involved and ***how*** the support worker will help the client achieve their goals.
- **Service delivery** - The support worker is responsible for working with the client to reach their goals and outcomes. The support worker must review and ensure they have the necessary information. This includes understanding the client's situation, and the support required to help them achieve their wellness and reablement goals.
- **Review –** Both the care coordinator/facilitator or the support worker work directly with the client. Therefore, these roles are best placed and most informed to review client experiences and success. Reviewing approaches and client outcomes is essential to quality and continuous improvement. Undertaking regular reviews ensure that the CHSP provider's organisation continues to deliver high-quality and outcomes-focused support to clients.

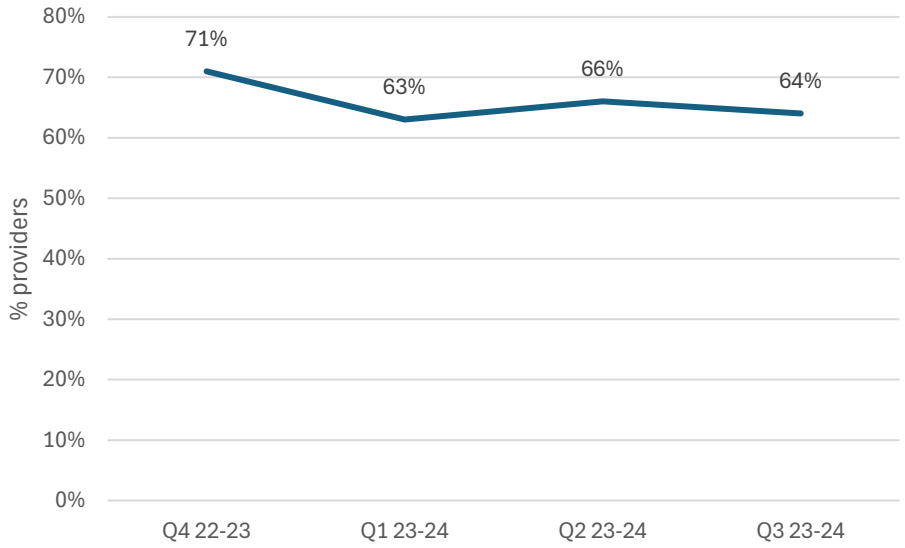
2.1.3. Aged Care Quality and Safety Commission, Sector Performance Report

Every quarter the Aged Care Quality and Safety Commission releases a sector performance report of sector-wide performance on safety and quality. This performance reporting is based on assessments of the level of compliance with the previous Aged Care Quality Standards (ACQSC 2019b).

The Aged Care Quality and Safety Commission also identified that the trend in compliance with standards has declined over the last year for in-home service providers ACQSC (2024).

> Overall compliance rates in home services remain lower than in residential care. This quarter only 64% of home services were fully compliant with the Quality Standards assessed in a quality audit (ACQSC 2024).

Figure 2-1: Proportion of in-home service providers compliant with all 42 standard requirements, Q4 2022-23 to Q3 2023-2024



One of the key observations from the most recent report was that there was significant room for improvement in relation to ***assessment and care planning***, particularly for in-home services.

> Quality Standard 2 (Assessment and planning) is a rising area of concern. (For) in-home services this standard now has more non-compliance than any other. Over a quarter of audited providers failed at least one requirement of this standard. This included failing to manage risk when there had been a change in circumstance, and poor communication and documentation (ACQSC 2024).

AGED CARE QUALITY AND SAFETY COMMISSION, SECTOR PERFORMANCE REPORT (ACQSC 2024)

The sector performance report is based on audit findings, complaints, serious incidents as well as mandatory reporting, the latter including reporting under the Quality Indicators Program. The latest report covers the period January to March 2024 and summarises findings from 1,220 online survey responses.

In relation to care planning, the survey identified that there had been an increase in the proportion of providers undertaking care planning for clients for CHSP services from 74% reporting care plans are always completed in 2022 to 77% in 2023.

Care planning was more frequently undertaken for some service types than others, with a high proportion of care plans for personal care (88%) and domestic assistance (88%) compared to a low proportion for assistance with care and housing services (24%) and for goods, equipment and assistive technology services (24%).

Whilst care planning occurs for a high proportion of clients, the survey results show that there is variation in the extent to which the care planning process is based around person-centred care principles. For example, less than two thirds (65%) of care plans always considered client preferences and a similar proportion (64%) identified client goals to maintain/regain functional capacity and social connections.

The survey also identified that only 59% care plans always identified whether or not a client had cognitive impairment or dementia, with one quarter (25%) of care plans 'mostly'.

2.1.4. Care management

The *Final Report on Co-designing the care management role for the Support at Home Programme* (September 2022) identified that there are differing perspectives surrounding the scope and definition of **care management** (DHAC 2022). However, the report considers that there is broad stakeholder agreement on two key activities:

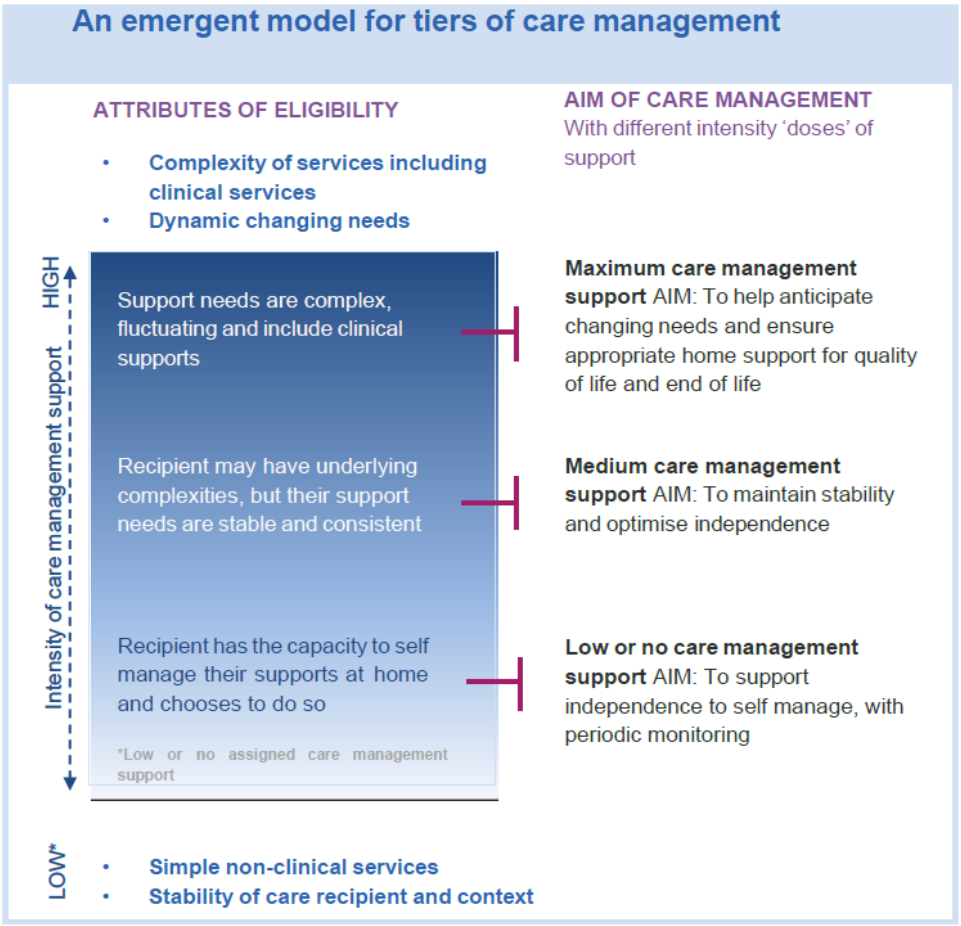
- Care planning and navigation of services, aligned to the person's care plan; and
- Monitoring and assessment of the quality and outcomes of services.

It acknowledges that across these activities "there is significant complexity in the roles and responsibilities of stakeholders. This includes their accountability, communication, workforce capability and capacity constraints" (DHAC 2022:4).

The Final Report identified an emergent model for tiers of care management based on a continuum of intensity of care management support as outlined in Figure 2-2. This model assumes that:

- Highest intensity of care management would be for participants whose support needs are complex, fluctuating and include clinical supports.
- Lowest intensity of care management would be for participants who have the capacity to self-manage their supports at home and who choose to do so (DHAC 2022:11).

Figure 2-2: Tiers of care management



2.1.5. Support at Home program – Frequently Asked Questions – September 2024

This document from the Commonwealth Government Department of Health and Aged Care sets out a number of questions and answers relevant to the transition to the Support at Home program (DHAC 2024d). Of note for CHSP providers, the document confirms that this programme will transition to the Support at Home programme no earlier than 1 July 2027. By contrast, the HCP programme and Short-Term Restorative Care (STRC) Programme will transition from 1 July 2025 (DHAC 2024d).

LEVELS OF SUPPORT AT HOME AND SINGLE ASSESSMENT MODEL (DHAC (2024d)

Eight levels

Under the Support at Home programme, there will be eight levels of services (in contrast to the current CHSP entry-level service and the four HCP levels). In addition to the eight levels, there will be two short-term classifications:

- Restorative Care Pathway to build or regain functions to remain independent (e.g., allied health services).

- End-of-Life Pathway to boost services for people diagnosed with 3 months or less to live to enable them to remain at home.

There will be a separate funding system for Assistive Technology and Home Modifications (AT-HM) Scheme.

Single assessment

Under the Support at Home programme, a single process of assessment is applicable from 1 July 2024 for assessments for all existing aged care services including Home Care Packages and CHSP services. The Integrated Assessment Tool determines the level and type of care needs required by older people.

Sole contracted provider

There is an expectation that there will be a single Support at Home service provider contractually engaged to deliver services to older people. The contracted provider has the option of subcontracting with other service providers to deliver services needed by an older person.

Participants can use third party-services if their provider supports these arrangements. Their provider will have regulatory responsibility for all services delivered under Support at Home.

Care management

Up to 10% of funding is able to be allocated for care management services under the Support at Home programme. These care management services are intended to enable the planning and coordination of services relevant to an older person's needs.

CARE MANAGEMENT (DHAC, 2024d)

Care management includes:

- Care planning
- Service coordination
- Budget management
- Monitoring, review and evaluation
- Support and education.

Care partner

A care partner is the nominated role to undertake care management in the Support at Home programme. This role would have a minimum of Certificate IV training qualifications in a non-clinical care partner role and tertiary health related qualifications such as nursing for a clinical care partner role.

Care planning

Providers are expected to undertake care planning in delivering care management services. Care planning will involve a care partner working with a participant to identify their aged care needs, goals, preferences and existing supports. This will be documented in a care plan, which will be reviewed annually at a minimum and more frequently if required.

The care plan is guided by the support plan developed in the aged care assessment process.

Services available under Support at Home

The eligible services available under Support at Home funding will be described in a service list. There is a clear distinction made between clinical services versus personal care services. Personal care services are described under the broad category of 'help with activities'.

Care management services are intended to enable the planning and coordination of services relevant to an older person's needs.

SUPPORT AT HOME SERVICES (DHAC 2024d).

Support at Home services include a range of services:

- **clinical services**, such as nursing
- **help with activities**, such as participating in their community, personal care, meals, transport, cleaning, social support and home maintenance
- **respite services** for carers to have a break.

2.1.6. Support at home program manual, 2024

Care management

Care management is defined in the Support at Home Program Manual released in October 2024 as comprising:

- Care planning
- Service Coordination
- Monitoring Review and evaluation
- Support and education (DHAC 2024c:41-42).

CARE MANAGEMENT COMPONENTS (DHAC 2024c:41-42)

Care planning

- Identifying and assessing participant needs, goals, preferences and existing supports.
- Developing and reviewing care plans.
- Reviewing agreements.

Service coordination

- Communication and coordination with workers involved in the delivery of services and with the participant and their family or informal carers
- Budget management and/or oversight
- Facilitating transitions in care

Monitoring, review and evaluation

- Engaging in ongoing care discussions.
- Case conferencing.
- Monitoring and responding to changing needs and emerging risks.
- Evaluating goals, service quality and outcomes.

Support and education

- Supporting participants to make informed decisions.
- Supporting and integrating reablement approaches.
- Providing independent advice, information and resources.
- Health promotion and education.
- System navigation and linkage.
- Problem solving issues and risks.
- Ensuring participant views, rights and concerns are heard and escalated.
- Assisting the participant with providing complaints and feedback.

Care partner

Care management activities are delivered by a Support at Home provider through a care partner (DHAC 2024c:42).

CARE PARTNER (DHAC 2024c:42)

- A care partner is an appropriately trained person who delivers care management services in Support at Home and supports participants to achieve the best outcomes from the aged care services they receive.
- Care partners will have preferred qualifications (e.g., a Certificate IV in Aged Care), with clinical care partners required to hold tertiary health related qualifications (e.g., in nursing).

2.1.7. Pricing of in-home services for the Support at Home program

The Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for determining prices for the new Support at Home program services. This has involved collection of cost data from a representative cross-section of providers to determine the costs required to deliver each of the services relevant to the in-scope service list of the Support at Home program (IHACPA September 2024).

The pricing structure is likely to identify the efficient price for delivery of Support at Home services and to also include adjustments for the additional costs of service delivery in particular contexts. That is IHACPA pricing advice will include:

- recommended prices for services on the Support at Home service list
- prices differentiated by time of delivery (standard business hours and non-standard business hours) and day of delivery (weekdays, Saturday, Sunday, and public holidays)
- recommended pricing adjustments (if any) for services delivered in rural and remote areas
- recommended pricing adjustments (if any) for services delivered to people with diverse backgrounds and life experiences, including Aboriginal and Torres Strait Islander people and other groups (IHACPA September 2024).

Of particular note, IHACPA also has responsibility for the development of hourly prices for the care management component of the Support at Home program. IHACPA appears likely to rely on two separate care management prices:

- Clinical care management
- Non-clinical care management (IHACPA September 2024).

3. Current issues and challenges

Aspex consulting conducted three pre-workshop consultations with each local government in the period 18 to 19 September 2024. These consultations involved discussion around current issues and challenges as well as the identification of future opportunities relevant to **care management and clinical governance**. A workshop was held on 23 September 2024 to further review and discuss the current state analysis and the future opportunities in relation to care management and clinical governance.

The current chapter summarises the current issues and challenges and chapter four presents the future opportunities that were identified at consultations and the workshop.

3.1. WIDER SYSTEM ISSUES

There are wider system issues that have a direct impact on the approach to care management for entry-level CHSP services.

Funding

One key issue is the level of funding available for CHSP services. Local government currently cross-subsidises the provision of CHSP services because the cost of the required service inputs is greater than the current levels of funding for CHSP services available from the Department of Health and Aged Care (the department).

A further compounding issue is that there is no separate line item for care management for CHSP services as distinct from the explicit funding of care management for Home Care Packages.

Care complexity

As people stay at home longer, there is a progressive increase in the complexity of their personal care needs. This leads to the risk that the care services available under CHSP are not sufficient to meet the complexity of individual client care needs. This can lead to challenges for CHSP service providers seeking to meet client care needs without exceeding the scope of services able to be safely provided within the CHSP delivery model.

Lack of care continuity

Given the community need and population ageing, there is a steadily increasing demand for CHSP services. In some instances, client referrals for CHSP are made for clients whose needs might be more appropriately met with a higher level of care through HCPs. However, delays in accessing a HCP can lead to some clients with relatively high needs receiving CHSP services (often more than one type of service concurrently) on an interim basis. As packages become available, clients then transition to a different provider. This results in frustration for clients as continuity in care is lost as they are transferred to a different provider to receive services under their HCP. For CHSP service providers,

the inability to provide continuity presents challenges as there are significant resources associated with the establishment and set-up of CHSP care plans, site visits and risk assessments and the orientation of home care workers to the new client. When there is a high churn, this limits the extent to which home care workers can establish ongoing relationships with clients since the period of care during which services are provided can be quite short. Person-centred care is more difficult to achieve when there is a lack of continuity of care for clients.

3.2. RISK MANAGEMENT

There is a strong focus on risk management at each of the local governments. Each council emphasises the importance of preventing and managing Occupational Health & Safety (OH&S) risks in the delivery of home-based services. One consequence of this is the tension that is created when providing the service between managing risk and applying person-centred care principles including dignity of risk.

A further challenge is that whilst each council has an explicit risk management framework, there is no explicit clinical governance framework in place for in-home services such as CHSP.

3.3. TIMELINESS OF SERVICE REVIEWS

Each of the councils recognises the importance of completing annual reviews for CHSP services. There is a significant challenge in completing these service reviews within the 12-month period given the large number of clients receiving CHSP services, with some clients receiving multiple CHSP service types.

In addition to the mandatory 12-month reviews, each local government has processes in place to facilitate a review of client needs in response to changes in care needs and/or in response to client requests for additional or different services.

The feedback from consultations is that the current monitoring systems could be further developed to enable more proactive monitoring of changes to a clients' care requirements. Currently, councils consider that monitoring of client care needs tends to be reactive. This means that the identification and reporting of changes in the needs of the client is made in response to issues being raised either by the home care worker or by the client, their carer or family to the home care worker.

Anecdotally, there is a view that a proportion of clients have care needs beyond the scope of CHSP services. The number of clients in this category cannot be routinely monitored within existing systems – current systems monitor reports by home care workers about care need issues or request by clients or carers for a change in services.

Other reports are used to monitor the timeliness of clients requiring care plan updates.

3.4. ESCALATION PATHWAYS

Each council has escalation pathways in place to ensure that additional care needs of clients can be reviewed and facilitated. This typically requires that escalation requests are reviewed by team leaders and in turn by their managers. If there is a need for a clinical service, such as a general practitioner (GP), allied health or home nursing service, then these clinical services are provided by external providers.

If there is a need for a different level of aged care services beyond the scope of CHSP, this requires a referral to My Aged Care for review.

There is a view that the escalation pathways provide the necessary assurance that clients' needs for escalation can be identified and escalation of care can be facilitated by existing processes. That said, there was also a recognition that escalation pathways could be further streamlined to reduce the number of 'touch points' necessary to review and approve care escalation. Streamlining of escalation pathways was considered especially important for addressing more urgent care escalation requests.

3.5. TRAINING

Each of the councils have specific training models relevant to CHSP. These include routine training modules for induction of new home care workers. Training is also provided for specific areas such as infection control, medication safety and management of OH&S risks in home care settings.

Whilst the existing training approach was acknowledged to be important, it was not considered to be sufficient. There was a view that whilst home support workers may have undertaken training, this does not necessarily translate into practice change in the delivery of personal care.

In the future, there was a recognition training needs to address the different requirements in service delivery – that is, training of home support workers as well as training in supervision and care management roles for team leaders and managers.

3.6. WORKFORCE CAPACITY AND CAPABILITY

There are challenges in the workforce in terms of the sector-wide trends of workforce ageing and workforce turnover. A challenge into the future is that the Support at Home reforms may further introduce market competition leading to supply challenges for the home support workforce.

One specific challenge local government face in the lead-up to the Support at Home model is the need to clarify expectations around roles and responsibilities for entry-level CHSP services in the care management context. This is an issue that is relevant to the way in which councils will need to specifically define any changes to roles and responsibilities of team leaders and managers to ensure that services align with the direction of the reforms and government policy expectations.

4. Future Opportunities

This chapter summarises future options identified at the workshop for enhanced care management and clinical governance for CHSP services in preparation for the transition to Support at Home no earlier than 2027.

4.1. CLINICAL GOVERNANCE

Clinical governance framework

The development and implementation of a clinical governance framework is a clear opportunity for local governments to support their approach to prepare for the transition to Support at Home and to provide a framework for assuring safety and quality of home care services.

Within the clinical governance framework, a risk-based approach will be relevant to the design of systems and processes relevant to assuring safety and quality. This means a risk-based approach will be applicable to:

- Processes for undertaking service reviews for clients with highest need
- Involvement of home support workers in service reviews
- Escalation processes for clients with changes in need.

Consolidation of case management role

A strengthened case management role is considered relevant to support proactive risk management and to enable person-centred care.

4.2. SERVICE MODEL SCOPE

The opportunity to extend the scope of the service model to include Home Care Packages is a clear opportunity to provide greater workforce capability and to support continuity of care for clients. This opportunity is contingent upon the risk appetite of individual local governments and is also subject to a consideration of the associated transition costs and additional resources that would be required to support such an expansion in service offering.

4.3. PARTNERSHIPS

There are significant opportunities for councils to develop strengthened partnerships to enable more seamless provision of services that are outside the current scope of CHSP services. The range of partnerships that may be developed is diverse and includes:

- Partnerships with providers of HCPs to support clients to have the opportunity to transition seamlessly when higher care is required

- Partnerships with external clinical providers who could provide additional assessment and clinical services to address short term requirements as part of care escalation pathways
- Partnerships with virtual care providers who may provide additional clinical support as required for care escalation
- Partnerships with training providers.

4.4. TRAINING

A strategic training framework is considered relevant to address the range of training requirements associated with the transition to the Support at Home service context. The value of a training framework is that this would identify what types of training are required for different roles.

Specific additional areas of focus for training include the following:

- Training in behaviours of concern as well as clinical and physical deterioration
- Training to support care management including:
  - Knowledge transfer
  - Case conferencing
  - Peer review
  - Reflective practice

4.5. DIGITAL SYSTEMS

One important system capability enhancement for care management is support tools for assessment and care planning.

Depending on the strategic position identified by local government in relation to expansion of service scope to include HCPs, there will be a requirement to assess the functionality of the client management system. This may require local government to invest in a system upgrade or replacement.

Another option that has the potential to improve service effectiveness is the use of digital systems to support assessment and care planning. This could extend to virtual assessments and the use of artificial intelligence (AI).

4.6. CAPABILITY

There is a shared view that within the CHSP home support workforce there is an appetite to increase capability and undertake a diversity of practice. This opportunity aligns directly with the potential to expand the scope of responsibilities that home support workers undertake as part of a focus on person-centred care and to promote greater continuity of care.

Other approaches to enhancing workforce capability that may be relevant include:

- Building the capability within the workforce to address behaviours of concern and to better provide care for clients with dementia and for clients with mental health issues
- Building the capability of the workforce through promoting pathways for home support workers to undertake Certificate IV training
- Supporting the role of carers as a way of promoting clients ability to live independently for longer in their own home setting.

The following appendix provides a summary of each local government's current arrangements for CHSP clinical governance and care management.

A1. Current CHSP home support service models

This section provides a summary of each local government's current CHSP home support service delivery approach at the current time. This is based on feedback from consultations and summary overview of documents provided. A more detailed review will be undertaken in stage 2 of the project.

A.1.1. CITY OF WHITTLESEA

Organisational Structure

- There are three direct care teams at the City of Whittlesea – each team is made up of approximately 30 home support workers and reports to a direct care supervisor, who then reports to the direct care coordinator, as per Figure 4-1
- Quality and compliance coordinator is part of the Ageing Well team and works across the unit managers. It is a new role under the restructuring of the previous role of quality coordinator, there is an advisory committee in the process of being set up to manage quality audits
- The City of Whittlesea also runs dementia support under its "Positive Ageing" team.

Figure 4-1: City of Whittlesea Organisational Structure for Direct Care

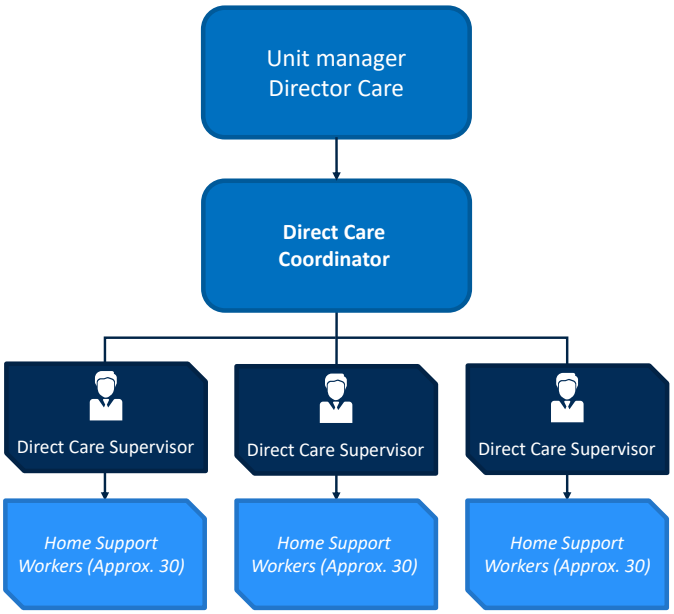
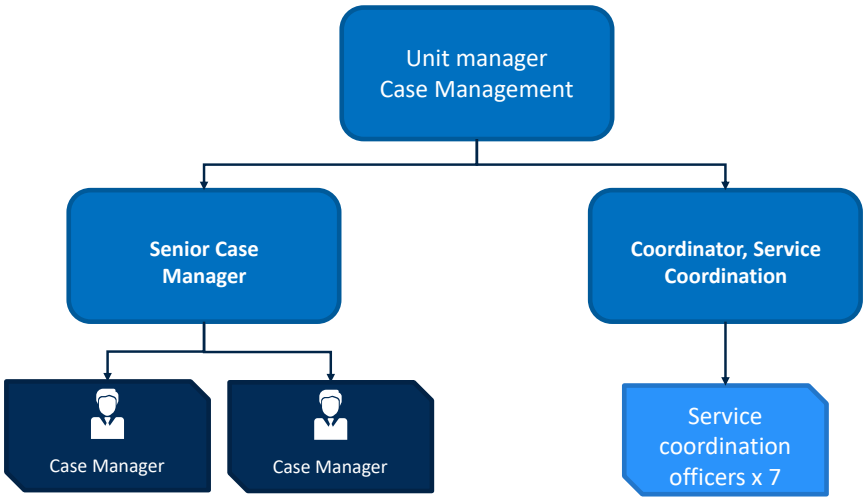


Figure 4-2: City of Whittlesea Organisational Structure for Case Management



Client and Workforce Numbers

- 2,551 active CHSP clients (31 Aug 2024)
- 389 of total active clients are personal care clients (31 Aug 2024)
- 90 home support workers
- 3 EFT Case managers supported by a team of 7 service coordinators

Clinical Governance

- **Risk management** – The City of Whittlesea has a Risk Management Framework that applies to the whole organisation. The main focus of the framework is to manage corporate risk which includes strategic risks and operational risks
- **Clinical governance framework** – The City of Whittlesea does not have a specific clinical governance framework**.** The council is planning to develop an advisory committee for quality audits and is likely to develop a clinical governance framework in the future.
- **Workforce minimum requirement** – Certificate III is the competency requirement for home support workers.
- **Training module** – Induction of new workers is a key requirement. This is supported by the commencement of work instructions. Some additional training is also made available, such as to support medication prompting and to support clients with dementia.
- **Incident management system** – there is an incident management system in place, which captures important client or staff incidents or issues.

Care Management

- **Service Reviews** – There is a CHSP requirement for service plan reviews every 12 months for all CHSP clients. The City of Whittlesea works to ensure compliance against this measure.

- **Escalation pathway/processes** – The escalation process currently includes multiple touch points including care supervisors, case managers, and coordinator. The City of Whittlesea is aiming to further streamline this process in the future.

Partnerships

- The City of Whittlesea is exploring opportunities to strengthen partnerships to facilitate access to a range of services including clinical services such as nursing and allied health services, as well as meals and home maintenance and potentially partnerships with providers of HCPs.

A.1.2. DAREBIN CITY COUNCIL

Organisational Structure

- There are three community support teams at Darebin City Council, comprising approximately 35 community support workers per team, who report to the team leader of that respective team, see Figure 4-3
- A safety team leader also reports to community support team leaders

Figure 4-3: Darebin City Council Organisational Structure for Home Support Services

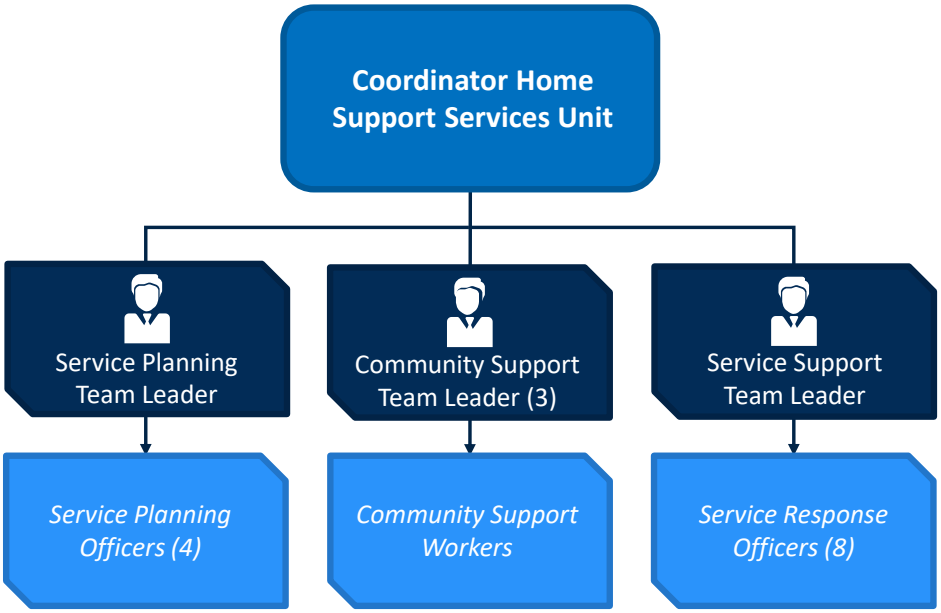
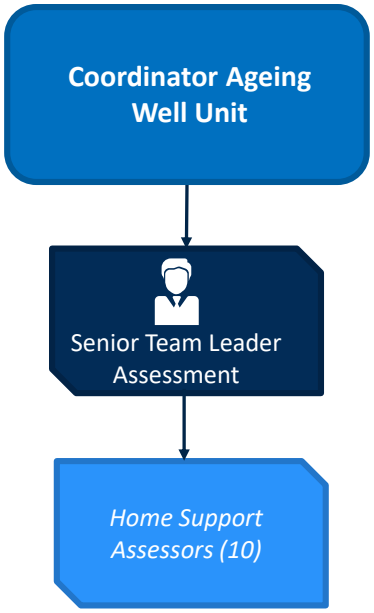


Figure 4-4: Darebin City Council Organisational Structure for Home Support Assessment Services



Client and Workforce Numbers

- Approximately 2,400 active CHSP clients
- 387 of total active clients are personal care clients
- 104 community support workers
- 10 home support assessors

Clinical Governance

- **Risk management** – The safety team looks after occupational health and safety and monitors issues around work or the client's home environment. Quality and safety used to be one team/department but are now separate
- **Workforce minimum requirement** – Most community support workers are qualified with a Certificate III
- **Staff feedback** – Community support workers have access to bi-monthly team meetings, monthly 1:1 meetings with their team leader and 6 monthly performance reviews
- **Data and reporting** – Darebin City Council captures detailed client and service delivery data, and endeavours to further broaden the range of its data collection
- **Incident management system** – The council has a good incident management process which feeds into its overall continuous improvement plan

Care Management

- **Service review processes** – Darebin City Council is able to get through most of its service plan reviews within 12 months

- **Escalation pathways/processes** – The council has established internal communication pathways around changes in client welfare, client needs and/or circumstances
- **Service delivery** – Darebin City Council is looking to strengthen its service delivery so the process can be more streamlined, with services prioritised based on urgency

Partnerships

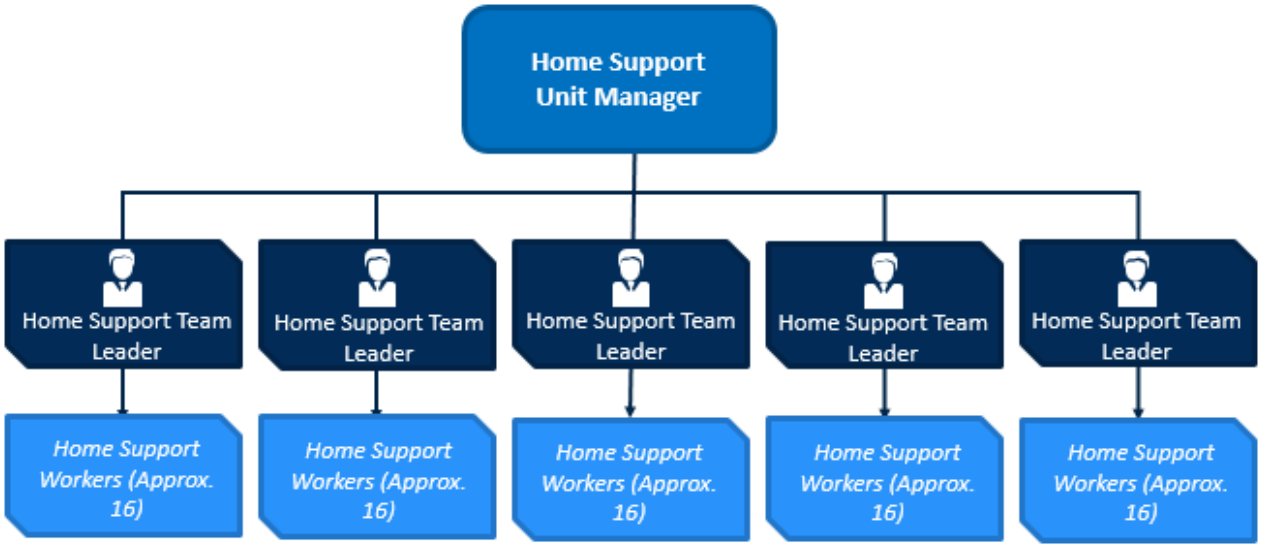
- Darebin City Council is currently focused on basic care management, where clients are referred back to their GPs or other healthcare professionals for external clinical care needs. In future, the council may look into broader partnership strategies to expand service scope, if that aligns with the organisation's strategic objectives and risk appetite

A.1.3. MERRI-BEK CITY COUNCIL

Organisational Structure

- There are five home support teams at Merri-Bek City Council. Each team is comprised of approximately 16 home support workers who report to their respective team leader, and the five team leaders then report to the unit manager for home support, see Figure 4-5
- A quality manager reports to Strategy and Business Intelligence Coordinator who then reports to the branch manager followed by the director.

Figure 4-5: Merri-bek City Council Organisational Structure for Home Support Services



Client and Workforce Numbers

- Approximately 2800 active CHSP clients
- 279 of total active clients are personal care clients
- Approximately 80 home support workers

Clinical Governance

- **Risk management** – Safety is a priority at Merri-bek City Council
- **Clinical governance framework** – Clinical governance is embedded into operations, but not part of a standalone clinical governance framework
- **Workforce minimum requirement** – Certificate III is the competency requirement for home support workers.
- **Staff feedback: 1:1** follow-up sessions between team leaders and home support workers every **6-weeks**, additional to **quarterly reviews**
- **Data and reporting** – Reporting system tracks client hours, compliments versus complaints, overdue reviews, clients awaiting care plan etc
- **Training** – Merri-bek City Council is looking to strengthen the personal care team's mental health skillsets and capability

- **Incident management system** – Merri-bek City Council has an established incident management system for staff and clients, mostly clients

Care Management

- **Service reviews** – Annual service plan reviews are currently the sole responsibility of team leaders, with some involvement from the home support workers. The council recently implemented a "client review letter" to help further enhance the process
- **Escalation pathways/processes** – Home support workers initiates escalation processes. Home support workers highlight changes in client circumstances either via direct call or by filling in a form if non-urgent
- **Service delivery** – The home support workforce at Merri-bek Council is open to upskilling, in order to broaden their service offerings to clients

Partnerships

- Merri-bek City Council's current service delivery is focused on entry level care, but is keen to explore opportunities to strengthen partnerships to facilitate access to a range of services including clinical services such as allied health and potentially HCPs.

A2. Consultation List

Below is a list of all stakeholders consulted for stage 1 of the extended CHSP project.

Table 4-1: Extended CHSP Project Consultation List

Name of Provider	Name	Role	Consultation Date
City of Whittlesea	Antoinette Mertins	Service Planning Coordinator, Ageing Well	18 Sept 2024
City of Whittlesea	Daniel Calleja	Unit manager for home care program	18 Sept 2024
City of Whittlesea	Lucy Antonelli	Senior case manager for care management	18 Sept 2024
Darebin City Council	Anja Hauenschild	Coordinator Ageing Well	18 Sept 2024
Darebin City Council	Nathan Korotkov	Senior Team Leader Service Projects	18 Sept 2024
Merri-bek City Council	Lisa Raywood	Strategy and Business Intelligence Coordinator	19 Sept 2024
Merri-bek City Council	Paul Moffitt	Acting Unit Manager for Home Support	19 Sept 2024
Merri-bek City Council	Brennan Carlson	Unit Manager of Social Support	19 Sept 2024
Merri-bek City Council	Diana Carroll	Quality Manager	19 Sept 2024
ACCPA	Anita McStay	Senior Policy Advisor	9 Sept 2024
ACCPA	Jane Floyd	Advisor - Home and Community Care	10 Sept 2024
ACCPA	Beth Dawson	CHSP Advisor	10 Sept 2024

A3. References

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