Meals on Wheels

Meals on Wheels Australia

Response to

Department of Health and Aged Care's In-Home Aged Care Discussion Paper

More than just a meal

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Summary

Meals on Wheels Australia (MOWA) welcomes the opportunity to respond to the Department of Health and Aged Care's In-Home Aged Care Discussion Paper. MOWA acknowledges that the Discussion Paper has responded to many of the issues raised during recent consultations.

MOWA supports the program design element enabling more consumers to choose their preferred providers and commends the acknowledgement that meals providers will require a better funding model than a solely activity-based system.

In this submission MOWA will comment on the proposal for Care Partners, the introduction of client budgets, co-ordinating care across multiple providers, supplementary and additional grants, and innovation.

This submission will also comment on current and proposed funding arrangements and present an alternative funding model that offers choice to the client, flexibility for the provider and value for the Government.

more than just a meal

Care Partners for Older Australians

MOWA members support the program design element enabling more consumers to choose their preferred providers for different support needs. We note that many providers do not directly provide the full suite of potential service types and choose not to do so. Home Care Package providers regularly outsource provision of meal services to Meals on Wheels organisations via subcontracting mechanisms. Where the chosen service providers are each registered providers, this reform would eliminate the administrative overhead of contract management and the risk of bad debts that regularly accrue in the current system.

The paper does not make it clear whether an older Australian could choose to get the same service type from more than one provider. MOWA notes that this is a limitation of the current CHSP system that has frustrated service users but would increase the complexity of monitoring service usage against budget.

Should a care partner be accountable for monitoring outcomes and changes in clinical and care needs, and ensuring the older Australian is receiving their services? How might this work?

MOWA welcomes the proposal that care partners be introduced to the in-home care program. The removal of the former case management service type from low-level community care created issues for clients by removing advice and assistance to negotiate access to a choice of providers.

It is worth noting that if the assessment system were sufficiently robust, the need for care partners may be reduced to the ongoing support and adjustment of services for clients.

Conflicts of interest

To prevent conflicts of interest, the assessment of older Australians should be performed by agencies independent of care provision that have a proven record in aged care assessment. To provide genuine choice and control for older Australians making decisions about their care, care partners should be independent of care delivery. This will ensure transparency, accountability of decision making and removal of conflicts of interest. Care partners must come either from government or from organisations that are wholly independent of providers and must not be permitted to enter any direct financial relationships with specific care providers.

Care partnering must only be delivered by an independent organisation that specialises only in care partnering. Care partners could also be an extension of assessment thus maintaining independence for service delivery and more efficient than two separate structures. Systems that do not do this leave themselves open to manipulation and special pleading that inevitably make them unable to meet the client's needs and to vastly overspend.

Access to Care Partners

The Aged Care Royal Commission into Aged Care Quality and Safety concluded that the current aged care system is complex and difficult to navigate. Entry into the aged care system, or the urgent need to require more care, is a stressful time for older Australians and their families. Assistance with advice and navigation from a Care Partner should be available, either where required or requested, for every client from the time of their acceptance of eligibility for in-home care, that is before a full assessment.

Clients should be able to access short-term care partnering, such as when initially setting up care arrangements, or when there is a significant health event.

The need for a Care Partner is the decision of the client, not a decision to be made by an assessor, except in a specified set of circumstances, such as diminished capacity.

If a Care Partner accepts the care responsibilities of some, or all, of the care of a client, including in conjunction with other providers, they should be accountable for monitoring and reporting on outcomes from the advice and support they provide, and to report on changes in care needs.

Regulations that mandate a timeframe for reply to, and action on, changes to care plans or service delivery should be drafted with penalties for non-compliance.

Accountability

The role of the Care Partner in a client's aged care experience will be in a range from one-off assistance for entry level care to assisting older Australians with complex care needs. Care Partners would be accountable to their clients in meeting the needs outlined in the support plan. Care partnering activities will be recorded on a designated portal and will include any communications, decisions, activities and outcomes performed in partnering with the client to make good decisions about which providers will meet their care needs. These records are to be provided to the client.

This portal must be developed to encompass the complexity of the aged care system but the interface must be administratively simple and easy to negotiate for all levels of user.

Care Partners would be accountable to the aged care system by meeting a significant percentage of the KPIs for care partnering, such as communications protocols, network connections, advocacy, assessment of client satisfaction or independence of service provision.

The Care Partner must work within a time frame to deliver the care partnership. Clients and the care providers they have chosen must be fully informed of all decisions. The ongoing role of the Care Partner in that client's aged care management must be decided and the level of involvement agreed upon. The levels of involvement may range from care partnering being no longer required to complex and ongoing arrangements for care partnering.

Monitoring role

Where an older Australian chooses to engage a care partner, it is appropriate for the care partner to regularly meet with the older Australian to discuss how well the support plan is meeting the person's current needs and to support the older Australian to receive the quality and quantity of services to which they are entitled. This may include referral for reassessment or reablement where support needs have changed. It is suggested that a timeframe be established for any adjustments to care plans such as a 4-8 week time frame after the commencement of care.

If an older Australian is using more than one provider, how can information and observations of care workers from different organisations be communicated to the care partner?

A portal that is well-designed, simple to use and accessible to all involved in care, including the client, with varying levels of access, would ensure that the information in support plans can be available to all necessary providers and the client within agreed business rules about privacy and confidentiality. This portal will also capture data and maintain records of observations and changes to support plans. Data protection and confidentiality concerns would be managed by the portal and not individual providers with different systems. Provision must be made in the business rules for the portal about reporting, from the volunteer or care worker in the home right through all levels of the care provider.

Does it matter where the care partner sits?

MOWA recommends that the care partner sit independently from other providers. Where a care partner is required, clients should have equitable access to independent care partners to ensure there is no conflict of interest with care providers, and that there is equitable accountability expected from care providers.

A care partner can support transitions in care and proactive responses to prevent crises. What, and how, should a care manager be held accountable for this role?

The roles and responsibilities of Care Partner should be outlined in the relevant Program manual with clear guidelines that explain the interface between the two roles. The roles must be well designed, with clear boundaries and have achievable KPIs with penalties for non-compliance.

The Care Partner is responsible for the active care of the older Australian. Their responsibility is also to monitor the client. The Care Partner is responsible for working with the client to organise that care. Care Partners will assist older Australians with varying assessed levels of need for intervention and support and work with one or more care providers and other agencies to assist with decisions about care providers that will lead to the best outcome for the client. Managing transitions in care and the responsibilities of each of these providers should be outlined in a reporting framework between the two roles. The framework should be developed on risk management principles. A hierarchy of risk will denote when responses from either role are required and how each organisation is to respond in a crisis. An organisation's duty of care does not diminish because there are multiple providers involved in a person's care, so any of the providers involved in a client's care can communicate with a Care Partner, where there is one involved.

The reporting principles and framework between care providers and care partners must be conveyed to all people involved in a person's care and formally acknowledged by all necessary parties. Both the care provider and the Care Partner will have protocols to follow and specific actions to perform. Consideration must be given to client choice as to which services they may need to suspend to increase other care types in a crisis. Using dignity of risk principles can assist with these decisions.

Reporting also requires compliance. There should be regulated and clearly stated consequences of non-compliance. Compliance should continue to be monitored by an independent authority and organisations should continue to be regularly monitored. A new Aged Care Act will require new regulations and standards for care providers to be assessed against. The regulations and criteria for compliance against these standards must be proportionate to the complexity of care provision from that organisation.

There must be transparency for the public. A Care Partner's KPIs must also be communicated to Older Australians and the public in a way that provides clear and concise progress against those KPIs – e.g. star ratings such as the "Nursing Home Compare" website in the USA or release of the results of quality reviews such as the percentages of consumers who receive quality care.

Progress of the Care Partner in delivering their part in the support plan should be monitored by the assessment agency. The Assessor would have procedures to follow if the Care Partner was underperforming.

What does successful care management look like? What should a care partner's 'Key Performance Indicators' look like?

A care partner:

- Must follow established reporting frameworks – who needs to know, why, when and how, a certain percentage of the time, e.g. 85%

- Must use regulated communication methods e.g., red flag reports on care portal, mandatory contact with client with established time frames, including any carers involved in all communications, update centralised support plans within an established time parameter a certain percentage of the time, e.g. 85%

- Ensures accountability guidelines are followed including performance measures available to the public e.g. through their website, client communications, any national star-rating system.

- Must inform the community of the results of quality assurance reviews including any notices of improvement or further non-compliance.

- In the event of a crisis, from that of an individual client to an event that affects an entire organisation e.g. data breach, dealing with natural disasters, the care partner must follow established procedures, communications and actions timeframes proportionate to the crisis (from immediate to x number of working days) to achieve a timely and good result in changing a client's care needs.

What should the role of a care partner be in relation to ensuring services are meeting quality standards? How might this link to Quality Indicators for in-home aged care providers?

Quality care requires a robust regulation framework that centres on risk management and mitigation. Risk reduction frameworks and the measurement of Quality Indicators must be proportionate to the service delivered.

The Quality Indicators to be developed for in-home care would have some crossover with those developed for residential care. For example, in-home care Quality Indicators would require meals providers to meet the indicators for addressing unplanned weight loss by improving nutritional intake, clinical reporting where specialised meals are required, reporting of falls and major injury, improvements in the activities of daily living, positive interactions with workforce, positive consumer experience and improvements in quality of life of the client.

Comparable quality assurance systems must also be included as evidence of compliance. For example, the preparation and delivery of meals is a low-risk care category. Several of the indicators for quality meals provision are already dealt with by State regulations e.g. NSW Food Safety Audits, the requirement for certified Food Safety Supervisors. A national standard for nutritional requirements of meals supplied to older Australians under any Commonwealth Funded program should be established, and the use of these standards should be mandated for meals supplied to older Australians who have been assessed as needing nutritional support or requiring food security.

MOWA notes that the Aged Care Quality and Safety Commission has flagged a risk proportionate model of regulation to accompany the new Aged Care Act. MOWA recommends that proportionate risk for meals includes not only risk to clients but also risk to the organisation or the sector, for example when a large production kitchen that provides many thousands of meals a day to a large region is found to have caused an outbreak of food-borne illness.

To meet the quality indicators of unplanned weight loss, activities of daily living, consumer experience and quality of life it should be mandatory that a high proportion of delivered meals meet the nutrition guidelines for older Australians. Meals on Wheels has established a taskforce of dietitians who will certify the proportion of meals provided that meet these guidelines. Certification will be conducted annually.

If an older Australian chooses to use different providers to deliver different services, what should be the responsibilities of each provider to communicate with each other, and with the older Australians' care partner? How should these responsibilities differ for providers of different service types (for example domestic assistance vs nursing)?

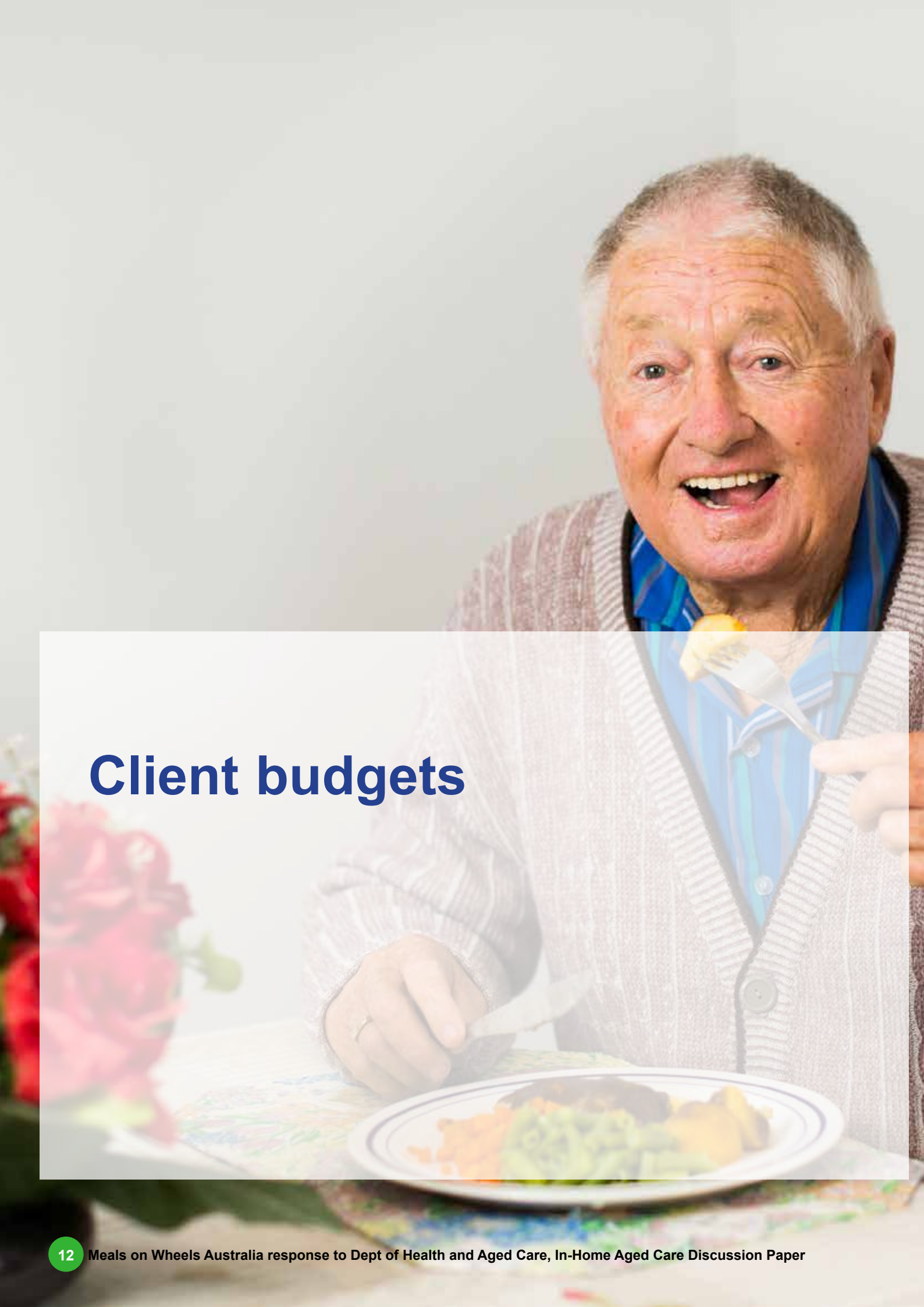
Providers should have the responsibilities (and methods for meeting these responsibilities) clearly outlined in grant agreements and the operating manual for the Program. Regulations that mandate a timeframe for reply to and action on changes to care plans or service delivery should be drafted with penalties for non-compliance. A communications protocol must be developed in conjunction with a care portal with structured and appropriate access to all involved in a client's care. Support plans should include all providers agreed responsibilities and a framework for communicating changes in care or concerns about increased need.

Direct care workers can only be held accountable for observations and reporting that is within their scope of practice and/or incident management system requirements. For example, a meal delivery volunteer may observe a wound and, upon asking, hear that the client has fallen. The meal service provider should be responsible for reporting the observation, but the care partner should be accountable for arranging a mobility assessment or wound assessment depending on what other services are already in place.

The communications protocol should include the compulsory use of a care portal - a central system for the storage and input of progress against the clients support plan and any changes to that plan. Responsibility for updating the portal will lie with every provider involved in a client's care, including the activity reporting system.

While most clients will communicate directly with providers as they do now, clients who are unable or choose to make the care partner responsible for managing all communication should be able to access this option. This should be included in the client's support and communications plan. Communications protocols must not be overly complex. Most organisations already have communications policies.

There should be clear pathways for Older Australians, and any other care providers involved in providing care, to address any issues in a timely and effective way where the communications between care providers are problematic, or service delivery is of poor quality. Enhancing the scope of advocacy organisations such as OPAN to monitor and address issues with communications would assist with ensuring providers meet their responsibilities.



Client budgets

Should the older Australian be responsible for managing their own budget and ensuring they stay within their funding entitlements? How might this work?

Individualised funding needs to be distinguished from individualised care planning. Individualised care planning and person-centred care can be delivered with any funding model. To provide genuine choice and control in the aged care system having responsibility for their own care decisions must be an option for clients.

People who choose to manage their own care must be supported by a well-designed interface and positive user experience. If managing their own care can be made to work well for the client, it will be a cost saving to government. A care portal should be built that is simple to use and integrated with any other systems that care providers are required to use to manage the delivery of care and report on outcomes.

It is unlikely that most older Australians will choose to manage their care, however, although this percentage will possibly increase as a more tech savvy cohort enters aged care. Repeated offerings of this option e.g. HCP and NDIS, have shown that, while a small proportion of people want to manage their own budgets, most people do not. In the experience of Netherlands in-home care provision only 15% of people chose to self-manage. The remaining 85% chose to use the services of a trusted provider to manage their budget. This percentage is similar to the NDIS percentage of self-managed participants. Many of the people who manage their HCP's have assistance from family members to organise their care and manage their budget.

Older Australians will therefore most likely prefer another person or entity to manage their care. Should clients receive a budget and choose a provider to manage that budget, this budget management should be independent of care providers and could fall under the purview of care partners who are required to be separate from care delivery.

MOWA believes that it is more important that older Australians are able to have genuine choice and control over their care and respect paid to their decisions, than expecting people who do not wish to manage their own budget being required to do so. MOWA would like to emphasise that comprehensive assessment is the key to ensuring accurate service provision. People cannot make good choices if the complete range of their needs are not considered. It is the experience of many meals services that nutrition screening is inadequate and not included in the requirements of a consumer on a HC package. A better understanding of the basic nutritional needs of older Australians is required.

MOWA suggests that adopting the funding model proposed that is based on the AN-ACC would eliminate the need for a client to be allocated a budget to manage. The client would receive an allocation of relative value units (RVUs) of care and the provider, or providers are responsible for the management of RVUs and the budget behind them.

Should individual budgets be implemented, and the majority of clients choose not to manage their own care, a system of oversight of those budgets will be required. This may be a simple as a detailed monthly statement of services used and expenditure against the quarterly budget. A red flag method could be used to alert the client that a certain percentage of their budget is expended. This would be a role for care partners.

The paper is not explicit about what 'managing their own budget' means. If clients do not receive a bucket of funds to directly manage, then the responsibility relates only to monitoring service use against the service plan. If services are funded at a consistent national price, then monitoring the allocated service use is all that is needed. This form of self-monitoring may give rise to 'droughts and floods' of service use, where allocations are saved early in the quarter just in case, then urgently demanded to be delivered in short time frames at the end of the quarter. Responsibility for ensuring that consumers pay their required contributions is also muddied where consumers self-manage.

Any budgeting tool would need to include a method of including client contributions.

Co-ordinating multiple providers

What challenges might providers and older Australians face in coordinating services across multiple organisations? How might these challenges be overcome?

A collaborative focus on care

The marketisation of aged care has seen a substantial shift from the co-operative and collaborative focus on care that existed under HACC service provision. Care provided in a collaborative context gets the best results for the client rather than designing a model where organisations compete for customers that commodifies older Australians. It is the antithesis of collaboration. MOWA supports the emphasis to be placed on the client's choice in selecting care providers that function and cooperate in the client's best interests. This emphasis means that a shift in care philosophy is required, and MOWA supports the policy that care provision and care choice (Care Partners) are exclusive of each other. This allows for a more collaborative approach to care and strong networks.

Within the existing HCP system, there is already a requirement for coordination of services to a client who chooses or needs services delivered by another organisation. Currently this is formally managed via contractual obligations where the package is paying for the brokered services. Increasingly, exhausted package funds require some services to be provided via the CHSP and there are effective mechanisms in place between providers to coordinate services – primarily, the brokered or CHSP provider is responsible for managing the service provision of the specific services on a day-to-day basis and there is a mutual responsibility to communicate about changes in the consumer's situation and needs.

Localised networks

A national system such as My Aged Care lacks the capacity to deliver localised solutions to older Australians care needs. Localised solutions are proven to work to achieve client outcomes. Older Australians want to know what supports they are assessed as needing and who is best placed in their region to deliver those supports to them. An expectation that someone in need of support at home will trawl through a nationally based website to find local care providers is misguided. Whilst the percentage of older Australians who are computer literate is increasing, most people in the 75+ age group would prefer to find information through other means, hence the need for care partners.

Establishing regional hubs involving assessment services, care partners, provider networks, interagencies, and sector support would be positive steps in developing collaborative solutions to care. A return to localised continuum of care aged care interagency meetings could be of benefit. These interagency meetings formerly provided a venue and method whereby providers would work together to provide a range of care solutions for individual clients with the emphasis on delivering quality care utilising the whole of the care spectrum, and not capturing consumers within their organisation.

Locally based care partners or the assessment service could be the leads for interagency meetings. Specialised or statewide providers could participate via videoconference as required.

Increased administration

Consideration needs to be given to the significant impost of time and resources that a collaborative approach to the care of older Australians would place upon providers. The administration to support this should be funded accordingly within the 'efficient pricing' or as a separate service type. Some consideration needs to be given to the percentage of resources that a provider will be expected to assign to collaborative care. The resources expected to be used to co-ordinate care must be proportional to the size of the care provider's organisation.

Financial risk to provider and client

Under grant funding CHSP clients currently have access to services from multiple organisations without financial risk to any party. Services delivered to a client who uses multiple service providers, and whose individual budget is in deficit, create a risk that does not currently exist for either client or provider.

As discussed in the section regarding funding models, this risk need not exist at all if individual budgets were replaced with an allocation of RVUs. The risk of over-spending on an individual's budget puts the financial burden completely on the older Australian and consequently jeopardises their own support needs as well as the financial integrity of the service provider.

Further, it is not necessary to manage collaboration and coordination via sub-contracting mechanisms. These mechanisms have also produced significant financial risk to the sub-contracted (often CHSP) provider in the existing system. Perpetuating them adds administrative overhead for both the direct service provider and the contracting provider where each is a registered provider. HCP providers' handling fee for a fortnightly meal service invoice can often match or exceed the cost of the meal service to the package.

Supplementary and Additional Grants

+ Innovation

What key services and types of providers may require supplementary or additional grants?

MOWA welcomes the Department's recognition of provider feedback that some service types will require capacity funding to 'keep the doors open'. This will allow activities to be maintained during fluctuations in client numbers, to allow for rural and remote care or care to niche communities, including those in metro areas.

MOWA welcomes the recognition of meal service provider requirements for a continuation of a level of grant funding for capacity, and will work directly with Department officials to progress this initiative.

Meals providers will require capacity grants to ensure that infrastructure, utilities, wages of indirect care staff, maintenance of equipment, etc, that are required regardless of activity levels can be maintained.

There has been minimal capital funding available to CHSP providers since the HACC split. Access to capital funding is necessary for improvements to infrastructure, purchase of vehicles, innovative building solutions etc. to ensure providers can improve services and facilities.

Which diverse groups may be at-risk from the shift to activity-based payments, both in remote areas and metropolitan areas, and what are the specific supports grants should address?

Any service provider, regardless of location, that deals with specific or niche populations, e.g. rural and remote CALD, Aboriginal and Torres Strait Islanders, LGBTQI+ may have fluctuations in service delivery. Grants that recognise funds are required to 'keep the doors open' and provide care in a culturally safe way, regardless of activity levels, would address this.

Thin markets and collaborative care solutions can lead to innovation. Huge systemic change, as is proposed, can lead to innovation as the care sector develops service delivery under the new program. An innovation fund should be established for trialling new models and types of care provision and funds should be available to encourage the broadening of the successful and scalable innovative practices.

CALD-specific meal service providers operating in metropolitan areas have additional cost imposts related to long travel times/costs to reach dispersed customers, requirements for translated materials and more restricted access to paid and voluntary workers who can converse in the relevant community languages.

What should be the reporting requirements of these grants?

Capacity funding that covers basic infrastructure, wages and administration costs could be reported on via established financial reporting records supplied to funding bodies ASIC, ACNC, Dept of Fair Trading, ATO etc. a simple acquittal could be required.

Activity funding will be reported via a payment portal.

Progress on variations in funding or activity allocations should be reported to the funding department quarterly. Care partners will also need to be informed about service capacity. Reviews of grant performance and quality assurance results should also be reporting requirements.

In the case of innovative projects, an evaluation report of the projects successes and failures against funded objectives should be required, and the lessons and recommendations made available to the aged care system and the wider community.

What are the fairest arrangements for reporting on grant performance, including options for the roll-over of funds across periods, or to other essential service delivery?

Organisations should be required to report to their communities including via a national rating system. A weighted rating system may be required to produce comparable ratings to organisations that operate in better markets.

Innovative flexibility options should be explored such as rolling over of funds or outputs. Pooling of funds with other providers in the same thin market would spread the risk. A regional or community specific approach to activities should also be investigated with innovation funding available to trial new models.

What are the benefits and limitations providers anticipate in distributing pooled funds: which services should see increased use, and which may be limited by workforce availability? How should the flexible pool be set – is 25% of client budgets appropriate?

MOWA recognises that service delivery can fluctuate and welcomes the suggestion that a flexible pool of activities may be offered. MOWA suggests that if the Relative Value Unit (RVU) model is instigated, as used in the AN-ACC, the flexible pool should be a percentage of RVUs rather than a budgetary amount.

What should be included in guidance for prioritising the use of the funds across clients?

The proposed flexibility provisions would greatly mitigate the current challenge where clients have a package that is lower than their assessed need, or have temporary or long-term increased needs. Meal service providers frequently hear from distressed clients that their HCP provider has told them they must reduce or cease their delivered meal service so that they can use their package for other services e.g. wound care. The client is then either left without a food service or required to pay full cost recovery unless they have approval for CHSP meals (with a higher consumer contribution). Increasingly, HCP providers make these changes without reference to the meal service provider, resulting in non-payment by the HCP for meal services and/or large bills for customers.

Reforms that mitigate the requirement for consumers to forgo one essential service type for another are critical.

Flexibility provisions should be based on an established hierarchy of needs. These needs should be classified according to risk. Food security (delivered meals, social support for shopping, meal preparation) is a higher priority than garden maintenance for example. Other priorities could be transport to medical appointments, urgent home maintenance, wound care – based on a risk mitigation framework. Flexibility provisions are also useful for clients referred for re-ablement, such as an intense period of care after a hip replacement.

Are there any unintended consequences of this type of payment model?

The proposal appears to assume that a single provider will be responsible for holding or managing a consumer's budget. Given that most CHSP and many (>30%) HCP recipients have multiple service providers, how is the 25% rule meant to apply?

A consequence of this model is the risk of providers over-committing their flexibility provisions within the annual allocation. This model locks in the specific funding to a particular client and eliminates the flexibility to deal with any changes in their care needs.

This model also provides flexibility for providers like that which is offered by the AN-ACC system. If the providers were funded on an RVU basis, the RVUs could be moved efficiently between clients to deal with daily needs and temporary increases in care needs. The provider cannot over-commit under an RVU system as they must stay within the overall RVU's that they have contracted for, but can, as needed, shift those RVUs around between clients to meet additional needs. Providers could apply for more RVUs up to a certain percentage of their annual allocation. That would reduce dramatically the requests for additional funds for individual clients and the need to return unspent funds on others.

A provider's requirement for flexibility funds for two years should trigger a review of the care allocation, and this should be increased if judged as necessary.

Innovation

MOWA has discussed with the Department that fixed service descriptions and pricing will stifle innovations that would better support older people to remain living safely and independently as possible at home. There is a risk that fixed service descriptions only encourage providers to do the same things more cheaply. The theory that two providers competing for the same client and the same service will have to compete on quality will create diminishing returns – at some point increasing quality will demand a higher cost base or a compromise on some element of the service, unless the 'extra service' cost is borne by the consumer.

Funding models

Consultations and the reform process

The proposed fee for service funding model for the In-Home Care Program is a radical change in arrangements. A fee-for-service model will mean there are less resources for providers to provide direct service. The CHSP program has faced lack of funding and lack of certainty since its inception in 2012. Strategic planning and workforce development has been difficult in an environment where there has been a long-standing uncertainty about the continuity of service delivery.

The consultation process has been limited and the consensus among MOWA members is the consultation is that in name only – the decisions have been made already and consultations have been arranged after that. MOWA welcomes the delay of the rollout of the new program until 2024 to allow for alternate models to be considered. If the proposed model were to go ahead, even this timeframe may be too short for such a radical transformation.

Substantial work must therefore be done in the background to develop a new program and to inform care providers about the new landscape and their place in it. A return to localised presentations from government (as opposed to webinars) would be welcomed. The presence of regional departmental officers who were aware of localised issues and had a good understanding of program delivery have been sorely missed by providers.

Though this paper has made small concessions to previous feedback about the need for greater funding certainty for meals providers, and need for varying prices for different service models, there are elements of the model that appear immutable and non-negotiable whilst matters of significant importance (the assessment process, support plan, consumer contributions and service list) have been glossed over or lack enough detail to enable meaningful consultation.

Meals on Wheels reiterates that we do not support the model as proposed and that the AN-ACC model is a superior model for implementation in our sector.

What are the positive and negative experiences providers have from current grant programs for in-home care, and the key learnings for future provision of grant funding?

Grant funding

CHSP meals providers have been grant funded for decades. While this has provided a level of certainty for providers and governments, the entry-level care sector has been kept in a 'set-and-forget' method of allocation of funds and outputs with no real examination of the need for growth or re-allocation according to demographics, performance etc.

Grant funding has also constrained the understanding of the value of some types of service delivery. MOWA believes that it is time to define the various meal service types, including social (group) meal services and the relative real value of each form of meal service provision, and has developed tools to demonstrate that value to older Australians, their community and government.

Grant fundings 'set and forget' mindset limits providers who have provided quality service to their community from providing more care in that community once their contracted outputs have been exceeded. A mix of grant and activity-based funding will mitigate this risk where consumers prefer a particular provider.

Growth funding has been difficult to obtain and almost non-existent since the HACC split in 2012, with the exception of the emergency management grants during the early stages of the COVID-19 outbreak.

Positive benefits of grant funding

♥ Provides income certainty when service volume and intensity fluctuates

♥ Preferred by organisations providing services that have relatively high capital costs and/or reliance on volunteer labour and by organisations whose tangible outputs are not measured in hours of service

Limitations of grant funding

Consideration needs to be given to the significant impost of time and resources that a collaborative approach to the care of older Australians would place upon providers. The administration to support this should be funded accordingly within the 'efficient pricing' or as a separate service type. Some consideration needs to be given to the percentage of resources that a provider will be expected to assign to collaborative care. The resources expected to be used to co-ordinate care must be proportional to the size of the care provider's organisation.

X It locks funds in with specific providers in specific geographic areas and is not flexible to follow shifts in client demand or need

X It is hard to get an increase in funding when demand or service delivery cost grows

X It does not address underfunding or disparities within or across jurisdictions, as illustrated in the Deloitte report on CHSP funding. The difference between contracted meal price and expended and actual price needs further examination as a means of understanding the perceived underperformance of meal services. The AN-ACC model supports an independent pricing authority (IHACPA) to examine on an annual basis service delivery cost and then set the price.

X It doesn't allow an accurate picture of the cost to serve an individual, as all service outputs are assumed to cost the same

X It is believed to limit the consumer's ability to choose their provider, because of historic policy settings about no duplication of services and ensuring that the maximum number of people receive a basic level of benefit

X Within the existing HCP system, there is already a requirement for coordination of services to a client who chooses or needs services delivered by another organisation. Currently this is formally managed via contractual obligations where the package is paying for the brokered services. Increasingly, exhausted package funds require some services to be provided via the CHSP and there are effective mechanisms in place between providers to coordinate services – primarily, the brokered or CHSP provider is responsible for managing the service provision of the specific services on a day-to-day basis and there is a mutual responsibility to communicate about changes in the consumer's situation and needs.

MOWA strongly supports the implementation of an AN-ACC funding model for in-home aged care, noting that the business rules and national efficient price may vary from residential care. MOWA has commenced a proof-of-concept exercise on this combined grant (capacity) and activity-based (capability) funding model. It differs from the proposed model as the grant component incorporates risk sharing, more regular review and adjustment to minimise risk of locking funds into specific providers or regions, and consideration of geography and scale within a single grant. See further detail below.

Competitive grants for thin markets

While MOWA welcomes the proposal that thin market grants should be for five years, we believe that opening a competitive grant process in thin markets will ultimately reduce choice in those markets. Competitive tendering currently results in an uneven playing field for providers who wish to apply for these grants. Large organisations have more resources to complete tenders. These large providers do not tend to have a local presence in thin markets and the result, as reported by MOWA member services, is a degradation of local service provision or the withdrawal of service altogether due to inability to provide service due to distance or cost factors. This results in a reduction of a locally directed presence and service delivery, exacerbating the already thin market situation in that region.

Smaller organisations in thin markets (including culturally specific services operating across metropolitan areas) need to have grant funding in order to be able to compete with these large organisations for their existence. There must be an equitable principle in funding to ensure small local services can continue to operate and that older Australians have equitable access to a range and choice of services.

MOWA notes that an AN-ACC funding model would eliminate the requirement for thin market grants, as this element would be factored into the base care tariff.

Funding rates, pricing and consumer contributions

The consultation paper avoids consideration of consumer contributions within the funding/revenue mix. The future program must make a consistent ruling regarding any requirements for consumers to pay for the cost of ingredients related to government-funded meal services.

It is noted that the paper refers to 'meal services' and 'delivered meals'. Policy directions focused on wellness, re-ablement and social engagement have supported the growth of meal services that are not delivered at the clients' homes.

The consultation paper recognises MOWA's position that funding rates ought to vary between 'drop-and-go' meal services and those that are combined with face-to-face social connection.

These factors must be resolved in determination of grant funding while activity-based payments must also address variances in costs related to the individual needs of consumers, including special dietary requirements and texture modification. The AN-ACC funding model most simply addresses each of these matters.

The interface between existing programs needs to be clarified before a new program is developed. For example, there is currently a discrepancy between the new HCP manual for 2023 which states that the HC package pays for ingredients in consumer's meals and CHSP manual that continues with a long-standing policy that clients are provided with a pension that must be used to purchase food and therefore the cost of ingredients are charged to the client.

The inadequacy of only providing activity-based funding

It is clear from the discussion paper that the government has accepted the need for capacity funding as well as activity-based funding. This change is welcomed by MOWA. A shift to purely activity-based funding would be worse than the grant-funding approach which always lagged behind cost increases and prevented innovation to improve services. A solely activity-based funding model would be administratively labour intensive for services already stretched in service provision. Activity-based payments are a blunt and unsophisticated way to reduce the possibility of large amounts of unspent funds. This payment system transfers all risk from Government to the provider and hence to the client.

Much as the funding system for Federal Government agencies and Departments recognises the need for infrastructure, regardless of the level of activity undertaken within that infrastructure. A good example is the funding for the defence forces of Australia. There are capital costs necessary to equip and train a meaningful military. Were Defence forces to be funded only on activity, the funding levels would be a tiny fraction of what they currently are. The defence forces would be unable to deal with any threat to Australia's national security that arose for lack of buildings, armoured vehicles, aircraft, ships and munitions as these are not funded on the basis of their current activities. Were the defence forces also to be funded in arrears for their activity levels in peacetime they would be receiving insufficient funds to staff even a fraction of a meaningful military defence capability. In fact, they are funded to enable them to have the equipment and the manpower to respond immediately to the defence needs of the country. The same principal should apply to those providing essential care and compassion to our aged community, many of whom have served Australia with equal distinction in the military of the past.

Meals services are reliant on infrastructure such as production kitchens, freezers and vehicles as well as wages and administration, volunteer management and training. A fit for purpose funding system recognises these costs occur regardless of outputs. A highly government regulated care model with funding to support infrastructure is essential to providing ongoing quality care and support.

Activity based payments for services delivered would be outside of this funding, allowing providers to continue to provide care regardless of events like seasonal variations, fluctuations in client numbers etc.

Meals on Wheels Australia proposes an alternative funding model

MOWA, in conjunction with Australian Health Services Research Institute has been working on a funding model that builds on work from the Independent Health and Aged Care Pricing Authority (IHACPA). This model is also used to fund residential care and schools and recognises that teaching and health care, which are the activities in these areas, cannot occur without the capital costs necessary before teaching and health care take place. Similarly, the AN-ACC model is currently used in residential aged care.

Providers would be funded for both capacity and activity. Capacity funding is to provide operational certainty and activity funding is used to provide care. Funding for capacity (a Base Care Tariff) should not be grants-based but rather an integrated part of the system, similar to the AN-ACC funding model for residential care. The level of capacity funding should be determined annually by the IHACPA.

Activity funding would be determined by establishing a relative value unit (RVU) for the preparation and delivery of a meal and then applying that RVU to an established set of classifications to determine the activity fee that would be attached to the assessed care requirements of an Older Australian. The RVU would be determined by the complexity of care required. The application of RVUs to activities would be based on an agreed set of variables (classifications) that constitute the scope of meals provision.

Relative Value Unit

Relative Value Unit is a unit based on the resources required to perform a single service or intervention. An RVU measures the time, intensity, and skill required to provide the service and a financial value can be assigned to it.

What is the value of a meal?

The basic value unit for the RVU for delivered meal provision should be the basic definition of a meal contained in the relevant program manual. The definition of a delivered meal and the establishment of its RVU should be evidence-based and established in conjunction with meal providers and peaks. This RVU can then be applied to an established set of classifications that would have been developed alongside the new assessment tool.

How would the RVU be determined?

Despite the establishment of a delivered meals system and service type over 60 years ago, very little research has been conducted into the value of a delivered meal to the client and to the community. Some work is underway to establish this value with the Future Fit project. Conducting an in-depth analysis of the cost and savings of service delivery through an Independent Pricing Tribunal with the Independent Health and Aged Care Pricing Authority setting the price, such as reductions in hospitalisations, malnutrition, social isolation.

In the first instance the price would obviously be determined based on the cost of current provision. But in the longer term the price should be based on evidence about the nutritional needs of older Australia and the cost of meeting these. This introduces the concept of paying for outcomes, not just inputs.

Improving nutrition of older Australians will lead to a reduction in hospitalisations – particularly for long stay admissions such as hip fractures due to a fall. These falls often occur because of reduced muscle mass due to lack of protein in the diet. A significant percentage of hip fractures lead to permanent institutionalisation. While it is hard to measure the success of prevention of hospitalisations, this benefit to the community should be taken into consideration when establishing the value of a meal.

Hospital costs are more than $3000 per day. The provision of meals that meet national guidelines for older people's nutrition will assist in delaying the loss of muscle tissue, thereby preventing falls and the consequences. The recognition of the problems caused by malnourishment and undernourishment in Older Australians was highlighted in the findings of the Royal Commission into Aged Care Quality and Safety.

National meal guidelines should be updated and established as the KPI for meals provision. Under a classification system, as described above, people with more complex dietary needs such as pureed, minced, diabetic would attract a higher RVU.

It is agreed by member services that the current unit price of meals (a range from $7.50 - $13.00) set by the DOHAC 2021 needs reviewing.

Classifications for delivered meals

MOWA proposes that a scale of assessed care need is required to recognise that a delivered meal can also be accompanied by dietary requirements based on assessed clinical support needs and social support and monitoring of clients to varying degrees.

MOWA's peak bodies are working with the Australian Health Services Research Institute in developing a classifications system for meals and the complexity in meal provision.

How would an RVU based activity fee system work?

Under the proposed In-Home Care program, the nutrition support needs of an older Australian would be established at the time of assessment. There are well-established nutrition screening tools in use, including by the NSAF. The client would be assessed as needing a certain level of nutritional support. The activity fee for that support level would then be assigned a relevant RVU based on the classifications in the support plan.

An RVU based system will prevent providers 'cherry-picking' the clients most easily serviced and leaving more complex clients on waiting lists for longer. Using this model there would no longer be a financial incentive for providing care only to clients with low needs.

There would no longer be unused funds in the system as organisation receive activity payments based on RVUs provided as care. Remaining unused RVU's would simply cease to exist at the end of the year.

How would performance against contract be measured?

A provider's performance would be measured against RVUs provided according to an allocation in the client's support plan, which is developed by the assessor and care partner, if required.

The organisation's performance can be measured against total RVUs provided.

Providers can show that they were able to provide care of varying complexities because of the RVUs assigned to each support plan. If an RVU-based activity fee was assigned there would be no unspent funds in client's accounts, just unused RVUs.

MOWA supports the proposals set out in the submission of the Support at Home Alliance but recommends that the tolerance band be 20% rather than 10%.

What is the advantage to government?

The advantages to government are set out in the Support at Home Alliance submission. Business rules will need to be developed to cover service issues such as late notice cancellations. However, these can be incrementally developed over time, and we do not foresee any major obstacles to the development of these.

The advantage that the adoption of this model provides is that it achieves the elimination of the substantial sums currently lying idle in the HCP system, but in a way that enhances the capacity of the providers in the combined CHSP, HCP space to deliver quality care.

If the RVU model were adopted the quarterly budget for clients would be unnecessary. Choice and control are still maintained because the flexibility would be in the RVUs, rather than funds. The 25% flexibility proposed in the discussion paper would be unnecessary if RVU's are allocated to the provider instead of to clients' individual budgets. This would allow the provider to make flexible arrangements for a greater number of clients without needing to constantly review and get approval for increases to individual budgets. For example, if providers were allowed 25% flexibility for either an individual's RVU's or the group of client's RVU's then that would allow the provider to meet the varying needs of clients as circumstances change without the need for a reassessment such as when a client has just come out of hospital and needs more meals that the assessment has been allocated.

The flexibility of RVUs could be reviewed on an annual basis. RVU's not delivered could be rolled over, but a business case must be made to do so. A mechanism for demonstrating an increased allocation of RVUs could be included in flexibility provision.