



ACCV RESPONSE

TO

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**The Role of Case Management, and its
Relationship to Care Coordination and
Assessment.**

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Introduction.

The focus of this paper is to examine Case Management, drawing out its difference to care coordination and also to consider the close relationship between case management and assessment of client need.

A BRIEF DATA SNAPSHOT OF COMMUNITY CARE

During 2008-09, approximately 862,500 clients were reported as receiving HACC services.

As at June 30th 2010, nationally there were 42,728 CACP, 5,587 EACH and 2,583 EACH-D places

In 2009-10, some 143,387 carers were provided with assistance through the National Respite for Carers Program. This figure includes 37,076 carers assisted with respite through respite services; 100,273 carers assisted to receive respite through Commonwealth Respite and Carelink Centres and 6,038 carers who received counselling services. Respite services funded under the National Respite for Carers Program provided approximately 5,120,588 hours of respite in 2009-10. This was delivered through over 650 respite services in a variety of settings, including day respite in community settings, in the home and in respite cottages.

There is a current population of almost 900,000 HACC Service users¹ and 51,000 packaged care service users nationally². In addition In 2009-10, more than 147,387 carers received assistance, through the Commonwealth’s National Respite for Carers Program.³

For the current population of packaged care clients, case management is an important reason for being on a care package. Given that many clients who receive HACC services are often on similar service direct service hours to clients who are receiving a CACP, the reason for being assessed as requiring a CACP, especially if person has already been using HACC is the Case Management component.

For packaged care clients, case management is a normal component of care and support arrangements, not the exception. While not all clients need the same level of case management, it is rare that people would receive support and care under a packaged care program without even some episodic or intermittent case management.

¹ Home and Community Care Program 1 July 2008 to 30 June 2009 Annual Report. Commonwealth of Australia. 2010

² Report on the Operation of the Aged Care Act 1997 1 July 2009 – 30 June 2010. Commonwealth of Australia. 2010.

³ Australian Government Department of Health and Ageing. Annual Report 2009–2010. Commonwealth of Australia. 2010

The distinction and relationship between care coordination and case management.

Care coordination is largely a customer service and administration function which is necessary to deliver a coordinated package of support services to clients. Case Managers will, in some packaged care services, undertake care coordination due to staffing arrangements (such as in very small services), or where there are some complicating factors in making the referral for establishing instrumental supports.

Case management is a much broader and client focussed function covering:

- Assessment, care planning, creating innovative solutions to problems and evaluating outcomes
- Crisis support
- Motivational counselling and other counselling or “talking based” approaches to dealing with people’s problems.
- Behavioural management
- Specialised interventions in niche areas of case management work which depend on the attributes of the client population and the case managers’ skills - eg a case manager who is also a clinician and undertakes case management with clients who have motor neurone disease.
- Health promotion
- Individual and community advocacy.

Case management relies upon a skill set involving counselling (and sometimes its sub-variants in family therapy, and Cognitive Behavioural Therapy perspectives), as well as a knowledge and skills pertaining to social inclusion, working with communities of interest, advocacy (eg dealing with other services systems and program silos). A wholistic health outlook embracing an understanding prevention, early intervention, recovery of function and independence is essential.

Case management is not required by all community care clients and care coordination is a useful and efficient for simple services arrangements in the short term. It is a feature of the HACC services system and is called “services coordination”.

The amount of Case Management input for any one client is balanced towards clients’ needs and is aware of the situation in which some clients will require little or no regular Case Management. However, this is not to say that low density but well targeted interventions might be the result of short and intense case management. This is the approach of restorative models such as the Silver Chain HACC Health Improvement Program (HIP) or the Victorian HACC Active Services Model (ASM)

Similarly, care coordination, on its own, may not be required work for people who essentially require case management. Instrumental supports while important - e.g . 2 hours of home cleaning per fortnight, or delivered meals are, in care terms, often only an intermediate or partial step in supporting people. A community care model which solely coordinates a consumer “shopping” for “off the shelf” services will not provide adequate or viable support structure for many people.

A coordinated package of instrumental services may able to stabilise a situation for some older people. However, a very real risk is that for many others this will fall short of other unaddressed needs which may see a client re-appearing at a hospital emergency department with an acute

CASE MANAGEMENT – A STUDY

An 83 year old gentleman with limited English skills was discharged from hospital following a stroke. Although the stroke was not serious, it left him with less ability to perform tasks of daily living. The client has two daughters who are unable to assist as much as needed due to work and family life commitments. The family contacted Benetas who arranged for a case manager to visit the client. The case manager organised a family meeting to discuss client needs and how they can be met. An interpreter was organised to allow client's full participation in the process. As a result of the discussion the case manager organised a referral to ACAS for reassessment and deciding client's eligibility for an EACH package as well as a referral to an Occupational Therapist (OT) to assess for home modification. Following the OT's recommendation, the client was assisted by the case manager to forward an application to the Aids and Equipment program to provide funding for all the necessary modifications. The client was accepted into the EACH program, but in the meantime the case manager had organised extra services as well as visits from a volunteer to assist client and family.

manifestation of a chronic disease or in a general state of “non-coping”. This, in particular refers to people who have other underlying intrapersonal and social factors impacting on their ability to maintain stability in their lives without a constant threat of real or perceived physical , psychological, or social crisis.

Special needs groups - such as near/ homeless people or people living in private boarding houses or Supported Residential Services (SRS) may not require any domestic support, meals or even personal care assistance where these may already be provided – but they may have a need for a case manager to promote social inclusion and a more adaptive response to the world – a health and wellbeing focus. An example might be supporting a person to self manage their diabetes or asthma better. A further example might be re-equipping people, living in such accommodation, with the capacity to return to a more independent setting or form of accommodation.

Case management is therefore the most important intervention when people have complexity of need. Typically complexity of need relates to complexity of service response. This often sees multiple service providers, family, friends or acquaintances involved in supporting a given individual.

There are other broad parameters of complexity which may include:

- Labile physical or mental health
- Steadily accumulating frailty
- Absent, or unstable informal or family supports.
- Primary carer and care recipient issues and carer burnout.

Other important attributes of people which create special needs and contribute to these broad parameters of complexity include:

- mental health issues (especially depression and anxiety),
- the various dementias and associated cognitive and behavioural issues
- cultural diversity
- sexual diversity.
- substance issues (particularly alcohol)

- stroke and acquired brain injury including alcohol brain injury
- grief
- family issues (including overly well-intended protective family members, family pressure for parents to expeditiously enter residential aged care).
- elder abuse,
- domestic violence

Ceasing Services

Findings of the 2008 Community Care Census include the most common reason for ceasing service delivery. Twenty-eight per cent of clients leaving packaged care during the census period to move into high level residential care. For the CACP clients the proportion of clients ceasing services to enter high level residential care (21 per cent of all CACP cessations) remained at a similar level to that observed in the 2002 survey (19 per cent). The 2002 survey did not include EACH clients.

The second most common reason for cessation of assistance was that the care recipient was moved to low level residential care (22 per cent), and the third most common reason was that the care recipient had died (20 per cent). For CACPs the 2008 findings that 26% of people leaving CACP moved to residential low care while 18% of CACP recipients died are comparable to the findings reported in 2002 (23 per cent and 19 per cent respectively).

Other reasons for cessation of assistance in the 2008 survey included: no longer needed assistance (13 per cent), moving from their current area of service provision (5 per cent of all cessations), and care recipient terminated service (4 per cent).

Some of these attributes will their highest rates of prevalence in older populations and often result in crises for the client and/or their carers with general breakdown in people’s ability to cope. These sub groups of people need case management bundled into their care and support arrangements as a matter of course. The element of advocacy involved here does not “fight the system” but instead keeps the system connected to people when there are other external threats (eg elder abuse, mental health issues),

A case manager who follows people into in residential care would be a useful extension to current case management roles. This extended role would enable people to continue to remain engaged with the community. An example of a sub group for whom this has already occurred are Young People In Nursing Homes (YPINH). Residential care has often been regarded as being underpinned by an assumption that “the residential facility is responsible for everything – it is therefore the person’s entire universe”. This has potentially inherent risk of promoting an institutional model.

The relationship between Case Management, Assessment and Resource Allocation.

Risks of services poorly matched to needs.

Even for those people whose predominant “spend” are on direct services there are two risks associated with delivering these services without some minimal case management.

The first risk is that people will languish with inadequate direct care support or attention paid to other emerging needs

The second risk is that people will be receiving substitution services as a matter of convenience for which they have no essential need. Substitution models are those models which essentially perform

for people instrumental tasks which they cannot perform for themselves. This contrasts to active or restorative services which aim to restore people to an independent state as possible in that domain in which they might be experiencing difficulty.

This creates a risk of inefficiently spending taxpayer dollars. In some Australian jurisdictions in the HACC services system over the past few years, as well as similarly targeted services system overseas, there has been a strategy to migrate from where possible from substitution models to “active services” or restorative models..

In practice some consumers may have ended up on substitution services, particularly in the HACC spectrum of the services system, receiving services of convenience for which they have no essential need. This may have occurred because of temporary incapacity for which they commenced receiving services (eg after a hospital admission) without ongoing and active monitoring of evidence of sustained need. Moreover, many people may not have been provided with the means to re-establish functional independence. An example is a person receiving delivered meals who may have benefitted from re-skilling to prepare their own meals (eg a widowed male whose wife always prepared meals).

It is likely that, for some, there is also an entitlement or welfare outlook which has people believing that access to home cleaning or delivered meals is simply a right for people over a certain age.

This risk of a “set and forget” phenomenon is, however, less prevalent in packaged care programs or residential aged care facilities. Given the complexity or labile nature of people’s needs in these programs and settings the very nature of care as it is generally delivered is dynamic with regard to the level and type of service delivery. Evidence from the Department of Health and Ageing’s 2008 Community Care Census showed that recipients of EACH and EACHD services stay in packaged care for shorter periods than their CACP counterparts. At the time of the 2008 Census nearly 57 per cent of all current CACP recipients had been receiving care for more than 12 months since their last ACAT assessment, compared with 41 per cent of EACH recipients, and only 23 per cent of EACHD recipients.

Similarly, data reported by the Australian Institute of Health and Welfare (AIHW)⁴ of separations (departures) from packaged care show that 52 per cent of those leaving CACPs had been receiving packaged care for only twelve months or less. This short time span spent by clients in community care programs is even more pronounced for EACH and EACD-D clients for whom separation within 12 months occurs for 63 per cent of those leaving EACH and 97.5 per cent of those leaving EACH-Dementia programs.

Allocating and rationing resources.

In the present system, the ACAS⁵ or HACC entry assessment⁶ does not constitute the entire realm of assessment, care planning and definitive resource allocation. Whereas ACAS and HACC Entry

⁴ AIHW 2011. Pathways in aged care: program use after assessment. Data linkage series. Cat. no. CSI 10. Canberra: AIHW.

⁵ ACAS Assessment has some limited control over resource allocation in as much as deeming eligibility for particular program types e.g CACP versus EACH or Residential Low Care vs Residential High Care.

⁶ HACC is possibly closer to the proposed model of the PC. In Victoria at least, the HACC living at Home assessment that is conducted by a designated HACC Assessment Agency determines the referrals to other

assessments determine program eligibility, the roles of care planning and concomitant resource allocation sit largely with the HACC service provider or Commonwealth Approved Provider.

In the HACC sector, HACC service hours are not by regulation or design capped or allocated on a per client basis. The limit of resources per client is largely left to the service provider and is theoretically limited only by the total service agreement hours for the particular service type for which the service provider receives funding⁷. Rationing occurs at a population level insofar as the number clients whom an agency chooses to service at any one time and the corollary waiting lists or waiting times it is prepared to work with.

For residents in Aged Residential Care Facilities, where sufficient incrementation in care needs have occurred under both the former Resident Classification Scale and the current Aged Care Funding Instrument, new funding claims using the instrument are undertaken by the approved provider and re-submitted to the Department of Health and Ageing. Notional resources per resident are limited the funding amount for the classification outcome and ultimately by the maximum ACFI payment level.

Even in packaged care programs, packages are essentially “pooled” and there is an internal resource re-allocation (see further below). Importantly, care is planned, then implemented and evaluated/ re-assessed in cyclical fashion.

In packaged care the largely two tiered funding system has admittedly been problematic– especially for CACPs. CACP obliges service providers to a fixed number of clients and the packages system thereby essentially determines a notional upper limit for clients. Moreover, the amount per client is relatively small – given that this program is meant to respond to mid-tier levels of need and some clients are receiving CACP levels of service in the HACC services system.

In spite of this some clients receive services to a level less than the daily package funding provided to the provider on their behalf, while others will actually receive services greater than the level a single package on its own could fund. This is because providers essentially end up managing a funding pool. Clients end up receiving services according to need because the client population of any service is well managed to ensure that delivered services are fine-tuned according to these needs. The fine tuning is achieved through the ongoing cyclical and exceptional re-assessment of clients performed by case managers. Thus case management manages both client and resource risks.

Timely Assessment and Care Planning. This raises the question that should funding assessment shift to a central agency as to how sufficient cyclical re-appraisal of clients needs and care re-planning will occur. How will clients with new emergent needs receive timely re-assessment as and when they need it? The flaw, as it were, or otherwise essential design characteristic of the proposed ASGA assessment is that assessment is a “point in time”, or ‘snapshot’ process. Yet the features about resource allocation as discussed in the paragraphs immediately above occur because they respond to both the longitudinal and re-iterative nature of assessment and care planning which permit services to respond flexibly to clients’ needs.

HACC service providers. However even HACC service providers conduct their own service specific assessments. The resource allocation per client in terms of hours still sits with the service provider .

⁷ The exception here being HACC Community Options Packages

Pathways In Aged Care: program use after assessment - AIHW Feb 2011.

The PIAC (Pathways in Aged Care) cohort study linked data for key national aged care services for a cohort of 105,000 people. The cohort comprises people who had a completed assessment by an Aged Care Assessment Team (ACAT) under the Aged Care Assessment Program (ACAP) in 2003–04. The PIAC cohort was divided into groups based on use of aged care programs before the first completed assessment in 2003–04:

- *Continuing path cohort*: clients who had used ACAT-dependent services (27,640 people) – 26%
- *HACC and/or VHC before cohort*: clients who had used only HACC or VHC services (42,974) – 41%
- *No previous care cohort*: clients who had not previously used aged care services (34,463). – 33%

Just over 40% of the cohort with no previous use of aged care programs accessed HACC or VHC following their ACAT assessment while 25% of the no previous care cohort did not newly access any care programs within 2 years.

In particular, among no previous care cohort members the proportion who were admitted to permanent RAC more than doubled between 3 months and 24 months after their first assessment in 2003–04— from 17% of clients still living to 34%

People who had not used aged care services before their reference assessment were less likely than others to take up these services within the study period. In the 2-year period after the ACAT assessment, just over a quarter of the no previous care group died. Just over one-third of those still alive after 2 years were in permanent residential care, 8% were in receipt of a community care package and 15% were HACC or VHC clients only.

Assessment is much more than the simple completion of a tool or asking of questions. Clients will generally not reveal everything about themselves, their challenges, capabilities and supports in one interview or visit. Assessment is also a process of observation, and home- based assessments include observation of people’s social and physical environments. Assessment relies also on observing and even measuring patterns. Continence and behavioural issues are good examples. Importantly as any anthropologist will advise –good assessment requires that one “goes native”. Relationships of trust must initially be transacted, with clients, carers, families, clans and, sometimes, whole communities. These often take time and repeated visits to build.

For some groups (eg Homeless, ATSI, GLBTI, refugees and torture survivors), a larger central mainstream ASGA may of itself present a substantial barrier to accessing the services system. How would the ASGA access hard to reach populations who require a more active “case finding “ approach including people who are isolated, older people and many of the special needs attributes groups listed above. Research data bears out that not everyone simply has a smooth logical path through aged care commencing with low intervention services. The AIHW Pathways in Aged Care Study earlier quoted also shows that for many people who are assessed by an Aged Care Assessment Service as their first ever contact with the aged care services system more than half of these people have died or entered permanent residential aged care within two years.

By the time people need Residential Care they do so because the situation they are in has reached a crisis point for themselves or their carers. This again might mean that the assessment made in a crisis situation might be best suited to a person’s most immediate needs, but not their longer term support and care. It may amount to a parenteral assessment especially if the crisis has severely and temporarily taxed the individual’s personal capacity to engage in the process.

For many people, arriving at a “crisis point” may involve a more medium term “managed crisis” with a case manager who has aided the client’s transition to an alternate setting such as a residential aged care facility. This will have been achieved through repeated assessment and incremental adjustments of care plans. As, the earlier reported data shows needs change even more quickly once people are needing higher levels of support.

Needs assessment and care planning, for many, is highly evolutionary and incremental. Many people remain in the community in a state of “chronicity” and don’t readily come to surface to be reached by assessment services. Even if they do - eg for a single support item such as meals – this is only the tip of the iceberg which is revealed. Service avoidance and mistrust is the modus operandi and chosen position of many older people. It is unlikely that many older people choose to engage readily or actively seek a full spectrum of support for all of their unmet and potentially “supportable” needs. Even if an astute assessor were to have a very complete insight into the entire picture of someone’s needs quite quickly, it is unlikely that they are going to overwhelm a person with a whole package of interventions all at once.

Can a central gateway really have the time and focus to work in this way?

There is a real value proposition that case management can create fiscal efficiencies as against the set an forget model where services, once established continue unabated. Clarity is required about how even this type of monitoring and fine tuning will be achieved.

A cost - risks - benefits analysis of initial assessment, care planning, resource allocation and initial care coordination sitting with ASGA versus commencing these processed via an external Approved Provider in a case management model. This question also needs to consider stratifying the different approaches for different target groups.

If we are going to have a very consumer responsive community care system, especially for higher or more complex needs groups then the incremental funding model is one actually increments throughout the care - not the beginning. How would flexible incrementation be achieved by a central agency with regard to the ASGA and the proposed building blocks funding model?

If Approved Providers were to assess, plan care and allocate resources what would constitute an appropriate and balanced means to validate these processes and achieve accountability?

What outcome measures for independence and wellbeing will be used to measure, manage an improve the performance of a system, which is critical for the health, social and economic well being of older people and the broader community?

Recommendations.

Recommendation 1.

That Case Management automatically be assumed as a funded building block element of care and support for clients whose care needs achieve a threshold level which equates to the current Community Aged Care Package.

Recommendation 2.

That Case Management automatically be assumed as a funded building block element of care and support for all clients aiming to achieve restorative goals.

Recommendation 3.

That re-assessment for funding reviews is undertaken by Case Managers where clients have a Case Manager. Appropriate validation mechanisms at the aged care provider level would continue to ensure appropriate accountability of provider assessments.

Recommendation 4.

That the Australian Seniors Gateway Agency ensures all community care clients are reviewed at least annually and these reviews be contracted out to case managers.

Recommendation 5.

Establishing as a default feature of the new model that Case Management is given carriage by the main “provider” whom the client selects for services delivery (key worker type model) unless otherwise chosen by the client.

Recommendation 6.

That the best available evidence is used to establish a robust model for the longer term by addressing a series of questions and issues to be given adequate investment by the Commonwealth as part of the transition period. The Transition period must be used to test the most cost and client effective approaches to Case Management, Care Coordination and Assessment by:

6.1 Properly testing the best approach to the setting and mode of assessment.

6.2 Establishing use of client outcome measures.

6.3 Re-building robust funding models and instruments from the ground up that meet people’s needs without services having to resort to distorting or compensating mechanisms.

6.4 Fully understanding the best way to enhance wellbeing, restore independence versus palliating need and who this works for (CDC sensitive and Restorative sensitive populations)

6.5 Further determining what the system is there to pay for – delineating between the necessary and desired. This requires both community consultation and a research approach.

6.6 Establishing the best basis for a “consumer directed” approach that balances consumer choice with population need and fiscal efficiency.

6.7 Determining the downstream costs of not intervening early – what large downstream costs could be prevented by small upstream spending?

6.8 Establishing greater clarity about the threshold level of services, triggers and target groups for whom Case Management is automatically part of their care and support funding