AUSTRALIAN GOVERNMENT AGED CARE FINANCING AUTHORITY

THE INCREASING USE OF RESPITE CARE AND THE APPROPRIATENESS OF THE CURRENT ARRANGEMENTS, INCLUDING FUNDING STRUCTURES, FOR PROVIDERS AND CONSUMERS.

Submission

20 April 2018
ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading aged care peak body supporting over 700 church, charitable and community-based, not-for-profit organisations. Not-for-profit organisations provide care and accommodation services to about one million older Australians.¹

ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians.

Aged care providers make a significant $17.1 billion contribution to the economy by producing outputs, employing labour, paying wages and through buying goods and services.² This is akin to the contribution made by the residential housing, beef and dairy industries. In many regional and rural areas aged care is the largest employer, which is where the majority, if not all, providers are not-for-profit.

ACSA members are important to the community and the people they serve, and are passionate about the quality and value of the services they provide, irrespective of their size, service mix or location.

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THE INCREASING USE OF RESPITE CARE AND THE APPROPRIATENESS OF THE CURRENT ARRANGEMENTS, INCLUDING FUNDING STRUCTURES, FOR PROVIDERS

FEEDBACK

As requested by the Aged Care Financing Authority (ACFA), ACSA has obtained the views of its membership on the increasing use of residential respite care and the appropriateness of the current arrangements.

The last Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC), conducted in 2015, found that nearly 95 per cent of people aged over 65 years live in households and one-third of these older people needed assistance with daily activities.3

There are approximately 2.7 million family and friend carers in Australia, of whom 860,000 are primary carers, with 400,000 of these providing care for someone aged over 65 years. More than one in five of those caring for a partner were over 65 years old themselves, and about one third were the primary carer.4 The majority of primary carers of a parent are aged 45 to 64 years old (63.7 per cent) and are mostly female.5

Approximately a third of all primary carers spent, on average, over 40 hours per week in their caring role. For primary carers aged over 65 years, this increased to 41.5 per cent reporting that they average over 40 hours per week in their caring role.6

Deloitte Access Economics valued the replacement cost of the care provided by family and friend carers in 2015 at $60.3 billion.7

Respite care provides short intervals of rest from the caregiving relationship to support the health and wellbeing of both the carer and the care recipient.

1. The process for applying for and seeking access to respite care

The current policy framework places the emphasis on meeting the needs of the care recipient, with limited recognition of the needs of carers in their own right.

From the perspective of the carer, access to respite care has become extremely fragmented and difficult to navigate as Home Care services have moved the focus of providing services primarily to

the care recipient. The care recipient’s perception of the need for respite may not be reflective of
the actual needs of the carer.

Information services available by phone or on-line can present an immediate barrier for those
seeking access to respite care. For example, feedback received indicated that 1800 numbers can
be challenging especially for those in rural and remote areas, Aboriginal and Torres Strait Islanders
(ATSI) and people from culturally and linguistically diverse (CALD) communities. Reasons for this
range from not having easy access to a phone, to the cost of a call, to ‘not knowing who they will
talk to’. Many older people also find computer literacy challenging.

Aged-care, ATSI and CALD respite providers stress that information and support is best accessed
at the local level through ‘person to person trusted relationships’. Applicable information,
provided through a variety of resources which are available in multiple languages and supportive
of people with vision difficulties and/or a hearing impairment, will support consumers to
understand and access respite options.

Feedback from providers and consumers indicates access, initial entry and navigation of the respite
system is time consuming and difficult. Some examples include:

- Lack of general knowledge that My Aged Care is the entry point to access respite care
- Difficulty in accessing information about availability of respite services and more
  specifically, availability within the consumer’s local community
- A reduction in the number of available respite beds within residential aged care
  facilities
- Difficulty in accessing crisis or emergency respite
- Delays in assessments through My Aged Care
- General Practitioners, social workers and hospital staff not being familiar with the
  intake processes and options for respite care
- Many residential respite providers are not resourced to provide an appropriate
  environment to support respite for people with high care needs and/or dementia

RECOMMENDATION 1:

Re-orientate respite services, particularly the assessment and eligibility processes, to consider
and include the needs of both the carer and the care recipient.

POSSIBLE STRATEGIES:

- Improved and ongoing education for the My Aged Care Contact Centre staff and RAS /
  ACAT assessors so they understand and include the needs and expertise of carers
  when assessing a care recipient for services. RAS and ACAT assessors need to
  consistently use the questions in the National Screening and Assessment Form that
  relate to carers to identify carer needs
- As a component of integrating carer support services, develop a respite booking
  system to enable consumers to plan around respite availability and to make advance
  bookings as needed

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8 Carers Australia, February 2017, Improving access to aged residential respite care,
9 Ibid
• Support carers to access emergency respite by providing a dedicated contact point for access to emergency respite care, facilitate phone and/or retrospective assessment processes for emergency situations and ensure that funding models support providers to offer flexible services which can meet emergency demands
• Develop connections between respite service providers and the acute and primary health care sectors and develop education strategies and tools to improve knowledge of the respite intake processes and options across the health sector continuum
• Develop funding incentives to support appropriate residential care environments for people, especially those with high care needs and/or dementia

2. Bottlenecks or delays in accessing either residential or non-residential respite care

Providers report significant delays in consumers obtaining an ACAT assessment for respite care resulting in some consumers being discouraged from continuing with the respite process and possibly even considering permanent residential care prematurely.

Lack of availability of residential or non-residential respite at the time that it is needed often leaves carers with no other option than to admit the consumer into hospital. This places additional pressures on the acute care system.

Administratively, My Aged Care currently results in difficulties for providers wishing to access a respite referral if the care recipient has previously received respite services from another provider. This means that a provider who has previously provided respite services needs to reject the code so that a new provider can access the referral. A referral for respite services is ongoing, not episodic.

The referral process in place through My Aged Care is not responsive to crisis or emergency respite. Given the variety of CHSP respite options, My Aged Care and RAS processes may result in referrals to a provider who does not provide that particular respite service type. This process delays access to respite services.

Delays are further compounded when medical officers, social workers and hospital staff are not familiar with the respite options and intake process.

RECOMMENDATION 2:

Streamline processes and improve coordination of respite services across non-residential and residential aged care providers.

POSSIBLE STRATEGIES:

• To eliminate the need to reassess a care recipient each time care needs change, which results in delays in appropriate respite care provision, a single respite approval by ACAT should occur to make the process consistent with that for permanent residential care recipients
• The Commonwealth Respite and Carelink Centres (CRCC) programme should continue and its role publicised widely across the health care sector
• CRCC, Commonwealth Home Support Program (CHSP) and Home Package providers should be able to access a ‘real-time’ booking service for respite, ideally using one of the current platforms such as My Aged Care but with easy navigation tools
• A simplified electronic submission and approval process should be developed to enable providers to quickly access additional respite days in response to consumer demand and need

• To improve the certainty in regards to an individual care recipient’s eligibility to receive residential respite, respite balances for individual care recipients should be accessible to providers in real time rather than a month in arrears

3. Whether the current provider funding structures for the provisions of residential respite care are appropriate

A critical component in the supply of residential respite services is ensuring that the funding structures are adequate to support providers in delivering these services. Recent StewartBrown data\(^\text{10}\) indicates that 41% of residential aged care providers are making a loss, this rises to 56% for outer regional/remote providers. The provision of respite services should not be to the detriment of the financial viability and sustainability of providers.

A residential care service provider may be paid either a low care or high care subsidy and supplement for providing respite care to an eligible care recipient on an allocated respite bed-day basis. Providers indicate that due to the ever-changing needs of care recipients, the low care classification sometimes does not accurately reflect the actual level of care required. The continuation of categorising respite as either low or high care is no longer congruent with the rest of the aged care system.

Under the Aged Care Act, a respite admission into residential care is considered the same as a permanent admission. The admission, assessment and care planning processes are the same whether a resident is staying a week or permanently. The rapid turnaround of respite care recipients can draw heavily on clinical and administrative staff which is not supported by adequate funding. This may be seen by some providers as a disincentive to provide respite services.

Residential respite care recipients are required to pay a basic daily fee of 85 per cent of the single basic age pension. The cost of overnight or short-stay respite services may be prohibitive when the care recipient and carer are still trying to maintain a household with all of the associated ongoing costs.

Residential respite care recipients are not required to pay any accommodation costs, despite often having high expectations in relation to the quality of their accommodation. Providers state that not receiving any funding to assist with accommodation costs impacts on the financial viability of providing respite services.

Some providers report that they find maintaining occupancy of a dedicated respite bed too administratively burdensome. Additionally, empty respite bed-days impact on viability and sustainability. Many providers set budgets projecting an anticipated occupancy rate and indicate that respite cancellations can have an adverse impact on viability. Cancellations can be due to change of circumstances, changing health status including hospitalisation or because the client or carer decides they do not want to use the pre-booked respite service as planned. This can result in an unoccupied bed for an extended period of time. The administrative burden is linked to maintaining a booking calendar, monitoring client eligibility for respite days, liaising with family and GP’s about the respite admission or finding another client if a cancellation is received. In such

\(^{10}\) Aged Care Financial Performance Survey, December 2017 Summary Results Analysis, StewartBrown 2018
cases, some providers report a preference for using allocated respite days in an ad hoc manner, following the discharge of a resident. Often, this may turn into a transition to permanent admission.

Most providers indicate that it is not financially viable to keep a bed empty for the purpose of meeting emergency respite needs. They may be able to accommodate emergency requests if there has been a discharge and no one has yet committed to the bed as a permanent resident. It was suggested that block funding for emergency respite beds might offer some incentive for providers.

Emergency respite requires a current ACAT assessment and the timeframe to access this assessment can prevent providers from assisting in emergency situations.

RECOMMENDATION 3:

Review residential respite funding to ensure that providing respite is a viable proposition for residential service providers.

POSSIBLE STRATEGIES:

- Accommodation costs for respite beds should be covered either by the Government and included in respite funding or the consumer if they have the capacity to pay, as is the case with permanent residential care recipients. This could also assist in the provision of dedicated respite suites e.g. equipment, aids, televisions and comfortable chairs
- Respite funding models should include an additional supplement to assist with the increased care needs of people with reactive behaviours, especially given the short-term nature of respite and the additional workload involved in settling these care recipients into an unfamiliar environment
- The cost of administration, assessment and care planning that is incurred by providers regardless of the duration of the respite stay, should be funded by Government as an incentive for providers to offer shorter respite periods
- Consumers should be able to use HCP funds to contribute to residential respite services, especially as package services are not likely to be delivered during the period of residential respite
- Consider block funding models to encourage providers to maintain the availability of emergency respite beds

4. **Whether the current system for allocating respite bed days to residential care providers impacts the availability and provision of respite care**

Providers believe there are not enough respite places available for the community and the current system of allocating respite does not encourage flexibility. This ultimately disadvantages the community.

Some providers use their respite allocation to provide dedicated respite bed(s). In these instances, regular bookings are quite common where consumers book periods of time across the year. Most of these providers indicate that their close relationship with community and/or co-location with retirement villages provides some back up if there are unexpected cancellations. Providers report that due to the complexity of managing the admission process within residential aged care and the time it takes for clinical staff to assess and attend to care planning for individuals, they are reluctant to provide respite for less than two weeks. Having clients that return regularly to the same provider can reduce the time taken for the admission process. Providers indicated that although respite is
for an agreed timeframe, there are times when the care recipient in respite cannot return to their previous accommodation either because they have deteriorated or the carer is no longer able to provide the care. This creates additional complexities for the provider.

In relation to the increased use of respite days within residential care since the July 2014 reforms, there was agreement that many providers are using respite days to transition clients to permanent residential care. The reasons this may occur include:

- The Assets and Income Assessment may not have been completed. This can create a risk to providers who have agreed to a contract before receiving this information. Also, if the contract is signed without completed financial information, there is an administrative burden placed on the provider to calculate and back-date fees and charges.
- Hospitals are keen to discharge people who have been assessed as requiring residential care. Providers report that it is not uncommon to receive referrals from Hospital Discharge Planners requesting 63 days (the maximum) of respite and many consumers are well aware of their eligibility for 63 days of respite care per year.
- Consumers may want to experience the care at a facility prior to signing a contract (they might be hoping that a bed becomes available at a facility of choice – e.g. closer to family). It is also less costly for consumers to use respite services than be admitted permanently.

There needs to be consideration as to how this period of transition to permanent placement can be funded, to reduce skewing of respite day data in residential aged care facilities.

**RECOMMENDATION 4:**

*Review existing respite arrangements in residential care to ensure that objectives are being met.*

**POSSIBLE STRATEGIES:**

- Consider a funding stream to assist care recipients to transition to permanent care, therefore reducing the skewing of respite data in residential aged care facilities.
- Re-evaluate the geographical location of available respite places/services against increasing unmet need

**5. Costs to consumers and/or carers to access respite care**

For consumers, understanding the financial implications of accessing respite services is often complicated and confusing.

Residential respite care recipients are required to pay a basic daily fee of 85 per cent of the single basic age pension.

The cost of overnight or short-stay respite services may cost more than the residential respite option and therefore particularly prohibitive when the care recipient and carer are still maintaining a household with all of the associated ongoing costs.

However, overnight or short stay respite offers flexibility that can be difficult to obtain in a residential care environment. Due to viability and administrative concerns outlined earlier in this submission, residential care providers will often only offer two weeks as a minimum respite period. This period of respite may be excessive for the needs of some carers.\(^{11}\)

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\(^{11}\) Aged Care Funding Authority, Annual Report on the Funding and Financing of the Aged Care Sector – 2017 p.55
Whilst financial hardship assistance is available, feedback indicates that consumers are not always aware of this avenue for assistance and the process of application is once again complicated and time consuming.

**RECOMMENDATION 5:**

Consult with stakeholders to identify realistic cost structures to support overnight respite options and standardise consumer fees, whether respite is accessed through flexible cottage style accommodation or residential.

**POSSIBLE STRATEGIES:**

- Improve the uptake of the government financial hardship provisions for respite care by better informing the community about the availability of hardship payments and providing assistance for the process via the CRCC
- Allow consumers already in the system to use their surplus HCP funds or HCP subsidy paid during the respite period to contribute to the cost of flexible overnight or residential care respite. Advantages of this approach include that home care staff could spend time with a consumer in a RACF to help settle them in and provide social support in the absence of the primary carer. This would especially benefit consumers living with dementia or those from CALD backgrounds.

6. **Impact of the current arrangements on equity of access for respite recipients, including access in an emergency, or to residential respite for periods of less than one week**

The current arrangements do not support equity of access to emergency or short stay respite for all consumer groups.

Consumers living in rural, regional and remote areas with limited respite available may be disadvantaged by having to seek respite options in other locations and unfamiliar environments.

Generally, access to emergency respite seems to be a matter of being lucky enough to be in the right place at the right time. If there is a respite bed available within residential aged care, the consumer often has to accept the timeframe that the provider is offering. If the available time period does not meet the needs of the carer, there may be additional stress considering other options or seeking additional respite services to cover the required respite period.

The process used for CHSP respite supports planned respite however does not support emergency or crisis respite. As discussed, the cost of overnight and short stay respite services may be prohibitive for consumers and carers who are at the same time meeting the cost of daily living in the community.

Consumers with special needs such as people living with dementia need to be considered when reviewing and developing respite options. Current funding models need to be adjusted to support the additional staff time and the provision of a secure environment that may be required when providing care to a person living with dementia.

**RECOMMENDATION 6:**

Respite services should be available wherever and whenever needed regardless of location, financial status of the consumer or special needs.
POSSIBLE STRATEGIES:

- Increase the availability of and access to funded respite services in rural, regional and remote areas
- Consider hardship provisions for carers, and those they care for, who cannot afford respite
- Funding needs to be provided to support appropriate residential care environments for people with high care needs and/or dementia

7. Any unintended impacts or consequences of the current arrangements supporting access to residential respite care

When consumers and their carers are unable to access respite, either in their home, community or in residential care, there is a risk that the consumer may require admission to the acute sector or permanent residential care due to carer stress and fatigue. In these circumstances, the cost to government is greater than if the care recipient was able to remain living in the community.

Respite funding has not kept pace with the cost of care, resulting in providers being less inclined to offer adequate and flexible respite to the community.

Reluctance of some General Practitioners to provide medical services to their patients while in residential respite care reduces medical support to the care recipient and clinical support to staff.

There is a need to educate residential care workers on the importance of maintaining the care recipient’s capabilities and level of independence so that care requirements are not increased upon discharge, placing additional stress on the primary carer.

Carers currently in the workforce who are unable to access appropriate respite may be forced to leave work prematurely.

8. Use of Commonwealth Home Support Programme respite care services and the interaction with other programs that deliver respite services, including residential respite care

Current respite options are spread across the three aged care program streams; Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) Program and Residential Care. Regional Assessment Services assess eligibility for CHSP services providing centre based respite, cottage and flexible respite.

Eligibility for a HCP is assessed by ACAT, based on the needs of the care recipient which may, or may not, identify respite. The package funds are used to deliver the support and services identified in the care recipient’s care plan. The need of the carer for respite may not necessarily be considered as a goal of the care recipient and may not be reflected in the care plan.

Residential respite is assessed and approved by ACAT.

Feedback indicates that where a provider only offers respite within either CHSP, HCP or residential care programmes there is limited effective interaction between the various respite programs resulting in fragmented service delivery to consumers. The transitions are more likely to be seamless where all respite options are offered within one organisation.
RECOMMENDATION 7:

Reconsider the continuum of respite services, including developing a single assessment and approval process which provides consumers with information in regards to the various options for respite and associated costs.

POSSIBLE STRATEGIES:

- Ensure that the needs of carers are seen as a priority to enable them to maintain their caring role
- Integrate the ACAT and RAS assessment teams and activities
- Ensure that respite options are considered and made more effective with any future integration of home care programs

9. Any other matters relevant to respite care

Aboriginal and Torres Strait Islanders

Aboriginal and Torres Strait Island peoples may not identify an individual as a carer, as the extended family often shares the provision of care, and may not be aware of respite opportunities or where to seek respite support.

We know that when accessing respite, Aboriginal and Torres Strait Islanders prefer cottage or other home like environments. The institutional environment of residential respite care may be culturally inappropriate.

Carer specific

Carers need support as a consumer group in their own right to assist them to sustain their caring role. There needs to be more of a carer-centred approach by incorporating the needs of the carer in ACAT/RAS assessments.

Better forward planning options are required to enable carers and the person they care for to plan short-term breaks.

Skills and knowledge of respite care staff

Providers have identified gaps in the skills and knowledge of care staff who are required to provide short term respite care in a permanent residential care setting. There needs to be a proactive approach to preparing staff to care for the needs of a care recipient requiring short-term care.

Providers have stated a respite toolkit to train staff would be a useful resource. Preferably a digital programme with printing options.

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