Government of **Western Australia**
South Metropolitan Health Service
Rockingham Peel Group

Aged Care Assessment and Community Pathways

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Aged Care Reforms and what brought about the changes?

The Australian Government established a Royal Commission into **Aged Care Quality and Safety** in 2021 to review our aged care system.

Outcome:

- **Updating the Aged Care Act 2024 -** Shift in priorities from providers and subsidies to the older people rights-based and person-centred approach.
- The system, with multiple assessment providers caused confusion for older people and families and had inconsistent assessment outcomes depending on assessor/provider and so, as of December 2024,

- Implementation of **Single Assessment System,** replacing the separate Regional Assessment Service (RAS) and Aged Care Assessment Team (ACAT) to a Single Assessment workforce. Included the Sector being semi privatised.
- Under the Single Assessment System, assessment organisations have a mix of clinical and non-clinical assessment staff to conduct both home support and comprehensive assessments.
- The single assessment pathway was intended to
    - make assessments simpler and easier, minimising the number of times an older person had to tell their story and reduce waiting times
    - Introduce new Support at Home Program



Service Programs under the Act

Commonwealth Home Support Program

- Entry Level, early intervention, block funded, flexible care

Support at Home Program

- Coordinated care management, catering for complex, high care and ongoing needs, short term pathways of care

Overview of Support at Home

Ongoing Services 8 Classifications for ongoing services and 4 classifications for transitioned HCP care recipients. Each classification has a quarterly budget.

Three short term pathways Assistive Technology and Home Modification (AT-HM) scheme, Restorative Care Pathway and End-of-Life Pathway.

Participant contributions Participants will pay contributions based on an assessment of their income and assets, and the type of services they receive.

Service pricing Prices must include the entire cost of delivering a service. Providers will initially set their own prices. Government has paused implementation of-set price caps.

Care management Care management services will be delivered by a care partner. 10% of a participant's ongoing budget allocated for care management.

Funding Levels

HCP Level	SaH Transitioned Annual Amount	SaH Level	Annual Amount
		1	$10,731.00
1	$10,986.50		
		2	$16,034.45
2	$19,319.45		
		3	$21,965.70
		4	$29,696.40
		5	$39,697.40
3	$42,055.30		
		6	$48,114.30
		7	$58,148.15
4	$63,758.20		
		8	$78,106.35

Type of Care	Funding	Weeks of Care
End of Life Care	$25,000.00 (total)	12 (can be extended to 16 weeks with no additional funding)
Restorative Care (max. 2 episodes per 12 months)	$6,000.00 (per episode)	16 (per episode)
Assistive Technology- Home Modifications	$500- $15,000	52 (must be spent, not just committed – in most instances)
Assistance Dog Maintenance	$2,000 per year	Ongoing

Restorative Care Pathway

The pathway focuses on early intervention through intensive allied health and or nursing services, with the aim of maintaining or regaining function, and reducing functional decline. The delivery of clinical services, including allied health, is central to achieving these outcomes. For addition information refer to the Restorative Care Pathway Guidelines.

Episodes and funding	Period of care of up to 16 weeks 2 units of restorative care for use in a singular episode. A participant will need to wait at least 3 months form completion of the original episode before being eligible to receive a second episode with the 12-month period. A unit of funding is approximately $6,000
Multidisciplinary team	Multidisciplinary team (MDT) of allied health and/or nursing professionals that provides the participant with a comprehensive, outcome-focused treatment plan and clinical supports. The inclusion of a medical professional is considered good practice but not mandatory. A restorative care partner will deliver restorative care management and coordinate the MDT.
Services	Access services from the Support at Home service list aligns with their assessed need. Assistive technology and/or home modifications may also be delivered during an episode of restorative care. The goal plan identifies the participant's needs, goals and preferences, and how their services will support them meet their goals.

End-of-Life Pathway

Under Support at Home an End-of-Life Pathway will help older people who wish to spend their final months at home with their families. The End-of-Life Pathway will be available to participants already accessing Support at Home, as well as older people who are not currently accessing services through the Support at Home Program.

Episodes and funding	12-week period, with possibility of extension to 16 weeks.
	Older person will receive approximately $25,000 of funding.
Services	Access to services on the Support at Home service list that aligns with the older persons needs, and complements other in-home palliative services provided.
	May be approved to access Assistive Technology if there is a need.
Eligibility	A medical or nurse practitioner must complete a medical assessment (Part B) on the form.
	To be eligible a participant must have 3 months or less to live. End-of-Life Pathway Form
	An Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.



Who is Eligible?

To be eligible for an **aged care needs assessment** an individual must be:

- Aged 65 or over; or
- An Aboriginal or Torres Strait Islander person and is aged at least 50 or homeless, or at risk of homelessness, and is aged at least 50.

Each of the above individuals must also provide information relating to the individual's care needs.

Care needs are defined under the Act as one of both of the following:

- The individual has difficulty (whether physically, mentally or socially) undertaking any daily living activities
- The Individual needs help from another person, or the assistance of an aid, to maintain their physical, mental or social capacity to function independently.

Referral Process

Community Referral

- Call: My Aged Care 1800 200 422 or
- Online: https://www.myagedcare.gov.au/make-a-referral
- Referral information - provide more detail to assist triage.
- Avoid premature referrals. **Goal** to remain independent at home.
- **Urgent Circumstances** call My Aged Care as the system has capacity to respond rapidly as apposed to an online referral.

Things to Consider

- Does the client have an unmet need.
- Do they have access to current service support or informal supports (liaise with provider).
- Alternative options to My Aged Care:
    - Department of Veterans' Affairs **DVA**
    - **GP Care Plan** ie Podiatry, Physiotherapy, Occupational Therapy
    - Community Health Outpatient Clinics

Common Challenges and Considerations

- Wait times for support at home funding
- Lack of interim supports in the community (CHSP)
- Impact of the algorithm in gaining increased support at home and/or priority system.
- Misconceptions and conflicting information.

Looking Outside My Aged Care

- Dementia Support Australia
- Carers WA
- Carer Gateway
- Care Finders
- Parkinson’s WA
- Silver Chain Continence

Questions?

