Department of Health and Aged Care

Co-designing the care management role for the Support at Home Program

Final report | September 2022

ThinkPlace

Introduction

About this co-design project

The Australian Government Department of Health and Aged Care (the Department) is delivering a series of aged care reforms, in response to the Royal Commission into Aged Care Quality and Safety. **The Department invited stakeholders to design and inform the future of care management in the Support at Home Program.** The reforms are considering how best to deliver care management to senior Australians.

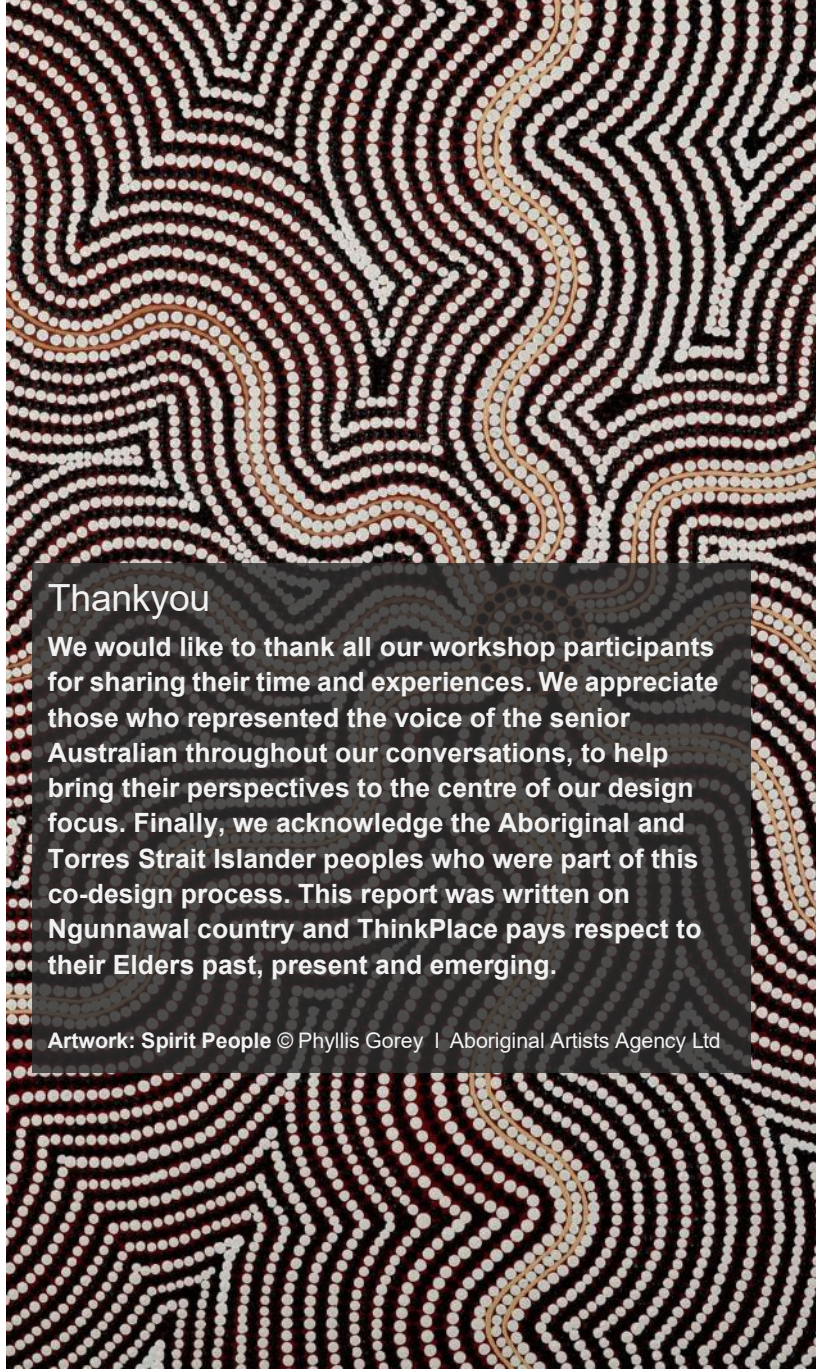
ThinkPlace was engaged to lead the facilitation of three comprehensive online workshops from February to March 2022, inviting stakeholders to collaboratively explore the future roles and responsibilities of the care manager, and provide recommendations for how this service might be structured so it best meets the needs of the aged care system in Australia.

Purpose of this document

The content in this report was informed and developed through a co-design process that sought input from industry professionals, government stakeholders, and senior Australians and carers with lived experience in the aged care sector. The co-design project did not aim to converge on a set, final model for care management, rather, this report captures the diverse, collaborative thinking from the broad stakeholders impacted by the reforms. It presents overall themes, insights, emergent ideas and hypotheses for how we might define and structure care management in the new Support at Home Program. The report provides prompting design questions and recommendations for the different themes or elements that should be considered when designing the final solution for care management.

Intended audience

This document is intended for all interested stakeholders and shares a summary of what was discussed in the consultation. It gives anyone who was not involved the opportunity to understand the co-design process and emerging concepts. The document does not provide a final outcome for the care management function of the Support at Home Program, rather, it provides useful direction and considerations as part of the ongoing design activities and implementation for the aged care reforms.



Thankyou

We would like to thank all our workshop participants for sharing their time and experiences. We appreciate those who represented the voice of the senior Australian throughout our conversations, to help bring their perspectives to the centre of our design focus. Finally, we acknowledge the Aboriginal and Torres Strait Islander peoples who were part of this co-design process. This report was written on Ngunnawal country and ThinkPlace pays respect to their Elders past, present and emerging.

Contents

"Our most important question is what does an older person really need to thrive at home?
Guidance, advice, someone who understands the system, can judge needs and quality of services, assist in the coordination of those services, and who can take responsibility for ensuring a quality outcome for that older person."

- Townhall session participant

Project background and context

What is the current state context?

This project takes place as the Department of Health and Aged Care is designing a policy for a new in-home aged care program, in response to the Royal Commission into Aged Care Quality and Safety. A reformed program – currently called Support at Home – would replace the Commonwealth Home Support Program (CHSP), the Home Care Packages (HCP) Program and the Short-Term Restorative Care Programme (STRC).

The proposed program includes a range of reforms, such as offering senior Australians the option to receive their support services from multiple providers, rather than restricting them to one. There are also changes to assessment, support plans with specified services, as well as revised service flexibility and reassessment approaches to support responsiveness to changes in individual needs. The Support at Home Program Overview paper provides an overview on the proposed design intent.

Previous engagements by the Department have uncovered a range of differing perspectives amongst stakeholders, particularly surrounding the scope and definitions of care management. Despite these differences, there is broad agreement care management primarily consists of two key activities:

1. Care planning and navigation of services, aligned to the individual's care plan
2. Monitoring and assessment of the quality and outcomes of the home care services

Across these activities there is significant complexity in the roles and responsibilities of stakeholders. This includes their accountability, communication, workforce capability and capacity constraints.

Why are we co-designing the future of care management?

Co-design actively engages multiple voices to ensure the final design solution is informed by diverse perspectives that understand the complexity of the aged care context for care management. The co-design process provided the opportunity for senior Australians, their families and carers, along with industry stakeholders to collectively engage in a dynamic discussion, exploring views and perspectives about the future definition of care management. This co-design engagement intended to support and inform the following strategic shifts for the Support at Home Program reform:

From		To
Unclear definitions of care management	>	Shared understanding of care management and definitions (including roles and responsibilities)
Inconsistent experience of care management for senior Australians	>	Program model supports a more consistent experience of care management
Current model vests all responsibility with the approved provider	>	Program model empowers seniors to choose multiple providers if they wish, balances clear accountabilities and dignity of risk

The aim of the co-design workshops was to build a shared understanding and consistent definition of care management and clarify the scope of the role of care managers in the new program. The insights and recommendations that emerged from this process are presented in this report.

Co-design engagement methodology

What are we making?

The report provides insights, emerging hypotheses and ideas from the co- design engagements, which form recommendations for determining the role of the care manager in the new program

The report contains a set of practical options and recommendations for the Department to consider in progressing the Support at Home Program design, along with thinking and questions that might inform broader stakeholders in their planning and implementation activities.

This report aims to communicate recommendations from the co-design group about:

- Eligibility for care management services
- Roles and responsibilities of a care manager
- Ways self-managed care works
- Care manager interaction points with the aged care system
- Ways care management works in a multiple provider environment

How did we collaborate with our diverse stakeholders?

In February and March 2022, the Department brought together diverse stakeholders to add valuable, collaborative input towards reimagining the future of the care management role and function within the Support at Home Program.

Who was involved?

We had **over 100 people participate.** This included senior Australians and their families or carers and industry representatives, including care managers, assessors, providers, peak bodies, regulators and other stakeholders from across the aged care sector.

What did we do?

2 x townhall style information sessions with approximately 100 people including seniors and industry representatives

3 x co-design workshops with approximately 40 participants representing the diverse perspectives across the aged care sector

1 x online survey with 104 responses from those involved in the co-design process

What was discussed?

Our focus question: **What are the key opportunities and considerations to design the most effective care manager role in the future?**

To unpack this, workshop participants looked closely at:

- What care management might look like in a perfect world
- Eligibility for care management
- Potential models for self management
- Implications of a multiple provider model on care management roles
- Roles, attributes and capabilities of care managers
- The accountability of care managers

Optimising the care management role and function

How might we optimise the role of care management in the future?

The following section presents the detail of a number of themes and recommendations discussed by the workshop participants:

- ❑ **Eligibility for care management should be determined proportionate to need**
- ❑ **Care management should support continuity of care and have the ability to be flexible and responsive to changing needs**
- ❑ **Self management of care is valued as it provides autonomy, but there should be safeguards and monitoring in place still**
- ❑ **The term and definition of care management should represent the value and purpose of the role**
- ❑ **Clinical expertise is desirable for some clients, however other skills such as social work, and soft skills such as communication and trust building are also valued**
- ❑ **There should be clear processes, systems and communication to manage shared accountability and the complexity of this within a multiple provider environment**
- ❑ **Technology and innovation should be used to enhance the role of care manager**

How could an optimised role of the care manager contribute to the experience and outcomes for seniors receiving care at home?

Workshop participants discussed options for how to optimise the role of care management for a desired future state. They shared the following perceived benefits and contributions that changes to care management could make to senior Australians receiving care at home, along with their relationship and experience with broader aged care and health services.

- Senior Australians receiving care at home feel **heard and respected**
- The role of care manager should support **recipient-centred care** including choice of provider, optimisation of independence, dignity of life and connection. **Care should be cognisant of and tailored to individual needs, context and culture**
- Care management is a role designed specifically for aged care, where care needs fluctuate, and deterioration can be rapid. Care managers understand ageing and should be **responsive, adjusting care to meet the senior person's changing needs**
- When senior Australians enter the aged care system and when needs change, tailored services and trusted relationships should be established quickly. **Stable, consistent support** contributes to the safety and independence of care recipients
- **Continuity of the relationship** between the care manager, care recipient, aged care and health service providers **supports continuity of care**. Trusted relationships should be established and maintained to support forward planning and decision making, reducing unplanned hospitalisation and unplanned transitions to residential care
- Trusted relationships should **support and sustain the informal support network**, leaving senior people feeling heard, seen and respected, which is essential to maintaining dignity
- Respite should be planned and timely to **sustain longer term independence** and the resilience of the informal support network
- **Care management should prolong independent living** and ensure appropriate home support for quality of life and end of life

SECTION 1

Recommendations for care management in the new program

Recommendations for care management

What did we learn about care management in the new program through our collaborative conversations in the workshop series?

The conversations surfaced questions and recommendations. The following pages also provide additional detail on ideas and concepts that emerged from the co-design process.

1.

Eligibility for care management

The new assessment process for Support at Home would assess senior Australian's eligibility for service types. Workshop participants expressed it is important care management eligibility and allocation should be structured to provide flexibility and capacity so care managers can be proactive and responsive. Participants agreed care management could be distributed proportionate to need, however rigid tiers of support could inhibit responsiveness.

1.1 How might we align the different levels of care management support with the skills of care managers, as required for the different categories of Support at Home?

2.

Continuity of care management

Workshop participants expressed the great importance of the relationship between the senior Australian and the care manager. They noted when a trusted relationship is established, where feasible, it be maintained. The trusted relationship enables continuity of care by anticipating changing needs, planning transitions, supporting decision making, and being a trusted ally in times of crisis and as health deteriorates.

2.1 How might the care manager role help to eliminate the disruption of transitions and support continuity of care?

2.2 How might care managers be part of a good safety net process that can rise and respond to concerns early, to prevent crisis incidents?

3.

Self management of care

Many workshop participants believe self management is an important way to optimise and balance senior Australians' autonomy and choice of providers (aligned to their care plan). It is recommended to include safeguards and supports that senior people can reach to in times of need. Some example options shared were short-term access to care management and periodic monitoring to pick up changing needs and support timely transition to increased care management when needed.

3.1 How might we best support a person who decides to self manage while respecting their right to dignity of risk?

3.2 How might we include the value of guidance, oversight and support provided by a care manager in a self management model?

4.

Capabilities and roles of a care manager

Participants felt support from a care manager needs to be personalised, responsive and forward thinking. The role should be about understanding the aspirational, social and environmental context and changing needs of the individual. They partner with the care delivery team and care recipient to plan, support and monitor the care plan and clinical goals. It was suggested the qualifications of a care manager, particularly clinical expertise, could be tiered to align with the varied ageing needs and context of the care recipient.

4.1 How might we communicate and educate the community about the status, value and experience of the care manager role, to enable us to recruit new and maintain current quality care managers?

Recommendations for care management cont.

What did we learn about care management in the new program through our collaborative conversations in the workshop series?

5. How care management is defined

The term ‘care management’ does not resonate with everyone because it implies a lack of agency for the senior Australian. Participants stressed the importance of the role of the care recipient as a partner and their rights to recipient-centred care and self-efficacy. There is opportunity to revisit the terminology to provide better clarity and ensure the value and purpose of care management is properly interpreted and understood.

5.1. How might we clearly define the difference between self management and care management, noting both can exemplify recipient- centred care?

6. Accountabilities within a multiple provider environment

clear Workshop participants noted a multiple provider model requires processes and protocols for responding to emergent risks and changing needs. They stressed the importance of having useable and accessible systems established to support communication, collaboration and information sharing between providers.

6.1 How will we ensure the right people are accountable for the right aspects of care, without overwhelming certain roles with all the accountability?

6.2 Who is accountable when recipients are self managing and there is no care manager involved?

7. Technology to enhance the role of care manager

Many workshop participants noted care management could be effectively supported through digital solutions, particularly for real time information sharing between stakeholders. Incorporating digitally enabled services and processes and assistive technologies could help alleviate workforce pressures and create more responsive care management services.

7.1 How might technology support a safety net for those self managing?

7.2 How might the monitoring of emergent health issues or other vulnerabilities by multiple parties be better supported by technology

8. Further considerations for care management

The participants discussed other important and adjacent elements within the broader Support at Home Program that should be considered when finalising the role of the care manager in the future.

8.1 How might we better define the link between assessment and care management?

8.2 How might we better manage risks, incident responses and escalation processes?

8.3 How might we consider the resource requirements for all stakeholders managing care when designing the funding model for Support at Home?

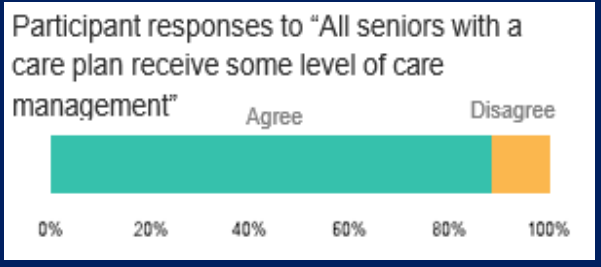
1. Eligibility for care management

Theme overview

Eligibility is focused on understanding which clients will require a care manager and the level of care management they should receive, as well as who might prefer to manage their own care and how could support be quickly made available if that preference changes. Regardless of the model, all senior people should have access to care management when needed.

We tested a hypothesised three-tiered model of care management to explore how this service might be distributed proportionate to need. Participants noted there is not necessarily a linear path of decline in care need and the model must be flexible enough to identify and respond to this. Additionally, when a senior person's need temporarily increases, they will likely need an increase in short-term care management to help them safely return to stability.

Survey insight



Recommendations about eligibility for care management

The following recommendations were informed by participants' exploration of the hypothesis of a three- tiered model of care management and the eligibility associated with these tiers:

1. **Apply a proportionate continuum of care management:** Care management should be structured to be responsive and proportionate to need and to support continuity of care ***(see next page for detail)***.
   Participants agreed senior Australians with the most complex and dynamic needs should be eligible to receive the highest level of support. While those with high independence and low in-home support requirements could be better placed to self manage their care (participants did note some
   form of care management should be accessible to anyone receiving in-home services, and there must be safety nets in place for those self managing their care) **–** ***(See Self management care on p.15*****).**
2. **Ensure flexibility to allow rapid response to changing needs:** Participants agreed rigid tiers of care management, along with long reassessment processes, would likely inhibit a care manager's ability to respond to the dynamics of people's ageing journey. Care managers should be able to use their professionalism to provide the right level of support at the right time. Their role should include
   anticipating changing needs, and they need agency to respond to this within the existing care plan. Participants suggested the hours allocated for care management should therefore be flexible.
3. **Provide a surge capacity option:** Participants felt a surge of care management support is required at the start of a senior person's Support at Home journey, while services and relationships are being established. This initial surge is an investment that aims to establish stability for the senior person and relationships with service providers. *(See Continuity of care management on p.13)*

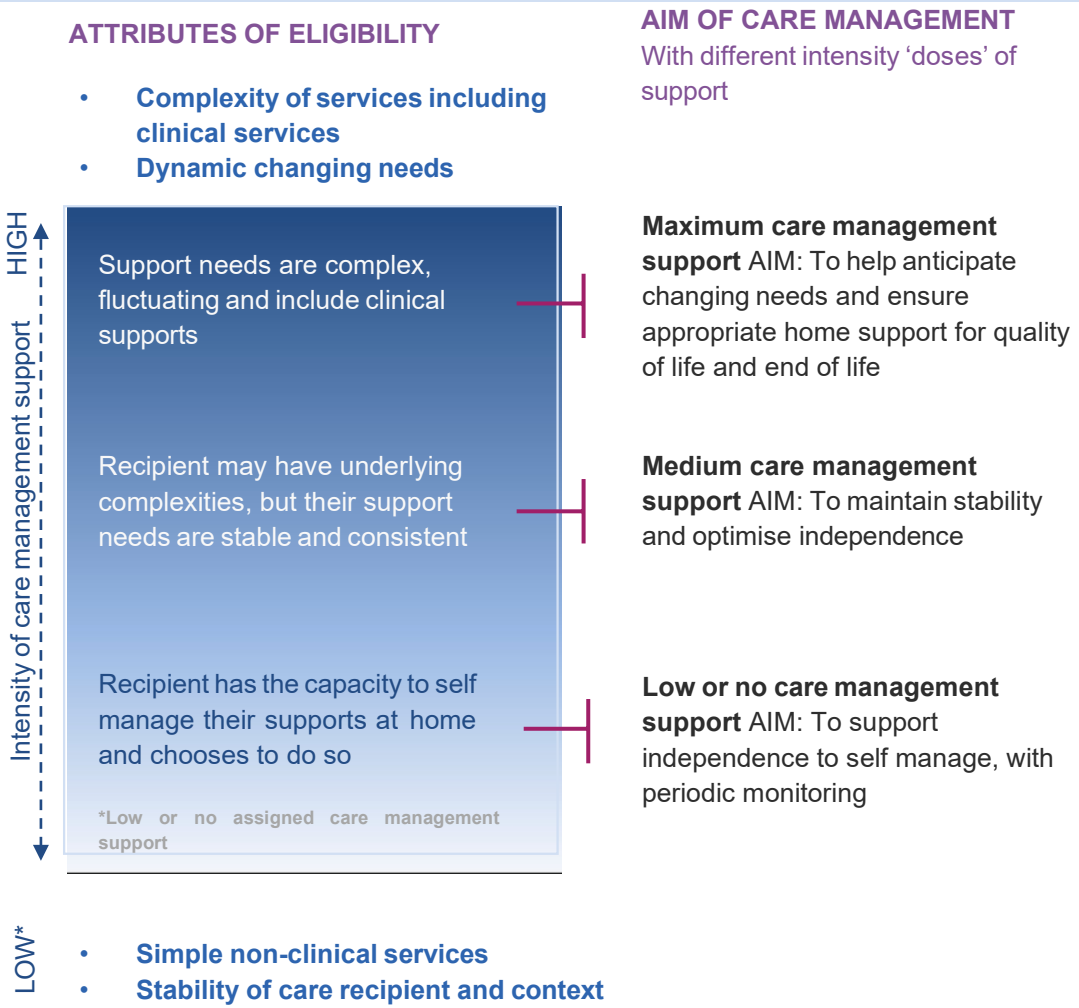
Summary recommendation

Care management should be distributed proportionate to need, rigid tiers aged care context where need for support fluctuates, deterioration can be rapid, and relationships with the capacity to respond matter most.

1.

Potential concepts and models for eligibility

An emergent model for tiers of care management



1.

EXPERIENCE EXAMPLES

Potential tiered levels of care management support

The workshop created indicative profiles for recipients requiring differing levels of care management (CM) support, noting there is potential for significant variation in health, environment and social context, and that care management should be responsive to these individual and fluctuating ageing needs. Many of these criteria tested well and aligned with the level of care management support that would typically be needed for those attributes, however, participants questioned if 'social networks' should be a criteria for capacity to self manage, noting recipients of care may not have supportive family.

Self managing recipient

My name is Marge Holland

I do need some help at home, but I know what I need. I want to feel that I am in control of my own lifestyle and decisions. I manage my own care. If I need more support, I know who to call.

ATTRIBUTES OF ELIGIBILITY

Physical health	Stable and supported.
Social network	I am not socially isolated.
Service coordination	I access few services (1 to 3), non-clinical.
Capability	I can make decisions, I have English literacy and digital capability, I understand my rights and responsibilities.

I want to manage my own care and I feel confident to make independent decisions about my supports at home.

Low CM support recipient

My name is Joy Martin

I live at home independently.

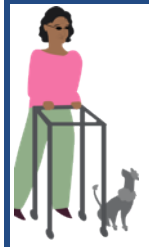
My care manager contacts me regularly to see how I am doing.

ATTRIBUTES OF ELIGIBILITY

Physical health	I have a complex condition that is well managed, my heath is currently stable.
Social network	I am not socially isolated.
Service coordination	I access multiple services but they are consistent and stable. I have been with the same providers for a while now and I am happy with the services.
Capability	I can manage independently at home with service supports in place.

I want a care manager to support me in decision making and achieving my care goals, and partner with me to coordinate the supports I receive from different providers

High CM support recipient



My name is Lizzie Brown

I live with my husband Joe. I am proud to be living at home. I can manage with the support I am getting, but my health is declining rapidly and my personal care needs change often.

ATTRIBUTES OF ELIGIBILITY

Physical health	In decline, complex comorbidities, declining mental health.
Social network	My husband and I live together, we both need support.
Service coordination	Complex services, including clinical supports.
Capability	Adequate to sustain quality of life at home.

Our support needs are complex and change often, we need our care manager to manage these supports so we can concentrate on day-to-day living, *"Relationship building is very important at this level, it can be a very emotional time for people and their supports."*

Continuity of care management

Theme overview

This theme explores how continuity of the care management relationship supports continuity of care.

Participants shared that care managers support continuity of care by anticipating changing needs, planning transitions, supporting decision making and being a trusted ally in times of crisis and as health deteriorates.

"Any tiered system should support the continuity of the care management relationship, as this relationship is key to achieving continuity of care."

"No matter what we do with assessment, this will have an impact on the other end – there needs to be tighter links between assessors and care managers so they do not operate in a vacuum."

Recommendations about how the continuity of care management supports continuity of care

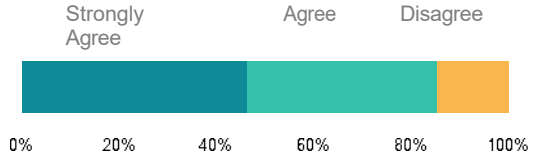
Workshop participants stressed a key part of good care management is the relationship. Trusting a care manager builds understanding about the needs and preferences of the senior Australian they are supporting. This becomes increasingly important when the individual has more complex contexts and service need. To support continuity of care in the new program, participants felt there should be:

1. **Flexibility and surge capacity without the need for reassessment:** The need for care management increases when needs change. Sometimes this can be for a short time while new services are established, and the recipient's health and support network is restabilised. Sometimes this is to support reablement. There should be an allowance for care managers to use their professional judgement to provide immediate, flexible care management services that anticipate and respond to people's dynamic ageing needs. *(See Ideas and concepts to support continuity of care on p.14).*

2. **Application of principles for continuity of care in design of assessments and service categorisation:** When designing the new assessment tool, assessment processes, and the categorisation of services, principles that help ensure continuity in the role of care management should be applied *(See Ideas and concepts to support continuity of care for emerging principles on p.14)*. Participants noted this could entail:
   - Flexible service provisions following any trigger point for reassessment
   - Seamless transitions to higher or lower levels of aged care services and care management supports
   - Clear handover processes during the reassessment and reestablishment of services

Survey insight

Participant responses to "A care manager makes a client's experience through aged care seamless"



Summary recommendation

A trusted relationship between the care manager and senior Australian is key to quality care management. Once a trusted relationship is established it should be maintained by allowing flexibility for short-term or surge service provision options that avoid disruption of this relationship.

Ideas and concepts to support continuity of care

PRINCIPLES AND PROCESSES SUPPORT CONTINUITY OF THE CARE MANAGEMENT RELATIONSHIP	
Continuity of care management support between tiers	Where feasible, the relationship between the care manager and senior Australian should be continuous across tiers and not disrupted because of a transition between tiers.
Handovers support continuity	Handovers should support continuity of care without seniors having to retell their story.
Enable agency to support the care manager	The care manager should have agency support to plan a transition rather than waiting for an external assessor.
Care managers can provide surge support as needed	There may be a surge in care management to establish stability and aged care supports, or to support reablement.
CARE MANAGEMENT SUPPORTS CONTINUITY OF CARE	
The care manager is the contact point for discharge from hospital	Following hospitalisation or other crisis scenarios, a care manager should be the point of contact to ensure services are in place and senior people do not fall through the gaps.
Anticipation of changing needs	The care manager has a role to look ahead and plan significant transitions.
Response to changing needs	When a service provider observes a change or deterioration in the individual's context there should be clear processes in place to activate the care manager so they can respond.

An experience of continuity of care management

Level of care management

Establish the supports

After assessment there is an initial surge in care management to establish stable services.

Anticipate and respond to changing needs

A service provider sees a deterioration and follows processes to notify the care manager.

The care manager can provide a short-term surge in care management to prevent incidents or crisis.

Provide continuity of support at times of rapid change or crisis

The care manager ensures significant transitions are planned.

Following an incident or a significant increase in care needs, the care manager establishes additional services while the recipient is waiting for reassessment.

The care manager provides comprehensive handovers to support continuity of care and ensure seniors do not have to retell their story.

3

INSIGHTS AND RECOMMENDATIONS

Self management of care

Theme overview

Some workshop participants, particularly senior Australians and carers who attended, felt self management is a priority. They value that it assists senior Australians to remain independent for as long as possible.

Self managing senior Australians have autonomy and can make decisions about their care (within the parameters of their care plan) increasing their empowerment and confidence.

Participants noted self managing seniors would need appropriate support to effectively manage their care, as well as clear safeguards to anticipate and respond to changing needs.

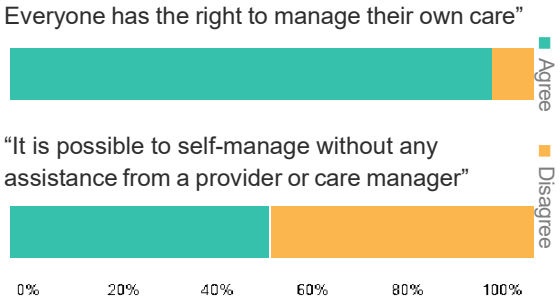
"Who will monitor changing care needs if there is no care management?"

Recommendations for self management

Opinions about the self management experience were quite polarised amongst participants *(see survey results on the left)*, however there was agreement all senior Australians have the right to self manage their care. Some safety nets may be incorporated in the Support at Home Program to ensure the changing needs and preferences of self managing clients are addressed:

1. **Establishment support:** Some form of short-term care management may be offered post assessment to ensure senior Australians can establish their services, are stable and able to manage their care ongoing.
2. **Periodic check-ins:** Participants had a strong view there should be a safety net for seniors managing their own care, with periodic check-ins as well as a channel for individuals to seek care management support when needed, for example through a call centre model.
3. **Proactively recognise and respond to changing needs or contexts:** In the absence of a specific care manager, adequate reporting and accountability for recognising changing needs should be established with those providers delivering care. This includes situations where care recipients themselves may not recognise they need more support at home. Where a provider believes a client's needs are changing, duty of care could require them to offer a referral to a care manager or provide information or resources on how to get reassessed, should the client choose.
4. **Information sharing:** There should be systems and processes for sharing information across multiple providers *(See Technology to enhance the role of care manager on p.22).*

Survey insight



Summary recommendation

All senior Australians should have the choice to self manage their care, and the system should be responsive to provide additional support if and when that preference changes.

Capabilities and roles of care managers

Theme overview

The care management role is critical in an aged care environment where health and independence can deteriorate rapidly, support needs fluctuate, and the service network is complex.

"Recipients of care need guidance, advice, someone who understands the system, can judge needs and quality of services, assist in the coordination of those services, and who can take responsibility for ensuring a quality outcome for that older person."

"Care managers need to be able to create and maintain complex professional networks to the wider health care system."

"Care management should be about relationships – not transactional."

(See Defining capabilities and roles of care managers for the other important attributes of a care manager on p.17)

Recommendations for capabilities and roles of care managers

Support from a care manager needs to be personalised, responsive and forward thinking. Care managers should be able to build a relationship with their client, act as their support and guide for navigating the aged care system and ensure a timely response to changing care needs. Therefore, participants noted the ideal capabilities and attributes of a care manager would sit within three key areas:

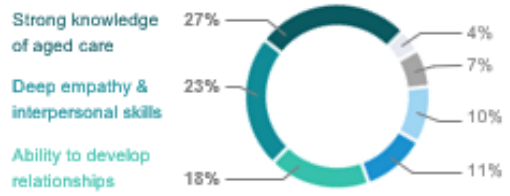
- **Care partnership and coordination** – Ensure the care recipient is receiving the right mix of care, at the right cadence to achieve their set care goals (aligned to their care plan)
- **Support–** Know the aspirational, social, and environmental context and changing needs of the care recipient, including their vulnerabilities, and provide support to ensure their care needs are met.
- **Clinical oversight/governance** – Understand and identify changing needs and respond accordingly

The exact required mix and dose of these capabilities and attributes will vary for different senior Australians and likely needs to be met through a team of support people. Therefore, participants noted the following considerations for the new program:

1. **Minimise the use of clinically trained staff to undertake administrative tasks:** Many participants felt strongly about the opportunity to provide administrative support instead of care managers for low needs contexts. This might incorporate a basic care management call centre, which may also help address any workforce shortages.
2. **Introduce a tiered capability model:** Applying a tiered model for the qualifications and skillsets of the care manager, which could align to the tiered model of the senior person's need and service complexities. This could reduce the need for blanket training requirements in this role.
3. **Establish care management teams:** This could include a mix of capabilities, such as clinical or social work, to be drawn upon at different times and levels to match the recipient's needs.

Survey insight

Participants were asked to select the three most important attributes of a care manager:



Summary recommendation

Support from a care manager needs to be personalised, responsive and forward thinking. Their role is to understand the aspirational, social and environmental context and changing needs of the care recipient. They partner with and coordinate the care team to set, support and monitor a recipient's care goals within the remit of their care plan.

EMERGING CONCEPTS AND DEFINITIONS

Defining the capabilities and roles of care managers

Emerging roles of a care manager

- **CLINICAL OVERSIGHT/GOVERNANCE** to understand and identify changing needs and ensure these are appropriately managed and serviced. This requires only enough clinical expertise to recognise needs have changed.
- **ENVIRONMENTAL SAFEGUARDING** to ensure the senior Australian client is safe when receiving their care. This includes applying human rights training and safeguarding principles and processes, as well as identifying and managing potential risks to the senior person.
- **CARE PARTNERSHIP AND COORDINATION** to set and track care goals, connect and refer to required services (as per the care plan), provide information and liaise with the multidisciplinary care team as required. This includes access to specialists to support current and identify trajectory of needs. It should always apply impartiality of care to ensure a level of independence/non-bias between aged care service providers.
- **ONBOARDING** to link people to the right services and help establish stability or support reablement. This builds relationships and an initial picture of the senior Australian's physical, emotional, and psychological needs and what they want and aspire for from their care. When establishing care, there should be awareness and respect that some personal information may not be disclosed.
- **MONITORING OUTCOMES** to ensure service provision aligns and is compliant with quality standards. This role is interlinked with the clinical oversight role, to ensure ongoing review and identification of different services or providers that may better meet the senior person's needs.
- **SUPPORT** for the senior Australian relies on building trust and understanding or their values, beliefs, context, vulnerabilities and goals. This helps to ensure care meets the individual needs and desired outcomes, which should include managing difficult and realistic conversations.

DESIRED QUALIFICATIONS

Workshop participants suggested the following qualifications would be important for care managers. However, they noted these may not be required for all roles and a tiered model of care management should consider which are needed for what context to balance skills with workforce capacity.

- Clinical qualification (e.g. health or nursing)
- Social work
- chronic disease management
- dementia care
- disability training
- Diversity training
- Human rights training
- Culturally appropriate care
- communications and relationship skills

DESIRED ATTRIBUTES | AS A CARE MANAGER …

… I have expert knowledge of the aged care and health systems.

… I have deep empathy for clients and strong interpersonal skills.

… I can establish and maintain trusted relationships.

… I understand and respect diversity and can tailor services to senior Australians' unique needs.

- I have a strong understanding of ageing so I can anticipate and spot changing needs.

…I am practical, pragmatic and organised.

… I am flexible, adaptive and reactive to a senior person's changing context.

… I can think critically to support and inform appropriate care decisions as the needs of the senior person change.

5

How care management is defined

Theme overview

Participants felt the term 'management' can evoke connotations of disempowerment, where the management of care by another person is seen as counter to the principle of recipient-centred care.

Care management needs to be defined in context of the intent of Support at Home, where recipient-centred care can be exemplified through both self management and care management.

"We have to always take on board it is the care recipient who decides what, how and when [for their care]. We may not agree with them, but we do not have the role, as care managers, to unduly influence or push them into a direction they have no desire go. We support, provide relevant and timely information and be receptive to the care recipient's needs and wants – as expressed by them and as supported by their care plan."

"Care management can't be all things to all people. But it needs to be able to recognise the various needs, intersectionality of risk, and be able to refer and get assistance to manage those needs."

Recommendations about the definition of care management

Many workshop participants shared a perception senior Australians, and their families may not understand the value of care management, further, they believe the role may use resources and funding that could otherwise be repurposed for additional services or products in the home.

Additionally, the workshop participants did not consistently differentiate between a care recipients' right to recipient-centred care and the way that care is managed i.e. managing their care themselves (or with their family and carers) versus having a care manager role supporting their care. Self management is seen by some as optimising the experience of recipient-centred care, leading to a strong position everyone should have the right to self manage their care (92% of workshop participants). At the same time, the role of a care manager as a partner to enable and advocate for and support the autonomy for the senior person is highly valued.

Given these positions, participants noted there is opportunity to:

1. **Highlight the value proposition of care management:** Strengthen how this role is described and positioned to senior Australians so people clearly understand the value of having a care manager.
2. **Define how care is supported by the role:** Clearly differentiate between the principle of recipient- centred care and care management, ensuring people understand the two are not mutually exclusive, rather that care management is one option available to support recipient-centred care. Clarifying this will allow senior Australians to make informed decisions about what level of care management they want to access (within their eligibility) and to what degree they want to self manage.

Summary recommendation

The term 'care management' does not resonate with everyone. There is a need to better define and position the difference between recipient-centred care and the management of that care. Revisiting the terminology is one way to provide better clarity. Introducing the term care partner could better represent the value of the role.

6 Accountabilities within a multiple provider environment

Theme overview

In the future, a multiple provider model aims to give senior Australians the flexibility to select the best provider for their specific needs as aligned to their care plan allocations.

A care manager should be responsible for deeply understanding the care recipient and their context, advocating for their care needs and ensuring they are receiving the right mix of care.

"Who is going to hold responsibility around services and follow up with the providers when there is an incident?"

"It would be a fantastic model if the right checks and balances were put in place."

Recommendations for establishing clear accountabilities

The ongoing role of the care manager should be to partner with the senior person to coordinate and monitor care between multiple providers and respond if there are concerns or when needs change. New frameworks for accountability and regulation will be required to provide **role clarity within a multiple provider environment to determine who is responsible and who is accountable for ensuring the best outcomes for senior Australians.** There will be new standards that support this, and an opportunity to consider how providers and care managers are regulated under the new *Aged Care Act*. While participants were not able to definitively solve the complexity of accountability in a multiple provider environment, the structure of accountability should consider the following:

1. **Care managers cannot be accountable for all aspects of care**: Participants strongly agreed care managers play an essential role but cannot be accountable for everything. There is potentially shared responsibility for many aspects of the role *(see following page for emerging accountabilities)*.

2. **Align accountability with care support intensity:** The accountability of care managers could align with the intensity of support they are providing recipients at different tiers. For example:

High intensity support	Low intensity support	Self management
The care manager is proactive and anticipates changing needs.	*The care manager is responsive to changing needs.*	*The care recipient is accountable for their decision to manage their own supports at home.*

3. **Enable independence of care managers:** This change could prompt independent care manager organisations that support seniors to access care from multiple providers, which was seen as beneficial by some participants. Structures of accountability should support recipient-centred care and ensure unbiased decision making by the care manager.

Survey Insight

The accountabilities most clearly attributed to care managers were:

- **Ensuring care is recipient-centred |**
  66% care manager 30% aged care provider 4%other
- **Triggering a reassessment before or in response to a crisis | 77% care manager**
  19% aged care provider 4%other
- **Responding to negligence or abuse |**
  66% care manager 26% aged care provider 8% other

Summary Recommendation

A multiple provider model requires clear processes and protocols for responding to emergent risks and changing needs. There should be systems to support communication, collaboration and information sharing between providers.

6. Potential accountabilities for different stakeholders

The engagement revealed some areas of agreement about the range of care manager accountabilities and how accountability and responsibility might be shared between care managers and providers.

ACCOUNTABILITIES IDENTIFIED	WHAT PARTICIPANTS NOTED
Responding to emergent risk and changing needs	*When a **care worker** observes a deterioration there should be clear processes in place to activate the **care manager** so they can respond.*
Triggering reassessment for senior Australians before or in response to crisis	*While the **care manager** may be accountable for triggering reassessment, the **care worker** also has a shared responsibility in raising the need for reassessment.*
Receiving and actioning senior Australian's complaints	*There should be shared accountability between **care managers** and **providers** to receive and respond to any complaints.*
Responding to negligence and abuse	*Responding to negligence and abuse should be the responsibility of **all**.*
Ensuring that care is recipient-centered	*Recipient-centred care is a principle of care at home. It is a **shared responsibility** to optimise recipient agency and choice at all levels of care.*
Supporting senior Australians making informed if risky choices	*The **assessor** should be accountable for ensuring self managing care recipients understand their rights and responsibilities and the principles of dignity of risk.*
Ensuring care is culturally appropriate	*Culturally appropriate care is a principle of care at home. **Care managers** should be accountable for determining what culturally appropriate care looks like to different recipients. In cases where a care manager is not attached to a particular provider, they may also assist in finding appropriate providers. All **service providers** should be accountable for delivering culturally appropriate care.*
The quality of the services delivered to the senior Australian	*There should be some shared responsibility between **care managers** and **care workers** to deliver quality care. Though ultimately the **provider** is accountable for the service they deliver.*
Effective two-way communication between the care managers and providers	*If the **care manager** is not getting good engagement from third parties, then that is a risk. There should be accountabilities on both sides to ensure communication does not break down.*
Support the client to make decisions around who is providing their care	*Carefully manage the communication and accountability systems to ensure the selection of providers is unbiased. It should be in the best interest of the senior Australian.*

6.

EMERGING CONCEPTS

Examples of accountabilities within a multiple provider environment

Mini scenarios discussed in the engagement provide concrete examples of how responsibilities and accountabilities might be shared between care managers and care workers. The Support at Home Program should use these scenarios to help test and validate the design for how accountabilities are structured.

Responding to emergent risk and changing needs

CARE RECIPIENT

I receive weekly support with shopping, transport and cleaning.

CARE WORKER

Responsible for noticing

I visit every week to provide transport. I notice the care recipient is finding it increasingly difficult to walk to the car.

If a care worker notices something of concern, there is a clear path to follow to ensure changing needs are recognised early.

CARE MANAGER

Accountable for responding

I receive a digital notice that my care recipient may be experiencing declining mobility. I call them to discuss their mobility.

There is a clear line of accountability for the care manager to:

- **Organise a reassessment**
- **Notify the client's GP of their concerns Use professional judgement to put in place immediate supports within the current care plan to help reduce the risk of falls**

Responding to negligence and abuse

CARE RECIPIENT

I receive weekly support from multiple providers. Recently a new provider started showering me, I do not like the way she talks about my body, I feel ashamed.

CARE WORKER

Responsible for noticing

I visit every week to provide care at home. I notice the care recipient is not showering. They tell me they do not feel safe with the other care worker.

If a care worker notices potential signs of abuse or neglect, there are escalation processes to follow to ensure appropriate action is taken.

CARE MANAGER

Accountable for responding

I receive a notification the care recipient may have a concern with a care worker. I call them to discuss their concern.

There is a clear line of accountability for the care manager to:

- **Notify the provider of concerns**
- **Escalate to regulatory bodies if required**
- **Monitor the safety of the senior person after a concern has been raised**

Make changes to their care to ensure their safety and to respect their choice

Ensuring care is socially and culturally appropriate

CARE RECIPIENT

I am a transgender woman. I know what support I need at home, but trust and psychological safety are very important to me.

CARE WORKER

Responsible for delivering a safe service determined by need

I understand from the care manager how to provide psychologically safe care to this care recipient. The care manager checks in with them to ensure they feels safe and provides me feedback accordingly.

CARE MANAGER

Accountable for determining need

I provide an open and safe environment for my care recipient to discuss their needs for psychological safety and what that looks like from the care they receive at home. I find care workers that are appropriate. I share information according to our agreement.

Lines of communication and information sharing between the provider and care manager ensure all are aware of the senior person's needs and context

Technology to enhance the role of care manager

Theme overview

In an environment where demand for care management is likely to exceed supply, technology has an important role to play in enhancing a care manager's connectivity with the multidisciplinary care team and oversight of senior Australian's care needs.

Integrated technology could boost workforce capacity, support real time data monitoring and sharing, and reduce administrative burden. It allows care managers to focus on their most important role, namely 'caring' for the senior Australian.

Furthermore, many participants noted they are beginning to see an increased level of digital literacy in the senior people being serviced in the aged care sector. Leveraging this will allow greater use of digital technology and tools to support recipient choice, help keep people informed, and facilitate feedback mechanisms.

"Technological innovations for monitoring are transformative for episodic care scenarios. It allows us to be on the front foot, so care managers can link in services as needed."

Recommendations for using technology to better support care managers

The following recommendations for leveraging technology to enhance the care manager role emerged from the workshop conversations:

1. **Real-time information sharing:** In a multiple provider model, participants stressed it is a high priority to ensure smooth communication and information sharing between care managers, providers, and the care recipients. This supports care delivery and shared accountabilities. There should be high-levels of interoperability of technology between partners to facilitate data/information exchange about the care needs, context, and ongoing health and wellbeing of the senior Australian.

1.1 Supporting accountabilities: Technology-supported information sharing was identified as a key element in deciding accountabilities. Participants noted care managers and providers cannot be held accountable if they are not provided with sufficient information to make decisions and act.

1.2 Automated notification and escalation: There is opportunity to use consumer profiles along with automated information sharing and escalation processes to raise and share red flags for elder abuse and changing need. For example, relevant providers are notified in real time of any changes to a person's care plan.

1.3 Digital support for continuity of care: There is an opportunity to design and implement effective communication systems and handoff processes that link care workers, care managers, assessors and care recipients. This should include strong feedback mechanisms between ground staff and policy makers.

Summary recommendation

Care management should be well supported with a digital solution for real time information sharing between stakeholders. Incorporating digitally enabled services and processes and assistive technologies could help alleviate workforce pressures and create more responsive care management service

8. Further considerations for care management

The co-design workshop participants raised a number of additional considerations that should be explored as part of finalising the model for care management in Support at Home. The following topics and prompting questions emerged:

Links between assessment and care management

Assessment was outside of the scope of this co-design engagement focus as other work is underway for assessment reforms. However, many participants felt strongly about the impact assessments will have on care management and service delivery. There should be greater integration and information sharing between assessors and care managers (and providers) to ensure the care plan is feasible to be implemented. Some initial ideas were shared:

- The assessor and care manager could be a shared role that is independent of provider organisations. There would need to be clear separation of duties, but a combined role would have accountability to see through from assessment to establishment of services (including having regard to availability and accessibility of services in rural locations).
- Wait times for reassessment should be shorter even if there is flexible care management to manage transitions. Having flexibility and focus on re- stabilisation by the care manager should reduce the burden on assessors.

What is the role of the assessor? Do they provide onboarding support and is there a need for ongoing care manager hours, or an allocation of hours in the establishment phase?

How do we ensure the vulnerability of a care recipient be addressed in the new assessment?

How will the care manager role work for rural and remote communities that have a lack of choice in services?

Risk management, incidents responses, and escalation processes

Risk management and incident response was discussed in the workshops, particularly with regards to accountability. The complexity of a multiple provider space should not be underestimated, and careful consideration should be made to ensure no unintended consequences arise. In addition to integrated processes, participants stressed there needs to be enough resourcing support for all providers to adequately identify and respond to risk incidents. Where there is a problem with the care manager, an independent process to report and respond should be available.

Who holds responsibility for following up with providers when there in an incident? How does this integrate seamlessly with the Serious Incident Response Scheme? How is the Quality Agency involved in this process?

How might risks be better managed to ensure people do not slip through the cracks? Who is accountable for risk when care recipients are self managing?

Funding model for care management and Support at Home

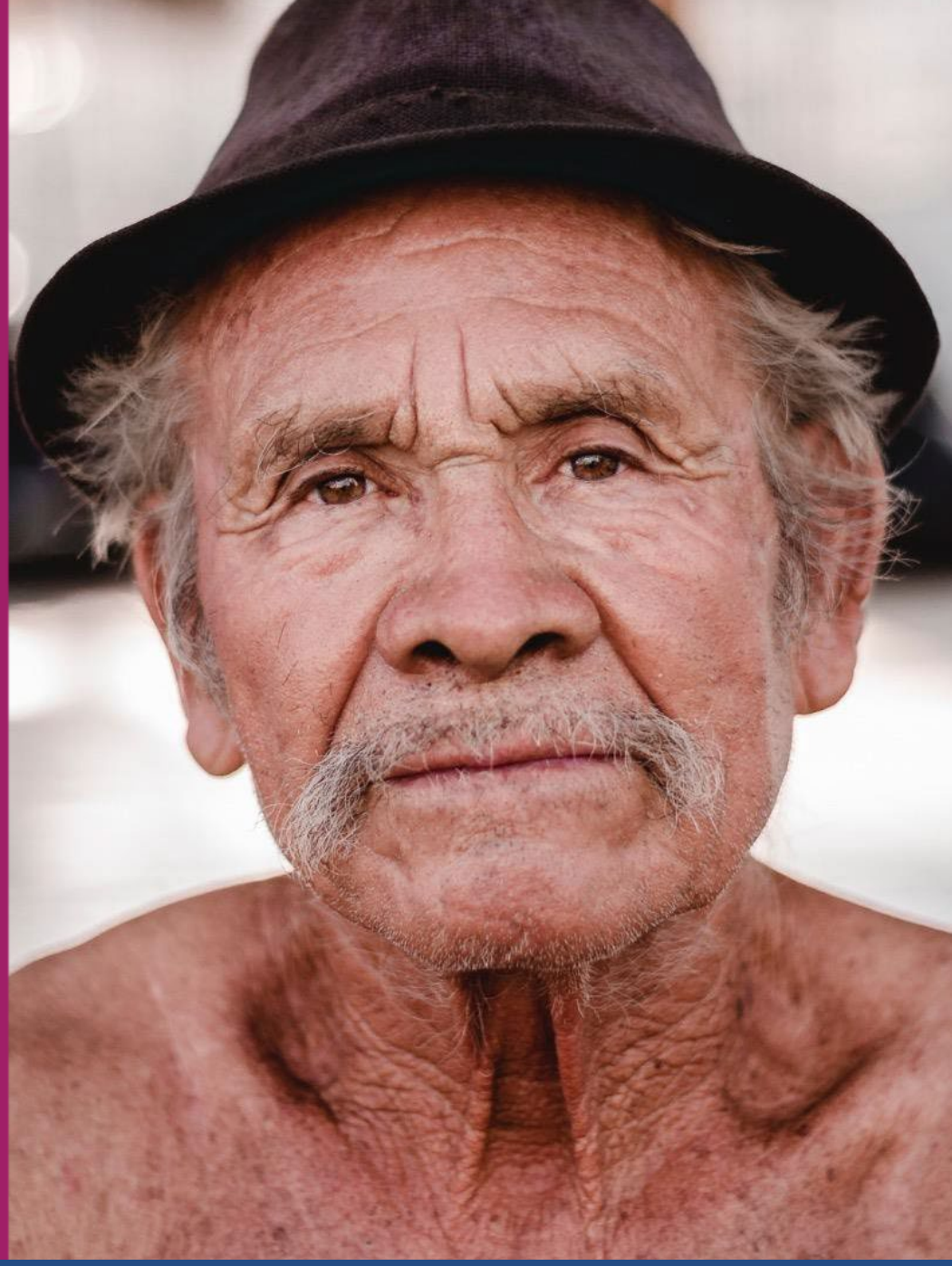
There is adjacent consultation occurring to consider the implication of the reforms to the funding model. However, throughout these engagements participants did express there must be consideration of the additional support load many providers face to help coordinate and respond to indirect care recipient requests and other information they may gather or receive about the senior Australian.

If care management is funded externally, how might providers be paid when their client has complex needs and purchases a number of services?

What is the funding consideration for the potential burden on providers where care recipients are self managing?

SECTION 2

Project intent and approach



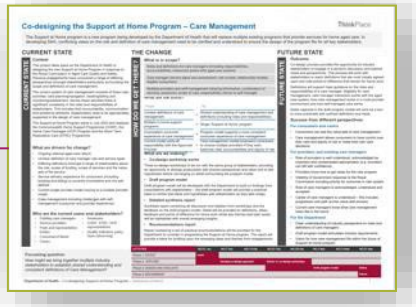
Process design journey

Intent | Explore | Design and evaluate

Intent

Intent meeting and initial project briefing.

An intent session with the Department of Health and Aged Care to define the current state, the change needed, and the desired future state.



Designing the workshops

Collaboratively design the co-design workshop plan.

Work with the Department of Health and Aged Care to co-design the workshops and tailor a series of activities to ensure we cover all the content and questions to achieve the required outcome.

Finding context

Workshop 1

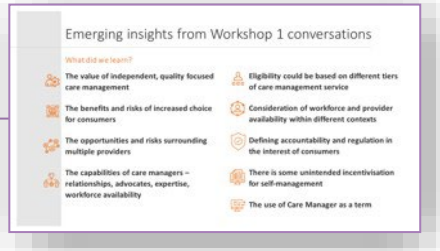
Explore the context of what care management is now and could be in the future.

The workshop participants consider what questions need to be asked when designing the future state of care management in Support at Home.

Find insights

Synthesise the findings from workshop 1 and identify overarching insights.

Identify insights to capture the current challenges and important future opportunities that might be leveraged by a new model for care management.



Process design journey

Design and evaluate

Recommend

Exploring possibilities

Workshop 2

Explore design questions for care management in the new program.

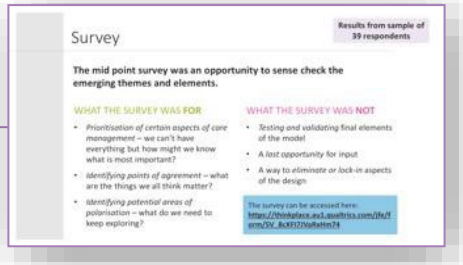
Participants explore different elements and aspects of care management and consider how these might be structured when redesigning this function and service for the Support at Home Program.

Understanding perspectives

Survey

Survey to test the emerging design concepts from workshop 2.

To identify areas of alignment across the broad stakeholder perspectives. It also shows what elements and concepts of the care management function have divergent opinions, which informs the focus for the final workshop.



Testing hypotheses

Workshop 3

Concepts from the first two workshops are refined into hypotheses about how care management might work in the future.

Participants test hypotheses and models to understand realistically how these could work, if they would work and what might need to be refined further to ensure success.

Putting it all together

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This final report provides a synthesis of the conversations and concepts that emerged through the co-design process.

This report provides input to inform the design of the care manager role, ensuring it is created through a collaborative and industry informed perspective.

Conclusion

In-home aged care reforms provide a significant opportunity to reimagine and improve how senior Australians receive aged care services at home.

This co-design process is one component of a series of consultations the Department of Health and Aged Care is conducting on the proposed program design for Support at Home. The Department welcomes further feedback from stakeholders on the recommendations included in this paper during this phase of program development.

The engagements brought together diverse perspectives and indicate points of alignment and polarised perspectives.

We have heard about the dynamic needs of the senior Australians and their carers, the varied context of different types of providers, the lessons and experience of current care managers, and the perspectives of other important stakeholders, such as assessors, industry peak bodies, regulators and other people or organisations that shape the aged care system.

The collaborative conversations and survey show where there is strong alignment about what should be within the scope for the care management role. We have identified aspects care management should clearly not be responsible for. Similarly, there are elements that are particularly challenging to define, however the co-design process was able to uncover options and considerations within these areas of complexity and polarised opinion.

The ideas and recommendations in this report should help to inform other parts of the Support at Home Program. As new parts of the program are designed, this too will help in solidifying the most appropriate model and approach to take for the future of care management.

Artwork: Spirit People by Phyllis Gorey

This story relates to our spirit ancestors, who walk among us as our guides. The circle in the centre is the main base camp for the spirit people. They walk with us always in our travels. The dots represent the ancestors, while the black dots represent us. The four circles depicted in each corner of the artwork represent our camps we live in. Our spirit ancestors come and take our loved ones, who have passed on and take them back to the main camp (centre) with them.

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