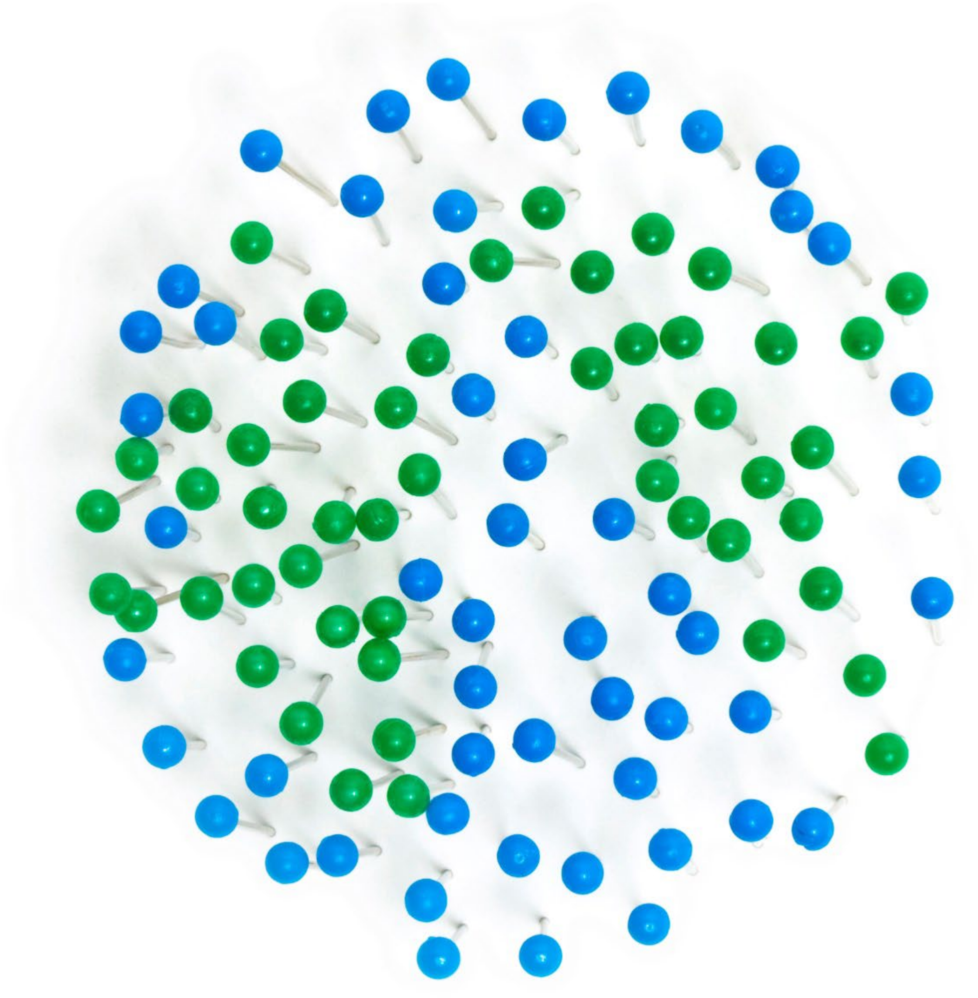


Evaluation of Phase One of the Specialist Dementia Care Program

Summative Report

April 2023

Contents

Glossary

Acronym/Term	**Full name**
ACT	Australian Capital Territory
BCR	Benefit cost ratio
BPSD	Behavioural and psychological symptoms of dementia
CAC	Clinical Advisory Committee
CNS	Clinical Nurse Specialist
CRT	Clinical Review Team
DSA	Dementia Support Australia
EN	Enrolled Nurse
NBA	Needs Based Assessment
NPI-NH	Neuropsychiatric Inventory – Nursing Home Version
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
RACF	Residential aged care facility
RN	Registered Nurse
SA	South Australia
SDCP	Specialist Dementia Care Program
SDCU	Specialist Dementia Care Unit
TAS	Tasmania
The Department	Australian Government Department of Health and Aged Care (formerly the Australian Government Department of Health)
VIC	Victoria
WA	Western Australia

Executive Summary

Background and scope

To better meet the needs of people with very severe behavioural and psychological symptoms of dementia (BPSD), the Australian Government established the Specialist Dementia Care Program (SDCP or 'the Program'). Each SDCP provider site (a Specialised Dementia Care Unit (SDCU)) offers these individuals tailored residential support, focused on reducing or stabilising symptoms over a period of approximately twelve months, with the aim of supporting their transition to less intensive care settings. As part of Phase One of the Program, ten SDCUs were established across Australia over the period 2019 to 2020.

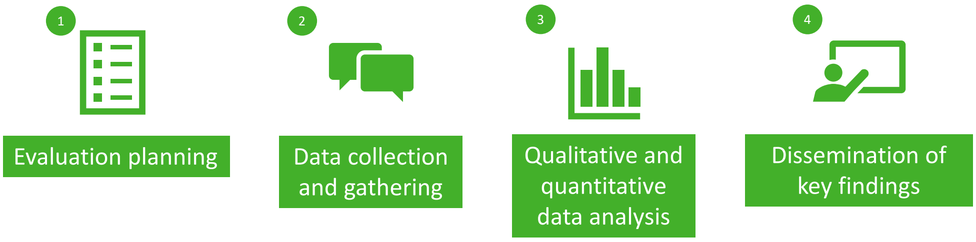
In July 2019, the former Australian Government Department of Health, now the Australian Government Department of Health and Aged Care (the Department) also engaged Deloitte Access Economics to undertake an evaluation of Phase One of the Program in order to generate contemporary evidence on the implementation, outcomes, and impact of providing tailored residential support for people with very severe BPSD. The evaluation activities and reporting schedule was staggered over a three-year period and comprised three annual reports.

- **Interim Report (2020) [SUBMITTED]:** The 2020 Interim Report focused on reviewing the implementation of the first 6 to 12 months of the first SDCU (Brightwater) and the NBA service.
- **Interim Report (2021) [SUBMITTED]:** The 2021 Interim Report focused on reviewing the implementation of all Phase One SDCUs, providing a summary of Program awareness, adoption, appropriateness of the model of care and clinical governance, fidelity to Program design and intent, and the key lessons learned.
- **Final Summative Report (2023) [THIS REPORT]:** This report updates the findings from the Interim Report, however mainly focuses on evaluating the Program outcomes achieved for residents and their carers and families, Program providers, and the broader health and aged care system.

Methodology

Deloitte Access Economics undertook a four-stage approach to inform this Report, as shown in Figure 1.1 below.

Figure 1.1 Evaluation approach



A mixed-methods approach was adopted, drawing upon a range of primary and secondary data sources. For this Report, primary data collection included stakeholder interviews and a survey administered to Program staff. Overall, the following stakeholders were consulted:

- SDCU staff, program managers and multidisciplinary in-reach clinicians
- needs based assessment (NBA) service program managers and assessors based across the country
- family/carers of current and former Program residents
- the Department's SDCP Project Team.

Insights gleaned through these primary data sources were triangulated with analysis of the following secondary data sources.

- **Six-monthly performance reports from SDCUs and the NBA service.** Report contents included de-identified information on client admissions, staff recruitment, the operations of the Clinical Advisory Committee (CAC), lessons learned, and emerging challenges.
- **NBA referral data.** Data included information on the number of referrals by organisation and region, the timeliness of the referral process, and eligibility decisions.
- **Clinical data from SDCUs.** Data included operational documentation (e.g., documented care processes, protocols and decision-making frameworks) and de-identified data related to outcomes of interest including clinical incidents.

Across the length of all evaluation activities over 3 years, 160 stakeholder interviews were conducted, and 2 staff surveys were administered to SDCU Program managers, clinical nursing staff, care staff, allied health staff, and in-reach specialist clinicians. These surveys achieved over 80 responses in total.

Evaluation findings

Referrals and transitions in

Program awareness and adoption

- Over the period September 2019 to June 2022, the Program received almost 1,000 referrals from either inpatient settings or mainstream RACFs. Growth in the volume of referrals coincided with the opening of new SDCUs before reaching a relatively steady volume per quarter in early 2021.

- Referral patterns by referrer type have become more balanced over time, shifting from around 70% of referrals originating from inpatient settings in 2019 to around 50% over the past 12 months. This supports insights gleaned through consultation that awareness of the Program has grown steadily across mainstream RACFs.

- When examining observed demand for the Program (proxied by referrals) compared to the supply of Program bed-days, it is theorised that referrals may be a reaction to perceived supply (i.e., referrers are encouraged/discouraged based on the perception of SDCU availability). ACT had both the highest number of referrals and the largest Program capacity relative to its estimated population with dementia. Of jurisdictions with SDCUs, NSW has both the smallest Program capacity and the lowest number of referrals relative to its estimated dementia population. It is acknowledged that separate to the Program, overall jurisdictional capacity to support people with very severe BPSD includes other services (e.g., Older Persons Mental Health services in NSW), which may influence observed Program demand. Phase Two intends to establish three additional SDCUs in NSW, one additional SDCU in WA, VIC, SA, ACT and the first SDCU in TAS. These sites are expected to become operational across 2023, with Program referral rates rising in response to increased Program capacity.

- Of the ~1,000 Program referrals received over the period September 2019 to June 2022, approximately 1 in 3 were assessed for suitability by an SDCU. Of those assessed for suitability, just over 1 in 2 were placed in a SDCU. This results in an overall placement rate of 1 in 5 referred to the Program.

    - The main reason a referral did not progress to an SDCU suitability assessment related to behaviors being ‘too mild’ (as assessed through the NBA service) and thus not meeting the Program eligibility criteria.
    - The main reason a SDCU suitability assessment did not progress to an offer of placement related to concerns the resident was a poor ‘fit’ within the current SDCU dynamics of existing residents and staff.
    - Families/carers were highly receptive to the concept of the Program and offers of placement were typically only declined due to distance reasons.

- Concurrent with increasing numbers of NBA referrals, the proportion of NBA referrals deemed eligible for assessment has declined across the length of the Program. This may be attributed to a high proportion of new referrers who are less familiar with the Program scope and eligibility criteria.

- Several strategies were identified as key enablers in driving Program awareness and referrals over the duration of the Program. These included leveraging networks of in-reach clinicians, building relationships with social workers in in-patient settings, leveraging networks in PHNs, integration with DSA and provider-specific promotional activities.

- At this stage of the Program, nine out of ten SDCUs had reached capacity (i.e., filled all beds at one time). However, there was wide underlying variation in the time taken to achieve this metric, with one SDCU at approximately half-capacity after more than two years. The following themes contribute to this variation:
    - **Provider risk appetite.** Many SDCUs slow to reach capacity had declined placement for residents assessed as eligible by the NBA service on the basis of poor 'fit' with the current resident and staff mix, as well as a view that some residents' needs were too complex and would create unnecessary risk for the provider. This supported insights from consultation that significant variation in risk appetite existed across SDCUs.
    - **Unique barriers that exist in regional areas.** People in regional and rural areas can face additional challenges in meeting the NBA eligibility criteria where there is limited presence of a psychogeriatrician (or other relevant specialist) in their location, which is required as part of the Program eligibility criteria. Stakeholders noted that consultants administering the NBA process had worked collaboratively with patients, family members and health care workers in order to address this challenge.
- A separate measure of Program uptake is SDCU occupied bed-days (i.e., the annual occupancy rate). The Program's overall occupancy rate has improved markedly since Program inception, from 41% in FY20 and 54% in FY21 to 85% in FY22.
- The concept of the Program was well-received by families/carers, with offers for assessment typically only declined for distance reasons.

Timeliness and coordination of referral and transition-in process

- Stakeholders broadly agreed that the NBA process is working efficiently and effectively, although limited data availability and information-sharing across care settings remain the primary barriers to timely and comprehensive NBA assessments.
- Stakeholders broadly agreed that following client acceptance, the process for transition in is working well. For most SDCUs, the success of the transition in process has evolved and matured over time. Key enablers to the success of these transitions include:
    - **In-person provider assessments.** In-person assessments conducted by clinical representatives from the SDCU (following the initial needs-based assessment) are helpful in informing 'fit' discussions at CAC meetings.
    - **Early communication and expectation-setting with families/carers.** Stakeholders observed that family/carer buy-in at the outset is critical, with in-person site visits prior to placement a key enabling factor. Stakeholders also commented on the importance of setting pre-admission expectations with families/carers relating to the 12-month nature of the service model and what can be realistically achieved for residents.
    - **Socialising client information with staff pre-admission.** Routine discussion among care staff of a resident's unique needs and preferences prior to their placement (informed by NBA reports, observations from the provider's in-person assessment, and handover documentation from the referring facility) can help to increase staff confidence in their ability to manage resident behaviours.
    - **Flexible resourcing to support admissions**. Many SDCUs identified a need for extra resources on admission days, as newly admitted residents typically require more supervision as they adapt to the new environment.
- Patients from regional and rural areas can face additional barriers to timely access to the Program. The referral and transition in process was noted to be resource-intensive, from both a financial standpoint as well as due to difficulties coordinating this process. In addition to challenges sourcing specialist input (as described above), further issues noted included:
    - **Staff shortages.** Stakeholders observed staff shortages had contributed to the sole regional SDCU having to manage their Program occupancy in line with staff-patient ratios. It is noted however that labour shortages are not unique to the sole regional SDCU, and have been experienced more broadly across the aged care sector, particularly over the last several years.

  - **Additional resources required for long-distance transport.** The longer journeys to the SDCU from regional and rural areas can be more expensive and difficult to coordinate. Due to severity of BPSD, residents can also find long journeys distressing and may require sedation to ensure staff and resident safety, creating additional clinical considerations.

Delivery of care

Program resourcing

- High staff/resident ratios were considered a key enabler to Program success. Stakeholders observed that compared to mainstream RACFs, the Program ratios allowed for: greater levels of supervision; more time for staff to engage in person-centered care; more time to develop a better understanding of residents' needs and triggers; and improved continuity in care – which supports resident progress as they feel more familiar and comfortable with the staff delivering care.

- Strong Registered Nurse (RN) presence was also cited as critical to Program success, however the presence of a dedicated RN at each SDCU varied. Some sites had a SDCU-dedicated RN available during morning and afternoon shifts working in a unit leadership or clinical coordinator role. However, other SDCUs had reduced RN presence, with one SDCU led by an Enrolled Nurse (EN) with support from an on-call RN working across the broader facility.

  - Stakeholders across all sites felt that a dedicated SDCU RN was important for the success of the Program, with the RN playing an important role in care quality and safety, the security of residents and staff, maintenance of detailed clinical documentation, and in upskilling ENs and care staff.
  - The SDCP Framework requires "availability of a RN on-site 24 hours a day". Ambiguity in whether this means SDCU-dedicated or co-located with the provider's mainstream RACF is a likely reason for variation. Almost all in-reach clinicians emphasised that the specialist nature of the Program imposes an obligation on SDCUs to ensure an appropriate clinical staffing mix.

- Attrition of care staff was cited as a challenge faced by many sites. This appeared to be driven by an unfavourable risk-pay trade-off, when compared to working at mainstream RACFs. Remuneration for care staff is determined by providers rather than set by the Program. As a result, for providers to avoid administrative costs associated with high staff turnover, additional monetary incentives for care staff may be required.

- The staffing profile and input of in-reach clinicians is relatively standardised across SDCUs in metropolitan areas. Across most SDCUs, stakeholders reported employing a psychogeriatrician, geriatrician or psychiatrist who attends the SDCU one day per week to review each resident's care plan, participate in CRT meetings and provide consultation and education to care staff. For the sole regional SDCU, a clinical psychologist provides in-reach services.

Care service model

- Stakeholders across all SDCUs commented on the in-reach clinician model as a major strength of the Program. The support provided by the in-reach model was cited as a strength for the following reasons:

  - **Transitions in and out.** In-reach clinicians help to facilitate a seamless transition in process, particularly when the transition is from an inpatient facility. In addition, they have knowledge of appropriate external discharge options and help to ensure discharge planning is commenced early.

  - **Upskilling staff in the management of very severe BPSD.** In-reach clinicians play an important role in upskilling care staff in behavioural management approaches for very severe BPSD, both formally and informally.

  - **Instilling confidence in families/carers.** The in-reach clinicians help to instill confidence in families/carers on the specialised tertiary-level support provided in the SDCU, despite being in a mainstream RACF.

- Competence and confidence of care staff appears to have improved over time, however many stakeholders highlighted training of care staff in the management of very severe BPSD as an opportunity for improvement. A handful of SDCUs reported high levels of care staff confidence and competence in behavioural management for very severe BPSD. Effective methods for upskilling staff at these SDCUs mostly related to informal capacity building and on-the-ground mentoring. Approaches found to be effective included:
    - **Routine processes for debriefing with care staff.** Stakeholders at some SDCUs reported embedding debrief opportunities into regular team processes (e.g., post incident or as part of CRTs) to enable care staff to learn through reflective practice and real-life case-based discussions.
    - **Employing a dedicated nurse educator role.** Clinical in-reach stakeholders at these SDCUs observed the role has helped facilitate more proactive, timely and coordinated care.
    - **Using the CNC in an educator capacity.** Several sites highlighted the important role of the in-reach CNC in the provision of ad-hoc advice to nursing staff on best-practice behavioural management techniques. However, there appeared to be variation in the extent to which this occurred across SDCUs, with some CNCs perceiving their role to be more clinical than educational. Clarity in MoUs on the educator function of the CNC may help mitigate this challenge.
- There was broad agreement across stakeholders consulted that SDCUs deliver a more person-centered approach to care relative to mainstream RACFs. This was largely attributed to the staffing ratios which allow care staff to spend more one-on-one time with each resident. However, there are opportunities for improvement at some SDCUs.
- Stakeholders generally felt SDCUs needed additional enrichment activities. This was highlighted in the context of its important role in diverting behaviours of concern for people with very severe BPSD. In-reach clinicians noted that while most SDCU staff have experience working in aged care roles with a focus on personal and clinical care, the SDCU requires a more holistic approach that should include a recreational focus.
- Families/carers were broadly satisfied with their involvement in care decisions. The majority of families/carers were highly satisfied with the level of communication from SDCUs in relation to ongoing care planning. However, there is an opportunity to improve the timeliness of family/carer input into the initial care plan in some SDCUs, as some families/carers reported they were only invited to inform care planning several months post admission.

Clinical governance

- Across most SDCUs, stakeholders generally agreed that clinical governance mechanisms are working well. Overall, it was agreed that Clinical Review Teams (CRTs) and CACs broadly occur as intended, with CRTs typically occurring weekly and CACs monthly. Stakeholders felt that clinical governance mechanisms are appropriate and responsive to the Program model of care, with CRTs providing an opportunity to discuss client progress and clinical decisions (e.g., deprescribing), while CACs provide a forum to discuss placement decisions.
- Care staff input into client progress discussions is important for ensuring care is tailored to individualised needs and preferences and Phase Two sites should be encouraged to find ways to support this model (either by engaging them in CRTs or through routine debriefing sessions). It was noted that the benefits of this are two-fold:
    - First, care staff are involved in day-to-day care provision and have important and valuable insights to share regarding symptoms, and what behavioural management strategies are working.
    - Second, involvement in these discussions provides an important capacity building opportunity for care staff that would better enable them to care for a client cohort (i.e., people with very severe BPSD) with whom they typically have limited experience.
- Several in-reach clinicians observed a need for a regular Clinical-In-reach Community of Practice, given the target cohort requires specialist expertise, and in some cases, peer review to support clinical decision making. These stakeholders felt that clinical care in the dementia field, and the aged care sector more broadly, is siloed, with few opportunities for knowledge-sharing and consultation with peer practitioners. It is noted that since stakeholders were interviewed for this Report, the Department has commenced facilitating a regular Clinical-In-reach Community of Practice.

Transitions out and bounce backs

Timeliness and coordinating of discharge

- Over the period September 2019 to June 2022, 99 discharges (or separations from the Program) occurred. Almost two-thirds of these discharges (62) were due to settled BPSD. Although the remaining 38% of residents separated from the Program due to a reason other than settled BPSD, many typically separated due to death, the need for palliative care or a change in care needs (due to exacerbation of a comorbidity), as opposed to an exacerbation of BPSD. However, it should be noted that it was not possible to accurately quantify the proportion separated for each individual reason, due to variances in how SDCUs reported the 'other' reasons for discharges.

- Of the 62 residents discharged due to settled BPSD, almost 80% were discharged to a mainstream RACF operated by the same provider. Stakeholder consultations indicated that the majority of these discharges were transitioned to the provider's co-located mainstream RACF.

- The Program design feature allowing residents to transition to a co-located mainstream RACF operated by the same provider was recognised as a key Program success factor. Stakeholders noted a reluctance among mainstream RACFs to accept people with very severe BPSD, even where their symptoms had settled. Historically, this resulted in prolonged multi-year stays in acute care settings. The Program is able to overcome this challenge by co-locating the SDCU with a mainstream RACF (operated by the same provider) and offering placement at this facility post-Program. In addition, the internal transfer offers a more seamless continuity of care experience for the resident and their family/carer, while also aiding long-term symptom management as Program staff can more easily support care staff in the receiving facility.

- Stakeholders felt the majority of transitions out were successful and largely well-coordinated. Success factors included: early discharge planning; use of structured shared-care templates detailing resident needs, preferences and effective behavioural management strategies; and commitment to outreach and capacity building with staff at the receiving facility.

- Stakeholders early in the Program's implementation observed that where an external transition is required, it can take time to identify a suitable RACF discharge, causing prolonged stays in the SDCU. It was suggested that, as the Program grows, there may be an opportunity to consider use of a social worker (at a jurisdictional level) familiar with the local RACF landscape to support SDCUs with external transitions.

- Anecdotally, stakeholders observed that the majority of residents discharged to less intensive care settings due to settled BPSD remained stabilised in their discharge location. However, stakeholders also highlighted that mainstream RACF dynamics are an ongoing risk to sustaining settled BPSD post-Program. It is thus suggested that ways to monitor resident progress post-Program be investigated and considered. If such information was able to be collected on a more routine basis long-term, it could then be used to inform an assessment of whether a risk-stratified step-down discharge approach should be considered for certain high-risk clients. This information is also critical for informing a true understanding of the Program's clinical and economic value. See Recommendation 12.

Program administration

Program administration

- Stakeholders were largely satisfied with the overall management of the Program. Key enablers included early and regular engagement between the Department and providers, and ongoing commitment to knowledge sharing across SDCUs.

- Several barriers limited the collection of unit record data over the length of the Program including capacity limitations within SDCUs, unique data collection systems and data archiving processes. There may be an opportunity to strengthen data management and reporting systems within the Program to increase the type and consistency of data collected and support future evaluation activities.

Program costs

- Program costs and the design of the funding model were broadly perceived to be appropriate. However, it was noted that the financial viability for certain SDCUs was impacted by slow uptake. In addition, there is an opportunity for the Department to consider whether they should provide further guidance to SDCUs on optimally funded staffing levels, and whether it may be appropriate to move to tiered transition-out payments depending on the complexity of the discharge.

- The retention of care staff may require incentives to offset the perceived risks of working at the SDCU. Although some SDCUs reported higher levels of staff confidence and skill level and lower levels of care staff attrition over the course of the Program, there continues to be perceived safety risks in working with the resident cohort when compared to roles within mainstream RACFs for comparable pay.

Program scope

Recommendation 16 (Section 1) of the Royal Commission into Aged Care Quality and Safety states that[1]:

"By 1 July 2023, the Australian Government should review and publicly report on … the capacity of [SDCUs] to address the needs of people exhibiting extreme changed behaviour and whether further resources are required, and the suitability of SDCUs to support shorter stay respite for people living with moderate to extreme changed behaviour."

To support the Department's overall activities regarding this Recommendation, additional questions were included in the stakeholder consultation process for this report. A summary of the findings is provided below, with additional detail contained in Chapter 9.

Expanding the Program scope to include people exhibiting Tier 7 (extreme) BPSD

There was broad consensus among stakeholders that the current Program would not be suitable for people with Tier 7 BPSD. Stakeholders felt that:

- the current staffing profile of SDCUs, in particular the lack of 24/7 medical support and security personnel, is not equipped to provide quality and safe care to this cohort
- caring for Tier 7 residents would require higher staffing ratios above what the SDCUs provides
- current care staff were not equipped to manage Tier 7 BPSD residents, given the need for more specialised training.

Provision of short-stay respite

Stakeholders acknowledged there is a strong need for further support services targeted to carers of people exhibiting moderate to extreme BPSD, including across mainstream RACFs and people being cared for in home settings. However, there was strong consensus among stakeholders that providing short-term respite through the Program would be too

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[1] Royal Commission into Aged Care Quality and Safety (Final Report, March 2021) Ch 3.

disruptive to the respite resident, the Program residents, and may impact Program uptake. Stakeholder views included that short-term respite would:

- exacerbate respite residents’ BPSD due to transferring them in and out of the SDCU over a short period of time
- exacerbate Program residents’ BPSD, given their behaviours are heavily impacted by changes to the resident dynamic
- have broader implications on Program uptake, including increased waitlist times and difficulties discharging respite residents from the SDCU.

Program outcomes

Program residents

Settled BPSD behaviours

62% of residents that separated from the Program were transferred to less intensive care setting due to settled BPSD symptoms.

*For the remaining 38% of discharged residents, due to the age and medical complexity of Program residents, factors external to the Program were commonly stated as the reason for separation (e.g. death, need for palliative care, acute medical event).

Case study data on resident trajectories while in the Program showed a reduction in behavioural incidents, including agitation and aggressive behaviours.

Quality of life

Over the a resident's stay in the Program, stakeholders observed

- Improved mood and demeanour
- Increased socialisation
- Higher autonomy and freedom
- Decreased desire to leave
- Improved engagement in recreational activities
- Improved personal hygiene and comfort

Improved access to specialised care that meets care needs

☑ Increases local care options for people with very severe BPSD – with higher staffing ratios that enables more person-centred care

☑ Provides a bespoke model that enables reduced the use of chemical restraints

☑ The co-located nature of the model Increases access to mainstream RACF options long term once BPSD symptoms have settled, thereby reducing strain on acute care services

Families and carers

Improved mental health and wellbeing

Since their loved one was admitted to the Program, the majority of family/carers reported:

- a reduction in distress and caregiver burden
- an improvement in overall wellbeing.

This was attributed to:

- Relief from finally being able to access a specialist care option in a residential setting
- Reduced need to coordinate care for their loved one
- Reduced reliance on sedation to manage behaviours
- Improved socialisation and improved relationships with their loved one

Stronger support network

The Program provided an important source of **psychosocial support** and guidance for families/carers of Program residents, who often had distressing prior experiences in the health and aged care sectors.

The majority of family/carers felt more **listened to, respected** and **supported by staff** within the Program, compared to mainstream RACF care settings.

This was attributed to:

- Higher staffing ratios with regular tertiary-level specialist clinical input
- Strong focus on person-centred care and supported decision making under the model of care

Program staff and services

Staff capability and job satisfaction

The Program has supported:

Uplift in staff capability and confidence in caring for residents with very severe BPSD due to the strong focus on informal capacity building from in-reach clinicians and clinical leaders

Strong sense of job satisfaction and pride among SDCU staff, in-reach clinicians and provider-site management

Knowledge spill over of best-practice dementia care

The Program provides an opportunity for knowledge-spillover throughout the broader aged care sector through:

- acting as 'centres of excellence' and contributing to the evidence base on best-practice management of very severe BPSD
- multidisciplinary focus in the model of care which fosters knowledge-spillover across disciplines and care settings, creating broader capability uplift in the management of moderate to very severe BPSD more broadly
- providing direct education and upskilling opportunities to mainstream RACFs through post-discharge support.

Government

Quality of use medicines

The Program supports the quality use of medicines through:

Reduced use of psychotropics and pharmacological intervention due a model of care with better enables use of behavioral strategies to manage behavioral incidents

More timely and tailored medication reviews due to the high staffing ratios and regular specialist clinical input.

Avoided use of hospital and health services

Benefit-Cost Ratio = ~1.5

When operating near capacity the Program generates a significant return on investment for government.

If SDCUs had operated at full occupancy, it is estimated that the Program would have generated $1.46 to government for every $1 invested (i.e., a benefit-cost ratio of 1.46), using a time horizon that included 9-months of post-program benefits. This ratio increases to 1.76 when the time horizon is expanded to 18-months post-Program.

The size of the benefit cost ratio increases in line with the benefits realisation time horizon, as the primary value of the Program is its role as the only current intervention in Australia able to facilitate transition to a less intensive care setting *long-term*. By doing so, it results in significant avoided costs to the health system, given that in the absence of the Program, many Program residents would require long-stay psychogeriatric care in an inpatient setting.

Opportunities to strengthen Program outcomes moving forward

☑ Staff capability building:

Though staff competence and confidence had improved, it remains an area for improvement. Stakeholders across several SDCUs reported a desire for further formal training for Program staff in several areas, including risk management and escalation processes, delivery of person-centred care and behavioural management strategies.

☑ Regional and rural applicants:

Patients in regional and rural areas can face additional barriers in accessing the Program due to fewer referrals in their region, lower access to specialist input to satisfy the Program's eligibility criteria, and challenges associated with long-distance travel to transport residents to the SDCU.

There is an opportunity to explore the barriers faced by people in regional and rural areas which can decrease their access to the Program.

☑ Residents that are less responsive to the model of care:

There is a small proportion of residents whose behaviours do not settle over time. Certain stakeholders identified particular dementia types as potentially less responsive to the model of care, whereas other stakeholders believed such residents' resistant behaviours may be driven by comorbid conditions (e.g. a concurrent mental health condition).

In these situations, some residents require a prolonged stay in the SDCU due to difficulties discharging them into mainstream RACFs. Further exploration of care needs for these residents will help to identify opportunities to support SDCUs caring for this cohort.

☑ Data capture to further communicate Program outcomes:

Several barriers limited the collection of unit record data over the length of the Program, which impacted the ability to quantify several Program outcomes. Strengthening data management and reporting systems within the Program would increase the type and consistency of data collected and support future evaluation activities.

Implications for ongoing implementation

The evaluation identified the following opportunities to enhance the ongoing implementation and sustainability of the Program:

Department level

Referral and admission

1. Continue to work with DSA and SDCUs to create standardised promotional materials and informational resources regarding the referral and transition in processes to support future site openings. This should enable consistent messaging across sites (both within and across jurisdictions), support further education to prospective referrers around the eligibility criteria, ensure that providers have a consistent understanding of the target Program cohort, and reduce duplication of effort across SDCUs.

2. Continue to work with DSA and the existing and future regional SDCUs to identify and find solutions to unique barriers impeding timely referral, assessment and admission.

3. Consider providing increased guidance to SDCUs regarding the recommended frequency of CAC meetings, to create more standardisation across sites and improve the timeliness of suitability assessments.

Care delivery

4. For Phase Two sites, promote the importance of the in-reach clinicians' role in capacity building of care staff related to behavioural management. This could include highlighting the expected educational aspects of the role in discussions with the jurisdictional mental health agencies and including it in the Memorandum of Understanding.

5. Examine the feasibility of recommending the need for a SDCU dedicated FTE RN (as opposed to a co-located RN) once a site reaches full occupancy. Also consider promoting high staffing ratios for afternoons and evenings (e.g., a dedicated recreational staff member for afternoon shifts).

6. Consider the need to provide further clarity on expected formal training standards for care staff. As part of this, the Department should consider centralising training in behavioural management and offering it a national level.

7. As the Program grows (i.e., when Phase One sites reach full occupancy and Phase Two sites open), monitor the feedback provided by SDCUs related to their deployment of social workers within the model of care. Given stakeholder observations related to social workers supporting resident engagement, providing targeted psychosocial wellbeing support for Program staff and family/carers, and helping families and carers navigate the

transitional nature of the Program, continued positive feedback may warrant revised guidance around this role in the Framework.

8. Given variation in staffing arrangements across SDCUs, consider utilising the Audited Financial Acquittal reports to better understand how Program funding is being utilised across sites. This may reveal opportunities to provide further guidance to SDCUs on how the funding should be used to support adequate staffing levels. In addition, seek to understand the types of discharges that require additional financial support to inform whether a tiered approach to transition out payments (based on discharge complexity) may be appropriate.

9. Work with current SDCUs to explore the criteria each SDCU uses to monitor residents' progress and determine readiness for discharge. Identify any opportunities to apply these learnings to inform care planning processes for Phase Two sites.

Data collection

10. Consider providing standardised training to SDCUs on administration of the NPI-NH assessment tool and promote the consistent capture of NPI-NH scores at a domain level (particularly the domains related to aggression and agitation) in order to facilitate stronger resident monitoring and evaluation of Program efficacy.

11. Work with providers to understand current approaches to capturing aggregate data as part of their existing reporting obligations (e.g., National Aged Care Mandatory Quality Indicator Program (NACMQIP) and identify mechanisms which may allow this data to be provided for SDCUs. For example, consider whether it is possible for providers to insert a flag for an SDCU within the data systems used to capture these indicators. While the NACMQIP indicators will not provide a view on the Program's impact on residents over time, it will provide a view on the annual prevalence of incidents (e.g., falls, physical restraints, hospital presentations etc.), which could be used to profile how patterns of behaviour in an SDCU differ to those observed in mainstream RACFs.

12. To supplement insights from the NPI-NH on resident progress, consider selecting a small set of outcomes measures and work with SDCUs to consistently collect and report on these indicators at a resident level as part of six-monthly reporting. Suggested outcomes include:

    - number of ED presentations and unplanned admissions (including length of stay) during Program tenure
    - medication variances by drug class for discharging residents (e.g., 'reduction in dose' of antipsychotic) – to assess reduction in chemical restraints
    - discharge reason, where the following reasons are differentiated: escalation of BPSD, palliative care, change in comorbidities (e.g., acute medical event).

13. To further supplement data collected during a resident's stay, the Department and SDCUs could consider the feasibility of assessing longer-term outcomes associated with residents discharged due to 'successful reduction in very severe BPSD'. In particular, a key outcome for collection could be a six-monthly check-in of discharged Program residents' current care setting to understand the persistence of Program effects regarding symptom stabilisation. While it is acknowledged that this would increase administrative burden (and require the Department to negotiate with providers regarding how this process would practically be undertaken):

    a. a core driver of the Program's economic value to the wider health and aged care system is the length of time post-Program for which benefits can be assigned

    b. having data collection occur at the individual provider-level caps the administrative burden at the rate of Program discharges balanced with the expected rate of mortality occurring within the target Program cohort (which is elderly and medically complex)

    c. a trend observed across the Program was internal discharges to the provider's co-located mainstream RACF, simplifying this data-collection process.

    In addition, by tracking resident progress post-Program participation, it allows the Program to understand which residents are more likely to become unsettled in mainstream RACF settings. This information could then be used to:

- inform a risk stratified discharge approach when discharging high-risk residents to minimise bounce-backs or escalation to hospital (e.g., a step-down discharge approach)
- understand whether the selection of 12 weeks as the bounce-back period is appropriate for the observed post-discharge trajectory of behaviour.

Administration

14. Continue to commitment to knowledge sharing across Phase One and Phase Two SDCUs, by implementing a collaborative knowledge exchange platform to supplement the Community of Practice that allows providers to share tools and resources and informally share advice and reflect on learnings.

Provider level

15. As outlined in the SDCP Framework, ensure all care staff are trained in behavioural management for people with very severe BPSD prior to commencing their role. Work with other providers to identify appropriate training materials resources which could be leveraged to minimise duplication of effort.
16. For Phase Two sites, establish a structured CAC process that incorporates the key enablers of timely and coordinated suitability assessments, including clear role and responsibilities among CAC members, and strong information-sharing and feedback systems with referrers.
17. Consider opportunities to increase the availability of enrichment support for Program residents, such as the provision of more enrichment activities or the engagement of a dedicated recreation support coordinator.
18. As the Program grows, investigate the extent to which the perceived pay-risk trade-off is driving recruitment and retention issues among care staff. If this is the case, it may indicate that care staff are not employed at a level commensurate with the scope of the role, and this may need to be adjusted.
19. Ensure initial multidisciplinary team meetings consistently occur within one week of admission, and that discharge planning is discussed at this meeting, with a discharge plan developed shortly after. In the case of a likely external transition, identifying suitable locations should also commence as part of discharge planning.
20. Consider mechanisms for enhancing the role and input of care staff as part of CRTs or other discussions on client progress. The benefits of this are two-fold: it provides an important informal capability building opportunity for care staff, particularly as it relates to behavioural management techniques; it also provides more senior clinical staff with insight into daily behaviors and triggers observed on the ground.
21. When discharging a client, ensure the routine use of structured templates and processes (including ongoing outreach and follow up), for handover of information that includes a strong focus on the person’s unique needs and preferences, triggers and effective behavioural management strategies. As part of discharge outreach with receiving facilities, ensure staff continue to monitor the progress of discharged residents to identify residents at risk of bounce back and to inform ongoing improvements in discharge planning processes.
22. Implement processes to routinely reflect on the nature of the partnership with in-reach clinicians, including a discussion of scope for improvement or any need to update the Memorandum of Understanding.

1 Introduction

This chapter provides background on the Specialist Dementia Care Program and details the scope and methodology of the evaluation.

1.1 Program background

People exhibiting very severe behavioural and psychological symptoms of dementia (BPSD) require specialised and intensive support, which is difficult to provide within the context of mainstream residential aged care facilities (RACFs). As a result, this cohort faces barriers to receiving optimal care for their needs, and may have higher risk of being overmedicated, or of frequent use of emergency department or inpatient psychogeriatric services. These individuals may also be displaced from (or unable to be placed within) mainstream RACFs due to the impact of BPSD on other residents, staff retention, and the ability for the provider to comply with required standards. The Program was announced in 2016 to better meet the needs of this cohort. Funding commenced in FY2018-19 to establish up to 35 units, with at least one unit in each of the 31 Primary Health Network regions.

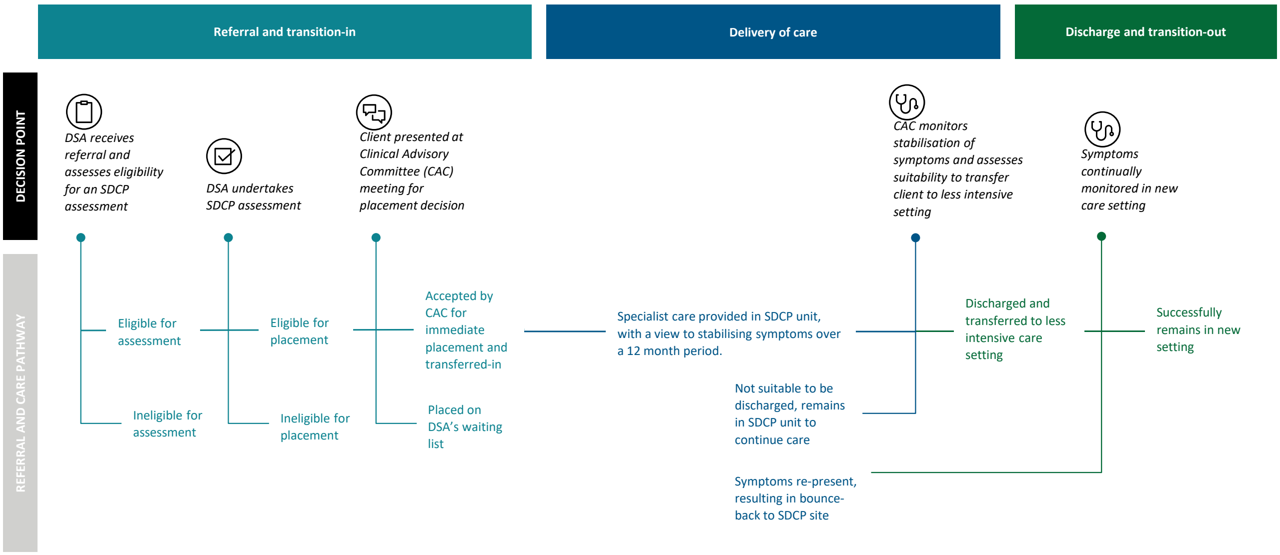
Each SDCU offers individuals specialised residential support, focused on reducing or stabilising symptoms over a period of approximately 12 months, with the aim of supporting their transition to less intensive care settings. The design of the Program was informed by a rigorous evidence base, which included a comprehensive literature review of comparable models, extensive consultation with industry and governmental stakeholder groups, and the provision of expert advice from dementia researchers.

The needs-based assessment (NBA) service, currently delivered by Dementia Support Australia (DSA), is a government funded service which supports the process for referral and assessment of eligibility for the Program. Once a person is deemed eligible for the Program by the NBA service, they are referred to a provide site. The provider will then undergo a separate administrative process to assess suitability for the person to be admitted to their unit.

Each provider is required to negotiate clinical access arrangements with their relevant state/territory health departments, with the goal of ensuring specialist-level care is delivered to residents. Arrangements typically result in a psycho-geriatrician (or similar specialist) and a Clinical Nurse Consultant (hereafter referred to as in-reach clinicians) providing on-site care at the SDCU up to two days per week.

An overview of the Program's referral and care pathway is depicted in Figure 1.1.

Figure 1.1 Specialist Dementia Care Program care pathway



Source: Deloitte Access Economics based on Department of Health and Aged Care information.

The approach to Program roll-out involves several phases, with Phase One consisting of 10 sites established between September 2019 and August 2020. Overall, 35 sites are intended to be established nationally, with coverage across every Primary Health Network region. The timing for the establishment of each Phase One site is provided in Table 1.1.

Table 1.1 Phase One SDCU implementation

State	Provider	Start date
WA	Brightwater Care Group, The Village (Brightwater)	September 2019
NSW	HammondCare Cardiff (Cardiff)	January 2020
VIC	HammondCare Caulfield (Caulfield)	January 2020
VIC	Villa Maria Catholic Homes, St Bernadette's Residential Aged Care Facility, Sunshine North (Villa Maria)	August 2020
VIC	Wintringham, McLean Lodge Hostel, Flemington (Wintringham)	August 2020
SA	Uniting Communities Inc, Aldersgate, Felixstow (Aldersgate)	April 2020
ACT	Uniting Church in Australia, Uniting Eabrai, Weston (Uniting Eabrai)	July 2020
QLD	Corp. of the Synod of Brisbane, St Martin's Nursing Home (St Martin's)	July 2020
QLD	Alzheimer's Association of Queensland Inc, Garden City Aged Care Service, Upper Mt Gravatt (AAQ)	March 2020
QLD	Good Shepherd Lodge Ltd, Good Shepherd, Mackay (Good Shepherd)	July 2020

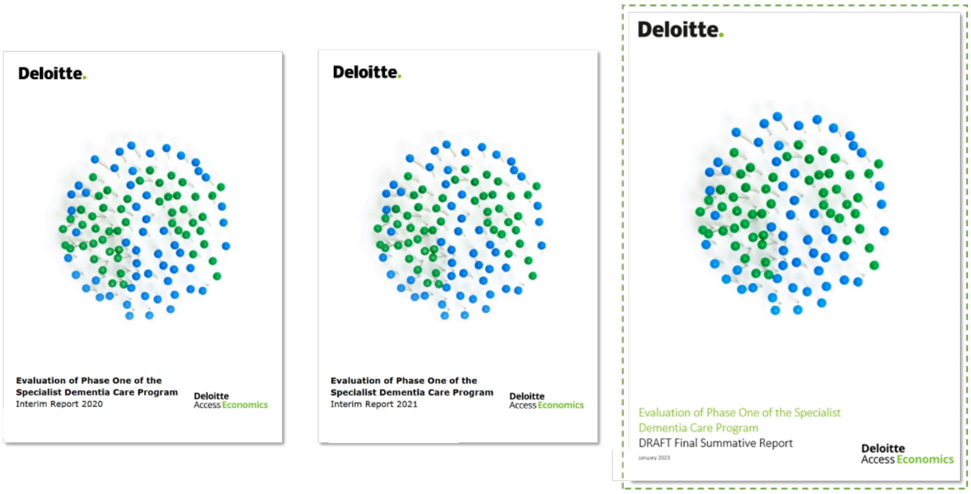
Source: Department of Health and Aged Care.

1.2 Evaluation of the Specialist Dementia Care Program

In July 2019, the Department engaged Deloitte Access Economics to undertake an independent evaluation of Phase One of the Specialist Dementia Care Program. The purpose of the evaluation is to generate contemporary evidence on the implementation, outcomes and impact of providing specialised residential support for people with very severe BPSD. By understanding the Program's strengths and areas for improvement, the Department and other key stakeholders can make informed decisions regarding ongoing Program investment and scalability to maximise the benefits for all Australians with dementia.

The evaluation activities and reporting schedule was staggered over a three-year period. Reporting (shown in Figure 1.2) comprised three annual reports, as described below.

Figure 1.2 Evaluation annual reports



Deloitte.

Evaluation of Phase One of the
Specialist Dementia Care Program
Interim Report 2020

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Access Economics

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Evaluation of Phase One of the
Specialist Dementia Care Program
Interim Report 2021

Deloitte
Access Economics

Deloitte.

Evaluation of Phase One of the Specialist
Dementia Care Program
DRAFT Final Summative Report
January 2023

Deloitte
Access Economics

- **Interim Report (2020) [SUBMITTED]:** The 2020 Interim Report focused on reviewing the implementation of the first 6 to 12 months of the first SDCU (Brightwater) and the NBA service.
- **Interim Report (2021) [SUBMITTED]:** The 2021 Interim Report focused on reviewing the implementation of all Phase One SDCU, providing a summary of Program awareness, adoption, appropriateness of the service model and clinical governance, fidelity to Program design and intent, and the key lessons learned.
- **Final Summative Report (2023) [THIS REPORT]:** This report updates the findings from the Interim Report, however mainly focuses on evaluating the Program outcomes achieved for residents and their carers and families, Program providers, and the broader health and aged care system.

1.3 Methodology

Deloitte Access Economics undertook a four-stage approach to inform this Report. Figure 1.3 provides an overview of this approach, with additional detail provided in subsequent paragraphs.

Figure 1.3 Overview of approach to inform the Final Summative Report

1 Evaluation planning

2 Data collection and gathering

3 Qualitative and quantitative data analysis

4 Dissemination of key findings

1.3.1 Stage One: Evaluation planning

Based on an existing set of evaluation questions formulated by the Department, a finalised Evaluation Plan was co-designed with the Department during project inception. This plan set out the key lines of investigation to pursue as part of the evaluation and identified the data sources to inform each area of investigation. The Evaluation Plan canvassed both an Implementation Evaluation and an Outcome Evaluation. Both components of the Evaluation Plan are provided in Table 1.2.

Table 1.2 Implementation and Outcome Evaluation questions

Domain	Evaluation question/s
Implementation Evaluation	
Awareness	To what extent are key referral sources and Program partners aware of, and understand, the SDCP, its purpose and the target resident cohort?
Adoption	What has been the reach and frequency of referrals to the SDCP?
Appropriateness	Are staff members competent and confident in their ability to provide specialist care for residents with BPSD? Is each SDCU sufficiently resourced to provide optimal care for people with BPSD? Have governance processes been implemented as intended and are they effective? Have the right mix of multidisciplinary clinicians been involved to enable optimal care?
Fidelity	Are resident transitions in and out of the SDCP operating as intended (i.e., timely, coordinated etc.)? Are the right policies and processes in place to enable staff to incorporate resident perspectives in decision-making? To what extent have person-centered care practices (i.e., respectful care, individualised care, strengths-based care etc.) been delivered?
Costs	To what extent does the SDCP make the best use of available resources and how does this differ across sites?
Sustainability	What were the key lessons learned and considerations for ongoing roll-out and scalability of the Program?
Outcome Evaluation	
Effectiveness	To what extent have person-centered care practices been delivered? To what extent has the SDCP improved clients' function, behaviour, quality of life and wellbeing? Are clients and their families/carers satisfied with their involvement in, and the continuity of, care transition processes across the system?
Efficiency	Is the SDCP considered cost-beneficial/cost-effective?

Based on Recommendation 16 (Section 1) of the Royal Commission into Aged Care Quality and Safety, ahead of the commencement of this report's evaluation activities, the Department also requested two additional areas of questioning be added to the stakeholder consultation activities, to support the Department's response. Accordingly, stakeholder consultation guides included these items, and findings are outlined in Chapter 8.

Note that this report is structured by the Program's care continuum rather than the evaluation questions. A mapping table is thus provided in the Appendix, linking each evaluation question to where the question is addressed in the report.

1.3.2 Stage two: Data collection and gathering

To inform the Final Report, data collection occurred between June 2022 and October 2022. A mixed-methods approach was adopted, drawing on a range of primary and secondary data sources.

Primary data collection

The objective of the primary data collection was twofold. First, the evaluation sought to understand developments since the 2020 and 2021 Interim Reports with regard to the implementation evaluation domains. Second, the evaluation sought to understand the impact of the Program on individual, service and system level outcomes. To achieve this, a diverse group of stakeholders were engaged to solicit a broad range of views.

For the Final Evaluation, the following stakeholders were consulted through 30 to 60 minute virtual semi-structured interviews:

- Program staff, Program managers, in-reach clinicians and Program referrers
- families and carers of current and former Program residents
- NBA service program managers and assessors based across the country
- the Department's SDCP project team.

In total, 63 consultations across the ten SDCUs and the NBA service were held, including 16 with families and carers.

Additionally, a survey was administered in September 2022. The survey remained in the field for ten weeks. While the survey received responses across a range of staff types (e.g. geriatricians, SDCU managers and personal care attendants), there were only eleven completed responses representing four of the ten units.

Primary data collected for the Final Evaluation Report was also analysed alongside the previous data collected for the 2020 and 2021 Interim Reports, which included:

- close to 100 consultations held across all SDCUs (Program staff, in-reach clinicians, NBA managers and assessors, and the Department's SDCP Project Team) from September 2020 to June 2021
- 78 survey responses in June 2020 from Program personnel, including care staff and clinical in-reach team members.

Secondary data collection

This Reports also draws upon the following secondary data sources:

- **Six-monthly performance reports from SDCUs and the NBA service.** Report contents included de-identified information on client admissions, staff recruitment, the operations of the Clinical Advisory Committee (CAC), lessons learned, and emerging challenges.
- **NBA referral data.** Data included information on the number of referrals by organisation and region, the timeliness of the referral process, and eligibility decisions.
- **Clinical data from SDCUs.** The secondary data included operational documentation (e.g., documented care processes, protocols and decision-making frameworks) and de-identified data related to outcomes of interest including clinical incidents, wellbeing and health service utilisation.

1.3.3 Phase three: Qualitative and quantitative data analysis

Thematic analysis of qualitative data from stakeholder consultation was conducted using Nvivo (QSR International) – a qualitative data analysis software specifically designed for interview transcripts, videos, photographs, drawings, surveys, and other information.

Quantitative analysis was performed on the secondary data as well as the survey results to identify changes over time in Program referrals and uptake, discharges and bounce-backs, as well as clinical incidents and wellbeing scores for Program residents. These outcomes were then triangulated with findings from the qualitative analysis to validate data results and gain more in-depth insights. As part of the quantitative analysis, a cost-benefit analysis was also performed on monetisable Program benefits and costs.

1.3.4 Phase four: Dissemination of key findings

Findings established through the data collection and analysis phases were synthesised across all data sources and summarised in the Evaluation Report (this document). In response to the key findings generated through the evaluation, the report also identifies a number of opportunities to guide the ongoing improvement and sustainability of the Program, as Phase Two SDCUs are established and implemented over the coming years.

1.4 Limitations

While every effort has been made to deliver a robust evaluation, the following limitations are noted:

Impact of COVID-19. The implementation and delivery of the Program over the past three years occurred within the context of the COVID-19 pandemic. It is acknowledged that COVID-19 has caused challenges for the aged care industry. At a provider-level, this has required new operational processes to protect staff and residents, during a time of significant labour shortages within the industry. Evaluation findings presented in this Report are conscious of this context.

Consistency of clinical data collection. In relation to potential outcomes of the Program, a reduction in clinical incidents (e.g., falls) and other behavioural incidents (e.g., BPSD-related resident-on-staff assaults) were identified as key lines of investigation to pursue, due to their impacts on key stakeholders. To this end, SDCUs were given a secondary data request document in September 2020 to ensure that data was collected to support this process. Outcome data received across the latter half of 2022 was highly varied in terms of granularity, the type of information provided, and the way that incidents were described or assessed. Deloitte Access Economics undertook a detailed data cleaning process to standardise this information and analyse it to a robust and defensible extent, however certain lines of inquiry were ultimately not able to be reliably pursued. To resolve this issue for future evaluation activities, recommendations have been provided for ongoing Program delivery related to contemporaneous and standardised data collection.

Timeframes of benefit realisation for cost-benefit analysis. One of the key Program intentions is to reduce the frequency and severity of BPSD in residents, in order to facilitate transition out to less intensive mainstream RACF. The potential for Program residents to require less resource-intensive health care services for several years after Program participation than would have occurred in the Program's absence is therefore a significant benefit. Provider performance reports detail successful discharges to mainstream RACFs due to settled BPSD on a unit record level, however there is no formal Program mechanism for tracking post-Program outcomes. Given this limitation, in the cost-benefit analysis (Chapter 6) assumptions were applied to inform benefits realisation timeframes of 9 and 18-months post-Program. To resolve this issue for future evaluation activities, recommendations have been provided for ongoing data collection related to post-Program outcomes.

1.5 Structure of this report

The remainder of this Report is structured as follows:

Chapter 2: Referrals and transitions in. This chapter presents key findings that emerged through evaluation activities as they relate to the referral and transition-in part of the care continuum.

Chapter 3: Delivery of care. This chapter presents key findings that emerged through evaluation activities as they relate to the delivery of care part of the care continuum.

Chapter 4: Discharge and transition out. This chapter presents key findings that emerged through evaluation activities as they relate to the discharge and transition-out part of the care continuum.

Chapter 5: Program outcomes. This chapter presents key findings that emerged through evaluation activities as they relate to the Program outcomes at an individual, service and system level for residents and their families/carers, Program staff and the broader health and aged care system.

Chapter 6: Economic evaluation. This chapter presents key findings from the cost-benefit analysis, where the costs and monetisable benefits of the Program are assessed relative to a comparator case where the Program does not exist.

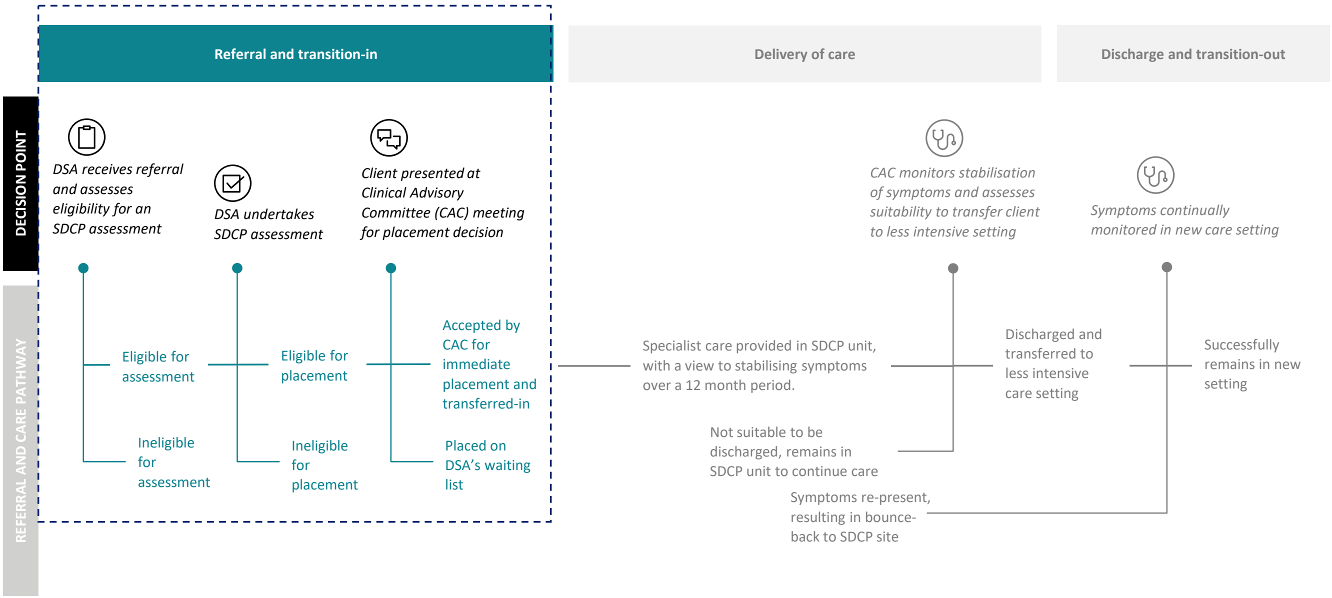
Chapter 7: Program administration. This chapter presents key findings that emerged through evaluation activities as they relate to Program costs and other administrative factors.

Chapter 9: Concluding remarks and implications for ongoing implementation. This chapter provides concluding remarks, as well as considerations for the implementation of Phase Two of the Program.

2 Referrals and transitions in

This chapter presents key findings as they relate to the referral and transition-in part of the Program's care continuum.

Figure 2.1 Referrals and transition-in component of the Program's care continuum



Source: Deloitte Access Economics based on Department of Health information.

An assessment of the referral and transition-in process is explored through the following sub-sections of the chapter:

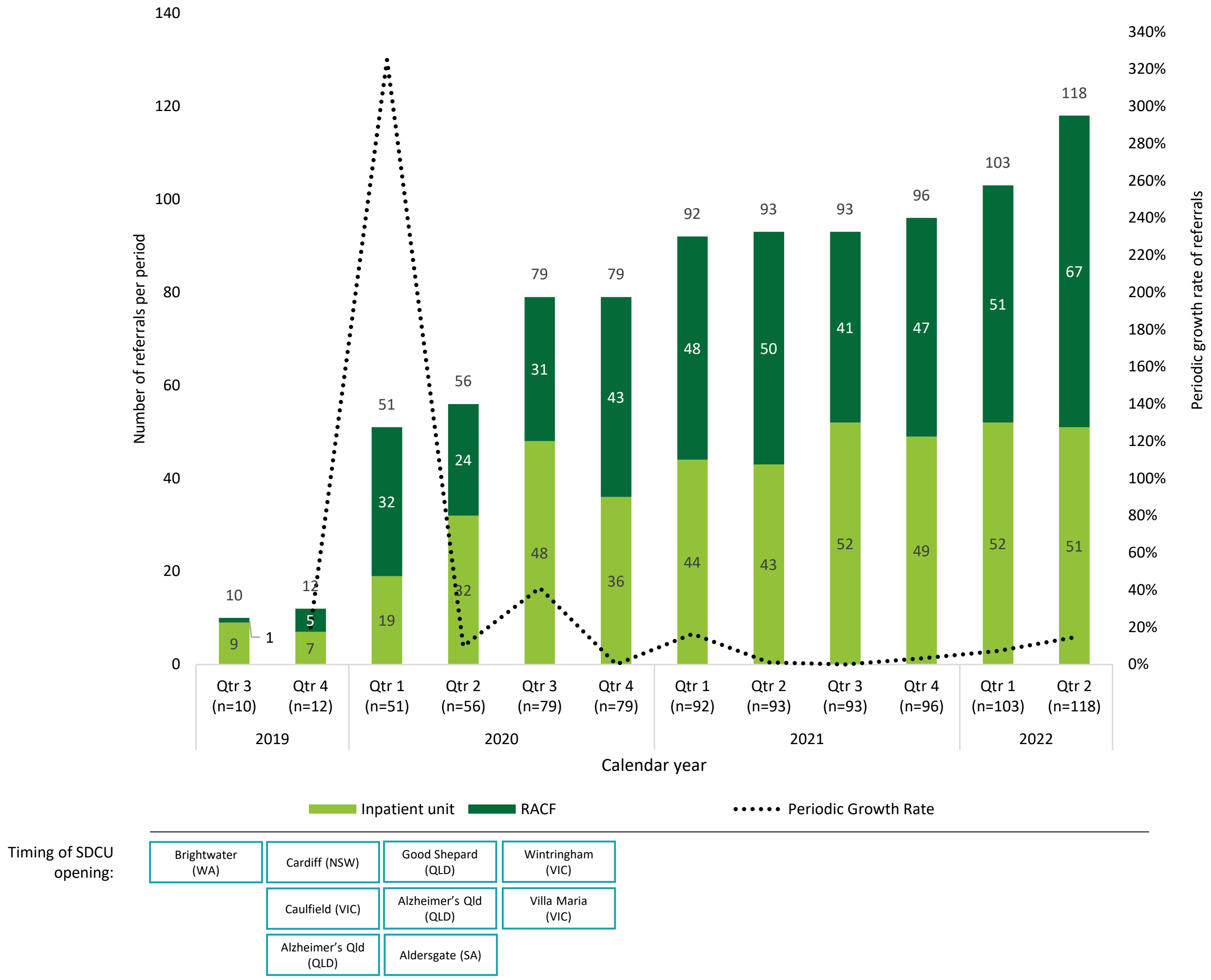
- program awareness
- program adoption and acceptability
- timeliness and co-ordination of referrals.

2.1 Program awareness

The opening of new SDCUs across Phase One coincided with growth in the rate of Program referrals (though rates of referral were also growing as of June 2022). Referrals by referrer type have now settled to a broadly even split between inpatient settings and RACFs. Across the states and territories, referral rates were correlated with the number of sites within the jurisdiction.

Awareness of the Program among referrers increased strongly during 2020, as nine of the Phase One SDCUs were implemented. While referrals were relatively stable during 2021, the first two quarters of 2022 have seen renewed growth (Figure 2.2).

Figure 2.2 Number of referrals by referrer, by quarter, by year and periodic growth rate of referrals

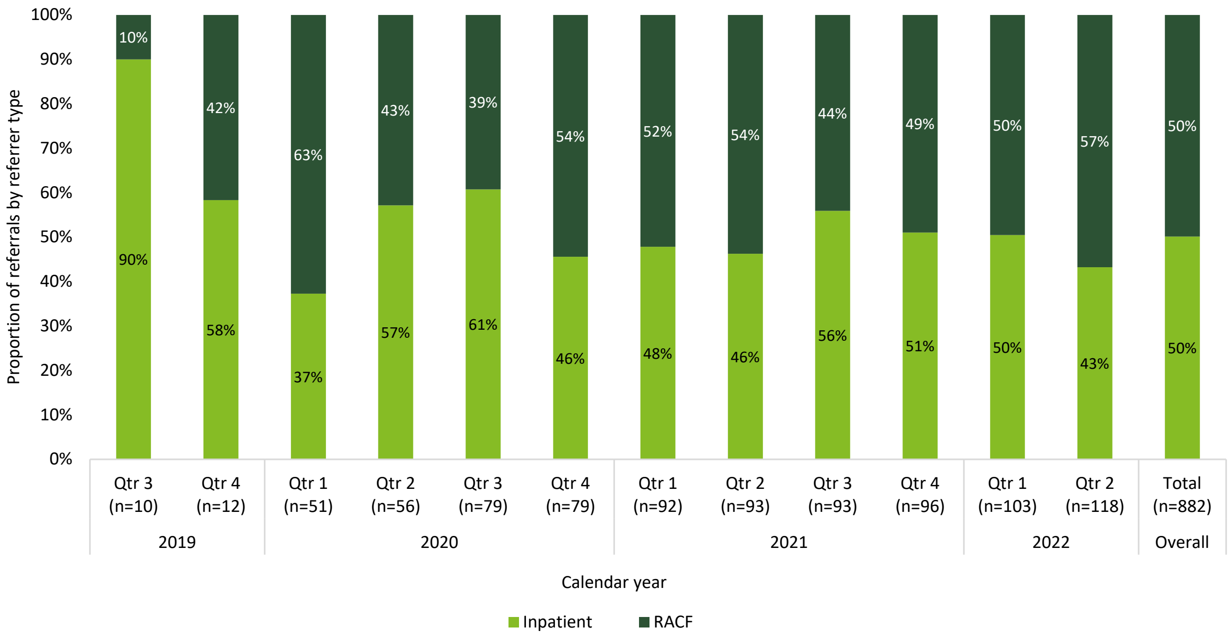


Source: Deloitte Access Economics calculations, based on NBA data July 2019 to June 2022.

Note: There are 109 referrals not shown, due to their referrer type being 'Other' (including not stated).

As shown in Figure 2.3, during the early phases of Program implementation, of the two key referrer types (inpatient units and mainstream RACFs), awareness of the Program was strongest among inpatient units. However, over time, referral patterns by referrer type have settled into a more balanced split, shifting from around 70% of referrals originating form inpatient settings at the time the first SDCU (Brightwater) opened in late 2019, to around 50% over the past 12 months. This supports insights gleaned through stakeholder consultation that awareness of the Program has grown across mainstream RACFs over time.

Figure 2.3 Distribution of referrals by referrer type, by quarter

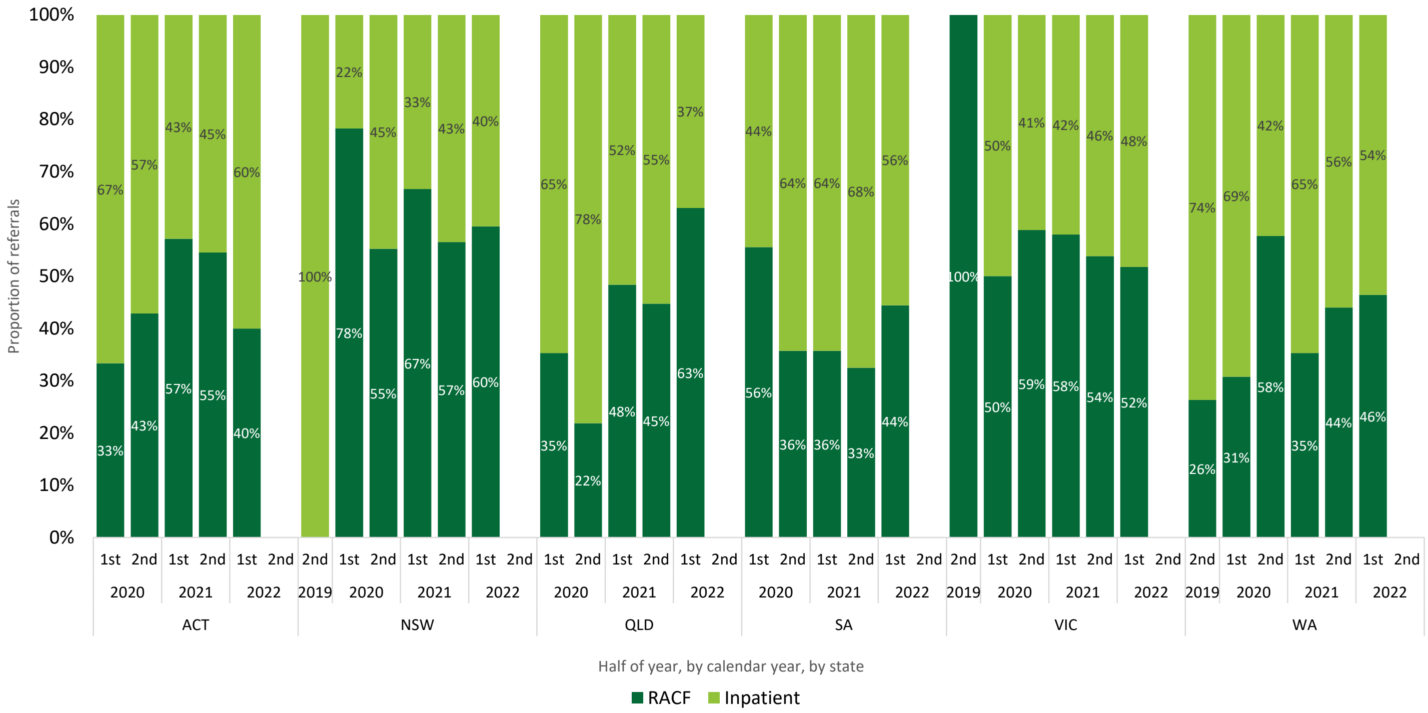


Source: Deloitte Access Economics based on NBA referral data, 2019 to 2022.

Note: There are 109 referrals not shown, due to their referrer type being ‘Other’ (including not stated).

At a state and territory level, there was variation in relation to referral patterns by referrer type. Since the **Interim Report (2021)**, QLD and WA have seen strong shifts towards RACF referrals, while NSW and VIC continue to receive the majority of its referrals from RACFs (see Figure 2.4).

Figure 2.4 Distribution of referrals by referrer type, by state/territory of referrer

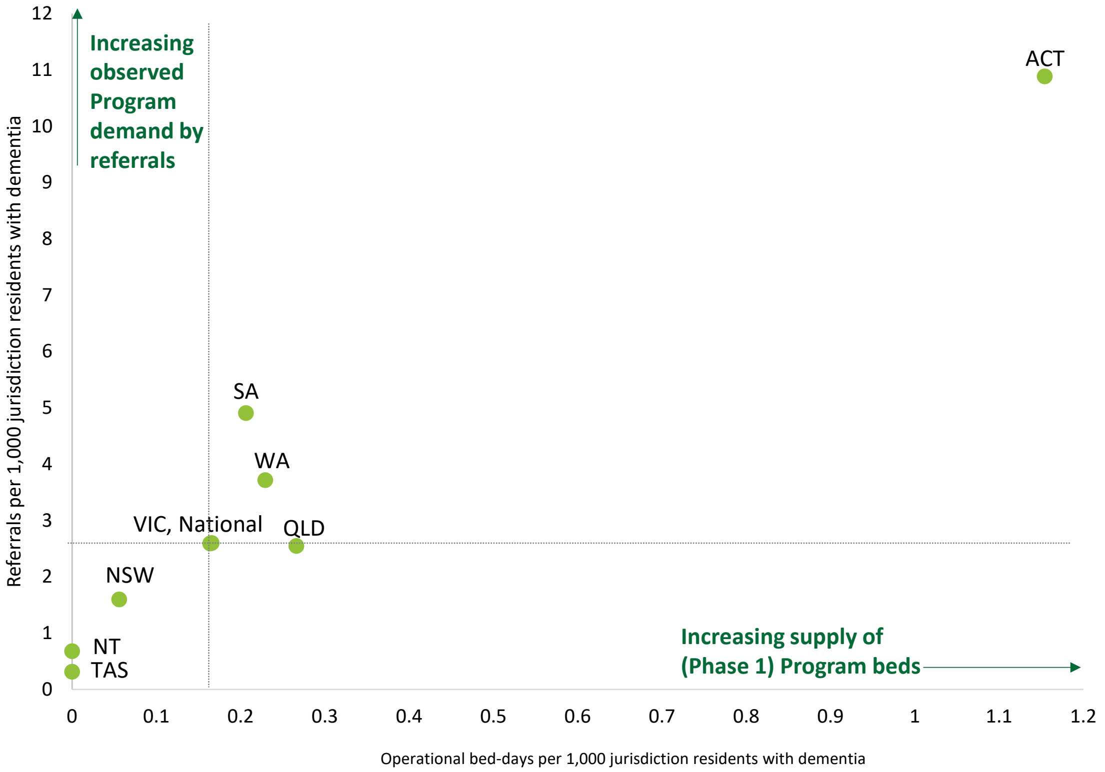


Source: Deloitte Access Economics analysis based on NBA referral data, July 2019 to June 2022.

Note: There are 112 referrals not shown, due to their referrer type being 'Other' (including not stated), or referrals from TAS and NT (suppressed due to low sample sizes).

To compare Program engagement across jurisdictions, Figure 2.5 displays each state and territory's number of Program referrals and operational bed-days, using a jurisdiction-specific denominator to adjust for differences in the potential Program cohort size. Here, observed demand for the Program is proxied by referrals, which are considered a key measure of Program awareness.

Figure 2.5 Program demand (indicated by volume of referrals) and supply, by jurisdiction



Source: Deloitte Access Economics analysis based on: NBA referral data (July 2019 to June 2022); Program cost data (provided by the Department) and AIHW (2022).

Note i: Operational bed-days are defined as non bounce-back bed-days at an open site.

Note ii: AIHW estimates of the number of people in each jurisdiction living with dementia use national prevalence estimates applied to each state/territory's age-sex population structure. Only a small proportion of this cohort would be eligible for Program participation.

Note iii: VIC and the national average are shown as one data point due to overlap.

It can be seen in Figure 2.5 that ACT has both the highest number of referrals and the largest Program capacity, relative to its population with dementia.[2] Conversely, of the jurisdictions with SDCUs, NSW has both the smallest Program capacity and the lowest numbers of referrals relative to its dementia population. When combined with the observed timing of growth in referrals and new sites opening seen in Figure 2.2, it may be theorised that referrals are a reaction to perceived supply (i.e., referrers are encouraged/discouraged based on the perception of SDCU availability). For SA, while referrals rates are close to twice the national average, it is noted that the sole SA SDCU (Aldersgate) had a high number of Program admissions relative to other sites. As an alternate contributing factor, it is also acknowledged that separate to the Program, overall jurisdictional capacity to support people with very severe BPSD includes other services (e.g. Older Persons Mental Health services in NSW and Acute Cognitive Units in QLD). Hence, these services operating alongside the Program may influence observed Program demand.

The Department has stated its intention of establishing 35 Program units nationally, including one in each PHN. To this end, Phase 2 will include three additional SDCUs in NSW, one additional SDCU in WA, VIC, SA, ACT and the first SDCU in TAS operationalising across 2023. It is expected that Program referral rates will strongly increase following expansions of jurisdictional capacity.

Concurrent with increasing numbers of NBA referrals, the proportion of NBA referrals deemed eligible for assessment has declined across the length of the Program. This may be attributed to a high proportion of new referrers who are less familiar with the Program scope and eligibility criteria.

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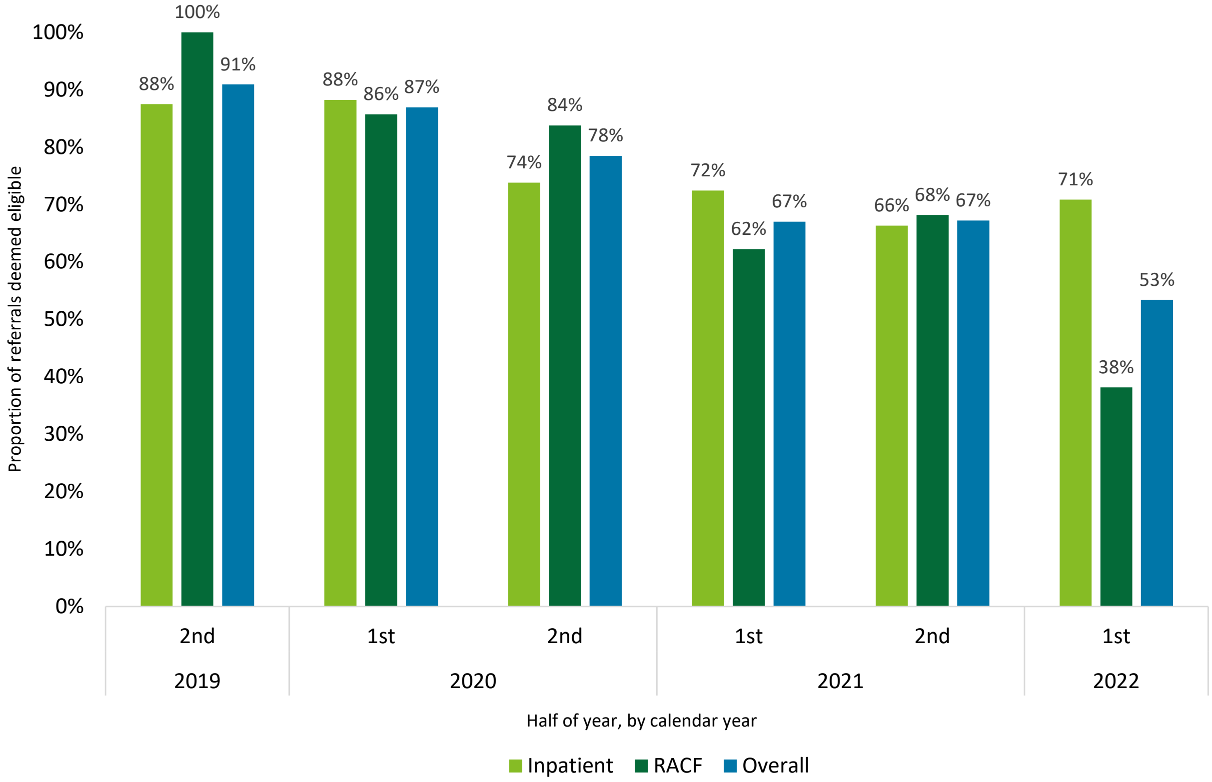
[2] The ACT has a single SDCU (Uniting Eabrai), and as such their large jurisdictional Program capacity is a function of their small population size. Other jurisdictions with fewer than 10,000 people estimated to be living with dementia (NT and TAS) do not have a site under Phase One.

Increasing understanding of the Program's eligibility criteria is important for maximising the efficiency of the NBA service. Over the life of the Program, 36% of NBA referrals did not undergo a formal SDCP assessment, either due to ineligibility or case closure.

Across the two key referrer types, rates of NBA referrals deemed eligible for assessment were broadly similar until 2022, where eligibility for referrals originating from inpatient settings rose to 71% while eligibility for referrals originating from RACFs declined to 38% (Figure 2.6). This is reflective of the growing proportion of referrals from RACFs, which is driven by an increasing number of 'new' unique RACF referrers who are less familiar with the Program scope and eligibility criteria. The proportion of ineligible referrals is an important metric that allows evaluators to monitor the extent to which referrers appropriately understand the Program's eligibility criteria. Therefore, it is suggested that the Department continues to monitor this metric over time, particularly as the number of 'new' unique referrers decreases.

Figure 2.6 Proportion of referrals deemed eligible for an NBA assessment, by calendar year and referrer type

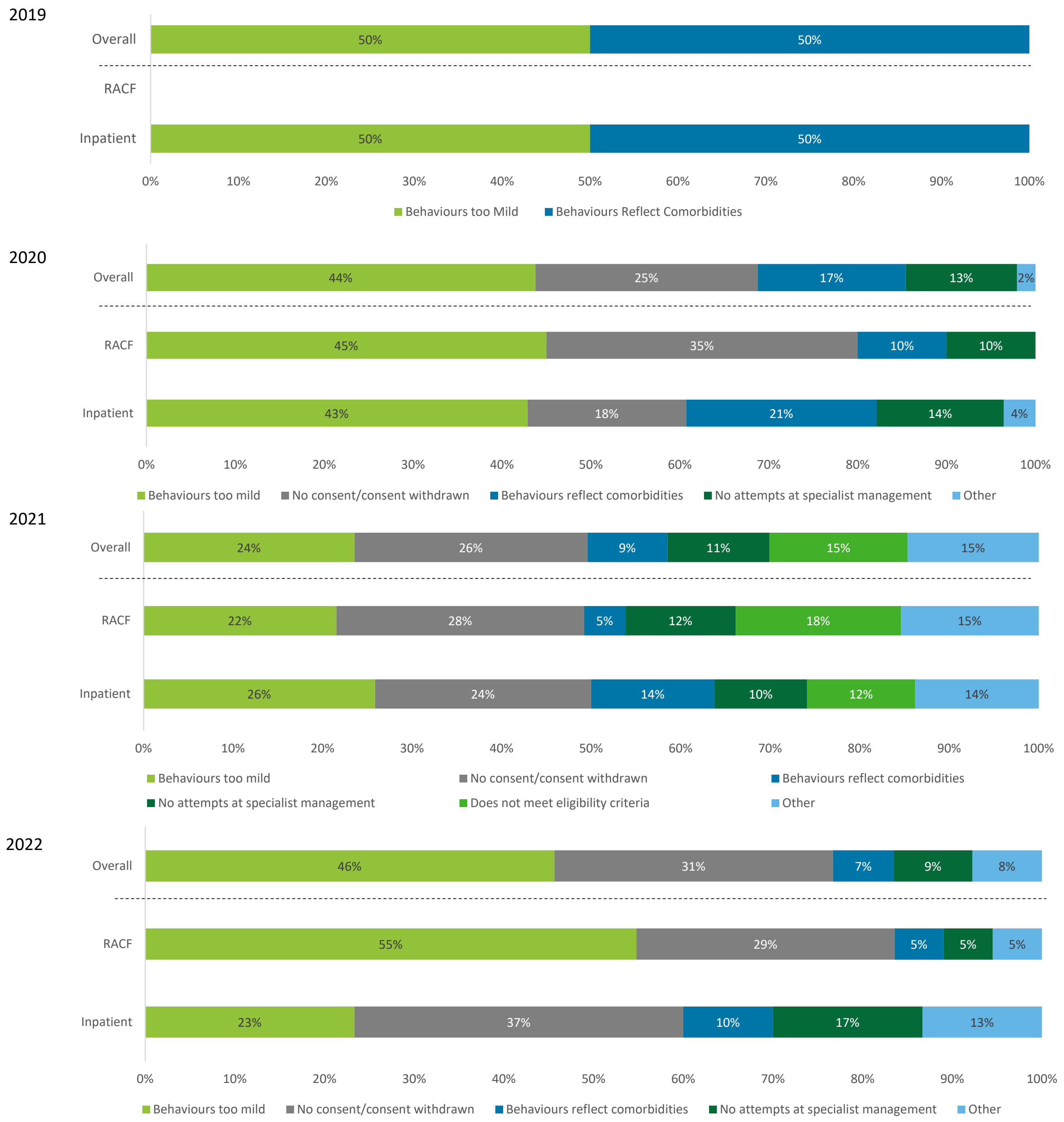


Source: Deloitte Access Economics analysis based on NBA referral data, July 2019 to June 2022.

Note i: There are 109 referrals not shown, due to their referrer type being 'Other' (including not stated).

In exploring the drivers of ineligible referrals, NBA referral data shows the most common reasons a referral was deemed ineligible for assessment was 'behaviours too mild' and 'no consent/consent withdrawn' (Figure 2.7). This was a consistent finding from 2020 onwards. Ahead of the opening of Phase Two sites, there is an opportunity for the NBA service to better communicate to prospective referrers the targeted severity of behaviours, particularly among prospective referrers who work at facilities located close to the new SDCUs.

Figure 2.7 Most common reasons for referral ineligibility, by referrer type and calendar year



Source: Deloitte Access Economics analysis based on NBA referral data, July 2019 to June 2022.

Note i: Additional thematic coding has been undertaken where reasons for ineligibility were considered to overlap.

In consultation, stakeholders described several factors influencing the effectiveness of referral processes, which may require increased focus in the coming year as Phase 2 sites are implemented.

- **Raising awareness of less intensive dementia behaviour supports, currently available through DSA.** Stakeholders reflected that referrers may still have a limited understanding of the range of dementia behaviour supports available for BPSD that are too mild for the Program, such as the Severe Behavioural Response Team (SBRT). It is noted that staff turnover within the aged care sector (particularly during COVID-19) may have been a significant contributing factor to this loss of facility-level knowledge. Across the breadth of stakeholder consultation, there were also inconsistent reflections on whether patients with dual mental health diagnoses or NDIS participants were eligible for the Program. It is suggested that DSA should consider alternative and/or sustained approaches to minimise this type of knowledge loss within mainstream RACFs (e.g., awareness-raising activities targeting provider-level management as management may be less likely to turn over, educational Program materials that may be accessed on-demand e.g., videos).

- **Feedback loops with referrers on reasons a referral was deemed ineligible.** Stakeholders observed improvements in awareness and understanding of the eligibility criteria among unique referrers who had previously submitted a referral and gone through the Program process. This was attributed in part to the improved feedback loops in the NBA and CAC processes (Section 2.2) which strengthened information-sharing with referring facilities, including the reasons a referral was deemed ineligible for the Program.

- **Decreasing risk tolerance.** An anecdotal theory raised for increasing referrals within mainstream RACFs for behaviours considered too mild for the Program was decreasing provider-level risk tolerance for BPSD. If continuing trends are observed related to inappropriate referrals for mild behaviours, indicating an ongoing decline in the willingness of providers to provide support for people with BPSD in mainstream facilities, a broader response to this issue may be required.

Stakeholders also identified several strategies which have served as key enablers in driving Program awareness and referrals over the duration of the Program:

- **Leveraging the networks of in-reach clinicians.** Consistent with the **Interim Report (2021)**, SDCU staff noted that in-reach mental health clinicians (who traditionally work at geriatric and psychogeriatric inpatient units) are key to driving awareness among inpatient referrers, given their existing networks in these settings.

- **Relationships with social workers in inpatient settings**. A number of stakeholders commented on the importance of using social workers who work in aged care settings to raise the profile of the unit. These staff members have existing networks with prospective referrers and are perceived to be credible in understanding the unique needs and ideal placement options for people with very severe BPSD.

- **PHNs.** Many SDCUs found it helpful to leverage PHNs and their networks to raise the profile of the Program across mainstream RACFs and in-patient settings.

- **Integration with other dementia support services.** Many SDCUs commented on the importance of incidental Program awareness-building where it is performed concurrently with other government-funded dementia support services. These services provide an opportunity to introduce staff at these facilities (who are likely to become referrers) to the Program and convey the eligibility criteria and referral process.

- **Provider promotional activities.** Some SDCUs noted their staff undertook targeted relationship-building and networking activities at the outset to drive awareness among local referrers, such as presentations at forums and conferences. More mature sites who were reported to have a strong clinical nursing governance structure, noted their nurse coordinator also regularly engaged in ongoing networking activities as part of their role. Consultations indicated that networking and targeted discussions were more effective than broad email distributions as they were able to target the clinician most likely to initiate referrals.

  Consistent with the Interim Report findings, stakeholders agreed there is an opportunity to support future site openings through better standardising the promotional materials developed across providers to ensure consistent messaging and reduce duplication of effort. For example, some families reported they only found out about the Program through online research by their own initiative.

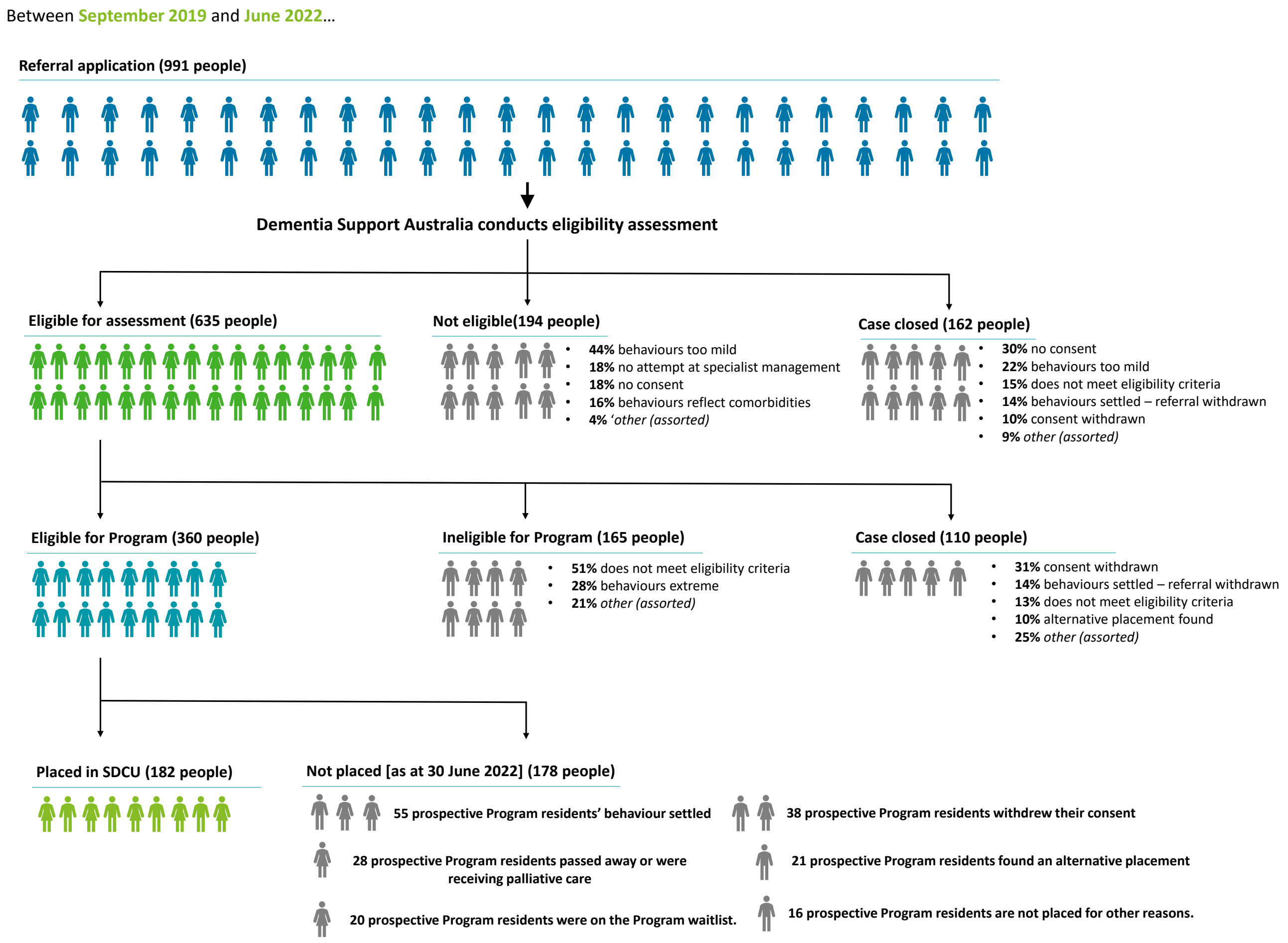
  State/territory engagement and buy-in. Stakeholders reported variation across jurisdictions as to the approach to engaging with and promoting the Program among the state/territory health departments. Internal health department promotion and acceptance has been more challenging where Acute Cognitive Units had existed prior to the Program (a similar model to the SDCUs – an inpatient unit in a non-hospital environment that supports people with very severe BPSD). In jurisdictions where these units operate, there was a perception that the referral process was more straightforward as both the referrers and units are located within the state government.

2.2 Program adoption

Over the period September 2019 to June 2022, of all Program referrals approximately one in three were assessed for suitability at a CAC. Of those assessed for suitability, just over one in two were placed in a SDCU. This results in an overall placement rate of one in five referred to the Program.

Figure 2.8 displays the overall level of Program uptake between September 2019 and June 2022, across each stage of the referral and placement process: referral application, NBA for Program eligibility, resident suitability assessment conducted by SDCU, placement.

Figure 2.8 Overall Program uptake



Source: Deloitte Access Economics analysis based on NBA referral data, July 2019 to June 2022.

From this overall view the following findings are noted.

- The NBA service plays a significant role in triaging the overall cohort referred to the Program. Approximately two-thirds of referrals are discharged prior to a suitability assessment being conducted by an SDCU. This process minimises the extent of provider resources that are required to assess suitability. As noted in Section 2.1 , the most common reason a referral is deemed ineligible for the Program was 'behaviours too mild'.
- The reasons for a provider's suitability assessment not resulting in a placement were relatively consistent across sites. The most common reasons prospective clients were deemed not suitable related to the resident not being a good 'fit'

within the current SDCU dynamics of existing residents and staff, or that their medical comorbidities were too complex and required treatment.

- Due to the age and medical complexity of the prospective Program cohort, approximately 30% of those not placed had their case closed due to behaviours settling and approximately 15% passed away (or were receiving palliative care) during the timeframe examined.

For equity cohorts where data quality was able to support estimation, the cohort referred into the Program was slightly less than the ABS population data across Aboriginal and/or Torres Strait Islander self-identification, culturally and/or linguistically diverse background, and regional/rural locality, noting the small data set available at this stage of the Program implementation.

At the point of referral, DSA collects demographic data to understand whether people self-identify as part of an equity cohort. For the cohort referred in Figure 2.8:

- 24.9% were from a regional/rural area
- 22.5% were from a culturally and/or linguistically diverse background
- 2.03% self-identified as Aboriginal and/or Torres Strait Islander.[3]

According to the Australian Bureau of Statistics, as of 2021:

- 33% of Australians lived outside of a capital city[4]
- 28% were born overseas[5]
- 4% self-identified as Aboriginal and/or Torres Strait Islander (noting that a third of this population is aged under 15)[6].

Across the remainder of the identified equity cohorts (care leavers; homeless; lesbian, gay, bisexual, transgender, intersex or questioning; parents of forced adoption or removed children; financially or socially disadvantaged; veterans), less than 1.5% of those referred identified as part of any of these cohorts individually (i.e., less than 1.5% identified as homeless). However, these cohorts were characterised by extensive missing data which limits the ability to accurately measure these indicators.

In relation to the cohort eventually placed, 45% identified as part of an equity cohort (noting that the cohorts described above are not mutually exclusive).

The concept of the Program was well-received by families/carers, with offers for assessment typically only declined for distance reasons.

Program referrers noted that where Program placement is suggested, families/carers are typically always willing to have their loved one assessed for eligibility. With regard to why an offer for placement might be declined by the family/carer, insights gleaned through consultation indicated this was typically only related to the distance between the family/carer residence and the location of the SDCU.[7] Stakeholders noted that almost all families/carers were highly receptive to the concept of the Program. Positive family/carer sentiment was supported by responses to the 2021 Program staff survey. With a mean agreement score of 4.5 (out of 5), *'the concept of the SDCP has been well received by families/carers'* was one of the highest rated attributes across all Likert scale questions asked in the survey.

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[3] Data provided by Dementia Support Australia (2023). Missing/inadequate data is excluded in this calculation.

[4] Australian Bureau of Statistics (2022), *50 years of capital city population change*, accessed 6 March 2023 from <https://www.abs.gov.au/articles/50-years-capital-city-population-change>.

[5] Australian Bureau of Statistics (2022), *Cultural diversity of Australia*, accessed 6 March 2023 from <https://www.abs.gov.au/articles/cultural-diversity-australia>.

[6] Australian Bureau of Statistics (2022), *Estimates of Aboriginal and Torres Strait Islander Australians*, accessed 6 March 2023 from <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release>.

[7] Stakeholders did not comment directly on this issue in relation to Aboriginal and Torres Strait Islander people with very severe BPSD, however it is noted that there is also a cultural preference to receive health care on country. Thus, long distances between a person's residence and the nearest SDCU is also expected to present barriers for Aboriginal and Torres Strait Islander people with very severe BPSD.

There has been a marked improvement in site occupancy since the Interim Report (2021). Over half of SDCUs achieved occupancy rates (based on occupied bed-days) of 80% or over in Financial Year (FY) 2021-22.

Reaching capacity (i.e. full occupancy first reached)
One way to examine Program uptake is to assess how long it took each SDCU to first reach capacity. The rate at which SDCUs were able to reach capacity varied. At this stage of the Program, nine out of ten SDCUs have achieved full Program occupancy (Figure 2.9). However, there was wide underlying variation in the time taken to achieve this metric (i.e. timelines differed between three months and over one and a half years), with one SDCU at approximately half-capacity after more than two years.

Stakeholders consulted highlighted several themes that help to understand variation in the extent to which different SDCUs are able to achieve and maintain full occupancy:

- **Provider risk appetite.** Many of the SDCUs slow to reach capacity have declined placement for residents who were assessed as eligible by the NBA service. Reasons for declining placement typically related to poor ‘fit’ with the current resident and staff mix, as well as a view that some residents’ needs were too complex and would create unnecessary risk for the provider. Indeed, observations from consultations indicated significant variation in risk appetite across SDCUs. Some providers take a view that no resident should be declined a placement based on need complexity and have accepted clients who were declined from other SDCUs for this reason.

- **Unique barriers that exist in regional and rural areas.** People in regional and rural areas can face additional challenges in meeting the NBA eligibility criteria where there is limited presence of a psychogeriatrician (or other relevant specialist) in their location, which is required as part of the Program eligibility criteria. Stakeholders noted that consultants administering the NBA process had worked collaboratively with patients, family members and health care workers in order to address this challenge.

Occupied bed-days (i.e. annual occupancy rate)
A separate measure of Program uptake is SDCU occupied bed-days. Unit-level SDCU data was used to build a bottom-up model of each site in terms of operational-bed-days (i.e. excluding bounce-back days) and occupied bed-days based on admission and discharge dates.[8] Since the **Interim Report (2021)** there has been a strong improvement in the Program’s overall occupancy rate, from 41% in FY20 and 54% in FY21 to 85% in FY21-22.

It is broadly estimated that in FY22 over half of the ten SDCUs achieved occupancy rates of at least 80%.

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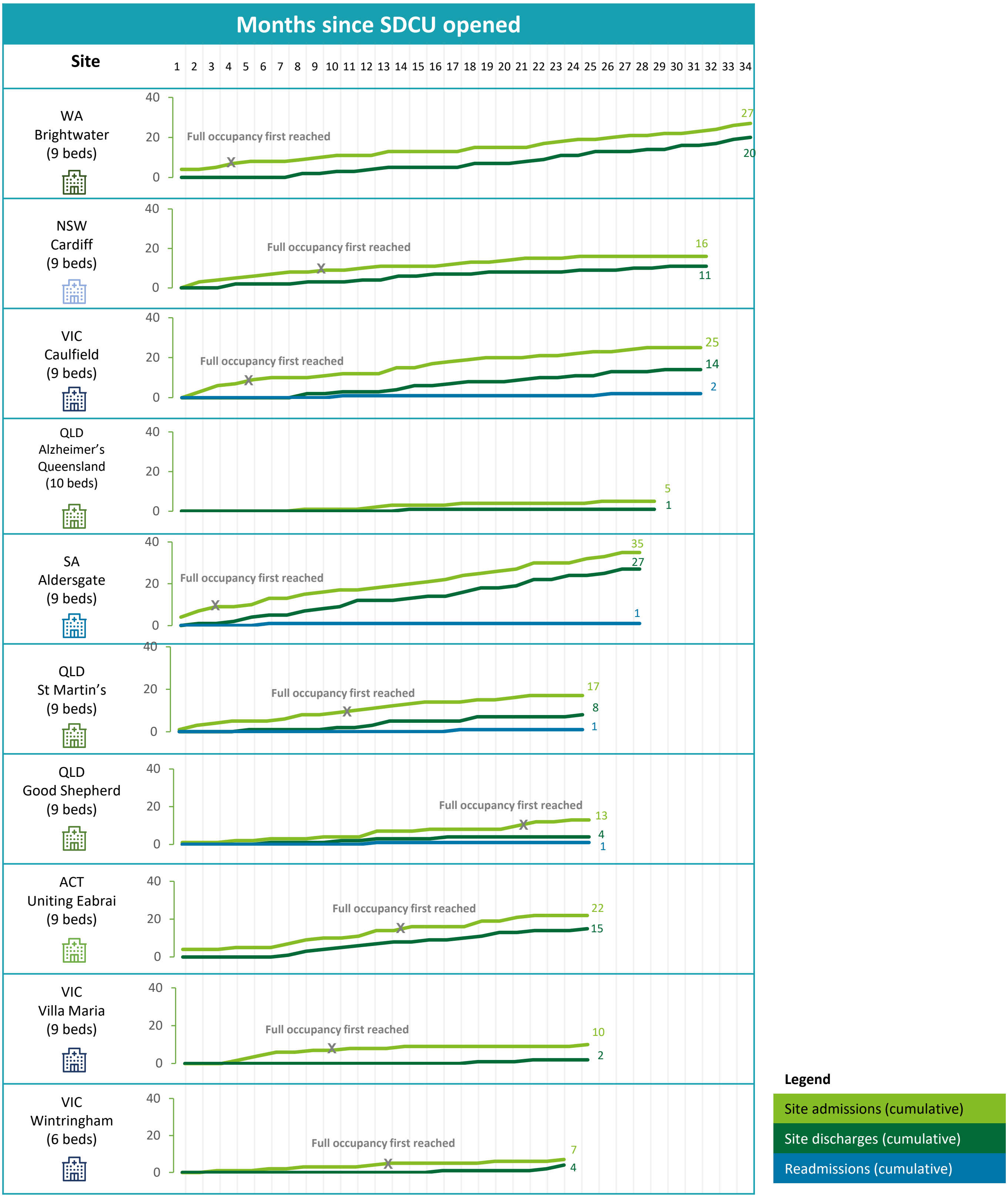
[8] For certain sites, unit record level data did not reconcile with other summary data tables reported by providers. Unit record level data was used as the primary source where discrepancies occurred.

Figure 2.9 Cumulative admissions, discharges and readmissions at each SDCU, by months since opening



Source: Deloitte Access Economics calculations, based on provider performance reports (July 2019 to June 2022).

It is recognised that site occupancy may be impacted by situations of complex resident dynamics (and the suitability assessment decision to introduce a new resident into the current mix), provider risk appetite for a prospective resident's behaviours at the time of suitability assessment, and site-specific views on discharge criteria that may encourage higher patient flows (e.g., discharging residents whose behaviours escalate or discharging patients who are palliative (see Section 4.1)). However, occupancy rates have a strong impact on the Program's value for money, as Program benefits can only be achieved if beds are filled. This issue is discussed in Chapter 6.

2.3 Timeliness and co-ordination of the referral and admission process

Stakeholders largely agreed the NBA process is working efficiently and effectively, although limited data availability and information-sharing across care settings remain the primary barriers to timely and comprehensive assessments.

Stakeholders were generally satisfied with the NBA process and there was consensus across all SDCUs that the assessment reports are comprehensive and high-quality. Regarding timeliness of assessment, the NBA service has exceeded all timeliness performance targets e.g., in the latest reporting period 98% of people referred to the Program had an on-site assessment within 2 weeks (Table 2.1). The transition from written to verbal consent for the NBA was believed to facilitate more timely assessments, however DSA noted difficulties accessing information across care settings can prolong the assessment process.

Table 2.1 DSA timeliness metrics

Indicator	Target measure	Performance			
		July - Dec '20	Jan - June '21	July - Dec '21	Jan – June '22
Triage referrals within one week (%) of referral acceptance and consent received	90	91.8	96.4	95.9	97.4
On-site assessment delivered within two weeks of referral being received (%)	85	93.2	93.7	94.6	98.2
Clinical review and recommendation for eligibility for SDCP delivered within 3 weeks of an on the ground assessment (%)	75	83.5	84.4	93.5	89.0

Source: NBA service referral data, July 2020 to June 2022.

Overall, stakeholders consulted felt the NBA assessment timeframe was reasonable, given the extent of information gathered, often from multiple care settings. Despite this, many stakeholders reported that some families/carers, referrers and Program staff can feel that the time from referral to presentation at a CAC meeting is too long. This is consistent with the **Interim Report (2021)**, which cited the referral and assessment timeframe as a specific issue in the context of referrals originating from inpatient settings. In inpatient settings, there are significant costs associated with an overnight bed-day. In addition, inpatient staff must rapidly understand if the Program is – or is not – a discharge option so they can commence discharge planning to alternative destinations, if needed.

To increase the timeliness of Program access for those currently in hospital, stakeholder suggestions across the Interim Report and this report's consultation processes have included that inpatient clients could be prioritised for NBA assessment, or that SDCUs could consider implementing protocols to prioritise these clients for suitability assessment ahead of those based in mainstream RACFs. However, when presented with these suggestions, other stakeholders held the view that fast-tracking the process for inpatients (as opposed to those residing in mainstream RACF settings) would be counter to the Program's goal of equity of access and may create adverse incentives.

A broader observation regarding timeliness of the referral process was that the frequency of CAC meetings varied across sites, with some SDCUs holding a CAC only once a month and others weekly or fortnightly to determine the applicant's suitability with the current resident mix. Thus, there is an opportunity to provide further guidance to SDCUs on the recommended frequency of CAC meetings to create more standardisation across sites and improve the timeliness of suitability assessments.

Stakeholders were also largely satisfied with level of information provided by DSA throughout the assessment process and contained in the assessment report. They noted DSA is responsive and maintains strong coordination and communication with the referring facilities, family/carers and CAC members. However, poor understanding of the assessment process was a common issue observed among new referrers. For example, new referrers often do not understand the difference between the NBA and CAC process, and they assume that a referral assessed by the NBA as eligible for placement equates to Program acceptance. Accordingly, there is opportunity for promotional activities to better communicate the assessment timeframes and steps required to improve expectation management among referring facilities and ensure referrers have a good experience with the service to encourage future referrals.

Figure 2.10 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to the timeliness of the NBA process

> *"At times it can be challenging to obtain information we require to determine eligibility – information that gives us the full picture. We have had to reassess people because it has been deemed later on that more information is available that was not shared in initial stages. So access to the most comprehensive information on eligibility can be a barrier."*
>
> *– DSA staff*

> *"Access to information [is a barrier], particularly in acute care settings as they have quite difficult CRMs to navigate… It can be difficult to get information and it is time consuming for them to provide us with that access to the information to be able to determine eligibility... That's probably the biggest disabler from an NBA perspective."*
>
> *– DSA staff*

Source: Deloitte Access Economics analysis of stakeholder consultation transcriptions, 2022

People in regional and rural areas face unique barriers to accessing the Program. This is due to the lack of specialist input in their region (required for a referral to be considered eligible for NBA assessment), as well as staff shortages and the long-distance transport journeys required for admission.

In addition to the challenges sourcing specialist input described in Section 2.2, stakeholders highlighted several other Program access barriers for people living in regional and rural areas:

- **Staff shortages.** Stakeholders observed staff shortages had contributed to the sole regional SDCU having to manage their Program occupancy in line with staff-patient ratios. It is noted however that labour shortages are not unique to the sole regional SDCU, and have been experienced more broadly across the aged care sector, particularly over the last several years.
- **Additional resources required for long-distance transport.** The longer journeys to the SDCU from regional and rural areas can be more resource-intensive, as they are expensive and difficult to coordinate. Anecdotally, the ease of transition often depended on the location of the referring facility, the mode of appropriate transport given the residents' needs, and the level of coordination between the referring facility and the SDCU. For example, transport options often considered include car, Flying Doctor and private jet service, all of which stakeholders noted can be expensive even where referring facilities split the costs with the resident. Due to severity of BPSD, residents can also find long journeys distressing and may require sedation to ensure staff and resident safety, creating additional clinical considerations. In one case, transport delays resulted in prolonged sedation and health complications for the resident, which required the transition to be deferred until the resident recovered.

Accordingly, there is opportunity for the Department to work collaboratively with regional SDCUs, the aged care sector (with input from DSA) and the relevant state/territory government to find solutions to barriers faced in regional areas.

The feedback loops with referrers and families have strengthened over time which has increased transparency and understanding of assessment outcomes and the Program's eligibility criteria.

The **Interim Report (2021)** identified a need to improve the visibility of referral outcomes (both triage decisions and assessment outcomes) through better feedback loops with referrers. Stakeholders commented that transparent feedback is important for increasing the rate of eligible referrals and for ensuring referrers have a good experience with the service, to encourage future referrals.

Since this time, DSA and SDCU staff across multiple sites reported that stronger feedback loops now exist to share triage, NBA and CAC assessment outcomes with referrers. This was facilitated through the provision of written feedback which provides referrers with more detail on reasons for placement decisions and next steps associated with placement on a waitlist (i.e., presentation at another SDCU's CAC, wait to re-present at the same CAC to reassess 'fit' following a discharge, additional external support options available to the applicant, etc.)

However, stakeholders across some SDCUs again identified a need for increased information-sharing from CACs to referring facilities and families/carers to improve understanding of suitability assessment outcomes. Some stakeholders also noted that assessment feedback is only provided to the referrer as opposed to the applicant's family/carer and previous care setting (e.g., the original mainstream RACF prior to an applicant's admission into acute care). To streamline these feedback loops, it was suggested in the Interim Report (2021) that a centralised platform accessible to referrers or families/carers could be used as an enabling mechanism. An alternative option may be to incorporate a requirement into the SDCP Framework that CACs provide feedback directly to family/carers during and after the referral and assessment process.

Transitions in were generally viewed as timelier and more coordinated as sites matured. Key enablers included flexible resourcing arrangements as well as strong communication and information-sharing between SDCUs, DSA, families/carers and the referring facility.

Consistent with the **Interim Report (2021)**, stakeholders across all SDCUs broadly agreed that following client acceptance, the process for transition-in is working well. For most sites, the success of the transition-in process has evolved and matured over time. Key enablers to the success of these transitions include:

- **In-person provider assessments.** In-person assessments conducted by clinical representatives from the SDCU (following an NBA process) are helpful in informing 'fit' discussions at CAC meetings. However, it was acknowledged that this can sometimes add to the delays associated with timely placement decisions and it is important to ensure these assessments occur in the period between an NBA process and before the next CAC meeting.

- **Early communication and expectation-setting with families/carers.** Stakeholders observed that family/carer buy-in at the outset is critical, with in-person site visits prior to placement a key enabling factor. The was high variation in family/carers' satisfaction with the SDCUs' communication pre-admission, with some stakeholders reporting instances of miscommunication between SDCUs, referring facilities and family/carers, leading to confusion as to who will support the resident through the admission process. Stakeholders also commented on the importance of setting pre-admission expectations with families/carers relating to the 12-month nature of the service model, what can realistically be achieved for residents, and the gradual nature of de-prescribing current medication.

- **Socialising client information with staff pre-admission.** Routine discussion among care staff of a resident's unique needs and preferences prior to their placement (informed by NBA reports, observations from the provider's in-person assessment, and handover documentation from the referring facility) was noted as an enabling factor. Stakeholders commented on the importance of these early discussions in increasing staff confidence in their ability to manage the resident and their behaviours.

- **Flexible resourcing to support admissions**. Sites consistently reported that new admissions can be highly disruptive to new and existing residents. It can disrupt the existing patient dynamic and require a higher level of staff supervision. Many SDCUs identified a need for extra resources on admission days, as newly admitted residents typically require closer supervision as they adapt to the new environment (described in Section 3.1).

Figure 2.11 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to the transition in process

> *“We have had people drop [the resident] off and they just wanted to leave. But we need a support person who knows the client to stay here for at least 4 hours to help them adjust. But many times they were not aware they had to stay. If they do not stay for that amount of time, it does not work as well. [It is] stressful for the staff [and] for the resident.”*
>
> *– Unit staff*

> *“Between both facilities, there was very open communication. I was invited to be there on the day. I was there when she was put into the transfer van and met her at the SDCP unit. I went through the whole induction. There was no sort of let down there at all. All the communication and process was brilliant.”*
>
> *– Family member*

> *“There was no real communication as to what was happening. I just happened to be [visiting the mainstream unit] on the transition day and soon realised I had to [pack up her belongings] because no one else seemed to be doing it. It was confusing. I did not get any communication about what was happening… [before the day] so it was just lucky that I visited [the mainstream unit] that day.”*
>
> *– Family member*

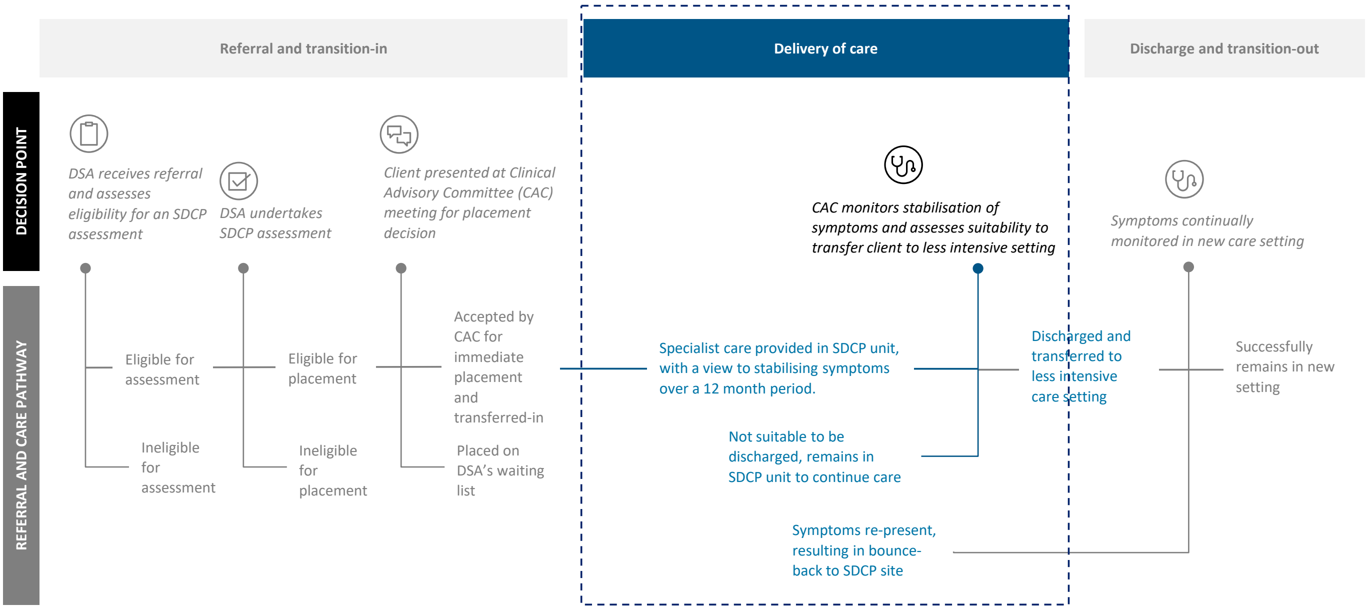
> *“[Before admission] we contacted the family and the current facility to talk about what [the resident] likes to do on a day-to-day basis [and create] a behavioural support plan with likes/dislikes, preferred routine… care information and so on. [It] had a lot of input from our CNC and the psychogeriatrician at the other facility – so we collated all of that information before [the resident] came in.”*
>
> *– Unit staff*

Source: Deloitte Access Economics analysis of stakeholder consultation transcriptions, 2022

3 Delivery of care

This chapter presents key findings as they relate to the delivery of care part of the Program's care continuum.

Figure 3.1 Delivery of care component of the care continuum



Source: Deloitte Access Economics based on Department of Health information.

An assessment of the care delivery process is explored through the following sub-sections of this chapter:

- program resourcing and staffing
- care service model
- clinical governance.

3.1 Program resourcing and staffing

High staff/resident ratios are considered a key enabler to Program success. Strong RN presence was also cited as critical to Program success, however the presence of a dedicated RN at each SDCU varied across sites. The model of clinical in-reach is relatively standardised across SDCUs in metropolitan locations, however unique barriers exist in regional areas.

Staffing levels

SDCU staff, in-reach clinicians and family members reported high levels of satisfaction with staffing ratios. These stakeholders observed that compared to mainstream RACFs, the Program ratios allowed for:

- greater levels of supervision
- more time for staff to engage in person-centered care
- more time to develop a better understanding of residents' needs and triggers
- an increase in continuity of staffing, supporting residents' progress as they feel more familiar and comfortable with the staff delivering care.

Several units have evolved their approach to staff rostering in response to Program learnings. For example:

- **Flexible resourcing to support admissions.** Many SDCUs identified a need for extra resources on admission days, as newly admitted residents typically require closer supervision as they adapt to the new environment.
- **Recreational support for afternoons.** At most sites, afternoon shifts have fewer staff than morning shifts, however the afternoon is when behaviours are most likely to escalate, and when recreational activities – which are critical to managing behaviours – typically occur. To address this issue, some sites have found it effective to recruit a dedicated recreational staff member for afternoon shifts.

Staffing mix

The SDCP Framework states specific requirements for SDCUs of the "*availability of a registered nurse (RN) on-site 24 hours a day*".[9] However, it does not prescribe set staffing ratios/staff mix, and thus considerable variation is seen across sites. Information on staffing ratios, staffing mix and recruitment is requested by the Department as part of six-monthly provider performance reports.

The main observation regarding staffing mix across SDCUs related to variation in the levels of RN presence. Some sites have a SDCU-dedicated RN available during morning and afternoon shifts working in a unit leadership or clinical coordinator role. However, other units have reduced RN presence, with one SDCU led by an Enrolled Nurse (EN) with support from an on-call RN working across the broader facility. It is noted that ambiguity in the Framework wording is likely contributing factor for the observed variation.

Almost all in-reach clinicians emphasised that the specialist nature of the Program imposes an obligation on SDCUs to ensure an appropriate staffing mix. These stakeholders felt the Framework should thus be more prescriptive on staffing mix requirements, with a view to ensuring standardisation and equity in the care experience. Stakeholders across all sites felt that a dedicated SDCU RN was important for the success of the Program, with the RN playing an important role in care quality and safety, the security of residents and staff, maintenance of detailed clinical documentation, and in upskilling ENs and care staff. Where SDCUs had limited access to an RN, stakeholders cited examples of delayed in-person medical assessments (due to wait-times for the on-call RN), and care staff being concerned for their safety when a resident's behaviours escalate.

In addition, as described in Section 3.2, informal on-the-job learning is a key driver of enhancing EN and care staff competence and confidence in resident behavioural management. SDCUs with a dedicated RN are able to use the role in a care educator capacity, where the RN uses day-to-day activities and incidents as an informal way to upskill ENs and care staff.

Care staff attrition

Attrition of care staff was cited as a challenge faced by many sites. This appeared to be driven by an unfavourable risk-pay trade-off, when compared to working at mainstream RACFs. Remuneration for care staff is determined by providers rather than set by the Program. As a result, for providers to avoid administrative costs associated with high staff turnover, additional monetary incentives for care staff may be required.

Clinician support types and SDCU attendance

Across most SDCUs, stakeholders reported employing a psychogeriatrician, geriatrician or psychiatrist who attends the SDCU one day per week to review each resident's care plan, participate in CRT meetings and provide consultation and education to care staff. Most units also employed a Clinical Nurse Consultant (CNC) as part of their clinical in-reach who attended the SDCU one to three days per week. The CNC typically also attended the CRT. Stakeholders highlighted the important role of the CNC for the following reasons: provision of specialist expertise to support care planning; family consultation; and upskilling ENs and care staff with day-to-day care tasks and behavioural management strategies. Units

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[9] Australian Government Department of Health (2020), Specialist Dementia Care Program framework, accessed 1 June 2022, <https://www.health.gov.au/our-work/specialist-dementia-care-program-sdcp> .

that did not have a CNC available acknowledged the role would be beneficial, but noted they were struggling to recruit the role in their region.

The clinical in-reach for the sole SDCU located in a regional area was limited to one psychologist, as the local hospital did not have a funded psychogeriatric service. At this site, an external psychiatrist is available in advisory on-call capacity, and a GP plays a more active role in clinical decisions, but neither is part of the contracted clinical in-reach team. Given the acute and rapidly evolving needs of the residents, stakeholders felt the absence of in-person specialist was a barrier to meeting resident needs in a timely and proactive manner.

24/7 support

Stakeholders across all SDCUs noted the clinical in-reach team were available on-site during their agreed days, with on-call support provided during other business hours.

Stakeholders at some SDCUs noted informal agreements to contact the psycho-geriatrician (or their equivalent) for support after standard business hours in the event of escalated incidents. Consultations with these clinical specialists indicated willingness to offer in-kind on-call support because of the lower staffing ratios and the absence of an RN during night shifts. However, no SDCU had formalised contracted 24/7 levels of support from clinical in-reach teams.

Where medical support is required during night or weekend shifts, SDCU staff typically contact the on-call geriatrician at the local hospital or transfer to the Emergency Department.

GP and allied health involvement at SDCUs broadly reflects the level of GP and allied health involvement at each provider’s co-located mainstream RACF.

GP involvement

All SDCUs reported regular access to a GP to oversee day-to-day medical care for residents. Most SDCUs used the same GP who services their broader facility one or two days per week. However, it was observed that the in-reach clinicians provide most of the clinical advice to SDCUs (rather than the GP), including decisions related to psychotropic medications, arranging ED transfers, any other business hours clinical support needs (via on-call availability). A small number of stakeholders felt that this was not always appropriate, as it could sometimes result in the in-reach clinician performing tasks which fell more under the GP’s scope of work, simply because the GP was not available to the SDCU at the time.

A small number of SDCUs felt that GP involvement was too infrequent at the SDCU given the higher-support needs of the residents relative to the mainstream RACF. They felt this occasionally impeded the timeliness of medical reviews and the ability to proactively manage resident needs. Relative to metropolitan SDCUs, the GP was more heavily involved in clinical decisions and discussions at the regional SDCU, often on an in-kind basis. In this case, the GP played more active role because there was no psycho-geriatrician (or equivalent) in the clinical in-reach team.

Level of allied health involvement

A principle of the SDCP Framework is to use “a multidisciplinary approach with formalised arrangements for access to specialist services, including clinical and allied health”. The Framework also states that providers are responsible for directly sourcing and funding allied health services.

Certain stakeholders observed minimal and sporadic involvement from allied health staff over the duration of the Program. This was raised in the context of the specialist nature of the Program. Only a small number of SDCUs described regular attendance from allied health staff rostered at the SDCU one or two days per week, with most other units accessing allied health support on an as-needs basis from allied health staff who service the broader facility.

Use of a social worker

Across the SDCUs, sites were also observed to have differing levels of access to a social worker. This could range from a social worker employed across the SDCU and co-located mainstream RACF, to an SDCU-dedicated social worker. Various roles that stakeholders described the social worker undertaking included:

- resident engagement (emotional and social support)
- family engagement (education and counselling support to families to build trust, gather important information about the resident, and prepare families for the transitional nature of the Program)

- staff engagement (staff wellbeing and debriefing after incidents).

Overall, stakeholders recognised that given the difficult circumstances that residents and their families/carers have experienced prior to placement in an SDCU, and the unique challenges associated with staff caring for this cohort, having a social worker that is focused on engagement and wellbeing is a valuable addition to the model of care.

It was also observed that where an external transition is required, it can take time to identify a suitable discharge facility. In the **Interim Report (2021)**, in-reach clinicians noted that in inpatient psychogeriatric settings, a social worker is tasked with identifying a suitable discharge location, which ensures a timely discharge. It was suggested that, as the Program grows, depending on the existing level of access to a social worker at an SDCU level, there may be an opportunity to consider use of a social worker at a jurisdictional level to support SDCUs with external transitions.

3.2 Care service model

Support from in-reach clinicians is considered a major strength of the model.

Stakeholders across all SDCUs commented on the in-reach clinician model as a major strength of the Program. The support provided by the in-reach model was cited as a strength for the following reasons:

- **Transitions in.** Ability to support a seamless transition-in, particularly when the transition is from an inpatient facility.
- **Upskilling staff in behavioural management.** Ability to upskill care staff in behavioural management approaches, both formally and informally (as described in Section 3.2).
- **Instilling confidence in families/carers.** The in-reach instils confidence in families/carers on the specialised tertiary-level support provided in the SDCU, despite being in a mainstream RACF.
- **Transitions out.** Knowledge of appropriate external transfer-out options, and the ability to support appropriate discharge planning early.

Competence and confidence of care staff appears to have improved over the duration of the Program, however many stakeholders highlighted training of care staff in the management of moderate to very severe BPSD as an opportunity for improvement.

Care staff competence and confidence

The Framework states "an expectation of higher staffing levels and expertise in dementia and behaviour management staffing". However, previous **Interim Reports (2020 and 2021)** found that some providers do not offer care staff specialised training outside of what is already offered as part of onboarding staff to their mainstream RACFs. In addition, most care staff did not have experience working with behavioural management relating to moderate to very severe BPSD or experience working with people with very severe BPSD specifically. A key takeaway related to care staff's lack of confidence in their ability to their prevent and manage very severe behaviours and there was a need to strengthen training in this area.

Stakeholder consultations as part of the Final Summative Report indicated an uplift in confidence and skill level across the length of the Program, however it remains an area for improvement. Again, in this round of consultations, many in-reach clinicians felt care staff were excellent in providing a high standard of basic personal care, however they generally did not have the specialist expertise to recognise triggers, pre-emptively manage behaviours of concern, or respond to behavioural incidents. Some stakeholders felt that low confidence with very severe BPSD behavioural management among care staff can lead to personal safety concerns, which has contributed to high rates of care staff attrition.

> *"We have found that the staff do have a need to be upskilled in particular areas for particular residents' needs. The cookie cutter approach they have been taught in training is not necessarily going to work for that person even though it seems to be a cookie cutter problem."*
>
> *– Unit leadership*

The importance of informal capacity building

A handful of SDCUs reported high levels of care staff confidence and competence in management of very severe BPSD, which was validated by in-reach clinicians and DSA representatives. Effective methods for upskilling staff at these SDCUs mostly related to informal capacity building and on-the-ground mentoring. Approaches found to be effective included:

- **Routine processes for debriefing with care staff.** Survey respondents and stakeholders at some SDCUs reported embedding debrief opportunities into regular team processes (e.g., post incident or as part of CRTs) to enable care staff to learn through reflective practice and real-life case-based discussions.
- **Employing a dedicated nurse educator role.** Clinical in-reach stakeholders at these SDCUs observed the role has helped facilitate more proactive, timely and coordinated care.
- **Using the CNC in an educator capacity.** Several sites highlighted the important role of the in-reach CNC in the provision of ad-hoc advice to nursing staff on best-practice behavioural management techniques. Stakeholders at one site also noted the CNC provides valuable support in identifying and coordinating additional training opportunities. However, there appeared to be variation in the extent to which this occurred across SDCUs, with some CNCs perceiving their role to be more clinical than educational. Clarity in MoUs on the educator function of the CNC may help mitigate this challenge.

> *"Where they succeeded was the hands-on leadership on the ground; the modelling, mentoring, and I guess [encouraging] the confidence to give it a go and see what would happen for the best outcome of the client."*
>
> *– Clinical in-reach*

Formalised training
Most SDCUs have implemented some form of formalised training in the management of very severe BPSD since the delivery of the Interim Reports. This was generally delivered on a one-off basis by the CNC or by DSA representatives using a workshop style format. However, some stakeholders raised concerns about variation in the quality and frequency of formal training across SDCUs and the duplication of effort. In addition, due to staff turnover and varied frequency of training delivery, several stakeholders reported some care staff have receiving limited to no formal specialised training outside of what is offered in providers' mainstream onboarding process. Through consultations and survey responses, stakeholders reported a desire for further formal training for Program staff in the following areas:

- risk management and escalation processes
- delivery of person-centred care
- the non-pharmacological and pharmacological strategies to manage very severe BPSD
- clinical care, assessment and documentation (e.g. pain assessment and management, clinical handover and information-sharing)
- emotional and empathetic care.

It was suggested that the SDCP Framework could be clearer in setting expectations on training standards and processes. In addition, the Department should consider centralising training in behavioural management and offering it a national level.

Care staff recruitment and retention
As highlighted by the learnings listed above, effective methods for upskilling staff takes time, as staff 'learn from doing' which increases with time in role. Many of the challenges associated with care staff competence and confidence are thus compounded by high attrition rates. Attrition rates are attributable to the perceived risk-pay trade off related to working in an SDCU compared to a mainstream RACF and the more general workforce shortages across the broader aged care sector.

Some SDCUs noted that to address recruitment challenges they will rotate care staff through their co-located mainstream RACF and the SDCU. However, they acknowledged this was not the ideal solution, with many stakeholders commenting on the importance of recruiting the right care staff for the Program. It was noted that SDCU care staff should be individuals who find working with people living with very severe BPSD rewarding and be able to maintain empathetic support in cases of agitative behaviours. This was generally cited as more important than formal qualifications. In support of this finding, there is evidence in the aged care literature to show that satisfaction in role is highly correlated with provision of person-centered care.

Overall, stakeholders felt SDCUs provided person-centered care, tailored to individualised needs and preferences. However, there are opportunities for improvement at some SDCUs.

Delivery of personalised care

The Framework states that SDCUs must adopt "an inclusive, person-centered and goal-oriented philosophy and approach to care that builds on the strengths and capacity of individuals". There was broad agreement across stakeholders consulted that SDCUs a deliver a more person-centered approach to care relative to mainstream RACFs. This was largely attributed to the staffing ratios which allow care staff to spend more one-on-one time with each resident. Anecdotal examples of individualised care included:

- placing favourite objects in each resident's room (e.g., photographs and preferred crafts, music playlists, television shows and movies)
- using residents' interest areas to better engage in conversation about those topics (e.g., history, travel, sport)
- placing a list of five 'likes' next to a resident's bed, which care staff care use as behavioural management strategies (e.g., bring a cup of tea, turn on jazz music, take outside for lunch).

> *"My brother has a love of pizzas. The unit and myself have an agreement that at least once or twice a month they were ordering pizzas for [client] and his fellow colleagues."*
> *– Family member*

> *"We set rooms up to suit the residents. Some residents have the bathroom fully equipped, their clothes are on the bed and all their stuff is in there already, whereas others we let them set it up how they like. Other people we have different shower chairs based on their needs. Lots of things to adjust."*
> *– Unit staff*

The garden and open home-like SDCU design was commended as an effective setup to enable person-centered care. It was noted that the design allows residents to go for a walk, engage in a range of desired activities (e.g., cleaning, cooking, gardening), while also providing enough space to distance themselves from others which helps to manage behaviours of concern.

Although SDCUs were largely perceived to provide a higher level of person-centered care than mainstream RACFs, there are opportunities for improvement. For example, some stakeholders identified the need to better navigate cultural differences and language barriers with culturally and linguistically diverse (CALD) residents to determine strategies for behaviour management and enrichment activities. A small number of stakeholders noted residents can often revert to their native language as their dementia progresses and their communication declines, making it more difficult for staff to complete daily tasks, understand resident needs and identify effective non-pharmacological interventions. In such cases, some SDCUs reported their staff needed to undertake additional research and problem-solving to identify strategies to improve engagement and communication with these residents. For example, staff may learn common phrases in different languages, read about a residents' culture to better understand their needs, or seek staff members or family members who speak the same language to overcome communication barriers when completing daily tasks (e.g., showers or administering medication). While a small number of stakeholders noted these communication barriers are an ongoing challenge to providing person-centred care, this issue is considered likely to be reflective of similar challenges faced across the age care sector more broadly as an increasingly culturally diverse cohort enters care.

Stakeholders generally felt SDCUs needed additional enrichment activities. This was highlighted in the context of its important role in behavioural management.

Need for additional enrichment activities

Several in-reach clinicians and allied health staff highlighted that boredom is detrimental to residents' cognitive and physical functioning. They noted that enrichment activities play an important role in diverting behaviours of concern for people with very severe BPSD. They also noted that while most SDCU staff have experience working in aged care roles with a focus on personal and clinical care, the SDCU requires a more holistic approach that should include a recreational focus.

The overall sentiment was that SDCUs could improve the availability of enrichment activities, particularly in the afternoons. Some in-reach clinicians observed that because of the cognitive impairment of some residents, SDCUs were reluctant to offer social and stimulation activities. In-reach clinicians felt SDCUs could better work with families/carers to identify appropriate activities aligned with capabilities, particularly given the staffing ratios. Activities could be as simple as reading or using sensory items.

Some SDCUs identified the need for more enrichment activities early on the Program. One SDCU has now employed an enrichment coordinator for afternoon shifts. Another SDCU uses their social worker in this same capacity. Both SDCUs felt these roles were critical to the success of their model and a driver of family/carer satisfaction.

Families/carers were broadly satisfied with their involvement in care decisions, however there is an opportunity to improve the timeliness of family/carer input into the initial care plan.

Communication preadmission/early post admission

In relation to the transition-in process, most families/carers were satisfied with the level of communication from the SDCU. Many noted the Program Manager reached out, prior to, or shortly after, admission, to gather information on the patient's history, interests, likes and dislikes. In many cases, they were provided with a tour of the SDCU prior to agreeing to placement, which helped to build their confidence in the Program and the decision to transfer their loved one. This was particularly effective in cases where the family/carer had reservations about the Program due to its transitional nature.

However, some families/carers felt communication from the SDCU could be improved, particularly in the initial care planning stage (i.e., post admission). Some families/carers were only invited to inform care planning (i.e., provide input into care approaches, recreational activities, food preferences etc.) several months post admission. Accordingly, there may opportunity for some SDCUs to review their existing admission processes to ensure a consistent and structured approach is taken to information-sharing with family/carers during the initial care planning stage.

> *"I got two emails – one from a random person asking if he has any spiritual needs and another from the team leader asking if he celebrates any cultural events. So I reached out asking if they wanted any information about his likes, dislikes, etc. and they thought they had already sent me a form about that but I had not received it. Only a few weeks ago I received a care plan where [lifestyle] information was integrated into it. It was an email [but] there were no meetings or opportunities to discuss it with them in detail."*
>
> *– Family member*

Communication as part of ongoing care

In relation to ongoing care and decision-making, the majority of families/carers were highly satisfied with the level of communication from SDCUs. Most families/carers reported participating in care plan review discussions with the multidisciplinary team every few months. They also noted the SDCU will contact for consent before initiating prescription changes or a chemical or physical restraints. The majority of families/carers felt they were able to contact the SDCU at any time to discuss the resident care and felt their opinions were genuinely valued by Program staff.

Some families/carers reported provision of conflicting information regarding a resident's care, which may be attributable to communication barriers between SDCU staff and in-reach clinicians at some sites (discussed in Section 3.3).

> *"[They are] so incredibly good at communication. The unit themselves were very good at updating us, sharing photos of what had happened that day or raising any concerns or potentially concerns. [They shared] the good things as well as the bad things so we knew what [the resident] was up to and how he was doing."*
>
> *– Family member*

3.3 Clinical governance

CACs and CRTs are largely working well across most units. Strong working relationships with in-reach clinicians are key to the success of these governance mechanisms.

Across the majority of units, stakeholders generally agreed that clinical governance mechanisms are working well. Overall, it was agreed that CRTs and CACs broadly occur as intended, with CRTs typically occurring weekly and CACs monthly. Stakeholders felt that clinical governance mechanisms are appropriate and responsive to the Program model of care, with

CRTs providing an opportunity to discuss client progress and clinical decisions (e.g., deprescribing), while CACs provide a forum to discuss placement decisions.

The following factors were cited as important success factors for strong clinical governance:

- buy-in from the provider's Executive management
- positive and collaborative relationships between SDCU staff and in-reach clinicians, with a commitment to openness and information sharing
- buy-in from all Program staff, who each recognised the value of the Program and shared a genuine commitment to ensuring its success.

The role of the CAC in placement decisions

At some SDCUs, stakeholders observed challenges in achieving consensus on the suitability of referrals during the CAC. The SDCP Framework states all CAC members are responsible for "advising on the placement assessments and admission of people to the specialist dementia care unit", however stakeholders highlighted that the provider has the ultimate power to accept a referral. Some in-reach clinicians felt that some providers make placement decisions based on the provider's risk appetite rather than resident suitability, which has contributed to slow uptake rates at certain sites.

Working relationships within CRTs

Tailoring care to the needs and preferences of each resident is critical to the Program's success. Stakeholders highlighted that weekly CRT discussions are important in enabling this type of individualised care by providing a forum to share insights and learnings on each resident, including reactions to different activities and food, their triggers, and their responses to different types of behavioural management strategies. Some sites reported stronger working relationships with in-reach clinicians than others, which appeared to correlate with levels of satisfaction with CRT meetings. The subset of sites who felt that CRT meetings could be improved, highlighted the following issues related to information sharing and coordination:

- lack of clarity in role responsibilities between in-reach clinicians, provider staff, and provider-staffed clinicians (e.g., GPs)
- lack of clarity in the frequency and processes for reporting as part of the CRT meetings
- approaches to family communication where pertinent information is raised during CRTs.

Care staff input into client progress discussions is an important for ensuring care is tailored to individualised needs and preferences. This has improved over time.

Care staff input

The **Interim Report (2021)** identified an opportunity for sites to better involve care staff (i.e., ENs and care staff) in CRT discussions related to client progress. It was noted that the benefits of this are two-fold:

- first, care staff are involved in day-to-day care provision and have important and valuable insights to share regarding symptoms, and what behavioural management strategies are working
- second, involvement in these discussions provides an important capacity building opportunity for care staff that would better enable them to care for a client cohort (i.e., people with very severe BPSD) with whom they typically have limited experience.

Two units interviewed for the Final Summative Report noted they now included care staff in weekly CRT meetings. However, most SDCUs do not include care staff in CRT meetings due to capacity constraints and the need for care staff to remain "on the floor". One SDCU noted they hold a debrief session for care staff on the floor following the meeting to ensure the relevant information is shared. Outside of CRTs, most in-reach clinicians acknowledged the importance of regularly engaging with care staff as part of their work to obtain insight and feedback on resident progress.

Some sites reported communication barriers across in-reach clinicians, GPs and allied health staff.

Communication across the multidisciplinary team

Overall, most SDCUs reported strong working relationships with in-reach clinicians. However, a handful of SDCUs reported barriers to an effective partnership. The main barrier related to fractured communication and information sharing across practitioners (in-reach clinicians, GPs and allied health staff), owing to differences in rostered days at the SDCU.

In some cases, this has affected the ability to ensure care is proactive and timely. For example, a stakeholder at one SDCU reported that the GP no longer attends CRT meetings, which limits the effectiveness of the meeting in assessing residents' behavioural and medical progress. In addition, in some cases, it has contributed to provision of conflicting information to families/carers regarding the resident's care needs and readiness for discharge.

Stakeholder commentary regarding the Program's interaction with the NDIS was limited. However, one site reported challenges in navigating SDCP care planning for NDIS-supported residents.

One SDCU reported caring for residents who received support through the NDIS in addition to the SDCP. A small number of stakeholders at this SDCU felt that care planning and goal setting for these residents could sometimes be more difficult than other residents due to the need to incorporate additional care goals under the NDIS and misaligned expectations between the NDIS and aged care staff. For example, one stakeholder felt the goals set under the NDIS did not sufficiently take into account limitations associated with the residents' dementia, which they noted resulted in ambitious care goals that could not always be met in practice.

Prioritising the establishment of a Clinical In-reach Community of Practice would support specialist clinical knowledge exchange.

Peer connections for in-reach clinicians

Several in-reach clinicians observed a need for a regular Clinical-In-reach Community of Practice, given the target cohort requires specialist expertise, and in some cases, peer review to support clinical decision making. These stakeholders felt that clinical care in the dementia field, and the aged care sector more broadly, is siloed, with few opportunities for knowledge-sharing and consultation with peer practitioners. One stakeholder provided an example of where they had sought advice from a DSA clinician on the use of medications, which strengthened their confidence and ability to implement legal and evidence-based practices.

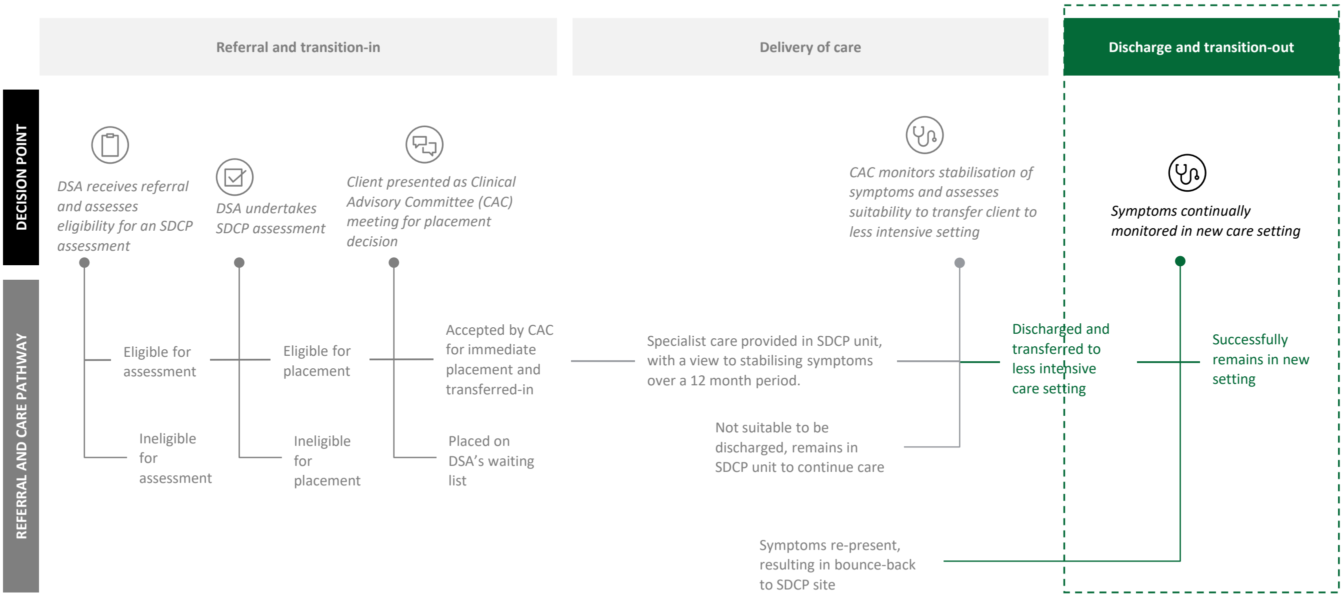
It is noted that since stakeholders were interviewed for this Report, the Department has commenced facilitating a regular Clinical-In-reach Community of Practice.

> *"It was definitely always going to be tricky balance to maintain between medical governance from hospital and site government from an RACF. But over the 2 years, there have been inroads about what is possible about reasonable expectations on [different] staff."*
>
> *– Clinical in-reach*

4 Transitions out

This chapter presents key findings as they relate to discharge and transition out phase of the care continuum.

Figure 4.1 Transition out component of the care continuum



Source: Deloitte Access Economics based on Department of Health information.

An assessment of the discharge and transition-out process is explored through the following sub-sections of this chapter:

- timeliness and co-ordination of discharge
- bounce-back of clients to an SDCU.

4.1 Timeliness and coordination of discharge

According to client-level data, the Program completed 99 discharges between September 2019 to June 2022, with almost two-thirds attributed to settled BPSD.

Number and location of discharges

According to six-monthly performance reports from SDCUs, 99 discharges occurred across all SDCUs over the course of the Program (hereafter referred to as separations due to the variation in end outcomes observed). Of these, almost two-thirds (62 residents) were separated to a less intensive care setting due to a reduction/settling in their BPSD. The remaining 37 residents were separated from the Program due to a change in care needs (e.g. acute medical event, progression of chronic disease, death or need for palliative care), or due to an escalation of BPSD.[10] The strong representation of changes in care needs as a cause of Program separation was partly attributed to the age and progression of disease among the Program's target cohort, which increased the likelihood that some residents would become palliative or require more acute care.

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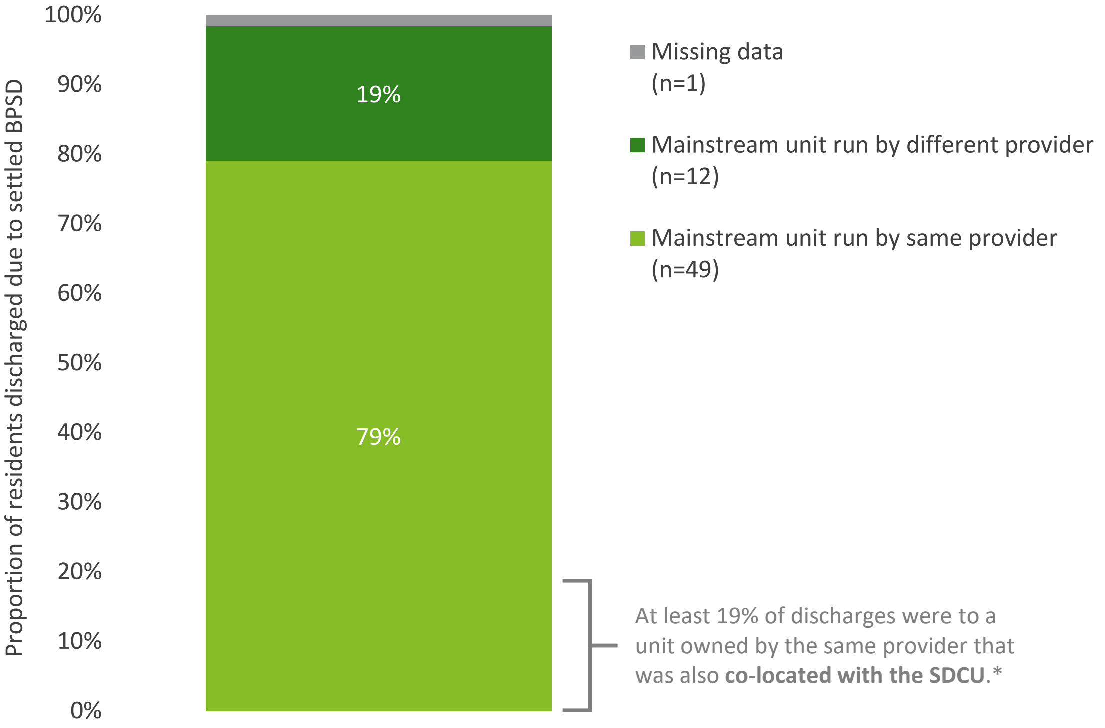
[10] For the residents separated from the Program for a reason other than the reduction/settling of symptoms, it was not possible to accurately quantify the proportion discharged for each individual reason. This was due to variances in how SDCUs reported the 'other' reasons for discharges. For example, some SDCUs reported on 'change in care needs' and 'palliative' separately, while other SDCUs included palliative residents within 'change of care needs'. The discharge data recorded in the six-monthly provider reports (at a cumulative and client level) and the clinical incident data also did not reconcile for some SDCUs. Despite these differences in coding, escalated BPSD were considered to represent a minority of separations.

While this group of residents separated for a reason other than the reduction/settling of BPSD, it is worth noting that many residents within this cohort were still reported to experience other benefits from the program (discussed in Section 5.2).

Of the 62 residents who were discharged to a less intensive care setting due to settled behaviours, 79% were discharged to a mainstream RACF setting operated by the same provider (Figure 4.2). At least 19% of all transitions were to a co-located RACF. However, based on insights gleaned through consultation, the true proportion is likely to be far higher. In the discharge data provided, many SDCUs did not distinguish between a RACF they operated that was co-located or located elsewhere.

Figure 4.2 Distribution of internal vs. external transitions out for residents who were discharged due to reduced/settled BPSD



At least 19% of discharges were to a unit owned by the same provider that was also **co-located with the SDCU**.*

Source: Deloitte Access Economics analysis of six-monthly performance reports, 2022
*Note: Some SDCUs did not specify the location of the mainstream RACF that is run by the same provider. Accordingly, the proportion of discharges that are made to a mainstream RACF that is co-located with the SDCU is likely higher than indicated in this chart based on insights gleaned through consultation.

The Program design feature allowing residents to transition to a co-located mainstream RACF operated by the same provider was recognised as a key success Program factor.

Internal and external transitions out were both considered to be a relatively straightforward process. Stakeholders noted that transitions out are a gradual process heavily dependent on the progress and needs of each resident, meaning the time required for each transition will vary across residents. Stakeholders did note however, that external transitions to a regional facility could be more time consuming due to the additional travel time required to transport the resident to the new facility.

Internal transitions to a co-located unit were identified as a key success factor of the model of care as it:

- **Increases residents' access to mainstream RACF options.** As the co-located unit is run by the same provider, internal transitions provide residents with easier access to a mainstream RACF that is willing to accept them (discussed further in Section 5.2.4).
- **Facilitates more coordinated discharges.** Internal discharges were generally preferred among some sites as staff felt they had more control over the process. For example, Program staff stakeholders noted internal transitions to a unit co-located with the SDCU can facilitate more convenient and frequent visits to the new unit prior to discharge (e.g., visiting the new unit for lunch or dinner), to help the residents gradually familiarise themselves with the environment.
- **Is the preferred choice among family/carers.** This is driven by family/carers' high satisfaction with the Program, as family/carers often build a high level of trust, confidence and familiarity with the SDCU staff. Where families chose to discharge to an external facility owned by a different provider, stakeholders observed the primary reason was often to move the resident closer to family, such as discharges to regional areas.
- **Facilitates easier post-discharge support.** The close proximity between the SDCU and co-located unit enables SDCU staff to visit the unit in person post discharge, which can provide stronger continuity of care to the resident and their family. It also allows the resident to be easily transferred back to a higher level of care at the SDCU, as needed.

As internal transitions to a co-located mainstream RACF was identified as a key success factor of the Program, comparable models replicated elsewhere should consider incorporating this design feature into future discharge planning processes.

The majority of transitions out were successful and largely well-coordinated. Success factors include early discharge planning, structured shared-care templates, and commitment to outreach with staff at the receiving facility.

Discharge success factors

Across SDCUs, stakeholders agreed the discharge process is well coordinated across SDCU staff, in-reach clinicians, DSA and the receiving facility. Most SDCUs have evolved their approach in response to learnings over time. Across both internal and external transitions out, the discharge success factors included:

- **Early discharge planning.** Stakeholders noted that in the case of an external discharge, it can take time to identify a suitable discharge facility. Some providers are reluctant to accept a resident because of their clinical history. In addition, not all RACFs have a dementia-focus. Some residents seeking an external discharge have remained in situ beyond their ready-for-discharge date because a discharge destination was not secured in time. Early discharge planning (at the time of admission), including discussions with potential discharge facilities, can mitigate this risk.
- **Structured shared care templates for handover.** Transitions out require in-depth knowledge transfer with staff at the receiving facility. Provision of information about resident needs and preferences, triggers and effective behavioural management strategies is critical to ensuring a successful placement. Most SDCUs use bespoke shared-care templates to provide this information.
- **DSA involvement.** Although DSA is involved in the admission process (through NBA and CAC meetings), following an SDCU admission they will typically only be consulted as part of their government-funded dementia behaviour support programs. Some stakeholders highlighted challenges in discharging a resident to an external facility – noting there was often a reluctance on the part of the receiving facility, given the resident's history of behaviours. In these cases, SDCUs are increasingly drawing on the support of DSA to help manage the transition out (this was recommended in the **2020 Interim Report**), with DSA able to provide upskilling assistance to staff at the receiving facility as part of their Severe Behavioural Response Team (SBRT) program.
- **Outreach with staff at the receiving facility.** Some SDCUs noted that in the case of external transitions, staff may spend up to one week on site at the receiving facility upskilling staff and ensuring the resident is comfortable in their new surroundings. In additional to support from DSA (discussed above), the clinical in-reach team also typically provides on-call support to the receiving facility on an ongoing basis to provide further advice and support, as needed. Several sites noted a member of their staff (such as CNC, nurse coordinator or social worker) maintains regular contact with the receiving facility during the 12-week bounce back period to support knowledge-sharing, monitor the residents' progress and support the family's transition to mainstream care.

- **Targeted family and carer support.** Due to families' high satisfaction with the Program (discussed further in Section 5) and previous negative experiences with mainstream RACFs, stakeholders noted family/carers can be reluctant to provide consent to discharge. Several SDCUs provide targeted psychosocial support to families and carers (e.g., through the social worker or nurse coordinator) to help allay family/carer fears relating to discharge and facilitate more timely transitions out.

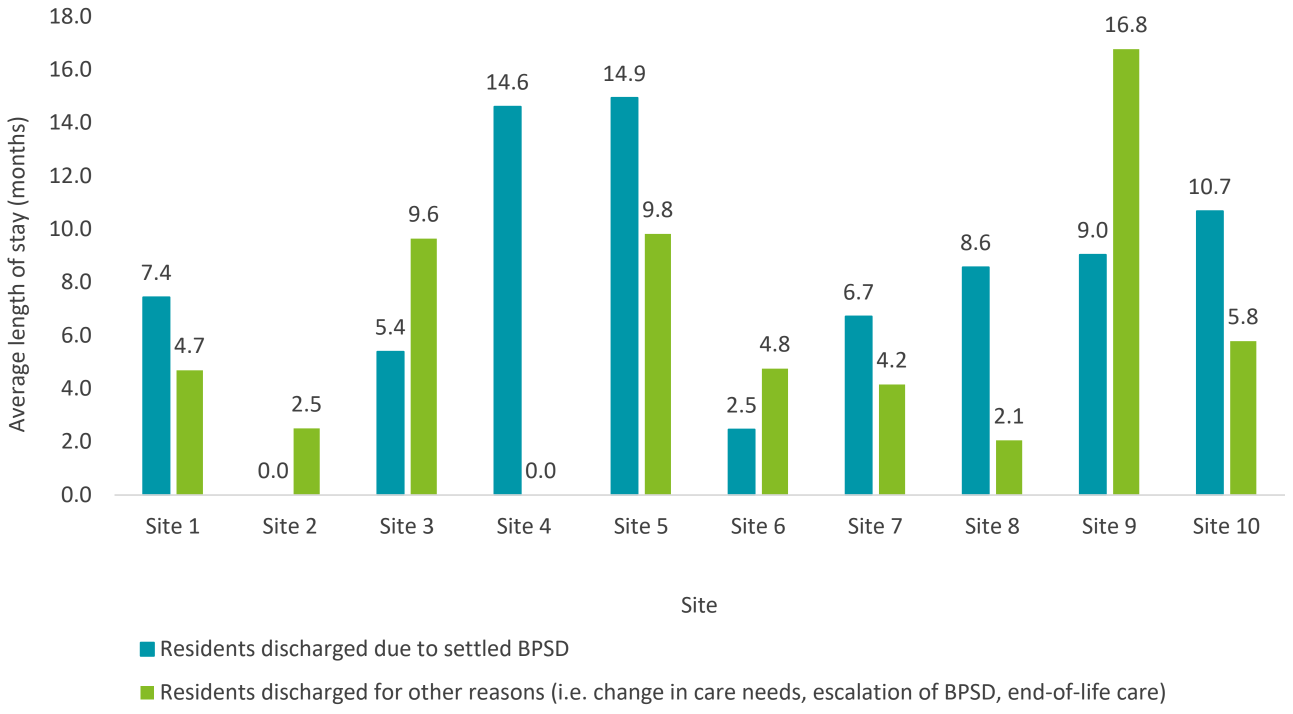
Potential role for social worker

Social workers with aged care expertise may help to support the timeliness of external transitions. As noted in the section above, stakeholders observed that where an external transition is required, it can take time to identify a suitable discharge facility. In-reach clinicians noted that in inpatient psychogeriatric settings, a social worker is tasked with identifying a suitable discharge location, which enables the timeliness of the discharge. It was suggested that, as the Program grows, there may be an opportunity to consider use of a social worker (at a jurisdictional level) to support SDCUs with external transitions.

There was high variation in the average length of stay across SDCUs and stakeholders expressed divergent views on the 12-month transitory intent of the Program, as discharges are individual to each residents' unique needs.

Stakeholders at some sites viewed the 12-month discharge benchmark as arbitrary, noting that some residents are ready for discharge well before the 12-month period while others require a longer stay before their BPSD settle enough to enable transition to a mainstream RACF. Program staff at several sites observed that the model of care allows discharge planning to be more focused on each residents' rate of progress, which can vary greatly by resident. Although the average length of stay across all discharged residents was 8 months, Figure 4.3 shows high variation across SDCUs and by reason for discharge. On average, eight out of ten SDCUs discharged residents who exhibited settled BPSD within 12 months of admission.

Figure 4.3: Average length of stay for discharged residents, by SDCU and reason for discharge



Source: Deloitte Access Economics analysis of six-monthly provider reports, 2022

Some stakeholders also expressed a view that in certain situations (e.g., difficult residents or residents nearing end-of-life) the focus should be on maintaining patient quality of life rather than discharge. As seen in Figure 4.3 above, there was also high variation in the average length of stay for residents discharged for reasons other than settled BPSD (e.g., escalated behaviours, change in care needs or those nearing end of life). It should be noted that it was not possible to compare the average length of stay for each individual reason within the 'other' category, as there was inconsistency in the way sites classified the reasons for discharge.

SDCUs reported divergent views relating to end-of-life care in particular. Program staff at some sites believed it was more appropriate to keep the resident in the SDCU to avoid additional disruption and stress, and to maintain continuity of care in an environment where they feel comfortable. Others however, strongly believed palliative care lay outside the scope of the Program as it was more appropriate to transition the resident to a ward with specialised palliative care staff and to create space in the SDCU for a new admission to support the existing Program waitlist.

4.2 Client bounce-backs

Over the course of the Program, fewer than ten residents (who were discharged) required readmission to an SDCU.

According to six-monthly performance reports, of the 62 residents who were discharged due to settled BPSD, fewer than 10 required readmission to an SDCU.

Anecdotally, post-discharge progress is highly individual to each resident and the conditions of the receiving facility (e.g., resident mix and staff capabilities). Stakeholders reported it can be difficult to predict whether a resident will require a bounce back admission but observed it is heavily dependent on how well the resident can adapt to the new unit dynamic and how closely their tailored care plan (developed in the Program) is followed. For example, one stakeholder noted a bounce back occurred because a clinician at the receiving facility altered the resident's medication shortly after admission, which exacerbated their BPSD. This highlights the importance of ensuring the enabling discharge factors mentioned above are in place to facilitate stronger communication with staff at the receiving facility and ensure care plans are closely followed. Indeed, all sites reporting a bounce-back noted it was a learning experience for the site, and adaptations such as increased outreach or support from DSA, have now been implemented.

The **Interim Report (2021)** found that one SDCU adapted their workflow to first discharge each resident to a step-down facility for two to three months, with the goal being to help the resident adapt to less personalised staffing ratios. This SDCU continues to be the only site consistently implementing a step-down approach, as the majority of SDCUs did not feel it was necessary. This is something to monitor long-term and consider as part of a potential risk-stratified discharge approach.

Anecdotally, the Program has successfully facilitated long-term symptom management in less intensive care settings for many discharged residents. Post-Program resident outcomes and care settings should be monitored on a more routine basis.

During the early stages of the Program, it was unclear the extent to which mainstream RACFs could sustain symptom management post-Program. However, a wider sample of discharge data was available for the Summative Evaluation Report. Secondary data and consultations indicate that, on the whole, the majority of residents (aside from the client bounce-backs described above) who were discharged due to settled BPSD remain stabilised in mainstream RACFs. While this is anecdotal, Program staff were able to comment on residents' post-discharge progress given most transitions occur internally and Program staff maintain regular contact with the receiving facility.

However, some stakeholders highlighted mainstream RACF dynamics as an ongoing risk to sustaining settled BPSD. Given residents respond well to the Program's quieter environment and higher staffing ratios, they noted it is possible that certain residents may become unsettled in mainstream RACF settings. Accordingly, it is suggested that the progress of discharged residents is monitored long-term. This information could then be used to inform an assessment of whether a risk-stratified step-down discharge approach should be considered for certain high-risk clients.

Figure 4.4 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to the barriers to long-term symptoms management

> *"The real challenge [is] because [our unit] does such a good job, it is hard for anyone else to do such a good job. Other facilities' understanding of the residents is just not the same at all."*
>
> *– SDCP Staff*

> *"SDCU staff are so good at stopping things before it happens, but personal care still requires 3 to 4 people and can still create the aggression. Once they transition to mainstream, they do not have 3 to 4 people who can provide it and the resident gets scared of it so it does not go well."*
>
> *– SDCP Staff*

> *"Mainstream… staffing is a problem. Some dementia support units have 50-60 patients to manage which is an issue. In the SDCU there are 7 to 10 beds so patients will get used to less residents around and one-on-one staffing… [In mainstream] there is a mixed group of patients… with different needs and understandings of each other."*
>
> *– SDCP Staff*

> *"One of our discharges went to [an external unit] and the person ended up being hospitalised. They got really unwell because [staff] could not administer their insulin."*
>
> *– SDCP Staff*

> *"Mainstream Care needs to be monitored better [on how they] manage care when they are provided care plans in advance from SDCP."*
>
> *– SDCP staff*

Source: Deloitte Access Economics analysis of stakeholder consultation transcriptions, 2022

5 Program outcomes

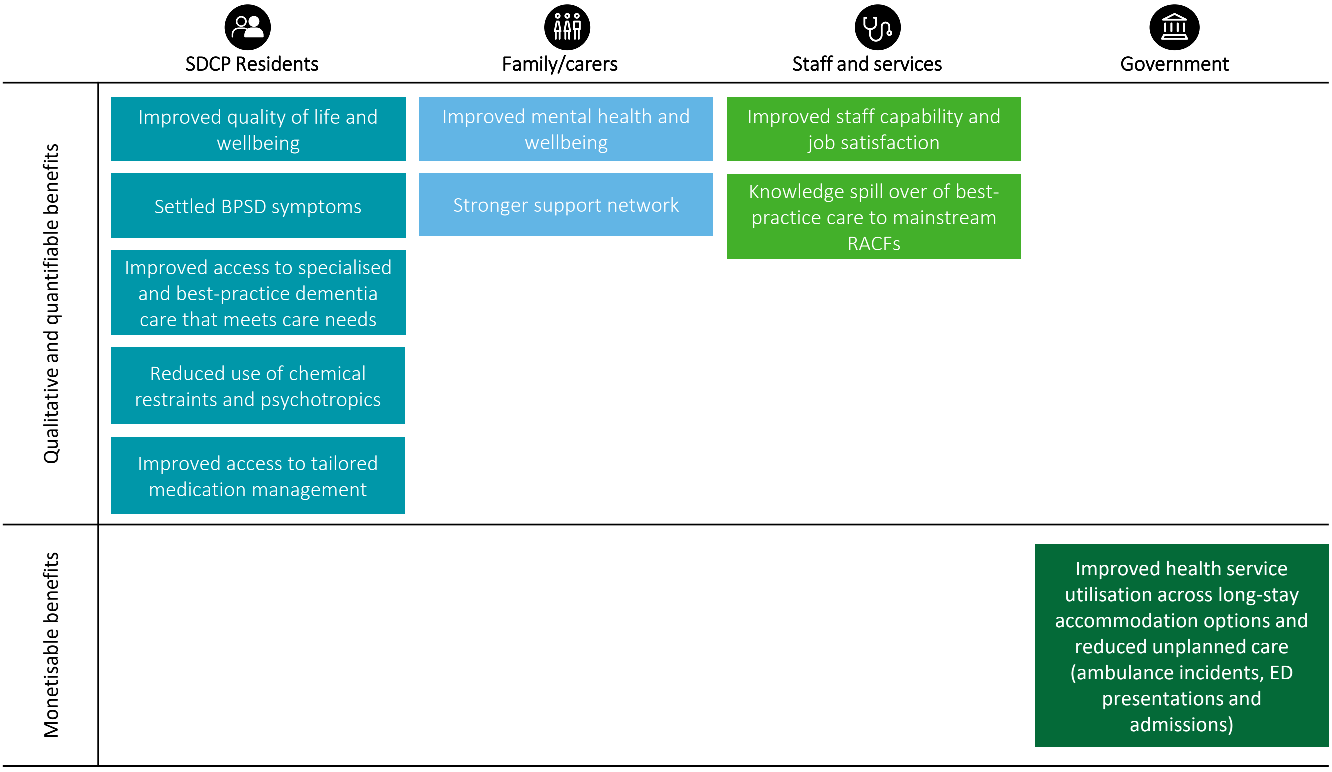
This chapter presents key findings related to Program outcomes at an individual, service and system level for residents and their families/carers, Program staff and the broader health and aged care system.

5.1 Approach

To evaluate the Program outcomes achieved (including those to be monetised in the economic evaluation), a benefits framework was developed based on the Evaluation Framework created at the Program outset and the key insights that emerged through data collection and analysis.

This framework is presented in Figure 5.1. The benefits considered in this framework are relative to a comparator case where the Program does not exist, and residents would instead be receiving care in a hospital or a mainstream RACF. Outcomes were categorised as monetisable, quantifiable (but not monetisable), or able to be discussed as part of a qualitative narrative. The quantifiable and qualitative outcomes are discussed in this Section, with the monetisable benefits discussed in Section 6.

Figure 5.1 Identified Program benefits



	SDCP Residents	Family/carers	Staff and services	Government
Qualitative and quantifiable benefits	Improved quality of life and wellbeing Settled BPSD symptoms Improved access to specialised and best-practice dementia care that meets care needs Reduced use of chemical restraints and psychotropics Improved access to tailored medication management	Improved mental health and wellbeing Stronger support network	Improved staff capability and job satisfaction Knowledge spill over of best-practice care to mainstream RACFs	
Monetisable benefits				Improved health service utilisation across long-stay accommodation options and reduced unplanned care (ambulance incidents, ED presentations and admissions)

Source: Benefits identified through evaluation activities. Deloitte Access Economics.

The following chapter sections describe key findings related to the qualitative and quantifiable (but not monetisable) outcomes depicted in Figure 5.1. Monetisable outcomes are reserved for discussion in Chapter 6.

5.2 Benefits for Program residents

5.2.1 Improved quality of life, health and wellbeing

Consensus across all stakeholders consulted that the Program led to significant improvements in residents' quality of life and overall wellbeing. This was the key driver of strong family/carer satisfaction with the Program.

Quality of life in people with moderate to very severe dementia can often be assessed observationally through family members and care staff by examining the person's affective state, behavioural indicators of discomfort and engagement with their environment.[11] This is due to the level of cognitive impairment among people with dementia, making self-reported quality of life often unreliable.

The majority of SDCU staff, in-reach clinicians and family/carers reported that they had observed major improvements in residents' quality of life over their course of their admission to an SDCU. This was evidenced through reports of:

- **Improved mood and overall demeanour:** Significant improvements were observed in residents' mental health and wellbeing and stakeholders reported residents often show a calmer demeanour and more positive expressions and behaviours over time. The majority of family members noted their loved one appeared more content in the SDCU compared to previous care settings.
- **Increased communication and interaction with family/carers:** Many anecdotal stories were provided of residents' improved communication and renewed social engagement with families/carers as well as more positive interactions with care staff and other residents. Stakeholders agreed this has fostered a stronger sense of belonging and human connection than residents experienced at previous facilities.
- **Improved personal hygiene:** Stakeholders reported personal care tasks can be easier in the SDCU, due to the more flexible approach to daily routines, more positive relationships with between residents and care staff, and reduced levels of aggression (discussed below). They provided examples of residents who had not received regular and thorough personal care (e.g., shower, hair wash or shave) in their previous care setting due to high aggression and noted such residents often displayed improvements in appearance and personal comfort after admission to the SDCU.
- **Higher autonomy and freedom:** Stakeholders reported residents are less restricted in the SDCU compared to mainstream care settings, with more privacy from others, ability to set their own daily routine, and space to wander freely. This was attributed to the restraint-free model of care as well as the spacious and less clinical unit design.
- **Decreased desire to leave:** Family members believed their loved one felt more at home in the SDCU compared to their previous care setting, as they no longer vocalised a need to leave the SDCU and 'return home'. Program staff also agreed that SDCU residents rarely made attempts to leave the unit, which they noted can be common among people with dementia in mainstream settings.
- **Increased engagement in daily tasks and activities:** Stakeholders observed higher participation in daily cleaning and personal care tasks, as well as engagement in enrichment activities (e.g., craft, movies or listening to music) compared to their previous care setting (discussed in Section 3.2).

Consistent with the **Interim Report (2021)**, the significant impact on residents' quality of life was identified as a major benefit of the Program among family/carers and Program staff and was a primary reason for family/carers' high satisfaction with the Program.

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[11] 'DOMS: The Dementia Outcomes Measurement Suite' (2022) *Dementia Centre for Research Collaboration* (Web Page, 2022) < https://dementiaresearch.org.au/doms/>; M. F. Weiner, et al., 'The quality of life in late-stage dementia (QUALID) scale' (2000) 1(3) *Journal of the American Medical Directors Association* 114; T.P. Ettema et al., 'QUALIDEM: Development and evaluation of a dementia specific quality of life instrument – validation' 22(5) *International Journal of Geriatric Psychiatry* 424.

Figure 5.2 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to quality of life among Program residents.

> *"They have gone from being a shell of a human to having their laugh and spark back. There have been none of the issues that they were having at [the previous facility]…[the resident] is happy, they laugh and seem to be enjoying life again."*
>
> *– Family member*

> *"They were eating and walking again. They had social contact with their family again… We see a lot of physical changes in their appearance but also in their ability to communicate with people and engage in social activities."*
>
> *– SDCP Staff*

> *"You read awful reports about what they've done in other facilities. But when they come to [the SDCU]… there is a massive change… in their mental health and wellbeing. Their cognition and communication improves, they socialise more. It is just really lovely to see that someone can improve so much when they are listened to and when they are having their needs met on a regular basis."*
>
> *– SDCP staff*

> *"[Residents] feel calm and comfortable as if it is their home. In other facilities, [patients] always have the urge to go home… and they [would] try to escape. But I have not seen that here…They do not have that [desire] to go home. So they must be feeling very at home here."*
>
> *– SDCP staff*

> *"Sometimes when we are [at the SDCU] [we see] she spends time laughing which is always good... She seems very relaxed and happy. She did have situations at [previous facility] where she did not eat much for 2 months which was a massive worry. But it was a complete difference to where she is now."*
>
> *– Stakeholder*

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

5.2.2 Settled BPSD

There was broad consensus across all stakeholder groups that the Program is highly effective in achieving its goal of managing very severe BPSD. This is evidenced by the number of successful transitions to less intensive care settings and observed reduction in behavioural incidents.

The majority of stakeholders (SDCU staff, in-reach clinicians and family/carers) consulted agreed that most residents experience reduced BPSD over their stay in the SDCU. These insights are supported by Program discharge data, which showed that approximately two-thirds of Program discharges transferred to less intensive care settings due to settled BPSD, and less than 10% of these resulted in a bounce-back. It is also worth noting here that the 'other' 37% of discharges were typically due to changes in care needs, rather than because BPSD had escalated (i.e., it is reflective of residents' underlying health, rather than the efficacy of the Program model of care).

Stakeholders attributed the successful management of very severe BPSD to the bespoke unit design, person-centred and restraint-free model of care, and the higher staff ratios (discussed in Section 3). Stakeholders did note the caveat that other factors may influence whether or not behaviors will settle, including the trajectory of dementia as well as the underlying medical complexity (e.g., residents require palliative care).

<u>Behavioural incidents</u>

Stakeholders broadly agreed that the main area of improvement in residents' BPSD was a reduction in agitation and aggression. The model of care was perceived to be highly effective at reducing physical aggression, however stakeholders' views were more varied on its ability to reduce verbal aggression.

These qualitative findings were supported by case study analysis performed on the clinical data provided by one SDCU which recorded the number of behavioural incidents[12] per resident.[13] Analysis showed that residents who were discharged

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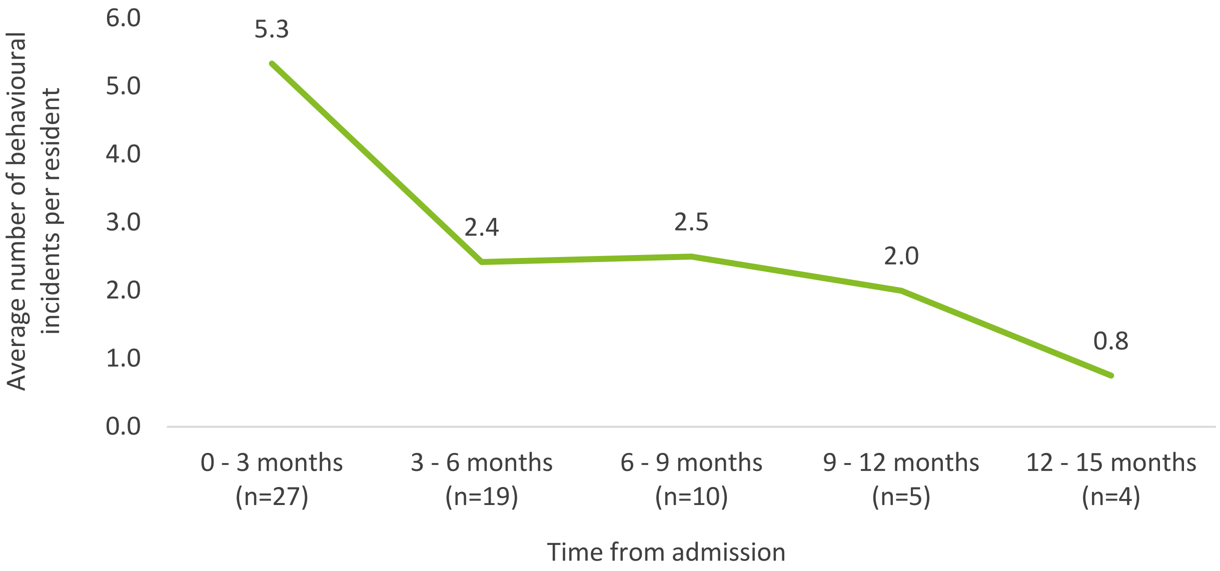
[12] 'Behavioural incident' includes any incident recorded for each resident which (1) was initiated by the resident and (2) involved aggression, agitation or abuse (physical or verbal).

[13] It was not possible to map behavioural incidents over time across all SDCUs due to variation in completeness of clinical data provided by sites (discussed further in Section 7). Accordingly, case study analysis was performed on a smaller number of sites wherever possible, to examine the available data in more detail.

from the Program exhibited, on average, a decrease in the number of behavioural incidents over the length of their stay (Figure 5.3).

Figure 5.3 Case study analysis: The average number of aggressive behavioural incidents recorded per resident, by time from admission (discharged residents)



Source: Deloitte Access Economics analysis of secondary data from one SDCU, 2022.

Note i: Analysis was performed on a cohort of 27 residents who had been discharged from the Program. The sample size decreases over time as the Program is transitional and there is no minimum stay period, meaning residents transition out of the SDCU once they are ready to be cared for in a mainstream setting.

Figure 5.4 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to reduced aggression among Program residents.

> *"Absolutely, [the SDCP] has been a complete turnaround. At the previous nursing home we were receiving notifications [on aggressive incidents] a couple times a week. Since they have been in the SDCU there have been maybe 2 notifications in 6 months and they were very early on.*
>
> *– Family member*

> *"The majority of [residents] have a massive reduction in behaviour. A few come in and you get the DSA report and you get scared thinking it will be a nightmare but after a few weeks you wonder why they are here because they settle so quickly."*
>
> *– SDCP Staff*

> *"It has gotten to the point where she is not aggressive at all anymore. I do not know if that is dementia progression or a combination with the staff treatment, but I honestly do not think she would be in the same situation if she was not there. I honestly think the care and support she has received at SDCP has helped her to get to the point where she is not so aggressive."*
>
> *– Family member*

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

It is worth noting that BPSD can often worsen following a residents' admission to the SDCU before showing an improvement over time. This trend was observed across most SDCUs and was attributed to the higher uncertainty and unfamiliar environment at admission which increases stress and behavioural triggers for new residents. Stakeholders noted it can often take several weeks to observe improvements in new residents, as it takes time for them to settle into their new environment and for SDCU staff to develop a deeper understanding of their needs to further tailor care planning.

Residents' BPSD can also fluctuate over their time in the SDCU. Across the majority of sites, Program staff reported that new admissions increase triggers for other residents within the unit, which can lead to a temporary exacerbation of their

BPSD. To manage this risk, some SDCUs roster additional staff during periods of new admissions to increase supervision and reduce the disruption to existing residents.

Figure 5.5 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to temporary exacerbation of symptoms during new admissions.

> *"We generally notice the stabilisation of symptoms. [During] the first week people are pretty settled. The second week is when we get a spike in agitation and aggression. But then we know them a little better and use non-pharmacological strategies. Then after a month, we know what non-pharmacological [strategies] will work and if the medications need to be changed."*
>
> *– SDCP Staff*

> *"Usually, patient escalation occurs around discharge dates and acceptance of new patients. Sometimes [we see changes] immediately or within a week later. Generally, [BPSD symptoms] settle down and de-escalate over time. [Symptoms] also increased during COVID because staff were in full PPE which created a new level of angst to residents."*
>
> *– SDCP Staff*

> *"When we have new admissions, the incidents change because it changes the dynamics, and relationships within the cottage. But after a while after the residents settle in, the incidents decrease."*
>
> *– SDCP Staff*

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

Cognitive functioning scores:

To assess improvements to resident cognitive and behavioural functioning, SDCUs were encouraged to use the Neuropsychiatric Inventory-Nursing Home (NPI-NH) tool. The NPI-NH is a validated tool commonly used to assess and characterise the neuropsychiatric symptoms for patients in nursing homes. Scores are recorded across twelve domains[14] and an overall score is then taken, with a higher score indicating higher severity. It is worth noting however, that aggregate NPI-NH scores are not the best indicator of Program efficacy for two primary reasons:

- **The Program's model of care targets some, but not all, NPI-NH domains.** The objectives of the Program mainly relate to the agitation and aggression domains.
- **Each domain is rated according to three metrics.** As the NPI-NH tool scores each domain on frequency, severity and occupational disruptiveness, a higher score may be due to changes in one of these criteria. However, given the progression of BPSD for residents, the definition of 'success' in their care goals may relate more to one metric (e.g., reducing the severity of symptoms but not the frequency).

Accordingly, to measure the extent to which the Program has contributed to a reduction in BPSD, data on individual domains and metrics would ideally be assessed. However, such analysis was not possible due to gaps in the secondary data provided by SDCUs. Of the ten SDCU sites, five provided data on NPI-NH scores, with only two sites providing NPI-NH scores broken down by domain. As a result of this small sample size, no major trends could be analysed at a domain level. When looking at aggregate NPI-NH scores, there was also high variation across sites in the average score at admission, which suggests the tool was applied differently across SDCUs. NPI-NH scores were also not consistently captured at three-month intervals until discharge, limiting the ability to map changes in scores over time. Accordingly, there is an opportunity to work with, and provide standardised training to, SDCUs to promote the consistent capture of NPI-NH scores at a domain level to facilitate stronger resident monitoring and Program evaluation activities. The implications of data collection limitations are discussed further in Section 7.

While analysis could not be performed by domain, analysis on aggregate NPI-NH scores instead looked at the directional change[15] for residents who were discharged due to settled BPSD. As shown in Figure 5.6, of the residents who were discharged due to settled BPSD, only 55% showed a decrease in aggregate NPI-NH score between their first and final assessment. Due to limitations in the data provided, it is not possible to accurately deduce the reason for this trend, as the drivers behind an increased or decreased NPI-NH score (being the individual domain scores) were not captured. Further, given the Program's model of care targets some, but not all, NPI-NH domains and each aggregate NPI-NH domain is rated across

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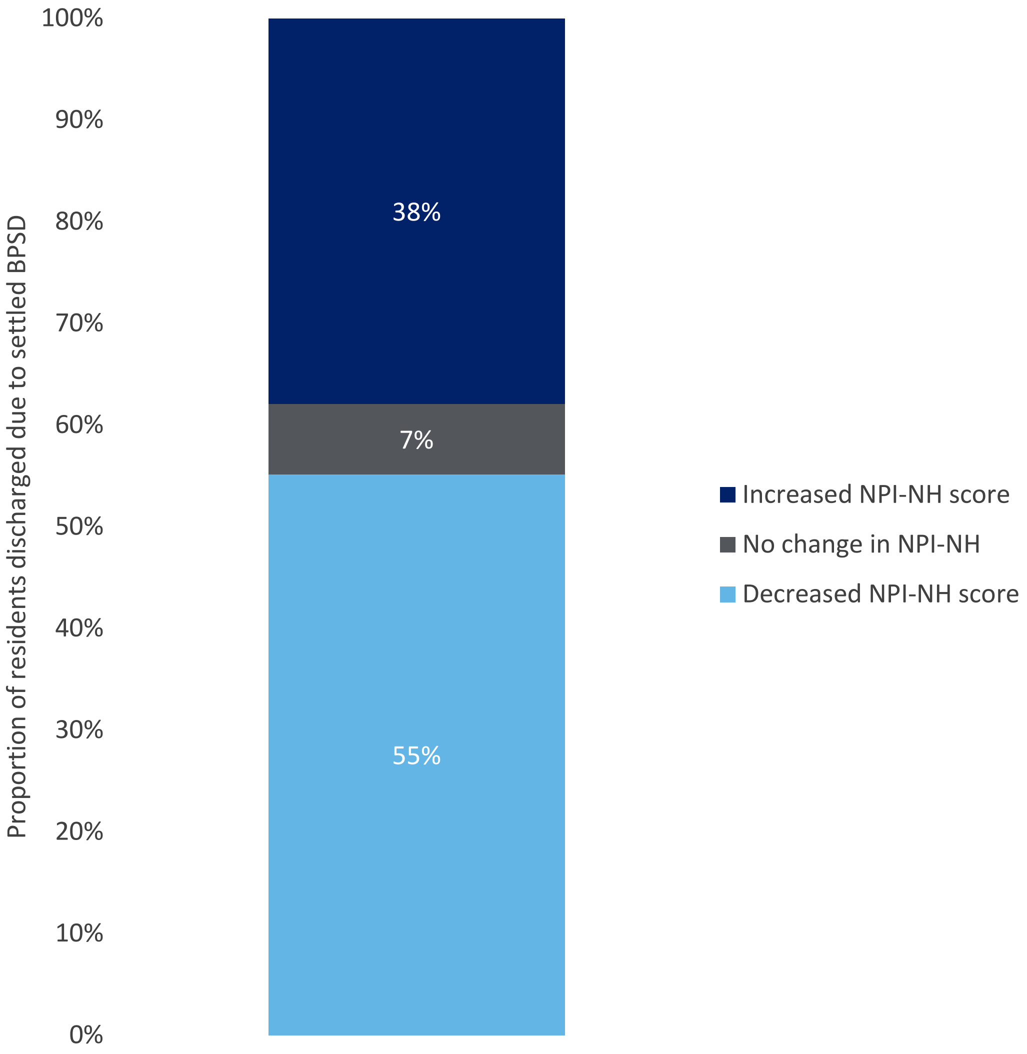
[14] The twelve domains are: Delusions, Hallucinations, Agitation/Aggression, Depression/Dysphoria, Anxiety, Elation/Euphoria, Apathy/Indifference, Disinhibition, Irritability/Lability, Aberrant Motor Behaviour, Appetite and Eating Disorders, and Sleep and Night-time Behaviour Disorders.

[15] Analysis looked at the directional change between resident's NPI-NH score at admission and their last recorded score before, or upon, discharge from the SDCU. It was not possible to compare the magnitude of change in scores over time across residents due to high variation across sites.

three metrics (as mentioned above), the aggregate NPI-NH score is not necessarily indicative of whether a resident showed settled or exacerbated behaviours.

Figure 5.6 Proportion of discharged residents whose NPI-NH score decreased, increased and did not change between admission and discharge (n=31)



Source: Deloitte Access Economics analysis of secondary data from four SDCUs, 2022

Given the inconsistent capture of NPI-NH data, there is also an opportunity to work with providers to explore any other measures SDCUs use to monitor residents' progress and determine readiness for discharge. This could help inform future learning for Phase Two sites, including valuable tools to tracking behavioural changes, structuring resident goals and setting expectations with families about what 'success' looks like for discharge.

There is a small proportion of residents whose BPSD does not settle over time, as their type of dementia or a comorbidity is less responsive to the model of care. Stakeholders identified this as a potential barrier to the Program's success due to the more resource-intensive care required and additional safety implications for residents and staff.

Stakeholders reported some residents do not show an improvement after 12 months in the Program and in some cases, exhibit escalated behaviours. These residents were believed to have BPSD that is less triggered by their environment and may instead be driven by other factors relevant to their type of dementia or other pre-existing diagnosis (e.g., other cognitive impairment or psychiatric illness).

It was noted that some residents who do not settle after twelve months cannot be easily discharged to a mainstream RACF, resulting in prolonged stay in the SDCU. This can impact the Program's success as it increases the resources required for the SDCU to provide safe and quality care. Stakeholders at a small number of sites noted this can also impede Program uptake, as the resident's complex behaviours must be factored into suitability assessments for Program applicants to ensure resident and staff safety. This was identified as a reason why a SDCU may operate below full capacity, as the provider may have limited options for the type of applicant they can accept into the existing resident mix.

5.2.3 Reduced use of chemical restraints and psychotropic medications

There was consensus across in-reach clinicians that the Program's model of care is effective in reducing the need for, and use of, chemical restraints in the care provided to Program residents.

Over the last several years, there has been an increased focus on the prescribing of psychotropic medications in the aged care system, including antipsychotics, anxiolytics/hypnotics (particularly benzodiazepines) and antidepressants.[16] The Royal Commission highlighted the high usage of these medication classes within residential aged care, noting their potential to be used as chemical restraints. Stakeholders consulted for this evaluation also observed that hospital environments are poorly suited to patients with BPSD, and that environmental triggers within inpatient settings can exacerbate symptoms. Based on reports from in-reach clinicians and families/carers, it is understood that prior to entry into the Program, most Program residents were vulnerable to medication prescribing patterns that prioritised reductions in behaviours of concern, with the potential for associated risks including oversedation.

In-reach clinicians consulted for this evaluation reported a reduction in the use of psychotropic medications for many residents in the Program, thus reducing their level of sedation and other commonly experienced side effects.[17] These stakeholders highlighted the following Program factors as enabling the reduced use of chemical restraints:

- The successful management of very severe BPSD through non-pharmacological strategies (discussed in Section 5.2.2) reduces the need for pharmacological intervention, especially instances of 'as required' administration.
- The higher level of staff supervision and regular specialist input (discussed in Section 3.1) facilitates more timely and tailored medication changes, allowing staff to find an optimal care plan with the lowest effective dose of psychotropics.

This theme was highlighted with the caveat that it not always be possible to cease the use of psychotropic medications for residents with very severe BPSD due to their severity of their symptoms and the progressive nature of their condition. It is also noted that medication deprescribing and the reduced use of psychotropics also benefits the broader aged care sector by facilitating the quality use of medicines. This is discussed further in Section 5.2.4.

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[16] From 1 January 2023, every government funded residential aged care facility will receive funding allowing them to employ or engage an on-site pharmacist or community pharmacy service, as part of the Australian Government's commitment to improve medication management and safety for aged care residents.

[17] Due to limitations in the unit-level data provided by SDCUs, it was not possible to quantify changes in prescribing patterns over time across sites. It is noted that based on stakeholder consultation, further data collection in this area would benefit from understanding the classes of medication de-prescribed or additionally prescribed, to understand trends in medication management in this cohort over time.

Figure 5.7 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to medication usage among Program residents.

> *"Medications are massively reduced. They are often on tons of sedatives, antipsychotics, lots and lots of medication – they are completely 'chokkas'. When the resident comes in, the psychogeriatrician does not mess with the medication for about a month while we get to know them and then they look at how we can reduce it. We ask the care staff in CRT meetings how they think the resident is going. We monitor the reduction in medication really closely."*
>
> *– SDCP Staff*

> *"[The staff] know their residents so well. They are able to see the early signs and early triggers. They intervene quickly. They can use all those non-pharmacological techniques before even needing to go for the psychotropics."*
>
> *– SDCP staff*

> *"We have so many strategies for [symptom management] prior to medication. Some [residents] are on some regular [medications] but staff are always looking to change or decrease those. It is very flexible. Given the amount of people who have come in [to SDCP]… the decrease in medication is definitely noticeable."*
>
> – SDCP Staff

> *"I think everyone has had reduced medications. When they come in, quite a few times PRN has been administered prior to transfer so trying to get baseline of the client can take 24-48 hours. But once we have baseline we look at medications and there [are] a few that… we have decreased so we eventually find a good mix for that client [by] swapping medications and mainly reducing the number of medications overall."*
>
> *– SDCP Staff*

Source: Deloitte Access Economics analysis of stakeholder consultation, 2022

5.2.4 Improved access to tailored medication management

The Program's model of care increases oversight over the management of resident medications.

Separate to reduced usage of chemical restraints and psychotropic medications, improved medication management in the Program cohort is also facilitated by frequent medication reviews performed by specialist in-reach clinicians. These reviews are informed by a level of staff supervision that is able better able to monitor residents' progress, and in the process identify unmet needs which may exacerbate BPSD (such as constipation or pain). This allows the implementation of more timely and tailored medication changes, including additional medications where clinically indicated to optimise resident wellbeing.[18] The National Medicines Policy (updated in 2022) contains four central pillars, including quality use of medicines and medicines safety. Actions that support this pillar may include "*monitoring outcomes; reporting adverse events; managing symptoms or side effects; minimising misuse, overuse and underuse; and empowering and supporting people to make decisions to use medicines safely and effectively*.[19]

5.2.5 Improved access to specialised dementia care that meets care needs

The majority of stakeholders strongly agreed the Program has improved access to specialised care that more appropriately meets the care needs of people with very severe BPSD.

As mentioned in the **Interim Report (2020)**, the Program's design was informed by a rigorous evidence base, including a review of comparable models locally and overseas, extensive consultation with industry and governmental stakeholder groups, and the provision of expert advice from dementia researchers. As discussed earlier in this Report, stakeholders across most sites felt that SDCUs have successfully implemented the best-practice principles that are embedded within the SDCP Framework, including:

- person-centered and restraint-free approach to care (see Section 3.2)
- supported decision-making with family/carers (see Section 3.2)
- multidisciplinary approach to care and increased access to specialist input (see Section 3.1).

Program staff and family/carers across most sites felt the Program is invaluable in providing people with very severe BPSD access to safe and high-quality care that meets their specialised care needs. They agreed the Program has addressed

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[18] It is noted that from 1 January 2023, every government funded residential aged care facility will receive funding allowing them to employ or engage an on-site pharmacist or community pharmacy service, as part of the Australian Government's commitment to improve medication management and safety for aged care residents. However, the frequent nature of specialist review is expected to continue to provide additional benefit to the Program cohort.

[19] Australian Government Department of Health and Aged Care (2022), *National Medicines Policy*, accessed 4 January 2023, <https://www.health.gov.au/resources/publications/national-medicines-policy?language=en>.

several barriers which previously limited access to appropriate care for people with very severe BPSD, including inadequate staff training on best-practice behavioral management strategies, inadequate infrastructure, and difficulties accessing specialist clinical input.[20] Program staff, DSA staff and family/carers across most SDCUs felt the Program had addressed a large service gap in dementia care options in their region.

Figure 5.8 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to quality of life among Program residents.

> *"[The SDCP] is exactly what society needs. There are just so many high care dementia patients… and so many [mainstream RACFs] in the area say they do high care dementia but they cannot handle it. We went through 3 or 4 [mainstream RACFs] in our area who said they could help but it turned out they could not."*
>
> *– Family member*

> *"Making more places like [the SDCP] available…would be good. More people going into nursing homes absolutely terrifies me. It is such a comfort to me knowing my mum is [in the SDCU]."*
>
> *– Family member*

> *"After seeing him in facilities before which were not tailored to this health issue, [the SDCU] copes with it really well. There is no overreaction… if one thing did not work, they were good at continually trying to better his care and make it better for him and for us."*
>
> *– Family member*

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

The Program has increased many residents' access to mainstream RACF options.

Stakeholders across several jurisdictions observed a reluctance among mainstream RACFs in their region to accept people with BPSD, even when their BPSD had settled. This can result in prolonged stay in acute care settings due to the limited care options available (the impact of the Program in minimising prolonged stay in acute care is discussed further in Section 6).

Stakeholders noted the Program's success in settling BPSD helps to overcome this stigma associated with BPSD and provides confidence to mainstream RACFs that a resident can be cared for in a mainstream setting. This is enabled by the SDCU discharge planning process (discussed in Section 4) which focuses on increasing the capability and confidence of staff in mainstream RACFs to care for this cohort. The design feature of the Program, whereby all SDCUs are co-located with a mainstream RACF (operated by the same provider) also enables better access to mainstream RACFs, as the resident is not required to apply to an external RACF provider and Program staff can more easily support care staff in the co-located unit to sustain long-term symptom management (discussed in Section 4).

At a system-level, by improving access to mainstream RACFs, the Program is able to release capacity to inpatient psychogeriatric services over the long term (where the resident would typically reside indefinitely in the absence of the Program). This is discussed further in 6.2.1.

5.3 Benefits for families/carers of Program residents

5.3.1 Improved mental health and wellbeing

Consensus that the Program has led to a reduction in caregiver burden for family/carers of residents.

The majority of family/carers reported a reduction in distress and burden once their loved one was admitted to the SDCU. Family/carers reflected on their personal experience seeking care for their loved one prior to admission to the SDCU, noting it was often highly distressing and frustrating due to limited appropriate accommodation options, reluctance among mainstream RACFs to accept their loved one, a high frequency of behavioural incidents, and the tendency of care providers to rely on chemical restraints as a management technique.

Family/carers noted that their own mental health tended to improve once they began to see improvements in their loved one's quality of life and BPSD (see Section 5.2). Several families/carers noted they were more often contacted by Program staff with positive updates on their loved one's progress as opposed to negative incidents, which was a change from their experience prior to the SDCU.

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[20] Royal Commission into Aged Care Quality and Safety (Final Report, March 2021) vol 2; Henry Brodaty, Brian M Draper, & Lee-Fay Low, 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery' (2003) 178(5) *The Medical Journal of Australia* 231.

DSA and Program staff expressed similar views. They noted many families/carers often exhibit symptoms of burnout (such as irritability, anxiety and fatigue) during the referral and transition in processes but show major improvements in overall wellbeing following admission. Stakeholders provided many examples where family/carers had more positive interactions with staff, appeared more content when visiting the SDCU, were more hopeful about their loved one's future, and regularly expressed how happy they were with the SDCU.

Several family members also reported that having access to specialist input, allied health and personal care in the same residence reduced the physical, economic and emotional burden of coordinating their loved one's care. They reported that prior to the SDCU, their experience caring for their loved one was a time-consuming, confusing and stressful process to arrange the necessary supports across a range of services (e.g., specialist appointments, hospital presentations, personal care, NDIS support, etc.).

Figure 5.9 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to reduced caregiver burden among families and carers.

> *"To have that ability of not having to worry about him is incredible after 3 years of worrying and stressing and not knowing what to do about it is incredible."*
> *– Family member*

> *"Before, I never felt comfortable going away but now, I feel comfortable to go away for a weekend holiday because I know she will be taken care of in such a good way. I just have that peace of mind and it is such a relief."*
> *– Family member*

> *"Every day I am just very grateful. Previously I would have to travel 2.5hrs to [his previous home] to visit and it was a massive burden just to get him basic care. But now I can feel comfortable and relieved that he has been cared for properly and I know he is happy and healthy."* *– Family member*

> *"[Families] go on a massive journey to get here. But we have received lots of positive feedback that they trust us and they feel listened to. A lot of them are very tense and blunt when they arrive but it is nice to see them relax as they spend more time here and get to know us."*
> *– SDCP Staff*

> *"[Talking] about the resident and their family, I cannot stress this enough. They come in so distressed and [after the SDCP] they have faith in the aged care system again."*
> *– SDCP Staff*

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

Many families/carers experienced improved relationships with their loved one following admission.

The reduction in residents' BPSD and improved communication and socialisation among residents (discussed in Section 5.2) was reported to facilitate more positive relationships between residents and family/carers and in turn, improve family/carer wellbeing. These families/carers noted that following many years of agitative behaviour managed by pharmacological intervention, their loved one is now calmer, more sociable, and willing to engage with care staff, family and friends.

This benefit was not observed across all family/carers of Program residents. Program staff across several sites highlighted that people with very severe BPSD often experience estranged relationships for many reasons, including the resident's age and severity of behaviours. It was common for some residents to receive limited or no contact from their family/carers throughout the Program. Program staff at some sites however, provided examples where family/carers had reconnected with their loved one and visited the SDCU on several occasions once they understood the residents' BPSD had settled.

Figure 5.10 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to improved relationships between residents and their families and carers.

> *" [At the previous facility] I would only stay 10 minutes because she did not engage and… I did not feel comfortable. It was getting really hard to go see her – she would get angry and scream… and hit you. But at [the SDCU] I can spend more time. It is a calmer situation where they… let mum be herself and she is able to relax. We can now have a nice quiet time… and go for a walk outside in the garden."*
>
> *– Family member*

> *"A resident came in who was estranged from his family. They really just did not come in at all. We had a meeting with them and we told them he had improved. [When they visited] they seemed to have their dad and father-in-law back. They even brought the grandkids in to see them. That was really nice to see – the family connecting again"*
>
> *– SDCP Staff*

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

5.3.2 Stronger support network

The majority of families and carers agreed the Program provided a stronger support network than other mainstream care settings. However, there is opportunity for family and carer support to become more embedded within the care pathway during Phase Two of the Program.

The majority of family/carers interviewed felt more supported by Program staff relative to their experience with mainstream RACFs. They attributed this to the higher staff ratios which allows staff more time to connect with residents and their family/carers, as well as the strong focus on person-centred care and supported decision-making.

Although the Program model of care does not deliver supports targeted towards family/carers specifically, the SDCP Framework (Service Delivery Principle 3) requires staff to take their considerations into account when developing care plans and in all care decision-making by "consulting, valuing and supporting carers and the caring relationship". Outside of their involvement in care planning discussions (discussed in Section 3.2), the majority of family/carers also felt more listened to, respected and supported by staff within the Program, noting that Program staff were an important source of support and guidance.

Several Program staff noted that given the provision of specialised support to families/carers is not required under the Framework, the support provided is often informal and ad hoc, leading to high variation across sites. Some SDCUs have begun to offer more targeted support for family/carers through their social worker or nurse coordinator roles (discussed in Section 4). Another site reported staff had established an informal peer support groups for families, as they noticed family/carers found it valuable to connect with others who had been through similar experiences. However, many stakeholders felt targeted psychosocial support is an ongoing area of need, given family/carers often arrive at the SDCU with high levels of carer guilt and burnout (discussed above). Accordingly, there is an opportunity to explore ways in which family support options could be strengthened into the care pathway.

Figure 5.11 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to improved relationships between residents and their families and carers.

"We found [SDCP staff and other families] became like our family as well. It had a really family oriented place. Members that were visiting their family - you could connect with them and it provided that rapport and support. I think that's really nice to have that [support] backup."

– Family member

"The scary part is what happens when our loved one leaves the SDCU to transition back into mainstream care; where suddenly the whole structure reverts to the way it was previously. Will this person become the shell of a human they were before, with no dignity and no will to live?"

– Family member

"The family [and] carers have been traumatised and [they] bring that trauma to the SDCP. After admission [to SDCP] it feels very relaxed because things have settled but as soon as we talk about transition-out it changes. So many [families]… refuse to give consent. The staff in SDCP are struggling because they now need to support the family member because the transition-out depends on family consent."

– Program staff

Source: Deloitte Access Economics analysis of stakeholder consultations, 2022

5.4 Benefits for Program staff and other services

5.4.1 Improved staff capability and job satisfaction

Most Program staff reported that working in the SDCU has fostered a strong sense of job satisfaction and pride in their work.

Clinical in-reach staff, program managers and clinical nursing staff from the majority of SDCUs felt that working for the Program has been professionally rewarding. They were proud to contribute to a specialist program and commented on how rewarding it felt to witness profound improvements in residents' BPSD and quality of life as a result of their support. Staff satisfaction is pertinent given that research has shown that job satisfaction among aged care staff is positively correlated with provision of person-centred care. In addition to the care benefits for residents, job satisfaction among aged care staff is also recognised as a crucial element to supporting higher productivity, reducing job-related stress and improving staff retention.[21]

However, it is noted that job satisfaction was more varied among care staff. The complexity and severity of BPSD among Program residents can create an unfavourable risk-pay trade-off for care staff (relative to working on mainstream RACFs), which can contribute to lower job satisfaction and staff attrition. Care staff who reported relatively high job satisfaction also reported relatively higher levels of confidence in their ability to care for and manage residents with very severe BPSD (discussed in Section 3.2).

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[21] Ching-Yuan Huang, et al., 'The impact of person-centred care on job productivity, job satisfaction and organisational commitment among employees in long-term care facilities' (2020) 29(15) *Journal of Clinical Nursing* 2967; Santhiny Rajamohan, Davina Porock and Yu-Ping Chang, 'Understanding the Relationship Between Staff and Job Satisfaction, Stress, Turnover, and Staff Outcomes in the Person-Centered Care Nursing Home Arena' (2019) 51(5) *Journal of Nursing Scholarship* 560.

Figure 5.12 Quotes representing dominant qualitative themes from consultations and the Program staff survey related to staff satisfaction.

> *"For our staff, it is hard work but we do not have a big staff turnover. They take joy in being able to find a 'fix' for that person – they enjoy the problem-solving aspect and being able to reflect on how much they can help the person and make an impact on their life. I have enjoyed looking at our staff's satisfaction in the program."*
>
> *– SDCP Staff*

> *"It has been a rewarding experience for me personally. You see a change in behaviours. When you go from ducking and being really cautious [around a resident] to then being able to go sit down next to them and have a chat and make them a cup of tea – it is really rewarding."*
>
> *– SDCP Staff*

> *"Being able to transition them out to mainstream and seeing them settle and being able to have a better experience in the mainstream system afterwards is so rewarding. I feel really proud of the work we are doing here to be honest with you."*
>
> *– SDCP staff*

Source: Deloitte Access Economics analysis of stakeholder consultation, 2022

5.4.2 Knowledge spill over

The Program's success in stabilising very severe BPSD for residents strengthens the evidence base on best-practice dementia care and provides a valuable opportunity for knowledge-spill over across the broader aged care sector.

The Program benefits discussed throughout this Chapter provide valuable evidence on the benefits of this type of program for consumers, family/carers of people with very severe BPSD, providers, and the broader aged care sector. In addition, the clinical governance structures and multidisciplinary focus in the model of care (see Section 3) also fosters knowledge-spillover across disciplines, as many clinical in-reach, GPs and allied health staff in the Program also work across other settings. This creates stronger networking opportunities across practitioners, which can help to promote holistic approaches and further opportunities for knowledge-spillover. This is further supported by the recently established Community of Practice for in-reach clinicians which aims to facilitate knowledge-sharing and consultation among peer SDCU practitioners.

The post-discharge support provided by SDCU staff and DSA also provides more direct upskilling opportunities and knowledge-spillover to broader mainstream aged care services. The ability to coordinate with mainstream RACFs, inform their care planning process (through the discharge planning processes described in Section 4.1) and link them in with a broader suite of dementia support (e.g., through DSA) provides a large opportunity to educate staff in mainstream RACFs on the evidence-based strategies to best practice dementia care. Stakeholders felt this is facilitating a gradual uplift in the quality of dementia care provided by mainstream RACFs on a larger scale, which will continue further as the Program moves into Phase Two.

5.5 Benefits for government

5.5.1 Improved health service utilisation across long-stay accommodation options and reduced unplanned care.

Government benefits related to improved health service utilisation are described in Chapter 6.

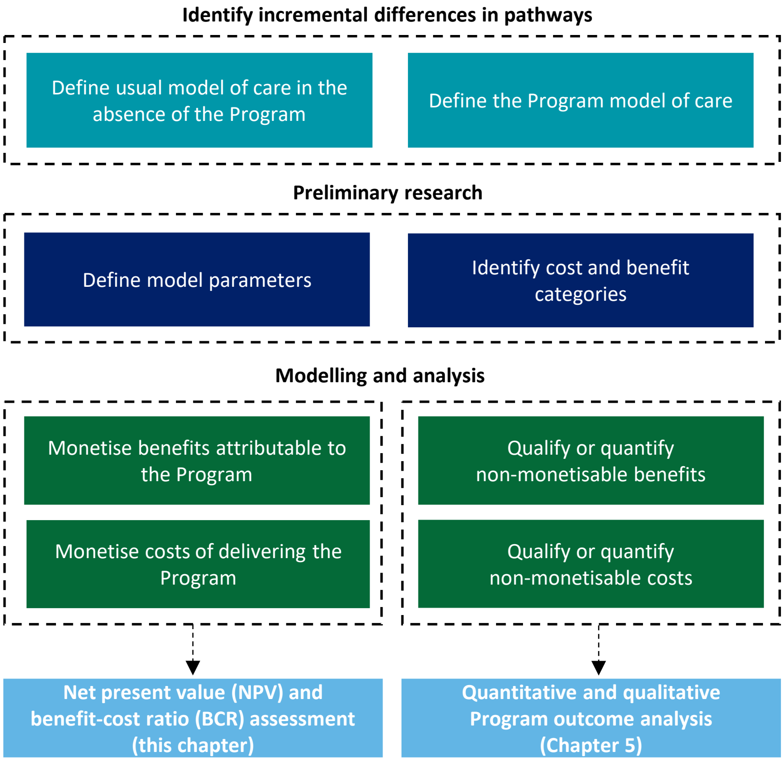
6 Economic evaluation

This chapter presents key findings from the economic evaluation of the Program relative to a comparator case (usual care in the absence of the Program).

6.1 Economic evaluation approach

The economic evaluation approach comprised five steps, as outlined in Figure 6.1.

Figure 6.1 Overview of approach



Source: Deloitte Access Economics.

1. **Identify incremental differences in pathways between the Program and a 'comparator case'**. The first step of the economic evaluation involved understanding the likely care settings and pathways for residents in the absence of the Program (the comparator case). This step was required to ensure that all costs and benefits associated with the Program were evaluated incrementally, compared to what would have occurred in the Program's absence.

2. **Define the model parameters.** The second step required identifying the modelling approach, stakeholder perspectives that would be modelled (the referent groups), the time horizon for benefits realisation and discount rate.

3. **Identify key costs and benefits.** Following this, the Program was costed based on cost data provided by the Department and monetisable Program benefits were identified. Of the Program benefits outlined in Figure 6.1, the only monetisable Program benefits related to the avoided use of hospital and health services.

4. **Modelling and analysis.** Analyses was undertaken in line with the identified costs and monetised benefits. Where data gaps existed, assumptions were made using publicly available data or using statistical techniques.
5. **Overall value-for-money assessment.** A Net Present Value (NPV) and Benefit-Cost Ratio (BCR) were calculated and discounted to present value in FY2019-20 dollars.

The modelling parameters are summarised in Table 6.1.

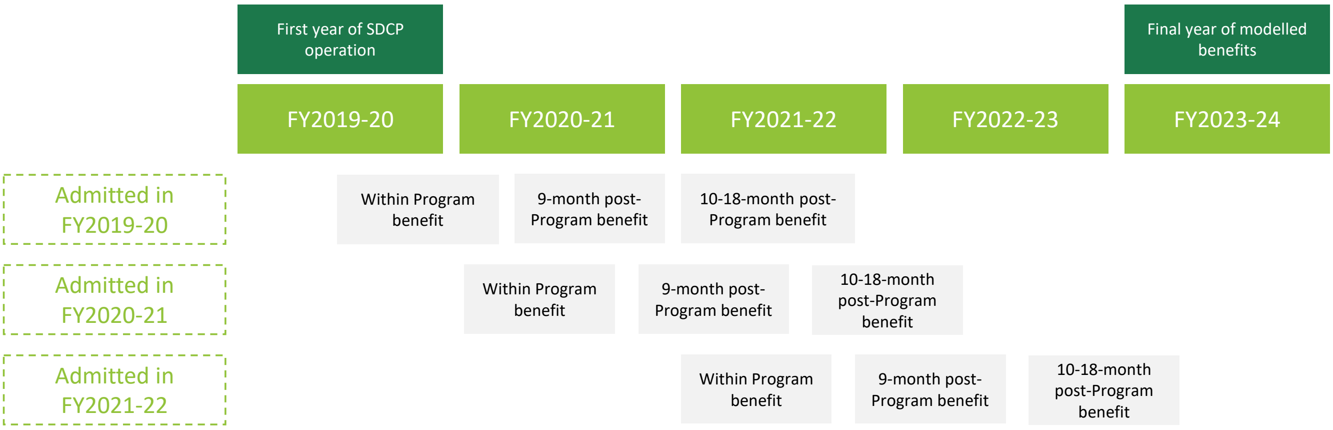
Table 6.1 Key modelling parameters for the cost-benefit analysis

Parameter	Approach
Conceptual modelling methodology	A cost-benefit analysis estimates the incremental benefits and costs attributable to the Program that accrue to the agreed referent group/s, across the modelled time horizon. This process generates a Net Present Value (NPV) and a benefit-cost ratio (BCR). A positive NPV indicates that economic resources are allocated more efficiently under the intervention (the Program) compared to the base case. A BCR greater than 1 indicates that there are $x of present-value (PV) Program benefits for every $1 of PV Program costs.
Referent group(s)	The two referent groups for the cost-benefit analysis are government, as well as an overall societal perspective that encompasses both government and the community (including Program residents and their families/carers). It is noted that both Commonwealth and state and territory governments have funding responsibilities within the health and aged care system. In particular, Program impacts related to decreased hospital service utilisation are expected to benefit both levels of government. For the purposes of modelling, these two stakeholders are not differentiated, and instead considered as a single government stakeholder.
Time horizon	One of the key Program intentions is to reduce the frequency and severity of BPSD in residents, in order to facilitate transition out to less intensive mainstream RACF. The potential for Program residents to require less resource-intensive health care services for several years after Program participation than would have occurred in the Program's absence is therefore a significant benefit. Provider performance reports detail discharges to mainstream RACFs due to settled BPSD on a unit record level. However, once the three-month bounce-back period has concluded, there is no formal Program mechanism for tracking post-Program outcomes. Given this limitation, assumptions were used to model potential Program benefits beyond participation in the Program. This approach involved modelling two types of benefits realisation timeframes: • **Within Program**. Involved modelling the incremental Program costs and monetised benefits over the duration of each resident's stay in the SDCU. Retrospective unit record provider site data was used to calculate this benefit. • **Post-Program.** Involved modelling monetised benefits 9- and 18-months post-Program for a subset of residents admitted over the period FY2019-20 to FY2021-22. As these residents were admitted over this period, benefit accrual occurred over the period FY2020-21 to FY2023-24 (see Figure 6.2). To describe the key parameters underpinning this scenario: – **Incremental costs and benefits over the post-Program period.** In the modelled post-Program period, Program-specific costs are not incurred (e.g. top-up grant funding). However, costs are incurred to the extent that the care setting between the base case and the post-Program period has permanently changed (e.g. a person who would have stayed in long stay psychogeriatric care over the entire modelled period in the absence of the Program is instead permanently settled in a mainstream RACF after participating in the Program). Incremental post-Program benefits are

	realised in the form of avoided hospital and health service utilisation for residents discharged due to settled BPSD. For ‘other’ discharges, there are no post-Program benefits accrued as it is assumed that the resident transferred back to where they would have resided in the absence of the Program or the same event would have occurred (e.g., if the reason for the discharge was death), resulting in a neutral incremental benefit. – **Assumptions on post-Program care settings.** Due to the absence of data on post-Program outcomes and care settings for discharged residents, it was assumed that all discharges to less intensive care settings due to settled BPSD remained in this setting for either a 9-month or 18-month post-Program period. The limitations of this approach are acknowledged. Collection of data on post-Program outcomes would eliminate the need to rely on assumptions, and thereby, provide a more reliable estimate of the economic value of the Program. This is recommended as part of future Program data collection in Section 9.2.
Discount rate	Discount rates convert cash flows received in different periods to a present value, in recognition of the opportunity cost of capital over time. A discount rate of 5% is used (consistent with Medical Services Advisory Committee guidelines).

Source: Deloitte Access Economics.

Figure 6.2 Illustrative time horizon for benefits realisation

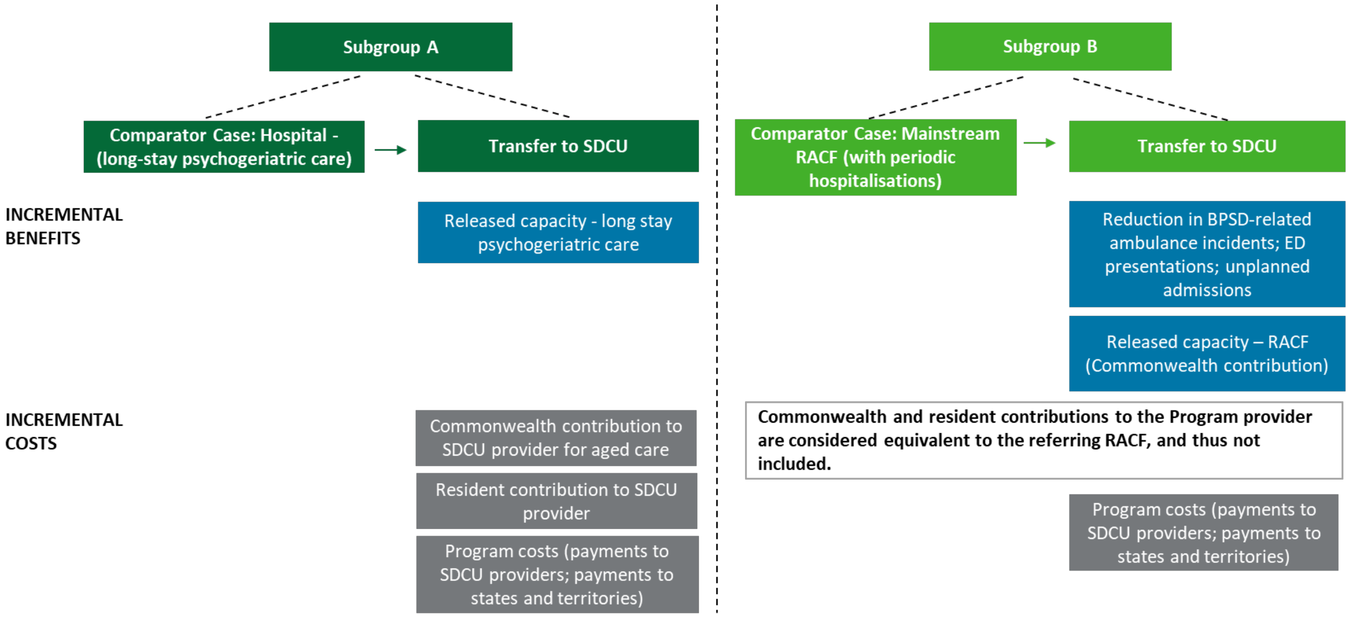


Source: Deloitte Access Economics.

6.1.1 Defining the comparator case (usual care)

From NBA referral data and stakeholder consultation, the two main referral sources identified for the Program were inpatient hospital settings and mainstream RACFs. These two models of care have significantly different underlying cost structures, and as such transfer into the Program would be expected to produce distinct sets of incremental costs and benefits. The model framework depicting these impacts is shown in Figure 6.3.

Figure 6.3 Cost-benefit analysis framework – incremental monetisable benefits and costs associated with delivering the Program



Source: Deloitte Access Economics.

For Subgroup A, it was assumed that in the absence of the Program the patient would have remained in long-stay psychogeriatric care. By receiving care in an SDCU, the incremental benefit is a released long-stay psychogeriatric care bed to the hospital system which is likely to be filled by latent demand within the community. The incremental costs for this sub-group are the Program costs provided to the SDCU provider and Commonwealth and residents contributions to the daily cost of aged care.

For Subgroup B, it was assumed that in the absence of the Program, the mainstream referring RACF would be the resident’s primary care setting. In such a case, it is assumed that due to exacerbations of BPSD unable to be managed by the mainstream RACF, the resident would require periodic hospitalisations – hospitalisation that would not be required if receiving care in an SDCU. The incremental reduction in ambulance incidents, ED presentations and unplanned admissions are therefore able to be monetised as benefits. Additionally, transfer of the resident from the mainstream RACF to the SDCU also releases one aged care place, which is similarly assumed to be filled by latent demand. The incremental costs for this sub-group are only the Program costs provided to the SDCU provider.[22]

6.1.2 Model schematic

A decision-tree depiction of the care pathways modelled to derive incremental costs and benefits associated with the Program is presented in Figure 6.4. The probabilities attached to each pathway were informed by SDCU admission and discharge data for the period FY2019-22.

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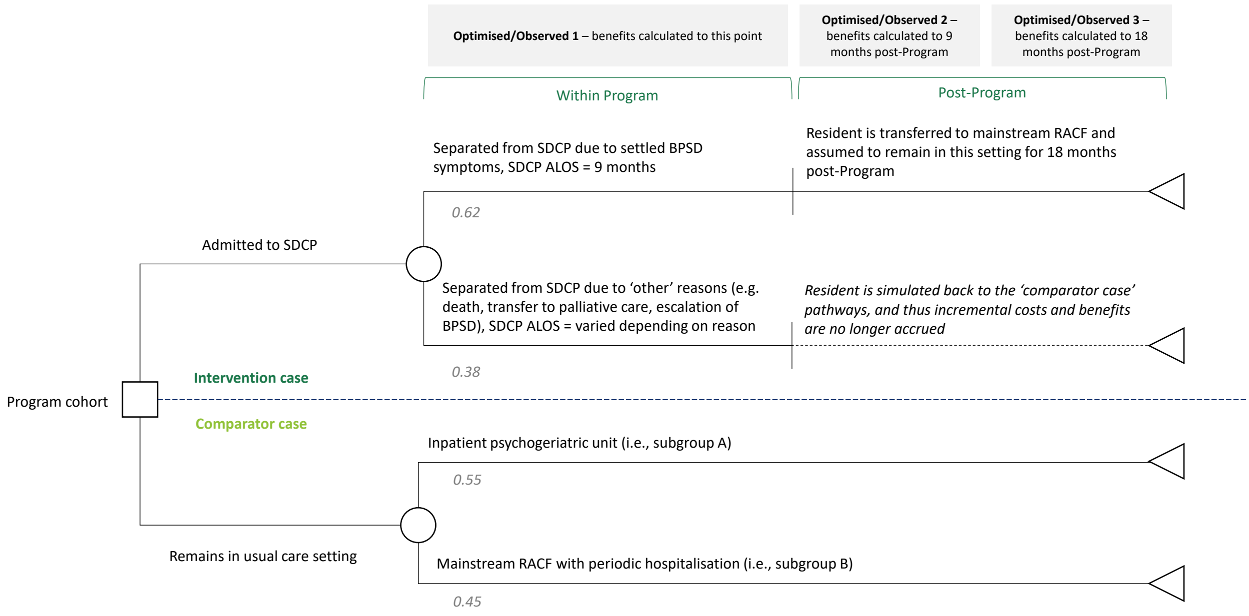
[22] Commonwealth and resident contributions were assumed equivalent between the mainstream referring RACF and the SDCU, in the absence of additional information.

Figure 6.4 Decision-tree schematic of care pathways modelled



Source: Deloitte Access Economics.

Note i: Probabilities informed by SDCU admission and discharge data. Assumptions on long-term care settings informed by stakeholder consultation.

6.1.3 Monetised benefits and costs

Monetised incremental benefits of the Program primarily relate to avoided unplanned hospital care, as well as the released capacity that the Program creates in long-stay psychogeriatric care and residential aged care. Given the latent demand present in the health and aged care system for these places, it is assumed that they will be occupied by another member of the community. As such, released capacity is an efficiency benefit as it allows more community demand to be met. Released capacity is valued at the funding provided for the place, however it is not a "cashable" saving to the health and aged care system.[23] As stated in Section 1.4, the monetisation of Program benefits post-participation was undertaken as a modelled scenario, noting that post-Program data collection is required to validate assumptions made. More detail on the monetisation methodology for each identified incremental benefit is provided in Appendix C.

Monetised incremental costs of the Program include Program costs (establishment costs, top-up grant payments, transition payments (paid in advance), state/territory SDCP partnership payments (for in-reach clinician services), and NBA service payments, as well as residential aged care costs for Subgroup A). More detail on the monetisation methodology for each identified incremental cost is provided in Appendix C.

The following limitation is noted: Subgroup A resides in hospital under the base case, and it is thus likely that as a result of Program participation, there would be a certain number of BPSD exacerbations which would require hospital treatment (previously treated on-site within the comparator case). These interventions would therefore need to be treated as monetised costs for Subgroup A. A Program rate of BPSD-related ED presentations was not able to be established from clinical data, and the staff survey was phrased to ask about incremental changes in ED presentations, relative to mainstream RACF residency. As a result, this monetised cost is not included for Subgroup A currently.

6.2 Summary results

Summary results are presented using the following scenarios for the three time horizons described in Table 6.2:

1. **Optimised:** The Optimised Program BCR was calculated based on all four financial years of Program activity, the observed Subgroup A/Subgroup B proportional split and full Program occupancy. This BCR is designed to inform an

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[23] As a hypothetical example, a "cashable" saving would be achieved if the Program allowed a long-stay psychogeriatric care bed to be decommissioned.

understanding of the ceiling of benefits able to be monetised, relative to Program costs. It is also provided to be conscious of contextual factors during the Program implementation (e.g. COVID-19 and labour shortages within the aged care industry) which may have impacted the ability of providers to increase their site occupancy.

2. **Observed:** The Observed Program BCR was calculated based on all four financial years of Program activity, the observed Subgroup A/Subgroup B proportional split and observed Program occupancy. This BCR is designed to inform an understanding of the benefits able to be monetised at this time, relative to Program costs and based on observed SDCU occupancy dynamics during Phase 1.

It should be noted, the aged care system has recently moved to the Australian National Aged Care Classification (AN-ACC) funding model as of 1 October 2022. For the purposes of modelling additional benefits in FY2022-23 and FY2023-24, the value of released capacity of aged care was assumed to be constant in real terms from the estimates calculated for FY2021-22. The aged care contribution methodology would thus require refinement moving forward once data is able to be collected on the average funding received under the AN-ACC funding system.

A summary of the Program's incremental benefits and costs relative to what would have occurred in the absence of the Program (usual care) is shown in Table 6.3, with BCR results in Table 6.4 and Figure 6.5.

Table 6.2 Summary overall Program results (FY2019-20, real)

Scenario:		Optimised			Observed		
	Benefits realisation time horizon:	1: Within Program only	2: Within Program + 9 months post-Program	3: Within Program + 18 months post-Program	1: Within Program only	2: Within Program + 9 months post-Program	3: Within Program + 18 months post-Program
	Occupancy rate:		100%		41% in FY19-20,	54% in FY20-21,	85% in FY21-22
Perspective	**Benefits**						
Government	Subgroup A - Released capacity (long stay psychogeriatric care)	$35,297,967	$49,325,930	$63,059,733	$23,569,923	$32,824,434	$41,859,416
Government	Subgroup B - Avoided ED presentations	$306,368	$422,324	$533,008	$200,531	$276,516	$349,331
Government	Subgroup B - Avoided ambulance utilisation	$244,423	$337,649	$427,714	$160,555	$221,840	$281,090
Government	Subgroup B - Avoided unplanned admissions	$3,490,867	$4,815,483	$6,111,463	$2,290,242	$3,163,961	$4,016,540
Government	Subgroup B - Released capacity (aged care) - Commonwealth contribution	$5,157,280	$7,161,798	$9,121,949	$3,414,272	$4,736,268	$6,025,781
Societal	**Total Benefits**	**$44,496,905**	**$62,063,185**	**$79,253,867**	**$29,635,524**	**$41,223,018**	**$52,532,158**
Perspective	**Costs**						
Government	Subgroup A and B - Establishment cost	$4,238,672	$4,238,672	$4,238,672	$4,238,672	$4,238,672	$4,238,672
Government	Subgroup A and B – Top-up grant payments	$19,634,754	$19,634,754	$19,634,754	$19,634,754	$19,634,754	$19,634,754
Government	Subgroup A and B - Transition payments	$1,325,124	$1,325,124	$1,325,124	$1,325,124	$1,325,124	$1,325,124
Government	Subgroup A and B - State/territory SDCP partnership payments	$6,254,526	$6,254,526	$6,254,526	$6,254,526	$6,254,526	$6,254,526
Government	Subgroup A and B - NBA payments	$2,201,487	$2,201,487	$2,201,487	$2,201,487	$2,201,487	$2,201,487
Government	Subgroup A – Residential aged care, Commonwealth contribution	$6,476,597	$8,938,753	$11,309,861	$4,248,305	$5,865,502	$7,425,369
Families/carers	Subgroup A – Residential aged care, Resident contribution	$2,318,951	$3,203,432	$4,057,916	$1,523,257	$2,104,693	$2,666,828
Societal	**Total Costs**	**$42,450,111**	**$45,796,748**	**$49,022,340**	**$39,426,125**	**$41,624,758**	**$43,746,761**

Source: Deloitte Access Economics calculations.

Table 6.3 Program level BCR results – Government perspective

	Optimised			Observed		
Benefits realisation time horizon:	1: Within Program only	2: Within Program + 9 months post-Program	3: Within Program + 18 months post-Program	1: Within Program only	2: Within Program + 9 months post-Program	3: Within Program + 18 months post-Program
Benefits	$44,496,905	$62,063,185	$79,253,867	$29,635,524	$41,223,018	$52,532,158
Costs	$40,131,160	$42,593,316	$44,964,424	$37,902,868	$39,520,065	$41,079,933
NPV	$4,365,745	$19,469,869	$34,289,443	-$8,267,345	$1,702,953	$11,452,225
BCR	**1.11**	**1.46**	**1.76**	**0.78**	**1.04**	**1.28**

Table 6.4 Program level BCR results – Societal perspective

	Optimised			Observed		
Benefits realisation time horizon:	1: Within Program only	2: Within Program + 9 months post-Program*	3: Within Program + 18 months post-Program	1: Within Program only	2: Within Program + 9 months post-Program	3: Within Program + 18 months post-Program
Benefits	$44,496,905	$62,063,185	$79,253,867	$29,635,524	$41,223,018	$52,532,158
Costs	$42,450,111	$45,796,748	$49,022,340	$39,426,125	$41,624,758	$43,746,761
NPV	$2,046,794	$16,266,437	$30,231,527	-$9,790,602	-$401,740	$8,785,397
BCR	**1.05**	**1.36**	**1.62**	**0.75**	**0.99**	**1.20**

Source: Deloitte Access Economics calculations.

Note i: *A visual depiction of the results from this scenario is presented in Figure 6.5.

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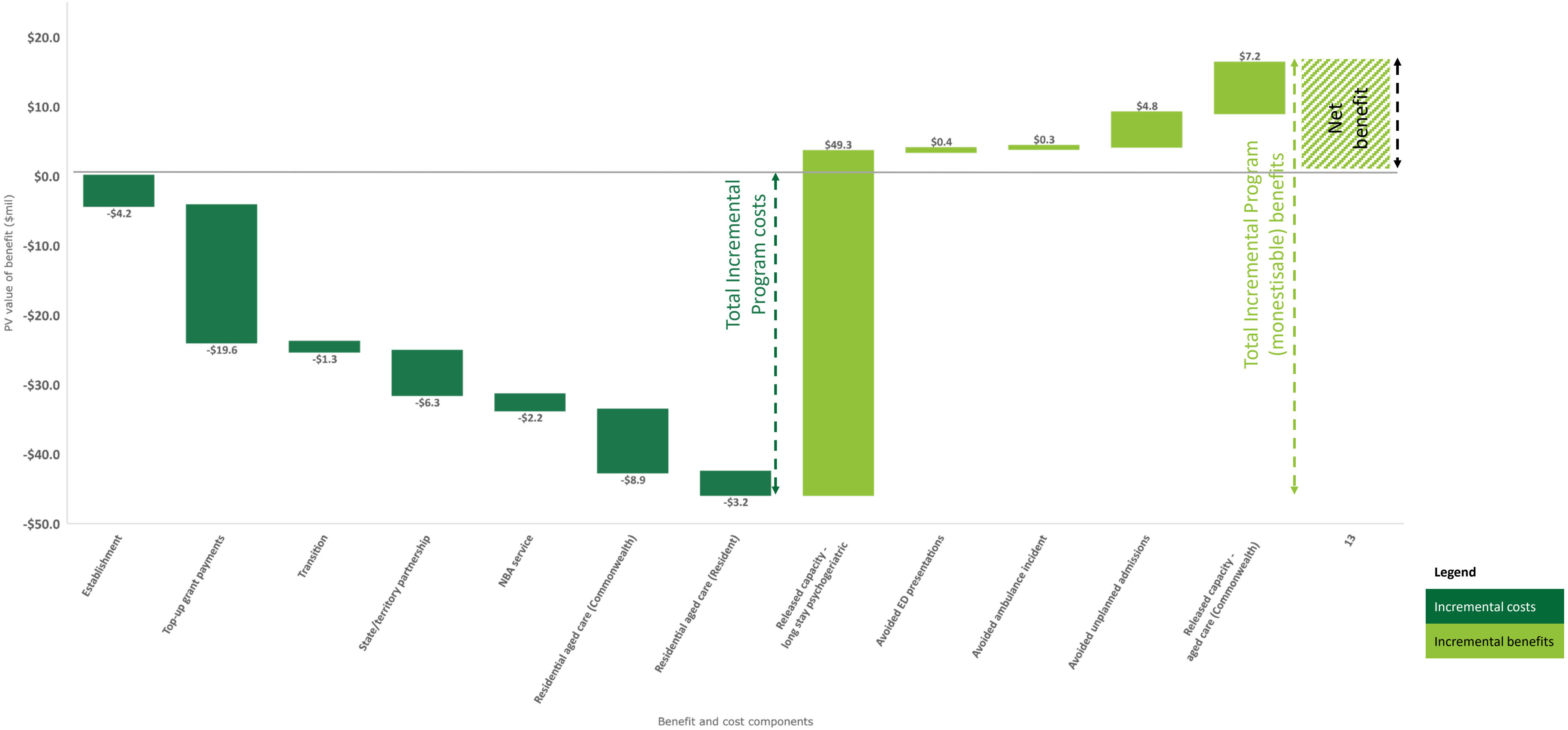
Figure 6.5 Optimised 2 scenario – societal perspective. Occupancy rate: 100%. Benefits realisation timeframe: Within Program + 9 months post-Program. (PV, $m)



Source: Deloitte Access Economics.

6.2.1 Program value for money – observations and insights

The figures presented in the preceding section highlight several key themes:

When operating near capacity the Program generates a positive return on investment for government.

If SDCUs had operated at full occupancy, it is estimated that the Program would have generated $1.11 to government for every $1 invested (i.e., a BCR of 1.11), when using the most conservative benefits realisation time horizon that considered only the immediate benefits generated while each resident was part of the Program (i.e., the 'within Program' scenario). When expanding the time horizon to 9- and 18-months post-Program participation, the BCR increases to 1.46 and 1.76, respectively.

SDCU occupancy rates are a key driver of the BCR. Under a scenario where observed occupancy rates were used (i.e., 41% in FY19-20, 54% in FY20-21, 85% in FY21-22), the 'within Program' BCR for government was comparatively lower at 0.78, increasing to 1.04 and 1.28, as 9 and 18-month post-Program benefits were added.

This result is driven by the fixed nature of several Program costs (e.g., infrastructure, labour costs), relative to the variable nature of both the immediate benefits – that accrue with each occupied bed, and the longer-term benefits – that accrue with each discharge to a less intensive care setting due to settled BPSD.

The value of the Program increases the longer each discharged resident remains in less intensive care settings.

The size of the BCR increases in line with the benefits realisation time horizon. The government payer BCR increases significantly when expanding the time horizon from Program discharge date (i.e., the 'within Program' scenario) to 18-months post-Program. If the time horizon were expanded further, the BCR would continue to increase. However, it is expected that gains would become increasingly marginal over time due to events such as death or need for palliative care.

This shows that the primary value of the Program is not the immediate cost-savings that may be generated by substituting inpatient care with specialist residential care for a 12-month period, but the Program's role as the only current intervention in Australia able to facilitate access to a less intensive care settings long-term. Part of the Program's efficacy in this area is attributable to its specialist model of care and environment, which is better able to achieve stabilisation of BPSD. However, a secondary factor is the co-located design feature of the Program. As discussed in Section 5.2, stakeholders noted a reluctance among mainstream RACFs to accept people with very severe BPSD, even when their symptoms had settled. This can result in a prolonged multi-year stays in acute care settings. The Program is able to overcome this challenge by co-locating the SDCU with a mainstream RACF (operated by the same provider) and offering placement at this facility post-Program. Internal transitions to a co-located RACF also aids long-term symptom management as Program staff can more easily support care staff in the receiving facility.

Given post-Program outcomes are a key lever in demonstrating the economic value of the Program, effort should be made to collect data on care settings and outcomes for all discharged residents on a routine basis. This is discussed further in section 9.2.

For people with very severe BPSD, the Program achieves better outcomes and is less expensive to deliver than long-stay psychogeriatric care.

While it is noted above that the primary value of the Program is its role in facilitating access to less intensive care settings long-term, it is also noted that the Program offers cost-savings as an inpatient psychogeriatric care substitution model. That is, the per day Program costs associated with delivering specific and targeted care in a bespoke environment for people with very severe BPSD is well below the funding rate per bed-day for long-stay psychogeriatric care. It delivers these cost-savings *in addition* to the qualitative benefits described in Chapter 5.

Released capacity of long-stay psychogeriatric care was the largest monetisable Program benefit estimated across all scenarios evaluated. This was based on data that showed 55% of Program residents had originated from inpatient psychogeriatric care settings (i.e., subgroup A) – and an assumption that they likely would have remained in this setting in the absence of the Program.

7 Program administration

This chapter presents key findings that emerged through evaluation activities as they relate to Program costs and other administrative factors.

An assessment of Program administration is explored through the following sub-sections of this chapter:

- general Program administration and governance
- data management and reporting systems
- Program costs.

7.1 Overall Program management

Stakeholders were largely satisfied with the overall management of the Program. Key enablers included early and regular engagement between the Department and providers, and ongoing commitment to knowledge sharing across sites.

Over the course of the Program, stakeholders agreed the Department has established positive relationships with providers and strong processes to support their implementation of the Program. Although the Department's Program oversight has a compliance component to monitor SDCUs' implementation, it also places a strong focus on collaboration and empowerment given the specialised nature of the Program. Themes highlighted included:

- **Early engagement with providers.** The Department engaged with Phase One sites early to support site readiness prior to opening, meeting with each provider monthly. This was identified as a key enabler to Program management by facilitating a shared understanding of Program implementation and site requirements, as well as building positive relationships and open communication channels between the Department and providers. Now that Phase One providers have all been in operation for at least 18 months, frequency of engagement occurs on a quarterly basis.

- **Commitment to knowledge-sharing.** The Department established the Community of Practice (CoP) to assist providers in developing support networks and to engage in knowledge sharing. Stakeholders across all SDCUs cited the CoP as a strength of the Program and noted it has proven effective in providing a forum to share learnings, quality improvement practices and resources – factors that are especially important given the specialised nature of the Program. Several stakeholders agreed there is an opportunity to use other knowledge exchange mechanisms to support Phase Two providers. Suggestions included onboarding workshops for Phase Two sites and a resource library for providers to access which shares valuable learnings and provides examples of established templates (e.g., care planning, discharge processes, Memorandum of Understanding templates).

In addition, stakeholders across sites were complementary of the Department's role in supporting providers. It is noted that the Department has already taken steps to innovate and improve the Program, having responded to several of the recommendations from the previous Interim Report such as implementing a Working Group for in-reach clinicians.

7.2 Data management and reporting systems

Several barriers limited the collection of unit record data over the length of the Program. There is an opportunity to strengthen data management and reporting systems within the Program to increase the type and consistency of data collected and support future evaluation activities.

There was high variation in the secondary data provided by SDCUs in terms of the completeness and consistency of client-level data collected. This impacted the extent to which clinical incidents and outcomes could be analysed to quantify changes over time and identify trends across sites. Table 7.1 summarises the key limitations with client-level data collected and the implication on data analysis.

Table 7.1 Limitations with the client-level data provided by SDCUs

Variable name	Key limitations with data collection
Client profile and admission (E.g., DOB, gender, admission date, special needs category, discharge date, reason for discharge and discharge facility)	• Some sites only provided information on residents over a six-month period. One site did not provide any client profile and admission data. • For a small number of sites, the admission and discharge data provided did not reconcile with occupancy data provided in the six-monthly performance reports. • The majority of sites did not provide consistent data on special needs categories, which limited the ability to analyse levels of access to the Program across different client groups (such as regional, rural and remote, Aboriginal and Torres Strait Islander, culturally and linguistically diverse).
Clinical incidents (E.g., use of restraints, as well as the number and severity of falls, wounds, infections, pressure injuries and behaviours of concern)	• Approximately five sites[24] provided clinical incident data at a unit record level over their entire operating period. One site did not provide any clinical incident data. • Some sites provided a severity score for each clinical incident however, the approach to classifying the severity varied across sites.
Medication variances (E.g., frequency and dosage, changes in medications prescribed, reasons for medication variance)	• Two sites provided unit record data on medication variances, which included the type of medication and variation applied. • Most sites provided aggregate information only (i.e., total number of medications initiated, ceased, or altered per resident over the length of stay) and did not specify the type of medication. • Three sites did not provide any data on medication variances.
Wellbeing and functioning (I.e., NPI-NH scores for each resident at admission and at 3-monthly intervals until discharge)	• Five sites provided data on residents' aggregate NPI-NH scores, with only two providing scores also broken down by domain. This limited analysis at a domain level, which is more appropriate for assessing Program efficacy, as noted in section 5.2. • Where sites provided NPI-NH data, some residents did not have consistent scores recorded at each 3-month time interval. • There was high variation in the average NPI-NH score at admission across SDCUs, suggesting there may be variation in how the assessment is conducted across sites.
Health service utilisation (E.g., unplanned hospital transfers)	• Two sites provided health service utilisation data at a unit record level for each resident.

Stakeholders identified several key barriers which impacted the provision of comprehensive unit record client-data:

1. **Capacity limitations within SDCUs.** Staff shortages impacted sites' abilities to routinely collect and record data on clinical incidents. This challenge was also exacerbated by additional capacity restraints caused by ongoing COVID-19 disruptions.
2. **Unique data collection systems.** Each SDCU works within their provider's existing data collection platforms (common across each RACF they operate), which created challenges in aggregating and comparing data across systems.
3. **Data archiving processes.** A small number of sites only provided data for a six-month period, as they advised information from previous periods had been archived and such records were difficult to access in a timely manner.

7.3 Program costs

Program costs were broadly perceived to be appropriate. However, it was noted that the financial viability for certain providers was impacted by slow uptake, and further investigation may be required to understand areas where providers require further guidance on optimally funded staffing levels and transitions out.

The Program uses a blended funding model that comprises fixed funding elements (e.g., top-up grant payments irrespective of bed occupancy), as well as outcomes-based grant payments (e.g., transition payments). Providers also receive standard

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[24] The number of sites varied by clinical incident variable.

residential aged care funding from both the Commonwealth and resident contributions. According to the Program Framework, this model was pursued in order to balance objectives including:[25]

- an occupancy-based component to ensure funding is linked to care delivered
- top-up grant funding to enable providers to meet fixed costs, maintain a skilled workforce and capacity to accept clients at short notice
- provision within the top-up grant funding to support capital upgrade and maintenance
- incentives for client throughput to ensure as many clients can be supported as possible within the fixed number of places
- recognising and funding the supports needed to enable clients to successfully transition to mainstream services.

Overall, the funding model for the Program (as a combination of fixed top-up grant funding and outcomes-based payments) was broadly seen to be appropriate. Providers largely felt the Program costs provided by the Department were sufficient to meet the requirements of the Program, both capital costs and operational costs. Regarding the effectiveness of the outcome-based aspect of the funding model, which offers an additional payment for every client that successfully transitions out of the Program, it was noted that providers have a higher incentive to achieve a positive outcome for clients than by payments from increased throughput.

Although stakeholders were broadly satisfied with the overall funding structure, stakeholder consultation and provider performance reports revealed several considerations:

- **Daily top up amount for specialist staffing.** There were varied perceptions on the adequacy of the daily top-up grant funding amount to resource appropriate staffing levels. Most sites were able to recruit adequate staffing required for the SDCU however, a small number of sites did not feel the funding was sufficient to achieve optimal resourcing. Therefore, there is an opportunity for the Department to utilise the Audited Financial Acquittal reports[26] (provided at the conclusion of the next financial year) to validate observations and better understand how funding is being utilised across sites. This may reveal opportunities to provide further guidance or parameters to providers on how the funding should be used to better support adequate staffing levels.

- **Impact of slow uptake rates.** Despite receiving top-up grant payments for each bed irrespective of occupancy, low occupancy can impact the Program's financial viability for providers due to the absence of daily resident/Commonwealth contributions. Stakeholders identified this as a barrier during the first year of operation and many sites noted that they had exceeded the budget for the SDCU in the initial phase of implementation. This was largely due to recruiting FTE to support full occupancy from opening yet taking longer than expected to achieve full occupancy. Some providers were able to minimise these costs by using the newly recruited FTE in other co-located RACFs until they were required at the SDCU. However, this challenge has persisted for some SDCUs that have continued to operate below full occupancy at different stages in the Program (discussed in Section 2).

- **Transition out payments to support the discharge process.** There were varied perceptions as to whether the transition out payments were adequate. The majority of stakeholders did agree that the transition out process is more resource-intensive due to the level of outreach required with mainstream RACFs to support a successful discharge (discussed in Section 4.2). However, most SDCUs were able to sufficiently resource transitions out, which may be partly driven by the lower cost of an internal transition which offsets more intensive external transitions. However, some SDCUs felt that the payment did not always cover the full cost of the transition out. Accordingly, there is an opportunity to explore the elements of a transition out which may require higher resourcing and where providers may require more financial support (i.e., a tiered approach to transition-out payment based on discharge complexity).

The retention of care staff may require incentives to offset the perceived risks of working at the SDCU.

The risk-pay tradeoff for care staff was identified as a key driver of care staff attrition in SDCUs (Section 3.1) following similar findings in the Interim Report (2021). Although some SDCUs reported higher levels of staff confidence and skill level

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[25] Australian Government Department of Health (2020), Specialist Dementia Care Program framework, accessed 1 June 2022, <https://www.health.gov.au/our-work/specialist-dementia-care-program-sdcp> .

[26] As part of the reporting requirements across the activity period, financial declarations are requested annually to verify that grant funds were spent in accordance with the grant agreement. An Audited Financial Acquittal Report is then provided at the conclusion of the activity period.

and lower levels of care staff attrition over the course of the Program, there continues to be perceived safety risks in working with the resident cohort when compared to roles within mainstream RACFs for comparable pay. It was suggested that further training and support for care staff may facilitate higher staff confidence and job satisfaction among care staff (as mentioned in Section 3 and Section 5.3). However, consistent with the **Interim Report (2021)**, if this issue persists as the Program moves into Phase Two, care staff may need to be recruited at higher levels that better reflect the scope of their role.

8 Expanding Program scope

Recommendation 16 (Section 1) of the Royal Commission into Aged Care Quality and Safety states that:

"By 1 July 2023, the Australian Government should review and publicly report on:

- *a. Whether the number of Specialist Dementia Care Units established or planned to be established is sufficient to address need within the areas and populations they are designed to cover*
- *b. the capacity of [SDCUs] to address the needs of people exhibiting extreme changed behaviour and whether further resources are required; and*
- *c. the suitability of SDCUs to support shorter-stay respite for people living with moderate to extreme changed behaviour."*[27]

As the evaluation activities for this report commenced, the Department asked Deloitte Access Economics to canvass stakeholder views regarding statements (b) and (c), to support the Department's overall activities regarding this Recommendation.[28] To that end, additional questions were added to the stakeholder consultation guides, such that Program stakeholders (SDCU staff, Program managers, in-reach clinicians and Program referrers) and DSA stakeholders (NBA service program managers and assessors) were asked to reflect on potential Program expansions for respite services and people exhibiting Tier 7 (extreme) behaviours, including any potential limitations or additional resources required. The findings are outlined below.

Stakeholders largely agreed that short-term respite would not be an appropriate offering within the Program.

Stakeholders acknowledged there is a strong need for further support services targeted to carers of people exhibiting moderate to extreme BPSD, including across mainstream RACFs and people being cared for in home settings. However, there was a strong consensus among stakeholders that providing short-term respite through the Program would be too disruptive to the respite residents, as well as for the broader Program.

Disruptions to respite residents and their carers

Stakeholders broadly agreed that short-term respite would not provide enough time for the Program to have a positive impact on settling BPSD, as it can take time for residents to begin showing improvements (see Section 5.2). Further, they believed transferring a patient in and out of the SDCU over a short period of time would likely exacerbate their BPSD, as transitions in and out of the SDCU can be highly disruptive to patients and can often cause behaviours to worsen temporarily.

Accordingly, the exacerbation of BPSD would likely minimise the short-term relief afforded to the respite carer. Some Program staff also noted that family/carers are also involved in the transition in and care planning process for new admissions, which would further reduce the relief given to carers during the respite period.

Long-term disruptions to existing Program residents and SDCU staff

The high resident turnover from short-term respite residents was also expected to exacerbate BPSD among current residents, given their BPSD can be heavily impacted by changes to the resident dynamic (see Section 5.2). Most Program staff believed respite residents would be difficult to integrate into the existing resident mix and could hinder the progress of existing Program residents. It was also suggested that exacerbated BPSD could place additional strain on care staff. Stakeholders at some SDCUs felt that the current level of staff confidence, skill level and capacity at their site would not be equipped to manage the mix of respite and longer-term residents.

Impact on Program uptake

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[27] Royal Commission into Aged Care Quality and Safety (Final Report, March 2021) Ch 3.

[28] Statement (a) was not included in the requested additional activities.

Stakeholders also felt that short-term respite would have broader implications on Program uptake, as the admission of respite residents may:

- increase waitlist times for existing Program applicants, by reducing the number of Program beds available
- create difficulties transitioning respite residents that would qualify for the Program back to their original care setting following a respite period, given reluctance among families and mainstream RACFs to discharge (see Section 4.1)
- create incentives among providers to favour either respite or longer-stay Program admissions, depending on the different funding options available for different cohorts.

It was suggested that a more appropriate alternative may be to provide outreach support to carers within their existing care setting, for example through relief carers, additional care staff or further education opportunities on best-practice dementia care. This could provide much needed relief to existing carers and valuable opportunities for education and capability uplift, whilst avoiding disruptions of moving the person between care settings.

There was broad consensus that the current Program would not be suitable for people exhibiting extreme BPSD.

Stakeholders across most sites acknowledged there is demand in their state or territory for specialist support for patients exhibiting Tier 7 BPSD and they believed elements of the SDCP Framework (such as the unit design and focus on person-centred care) would be beneficial to this cohort. However, stakeholders believed the current staffing profile of SDCUs (outlined in Section 3.1) is not equipped to provide quality and safe care to Tier 7 residents. To safely support residents exhibiting such extreme behaviours, the Program's model of care would need to include:

- 24/7 medical support to ensure timely access to clinical assessments and pharmacological interventions
- more specialised training for Program staff to strengthen their capability and confidence in managing more extreme behaviours
- higher staff ratios for care staff to ensure adequate supervision and safety precautions
- security personnel within the SDCU to protect staff, resident and visitor safety.

Stakeholders generally did not believe the current care staff were equipped to manage Tier 7 (extreme) BPSD, given their current confidence and skill level, and need for more specialised training in very severe BPSD (see Section 3.2). Anecdotally, previous Program residents whose behaviours escalated were discharged to an alternative care setting because the care staff were not equipped to manage extreme behaviours or the resident was seen to escalate other residents' symptoms. It was also suggested that more risk averse providers may be reluctant to accept people exhibiting extreme behaviours, given the higher care, safety and security needs of this cohort and the strict reporting requirements under the Aged Care Quality Standards.

9 Implications for ongoing implementation

This chapter provides concluding remarks as well as a summary of the key lessons learned and considerations for implementation of Phase Two of the Program.

9.1 Concluding remarks

Overall, findings generated through the evaluation activities show that the Program has been well implemented to date. Of note, awareness of the Program has continued to grow over time and most sites have now achieved full or high occupancy rates. There was consensus across stakeholders consulted that transitions in and out of the Program have become more efficient and coordinated over time. In addition, the clinical governance structures and Program partnerships (with specialist in-reach clinicians employed by state/territory health departments) have been effective in supporting optimal care for people with very severe BPSD. Key to implementation success has been an ongoing commitment to knowledge exchange across SDCUs and a strong focus on evolving in response to learnings – two critical success factors given the infancy of the Program and the new way of delivering aged care for all participating providers. There is opportunity to apply the early learnings from Phase One to support the implementation of Phase Two sites.

Evaluation findings also indicate the Program has successfully achieved its objectives to:

- **Provide care for people exhibiting very severe BPSD who are unable to be effectively cared for by mainstream aged care services.** SDCUs provide a purpose-built dementia friendly environment that facilitates better management of very severe BPSD, reduced use of chemical and physical restraints, and fosters higher quality of life for residents. This has also provided additional benefits to family/carers of residents through reduced carer burden and distress.

- **Provide care with a focus on stabilising and reducing the person’s symptoms over time.** The model of care has been effective in settling very severe BPSD for the majority of residents. It has enabled 62 residents to be transitioned to less intensive care settings as a result, with the majority experiencing long-term symptom management within mainstream RACFs.

- **Enhance the existing health and aged care service systems for people with very severe BPSD.** SDCUs have increased the care options available to people with very severe BPSD by improving residents’ access to mainstream RACFs. The successful transition of residents into mainstream RACFs has also led to cost savings for Government through avoided use of hospital and health services. If SDCUs had operated at full occupancy, it is estimated that the Program would have generated $1.11 to government for every $1 invested (i.e., a NPV BCR of 1.11), when using the most conservative benefits realisation time horizon that considered only the immediate benefits generated while each resident was part of the Program. When expanding the time horizon to 9- and 18-months post-Program participation, the BCR increases to 1.46 and 1.76, respectively.

- **Generate evidence on best practice care for people exhibiting very severe BPSD that can be adapted for use in mainstream settings to benefit all people with dementia.** Through the successful management of BPSD, SDCUs act as ‘centers of excellence’ that demonstrate and promote best-practice care for people with very severe BPSD to the broader aged care sector through facilitating knowledge-spillover with mainstream RACFs.

Alongside these takeaways, the evaluation identified several lessons learned and opportunities to enhance the ongoing implementation for current SDCUs, support the scalability of SDCUs as part of Phase Two, and ultimately optimise the outcomes realised across the Program.

9.2 Implications for ongoing implementation

Department level

Referral and admission

1. Continue to work with DSA and SDCUs to create standardised promotional materials and informational resources regarding the referral and transition in processes to support future site openings. This should enable consistent messaging across sites (both within and across jurisdictions), support further education to prospective referrers around the eligibility criteria, ensure that providers have a consistent understanding of the target Program cohort, and reduce duplication of effort across SDCUs.

2. Continue to work with DSA and existing/future SDCUs in regional areas to identify and find solutions to unique barriers impeding timely referral, assessment and admission.

3. Consider providing increased guidance to SDCUs regarding the recommended frequency of CAC meetings, to create more standardisation across sites and improve the timeliness of suitability assessments.

Care delivery

4. For Phase Two sites, promote the importance of the in-reach clinicians' role in capacity building of care staff related to behavioural management. This could include highlighting the expected educational aspects of the role in discussions with the jurisdictional mental health agencies and including it in the Memorandum of Understanding.

5. Examine the feasibility of recommending the need for a SDCU dedicated FTE RN (as opposed to a co-located RN) once a site reaches full occupancy. Also consider promoting high staffing ratios for afternoons and evenings (e.g., a dedicated recreational staff member for afternoon shifts).

6. Consider the need to provide further clarity on expected formal training standards for care staff. As part of this, the Department should consider centralising training in behavioural management and offering it a national level.

7. As the Program grows (i.e., when Phase One sites reach full occupancy and Phase Two sites open), monitor the need to recruit a part-time social worker role in each jurisdiction for the purpose of strengthening person-centered care for residents, supporting external transitions and providing targeted psychosocial wellbeing support for Program staff and family/carers.

8. Given variation in staffing arrangements across SDCUs, consider utilising the Audited Financial Acquittal reports to better understand how Program funding is being utilised across sites. This may reveal opportunities to provide further guidance to SDCUs on how the funding should be used to support adequate staffing levels. In addition, seek to understand the types of discharges that require additional financial support to inform whether a tiered approach to transition out payments (based on discharge complexity) may be appropriate.

9. Work with current SDCUs to explore the criteria each SDCU uses to monitor residents' progress and determine readiness for discharge. Identify any opportunities to apply these learnings to inform care planning processes for Phase Two sites.

Data collection

10. Consider providing standardised training to SDCUs on administration of the NPI-NH assessment tool and promote the consistent capture of NPI-NH scores at a domain level (particularly the domains related to aggression and agitation) in order to facilitate stronger resident monitoring and evaluation of Program efficacy.

11. Work with providers to understand current approaches to capturing aggregate data as part of their existing reporting obligations (e.g., National Aged Care Mandatory Quality Indicator Program (NACMQIP) and identify mechanisms which may allow this data to be provided for SDCUs. For example, consider whether it is possible for providers to insert a flag for an SDCU within the data systems used to capture these indicators. While the NACMQIP indicators will not provide a view on the Program's impact on residents over time, it will provide a view

on the annual prevalence of incidents (e.g., falls, physical restraints, hospital presentations etc.), which could be used to profile how patterns of behaviour in an SDCU differ to those observed in mainstream RACFs.

12. To supplement insights from the NPI-NH on resident progress, consider selecting a small set of outcomes measures and work with SDCUs to consistently collect and report on these indicators at a resident level as part of six-monthly reporting. Suggested outcomes include:
    - Number of ED presentations and unplanned admissions (including length of stay) during Program tenure.
    - Medication variances by drug class for discharging residents (e.g., 'reduction in dose' of antipsychotic) – to assess reduction in chemical restraints, a key program objective.
    - Discharge reason, where the following reasons are differentiated: palliative care, change in comorbidities (e.g., acute medical event), escalation of BPSD.
13. To further supplement data collected during a resident's stay, the Department and SDCUs could consider the feasibility of assessing longer-term outcomes associated with residents discharged due to 'successful reduction in very severe BPSD'. In particular, a key outcome for collection could be a six-monthly check-in of discharged Program residents' current care setting to understand the persistence of Program effects regarding symptom stabilisation. While it is acknowledged that this would increase administrative burden (and require the Department to negotiate with providers regarding how this process would practically be undertaken):
    a. a core driver of the Program's economic value to the wider health and aged care system is the length of time post-Program for which benefits can be assigned
    b. having data collection occur at the individual provider-level caps the administrative burden at the rate of Program discharges balanced with the expected rate of mortality occurring within the target Program cohort (which is elderly and medically complex)
    c. a trend observed across the Program was internal discharges to the provider's co-located mainstream RACF, simplifying this data-collection process.

    In addition, by tracking resident progress post-Program participation, it allows the Program to understand which residents are more likely to become unsettled in mainstream RACF settings. This information could then be used to:
    - inform a risk stratified discharge approach when discharging high-risk residents to minimise bounce-backs or escalation to hospital (e.g., a step-down discharge approach)
    - understand whether the selection of 12 weeks as the bounce-back period is appropriate for the observed post-discharge trajectory of behaviour.

Administration

14. Continue to commitment to knowledge sharing across Phase One and Phase Two SDCUs, by implementing a collaborative knowledge exchange platform to supplement the Community of Practice that allows providers to share tools and resources and informally share advice and reflect on learnings.

Provider level

15. As outlined in the SDCP Framework, ensure all care staff are trained in behavioural management for people with very severe BPSD prior to commencing their role. Work with other providers to identify appropriate training materials resources which could be leveraged to minimise duplication of effort.
16. For Phase Two sites, establish a structured CAC process that incorporates the key enablers of timely and coordinated suitability assessments, including clear role and responsibilities among CAC members, and strong information-sharing and feedback systems with referrers.
17. Consider opportunities to increase the availability of enrichment support for Program residents, such as the provision of more enrichment activities or the engagement of a dedicated recreation support coordinator.

18. Ensure initial multidisciplinary team meetings consistently occur within one week of admission, and that discharge planning is discussed at this meeting, with a discharge plan developed shortly after. In the case of a likely external transition, identifying suitable locations should also commence as part of discharge planning.
19. As the Program grows, investigate the extent to which the perceived pay-risk trade-off is driving recruitment and retention issues among care staff. If this is the case, it may indicate that care staff are not employed at a level commensurate with the scope of the role, and this may need to be adjusted.
20. Consider mechanisms for enhancing the role and input of care staff as part of CRTs or other discussions on client progress. The benefits of this are two-fold: it provides an important informal capability building opportunity for care staff, particularly as it relates to behavioural management techniques; it also provides more senior clinical staff with insight into daily behaviors and triggers observed on the ground.
21. When discharging a client, ensure the routine use of structured templates and processes (including ongoing outreach and follow up), for handover of information that includes a strong focus on the person’s unique needs and preferences, triggers and effective behavioural management strategies. As part of discharge outreach with receiving facilities, ensure staff continue to monitor the progress of discharged residents to identify residents at risk of bounce back and to inform ongoing improvements in discharge planning processes.
22. Implement processes to routinely reflect on the nature of the partnership with in-reach clinicians, including a discussion of scope for improvement or any need to update the Memorandum of Understanding.

Appendix A: Evaluation domain mapping

A 1: Mapping table between report sections and evaluation framework domains / questions

Domain	Evaluation question/s	Section of the Report
Implementation		
Awareness	To what extent are key referral sources and Program partners aware of, and understand, the Program, its purpose and the target resident cohort?	Section 2.1
Adoption	What has been the reach and frequency of referrals to the Program?	Section 2.2
Appropriateness	Are staff members competent and confident in their ability to provide specialist care for residents with BPSD?	Section 3.2
	Is each SDCU sufficient resourced to provide optimal care for people with BPSD?	Section 3.1
	Have governance processes been implemented as intended and are they effective?	Section 3.3
	Have the right mix of multidisciplinary clinicians been involved to enable optimal care?	Section 3.1
Fidelity	Are resident transitions in and out of the Program operating as intended (i.e., timely, coordinated, etc.)?	Section 2.3 (Transitions in) and Section 4.1 (Transitions out)
	Are the right policies and processes in place to enable staff to incorporate resident perspectives in decision-making?	Section 3.2
	To what extent have person-centered care practices (i.e., respectful care, individualised care, strengths-based care, etc.) been delivered?	Section 3.2
Costs	To what extent does the Program make the best use of available resources and how to this differ across sites?	Section 7
Sustainability	What were the key lessons learned and considerations for ongoing roll-out and scalability of the Program?	Section 9.2
Outcome		
Effectiveness	Person-centered care – to what extent have person-centered care practices been delivered?	Section 3.2
	Quality of life – To what extent has the Program improved clients' function, behaviour, quality of life and wellbeing?	Section 5.2
	Care process and transitions – Are clients and their families/carers satisfied with their involvement in, and the continuity of, care transition processes across the system?	Section 2.3, Section 3.2 and Section 5.3
Efficiency	Value for money – Is the Program considered cost-beneficial/cost-effective?	Section 6
Equity	Equity of access – To what extent does the SDCP meet the needs of different client cohorts with BPSD?	Section 2.2

Following the development of the Evaluation Plan, the Department also requested an additional line of investigation be added to the Final Evaluation, being questions stemming from Recommendation 16 of the Royal Commission into Aged Care Quality and Safety. Accordingly, two addition evaluation questions were added to the scope of the Final Evaluation to investigate two potential expansions of the Program scope:

1. whether SDCUs have capacity to address the needs of people exhibiting extreme changed behaviour (Tier 7 BPSD) and whether further resources are required; and
2. the suitability of SDCUs to support shorter-stay respite for people living with moderate to extreme changed behaviour (Tier 6 BPSD).

The findings for each line of investigation are outlined in Chapter 8.

Appendix B: Monetisation approach

Monetised benefits

National Activity-Based Funding model

Benefits related to avoided hospital utilisation are valued at the funding provided for the episode of care. Australia has a national activity-based funding (ABF) model which funds public hospitals to provide a range of services, including emergency department, acute admitted and sub-acute. Different types of services delivered are assigned a common unit of resource utilisation (the National Weighted Activity Unit, or NWAU) which is funded at the National Efficient Price (NEP). This process allows for a consistent determination of funding based on NWAUs across a wide range of services delivered.[29] The Independent Hospital and Aged Care Pricing Authority (IHACPA) determines the National Efficient Price each year and provides classification material to determine the NWAU assigned for specified services. For the modelling process, each financial year used the relevant NEP and classification material. Nominal dollars were converted to FY2019-20 real dollars using the AIHW's Government Final Consumption Expenditure hospital and nursing home price index. It is noted that multiple states have state-based localisations of the national ABF model, including State Efficient Prices. However, given the national scope of the Program the national ABF model was used as a representative approach.

Released capacity – long-stay psychogeriatric care (Subgroup A)

From the primary and secondary data collected, the monetisation process initially recognised that prospective residents may be cared for under several different services within a hospital setting, depending on the hospital in question. There was insufficient granularity of data to apportion bed-days in a way which addressed this complexity, and this is noted as a limitation of the analysis. Instead, a representative service classification was sought to consistently monetise released capacity.

Given the length of time that the prospective resident would be hospitalised for under the base case, the admitted sub-acute episode type '*Admitted Psychogeriatric – Long term care*' was used. One year exceeded the upper bound length of stay for this episode type (200 days), and as a result the first 200 days are funded at the inlier price weight (NWAUs), with each remaining day funded at the long-stay outlier *per diem* rate. A total year funding value was calculated, and then divided by 365 to determine a weighted-average funding rate per bed-day.

Table B 1 details the results of this assessment.[30] **The long-stay psychogeriatric care capacity released over the duration of the Program was estimated to be valued at a PV of $35,297,967 in FY2019-20 dollars.** This is the largest benefit observed across both subgroups and is greater than the sum of all other monetised benefits.

Table B 1 Released capacity – long stay psychogeriatric care (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Funding rate per occupied bed-day	-	$935	$1,194	$1,254
Value of released capacity	**-**	**$3,444,004**	**$16,657,698**	**$17,628,411**

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[29] As a hypothetical example, Admitted Acute Service A which is assigned 2.0000 NWAU is funded at twice the amount of Admitted Subacute Service B, which is assigned 1.0000 NWAU.

[30] The value of released capacity presented is the value associated with the 'Optimised' 1 scenario. Please refer to Section 6 for the 'Optimised' scenario description.

Source: Deloitte Access Economics calculations.

Reduction in BPSD-related ED presentations (Subgroup B)

Monetised benefits associated with a reduction in BPSD-related ED presentations is dependent on being able to estimate the incremental change in the number of presentations between the base case (a mainstream RACF) and the Program. Given the innovative nature of the model of care, to generate these estimates a series of detailed questions were asked in the Program staff survey. Questions were asked regarding respondent's views on the number of annual ED presentations avoided, the likelihood that the avoided ED presentation would have resulted in an unplanned admission, and typical lengths of stay for BPSD-related unplanned admissions. Survey analysis found that on an annual basis, approximately 3.67 ED presentations were estimated to be avoided, with 78% of BPSD-related ED presentations estimated to lead to unplanned admissions.[31] Thus, 3.67 avoided ED presentations were assigned for every 365 bed-days.

Monetisation of this benefit involved two different classification systems over the modelled period, Urgency Related Groups between FY2019-20 to FY2020-21, and the Australian Emergency Care Classification in FY2021-22. Urgency Related Group coding classifies episodes by triage category, episode end status (including admitted/not admitted) and major diagnostic block. For these years, a weighted average funding rate was calculated based on the proportion admitted versus non-admitted, with a triage category 2 psychiatric illness. For FY2021-22, the episode type '*Dementia and other chronic brain syndromes Complexity A*' was selected.

Table B 2 details the results of this assessment.[32] **Avoided ED presentations over the duration of the Program were estimated to be valued at a PV of $ $306,368 in FY2019-20 dollars.**

Table B 2 Avoided ED presentations (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Number of ED presentations avoided, overall	-	30	115	116
Weighted average funding per ED presentation[33]	-	$1,232	$1,283	$1,229
Value of avoided ED presentations	**-**	**$37,345**	**$147,169**	**$142,071**

Source: Deloitte Access Economics calculations.

Reduction in BPSD-related unplanned admissions (Subgroup B)

As described above, quantification of this benefit was based on the number of avoided ED presentations per 365 occupied bed-days, and the proportion of ED presentations that were estimated to end in an unplanned admission. Survey respondents estimated the average length of stay for an unplanned admission of this type to be 19 days. This is observed to be longer than AIHW analysis which estimated an average length of stay of 13 days in FY2020-21 for dementia as a principal diagnosis.[34] However, the severity of this cohort in comparison to the broader dementia cohort was theorised to contribute to this result. The benefit was monetised using the Diagnostic Related Group (DRG) classification '*Dementia and Other*

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[31] These estimates were based on six survey respondents, and thus it is acknowledged that the quantification process is based on information from a low sample size. As stated in the Limitations section for this report, the staff survey remained open for ten weeks to maximise the response rate. Deloitte Access Economics sought to validate the magnitude of this estimate against national ED presentation data sets for patients with dementia as a principal diagnosis (the closest proxy for BPSD exacerbations). However, given that BPSD 'tiers' are not a type of classification used in national data sets, patient-level frequency distributions of ED presentations by dementia severity were not able to be constructed to inform the estimation process.

[32] The value of avoided ED presentations is the value associated with the 'Optimise 1' scenario. Please refer to Section 6 for the 'Optimised' scenario description.

[33] It is noted that the AIHW estimated the average cost of a dementia-related ED presentation to be close to $1000 in FY2018-19 dollars. It is assumed that for the Tier 6 BPSD cohort, there is either a higher proportion of patients that require admission (increasing the funding per presentation), or the severity of behaviours increases the triage category assigned. See <https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/health-and-aged-care-expenditure-on-dementia/total-health-expenditure-and-expenditure-on-hospital-services-1#outpatient_ED>.

[34] AIHW (2022), *Dementia in Australia*, accessed 15 December 2022, < https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/health-services-used-by-people-with-dementia/hospital-care>.

Chronic Disturbances of Cerebral Function, Major Complexity'. A 19-day length-of-stay was within the inlier range for this classification, and therefore the episode was priced at the inlier price weight (NWAUs).

Table B 3 details the results of this assessment.[35] **Avoided unplanned admissions over the Program duration were valued at a PV of $3,490,867 in FY2019-20 dollars.**

Table B 3 Avoided unplanned admissions (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Number of unplanned admissions avoided, overall	-	24	89	90
Weighted average funding per unplanned admission	-	$20,362	$17,609	$18,448
Value of avoided unplanned admissions	**-**	**$481,273**	**$1,575,796**	**$1,663,493**

Source: Deloitte Access Economics calculations.

Reduction in BPSD-related ambulance incidents (Subgroup B)

For each ED presentation avoided, it was assumed an ambulance was utilised to transport the patient to hospital.[36] States and territories have a wide range of funding mechanisms for ambulance services, including automatic state-based coverage and membership-based coverage. Certain jurisdictions also split their fees into a call-out fee, plus a variable rate per kilometre travelled. From publicly available information related to fees and charges in QLD, NSW, ACT, VIC, SA and WA, a broad estimate of $1000 per incident was assumed, constant across the financial years of the model. When considering the potential fee charges to Program residents and their families, it was noted that multiple jurisdictions fully subsidise ambulance fees for concession card holders. As such, the full value of this monetised benefit was assigned to government.

Table B 4 details the results of this assessment.[37] **Avoided ambulance incidents over the duration of the Program was valued at a PV of $ $244,423 in FY2019-20 dollars.**

Table B 4 Avoided ambulance incidents (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Number of avoided ambulance incidents, overall	-	30	115	116
Funding per ambulance incident (estimate)	-	$1,000	$1,000	$1,000
Value of avoided ambulance incidents	**-**	**$30,302**	**$114,727**	**$115,605**

Source: Deloitte Access Economics calculations.

Released capacity – aged care (Commonwealth contribution) (Subgroup B)

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[35] The value of avoided unplanned admissions is the value associated with the 'Optimised 1' scenario. Please refer to Section 6 for the 'Optimised' scenario description.

[36] Anecdotally, from stakeholder consultation it was understood that SDCUs had varying protocols related to the involvement of police for BPSD exacerbations requiring emergency intervention. As an additional example of state-funded service utilisation, the extent to which police involvement may be avoided would also represent a benefit to government. This benefit was not able to be parameterised with confidence, and therefore has not been included.

[37] The value of avoided ambulance incidents is the value associated with the 'Optimised 1' scenario. Please refer to Section 6 for the 'Optimised' scenario description.

Released capacity relates to system-level efficiency benefits, and as such they include the Commonwealth contributions to an aged care place but exclude resident contributions. Commonwealth contributions to an aged care place considered relevant for this evaluation include:[38]

- Aged Care Funding Instrument (ACFI) fees – basic care subsidies which are based on need assessments across Activities of Daily Living, Behaviour, and Complex Health Care[39]
- accommodation supplements for supported residents
- other supplements (e.g., homeless supplements).

It is assumed that the replacement resident that occupies the aged care place now freed by the Program attracts the sectoral average Commonwealth contributions across all areas. Average ACFI subsidies per day were sourced from *Aged Care Funding Instrument Monitoring Reports* prepared monthly by the Department of Health and Aged Care. Average accommodation and other supplement subsidies per day were sourced from the Aged Care Financing Authority's *Ninth Report on the Funding and Financing of the Aged Care Industry (2021)*.

Table B 5 details the results of this assessment.[40] **Released capacity to the aged care system over the duration of the Program was estimated to be valued at a PV of $5,157,280 in FY2019-20 dollars.** This was the largest benefit observed for Subgroup B.

Table B 5 Released capacity – Commonwealth contribution (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Average ACFI subsidy, per occupied bed-day	-	$179	$189	$198
Accommodation supplement and other supplements, per occupied bed-day [i]	-	$20	$20	$20
Value of released capacity (Commonwealth contribution)	**-**	**$600,831**	**$2,388,074**	**$2,516,007**

Source: Deloitte Access Economics calculations.

Note i: In the absence of additional information, accommodation and other supplement values were assumed constant across all modelled financial years.

Monetised costs

Program costs (Subgroup A and Subgroup B)

Program costs associated with the model of care include:

- establishment costs
- top-up grant payments
- transition payments (paid in advance)
- state/territory SDCP partnership payments (for in-reach clinician services)
- NBA service payments.

All Program costs were provided by the Department, summarised in Table B 6.

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[38] COVID-19 funding supplements per day were not included.

[39] Program data was collected to the end of FY2021-22, with historical ACFI payment data used as a model input. The aged care system has recently moved to the Australian Aged Care Classification (AN-ACC) funding model as of 1 October 2022. As a result, for the purposes of modelling additional benefits in FY2022-23 and FY2023-24, the value of released capacity was assumed to be constant in real terms from estimates calculated in FY2021-22. The aged care contribution methodology will therefore require refinement moving forward once data is able to be collected on average funding received under the AN-ACC funding system.

[40] The value of released capacity (Commonwealth contribution) is the value associated with the 'Optimised' scenario. Please refer to Section 6 for the 'Optimised' scenario description.

Table B 6 Full Program costs (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Establishment cost	$513,021	$3,700,000	$0	$0
Top-up grant payments	$0	$2,231,700	$9,394,241	$9,322,915
Transition payments	$0	$295,200	$560,268	$547,210
State/territory SDCP partnership payments	$209,313	$1,535,000	$2,305,885	$2,539,793
NBA service payments	$0	$934,000	$689,500	$673,430
Total Program costs	**$722,333**	**$8,695,900**	**$12,949,894**	**$13,083,347**

Source: Department of Health and Aged Care.

Residential aged care costs – Commonwealth contribution (Subgroup A)

For Subgroup A, entry into the residential aged care system at an SDCU attracts residential aged care costs. These costs may be split into Commonwealth contributions and resident contributions. The approach to monetisation of Commonwealth contributions followed the same process as discussed in released capacity (Commonwealth contribution) above, with an exception for the calculation of ACFI fees. A Program resident is likely to have higher needs than the sectoral average aged care place, and as a result fees were calculated based on the assumption of high need across Activities of Daily Living, high need across Behaviour, and medium need across Complex Health Care. Fees for each financial year were sourced from the Schedule of Subsidies and Supplements for Aged Care, published on the Department website.

Table B 7 details the results of this assessment.[41] **Incremental costs from Commonwealth contributions to Program providers for Subgroup A over the duration of the Program was estimated to be valued at a PV of $6,476,597 in FY2019-20 dollars.**

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[41] The value of residential aged care costs (Commonwealth contribution) is the value associated with the 'Optimised 1' scenario. Please refer to Section 6 for the 'Optimised' scenario description.

Table B 7 Residential aged care – Commonwealth contributions (Subgroup A) (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Average ACFI subsidy, per occupied bed-day	-	$198	$199	$196
Accommodation supplement and other supplements, per occupied bed-day[i]	-	$20	$20	$20
Value of residential aged care costs (Commonwealth contributions)	**-**	**$806,359**	**$3,055,175**	**$3,043,503**

Source: Department of Health and Aged Care.

Note i: In the absence of additional information, accommodation and other supplement values were assumed constant across all modelled financial years.

Residential aged care costs – resident contribution (Subgroup A)

Subgroup A's entry into the residential aged care system also attracts residential contributions. Resident contributions to an aged care place considered relevant for this evaluation include:

- basic daily fees
- mean tested fees
- other care fees
- accommodation payments
- extra service fees
- additional service fees.

It is assumed that the prospective Program resident pays the sectoral average resident contributions. Average residential fees per day across all fee types listed was sourced from the Aged Care Financing Authority's *Ninth Report on the Funding and Financing of the Aged Care Industry (2021)*.

Table B 8 details the results of this assessment.[42] **Incremental costs from resident contributions to Program providers for Subgroup A over the duration of the Program was estimated to be valued at a PV $2,318,951 in FY2019-20 dollars.**

Table B 8 Residential aged care – resident contributions (Subgroup A) (FY2019-20 dollars, real)

Element	FY2018-19	FY2019-20	FY2020-21	FY2021-22
Total resident contribution, per bed-day[i]	-	$78	$78	$78
Value of residential aged care costs (resident contributions)	-	$287,485	$1,088,470	$1,096,798

Source: Department of Health and Aged Care.

Note i: In the absence of additional information, resident contributions were assumed constant across all modelled financial years.

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[42] The value of residential aged care costs (Commonwealth contribution) is the value associated with the 'Optimised' scenario. Please refer to Section 6 for the 'Optimised 1' scenario description.

Limitation of our work

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Deloitte Access Economic Pty Ltd

+61 7 3308 7223

www.deloitte.com.au

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