



Department of Health  
**Options for the assessment,  
classification and funding  
model for the unified aged  
care at home program**

**Final Report**

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# Abbreviations

AAA	Area Agency on Aging
ABF	Activity based funding
ACAT	Aged Care Assessment Teams
ACF	Assessment, classification, and funding
ACFR	Aged Care Financial Report
ADL	Activities of daily living
AHA	Australian Healthcare Associates
AHSRI	Australian Health Services Research Institute
AN-ACC	Australian National Aged Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient
APA	Allocation personnalisée d'autonomie
APCS	Annual Prudential Compliance Statement
AR-DRG	Australian Refined-Diagnosis Related Groups
AT	Assistive Technology
ATM	Approach to Market
BelRAI	Belgium adapted interRAI HC
BESADL	Belgian Evaluation Scale for Activities of Daily Living
CALD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
CF	Classification and funding
CHESS	Changes in Health, End-stage disease and Signs and Symptoms
CHSP	Commonwealth Home Support Programme
CIHI	Canadian Institute for Health Information
COTA	Council on the Ageing
DHB	District health boards
DSS	Department of Social Services
FP	For-profit
FIM	Functional Independence Measure
HCP	Home Care Packages
HHRG	Home Health Resource Groups
IADL	Instrumental activities of daily living
IHPA	Independent Hospital Pricing Authority
interRAI HC system	interRAI home care system
LGBTIQ	Lesbian, Gay, Bisexual, Transgender/Transsexual, Intersex and Queer/Questioning
LHIN	Local health integration network
LTC	Long term care
MBS	Medicare Benefits Schedule
MDS	Minimum dataset
MHCT	Mental health clustering tool
MVP	Minimal viable product
NASC	Needs Assessment Service Coordination
NDIS	National Disability Insurance Scheme
NEC	National Efficient Cost
NEP	National Efficient Price
NFP	Not-for-profit
NHHCS	National Home and Hospice Care Survey

NHS	National Health Service
NPS	National Prioritisation System
NSAF	National Screening and Assessment Form
OASIS	Outcome and Assessment Information Set
RAS	Regional Assessment Service
RUCS	Resource Utilisation and Classification Study
RVU	Relative Value Unit
THL	Finnish Institute for Health and Welfare
TSB	Targeted Service Bundles

# Executive Summary

On the 30<sup>th</sup> January 2020, the Australian Government Department of Health (Department) engaged HealthConsult to:

***“develop options to inform the assessment, funding and classification model to underpin a single unified system for care of the elderly in the home”***

The project was commissioned following the Australian Government’s announcement on 25<sup>th</sup> November 2019 (in the context of measures to respond to the Royal Commission into Aged Care Quality and Safety’s Interim Report) of its intention to undertake the preparatory analytic work needed to support the establishment of a single unified system for care of the elderly in the home. This initiative would unify the current Home Care Program (HCP) and Commonwealth Home Support Programme (CHSP).

This project represents phase one of a multi-phase approach to developing the assessment, classification, and funding (ACF) model for the unified program. Phase two, which will likely involve the development and testing of the preferred ACF model is out of scope.

## CONTEXT AND METHODOLOGY

The phase one project to develop options for potential ACF models was conducted in an environment where early policy and program design work was being progressed by the Department in parallel. It was also undertaken while the Royal Commission was evolving its thinking regarding how best to respond to the challenges in the aged care system. In particular, the findings and recommendations of Royal Commission will determine the final design of the service model(s) to be used in the unified aged care at home program.

For these reasons, the project focussed on developing, at a technical level, the options for the ACF model and evaluating them to arrive at a preferred option. This approach was designed to ensure that the preferred ACF model could be used once the policy and program development work was completed. The project involved a documentation and literature review, as well as an iterative options development process executed in partnership with the Department. That process included three workshops with key Departmental staff, and two rounds of targeted stakeholder consultation. The Department also facilitated several discussions with project teams conducting related projects to optimise alignment and complementarity of outputs.

## EVALUATION CRITERIA

Guiding principles used in analogous contexts across the health and aged care sectors were used as the starting point for developing an appropriate set of evaluation criteria for choosing from the developed ACF options. Principles at a system level were also taken from the Royal Commission’s Consultation Paper 1 and the project objectives set by the Department. Principles at a more technical level were taken from the work of the Independent Hospital Pricing Authority (IHPA) relating to activity based funding (ABF) in public hospitals and the Australian Health Services Research Institute (AHSRI) relating to the early work on the development of the Australian National Aged Care Classification (AN-ACC) system.

These four sources yielded 53 guiding principles. These principles were analysed and mapped to one or more of the ACF model components. They were then consolidated (to remove duplication) and refined into criteria specific to the evaluation of options for each ACF model component. Some criteria were used for more than one component, although each time they are interpreted in the context of the ACF model component being considered. This process resulted in three initial sets of criteria, seven for the assessment model, seven for the classification model, and nine for the funding model. The initial criteria were refined through stakeholder consultation, including a workshop with key Departmental staff, before being used to evaluate the options.

## OPTIONS DEVELOPMENT

Drawing on the documentation and literature review and the information obtained from stakeholder consultations, discussion papers were developed that set out options for four components of the ACF model individually:

- Data collection (unit of count) options underpinning the ACF model
- Assessment model options
- Classification model options
- Funding model options.

These discussion papers were exchanged with the Department to consolidate ACF model concepts and then used as the basis of targeted stakeholder consultation. This process allowed ideas to be brought forward and considered at the ACF model component level.

## DATA COLLECTION OPTIONS

**Option D1 – Service events:** data collection would be based on counting all “service events” delivered. A service event could be defined as the provision of one of the service types (e.g. personal care, domestic assistance) to a care recipient on a single occasion.

**Option D2 – Episodes (includes service events):** data collection would be based on counting “episodes of care”. An episode of care could be defined as an individual person for a defined period who receives one or more aged care at home services. The episode of care would be built up from the service events provided to a consumer while the episode of care is in progress.

## ASSESSMENT MODEL OPTIONS

**Option A1 – Proportionate assessment:** an assessment model that would be graduated and risk based, meaning that the investment in the assessment process would be proportionate to the service and financial risk associated with individual consumers (i.e. lower risk/lower resource need consumers may access services after screening/triage without detailed assessment).

**Option A2 – All consumers assessed:** an assessment model that would require assessment on each consumer that has been registered and screened/triaged for aged care in the home services. There could be expedited, short term access to a limited range of support services pending assessment. The assessment would be completed using a standardised instrument, noting that some aspects of the instrument may not be applicable to some consumers.

Option A1 reflects the guidance provided by the Department for proportionate assessment to be considered. Options A1 and A2 feature reablement focussed assessment (for consumers identified as suitable through the screening/triage or the care assessment process). They also feature the assessment of the informal carer’s support needs (e.g. for coaching, counselling or respite support), as well as considering the impact that the presence or absence of an informal carer has on care recipient’s assessed needs.

## CLASSIFICATION MODEL OPTIONS

**Option C1 – Service event level classification:** the classification system would be developed at the service event level. The categories would be based on the characteristics of the service delivered (i.e. the service type, which could be derived by refining the current CHSP categories), not on the characteristics of the consumer receiving the services. Each service provided to a consumer would be classified into the most appropriate service type.

**Option C2 – Banded classification system:** the classification system would be based on grouping consumer episodes into bands with similar needs/expected resource use. Logically, the existing banded level of care classification system used in HCP would be applied at the episode level. It would need to be refined and expanded to account for a greater range of consumer needs (including for consumers currently receiving services under the CHSP).

**Option C3 – Refine and modify RUG-III-HC:** the classification system would be based on the use of the existing American-developed interRAI RUG-III Home Care (RUG-III-HC) classification system, modified to be suitable in the Australian setting. RUG-III-HC is derived from the use of the interRAI system, which is a proprietary assessment tool.

**Option C4 – Refine and modify AN-ACC:** the classification system would be based on the further development of the AN-ACC classification for use in the unified aged care at home program (the current AN-ACC was developed specifically for use in residential aged care). A whole new aged care at home branch at the start of the classification system would need to be developed.

**Option C5A – Fit-for-purpose classification – episode level only:** would be the development of a fit-for-purpose classification system at the episode level. Data gained from the assessment process would inform which episode type consumers or carers are allocated to (e.g. screening/triage could result in a consumer either ending up in an ongoing care or short-term care episode whereas those that undergo further assessment can end up in any episode care type).

**Option C5B – Fit-for-purpose classification – mixed service event and episode level:** would be the development of a fit-for-purpose classification system using a mixed service event and episode level approach. This option would align the classification system with the proportionate assessment model, so classes for consumers accessing via screening/triage only would be service event based, and classes for consumers accessing via assessment would be episode based.

Options C3, C4, C5A, and C5B all potentially feature the use of targeted service bundles (TSBs), which were suggested by the Department for consideration in developing the classification and funding models. TSBs represent expert-developed service bundles for groups of consumers with similar needs/risks/resource requirements. They would be used to improve alignment of services needed (as determined by independent assessment) with services delivered.

## FUNDING MODEL OPTIONS

**Option F1 – Service event level funding with service event classification:** would be a service event level funding model using the service event classification system. Two implementation approaches could be possible. The funding for each consumer could be capped (based on the assessment approval) with services provided up to the capped amount. Alternatively, an uncapped approach could be used, where all in-scope services provided would be funded.

**Option F2 – Episode funding with fit-for-purpose classification:** would be an episode level funding model using the fit-for-purpose episode level classification. All consumers would be assigned to a category in the classification system. The relative value unit (RVU) associated with that category would be used to determine the funding amount. A consumer may be allocated more than one funding amount if they are experiencing parallel episodes.

**Option F3 – Mixed service event and episode funding:** would be a mixed service event and episode level funding model using the fit-for-purpose mixed service event and episode level classification system. This model would also be aligned to proportionate assessment. The episode level funding model would be used to fund consumers that undergo assessment (i.e. assessed and assigned an episode class). The service event level funding model would be used to fund other consumers (i.e. low risk/low resource use consumers accessing services via screening/triage only).

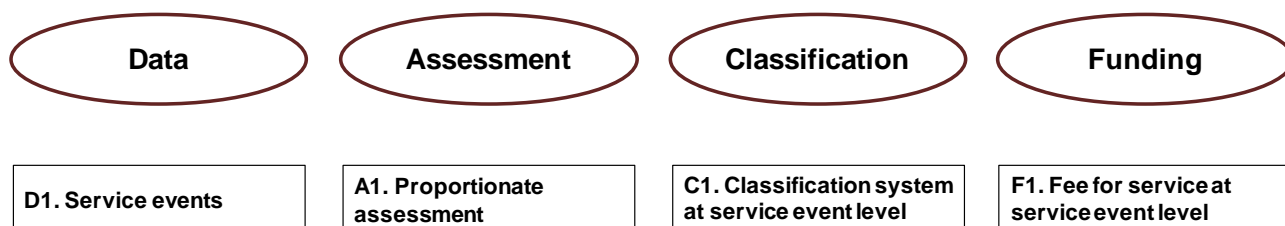
Options F1, F2, F3 would all require consideration of the possible use a fundholder/authoriser in the payment process. Funds could be managed/authorised by a single provider, an independent care coordinator (or equivalent), or the consumer or their representative (self-management). Consideration of an approach to setting prices at the service event level (all Options) and/or the episode level (Options F2 and F3) would also be required. Finally, all options require consideration of funding adjustments to reflect unavoidable costs associated with service characteristics (e.g. service provided in or out of hours, rural and remote location, operating in thin markets) and/or

client characteristics not used in classification (e.g. Aboriginal and Torres Strait Islander status, homeless, CALD, and/or LGBTIQ).

### CONSOLIDATED ACF MODEL OPTIONS

Logically, by making one choice from the alternatives for each of the four ACF model components discussed above, there are 72 possible options for the consolidated ACF model. A short-listing process was used that involved judgement, with reference to the learning derived from the documentation and literature review, and the input obtained from stakeholders. Those judgements were endorsed at workshops with key Department staff, leaving three consolidated ACF model options to be evaluated in detail. Those options are shown in Figures ES.1 to ES.3.

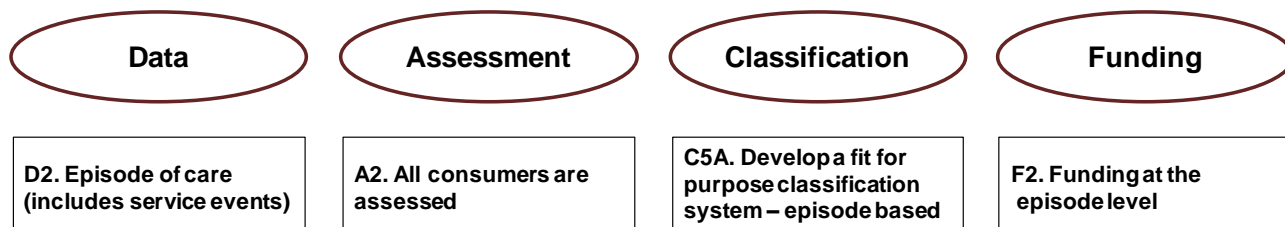
**Figure ES.1: Option 1 – Service event level classification and funding**



Option 1 combines data collection at service event level (D1) with a service event level classification (C1) and funding (F1) system. Proportionate assessment (A1) is used, as there is no need to gather detailed assessment data to drive the classification system. However, screening/triage and/or assessment data would need to be used to define and approve the package of services that is offered to consumers.

By way of analogy, this option is similar to many aspects of Medicare Benefits schedule (MBS) or the clinic-based payment system used for non-admitted patients under public hospital ABF. Each service provided would be classified into a service type class for which there would be a pre-specified payment (set with reference to a standardised price schedule).

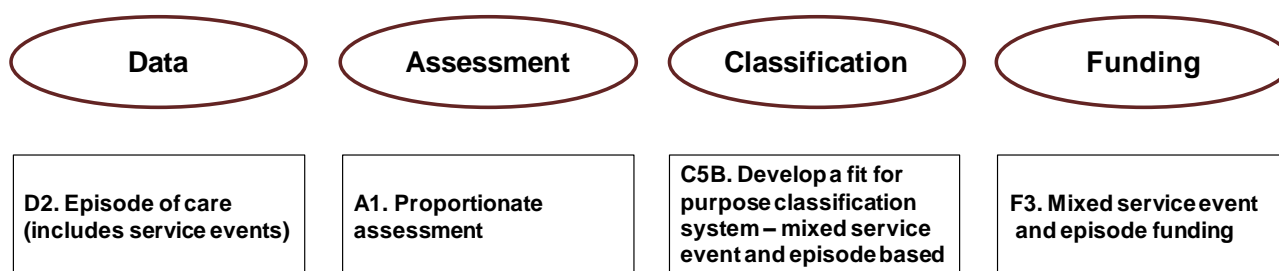
**Figure ES.2: Option 2 – Episode level classification and funding**



Option 2 combines data collection at episode level (D2) with a fit-for-purpose episode based classification (C5A) and an episode level funding (F2) system. The all consumers are assessed option (A2) is used, as the assessment data is needed to drive the episode level classification system. All consumers and informal carers (where their needs are assessed) would be classified into an episode, which could be ongoing, where intervals (e.g. monthly) would be funded, or short term which could be funded progressively or once-off depending on its length.

This approach is similar to many aspects of the AN-ACC classification and funding system developed for residential aged care. There are also similarities to the Australian Refined Diagnosis Related Groups (AR-DRG) based system used for the payment of admitted episodes in public hospital ABF. For example, it is not the interim products used in an episode that are paid for (e.g. bed days, theatre time, diagnostic tests, etc. in an admitted patient episode in hospital) but the overall episode has a specified payment (set with reference to the RVU associated with the episode class). The key difference is that consumers may be classified concurrently into, and hence funded for, more than one episode at the same time.



**Figure ES.3: Option 3 – Mixed service event and episode level classification and funding**

Option 3 combines data collection at episode level (D2) with a fit-for-purpose mixed service event and episode level classification (C5B) and funding (F3) system. The proportionate assessment option (A1) is used, reflecting the fact that consumers who access services directly from screening/triage will be classified and funded using only service events (given there would be insufficient data to drive episode level classification via screening). Consumers and informal carers who undergo an assessment would be classified and funded using only episodes. The technical features of the mixed model would be similar to those used in the service event and episode level approaches described above.

This approach also has similarities to hospital ABF, where some services are funded using a service event approach (e.g. non-admitted patients) and other services are funded using an episode approach (admitted patients). The fit-for-purpose approach is a tailored solution to accommodate the wide spectrum of needs that are likely to be expressed in the unified aged care at home program from low (e.g. 53.4% of CHSP consumers used only one service type in 2018/19) to high (e.g. 47% of consumers in HCP received a Level 3 or 4 package in 2018/19). Thus, the response by the unified aged care at home program would be proportionate to the expressed need and the resources needed to meet that need (i.e. a risk-based approach to the ACF model that optimises the use of available resources).

## IDENTIFICATION OF PREFERRED OPTION

The three consolidated ACF model options were then evaluated to arrive at a preferred option. The approved evaluation criteria were applied to each of the choices made for the components of the ACF model, that were used in one or more consolidated option. Table ES.1 presents the overall evaluation scores for each Options 1 to 3, which informs the selection of a preferred option.

**Table ES.1: Evaluation scoring – all three consolidated ACF model options**

Option number	Assessment Component		Classification Component		Funding Component		Total Score
	Model	Score	Model	Score	Model	Score	
Option 1	Proportionate assessment	87	Service event-based	54	Service event level funding	64	205
Option 2	All consumers assessed	79	Fit-for purpose – episode	76	Episode payment	77	232
Option 3	Proportionate assessment	87	Fit-for purpose – mixed service event and episode	77	Mixed service event and episode	79	243

The scores reflect a preference for Option 3, that reflects the additional tailoring done to fit the ACF model to desired program goals and objectives. Specifically, Option 3 allows for:

- An assessment model that tailors the level of assessment to the level of a consumer's need/expected resource use (i.e. a risk-based approach that optimises the use of the available assessment resources).
- A classification model that allows a consumer to be in more than one class concurrently, which provides flexibility to mix ongoing care episodes with short-term care episodes to dynamically respond to changes in consumers' care needs.

- A classification model that uses the development of TSBs, as the mechanism for identifying the set of support services that will best meet the needs of consumers in each class (as determined by the consumers' characteristics).
- A funding model that uses the simplicity of service event funding for consumers with lower needs/expected resource use, thereby not tying up resources in the more comprehensive episode approach for the lower risk consumers.
- A funding model that incentivises the use of TSBs to maximise the alignment between support services delivered and support services needed, as determined by the independent assessment process.
- A classification and funding approach that explicitly creates and funds reablement episodes separate to ongoing episodes (either on entry of a consumer to the unified aged care at home program or in response to a change in care needs while the consumer is in an ongoing care episode), which creates a significant opportunity for the emergence of providers specifically focused on reablement care.

The preferred option provides a sound and clear basis for proceeding with the development of the ACF model for the unified aged care at home program. It is the result of careful consideration and evaluation of the alternatives.

## **IMPLEMENTATION AND TRANSITION ARRANGEMENTS**

There are a range of implementation and transition issues potentially associated with the proposed ACF model. A preliminary discussion of the possible impacts of the preferred option on the key stakeholder groups has been presented in the context that any significant change in the ACF model for aged care at home services has potential risks and benefits. Many of these risks and benefits will be better understood towards the end of the phase two work once the components of the ACF model have been developed and tested.

Should Government decide to proceed in developing the preferred option, the next step in the process would be to formulate and execute a development and testing plan for the preferred ACF model. Phase two would include the development of the assessment model (including digitised versions of the assessment instrument); the development of the classification system (including the supporting software) and the development of the funding model (including the initial pricing schedules for service events and episodes). A significant empirical data collection involving providers of aged care at home services would form a key part of this work. Approximately 15 months would be required to undertake the development and testing work. A trial of the ACF model infrastructure should then be considered, prior to finalising the ACF model components ready for implementation.

As part of the development and testing work, a comprehensive transition plan would need to be developed to mitigate and manage the risks associated with a change of the magnitude envisaged. The transition plan would also need to identify a process for ensuring that benefits are realised. An important part of that plan should be workforce development, to ensure that the integrated assessment tool (which will include the screening/triage protocol) can be applied consistently. Training will be needed to ensure that consumers with similar needs and characteristics are channelled in a consistent fashion through the new ACF model for the unified aged care at home program, without creating barriers to service access.

There will also be a need for the transition plan to address the significant systems development work that will be required to implement the new ACF model. There will need to be substantial redevelopment of data collection and storage systems to collect, store and report on the MDSs that will be created for assessment and service delivery. Redevelopment of government and provider financial systems will also be required to support application of the new funding model. Some of this work could be done in parallel with the phase two work on the development and testing of the ACF model, but there will also be considerable work required once the ACF model is finalised.

# 1

## Introduction

On the 30<sup>th</sup> January 2020, the Australian Government Department of Health (Department) engaged HealthConsult to:

***“develop options to inform the assessment, funding and classification model to underpin a single unified system for care of the elderly in the home”***

### 1.1 BACKGROUND

The proportion of people aged 65 years or over in Australia is projected to increase. Rapid population ageing, increased life expectancy and the effect of chronic disease on the population (particularly cognitive impairments such as dementia), means that there is a growing demand for aged care and greater pressure on government budgets. As well as extra demand for aged care, we can expect changes in the needs of people requiring care, with shifting patterns of disease; more diverse preferences for, and expectations of, care; changing wealth levels; and developments in technology.

To address various current issues in the delivery of aged care services and determine how to best meet the challenge of meeting aged care needs in the future, the Government established a Royal Commission into Aged Care and Quality and Safety in October 2018<sup>1</sup>. The Royal Commission’s work is in progress via the continuing production of research and discussion papers; and public hearings and workshops.

The Royal Commission released an Interim Report in October 2019. On the 25<sup>th</sup> November 2019, in the context of measures to respond to the Interim Report, the Government announced its intention to undertake the preparatory analytic work needed to support the establishment of a single unified system for care of the elderly in the home. This unified system will be developed by bringing together the CHSP and the HCP program; offering flexible care services that are tailored to consumers’ needs.

### 1.2 AIM AND OBJECTIVES

This project represents phase one of a multi-phase approach to developing the ACF model for the unified system. Phase two, which will involve the development and testing of the chosen ACF model was out of scope. The scope of phase one was to provide advice to the Department on options for the ACF model.

The objectives of the first phase included:

- Conduct a review of local and international models/tools that are used in home and community care settings which will influence the assessment, classification and funding models developed for the Australian community setting.
- Develop options (including a recommended option) for an ACF model for a single unified system for care of the elderly in the home.
- Analyse how the proposed options address the objectives outlined in the Approach to Market (ATM) document (these objectives are reproduced in Appendix D).

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<sup>1</sup> <https://agedcare.royalcommission.gov.au/Pages/Terms-of-reference.aspx>

- Consider the likely demand and recommend ways to measure demand as part of the model development.
- Consider implementation and transition.

### 1.3 POLICY CONTEXT

All parties acknowledged that this project needed to move forward in an environment where there was considerable related work being done in parallel. In particular, the final design of the service model(s) and program arrangements will be determined by Royal Commission's findings and recommendations.

In this environment, the Department provided some specific guidance on policy options that should be considered in developing the ACF model. The guidance included:

- **Proportionate assessment:** the use of an approach where the investment in the assessment process is proportionate to the need/risk and service associated with individual consumers should be considered (i.e. lower risk/lower resource need consumers may access services up to a threshold without detailed assessment).
- **Reablement focus:** the need to conduct assessments using a reablement lens, where appropriate, should be considered to maximise opportunities to improve/restore function; also the method for embedding incentives in the program design to stimulate the use of short-term reablement services throughout the program should be considered.
- **Informal carer needs:** the assessment process should consider the needs of the informal carer (e.g. for training, coaching, counselling or respite support), as well as considering the impact that the presence or absence of an informal carer has on the assessment of the care recipient's needs.
- **TSBs:** the development of service bundles for groups of consumers with similar needs/risks/resource requirements should be considered for use in the classification and funding system (the TSBs would be used to improve alignment of services needed (as determined by independent assessment) with services delivered).

The ACF model options development process was not constrained to include this guidance. It was, however, explicitly considered as part of the options development process. The concepts were also discussed with stakeholders as part of the consultation process. They were embedded into several of the options developed for evaluation.

### 1.4 PROJECT METHODOLOGY

The project was carried out in six main stages between February and May 2020.

- (1) **Situation analysis** – A review of documentation provided by the Department was undertaken to develop a full understanding of the current programs' configuration and data collection, and the parallel work in progress. This review informed stakeholder engagement and initial policy options development. Supplementing this work was a targeted literature review (scientific and grey literature) to identify models and tools that are used internationally or nationally for assessment, classification, or funding of aged care at home services.
- (2) **Initial stakeholder consultation** – A stakeholder consultation process was undertaken to discuss the current aged care at home programs, aspirations for the unified program, and to garner a wide variety of views on the desirable features of models for ACF for aged care at home for the unified program.

- A workshop was facilitated in Canberra on the 26<sup>th</sup> February 2020 with key staff at the Department including representatives of aged care program management; policy; and data collection and reporting.
- Initial consultations with key stakeholders were conducted by HealthConsult on the 28<sup>th</sup> February and 2<sup>nd</sup> March 2020 via teleconference (list of interviewees in Appendix A).
- International subject matter expert - A meeting was held with Professor Peter Gore (Professor of Practice Ageing and Vitality, Newcastle University, United Kingdom) on the 4<sup>th</sup> March 2020 by videoconference to discuss the potential application of the trajectory of functional decline in determining older persons' support services needs.

(3) **Discussion papers and preliminary options** – A series (six) of discussion papers were developed and exchanged with the Department to consolidate concepts relating to the development of the ACF model. The discussion papers focused on the following topics:

- Summary of initial stakeholder consultation process
- Data collection (counting units)
- Criteria to evaluate ACF model options
- Assessment options
- Classification options
- Funding options

The discussion papers were the basis for developing a paper on the proposed evaluation criteria and the preliminary options for each component of the ACF model (i.e. assessment, classification, and funding), which included a proposed short-list of consolidated options for further work-up and evaluation.

(4) **Second round stakeholder consultation** – Using the preliminary options paper, a second round of consultation was undertaken to discuss and refine the ACF model options and the evaluation criteria to be used to identify the preferred option for the new unified aged care at home program.

- A teleconference workshop was facilitated on the 6<sup>th</sup> April 2020 with key staff at the Department including representatives of aged care program management; policy; and data collection and reporting.
- Second round consultations with a broader group of stakeholders (including those in the initial consultations) were conducted by HealthConsult from 14<sup>th</sup> to 20<sup>th</sup> April 2020.

This process concluded that four consolidated options (i.e. the assessment, classification and funding model component options combined) were suitable for further work-up.

(5) **Development and evaluation of short listed ACF options** – Drawing on the information obtained from the second-round stakeholder consultations and the documentation and literature review, the short-listed options were further developed. They were then appraised against the agreed evaluation criteria leading to the identification of a preferred option. This work was presented in a paper that was considered by a third workshop with key staff at the Department, held by teleconference on 11<sup>th</sup> May 2020. At this workshop there was support for the preferred option.

(6) **Assess implementation and transition arrangements** – Based on the preferred option, a preliminary consideration of the implementation and transition issues was developed, which included an initial discussion of the possible impacts of the preferred option on the key stakeholder groups (consumers, providers and Government).

## 1.5 PURPOSE OF THIS DOCUMENT

This document presents the final report of the first phase of the work. This report includes:

- **Chapter 2:** presents a summary of the situation analysis results
- **Chapter 3:** presents the evaluation criteria used for choosing amongst ACF model options
- **Chapter 4:** presents and describes the options developed and considered for each component of the ACF model
- **Chapter 5:** presents the short-listed consolidated ACF model options and the evaluation against the criteria of the choices that are used for each ACF model component in each short-listed option, leading to the identification of a preferred consolidated option and a preliminary consideration of the implementation and transition issues.

## Situation analysis

This Chapter summarises the information derived from the situation analysis process, including a description of the existing CHSP and HCP programs and key conclusions from the documentation and literature review.

### 2.1 ACCESS ARRANGEMENTS FOR CHSP AND HCP

Health professionals and other service providers in the community can refer patients to My Aged Care (online, phone or fax), or older persons can check their eligibility online at the My Aged Care website and apply for phone-screening and a face-to-face assessment (if required). Based on the screening, an individual may be referred for assessments by a Regional Assessment Service (RAS) for entry-level support and linkage to CHSP services; or an Aged Care Assessment Team (ACAT) if they have more complex and multiple care needs for referral to the appropriate services such as the HCP Program, residential or transitional care. The National Screening and Assessment Form (NSAF) supports the collection of information for the screening and assessment processes conducted under My Aged Care.

An assessment builds on the information collected in the My Aged Care contact centre registration and screening process. The assessor (RAS or ACAT) gathers more detailed information on the client to determine the level of need and care type; and works with the client to establish a support plan that best meets their needs and goals.

#### 2.1.1 CHSP assessment

An assessment for CHSP services is undertaken by the RAS, generally face-to-face in the client's usual accommodation setting. A trained RAS assessor will collect information on the client's holistic care needs, with consideration of both informal and formal services, as well as reablement pathways, where appropriate. On completion of the assessment for CHSP services, the RAS may determine the client's needs to be more complex than initially thought and refer to an ACAT for a comprehensive assessment.

#### 2.1.2 HCP assessment

A comprehensive assessment to determine a client's eligibility for care types under the *Aged Care Act 1997* is undertaken by the ACAT, generally face-to-face in the client's usual accommodation setting. A trained ACAT assessor will collect similar client information as the CHSP assessment, but comprehensively assess the client's physical capability, medical condition, psychosocial factors, cognitive and behavioural factors, physical environmental factors and restorative needs. The ACATs also determine the person's priority for care as part of the assessment. The priority, along with the date of approval for care, are the two factors that the National Prioritisation System (NPS) takes into account in the process for release of packages.

### 2.2 COMMONWEALTH HOME SUPPORT PROGRAMME

The CHSP helps senior Australians access entry-level support services to live independently and safely at home. Service providers work with CHSP clients to maintain their independence. Support can include help with daily tasks, home modifications, transport, social support, allied health, and nursing care. CHSP also provides access to respite services. The CHSP includes four

sub-programs (Community and Home Support subprogram, Carer Relationships and Carer Support subprogram, Assistance with Care and Housing subprogram and Service System Development Subprogram (not targeted to individual consumers)). Each sub-program has its own objective, eligibility criteria and service types.

### 2.2.1 Service utilisation<sup>2</sup>

The CHSP provided services to 840,985 clients in 2018-19. The number of CHSP clients per 1,000 people in the target population has increased from 195 in 2017-18 to 204 in 2018-19. Approximately 5% of CHSP clients also access the HCP concurrently. The value of services delivered to approximately 7% (58,869) of CHSP clients exceeds the threshold for a Level 1 HCP.

Over half (53.2%) of CHSP clients only used one distinct service type in 2018-19 (Domestic Assistance, Allied Health, and Transport were the top three service types accessed by this cohort). A further 23.3% of clients accessed only two service types (Domestic Assistance and Home Maintenance, Domestic Assistance and Allied Health, Domestic Assistance and Social Support were top three pairs). A further 11.9% of clients accessed only three service types (Domestic Assistance, Allied Health and Home Maintenance; Domestic Assistance, Social Support - Individual and Transport; Domestic Assistance, Home Maintenance and Transport were top three triplets). This data means that 88.4% of the clients who accessed a service in 2018/19, used three or fewer service types.

Deloitte reported that the clients who only accessed one service type used 9 million sessions (22% of all sessions) in 2018-19. Further analysis by Deloitte found that in 2018-19, there was an average of 6,298 distinct service bundles accessed each month.

The Australian Government pays for CHSP services via grants to providers. Processes for receiving grants under CHSP may include direct selection/one-off ad hoc, targeted competitive, or expression of interest. CHSP service providers use the grant funding to provide relevant services as described in their Activity Work Plan. Grant funding is paid quarterly upon execution of a grant agreement.

The National Guide to the CHSP Client Contribution Framework<sup>3</sup> guides CHSP service providers and CHSP clients on client contribution arrangements. Client contributions totalled around 10% of total CHSP funding in 2018-19.

In 2017-18, total CHSP funding from the Government amounted to \$2.3 billion, including funding carried forward<sup>2</sup>. \$50 million per year in Growth Funding was offered over two years from 2018-19 to a select number of existing CHSP service providers with a strong record of delivery. Average funding per consumer ranged from \$1,069 in SA to \$2,185 in the NT in 2017-18<sup>2</sup>.

CHSP service providers must provide financial and performance data in line with their CHSP Grant Agreement and Activity Work Plan details. Activity and performance data are reported through the Department of Social Services (DSS) Data Exchange portal. Services are reported by service type and time period delivered – day, month, hours and/or minutes duration. Services delivered are entered for each ‘individual client’<sup>4</sup> and unidentified ‘group’<sup>5</sup> clients, as well as ‘support persons’<sup>6</sup>.

Figure 2.1 summarises the framework of CHSP, including sub-programs and service types.

<sup>2</sup> Data for this section obtained from Deloitte Access Economics (Dec 2019) CHSP Data Study DRAFT and a CHSP aggregate data extract provided by the Department to HealthConsult on 30<sup>th</sup> April 2020.

<sup>3</sup> Australian Department of Health National Guide to the CHSP Client Contribution Framework 2018 Available at <https://www.health.gov.au/resources/publications/national-guide-to-the-chsp-client-contribution-framework> Accessed 16Mar2020

<sup>4</sup> **Individual client:** A client who has had a client record created within the Data Exchange and attended a session within the reporting period

<sup>5</sup> **Group client:** A client attending a session without a client record. Attendance is recorded as an ‘unidentified client’ in the Data Exchange. No demographic data is recorded against this client.

<sup>6</sup> **Support persons:** A person attending a session that does not meet the definition of a client. They could be a carer of the client, a family member or young children.



**Figure 2.1: CHSP sub-programs and service types/activity**

Community and Home Support	Carer Relationships and Carer Support	Assistance with Care and Housing	Service System Development
<ul style="list-style-type: none"> <li>• Allied Health and Therapy Services</li> <li>• Domestic Assistance</li> <li>• Goods, Equipment and Assistive Technology</li> <li>• Home Maintenance</li> <li>• Home Modifications</li> <li>• Meals</li> <li>• Nursing</li> <li>• Other Food Services</li> <li>• Personal Care</li> <li>• Social Support- Individual</li> <li>• Social Support-Group</li> <li>• Specialised Support Services</li> <li>• Transport</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Centre-based respite:</b></li> <li>• Centre based day respite</li> <li>• Residential day respite</li> <li>• Community access-group respite</li> <li>• <b>Cottage respite:</b></li> <li>• Overnight community</li> <li>• <b>Flexible Respite:</b></li> <li>• In-home day respite</li> <li>• In-home overnight respite</li> <li>• Community access – individual respite</li> <li>• Host family day respite</li> <li>• Host family overnight respite</li> <li>• Mobile respite</li> <li>• Other planned respite</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Assistance with Care and Housing:</b></li> <li>• Housing services</li> <li>• Community care</li> <li>• Other support services specifically targeted at avoiding homelessness or reducing its impact</li> </ul>	<ul style="list-style-type: none"> <li>• Sector Support and Development Activities e.g. staff training on using a wellness approach to services</li> </ul>

Source: Department of Health CHSP Program Manual 2018-2020

**2.2.2 Performance reporting**

Performance information (e.g. client characteristics and service delivery data) is required to be collected by grant recipients at the client level and entered directly into the online Data Exchange system. Where collection of client level data is not appropriate due to the CHSP Activity involving a large group, aggregate reporting is permitted (unidentified 'group' clients). Data submission requirements are stratified into a minimum mandatory dataset and extended voluntary dataset.

Performance data elements (service types delivered, time period, duration, clients) are entered into the Data Exchange system and outputs are calculated (Figure 2.2) for service delivery.

**Figure 2.2: CHSP service delivery outputs**

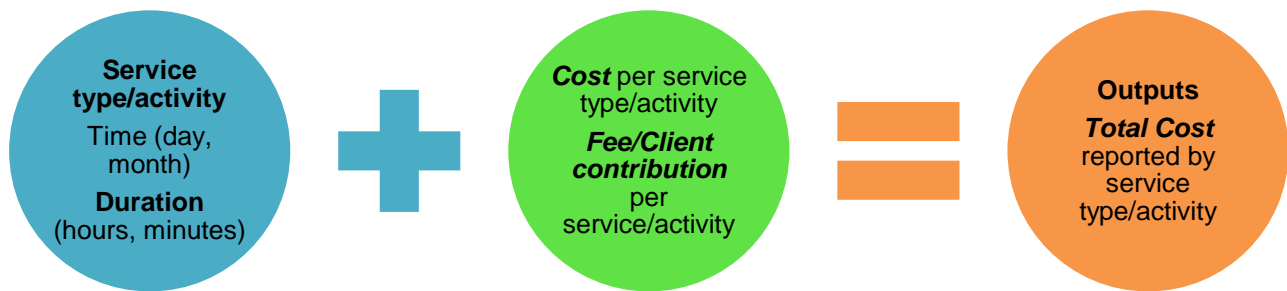


Source: Department of Health CHSP Program Organisation Overview Report Guide 2017

**2.2.3 Financial reporting**

CHSP service providers must submit a Financial Acquittal Report in accordance with the CHSP Grant Agreement Item E (Reporting). Service costs and client contributions by service types/activities for each sub-program are reported. Cost data elements (cost per service type/activity delivered, fee/client contribution per service type/activity collected) are entered into the Data Exchange system and outputs are calculated (Figure 2.3).

Figure 2.3: CHSP service cost outputs



Source: Department of Health CHSP Program Organisation Overview Report Guide 2017

### 2.2.4 Summary

A range of data is currently collected on CHSP care recipients, services provided, and costs. Outputs are reported for each of 17 defined service types across three of the four subprograms. The output units can be hours, units of service, or dollars. In practice, each service type has a major output unit, most of which are hours. For each service type, sessions are counted, at which there can be one or more consumers, and multiplied up to give an aggregate output measure.

Providers are funded to deliver the number of outputs detailed in their funding agreement Activity Work Plan (at the output price specified in the funding agreement). The actual volume of services delivered (i.e. higher or lower than target) does not change the grant funding amount paid. However, providers are required to report on and acquit the funds/costs for all services (down to the service type level). The Department retrospectively compares funded and targeted outputs with actual funds expended and services delivered. This information reflects the provider's past performance, which is considered when assessing subsequent grant applications.

There is a basis for building a casemix approach to classification and funding for the CHSP, given the history of counting and reporting services provided to consumers. However, there is no history of counting episodes of care provided to individual consumers for the purposes of classification and funding. Thus, refinements to the data collected would be needed for the purpose of the ACF model development project. Nevertheless, analysis of the existing data could be used to guide the design of phase two of the ACF development project.

## 2.3 HOME CARE PACKAGES PROGRAM

The HCP program supports older people with complex care needs to live independently in their own homes. It uses a consumer-directed care approach to make sure the support suits a person's needs and goals.

Service are supplied through an HCP by approved providers – typically involving a coordinated mix of services that can include:

- help with household tasks
- equipment (such as walking frames)
- minor home modifications
- personal care
- clinical care such as nursing, allied health and physiotherapy services.

There are four levels of Home Care Packages — from level 1 for basic care needs to level 4 for high care needs. Once approved for a level of care, the person enters the NPS to be assigned a

package at the level they have been approved for. If a person has been assessed as eligible for a particular level of HCP, but there are no packages available at that level, they can be offered a lower level package as an interim measure until a higher-level package is available.

### **2.3.1 Service utilisation**

The HCP Data Report 2<sup>nd</sup> Quarter 2019-20<sup>7</sup> states that there were 128,781 people in an HCP at 31 December 2019. Of these, 60,000 (47%) were in a level 3 or 4 HCP. There were 37.5% (16,368) more consumers in a level three or four HCP than 31 December 2018 (43,632). 8.5% and 44.9% of consumers were in a level one or two HCP respectively.

The HCP Data Report also stated that at 31 December 2019, there were 58,936 people who were seeking an HCP at their approved level, who had not yet been offered an HCP. Of these people, 96.3% (56,777) had been provided with an approval to access CHSP.

According to the Home Care Provider 2019 Survey<sup>8</sup> draft report, the average hours of direct care provided to consumers per week range from 1.5 hours under a Level 1 package to 8.8 hours under a Level 4 package. Package utilisation across all HCP levels averages 81% with the highest utilisation rate being 84% for Level 4 packages. Package utilisation is the value of services charged against a package as a proportion of the total funds available. Unspent funds averaged \$7,521 across all package levels for financial year 2018-2019 ranging from \$2,098 for a Level 1 package and \$15,182 for a Level 4 package. Almost 30% of client package funds are allocated to administrative and case management functions.

Personal care; cleaning and household tasks; social support, shopping services and community access, and care management represent the top four services provided as proportion of total hours per package per fortnight in the Home Care Provider Survey draft report<sup>9</sup>. Figure 2.4 shows that the proportion of total hours accounted for by personal care increased from Level 1 to Level 4 HCPs, while the proportion of total hours accounted for by cleaning and household tasks, and care management decreased.

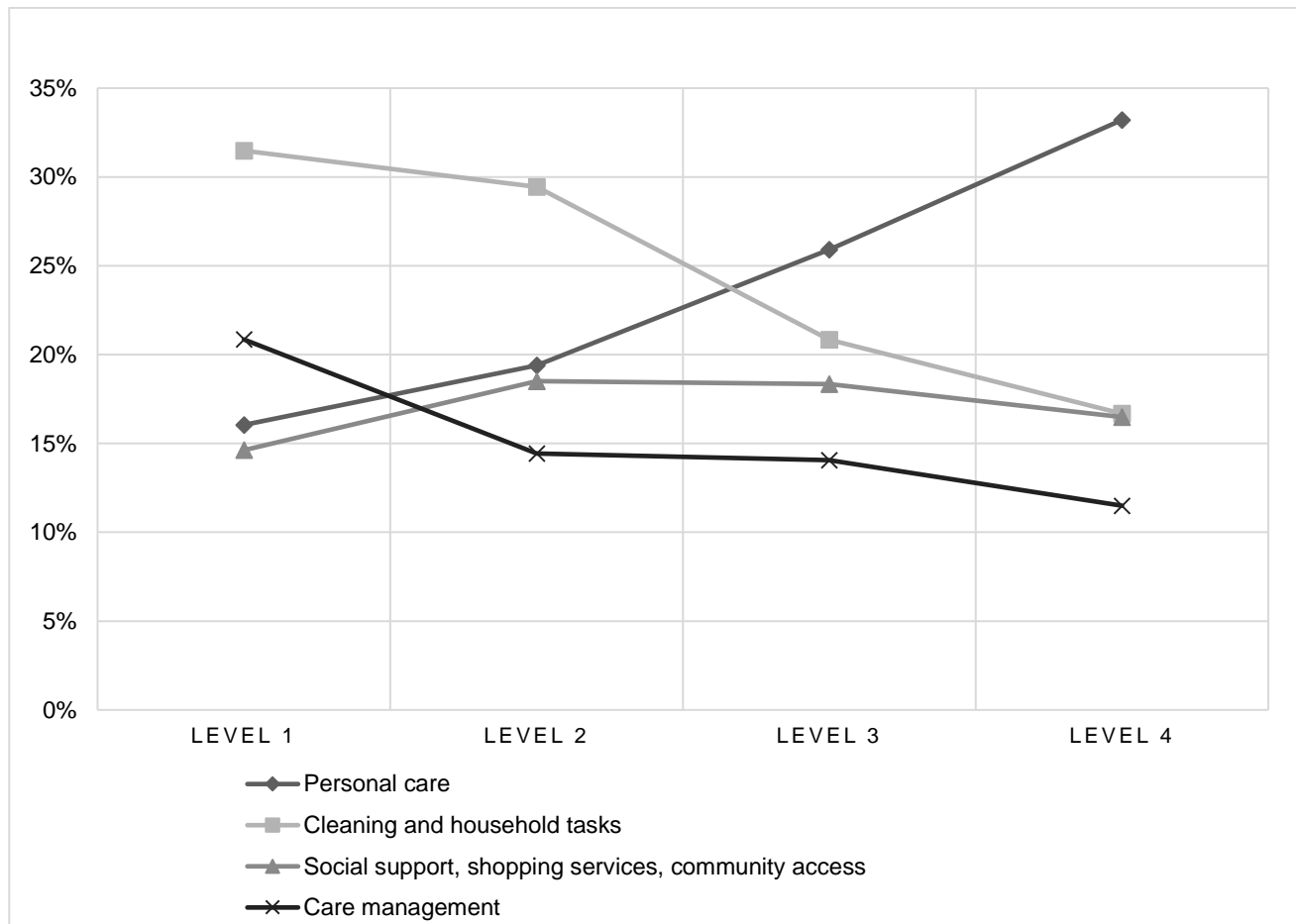
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<sup>7</sup> Australian Department of Health Home Care Packages Program – Data Report 2<sup>nd</sup> Quarter 2019-20 Available at <https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2019/December/Home-care-packages-program-data-report-1-July-%E2%80%93-30>

<sup>8</sup> Stewart Brown (March 2020) Home Care Provider Survey Analysis of Data Collected DRAFT

<sup>9</sup> Stewart Brown (March 2020) Home Care Provider Survey Analysis of Data Collected DRAFT

Figure 2.4: Hours of service provided as proportion of total hours for top four service types



Source: Stewart Brown Home Care Provider Survey draft report Mar 2020 (416 service providers representing 45% of all approved home care providers at June 2019 and 51% of the HCPs operational at the time of the survey)

### 2.3.2 Funding

The total amount of funding in an HCP budget is made up of:

- **Government subsidy** – including supplements for specific care needs if a person is eligible (e.g. at 30 June 2019, around 1 in 11 (9%) people using home care were receiving the Dementia and Cognition Supplement, indicating they had moderate to severe levels of cognitive impairment associated with dementia or other conditions<sup>10</sup>)
- **basic daily fees** (up to \$10.75) – payable by everyone who receives a package
- **income-tested care fees** (up to \$30.86) – payable by people who have income over a certain amount – with annual lifetime limits
- **amounts for additional care and services** – payable if a person wants extra services that the package funding would not otherwise cover.

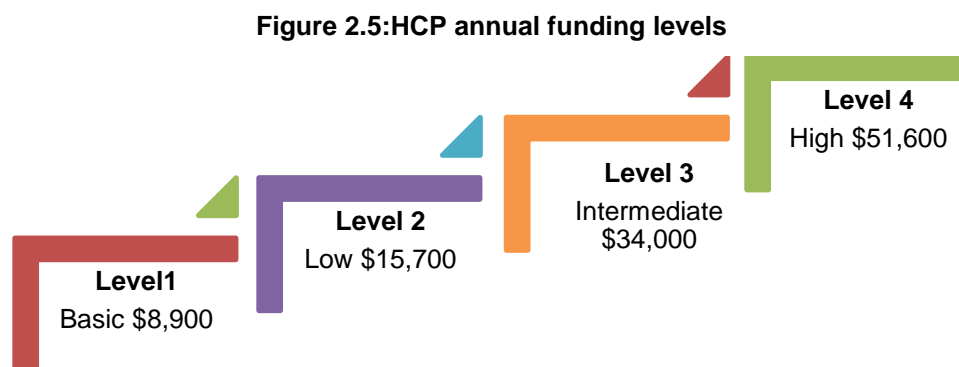
The Government and the care recipient pay these amounts directly to the provider. HCP providers set prices for each of their HCP services. They can provide services directly (using staff) or subcontract other organisations to provide services. Care recipients work with their chosen provider to identify care needs and best match services to address needs in the most efficient approach.

All HCP providers must meet price transparency requirements. Price transparency means providers must publish their service prices on My Aged Care and review them annually; and include a copy of their pricing schedule in their home care agreements. HCP providers must only

<sup>10</sup> AIHW GEN Aged Care Data – People's care needs in aged care. Available at <https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care> Accessed 7 May 2020

charge prices listed in their pricing schedule unless a different arrangement is agreed with the client. Consumers use the online [Find a provider tool](#) to compare costs across providers, to ensure they get the most value.

Figure 2.5 shows the approximate level of annualised funding across the four levels of HCPs.



Source: Funding levels sourced from myagedcare.gov.au

### 2.3.3 Data collection and reporting

HCP providers must submit an Aged Care Financial Report each financial year, and meet the record keeping requirements for approved providers.

The number of HCP approvals and distribution of HCP levels (one to four) is reported at an aggregate level by state and territory<sup>11</sup>. Individual client data (demographics, characteristics) is not collected and reported.

The status of people who have been approved and/or offered or not yet offered an HCP is reported and stratified by care level. Wait times with the NPS are also collected and reported, stratified by care level.

### 2.3.4 Financial reporting

Approved providers of home care must complete the Aged Care Financial Report (ACFR) each financial year. This is completed online via the Data Exchange portal, guided by the Annual Prudential Compliance Statement (APCS) Guidelines<sup>12</sup>.

HCP service providers also report exit amounts. An exit amount is an amount that can be deducted by a home care provider from a person's unspent home care package amount if the person leaves their care. This may happen if the person decides to change their home care provider or when they leave home care altogether.

### 2.3.5 Summary

The HCP Data Report (quarterly report) provides a range of aggregate data about care recipients, the outcomes of the approval process, and those waiting for access to a package. There is no data on individual consumer characteristics or services received held by the Department.

Recognising the limited data available, the Department commissioned StewartBrown to undertake a survey of HCP providers. The survey was at provider level and responses covered a little over

<sup>11</sup> Australian Department of Health Home Care Packages Program – Data Report 1<sup>st</sup> Quarter 2019-20 Available at <https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2019/December/Home-care-packages-program-data-report-1-July-%E2%80%93-30> Accessed 17Mar2020

<sup>12</sup> Australian Department of Health Annual Prudential Compliance Statement Guidelines Available at <https://dss.formsadministration.com.au/dss.nsf/DSSForms.xsp> Accessed 17Mar2020

50% of the active packages. The survey did not collect data about individual package recipients and the services they received, but it did collect data on the numbers and types of services delivered by HCP approved providers.

It is concluded that the current HCP data collection and reporting arrangements will not support building a casemix approach to classification and funding. The program's data collection requirements and system will need to be developed. There is an opportunity to draw on the current CHSP arrangements, as refined for the purposes of the ACF model development project.

## **2.4 DOCUMENTATION REVIEW**

A documentation review was undertaken to build understanding of the current CHSP and HCP programs, and the work being done on several related projects commissioned by the Department. This section summarises key learnings.

### ***2.4.1 Topic papers prepared by the Department***

As part of the ongoing work on the development of policy for, and the design of, the unified program, the Department developed a series of topic papers. Several of these papers, which spanned a range of key policy areas, were provided as input into the ACF model development process and influenced the development of options. The papers reviewed covered topics including the entry into the unified system; allocation of care and services to people; finding and arranging care and services; support for consumers and their informal carers; change (responsiveness of the system); exploration of TSBs; and funding in the unified system.

These papers were used as input to the submission of a Commonwealth<sup>13</sup> response to the submissions of Counsel Assisting (Adelaide hearing 4 March 2020) on future aged care program redesign to the Royal Commission. Many of the developed ACF model options incorporated positions put forward in the Commonwealth's submission. In particular, the paper reflects continued strong emphasis on consumer choice and control. It also emphasises the need for flexibility for consumers to build their own bundle of care and supports consistent with outcomes of the independent needs assessment) within the relevant funding classification.

### ***2.4.2 The CHSP Data Study – Deloitte Access Economics***

The CHSP Data Study undertaken by Deloitte Access Economics reviewed the current and future demand for lower level care in the home. It reviewed the service provider market (current and projected demand impact), intersection with the HCP program, and variation/patterns in clients care needs and progression through the aged care system. As noted, the study found most clients (53.4%) use one service type only, with Domestic Assistance, Allied Health and Therapy Services, and Transport the most common service types. This data highlights the need to approach assessment in a unified program in a consumer-centred manner and use resources efficiently. With 27% and 23% of service providers underspending and overspending block funds respectively, a more cost-efficient approach to encourage needs-based service provision is required.

### ***2.4.3 Home Care Provider Survey – StewartBrown***

The HCP Survey Report written by StewartBrown analysed the units of care and services delivered to consumer cohorts, and service costs to individual package budgets. Package utilisation averaged 81% (value of services charged against a package as a proportion of the total funds available), reinforcing the need to encourage a standardised cost-efficient approach in a unified

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<sup>13</sup> Submission by the Commonwealth, as represented by the Department of Health, the Department of Social Services and the Aged Care Quality and Safety Commission in response to Counsel Assisting's Submissions to the Royal Commission's Adelaide hearing on 4 March 2020 relating to system redesign, 22<sup>nd</sup> April, 2020.

home care program. There was very little difference in the overall amount charged against package levels based on age, not unexpected given the variability in the natural trajectory of decline in older persons. Also reflective of the change in service types from level one to level four HCPs (e.g. the hours/proportion of personal care increased), the need for a unified home care program to allow consumer movement both within and between classification groups/levels to respond to change in circumstances (temporary or ongoing) is highlighted.

Analysis of the HCP Survey also noted the increasing amounts expended on consumables and capital purchases, noting that they still only represent 2% and 3% of expenditure. Based on data collected in StewartBrown's deep dive analysis, the most popular capital purchases were washing machines followed by televisions, fridge/freezers, and mobility aids. The most common consumables included continence aids, nutrition supplements and dressings/bandages.

#### **2.4.4 Review of AT Programs in home-based aged care – Australian Healthcare Associates**

The Review of Assistive Technology (AT) Programs in Australia (in home-based aged care) undertaken by Australian Healthcare Associates (AHA) includes mobility aids in the definition of AT. Initial findings noted access to AT for older Australians to be inequitable, with confusion about the scope of practice of RAS and ACAT assessors to prescribe AT. A national approach to AT, including information resources, advice and screening tools was identified among a number of preliminary implications for the Department to consider. This work suggests that AT should be considered as a service type in the unified program and that the classification system may need to include classes where AT is all or part of the service bundle.

#### **2.4.5 Forecast of the demand and distribution of aged care services – EY**

EY is developing a model to forecast the demand and distribution of aged care services in Australia over the next 30 years. The minimal viable product (MVP or model prototype) draws on data from the Survey on Disability and Aged Care, Australian Bureau of Statistics population data and other sources to inform the modules within the model (population and household, frailty and support needs, income and assets, behaviours, interactions). The model will likely be able to accommodate the ACF model concepts, with configuration of modules to reflect the thresholds and domains based on the development of assessment tool(s) and classification system. The parallel work undertaken to review and analyse CHSP and HCP program data also highlights the current program data constraints, and the need to carefully consider the infrastructure development, implementation and transition for a new unified home care program.

#### **2.4.6 Evaluation of the CHSP Reablement Trial – Australian Healthcare Associates**

Preliminary evaluation findings into the CHSP Reablement Trial (Promoted Independent Living budget measure) by AHA indicate the trial model to be effective in increasing the rate at which clients are recommended for reablement following a RAS assessment. However, with trial and program data constraints, service type utilisation was used as a proxy indicator for effectiveness. While the preliminary evaluation reported some notable decreases in service utilisation, particularly in the number of CHSP service types recommended, trial clients did not report any reduction in their level of independence six months after assessment.

The integration of wellness and reablement approaches into a unified home care program appears to be contingent on the workforce knowledge and confidence, along with standardised tools that allow the workforce to identify consumers that may be appropriate for reablement. While there has been evidence of slowing functional decline through reablement interventions, discussed in New horizons in the compression of functional decline<sup>14</sup> – to identify which interventions are most

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<sup>14</sup> Gore, Peter G et al. "New horizons in the compression of functional decline." *Age and ageing* vol. 47,6 (2018): 764-768. doi:10.1093/ageing/afy145

effective at which stages - program monitoring to link consumer outcomes to service interventions is required to evidence effectiveness and efficiency.

## 2.5 ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY<sup>15</sup>

The Royal Commission commenced a series of hearing in January 2019, with hearings to be conducted in all capital cities and several regional locations (currently suspended due to COVID-19). The Office of the Royal Commission has published a series of eight Background Papers to date, along with three commissioned Research Papers, spanning a range of aged care topics. An Interim Report was submitted to the Governor-General of the Commonwealth of Australia on 31 October 2019. The report presents the work undertaken by the Royal Commission through to September 2019. It reveals endemic and system-wide problems with aged care in Australia and provides guidance on the Commission's thinking (excluding recommendations). It also set out the future directions of the inquiry - quality and safety issues, provider perspectives, funding arrangements, governance, leadership and accountability, and options for systemic reform.

Subsequently, the Royal Commission undertook a public consultation process commencing 6 December 2019 with the publication Consultation Paper 1 Aged Care Program Redesign: services for the future. The consultation paper presented the Royal Commission's thinking into a future aged care system, including how programs might be redesigned and operate together in the aged care system. The consultation paper primarily suggested that the aged care system be arranged into an entry level support stream, a care stream, and an investment stream.

After a consultation process involving submissions and subsequent hearing, the recommendations for program design in Counsel Assisting's submission to the 4 March 2020 Royal Commission hearing depart from the Consultation Paper in some respects. These differences include all consumers being assessed, needs based entitlement (not rationed) approach inclusive of wellness and reablement, and levels of funding (corresponding to classifications) being linked to actual cost data ascertained by an independent pricing authority.

The need for flexible funding arrangements to ensure that the spectrum of required home support and home care services are available in all areas (geographically) was also expressed. The consideration of pricing adjustments informed by a costing study and policy decisions was discussed as a core feature in the funding model component. The ideas expressed in the submission to the 4 March 2020 hearing have been reflected in one or more of the developed ACF model options. It should be noted that the work of the Royal Commission is not finalised, and its recommendations will be outlined in the final report to be released.

## 2.6 LITERATURE REVIEW

A targeted literature review (published and grey literature) was undertaken to consider possible changes to aged care at home services (i.e. coming out from the Royal Commission process) and learn from international home and community care services ACF models. This information was used to inform the development of options for the assessment, classification, and funding for a unified home care program. This section briefly summarises key learnings. Further details are provided in Appendix B.

### 2.6.1 *Review of features of home care internationally*

The characteristics pertaining to ACF models for aged care at home were explored in a selection of OECD countries<sup>16</sup>. A single-entry system (localised access) with a standardised assessment and classification process (needs based), predominantly funded by a public long term care (LTC)

<sup>15</sup> Royal Commission into Aged Care Quality and Safety hearings, at <https://agedcare.royalcommission.gov.au/Pages/default.aspx>

<sup>16</sup> Germany, Belgium, Finland, Japan, Sweden, Denmark, New Zealand, England, Scotland, Canada, United States, Netherlands, France.



insurance scheme with means-tested contributions, was the most commonly used approach in the selection of OECD countries reviewed.

A summary of the key features of ACF, and funding including in the international countries reviewed is outlined in Figure 2.6. A detailed summary of key elements and/or tools used for **assessment, classification or funding** of care in the home for the elderly internationally for each OECD country reviewed is presented in Appendix B (Table B.1).

**Figure 2.6: Key ACF elements of home care internationally**

### Assessment

- Local government municipality departments are largely responsible for undertaking assessments utilising a national standard assessment tool, with several countries employing a multidisciplinary board/team review in conjunction with the assessor.
- In the 13 OECD countries reviewed, five (38%) use the interRAI system to varying degrees (sometimes with adaptations), eight (62%) use assessments to identify ability for consumers to undertake activities of daily living (at a minimum).
- Reassessment undertaken annually, biannually and/or on request.
- Reablement/preventative support programs undertaken in conjunction with home care in some countries.
- Care coordination generally undertaken by the assessor based on the individual care plan (unless client selects options of cash benefits).
- The client-centred principles of free choice to select service provider(s) is available in several countries, to a lesser degree collaboration between clients and service providers to develop individual needs and service plan (based on needs assessment) is available.
- Limited formal assessment of carer needs (undertaken in New Zealand and Scotland); carer support in the form of monetary allowance (fixed, hourly based wage), training and respite is common.

### Classification

- Individual care plan developed (based on assessment) with classification into a care needs level, services procured accordingly to meet care needs.
- National classification system generally utilised.
- Classification based on hours and types of care required or to a much lesser degree interRAI RUG-III case-mix.

### Funding

- Private and public LTC insurance schemes.
- Means-tested co-payments for consumers (capped, uncapped).
- Consumers can choose between cash benefits, personal budgets, and in-kind services (or a combination of cash and in-kind benefits).
- Benefits paid are differentiated according to the level of care needed and the setting in which care is received (care levels).
- Government sets fee schedule for LTC services.

Note: The scope of consumer needs covered in the programs reviewed is likely to differ. Program eligibility criteria were not readily available for all countries reviewed and there are different arrangements for access to aged care home services.

## 2.6.2 Review of home care in other service streams

Models and tools that are used nationally and internationally for **assessment, classification or funding** of home and community care services in other service streams were also reviewed. The relevant characteristics of models used for mental health services in the UK, and rehabilitation and residential aged care in Australia were reviewed. The key features are presented in Figure 2.7 and detailed summaries by stream are included in Appendix B, Table B.2.

Figure 2.7: ACF tools and models in other service streams

### Mental Health Services UK

- Consumers are assessed using a mental health clustering tool (MHCT, consists of 18 scales), and classified into one of 21 clusters.
- The clusters vary by; severity of need, complexity of need, acuity, intensity of likely treatment response, anticipated course of illness etc.
- A decision tree is used to identify if the presenting needs are non-psychotic, psychotic or organic.
- Once a service user has been allocated to a cluster, their care coordinator will talk through what interventions are available to them. This is referred to as a care package and includes predefined services/interventions that are prescribed by a given cluster.

### Rehabilitation (AN-SNAP classification)

- The AN-SNAP classification was selected by the IHPA as the classification system to be used for activity based funding for sub-acute and non-acute care.
- Patients are assessed on functional impairments, age and other validated clinical assessment tools to measure indicators relative to palliative care, and psychogeriatric care.
- The AN-SNAP version 4 classification has two branches, admitted and non-admitted. The variables used to define the rehabilitation classes include impairment, age (or Age Type), Functional Independence Measure (FIM) cognition score, and a weighted FIM motor score.

### Aged care (AN-ACC system)

- AN-ACC is a new assessment and funding model developed as part of the Resource Utilisation and Classification Study (RUCS) for residential aged care.
- The AN-ACC Assessment Tool is intended to be used to assess all new residents entering care as well as existing residents whose care needs increase.
- Assessment for funding purposes to be undertaken by external assessors capturing the information necessary to assign a resident to a payment class.
- AN-ACC Version 1.0 comprises 13 classes.

## 2.7 TARGETED SERVICE BUNDLES

As highlighted, the Department provided guidance on the possible use of TSBs to define the service offerings in the unified program. This concept is new to casemix classification systems in Australia, where the focus has been on identifying classes where individuals have similar needs and expected resource use based on empirical data on current practices. TSBs take this process a step further and define a package of services that would best meet the needs of consumers assigned to a class. This determination is made by experts normally with reference to data on current practice, using a consensus building process (e.g. Delphi). Iteration can be used in the process so that the final casemix classes are derived from empirical data and expert judgement.

There are examples of the use of service bundles for classification and funding service in overseas systems. Specifically, the international literature review identified the Mental health clustering tool (MHCT) used in the National Tariff Payment System for mental health in the UK. In this application, once a service user has been allocated to one of 21 clusters (group of people with similar characteristics as identified from a holistic assessment and then rated using the MHCT), their care coordinator will talk through what interventions are available to them. The result is referred to as a care package and includes predefined services/ interventions that are prescribed for a given cluster (i.e. equivalent to a TSB).

Use of the TSB concept presents the opportunity to link assessed need to more targeted service arrangements and funding than the current HCP program, whilst still attaching the funding to the care recipient, unlike the current CHSP. It will also provide a mechanism for ensuring that individuals with like needs and circumstances receive like care and services (and associated funding), thereby improving equity within the system. There is also the opportunity to optimise the use of resources by using the TSBs to align services and associated funding more closely to consumer's assessed needs.

As with the MHCT in the UK, consumer choice can be enabled by allowing flexibility in the use of the TSBs in determining the service provided to an individual consumer. For instance, the quantity of domestic assistance, allied health and therapy, and nurse services in the TSB could be varied for an individual consumer, but there would be a requirement to have some of each service type, if this mix is specified in the TSB as the optimal response to assessed need. There is the potential for the funding system to provide incentives for delivering service packages that are closely aligned to the TSB to improve the program's impact.

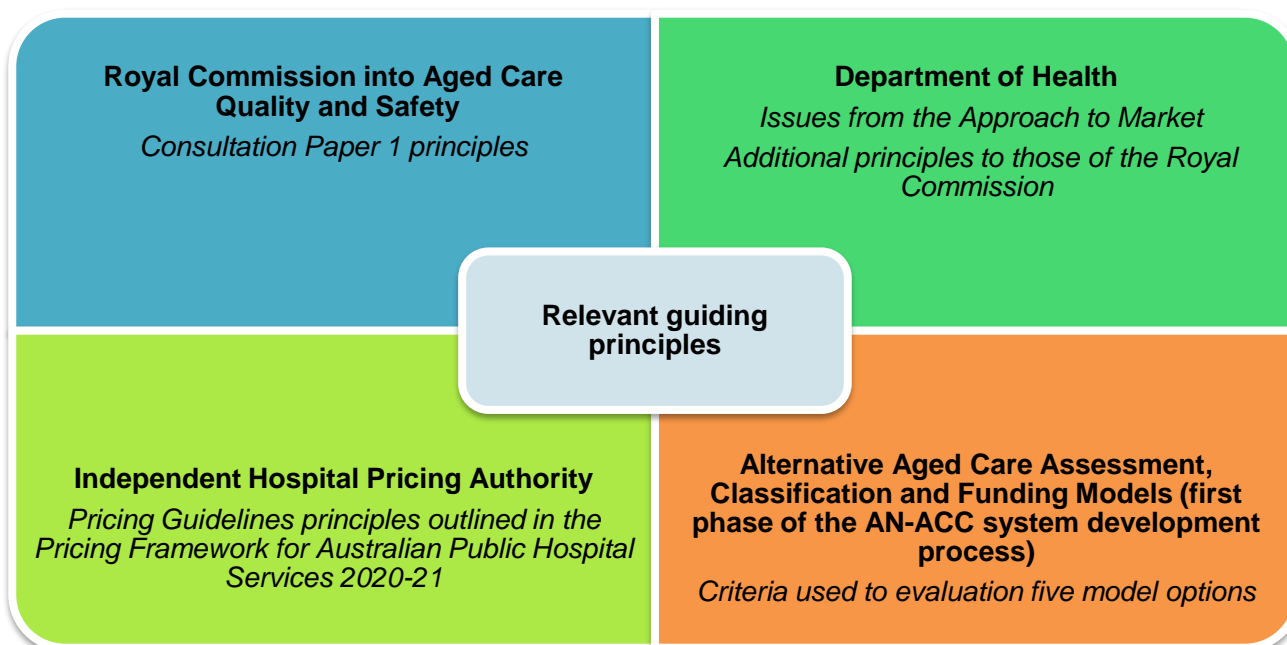
## Evaluation criteria for the ACF options

This Chapter summarises the process for developing the evaluation criteria for choosing between the developed ACF model options. The final criteria are then presented for the ACF components of the model.

### 3.1 CRITERIA DEVELOPMENT PROCESS

To develop an appropriate set of evaluation criteria for choosing from the developed ACF options, guiding principles used for similar applications in the health and aged care sectors were identified as the starting point, as outlined in Figure 3.1.

Figure 3.1: Sources of relevant guiding principles for evaluation of ACF model options



As described in Appendix D, which presents a summary of the process for the development of the evaluation criteria, **53 guiding principles** were derived from these four sources and categorised into principle type, as follows:

- **service system/sector stability (service system)**: the principle largely guides the design of the overall service system, but may also be relevant to choosing amongst assessment, classification and funding system options
- **classification and funding system (CF system)**: the principle largely guides the design of the classification and funding system (taken to include assessment for the purpose of this project) and is relevant to choosing amongst assessment, classification and funding model options
- **implementation and operation processes ('process')**: the principle largely guides choices amongst assessment, classification and funding model options based on ease of implementation and operation considerations.

Each guiding principle was then classified as having a **direct** or **indirect** impact on choosing amongst the ACF model options. **Direct impact** principles are more likely to influence the choice

of ACF model options, whereas **indirect impact** principles aid the consideration of the direct principles and are likely to be subject to a broader range of influencing factors.

Each relevant guiding principle was also categorised and mapped to one or more of the **assessment**, **classification** and **funding** model components. Each of the ACF model components are defined as:

- **Assessment:** the process and associated tools that will be used to assess the needs of an older person for support from the unified aged care at home program; assessment outcomes will then be used to develop care plans and to drive the classification and funding models.
- **Classification:** the system that classifies individual consumers into classes where each person in a class has similar care needs and requires similar levels of resources to fund support services to meet those needs.
- **Funding:** the model that will be used to allocate funds for service provision in the unified aged care at home program; it will use the classification system in the allocation process.

The mapping of the **principles** to the **model components** (i.e. assessment, classification and funding), which involved making a judgement on the aspect of the model that the principle was most applicable to, is provided in Appendix D, Table D.1. Once the principles were grouped in the ACF model components, they were consolidated (to remove duplication) and refined into direct impact evaluation criteria. Some criteria were used more than once, although each time they were interpreted in the context of the ACF model component being considered (Appendix D, Table D.2).

Given it was felt that several of the principles should be applied to more than one model component, a suggested list of evaluation criteria for each model component was developed. The three sets of criteria were endorsed at the second departmental workshop. Refinements to the originally proposed criteria were made after a process of stakeholder consultation.

### **3.2 CRITERIA TO EVALUATE THE ASSESSMENT, CLASSIFICATION AND FUNDING MODEL OPTIONS**

The final three sets of criteria for evaluating the ACF model options are presented in Table 3.1 (Assessment), Table 3.2 (Classification) and Table 3.3 (Funding). To aid in the consistent application of the evaluation criteria, guidance is included on how each criterion should be applied in the process of evaluating the ACF model options. Note that, although the same criterion may be used for more than one ACF model component, the guidance is specific to the component in which it is used.

Table 3.1: Criteria to evaluate assessment model options

Principle type	Criterion	How criteria will be applied
Service system	Provide equity of access, regardless of location, means or specific needs (e.g. cultural needs, vulnerable consumers)	Higher evaluation scores for options where the assessment model minimises any barriers to access for consumers that meet the eligibility criteria, including by enabling access via a variety of modes (e.g. face-to-face, electronic, via GP, etc.) and enhances the consumer experience by providing them with choice and dignity.
	Support older peoples' informal care relationships and connections to community	Higher evaluation scores where the assessment model supports and sustains existing informal care relationships (informal carers, family, friends) and/or connections to the community and does not require consumers to sever these existing relationships in order to get access to aged care at home support.
	Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	Higher evaluation scores where the assessment model supports the delivery of evidence-based care specific to the assessed needs of the consumer in the context of the preferences and holistic care (clinical and non-clinical) of consumers.
Process	Be transparent, easy to understand, administer and navigate	Higher evaluation scores where the assessment model is easy to understand and administer by government and also easy for consumers and providers to understand and navigate.
CF system	Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	Higher evaluation scores where the assessment model is suitable for use across the full range of consumer care needs. Higher evaluation scores where the assessment model has dynamic and predictive features that respond/predict to consumer's changing needs (i.e. through the re-assessment triggers).
	Be capable of being implemented, monitored and evaluated on an ongoing basis	Higher evaluation scores where the assessment model is simpler and less time-consuming to implement; and where the operation of the assessment model generates data that allows it to be monitored and evaluated for the purposes of continuous improvement.
	Maximise independence, functioning and quality of life for older people to live at home	Higher evaluation scores where the assessment model generates outcomes that are most likely to maximise independence, functioning and quality of life for older people (i.e. the assessment model allows identification of the support services that will best meet care needs).

**Table 3.2: Criteria to evaluate classification model options**

Principle type	Criterion	How criteria will be applied
Service system	Support older peoples' informal care relationships and connections to community	Higher evaluation scores where the classification system takes into account existing informal care relationships and/or connections to the community and does not disadvantage those that have such supports in place.
	Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	Higher evaluation scores where the classification system supports the delivery of evidence-based care specific to the assessed needs of the consumer in the context of the preferences and holistic care (clinical and non-clinical) of consumers.
Process	Be transparent, easy to understand and navigate	Higher evaluation scores where the data collection required to drive the classification system is easy to understand and administer by government and also easy for providers to comply with and understand.
CF system	Support diversity and choice, and encourage innovation in service delivery	Higher evaluation scores where the classification system better reflects the need for diversity and choice in developing the classes and does not create perverse incentives that stifle innovation in service delivery.
	Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	Higher evaluation scores where the classification system is suitable for use across the full range of consumer care needs.
	Be capable of being implemented, monitored, and evaluated on an ongoing basis	Higher evaluation scores where the classification system is simpler and less time-consuming to implement; and where the classification system data can be used for monitoring and evaluation for the purposes of continuous improvement.
	Identifies the need/cost/risk groups in the community	Higher evaluation scores where the classification system minimises within class and maximises across class variance in the need cost and risk of consumers (determined statistically and/or by expert judgement).

**Table 3.3: Criteria to evaluate funding model options**

Principle type	Criterion	How criteria will be applied
Service system	Support older peoples' informal care relationships and connections to community	Higher evaluation scores where the funding model takes into account existing informal care relationships and/or connections to the community and does not disadvantage those that have such supports in place.
	Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	Higher evaluation scores where the funding model supports the delivery of evidence-based care specific to the assessed needs of the consumer in the context of the preferences and holistic care (clinical and non-clinical) of consumers.
	Is equitable, efficient (with reference to the efficient cost of service delivery) and supports timely delivery of quality support services	Higher evaluation scores where the funding model delivers payments that are fair and equitable that are set with reference to the efficient cost of delivering services, including being based on the same price for the same service across types of services (e.g. public, private or not-for-profit providers); and can ensure payments are made efficiently to support timely delivery of quality support services.
Process	Be transparent, easy to understand and administer	Higher evaluation scores where the funding model is easy to understand and administer by government and also easy for consumers and providers to understand and navigate.
CF system	Support diversity and choice, and encourage innovation in service delivery	Higher evaluation scores where the funding model does not create perverse incentives that restrict diversity and/or choice or stifle and/or prevent innovation in service delivery.
	Be affordable and sustainable	Higher evaluation scores where the funding model is affordable to government, providers and consumers (with clear co-payment policy, where applicable) and can be sustained.
	Provide a continuum of care that is dynamic and predictive to account for changing care needs	Higher evaluation scores where the funding model supports the full range of consumer care needs and is adaptive to account for changing care needs.
	Be capable of being implemented, monitored, and evaluated	Higher evaluation scores where the funding model is simpler and less time-consuming to implement; and where the operation of the funding model generates data that allows it to be monitored and evaluated for the purposes of continuous improvement.
	Provide certainty for government, providers, and consumers	Higher evaluation scores where the funding model allocates sufficient resources to assure consumers they will receive the services they need; to assure providers that they will be funded to provide the services required; and to assure government that the allocated funds are being used optimally to achieve the program objectives.



## Options for each ACF model component

This Chapter presents a description of the development process and then details the options that were considered for data collection (unit of count approach), assessment, classification, and funding components of the ACF model.

### 4.1 OPTIONS DEVELOPMENT PROCESS

Given the fluid environment in which the project was conducted, it was decided to focus the work at the technical level (noting that some policy and program development matters were being progressed while the project was in progress). This technical work addressed four components of the ACF model individually:

- Data collection (unit of count) options underpinning the ACF model
- Assessment model options
- Classification model options
- Funding model options.

Discussion papers were developed for each model component and used as the basis of an iterative process involving workshops with key Department staff and two rounds of targeted stakeholder consultation. This iteration allowed ideas to be brought forward and considered at the component level. The choices identified through this process were put together to produce consolidated ACF model options that became the subject of evaluation (see Chapter 5).

### 4.2 DATA COLLECTION – UNIT OF COUNT OPTIONS

This section summarises the options for data collection for the unified program, noting that the situation analysis process concluded that significant improvements were needed to support a casemix based approach to classification and funding.

#### 4.2.1 *Option D1: Unit of count: Service event*

The simplest option for data collection in the unified program is to count all “service events” delivered. A service event could be defined as the provision of one of the service types to a care recipient on a single occasion. This option is similar to the current CHSP data collection arrangements but different to HCP.

For each service type, the service event would be categorised as either an individual service event or group service event (where relevant). Individual service events would be defined and counted when only one consumer is receiving the service. Group service events would be defined and counted when a group of consumers receives the service together. Both service event types could be reported against the care recipient for different services (where applicable).

The service types (or classes) that currently exist (under CHSP) could be used as the basis for the data collection. They would need to be reviewed and refined. Then the unit of output (e.g. hours, km, etc.) which would be counted for each service type would need to be determined. As part of a service type review process, the associated service type counting rules and units of count should also be reviewed. For example, for the service type transport, the output unit is currently number of trips, however km per trip may be a better measure.

If this approach was adopted, the classification would be based on service characteristics, not client characteristics, and it is likely that payment would need to be made on a service event basis, accordingly to a pre-determined schedule of prices using the output units.

For services currently provided under CHSP, data collection of service events would largely amount to a refinement of the current data collection arrangements. For services currently provided under HCP, this approach represents major change, and would add data collection requirements to approved HCP providers.

#### **4.2.2 Option D2: Unit of count: Episode of care (includes service events)**

The other option for data collection in the unified program is to count “episodes of care”. An episode of care in the unified program could be defined as an individual person for a time period who receives one or more aged care at home services. The time period of an episode of care would be indefinite, however consideration would need to be given to how the funding will be provided to service providers (e.g. monthly).

The data collection for episode of care would be built up from the service events provided to a consumer while the episode of care is in progress. This means that counting at the episode level would also require counting of service events (the two options are not mutually exclusive, data collection at the episode level must include data collection on service events).

This approach would mean that the number of care recipients in a given period would not equal the number of episodes, as the same person could have multiple episodes within a defined period due to a change in classification or to moving into, out of, and back into the unified program. There is also the possibility that an individual consumer may have more than one episode in progress concurrently, for instance a short-term reablement episode in parallel with an ongoing care episode.

The episode level data would be used to develop an episode-based based classification system. Classes would be based primarily on the characteristics of the care recipient, with the collected service event data used as part of identifying classes with similar expected resource use. The empirical approach to defining the classes could be supplemented with a normative approach (i.e. Expert Panels to identify TSBs, see classification system options).

This option has some similarities to the current HCP approach (the episodes could be regarded as analogous to a consumer in one of the four package level bands). However, there is no data on the on the service events provided to HCP consumers routinely collected centrally and/or by Government. The episode concept is not used in the current CHSP data collection.

### **4.3 ASSESSMENT MODEL OPTIONS**

This section describes two options for the assessment model: proportionate assessment and all consumers assessed. The assessment model options presented cover the continuum from screening/triage though to reassessment.

#### **4.3.1 Option A1: Proportionate assessment**

**Option A1 is to develop a proportionate assessment process, which is graduated and risk based (i.e. it does not involve cumbersome processes for relatively low risk, low need consumers to access support services).**

Figure 4.1 describes the possible pathways associated with the proportionate assessment model and what happens once a consumer has reached the screening/ triage process (noting there may be multiple pathways to this point). It shows that when a consumer goes through the screening/triage process, they are either directed to:

- direct access to services as it has been determined that they are low need/low resource user (i.e. likely needing access to one or two of a restricted range of pre-defined service types)
- assessment (i.e. more than two of the pre-define service types are required and/or other service types are required and/or issues identified that need further investigation).

Figure 4.1 provides an illustration of how the proportionate assessment model may operate, noting that its development, parameters and thresholds will be determined as part of the phase two work. For example, Figure 4.1 divides assessments into care assessments, reablement assessments, and informal carer assessments. This division is to indicate that there are likely to be different tools used that reflect the target of the assessment, it does not imply that assessments will be done by different workforces. In fact, the model envisages the use of an integrated assessment tool that uses flags/branching logic to take the assessor to the appropriate module, and for care assessment, through a graduated process culminating in the extended assessment.

The volume data shown in Figure 4.1 has been derived from an analysis of 2018/19 CHSP and HCP data. It does not represent demand projections (as per Chapter 2, the Department has commissioned EY to model demand for aged care). Necessarily, the assumptions used to derive the 'first cut' estimates are subject to uncertainty, as the existing data has limitations and the details of the model, particularly the threshold for when a consumer needs to be assessed, need to be developed. More information on how the estimates were produced can be found in Appendix C.

Several key features of the proportionate assessment model are further described below.

### **Access via screening/triage**

Eligible consumers determined to have low needs, which can be met by low resource level services would have access to a defined set of service types from screening/triage and require no further assessment. The exception being if the screening/triage process identified any opportunities for reablement (e.g. to improve function), there would be a referral for a reablement focussed assessment. The direct access to services could be time limited or provided on an ongoing basis until a change occurred that required further assessment. For example, short term care may include one-off home modifications, whereas ongoing social support (e.g. to sustain or improve connections to the community) would be regarded as ongoing care. Not all service types and/or service volumes (i.e. the volume of services needed will be part of determining risk) will be available via this pathway. The thresholds for using this care pathway would be determined by a formula that has regard to need and expected resource use, as part of phase two of the ACF model development work.

### **Assessment tools**

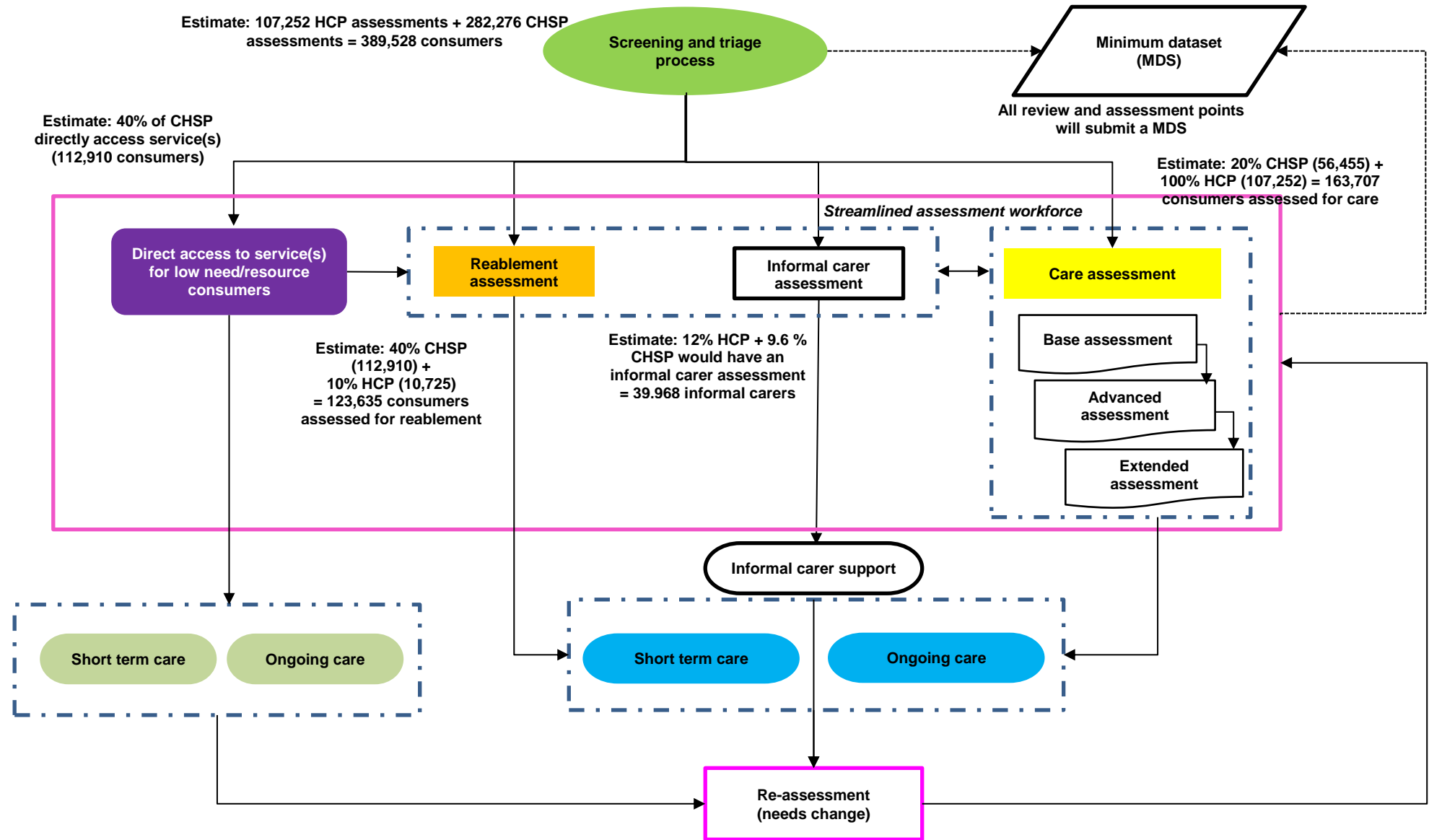
As indicated, the assessor would have access to an integrated suite of fit-for-purpose tools where there are separate modules for screening/triage, ongoing care assessment, informal career assessment and reablement focused assessment. Ideally, every tool used would be digitally enabled and administered on an iPad or equivalent device. The development of a fit for purpose assessment tool would be part of the next phase of the ACF model project.

The domains included in the tools used for ongoing care assessment and reablement focussed assessment are likely to be similar to the domains used in NSAF:

- Physical function domain (e.g. mobility, activities of daily living (ADLs))
- Psychological – cognition (and communication abilities), behavioural and mental health (including frequency of occurrences)

- Home and Personal Safety (includes home maintenance)
- Social domain (e.g. organisation of everyday life and social contacts including assessing presence or not of an informal carer)
- Medical domain (e.g. presence of health condition(s))

Figure 4.1: Flow diagram describing the proportionate assessment model



The domains included in the tools used for informal carer assessment are likely to be different from the ones listed above and will vary depending on whether the carer is being independently assessed or assessed as part of the care recipient's assessment (for ongoing care or reablement focused assessment).

For those deemed to require assessment for ongoing care, the assessment process would be stepped in complexity. The assessor would start with the base level assessment. Depending on responses to key questions the assessor would progress to advanced assessment. Again, depending on responses to key questions the assessor would progress to extended assessment. It is anticipated that the likely required level of assessment would first be determined as part of the screening/triage process.

In addition, there would be trigger points within the assessment tool that guide the assessor to the most appropriate level of assessment based on threshold values in the utilised tools. For example, most tools produce scores or ratings that define a consumer's situation as being mild, moderate, or severe. As an example, if the consumer scored 'mild' on all tools, they would require only a base assessment. If the consumer is scored as 'moderate' on any of the tools, their assessment would be escalated to advanced assessment. If the consumer is scored as 'severe' on any of the tools, their assessment would be escalated to an extended assessment. The outcome of the care assessment would be a package of services for the consumer based on the identified need.

### **Reablement assessment**

Whether the consumer should undergo a reablement focused assessment or not will be identified as part of the screening/triage process and/or through the care assessment. Current program data limitations mean consumer characteristics may not be able to be captured and linked to reablement interventions. The evaluation of CHSP reablement trial will contribute to the evidence, noting that further work may be required after trial completion. Development of a minimum dataset (MDS), and standardised reablement assessment tools (e.g. quantitative ADL based tool to measure functional decline) with defined outcomes is required to derive a set of consumer characteristics linked to positive reablement outcomes. The importance of consumer motivation to undertake a reablement assessment and intervention is also acknowledged as a key factor. The scope of services accessed directly whilst undergoing reablement assessment and/or interventions is likely to be limited to a subset of service types.

Most stakeholders interviewed thought that targeted reablement for suitable clients can provide supportive care to uplift or maintain individuals' capacity to carry out ADLs and/or instrumental ADLs (IADLs). An increased focus on preventative and early interventions with the aims of maintaining and restoring function and sustaining independence requires early assessment. Denmark is a flagship country in leading the preventative and reablement approach through undertaking restorative/ preventative assessments in conjunction with home care assessments. Local government (municipality) departments in the OECD countries reviewed were largely responsible for undertaking discrete assessments utilising a national standard assessment tool, with several countries employing a multidisciplinary board/team review in conjunction with the assessment.

### **Informal carer assessment**

Assessment of an informal carer's support needs is proposed to be undertaken as part of the unified aged care at home program. As the capacity and capability of informal carers will vary widely, not all informal carers will need to undergo an assessment. As suggested above, the assessment tool used for the informal carer would be a separate tool to the one applied to the consumer. The specific module would be included in the integrated suite of tools required to undertake an assessment for the unified program. Assessment of the informal carer enables their right to exercise choice around accessing services such as respite. Informal carer assessments

are undertaken in Scotland and New Zealand to determine respite needs. Assessment of the informal carer's support needs is supported by stakeholders interviewed.

The needs of the informal carer are likely to result in support services that may include training, coaching, counselling, and/or respite care. Counsel Assisting's submission to the Royal Commission (Adelaide Hearing 4 March 2020<sup>17</sup>) noted the guidance and tools for conduct of assessments should be revised in order to, firstly require assessment of the needs of informal carers in their own right, and for generation from that assessment of a quarantined entitlement for carer supports and respite.

## **Reassessment**

It is suggested that the need for reassessment is triggered by a change in a consumer's circumstances or need (identified by the consumer/carer and/or providers). The change in a consumer's circumstances may be permanent (e.g. informal carer no longer available) or may be temporary (e.g. additional support is required while the informal carer is on vacation and/or to assist with recovery post hospitalisation). Once the request for a reassessment has been made, the assessment model would determine the most appropriate module (i.e. care assessment or reablement assessment). If a consumer had accessed services via screening/triage only and their needs change, minor adjustments may be accommodated in the direct access pathway (subject to the threshold continuing to be met), otherwise the assessment model would be triggered.

## **Data collection**

For each assessment process, whether it was the triage/screening, or base, advanced or extended assessment, informal carer or reablement focused, data would be generated by administering the assessment tool(s). Some of this data would be defined in the MDS, and would need to find its way into a data repository, which will be used to drive the classification and funding models; and ongoing monitoring and evaluation.

### **4.3.2 Option A2: All consumers assessed**

Option A2 is to undertake a standardised assessment on each consumer that has been registered and screened for aged care in the home services. Counsel Assisting's submission to the Royal Commission (Adelaide Hearing 4 March 2020) stated comprehensive assessments establishing the eligibility for funding and care planning should be conducted for all consumers. Undertaking comprehensive assessment is intended to be part of reorientation of the system towards wellbeing and independence.

Figure 4.2 describes the possible pathways associated with all consumers being assessed and what happens once a consumer has reached the screening/triage process (again noting there may be multiple pathways to this point). The key differences relative to proportionate assessment are:

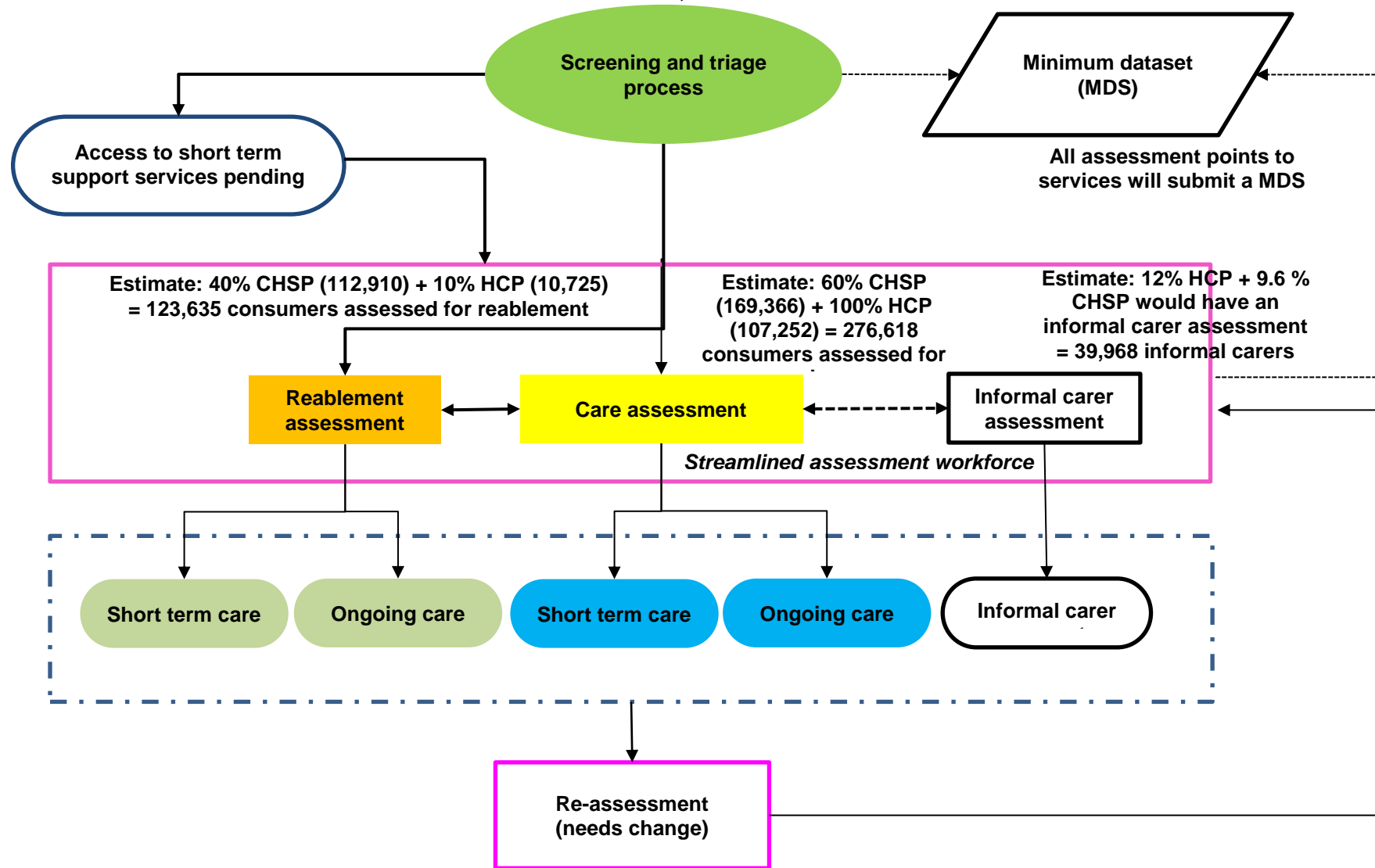
- all consumers are assessed for entry into the unified program, although there may be expedited, short term access to a limited range of support services pending assessment
- assessment is completed using a standardised instrument, there is no graduated assessment as such, although some parts of the instrument may not be applicable to some consumers.

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<sup>17</sup> Royal Commission into Aged Care Quality and Safety at <https://agedcare.royalcommission.gov.au/hearings/Pages/default.aspx>

Figure 4.2: Flow diagram describing the possible pathways associated with the all consumers assessed model

Estimate: 107,252 HCP assessments + 282,276 CHSP assessments = 389,528 consumers





All other features of the model (reablement assessment, informal carer assessment, reassessment and data collection) are identical to the proportionate assessment model. Again, the estimated volumes included in Figure 4.2 on the number of new assessments, care assessments, reablement assessments, and informal carer assessments has been derived from an analysis of 2018/19 CHSP and HCP data. The estimates are provided with the same caveats regarding uncertainty as described in relation to in Figure 4.1 (see Appendix C for more information on estimation process).

## 4.4 CLASSIFICATION MODEL

This section describes the six options considered for a classification model for the unified program. Regardless of which classification model is chosen, a process would need to be established so that the developed classification system undergoes ongoing evaluation and refinement. Data generated by the assessment and service delivery processes (i.e. MDS) should be used in the ongoing evaluation and refinement process

### 4.4.1 Option C1: Service event level classification

Option C1 is the development of a classification system at service event level. The categories would be based on the characteristics of the service delivered (i.e. the service type), not on the characteristics of the consumer receiving the services. Each service provided to a consumer would be classified into the most appropriate service type.

It is suggested that the existing service type categories in the CHSP be refined and used as the basis of a service event-based classification system. However, new service types may need to be considered to give effect to the intended broader scope of the unified program (e.g. to better support informal carers or to put more emphasis on social connectedness, or to reflect emerging AT support services).

Figure 4.3 describes how a service event-based type classification would work where each service type or class provided would fit into one category. The service type classes shown are those included under the current CHSP, plus some additional classes to be developed.

Given that it is suggested each class describes a service provided, the service providers or consumers would have flexibility to determine the services provided/received (consistent with the scope of their assessment approval/care plan). TSBs would not be needed under a service event level classification, as there would be no classes defined using consumer characteristics.

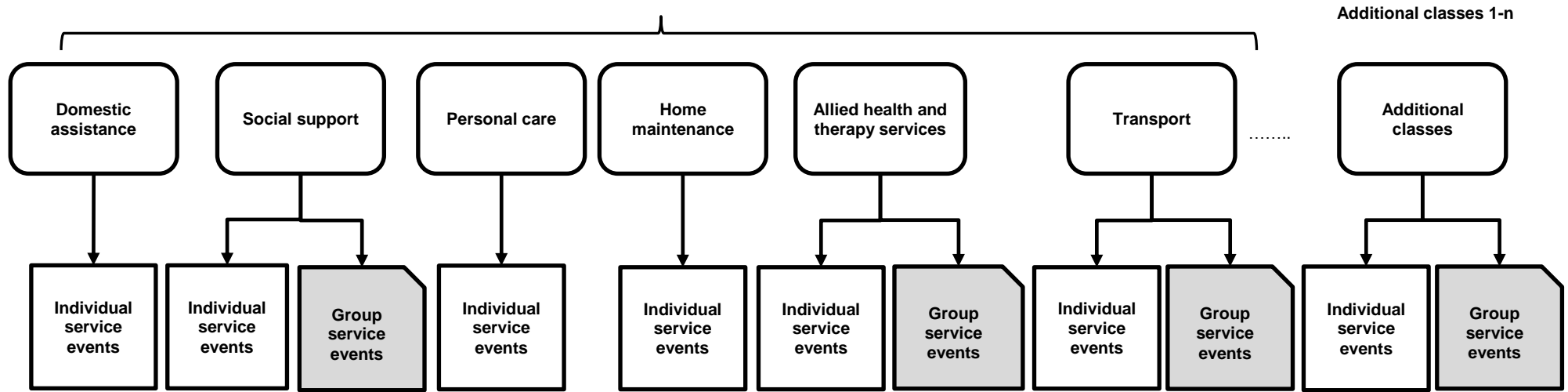
As described in Section 4.2.1, for each class or service type, the service event would be categorised as either an individual service event or group service event (where relevant). Each class would have a unit of output (e.g. hours, km etc) determined.

For those consumers assessed under the **reablement-focussed assessment**, the reablement needs would be determined from assessment, and the service provided would fit into the service event classification. The classes available under “reablement” would likely be a subgroup of all the classes included in the classification system.

An average cost for each class or service type (usually based on costing study calculations) would need to be derived along with an associated RVU. The RVU reflects the comparative costs of providing services to consumers in one class relative to another. The RVUs should be developed using empirical data on service utilisation and costs.

Figure 4.3: Flow diagram describing how a service event level classification would work

Current 17 CHSP classes (to be modified post review)



#### **4.4.2 Option C2: Banded classification system**

Option C2 is the development of a banded classification system. Logically, the existing banded level of care classification system used in HCP could be applied at the episode level. It would need to be refined and expanded to account for a greater range of consumer needs (including for consumers currently receiving services under the CHSP).

Work would be required to align the existing bands more closely with consumer characteristics. Developing additional bands specifically for low need consumers (i.e. the majority of the consumers currently accessing CHSP), and reablement focused services would also be required. Reablement needs would be determined from screening/triage and assessment, and support services provided as an episode of care if appropriate, independent of the ongoing care level assigned.

In most of the reviewed OECD countries, classification was typically based on number of hours and/or types of care required (based on care needs) into a care needs level with an associated level of funding. Weighted assessment modules and/or algorithms were utilised in some home care models (Germany and Japan respectively) to assign to care levels. Germany's assessment tool score originally classified individuals into five levels to determine the level of care needed (dependency). The five dependency levels were subsequently refined to account for daily supervision needs in addition to ADLs and IADLs.

#### **4.4.3 Option C3: Refine and modify RUG-III-HC**

Option C3 is the use of the existing interRAI RUG-III-HC classification system, modified to be suitable in the Australian setting. As implied, RUG III HC is derived from the use of the interRAI system, which is a proprietary assessment tool.

The interRAI home care (HC) system enables a range of decision support tools that assist the assessor in planning and monitoring care. These include:

- Scales for ADLs, cognition, communication, pain, depression, and medical instability
- Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
- Screening systems to identify appropriate outreach and care pathways for prospective clients
- A quality monitoring system (Home Care Quality Indicators, or HCQIs)
- A case-mix system that creates distinct service-use intensity categories (RUG-III-HC)

The RUG-III-HC methodology assigns each consumer to one of 23 groups based on clinical characteristics determined from the assessment outcomes. Each of the 23 RUG-III-HC groups fall into one of seven clinical categories.

Some stakeholders interviewed noted that one advantage of using the RUG-III-HC approach was the opportunity to benchmark Australian data to international practice. Other stakeholders felt the RUG-III-HC was too clinical and not applicable in the Australian context.

#### **4.4.4 Option C4: Refine and modify AN-ACC**

Option C4 is the further development of the AN-ACC classification for use in the unified aged care at home program. The current AN-ACC classification system was developed specifically for use in residential aged care. A whole new aged care at home branch at the start of the classification system (similar to AN-SNAP for sub-acute care, which starts with admitted and non-admitted branches), would need to be developed.

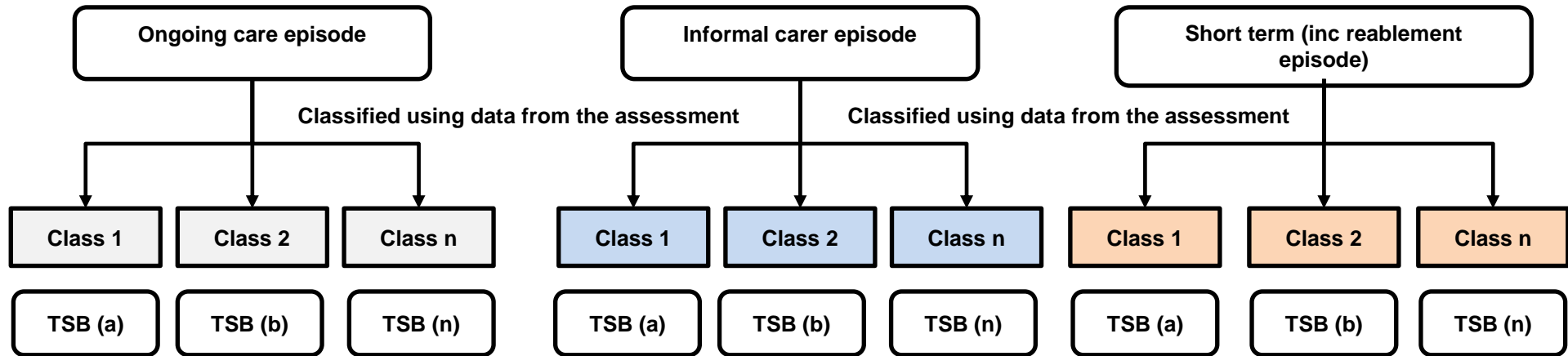
The classification would be based primarily on a person's assessed level of need across the usual domains (e.g. functional status, cognition, behavioural). Other characteristics such as diversity could also be considered. Low level consumers, informal carers, and reablement may be classified in separate sub-branches (with one or more class).

Counsel Assisting's submission to the Royal Commission (Adelaide Hearing 4 March 2020) stated the levels of funding corresponding to classifications must be linked to actual cost data for residential care. The same principle could be applied to home care to enable transparency and sustainability in funding. The key cost drivers for aged care at home will be different to residential aged care. As such, refining AN-ACC by adding an aged care at home module is not significantly different to developing a fit-for-purpose classification system (see Options C5A and C5B).

#### **4.4.5 Option C5A: Fit-for-purpose classification – episode level only**

Option C5A is the development of a fit-for-purpose classification system for aged care at home at the episode level, as illustrated in Figure 4.4. Data gained from the assessment process would inform which episode type consumers or carers are allocated to (e.g. screening/triage could result in a consumer either ending up in an ongoing care or short-term care episode whereas those that undergo further assessment can end up in any episode care type).

Figure 4.4: Flow diagram describing how an episode-level classification would work



Although three different types of episodes are shown (i.e. ongoing care episode, short term episodes and informal carer episodes), for any consumer, two or all three, episode types could occur in parallel. For those consumers accessing services through direct access (under the proportionate assessment model) or while waiting for an assessment (under all consumers assessed model), there will be circumstances where the different episode types will occur sequentially (i.e. short-term episode before the ongoing care episode).

More rigorous definitions and counting rules would need to be established, but this approach implies that the classification system would be developed based primarily on the characteristics of the care recipient. It is suggested that the development of the classes be based on a hybrid empirical data analysis and expert judgement approach, which includes:

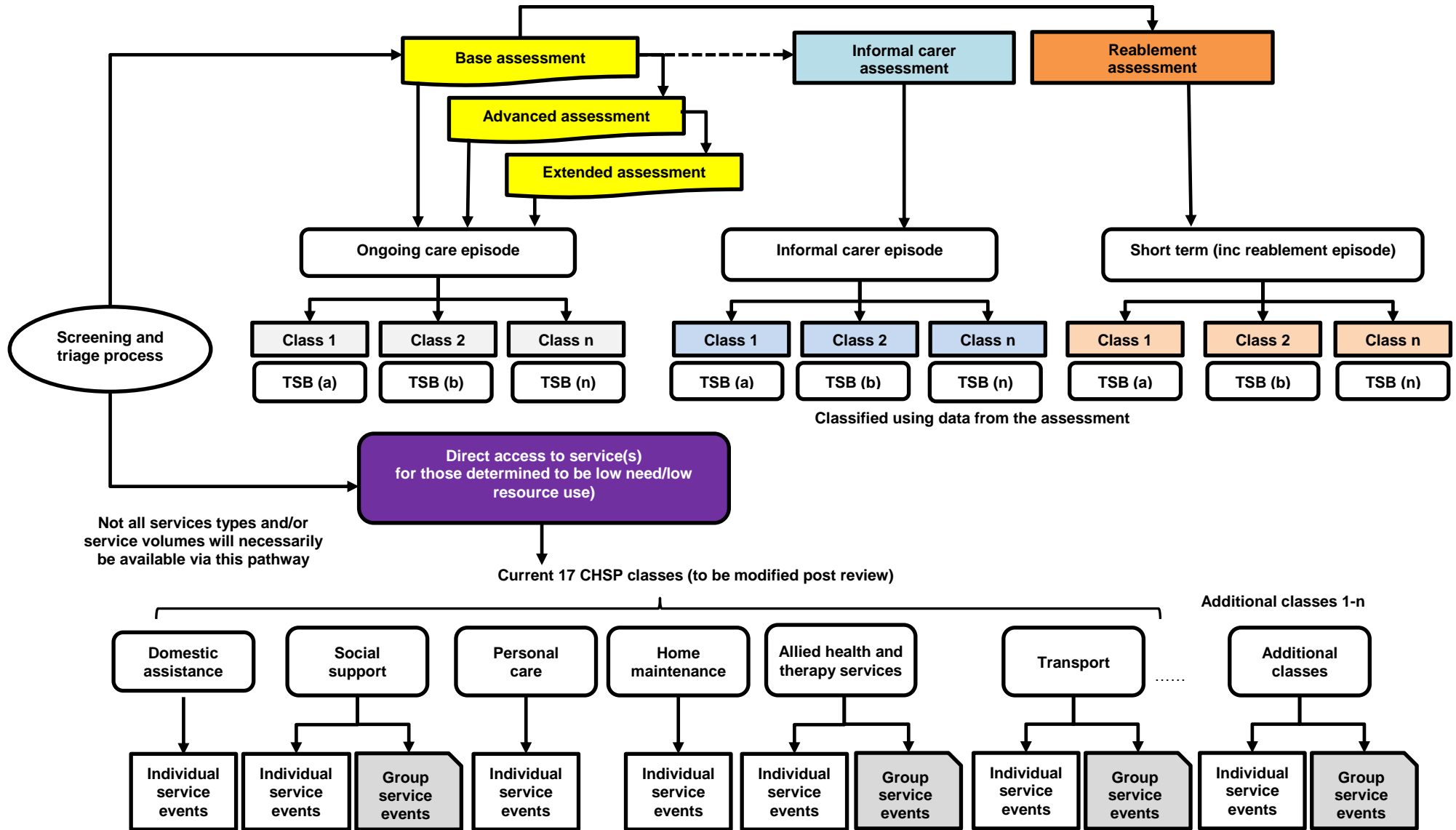
- Empirical data collection to ascertain consumer characteristics (variables derived from the assessment instrument) and measure episode-level costs (note the need to study ongoing episodes, short term episodes and informal carer episodes)
- Development of the initial classes using variance reduction techniques on the empirical data and then determining the most common service bundles for each initially defined class
- Expert panel review of the empirically derived classes and service bundles to determine TSBs that define the volume and mix of services that would best address the needs of consumers assigned to each class
- Developing the final classes and associated RVUs by testing the impact of the defined TSBs on the definition of the classes using further data analysis, referring the results back to the expert panel and iterating until the most appropriate balance between expert judgement and statistical analysis of the empirical data is reached.

As described in the assessment model options, it is suggested that service providers or consumers can request reassessment when care needs change. The outcomes of the reassessment would determine the new aged care at home classification system class.

#### **4.4.6 Option C5B: Fit-for-purpose classification – mixed service event and episode level**

Option C5B is the development of a fit-for-purpose classification system for aged care at home using a mixed service event and episode level approach, as illustrated in Figure 4.5. This option aligns the classification system with the proportionate assessment model, so classes for consumers accessing via screening/triage only will be service event based, and classes for consumers accessing via base, advanced or extended assessment will be episode based. The details of how the two main branches would work are described in Section 4.4.1 (service event level) and 4.4.5 (episode level).

Figure 4.5: Flow diagram describing how a mixed service event and episode-level classification would work



## 4.5 FUNDING MODEL

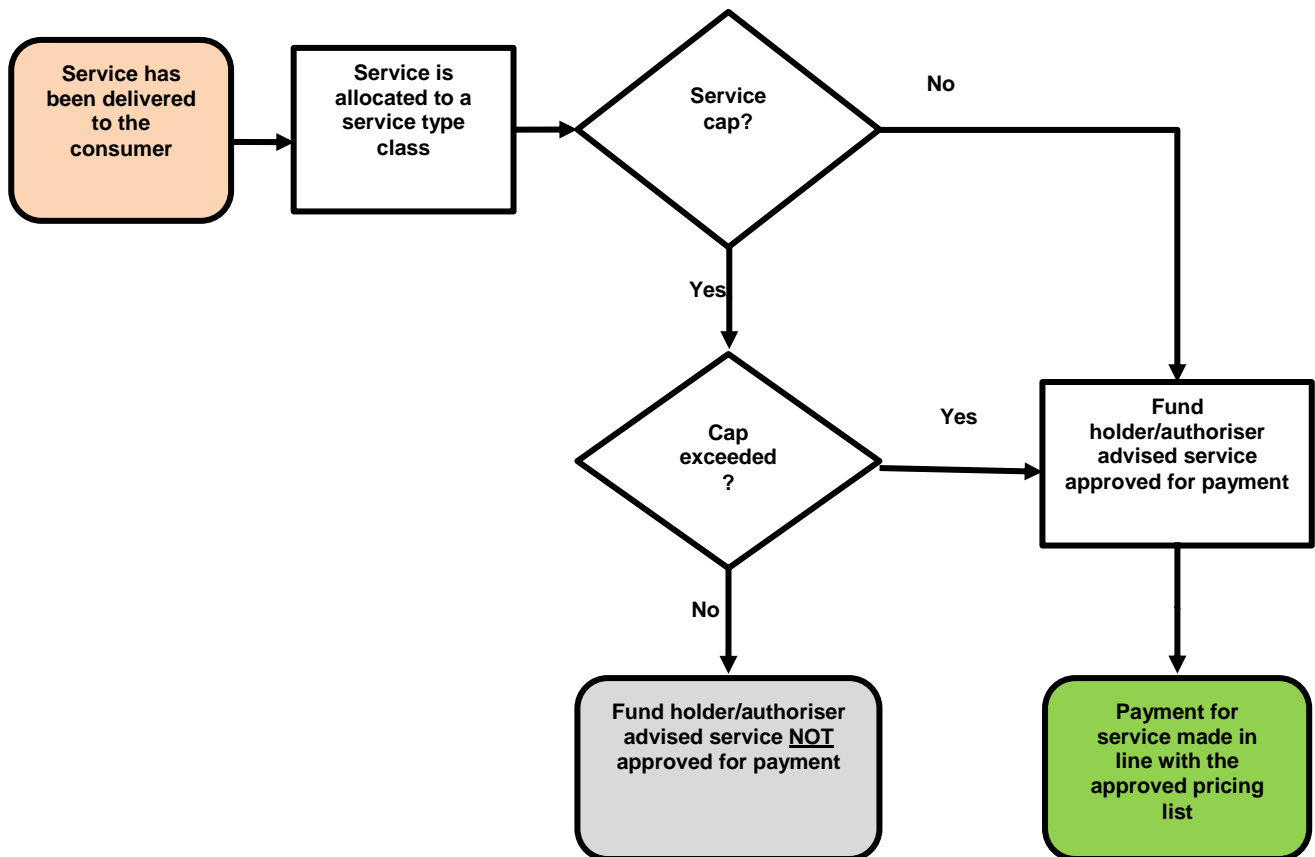
This section describes the three options considered for a funding model for the unified program. Some key features that would need to be addressed in each model option are also described.

### 4.5.1 Option F1: Service event level funding with service event classification

Option F1 is a service event level funding model using the service event classification system. Two implementation approaches are possible. The funding for each consumer could be capped (based on the assessment approval) with services provided up to the capped amount. Alternatively, an uncapped approach could be used, where all services provided that were within the scope of the program would be funded. In most of the OECD countries reviewed<sup>18</sup> funding was typically at service event level, or a hybrid approach of service event level funding and/or cash benefits, based on the care needs level funding cap.

Figure 4.6 shows that under a service event level funding model, once a service is delivered it will need to be allocated to a service type or class. If there are caps set on the service type for the consumer (i.e. pre-determined with reference to the defined care plan), a process to assess whether the cap has been exceeded will be needed. If the payment authority or fund holder/authoriser (if used) determines the service cap has not been reached, then payment would be made in accordance with the price list. This approach could be applied prospectively (i.e. payment made in advance and then reconciled based on services delivered) or retrospectively. If there is no payment cap, then only a process to verify that the service was within program scope would be needed.

Figure 4.6: Illustrative process for service event level funding with service event classification



<sup>18</sup> Germany, Belgium, Finland, Japan, Sweden, Denmark, New Zealand, England, Scotland, Canada, United States, Netherlands, France



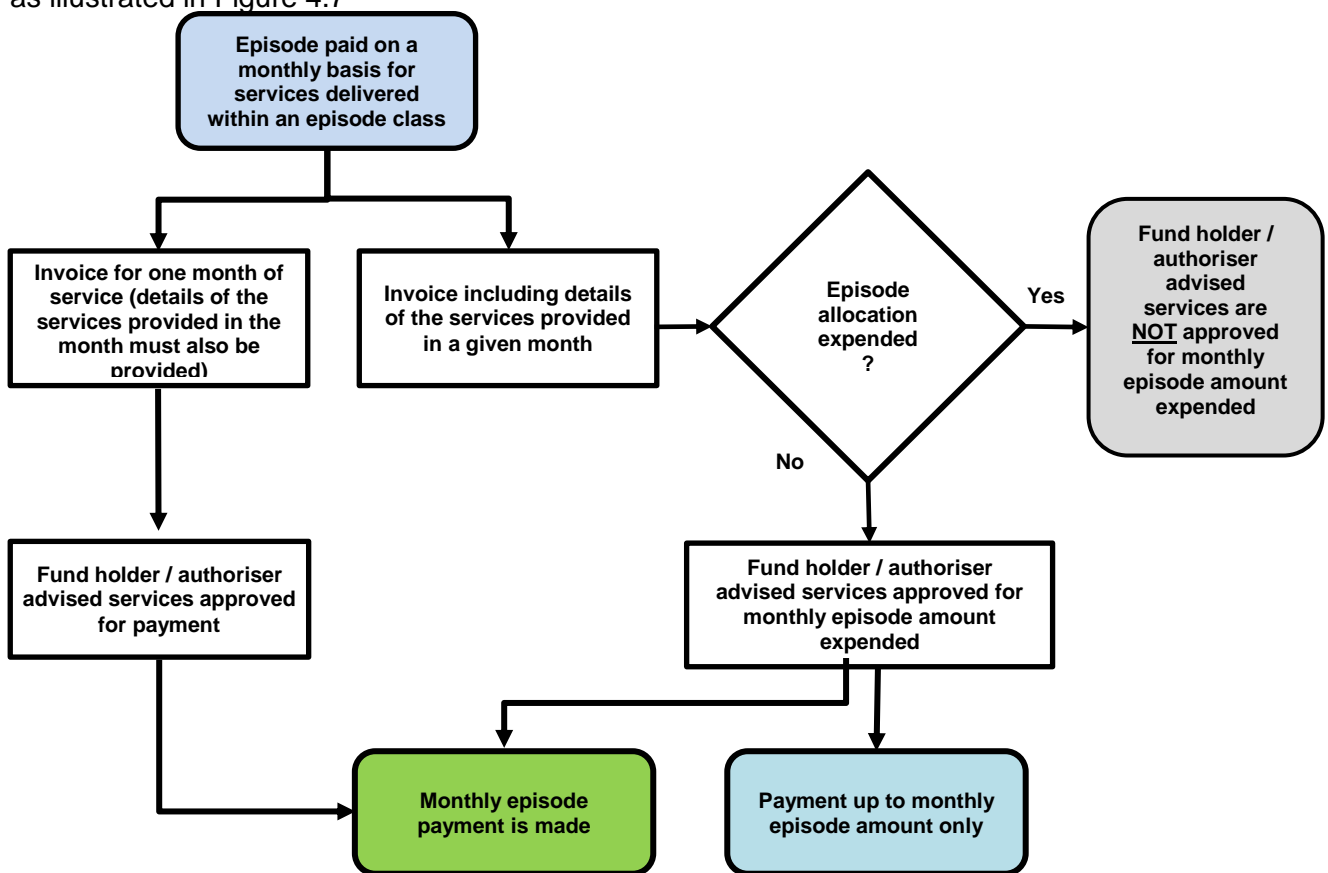
Please note that there are multiple possibilities for how service event level funding could be implemented, and it is not necessary to use a fundholder/authoriser. Whatever the implementation approach, the cycle of billing for services would need to be determined. The options include:

- invoice for each service event
- monthly accounts for each consumer
- monthly accounts for each approved provider

There would be higher administrative burden with the first option (i.e. individual service event invoices). Depending on how aged care provider’s billing systems are set up and whether individual caps are set, aggregate monthly accounts for all consumers who receive a service would most likely be preferred by service providers. Again, it is highlighted that such accounts could be processes prospectively of retrospectively.

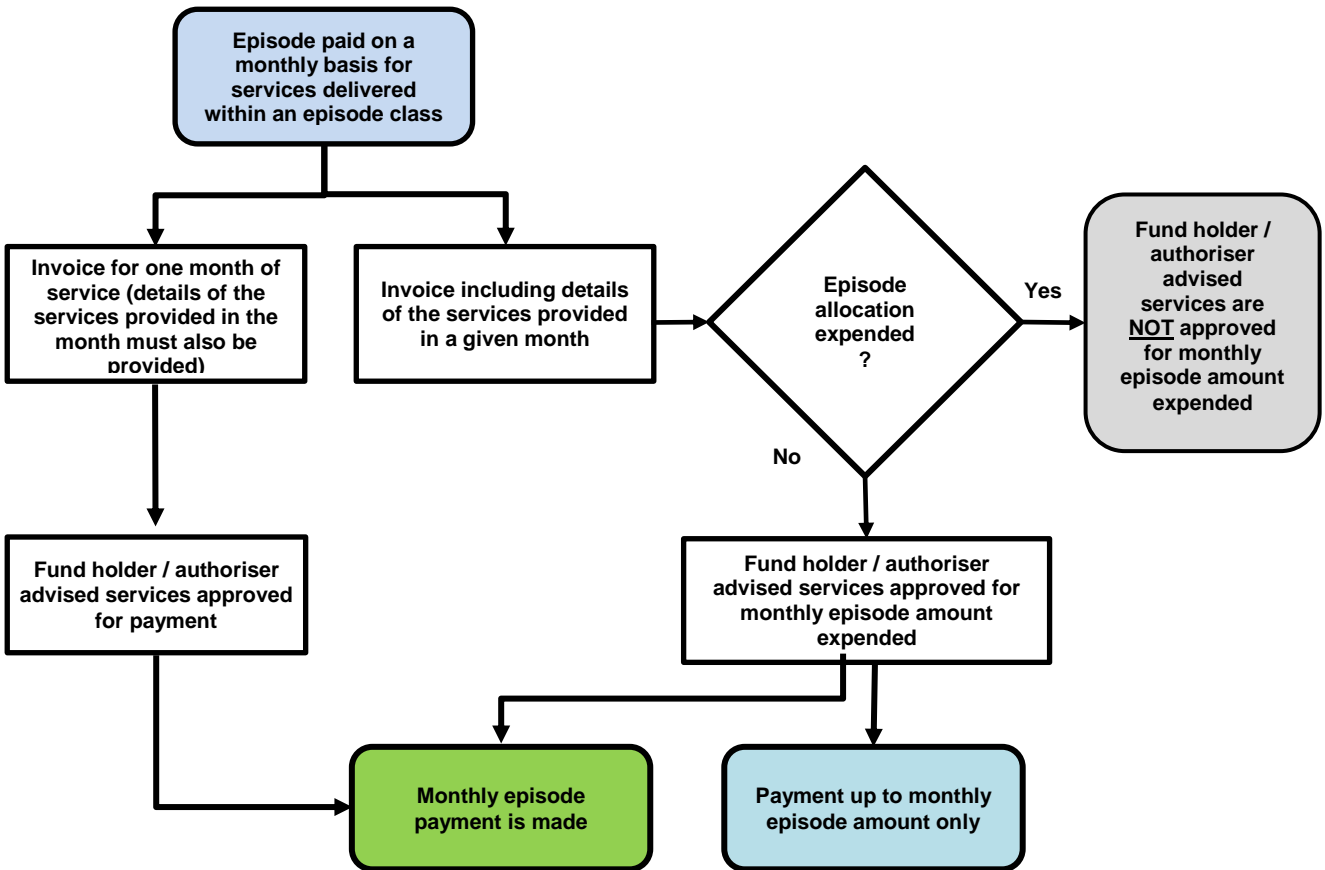
**4.5.2 Option F2: Episode funding with fit-for-purpose classification**

Option F2 is an episode level funding model using the fit-for-purpose episode level classification, as illustrated in Figure 4.7

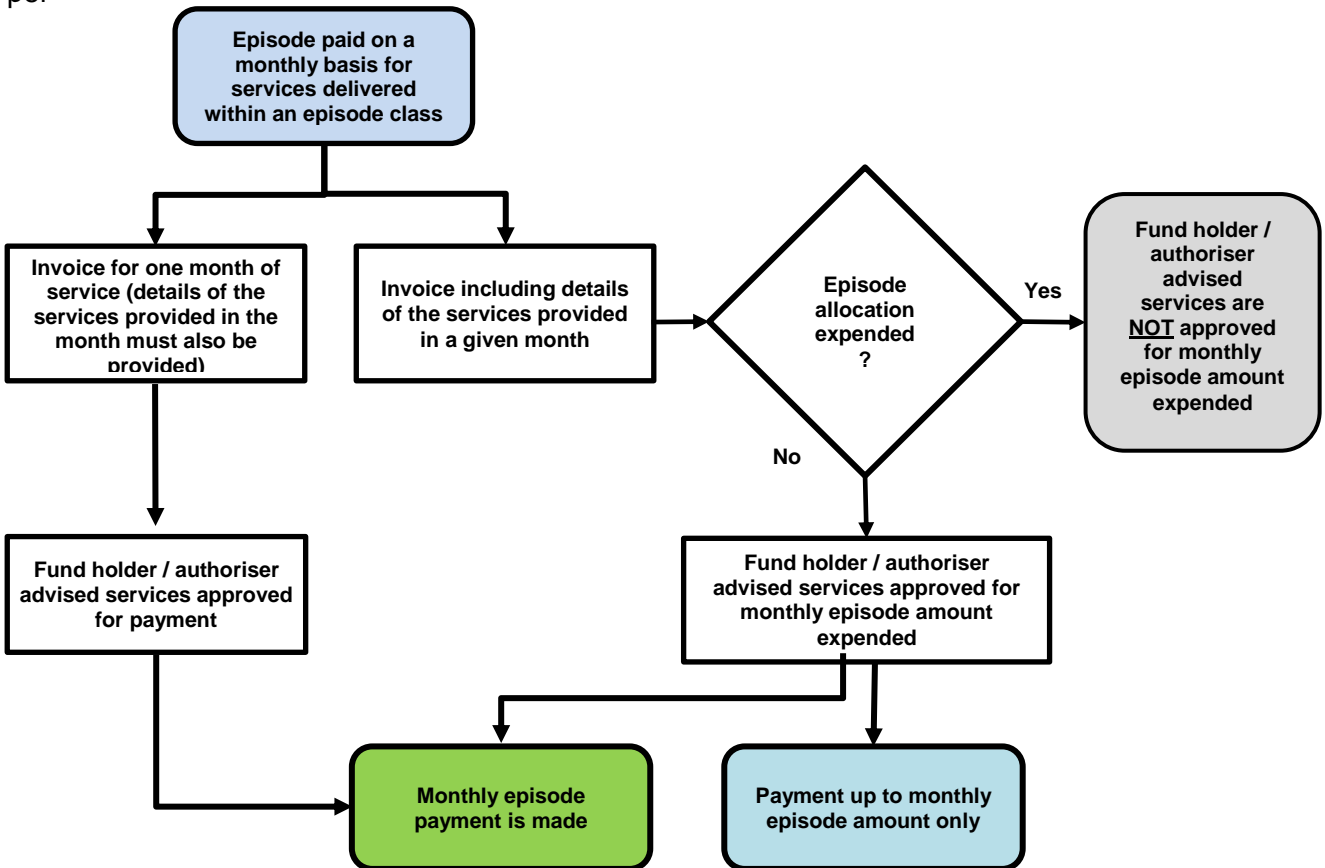


. With an episode funding model, all consumers would be assigned to a category in the classification system. The RVU associated with that category would be used to determine the assigned funding amount. A consumer could be allocated more than one funding amount, if they were experiencing parallel episodes.

**Figure 4.7: Process for episode funding with fit-for-purpose classification**



Arrangements for billing would need to be determined. Given that an episode of care could potentially take years to complete, it is suggested that periodic payments be made to providers. As per



, those payments could be made for the whole episode for the month either prospectively or

retrospectively or with or without reconciliation to the actual service events delivered, noting that fundholder/authoriser approval would be needed. The billing options include:

- approved providers issue individual episode invoices that are segmented into an appropriate period (e.g. month) for each ongoing care episode
- approved providers issue one invoice for the period (e.g. month) aggregating all the ongoing care episodes (partially or fully completed) for every eligible consumer who is provided with a service within the service.

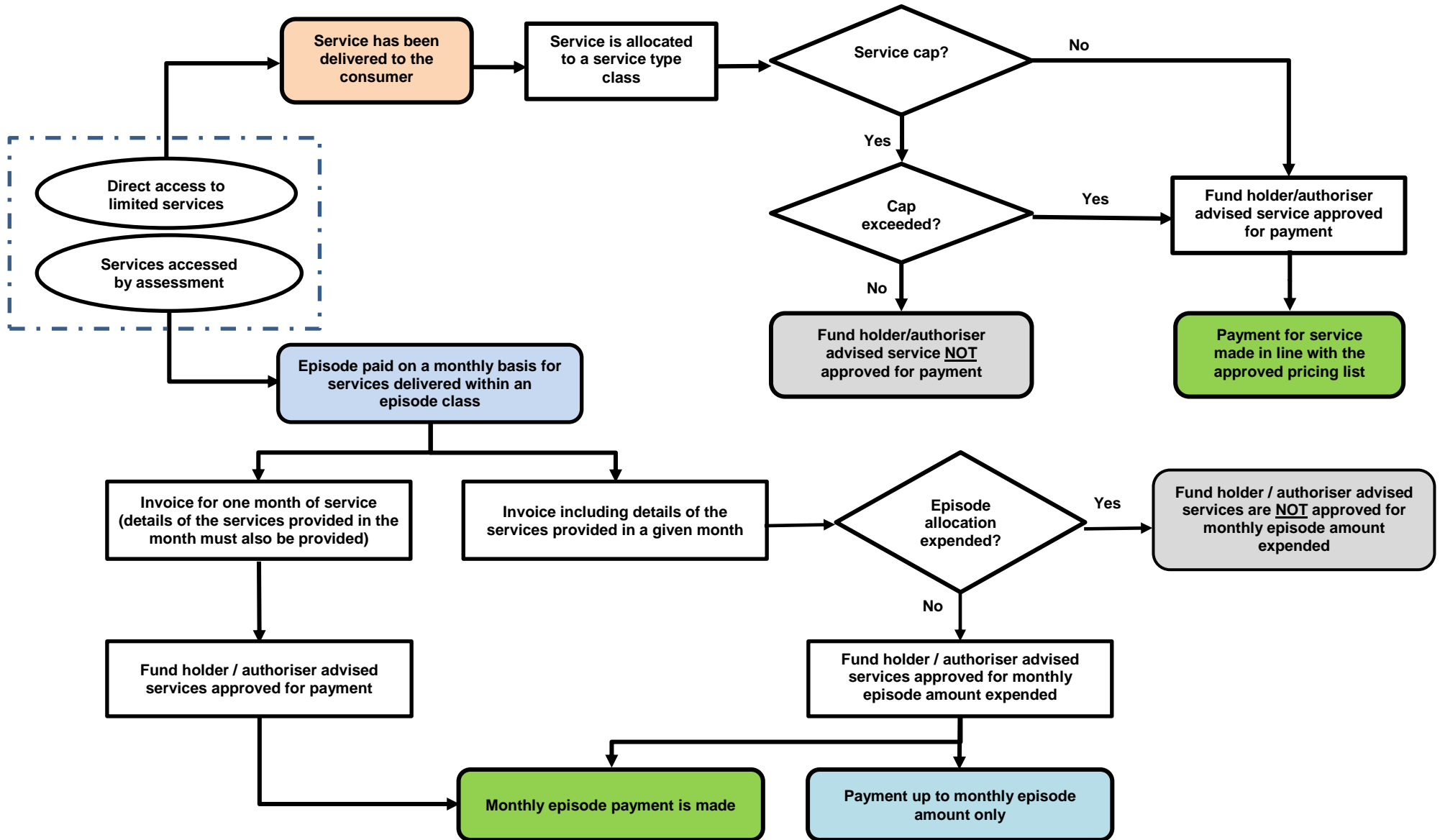
Even if payment is made only at episode level (lower branch), regardless of the actual services received by the consumer, the detail of service events delivered in the month must still be provided. If no details were required on the monthly invoice about the services rendered, then no comparison of services received by the consumer to the TSB determined most appropriate for the consumer's class can be made. Similarly, not reporting actual services delivered would inhibit program assurance, monitoring and evaluation activities.

To enhance consumer choice, it is suggested that the funding model allows some flexibility with respect to varying the services to from those prescribed in the TSB. One approach is to allow service providers or consumers to determine the services to be provided/received (within prescribed guidance). For example, the guidance could advise that a consumer could vary, within the funding amount for the class, the volume of each service type received in the service mix defined by the TSB, but would have to include at least some units of each prescribed service type.

#### **4.5.3 Option F3: Mixed service event and episode funding**

Option F3 is a mixed service event and episode funding model using the fit-for-purpose mixed service event and episode level classification system, as illustrated in Figure 4.8. It shows that this funding model is also aligned to the proportionate assessment approach. The episode level funding model would be used to fund only consumers that undergo assessment (i.e. consumers who are assessed and assigned an episode class). The service event level funding model would be used to fund other consumers (i.e. low risk/low resource use consumers accessing services via screening/triage only). The details for each arm of this blended approach are as per the service event model (refer to 4.5.1) for screening/triage consumers and as per the episode model (refer to 4.5.2) for assessed consumers.

Figure 4.8: Process for mixed service event and episode funding with fit-for-purpose classification



#### 4.5.4 Fundholder/authoriser

Whatever funding model option is chosen, the possible use a fundholder/authoriser in the payment process will need to be considered, noting that it is possible to implement all three models without a fundholder/authoriser. The use of a fundholder/authoriser is considered more appropriate for episode level funding than for service event level funding. If a fundholder/authoriser is used, then funds could be held/authorised by a single provider (this choice also enables block funding for multiple consumers being receiving services from the provider); an independent care coordinator, case manager or 'care finder'; or the consumer or their representative (self-management).

Using the episode level model to illustrate (it is better suited to the use of a fundholder/authoriser), the monthly payment could be made prospectively or retrospectively directly to a service provider (similar to the current HCP arrangements, with or without quarantining funds for services delivered to that consumer). Where the service provider is fundholder/authoriser, it is suggested that:

- the provider as fundholder/authoriser controls the funds allocated to the episode
- the provider is responsible for care coordination and, where needed, case management for which a portion of the funds is retained (in accordance with the price schedule)
- the provider is responsible for delivering the services to the consumer according to the approved care plan (based on the TSB for that class).
- where the provider does not offer the required services, in consultation with the consumer, they can procure services from other local providers
- the provider is responsible for reporting/billing the services in accordance with the options provided for in the episode funding model and ensuring the episode allocation is not exceeded.

Alternatively, the control of the funds allocated for each episode could be given to an independent care coordinator (or equivalent, including providers that specialise in care coordination/case management). This option is more appropriate when there are multiple providers. Where an independent care coordinator (or equivalent) is the fundholder/authoriser, it is suggested that:

- the care coordinator as fundholder/authoriser controls the funds allocated to the episode
- a portion of the funds is retained for care coordination and, where needed, case management (in accordance with the price schedule)
- the care coordinator, working with the consumer is responsible for procuring the required services from one or more providers according to the approved care plan (based on the TSB (reference bundle) for the episode class)
- the providers deliver the required services to the consumer according to the care plan and are paid on a service event basis after approval by the care coordinator who would ensure that the episode allocation is not exceeded (actual payment may be made by Government)
- the care coordinator is responsible for reporting all the procured the services.

Finally, the control of the funds allocated for each episode could be given to the consumer (or their representative). Where the consumer is the fundholder/authoriser, it is suggested that:

- it is established that the consumer (or their representative) has the capability to self-manage, including to determine the need to appoint a case manager; or the consumer (or representative) is provided with additional support to enable self-management.
- the consumer (or representative) as fundholder/authoriser controls the funds allocated to the episode
- the consumer is responsible for procuring the required services from one or more providers according to the approved care plan (based on the TSB for the episode class); or the consumer could engage the services of a care coordinator to perform that function (equivalent to the independent care coordinator option)

- the providers deliver the required services to the consumer according to the care plan and are paid on a service event basis after approval by the consumer who would ensure that the episode allocation is not exceeded (actual payment may be made by Government)
- a possible mechanism for enabling fundholding/authorising consumers would be the use of a debit card or an on-line booking/authorising system to allow monitoring of the episode allocation and enable the reporting of the procured the services.

Ideally, it is desirable for all three models to be enabled. That way consumers could choose the option that best suited them, knowing all options are available. Allowing all options creates challenges for the ongoing operation and monitoring of the aged care at home program. Different arrangements for data collection and billing would need to be designed and implemented.

As discussed, although the options are illustrated for the episode level model, the same approaches could be enabled for the service event model. Because the episode concept is not used in that model, there would be no episode allocation to monitor but, if a funding cap is used, the same monitoring principles could apply. It is, however, considered that for the service event funding model it may be simpler to make the payment for each service event directly to the provider without the use of a third-party fundholder/authoriser.

#### **4.5.5 Setting of prices**

Whatever funding model option is chosen, there will need to be an approach to setting prices at the service event and/or the episode levels.

Wherever service event level funding is used, prices can be set in one of two ways:

- service providers independently set prices for each service type for a defined period (a market-based approach).
- a standardised schedule of prices is developed with reference to the reasonable costs of delivering a unit of service for each service type (needs an empirical costing study, which would also form part of the service event classification development process).

A market-based approach to setting episode prices will not be suitable. Rather, the RVUs for each class in the classification system should be the basis for setting prices where episode level funding is used. The RVUs would come from the empirical study used in the episode level classification development process. The RVUs would be used in a funding formula that also factors in policy considerations such as program financing policy, consumer co-payment policy and allowable adjustments for unavoidable costs (see Section 4.5.6).

Counsel Assisting's submission to the Royal Commission (Adelaide Hearing, 4 March 2020) states the levels of funding (corresponding to classifications) must be linked to actual cost data ascertained by an independent pricing authority. This position, if adopted, strongly supports the need for prices to be determined using an empirical costing study.

#### **4.5.6 Funding adjustments**

As stated, whatever funding model option is chosen, a range of adjustments may be needed to the payment model to reflect unavoidable costs associated with factors, such as:

- Service characteristics such as service provided in or out of hours, rural and remote location, operating in thin markets, etc.
- Client characteristics not used in classification e.g. Aboriginal and Torres Strait Islander, homeless, CALD, LGBTIQ, etc.

The evidence base for such adjustments could be produced by the empirical costing study proposed for price setting. Purposeful sampling of study participants would be required to ensure that the possible adjustment characteristics are reflected in the generated data.

Several stakeholders interviewed stated that consideration of additional cost factors for rural/remote service providers, and thin markets for minority groups was required. Counsel Assisting's submission to the Royal Commission (Adelaide Hearing, 4 March 2020) also noted loadings for higher costs in rural, regional and remote areas should also apply to the extent that materially higher costs are demonstrated by reason of remoteness. In cases of very thin markets, providers may receive guaranteed base funding in return for provider of last resort obligations.

It is widely accepted that service providers in rural and remote areas are likely to incur more transport costs associated with greater distances to travel to clients. They may also incur higher labour costs to attract and retain a skilled workforce. It is also reasonable to assume that rural and remote areas will operate in comparatively thin (or no) markets relative to metropolitan and inner regional areas. As such, service sustainability may be a consideration in setting funding levels.

The proportion of the population with diverse needs (e.g. Aboriginal Torres Strait Islander people, the homeless, CALD and LGBTIQ groups) will also differ across geographic areas. Providers in these areas may need additional resources and/or specific workforce experience and skills to address diverse population needs, which may also result in comparatively higher operational costs.

Counsel Assisting's submission to the Royal Commission (Adelaide Hearing, 4 March 2020) also noted that some diverse groups may have needs that should attract loadings or supplementary funding, as those needs may reasonably require incurring of greater costs. There may be scope in the way loadings and supplements are granted to provide incentives for specialist accreditation for services that meet those needs.

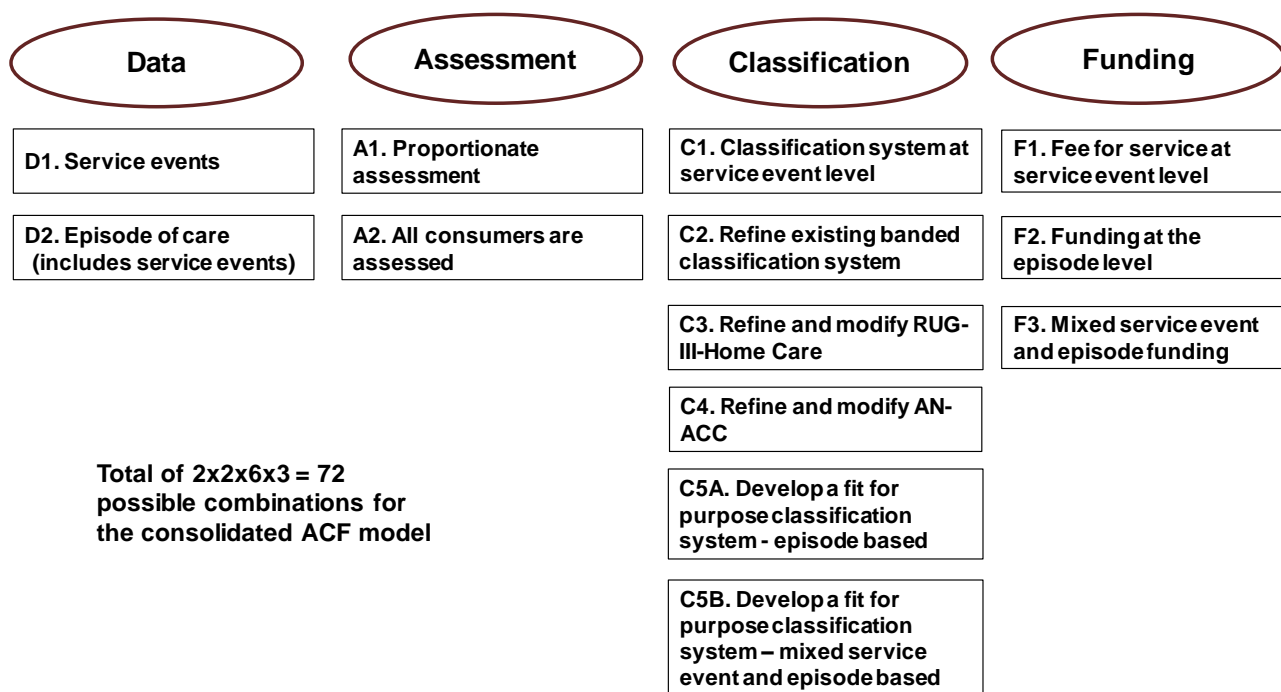
## Consolidated ACF model options and evaluation

This Chapter presents the consolidated ACF model options, derived by making one of the possible choices for each component of the model. It describes the process for short-listing the consolidated ACF model options and then evaluates the assessment, classification and funding model choices chosen in the three short-listed options. The total evaluation scores for the three consolidated options are then derived by adding the scores of the component model choices they use, leading to a preferred option.

### 5.1 POSSIBLE CONSOLIDATED ACF MODEL OPTIONS

Figure 5.1 lists the possible choices for each component of the ACF model, including the associated data collection. Logically, by making one choice from the alternatives for each of the four components, there are 72 options for the consolidated ACF model. Not all the choices plausibly fit together, but it is considered possible to make many of the consolidated options work.

Figure 5.1: Possible combinations for the consolidated ACF model



The short-listing process involved applying judgement, with reference to the learning derived from the documentation and literature review, and the input obtained from stakeholders. Aside from the classification, it was decided that none of the choices for the other components of the ACF model would be eliminated at this stage. For the classification system, it was concluded that:

- Option C2:** Refinement of the existing banded classification system was considered unlikely to offer the granularity required to categorise consumers based on similar needs. There were concerns that the use of a banded classification in the HCP resulted in the services provided not being well aligned to the services needed. It may also produce unequal outcomes for consumers with like needs. Although there was some support for the flexibility for providers offered by this option, with reference to how it is used in HCP, it was considered that this flexibility could be achieved using other models.



- **Option C3:** There was some support for the use of interRAI and the RUG III HC classification amongst stakeholders consulted, largely due to potential benefits of international benchmarking, although it was acknowledged that there are other ways to pursue these benefits. More stakeholders expressed concerns about the possible use of RUG III HC, citing that the system was developed for aged care systems outside Australia and observing that it was too clinically focussed rather than support care focussed (aged care is a social care system rather than a health care system).
- **Option C4:** It was determined that the refinement and modification of AN-ACC by adding an aged care at home branch is not significantly different to the option of developing a fit-for-purpose classification system for aged care at home. Both options would involve significant empirical data collection and analysis. Once developed the fit-for-purpose classification could be regarded as a branch of AN-ACC or as a stand-alone classification system.

These judgements effectively led to the decision to eliminate Option C2, and to consider C4 as equivalent to C5A or C5B at this stage of the process. These decisions were endorsed at the second workshop with key Department staff. With respect to C3, it was agreed at the second workshop with Department staff that further research on the interRAI RUG III HC system and its application in other OECD countries was required to determine its suitability for potential use in Australia. This information (refer to section 5.2) was used to make a final decision on whether Option C3 would be further considered.

## 5.2 interRAI RUG-III-HC AS THE CLASSIFICATION SYSTEM

This section summarises the additional information gathered on the interRAI RUG-III-HC system, to determine its suitability for potential use in Australia, with further detail in Appendix E.

The interRAI HC system was developed for use with adults in home and community-based settings. It is licensed product, with non-commercial organisations (e.g. governments, care providers) generally granted a royalty-free license (with conditions).

Using a desktop review, the use of the interRAI HC and/or the RUG-III-HC classification system in a selection of OECD countries was investigated. A summary of the findings includes:

- The application of the interRAI HC assessment tool and resulting assessment data is variable. Program and socioeconomic data are also collected in parallel to interRAI in varying degrees.
- The drivers to use the interRAI HC system primarily appear to be the desire for a:
  - standardised approach to assessment
  - MDS that is able to capture functional status of consumers
  - access to functionality to use as a quality indicator for the care of older individuals (Home Care Quality Indicators)
  - enabling benchmarking (nationally and/or internationally).

It was found that only Canada (widespread use) and the USA (selective use) use the RUG-III-HC classification system. Use of multiple and/or other classification systems by countries using the interRAI HC assessment tool appears to reflect the regulation and legislation of their health and aged care sectors, funding streams, decentralisation of service delivery and funding determination to the regional/local level.

In addition to the relatively limited use of the RUG-III-HC classification system overseas, various problems were identified with using it as the basis for classification in the ACF model:

- Extensive testing and modification of the 'off the shelf product' would still be required to ensure suitability for use in the Australian system.
- There are likely to be product licensing issues associated with making any significant changes to the system to fit the design of the unified aged care at home program, specifically:

- the proportionate assessment option, which allows access to services via screening/triage is not enabled in the 'off the shelf' product (need the interRAI assessment data to drive the classification system)
  - unmodified the interRAI RUG-III-HC classification system does not offer the flexibility to allow consumers to be in more than one classification class (i.e. cannot implement parallel ongoing care and short term, including reablement episodes)
  - the system is designed for long-term care and does not include time limited services (e.g. restorative care, respite) in an upfront and/or intermittent manner.
- Benchmarking Australian home care services using interRAI HC to international service provision may not be as informative due to translation and applicability issues.

For these reasons, the interRAI RUG-III-HC option was not developed further, noting it would have received low scores against the evaluation criteria, given the above limitations. This decision was endorsed at the third workshop with key Department staff.

### 5.3 SHORT-LISTED ACF MODEL OPTIONS

Elimination of the use of RUG III HC as the classification system left three ACF model options short-listed for further analysis and evaluation.

#### 5.3.1 Option 1: Service event level classification and funding

The first option represents a pure service event level approach, as shown in Figure 5.2.

Figure 5.2: Service event level classification and funding

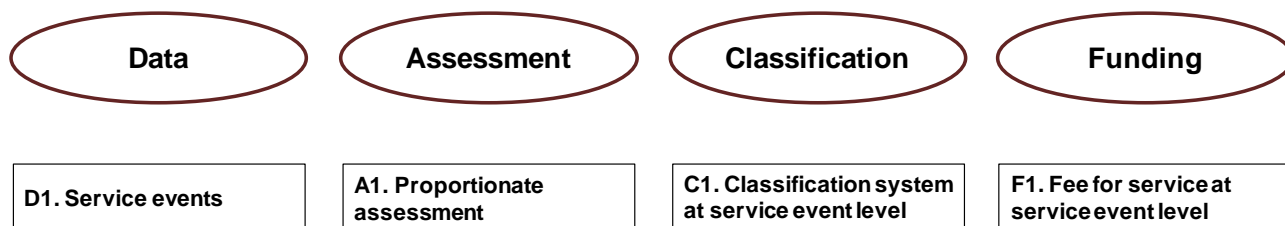


Figure 5.2 shows that Option 1 combines data collection at service event level (D1) with a service event level classification (C1) and funding (F1) system. Proportionate assessment (A1) is used, as there is no need to gather detailed assessment data to drive the classification system. However, screening/triage and/or assessment data would need to be used to define and approve the package of services that is offered to consumers.

By way of analogy, this option would be similar to many aspects of the MBS or the clinic-based payment system used for non-admitted patients under public hospital ABF. Each service provided would be classified into a service type class for which there would be a pre-specified payment (set with reference to a standardised price schedule).

#### 5.3.2 Option 2: Episode level classification and funding

The second option represents a pure episode level approach, as shown in Figure 5.3.

**Figure 5.3: Episode level classification and funding**

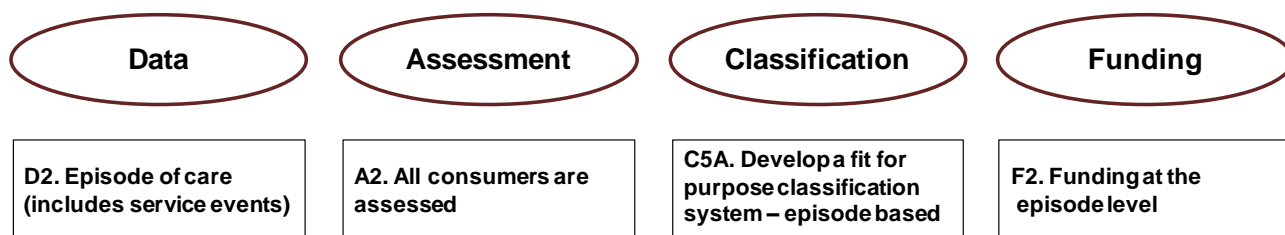


Figure 5.3 shows that Option 2 combines data collection at episode level (D2) with a fit-for-purpose episode based classification (C5A) and an episode level funding (F2) system. The all consumers are assessed option (A2) is used, as the assessment data is needed to drive the episode level classification system. All consumers and informal carers (where their needs are assessed) are classified into an episode, which could be ongoing (where time slices (e.g. monthly)) would be funded or short term (which could be funded progressively or once-off depending on length).

This approach is similar to many aspects of the AN-ACC classification and funding system developed for residential aged care. There are also similarities to the AR-DRG based system used for the payment of admitted episodes in public hospital ABF. Under this approach, the overall episode has a specified payment (set with reference to the RVU associated with the AR-DRG) rather than products or services used in the admitted patient episode being paid for (e.g. bed days, theatre time, diagnostic tests, etc.). The key difference between those classification systems and the one proposed for the unified program is that consumers may be classified and hence funded into more than one episode at the same time.

**5.3.3 Option 3: Mixed service event and episode level classification and funding**

The third option represents a mixed service event and episode level approach, as shown in Figure 5.4.

**Figure 5.4: Mixed service event and episode level classification and funding**

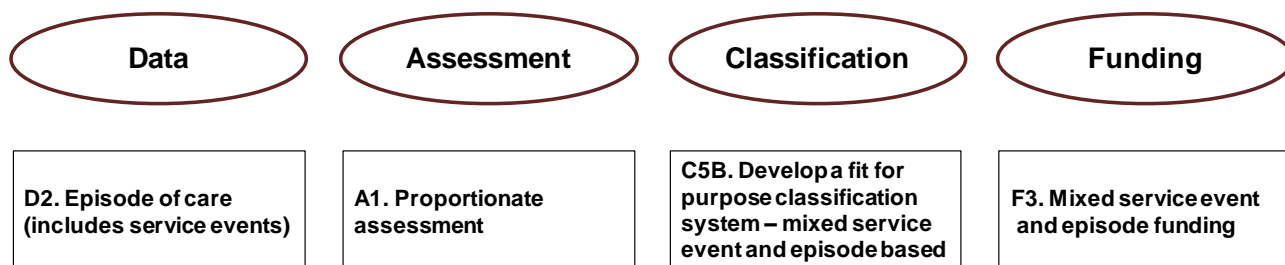


Figure 5.4 shows that Option 3 combines data collection at episode level (D2) with a fit-for-purpose mixed service event and episode level classification (C5B) and funding (F3) system. The proportionate assessment option (A1) is used, reflecting the fact that consumers who access services directly from screening/triage would be classified and funded using service events only (there would not be sufficient data to drive episode level classification). Consumers and informal carers who undergo an assessment would be classified into an ongoing episode, where time slices (e.g. monthly) would be funded; or short-term episode, which could be funded progressively or once-off depending on its length.

This approach also has similarities to hospital ABF, where some services are funded using a service event approach (e.g. non-admitted patients) and other services are funded using an episode approach (admitted patients). The fit-for-purpose approach would be tailored to reflect the likely wide spectrum of needs that will be expressed in the unified aged care at home program from low (53.4% of CHSP consumers used only one service type in 2018/19) to high (47% of consumers in HCP received a Level 3 or 4 package in 2018/19). Thus, the response by the unified aged care at home program is proportionate to the expressed need and the resources needed to

meet that need (i.e. a risk-based approach to the ACF model that optimises the use of available resources).

The technical features of the mixed model would be similar to those used in the service event and episode level approaches described above. The difference is that they would be applied to the subset of unified aged care at home program consumers that is most appropriate based on need/risk/likely resource use. As explained when discussing the proportionate assessment model, determining the circumstances (thresholds) for consumers switching from a service event to an episode level approach will be a key feature of the mixed model option.

#### **5.4 EVALUATION OF ASSESSMENT MODEL OPTIONS**

This section presents the evaluation against the criteria for the proportionate assessment model (A1) used in Options 1 (refer to section 5.3.1) and Option 3 (refer to section 5.3.3) and the all consumers assessed model (A2) used in Option 2 (refer to section 5.3.2).

##### **5.4.1 *Proportionate assessment (A1)***

Table 5.1 presents the score and rationale against each evaluation criteria for the proportionate assessment model.

**Table 5.1: Evaluation scoring for the proportionate assessment model**

<b>Evaluation criterion</b>	<b>Score</b>	<b>Rationale</b>
Provide equity of access, regardless of location, means or specific needs (e.g. cultural needs, vulnerable consumers)	9	Allows flexibility for GPs and other health professionals to be involved in screening/triage, as all consumers do not need to be assessed by the assessment workforce. Allows access to assessment via a variety of modes including face-to-face and electronic. Improves choice for consumers (i.e. do not require full assessment to access low need/low resource services). De-novo assessment instrument design includes focus on consumers with specific cultural needs or vulnerabilities.
Support older peoples' informal care relationships and connections to community	9	Recognises the existence of informal care relationships (informal carers, family, friends) and explicitly provides for assessment of informal carers (using a specific tool) to support sustainability. Provides for services to support the consumer's connections to the community.
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	8	Driven by an integrated assessment tool that enables a graduated approach to assessment from screening/triage only to extended assessment. De novo design will draw on existing best practice assessment tools and focus on building a tool that can determine the most appropriate services to meet the clinical and social support needs of consumers.
Be transparent, easy to understand, administer and navigate	9	Intuitive approach, the greater the need and resource requirement, the more detailed the assessment. Uses digitally enabled assessment tool so that users will only need to navigate those parts of the assessment that are applicable to the individual consumer being assessed. Includes trigger points based on data collected that will dynamically take the user to the next level of assessment where required.
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	9	Explicitly designed to work across the full range of consumer needs from low to high, in contrast to a 'one size fits all' approach to assessment. Provides for re-assessment triggers that include both consumer and provider requested reassessment, as well as (after further development) predictive analytics derived reassessment triggers.
Be capable of being implemented, monitored, and evaluated on an ongoing basis	9	Easier to implement, as it is estimated (note caveats) that over 100,000 aged care at home consumers per year will not need assessment (they access services via screening/triage only). Collection of the MDS for each assessment type (to drive classification and funding), as well as collection of utilisation data at service event and episode level provides strong basis for ongoing program monitoring. Comparison of assessment outcomes with service delivery outcomes will be a valuable tool in evaluation.
Maximise independence, functioning and quality of life for older people to live at home	8	Includes explicit focus on identifying reablement opportunities in the screening/triage and, where undertaken, assessment processes. Assessment model tailored to the identification of the support services that will improve function, as well as best meet care needs, which in turn will be provided in either short-term care or ongoing care packages.
<b>TOTAL</b>	<b>61</b>	<b>Converts to 87/100</b>

#### 5.4.2 All consumers assessed (A2)

Table 5.2 presents the score and rationale against each evaluation criteria for the all consumers assessment model.

**Table 5.2: Evaluation scoring for the all consumers assessed model**

<b>Evaluation criterion</b>	<b>Score</b>	<b>Rationale</b>
Provide equity of access, regardless of location, means or specific needs (e.g. cultural needs, vulnerable consumers)	7	Includes flexibility for GPs and other health professionals to be involved in screening/triage, however all consumers will need to progress to assessment by the assessment workforce. Allows access to assessment via a variety of modes including face-to-face and electronic. Also allows short-term access to a limited range of services pending assessment. De-novo assessment instrument design includes focus on consumers with specific cultural needs or vulnerabilities.
Support older peoples' informal care relationships and connections to community	9	Recognises the existence of informal care relationships (informal carers, family, friends) and explicitly provides for assessment of informal carers (using a specific tool) to support sustainability. Provides for services to support the consumer's connections to the community.
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	7	Driven by a standard assessment tool that is applied to all consumers (noting that some parts may not be applicable). De-novo design will draw on existing best practice assessment tools and focus on building a tool that can determine the most appropriate services to meet the clinical and social support needs of consumers.
Be transparent, easy to understand, administer and navigate	8	All consumers undergo same assessment process, so easy to understand. Use digitally enabled assessment tool that will make data to drive classification and funding systems easy to collect. May result in redundant work and data as even low need/low resource use consumers will undergo assessment.
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	9	Assessment process is standardised so the response to changing care needs will be the same for all consumers. Includes provision for re-assessment triggers that will allow both consumer and provider requested reassessment, as well as (after further development) predictive analytics derived reassessment triggers.
Be capable of being implemented, monitored, and evaluated on an ongoing basis	7	Resource intensive to implement, as all aged care at home consumers will need assessment (it is estimated (note caveats) that following screening/triage more than 100,000 extra consumers need to be assessed each year relative to the proportionate assessment model). Collection of the MDS for assessment (to drive classification and funding), as well as collection of utilisation data at service event and episode level provides strong basis for ongoing program monitoring. Comparison of assessment outcomes with service delivery outcomes will be a valuable tool in evaluation.
Maximise independence, functioning and quality of life for older people to live at home	8	Includes explicit focus on identifying reablement opportunities in the screening/triage and assessment processes. Assessment model tailored to the identification of the support services that will improve function, as well as best meet care needs, which in turn will be provided in episode level short-term care or ongoing care packages.
<b>TOTAL</b>	<b>55</b>	<b>Converts to 79/100</b>

### 5.4.3 Comparison

As shown in Table 5.1 and Table 5.2, the proportionate assessment option is ranked higher than the all consumers assessed option (87 compared to 79 out of 100). Table 5.3 provides some insight into the difference by directly comparing the scores against each criterion. Proportionate assessment scores better on the equity of access criteria (largely because a significant group of consumers do not need to be assessed to obtain access to support services), whereas the all consumers assessed option is considered to increase the risk of delays in access to support services due to waiting lists forming for access to the assessment service.

**Table 5.3: Comparison of proportionate assessment and all consumers assessed evaluation scores**

Evaluation criterion	Evaluation Scores	
	Proportionate Assessment	All consumers assessed
Provide equity of access, regardless of location, means or specific needs (e.g. cultural needs, vulnerable consumers)	9	7
Support older peoples' informal care relationships and connections to community	9	9
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	8	7
Be transparent, easy to understand, administer and navigate	9	8
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	9	9
Be capable of being implemented, monitored, and evaluated on an ongoing basis	9	7
Maximise independence, functioning and quality of life for older people to live at home	8	8
<b>TOTALS</b>	<b>61 (87/100)</b>	<b>55 (79/110)</b>

The other major difference in scoring is for the implementation related criterion, where proportionate assessment again scores better. The principal reason for the difference is the fact that under proportionate assessment, it is estimated (note caveats) that somewhere in excess of 100,000 unified aged care at home consumers each year will be able to access support services (including ongoing care) directly via screening/triage. The proportionate assessment approach will therefore result in fewer resources needed to implement the assessment model.

## 5.5 EVALUATION OF CLASSIFICATION MODEL OPTIONS

This section presents the evaluation against the criteria for the service event level classification model (C1) used in Option 1, the episode level classification model (C5A) used in Option 2 and the mixed service event and episode level classification model (C5B) used in Option 3.

### 5.5.1 Service event level classification (C1)

Table 5.4 presents the score and rationale against each evaluation criteria for the service event level classification model.

**Table 5.4: Evaluation scoring for the service event level classification model**

<b>Evaluation criterion</b>	<b>Score</b>	<b>Rationale</b>
Support older peoples' informal care relationships and connections to community	4	No specific provision in the classification system for supporting informal care relationships and connections to the community, relies on the assessment process determining such needs and the development and execution of a care plan by a care coordinator or provider that includes relevant support services to meet the needs.
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	4	No specific provision in the classification system for supporting the delivery of evidence-based care, relies on the assessment process making a determination of what evidence-based care is needed and the development and execution of a care plan by a care coordinator or provider that includes relevant support services to meet the needs.
Be transparent, easy to understand and navigate	9	Classification is only by service type, so easy to understand. Requires collection of data on every service delivered, which is a logical extension to current approach, particularly for CHSP.
Support diversity and choice, and encourage innovation in service delivery	5	No specific provision in the classification system to support diversity and choice or innovation in service delivery. But care coordinators and/or service providers will not be inhibited by the classification system from offering choice to consumers or innovating via the development of care plans and the delivery of services.
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	5	No specific provision in the classification system for prediction of care needs or response to change in care needs. But care coordinators and/or service providers will not be inhibited by the classification system from predicting and/or responding to changes in care needs.
Be capable of being implemented, monitored and evaluated on an ongoing basis	8	Requires fewer resources to develop the classification system, so easier to implement. Can be monitored and evaluated at the service type level, no direct connection to consumer characteristics in the classification system.
Identifies the need/cost/risk groups in the community	3	Classification is based on service types, so no direct connection to consumer need/risk/cost groups.
<b>TOTAL</b>	<b>38</b>	<b>Converts to 54/100</b>

### 5.5.2 Fit-for-purpose classification – episode level (C5A)

Table 5.5 presents the score and rationale against each evaluation criteria for the fit-for-purpose classification model at episode level.

**Table 5.5: Evaluation scoring for the fit-for-purpose classification – episode level**

<b>Evaluation criterion</b>	<b>Score</b>	<b>Rationale</b>
Support older peoples' informal care relationships and connections to community	8	Classification system specifically provides for classes for informal carer episodes. The TSBs associated with the episode classes can make explicit provision for services to support consumers' connections to the community.
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	8	The use of TSBs associated with the episode class is an explicit mechanism to tie the classification system to evidence-based care according to individual need. There is provision for the inclusion of services to address clinical and non-clinical care needs as part of developing the TSBs.
Be transparent, easy to understand and navigate	7	The episode level idea is easy to understand but episode and service event level data collection is required, which adds complexity relative to a service event-based classification system.
Support diversity and choice, and encourage innovation in service delivery	8	The classification system design process will specifically take account of diversity in developing the classes (in both the analysis of empirical data and in the development of TSBs). Choice will be enabled by allowing some variation between the services delivered to a consumer and the TSB for the episode class. Allowing variation will also create scope for service providers to innovate, and the built-in refinement of the classification system will reflect those innovations.



Evaluation criterion	Score	Rationale
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	6	Using episode-based classes for low need/low resource use consumers may be difficult. The use of potentially parallel ongoing care and reablement episodes and classes provides a mechanism (the use of short-term episodes) for directly responding to changing care needs. Close alignment with the reassessment policy will provide the mechanism for changing classes to reflect changed care needs.
Be capable of being implemented, monitored and evaluated on an ongoing basis	7	Requires mixed empirical data collection and expert panel process to develop the classification system, hence more time and resources (relative to service event-based classification), so more difficult to implement. Provides a basis for monitoring and both service event and episode levels and a powerful connection between consumer characteristics and services used, which forms the basis for evaluation and ongoing refinement of the classification system.
Identifies the need/cost/risk groups in the community	9	Specifically designed to define classes based on consumers with similar needs/costs/risks. Classes need to be updated periodically using the monitoring and evaluation data to ensure currency with evolving needs/risks/costs.
<b>TOTAL</b>	<b>53</b>	<b>Converts to 76/100</b>

### 5.5.3 Fit-for-purpose classification – mixed service event and episode level (C5B)

Table 5.6 presents the score and rationale against each evaluation criteria for the mixed service event and episode level classification model.

**Table 5.6: Evaluation scoring for the fit-for-purpose classification – mixed service event and episode level**

Evaluation criterion	Score	Rationale
Support older peoples' informal care relationships and connections to community	8	Classification system specifically provides for classes for informal carer episodes. For consumers who undergo assessment, the TSBs associated with the episode classes can make explicit provision for services to support consumers' connections to the community. Low need/low resource use consumers can have services to support connections to the community included in their care plan and classified by service type (e.g. transport).
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	8	For consumers who undergo assessment, the use of TSBs associated with the episode class is an explicit mechanism to tie the classification system to evidence-based care according to individual need (TSBs will provide for services to address clinical and non-clinical care needs). Low need/low resource use consumers will have their services well matched to need through screening/triage only.
Be transparent, easy to understand and navigate	7	Classifying low risk/low resource need consumers using service events only simplifies system for the 40% of clients accessing services via screening/triage. The episode level idea is easy to understand but episode and service event level data collection is required, which adds complexity relative to an only service event-based classification system.
Support diversity and choice, and encourage innovation in service delivery	7	For consumers who undergo assessment, the classification system design process will specifically take account of diversity in developing the classes (in both the analysis of empirical data and in the development of TSBs). Choice will be enabled by allowing some variation between the services delivered to a consumer and the TSB for the episode class. Allowing variation will also create scope for service providers to innovate, and the built-in refinement of the classification system will reflect those innovations. For low/need/low resource use consumers care coordinators and/or service providers will not be inhibited by the service event classification system from offering choice to consumers or innovating via the development of care plans and the delivery of services.

Evaluation criterion	Score	Rationale
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	9	The low need/low resource end of the continuum of care is better reflected by the simpler service event-based classification approach. The use of potentially parallel ongoing care and reablement episodes and classes provides a mechanism (the use of short-term episodes) for directly responding to changing care needs. Close alignment with the reassessment policy will provide the mechanism for changing classes to reflect changed care needs.
Be capable of being implemented, monitored and evaluated on an ongoing basis	7	Requires mixed empirical data collection and expert panel process to develop the mixed classification system, hence more time and resources (relative to the other two options), so more difficult to implement. Provides a basis for monitoring and both service event and episode levels. For consumers who undergo assessment, provides a powerful connection between consumer characteristics and services used, which forms the basis for evaluation and ongoing refinement of the episode level classification system.
Identifies the need/cost/risk groups in the community	8	For consumers who undergo assessment, specifically designed to define classes based on similar needs/costs/risks groups. Classes need to be updated periodically using the monitoring and evaluation data to ensure currency with evolving needs/risks/costs.
<b>TOTAL</b>	<b>54</b>	<b>Converts to 77/100</b>

#### 5.5.4 Comparison

As shown in Table 5.4 to Table 5.6, the service event level classification ranks much lower than the two fit-for-purpose options (54 compared to 76 and 77 out of 100). Table 5.7 provides insight into the difference by directly comparing the scores against each criterion. It shows that the service event level classification option performs poorly on all criteria except the ease of understanding and implementation related criteria (it is simpler than the other two). For the other criteria, the absence of a clear link between the classification system and the needs of consumers accessing the unified aged care at home program, as described by their individual characteristics, results in low scores. This scoring is consistent with best practice in classification system design, which prefers classification based on consumer characteristics rather than service delivery characteristics. In effect the agreed evaluation criteria quite strongly bring out that preference for best practice.

**Table 5.7: Comparison of the three classification model options evaluation scores**

Evaluation criterion	Evaluation scores		
	Service event level	Episode level	Mixed service event and episode level
Support older peoples' informal care relationships and connections to community	4	8	8
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	4	8	8
Be transparent, easy to understand and navigate	9	7	7
Support diversity and choice, and encourage innovation in service delivery	5	8	7
Provide for a continuum of care that is dynamic and predictive to account for changing care needs; and be able to respond to consumers in a timely manner	5	6	9

Evaluation criterion	Evaluation scores		
	Service event level	Episode level	Mixed service event and episode level
Be capable of being implemented, monitored and evaluated on an ongoing basis	8	7	7
Identifies the need/cost/risk groups in the community	3	9	8
<b>TOTALS</b>	<b>38 (54/100)</b>	<b>53 (76/100)</b>	<b>54 (77/100)</b>

For the two fit-for-purpose options, the evaluation scores are very similar. The biggest difference is in the continuum of care related criterion, where the mixed service event and episode level option scores higher. This higher scoring is because service event level classification is better suited to the low need/low resource end of the continuum of care spectrum. The use of an episode level classification for these consumers is considered clumsy, as they access only one or two service types, and often not in large volumes. The need to collect the data for episode level classification makes it much harder to respond dynamically to changing care needs. In most other respects, the two models score very close, noting that TSBs would be used for all consumers in the episode level model but only for those consumers classified at the episode level for the mixed model.

## 5.6 EVALUATION OF FUNDING MODEL OPTIONS

This section presents the evaluation against the criteria for the service event level funding model (F1) used in Option 1, the episode level funding model (F2) used in Option 2, and the mixed service event and episode level funding model (F3) used in Option 3.

### 5.6.1 Service event level funding (F1)

Table 5.8 presents the score and rationale against each evaluation criteria for the service event level funding model, noting that it is assumed that this option is used in conjunction with service event level classification.

**Table 5.8: Evaluation scoring for service event level funding with service event classification**

Evaluation criterion	Score	Rationale
Support older peoples' informal care relationships and connections to community	6	Relies on the assessment process determining the needs for supporting informal career relationships and connections to the community and the development and execution of a care plan by a care coordinator or provider that includes relevant support services to meet the needs. Service events provided in accordance with the plan will be funded (subject to any cap that may be used).
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	5	Relies on the assessment process determining what evidence-based care is needed and the development and execution of a care plan by a care coordinator or provider that includes relevant support services to meet the needs. Service events provided in accordance with the plan will be funded (subject to any cap that may be used).

Evaluation criterion	Score	Rationale
Is equitable, efficient (with reference to the efficient cost of service delivery) and supports timely delivery of quality support services	6	Relies on care coordinator or provider developing and executing a care plan that reflects equitable service provision; note consumers with similar needs may receive quite different mix of service. Promotes efficiency at the service event level (by using a price schedule based on efficient cost), but no efficiency incentive at consumer level. No explicit features to support timely delivery of quality support services, but no inhibitors either.
Be transparent, easy to understand and administer	9	Every service delivered would be paid (subject to any cap), so easy to understand. Requires billing at service event level (aggregate monthly billing is possible), but this is a logical extension of what happens now, particularly for HCP.
Support diversity and choice, and encourage innovation in service delivery	5	No specific provision in the payment model to support diversity and choice or innovation in service delivery. But care coordinators and/or service providers will not be inhibited by the payment model from offering choice to consumers or innovating via the development of care plans and the delivery of services.
Be affordable and sustainable	8	Payment model itself will not determine affordability and sustainability. Service event prices will be set with reference to efficient costs, but the actual payment to providers will be determined by Government policy on funds available and any required consumer co-payments.
Provide a continuum of care that is dynamic and predictive to account for changing care needs	5	No specific provision in the payment model for prediction of care needs or response to change in care needs. But where care coordinators and/or service providers predict and/or respond to changes in care needs in care planning and service delivery, the associated support services will be paid (subject to any caps).
Be capable of being implemented, monitored and evaluated	7	Requires fewer resources to develop the payment model, so easier to implement. Costing study will be required to set prices (required in all options). The data generated by operating the funding model will allow monitoring and evaluation at the service type level but there is no direct connection between payment and consumer characteristics so evaluation of effectiveness at the consumer level is inhibited.
Provide certainty for government, providers and consumers	7	The payment model itself will not provide this certainty. Certainty for government is best assured by using a funding cap at individual consumer level and an effective monitoring process that demonstrates allocated funds are being used optimally to achieve the program objectives. The process for setting the funding cap needs to assure consumers that they will be allocated enough resources to receive the services they need. Providers need to be confident that they payment amounts will enable them to provide the services required to meet consumer's needs.
<b>TOTAL</b>	<b>58</b>	<b>Converts to 64/100</b>

### 5.6.2 Episode level funding (F2)

Table 5.9 presents the score and rationale against each evaluation criteria for the episode level funding model, noting that is assumed that this option is used in conjunction with episode level classification model.

**Table 5.9: Evaluation scoring for episode level funding with fit for purpose classification – episode level**

Evaluation criterion	Score	Rationale
Support older peoples' informal care relationships and connections to community	8	Funding model will directly pay for informal carer episodes (there will be episode classes in the classification system). The TSBs associated with the episode classes will have explicit provision for services to support consumers' connections to the community, which will be reflected in the payment amount.

Evaluation criterion	Score	Rationale
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	8	Basing the RVU (which determines the payment amount) on the TSBs associated with each episode class is an explicit mechanism in the funding model to tie payment to the provision of evidence-based care according to individual need. Allowing TSBs to include services to address clinical and non-clinical care needs means that payment is better aligned to consumer preferences and holistic care.
Is equitable, efficient (with reference to the efficient cost of service delivery) and supports timely delivery of quality support services	8	Using TSBs is likely to result in more equitable outcomes as consumers with similar needs/risks will be allocated funding to receive quite similar bundles of service. Promotes efficiency at the consumer level by using RVUs developed with reference to actual service delivery cost and the optimal mix of services determined by the TSB. No explicit features to support timely delivery of quality support services, but no inhibitors either.
Be transparent, easy to understand and administer	7	Episode level payment is a well understood concept. Could be based on billing at service event level (aggregate monthly billing is possible) up to the fee level determined by the episode class, but this is a logical extension of what happens now, particularly for HCP. Could also be based on monthly billing using the RVU and price for the episode class.
Support diversity and choice, and encourage innovation in service delivery	8	Funding model will pay for episodes where the classification system takes account of diversity in determining the class. It will enable choice by paying for services even if there is some variation (limits to be determined) between the services delivered to a consumer and the TSB for the episode class. Paying for variation will also create scope for service providers to innovate, and the built-in refinement of the funding model will reflect those innovations.
Be affordable and sustainable	8	Funding model itself will not determine affordability and sustainability. The prices for episode classes will be set with reference to efficient costs and expert determined TSBs, but the actual payment to providers will be determined by Government policy on funds available and any required consumer co-payments.
Provide a continuum of care that is dynamic and predictive to account for changing care needs	7	Using episode payments for low need/low resource use consumers adds some complexity. Funding model will pay for parallel ongoing care and short-term (reablement) episodes, thereby providing a mechanism to fund responses to changing care needs. Application of the reassessment policy will provide the mechanism for changing classes to reflect changed care needs, which will then be funded using the new episode class.
Be capable of being implemented, monitored, and evaluated	7	Episode level funding model is easy to implement once the classification system has been developed. Costing study will be required to determine RVUs and set prices (required for classification development in any case). The data generated by operating the funding model will allow monitoring and evaluation at the service type and episode levels. It directly connects payment to consumer characteristics to enable evaluation of effectiveness at the consumer level.
Provide certainty for government, providers, and consumers	8	The use of episode-based payments improves certainty. For government, the RVU and price for each episode represent a funding cap at the individual consumer level and the TSBs provide some assurance that allocated funds are being used optimally to achieve the program objectives. The process for setting the funding cap needs to assure consumers that they will be allocated enough resources to receive the services they need. The funding level for each episode will be known to providers to enable them to develop models to provide the services required to meet consumer's needs.
<b>TOTAL</b>	<b>69</b>	<b>Converts to 77/100</b>

### 5.6.3 Mixed service event and episode level funding

Table 5.10 presents the score and rationale against each evaluation criteria for the mixed service event and episode level funding model, noting that is assumed that this option is used in conjunction with the mixed service event and episode level classification model.

**Table 5.10: Evaluation scoring for mixed service event and episode level funding with fit for purpose classification**

Evaluation criterion	Score	Rationale
Support older peoples' informal care relationships and connections to community	8	Funding model will directly pay for informal carer episodes (there will be episode classes in the classification system). For consumers who undergo assessment, the TSBs associated with the episode classes will have explicit provision for services to support consumers' connections to the community, which will be reflected in the payment amount. Low need/low resource use consumers can have services to support connections to the community included in their care plan and funded on a service event basis.
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	8	For consumers who undergo assessment, basing the RVU (which determines the payment amount) on the TSBs associated with each episode class is an explicit mechanism in the funding model to tie payment to the provision of evidence-based care according to individual need. Allowing TSBs to include services to address clinical and non-clinical care needs means that payment is better aligned to consumer preferences and holistic care. Low need/low resource use consumers can have evidence-based services included in their care plan and funded on a service event basis.
Is equitable, efficient (with reference to the efficient cost of service delivery) and supports timely delivery of quality support services	8	For consumers who undergo assessment, using TSBs is likely to result in more equitable outcomes as consumers with similar needs/risks will be allocated funding to receive quite similar bundles of service. Episode funding promotes efficiency at the consumer level by using RVUs developed with reference to actual service delivery cost and the optimal mix of services determined by the TSB. For low need/low resource use consumers, service event level funding promotes efficiency at the service event level (by using a price schedule based on efficient cost). Funding model has no explicit features to support timely delivery of quality support services, but no inhibitors either.
Be transparent, easy to understand and administer	8	For consumers who undergo assessment, episode level payment is a well understood concept. Could be based on billing at service event level (e.g. using aggregate monthly billing) up to the fee level determined by the episode class (a logical extension of what happens now for HCP). Could also be based on monthly billing using the RVU and price for the episode class. For low need/low resource use consumers, service event level funding is also easy to understand. Every service delivered would be paid (subject to any cap). Requires billing at service event level (aggregate billing possible).
Support diversity and choice, and encourage innovation in service delivery	7	For consumers that undergo assessment, the episode funding model will pay for episodes where the classification system uses diversity in allocating the class. It will enable choice by paying for services even if there is variation (limits to be determined) between the services delivered and the TSB for the episode class. Paying for variation will also create scope for service providers to innovate, and the built-in refinement of the funding model will reflect the innovations. For low need/low resource use consumers, the service event level funding model will not inhibit care coordinators and/or service providers from offering choice to consumers or innovating via the development of care plans and the delivery of services.
Be affordable and sustainable	8	Funding model itself will not determine affordability and sustainability. The prices for episode classes will be set with reference to efficient costs and expert determined TSBs. The prices for service events will be set with reference to efficient costs. The actual payment to providers will be determined by Government policy on funds available and any required consumer co-payments.
Provide a continuum of care that is dynamic and predictive to account for changing care needs	8	Using service event level funding to make payments for low need/low resource use consumers is better suited to the lower end of the service continuum. For consumers who undergo assessment, the funding model will pay for parallel ongoing care and short-term (reablement) episodes, thereby providing a mechanism to fund responses to changing care needs. Application of the reassessment policy will provide the mechanism for changing classes to reflect changed care needs, which will then be funded using the new episode class.

Evaluation criterion	Score	Rationale
Be capable of being implemented, monitored, and evaluated	9	Use of service event level funding for low need/low resource use consumers is simpler than episode funding. For consumers who undergo assessment, episode level funding model is easy to implement once the classification system has been developed. Costing study will be required to determine RVUs and set prices for service event and episode level funding models (required for classification development in any case). The data generated by operating the funding model will allow monitoring and evaluation at the service type and episode levels. For episode funding, payment is directly related to consumer characteristics to enable evaluation of effectiveness at the individual consumer level.
Provide certainty for government, providers, and consumers	7	Use of service event level funding with a funding cap at individual consumer level and an effective monitoring process can demonstrate for Government that the allocated funds are being used optimally to achieve the program objectives. For episode funding, the RVU and price for each episode represent a funding cap at the individual consumer level and the TSBs provide some assurance that allocated funds are being used optimally to achieve the program objectives. The process for setting the funding cap needs to assure consumers that they will be allocated enough resources to receive the services they need. The funding level for service event and episode will be known to providers to enable them to develop models to provide the services required to meet consumer's needs.
<b>TOTAL</b>	<b>71</b>	<b>Converts to 79/100</b>

#### 5.6.4 Comparison

As shown in Table 5.8 to Table 5.10, the service event level funding model ranks lower than the episode level and the mixed service event and episode level models (64 compared to 77 and 79 out of 100). Table 5.11 compares the evaluation scores for the three models for each criterion. It shows that the service event level funding model scores lower (sometimes equal) on most criteria except the ease of understanding related criterion (service event level funding is simpler). For several, the absence of a clear link between the funding model and the needs of consumers accessing the unified aged care at home program, results in low scores. This is particularly the case for the criterion that relates to matching care to needs (left to providers, no mechanism in funding model), the equity criterion (greater risk of consumers with similar needs receiving different packages of services) and the criterion on diversity and choice and encouraging innovation (again left to providers, no mechanism in funding model).

**Table 5.11: Comparison of the three funding model options evaluation scores**

Evaluation criterion	Evaluation scores		
	Service event level	Episode level	Mixed service event and episode level
Support older peoples' informal care relationships and connections to community	6	8	8
Deliver evidence-based care according to individual need including considering clinical and non-clinical care needs (such as social supports)	5	8	8
Is equitable, efficient (with reference to the efficient cost of service delivery) and supports timely delivery of quality support services	6	8	8
Be transparent, easy to understand and administer	9	7	8
Support diversity and choice, and encourage innovation in service delivery	5	8	7
Be affordable and sustainable	8	8	8

Evaluation criterion	Evaluation scores		
	Service event level	Episode level	Mixed service event and episode level
Provide a continuum of care that is dynamic and predictive to account for changing care needs	5	7	8
Be capable of being implemented, monitored and evaluated	7	7	9
Provide certainty for government, providers and consumers	7	8	7
<b>TOTALS</b>	<b>58 (64/100)</b>	<b>69 (77/100)</b>	<b>71 (79/100)</b>

Similar to the classification system scoring, the episode level and the mixed service event and episode level funding models have comparable scores. The biggest difference is in the implementation related criterion, where the use of service event level funding (simpler) for low needs/low resource use consumers results in the mixed model receiving a higher score. Also, the use of an episode level funding for these consumers is considered overly complex, so again the mixed model receives a slightly higher score on the easy to understand and administer criterion. There is also a small difference with respect to the ability to 'respond dynamically to changing care needs' criterion. The mixed model makes it simpler to respond to low need/low resource use consumers, noting the parallel episode idea applies to both models for consumers with higher care needs. In most other respects, the two models score very close, noting that TSBs would be used for all consumers in the episode level funding model but only for those consumers funded at the episode level for the mixed model.

## 5.7 DETERMINE PREFERRED OPTION

Drawing on the scores for each of the choices made for the components of the ACF model, Table 5.12 presents the overall evaluation scores for each Options 1 to 3, which informs the selection of a preferred option.

**Table 5.12: Consolidated scoring – all three options**

Option number	Assessment Component		Classification Component		Funding Component		Total Score
	Model	Score	Model	Score	Model	Score	
Option 1	Proportionate assessment	87	Service event-based	54	Service event level	64	205
Option 2	All consumers assessed	79	Fit-for purpose – episode	76	Episode payment	77	232
Option 3	Proportionate assessment	87	Fit-for purpose – mixed service event and episode	77	Mixed service event and episode	79	243

The scores reflect a preference for Option 3, that results from the additional tailoring that has been done to fit the ACF model to desired program goals and objectives. Specifically, Option 3 allows for:

- An assessment model that tailors the level of assessment to the level of a consumer's need/expected resource use (i.e. a risk-based approach that optimises the use of the available assessment resources).



- A classification model that allows a consumer to be in more than one class concurrently, which provides flexibility to mix ongoing care episodes with short-term episodes to dynamically respond to changes in consumers' care needs.
- A classification model that uses the development of TSBs, as the mechanism for identifying the set of support services that will best meet the needs of consumers in each class (as determined by the consumers' characteristics).
- A funding model that uses the simplicity of service event funding for consumers with lower needs/expected resource use, thereby not tying up resources in the more comprehensive episode approach for the lower risk consumers.
- A funding model that incentivises the use of TSBs to maximise the alignment between support services delivered and support services needed, as determined by the independent assessment process.
- A classification and funding approach that explicitly creates and funds reablement episodes separate to ongoing episodes (either on entry of a consumer to the unified aged care at home program or in response to a change in care needs while the consumer is in an ongoing care episode) thereby creating a significant opportunity for the emergence of providers specifically focused on reablement care.

The preferred option provides a sound and clear basis for proceeding with the development of the ACF model for the unified aged care at home program. It is the result of careful consideration and evaluation of the alternatives.

## **5.8 PRELIMINARY CONSIDERATION OF IMPLEMENTATION AND TRANSITION ISSUES FOR THE PREFERRED OPTION**

There are a range of implementation and transition issues potentially associated with the proposed ACF model. This preliminary discussion of the possible impacts of the preferred option on the key stakeholder groups is presented in the context that any significant change in the ACF model for aged care at home services has potential risks and benefits. Many of these risks and benefits will be better understood towards the end of the phase two work once the components of the ACF model have been developed and tested.

### **5.8.1 Impact on consumers**

Consumers should experience improvements in access to support services from the unified program. It is estimated (noting the caveats) that more than 100,000 consumers each year will be able to access short term or ongoing care (for a defined range of service types) directly from screening/triage, without the need for further assessment. As well as determining the need for assessment, the screening/triage protocol will be designed to include tools to identify consumers where there is the potential for functional gain. These consumers will be referred to a reablement focussed assessment that may result in a package of short-term care to realise the functional gain opportunity. Reablement care may be provided before any need for ongoing care is determined or may be provided in parallel with ongoing care.

An important feature of the classification and funding systems is the development of TSBs for each episode class. By determining the set of services to be provided to a consumer with reference to the TSB associated with their assigned class, equity will be improved. Specifically, it will be much more likely that consumers with similar needs will be offered similar resources (service bundles). Consumers will be able to exercise choice and

control by varying the offered TSBs within guidance that ensures that service bundles provided directly address assessed needs. There may be funding incentives for matching services provided to need thereby optimising resource use in the unified aged care at home program.

The funding model will enable consumers to exercise choice regarding their service provider and/or fundholder/authoriser. Consumers may be able to use a single provider (that may also be the fundholder), or they may elect to engage a care coordinator (or equivalent) as the fundholder/authoriser (much more likely if they choose to use multiple providers). For consumers who wish to, there will be the option of self-managing their care and hence allocated funds. These fundholder/authoriser options will be enabled by systems developed to support the new funding model.

Further research and consultation with consumers and carers (and their representatives) should also be undertaken to inform the design of the unified program enabling the implementation of the ACF model to ensure that the benefits to consumers are optimised and realised.

### **5.8.2 Impact on the provider sector**

Providers of aged care at home services will need to enhance their systems to collect the data required by the MDSs. Financial system changes will be required to adjust to output based funding, including billing for services delivered (either for individual consumers or a monthly combined bill for all consumers receiving a funded service). Generating and analysing such data should assist service providers in adapting their financial management practices to the new funding arrangements. Importantly the funding model will feature adjustments that recognise unavoidable costs associated with some consumers (e.g. diverse needs) and service characteristics (e.g. remote location), which could improve providers' financial position.

Various mechanisms in the classification and funding models will see providers receive funding that is better aligned with consumer needs and services delivered. Such changes could create challenges for providers, particularly in circumstances where there is not close alignment. The use of TSBs will give providers certainty about the level of services that will be funded for consumers in each classification system class, while enabling them some flexibility to tailor services to address the specific circumstances of a consumer. For some providers, that may be less flexibility than they have now. However, providers may be able to access funding incentive payments to closely align services delivered with the needs-based TSBs.

The use of a proportionate assessment approach will ensure that resources are better utilised, with the screening/triage and assessment response being proportional to the need/risk/resources associated with the consumer. This risk-based approach should maximise the funding available for the delivery of support services (recognising that in many circumstances, assessment is a service in its own right). It should also ensure that optimal use is made of the available screening/triage and assessment workforce. Costs will be incurred to train the workforce engaged in screening/triage and assessment in the use of new tools, particularly the consistent application of the threshold for requiring assessment.

The ACF model should create various opportunities for providers to innovate. Funding the delivery of short-term care alongside ongoing care removes the perverse incentives associated with providing reablement or restorative services to consumers, thereby reducing their needs for ongoing care and hence the funding available to the provider. In contrast, explicitly providing for short-term care should create an opportunity for providers to emerge that specialise in reablement or restorative services. Similarly, the new ACF model potentially creates opportunities for providers to specialise in providing support to informal carers (e.g. coaching or psychological support).

Finally, the new ACF model may impact on providers outside the aged care sector. A key consideration that was outside the scope of the ACF model development work (it is being addressed as part of the design of the unified aged care at home program) is the workforce that will be authorised to undertake screening/triage, which may include the specialised aged care workforce but may also include other health professionals such as GPs.

### **5.8.3 Impact on Government**

The project has been conducted in parallel with a range of other projects and initiatives that will impact on the final design of the unified aged care at home program. The final program design will also be determined by the recommendations and findings of the Royal Commission. Drawing on all this work, various policy and program development matters for the unified program will need to be determined by Government, such as service inclusions and exclusions, and program financing policy (including co-payment policy). These decisions will be key to finalising ACF model parameters and allowing robust forward estimates of service utilisation and program expenditure to be made. That process will lead to a better understanding of risks and the development of a more detailed plan for transition to the new ACF model that features a risk mitigation and management strategy.

There will also be impacts on the data that needs to be collected by Government for the unified program. MDSs will be designed for all aspects of the ACF model that need to be collected routinely to enable program monitoring, and evaluation and refinement of the classification and funding models. Data collection systems will need substantial redevelopment to accommodate these new MDSs. There will also be a need for the periodic collection of data on service delivery costs to enable the RVUs associated with the classification systems to reflect current practices. This same data could also be used to revise price schedules associated with the funding model. Collection frequency needs to be determined but it is suggested that given the dynamic nature of the aged care at home system every two to three years would be appropriate.

Government will also need to redevelop transaction processing systems used in making payments for services delivered. The proposed ACF model envisages payment on an output basis (service events and episodes), so existing systems that are based on grant funding and/or funding to the level of the financial cap in the approved package would not be suitable. There are a range of possibilities for how the systems are developed, particularly if various fundholding/authorising models are going to be enabled. Significant system development costs are likely to be incurred.

Government will need to take a lead role in sector readiness and transition to the new arrangements. Significant work will be required to provide the legal and system enablers to implement the ACF model, such as enabling legislation and ICT systems.

### **5.8.4 Transition arrangements**

Should Government decide to proceed in developing the preferred option, the next step in the process would be to formulate and execute a development and testing plan for the preferred ACF model. This work would include the development of the assessment model (including digitised versions of the assessment instrument); the development of the classification system (including the supporting software) and the development of the funding model (including the initial pricing schedules for service events and episodes). A significant empirical data collection involving providers of aged care at home services would form a key part of this work. Approximately 15 months would be required to undertake the development and testing work. A trial of the ACF model infrastructure should then be considered, prior to finalising the ACF model components ready for implementation.

As part of the development and testing work, a comprehensive transition plan would need to be developed to mitigate and manage the risks associated with a change of the magnitude envisaged. The transition plan would also need to identify a process for ensuring that benefits are realised. An important part of that plan should be workforce development, to ensure that the integrated assessment tool (which will include the screening/triage protocol) can be applied consistently. Training will be needed to ensure that consumers with similar needs and characteristics are channelled in a consistent fashion through the new ACF model for the unified aged care at home program, without creating barriers to service access.

There will also be a need for the transition plan to address the significant systems development work that will be required to implement the new ACF model. As discussed above, there will need to be substantial redevelopment of data collection and storage systems to collect, store and report on the MDSs that will be created for assessment and service delivery. Redevelopment of government and provider financial systems will also be required to support application of the new funding model. Some of this work could be done in parallel with the phase two work on the development and testing of the ACF model, but there will also be considerable work required once the ACF model is finalised.

## Appendix A : Stakeholders consulted

### A.1 STAKEHOLDER LIST

Table A.1: List of stakeholders consulted throughout the project

Name	Role	Organisation	First round stakeholder consultation	Second round stakeholder consultation
Dr Anna Howe	Honorary Professor	Department of Sociology, Macquarie University	✓	✓
Pat Sparrow	CEO	Aged and Community Services Australia	✓	✓
Professor Kathy Eagar	Director	AHSRI (University of Wollongong NSW)	✓	✓
Nick Mersiades	CEO	Catholic Health Australia	✓	✓
Tim Hicks Troy Speirs	General Manager Policy & Advocacy Senior Policy Advisor	Leading Age Services Australia	✓	✓
Ian Yates -	CEO	Council on the Ageing (COTA)	✓	✓
Paul Ostrowski	CEO	Care Connect	✗	✓
Mary Reid Sue Elderton	Interim CEO National Policy Manager	Carers Australia	✗	✓
Bryan Lipmann	CEO	Wintringham Specialist Aged Care	✗	✓
Sharyn Broer	President	Meals on Wheels Australia	✗	✓
Michael Robinson	General Manager Service Strategy	Australian Unity	✗	✓

## Appendix B : Situation analysis information

### B.1 DOCUMENTS PROVIDED UNDER C.A.2(G) UNDER THE CONTRACT

The following documents were reviewed and considered as input into this project:

- Draft Potential models for Aged Care at Home Program
- Care in the Home – Current State Analysis
- Draft Concept paper (Nov 2019)
- Paper – single unifying system for care of the elderly at home (Jan 2020)
- Draft Review of international home care models
- Draft CHSP data study reports
  - CHSP Draft Report
  - Deloitte Access Economics CHSP Data Study Public Report
  - Section 4.6
- Home Care Packages Program survey utilisation
  - Survey data template and deep dive survey template
  - Deep data dive survey template
- Home Care Provider Survey Report DRAFT (Mar 2020)
- AHA AT Review – Economic Modelling Methods Paper 1
- AHA AT Review – Initial Report (31 Jan 2020)
- Denmark and the Danish Healthcare System
- Royal Commission into Aged Care Quality and Safety - Submissions by the Commonwealth in response to Submissions of Counsel Assisting (Adelaide hearing 4 March 2020) Future aged care program redesign
- EY and Department of Health Aged Care Demand Model - fortnight status (9 Apr 2020)
- AHA Promoting Independent Living Reablement Trial: Findings brief (Apr 2020)

#### ***Royal Commission into Aged Care Quality and Safety<sup>19</sup>***

- Statement of Dr Jane Fischer 29 May 2019 (representative of Palliative Care Australia)
- Perth Hearings (24-28 June 2019): Palliative Care – Common Ground Propositions
- Consultation Paper 1 (6 Dec 2019)
- Relevant stakeholder submissions January 2020
- Research Paper 2 – Review of International Systems of Long-term Care of Older People (Flinders University) (24 Jan 2020)
- Research Paper 3 - Review of Innovative Models of Aged Care (Flinders University) (24 Jan 2020)
- Transcript of proceedings (Adelaide) 10am Wednesday 4 March 2020

<sup>19</sup> Publications released by the Royal Commission into Aged Care Quality and Safety Available at <https://agedcare.royalcommission.gov.au/publications/Pages/default.aspx>

## B.2 AGED CARE IN THE HOME INTERNATIONALLY

Table B.1 summarises key features of international systems for of aged care at home.

**Table B.1: Assessment, classification and funding characteristics of international programs providing care for the elderly at home**

Country	Assessment	Classification	Funding source(s) and mechanism
<p><b>Germany<sup>20</sup></b></p> <p>Home Care (Long Term Care, LTC)</p> <p>All ages with approved needs</p>	<p><b>Initial</b></p> <ul style="list-style-type: none"> <li>LTC insurance funds staff (care advisors) analyse the need of care on the basis of the Medical Advisory Boards guidelines.</li> <li>Assessment tool incorporates need for supervision</li> <li>The new evaluation instrument for determining the need for care comprises six modules that are weighted differently in the final overall score<sup>21</sup>: <ul style="list-style-type: none"> <li>Mobility (10%)</li> <li>Cognitive and communicative abilities (higher value from module 2 and 3, in total 15%)</li> <li>Behaviour and psychiatric problems (higher value from module 2 and 3, in total 15%)</li> <li>Self-care (40%)</li> <li>Dealing with requirements due to illness or therapy (20%)</li> <li>Organisation of everyday life and social contacts (15%)</li> </ul> </li> <li>The amount of care provided depends on the needs of the individual but is limited in value according to the assigned level of dependency and available services included in a pre-defined catalogue</li> </ul> <p><b>Reassessment</b></p> <ul style="list-style-type: none"> <li>The assessment of the need of long-term care has to be repeated regularly every six months.</li> </ul> <p><b>Case management and/or care coordination:</b></p> <p>Care advisors/case managers (mostly nurses) are from LTC insurance funders</p> <p><b>Carer supports</b></p> <ul style="list-style-type: none"> <li>LTC insurance funds must offer training courses for family carers and voluntary carers</li> </ul>	<ul style="list-style-type: none"> <li>A plan for the provision of social benefits and rehabilitation, preventative, curative or other medical, and care based social assistance based on the MDK report.</li> <li>Clients are assessed and classified into one of five levels to determine the level of care needed. Focuses on individual ability to manage in the face of sustained physical, cognitive, or psychological impairments or health-related stresses or requirements<sup>22</sup>. <ul style="list-style-type: none"> <li>PG1 - No need for ADL assistance, but may benefit from general supervision and preventive/ancillary services.</li> <li>PG2 - Need for assistance with personal hygiene, feeding or mobility for at least two activities at least once a day and additional need help in the household several times during the week for at least 90 minutes a day with 45 minutes accounted for basic care.</li> <li>PG3A – PG2 + need for daily supervision</li> <li>PG3B - Need for assistance in at least two basic ADLs at least three times a day at various times and additional help in IADLs several times a week for at least 3 hours a day with 2 hours accounted for basic care.</li> <li>PG4A – PG3B + plus need for daily supervision</li> <li>PG4B - Need for assistance in at least two ADLs around the clock and additional help in IADLs several times during the week for at least 5 hours per day with four hours accounted for basic care.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>LTC insurance (compulsory) for home and residential care is funded by social insurance (fixed percentage of income contribution) and private insurance schemes (age-rated premiums).</li> <li>LTC insurance benefits are not a “core protection”, i.e. they represent basic provision, which may not always cover all requirements in individual cases</li> <li>Clients can choose between cash benefits and personal budgets and in-kind services. (or a combination of cash and in-kind benefits), that is binding for 6 months.</li> <li>LTC funders provide a list with a comparison of services and prices of the facilities in the area.</li> <li>In each Land (state) associations of LTC funds negotiate bilaterally with associations of LTC service providers over payment rates and other contract provisions<sup>22</sup>.</li> <li>LTC funds reimburse authorised service providers or clients who opt to receive benefits in cash pay service providers directly.</li> <li>Benefits paid are differentiated according to the disability levels and the setting in which care is received (care levels)<sup>22</sup> <ul style="list-style-type: none"> <li>Home care – benefits in kind</li> <li>Home care – cash benefit (about half that of benefits in kind)</li> <li>Day and evening care</li> <li>Nursing home care</li> </ul> </li> </ul>

<sup>20</sup> OECD. (2013). A good life in old age?: OECD Publishing. <https://www.oecd.org/els/health-systems/Germany-OECD-EC-Good-Time-in-Old-Age.pdf> Accessed 12 Feb 2020

<sup>21</sup> Link S. Long Term Care Reform in Germany – At Long Last, issue Jul 2019. Available at <http://www.genre.com/knowledge/publications/ri19-8-en.html> Accessed 20Feb2020

<sup>22</sup> Nadash et al, The German Long-Term Care Insurance Program: Evolution and Recent Developments, The Gerontologist, Volume 58, Issue 3, June 2018, Pages 588–597, <https://doi.org/10.1093/geront/gnx018>

Country	Assessment	Classification	Funding source(s) and mechanism
	<ul style="list-style-type: none"> <li>Counselling for persons in need of care and their relatives is provided by case managers</li> <li>Respite care available</li> <li>LTC funders pay public pension and unemployment insurance contributions, health insurance, and LTCI for qualifying caregivers, who must provide at least 14 (from 2017, 10) hours a week of care in the care recipient's home, and be limited in their ability to work due to caregiving responsibilities<sup>22</sup>.</li> </ul>	<ul style="list-style-type: none"> <li>PG5A – PG4B + need for daily supervision</li> <li>PG5B - Need assistance at the PS III level for at least 7 hours a day with at least 2 hours during the night or needing basic care that can only be provided by more than one person simultaneously</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>Home-based care services must be accredited and aligned to a quality management system (ISO, E-Qulin)</li> <li>Indicators related to clinical effectiveness, satisfaction and experience of long-term care services are collected and publicly reported. There is also a national data collection on waiting times for LTC.</li> </ul>	
Belgium <sup>23</sup>  Social care (domestic care and other support)	<p><b>Assessment</b></p> <ul style="list-style-type: none"> <li>Clients initiate a request for LTC services through medical services (e.g. GP), nurse or social worker, who then undertake an assessment.</li> <li>Assistance to Older People (APA)-THAB Guidelines used to guide doctor's assessment (assessment for cash allowance)</li> <li>Patients dependency is assessed by the Belgian Evaluation Scale for Activities of Daily Living (BESADL), which is adapted from the Katz<sup>24</sup> scale. (assessment for nursing care).</li> <li>The tool evaluates the six original domains of the 'Index of ADL': bathing (personal hygiene), dressing, transfer, toileting, continence, and eating (feeding). Each function is scored 1 (no help) to 4 (complete help), a higher score indicating higher dependency<sup>25</sup>.</li> </ul> <p><b>interRAI trial</b></p> <ul style="list-style-type: none"> <li>BelRAI<sup>26</sup> piloted to assess physical, cognitive, psychological and social needs. The BelRAI assessment instruments are based on scientifically validated instruments from interRAI. The interRAI tools also provide validated algorithms that use the collected information to calculate the functioning of the person, their care risks and his strengths and weaknesses. The</li> </ul>	<ul style="list-style-type: none"> <li>APA-THAB Guidelines use a six item ADL and risk awareness scales (0 to 3) to allot points, these points are aggregated into five categories with a maximum cash allowance per year (indexed)</li> <li>BEDSADL assesses six capabilities on a four-scale range and assessment of cognitive states to classify clients into three main categories of dependency - levels A, B, C/dement.</li> <li>The eligibility for and intensity of care (and the corresponding level of financial intervention by the federal health insurance system) is determined using the same criteria as in residential care. Home care services include help with IADLs and personal care, such as cleaning and other domestic tasks. Eligibility depends on the severity of the patient's limitations, which also determines the number of hours of care provided<sup>27</sup></li> </ul> <p><b>Data collection and purpose – BelRAI</b></p> <ul style="list-style-type: none"> <li>BelRAI (adapted from InterRAI standardised assessment instruments) was piloted 2009-11, work</li> </ul>	<ul style="list-style-type: none"> <li>Belgium's public health insurance system (INAMI/RIZIV) provides for comprehensive universal coverage for all cost associated with acquiring assistance for daily activities. This is organised at the federal, regional and municipal levels. This benefit is subject to a personal contribution (income related).</li> <li>Per diem lump sum system covers nursing interventions for patients with deficiencies in the ADL. Fee-for-service system covers technical nursing interventions, which require a doctor's prescription. In order to limit supply-induced care provision in the fee-for service financing, a maximum day-limit was fixed, which equals the smallest lump sum, i.e. for the lowest level of dependency (level A).</li> <li>Level A clients are reimbursed through fee for service-related payments.</li> <li>Level B or C/dement clients are reimbursed through lump sums, a fee for service payment system based on the number of days of care<sup>28</sup>.</li> </ul>

<sup>23</sup> Sermeus W, Pirson M, Paquay L, Paolet J, Falez F, Stordeur S, Leys M. Financing of home nursing in Belgium. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE). 2010. KCE Reports 122C. D/2010/10.273/07

<sup>24</sup> Shelkey, M & Wallace, M. (2000). Katz Index of Independence in ADL. Director (Cincinnati, Ohio). 8. 72-3.

<sup>25</sup> Sermeus et al. Financing of home nursing in Belgium. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE). 2010. KCE Reports 122C. D/2010/10.273/07 Available at <https://kce.fgov.be/sites/default/files/atoms/files/d20101027307.pdf> Accessed 20Feb2020

<sup>26</sup> BelRAI Available at <https://www.belrai.org/nl>

<sup>27</sup> WILLEME P (2010) LTC System for the Elderly in Belgium. ENEPRI Research Report No.70. Available at [www.ceps.eu](http://www.ceps.eu)

<sup>28</sup> A. Brugiavini et al., Vulnerability and Long-term Care in Europe, Available at [https://doi.org/10.1007/978-3-319-68969-2\\_1](https://doi.org/10.1007/978-3-319-68969-2_1)



Country	Assessment	Classification	Funding source(s) and mechanism
	<p>algorithms also indicate what the person's concerns are and enable the care provider to draw up a high-quality care plan.</p> <ul style="list-style-type: none"> <li>The BelRAI system has simplified questionnaires ("screeners") and extensive tools. The screeners allow to estimate in a limited lead time whether or not the person needs an extensive BelRAI assessment.</li> <li>In some cases, it appears that a full assessment is unnecessary. For example, the palliative screener allows to estimate whether a full assessment "palliative care" is useful.</li> <li>BelRAI allows the assessor to compare assessments from the past, today and tomorrow. The care scales can indicate an evolution over time, making it easier to observe changes in someone's care needs.</li> </ul>	<p>underway to implement with a focus to use data for quality improvement and reimbursement.</p> <ul style="list-style-type: none"> <li>Data is entered by healthcare providers in a free online platform. All data is stored in the central BelRAI database so that it can be shared with all healthcare providers involved. BelRAI is accessible to recognized practitioners of an official care profession in Belgium. To gain access to the central BelRAI platform, the healthcare provider must be known in a central database (CoBHRA plus). Currently (April 2019) these are only the holders of a diploma and visa linked to a care profession that is included in CoBHRA + in accordance with the coordinated law of 10 May 2015 regarding the practice of care professions (link is external) (the former Royal Decree no. 78).</li> <li>In addition, a healthcare provider who registers on the BelRAI platform can only consult the details of their own patients.</li> <li>Healthcare institutions and healthcare organisations can also integrate BelRAI into their own software environment. Data can be exchanged between the central BelRAI database and its own software via the BelRAI web service. The integration between software packages is also possible for the software packages of private practices of independent care providers.</li> <li>The privacy of the client is guaranteed throughout the BelRAI process.</li> </ul>	
<p><b>Japan<sup>29</sup></b></p> <p>Long-term care (in-home services), preventative long-term care,</p>	<p><b>Initial</b></p> <ul style="list-style-type: none"> <li>Single entry assessment system - Client contacts local Municipal government section in charge and undertakes a standardised needs assessment (computer aided 74-item questionnaire) to certify need for support/long term care along with a medical review.</li> <li>Those clients not certified to receive long-term care but likely to need long-term care/support in the future are offered services not covered by LTC insurance</li> </ul> <p><b>Reassessment</b></p> <ul style="list-style-type: none"> <li>Need levels are reassessed every two years or upon request following a change in health<sup>30</sup>.</li> </ul>	<ul style="list-style-type: none"> <li>The 74 items of assessment with their scores are calculated and groups into five intermediate evaluation groups. The score of each item and total score for each intermediate evaluation groups is used to derive the estimated time required for caregiving [services]. There is a decision tree for the estimation of care giving time for each of the 8 care categories: eating, toileting, mobility, personal hygiene, indirect assistance, BPSD related care, functional training related care and medical services<sup>31</sup>.</li> <li>The results of the standardised questionnaire and a report from the client's physician are reviewed by a local [care certification] committee (care manager,</li> </ul>	<ul style="list-style-type: none"> <li>Compulsory LTC insurance scheme for home and residential care is funded by premiums, taxation revenue and co-payments (~10% minimum, based on income).</li> <li>The government sets a fee schedule for each LTC service. Since 2009, a financial incentive for high performing LTC providers has been added to the fee-for-service payment schedule. This is set to reward providers that exceed minimum requirements on certain criteria such as improvements in physical functions.</li> <li>The program is administered by municipalities, which sets premiums and licenses providers.</li> </ul>

<sup>29</sup> OECD. (2013). A good life in old age? Japan: OECD Publishing. <https://www.oecd.org/els/health-systems/Japan-OECD-EC-Good-Time-in-Old-Age.pdf>

<sup>30</sup> Japan Health Policy Now. Long Term Care Insurance. <http://japanhpn.org/en/longtermcare/> Accessed 14Feb2020

<sup>31</sup> Matsuda et al (2011) Eligibility Classification Logic of the Japanese Long Term Care Insurance. Asia Pacific Journal of Disease Management 2011;5(3), 65-74

Country	Assessment	Classification	Funding source(s) and mechanism
	<p><b>Case management and/or care coordination:</b></p> <ul style="list-style-type: none"> <li>Case managers have the responsibility for creating care plans and monitoring conditions, from assessment to referral and end of care, which covers both LTC and health care.</li> <li>Clients can choose between care managers as well as service providers</li> </ul> <p><b>Carer supports</b></p> <ul style="list-style-type: none"> <li>Carers can take leave from their employment for up to 93 days with 40% of their wage paid through the employment insurance if the company does not compensate during the leave.</li> </ul>	<p>physicians, allied health etc) that determines the beneficiary's level of need and corresponding quantity of services</p> <ul style="list-style-type: none"> <li>Clients are assigned to one of seven levels.</li> <li>Care level (1 to 5) for long-term care or Support level (1 &amp; 2) for preventative long-term care. A Care plan is developed for the individual client.</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>National surveys collect information on LTC services and utilisation; the collection of quality information and user satisfaction is limited (program monitoring, financial assurance).</li> <li>The system has three types of public reporting. The first is mandatory for all service providers; the second is mandatory for small-scale multifunctional home care, daily group care for the seniors with dementia and community-based LTC prevention providers, while the last is a voluntary procedure for welfare facilities for the elderly. Municipalities are responsible for public reporting in the first two cases, while contracted agencies are responsible for voluntary reporting (JPHA, 2009). Under the mandatory reporting system, all service providers are required to submit information on staffing registration, vacancies, and a list of available services, as well as results of investigators' surveys.</li> </ul>	<p>Each municipality determines the ratio of the fee collected from insured persons. The contribution is reviewed every three years.</p> <ul style="list-style-type: none"> <li>All service providers whose LTC fees are reimbursed by LTCI should be accredited by the prefecture of each municipality. The standards for certification related to human resources, complaints handling procedures and elderly protection, management and administration, and care services provided.</li> <li>Each level of need has its own service ceiling after which individuals and families pay most costs with benefits for low income individuals. The preventative care levels have lower benefit ceilings and include activities such as strength training and home modifications.</li> </ul>
<p>Sweden<sup>3233</sup></p> <p>Social care Elderly care Home care</p>	<p><b>Initial and/or reassessment pathways and tools:</b></p> <ul style="list-style-type: none"> <li>No standardised formal assessment tool used</li> <li>Care managers employed by the municipality assess need through interviews with the person requesting care and there are no standardised instruments or guidelines to support the need assessment process. Eligibility is based on cognitive and functional limitations, and is not means-tested. Citizens are entitled to appeal the care-manager decision to an administrative court if he/she is not satisfied with the decision.</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>A "care manager" employed by the municipality determines eligibility, and the level and types of service a recipient is eligible for</li> </ul> <p><b>Carer support</b></p>	<ul style="list-style-type: none"> <li>No specific categories, benefits allocated at the discretion of the assessor</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>Sweden has set up a system of "Open Comparisons" that compares how different counties perform on a number of presents health care indicators across Sweden. Open Comparisons reports are mostly covering health care indicators, but also cover certain aspects of elderly care.</li> </ul>	<ul style="list-style-type: none"> <li>The majority of LTC services (85% in 2010) is financed through local municipal taxes. Government grants to the municipalities cover 11-12% of the costs of LTC. The remaining is financed through user fees (3-4%). The level of user co-payment is capped and based on income.</li> <li>Starting in 2010, performance-based incentives are being awarded to municipalities showing that they reach agreed performance objectives, these include reduction of unnecessary hospitalisations among elderly people or in the number of elderly people being re-hospitalised without 30 days after an initial discharge, and the use of inappropriate drugs. Financial incentives are also offered for inclusion of</li> </ul>

<sup>32</sup> Elderly Care in Sweden Available at <https://sweden.se/society/elderly-care-in-sweden/>

<sup>33</sup> Australian Government Productivity Commission (2011) International experience inquiry report, Appendix D: International experience Available at <https://www.pc.gov.au/inquiries/completed/aged-care/report>

Country	Assessment	Classification	Funding source(s) and mechanism
	<ul style="list-style-type: none"> <li>Sweden's Social Services Act states that elderly people who have lived together for an extended period can continue to do so even when one of them needs to move into supported accommodation, a revision from 2012 – may be more relevant in a carer context</li> </ul>		elderly patient information into the Dementia and Senior Alert registers.
Finland <sup>34,35</sup> Home care services	<p><b>Initial assessment</b></p> <ul style="list-style-type: none"> <li>Local municipalities are responsible for needs assessment and eligibility criteria. The Social Welfare Act secures the access of people aged 75 and older to a social service needs assessment within seven days of contacting their municipality<sup>36</sup>.</li> <li>Social workers or care managers undertake assessments using standardised assessment tools used (interRAI based) and develop an individual care plan.</li> <li>Legislation requires the use of some kind of assessment system and the RAI system is the most popular one. In Finland, RAI tools are most widely used in elderly services in the evaluation of home care and 24-hour care clients.</li> <li>A comprehensive service needs assessment aims to identify not only the need for assistance but also the factors that affect it. Based on the assessment, the client counsellor draws up a plan for appropriate services, care or rehabilitation, as well as measures to improve the client's situation.</li> </ul> <p><b>Reassessment</b></p> <ul style="list-style-type: none"> <li>Service and care plans are re-assessed at regular intervals and as necessary.</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>Municipalities are responsible for arranging services. The municipality grants services on the basis of an individual service needs assessment. Municipalities may produce the services themselves or buy them from other municipalities or from private service providers. Care managers employed by municipalities.</li> </ul>	<ul style="list-style-type: none"> <li>Home care customers can also receive health care and medical treatment in their homes if these services cannot be reasonably organised in any other way<sup>37</sup>.</li> <li>A national quality framework for care of older people is in place. The framework specifies key dimensions of quality of care such as prevention and early intervention, comprehensive assessment, and workforce, and standards to be met.</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons<sup>38</sup> obliges the government to monitor the well-being of old people as well as other outcomes of the Act.</li> <li>Finland collects information on LTC quality through the voluntary participation of care providers to the RAI assessment instruments.</li> <li>Data covers 30% of home care services.</li> <li>Comparative information containing summaries and averages of individual data is utilised in the management and development of an organisation providing services for the elderly and disabled. Comparative data can be used to look at indicators that describe the needs of the entire customer base or the quality of operations, for example.</li> <li>Finland Department of Health and Welfare provides benchmarking information and research from RAI assessments to help develop services that meet customer needs and are effective. For this statutory</li> </ul>	<ul style="list-style-type: none"> <li>Services funded by local authorities through local taxes and government grants are supplemented by means tested co-payments<sup>39</sup>.</li> <li>Currently no personal budgets, services determined to be needed are provided in kind or cash for informal care support, care allowance for pensioners or tax deductions for services.</li> <li>The whole Finnish social and health care service system – including LTC – will be totally changed under the social and health care reform (SOTE), which is planned to come into force in 2020. Personal budgets for LTC are planned under these reforms.</li> </ul>

<sup>34</sup> OECD. (2013). A good life in old age? Finland: OECD Publishing Available at <https://www.oecd.org/els/health-systems/finland-OECD-EC-Good-Time-in-Old-Age.pdf> Accessed 14Feb2020

<sup>35</sup> Finland Department of Health and Welfare Ageing – Assessment of service needs with the RAI system Available at <https://thi.fi/fi/web/ikaantyminen/palvelutarpeiden-arviointi-rai-jarjestelmalla> Accessed 23Apr2020

<sup>36</sup> Finland Ministry of Social Affairs and Health. Legislation safeguards the services and benefits. <https://stm.fi/en/old-people> Accessed 17Feb2020

<sup>37</sup> Finland Services for the Elderly Available at <https://www.suomi.fi/services/home-care-city-of-helsinki/a6754c9a-073b-4e3b-9ca7-8811772d7a9b> Accessed 17Feb2020

<sup>38</sup> Finland Act on Support the Functional Capacity of the Older Population and on Social and Health Services for Older Persons Available at <https://www.finlex.fi/fi/laki/ajantasa/2012/20120980> Accessed 23Apr2020

<sup>39</sup> Roberts K. (2017) International aged care: a quick guide. Research paper series 2016-17. Available at [https://www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/rp/rp1617/Quick\\_Guides/IntAgedCare](https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/IntAgedCare) Accessed 10Feb2020

Country	Assessment	Classification	Funding source(s) and mechanism
	<ul style="list-style-type: none"> <li>Home care services are defined together with the customers and their families or others close to them. The plans also determine the customers' possibilities to use private services and the possibilities of family members and others to provide help.</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Municipalities may grant informal care support for a relative or friend of a person being cared for</li> </ul>	<p>task, Finnish Institute for Health and Welfare (THL) compiles a database of all RAI assessments made in Finland, which is used in accordance with THL's information security policy.</p>	
Denmark <sup>40</sup> Home care	<p><b>Initial</b></p> <ul style="list-style-type: none"> <li>Home care services are offered after a thorough assessment of individual needs and with the specific aim of restoring, maintaining and improving mental and physical functionality. Doctors can also prescribe home nursing services<sup>41</sup>.</li> <li>Municipalities are required by law to assess if a person in need of home care services could benefit from a reablement scheme in the form of a specific training programme aiming at regaining physical or social functionality and achieving better quality of life. Every reablement scheme must be limited in time and adjusted to the individual needs and capabilities of the elderly.</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>Case managers are employed by the municipalities evaluate individual needs, and assist with planning for independent living.</li> <li>The principle of free choice is fundamental to Danish elderly care. The municipality must provide a choice between different service providers of home care and food services. The local authorities are under the obligation to ensure that there are at least two providers of home care services, of which one can be a public provider.</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Whereas informal care giving by relatives is not common, help for family care giver will be supported by the local authorities. Substitute or respite care will be offered as well as cash</li> </ul>	<ul style="list-style-type: none"> <li>Home care falls in two categories: practical help (e.g. cleaning and laundering) and personal care (e.g. bathing and shaving). The municipality provides these services free of charge. Elderly people may also receive food services based on an assessment of individual need.</li> <li>All municipalities offer their elderly citizens preventive home visits. Such visits improve prevention and health promotion efforts by providing advice and guidance on activities and supporting opportunities to maintain and improve well-being and functional ability in elderly citizens<sup>40</sup>.</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>Services provided through home care are not registered systematically<sup>43</sup> and vary between municipalities.</li> <li>Data collection on provision of home care services is largely operational with 19 service indicators<sup>44</sup>.</li> <li>The indicators consist of referral and provided home care, home nursing, rehabilitation, preventative home visits, nursing homes, qualitative indicators, clinical pathways and readmissions and ratio of direct contact. Primarily, the indicators are directed at the elderly area, but home care, home nursing, rehabilitation and nursing homes also includes data for citizens less than 67<sup>44</sup>.</li> </ul>	<ul style="list-style-type: none"> <li>Services are funded by local authorities through local taxes and government grants, with some means-tested co-payments for food and accommodation<sup>45</sup>. A maximum limit for co-payment has been set at national level and the cost cannot exceed average production cost for food services.</li> <li>Municipalities are fully responsible for public governance, provision, delivery and financing of elderly care in Denmark. While the Social Service Act constitutes the framework for the services provided by municipalities and their obligations within the entire area of social services, the extended self-rule principle for local government in Denmark means that the municipalities decide on the specific methods and service levels they wish to apply</li> </ul>

<sup>40</sup>Denmark Ministry of Health (2017) Healthcare in Denmark an overview. Available at [http://www.sum.dk/Aktuelt/Publikationer/~media/Filer%20-%20Publikationer\\_i\\_pdf/2016/Healthcare-in-dk-16-dec/Healthcare-english-V16-dec.ashx](http://www.sum.dk/Aktuelt/Publikationer/~media/Filer%20-%20Publikationer_i_pdf/2016/Healthcare-in-dk-16-dec/Healthcare-english-V16-dec.ashx) Accessed 17Feb2020

<sup>41</sup>Healthcare Denmark Home Care Available at <https://www.healthcaredenmark.dk/the-case-of-denmark/integrated-care-and-coherence/home-care/> Accessed 17Feb2020

<sup>43</sup>Schmidt M, Schmidt SAJ, Adelborg K, et al. The Danish health care system and epidemiological research: from health care contacts to database records. Clin Epidemiol. 2019;11:563–591. Published 2019 Jul 12. doi:10.2147/CLEP.S179083

<sup>44</sup>Denmark Statistics Documentation of statistics for Elderly – Indicators 2018. Available at <https://www.dst.dk/en/Statistik/dokumentation/documentationofstatistics/elderly---indicators/statistical-presentation> Accessed 27Feb2020

<sup>45</sup>Roberts K. (2017) International aged care: a quick guide. Research paper series 2016-17. Available at [https://www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/rp/rp1617/Quick\\_Guides/IntAgedCare](https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1617/Quick_Guides/IntAgedCare) Accessed 10Feb2020

Country	Assessment	Classification	Funding source(s) and mechanism
	<p>allowances for palliative care. Under specific circumstances a carer of a closely connected.</p> <ul style="list-style-type: none"> <li>• Carer can be employed by the municipality up to 6 months<sup>42</sup>.</li> </ul>		
<p><b>New Zealand</b><sup>46,47,48</sup></p> <p>Available to New Zealand citizens or residents</p> <p>Home and community care services case-mix model (HCSS CM)</p>	<p><b>Initial assessment</b></p> <ul style="list-style-type: none"> <li>• Individual is referred to the district health board's Needs Assessment Service Coordination (NASC) agency belonging to the local</li> <li>• National standard assessment is performed over the phone, NSAC office or at home</li> <li>• Care plan is developed to meet individual's goals and support needs</li> <li>• interRAI tool assessment instrument used for all people aged 65+ years to assess needs and for data collection and reporting. The NZ version of the interRAI-HC includes 236 individual questions, assessed 20 domains, which generate 27 validated instrument scores that guide patient treatment<sup>49</sup>. The adaption of the interRAI-HC for NZ included extensive Māori consultation to ensure that a framework to perform culturally appropriate assessments was established, and so that accurate, systematic and comprehensive ethnicity data were made available</li> <li>• The interRAI-HC instrument is used to form 27 scales, including: a Depression Rating scale, the Changes in Health, End-stage disease and Signs and Symptoms (CHESS) scale, and the ADL scale. The interRAI International Home Care Frailty Scale is expected to be introduced into New Zealand before the end of 2020<sup>50</sup>. The scale comprises 29 assessment items that best correlate with a select group of dependent measures representing accumulating declines and clinical complications. The frailty scale items address the areas of function, movement, cognition and communication, social life, nutrition and clinical symptoms</li> <li>• The instrument is partitioned into 20 domains named: <ul style="list-style-type: none"> <li>➢ A: Identification Information</li> <li>➢ B: Intake and Initial History</li> <li>➢ C: Cognition</li> <li>➢ D: Communication and Vision</li> <li>➢ E: Mood and Behaviour</li> <li>➢ F: Psychosocial Well-being</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Individuals are classified according to level of need: very low, low, medium, high or very high</li> <li>• If a person is classified as high or very high, they become eligible for residential care services</li> <li>• Different districts use different classification models that include: <ul style="list-style-type: none"> <li>• Home and Community Case mix model (versions) currently operating in seven DHB regions</li> <li>• Restorative/responsive Home Support Delivery Model</li> <li>• interRAI assessment</li> <li>• Other relevant national integrated services such as ACC's Integrated HCSS contract funding and delivery model.</li> <li>• A case for development of a national case mix delivery and contracting framework was put forward in 2018 by Home and Community Health Association<sup>48</sup>.</li> </ul> </li> </ul> <p><b>Data collection and purpose</b></p> <p>InterRAI prepares annual reports on:</p> <ul style="list-style-type: none"> <li>○ Program data: No. of, and type of assessments completed</li> <li>○ Patient level: no. of people who exercise, no. of people visited by a family member, no. of people who left their home, no. of people who drove a vehicle, age, gender, cultural background</li> <li>○ Purpose of data collection: to improve cultural competency, to understand people's needs, to highlight key health issues, research purposes, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Free service up to a certain income threshold; means-tested co-payment applied to services if above the specified income threshold</li> <li>• Funded by individual district health boards (DHBs) from general tax</li> <li>• DHBs negotiate contracts with providers based on the needs of their older population, market forces and specific requirements of the providers. Arrangements may be individualised (per client, may be fee for service basis for restorative care) or bulk funding.</li> <li>• DHBs each set thresholds for access to services.</li> <li>• Private funding</li> </ul>

<sup>42</sup> European Network of Economic Policy Research Institutes (2010) The Long-Term Care System in Denmark Available at <https://www.files.ethz.ch/isn/122389/Denmark.pdf> Accessed 17Feb2020

<sup>46</sup> Department of Health. (2019). *Aged Care at Home: International Insights Report*. Retrieved from MyAgedCare

<sup>47</sup> Health, M. o. (2011). *Needs Assessment and Support Services for Older People: What you need to know*. Wellington

<sup>48</sup> Fernhill Solutions. (2018). *Putting the Case - Improving the viability, delivery and outcomes of New Zealand's home and Community Support Services. A national casemix delivery and contracting framework*. Retrieved from <http://www.hcha.org.nz/assets/Uploads/Fernhill-HCHA-Casemix-2018.pdf>

<sup>49</sup> Schluter et al (2016). Comprehensive clinical assessment of home-based older persons within New Zealand: an epidemiological profile of a national cross-section. Australian and New Zealand Journal of Public Health Volume 40, Issue 4 <https://doi.org/10.1111/1753-6405.12525>

<sup>50</sup> New Zealand interRAI Annual Report 2018/19 Available at [https://www.interrai.co.nz/assets/9169ec695a/00-AR\\_interRAI\\_2019-FINAL\\_WEB.pdf](https://www.interrai.co.nz/assets/9169ec695a/00-AR_interRAI_2019-FINAL_WEB.pdf)

Country	Assessment	Classification	Funding source(s) and mechanism
	<ul style="list-style-type: none"> <li>➤ G: Functional Status</li> <li>➤ H: Continence</li> <li>➤ I: Disease Diagnoses</li> <li>➤ J: Health Conditions</li> <li>➤ K: Oral and Nutritional Status</li> <li>➤ L: Skin Condition</li> <li>➤ M: Medications</li> <li>➤ N: Treatment and Procedures</li> <li>➤ O: Responsibility</li> <li>➤ P: Social Support</li> <li>➤ Q: Environmental Assessment</li> <li>➤ R: Discharge Potential and Overall Status</li> <li>➤ S: Discharge</li> <li>➤ T: Assessment Information.</li> </ul> <ul style="list-style-type: none"> <li>• The Supporting Allocations Tool is used to categorise individuals into complex or non-complex patients. Non-complex patients are assessed on their level of independence and complex patients are assessed on disability, cognitive impairment, levels of social support, continence and levels of dependence</li> <li>• InterRAI offers different levels of assessments e.g. contact assessment for low non-complex cases and home care assessments for complex cases. Other assessments are Community Health Assessment, Palliative Care Assessment and Long-Term Care Facilities assessment</li> <li>• Support workers, nurses, physiotherapists are other healthcare workers conduct the assessment</li> </ul> <p><b>Reassessment</b></p> <ul style="list-style-type: none"> <li>• Need for services is checked at regular intervals (minimum yearly) by the service provider to ensure support services are adequate. Individuals can request a review of services at any time</li> <li>• Initially conducted as a phone assessment which determines whether further services are required or warrants a full assessment</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>• Care co-ordinator identifies the most appropriate services and support options based on needs assessment outcomes</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>• Respite care services available according to needs assessment</li> <li>• Carer support subsidy provides subsidised funding for alternative care (e.g. home care, residential respite care, day care). This support is offered according to the needs assessment.</li> </ul>		

Country	Assessment	Classification	Funding source(s) and mechanism
<p><b>England</b><sup>51,52,53,54,55,56</sup></p> <p>Social care services are available for all eligible people as assessed by the care assessment tool. This service is only provided to those with very high needs.</p> <p>Reablement approaches are also supported</p>	<p><b>Initial assessment</b></p> <ul style="list-style-type: none"> <li>Free care/needs assessment services provided by the local council via the adult social services department</li> <li>Assessment is accessible to everyone regardless of income, savings and care needs</li> <li>Assessment is conducted by a social care professional (occupational therapist, nurse or social worker) via telephone or in person</li> <li>Care plan is developed at the end of assessment</li> <li>Assessment for services considers care provided by families. Carer's assessment is conducted to understand the carer's needs to continue providing care</li> <li>Assessor also consults with person's GP or nurse (if consented)</li> <li>Means test is also performed to determine individual's contribution to services</li> <li>Each local council has a different assessment procedure that is governed by the national criteria</li> <li>Some councils offer self-assessments</li> </ul> <p><b>Reassessment</b></p> <ul style="list-style-type: none"> <li>Individuals can request a reassessment at any time</li> <li>the local authority is required to conduct a reassessment at least once a year</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>Care managers from the local council or home care agencies coordinate the agreed services according to the care plan.</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Social care services offers carers: <ul style="list-style-type: none"> <li>Respite care</li> <li>Information on local carer support groups</li> <li>Help with caring</li> <li>Equipment to help in the caring role</li> <li>A personal budget (cash)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Strict needs-based eligibility criteria</li> <li>Organisation and delivery of services vary at the local level</li> <li>People with low needs cannot access the main social care system</li> <li>Dual funded packages from the National Health Service (NHS) and social services provide nursing (to address medical needs) and a care worker (to address personal care needs)</li> </ul> <p><b>Data collection</b></p> <ul style="list-style-type: none"> <li>Providers are registered with an independent national body and are assessed on financial, operating and quality standards</li> <li>Patients complete national user surveys on quality of services and satisfaction</li> <li>Home care agencies are monitored by the Care Quality Commission and are required to follow the standards for staff recruitment, user protection, policies, procedures and complaints.</li> </ul>	<ul style="list-style-type: none"> <li>Means-tested funding</li> <li>Funded by local government through national taxation</li> <li>Advisory guidelines available for service charges</li> <li>Funding of services varies at the local level</li> <li>Direct payments are made to individuals to purchase social care services</li> <li>Cash benefits are paid according to the individual's asset levels.</li> <li>People (except those below the poverty threshold) are expected to contribute all of their income except for an allowance for living costs</li> <li>From April 2020, cost of care will be capped to £72,000 for people aged 65+ years</li> </ul>

<sup>51</sup> Department of Health. (2019). *Aged Care at Home: International Insights Report*. Retrieved from My Aged Care

<sup>52</sup> Age UK. (2020). Care needs assessment. Retrieved from <https://www.ageuk.org.uk/information-advice/care/arranging-care/care-needs-assessment/>

<sup>53</sup> BBC News. (2016). How the care system works across the UK. Retrieved from <https://www.bbc.com/news/health-30902552>

<sup>54</sup> Age UK. (2019). Carer's assessment. Retrieved from <https://www.ageuk.org.uk/information-advice/care/helping-a-loved-one/getting-a-carers-assessment/>

<sup>55</sup> Service, T. M. A. How a local authority care needs assessment work. Retrieved from <https://www.moneyadvice.service.org.uk/en/articles/how-a-local-authority-care-needs-assessment-works>

<sup>56</sup> Counsel and Care. (2010). *Community Care: understanding the system*. Retrieved from London: <http://www.firststopcareadvice.org.uk/downloads/kbase/1522.pdf>

Country	Assessment	Classification	Funding source(s) and mechanism
<p><b>Scotland</b><sup>57,58,59,60</sup></p> <p>Social care: Anyone aged 65+ years is entitled to free personal care based on their needs assessment</p>	<p><b>Initial assessment</b></p> <ul style="list-style-type: none"> <li>Individuals contact the social care department at their local council to request a care assessment</li> <li>A care assessment is followed by a financial assessment to determine co-payment</li> </ul> <p><b>Reassessment</b></p> <p>Reassessment can be completed at any time as requested by the individual or their carer</p> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>The local council is responsible for implementing the outcomes of the assessment</li> <li>Councils can choose to purchase home care services from the private and voluntary sector</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Councils assist carers in developing an adult care support plan</li> <li>Carers' centres offer practical support, advice and information</li> <li>Carer assessments are conducted to determine carer needs</li> <li>Carer's assessment will determine availability of respite services</li> </ul>	<p>4 options of support are available:</p> <ul style="list-style-type: none"> <li>Direct payments can be made to individuals to arrange their own home care</li> <li>Individuals choose the support they require and the council holds the money and arranges support services as requested</li> <li>The council chooses and arranges the support services</li> <li>Mix of options 1, 2 and 3 for various aspects of the support services</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>Patient level data (age, gender, ethnicity, living arrangements) and provider level data (no. of clients, hours of services, cost of service provision, source of service provision i.e. council/private/voluntary, service type and use of various levels of support) is collected and reported on the government's website</li> </ul>	<ul style="list-style-type: none"> <li>Funded by local authorities and by individual co-payment based on financial assessment</li> </ul>
<p><b>Canada</b><sup>46,61,62,63,64</sup></p> <ul style="list-style-type: none"> <li>Home care services are offered to people of all ages and of varying needs</li> <li>Services aim to keep people out of hospitals or long-term care facilities</li> <li>Eligibility is defined by each jurisdiction</li> </ul>	<p><b>Initial assessment</b></p> <ul style="list-style-type: none"> <li>In Ontario, individuals contact their local health integration network (LHIN) who is responsible for assigning a case manager/coordinator</li> <li>Case manager conducts needs assessment via standardised assessment tool interRAI Home Care.</li> <li>Based on the assessment, the case manager provides information on the services that the LHIN can provide</li> <li>The case manager visits the individual's home to conduct a health assessment and a home care plan is developed to meet the individual's needs</li> <li>The case manager selects the provider</li> <li>Private care is organised for those who do not qualify for government-funded care</li> </ul> <p><b>Reassessment</b></p>	<ul style="list-style-type: none"> <li>Home care services are made up of: <ul style="list-style-type: none"> <li>Home care health services (nursing, allied health)</li> <li>Support services (personal support workers/volunteers help with bathing, meal preparation, etc.)</li> </ul> </li> <li>Individuals are classified into 1 of the 23 case-mix groups using RUG-III/HC. Classification is done according to clinical characteristics, ADLs and IADLs<sup>65</sup></li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>Program level data collected on mortality rates, QoL, rate of hospitalisations and healthcare costs</li> <li>Patient level data is collected via the Canadian Community Health Survey on number of households</li> </ul>	<ul style="list-style-type: none"> <li>High out-of-pocket costs</li> <li>Funded by individual provinces from tax and from federal funding, private funding and individual co-payment</li> <li>Non-professional services require co-payments that is matched to income</li> <li>Different provinces fund variable hours of home care services e.g. Nova Scotia 100hours/month, Ontario 90 hours/month</li> <li>Healthcare services are government-funded and support services are funded by the LHIN</li> <li>Eligible individuals can choose to receive direct funding to pay for home care services</li> </ul>

<sup>57</sup> BBC News. (2016). How the care system works across the UK. Retrieved from <https://www.bbc.com/news/health-30902552>

<sup>58</sup> Care Information Scotland. (2018). Care at home. Retrieved from <http://careinfoscotland.scot/topics/care-at-home/>

<sup>59</sup> Carers Scotland. (2014). *Assessments: Your guide to getting help*. Retrieved from [http://www.carersuk.org/images/Factsheets/Factsheet\\_S1020\\_Assessments\\_-\\_guide\\_to\\_getting\\_help.pdf](http://www.carersuk.org/images/Factsheets/Factsheet_S1020_Assessments_-_guide_to_getting_help.pdf)

<sup>60</sup> Scottish Government. (2017). *Social Care Services in Scotland: 2017*. Retrieved from <https://www.gov.scot/publications/social-care-services-scotland-2017/pages/3/>

<sup>61</sup> Gilmour, H. (2018). *Formal home care use in Canada*. Retrieved from <https://www150.statcan.gc.ca/n1/pub/82-003-x/2018009/article/00001-eng.htm>

<sup>62</sup> CIHI. Home Care. Retrieved from <https://www.cihi.ca/en/home-care>

<sup>63</sup> Home and community care. (2014, 01/06/19). Retrieved from <https://www.ontario.ca/page/homecare-seniors>

<sup>64</sup> Khayat-zadeh-Mahani, A., & Leslie, M. (2018). Policies supporting informal caregivers across Canada: a scoping review protocol. *BMJ Open*, 8(6). doi:10.1136/bmjopen-2017-019220

<sup>65</sup> interRAI RUG-III Home Care classification Available at [https://www.interrai.org/assets/files/Case-Mix%20Classification/rug-iiihc\\_23\\_diagram.pdf](https://www.interrai.org/assets/files/Case-Mix%20Classification/rug-iiihc_23_diagram.pdf) Accessed 17Feb2020



Country	Assessment	Classification	Funding source(s) and mechanism
<ul style="list-style-type: none"> <li>Each jurisdiction has different assessment and case management processes</li> </ul>	<ul style="list-style-type: none"> <li>Individuals are reassessed if their needs change</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>Case manager allocated to individual to conduct needs and health assessment and accordingly allocate a provider</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Financial support provided to family members to provide care in some jurisdictions</li> <li>Informal carers are usually not paid</li> </ul>	<p>receiving services, cost and sources of payment, socioeconomic characteristics of households, etc.</p> <ul style="list-style-type: none"> <li>The Canadian Institute for Health Information (CIHI) collects and reports on clinical, administrative and resource utilisation data from publicly funded home care programs</li> </ul>	
<p><b>USA</b><sup>66,67,68,69,70</sup></p> <ul style="list-style-type: none"> <li>Home care services (Medicare) for people aged 65+ years. Must also be eligible for residential care services to receive home care services</li> <li>Medicaid programmes cover home care services for the poor</li> <li>Individuals can have dual eligibility of Medicare and Medicaid</li> <li>Community living assistance services and supports programme</li> <li>Personal Care Services Case-Mix Model (PCS CM)</li> </ul>	<p><b>Initial and/or reassessment pathways and tools:</b></p> <ul style="list-style-type: none"> <li>Income and asset-based means tests for the poor</li> <li>Individuals self-assess their home care needs and contact the local Area Agency on Aging to obtain information on how to access services</li> <li>HHRG uses the Outcome and Assessment Information Set (OASIS) to assess and classify into case-mix groups</li> <li>Home care services use Minimum Data Set – Home Care (MDS-HC) to assess individuals needs</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>The local Area Agency on Aging (AAA) address needs of all older persons at the regional and local level. They coordinate and offer services to help older adults remain at home (e.g. meals on wheels, homemaker assistance, etc)</li> <li>Geriatric care managers (nurse or social worker) develop a long-term care plan and help individuals find services. Cost for this service is covered by the individual</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Some states provide funding or reimbursement to caregivers but eligibility varies by each state</li> <li>The National Family Caregiver Support Program provides grants to states and territories to support families and informal caregivers. Services for caregivers include respite, access to database of service providers, and counselling and training services</li> </ul>	<ul style="list-style-type: none"> <li>People with high assets are not eligible for services</li> <li>People with median incomes do not receive support for low care needs</li> <li>PCS CM comprises of 11 case-mix groups where individuals are classified according to their cognitive functioning, ADLs, IADLs, continence and the presence of a problem diagnosis</li> <li>HHRG classification process assigns individuals to 1 of the 153 case-mix groups according to their clinical severity, functional status and service utilisation.</li> <li>RUG-HCC consists of 11 case-mix groups where individuals are classified according to their needs for nurse monitoring, rehab, special care and presence of paralysis</li> <li>RUG-III/HC includes 21 case-mix groups which classifies individuals according to clinical categories, ADLs and IADLs using MDA-HC assessment tool.</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>National Home and Hospice Care Survey (NHHCS) collects information on home health and hospice care agencies (staff and services) and the people they provide services to</li> </ul>	<ul style="list-style-type: none"> <li>Funded by the federal Medicare programme via general tax, Medicare premiums and congress funds</li> <li>Medicaid programmes funded by state</li> <li>Issues between state and federal funding</li> <li>People are expected to contribute all of their income except for an allowance for living costs</li> <li>Individuals are automatically enrolled into voluntary funding schemes with opt-out options</li> <li>Cash benefits provided for home care</li> </ul>

<sup>66</sup> Department of Health. (2019). *Aged Care at Home: International Insights Report*. Retrieved from MyAgedCare:

<sup>67</sup> Jones, A. L., Harris-Kojetin, L., & Valverde, R. (2012). *Characteristics and Use of Home Health Care by Men and Women Aged 65 and Over*. Retrieved from <https://www.cdc.gov/nchs/data/nhsr/nhsr052.pdf>

<sup>68</sup> Eldercare Locator. Area Agencies on Aging. Retrieved from [https://eldercare.acl.gov/Public/About/Aging\\_Network/AAA.aspx](https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx)

<sup>69</sup> Administration for Community Living. (2019). National Family Caregiver Support Program. Retrieved from <https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program>

<sup>70</sup> National Institute on Aging. (2017). Aging in Place: Growing Older at Home. *Health Information*. Retrieved from <https://www.nia.nih.gov/health/aging-place-growing-older-home>

Country	Assessment	Classification	Funding source(s) and mechanism
<ul style="list-style-type: none"> <li>Home Health Resource Groups (HHRG) provides nursing and allied health services</li> </ul>			
<p><b>Netherlands</b><sup>71,72,73,74</sup></p> <ul style="list-style-type: none"> <li>Long-term care was decentralised to municipalities for domestic care and social support and to health insurers for home nursing care in 2015</li> <li>Social support is provided for individuals who are unable to cope on their own and unable to participate in society</li> </ul>	<p><b>Initial assessment</b></p> <ul style="list-style-type: none"> <li>Individuals contact their municipality to organise a free assessment</li> <li>Eligible individuals are assessed via a standardised and centralised tool</li> <li>Assessment also looks at care givers and the care they can provide</li> <li>District nurses assess health care needs and develop a care plan with the individual.</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>The municipality provides non-medical support at home and coordinates services according to individuals' needs</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Financial support provided to family members to provide care in the form of an hourly wage<sup>75</sup></li> <li>Carers are supported by the municipality through respite care and other support services</li> </ul>	<ul style="list-style-type: none"> <li>There is no objective standard determining what sort of need requires what forms of care and support for social and domestic assistance; the professionals judge each case on its own merits and appeal to individual responsibility and the mobilisation of social networks where possible<sup>76</sup>.</li> <li>Classification is based on hours and types of care required</li> <li>Customised (tailored to the individual but does not include medical care) or standard services are offered to eligible individuals</li> <li>Individuals who needs 24-hour care are entitled to a place in a residential facility</li> <li>Assistive technology at home is also subsidised via the European Ambient Assisted Living joint programme</li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>To monitor and evaluate developments in long-term care, the Dutch system uses two instruments: The Social Domain Monitor (Monitor Social Domein) and the Long-term Care Monitor (Monitor Langdurige Zorg)<sup>77</sup>. The Social Domain Monitor gives an insight into outputs, costs and client satisfaction under (among others) the Social Support Act. It provides this information at the municipal level and therefore helps municipalities communicate information to their citizens. The actual quality and efficiency of the care provided is not measured. The Long-term Care Monitor publishes statistics on six themes: population, indication, use (including the relation between indication and use), accessibility, expenditure &amp; volume and contribution. Again, it only provides</li> </ul>	<ul style="list-style-type: none"> <li>People pay an income-related premium for mandatory social insurance that covers nursing and personal care</li> <li>Services incur significant personal contributions</li> <li>Funding provided by local authorities from general taxes</li> <li>Risk-adjusted capitation payment used to purchase care packages from providers</li> <li>Individuals can choose between personal cash (personal health budgets) to select and purchase services or direct care provision</li> <li>Service/cash budgets are defined by need, income, household composition and age</li> </ul>

<sup>71</sup> Department of Health. (2019). *Aged Care at Home: International Insights Report*. Retrieved from MyAgedCare:

<sup>72</sup> Ministry of Health, Welfare and Support. What assistance can I get at home from my municipality? Available at <https://www.government.nl/topics/care-and-support-at-home/question-and-answer/assistance-at-home-from-my-municipality>

<sup>73</sup> Ministry of Health Welfare and Support. Living independently for longer. Available at <https://www.government.nl/topics/care-and-support-at-home/living-independently-for-longer>

<sup>74</sup> National Institute for Public Health and the Environment. (2014). *Dutch Health Care Performance Report*. Available at Bilthoven: <https://www.rivm.nl/bibliotheek/rapporten/2015-0050.pdf>

<sup>75</sup> Muir, T. (2017), "Measuring social protection for long-term care", OECD Health Working Papers, No. 93, OECD Publishing, Paris. <http://dx.doi.org/10.1787/a411500a-en>

<sup>76</sup> European Social Policy Network Thematic Report on Challenges in long-term care Netherlands 2018 Available at

[https://ec.europa.eu/social/main.jsp?pager\\_offset=20&advSearchKey=espnltc\\_2018&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0](https://ec.europa.eu/social/main.jsp?pager_offset=20&advSearchKey=espnltc_2018&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0) Accessed 29Apr2020

<sup>77</sup> Dutch public monitor portal Available at <https://www.waarstaatjegemeente.nl/>

Country	Assessment	Classification	Funding source(s) and mechanism
<p><b>France</b><sup>78,79,80,81</sup></p> <p>The National Solidarity Fund for Autonomy (CNSA) finances the Allocation personnalisée d'autonomie (APA) which provides benefits to the elderly (over 60 years)</p>	<p><b>interRAI</b></p> <ul style="list-style-type: none"> <li>The development and implementation of the interRAI instruments in France has occurred in a staged approach from the early nineties. Voluntary implementation and application of the interRAI instruments to test out acceptability and benchmark quality indicators was undertaken</li> <li>In 2009, an integrated model of care for the elderly population was implemented at the national level. Integrated care is a collective approach involving all stakeholders in a defined territory, addressing the fragmentation of services through interdependent mechanisms and tools. Between 2009 and 2012 the integrated care organisation was piloted in 17 sites and case managers used one of three assessment tools, interRAI being one, for older people with complex health and social needs. Between 2012 and 2017, the integrated care model has been extended to 352 sites covering 98% of the national territory. In 2016 interRAI-HC was chosen as the mandatory instrument for the case managers from a national call to tender to choose a standardised comprehensive assessment tool for case managers. The criteria for tool choice were: <ul style="list-style-type: none"> <li>existence of a conceptual framework with an international functional classification</li> <li>a multidimensionality approach</li> <li>relevance to older people with loss of autonomy</li> <li>possibility to perform the assessment at home</li> <li>relevance to care planning</li> <li>overview of resource utilisation</li> <li>scientific validity</li> <li>existence of an international network</li> <li>active development.</li> </ul> </li> </ul> <p><b>Assessment</b></p> <p>The government defines national health and social policies through legislation, and different territorial levels are involved in managing and funding the two sectors. Regional and local administrations</p>	<p>information on outputs and access, not on the actual quality of the care provided (outcome). Both monitors are open source.</p> <ul style="list-style-type: none"> <li>Monthly cash allowance is provided according to assessed level of dependence</li> <li>There are 4 levels of allowances: <ul style="list-style-type: none"> <li>Gir 1 (high level of dependency): €1713 max</li> <li>Gir 2: €1375 max</li> <li>Gir 3: €931 max</li> <li>Gir 4: €662 max</li> </ul> </li> </ul> <p><b>Data collection and purpose</b></p> <ul style="list-style-type: none"> <li>Data is reported by the Ministry of health and social affairs on the number of beneficiaries, age of individuals, proportions of each level of allowance accessed, residential status, gender, etc.</li> <li>Different bodies – DREES; the Directorate for Research, Studies, and Statistics (DARES); and the National Institute of Statistics and Economic Studies (INSEE) – carry out quantitative and sometimes qualitative studies to collect information on the LTC sector and analyse the measures and policies in place. The new CARE survey was launched in 2015 by DREES. It has three main objectives: to monitor changes in dependency; estimate the burden resulting from dependency; and evaluate the extent to which family members are involved in caring for elderly people.</li> </ul>	<ul style="list-style-type: none"> <li>APA is funded by local authorities (via tax) and the CNSA contributes up to 32.4% of the local authorities' expenses for APA.</li> <li>Coverage levels based on income</li> <li>Cash is provided for home care services</li> </ul>

<sup>78</sup> CNSA. National Solidarity Fund for Autonomy. Retrieved from [https://www.cnsa.fr/documentation/national\\_solidarity\\_fund\\_for\\_autonomy.pdf](https://www.cnsa.fr/documentation/national_solidarity_fund_for_autonomy.pdf)

<sup>79</sup> Department of Health. (2019). *Aged Care at Home: International Insights Report*. Retrieved from MyAgedCare:

<sup>80</sup> OECD. (2011). Help Wanted? Providing and Paying for Long-Term Care. Retrieved from <https://www.oecd.org/france/47902097.pdf>

<sup>81</sup> Le Bihan, B., & Martin, C. (2018). French social and long term care system. *Korean Institute for health and social affairs KIHASA*, 7, 5-15. Retrieved from <https://halshs.archives-ouvertes.fr/halshs-02058183/document>

Country	Assessment	Classification	Funding source(s) and mechanism
	<p>execute national health policies under close supervision from the government, whereas the decentralised French local authorities – départements – are responsible for social policy. In the elderly care sector, the départements have a statutory obligation to define local policy orientations in their territory; finance and implement the national APA; and regulate care services within their territory. In addition, municipalities can develop specific voluntary measures to support older people.</p> <ul style="list-style-type: none"> <li>• Assessment based on ADLs</li> <li>• Currently interRAI assessment tool is only mandated in the city of Marseille for home care services</li> <li>• A personalised support plan is developed by a social-medical team and a care-giver is employed to support ADL and IADL (instrumental activities of daily living) services.</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>• Local departments coordinate services</li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>• Financial support provided to family members to provide care in the form of an hourly wage<sup>82</sup></li> <li>• Employed family caregivers can take 3 months of unpaid leave to provide care.</li> <li>• Approximately 10% of caregivers are paid under the APA.</li> <li>• Tax reductions are available for carers</li> </ul>		

Table B.2 outlines assessment, classification and funding characteristics of programs providing care at home and the community in other sectors.

**Table B.2: Assessment, classification and funding in other service streams**

Country	Assessment	Classification	Funding source(s) and mechanism
<p>UK<sup>83,84,85,86</sup></p> <p><b>Mental Health Services</b></p>	<p><b>Initial and/or reassessment pathways and tools:</b></p> <p><b>Initial</b></p> <ul style="list-style-type: none"> <li>• A clinical assessment using the MHCT, consists of 18 scales) is conducted to determine a patient's cluster</li> <li>• People are referred for an initial assessment where they are allocated to a cluster</li> </ul>	<ul style="list-style-type: none"> <li>• Patients are classified into one of 21 clusters that cover a range of diagnosis and needs and vary by: severity of need, complexity of need, acuity, intensity of likely treatment response, anticipated course of illness etc.</li> </ul>	<ul style="list-style-type: none"> <li>• A national payment system was developed according to the needs-led clusters model where payments are provided to a provider or group of providers for an individual patient's episode of care.</li> </ul>

<sup>82</sup> Muir, T. (2017), "Measuring social protection for long-term care", OECD Health Working Papers, No. 93, OECD Publishing, Paris. <http://dx.doi.org/10.1787/a411500a-en>

<sup>83</sup> Painter, J., Trevithick, L., Hastings, R., Ingham, B., & Roy, A. (2017). The extension of a set of needs-led mental health clusters to accommodate people accessing UK intellectual disability health services. *Journal of Mental Health*, 27(2), 103-111. Retrieved from <http://shura.shu.ac.uk/15378/3/Painter%20Extension%20of%20a%20set%20of%20needs-led%20mental%20health%20clusters.pdf>

<sup>84</sup> NHS England. (2017). *Mental Health Clustering Booklet*. England Retrieved from

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/523135/Annex\\_D\\_Mental\\_health\\_clustering\\_booklet.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523135/Annex_D_Mental_health_clustering_booklet.pdf)

<sup>85</sup> NHS. (2018). Mental health assessments. *NHS services*. Retrieved from <https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-assessments/>

<sup>86</sup> NHS. (2018). Carer's assessment. *Support and benefits for carers*. Retrieved from <https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carers-assessments/>

Country	Assessment	Classification	Funding source(s) and mechanism
	<p><b>Reassessment</b></p> <ul style="list-style-type: none"> <li>Reassessments are conducted at all planned care programme approach (CPA) reviews or other formal care reviews and at any other point where a significant change in planned care is warranted</li> </ul> <p><b>Case management and/or care coordination</b></p> <ul style="list-style-type: none"> <li>Each person is allocated a care co-ordinator (nurse, social worker, occupational therapist, psychologist, psychiatrist or employment specialist)</li> <li>The care co-ordinator: <ul style="list-style-type: none"> <li>is responsible for organising regular reviews</li> <li>is the first point of contact if there are any concerns</li> <li>develops a care plan</li> <li>offers support to the individual, family and friends if needed.</li> </ul> </li> </ul> <p><b>Carer support</b></p> <ul style="list-style-type: none"> <li>Carers undergo a free carer's assessment to determine what services are required to continue providing care.</li> <li>Services for carers include: <ul style="list-style-type: none"> <li>Professionals who can take over caring so that the carer can have a break</li> <li>Gym membership and exercise classes to relieve stress</li> <li>Help with taxi fares if unable to drive</li> <li>help with gardening and house work</li> <li>training on how to lift safely</li> <li>liaising with local support groups</li> <li>advice on carer benefits</li> </ul> </li> </ul> <p>The local council may help with costs if deemed eligible by the financial assessment (means test)</p>	<ul style="list-style-type: none"> <li>Nationally in mental health clustering, the presentations are broadly categorised into: <ul style="list-style-type: none"> <li>Emotional difficulties – for example depression, anxiety etc.</li> <li>Psychosis – for example Bi-Polar, Schizophrenia etc.</li> <li>Memory difficulties – for example Alzheimer's</li> </ul> </li> <li>A 'step up' and 'step down' approach is used for transitioning patients between clusters</li> <li>Process of classification: <ul style="list-style-type: none"> <li>The 18-scale MHCT tool is used to rate the individual's identified needs</li> <li>A decision tree is used to identify if the presenting needs are non-psychotic, psychotic or organic</li> <li>The most appropriate cluster is chosen based on the patient's needs</li> <li>A rating grid is completed to assess the appropriateness of the chosen cluster</li> </ul> </li> <li>Once a service user has been allocated to a cluster, their care coordinator will talk through what interventions are available to them. This is referred to as a care package and includes predefined services/interventions that are prescribed for a given cluster.</li> <li>An individual care plan is then developed that includes their care package and any other interventions recommended.</li> </ul>	<ul style="list-style-type: none"> <li>Mental health services are funded by the NHS and are free for patients</li> </ul>
<p><b>Australia</b></p> <p><b>Rehabilitation</b></p> <p>The Australian National Sub-Acute and Non-Acute patient (AN-</p>	<p><b>Initial and/or reassessment pathways and tools:</b></p> <ul style="list-style-type: none"> <li>Patients are assessed on functional impairments, age and other validated clinical assessment tools to measure indicators relative to palliative care, and psychogeriatric care.</li> <li>Patient function is assessed using the FIM™ instrument at the start of a rehabilitation episode of</li> </ul>	<ul style="list-style-type: none"> <li>The AN-SNAP version 4 classification has two branches<sup>89</sup>:</li> <li>The admitted branch consists of 89 overnight and 6 same-day classes spanning rehabilitation, palliative care, GEM, psychogeriatric and non-acute care types.</li> </ul>	<ul style="list-style-type: none"> <li>The National Pricing Model Technical Specifications, National Efficient Price, and National Efficient Cost documents published annually by IHPA provide guidance as to how classification and</li> </ul>

<sup>89</sup> Green J, Gordon R, Blanchard M, Kobel C and Eagar K. (2015), Development of AN-SNAP Version 4: Final Report, Centre for Health Service Development, University of Wollongong

Country	Assessment	Classification	Funding source(s) and mechanism
<p><b>SNAP) Classification</b> was selected by the IHPA as the ABF classification system to be used for subacute and non-acute care<sup>87</sup>.</p>	<p>care and at the end of a rehabilitation episode of care. Admission assessment is collected within 72 hours of the start of a rehabilitation episode. Discharge assessment is collected within 72 hours prior to the end of a rehabilitation episode<sup>88</sup>.</p>	<ul style="list-style-type: none"> <li>The non-admitted branch consists of 35 classes spanning rehabilitation, palliative care, GEM and psychogeriatric care types.</li> </ul> <p>Variables used for classification<sup>90</sup>:</p> <ul style="list-style-type: none"> <li>Admitted branch: <ul style="list-style-type: none"> <li>Care type – characteristics of the person and the goal of treatment</li> <li>Function (motor and cognition) on admission – all care types</li> <li>Phase (stage of illness) – palliative care</li> <li>Impairment – rehabilitation</li> <li>Behaviour – psychogeriatric</li> <li>Age – palliative care, rehabilitation, non-acute and to identify paediatric episode/phases</li> <li>Age Type – (optional) an indicator variable that overrides age to decide between the paediatric and the adult classes for rehabilitation and palliative care</li> <li>Length of stay (LOS) – psychogeriatric and non-acute</li> <li>Same-day flag – to distinguish between same-day and overnight episodes/phases</li> </ul> </li> </ul> <p>Many of the variables used to group to AN-SNAP v4 are on recognised clinical assessment tool.</p> <p>The following additional variables are included in the non-admitted classes of AN-SNAP V4:</p> <ul style="list-style-type: none"> <li>Problem severity – palliative care</li> <li>Focus of Care – psychogeriatric care</li> </ul>	<p>price weights are applied and calculated<sup>91</sup>.</p> <ul style="list-style-type: none"> <li>The AN-SNAP cost model parameters comprise the following<sup>92</sup>: <ul style="list-style-type: none"> <li>Same day price weight: applicable to records within a same day SNAP class or admitted and discharged on the same day in a palliative care type.</li> <li>Short stay outlier per Diem rate: applicable to records that are not same day and have a length of stay shorter than the lower bound</li> <li>Inlier episodic rate: applicable to records with a length of stay within the upper and lower bound of the specific AN-SNAP v4 class.</li> <li>Long stay outlier per Diem rate: applicable to records with a length of stay longer than the specified upper bound.</li> </ul> </li> </ul>

<sup>87</sup> IHPA Classifications Subacute and non-acute care Available at <https://www.iHPA.gov.au/what-we-do/subacute-and-non-acute-care> Accessed 26Feb2020

<sup>88</sup> AIHW Metadata Online Registry. Functional Independence Measure. Available at <https://meteor.aihw.gov.au/content/index.phtml/itemId/495857> Accessed 18Feb2020

<sup>90</sup> Green J, Gordon R, Kobel C, Blanchard M and Eagar K. (2015), AN-SNAP V4 User Manual, Centre for Health Service Development, University of Wollongong. Available at [https://www.iHPA.gov.au/sites/default/files/Documents/an-snap\\_classification\\_version\\_4\\_user\\_manual.pdf](https://www.iHPA.gov.au/sites/default/files/Documents/an-snap_classification_version_4_user_manual.pdf) Accessed 26Feb2020

<sup>91</sup> Independent Hospital Pricing Authority <https://www.iHPA.gov.au/>

<sup>92</sup> IHPA 2019 National Pricing Model Technical Specifications 2019-20 Available at <https://www.iHPA.gov.au/publications/national-pricing-model-technical-specifications-2019-20> Accessed 26Feb2020

Country	Assessment	Classification	Funding source(s) and mechanism
		<ul style="list-style-type: none"> <li>○ Assessment only – rehabilitation and psychogeriatric</li> <li>○ Clinic type – GEM</li> <li>○ Single day of care without ongoing care plan – GEM</li> <li>○ Multidisciplinary – all care types</li> </ul> <p>The variables used to define the rehabilitation classes include impairment, age (or Age Type), FIM™ cognition score, a weighted FIM™ motor score and, in the non-admitted setting, assessment only.</p>	
<p><b>Australia</b></p> <p><b>Aged Care</b></p> <p><b>AN-ACC system<sup>93</sup></b></p> <p>AN-ACC is a new assessment and funding model developed as part of the Resource Utilisation and Classification Study (RUCS). RUCS was undertaken to developing a sound empirical evidence base on what drives relative care costs in residential aged care, both at the resident and facility level, to help inform Government consideration of reform options and in the development and design of a new funding model.</p>	<p><b>Initial and/or reassessment pathways and tools<sup>94</sup>:</b></p> <p><b>Initial</b></p> <ul style="list-style-type: none"> <li>● Resident assessment for funding to be separate from resident assessment for care planning purposes</li> <li>● Assessment for funding purposes to be undertaken by external assessors capturing the information necessary to assign a resident to a payment class</li> <li>● Assessment related to care planning to be undertaken by the residential aged care facility based on resident needs and underpinned by consumer directed care principles.</li> <li>● The AN-ACC Assessment Tool should be used to assess all new residents entering care as well as existing residents who care needs increase. The tool is comprised of nine sections assessing: <ul style="list-style-type: none"> <li>○ Technical nursing requirements</li> <li>○ Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)</li> <li>○ Australia-modified Karnofsky Performance Status</li> <li>○ Palliative Care</li> <li>○ Frailty</li> <li>○ Braden Scale – Predicting pressure sore risk</li> <li>○ Australian-modified FIM</li> <li>○ De Morton Mobility Index – modified</li> <li>○ Behaviour Resource Utilisation Assessment</li> </ul> </li> </ul> <p><b>Reassessment</b></p>	<ul style="list-style-type: none"> <li>● Residential aged care costs are driven by care burden associated with end of life needs, frailty, functional decline, cognition, behaviour and technical nursing needs.</li> <li>● Based on a new funding assessment tool purposefully developed as part of this study, a casemix classification termed the AN-ACC has been developed.</li> <li>● AN-ACC Version 1.0 comprises 13 classes and explains 50% of the variance in the cost of individual resident care. There is a fivefold variation in cost between the least and most expensive AN-ACC class.</li> </ul>	<ul style="list-style-type: none"> <li>● Provision of a one-off adjustment payment for each new resident that recognises additional, but time-limited, resource requirements when someone initially enters residential care;</li> <li>● A fixed price per day for the costs of care that are shared equally by all residents. This may vary by location and other factors;</li> <li>● A variable price per day for the costs of individualised care for each resident based on their AN-ACC case-mix class.</li> </ul>

<sup>93</sup> Australian Department of Health Proposal for a new residential aged care funding model Consultation paper March 2019. Available at [https://www.health.gov.au/sites/default/files/documents/2019/12/proposal-for-a-new-residential-aged-care-funding-model-consultation-paper\\_0.pdf](https://www.health.gov.au/sites/default/files/documents/2019/12/proposal-for-a-new-residential-aged-care-funding-model-consultation-paper_0.pdf) Accessed 26Feb2020

<sup>94</sup> Westera A et al. (2019) The AN-ACC assessment model. The Resource Utilisation and Classification Study: Report 2. Australian Health Services Research Institute, University of Wollongong. ISBN 978-74128-296-2

Country	Assessment	Classification	Funding source(s) and mechanism
	<ul style="list-style-type: none"><li>• Protocols for reassessment have been included in the AN-ACC funding model. It is proposed that the funding model include no formal requirement for reassessment of residents.</li><li>• The threshold for a reassessment is that the home anticipates that the person's individualised payment would increase by more than 20% of the national average payment per day. This would involve, in most cases, the movement of the resident within the AN-ACC classification from one major branch to another (e.g. independent mobility to assisted mobility).</li><li>• Three conditions were found to most frequently result in a significant change in resident care need in the reassessment study, and are proposed as triggers for homes to request a reassessment:<ul style="list-style-type: none"><li>• Significant hospitalisation</li><li>• Significant change in mobility</li><li>• A standard time period for reassessment</li></ul></li></ul>		



## Appendix C : Assessment volume estimates

### C.1 SOURCES AND ASSUMPTIONS OF THE ESTIMATES

The volume data presented in this Appendix has been derived from an analysis of 2018/19 CHSP and HCP data. It does not represent demand projections (as per Chapter 2, the Department has commissioned EY to model demand for aged care). Necessarily, the assumptions used to derive the 'first cut' estimates are subject to uncertainty, as the existing data has limitations and the details of the assessment model, particularly the threshold for when a consumer needs to be assessed, need to be developed.

#### Assessments undertaken in 2018-19 for CHSP and HCP (derived from NSAF data):

- 107,252 ACAT approvals of eligibility for home care
- 282,276 assessments undertaken for CHSP

The number of ACAT approvals of eligibility for home care is used as a proxy indicator for assessments as some people are approved for more than one type of care. In 2018-19, there were 175 482 completed ACAT assessments (equivalent to 42.5 per 1000 older people) and 200 695 approvals for residential aged care and the Home Care Package program. ACAT assessments are reported aggregately in the Report on Government Services.

Assessments undertaken for CHSP is derived from NSAF data used in the Deloitte CHSP Data Study, taken from the analysis of reported triggers for assessments and health conditions. This is an estimate only due to incomplete data fields, and likely under representative of assessments undertaken in 2018-19.

#### Consumers with an informal carer:

- 20% (21,450 consumers assessed to be eligible) of HCP consumers are estimated to have an informal carer
- 16% (45,164 consumers assessed) of CHSP consumers have an informal carer

The number of HCP consumers with an informal carer is not included in the HCP program data collection. The Stewart Brown Home Care Provider Survey 2020 analysis of living arrangements of HCP consumers found 43% lived alone, with 24% and 29% living with family or a partner respectively. It also noted the average age at first entry into HCP was 79.9 years. Given the propensity for individuals to naturally experience a trajectory of decline and decrease in functional status, it is assumed the level of informal care and support is higher with HCP consumers (compared to CHSP consumers).

The number of CHSP consumers with an informal carer is drawn from the Deloitte CHSP Data study subject to the caveats noted above in assessments undertaken. This proportion of consumers reported to have an informal carer is not dissimilar from the reported proportion of consumers with an informal carer in the 2017-18 GEN data (publicly available) which ranged from 29.1% to 13.7% across 5-year age group intervals<sup>95</sup>.

#### Informal carer assessment:

- 60% of informal carers will likely undergo an informal carer assessment
  - 12,870 informal carers of HCP consumers (12% of HCP consumers informal carers assessed)
  - 27,098 informal carers of CHSP consumers (9.6% of CHSP consumers informal carers assessed)

<sup>95</sup> CHSP aged care services 2017-18 Available at <https://www.gen-agedcaredata.gov.au/Resources/Dashboards/Commonwealth-Home-Support-Programme-aged-care-serv> Accessed 5May2020

It is acknowledged that not all informal carers will require an assessment as there will be a wide range in the amount (hours) of care provided, and in the capacity and capability of informal carers. The findings of the Disability, Ageing and Carers Australia Survey 2018<sup>96</sup> reported 36% of informal carers aged 45 years and over to be a primary carer. Informal carers aged 45 years over is used as 72.4% of informal carers were reported to be a spouse, daughter or son. The primary support used by informal carers is respite. The proportion of informal carers that have either previously used respite care and needs more, or have never received respite care but needs it was 14.9% and 7.6% of informal carers aged 45-64 years and over 65 years respectively.

This proxy estimate is also based on the assumption informal carers are a part of a workforce that is increasingly working to older ages<sup>97</sup>, thus perhaps requiring additional supports.

#### Reablement assessment:

- 10% (10,725 consumers) of current HCP consumers are estimated to be appropriate for reablement ***in parallel to being assessed for ongoing care***
- 40% (112,910 consumers) of current CHSP consumers are estimated to be appropriate for reablement

It is assumed that minimal HCP consumers may be appropriate for a reablement assessment given the higher complexity and/or lower functional status of HCP clients

The evaluation of the CHSP Reablement trial found up to 40% of consumers assessed could be appropriate candidates for restorative care<sup>98</sup>. Based on a conservative estimate of consumers that undergo a RAS assessment for CHSP, 112,910 consumers may be appropriate to undergo a reablement assessment proceeding screening and triage.

#### Direct access:

- 40% (112,910 consumers) of current CHSP consumers likely to access services directly from screening and triage (note the basis for this estimate has a high degree of uncertainty)

This estimate is based on 53.2% of CHSP consumers accessing only one or two service types in 2018-19<sup>99</sup>, along with the potential for 40% of CHSP consumers estimated to be appropriate for reablement. As there is no data available to determine how well the assessed needs of consumers are met (services delivered), a more conservative estimate has been applied.

<sup>96</sup> Disability, Ageing and Carers, Australia: Summary of Findings, 2018 4430.0 released 24 Oct 2019 Available at [https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4430.0Main%20Features62018?opendocument&tabname=Summary&pro\\_dno=4430.0&issue=2018&num=&view=](https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4430.0Main%20Features62018?opendocument&tabname=Summary&pro_dno=4430.0&issue=2018&num=&view=) Accessed 5May2020

<sup>97</sup> AIHW 2018 Older Australia at a glance. Available at <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/social-and-economic-engagement/employment-and-economic-participation> Accessed 5May2020

<sup>98</sup> AHA Preliminary Report Evaluation of CHSP Reablement Trial 2020

<sup>99</sup> Deloitte Access Economics CHSP Data Study draft report Dec 2019

Figure C.1: CHSP consumer assessments modelled on proportionate assessment approach

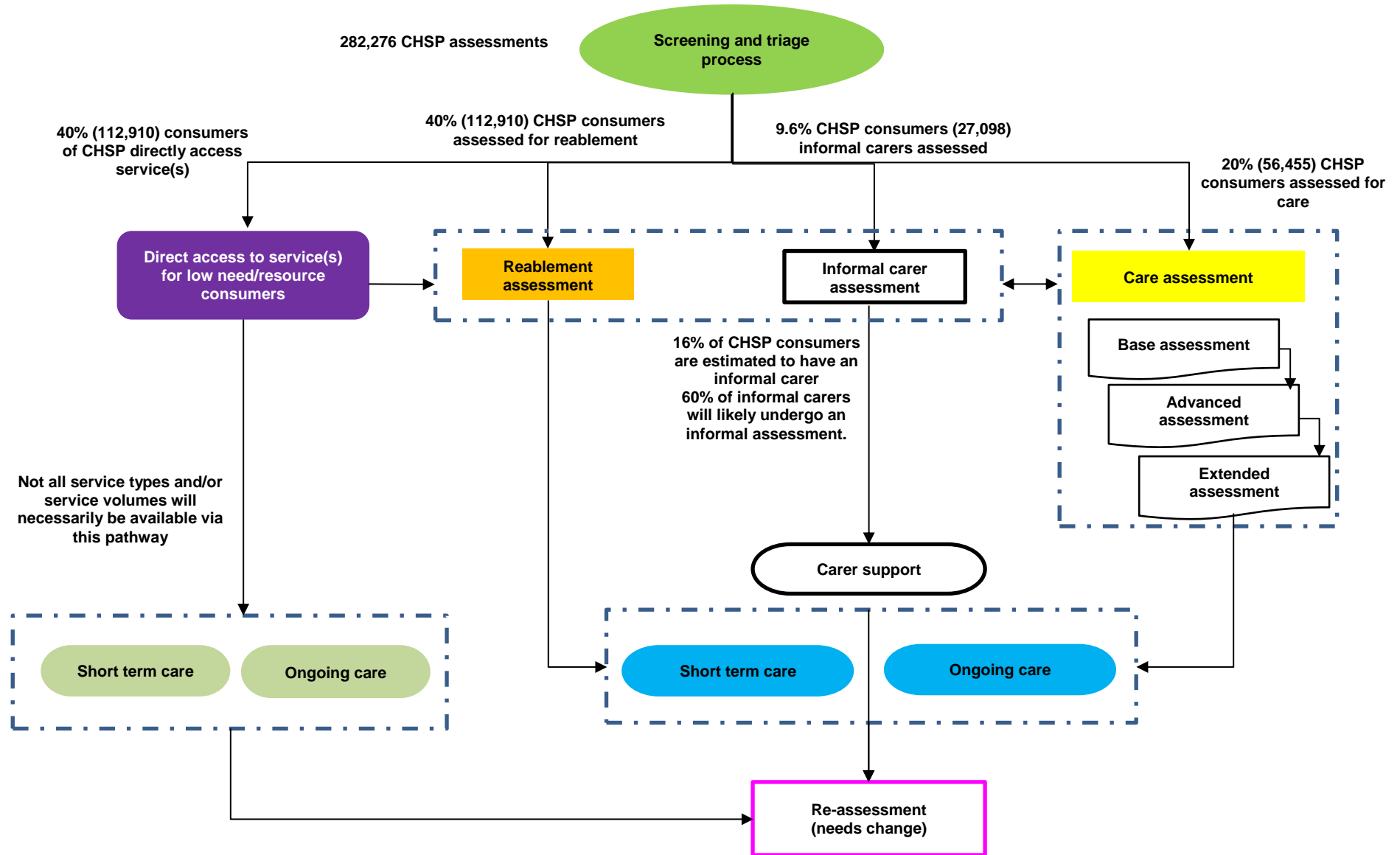
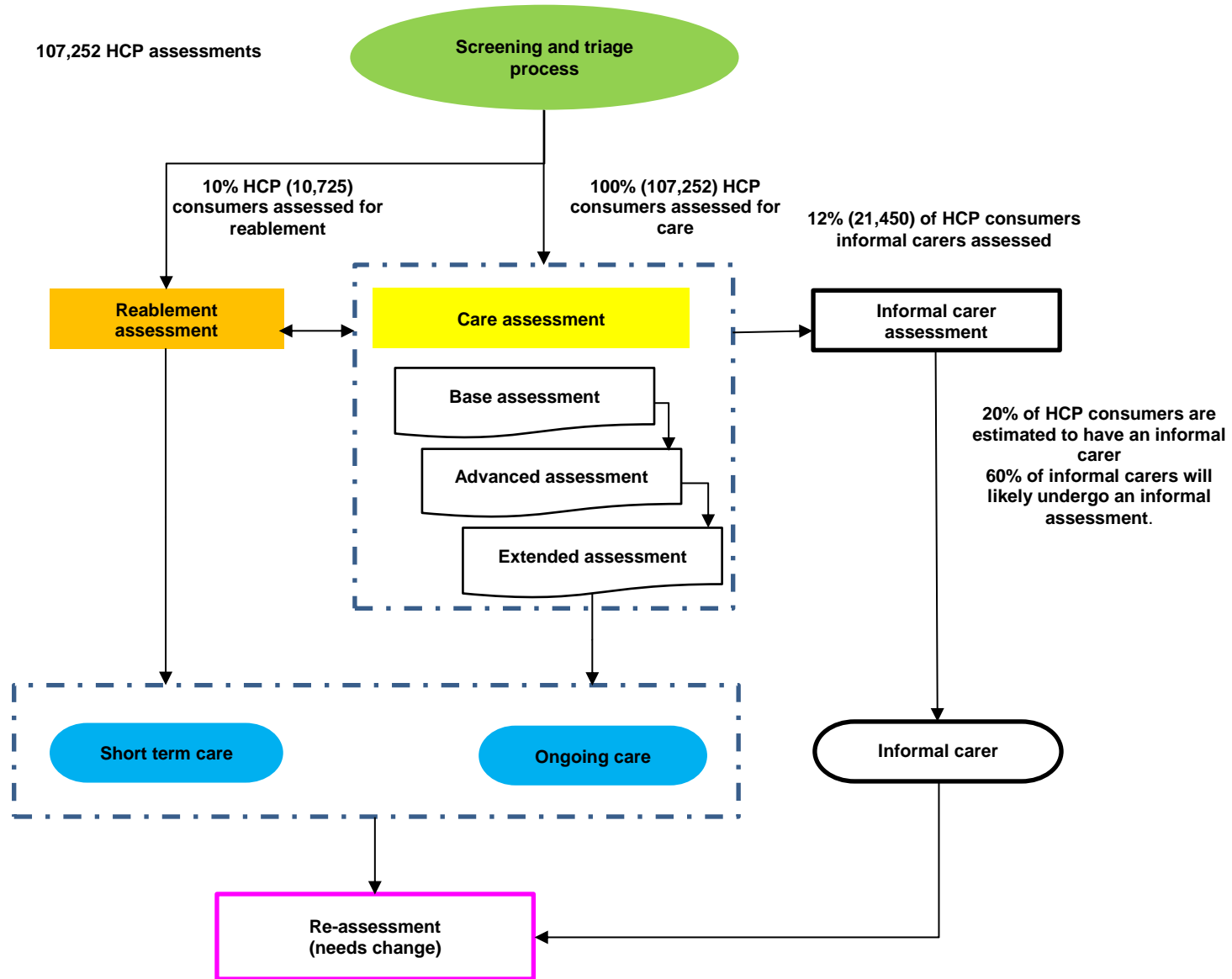


Figure C.2: HCP consumer assessments modelled on proportionate assessment approach



## Appendix D : Criteria used for evaluating ACF model options

This Appendix describes the process that was undertaken to arrive at an evaluation criteria for assessing each of the ACF model components.

### D.1 GUIDING PRINCIPLES DRAWN FROM THE HEALTH AND AGED CARE SECTORS

This section outlines guiding principles drawn from the health and aged care sectors, including the current Royal Commission into Aged Care Safety and Quality ('Royal Commission'), that were considered to be relevant to developing criteria for assessing the preliminary ACF model options.

#### D.1.1 *Royal Commission into Aged Care Safety and Quality*

The Royal Commission released Consultation Paper 1 Aged Care Program Redesign: services for the future to start a public consultation process on 6<sup>th</sup> December 2019. The paper primarily suggested that the structure of a redesigned aged care system be arranged into an entry level support stream, a care stream, and an investment stream.

After a consultation process involving submissions and subsequent hearings, the recommendations for program design in Counsel Assisting's submission to the 4 March 2020 Commission hearing depart from the Consultation Paper in some respects. These differences include all consumers being assessed, needs based entitlement (not rationed) approach inclusive of wellness and reablement, and levels of funding (corresponding to classifications) being linked to actual cost data ascertained by an independent pricing authority.

The Royal Commission's Consultation Paper 1 did propose principles that should underpin the redesign of the aged care system proposed (noting that these principles may change as part of the Royal Commission's ongoing processes), which were:

- be underpinned by respect and support for the rights, choices and dignity of older people
- ensure quality and safe care is fundamental to the operation, funding and regulation of the system
- provide equity of access, regardless of location, means or background
- be transparent, easy to understand and navigate
- deliver care according to individual need
- maximise independence, functioning and quality of life for older people
- support older people to have a good death
- support older peoples' informal care relationships and connections to community
- enable the recruitment and retention of a skilled, professional and caring workforce
- support effective interfaces with related systems, particularly health and disability
- be affordable and sustainable, both for individuals and the broader community
- be capable of being implemented, monitored and evaluated.

As was intended, these principles are fashioned to guide redesign of the aged care system rather than for use in choosing between options for the ACF model for aged care at home services. That said, some principles are relevant to developing ACF model options, particularly "deliver care according to individual need" and "be capable of being implemented, monitored and evaluated".

#### D.1.2 *Department of Health*

In commissioning the development of options for the ACF model for aged care at home, the Department set out issues that need to be considered. The Department also advised some extra principles which build on the principles included in the Royal Commission's Consultation Paper 1:

***Issues from the ATM document***

The ATM seeking consultancy services to develop options to inform the ACF model to underpin a single unified system for care of the elderly in the home set out several issues to be considered, which were:

- The single unified system for care of the elderly in the home will bring together two separate programs that currently have different assessment, funding, care, and data and reporting arrangements.
- The system will also include services that are not currently well catered for by either program – such as carer supports, increased investment and reablement services or separately funded care coordination services that the model will need to consider.
- The model will need to consider clinical and non-clinical care needs (such as social supports) that go to the makeup of the recommended services and funding classifications.
- The model will need to be dynamic and predictive to account for changing care needs (based on reablement, wellness or decline), as well as identify up front/short term/one off care needs versus ongoing services within the TSBs.
- The model will also need to identify the need/cost/risk groups in the community and where longer-term support is required.
- The model should account for demand across states and regions based on current and predicted under and over supply. The model will also need to consider what arrangements are required for rural and regional areas where economies are required for service viability (such as fixed cost or provider of default arrangements).
- How incentives for maintenance or reablement of health status/function of recipients may be built into future funding arrangements, and how the system works to help manage demand.
- Interface with the broader health and aged care system required for a unified system e.g. Primary Health Networks, acute care services, palliative care services, residential care services etc.

An important assumption in these issues is that TSBs will be a feature of the new ACF system (although the Department did indicate that other options for achieving the objectives could be contemplated if they are justified). As per the ATM, it is intended that these issues will be addressed in more detail by the fully developed ACF model (i.e. at the end of Phase two of the work) but some of them are clearly relevant to the development of options (Phase one).

***Additional principles advised by the Department***

As part of the Phase one work, the Department put forward several extra principles that should be considered (in addition to the Royal Commission principles), which were:

- support person-centred care that is safe and responsive to each individual's needs, goals, values and preferences
- support diversity and choice, and encourage innovation in service delivery
- assist families and carers to support their loved ones
- provide a continuum of care that supports people as their care needs change, including a dignified death.

Much like the Royal Commission's principles, these principles are stated at a broad level to guide overall system design. For the purposes of developing ACF model options, they do illustrate the need to strike a balance between various aspirations, e.g. for the first one "each individual's needs, goals, values, and preferences" may not align if "needs" are determined by professional assessment and "goals, values and preferences" are determined by the care recipient.

### D.1.3 Independent Hospital Pricing Authority

IHPA provides a relatively mature model of classification and funding systems development to support ABF in Australian public hospitals. The decisions made by IHPA in pricing in-scope public hospital services are evidence-based and use the latest cost and activity data supplied to IHPA by State/Territory Health Authorities. In making these decisions, IHPA balances a range of policy objectives including improving the efficiency and accessibility of public hospital services. This process involves exercising judgement on the weight to be given to different policy objectives.

The **Pricing Framework for Australian Public Hospital Services 2020-21**<sup>100</sup> (the Pricing Framework) is the key strategic document underpinning the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the financial year 2020-21.

The **Pricing Guidelines** outlined in the Pricing Framework signal IHPA's commitment to transparency and accountability as it undertakes its work. They are the overarching framework within which IHPA makes its policy decisions.

Principles from the Pricing Guidelines (Pricing Framework):

- **Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising ABF and block grant funding:**
  - *Timely-quality care:* Funding should support timely access to quality health services.
  - *Efficiency:* ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
  - *Fairness:* ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.
  - *Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:* Funding design should recognise the complementary responsibilities of each level of government in funding health services.
- **Process Guidelines to guide the implementation of ABF and block grant funding arrangements:**
  - *Transparency:* All steps in the determination of ABF and block grant funding should be clear and transparent.
  - *Administrative ease:* Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
  - *Stability:* The payment relativities for ABF are consistent over time.
  - *Evidence-based:* Funding should be based on best available information.
- **System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:**
  - *Fostering clinical innovation:* Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
  - *Promoting value:* Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.
  - *Promoting harmonisation:* Pricing should facilitate best practice provision of appropriate site of care.
  - *Minimising undesirable and inadvertent consequences:* Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
  - *ABF pre-eminence:* ABF should be used for funding public hospital services wherever practicable.
  - *Single unit of measure and price equivalence:* ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between

<sup>100</sup> IHPA Pricing Framework 2020-21 Available at <https://www.ihoa.gov.au/sites/default/files/minisite/static/8601/pricing-framework-2020-21/pricing-framework/pricing-guidelines/overview.html>

different care types and service streams through a single unit of measure and relative weights.

- *Patient-based*: Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- *Public-private neutrality*: ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.

As can be seen, these principles range from system level considerations such as “timely-quality care” and “fairness”, to considerations relating to the implementation of the funding system like “transparency” and “administrative ease”, to specific considerations relating to the design of the funding system like “single unit of measure” and “patient based”. Many of the principles relating to implementation and payment system design are relevant to evaluating ACF model options.

#### **D.1.4 Future Funding models for residential aged care (AN-ACC)**

The AHSRI at the University of Wollongong was commissioned by the Australian Government Department of Health to develop options and recommendations for future funding models to be adopted for the residential aged care in Australia. The final report of the study published in 2017<sup>101</sup>, identified five options and recommended a preferred option, which when implemented, led to the development of the Australian National Aged Care Classification (AN-ACC) system. The 14 criteria used by AHSRI to evaluate the five options were<sup>102</sup>:

- Integration with pathways and structures (was not assessed)
- Certainty for government
- Certainty for providers
- Adequacy of price for providers (was not assessed)
- Equity
- Alignment with aged care cost drivers
- Incentives for maintenance and reablement (was not assessed)
- Interface with the broader health system (was not assessed)
- Incentives for innovation and efficiency
- Continuity between home and residential care
- Operational efficiency
- Robustness
- Suitability for use under external assessment arrangements
- Implementation and transition considerations

As shown above, four of the criteria were not assessed in choosing between the five options, as to do so would have required further detail about the assessment and funding systems. Those four criteria are probably not that relevant to the evaluation of the ACF model options to be developed for aged care at home. But, given the current project includes consideration of the assessment model options, the “integration with pathways and structures” and “incentives for maintenance and reablement” criteria may need to be considered.

Most of the other 10 criteria used by AHSRI are relevant, except for “suitability for use under external assessment arrangements” as these are already a feature of accessing aged care at home services. A significant issue to consider is that the AHSRI work was not done in an environment of significant redesign to the aged care system. The unified aged care at home program context is more fluid, where many features of the design (including the future arrangements for assessment) of the unified aged care at home program are not yet determined, hence it is more difficult to assess options against the criteria.

<sup>101</sup> McNamee J, Poulos C, Seraji H et al. (2017) *Alternative Aged Care Assessment, Classification System and Funding Models Final Report*. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong

<sup>102</sup> *ibid*



### D.1.5 Discussion

We drew together the principles from the four different sources that have been used to assess options for system development (either for the overall care system or for classification and funding models). We also reviewed many of the submissions made to the Royal Commission in response to Consultation Paper 1. Most of these submissions offered comment on the Royal Commission's principles, usually by expressing support or by suggesting additions. Overall, we thought that the suggested additions were almost always directed at overall aged care system design and could often be regarded as a re-expression of the Royal Commission's principles using different wording.

Accordingly, we judged that there was no significant new information in those submissions that is immediately relevant to developing criteria for choosing amongst ACF model options. So, the determination of the criteria to be used to assess the ACF components was drawn from the four sources listed above.

## D.2 PRIORITISATION OF KEY PRINCIPLES

This section consolidates the principles that were identified in Section D.1, categorises them in terms of relevance and arrives at a set of criteria that is suggested for use in choosing between ACF model options for the unified aged care at home program.

### D.2.1 Categorisation of principles

All the guiding principles referenced in Section D.1 were first categorised into principle type, as follows:

- **service system/sector stability (service system):** the principle largely guides the design of the overall service system, but may also be relevant to choosing amongst assessment, classification and funding system options
- **classification and funding system (CF system):** the principle largely guides the design of the classification and funding system (taken to include assessment for the purpose of this project) and is relevant to choosing amongst assessment, classification and funding model options
- **implementation and operation processes ('process'):** the principle largely guides choices amongst assessment, classification and funding model options based on ease of implementation and operation considerations.

Each guiding principle is then classified as a **direct** or **indirect** impact on choosing amongst ACF model options. **Direct impact** principles are more likely to influence the choice of ACF model options, whereas indirect principles aid the consideration of the direct principles and are likely to be subject to a broader range of influencing factors. Each relevant guiding principle has also been categorised and mapped to one or more of the **assessment**, **classification** and **funding** model elements. Each of the model elements are defined as:

- **Assessment:** the process and associated tools that will be used to assess the needs of an older person for support from the unified aged care at home program; assessment outcomes will then be used to develop care plans and to drive the classification and funding models.
- **Classification:** the system that classifies individual consumers into classes where each person in a class has similar care needs and requires similar levels of resources to fund support services to meet those needs.
- **Funding:** the model that will be used to allocate funds for service provision in the unified aged care at home program; it will use the classification system in the allocation process.

The *mapping* of the **principles** to the **model elements** (i.e. assessment, classification and funding) involved making a judgement on which aspect of the model the principle was most applicable to. The outcome of this work is presented in Table D.1.

Table D.1: Categorisation and mapping of guiding principles

Principle Number and Source	Principle	Principle type	Impact	Assessment, classification or funding
<b>Royal Commission into Aged Care Quality and Safety</b>				
1 RC	Be underpinned by respect and support for the rights, choices and dignity of older people	service system	indirect	assessment
2 RC	Ensure quality and safe care is fundamental to the operation, funding and regulation of the system	CF system	direct	classification funding
3 RC	Provide equity of access, regardless of location, means or background	service system	direct	assessment
4 RC	Be transparent, easy to understand and navigate	process	direct	assessment classification funding
5 RC	Deliver care according to individual need	service system	direct	assessment classification
6 RC	Maximise independence, functioning and quality of life for older people	CF system	direct	assessment classification
7 RC	Support older people to have a good death	service system	indirect	N/A
8 RC	Support older peoples' informal care relationships and connections to community	service system	direct	assessment classification funding
9 RC	Enable the recruitment and retention of a skilled, professional and caring workforce	service system	indirect	N/A
10 RC	Support effective interfaces with related systems, particularly health and disability	service system	indirect	assessment
11 RC	Be affordable and sustainable, both for individuals and the broader community	CF system	direct	funding
12 RC	Be capable of being implemented, monitored and evaluated.	CF system	direct	assessment classification funding
<b>Department Principles</b>				
13 Dept Sup	Support person-centred care that is safe and responsive to each individual's needs, goals, values and preferences	service system	indirect	assessment
14 Dept Sup	Support diversity and choice, and encourage innovation in service delivery	CF system	direct	classification funding
15 Dept Sup	Assist families and carers to support their loved ones	service system	direct	assessment classification funding
16 Dept Sup	Provide a continuum of care that supports people as their care needs change, including a dignified death	CF system	direct	assessment classification
17 Dept ATM	The single unified system for care of the elderly in the home will bring together two separate programs that currently have different assessment, funding, care, and data and reporting arrangements.	service system	indirect	N/A
18 Dept ATM	The system will also include services that are not currently well catered for by either program – such as carer supports, increased investment and reablement services or separately funded care coordination services that the model will need to consider.	service system	direct	assessment classification funding

Principle Number and Source	Principle	Principle type	Impact	Assessment, classification or funding
19 Dept ATM	The model will need to consider clinical and non-clinical care needs (such as social supports) that go to the makeup of the recommended services and funding classifications.	service system	direct	assessment classification funding
20 Dept ATM	The model will need to be dynamic and predictive to account for changing care needs (based on reablement, wellness or decline), as well as identify up front/short term/one off care needs versus ongoing services within the TSBs.	CF system	direct	assessment classification funding
21 Dept ATM	The model will also need to identify the need/cost/risk groups in the community and where longer-term support is required.	CF system	direct	classification
21 Dept ATM	The model should account for demand across states and regions based on current and predicted under and over supply. The model will also need to consider what arrangements are required for rural and regional areas where economies are required for service viability (such as fixed cost or provider of default arrangements).	CF system	direct	funding
22 Dept ATM	How incentives for maintenance or reablement of health status/function of recipients may be built into future funding arrangements, and how the system works to help manage demand.	CF system	direct	classification funding
23 Dept ATM	Interface with the broader health and aged care system required for a unified system (e.g. Primary Health Networks, acute care services, palliative care services, residential care services etc).	service system	indirect	assessment
<b>Independent Hospital Pricing Authority</b>				
24 IHPA	<b>Timely-quality care:</b> Funding should support timely access to quality health services.	service system	indirect	funding
25 IHPA	<b>Efficiency:</b> ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.	service system	indirect	funding
26 IHPA	<b>Fairness:</b> ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.	service system	indirect	funding
27 IHPA	<b>Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:</b> Funding design should recognise the complementary responsibilities of each level of government in funding health services.	service system	indirect	N/A
28 IHPA	<b>Transparency:</b> All steps in the determination of ABF and block grant funding should be clear and transparent.	process	indirect	funding
29 IHPA	<b>Administrative ease:</b> Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.	process	direct	assessment classification funding
30 IHPA	<b>Stability:</b> The payment relativities for ABF are consistent over time.	CF system	indirect	funding
31 IHPA	<b>Evidence-based:</b> Funding should be based on best available information.	CF system	indirect	assessment classification funding
32 IHPA	<b>Fostering clinical innovation:</b> Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.	CF system	direct	classification funding
33 IHPA	<b>Promoting value:</b> Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.	CF system	direct	funding
34 IHPA	<b>Promoting harmonisation:</b> Pricing should facilitate best practice provision of appropriate site of care.	service system	direct	assessment
35 IHPA	<b>Minimising undesirable and inadvertent consequences:</b> Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.	CF system	direct	classification funding
36 IHPA	<b>ABF pre-eminence:</b> ABF should be used for funding public hospital services wherever practicable.	service system	indirect	NA

Principle Number and Source	Principle	Principle type	Impact	Assessment, classification or funding
37 IHPA	<b>Single unit of measure and price equivalence:</b> ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.	CF system	direct	classification funding
38 IHPA	<b>Patient-based:</b> Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.	CF system	direct	classification
39 IHPA	<b>Public-private neutrality:</b> ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.	service system	indirect	N/A
<b>Residential Aged Care Funding</b>				
40 RACF funding	Integration with pathways and structures (was not assessed)	CF system	direct	assessment classification
41 RACF funding	Certainty for government	CF system	direct	funding
42 RACF funding	Certainty for providers	CF system	direct	funding
43 RACF funding	Adequacy of price for providers (was not assessed)	CF system	indirect	N/A
44 RACF funding	Equity	service system	indirect	funding
45 RACF funding	Alignment with aged care cost drivers	CF system	direct	classification funding
46 RACF funding	Incentives for maintenance and reablement (was not assessed)	CF system	direct	classification funding
47 RACF funding	Interface with the broader health system (was not assessed)	service system	indirect	assessment
48 RACF funding	Incentives for innovation and efficiency	CF system	direct	classification funding
49 RACF funding	Continuity between home and residential care	CF system	direct	assessment classification
50 RACF funding	Operational efficiency	service system	indirect	funding
51 RACF funding	Robustness	process	indirect	assessment classification funding
52 RACF funding	Suitability for use under external assessment arrangements	service system	direct	N/A
53 RACF funding	Implementation and transition considerations	CF system	direct	assessment classification funding

### D.2.2 Consolidation and prioritisation

The guiding principles provide a rich source of information to shape the development of criteria for choosing amongst ACF model options. There is clearly considerable duplication and many of the principles describe closely related concepts. That is a positive outcome, as it allows us to analyse confidently the reference information we have sourced, to suggest a set of fit-for-purpose set of criteria for evaluating ACF model options.

To start the analysis, we grouped the identified principles into the ACF model elements to which they are considered to best apply, including separate categories where we believe that a principle applies to more than one model element (refer to Table D.2).

**Table D.2: Consolidation of direct impact principles to key ACF model element**

ACF model element	Principle type	Impact	Principle id	Principle
Assessment	Service system	Direct	3 RC	Provide equity of access, regardless of location, means or background
			34 IHPA	Promoting harmonisation: Pricing should facilitate best practice provision of appropriate site of care.
Classification	CF system	Direct	21 Dept ATM	The model will also need to identify the need/cost/risk groups in the community and where longer-term support is required.
			38 IHPA	Patient-based: Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
Funding	CF system	Direct	11 RC	Be affordable and sustainable, both for individuals and the broader community
			21 Dept ATM	The model should account for demand across states and regions based on current and predicted under and over supply. The model will also need to consider what arrangements are required for rural and regional areas where economies are required for service viability (such as fixed cost or provider of default arrangements).
			33 IHPA	Promoting value: Pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centred care.
			41 RACF funding	Certainty for government
			42 RACF funding	Certainty for providers
Assessment	Process	Direct	4 RC	Be transparent, easy to understand and navigate
			29 IHPA	Administrative ease: Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
Classification	Service system	Direct	8 RC	Support older peoples' informal care relationships and connections to community
			15 Dept Sup	Assist families and carers to support their loved ones
			18 Dept ATM	The system will also include services that are not currently well catered for by either program – such as carer supports, increased investment and reablement services or separately funded care coordination services that the model will need to consider.
			19 Dept ATM	The model will need to consider clinical and non-clinical care needs (such as social supports) that go to the makeup of the recommended services and funding classifications.
			12 RC	Be capable of being implemented, monitored and evaluated.
Funding	CF system	Direct	20 Dept ATM	The model will need to be dynamic and predictive to account for changing care needs (based on reablement, wellness or decline), as well as identify up front/short term/one off care needs versus ongoing services within the TSBs.
			53 RACF funding	Implementation and transition considerations
Assessment	Service system	Direct	5 RC	Deliver care according to individual need
Classification	CF system	Direct	6 RC	Maximise independence, functioning and quality of life for older people
			16 Dept Sup	Provide a continuum of care that supports people as their care needs change, including a dignified death

ACF model element	Principle type	Impact	Principle id	Principle
			40 RACF funding	Integration with pathways and structures (was not assessed)
			49 RACF funding	Continuity between home and residential care
Classification	CF system	Direct	2 RC	Ensure quality and safe care is fundamental to the operation, funding and regulation of the system
Funding			14 Dept Sup	Support diversity and choice, and encourage innovation in service delivery
			22 Dept ATM	How incentives for maintenance or reablement of health status/function of recipients may be built into future funding arrangements, and how the system works to help manage demand.
			32 IHPA	Fostering clinical innovation: Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
			35 IHPA	Minimising undesirable and inadvertent consequences: Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
			37 IHPA	Single unit of measure and price equivalence: ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
			45 RACF funding	Alignment with aged care cost drivers
			46 RACF funding	Incentives for maintenance and reablement (was not assessed)
			48 RACF funding	Incentives for innovation and efficiency

## Appendix E : Overview of interRAI RUG-III-HC system

The option to refine and modify RUG-III-HC received some limited support, with stakeholders largely citing the fact that the system was developed for aged care systems outside Australia and observing that it was too clinically focussed rather than support care focussed (aged care is a social care system rather than a health care system). Cognisant of these challenges, further review of the interRAI Home Care system, its application in other OECD countries, and the Australia context has been undertaken to confirm the suitability of this classification system option.

### E.1 WHAT IS THE INTERRAI HC SYSTEM?

The interRAI HC system was developed for use with adults in home and community-based settings. The assessment instrument is generally used with the frail elderly or persons with disabilities who are seeking or receiving formal health care and supportive services. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. The interRAI system is a licensed product, non-commercial organisations (e.g. governments, care providers) are generally granted a royalty-free license. The major clauses within the interRAI royalty-free licenses include:

- the instrument is not to be changed substantially (excepting individual identifiers and demographics), although additional items can be added
- only licensed translations can be used
- electronic data from use of the instrument are to be shared with interRAI, subject to existing laws on confidentiality and data use.

The HC system supports a range of decision support tools that assist the assessor in planning and monitoring care. These include:

- Scales for ADLs, cognition, communication, pain, depression, and medical instability
- Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
- Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and Method for Priority Levels (MAPLe) systems)
- A quality monitoring system (Home Care Quality Indicators, or HCQIs)
- A case-mix system that creates distinct service-use intensity categories (RUG-III-HC)
  - RUG-III-HC categorises consumers in groups based on clinical characteristics. The RUG-III-HC methodology assigns each consumer to one of 23 groups based on assessment outcomes. Each of the 23 RUG-III-HC groups fall into one of seven clinical categories.

### E.2 WHO USES THE INTERRAI HC SYSTEM?

In assessing the suitability of use of interRAI HC and/or the RUG-III-HC classification system in Australia, its use in a selection of OECD countries was investigated. A summary of the findings include (additional detail provided in Table E.1):

- New Zealand and Canada both use the interRAI HC assessment tool nationally. However, only Canada utilises the RUG-III-HC classification system (noting territory and province differences in levels of home care hours funded). New Zealand uses an adapted version of the interRAI HC assessment tool, and has multiple classification systems in use to account for the restorative/responsive model that operates in parallel. District Health Boards (DHBs) also each

set thresholds for access to services. Arrangements may be individualised (per client, may be service based for restorative care or bulk funding).

- The interRAI HC assessment tool is used to some extent in Finland and the USA. Finland legislation requires the use of some kind of assessment system and the interRAI HC assessment tool is the most widely used in elderly services in the evaluation of home care and 24-hour care clients. In the absence of a classification system, home care service delivery is guided by a national quality framework which specifies key dimensions of quality of care such as prevention and early intervention, comprehensive assessment, and workforce, and standards to be met. USA uses multiple assessment tools and classification models [including interRAI] to reflect the multiple funding streams (Medicare, Medicaid) and programs (Personal care, Home Help Resource Groups, Community living assistance services).
- France use of the interRAI HC assessment tool is limited and currently only mandated for use in Marseilles. Assessment for home care services is based on ADLs, with a personalised support plan developed by a social-medical team and care-giver employed to support ADL and IADL services based on assessed level of dependence (four levels with an associated monthly allowance).
- Belgium trialled an adapted version of the interRAI HC assessment tool in 2009-2011. Work is purported to be underway to develop this further. Currently the Belgian Evaluation Scale for Activities of Daily Living (BESADL, adapted from the Katz scale) is utilised.

The interRAI HC system is reported to be used by private organisations (to what degree and exact extent could not be fully determined) in a number of countries including United Kingdom, Netherlands, Germany, Italy, Austria, Portugal, China, Japan and Australia.

### E.3 USE OF INTERRAI HC IN AUSTRALIA

The drivers to use the interRAI HC system primarily appear to be the desire for a:

- standardised approach to assessment
- MDS that is able to capture functional status of consumers
- functionality to use as a quality indicator for the care of older individuals (HCQIs), and
- be benchmarked (nationally and/or internationally).

Utilisation of the interRAI HC system and use of the RUG-III-HC classification system means all consumers need to be assessed, and so proportionate assessment would not be an option. There was very little support for the *all consumers* assessed option (except COTA) received during the stakeholder consultation process. Most stakeholders did not think it represented the best use of resources. There was concern that it may create waiting list barriers to access, and that it would require an assessment workforce that was too large.

The application of the interRAI HC assessment tool and resulting assessment data in the OECD countries reviewed is variable. Program and socioeconomic data are also collected to varying degrees. Coupled with the different home care service delivery models (program eligibility, funding streams, informal carer supports, workforce etc), benchmarking internationally presents a more considered, somewhat difficult exercise. Hence benchmarking Australian home care services using interRAI HC to international service provision may not as informative due to transferability and applicability issues.

National benchmarking to ensure consumers needs are being met by the home care system in a manner that is efficient and timely (e.g. Finland) is valuable. However, there is also value derived from building a set of evidence-based quality and outcome indicators along with program data (operations and financials) linked to assessed needs. This approach would allow alignment to our existing quality care standards (e.g. Australian Aged Care Standards), building on and strengthening existing quality and safety monitoring in the aged care sector in Australia.



Only Canada and the USA use the RUG-III-HC classification system, not unexpected given the interRAI system was originally based on the US budgetary and regulatory reforms of their aged care system. New Zealand has multiple classification systems, most notably the Restorative/responsive Home Support Delivery Model. New Zealand Home and Community Health Association put forward a consultancy proposal in 2018 to develop a case-mix classification system to facilitate more equitable service delivery model that incentivises best practice, quality and innovation. It noted that the RUG-III-HC classification system was too broad for the New Zealand setting. The use of multiple and/or other classification systems by countries using the interRAI HC assessment tool appears to reflect the regulation and legislation of their health and aged care sectors, funding streams, decentralisation of service delivery and funding determination to the regional/local level. This highlights the difficulty with selecting an 'off the shelf product'.

A classification approach groups consumers with similar needs that predict expected resource use. The resource use of consumers of aged care services in the home can change rapidly and often. It may be in response to an event that requires additional time-limited services (e.g. respite, personal care), or services to uplift a consumer's ability to undertake an ADL(s) that has deteriorated. An event may be planned or unplanned such as an informal carer falls ill, or the palliative care needs of a consumer change (as highlighted in the witness statement to the Royal Commission from Dr Jane Fischer, representative of Palliative Care Australia). A responsive system to better facilitate the movement of consumers both within care settings and care system is a key underlying principle. In its standard form (unmodified), the interRAI RUG-III-HC classification system does not offer the degree of flexibility to allow multiple consumers to be in more than one classification class. Clinically focussed, it does not include time limited services (e.g. restorative care, respite) in an upfront and/or intermittent manner.

For these reasons, the interRAI RUG III HC option was not developed further (it would have received low scores against the evaluation criteria, given the above limitations).

Table E.1: OECD countries use of interRAI system for home care of the older person at home

Country	interRAI HC assessment tool	RUG-III-HC classification system	ACF data collection
New Zealand	<p>✓ implemented nationally</p> <ul style="list-style-type: none"> <li>The NZ version of the interRAI-HC includes 236 individual questions, assessed over 20 domains, which can generate 27 validated instrument scores that guide patient treatment. The adaption of the interRAI-HC for NZ included extensive Māori consultation to ensure that a framework to perform culturally appropriate assessments was established, and so that accurate, systematic and comprehensive ethnicity data were made available</li> <li>interRAI Contact Assessment used for low non-complex consumers</li> </ul>	<p>✗</p> <ul style="list-style-type: none"> <li>Individuals are classified according to level of need: very low, low, medium, high or very high. If a person is classified as high or very high, they become eligible for residential care services</li> <li>Different districts use different classification models that include: <ul style="list-style-type: none"> <li>➤ Home and Community Case mix model (versions) currently operating in seven DHB regions</li> <li>➤ Restorative/responsive Home Support Delivery Model interRAI assessment</li> <li>➤ Other relevant national integrated services such as ACC's Integrated HCSS contract funding and delivery model.</li> </ul> </li> <li>A case for development of a national case mix delivery and contracting framework was put forward in 2018 by Home and Community Health Association</li> </ul>	<p>✓</p> <ul style="list-style-type: none"> <li>Data submitted to interRAI and annual reports produced on New Zealand home care assessments and consumer assessment outcomes for a 12-month period (typically not longitudinal).</li> <li>National Health Identifier is used in the interRAI HC assessment, theoretically the interRAI HC assessment data can then be linked to health system data.</li> </ul>
Canada	<p>✓ implemented nationally</p>	<p>✓</p> <ul style="list-style-type: none"> <li>Individuals are classified into 1 of the 23 case-mix groups using RUG-III/HC. Classification is done according to clinical characteristics, ADLs and IADLs</li> <li>Note territory and province differences in the funding of hours of home care services e.g. Nova Scotia 100hours/month, Ontario 90 hours/month</li> </ul>	<p>✓ variable</p> <ul style="list-style-type: none"> <li>Program level data collected on mortality rates, QoL, rate of hospitalisations and healthcare costs</li> <li>Patient level data is collected via the Canadian Community Health Survey on number of households receiving services, cost and sources of payment, socioeconomic characteristics of households, etc.</li> <li>The CIHI collects and reports on clinical, administrative and resource utilisation data from publicly funded home care programs.</li> <li>Assumed data submission to interRAI</li> </ul>
USA	<p>✓ moderate (24 states) multiple assessment tools</p> <ul style="list-style-type: none"> <li>Individuals self-assess their home care needs and contact the local Area Agency on Aging to obtain information on how to access services</li> <li>HHRG uses the Outcome and Assessment Information Set (OASIS) to assess and classify into case-mix groups</li> <li>Home care services use Minimum Data Set – Home Care (MDS-HC) to assess individuals needs</li> </ul>	<p>✓ multiple classification systems</p> <ul style="list-style-type: none"> <li>Personal Care Services Case-Mix Model (PCS CM) comprises of 11 case-mix groups where individuals are classified according to their cognitive functioning, ADLs, IADLs, continence and the presence of a problem diagnosis</li> <li>Home Health Resource Groups (HHRG, nursing and allied health services) classification process assigns individuals to 1 of the 153 case-mix groups according to</li> </ul>	<p>✓ variable</p> <ul style="list-style-type: none"> <li>National Home and Hospice Care Survey (NHHCS) collects information on home health and hospice care agencies (staff and services) and the people they provide services to</li> <li>Assumed data submission to interRAI</li> </ul>

Country	interRAI HC assessment tool	RUG-III-HC classification system	ACF data collection
		<p>their clinical severity, functional status and service utilisation.</p> <ul style="list-style-type: none"> <li>RUG-HCC consists of 11 case-mix groups where individuals are classified according to their needs for nurse monitoring, rehab, special care and presence of paralysis</li> <li>RUG-III/HC includes 21 case-mix groups which classifies individuals according to clinical categories, ADLs and IADLs using MDA-HC assessment tool</li> </ul>	
Finland	<p style="text-align: center;">✓ moderate</p> <ul style="list-style-type: none"> <li>Legislation requires the use of some kind of assessment system and the RAI system is the most popular one. In Finland, RAI tools are most widely used in elderly services in the evaluation of home care and 24-hour care clients</li> </ul>	<p style="text-align: center;">✘</p> <ul style="list-style-type: none"> <li>A national quality framework for care of older people is in place. The framework specifies key dimensions of quality of care such as prevention and early intervention, comprehensive assessment, and workforce, and standards to be met.</li> </ul>	<p style="text-align: center;">✓ variable</p> <ul style="list-style-type: none"> <li>Finland collects information on LTC quality through the voluntary participation of care providers to the RAI assessment instruments. Data covers 30% of home care services.</li> <li>Finland Department of Health and Welfare provides benchmarking information and research from RAI assessments to help develop services that meet customer needs and are effective. For this statutory task, THL compiles a database of all RAI assessments made in Finland, which is used in accordance with THL's information security policy.</li> <li>Comparative information containing summaries and averages of individual data is utilized in the management and development of an organization providing services for the elderly and disabled. Comparative data can be used to look at indicators that describe the needs of the entire customer base or the quality of operations.</li> </ul>
France	<p style="text-align: center;">✓ limited</p> <ul style="list-style-type: none"> <li>Assessment based on ADLs</li> <li>Currently interRAI assessment tool is only mandated in the city of Marseille for home care services</li> <li>A personalised support plan is developed by a social-medical team and a care-giver is employed to support ADL and IADL (instrumental activities of daily living) services.</li> </ul>	<p style="text-align: center;">✘</p> <ul style="list-style-type: none"> <li>Monthly cash allowance is provided according to assessed level of dependence</li> <li>There are 4 levels of allowances: <ul style="list-style-type: none"> <li>➤ Gir 1 (high level of dependency): €1713 max</li> <li>➤ Gir 2: €1375 max</li> <li>➤ Gir 3: €931 max</li> <li>➤ Gir 4: €662 max</li> </ul> </li> </ul>	<p style="text-align: center;">✓ variable</p> <ul style="list-style-type: none"> <li>Data is reported by the Ministry of health and social affairs on the number of beneficiaries, age of individuals, proportions of each level of allowance accessed, residential status, gender etc.</li> <li>Different bodies – DREES; the Directorate for Research, Studies, and Statistics (DARES); and the National Institute of Statistics and Economic Studies (INSEE) – carry out quantitative and sometimes qualitative studies to collect information on the LTC sector and analyse the measures and policies in place. The new CARE survey was launched in 2015 by DREES. It has three main objectives: to monitor changes in dependency; estimate the burden resulting from dependency; and evaluate the</li> </ul>

Country	interRAI HC assessment tool	RUG-III-HC classification system	ACF data collection
			<p>extent to which family members are involved in caring for elderly people.</p> <ul style="list-style-type: none"> <li>Assumed data submission to interRAI</li> </ul>
Belgium	<p style="text-align: center;"><b>x</b></p> <ul style="list-style-type: none"> <li>BelRAI adapted from interRAI HC and trialled in 2009-11</li> <li>BESADL, which is adapted from the Katz scale is utilised.</li> </ul>	<p style="text-align: center;"><b>x</b></p> <ul style="list-style-type: none"> <li>BEDSADL assesses six capabilities on a four-scale range and assessment of cognitive states to classify clients into three main categories of dependency -levels A, B, C/dement</li> </ul>	<p style="text-align: center;"><b>?</b></p> <ul style="list-style-type: none"> <li>Work purported to be underway to implement BelRAI with a focus to use data for quality improvement and reimbursement. Data is entered by healthcare providers in a free online platform. All data is stored in the central BelRAI database so that it can be shared with all healthcare providers involved. BelRAI is accessible to recognized practitioners of an official care profession in Belgium.</li> <li>High level program data collection.</li> <li>The Permanent Sample<sup>103</sup> (EPS) tracks all health expenditure reimbursed for a group of persons, over the years. This group is composed on the basis of a random drawing of approximately 1 in 40 of members of the health insurance funds.</li> </ul>

<sup>103</sup> Belgium EPS data coordinated by the Technical Commission (InterMutualistic Agency (IMA)) <https://www.aim-ima.be/Permanente-steekproef-EPS> Accessed 29Apr2020