Submission to the Productivity Commission Inquiry
Caring for Older Australians

Centre for Health Service Development, University of Wollongong
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Summary

Our submission comments primarily on improving clinical outcomes and the information management aspects of aged care. The evidence we cite is our health service research and development work that suggests it is possible to build and support a national benchmarking system that will contribute to improved aged care outcomes.

Our research evidence comes from our research projects and our existing programs of service development in the health, community aged and disability and primary care sectors and in the related specialised areas of measuring and reporting rehabilitation and palliative care outcomes. The areas of research and development that are relevant to this submission are briefly outlined (with links to more detailed background material) in the Appendix.

We limit our comments to those areas of the Commission's *Issues Paper* related to how well the mainstream service system is meeting the needs of specific groups, planning mechanisms for aged care services operating across settings, opportunities afforded by some consistency with the health reforms and technical and allocative efficiency issues.

The core of our submission is that the current health reforms, including the proposed changes in aged care roles and responsibilities, at the very least require a continuous electronic record, standardised and more consistent methods of assessing needs, agreed ways of classifying service users and routinely useful data systems for measuring the outcomes of service provision. The systems of assessment, classification and outcome measurement already exist and are voluntary, capable of supporting a national benchmarking approach, and can summarise agency-level as well as state and national data. We are familiar with these systems in clinical rehabilitation palliative care, and in mental health.

The systematic and routine collection of outcomes information in both inpatient and ambulatory settings is relatively easy; the challenge for aged care is to develop these systems across settings and use a common approach across programs. This development work is a continuing role and it needs to be found a home. A previous Commission report on the not-for-profit sector recommended (R.5.4) that a focus of research be supported within a framework designed for improving *community care effectiveness.*[1]

The Commission's recommendations will need to be driven by concerns for improving effectiveness, reducing fragmentation and improving continuity, given the complexity of the aged care system - across community and facility-based care, and the public and private sectors - and this highlights the need to promote continuity between different types and levels of aged care, and between aged, primary, acute, sub-acute, disability services and palliative care services.

Our Centre's service development work to date suggests it is possible to build and support a national benchmarking system that will contribute to improved aged care outcomes. It would do this by systematically collecting distributing clinical and management information to agencies and service units, as well as publishing annual reports, which promote a basis critical reflection and practical local action based on evidence of the outcomes achieved by providers. One precondition to implementing such a system is education, training and certification in the use of outcome measures.

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Beyond measuring the efficiency of inputs and outputs

A current trend in aged care provision, as the Commission's *Issues Paper* pointed out, "has been greater emphasis on community care and a re-balancing from low level residential care to high level residential care." (p.8) The Commonwealth's planning target of 113 aged care places for every 1000 people aged 70 years or over by June 2011 includes 44 places each for residential high and low care and 25 community care places (21 CACPs and 4 EACH).

In addition, at all levels of aged care, there have been a large number of pilots and trials aimed at promoting more flexible care, to test new models of care and tailor service responses for specific population target groups; e.g. coordinated care and case management trials, new care packages for carers, older carers, dementia, autism and mental health carers, and for younger people with disabilities in residential care.

The current inputs across the levels of government go beyond community aged care to include primary care more broadly, and at State and Local Government levels a range of community support services and voluntary and not-for-profit providers are helped to operate services for the same range of population groups.

And the outputs of all these funded services are reported to their various and multiple program managers in terms of hours of services delivered, paid fee for service sessions, kilometres travelled, numbers attending groups, and so on.

In this service provider context, 'efficiency' has three meanings:

- inputs can be measured and distributed in more equitable ways to improve allocative efficiency (to achieve the best mix of outputs to meet the health needs of the population);
- outputs can be counted with the aim being to increase technical efficiency (to achieve the production of the required output at the lowest cost); and
- inputs and outputs can be planned and adjusted to achieve greater dynamic efficiency (to make the service responses more substitutable, in order to improve the adaptability of the system over time).

Then at the family and individual service user levels, 'efficiency' can mean different things because a diverse mix of informal and paid care arrangements are possible, and 'effectiveness' depends on there being good fit between what is offered and the user's goals as *they* understand them. The efficiency of formal services refers to doing things in the 'right manner' and getting the maximum output with minimum resources. Effectiveness, on the other hand, refers to doing the 'right things' and depends on measures of whether the actual 'output' meets the desired 'outcomes'.

Systems for measuring effectiveness imply the primacy of *outcomes-based thinking* about what care and support is received and *how* it is experienced by the user is an indicator of quality. Outcome measurement takes into account a wide range of variation in the models of care, the user's goals and the best ways of attaining them that are adapted to suit the individual's circumstances.

And that is where the question of incorporating the experience of the individual service user can come in. What are the outcomes for the care recipients and unpaid carers from all the inputs and outputs of service provision?

Looking at this question from the user perspective, it is small consolation to be living in area that receives its fair share of aged care resources, and to be receiving a package of care commensurate with your needs, if your experience of that care leaves serious deficiencies like having long periods of uncontrolled pain.

Towards measuring outcomes for people individually and collectively

Measuring outcomes as a means of improving the effectiveness of services encourages innovation as it demands that service users, their informal carers and providers think about the different ways they can meet their desired goals. This approach has been used as a basis for both applied research and quality improvement in Australia, using the same collective assumptions about the roles of information on effectiveness and efficiency as those that guide the Cochrane Collaboration[2].

The question of whether aged care inputs at the level of national planning targets and outputs at local levels actually make a measurable difference for consumers can be answered. Testing whether new models of care actually improve outcomes for service users or residents of facilities, requires user experiences and goals to be built into an outcomes measurement framework.

What we mean by an outcomes measurement framework includes client classifications based on the goals of the service response being offered, along with suitable definitions of what constitutes an *episode of care*, so that meaningful comparisons can be made over standardised periods of time.

By comparing the outcomes for clients who are of a particular type i.e. in a discrete class, in terms of the different outcomes being measured (e.g. functional gains, client and carer well-being or quality of life measures, or pain scores), then the practical experiences of service users are able to be built in to a quality improvement system.

The logic supporting the quality improvement system is that changes in standardised measures of user characteristics and their experiences of care, along with the level of services received and ratings of satisfaction, can be measured over two points in time, may be attributable to different types of service responses.

In our experience, the question of whether aged care and support services actually make a measurable difference for carers and consumers, can be answered by an information management system using routinely collected data, and does not have to be addressed by doing a series of expensive 'one-off' studies in different settings.

Finding answers about what actually makes a measurable difference for carers and consumers is a complex undertaking, the timelines involved in building sustainable benchmarking systems are long, and workable systems have to be built up from assessment through to care planning and case closure, using rigorous and practical methods that can collect the right data.

Once workable systems have been implemented and the right data are being routinely collected, then it is possible to explore, in a logical order of developmental steps, how different benefits to service users are achieved and how those benefits can be more easily measured over the course of the client and carer journeys through aged care services and in the closely related systems of acute and primary health care, as well as other social and residential support programs.

Assessment

The first step in building a logical approach to aged care service provision across settings is to find the care recipients and carers who can benefit most from particular service responses. This is the role of an assessment system that is broad and shallow at the start, so as to be able to capture the full spectrum of needs from promoting wellness and using rehabilitation potential, to 'navigation support' for low and high support needs, through to specialist interventions for chronic diseases and palliative care[3].

The next step is match the client and carer characteristics on key variables known to be associated with the costs of care and support; i.e. the level of functional dependency, carer status, care network sustainability, social isolation, the level of service provision requested and the complexity of the goals in the care and support 'package'.

The research and development model can be designed for various ways of controlling for variation. This implies standardising the way clients and their carers are classified, working out a standard way to capture an 'episode' of care and support, particularly in the community where there are so many service types and client types and goals of care.

The intelligent design of an intake assessment system involves picking the right variables for outcome measurement so that the right questions are asked from the start and any changes can be routinely and consistently measured over time. In scientific terms a set of dependent variables are used to assess the same key features of classes of clients and carers at the start.

Intelligent design, rather than unplanned evolution means supplementing (not replacing) the current Aged Care Assessment Team structures and information services such as Commonwealth Carelink and the national Access Points Demonstration Pilots with a Commonwealth funded and administered national network of distributed access and information centres.

These would be not so much the 'one stop shops' favoured by centralising bureaucracies, but *distributed assessment networks* linked a regional data repository and routinely using a suit of consistent and standardised tools.

The aim of supporting common system used by a distributed network would be to provide a fair, consistent and timely assessment and information service and common entry point criteria for all aged care services. It would share a common 'R&D culture', like those developed in rehabilitation and palliative care, where there is now a measure of consensus on what are the best tools to use to measure functional independence, or to capture palliative care pain scores.

This development strategy means agencies do not have 're-invent the wheel', and neither do they have to comply with one centralised system. This design envisages a set of regional data repositories using common tools so that outcomes can be compared within and across the same set of 'client types' and comparisons made across different care and support models and service settings.

The assessment challenge is to find a small set of key indicators that provide a good picture of how well the aged care service system is doing. We already know from numerous pilots and trials and existing systems that these key indicators are the level of functional dependency, carer status, care network sustainability, social isolation or other factors useful for measuring well-being, and these can be standardised and used to track their 'change scores' over time.

The resources involved in moving in the direction we have proposed are considerable, but so are the benefits. For example in community health and aged care in Queensland between 2004 and 2006, the Health Department successfully introduced a standardised assessment tool (the Ongoing Needs Identification – ONI Tool) that included a capacity for priority rating[4]. This development was supported by an adequately resourced change management strategy. In a similar development process in Victoria, the Service Coordination Tool Templates (SCTT) was introduced as a means of information sharing for their Primary Care Partnerships[5].

In terms of the strategic direction for community aged care and primary health care, moving beyond what are largely transactional data systems based on measuring outputs is essential. If aged care services are to be in a position to demonstrate what they do and the outcomes they achieve, the capacity to capture care goals and outcomes is fundamental and not something that can easily be built in at a later date.

The challenge of integrating aged care data – not for its own sake but to improve continuity and help service users in navigating the aged care system

Because of the complexity of the current system, there is also the need for easily accessible and understood information and guidance for older people and their carers about how to access services, and about their availability and quality.

The recently announced reforms to create a National Health and Hospitals Network and 'Medicare Locals' include proposals to create regional 'one stop shops' which could incorporate many of the above features. The steps to procure and build a regional system with the capacity to capture standard measures for each class of client and carer can and should begin before the supporting IT systems become available. An outline of the steps to build an integrated system with continuity over time, between providers and settings, is as follows:

1. Ensure the functional requirements for the system actually specify the requirement for the concepts of an 'episode of aged care' within a lager classification system. These would include specifying the functionality for the goal of each episode for each client and/or carer, how assessment information is entered and outcomes measured.

2. Standardise the definitions of the types of aged care clients and carers, agreed lists of possible goals for each client/carer and the standardised clinical assessment tools to be used to measure both client/carer needs and outcomes. This task needs to be done collaboratively with panels of providers and consumers; it cannot be done by IT or by information management experts alone.

3. Assess and procure the system, or modules of existing systems, that meet the functional requirements.

4. Provide training for aged and primary care staff and clinicians on how to use both the IT system and the clinical functions built into the system. The key training is the clinical component, which will need to focus on why and how to embed the concept of the episode of care into day to day aged care practice. This is more about system re-design than it is about IT systems alone.

5. Develop policies and procedures that reinforce the collection of the care goal and the outcome of each client/carer episode. This will necessarily require the mandated use of a suite of standardised clinical assessment tools in day to day clinical practice. It will also require clear business rules on what indicates the beginning or closure of an episode and agreement on standardised triggers for further assessment or referral on to other providers. There will also need to be agreement on what information should, with the client's consent, be shared with other providers involved in their care (e.g., their GP).

This level of performance measurement implies an understanding of a classification approach in the field, with rules for classification based on the goal of care for each client/patient. Key client characteristics (such as measures of physical function, mental health and well being and so on) that capture how well the goal of care is being achieved are essential. But, on a day to day basis, these concepts are relatively unfamiliar to aged care providers, who are mainly concerned with program reporting requirements.

Underpinning this development is the need for an adequately resourced change management strategy that focuses on the collection and use of information. Standard clinical assessment tools and outcome measures need to be embedded in day to day clinical practice and not regarded as a (burdensome) data add on solely for reporting purposes. Where possible, data should be sourced as a by-product of the information in client management systems used to manage the day-to-day operations of the health and care industries.

Reporting of data to a *regional data repository* will need to be more closely aligned with the way client information systems store data so that the number of times information needs to be reported will be significantly reduced. Characteristics about the client, the individual service provider, the organisation providing the service, and the service 'event' will each need to be reported in separate data streams to avoid the need to report the same information multiple times.

We see this regional data repository model as consistent with the previous Commission report on the not-for-profit sector, which recommended (R.5.4) that a focus of research be supported within a framework designed for improving *community care effectiveness.*

Whereas *e*fficiency refers to quantity or speed and focuses on the processes or "means" of service delivery, *effectiveness* refers to quality and is about doing the right things, focussing on the end 'outcomes' and necessarily involves thinking long term. In management terms, it is commonly asserted that organisations have to be both effective and efficient in order to be successful.

Implications of the national health reforms for systems to improve the effectiveness of the aged care system and support outcome measurement

The interlocking reforms are complex and their implementation will necessarily involve working out compromises, and the need to accommodate local issues. However, a set of common guiding principles can be articulated, and these are about using common tools and methods of analysis and building a shared vision over time, These common principles are summarised in this section.

Classifying clients based on need

Hospital reform, in particular the COAG-driven shift to activity-based funding , implies increasing sophistication in the classification of patients and the costing of service provision, both inside and outside of acute care[6]. Classification-based allocation models already exist in the aged care and disability sectors in NSW Post School Programs, and in demand management strategies as seen in the NSW Home Care Service's use of the routinely collected Functional Screening Tool. The implications of the COAG reforms are in the strengthening of a base for developing more of these technical tools.

Local-level planning roles

Population level planning and fund-holding roles under Medicare Locals are being proposed in areas of 'market failure', and this recognises the limitations of a dominant fee-for-service model that has evolved under the ad hoc reforms in providing greater access to allied health services under Medicare.

This planning function – which has to be for the whole community, not just those enrolled in GP practice networks – is proposed to include the development of a Healthy Communities Report for each Medicare Local's catchment area....'A Healthy Communities Report is expected to be developed for each Medicare Local's local area, as part of the performance and accountability arrangements built into the new National Health and Hospitals Network.'

What that structure will look like will depend very much on local conditions, but common methods and models will evolve over the next five years. How to build the right sort of hybrid public-private and community-based 'space' for the planning and delivery of primary and community aged care is probably biggest 'unknown' at this point, but the time scale proposed suggests there will be time to work this out, and the shape of a viable community aged care sector space is becoming clearer.

The relationships between specialist services, primary care and community aged care are yet to be articulated, giving scope for influencing the practicalities of reform. The potential advantages for aged care within, or on the edge of health sector reforms, are going to be in strengthening a set of non-institutional services in the community, building the capacity to address local concerns

apart from more fee for service medicine, and forming useful alliances across sectors, and 'responsible for a range of functions aimed at making it easier for patients to navigate the local health care system and to provide more integrated care.'

A common focus on demonstrating effectiveness

The proposed Healthy Communities Reports would be a means of supporting the use of regionally managed data reporting on the effectiveness of community care as recommended for the not-for-profit sector by the Productivity Commission. Profiles of local service users in different programs, based on (for example) routinely collected functional dependency scores, can provide a snapshot of client characteristics and changes in scores for individuals over time.

This client data can be used to provide outcome indicators if they are linked to the goals of care. Change scores that show improvements in function could be useful where the interventions had 're-ablement' aims, while maintenance and support services would benefit from systematically reviewing their clients changes in dependency linked to the intensity of their service provision.

The health and aged care reforms may eventually be able to come together with disability reforms with all three sectors contributing to common ways to understand need and measure outcomes. These may emerge in the planning to manage the transitions from state to national funding and from consideration of client pathways, for example from hospital to community and from disability to aged care.

Improving continuity as a reform goal

The new national arrangements under the COAG and health reforms for basic community care maintenance and support services recognise the requirement for careful planning and management to ensure continuity of care for clients. The current understanding is that the Commonwealth will work with the States to develop new funding arrangements for community care to come into effect from 1 July 2011. Commonwealth operational responsibility for HACC aged care services is expected from 1 July 2012 and it is not expected that service deliver mechanisms will substantially alter before 1 July 2015, so there is time to plan.

Some common aims are to replace (and/or supplement) the existing funding systems for eligible populations with systems to ensure a range of support options are available, including more capacity for individualised approaches. Coordinated packages of care services are a common aim, and to improve continuity from the point of view of clients and carers, packages should include accommodation support, aids and equipment, respite, transport and a range of community participation and day programs available either short term or for a person's lifetime.

Conclusion

The Commission's recommendations will need to be driven by concerns for improving effectiveness, reducing fragmentation and improving continuity, given the complexity of the aged care system - across community and facility-based care, and the public and private sectors - and this highlights the need to promote continuity between different types and levels of aged care, and between aged, primary, acute, sub-acute, disability services and palliative care services.

Our Centre's service development work to date suggests it is possible to build and support a national benchmarking system that will contribute to improved aged care outcomes. It would do this by systematically collecting distributing clinical and management information to agencies and service units, as well as publishing annual reports, which promote a basis critical reflection and practical local action based on evidence of the outcomes achieved by providers. One precondition to implementing such a system is education, training and certification in the use of outcome measures.

About the Centre for Health Service Development

The Centre for Health Service Development (CHSD) was established in 1993 and is a self-funded research and development centre of the Sydney Business School and is one of the University of Wollongong's Research Strengths (http://chsd.uow.edu.au/). It aims to improve the management and provision of health and community services in Australia by achieving greater equity in resource distribution, fairer access to services, better continuity within and across the health and community care sectors, and using evidence to assist management decision-making.

To achieve these aims the CHSD has created a set of ongoing service development programs and also carries out short and long term projects guided by its research themes: client classification across settings; health and community care financing; care coordination and integration; outcome measurement; service delivery and organisation; and tools to assist management decision-making.

The particular projects and programs that have informed this submission include our research on the assessment of need and outcome measurement in community care and disability programs, the evaluation of the national 'Encouraging Best Practice in Residential Aged Care Program', various evaluations of hospital avoidance pilots, and our information management and service and sector development programs:

The **Australian Centre for Clinical Terminology and Information** (http://chsd.uow.edu.au/accti/) has expertise in information strategies to support e-health initiatives with consistent, current and reliable clinical documentation.

The **National Casemix and Classification Centre** (http://nccc.uow.edu.au/index.html) is responsible for the development of the Australian Refined Diagnosis Related Group (AR-DRG) Classification System and is funded by the Australian Department of Health and Ageing to promote and support the use of acute care health classifications linked to funding.

The **Australasian Rehabilitation Outcomes Centre** (http://chsd.uow.edu.au/aroc/) supports a national benchmarking system to improve clinical rehabilitation outcomes in both the public and private sectors by the systematic collection of outcomes information in both inpatient and ambulatory settings. It distributes clinical and management information to clinical units as well as annual reports that summarise the Australasian data and provides education, training and certification in the use of outcome measures.

The **Palliative Care Outcomes Collaboration** (http://chsd.uow.edu.au/pcoc/) is a voluntary quality initiative to assist palliative care service providers to improve practice and meet the "Standards for Providing Quality Palliative Care for All Australians". Its aim is to develop and support a national benchmarking system that will contribute to improved palliative care outcomes. It is a collaboration between four academic centres and is divided into four geographic zones for the purpose of engaging across Australia with palliative care service providers.

The **Australian Health Outcomes Collaboration** (AHOC) disseminates information about health outcomes research, provides advice on the selection of measures for health outcomes as well as education and training. It distributes measures and instruments used in health outcomes assessment. http://chsd.uow.edu.au/ahoc/

The **Australasian Occupational Science Centre** (AOSC) is located at the University's Shoalhaven Campus, in Nowra and provides community education programs and conducts research projects on the relationship between health and purposeful occupation and public health policy. http://shoalhaven.uow.edu.au/aosc/

[1] Productivity Commission Research Report – Contribution of the Not-for-Profit Sector (Feb 2010). Building a better evidence base for social policy: Recommendation 5.4: The Australian Government should provide funding for the establishment of a Centre for Community Service Effectiveness ... Among its roles, the Centre should provide: a publicly available portal for lodging and accessing evaluations and related information provided by not-for-profit organisations and government agencies; guidance for undertaking impact evaluations; support for 'meta' analyses of evaluation results to be undertaken and made publicly available.

[2] Trisha Greenhalgh, BMJ 2004;328:529 (28 February), doi:10.1136/bmj.328.7438.529 Book review: Archie Cochrane (1972) Effectiveness and Efficiency: Random Reflections on Health Services. "Effectiveness (whether treatments work—a dimension we now call efficacy) and efficiency (optimal use of resources) were, Cochrane said, two fundamental pillars on which the NHS ought to be run. He added a third—equality of provision across socioeconomic groups (which we now call equity), and called for better data, better training, more systematic reflection on practice, greater use of computers, and the setting up of independent watchdogs to monitor standards in the NHS."

[3] At the individual level, initial and ongoing needs identification and assessment systems that are linked to priority-rating systems (such as the ONI-N in NSW and in the national system of community care needs assessment (http://chsd.uow.edu.au/Publications/2007_pubs/accna_report07.pdf) are designed to give priority to those in greatest need or at greatest risk.

[4] Stevermuer TL, Owen A, Williams K and Masso M (2007) *Priority rating for community care.* Australian Health Review. 31 (4): 592-602.

[5] See Service Coordination Tool Templates http://www.health.vic.gov.au/pcps/coordination/index.htm

[6] The proposal for reform of the Australian health system - 'A National Health and Hospitals Network for Australia's Future', had as a key feature national introduction of Activity Based Funding (ABF). http://chsd.uow.edu.au/activity_based_funding.html