

## ASSESSMENT AND THE AGED CARE SERVICE SYSTEM

### Introduction

Assessment is the cornerstone of a responsive, well targeted and sustainable aged care service system. Australia's current assessment system is fragmented, based on funding programs rather than on the individual, differs between organisations and creates variable outcomes for individuals. The current reform process provides an opportunity to significantly improve the assessment approach and process. This is important because getting assessment right in a service system achieves the following outcomes:

1. Supports older people's independence and access to the right type and level of service they need at any given point in time;
2. Ensures that older people with similar needs, regardless of where they live, their cultural or ethnic background or the services they access, have a similar outcome in terms of the level of resources made available to support them; and
3. Effectively manages access to, and controls public expenditure on, Government funded aged care services.

While all of these outcomes are important they can sometimes be at odds with each other, particularly in fiscally constrained times. This will need to be considered in development of the assessment approach within a reformed aged care system.

This paper provides ideas, and outlines issues, to inform the development of an effective and efficient assessment approach and process which balances the above outcomes across the aged care service system – both home and residential care.

### Definitions

The term assessment is often used and can mean different things to different people. For the purposes of this paper the following definitions have been used:

*Eligibility Assessment* – gathers an individual's details including a short functional profile (undertaken with a wellness focus) and trigger questions to determine whether the person is eligible to receive Government funded support services.

*Comprehensive face to face assessment* – this builds on the basic information gathered in the eligibility assessment by supplementing it with in-depth information, gathered by direct observation as well as self reporting, about an individual across a broad range of domains. It is a process that identifies a person's residual functional capabilities, limitations, and possibility of or potential for, functional improvement in order to plan and deliver the most appropriate support options that enable the person to:

- live as independently as possible; AND/OR
- be supported to live with dignity.

The assessment underpins a consumer directed, wellness focussed support plan designed to assist a person to achieve their goals and optimise their quality of life. It occurs with someone in person, usually and preferably, at the person's dwelling.

*Specialised Assessment* – gathers information about a specific issue or condition for which the assessor must have specialised skills and expertise (e.g. cognitive impairment<sup>1</sup>, vision impairment or blindness, nutrition, home modifications). This may be able to be completed within a comprehensive face to face assessment or may require referral to a specialist assessor<sup>2</sup>.

*Support Plan* – a strength based plan which outlines the goal for service provision and the type of assistance required. It can be either a plan for a time limited period or a plan for ongoing service provision (which is regularly reviewed and revised as required). The plan should capture the real formal and informal assistance required, (rather than merely being a reflection of the kind of support available in the system), as well as outlining what will be provided. Over time this will support service system planning and development.

*Review* – ongoing monitoring of the individual's progress against their goals, their circumstances and needs through service provision.

*Reassessment* – an assessment scheduled for a particular time after service provision has commenced. It determines whether the goals of the first assessment have been met and what support may be needed in the future. A reassessment can also be requested or triggered by a significant change in consumer or carer need (including some form of crisis or decline or improvement in functional ability) which results in the need to review and change the support provided.

This paper recommends a wellness and reablement approach for both the assessment process and service delivery. For the purposes of this paper the following definitions have been used:

*Wellness* - a philosophy that focuses on whole of system support to maximise clients' independence and autonomy. It is based on the premise that even with frailty, chronic illness or disability; people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and independently. It emphasises prevention, optimising physical function and active participation. It focuses on finding the service solutions to best support each individual's aspirations to maintain and strengthen their capacity to continue with their activities of daily living, social and community connections. The provision of reablement services is part of this philosophy.

*Reablement* - the use of timely assessment and short term, targeted interventions to:

- Assist people to maximise their independence, choice, health outcomes and quality of life;
- Appropriately minimise support required and reliance on future and or alternate support;
- Maximise the cost effectiveness of programs; and
- Support people to continue to participate and remain engaged in their local communities as they wish.

<sup>1</sup> It is suggested that this assessment process could be used to support the Dementia Supplement eligibility process.

<sup>2</sup> The specialised assessment may result in referral to medical/health services to ensure diagnosis and management occurs.

The basis of the approach is to help people regain and/or maintain their physical and cognitive function and independence (after an illness, hospitalisation, disability or crisis or to halt any decline in capabilities) to the fullest extent possible for each individual.

## The current assessment and service delivery approach

Assessment for aged care services – including services provided to people in their own homes and residential care facilities – predominantly uses a traditional deficit model. This means the assessment gathers information on the things the older person can't do and equates them to a need for existing Government funded services<sup>3</sup>.

Currently Government funding supports 113<sup>4</sup> residential care and community package places per thousand of the population aged over seventy years and a range of community based services including Home and Community Care (HACC), National Respite for Carers (NRCP) and Day Therapy Centre (DTC) programs. The quantum of funding for HACC, packaged and residential care increases each year but there is still generally not enough services to meet the demand.

Initial assessment, to determine eligibility and a level of need (low or high care) for packaged care and residential care is undertaken by Aged Care Assessment Teams (ACAT)<sup>5</sup>. As a result of the assessment the individual accesses a service when one is available and/or they are ready to receive support.

Service providers then undertake their own assessment to determine what, and how it, will be delivered as well as the frequency of support provision. Service providers also undertake workplace health and safety (WHS) assessments. The services are delivered as flexibly as they can be within the current program constraints.

In the case of residential aged care a specific amount of funding is allocated for each individual using the Aged Care Funding Instrument (ACFI). There is a validation process in place for ACFI funding.

Packaged care provider assessment determines what services and support will be provided within the relevant package (level 1, 2, 3 or 4) that is available. Assessment for other home based services, such as those funded by HACC, is undertaken by individual service providers except in Western Australia and Victoria where Regional Assessment Services (RAS) for access to HACC services have been introduced.

In some cases the tools used by any of the above assessment bodies are standardised accredited tools, in others the tools have been developed and prescribed by Federal or State Governments and in others developed by the provider. ACATs have a recommended assessment toolkit with standardised assessments although its use is variable across the jurisdictions.

<sup>3</sup> Victoria and Western Australia undertake a wellness or reablement approach and assessment in Home and Community Care (HACC) funded services.

<sup>4</sup> This increases to 125 places per thousand of the population aged seventy years and over by 2022.

<sup>5</sup> In Victoria these bodies are called Aged Care Assessment Services. In this paper the term ACAT is used to refer to both.

Assessment for Veterans Home Care (VHC), which continues to sit outside of the main aged care service system, occurs through a specifically contracted assessment service (generally a separate arm of an aged care service provider for a specific geographic area) and is undertaken over the phone, using a structured tool mandated by DVA.

Older people also access transition care but can only be assessed for these services in hospital.

In this system, older people have to provide and repeat their information many times. At first to the initial assessment organisation (either the ACAT or a community service) and then again as individual service providers (in some cases multiple providers) assess to determine how and what they will provide.

The underlying service provision assumption is that the person will require ongoing support and that over time their needs will escalate requiring an increasing level and intensity of service delivery.

The current system is based on funding programs rather than the individual older person and is undertaken by a range of organisations using different tools. It is quite variable across the country in terms of timeliness, outcome and quality.

## Proposed assessment reform

The Gateway was a key recommendation of the Productivity Commission's *Caring for Older Australians* report. Designed to address the variable assessment outcomes and significant difficulties people have in accessing aged care services it was conceived as a regionalised service that would allocate resources to the individual (rather than granting funds to service providers) based on assessed need.

The 2012 aged care reform agenda included a scaled down *My Aged Care Gateway* (the Gateway) which was launched on 1/7/2013. It is a national call centre and website which provides a single point for consumers for information about, and access to, aged care services. Over time it is proposed that the Gateway will provide information, undertake assessments for Commonwealth Government funded aged care services, hold a centralised electronic client record system and provide a service matching and referral service.

The Gateway is being implemented in stages. It currently provides information about Commonwealth funded aged care services and transfers consumers to various services if requested. Plans are in place to expand the service information available at the Gateway to include other than Commonwealth funded services for older people.

Work has commenced on developing a nationally consistent assessment framework and tool for use through the Gateway. The full detail of the proposed assessment framework is outlined in the Centre of Health Service Development's (CHSD) June 2012 paper *A Model and Proposed Items for the New Assessment System for Aged Care*. In summary the framework assumes that assessment is a continuous process in which a consumer moves through a continuum of assessed levels as needs are identified.

The framework has three assessment levels:

- Level 1 Assessment – consumers that require basic services, but do not require a comprehensive assessment. It is proposed that this be conducted predominantly by telephone with access to a face to face assessment if required.
- Level 2 Assessment – consumers that require a more substantial use of services including elements of personal care, home modification or nursing. It is proposed that some of these assessments occur via telephone and others face to face.
- Level 3 Assessment – consumers that require a more comprehensive clinical assessment for higher levels of care under the *Aged Care Act 1997*. These assessments will be conducted face to face.

A tool was designed and trialled for Level 1 and 2 (assuming the bulk would occur as a telephone assessment) with a view to commencing assessment at the Gateway from 1/7/2014<sup>6</sup>. The trial highlighted some positive aspects of the proposed framework as well as some of the limitations of deficit based telephone assessment. Further work is to occur on developing the Level 3 assessment. As a result of the trial and the recent change of Government the start date for the assessment function at the Gateway is likely to be delayed.

Work has also been occurring on the:

- Development of carer assessments and Carer Support Centres. Further work and consideration of how carer's needs are assessed both with the individual for whom they care and in their own right, is needed; and
- Creation of a linking service for vulnerable people. Its role and relationship to the Gateway and in supporting vulnerable people to be assessed and access services will need exploration.

VHC is set to remain separate from all of these reforms. The National Aged Care Alliance (the Alliance) recommends that VHC should be accessed via the Gateway, improving veteran awareness of other services available to them through the aged care service system.

The Alliance supports the introduction of the Gateway and having a nationally consistent assessment approach and process. However the inadequacy of the current approach and system, as well as the outcomes of the trial, demonstrates that there is a need to develop a more effective and efficient assessment system.

***Recommendation 1: The Alliance affirms the need for, and supports, the ongoing implementation of the Gateway.***

***Recommendation 2: VHC services should be accessed via the Gateway improving veteran awareness of other services available to them through the aged care service system.***

<sup>6</sup> University of Wollongong, 2013, *Final Project Report on the Validation and Field Trials of the Assessment Framework and Tool for Aged Care*, Centre of Health Service Development, Australian Health Service Research Institute, 30 August 2013.

## A new approach to assessment and service delivery

### Designing a new assessment system

Australia's aged care system is designed to support older people, and where relevant their carers, to live as independently as possible. It aims to keep people in their own home and community wherever possible. It also acknowledges that for some people, at some stage and in certain circumstances, residential care may be required. To meet these objectives efficiently and effectively the current assessment process needs to be redeveloped and made fit for purpose.

In this context the Alliance suggests that the purpose of an assessment is to determine an individual's emotional and behavioural skill, health status, competencies and characteristics including understanding what needs to occur for that individual to:

- Have personal, social and psychological development and wellbeing;
- Maintain and contribute to satisfying relationships with family<sup>7</sup> members, peers, and community<sup>8</sup>; and
- Manage their own life, (as far as is possible) given their individual circumstances<sup>9</sup>.

Assessment (and service delivery) must always be culturally safe and appropriate, which includes addressing the particular requirements of special needs groups.

The assessment is most useful and valid when based on reliable sources of information, including direct observation of an individual. The information gathered can then be used to:

1. Determine whether or not the individual meets the requirements/criteria for services or support that are being offered and/or funded for a particular target group of people; and
2. Where they are eligible, establish the support/services an individual requires to address their identified needs to support them to live, either at home or in a residential setting, as independently as possible.

### Assessment and the ageing process

The most common view of ageing is one of continual physical and cognitive decline resulting in an increasing need for services and support.

People, both the individual who needs support and their carer, often first come into contact with the aged care service system at a time of stress or crisis, including during a period of hospitalisation. It is at this time that assessment occurs, taking into account the informal or family care that is provided, and determines the ongoing level of service required unless the person is explicitly being assessed for a transition care service. Services are then provided and the individual is monitored, reviewed and reassessed by individual service providers.

<sup>7</sup> Family refers to both biological family and/or designated family members.

<sup>8</sup> Community refers to both the area where a person resides and interacts as well as specific community support organisations for special needs groups.

<sup>9</sup> This may be more limited in a residential aged care setting than for an older person who continues to live in their own home.

Evidence now shows that older people's health and function is not linear<sup>10</sup>. Older people can and do improve or regain function after periods of illness, hospitalisation or disability.

Ideally a reformed aged care system would reflect the ageing process - a series of ups and downs rather than a linear progression of decline and loss of function. Both assessment and service provision – home and residential care - needs to operate from that premise and not lose the opportunity to treat or ameliorate conditions. This would mean that services and support would be able to be offered:

- As a one off event - such as a home modification which when completed means the person has no further need for services/support at that point in time;
- In the short term (6 – 12 weeks) - such as rehabilitation support, therapy and assistance with daily living tasks after a fall or illness – after which the person may not require any further services/support or perhaps need a lower level of services and support. Short term service provision could occur in a person's own home or in a residential care facility;
- As an intermittent support (such as periodic transport, one off household maintenance tasks on an annual basis or support for relapsing conditions such as osteoarthritis, MS or muscular dystrophy. Residential care may be appropriate in some instances; or
- In an ongoing way in a person's own home - such as regular assistance with showering or community transport to stay connected to favourite activities and networks or ongoing therapy to maintain function - to meet a longer term need that enables the individual to be as independent as possible; or
- In an ongoing way in a residential care service – where the person is unable to continue to live in their own home and needs a high level of support on a daily basis to live in as dignified a way as possible.

***Recommendation 3: The assessment process should be culturally appropriate, carer inclusive, take a wellness/reablement approach and support the ageing process. It would cover assessment for home support (including VHC), transition and residential care services.***

## Assessment in a reformed aged care system

The new assessment process should assess for the full range of services – home support (including VHC), transition care and residential care.

Three distinct levels or types of assessment need to be undertaken as part of an effective and efficient assessment approach and system:

<sup>10</sup> Verbrugge and Jette 1994 – *The Disablement Process*. Social Science of Medicine 38 (1), 1 – 14.

Tinetti M.E, Baker D., Gallo W.T. Nanda A., Charpentier P and O'Leary J. (2002) *Evaluation of a restorative care versus usual care for older adults receiving and acute episode of home care*. Journal of American Medical Association 287, 2098-2105.

Care Services Efficiency Delivery Programme (2007) '*Homecare Re-ablement Workstream: Retrospective Longitudinal Study*' November 2007', Department of Health, London, United Kingdom.



## 1. Eligibility assessment (refer definition page 1).

The Gateway is ideally placed to provide an eligibility assessment for Commonwealth funded aged care services. In this way the Gateway can centrally monitor demand, access and unmet need within the system as well as managing Government expenditure.

Over time people will come to the Gateway to find out about aged care services and then by extension whether or not they (or their loved one) would be eligible to receive support.

This type of assessment can be done over the telephone, although special needs groups<sup>11</sup> may still need access to comprehensive face to face assessment and/or additional supports (such as access to interpreters or cultural support workers to help the person through the assessment process) at this level. Older people with a disability that creates communication challenges may also need such assistance.

The assessment tool utilised needs to focus on understanding the person's circumstances and take a problem solving approach so that the right pathway is defined for each individual and, their carer where relevant.

Where a person is ineligible for a Commonwealth funded aged care service the assessment process should suggest other avenues of support available to the person. The Gateway would then provide information to the person so that they can find the supports they require. In some cases this may include referral to services<sup>12</sup>.

Where a person is eligible and the assessment clearly identifies that there is no reason for further exploration they may be referred directly to a service provider.

Where a person is eligible and the assessment identifies that there are a range of potential relevant responses the person will progress to having a comprehensive face to face assessment undertaken.

Considerable thought and work will be needed to develop 'trigger' questions which can confidently be used to refer either for a comprehensive assessment or direct service delivery. Trigger questions should take into account the needs and life experiences of both the individual requiring services, and their carer where relevant, to determine the most appropriate course of action.

<sup>11</sup> This describes those people living with cognitive impairment and dementia, people with a mental health issue, and the special needs groups as defined in the Aged Care Act 1997 Principles (as amended), which include:

- People from Aboriginal and Torres Strait Island communities;
- People from culturally and linguistically diverse backgrounds;
- People who live in rural and remote areas;
- People who are financially or socially disadvantaged;
- Veterans;
- People who are homeless, or at risk of becoming homeless;
- Care leavers\*;
- Parents separated from their children by forced adoption or removal;
- Lesbian, gay, bisexual, transgender and intersex (LGBTI) people; and
- People of a kind (if any) specified in the Allocation Principles.

In addition this encompasses individuals who have specific cultural, spiritual, ethical and privacy requirements that need to be recognised and supported to ensure quality care provision.

\* Care-leaver means a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century.

<sup>12</sup> Consideration is currently being given to the inclusion of information on services (other than Government funded aged care) being available from the Gateway. This is critical to ensure a useful experience for the older people who access the Gateway.



*Direct Referral to a Service*

As referenced above, there may be instances where this level of assessment is able to determine a specific and confined need for a particular type of service or where the older person themselves, or their carer, has clearly determined what they need. The reason why they need the service is key to determining whether direct referral is the most appropriate course of action or whether there are other issues that would be best addressed through a comprehensive assessment. For example, it could be that all the older person needs is transport to attend appointments and do the shopping because they are unable to drive and there is no public transport available. In such a case the Gateway should be able to refer the person straight on to a community transport service able to meet that need. However, if the need for transport is as a result of mobility issues then a comprehensive assessment may be beneficial. Another good example where direct referral for service would be appropriate is where a person needs a specific health intervention such as wound or stoma care.

If the person and their carer is experiencing an emergency or requires urgent service delivery, for example the carer is going into hospital and emergency respite care is required, a referral for direct service would be made on the basis of the eligibility assessment.

It should be acknowledged that the consumer will always make the final decision of whether they wish to be referred for a comprehensive assessment or not. They may self assess and elect, either prior to or at this point, to go directly to service providers they believe can fulfil their needs<sup>13</sup>. This is more likely to be an option for home care services.

Any referral made by the Gateway should always reflect the consumer's informed choices.

If following such a referral and/or emergency service provision there are concerns that the consumer requires more, or different services, the provider will need to support the person to have a comprehensive face to face assessment and/or provide service co-ordination. This approach (sometimes referred to as a 'no wrong door' approach) is simple, responsive to the consumer and respectful of the older person's choices.

*Recording the Assessment and Support Plan*

The eligibility assessment, and any resulting support plan with a service provider, would be captured on the Gateway's electronic client record system. The data on the client record may need to be confirmed by service providers to ensure the accuracy of the assessment and service delivery.

*The Assessment Tool*

An evidence based eligibility assessment tool will need to be developed (or adapted)<sup>14</sup> for this purpose which captures basic personal information and determines the required pathway.

Having the eligibility assessment occur at a centralised point should support consistency of approach and outcome so important in achieving equity of access.

<sup>13</sup> The bulk of Aboriginal and Torres Strait Islander clients either self refer or are referred by family to local service providers and it is suggested that this is unlikely to change. There needs to be a mechanism which ensures that these people and their details (including service history) are recorded in the central client record.

<sup>14</sup> WA and Victoria have tools that could form the basis of new eligibility and comprehensive face to face assessment tools.

***Recommendation 4: Eligibility assessments should be undertaken by appropriately trained staff at the Gateway. In most instances these would occur over the telephone. Where the older person or their carer needs other support, such as an interpreter or other cultural expertise the eligibility assessment would be undertaken face to face.***

## **2. Comprehensive face to face assessment. (refer definition page 1)**

Where the eligibility assessment determines that the individual has a range of needs which require support, a comprehensive face to face assessment needs to be undertaken by appropriately trained<sup>15</sup> staff. Some people may benefit from having other workers – such as an Aboriginal and Torres Strait Islander or an LGBTI support worker – participate in the assessment process to provide support and advocacy.

Input from significant others (including family) may also be important, and in some cases essential, during the assessment. This needs to be balanced with ensuring that the focus remains on the older person being assessed.

Carer assessment could also occur as part of the face to face process but there may be a need for a separate assessment for some issues (such as when a carer is considering relinquishing care) to be addressed.

Specialised assessments<sup>16</sup> - for example a nutritional assessment or a disability (such as blindness) based assessment, an Occupational Therapy assessment for home modification or assistive technology or where particular cultural skills are required for an LGBTI or Aboriginal and Torres Strait Islander or CALD person assessment - may need to occur or be contracted in as part of this assessment.

The outcome of the assessment process would be:

- An initial support plan based on an agreed goal/s for the person, and their carer where relevant. The plan would include the combination of formal (Commonwealth funded aged care services) and informal supports able to be provided. The plan would be agreed between the assessment service, the individual and/or their carer along with any relevant service delivery organisation/s. The opportunity to diagnose, treat and/or ameliorate medical conditions should also not be lost, with any support plan involving the person's GP as appropriate; and/or.
- Referral to any other required/relevant services (other than Commonwealth funded aged care), including disability, health or culturally specific supports.

It is suggested that the support plan be based on a short term reablement service provision period<sup>17</sup> across all of the aged care service responses (including residential care) prior to decisions about ongoing support needs being finalised. In most circumstances this will allow the individual the opportunity to regain or enhance existing function or capability and may result in a lower level of ongoing service provision being required.

<sup>15</sup> Appropriately trained staff includes qualified health practitioner registered under the National Law, or other registration scheme, acting within their scope of practice and others.

<sup>16</sup> Specialised assessments benefiting older people are many and varied – this list is not exhaustive.

<sup>17</sup> This service response is discussed in more detail at page 2

There may be some exceptions to the reablement period, for example where a person is receiving end of life care or where it makes sense to move straight to the development and provision of a longer term, or ongoing, plan.

Making the support plan short term – and ensuring the consumer and the carer are aware of this – will enable the provider to cease or reduce services in some instances or maintain or increase support in others. In this way the cost efficiency and capacity of the system is improved without jeopardising the support needs of older Australians.

A guarantee needs to be provided that where someone is assessed as requiring ongoing services they will be provided to avoid any undue stress or anxiety for the older person and their carer.

The outcomes of the face to face assessment process, however delivered, would be captured on the Gateway's electronic client record system.

#### *Delivering face to face assessments*

Clearly face to face assessment can't be undertaken by the current national Gateway (a national call centre and website). The need to undertake face to face assessments requires local capacity to be available.

There are options for the delivery of face to face assessment including:

##### a) Maintenance of the current system

This would continue the current practice of those people with lower level needs being assessed by HACC funded service providers and those with higher level needs being assessed by ACATs. There are processes in place, such as residential accreditation and validation and the common community care standards, which set out the requirements and monitor the delivery of the current assessment approach at service provider level.

In this model the Gateway undertakes the eligibility assessment and accurately refers on to either a service provider or an ACAT. Accuracy is key to avoid the individual going to a service provider for a HACC, NRCP or DTC assessment only to then be referred on to an ACAT if their needs are determined to be higher or vice versa.

A standardised assessment tool could be mandated for use by the ACAT's and HACC service providers with the data and outcomes captured for the Gateway client record. (Refer to table on next page).

Advantages of approach	Disadvantages of approach
No real system change is required – current ACAT, VHC and HACC funding and delegation arrangements would remain in place.	No system change - despite the Productivity Commission report <i>Caring for Older Australians</i> recommending changing the system based on extensive consultation and analysis of its shortcomings.
Continuity for clients by being able to remain with the one service provider (HACC).	Potential risk of “client capture” so the person only receives the services the one provider can offer for HACC <sup>18</sup> and VHC services.
Assists and supports in building the relationship with service providers from the beginning.	ACATs continue to operate as they do now which is variable around the country as a result of issues with existing funding arrangements and varying state government policies.
Utilises locally based knowledge in delivering and recommending other services where required.	Consumers potentially continue to be passed between assessments for different funding programs.
May limit the potential of creating bottlenecks to accessing HACC services.	More likely to result in different outcomes for consumers even within funding programs.

b) Independent regional assessment services

While there are resource constraints, regionalised assessment services (potentially branded as the Gateway) could be developed, over time, by combining existing ACAT and HACC funding. This would create an assessment service which operates on the needs of the individual person rather than on Government funding programs. A regional assessment service would operate under formal contractual arrangements including requirements for employing appropriately trained/skilled personnel and performance indicators. The service could be provided by a number of agencies that would be required to obtain good knowledge of, and build strong connections with, all local services in the region.

Options for the regional assessment service include:

- Local governments;
- Individual or networks of service providers<sup>19</sup> (this is not dissimilar to the Veterans Home Care Service system and is sometimes referred to as a “hub and spoke” model);
- Existing Government agencies (such as Centrelink or Medicare); or
- ACATs.

Attachment 1 considers these options and comments on the advantages and disadvantages of each of the above as a possible provider.

Whichever agency (or combination of agencies) is utilised, the process should be seamless for the individual.

This approach is more in line with the original Gateway concept (outlined by the Productivity Commission) and also with the roll out of the NDIS.

<sup>18</sup> HACC will be subsumed into the Commonwealth Home Support Program (CHSP) from 1/7/2015. The design of CHSP may assist to overcome this issue if it moves to operations on an outcome basis and more in line with CDC packaged care provision.

<sup>19</sup> In some areas the most appropriate assessment providers may be a GP or a CALD or Aboriginal and Torres Strait Islander specialist service.

Regions would need to be defined and could align with other existing regional boundaries such as those of the ACATs or Medicare Locals.

Consideration could also be given to the creation of a virtual regional assessment service (or at least some elements of the assessment process being undertaken virtually.) This means that individual assessors, drawn from different organisations within a region, work independently to undertake assessment and referral. Such a service is already operating in some rural/regional areas in Western Australia. Inbuilt support mechanisms which would maintain and further develop assessor skills and competencies are needed in such a model. The suitability of a virtual regional assessment service option could not be fully evaluated until the final assessment model is determined.

Further work would be required to scope:

- The respective roles of a regional assessment service with individual service providers;
- Resource requirements; and
- Quality and performance measurement and assurance.

Advantages of approach	Disadvantages of approach
Minimal cost implications – combines existing assessment resources more efficiently.	Potential to create a bottleneck to the system and be less timely for older people.
Creates independence from service provision resulting in better control of Government expenditure.	State Government and/or ACAT constraints perpetuate the current inability for equity across jurisdictions.
Regionally based so able to capitalise on local knowledge about all services (both Commonwealth funded and others).	Potential loss of innovation at service provider level.
Supports a reablement approach.	Potential “cookie cutter” approach to goal setting and service referral.
Avoids “client capture” where the consumer has and/or wants other alternatives.	May impact on continuity of care.
Supports a centralised waitlist and referral process.	Requires changes to current standards and monitoring processes within programs (e.g. common community care standards require intake assessment).

#### c) Choice of Assessing Body

Some Alliance members have suggested that consumers should be able to choose between having an assessment from a regional service or from an ‘approved provider assessor’. Regardless of which assessing body the person chooses the results of the process would need to be undertaken utilising the same assessment tool and the outcomes captured on the electronic client record.

The advantages and disadvantages outlined for option a) and b) would all apply in this model but the effect would be felt at an individual consumer, rather than at the system, level. Its real strength would be:

- Avoiding creation of a bottleneck; and
- Streamlining the process by combining the comprehensive assessment with those that can only be done by a service provider (e.g. workplace health and safety).

However the risks would include having differential outcomes for people and the model does not fully overcome the issue of client capture.

d) GP Assessment

GPs already undertake, and are remunerated for, comprehensive medical assessments (CMA). Sometimes this assessment is delegated to a practice nurse. It may be possible to expand these assessments to include social and wellness aspects so that GPs can also undertake the comprehensive aged care assessment<sup>20</sup>. Additional training<sup>21</sup> may be required to support this occurring.

GPs are widely available throughout the community and this approach would support integration of record keeping with the PCeHR.

Nurse practitioners are an emerging workforce in aged care and their private practice services could also be considered as part of the new assessment model, especially in concert with approved provider practices.

Advantages of approach	Disadvantages of approach
Localised availability of GPs.	Medical assessment model would need to be adapted for purpose.
CMAs are already funded through Medicare and could better align with aged care assessment.	Adds to Medicare Schedule.
Independent from aged care service provision.	Takes GPs away from services only they can provide to carry out assessments that can be undertaken by appropriately trained others.
Many older people already have a strong relationship with their GP.	GPs knowledge of aged care and other relevant service options is variable. Training would be required.

*The Alliance's Preferred Comprehensive Face to Face Assessment Provider*

There is strong agreement by all Alliance members that comprehensive assessment should occur face to face, be designed around the needs of the individual older person (rather than based on current Commonwealth Government funding programs) and support wellness and reablement service provision. On the basis of this agreement the Alliance does not support maintaining the current assessment model although it is acknowledged that this may continue in a time limited way as part of transition to a new system.

Those Alliance members that support an independent regional assessment model do so because they believe it provides greater support and choice to older people and avoids conflict of interest of embedding assessment within ongoing service provision. This model is also seen as an effective way to support equity of access and exercise control over Government expenditure which is increasingly important as demand for services grows in line with the ageing of Australia's population.

<sup>20</sup> The comprehensive Geriatric Assessment, conducted by Geriatricians, (Medicare Items 141/145) should be considered in this light as they include the psychosocial and functional aspects in combination with the diagnosis and management aspects of health conditions.

<sup>21</sup> This would be training specific to ageing, aged care and special needs groups as outlined elsewhere in this paper.

Those Alliance members that support assessment by service providers do so because they believe the relationship between the older person and the provider commences at the time of assessment and that there is a risk of duplication and inefficiency in the creation of an independent system. This approach is seen to capitalise on good local level knowledge to support older people make informed decisions and to ensure immediacy of service provision.

Those Alliance members that support GP assessment do so because they believe that connecting the aged care and primary health care systems and utilising existing resources and infrastructure (rather than creating new) is the most efficient approach. There is also support for bringing the important health and medical assessment together with the social and other elements within a comprehensive aged care service assessment. It is also supported as being independent from service provision.

***Recommendation 5: All comprehensive assessments should be undertaken by appropriately trained persons, face to face preferably in the older persons own home with input from significant others where relevant and agreed to by the older person. The comprehensive assessment would include an assessment of the carer where relevant.***

### **3. Ongoing review and reassessment (refer definitions on page 2)**

As a result of the comprehensive face to face assessment, services are provided by aged care organisations<sup>22</sup>.

There are some assessments such as a workplace health and safety assessment of a consumer's home that can only be undertaken by the service provider and these will need to continue as part of the new system.

Regardless of how the comprehensive face to face assessment is delivered, the review and reassessment function would need to be undertaken by the service provider. The provider is in one of the best positions to understand what the ongoing needs will be, having worked with the individual through their initial support plan. The initial support plan would provide some indication of an anticipated or likely outcome. In this way the potential demand on the regional assessment service is limited avoiding the creation of a bottleneck.

The service provider would then develop the long term support plan which would be reviewed on an ongoing basis. Relevant information from the support plan would be recorded on the electronic client record.

A formal reassessment is recommended annually in line with current practice in most organisations and funding programs. A consumer should be able to request reassessment occur with involvement of another support organisation (such as a culturally specific or LGBTI support service) and/or by another party (including a regional assessment service if this option proceeds) where, for whatever reason, they are uncomfortable with it being undertaken by a service provider.

There would need to be some sort of validation<sup>23</sup> process particularly where there is significant variation between the initial support plan anticipated outcome and ongoing service provision, and for managing control over "care creep"<sup>24</sup>.

<sup>22</sup> This section relates only to the provision of Commonwealth funded aged care services.

<sup>23</sup> Validation ensures that funding is being used for the purposes stated as a result of the assessment and which achieve the agreed health and wellbeing outcomes for each person.

<sup>24</sup> Care creep is a gradual increase in care over time because extra assistance is put in when need arises because of illness or an event but is then not readjusted when no longer required.



This could be achieved through the electronic client record and/or in a model with an independent regional assessment capacity that body may have a role to play. Any such validation mechanism would need to be simple, maintain the focus on the needs of the individual and not increase red tape in the aged care service system and be free of validator bias. It would work with, or replace, the existing residential care validation system.

***Recommendation 6: Ongoing review and reassessment should largely be undertaken by service providers unless a consumer specifically requests an independent reassessment process.***

## Related assessment functions

Supporting assessment and people's access to aged care services also includes the functions of:

- Service matching (based on informed consumer choice);
- Referral to service providers;
- Keeping a client record<sup>25</sup>; and
- Managing waiting lists.

The Productivity Commission's original recommendations had these functions managed at the regionalised Gateway services. When Government introduced the Gateway these functions were seen to be able to delivered nationally.

The Alliance believes that these functions will be more effectively delivered by regionalised assessment services with the client record and waiting lists driven by an IT solution through the national Gateway.

***Recommendation 7: The secure electronic client record should be developed, integrated with the PCeHR and IT capacity built to support its implementation.***

## Resourcing the assessment system

This paper is based on using the existing assessment resources that are currently allocated to ACATs and to services funded under HACC Service Group 2<sup>26</sup>. This means that, depending on the option chosen, resources would be removed (or decreased) from individual ACATs and service providers. Some of the resource requirements could be met, or at least offset, through HACC growth funding.

There will also be a need for Government investment to develop and implement assessment tools, processes and systems (including IT) to ensure successful implementation of the proposed approach. This should be able to be supported by a more efficient process which manages Government expenditure effectively.

Training for assessment staff will be crucial to support the move to wellness and reablement. In addition cultural competency, knowledge of the ageing and complex chronic disease process would also be required.

<sup>25</sup> The client record should be the PECHR amended to keep details of aged care and offered on an "opt out" basis. The Alliance has provided specific advice about the client record in its Gateway Advisory paper and this should be reviewed as part of this development process.

<sup>26</sup> Assessment services in HACC are identified as assessment in Service Group 2. It is believed that assessment is also undertaken using funds within other service groups but the data on this is imprecise. It would not be possible to identify assessment services other than those in Service Group 2 for reallocation.

## Implications for service provision

The way assessments are undertaken and the outcomes for individuals are heavily reliant on the services and support that can subsequently be offered to the older person.

The proposed assessment system embeds a wellness and reablement approach in all aged care services and this is a fundamental shift. Currently the DTC program is the only explicitly funded aged care program to do so. In this service delivery model the role of DTCs would be built on and support greater integration in the service system. It should also achieve greater alignment with transition care services which are of course currently initiated after an in hospital stay.

Initially services would be provided on a short term basis (across all home based and residential services) at whatever level of need the person has<sup>27</sup>. During the period of short term provision the person has the opportunity to improve or regain function and manage more independently. An individual may choose not to actively participate in such a reablement approach and can't be forced. However over the short term period of service provision the person may change their mind and/or still experience functional improvements.

In this way service provision is not locked in nor is it delayed (where and assuming the relevant services required are available). This would also enable support to be provided to people who are travelling, an increasing feature of Australia's ageing population.

The real advantage to this approach is that evidence has shown that when reablement is effective individuals may need no, or a lower level of, services for anything up to five years. This will create savings in the system enabling people who can not currently get a service to receive some level of support or be assisted to regain their independence. Short term reablement services should be used to target and tailor effective support as and when it is needed. It should not be used to block access or to ration service provision by default.

All of the evidence for this is based on community care provision<sup>28</sup>. It has not been tested explicitly in residential aged care although transition care programs provide some evidence for the ability of older people to regain function after a crisis or stay in hospital. Hospitals need to ensure effective bed turnover, and if the risk is too high to send the person home, they see the only answer is permanent residential care<sup>29</sup> particularly where sub-acute care is not available or is seen as inappropriate. Giving residential providers the ability to use a bed and be funded for a time-limited reablement service would hopefully eliminate situations where the family have prematurely sold the seniors home and changed their life significantly, only to find later they could have gone home<sup>30</sup>.

<sup>27</sup> It is likely that, at least initially, short term service provision may only be able to be provided by organisations able to develop and deliver targeted, evidence based interventions.

<sup>28</sup> Parsons, Rouse, Robinson, Sheridan, Connolly *Goal Setting as a feature of homecare services for older people: does it make a difference?* Age and Ageing 2012 4: 24 – 29.

King, Parsons, Robinson, Jorgensen *Assessing the impact of a restorative home care service in New Zealand: a cluster randomised controlled trial* Health and Social Care in the Community (2012) 20 (4) 365 - 374.

<sup>29</sup> Alzheimer's Australia NSW *The Most Difficult Decision: Dementia and the Move to Residential Aged Care* 2012.

<sup>30</sup> There are a number of research studies that show the benefits of restorative care in residential care settings including Shathietal et al 2005; Morris et al 1999; Resnick and Fleishell 2002.

The funding would be provided from within the existing available resources. This could also be achieved by designating some services as dedicated reablement services<sup>31</sup>. It is suggested that funding be provided in the same way as it is for respite care. Just as for respite care, security of tenure provisions would not apply. Other provisions around the residential care agreement would also need to be adjusted to enable short term service provision.

This would require the development and adoption of culturally appropriate eligibility assessment and comprehensive face to face assessment tools<sup>32</sup>. Training for assessment and service delivery staff would also be required to gain maximum service efficiency.

The way this shift in service provision is presented to the older person and their families will be critical in managing both expectation and demand. In international models reablement services are commonly provided free of charge to encourage participation and in recognition of the overall savings it creates.

It should be noted that changing the model of service delivery will not address the problems presented by a rationed service system, the inadequacy of Government funding or the interface issues between funding programs.

***Recommendation 8: The system should be reoriented to support short term periods of reablement service provision prior to decisions being made about ongoing service and support requirements. This would be available in all home based services. Further consideration and development is needed for this to be viable and successful in residential care.***

## Transition

The assessment approach, and flow on changes to service delivery are significant. Whichever model is selected will require the development and implementation of a transition plan which would include:

- a) Developing eligibility and comprehensive face to face assessment tools.

This should be a priority action.

Given the established reablement assessment tools already in use in Victoria and Western Australia it may not be necessary for a trial to be undertaken. However considerable thought is required on the trigger questions in the eligibility assessment to ensure the person finds the right pathway and the tool supports inter-rater reliability to achieve equity of access.

While these tools would be mandated and used across the system, individual service providers may use other tools to complete their additional service information requirements. Where there are additional needs at the service provider level there should be no duplication of information collected in either the eligibility or comprehensive face to face assessment.

<sup>31</sup> Not all the Alliance members support short term reablement services being provided as part of all residential care service provision.

<sup>32</sup> WA and Victoria have tools that could form the basis of new eligibility and comprehensive face to face assessment tools.

b) Training assessment staff.

Training needs to occur to ensure assessment staff (for the eligibility assessment and for whichever agency/ies deliver the comprehensive face to face<sup>33</sup> assessment) are culturally competent, able to undertake a wellness/reablement based assessment and to develop the related support plans. Such training would include understanding the ageing process and being cognisant of the issues and concerns experienced.

A training period needs to be built into the development phase of the tools and be completed in time for introduction of the new approach. Ongoing development opportunities including mentoring and support for assessors are required in the new system. In addition monitoring and performance measurement need to be built into the system.

c) Creating independent assessment services (where comprehensive assessment option b is implemented).

It is accepted that moving to a regionalised assessment system (potentially delivered under the auspice of the Gateway) would take time.

For a set period of time (probably at least a year) the current assessment system would continue through the ACATs and HACC service providers although the new tools would be used.

During this time negotiations would occur to ensure aged care assessment funding in ACATs and HACC services are identified and made available for the new regional service. Government could elect to award the delivery of this service to one of the existing agencies or to have a competitive tendering process and select the best option in each local area.

d) Introduction of short term service provision.

Funding and security of tenure<sup>34</sup> arrangements would need to be altered to enable short term service provision right across the service system.

Training would be needed for a range of staff including direct care workers and case co-ordinators/managers to operate in the changed environment. Moving to short term provision requires significant whole of organisation cultural shift (from the governance through to delivery and administration) to ensure trained staff are fully supported to implement the change.

A clear communication strategy would need to be developed and implemented to ensure that service providers and consumers understand, and have confidence in, the change. The West Australian and Victorian experience will be instructive in the best way to achieve this and the likely timeframe.

Much more work and definition is required for a comprehensive transition plan and the Alliance will do this once a decision has been made on the assessment model to be implemented.

Improving assessment is very important and ideally the new approach would be introduced as early as possible. However, there is strong support that given the amount of reform currently occurring there are no significant changes to the assessment system until at least 1/7/2016. This enables the bedding down of the Gateway; new Home Support Program; and a range of residential care changes.

<sup>33</sup> ACATs already have an accreditation and training process to be assessors and delegates (including cultural competency) which could form the basis of such training although it would need to be updated in line with decisions made about the assessment model and process.

<sup>34</sup> Security of tenure applies to residential care and home care packages.

This timeframe enables the decision of the assessment model to be made and publicised well in advance of implementation. The decision would include a fully developed transition plan with clear timeframes to enable any affected service providers (including ACATs) to prepare. It also then gives the necessary time to develop a quality assessment tool as well as to design and conduct necessary contracting processes.

***Recommendation 9: A comprehensive transition plan – including training and development- should be developed and agreed with the aged care sector.***

## Conclusion/Recommendations

The aged care reform process affords opportunities for the system's capacity and operation to be improved and better equipped to meet the needs of growing numbers of older Australians. Redesigning the entry and assessment point and process is central to enhancing efficiency and effectiveness.

The Alliance has outlined a system and different options for its delivery, it believes will:

- Support older people's access to the services they need while maintaining their optimum independence;
- Increase the system's capacity to provide support to older people;
- Control and target Government expenditure; and
- Optimise existing resources and infrastructure.

The following recommendations support the introduction of this approach:

1. The Alliance affirms the need for, and supports, the ongoing implementation of the Gateway.
2. VHC services should be accessed via the Gateway improving veteran awareness of other services available to them through the aged care service system.
3. The assessment process should be culturally appropriate, carer inclusive, take a wellness/ reablement approach and support the ageing process. It would cover assessment for home support (including VHC), transition and residential care services.
4. Eligibility assessments should be undertaken by appropriately trained staff at the Gateway. In most instances these would occur over the telephone. Where the older person or their carer needs other support, such as an interpreter or other cultural expertise the eligibility assessment would be undertaken face to face.
5. All comprehensive assessments should be undertaken by appropriately trained persons, face to face preferably in the older persons own home with input from significant others where relevant and agreed to by the older person. The comprehensive assessment would include an assessment of the carer where relevant.
6. Ongoing review and reassessment should largely be undertaken by service providers unless a consumer specifically requests an independent reassessment process.
7. The secure electronic client record should be developed, integrated with the PCeHR and IT capacity built to support its implementation.

8. The system should be reoriented to support short term periods of reablement service provision prior to decisions being made about ongoing service and support requirements. This would be available in all home based services. Further consideration and development is needed for this to be viable and successful in residential care.
9. A comprehensive transition plan – including training and development - should be developed and agreed with the aged care sector.

The Alliance has made a number of recommendations in other papers, which if adopted would further support and improve the proposed assessment system. These include that:

- In the short term the home care packages and home support program (to be introduced from 1/7/2015) be combined into one program to support ease of access. For further details and rationale for this recommendation refer to the Alliance's Home Support Program Design paper.
- In the long term aged care move to an entitlement based on assessed need system with resources allocated through the Gateway and following the consumer as recommended by the Productivity Commission.
- A holistic advocacy program should be created which combines advocacy currently provided through the National Aged Care Advocacy Program (NACAP) and advocacy funded in the Service Group 2 within the HACC Program. For further details and rationale for this recommendation refer to the Alliance's Home Support Program Design paper.

## Possible comprehensive face to face assessment delivery organisations

Existing Infrastructure	Advantages	Disadvantages
Local Governments	<ul style="list-style-type: none"> <li>• Established regional boundaries</li> <li>• Well known in local communities</li> </ul>	<ul style="list-style-type: none"> <li>• Variable interest in, and knowledge of, ageing and aged care (except Victoria)</li> <li>• Potentially too many of them</li> <li>• Ongoing jurisdictional issues, level of control and national consistency</li> </ul>
Individual Service Providers (including GPs, ethnic specific service providers, Aboriginal and Torres Strait Islander service providers as appropriate to the local area)	<ul style="list-style-type: none"> <li>• In Regional, Rural and Remote (RRR) areas this may be the only appropriate option</li> </ul>	<ul style="list-style-type: none"> <li>• Conflict of interest with service delivery</li> <li>• Lacks independence and transparency on which reformed system is based</li> <li>• Varying governance arrangements</li> </ul>
Medicare Locals	<ul style="list-style-type: none"> <li>• Newly established</li> <li>• Primary function is integration and service co-ordination to enhance population health</li> <li>• Engaged with GPs</li> <li>• Address wider determinants of health encouraging healthy ageing, economic participation and independent living</li> </ul>	<ul style="list-style-type: none"> <li>• Lacks national consistency</li> <li>• Not well established, varying governance arrangements</li> <li>• Embeds ageing and aged care in a primary health framework which is only part of ageing and aged care</li> <li>• Focus predominantly on co ordination and linkages rather than any form of service delivery</li> </ul>
ACATs	<ul style="list-style-type: none"> <li>• Well established infrastructure</li> <li>• Known boundaries</li> <li>• Knowledge of ageing and aged care (Federal only programs)</li> </ul>	<ul style="list-style-type: none"> <li>• Many ACATs are placed in state based hospitals system,</li> <li>• Ongoing jurisdictional issues</li> <li>• Embeds in medical model</li> <li>• Current variability issues especially in extent of how multidisciplinary they are</li> <li>• Difficult to achieve organisational cultural shift required</li> <li>• Predominately seen as gatekeepers</li> <li>• Low level sector belief that this would create change/reform to the system</li> </ul>



Carer Respite Centres/ Carelink	<ul style="list-style-type: none"> <li>• Already exist in local areas</li> </ul>	<ul style="list-style-type: none"> <li>• Not well utilised</li> <li>• Very variable profile, some with good connections to communities, others not so</li> <li>• Narrow focus</li> </ul>
Medicare or Centrelink	<ul style="list-style-type: none"> <li>• Well established infrastructure</li> <li>• Known boundaries</li> <li>• Already undertakes residential care financial assessment</li> <li>• Improving rural and remote access</li> </ul>	<ul style="list-style-type: none"> <li>• Confuses service delivery and income support</li> <li>• Not core business</li> <li>• Knowledge of ageing and aged care</li> <li>• Combines service and financial functions</li> <li>• Older people generally reluctant to use</li> <li>• Veterans will not use Centrelink</li> <li>• Not linked with local aged care service networks</li> <li>• Lack of appropriately skilled staff</li> </ul>

The National Aged Care Alliance is the representative body of peak national organisations in aged care including consumer groups, providers, unions and professionals.

