

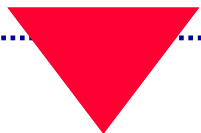
Using evidence to redesign the Australian aged care system: the Royal Commission and beyond

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The starting point

When in a deep hole stop digging

- ◆ The aged care system needs fundamental reform
- ◆ Just throwing money at it won't be one of the options on offer

The evidence / policy nexus in aged care

- ◆ Evidence-free policy 
- ◆ Policy-based evidence 
- ◆ Evidence-based policy 
 - Driving evidence-based practice 


Context: Aged Care Royal Commission Interim Report (Neglect)

- ◆ *Aged Care in Australia: A Shocking Tale of Neglect*
- ◆ “the aged care system fails to meet the needs of its older, vulnerable, citizens. It does not deliver uniformly safe and quality care, is unkind and uncaring towards older people and, in too many instances, it neglects them.”
- ◆ “The neglect that we have found in this Royal Commission, to date, is far from the best that can be done. Rather, it is a sad and shocking system that diminishes Australia as a nation.”

Government expenditure on aged care services, 2018-19 (\$ million)	Aust	Aust %
Assessment and information services	\$229.7	1.1%
Home care and support services	\$5,902.1	29.4%
Residential and flexible care services	\$13,831.9	68.8%
Aged care quality	\$146.9	0.7%
Total aged care expenditure	\$20,110.6	100.0%

Current aged care service mix

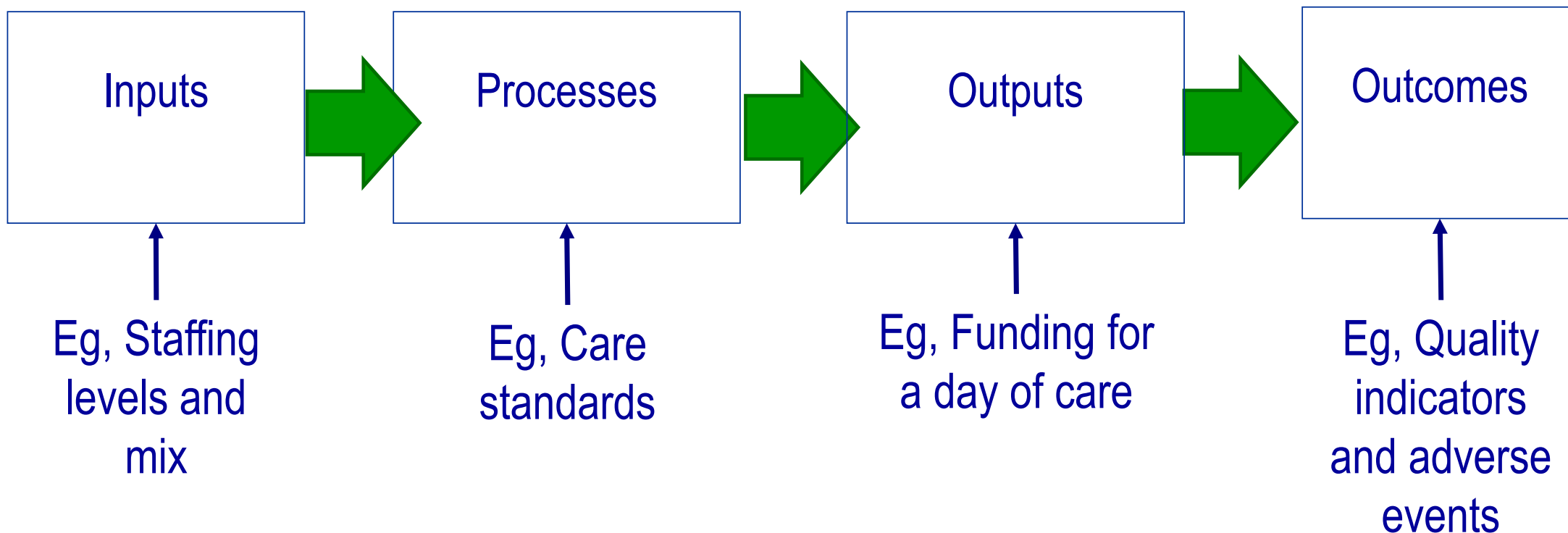
- ◆ ~840,000 low level home support (Commonwealth Home Support)
 - \$2.7 billion, \$2,800 per person
- ◆ ~150,000 higher level home support (Home Care Packages)
 - \$2.6 billion, ~\$20,000 per person. Range \$8,000 (L1) to \$50,000 (L4)
- ◆ ~240,000 residential aged care
 - \$13.8 billion, ~\$55,000 per person



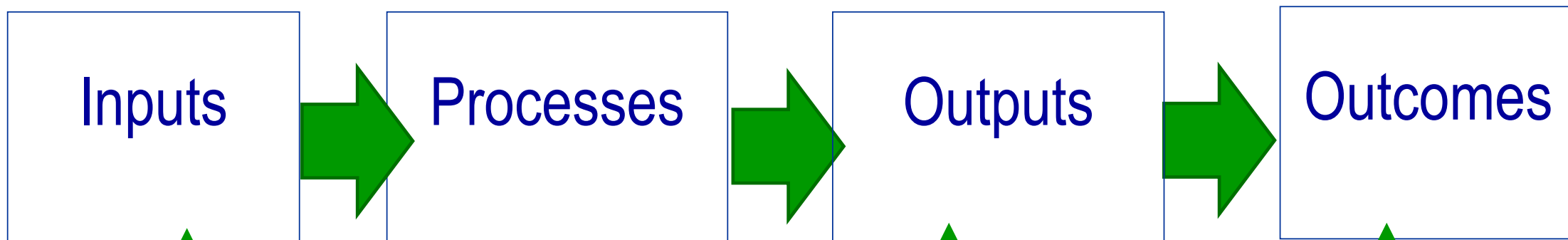
Evidence for system and service redesign: two quick examples

- Resource Utilisation and Classification Study (RUCS) and the AN-ACC casemix classification
- The evidence on staff ratios and star ratings

Intervention points in the aged care system



All underpinned by the legislative, economic and policy context and key intersections (health, housing etc)



Australian National Aged Care Classification (AN-ACC)
A classification of residents that adjusts for needs and risk and that predicts costs



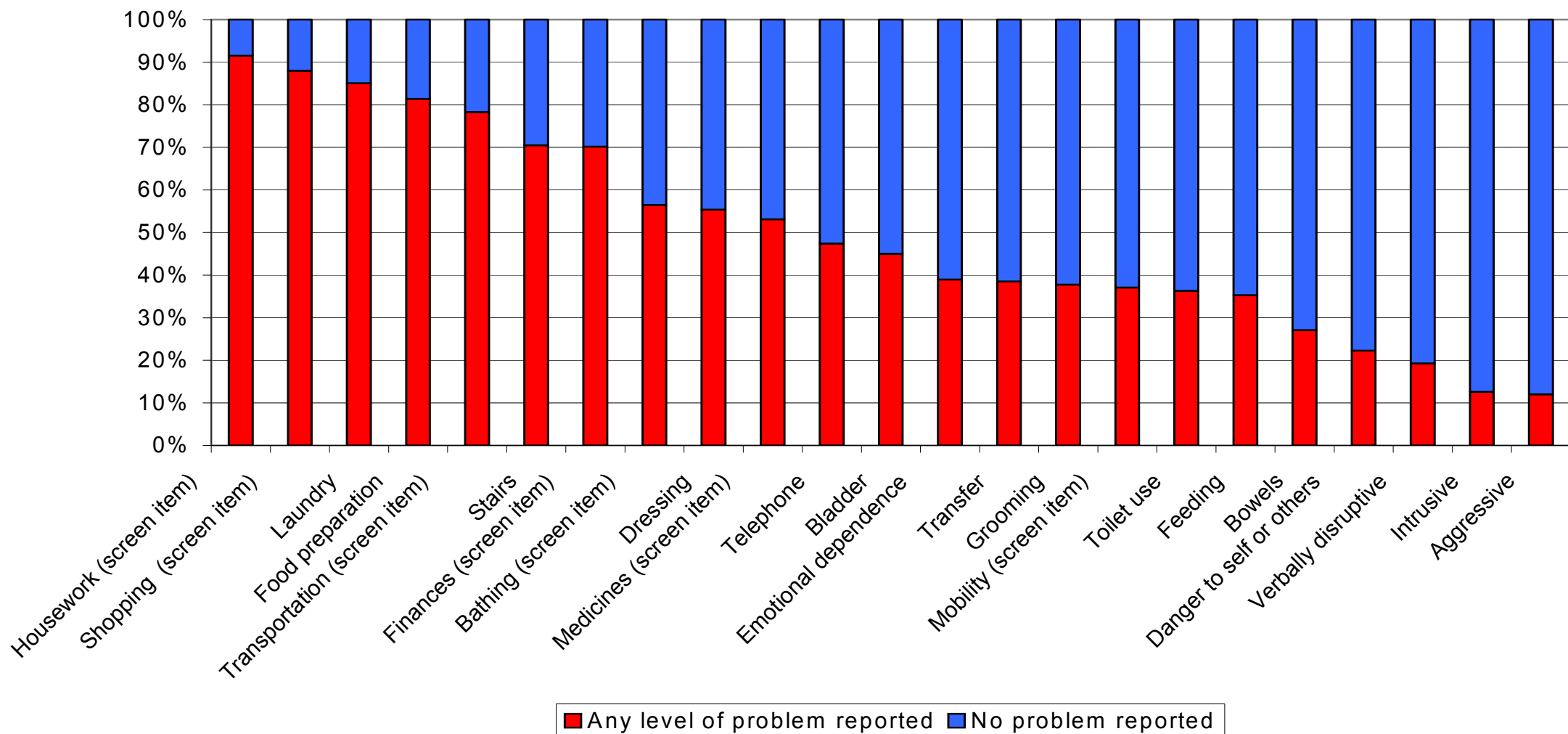
Care needs

The starting point for determining staffing requirements, payment models and quality and outcome measures in residential and in community care

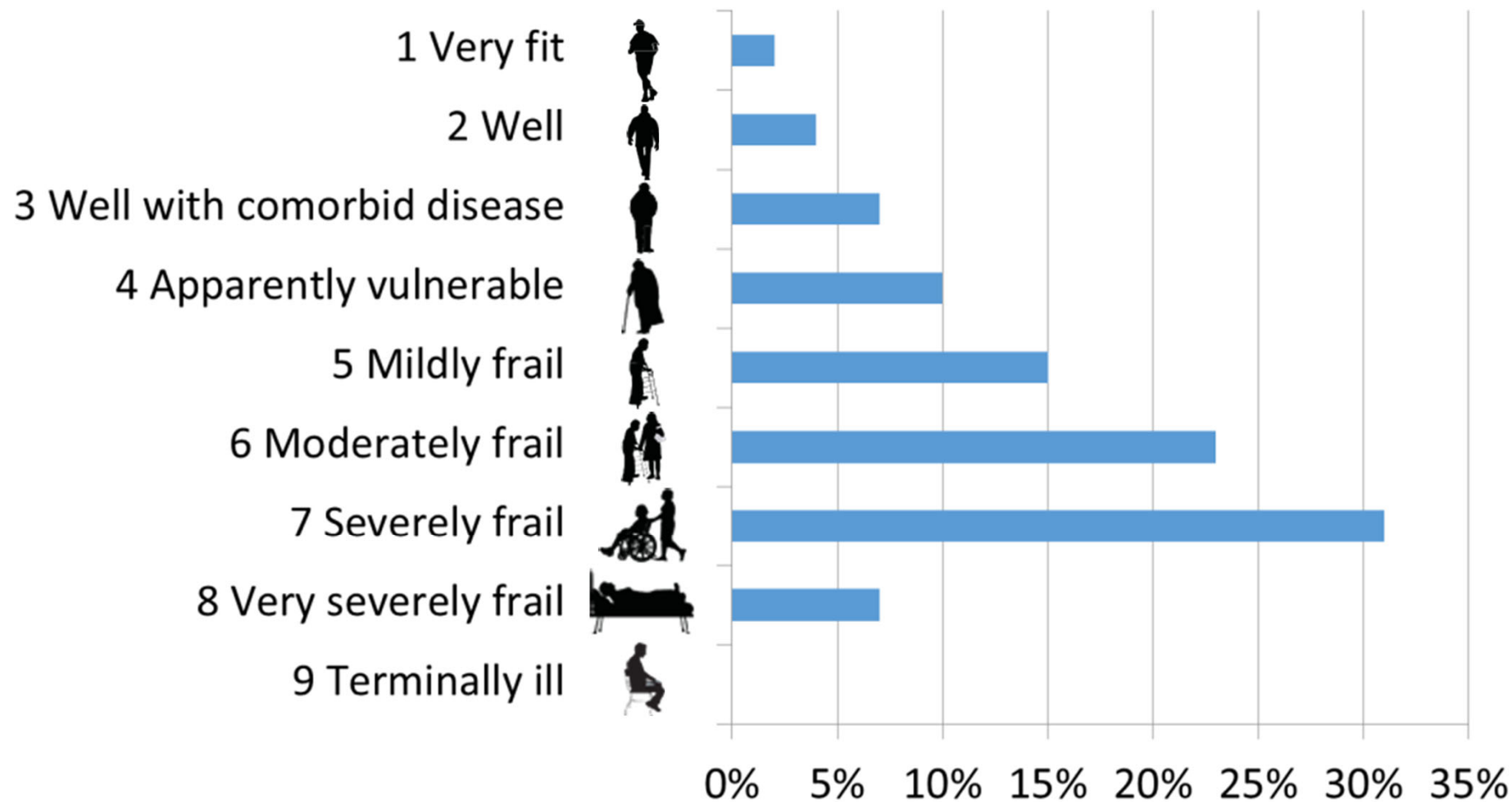
Need for aged care

- ◆ People don't need aged care because of their age
- ◆ People need aged care because they develop health conditions that result in functional loss, cognitive loss, behaviour issues &/or frailty
 - Social isolation & needs are the result, not the cause
- ◆ A social care system for older people isn't enough
- ◆ Holistic care with five major domains: health, function, social, residential and palliative

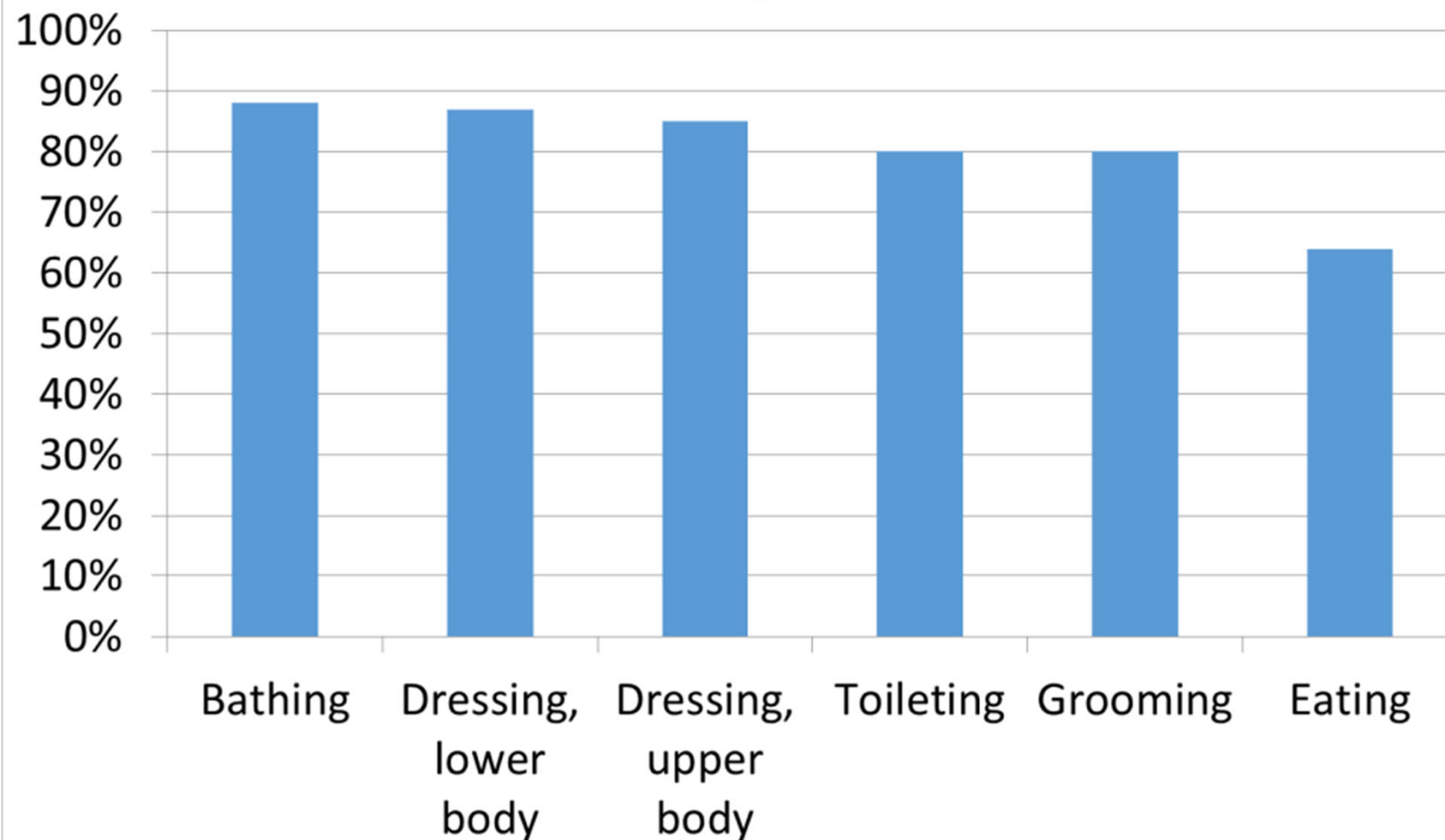
Profile of the HACC population on the functional assessment



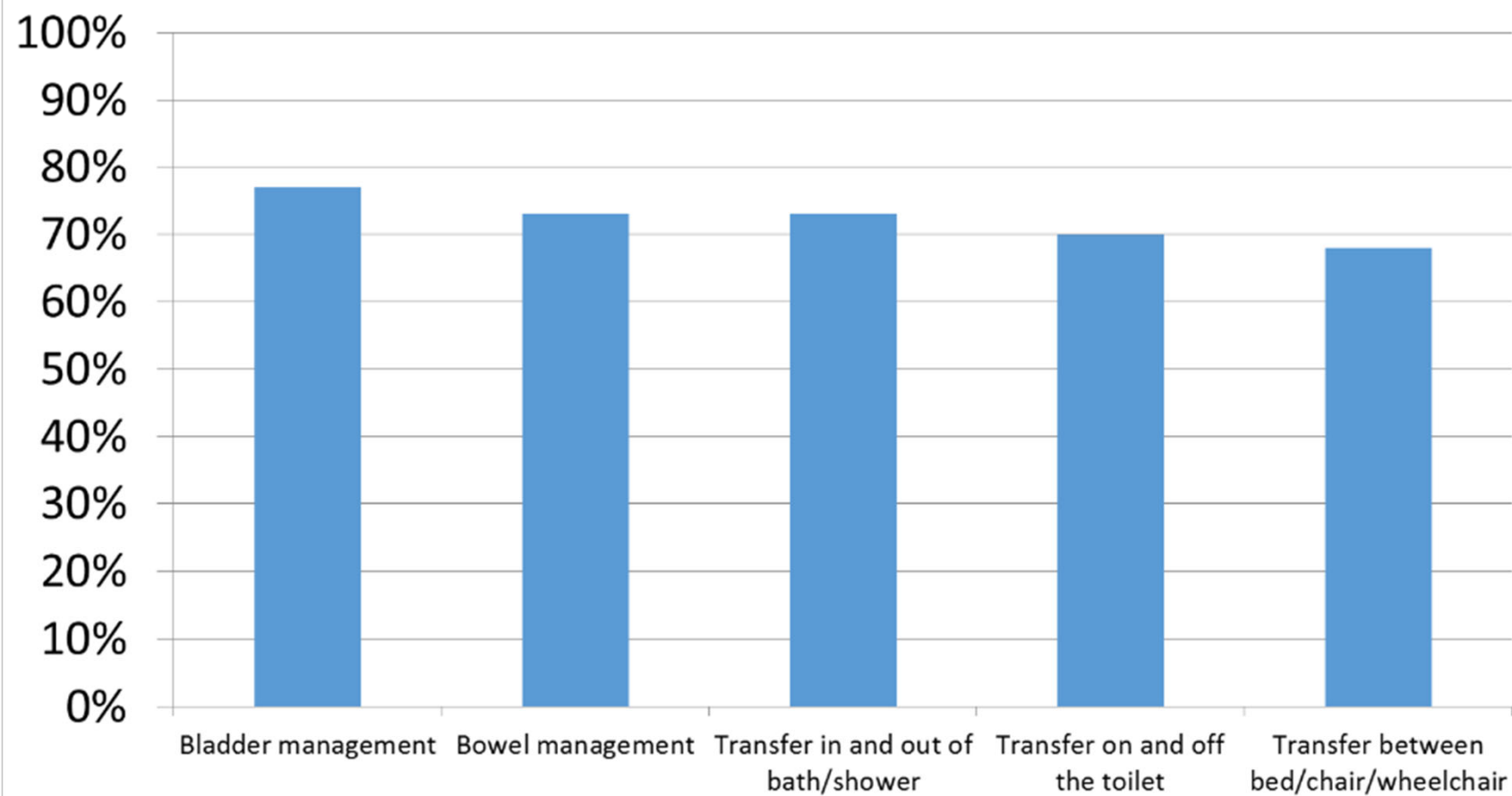
Frailty Profile



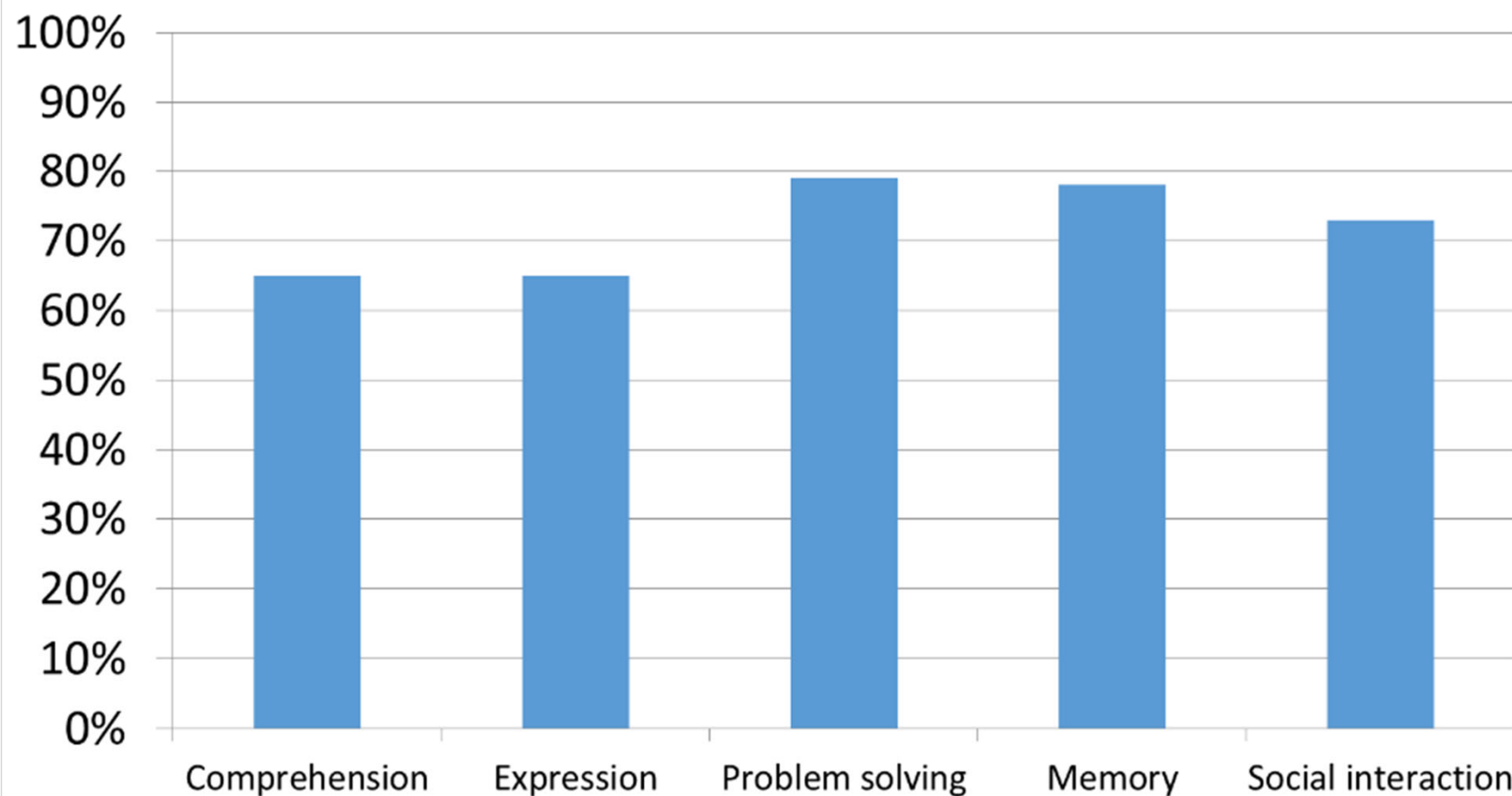
Self-care - % needing help from a carer



Continence and transfers - % needing help from a carer



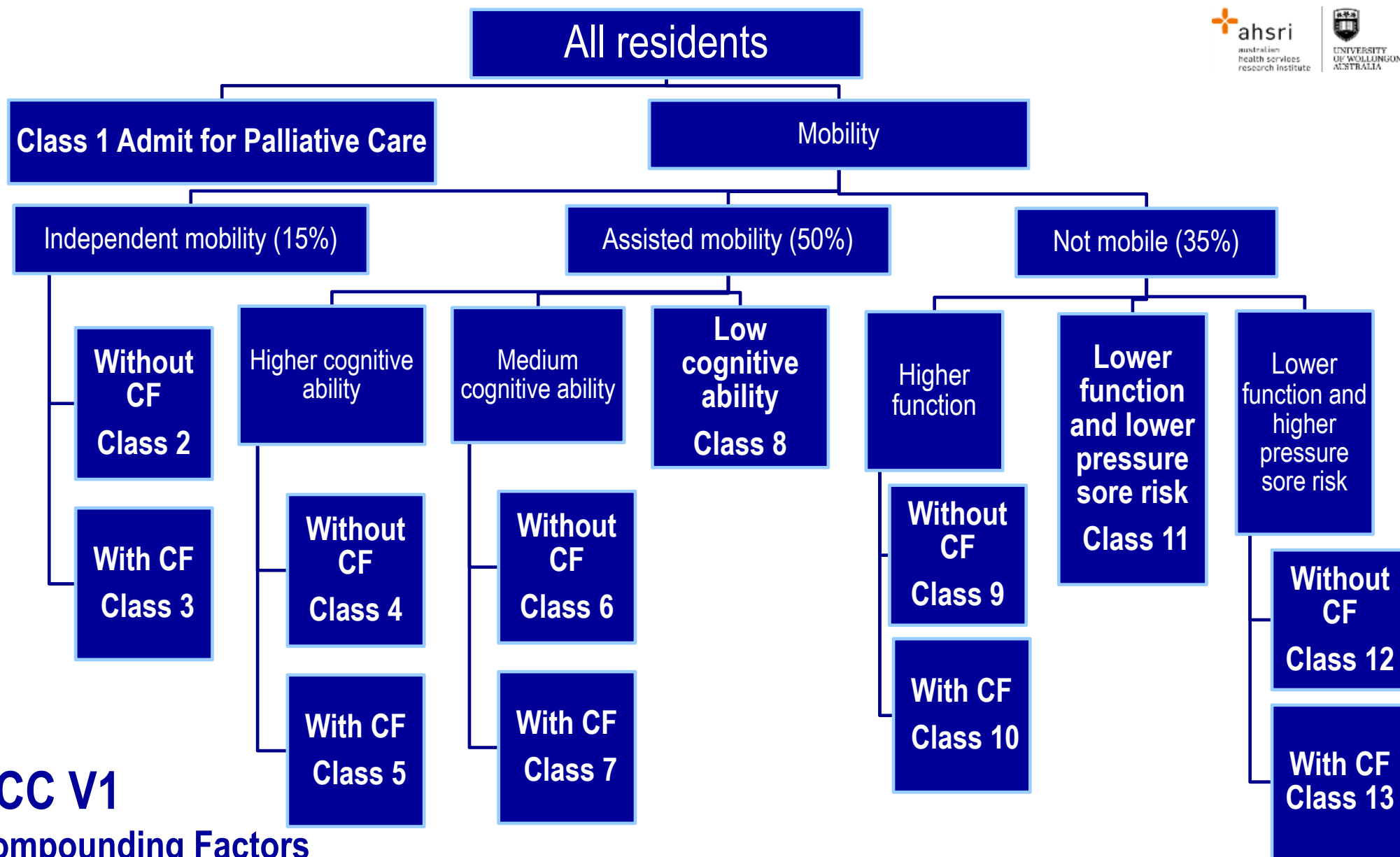
Communication and social cognition - % needing help from a carer





Australian National Aged Care Classification (AN-ACC)

A clear policy alternative to the current ACFI model



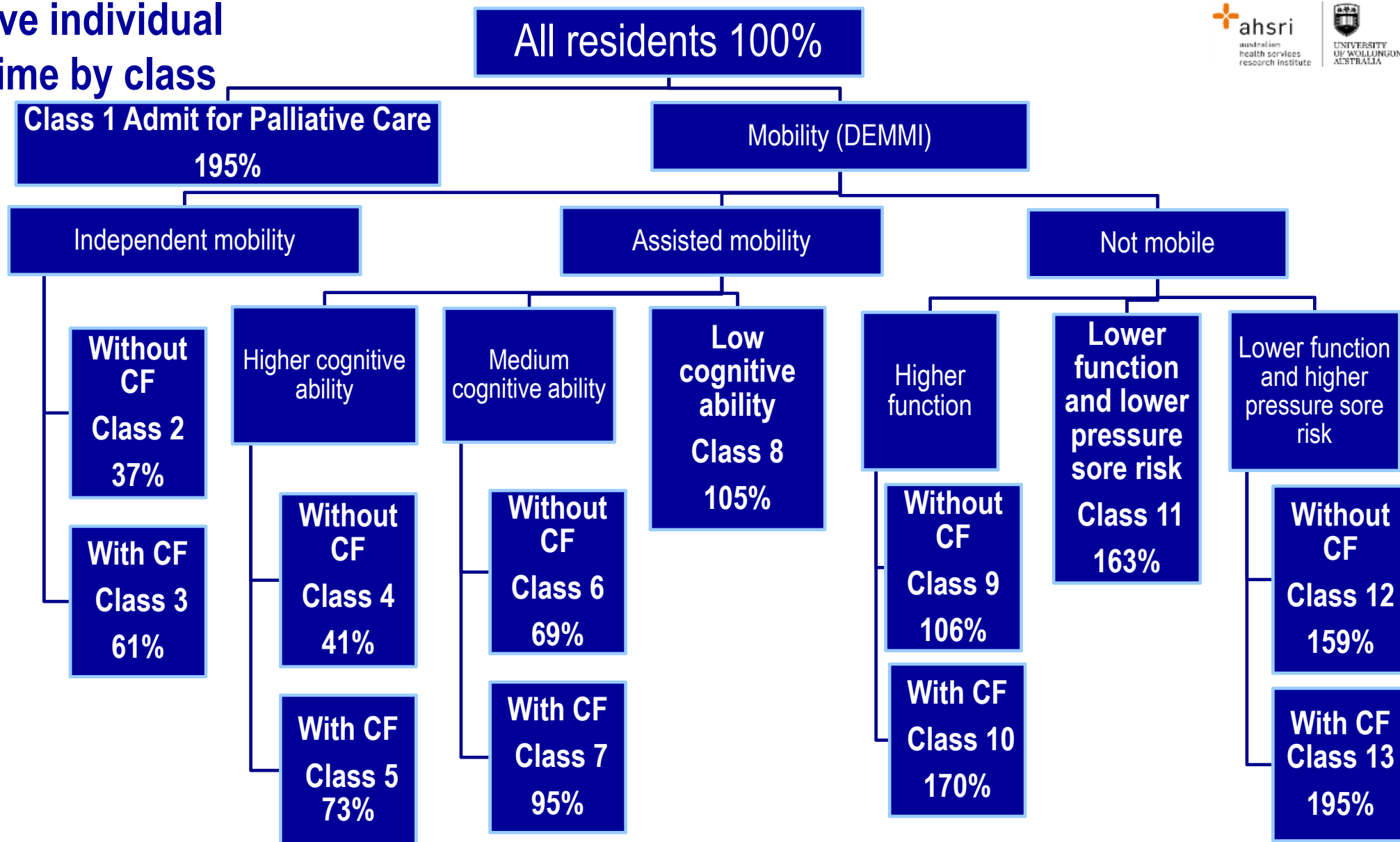
AN-ACC V1

CF = Compounding Factors

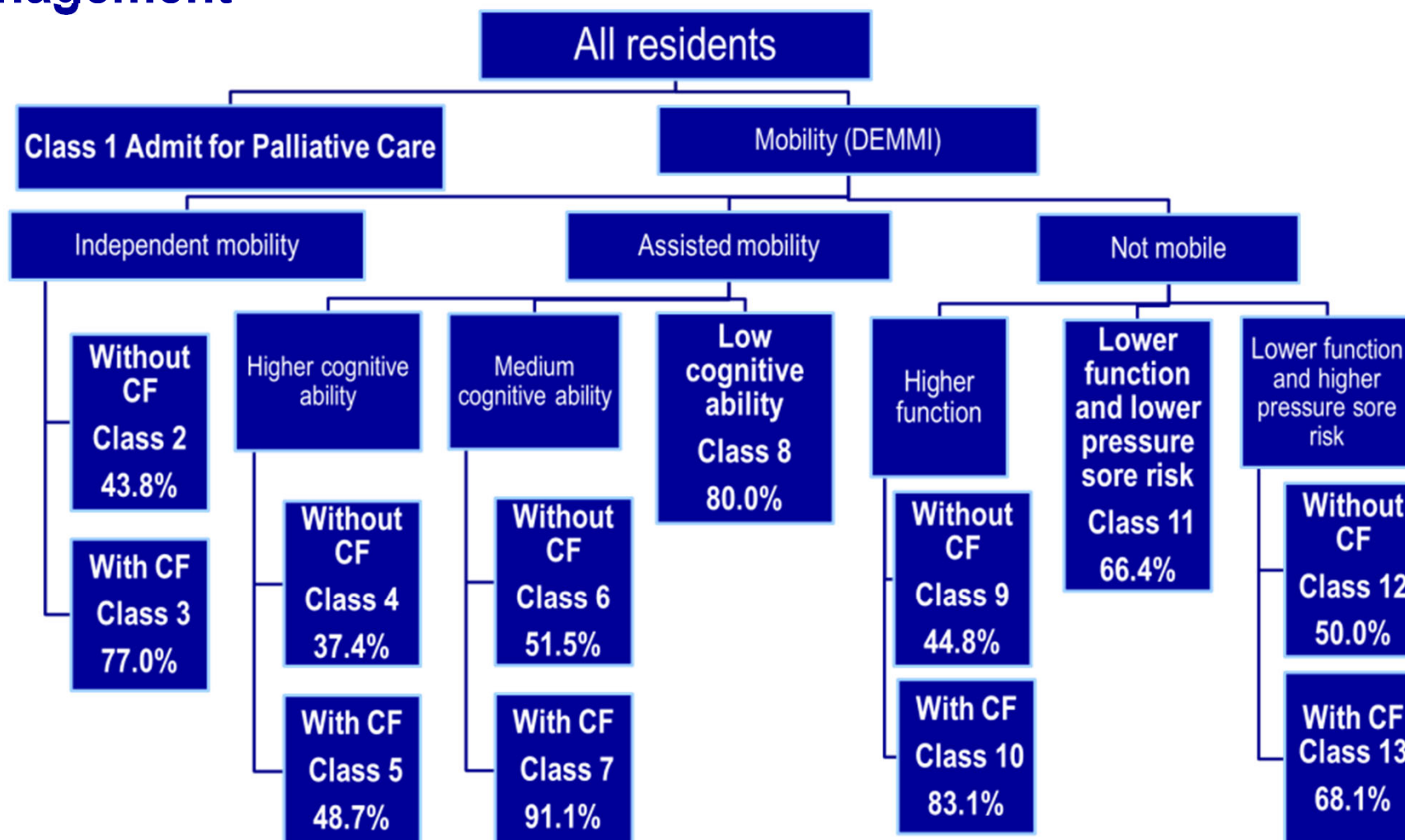
Each AN-ACC class

- ◆ Represents residents with similar needs for care
 - hence an evidence-based predictor of staff time
- ◆ Represents residents who cost about the same to care for each day
 - hence an evidence-based unit of payment
- ◆ Represents residents whose clinical risks and outcomes are similar
 - hence an evidence-based way of risk adjusting quality and safety indicators

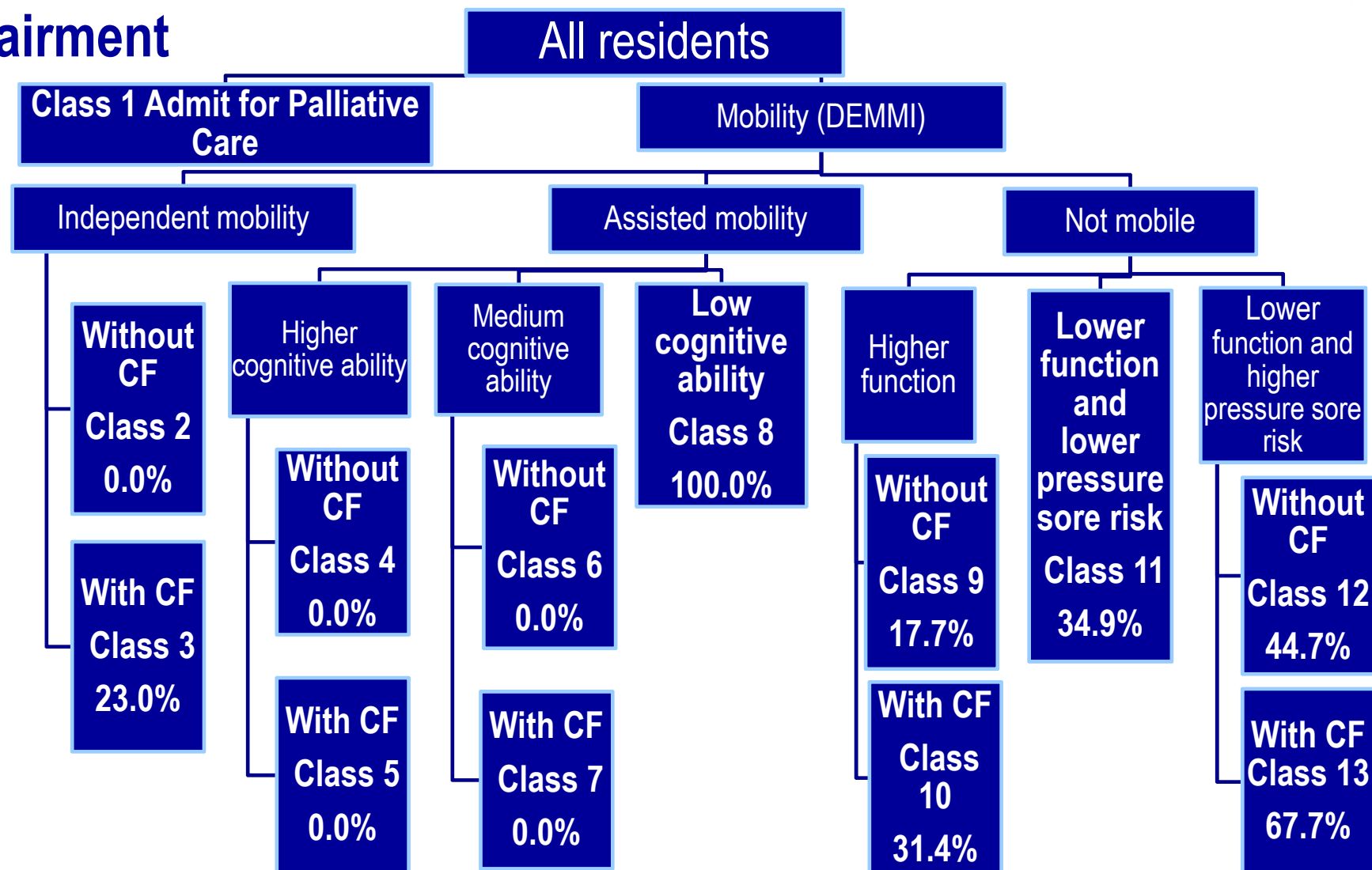
Relative individual care time by class



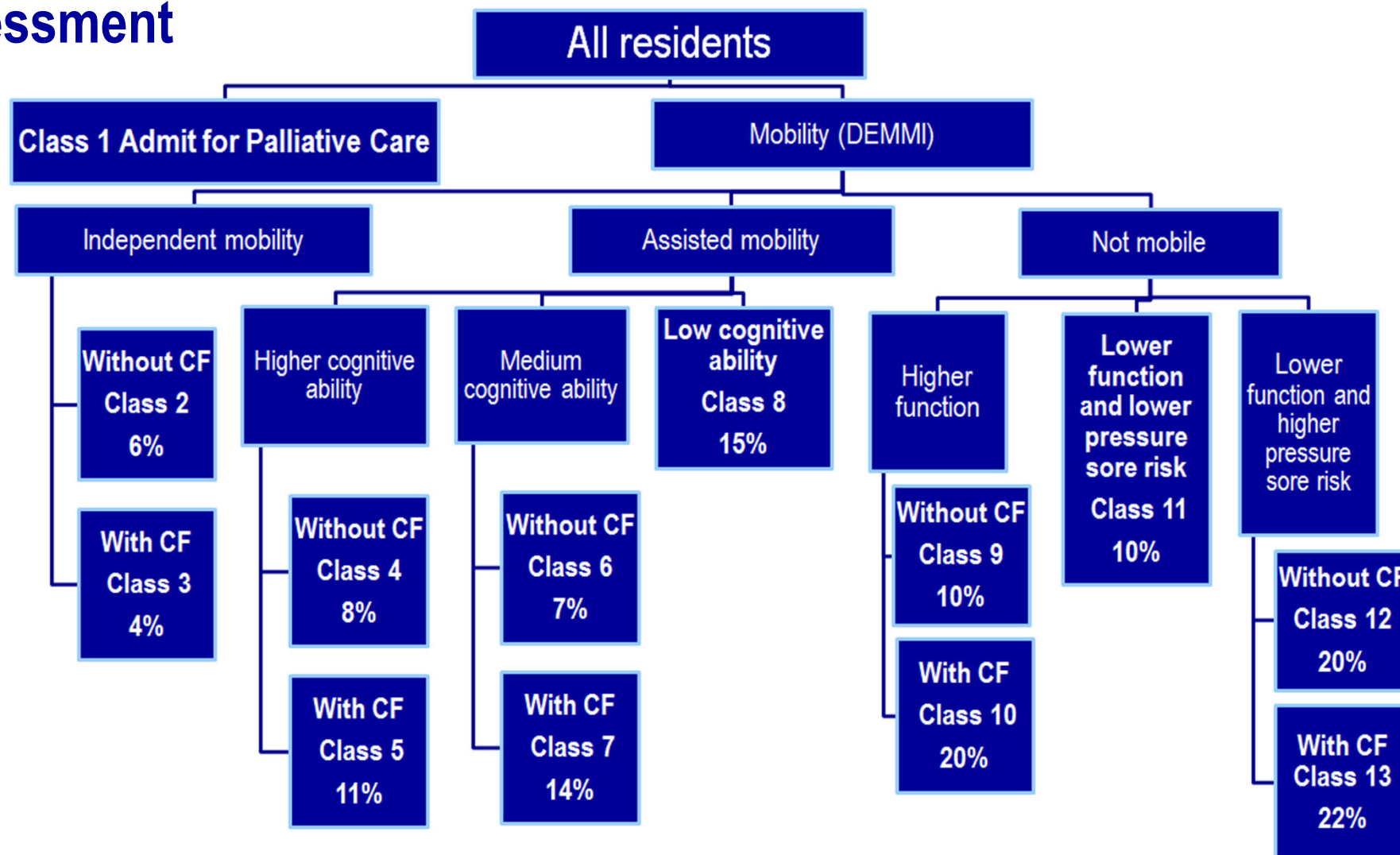
BRUA: % requiring extensive or intermittent behaviour management



FIM Cog: % with significant cognitive/communication impairment



Mortality rates by class 4-6 months after initial AN-ACC assessment



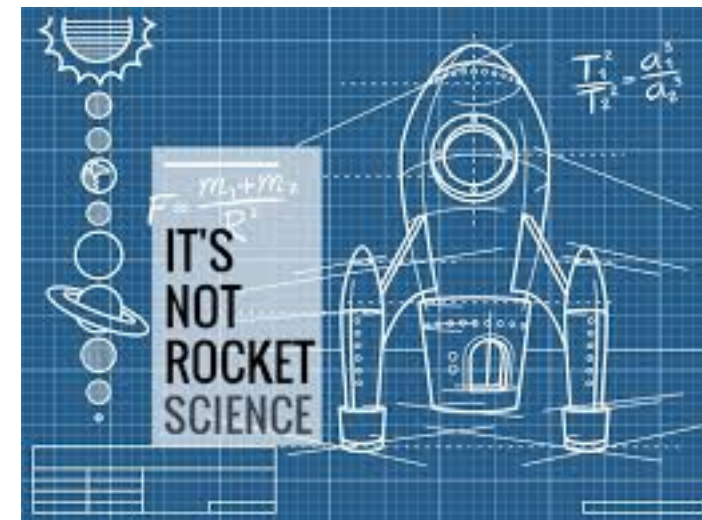


Staffing levels and ratios

Research commissioned by the Royal
Commission

Headline news – what a surprise!

- ◆ There is a direct causal relationship between:
 - Staff numbers and skill mix and
 - Quality and safety outcomes for consumers



Jurisdiction	Criterion	Yes	No
USA - Centers for Medicare and Medicaid Services (CMS)	30 minutes of RN time	62%	38%
	215 minutes of total staff time	18%	82%
	30 minutes of RN and 215 of total staff time	42%	58%
Germany	112 minutes of care	93%	7%
	50% of care provided by an RN	7%	93%
	Both requirements	7%	93%
Canada - British Columbia	180 minutes of nursing care	31%	69%
	22 minutes of allied health time	2%	98%
	Both recommendations	2%	98%
Victoria	Nursing ratios	1%	99%
Queensland	At least 66 minutes of RNs	1%	99%
	At least 44 minutes of ENs	3%	97%
	At least 110 minutes of AINs	68%	32%
	All three targets	0%	100%



Base an Australian system on the
American CMS Star Rating System:
Nursing Home Compare

The best internationally (except for allied health)
Staff ratios are part of a broader system

Nursing Home Compare three domains

- ◆ Staff hours (inputs)
 - casemix-adjusted
- ◆ Inspections (processes)
- ◆ Quality indicators (outcomes)
 - casemix-adjusted
- ◆ Missing consumer / carer experience of care measures
(needed for a balanced scorecard)

Standardised Patient Assessment Data

- ◆ Requirements for reporting assessment data:
 - Providers must submit standardised assessment data
- ◆ Data categories:
 - Functional status
 - Cognitive function and mental status
 - Special services, treatments, and interventions
 - Medical conditions and co-morbidities
 - Impairments
 - Other categories required by the Secretary
- ◆ Providers must also submit payroll data for reporting of staff ratios

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.

* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a 'G-level' deficiency (i.e. 20 points) are assigned.

Source: Centers for Medicare & Medicaid Services

Short Stay

New/worsened
PrU

New
Antipsychotic

Self Report
Mod/Severe Pain

Flu Vaccine

Pneumovax

Long Stay

Hi Risk PrU

Antipsychotic
Use

Self Report
Mod/Severe Pain

UTI

Catheter

ADL Decline

Long Stay

Fall Major Injury

Restraint Use

Lo risk
Incontinence

Weight loss

Depressive
symptoms

Pneumovax

Flu Vaccine

NH Compare Quality Measures

Staffing

- Registered nurse (RN) hours per resident day (50%) and
- Total staffing (RN+ licensed practical nurse (LPN) + nurse aide hours) hours per resident per day (50%)

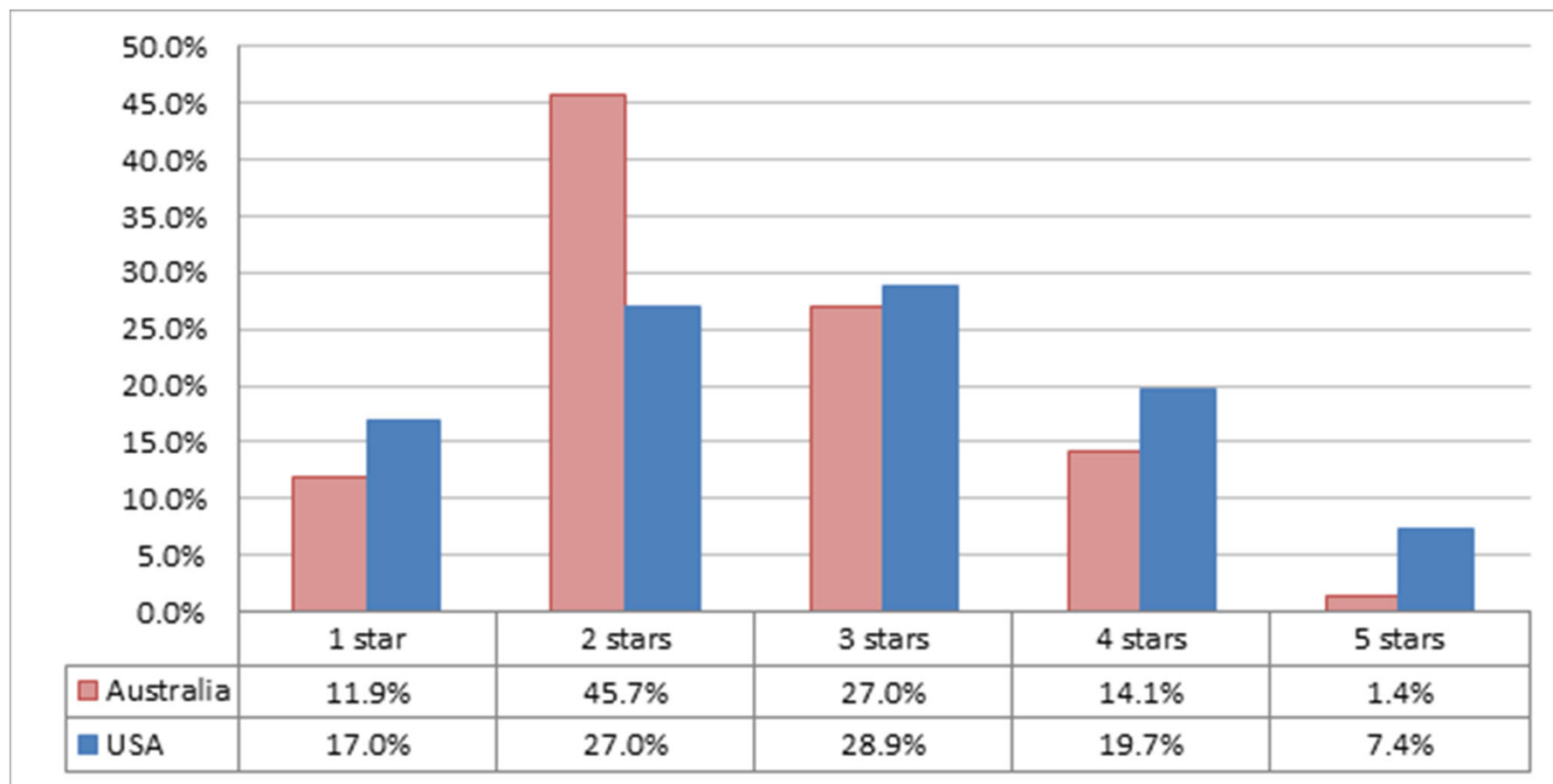
CMS staff time thresholds: minutes per resident per day

Staff type	1 star	2 stars	3 stars	4 stars	5 stars
RN	< 19	19 – 30	30 – 44	44 – 63	≥ 63
All care staff	< 186	186 – 215	215 – 242	242 – 264	≥ 264

**Australian current average: 180 minutes of total care staff time per day,
36 minutes of which is RN time**

RN rating and minutes		Total care staff rating and minutes				
		1	2	3	4	5
		< 186	186 - 215	215 - 242	242 - 264	≥ 264
1	< 19	★	★	★★	★★	★★★
2	19 - 30	★★	★★	★★	★★★	★★★
3	30 - 44	★★★ (Australian average)	★★★	★★★	★★★	★★★★
4	44 - 63	★★★	★★★	★★★★	★★★★	★★★★
5	≥ 63	★★★	★★★★	★★★★	★★★★★	★★★★★

Comparison of CMS star rating for staffing domain (combined rating)



Key findings using US standards

- ◆ 58% of all Australian aged care residents receive unacceptable (1 or 2 star) care hours
- ◆ 27% in facilities that have acceptable staffing levels (3 stars)
- ◆ 14% receive good care hours (4 stars) and
- ◆ 1% are in facilities with best practice care staffing levels (5 stars).

		Total nurse staffing rating and minutes					Total
		1 star	2 stars	3 stars	4 stars	5 stars	
RN rating and minutes		< 186	186 - 215	215 - 242	242 - 264	= 264	
1 star	< 19	11.9%	0.0%	0.8%	0.0%	0.0%	12.7%
2 stars	19 - 30	23.6%	0.3%	0.0%	1.1%	0.1%	25.1%
3 stars	30 - 44	20.9%	7.0%	0.9%	0.0%	2.3%	31.1%
4 stars	44 - 63	16.5%	1.4%	4.1%	7.7%	0.0%	29.7%
5 stars	= 63	0.0%	0.0%	0.0%	0.0%	1.4%	1.4%
Total		72.9%	8.7%	5.8%	8.8%	3.8%	100.0%



Raising the standard

- ◆ For all residents to receive at least 3 star care hours:
 - increase of 37% in total care staffing in those facilities currently rated 1 or 2 star
 - resulting in an overall increase of 20% in total care staffing across Australia
- ◆ 4 star requires a 37% increase in total care staffing
- ◆ 5 star requires a 49% in total care staffing



**My Top 10 wish list for the Royal
Commission's final report ...**

Reform 1

- ◆ Dispel the myth that competition and the market are the best mechanisms to drive efficiency, quality and innovation and to respond to aged care consumer demand
 - This is evidence free policy
 - ‘Neglect’ is clear:
 - ◆ aged care is not an industry; the ‘market’ is failing
 - Aged care needs to be built on relationships, not just transactions
 - The question is what mix should replace it

Reform 2

- ◆ Dismantle the aged care “industry” along with the Commonwealth aged care program management structures

Reform 3

- ◆ Introduce a national policy on the relationship between cost and price
 - Commonwealth payments to be sufficient to cover the cost of adequate and appropriate care
 - No profit care
 - ◆ Providers to use care payments for *care only*, no profit
 - Profit from accommodation and hotel services is a separate issue

Reform 4

- ◆ Reject the idea that there needs to be a trade off between clinically competent care and a social model of care
- ◆ Holistic care for older people includes meeting health, functional, social, residential and palliative care needs
 - Social model is essential but not enough
 - Respectful relationships & skilled clinical teams are key

Reform 5

- ◆ Abolish the current national 'one size fits all' approach
 - Abolish the My Aged Care gateway
 - Challenge the illusion that what works in Melbourne and Sydney can work in the Kimberley and Central Australia

Reform 5 (continued): Entry and assessment

◆ My Aged Care

- An obstacle course, not a gateway
- Why do we need one national gateway?
- Wouldn't it be better to have a regional system instead?

◆ Regional Assessment Services (low need)

- Why have a RAS? Why can't primary care assess for low need group?

◆ Aged Care Assessment Teams (high need)

- Is it possible to have specialist ACAT (medical, nursing, allied health) that are not linked to public hospital departments of geriatrics etc?

Reform 6

- ◆ Move to regional aged care authorities (potentially Primary Health and Social Care Authorities)
 - Strengthen regional partnerships (health, social care, local government, community organisations) and community capacity to support and promote healthy ageing
 - Age friendly community services stream

Reform 7

- ◆ Strengthen regional partnerships to support and develop responsive and sustainable aged care services
 - No wrong door
 - Assess for needs, strengths and preferences (and not just eligibility)
 - Local solutions, local ownership and community engagement

Reform 8

- ◆ Substantially increase funding but with strings attached
 - No profit care policy
 - ◆ care subsidies must be spent on care
 - A new AN-ACC funding model
 - ◆ Regional assessment
 - ◆ Residential care:
 - Adjustment payment, Base care tariffs and AN-ACC classification payment
 - ◆ Develop AN-ACC classification branches for other aged care
 - Home care, respite, community rehabilitation, MPS's, innovative care models (eg, payments for couples)

Reform 9

- ◆ Introduce five star public reporting building on the US CMS model.
 - Casemix-adjusted staff hours (inputs)
 - ◆ Three separate elements - nursing, allied health and total care staff
 - Inspections / accreditation (processes)
 - Consumer / carer experience of care (processes)
 - Casemix-adjusted quality indicators (outcomes)

Reform 10

- ◆ Strengthen the evidence base to allow consumers to make informed choices about the care they receive.
- ◆ Three models of care for the future
 1. Evidence informed practice
 2. Innovation with evaluation
 3. Innovation with informed consent:

I understand that the care I am receiving is not evidence-based and is not being evaluated

A better aged care future

- ◆ Evidence free policy 
- ◆ Policy-based evidence 
- ◆ Evidence informed policy 
 - Evidence informed practice 