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An Assessment Framework for Aged Care

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1 Executive Summary

As a result of the National Health Reforms the Australian Government has sole responsibility for the provision of aged care to people over the age of 65 years (except in Western Australia and Victoria).

With this national responsibility for the first time throughout most of Australia, the opportunity to improve care arrangements and to streamline aged care assessment processes is available, as is the experience built up through trials and research and development across a number of programs. It is now timely to use this opportunity to align the levels of aged care assessment with a continuous record, and do that in a planned and systematic way. This framework document sets out the recommended approach.

This assessment framework is designed to fit the guiding principles of the 2010-11 'one stop shop' Budget measure and be able to be implemented without losing the existing capabilities of the aged care system:

- To design the structure and components of an assessment framework for the new front end for aged care
- Review current assessment tools used for initial needs identification assessment and assess their suitability for use at the entry point to the aged care service system (the new front end)
- Develop an appropriate needs identification assessment tool for the new front end
- Undertake an initial validation of the proposed assessment tool using feedback provided by the Department of Health and Ageing and the Expert Clinical Reference Group (ECRG) formed for the project and make recommendations concerning further validation activities and future development.

The framework aims to find a balance between a system that is sufficiently wide in scope to take advantage of the new policy and funding environment yet practical enough to be useful in the field without jeopardising the considerable investments made to date in electronic information systems. The framework maps out a middle path so as to involve logical steps along a development pathway, using existing and new systems.

The scope of the project is to outline an assessment framework that will encompass all levels of assessment for aged care services and to design an initial needs identification tool for the new front end. Once the new front end is in place it is likely that some streamlining of more comprehensive assessment tools and processes may be required (e.g. ACAT and ACFI assessment processes) but this may form a separate project.

This first paper is concerned with the structure and components of the assessment framework and the most important considerations about how it would be introduced.

The brief for the framework paper was to examine:

- Current community and aged care service systems and their assessment processes (e.g. Home and Community Care; Veterans Home Care, Aged Care Assessment Teams and the Aged Care Assessment Program)
- The journeys and pathways for aged care clients from community care through to residential care placement
- An outline of key assessment issues for consideration along the assessment pathway
- Examples of assessment tools (in particular the ONI/ACCNA family and the ACCNA-R) that are commonly used for initial access to aged care community services
- Consider links and triggers to other assessments (e.g. ACAT assessments, deep and narrow assessments
- Issues and a model for a needs assessment tool for the new front end.

Design issues for consideration by the Department and the Expert Clinical Reference Group are illustrated in more detail in the various sections of the framework. Chapters 2, 3 and 4 provide necessary background information relating to the assessment framework. In Chapter 2 the context of the project is described. Chapter 3 provides a description of the current assessment processes and services provided for aged care (e.g. HACC style services, Aged Care Packages etc.). Chapter 4 examines the journeys and pathways for aged care clients.

Chapter 5.1 to 5.7 discusses assessment issues (levels, domains and principles of assessment); provides a description of initial needs assessment systems and ACAT assessment processes, briefly discusses the overlaps between these assessment processes and the triggers, algorithms, business rules and funding bands that may potentially apply. The latter two issues will be discussed further in Discussion Papers 1 and 2. The issues arising for ECRG and Departmental discussion from these sections are:

- *The breadth and depth of assessment along the assessment pathway.*
  Three levels of assessment are identified related to service need. It is recommended that at entry all applicants receive a short screening assessment including a small number of trigger items which serve to determine eligibility and to identify the need for further assessment. A second level of assessment containing follow up assessment profiles (e.g. a carer profile, psychosocial profile) and a priority rating is undertaken for clients who have more functional deficits and require more than a few low level services and this may also trigger a comprehensive assessment (third level of assessment). Comprehensive assessment, such as that currently provided by ACATS is provided for all clients requiring packaged care (CACP, EACH & Transition Care packages), and approval for entry to residential aged care on either a permanent or temporary (respite) basis.

- *The breadth and depth of assessment in relation to services initially requested (e.g. do all care applicants receive, for example, a functional screen assessment or may this be unnecessary for clients requesting only a few low level services).*
  An initial short functional assessment is useful to determine eligibility, identify the full range of needs and abilities of the person, assess re-ablement potential, and to identify clients with more functional deficits than their initial service request might imply.

- *Where assessments may include a range of informants, judgements are based on a set of questions asking 'can do', suitable for a self report, or a 'does do' approach if the judgement relies on observation. Some assessments are directly relevant to the question of capacity, where a combination of these approaches is used.*
  This issue is discussed in Chapter 5.4.1. The view taken is that it is preferable to provide services to people who need them because they can't perform the relevant tasks rather than to provide services to people who can do the task but prefer not to do it. The 'can do' approach has been used for the functional screen items in the current HACC MDS and is recommended for the initial screening assessment.

- *How to incorporate a re-ablement focus.*
  Items, such as the goal of care, can be included in the assessment process to identify clients who may desire or require re-ablement.

- *Issues concerning the suitability of current assessment tools. (e.g. ACCNA-R, ONI/ACCNA family) and the required modifications to enable a new front-end to connect to comprehensive assessment processes.*
  These tools are reviewed in Chapter 5.4. In the ACCNA-R the initial items from each aspect of assessment (e.g. each item of ADL and IADL assessment) act as triggers, if they are endorsed (Yes/No), for further or more comprehensive assessment of each item of function. These initial items and the follow up assessments are known as the base assessment pathway which can be of varying length dependent on the number of problems endorsed in the initial screening. Given this, at the onset of assessment it will not be clear

how much time it will take to complete an adequate initial assessment for the client. Assessments undertaken using ACCNA R could vary from 30 minutes to 2 hours although the average time estimated is 45 minutes to an hour.

In the ACCNA/ONI tools all clients are given the same nine item functional screen which has three graded response levels. The ACCNA/ONI family use overall scores on the functional screen as the trigger for further (or second level) assessment. Given this design feature, and given that a phone contact that goes for more than 30 minutes will be a burden on the caller and the assessor, the shorter approach undertaken by the ACCNA/ONI family is preferred.

In Chapter 5.8 a range of general assessment issues are discussed. Particular issues for ECRG and Departmental consideration are:

- *The modes of assessment administration along the assessment pathway (e.g. telephone or face to face, electronic or pen and paper).*
  The appropriate mode of assessment will relate to the comprehensiveness of the assessment. A comprehensive assessment such as that provided by ACATs would generally require a face to face assessment and given that a cognitive assessment is included it is not amenable to phone interview. For the initial screening assessment telephone administration is suggested although for clients with special needs (e.g. deafness, CALD, homeless etc.) a face to face assessment may be required.

- *Consideration of the most appropriate method for priority rating.*
  There are different Priority Rating systems in use. The ACCNA-R uses a system that allocates a priority per functional item and per domain for a person so that a person may have several different priority ratings. The ONI/ACCNA priority rating provides one overall rating per person and this approach is recommended

- *Approaches for handling urgency and emergency with respect to service referrals*
  Each referral to a service that is made after an assessment should be coded with a rating for urgency such as:
  - Low
  - Routine
  - Urgent.

  A 'fast track' response to an urgent referral may be required, for example, when there is a risk of harm. A flag that prompts the involvement of emergency services should be part of the initial assessment. An emergency response should not be delayed by the completion of a formal assessment process.

- *Rules for periodic reassessment and the definition of an episode of care*
  The result of an assessment is to determine:
  - The goals of the services to be provided
  - The services that are to be provided
  - The length of time for the services to be provided.

  These three components should comprise an "episode of care", a concept which is not commonly used in the current system. A reassessment at the end of the scheduled period, can determine whether the goals have been met, and help determine the components of the next episode of care.

- *The degree of detail required for carer assessment*
  At the initial assessment it is useful to identify whether the carer is providing information on behalf of the care applicant and whether the care applicant needs a carer and has a carer. If both these latter conditions are met, and the person is referred for a second level assessment, a carer profile could be undertaken which addresses issues such as the sustainability of care arrangements and can also be used as part of a priority rating for the client. If there are issues identified at this stage there may be a referral for a carer assessment as occurs with CENA (Carer Eligibility Needs Assessment) and CENA-R which are deep and narrow assessments of the carer including aspects such as carer burden leading to appropriate referrals for the carer. It is important for the data repository that data for the carer and the care recipient are linked.

  The results of these processes may be that the Carer might then be assessed as a care recipient in their own right although this would only apply to a small proportion of cases (estimated at approximately 20%). The ACCNA-R has built the capacity for assessment of the carer as a care recipient into the initial broad and shallow assessment for the care recipient and it is debateable whether this level of assessment for carers would be required at the new front end or is best addressed by a trigger that follows from the assessment processes described above.

- *Unmet Need*
  Unmet need is a major issue for all components of the aged care community service system and needs to be identified in the assessment system and the associated data repository. This level of analysis would not just look at the total numbers and types of services provided, but at identified needs and whether they have been met.

  These services may not be available to a person for a number of reasons such as:
  - Service not available.
  - Requested service not accessible due to long waiting time
  - Requested service not accessible due to inaccessible location
  - Requested service not accessible for other reasons.

  This information is more useful than just the number of occasions of service in understanding unmet need. It can also identify the common characteristics of people whose needs were unmet. Analysis of the occasions when services are not available to people who need them can provide an important source of evidence when planning for service provision. Decisions to allocate resources need to be based on evidence of need, both met and unmet.

In Chapter 6 a model for a needs assessment tool is outlined. A typology of assessment is used in the framework so as to link the first contact and ongoing needs identification, starting with an initial broad and shallow assessment. Decision support tools are built in and information is aggregated to the level of a central or regional or local Data Repository. The system requires a capacity to talk both ways, to strengthen links to local systems and have a level of standardisation and a capacity for the analysis of data. The quality of the data requires maintenance and maintaining quality implies embedding the assessment system in a training and accreditation program.

This framework moves on from previous approaches in proposing a national assessment system that incorporates and standardises current assessment practices, and provides clear pathways to people who need services. A key component is an assessment role delineation system. Under this approach, each aged care agency is formally recognised as being on a scale from 0 to 4, depending on their capability to assess client need. This framework recognises that assessments may be undertaken by stand alone assessment agencies, or by service provision agencies. It aims to build on and recognise what already exists in the field, rather than impose a new structure

or assessment model. It will provide flexibility and assist in connecting groups who do not use mainstream services.

A further fundamental enhancement in this framework is that it recognises that consumers require broadly three types of service:

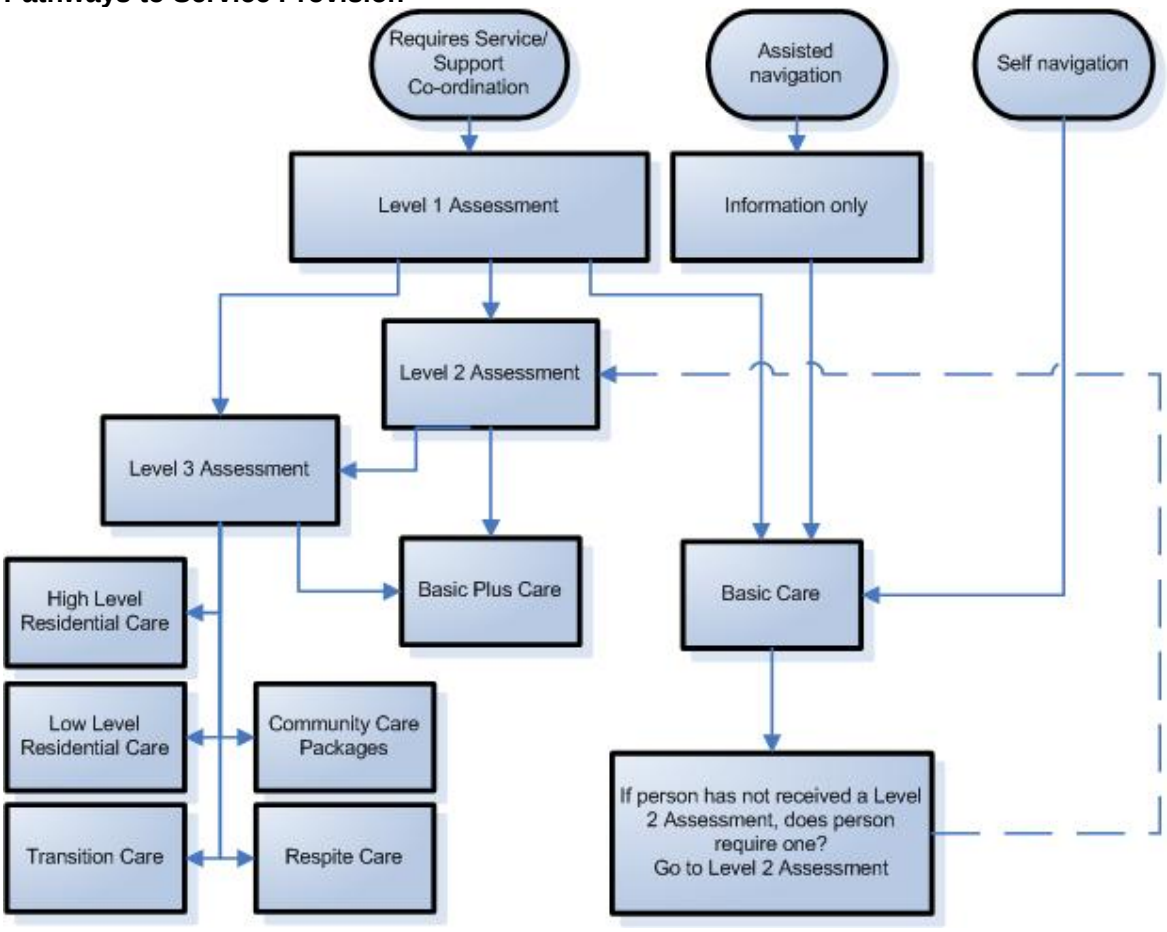
- Basic
- Basic Plus (a gradient of need between basic and packaged/residential care)
- Packaged/Residential care.

These three types of service need correspond to different levels of assessment:

- Basic Care - Broad and shallow core assessment with no follow-up profile assessment
- Basic Plus - Broad and shallow core assessment plus relevant profile assessment
- Packaged/Residential - Comprehensive assessment.

In all cases, the initial contact is for a broad and shallow core assessment that does not include any profile assessments. If these are required, a separate appointment is made. This process is depicted in the figure below:

Pathways to Service Provision



The new assessment system will not operate in isolation from service providers and other assessments. Maximum benefits will be realised if the system can collect data from and share information with the full range of service providers in the community service and health fields, ranging from care providers to general practitioners to acute hospitals. A data repository of this information that can be built up over time would be a valuable tool and resource for understanding

the needs of individuals and the community. Strong links to the local service provision system would help this as well as assist assessors to find appropriate services for people looking for them.

Issues for ECRG and Departmental consideration include:

- Consideration of the proposed levels of service need and assessment
- The proposed national assessment role delineation system.

The questions of the preferred models for the implementation of a 'front end' for initial information and assessment for discussion by the ECRG and the Department include:

- The degree of centralisation required and ways to ensure the consumer finds no wrong door
- How to managed a transition to a more centralised approach to aggregating data, and the benefits to be expected of a program of further research and development
- The consideration of particular issues for special needs groups (e.g. separate and specialised assessment hubs) and
- Analyses of the data to generate evidence to guide further development including finding data relating to the application of funding bands and measuring outcomes within the aged care and the community care system.

Following feedback from the Department and the ECRG appropriate revisions will be made to the Assessment Framework and this feedback will also help to advise the subsequent Discussion Papers.

2 Introduction

The population of Australia is ageing and living longer. By June 2010, 13.5% of the population was aged 65 years or over: approximately 3.05 million people (ABS, *2010*). By 2041 the proportion of Australians aged 65 years and over is predicted to be between 21% and 23% of the nation's population (ABS, 2011). The Australian Government has been concerned about the implications of this ageing trajectory, both in regard to financial and economic issues (The Treasury, 2010) and how to best provide care for this growing group (Productivity Commission, 2011a).

There has been progress in the implementation of the National Health Reforms, one outcome of which is that the Australian Government now has sole responsibility for the provision of aged care to people over the age of 65 years (except in Western Australia and Victoria). From 1 July, 2011 the Commonwealth is funding basic aged care community services through the state and territory governments. From 1 July, 2012, it will fund and administer these services directly. Now that the Australian Government has this sole responsibility for the first time throughout most of Australia, it can move decisively to improve care arrangements and to streamline assessment processes in a systematic way.

This project aims to improve the current processes for assessment of the needs and abilities of older Australians and their carers across a range of related programs. Assessment is a critical part in the organisation of delivery of services as it helps determine the type and intensity of services that are needed, explores why the services are needed, and provides a baseline from which providers can check whether the delivered services have been successful in meeting their aims. Services cannot be delivered effectively and efficiently unless a person's need for them has been established through an appropriate assessment.

This report describes the structure and components of an assessment framework for older Australians requiring assistance.

2.1 Background

The government took the first steps to implementing the 2010-11 'one-stop shop' Budget measure by working to improve access to information and assessment for those most in need of aged care services. Further development of this measure will be in the context of the Government's response to the Productivity Commission's report: Caring for Older Australians.

A key component of improving access to aged care services is ensuring frail older Australians are no longer subjected to multiple or inconsistent assessment processes to establish their eligibility for access to Australian Government subsidised aged care.

Principles that should underpin a new assessment system are:

- National consistency and equity in the assessment of clients (care recipients and carers) for aged care services through a more standardised and centralised intake model
- Assessment is based on needs identification that enables a holistic assessment of client need
- An Australian aged needs assessment tool to form the basis of the screening and base needs identification to take place at the new front end
- Integration between screening, base needs identification and comprehensive assessments to enable clients to transition smoothly along the assessment continuum
- Support for clients interfacing to and from other disability, health and mental health services and
- A service model that meets the needs of particular groups such as indigenous, culturally and linguistically diverse, homeless and regional/remote clients.

3 Current Aged Care System Processes

The current system of aged care, with its associated assessment processes, consists largely of four separate systems:

- The Home and Community Care system (HACC Program)
- Veteran's Home Care Program (VHC)
- Packaged Care (Aged Care Assessment Program) and Eligibility for Residential Care
- Residential Aged Care (Aged Care Funding Instrument: ACFI).

3.1 Home and Community Care

The HACC Program is a joint state and Commonwealth program that commenced in 1985. It funded a range of organisations, mainly non-Government organisations, to provide basic care services for people with low levels of need to help maintain their independence in their own homes. The HACC Target Population is defined as persons living in the community who, in the absence of basic maintenance and support services, are at risk of premature or inappropriate long-term residential care, including older and frail persons and younger persons with disabilities (moderate, severe or profound) and their carers (DOHA, 2011a). HACC services are subsidised but a contribution toward the cost of most of the services (copayment) is requested. This fee is calculated on the level of services to be received, the income level of the care recipient and their ability to pay, although fees may be waived or reduced when there is financial hardship. Most referrals to HACC services are self referrals (29%), followed by referrals by family or friends (15%), hospitals (14%) and GPs (11%).

The HACC Annual Bulletin (DOHA, 2011a) indicates the major items of occasions of service provided are assessment (37.7%), domestic assistance (31.6%) nursing care-home (20.9%) transport (17.6%), meals-home and centre (17.1%), home maintenance (17%), care coordination (14.1%), social support (14.1%) allied health care-centre (14.6%) and allied health care-home (11.1%) , centre-based day care (11.3%) and personal care (10%). The occasions of service metric, however, does not indicate the duration of the service or the numbers of different services per client. The HACC Annual Bulletin also examines the average hours of service for recipients for a number of these services. For example, assessment is commonly provided at an average 2.5 hours per year whereas the average for domestic assistance is 29 hours per year and for personal care it is 51.6 hours. The latter services are received by fewer clients but are more labour intensive. Other services are examined by a different metric such as number of trips for transport services and number of meals for meal services, making direct comparisons across categories of service difficult. For these reasons it is not possible to calculate a figure for average hours of HACC per client per year from the data in the HACC MDS Bulletins.

Data collected in the NSW Hunter Valley Access Point Trial (Samsa et al., 2009) was structured differently to that reported for inclusion in the Annual Bulletin, allowing additional interpretations to be made. Most HACC clients in the trial received one service (43.7%). There were 37.6% of clients receiving 2-3 services with the remainder (18.7%) receiving more than three services. Most requests for HACC Services were for a single service (84%). Of these requests, 54% were referred to only the initially requested service. The single services most requested were for transport, meals at home and home modifications (Samsa et al., 2009).

Based on the routinely reported data, in 2008–09 the statistically average HACC client was a 72-year-old woman born in Australia. She spoke English at home, lived with her family and received on average four hours of HACC services a month. This service was most likely to be one type of support, such as domestic assistance. If she received a combination of services, it was likely to include centre-based day care, meal delivery and transport (DOHA, 2010).

Because of the focus on basic home support services, the HACC eligibility criteria are very broad. The client needs to be living at home; be an older or frail person, or a person with a disability, and have difficulty doing everyday tasks such as dressing or preparing meals. They may also be a carer, most likely of a frail older person who would need to go into a residential aged care facility or hospital care if they were not being supported by the carer and HACC services.

Each provider of services has to carry out their own assessment of potential clients for their particular service. Service providers have to determine the practical details of meeting needs and in doing so require basic information in a common format that can be fed into an ongoing assessment system. The current assessment processes collect client characteristics and information about their circumstances with the focus mainly on the implications for service delivery and care planning and to support referral activity. Assessment is both initial as part of the front end/entry point function and ongoing to the extent that it forms part of a continuous client record.

The HACC Minimum Data Set includes items such as personal details (e.g. name, address, age, gender); circumstances of the care recipient (living arrangements and accommodation; DVA status, functional status); carer information (as appropriate), information about the service episode, and information about the service provided.

A functional screen is collected as part of the HACC Minimum Data Set (HACC MDS) using nine items covering self-care and domestic function instrumental activities of daily living, cognition and behaviour. This data is relevant to all HACC services but not all services collect it. National data are available for 33.5% of clients, but it is not analysed in relation to service use in the HACC Annual Bulletin (DOHA, 2011a). The Bulletin also notes there are some variations between the States and Territories in the participation rates (93%-100%) and some figures are unavailable for Victoria due to coding differences (e.g. transport, home modification, other food services and linen).

A person may apply for services from several HACC providers and will receive a very similar assessment at each of them, with the differences depending on the type of service being offered. This results in the person “having to repeat their stories” many times, which is frustrating for them and wasteful for service providers, who have limited resources to spend on assessment as well as on service delivery. Some jurisdictions and groups of services have developed their own systems to improve information sharing but these are generally not very sophisticated in terms of their “interoperability” with systems like ACAT assessments.

Many services have extensive waiting lists and their own ways of assigning priority for receiving an assessment and priority for particular services. In some cases this means that people have to wait until they are functionally more dependent in order to receive basic services. As well as there being few options for improving wellness, there are also waiting lists for Aged Care Packages for clients with more complex needs. HACC services are regularly required to continue to provide services to clients who require a higher level of care, either because of increasing frailty, the breakdown of carer arrangements or after a hospital episode (Willoughby City Council Submission to the Productivity Commission Report, 2011).

3.2 Veterans Home Care Program

The Department of Veterans Affairs (DVA) operates a Veterans Home Care Program (VHC) which has similar aims to the HACC Program. This program is designed to assist those veterans and war widows or widowers who wish to continue living at home, but who need a small amount of practical help. VHC services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. Apart from these services, limited social assistance services may also be provided as part of the Coordinated Veterans’ Care (CVC) program. Services not provided by VHC such as Meals on Wheels, community transport and other social support services are provided under the HACC program. VHC clients can access both HACC and VHC for services, but not for the same service from both programs at the same time.

Around 80,000 veterans received services through VHC in 2008-2009 (Productivity Commission, 2011c) and 78% of VHC recipients receive only 1 form of assistance. Approximately 77.7% of all VHC hours go to domestic assistance. The average client was approved to receive 51.3 hours per year of care and support, however, during 2006-2007 the average hours provided per veteran per year was only 36.82 hours (VHC, 2008:7) and around 17% of total hours approved for VHC core services were not provided in 2006-07 (VHC, 2008:15). This suggests either a significant degree of unmet need, or veterans' needs being met elsewhere.

The VHC conducts quite extensive initial assessment of clients which includes a) service information, eligibility and consent b) health profile, functional profile and cognitive and behavioural screens which include trigger items for more comprehensive assessment and a priority rating for those with greater need c) carer profile and d) profile supplements (health, function, cognition, behaviour) which are triggered by items in the original profiles. The assessment is based on that provided by the ACCNA/ONI family of tools which are described in Section 5.4.

3.3 Packaged Care and Eligibility for Residential Care: Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) is an initiative of the Australian Government. Under a cooperative working arrangement, the Australian Government provides grants to State and Territory Governments specifically to operate Aged Care Assessment Teams (ACATs) - known as Aged Care Assessment Services in Victoria. The focus of the ACAT's work is the assessment of the care needs of frail older people. In doing so, they assess all care needs of the person using a multi-disciplinary and multi-dimensional approach (DOHA, 2006).

Once a referral (including self referral) to an ACAT is made a comprehensive aged care assessment of the older person will be undertaken. The ACAT will then classify people as eligible for a:

- Low need package of approximate value of $13,400 per year (Community Aged Care Package; CACP)
- A high need package of approximate value of $44,800 per year (Extended Age Care at Home; EACH)
- A high need package with dementia of approximate value of $49,400 per year (EACH-Dementia).
- A Transitional Care Package – that varies between $163.14 and $181.21 (depending on the state or territory) per day.

If they are not eligible the client may be referred to HACC or VHC services or to other health and community services. Only 3% of referrals by ACATs were to HACC services.

In 2009/10 201,609 ACAT assessments were performed across Australia. There were 20,833 low care packaged (CACP) and 5,962 high care packages (EACH and EACH-D). There were 57,937 permanent and 57,503 respite admissions to residential aged care. In 2008/09, around 12,600 people received just over 14,000 episodes of Transition Care (AIHW, 2011b).

There is a considerable difference between the funds available for those with low needs as against those with a high needs. For example, an EACH package can provide a community care service package of 18-22 hours although the average staff hours of direct Care per EACH package were 12.28 hours per week excluding hours per week for case coordination and administration (Aged and Community Services Australia, 2011a). Whereas CACP packages can provide 6 hours of support, an average of 4.78 hours is actually received in direct care (Aged and Community Services Australia, 2011a) with an average of 1.32 hours for case coordination and administration. There is a considerable gap between these levels of support.

If a person was receiving a package of care, they are not eligible for most HACC services. However, around 35% of CACP clients also receive HACC Services, including nursing and allied

health services which are not available through CACPs (Aged and Community Services Australia, 2011b) but are available through the other packages.

Applicants for packaged care often have to wait considerable periods for assessment by an ACAT. For example, in many areas of Sydney the waiting time for an ACAT assessment is 6-9 months (Productivity Commission, 2011a). These packages are allocated to regions depending on their aged population, which means that there may be great variations between the regions in waiting lists and times to receive services.

An ACAT also carries out assessments for respite care, time limited transition care and low-level and high-level permanent access to residential aged care facilities.

ACAT assessments make use of the Aged Care Client Record (ACCR) to record and summarise client assessments. The ACCR is not a comprehensive assessment form and most ACATs have developed their own comprehensive assessment forms. The ACCR checklist covers client registration, intervention information, carer profile, activity limitations and assistance, an assessment summary and information for service providers and approval. The National Review of ACATs Report (Communio, 2007) made a range of recommendations for improving ACAT processes to achieve timelier, more consistent and more uniform quality assessments of frail older people. It had been found that ACATs used a wide variety of different tools for the assessment of their frail elderly clients. This report also indicated the need to develop a set of validated, specific assessment tools for ACATs to use in a consistent way (refer Section 5.5).

Although it is recommended that ACAP assessors make use of the recently developed standardised ACAP toolkit to populate the ACCR this is not mandatory (Sansoni et al., 2010). Thus it is potentially possible that a person could be classified as low need by one ACAT, but classified as high need by a different ACAT. ACAT assessments may need to be carried out again if a person's needs change or if they have not received a certain level of care within a specified timeframe.

ACAT assessments are carried out separately from any other assessment that the person has received from medical or allied health practitioners although ACATs can provide an interface between aged care services, community and health care services and have an important role to play in developing networks between general practitioners, clients and other service providers. A person who needs an ACAT assessment is likely to have had similar assessments from general practitioners such as a Health Assessment for people aged 75 years and older (MBS Items 701, 703, 705 and 707), in acute and sub-acute settings, and from other health and care providers. This raises the issue as to whether some of this earlier data could be used if the referral processes for GPs and other health agencies were streamlined.

3.4 Residential Aged Care Assessment: ACFI Assessment Processes

As mentioned above ACAT assessment also provides approval for permanent and temporary (e.g. respite care) access to high care and low care residential aged care facilities. However, once the client is admitted to a residential care facility a further comprehensive assessment of the client is taken within one month of their entry. A major purpose of this assessment is that it will determine the funding the residential care facility will receive for the client. The residential aged care facility receives a higher subsidy for clients with greater care needs.

The questions used for determining the level of need are activities of daily living (ADL: nutrition/eating, mobility, personal hygiene, toileting, continence); behavioural supplement (behaviours of concern, cognitive status as assessed by Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS-CIS), and depression as assessed by the Cornell Scale for Depression; and a Complex Health Supplement (CHC) which contains items on medication and complex health care.

The ratings from each item area are then added to generate a 4 level classification for each area relating the level of care required (independent = A; high level of assistance required = D). Each of these levels has a score associated with it and these are added for each domain (e.g. ADL) and the high/medium/low classification for each domain is based on this. Additive rules based on these domain scores are used to classify the overall category of need which then determines the funding subsidy for the client. The funding bands for the ACFI are discussed further in Section 5.7 and Table 6.

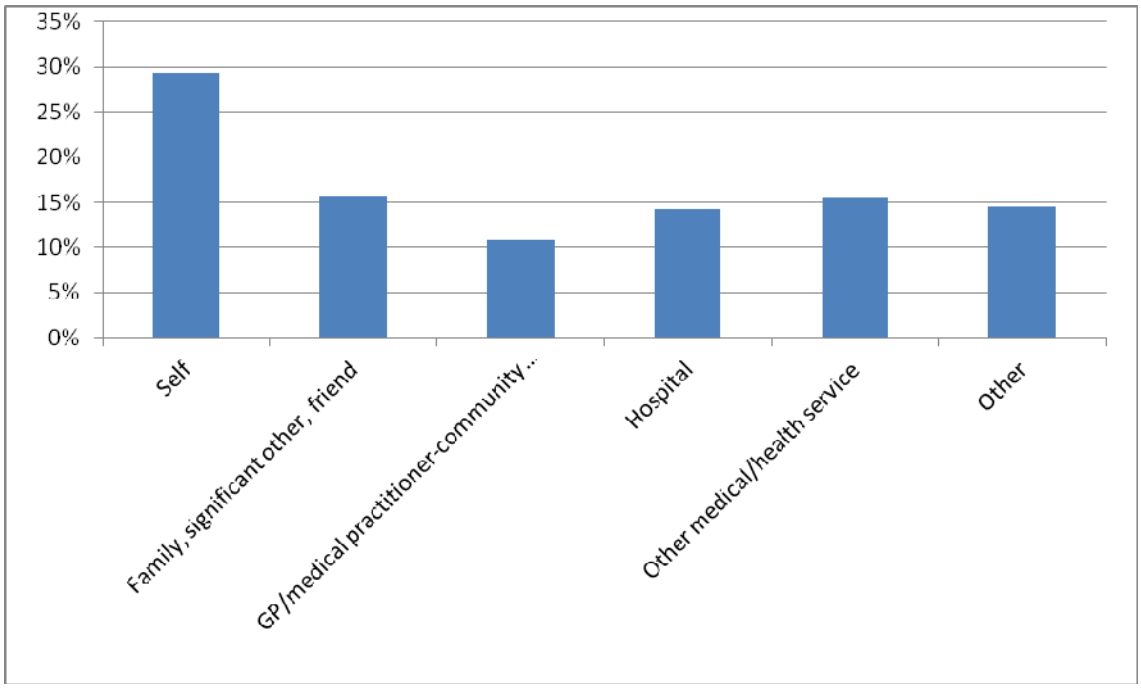
There is a great degree of overlap between the comprehensive assessments undertaken by ACATs and the ACFI. Both of these assessments examine ADL tasks, the same behavioural aspects (behaviours of concern, depression, etc.) and a cognitive assessment, but different assessment tools and items are used. If these assessment processes are aligned it may be possible to use a revised ACAT or third level assessment to determine appropriate funding bands and thus potentially removing the necessity to undertake a further assessment that is currently provided by the ACFI. It is thought that the streamlining of these assessment processes could form a follow-up project. This project is primarily concerned with developing a 'screening and base needs identification assessments to take place at the new front end' (contract). Although linkages to comprehensive assessment are explored the development of funding bands and potentially a case classification system is outside the scope of this project but consideration of this aspect needs to be kept in mind when developing a new front end for the assessment system.

4 Journeys of Aged Care Clients

Ageing is usually a slow and gradual process. People become frailer, sicker and lose functional abilities over a considerable period of time. During this time, they are likely to have had contact with their general practitioners and possibly an admission to hospital for an acute event; they may have had contact with a physiotherapist or another allied health professional.

When a person first approaches a community care service, they are likely to have had some previous contact with other health providers. They may have been seen by the acute health care system, mental health or disability services, or are clients of a specialised agency for a particular population group, such as a migrant support service or Aboriginal medical service. Figure 1 (DOHA, 2011a) shows that 29% of people were self–referred to HACC services, 16% were referred by a family member or friend, and 41% were referred by a health or medical service. The latter indicates that there has already been some assessment carried out on that person.

Figure 1 Referrals to HACC services (2009-10)



People who are looking for assistance from services may be divided into three broad groups:

- Self navigators, who can identify and find the services that they need
- Those who need some information to find the services that they need
- Those who require service/support co-ordination to find the services that they need.

A person's initial approach to a HACC service is often likely to be for a single service. As people struggle to carry out the normal activities of daily living, they may identify a problem in one particular area initially and seek a solution to this problem, such as:

- Inability to prepare meals
- Difficulty getting around their home
- Transport difficulties.

In the first year of the Hunter Valley Access Points Trial, 84% of requests were for a single service (Samsa et al., 2009). The majority (54%) of these requests for a single service were referred to that same service only. The most common relationships for this pathway were for:

- Transport for client
- Meals at home
- Home modifications.

This raises the question of how should an assessment system respond to this request for a single service. Do these requests need to be met with a broader assessment of the person and their situation or should they just be provided with the one service? A broader assessment may pick up other factors that are affecting the functional abilities of the person. An example may be of a person who wants meals delivered, but this is due to the death of their partner who had previously done all the food preparation. Can this person learn to prepare meals for themselves, which results in a better quality of life for the person, and less cost to the service system? One option may be to refer the person to that particular service that will carry out a service specific assessment but also identify whether the person has other needs that would be best dealt with a broader assessment and then refer them to a suitable assessing agency.

However, as a person continues to lose function and identify more problems in their activities of daily living, and require more services, an initial broader assessment is useful to identify the full range of needs and abilities of the person. An initial broad and shallow assessment is preferred for all service applicants.

4.1 Referral Sources to ACAT

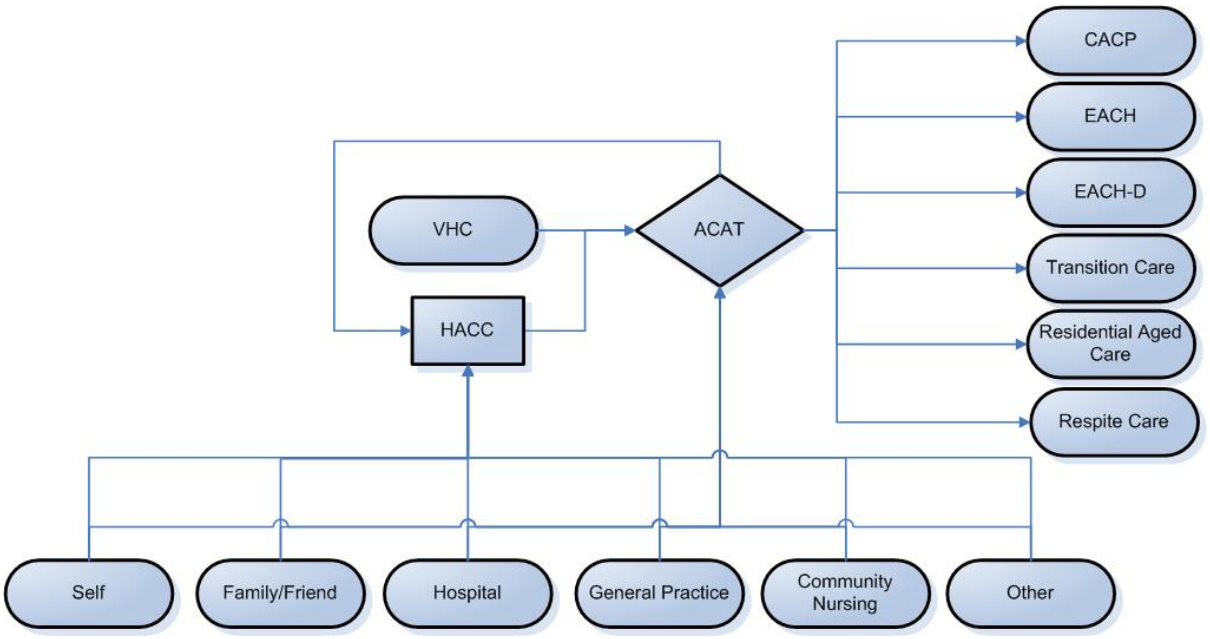
People may be referred to ACAT services by other organisations or self-refer. ACAT assessments are intended for people who need more than the usual range of HACC services. However, many people bypass using HACC Services and approach ACAT services directly. The Pathways in Aged Care Study (AIHW, 2011) found that almost half of new applicants for ACAT assessments had not received HACC or VHC services previously.

Table 1 Previous Service Use for ACAT Applicants

Services used previously	Percentage
HACC only	48.5%
VHC only	3.2%
HACC and VHC	3.8%
None	44.5%

This indicates many people are bypassing using HACC services entirely until they need a number of care services. The current pathways between different assessments and referral sources are illustrated below:

Figure 2 Current HACC – ACAT Pathways



5 Assessment Issues

5.1 Levels of Assessment

This paper views aged care needs assessment as a continuous or multi-tiered and multi-staged process beginning with an initial needs assessment when a client requests an aged care service followed by referral to the appropriate care service. At this early stage of assessment basic needs (e.g. activities of daily living, instrumental activities of daily living) and trigger items would be useful to identify those clients that would required more comprehensive assessment covering a broader rage of domains (e.g. a broad and deep assessment of physical and cognitive function, behavioural and psychological aspects and social function) such as occurs in an ACAT assessment or it may trigger a referral for a deep and narrow assessment of one particular aspect of health or function. Hence the depth of assessment for any domain will be broad and shallow at the beginning of the assessment process and become deeper and more comprehensive as further needs emerge as related to the ageing process as indicated in Table 2 below.

Table 2 Types of Assessments and their Different Purposes and Outcomes

Type	Scope	Purpose/outcome
1	Determine eligibility	(1) Eligible or (2) Not eligible (may include referral elsewhere for a more appropriate service) Proceed to another type of assessment
2	Shallow and narrow assessment of need	Determine next steps, including any other assessments required (initial action plan) Prompt further assessment
3	Shallow and broad assessment of need	Determine next steps, including any other assessments required (initial action plan) Prompt further assessment
4	Deep and broad assessment of need (comprehensive assessment)	Care planning, potentially including clinical interventions
5	Deep and narrow assessment of need (specialist assessment)	Care planning, potentially including clinical interventions
6	Assessment of need for a specific service (service specific assessment)	Agency-specific service plan
7	Determine the relative priority of consumer need(s)	Priority rating derived from other assessments

The purpose of the initial assessment is to obtain a broad view of the needs and abilities of the person and an understanding of their situation. It is to differentiate between people who:

- Have no problems and need no services;
- Have minor problems (i.e., low need), need some services (e.g., meals, home maintenance), but do not need a full comprehensive assessment;
- Have medium to high needs and require a comprehensive assessment.

The purpose of comprehensive assessment is to gather more detailed information about the more complex client's needs across a broader range of assessment domains (e.g. physical and cognitive function, behavioural and psychological aspects and social function). Comprehensive geriatric assessment is an interdisciplinary approach to the evaluation of older person's physical and psychological impairments and their functional disabilities. The rationale is that the early detection of risk factors for functional decline when linked to care interventions may help reduce the incidence of functional disability and dependency in older persons. In the Australian aged care context ACATs perform comprehensive assessments so as to match the frailer clients with more complex needs to an appropriate package of services related to need and to assess whether they require approval for entry to residential aged care services.

5.2 Domains for the Assessment of Need of Aged Care Clients

A large proportion of the literature on assessment within the community deals with the assessment of older persons (Byles, 2000) and there is a clear preference for multi-dimensional assessment, incorporating functional, social, disease, and environmental measures (Morris et al., 1997). In her review of published randomised controlled trials of health assessments for older people, Byles noted the components most commonly included in health assessments (Byles, 2000). These included the following: height/weight, blood pressure, vision/hearing, teeth or oral examination, balance and gait testing, medications, activities of daily living, instrumental activities of daily living, functional status, medical problems, nutrition, alcohol, smoking, exercise, depression, cognition, social support, service use and home environment.

Fleming et al (1995) described measures of physical and psychosocial function to detect problems and enhance the care of elderly persons from a review of pertinent articles and current standard textbooks of geriatric medicine. Key areas for review included activities of daily living, mobility, cognitive function, vision, hearing, continence and nutrition. Screening for depression and alcoholism is also recommended and evaluation of the well-being of the primary caregiver may be necessary for some elderly.

The assessment of the personal functional status of older persons in the OARS Multi-dimensional Functional Assessment Questionnaire (OMFAQ) includes basic demographic data, social resources, economic resources, mental health, physical health, and activities of daily living (Duke University, 1978). The second section of the instrument measures utilisation and perceived need for twenty-four non-overlapping services (Duke University, 1978).

In developing a client assessment instrument for the National Long Term Care Demonstration (Kemper et al., 1988), the factors that were considered important included physical health, mental health, ability to perform activities of daily living, social support and participation, financial and related resources, physical environment and living arrangements, and services.

InterRAI is a collaborative network of researchers across 30 countries which have developed a family of assessment instruments suitable for the assessment of the elderly and people with disabilities across a range of care settings. Thus the Home Care Assessment is only one of a number of tools for aged care assessment – there are also assessment forms for Community Health, Assisted Living, Long Term Care Facility, Acute Care, Post Acute Care and so forth. These different versions share quite a number of common assessment items but the items are tailored to the particular care setting. A comparison of the items contained in the Community Health and Home Care versions is provided in a report provided by Project Health (2008).

The InterRAI comprehensive assessment instrument contains the following domains: Identification information, Intake and initial history, Cognition, Communication and vision, Mood and behaviour, Psychosocial well-being, IADL Self performance and capacity, ADL self performance, Locomotion/walking, Continence, Disease diagnoses, Health conditions, Oral and nutritional status, Skin condition, Medications, Medical/health treatments and procedures including prevention, Social supports, Environmental assessment, and Overall status. Most of these domains are assessed by a cluster of items or by a validated scale.

As part of the development of a Framework for Selecting Tools for ACAT Assessment (Sansoni et al., 2009) reviewed the suitability of the InterRAI Home Care instrument for use by ACAT assessors. This assessment could be considered to be both comprehensive/broad and very deep. It addresses every domain required for ACAT assessment. However, the InterRAI Home Care Victorian Variant is a rather long instrument containing 297 items (Project Health, 2008) and it would appear to address these domains in somewhat more detail than would be required even for ACAT assessment. By comparison it is noted that the InterRAI Acute Care version is a much shorter instrument containing only 96 items across 11 domains, however, most ACAT assessments are undertaken in the home setting rather than in the acute care setting.

The Expert Clinical Reference Group for the ACAP viewed these tools positively but felt they were too lengthy and too deep a geriatric assessment for use ACAT assessment. However, the Home Care instrument contained a number of items that were considered very relevant to the selection of some screening items to help populate responses to the Aged Care Client Record (ACCR). The InterRAI tools are often used by specialist geriatricians and are more suited to that purpose. The InterRAI contains an assessment of some areas that are often overlooked in some comprehensive assessments – for example health prevention activities, skin conditions, foot problems, pain, social support/isolation, self reported health status and environmental status.

Maly et al. (1997) evaluated the clinical performance of simple screening instruments in selecting older people for outpatient comprehensive geriatric assessment. Screening measures for depression, urinary incontinence, falls and functional impairment were used; because these conditions have prevalence in community based samples of 15 to 30%, are potentially treatable and are often overlooked by the medical profession.

A systematic literature review by Stuck et al. (1999) reviewed 78 longitudinal studies published between 1985 and 1997 that reported statistical associations between risk-factors and subsequent functional decline in the elderly living in the community. Although the usefulness of the review is limited because it did not consider which risk factors are potentially modifiable, it provided evidence linking functional status decline to a range of risk factors and domains of client need.

The strongest evidence for an increased risk was found for:

- disease burden (number of co-morbidities);
- increased or decreased body mass index;
- low level of physical activity;
- reduced observed lower extremity function;
- cognitive impairment;
- no alcohol consumption compared to moderate consumption.
- low frequency of social contacts;
- poor self perceived health;
- smoking;
- poor self-reported vision;
- depression

One useful article provided an example of a consensus based approach; a group of European experts in health and social care met a consensus conference sponsored by the WHO. The conference had the aim of agreeing on a standardised medical and social assessment. Another article referred to the development of a tool to meet new legislative requirements in the UK. The legislation introduced a compulsory annual health check for people aged over 75 by their GP. Similar areas are covered in the Australian general practice assessments. The domains seen as important in both articles are outlined below in Table 3. Both can be seen to cover aspects relevant to the screening of people for dependency and/or obtaining information relevant to the delivery of care.

Table 3 Common Medical and Social Domains for Screening

EU Consensus conf. Domains (Philip, 1997)	Legislative requirements for UK GPs (Donald, 1997)	Australian GP assessments (RACGP, 2000)
Perceived health and well-being, Individual needs, goals and satisfaction with care, Confusion, behaviour and depression Vision, reading, hearing and chewing Instrumental and personal activities of daily living, Housing finance and carer	Sensory function Mobility Mental condition Physical condition Continence Social environment Use of medicines.	*Must consider*: ADLs, physical function, falls within last 3 months, BP pulse rate and rhythm, continence, medication review, mood, cognition social function, support required, carer status, vaccinations. *Should consider*: Multi-system review, fitness to drive, hearing and vision, oral health, diet and nutrition, foot care, sleep, risk factors, alcohol, smoking, home safety

For older populations, the literature indicates that a number of areas may be relevant:

- Medical aspects (for example diagnoses, measures of health and illness, medications)
- physical function (activities of daily living and instrumental activities of daily living and falls, vision and hearing)
- cognitive function and decision making capacity
- psychological/ behavioural symptoms (for example, depression and behavioural issues such as wandering, agitation etc)
- Social function (e.g. loneliness, social support available)
- Lifestyle factors and areas for health promotion (for example, smoking, alcohol, nutrition and exercise)
- Carer aspects.

As can be seen in the approaches outlined below these domains are commonly assessed by ACATs, as would be expected in a comprehensive assessment process where a detailed care plan is initiated. However, as indicated in Section 5.2, the depth of assessment required will vary dependent on whether the client is seeking community support packages (as in those currently provided by HACC or HACC type services) or whether the client is being assessed by ACATs for eligibility for more substantial aged care packages and/or residential aged care. For initial assessment it would seems sensible that only the key domains and necessary items for determining an appropriate service response (including referral for more comprehensive assessment) at this basic level are used. Thus the focus of initial assessment is likely to be on function as related to everyday living with some screening and trigger items to identify those with higher needs that may require more comprehensive assessment and potentially other services.

5.3 Principles for Assessment and the Selection of Tools and Items

The principles of designing effective assessment systems require an examination of the following aspects of the tools and items that are selected to form part of the assessment system as well as the system overall:

- Reliability
- Validity including
- The capacity to discriminate effectively between clients with differing needs
- Sensitivity to ageing (responsiveness)
- Practicability

- The collection of data in ways which will enable ongoing evaluation of the effectiveness of the assessment system.

Reliability is concerned with the consistency/ accuracy of measurement of tools/instruments and relates to their dependability. If no other relevant factors have changed in the interim the tool should produce the same results when repeated. If it doesn't it would be akin to using a bent ruler for measurement.

Validity is concerned with whether the tool is measuring what it actually claims to measure. There are various types of validity (e.g. face, content, criterion, discriminant, convergent, divergent validity etc.). Validity can be enhanced by selecting items and tools for the assessment process that already have had some assessment of their validity and reliability rather than to use items or tools that have no track record. This was the process undertaken by the ACAP-ECRG in selecting assessment tools and items for standardising ACAT assessment processes (Sansoni et al., 2010). All recommended tools for core assessments were reviewed using a standardised set of criteria and then were compared on these criteria.

For a front end assessment system discriminant validity or the capacity to discriminate effectively between clients with differing levels of need will be very important. For example, does the tool identify those with greater need accurately and as a result refer them appropriately for ACAT assessment? An example of establishing criterion validity for a tool is provided in Section 5.4 below where the functional dependency ratings derived from the functional screening tool (ACCNA/ONI family), which are used to trigger further assessment, are compared (sensitivity, specificity) with assessor based recommendations. Establishing validity for assessment tools and systems is an important but it is an ongoing process. Once the front end assessment has been designed it will need to be tested in real life settings to determine its validity.

Another important issue for the assessment tools is whether they are responsive to detecting the changes in older persons as their needs change – are the tools sensitive to changes that occur as part of the ageing process?

The collection of data in ways which will enable ongoing evaluation of the effectiveness of the assessment system is an important component relating to validity. The data collection system will need to be open to interrogation at the item level as well at the summary level. Summary data, such as that collected by the ACCR is useful for reporting on system information, but the actual assessment data collected is more important for establishing aspects such as validity and for the refinement of assessment processes.

Practicability is an important issue. The front end assessment system needs to be easy for assessors to use in the field and it should not place too much respondent burden on the care applicant or the assessor. If the assessment process is too long and taxing it is likely that important assessment items will be missed and poorer data quality will result.

Generally, in designing measurement suites it is preferred that the minimum number of items needed to address the issue is asked. Another general rule is not to ask people questions where the responses to the question will never be analysed – sometimes datasets include items, or a level of detail in the response categories, that designers might initially consider desirable but are later never analysed. However, some assessments of the elderly may prefer the use of yes/no formats in the interests of simplicity but in this case one needs to ensure there is a sufficient range in the response options for items to ensure sufficient sensitivity of the items in discriminating differences between members of the target group.

5.4 Initial Needs Assessment: Current Approaches and Domains Assessed

The Ongoing Needs Identification (ONI), the Initial Needs Identification (INI), the Australian Community Care Needs Assessment (ACCNA) and the Care Eligibility Needs Assessment (CENA) suites of tools (Samsa et al., 2007) have been developed from projects in a range of jurisdictions, trials and pilots from 2000-2008. Electronic versions of some of these tools are also available.

The ACCNA and the CENA were a national version of these tools which were developed in response to a review of community care, "A New Strategy for Community Care – The Way Forward" (DOHA 2008) and the purpose was to develop an assessment tool that would provide a nationally assessment process for community care. The ACCNA–R and CENA-R were also based on this work but have been adapted (refer Section 5.4.2) and provide a somewhat more complex online information assessment platform (Community Care Access Support System; CCASS) with a modified set of triggers, algorithms and business rules (AACS, 2010). This entire family of instruments have been largely developed for, and are most often used as, screening and assessment tools within the primary and community care sector in a number of State jurisdictions.

There is substantial diversity in the health status and needs of elderly consumers in the community sector. While some would benefit from a comprehensive assessment, for others this would be an unnecessary burden and intrusion. Consequently, a multi-stage problem identification and assessment system was developed to ensure comprehensive assessments were performed only on consumers who are likely to benefit from them. This is particularly relevant for community assessment as some clients may require access to no formal services, just one type of service or a minimal package of services.

The ONI and ACCNA family of instruments are used as a screening and assessment tools within the primary and community care sector. The first tier of assessment is characterised as 'broad and shallow' and provides flags for follow up assessments across a range of health and community support-related domains that are then used as necessary to respond to the clients' needs in the community sector. If the carer and psychosocial profiles are triggered a priority rating can be made. However, as the ONI/ACCNA tools also link to a number of second tier assessments, if all Tier 1 and most Tier 2 assessment devices are utilised, including a cognitive assessment, these become more comprehensive assessment tools similar to assessments that would be provided by ACATs. An outline of the profiles included in the ONI (as an example) is provided below.

Table 4 ONI Summary of Tools

Name of Tool	Explanation and contents	When to use
Core ONI	Forms the basis of the consumer registration and referral record and includes: Consumer contact information; Consumer service entry data set; Why the consumer is seeking services; and Action plan.	Mandatory if you want to register a consumer or make a referral.
Functional Profile Activities of Daily Living (FP)	A Tier 1 functional screening tool; Identifies equipment &/or aids that the consumer may use; and Triggers Tier 2 functional assessments.	Mandatory for HACC services program reporting
Living Arrangements (LAP)	Identifies consumer's living arrangements, legal and financial management status.	Mandatory for HACC services if the HACC MDS Supplementary Items form is not completed
Carer Profile (CP)	Identifies carer arrangements, carer issues and the sustainability of carer arrangements.	Mandatory for HACC services if the HACC MDS Supplementary Items form is not completed. Otherwise an **optional profile.**
Health Conditions Profile (HC)	Identifies issues about the consumer's health and physical wellbeing that may trigger appropriate referral.	**Optional profile** – use depending on consumer request and needs.
Psychosocial Profile (PP)	Identifies issues about the consumer's social, emotional and mental health that may trigger and appropriate referral.	**Optional profile -** but used for priority rating
Health Behaviours Profile (HB)	Identifies consumer's lifestyle behaviours that may trigger issues for further investigation and appropriate referral.	**Optional profile** may help in formulating an action plan.
HACC MDS Supplementary Items (HS)	Identifies additional current HACC MDS items if LAP & CP not completed.	Mandatory for HACC services if the LAP &/or CP are not completed
ONI Priority Rating Tool (OPR)	Includes options for establishing a consumer's priority rating based on the information gathered in the ONI Tools.	**Optional tool** at end combines need and risk items.

A core part of these assessment tools is the functional screen. The Functional Profile (Activities of Daily Living) identifies key areas in which a person requires assistance with daily living and quantifies the extent to which the person has to rely on someone else to help them. The focus is on normal activities of living in the person's own home and in the community.

The Functional Profile contains items on the client's capacity to do housework, getting out and about, shopping, managing medicines, managing money, walking, and bathing. It also contains two assessor rated items concerning cognition and behaviour, and an item on aids and equipment currently used from the HACC Minimum Data Set.

Table 5 Functional Profile

If you have difficulty, who helps you? Score: 1 No one; 2 Carer; 3 Service provider; 4 Other	To what extent is this need met? Score: 2 N/A - no need; 2 Fully met; 1 Partially met; 0 Completely unmet

Item	Question	Score	Record score	If difficulty, who helps?	Need met?
1	Can you do housework…				
	Without help (can clean floors etc)?	3			
	With some help (can do light housework but need help with heavy housework)?	2			
	Or are you completely unable to do housework?	1			
2	Can you get to places out of walking distance…				
	Without help (can drive your own car, or travel alone on buses or taxis)?	3			
	With some help (need someone to help you or go with you when travelling)?	2			
	Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	1			
3	Can you go out for shopping for groceries or clothes (assuming you have transportation)…				
	Without help (taking care of all shopping needs yourself)?	3			
	With some help (need someone to go with you on all shopping trips)?	2			
	Or are you completely unable to do any shopping?	1			
4	Can you take your own medicine…				
	Without help (in the right doses at the right time)?	3			
	With some help (able to take medication if someone prepares it for you and / or reminds you to take it)?	2			
	Or are you completely unable to take your own medicines?	1			
	If 1 or 2, reason for difficulty	Physical		Cognitive	
5	Can you handle your own money…				
	Without help (write cheques, pay bills etc)?	3			
	With some help (manage day-to-day buying but need help with managing your chequebook and paying your bills)?	2			
	Or are you completely unable to handle money?	1			
	If 1 or 2, reason for difficulty	Physical		Cognitive	
Do not ask the following 2 questions if the client scored 3 on all of the above 5 items (i.e., can do all 5 activities without help). Instead, for clients who scored 2 on all of the above items, record a 9 on each of the following 2 items to indicate that you did not ask the question.					
6	Can you walk…				
	Without help (except for a cane or similar)?	3			
	With some help from a person or with the use of a walker, or crutches etc	2			
	Or are you completely unable to walk?	1			
7	Can you take a bath or shower…				
	Without help?	3			
	With some help (e.g. need help getting into or out of the bath)?	2			
	Or are you completely unable to bathe yourself?	1			
TOTAL SCORE					
8	Does the person have any memory problems or get confused? *Assessor judgment*			☐ Y	☐ N
9	Does the person have behavioural problems (e.g. aggression, wandering or agitation) *Assessor judgment*			☐ Y	☐ N

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Thresholds to trigger a Tier 2 assessment are built into the form and these would trigger whether a further assessment of self care (ADL skills; Modified Barthel Scale; Mahoney and Barthel, 1965) or

domestic assessment (IADL; modified scale from Lawton and Brody, 1969) would be necessary. If the assessor rated item concerning whether the client has memory problems or gets confused, is checked and the functional screening items has indicated that the client cannot manage finances or medication then a cognitive assessment or referral for comprehensive assessment would also be warranted.

The profile uses the tool developed for the Commonwealth's Home and Community Care (HACC) Dependency Data Items Project in 2000, and it is also referred to as the HACC functional screen. It was developed by Eagar et al. (2002) but is based on the Older Americans Resources Schedule (OARS) Multidimensional Functional Assessment Questionnaire (Fillenbaum and Smyer, 1981). A detailed review of the functional screen and its performance analysed in terms of sensitivity and specificity across the domains of self-care, domestic functioning, behaviour and cognition is available in Green, et al. (2006). This study examined screening and assessment data on 456 clients, using their full assessment score to divide them into high and low dependency groups in order to examine the need (or trigger point) for further assessment. When compared to interviewer-based recommendations for further assessment, the functional screen was found to have greater sensitivity on all domains, as well as greater specificity for the self-care and domestic functioning domains. In pilot testing the functional screen was found to be acceptable to staff in terms of time and the burden on consumers. It required minimal training to administer and was suitable for self-report or the use of a proxy informant.

The Living Arrangements Profile contains a number of data items concerning living arrangements and accommodation that are very similar or the same to those required for ACAT/ACCR reporting.

The carer trigger items in the initial screen include items on carer need and carer availability. The assessor should consider using the additional carer profile if the care applicant needs a carer and has a carer. The Carer Profile contains additional items concerning background information about the carer, the care context, carer residency status, carer relationship, carer sources of support, current threats to carer arrangements and carer sustainability.

Use of the optional profiles (Health Conditions, Psychosocial Profile and Health Behaviours Profile) is triggered by answers to the core assessment items.

The Health Conditions profile was developed from the Owen et al. (2001) literature review and includes data items for self-rated health, bodily pain and the interference of pain with normal activities, vision, hearing, oral/teeth, speech, swallowing, falls, feet, vaccinations, driving, continence, height, weight and blood pressure pulse. Additionally, it includes a summary of self-reported health conditions and confirmed medical diagnoses, current medicines and assistance and referral options.

The Health Behaviours Profile (expanded health conditions profile) is a profile that is used to record information about the person's lifestyle and to identify any opportunities that may be available to improve their health and well being. Risk factors such as smoking, alcohol consumption, physical inactivity, hypertension, high blood cholesterol, obesity and inadequate fruit and vegetable consumption are responsible for large proportions of the overall burden of disease in Australia (Mathers et al. 2000).

The Psychosocial Profile can be used to screen for psychosocial issues related to emotional and mental well being, personal and social support, family and personal relationships and relationships with service providers. It provides a means of capturing some common risk factors associated with emotional and/or mental health problems (such as lack of social supports). This profile, therefore, identifies opportunities for screeners to consider and discuss referral options that may address the consumer's issues, where they are identified. The scale used here is the Kessler 10 (K10; Kessler et al., 2002) which has national norms and assesses anxiety and depression. It is used by a number of States within the Australian Mental Health Outcomes and Casemix Classification system.

It can be seen that for many clients with low needs the functional screen (mainly comprised of IADL items which relate to physical function and trigger items to potential other areas of need) will just be used in conjunction with the items needed for service response information (core ONI; Living Profile). The dimension of cognitive function would only be assessed it items relating to the management of finances, medication and memory problems/confusion are triggered. There are also a number of trigger items for the other profiles in the functional screen (Carer Need and Sustainability, Health Conditions, Health Behaviours, Psychosocial, and the Financial and Legal Profile). The completion of these profiles is dependent on the response to the screening/trigger items. The Veterans Home Care Assessment is based on this model.

Most items used in the ONI and ACCNA family derive from well established and validated instruments (e.g. OARS-MFAQ, K10) whereas others have been developed by the research team based on the advice of experts (e.g. nutrition and physical activity items).

The remainder of the ONI contains some HACC MDS items and the ONI Priority Rating Tool. This is discussed further in Section 5.8.6 (refer to Table 7). The ONI Priority Rating Tool provides a way of determining an individual consumer's priority for care, based on the assessor's judgments of their overall needs and risks, after carrying out the initial assessment. It is an optional tool for service providers to use if sufficient information is collected. The purpose of priority rating is to allow consumers to be consistently screened for their needs and their risks, with the intention that those with greater needs will get access to services first.

A small trial was conducted as part of the development of the ACCNA tool (a national version of the ONI) where one trial site included an ACAT which used the ACCNA to screen people on its waiting list to identify those most in need of a comprehensive assessment (Samsa et al., 2007; pp. 9 and pp. 56-57). The trial was not aiming to test whether the ACCNA could act as a substitute for an ACAT assessment. It was to see if the information collected in an ACCNA at the screening level could be used by the ACAT to inform its decision-making and as a starting point for more specialised and comprehensive assessments (Samsa et al., 2007, p.57).

A mix of paper, electronic and online versions of the ACCNA/ONI family of tools has been independently developed by software providers and client management system designers in collaborations across a series of projects for different jurisdictions and programs in NSW, South Australia, Queensland, and Victoria (see below).

5.4.1 The ACCNA-R

The ACCNA-R was developed by Applied Aged Care Solutions (AACS) who were appointed to further develop the ACCNA and CENA as online tools to support the national Access Points trials. AACS subsequently developed a software platform (Community Care Access Support System; CCASS), for the assessment tools to be used in the national access points trials - the ACCNA Revised (ACCNA-R) and CENA Revised (CENA-R).

The ACCNA-R has 11 modules which cover client information, initial case overview, eligibility and consent (modules 1-3), health conditions and medication use (module 4) sensory function and ADL and IADL function (modules 5-7), psychosocial profile (module 8) care arrangements (module 9) and client and carer summary profiles (modules 10 and 11) which are largely automatically filled from previous data entry.

As in previous ACCNA versions, it is also a tiered assessment but it uses a different approach. In the ACCNA-R the initial items from each aspect of assessment (e.g. each item of ADL and IADL assessment) act as triggers, if they are endorsed (Yes/No), for further or more comprehensive assessment of each item of function. Whereas the ACCNA/ONI family use overall scores on the functional screen as the trigger for further assessment.

These initial items and the follow up assessments are known as the base assessment pathway which can be of varying length dependent on the number of problems endorsed in the initial screening. Given this, at the onset of assessment it will not be clear how much time it will take to complete an adequate initial assessment for the client. A phone contact that goes for more than 30 minutes will be a burden on the caller – i.e. if the initial contact indicates moderate to low function or other complicating factors, then it will be likely the person will need a call-back.

The full ACCNA-R assessment pathway contains 1,828 questions if all trigger items and decision tree items are included and the completion of the entire assessment is known as the full assessment pathway. The full version of the ACCNA-R could really be described as a comprehensive assessment system or pool of potentially useful data elements, rather than a broad and shallow assessment.

Two of the project tasks are about the technical performance of the tools at the item level. In order to evaluate whether the items are useful in a practical sense, they should be tested in the context of their usefulness in routine practice in terms of assisting service responses to the common client conditions and pathways. The second of the project tasks originally identified is about the useability of the tools at the system level:

1. Evaluate the ACCNA-R/CENA-R including item wording and the appropriateness of response categories; and question sets to ensure that the questions make sense and are phrased correctly;

2. Evaluate the ACCNA-R/CENA-R question sets for correctness and appropriateness to ensure that it fits the purpose of the new front end assessment.

One purpose of the front end assessment is to build up useful information for the common record, and to filter key data elements (triggers, prompts, specific values and scores used in algorithms) for use in other types of assessment. These aspects will be considered in more detail in Discussion Paper 1 (refer Section 5.5 which will be prepared for ECRG discussion by Mid February.) Some initial considerations are outlined below and further information concerning carer issues and carer assessments can be found in Section 5.8.7.

In order to examine some of these aspects it is necessary to examine the assessment systems from which the ACCNA-R and CENA-R are derived. The ACCNA-R and the CENA-R are based on the ACCNA and CENA tools which have been briefly described above. Overall the ACCNA-R is a more complex/ extensive instrument than its precursors, which were designed as an initial needs assessment system capable of a telephone mode of administration. Issues to consider are whether some simplification of items and response categories in the ACCNA-R will be desirable, particularly if a telephone mode of administration is used.

The ACCNA Tier 1 Functional Screen (Samsa et al., 2008) is a short telephone or face to face administered questionnaire. It consists of 9 carefully selected and tested questions, which indicate client domestic, self-care, behaviour and cognitive functioning. The research literature had demonstrated a hierarchical relationship between domestic and self-care tasks (Katz et al., 1963; Green et al., 2006) with domestic tasks generally being lost before self-care tasks and this finding has been confirmed in subsequent studies using routinely collected data including the national HACC field trial (Eagar et al., 2001), the NSW Home Care Service, Post School Programs, independent evaluations in South Australia and Queensland (Eagar et al., 2006; Hibbert, 2005; SADHS, 2003; Stevermuer et al., 2003). The literature also indicates that inability to carry out some domestic tasks may be an indicator of cognitive impairment (Cromwell et al., 2003).

The ACCNA Tier 1 Functional Screen does not attempt to capture all aspects of function. Rather, the 9 items in the screen have been selected because they are good predictors of how well a person is functioning in other aspects of their life. Housework, travelling and shopping are domestic tasks that are generally lost early. A client who is independent in these tasks does not usually require a more detailed assessment of domestic or self-care tasks. Mobility and bathing

are self-care tasks that are generally lost later than domestic abilities but earlier than self-care tasks such as feeding or toilet use. A client who is independent in mobility and bathing does not generally require more detailed assessment of self-care tasks. In the ACCNA assessment for these tasks would only be undertaken if scores on the functional screen triggered the recommendation for further assessment.

By comparison in the ACCNA-R the functional screen has been embedded in the use of a larger set of IADL and ADL trigger items for all clients with yes/no response categories which then trigger quite detailed follow up questions for any item endorsed (about 19 questions per item). The yes/no response categories are not always the easiest way to capture useful information, which may be better represented along a continuum, for example by using scores of 1-3 in measuring function, so as to make good use of the functional hierarchy in combining with carer items to get a priority rating.

The ECRG and the Department will be expected to provide advice on the preferred approaches; with the general principle of assessment being to ask the smallest number of questions that are necessary at first contact.

Another important difference in the design of the ACCNA-R is that items ask what a client 'does do' whereas the ACCNA asks what the client 'can do'. It is important for useability that consistent scoring instructions are used. The ACCNA approach is designed for situations where direct observation is not possible (i.e. telephone contact) and some judgements by carers, informants or the clients are involved.

One rationale for asking questions in the 'can do?' format is to minimise scores that are a function of household task distribution rather than capability. If the question is framed as 'does do' it is likely that some people who can do the task will be assessed as not being able to do the task when in fact they can, although they may prefer not to. A person may be able to prepare meals but does not do it because another person currently undertakes this task.

The ACCNA-R approach is more complex, identifying what the client currently 'does do', then asking a follow up question as to who does the task if the client does not do it (17 options provided whereas ACCNA has 4 options for who provides assistance – no-one, carer, service provider and other) and then the assessor makes a rating as to whether the client 'can do' the task. The justification of the 'does do' approach is that the client can easily answer what they 'do do' but may need to estimate what they 'can do' if they haven't performed the task for a number of years (AACS, 2010). However, the 'does do' approach means that a person who doesn't cook because their partner does this task will be rated as having the same need as a person who genuinely can't do the task because of their disabilities.

It is preferable to provide services to people who need them because they can't perform the relevant tasks rather than to provide services to people who can do the task but prefer not to do it. The 'can do' approach has been used for the functional screen items in the current HACC MDS and it is also noted there are additional assessor ratings concerning the 'can do' aspect in the follow up items for function in the ACCNA-R. The ECRG and the Department will need to advise on the implications of the 'can do' versus the 'does do' approaches.

The ACCNA-R follows the tiered assessment approach which includes functional screening items and trigger items at the initial assessment phase leading to further assessment. The first part of the initial screen includes a series of Yes/No trigger questions concerning whether the care applicant has any health, or sensory (vision/hearing) or communication issues. This is followed by trigger questions concerning whether the applicant has any difficulty (even emerging issues) with the IADL activities of housework, shopping, meal preparation, transport, telephone, medication, finances and ADL items about mobility around home and garden, getting in or out of bed/chair, walking up and down stairs, dressing, grooming, eating, toileting, bathing/ showering. There are items on whether they have bowel or bladder issues, whether sad/depressed, whether isolated or lonely and satisfaction with the level of activity, participation and social involvement. There are

then 2 assessor rated items concerning memory problems and behaviours of concern. These are followed by the consent and eligibility items.

If the care applicant has a 'yes' response to any item this triggers a follow up assessment for that item. For example if the applicant has any health problem (which is likely to be most clients) then they will be asked a series of questions about their health conditions: whether health has interfered with their normal activities, whether there has been a deterioration in the last 6 months, when and why last in hospital, times in hospital last 12 months, bodily pain over last 4 weeks, whether seen a health professional about their pain, whether lost or gained weight, when last seen GP, whether has a regular GP, whether receives specific nursing services, whether nursing services are adequate, whether further health professional input is required, whether client's needs are met by these services, whether they receive allied health support and whether the carer plays a significant role in managing the health conditions of the care recipient. If the client endorses the medication screen a further 6 questions concerning medication use are then asked.

For functional abilities, if the client endorses an ADL/IADL item, then a follow up screen pertaining to only that ADL/IADL item would be triggered in the 'base assessment' pathway. They would not receive an assessment of their overall IADL function as occurs with the ACCNA/ONI in the initial screen as this has been replaced by the simple yes/no trigger items rather than response categories that reflect the degree of difficulty. If the client indicated they had problems using the telephone the follow up questions would include who helps you use the phone, could you use the phone by yourself if necessary, assessor rating concerning reason for assistance (Sensory/Communication; Mental/Behavioural; Physical Impairment; Physical Environment/Cultural), whether someone else does the task including an assessor rating of whether the applicant could do the task, whether there has been recent deterioration, whether OHS/Environmental issues apply, type of aids in place, adequacy of aids and an assessor rating of whether needs are met. Similar questions would be asked for every IADL or ADL item that is endorsed.

The advantage of the Yes/No screen questions is that the applicant is only asked further questions concerning their areas of identified difficulty. For some clients there may be only a few areas of difficulty which would lead to a shorter assessment quite amenable to phone interview. However, it can be seen from the examples above that for an applicant that endorses a number of these items the assessment could be very lengthy and become increasingly difficult to do over the phone. Section 5.4.2 below discusses implementation issues that arose for the ACCNA-R in the Access Point Trials where feedback indicated assessors viewed the approach as a 'comprehensive assessment' rather than an 'initial needs assessment' approach.

A disadvantage of using the Yes/No screening approach (vs. graded response categories) for the initial functional items is that it would be difficult to derive data from this system that could generate an average IADL and ADL profile for these applicants. These data could be useful for service planning purposes.

If the ACCNA-R were to be adapted for the new front end assessment system it could ask only the initial screen questions (Yes/No items) and leave the follow-up assessment for a face to face meeting if more than a small number of these items are endorsed. The design issue is that while the initial items may be too simple to derive useful data from them the follow up items may be too complex for an initial intake interview by telephone. The modular approach taken by the ACCNA where a shorter functional screen is completed by all applicants (Table 5) with 3 levels of response categories (without help/some help/completely unable), should be considered for the initial screening items. These items include triggers to further assessment profiles which could be undertaken further along the assessment pathway.

The ACCNA-R has also modified the ACCNA priority rating process which is shown in Table 7 and discussed in Section 5.8.6. As can be seen from the ACCNA-R examples, if a follow up assessment is taken for a particular aspect of function then questions are asked concerning unmet need and recent deterioration. The ACCNA-R approach considers that care domain aspects (e.g.

domestic assistance, personal care, behavioural needs, health care needs etc.) must have referrals and priorities generated for each of the identified care need areas (AACS, 2010).

For example, a person may have a triggered referral for domestic assistance that is set at a low priority but a triggered referral for the personal care domain that is set as a high priority. Also two people may have the same level of dependency and triggered referrals generated but they may have a different priority for service assessment indicated against the referrals (AACS, 2010). By contrast the ACCNA and ONI tools produce an overall priority rating for the applicant as can be seen in Table 7 in Section 5.8.6.

5.4.2 ACCNA-R and the Access Point Trials

The final evaluation of the Access Points Demonstration Projects (KPMG, 2009) reports on a number of projects that were established to provide easy access for care applicants to the community care service system, have their eligibility and needs assessed and receive referral to appropriate services or to be referred on for more comprehensive or specialist assessment. Ten access point projects were conducted across all States and Territories, with the exception of the ACT. Three projects trialled the ACCNA-R as the assessment system (Remote NT, Southern Tasmania and the Victorian Project). The NSW project used the ONI-N, Queensland used the ONI, and WA used the Client Needs Identification (CNI). For the SA metropolitan site the ONI+ was used while the INI was used for the country site, although in May 2009 a new common tool – Access Needs Identification (ANI but based on ONI/INI) was used.

Although it was outside the scope of the KPMG report (KPMG, 2009) for the evaluation to assess the ACCNA-R a number of issues were identified by KPMG concerning the use of the ACCNA-R during the course of the evaluation project.

In the NT the remote teams had been using a tool specifically designed for remote communities that provided sufficient information for referral to ACAT and which team members also believed had sufficient information for determining need for HACC services. For the access point trial they were required to additionally use the ACCNA-R which resulted in some duplication. Other issues raised were that it was designed for online administration which did not suit the face to face interactions that remote teams have with their clients. There were also major technical issues with data entry into the website platform from remote locations. There was also a lack of interface between the ACCNA-R and the local Community Care Information System they used. It was also found that some content was not culturally appropriate for Indigenous clients.

The Southern Tasmania user feedback was that the ACCNA-R is a ‘broad and deep’ tool rather than a ‘broad and shallow’ assessment. The Department of Health and Human Services (DHHS) reported that initial phone calls to the access point were taking an hour or more to complete and this had financial implications as the funding for the access point trial was based on an estimated time of 20-30 minutes per phone call. There were reports of a number of clients hanging up during the process due to the length of the interview. To save on time assessors made use of hand written notes and completed the online ACCNA-R later from these notes which raised issues concerning data accuracy. It was estimated that half the calls did not undergo an ACCNA-R at the point of contact. It was also noted that as the questions were triggered by previous responses the tool did not include HACC MDS items as mandatory fields and thus comparable information could not be easily captured.

In Victoria access point staff reported that the assessment using ACCNA-R is extensive (rather than broad and shallow) and lengthy with assessments on average taking between 45 minutes to an hour. The CCASS online platform was designed so that as the conversation was conducted the assessor could record information in the data base. However, it was found in practice this was difficult and thus only some information was entered into CCASS while the care applicant was on the phone.

There were also issues concerning the compatibility of ACCNA-R referral processes with Victoria's e-referral system which led to the double entry of data. The Southern Tasmanian project also reported difficulties with the referral processes embedded within ACCNA-R.

While it is clear that some of these difficulties could possibly be addressed by more training, or by increasing the compatibility between electronic systems, the length of time assessments take is an issue for any assessment, especially if it is to be used an initial intake tool.

5.5 Comprehensive Geriatric Assessment: ACAT Assessment

Aged Care Assessment Teams provide comprehensive aged care assessments for those clients wishing to access community care packages (Community Aged Care Program, EACH and EACH-D) and for assessment related to entry for Residential Care Services. The results of these assessments are recorded in summary form in the Aged Care Client Record (ACCR).

The ACCR contains 6 components:

- Client Registration (Items required for service response which include contact details, age, gender, marital status, living arrangements, type of accommodation, Aboriginal and Torres Strait Islander Status, language spoken at home etc.)
- Intervention Information and Contact Dates
- Carer Profile (has carer, co-residence of carer, relationship to carer)
- Activity Limitations and Assistance (need for assistance: self care, mobility, communication, health care tasks, transport, social and community participation, domestic assistance, meals, home maintenance; current use of help or supervision; currently received support; previous use and or need for respite care; recommended living arrangements)
- Assessment Summary and Information for Service Providers (Cognitive Behaviour/Psychological Aspects; Nutrition; Continence, Function and Activity Profile, Communication/Sensory, Allied Health Therapy, Usual GP or Medical Centre
- Approval.

It is suggested that Aged Care Assessment Teams use standardised assessment instruments and items that cover these domains to populate the Aged Care Client Record (Sansoni et al., 2010). It is recommended that all clients receive a cognitive assessment using a recommended tool (SMMSE/KICA/RUDAS/IQCODE) and that all clients are assessed using the Barthel Index for activities of Daily Living and the OARS IADL scale for instrumental activities of daily living or KICA-ADL for those from Indigenous backgrounds.

A range of standardised screening items (falls, pain, feeding swallowing, nutrition, dental, skin, feet, vision, hearing, continence, sleep, environment, smoking, alcohol, self rated health, decision making, depression, behavioural problems, change in mental state, loneliness, availability of help, mistreatment, recent stressful events, carer sustainability) are also used to both populate the ACCR and to determine if further assessment is required for a particular health aspect (e.g. for example a deep and narrow assessment for depression, incontinence or pain).

A number of follow up assessment tools were identified for the latter assessments (Sansoni et al., 2010). It is noted that these items share some overlap with the health conditions and health behaviour profile in the ONI and ACCNA family of tools and the ACCNA-R. These overlaps will be discussed briefly in Section 5.6 below and will be included in Discussion Paper 1.

It should also be noted that on permanent entry to a residential care facility a further comprehensive assessment using the Aged Care Funding Instrument is undertaken. The ACFI assessment includes assessment of ADL function (assessment of IADL assessment is not included as the client is in residential aged care), behaviours of concern, depression, and cognition and thus shares a large degree of overlap with ACAT assessment although different assessment tools are used.

It can be seen that the domains of medical aspects, diagnoses, cognitive function and decision making, psychological/behavioural aspects, social function, lifestyle factors and carer aspects are assessed through these processes in varying degrees of depth.

5.6 Overlaps and Linkages

A more detailed discussion paper on the overlaps between the ACCNA-R and the ACCNA family of tools will be developed for consideration by the Expert Clinical Reference Group in February.

A number of client characteristic and registration entry items are similar across the ACCNA family, including the ACCNA-R, and ACAT assessment systems. These include such items as the client name, age, gender, living arrangements, contact details, general practitioner and basic information about the carer (as applicable). It would seem that these basic details could be collected at the initial entry point to the assessment tool for those clients accessing services prior to an ACAT referral. This would reduce the load of ACAT assessors as these details would only need to be checked on the continuous electronic record for these clients and changes only made where relevant. Currently, approximately 50% of clients accessing ACAT services have already made use of HACC type services.

The ACCNA family of tools all include a functional assessment in their core assessments. In the ACCNA this is the functional screen which has been depicted in Table 5 above. The ACCNA–R also contains a different style of functional screen. There is substantial overlap between the ACCNA functional screen and that used ACAT assessments. This information may be useful to ACAT assessors and could be updated but as these clients have more complex needs it is thought that the completion of the additional items included in the recommended ADL and IADL components for the ACAT may still be required (Sansoni et al., 2010).

The standardised assessment for ACAT contains a number of screening items and should it be thought that some of these items may fit better in the front end (second level) of the assessment process then these items would only need to be updated at the ACAT assessment stage. The degree of overlap will depend on the number and type of assessment items contained at the assessment front end.

5.7 Triggers, Algorithms, Business Rules and Funding Bands

A detailed discussion paper on the triggers and algorithms and business rules that may apply to the new front end component of the assessment process will be developed for consideration by the Expert Clinical Reference Group and the Department in March. By this stage the ECRG recommendation concerning the front end assessment tool will have been incorporated in a proposed model for assessment.

One of the purposes of trigger items at the front end will be to identify clients that may require greater priority for service, comprehensive assessment and referral to ACAT for packaged care. Another issue for triggers at the front end may be to identify clients who have re-ablement potential.

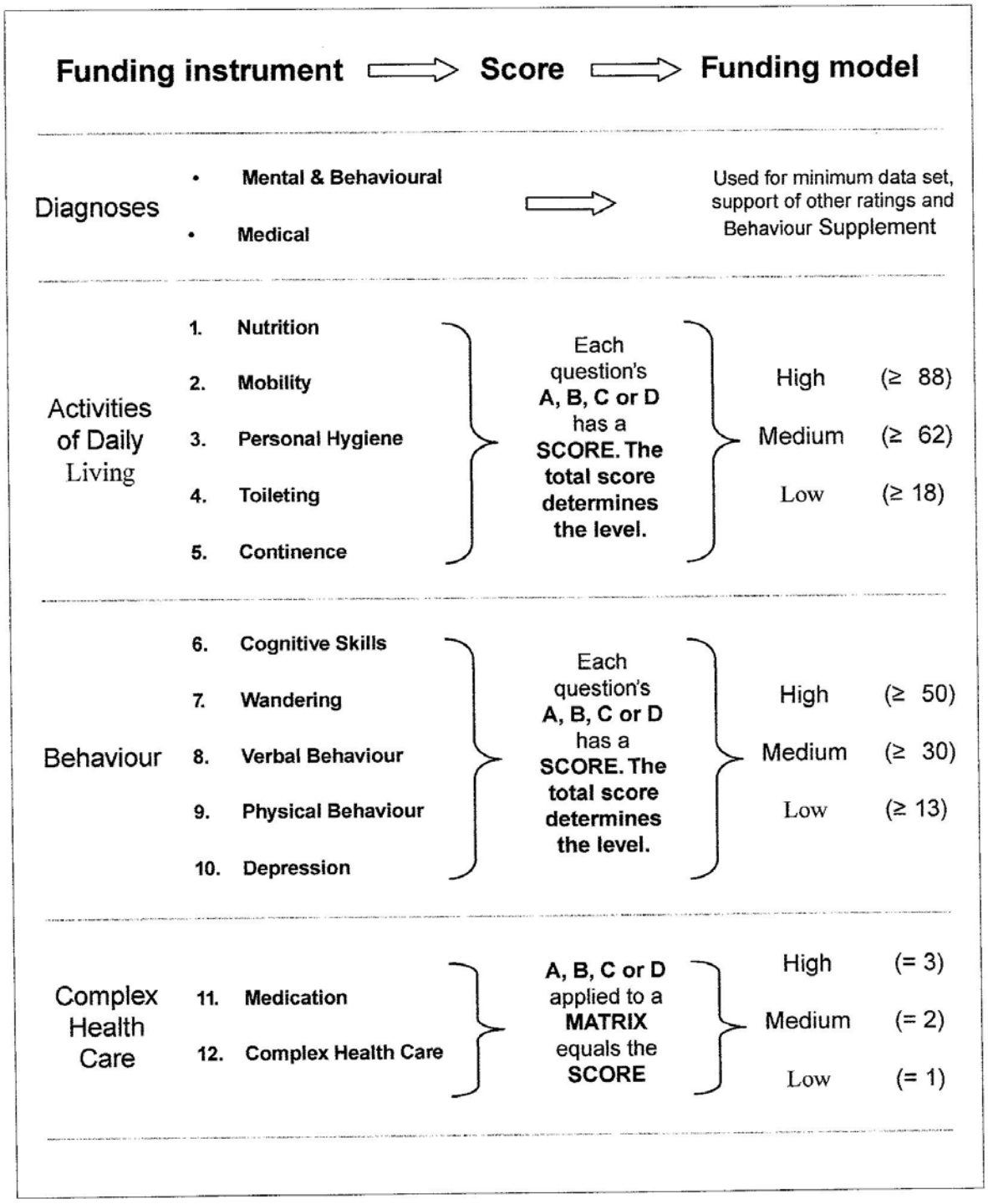
Another issue is that consideration of funding bands in relation to care needs could apply as occurs with the allocation of funds for residential aged care using the Aged Care Funding Instrument (ACFI). In the ACFI diagnostic information and 12 questions are used to categorise care recipients within low, medium or high care need bands and the funding for residential aged care is based upon this. The questions used for the determining the level of need are activities of daily living (ADL: nutrition/eating, mobility, personal hygiene, toileting, continence); behavioural supplement (behaviours of concern, cognitive status as assessed by Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS-CIS), and depression as assessed by the Cornell Scale for Depression; and a Complex Health Supplement (CHC) which contains items on medication and complex health care.

The ratings from each item area are then added to generate a 4 level classification for each area relating the level of care required (independent = A; high level of assistance required = D). Each of these levels has a score associated with it and these are added for each domain (e.g. ADL) and the high/medium/low classification for each domain is based on this. This is demonstrated in Table 6 below (DOHA, 2009).

Under the *new definition* (DOHA, 2009), to be appraised as High Care, the resident must have:

- A score of High in the ADL Domain; or
- A score of High in the CHC Domain; or
- A score of High in the Behaviour Domain together with a score above Nil in at least one of the ADL or CHC domains; or
- A score of Medium or High in at least two of the three domains.

Table 6 Interaction of the Aged Care Funding Instrument and the Funding Model



It can be seen from the above that additive rules based on scores are used to determine the category of need which then attracts differential funding. The clients categorised at any level can arrive there based on quite different needs for care.

Another approach is to use a branching classification structure (Eagar and Owen, 2001). In a **branching** structure (like that typically used in health), groups are formed based on both expected service cost and consumer characteristics. People with different needs are allocated to different

groups even if the expected service cost is the same. There are three criteria for a classification system that uses a branching structure:

- Each of the groups is 'iso-resource' - that is, people in each group require similar levels of resources;
- Each of the groups is sensible - people in each group require similar types of services because they have similar types of needs; and
- There are a manageable number of groups. If there are too few groups, each group will be too heterogeneous for the classes to be meaningful. If there are too many, they will not be able to be used for the purposes for which they were intended – population needs assessment, service planning and purchasing.

In an **additive** structure (like the residential aged care model), groups are formed based solely on expected service cost. People expected to require high cost support and care are all allocated to the 'high need' group even if their needs are different. There is no requirement that each group include people with similar types of needs.

There are two criteria for a care classification that uses an additive structure:

- Each of the groups is 'iso-resource'. That is, people in each group require similar levels of resources; and
- There are a manageable number of groups.

The difference is best illustrated by example. Two people with a disability both need intensive support and are both expected to require more than 40 hours of services a month. One is young and has an intellectual disability. The other is old and has a physical disability. In an additive model, both would be allocated to the same 'intensive need' group. In a branching model, they would be allocated to different groups because their needs (whilst equivalent in resource intensity) are judged to be different.

The main advantages of the branching structure are in looking ahead to the ability to monitor outcomes and track changes over time. The additive structure, while not being as sensitive to questions of outcomes, has distinct advantages in its ease of use.

The development of funding bands and a case classification system is outside the scope of this project but consideration of this aspect needs to be kept in mind when developing a new front end for the assessment system.

5.8 Other General Assessment Issues

5.8.1 Information Collected

Two types of information are generally collected during an assessment:

- Items relating to assessment
- Items required for planning an appropriate service response.

Items relating to assessment are those items that are required to assess the needs and abilities of the care recipient in their situation and relate to the purpose of the assessment. It may refer to their physical, cognitive and functional characteristics as well as their care situation, and circumstances. These items may change considerably over time.

Items required to formulate a service response are those items that are used to organise services, such as person's name and address, demographic information, ethnicity, links to current services, preferred sex of interpreter etc. Some of these items are generally static and others may change. It can be seen a large number of these items are required to be completed on application for either HACC services or for ACAT assessment. If a continuous electronic record is used and these items are streamlined to be consistent across assessment stages then these items would only

need to be checked by ACAT assessors rather than to be duplicated as currently occurs. There is a lot of overlap concerning these items across the HACC, VHC and ACAT assessment systems.

5.8.2 Mode of Assessment Administration

The appropriate mode of assessment will relate to the comprehensiveness of the assessment. A comprehensive assessment such as that provided by ACATs would generally require a face to face assessment and given that a cognitive assessment is included it is not amenable to phone interview.

From the discussion above in Section 5.4 the first stage of assessment could be to obtain a) client information and consent items that are required for a service response and b) assess clients by using a simple functional screen that is currently available within the ACCNA/ONI family of tools and is already included in the MDS for HACC Services. This functional screen contains seven items covering basic ADL and IADL function and two assessor rated items concerning cognition and behaviour. The first seven items are amenable to a telephone interview and are probably sufficient for a client seeking low level services. The items concerning cognition and behaviour are informant/assessor rated. These items may require the assessor to contact either the care applicant's GP or nominated carer or contact person (e.g. nominated family member).

Consideration could be given to the inclusion of a number of additional trigger items in the initial screening tool to flag the need for further assessment. In the ACCNA/ONI family of instruments trigger items include health interference (recipient rated), social support, carer need and availability, and financial and legal aspects (assessor/informant rated). Responses to items in the functional screen also flag the need for more in depth assessment of function.

A second level of assessment may sit between initial assessment at entry and ACAT assessment. Although the applicant may only be requesting a single service the initial functional screen might indicate the applicant has low or medium levels of function and thus may require additional services or be referred to an ACAT for a more comprehensive assessment (third level of assessment).

The priority rating tools in the ACCNA/ONI family require the completion of salient psychosocial and carer items in order for a priority rating to be determined. The process can be simplified because the scores are used to inform an assessor judgement. The completed carer and psychosocial profiles could form parts of the second level of assessment which would require a second telephone contact or possibly a face to face assessment. However, as many of these items are used as screening items within ACAT assessments their completion at a second level of assessment would mean that when referral to ACAT assessment occurs, the ACAT assessor would only need to check or update these items.

5.8.3 Pre-assessment Information

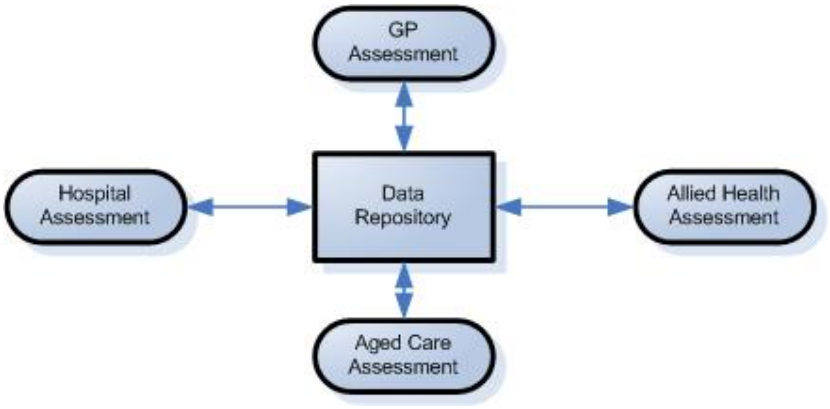
As most people who access aged care services will have had some contact with other health and service providers, much of the information (especially items required for a service response) that is required in the initial assessment may have already been collected by the referrer or other services that the person has used.

Rather than repeat the process of collecting the information from the client, it would be better to start with what has already been collected. In order to do this a standardised referral form for health professionals to the new front end could include items that could pre-populate and inform the assessment. For referral to ACAT the VHC already collect this information as part of their assessment process and likewise HACC services are required to collect this information as part of the HACC MDS.

Modern information technologies allow, with appropriate safeguards and protocols, the efficient transfer and sharing of information. A system which supports and encourages this sharing will

minimise wasted effort by service providers and frustration by clients. A data sharing model could look similar to:

Figure 3 Possible Data Sharing Model



GP, hospital and allied health assessments could be transmitted, with the permission of the client, electronically to a data repository (the data repository could be centralised or operate at a regional level). This information can be used by the aged care assessors to pre-populate and inform the assessment of the client. The assessment results and resulting actions will be stored in the data repository, and accessible for information and use by GPs, hospital and allied health staff, with the client's permission.

This process does not end with the initial assessment, but it would continue over time, building up a body of relevant assessment information that all participants can use to minimise duplication of assessments and minimise client frustration.

Over time the Data Repository would provide an important source of information about the client population, and the effectiveness of service provision to them. The Data Repository is a cornerstone of a standardised assessment system as it provides the facility to compare and understand the complete range of assessments.

5.8.4 Outcomes, Episode and Goals of Care

The policy aim of personalising service provision implies a systemic capacity for understanding the full range of a person's needs, as well as their goals in seeking a particular form of assistance (Owen et al., 2010). A standardised assessment can determine a person's needs but understanding their own goals is a key consideration for a more person-centred system and for determining the outcome of an intervention or an episode of care.

Currently, there is no way to determine whether the service has been effective in meeting a goal because these goals have not been identified. This has limited the aged care system's capacity to understand client outcomes (Owen et al., 2010).

Traditionally, aged care services have been provided on an ongoing basis to clients. Once people have been granted a service, they tend to continue to receive that service and are often reluctant to give up a service (even if they do not currently need it) as it may be difficult to re-obtain.

The goal of care should drive the services that are provided to meet the needs of the person. There are three broad goals of care:

- Improve current level of function and independence
- Maintain current level of function and independence
- Reduce rate of decline in level of function and independence.

Services that are put into place for a particular person depend not just on their level of function but also on what their person wants to achieve from these services. Take the example of two people who cannot currently prepare meals and have the same level of function and independence. One may want to learn to prepare meals themselves, but the other may not be able to do this. Both people may be referred to meals on wheels services but the first person may also be referred to an appropriate course to learn how to prepare meals. A scheduled reassessment after the course may determine that the person can now prepare meals and is now less reliant on delivered meals or may not need them at all.

The result of an assessment is to determine:

- The goals of the services to be provided
- The services that are to be provided
- The length of time for the services to be provided.

These three components should comprise an "episode of care", a concept which is not commonly used in the current system. A reassessment at the end of the scheduled period, can determine whether the goals have been met, and help determine the components of the next episode of care.

5.8.5 Reassessments

A reassessment of a person can determine whether the goals of the services that have been provided have been met. Reassessments can help refine the mix and timing of services to better meet the person's needs and their goals. Changes in item scores of the assessment provide evidence of change that need to be interpreted in the context of the goals of care.

The timing of planned reassessments will depend on the anticipated length of time of the current episode of care. A set of services may be delivered for three months, or twelve months, and then followed by the planned reassessment, or a new episode could be triggered by a change in the client's circumstances.

The reassessment at the end of an episode of care will determine whether the services provided have been effective in meeting the goals of the care. This can help determine whether the person's goals are still relevant, and the set of services needed for the subsequent episode of care.

An unscheduled reassessment may be needed if there has been an unanticipated change in the needs or situation of the person, such as an adverse health event, or a change in the carer situation.

5.8.6 Priority for Services

There is a limited supply of services that is never likely to meet the demands of all people who require them. The most common strategy for managing this demand is restricting numbers of services or packages that are available, and creating waiting lists. This does not take into account that some people may have greater needs for these services than others. So that a person who has greater needs than another person may have to wait the same length of time.

Current assessment tools such as the ONI/ACCNA have demonstrated that it is possible to develop simple tools that can give a priority to a person's relative need for service. The Priority Tool uses an algorithm using functional profile, carer situation and psychosocial or other issues. This does not determine a person's priority for a specific service as this is best done by a service specific assessment, but rather gives an overall picture of the person and their situation.

An example of a priority rating tool in common use is the ONI Priority Rating Tool. Its components are identified below in Table 7.

Table 7 ONI Priority Rating Tool

Risk	Need			
	Low Function	Medium Function		Good function but health, psychosocial or other problems
		With significant psychosocial or other problems	With no significant psychosocial or other problems	
No carer able to provide necessary care	**1**	**1**	**2**	**5**
Carer arrangements exist but are unsustainable without additional resources	**3**	**3**	**4**	**7**
Carer arrangements suitable and sustainable OR Carer not required	**6**	**6**	**8**	**9**

The Priority Rating Tool was designed for use as a paper or an electronic version. The paper version relied on combining particular item scores and assessor judgements and the electronic version was designed so that a priority rating was automatically generated when the minimum numbers of relevant items were completed. The Priority Rating Tool (as well as other triggers and prompts) was supported by algorithms that could be modified according to service availability or policy issues (Stevermuer et al., 2007). This tool offers a way to combine a lot of summarised screening information in the form of selected standard data items that were chosen on the basis of their ability to predict levels of need and to act as useful proxies or indicators for risks and urgency.

There are different Priority Rating systems in use. The ACCNA-R uses a system that allocates a priority per functional item and per domain for a person so that a person may have several different priority ratings. The ONI priority rating provides one per person.

5.8.7 Carer Assessments

Carers are an important part of the system that supports people living in the community. It is important to understand the nature and sustainability of carer arrangements, as unsustainable carer arrangements are likely to increase the need for more formal care and support services. A carer profile in the shallow and broad assessment would be triggered by whether a person needs a carer and has a carer. The role of this profile is to determine whether current care arrangements are sustainable, and if not, seek some action to improve this situation.

Carer assessments can be covered by a tiered model of assessment. Particular items that are characteristics of the care recipient's circumstances might be relevant at the initial contact (does the person have a carer) and form part of a priority rating (refer Table 7). Carer circumstances may be assessed in more detail as a separate carer profile within a more comprehensive client assessment, or for programs that are specifically for carers there are dedicated assessment tools (Ramsay et al., 2007) that are used when the carer is deemed to be a client in their own right.

At the initial assessment it is useful to identify whether the carer is providing information on behalf of the care applicant and whether the care applicant needs a carer and has a carer. If both these latter conditions are met, and the person is referred for a second level assessment a carer profile could be undertaken which addresses issues such as the sustainability of care arrangements and can also be used as part of a priority rating for the client. If there are issues identified at this stage there may be a referral for a deep and narrow carer assessment as occurs with CENA (Carer Eligibility Needs Assessment) and CENA-R which are deep and narrow assessments of the carer

including aspects such as carer burden leading to appropriate referrals for the carer. It is important for the data repository that data for the carer and the care recipient are linked.

The results of these processes may be that the Carer might then be assessed as a care recipient in their own right although this would only apply to a small proportion of cases (@ 10%). The ACCNA-R has built the capacity for assessment of the carer as a care recipient into the initial broad and shallow assessment for the care recipient and it is debateable whether this level of assessment for carers would be required at the new front end or whether it is best addressed by a trigger that follows from the assessment processes described above.

5.8.8 Urgency of Service

People who are assessed may be able to wait differing lengths of time for the services that they need. For, a person who is homeless and also needs assistance with a hearing aid, the homelessness is an issue that needs to be dealt with immediately whilst the assistance with a hearing aid may be provided routinely. Each referral to a service that is made after an assessment should be coded with a rating for urgency such as:

- Low
- Routine
- Urgent.

This should be based on the judgement of the assessor, as they will need to take into account all relevant circumstances.

5.8.9 Emergency Response

There needs to be a capacity in any assessment system for an emergency response, for example when current caring arrangements for someone with high levels of need have broken down. A 'fast track' response to an urgent referral may be required, for example, when there is a risk of harm. A flag that prompts the involvement of emergency services should be part of the initial assessment. An emergency response should not be delayed by the completion of a formal assessment process.

The emergency flag means that an issue has to be dealt with immediately. The assessment process for other services should be put on hold and resumed when the emergency has been dealt with.

5.8.10 Issues for Special Needs Groups

The purpose of an assessment is to help the service system understand the person's situation and assist them to access the appropriate services. This requires an understanding not just of their needs but also of the context in which they live and differences from that of the majority of Australians. These groups include:

- Older Australians from culturally and linguistically diverse backgrounds (CALD)
- Aboriginal and Torres Strait Islander people
- Older Australians living in rural and remote locations
- People with disabilities
- People with mental illness
- People who are homeless.

Special needs issues can be broken down into three broad groups:

- Cultural differences
- Lack of access to services
- Inability to participate in the assessment process.

For people from culturally and linguistically diverse backgrounds, a number of barriers have been identified by the Productivity Commission (2011a):

- Attitudes to the elderly, expectations of family care giving, roles of women and support groups, and beliefs about health and disability
- Beliefs, practices, religions, behaviours and preferences which can affect the propensity to use formal care services
- English language proficiency, which can affect access to information and services, communication of needs and participation in the wider community.

Establishing access hubs for older people from CALD backgrounds providing interpreter services and ensuring its diagnostic tools are culturally appropriate for the assessment of care needs has been suggested previously. Similarly access for other special need groups such as the homeless and rural and remote Indigenous people might be provided through similar hubs operating through established specialised services.

For people of Aboriginal and Torres Strait Islander background, issues are similar. Cultural differences may mean that the process of obtaining the relevant information that is required for an assessment of need should be adapted to suit the situation of the person who is being assessed. This information is best obtained by a person who has a good knowledge of the cultural issues involved and is trusted by the person seeking assistance. These issues are just as important in determining the appropriate set of services that may need to be put into place for that person as issues of care relationships will affect that. All these factors are equally relevant to mainstream providers in the service system, generally thought of as a set of cultural competencies (Hayter, 2009).

For older Australians living in rural and remote locations, there does not appear to be the same issue of complexity in navigating the service system. The National Evaluation of Access Points Demonstration Projects found that as there are very few service providers available, people (whether consumers or referrers) generally know how to make contact with services, and do not experience difficulties in navigating the system (KPMG, 2009). This means though, that the range of services available to them is limited, and more flexibility may be needed to work out how best to meet these needs.

People with Disabilities

Part of the National Health Reforms was a division of responsibility so that the Commonwealth took responsibility for all people over the age of 65, while the States and Territories are responsible for services delivered to people under 65 and 50 years and under for Indigenous Australians. The Commonwealth assumes responsibility for specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

As people who are currently receiving disability services approach the transition age of 65 years (50 years for Indigenous Australians), they should be offered an initial assessment for aged care services. This should be supported by information from their current service provider/s. The aim is to minimise disruption to the care of the person. This can be seen as an example of ‘ageing in place’ (Olsberg, 2005).

For ageing carers of people with disabilities, their needs would be covered by a carer assessment, either as a person requiring aged care services, or as a carer with support needs of their own.

People with Mental Illness

Mental illness and mental health issues in older ager are recognised as being complex, because of factors such as prior psychiatric history, current social circumstances such as isolation, the impact of multiple prescribing and drug interaction, as well as cognitive decline including dementia.

Community care assessments have included mental health and well-being as components of a psycho-social profile, in particular, by using the scores on the Psychological Distress Scale (K10) (Kessler, 2001) which have the advantage of their linkage to national normative data. The K10 is particularly useful as a screening scale as it includes scoring bands that recommend different levels of intervention, from self-help to primary care to specialist care. This use of the scale supports more reliable referral between generalist and specialist levels of care.

The mental health system through a series of national mental health plans has a highly developed assessment and outcomes measurement and reporting function, organised by the Australian Mental Health Outcomes and Classification Network (AMHOCM, 2012).using three components:

- a data bureau responsible for receiving and processing information;
- an analysis and reporting component providing analysis and reports of submitted data
- a training and service development component supporting training in the measures and their use for clinical practice, service management and development purposes.

Aged care assessments can interoperate with the mental health system through information exchange and the use of the standardised K10 tool within the psychosocial profile of the ACCNA (second level of assessment).

People who are Homeless

People who are homeless generally have poor relationships with mainstream service providers and often distrust providers that they are not familiar with. Assessments of these people's needs would best be done by a specialised service provider that they trust. Initial assessment by telephone for this group may be inappropriate.

5.8.11 Unmet Need

It has been identified earlier in this report that unmet need is a major issue for all components of the aged care community service system. The assessment system will be required to identify and record the needs of ageing Australians. It will identify the types of services that are needed to meet individual needs. Assessment information that has been collected in a data repository can be analysed for planning purposes. This level of analysis would not just look at the total numbers and types of services provided, but at identified needs and whether they have been met.

These services may not be available to a person for a number of reasons such as:

- Service not available.
- Requested service not accessible due to long waiting time
- Requested service not accessible due to inaccessible location
- Requested service not accessible for other reasons.

This information is more useful than just the number of occasions of service in understanding unmet need. It can also identify the common characteristics of people whose needs were unmet. For example, the unmet need of an individual with a high priority rating may be rated differently to that of an individual with a low priority.

Analysis of the occasions when services are not available to people who need them can provide an important source of evidence when planning for service provision. It is impossible to provide all services to all people who need them as there is a limited supply of financial resources to do so. Decisions to allocate resources need to be based on evidence of need, both met and unmet.

6 Issues and a Model for a Needs Assessment Tool

6.1.1 Hierarchies of Assessment

People seeking access to services will present with a wide variety of needs and other issues that need to be considered in helping them access the appropriate services that they need. It is important that these people receive the right level of assessment for their situation. All service seekers could receive a comprehensive broad and deep assessment at initial contact but it would be a waste of resources that would be better spent on service delivery.

An initial contact phase and 3 levels of assessment are identified. The different levels of assessment are linked so that later assessments should use the information that has been collected in earlier assessments.

6.1.2 Initial Contact

Initial contact may be via the telephone, the internet, or face to face although telephone administration is preferred. The initial contact may be for information only where people are seeking information on relevant services. Details about the information request should be recorded but no personal information needs to be recorded. If the person needs more assistance in obtaining access to services, the person should receive a Level 1 Assessment.

6.1.3 Level 1 Assessment

The initial broad and shallow assessment could be undertaken via the telephone, the internet, or face to face although telephone administration is generally preferred. It should take a maximum of 30 minutes and follow a conversational style, where the assessor assists the person to provide the necessary information in a way that suits the person seeking assistance, and is able to record the necessary information into the client record.

It would consist of:

- Goals
- Current service usage
- Functional profile
- Information needed for service response (demographic information)
- A set of trigger questions to identify other areas of need for further investigation.

If no other areas of need are identified, the person may be referred to basic services. If other areas of need are identified, the person may be referred to a Level 2 or 3 Assessment, depending on the extent of need identified. An appointment should be arranged for the next level of assessment, along with a request to bring any available information from current health and service providers such as medical reports.

6.1.4 Level 2 Assessment

This assessment will follow up on the issues identified earlier, and may cover one or more domains that have been previously identified in some depth as well as new areas of need that are uncovered. The person may be referred to a more complex range of services (called basic plus) and if a greater level of need is discovered, to a Level 3 Assessment.

6.1.5 Level 3 Assessment

This assessment is a broad and deep assessment suitable for people with complex needs, and can provide access to a variety of packages of care suitable for that person. It would also be used

as an assessment to access transition care, respite care and for admission to residential aged care facilities.

6.1.6 Pathways

A new information and assessment system should make it easier to allow people to access the services that they need. As noted above, people who make initial request for assistance may be divided into three broad groups:

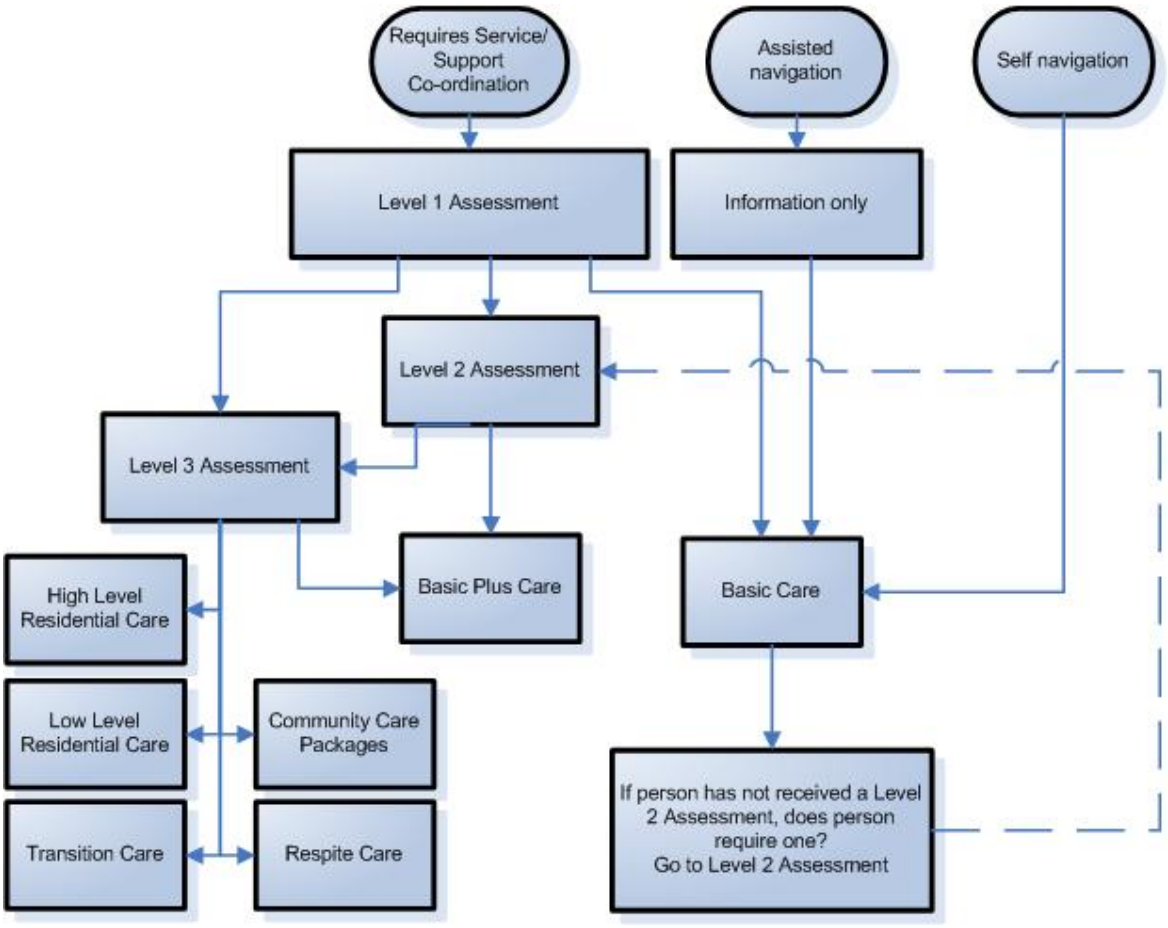
- Self navigators, who can identify and find the services that they need
- Those who need some information to find the services that they need
- Those who require service/support co-ordination to find the services that they need.

Each of these groups will have different pathways initially, when their level of need may be low. If they are connected to a service, the service provider should identify whether the person has additional needs that are best addressed by a Level 2 Assessment.

This is illustrated in Figure 4 that shows pathways to service provision. Self navigators are able to contact basic care services directly, assisted navigators may need some information about available services to find the appropriate services, and others who need service support and co-ordination will receive a Level 1 Assessment that may refer the person to other levels of assessments and to basic care services.

While a person who has not received a Level 2 Assessment is receiving services, the service provider will identify whether the person has additional needs that are best addressed by a Level 2 Assessment, and arrange for the person to receive one.

Figure 4 Pathways to Service Provision



6.1.7 Types of Care

3 broad types of care are identified:

- Basic Care
- Basic Plus Care
- Packaged/ Residential Care.

Basic Care is the provision of a small number of low-level services, such as Meals on Wheels services, Community Transport. Basic Plus Care is either the provision of a wider range of services, a higher volume of a small range of services for a person with more complex needs, or a person who needs a high level of need on a periodic basis. Packaged/ Residential Care is the provision of a variety of care services that is planned to meet the needs of an individual with complex needs (e.g. CACP, EACH and TCP packages) and approval for Residential Care including respite care.

A person who seeks services for the first time may have complex needs. A person who has been receiving services on an ongoing basis may require only basic care.

6.1.8 Decision Support Tools

Decision support tools should be built into the assessment tool to assist the judgement of the assessor. The skills and judgements of the assessor are critical to a “good” assessment and can be supported and not replaced by decision support tools, which can never be comprehensive enough to judge a person’s needs, abilities and situation.

During the assessment, a combination of information (an algorithm) that is recorded can be used to provide prompts to an assessor to "trigger" asking further more detailed information in identified domains. The assessor may judge that this may not be appropriate at that particular time as they may already have had that information provided, or other issues are more pressing.

Also, an algorithm can be used to suggest a referral to a service for that person in response to recorded responses. However the referral may not need to be made if the person is already receiving similar services to those that are recommended. Rules can be established to determine if the person needs to be referred to a more comprehensive ACAT type assessment.

The actual algorithms may be determined initially by expert judgement, e.g. an expert committee can determine what the initial algorithms are, but these should be reviewed regularly in response to data of how many responses are actually triggered, whether they are too few or too many, and how appropriate they are.

6.1.9 Data Repository

Older Australians who are seeking assistance are likely to already have extensive information about their health, needs and situation recorded with health and other service providers such as general practitioners or hospitals. Much of this information could help inform the assessment process and reduce the duplication of information requests to the person. This information should be provided when a person is referred for an initial assessment. Service providers and other assessments can link into this data repository to obtain relevant information and add information.

6.1.10 Links to Local Systems

The National Health Reforms have set up new regionally based infrastructure in the health system – local health/hospital networks for state and territory operated services and Medicare Locals to improve primary health care services. It was intended that each local health/hospital network and Medicare Local would service similar geographic regions and work together to improve the health of people in that region. Aged people are the heaviest users of health services, and so there is significant overlap between the user groups of these health services and any aged care infrastructure. It is likely that there would be benefits to all services (and users) if they co-operated on services for aged people. Better information sharing between these agencies about clients and available services would improve local care pathways, and there would be opportunities to better integrate care across the three settings.

One role of assessment is to determine what people's needs and situations are, and to identify what services should be put into place to meet the person's identified needs and goals. A knowledge of the service system that is available to meet these needs and goals is critically important to implementation of the assessment outcomes. There is little point in referring people to services with limited capacity to meet their needs, or to services that are inaccessible to the person. One of the key findings of the Final Evaluation Report of the National Evaluation of Access Points Demonstration Projects was that a mechanism to monitor service system capacity was an important support for Access Point staff in their allocation decisions (KPMG, 2009).

This can be done through formal means such as providing access to assessors to real time information about service waiting lists, or via other arrangements with service providers. As one of the functions of the new structure will be to provide referrals to services and organisations that are not part of the traditional aged care system there is benefit to assessors if they had a good understanding of the wider community to include groups such as church social groups and various informal networks that are part of the local community. It would be very difficult for an assessor that does not have good knowledge of the area to identify these informal supports and link a person into them.

6.1.11 Standardisation and Centralisation

Standardisation of assessment information is a key requirement for a national assessment system with the functions of understanding needs, comparison of levels of activities between providers, and measurement of client outcomes. These functions can be organised centrally, but are not dependent on having one centralised assessment service.

Standardised assessment information can be collected through a variety of modes that are complementary, such as

- Telephone call centre, regional and/or national
- Web-access
- Face to face assessment centre
- Service providers and other referrers.

The modes of access to the assessment system should reflect the characteristics and needs of the individuals and the communities in which they reside, rather than a predetermined one size fits all model. For example, a local service network will already include competent assessors, capable of providing a standardised assessment with appropriate training, accreditation and access to the data repository of client information.

A one stop shop for access to aged care services runs the risks of not being suitably accessible to many special needs groups. People living in rural and remote regions, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and other non mainstream groups may find it difficult to engage with a totally centralised approach. The location of the assessment service is not the key issue. The key issue is that all people receive an assessment that is delivered in a culturally and relevant manner and that data is stored centrally.

6.1.12 Assessment Role Delineation

There are many current service agencies with considerable skills, experience and investment in assessing the needs of clients. To build upon this capacity, it is important to understand what current service agencies are currently capable of, and also what they are planning to do. An assessment system should formally identify the role and capacity of each organisation in the system.

The Department of Health and Ageing could request that agencies identify their capabilities and planned capabilities as part of their Service Contracts, using a framework such as shown in Table 8.

Table 8 Suggested Categories for Assessment Capacity

Category	Assessment capacity	Illustrative examples of existing agencies
0	No ability for assessment	Day Care Centre
1	Level 1 and 2 Assessments for own clients	Meals on Wheels Service, Migrant health service, general practice nurse, hospital discharge planner
2	Level 1 and 2 Assessments for own clients, linked to Category 0 agencies, and people seeking services	Blue Care, Silverchain, Royal District Nursing Service
3	Independent assessment agency that can carry out Level 1 and 2 Assessments	NSW Home Care Referral and Assessment Centre, Hunter Valley Access Point
4	Independent assessment agency that can carry out Level 1, 2 and 3 Assessments	ACAT

Minimum and optimum standards for these Categories need to be made explicit as indicated in Table 9 and Table 10. Minimum standards would specify what agencies need now, or at the beginning of the implementation of a new framework, whilst optimum standards would specify what agencies would need to move towards in a designated time frame.

Table 9 Minimum Standards for Assessment Categories

Category	Dedicated assessment team	Telephony – multiple calls	Accredited Software for Level of Assessment	IT Connectivity To Data Repository	Knowledge of service system and referral pathways	Assessment Quality Assurance System
0						
1	No					Yes Internal
2	Single assessor or discipline	Yes	Yes	Yes	Yes	Yes External
3	Team with broad skill base	Yes	Yes	Yes	Yes	Yes External
4	Team with broad skill base Can recommend packaged/ residential care	Yes	Yes	Yes	Yes	Yes External

Table 10 Optimum Standards for Assessment Categories

Category	Dedicated assessment team	Telephony – multiple calls	Accredited Software for Level of Assessment	IT Connectivity To Data Repository	Knowledge of service system and referral pathways	Assessment Quality Assurance System
0						
1	No		Yes	Yes	Yes	Yes Internal
2	Single assessor or discipline	Yes	Yes	Yes	Yes	Yes External
3	Team with broad skill base	Yes	Yes	Yes	Yes	Yes External
4	Team with broad skill base Can recommend packaged/residential care	Yes	Yes	Yes	Yes	Yes External

Agencies with no ability for assessment (Category 0) agencies could form formal links with Category 2 (or higher level) agencies to assist referral pathways to Level 1 and 2 Assessments. List of these agencies and their approved Category for assessments should be made publicly available in an Assessment Agency Directory so that service seekers can find out what agencies are available and accessible to them.

People who are seeking assessment for services should be able to choose from a range of pathways. If they are already clients of or are familiar with a Category 1 or 2 agencies, they can begin the assessment process at this agency or choose an independent assessment agency. Indeed, until the capacity of independent assessment agencies has been increased to cover the whole population, a mixed methods approach is recommended. A single approach for people seeking assessment that relies on independent assessment agencies is likely to be expensive and not meet the needs of special needs groups.

Current Level 1 and 2 agencies will continue to carry out assessments for their own clients, as this information is needed for these agencies to understand the needs of their clients and provide

services to them. Dependence on independent assessment agencies without effectively integrating this with service agency assessments may result in parallel systems.

There may be concerns about perceived conflicts of interests by assessors from Level 1 and 2 agencies referring clients to their own agency rather than to other available agencies. If these service agencies are block- funded, there is no direct material gain. All assessment agencies should be monitored as part of a quality assurance system that would include whether there was excessive self referral by service provision agencies. Auditing of referrals would provide evidence of abuse of the system.

Recommendations for packaged/residential care would be made to Delegates of the Department who need to authorise the packages. If the condition of a person who is receiving packaged care changes, there would be benefit in service providers having the ability to recommend marginal changes to the Delegate without the need for a full Level 3 reassessment.

Assessors at all participating agencies need to be trained in the use of the assessment tools and accredited and credentialed for the various levels of assessment. Accreditation is an important part of the assessment system to ensure data quality and trust between assessors. If the quality of the information that is collected and stored in the data repository cannot be trusted by users who access this information, these users may repeat the collection of this information. This negates the potential benefit of minimising data collection.

7 Conclusions

This first paper has discussed the structure and components of the assessment framework. This paper has examined:

- Current community and aged care service systems and their assessment processes (e.g. Home and Community Care; Veterans Home Care, Aged Care Assessment Teams and the Aged Care Assessment Program)
- The journeys and pathways for aged care clients
- An outline of key assessment issues for consideration
- A description of current assessment tools (ONI/ACCNA family and the ACCNA-R) that are commonly used for initial access to aged care community services
- Issues to be addressed by a need assessment tool.

This first paper is concerned with the structure and components of the assessment framework and how it would be introduced.

This framework paper examined:

- Current community and aged care service systems and their assessment processes (e.g. Home and Community Care; Veterans Home Care, Aged Care Assessment Teams and the Aged Care Assessment Program)
- The journeys and pathways for aged care clients from community aged care through to residential care placement
- An outline of key assessment issues for consideration along the assessment pathway
- A description of current assessment tools (ONI/ACCNA family and the ACCNA-R) that are commonly used for initial access to aged care community services
- Consider links and triggers to other assessments (e.g. ACAT assessments, deep and narrow assessments
- Issues and a model for a need assessment tool for the new front end.

Issues for consideration by the Department and the Expert Clinical Reference Group were illustrated in the sections of the framework and included:

- The breadth and depth of assessment along the assessment pathway
- The breadth and depth of assessment in relation to services initially requested (e.g. do all care applicants receive, for example, a functional screen assessment or may this be unnecessary for clients requesting only a few low level services)
- Where assessments may include a range of informants, rules about whether judgements are based on a ‘can do’ or a ‘does do’ approach to the question of capacity, or whether a combination of these approaches is used.
- How to incorporate a re-ablement focus
- Issues concerning the suitability of current assessment tools and the required modifications to enable a front-end to connect to an ongoing assessment system
- The modes of assessment administration along the assessment pathway (e.g. telephone or face to face, electronic or pen and paper).
- Consideration of the most appropriate method for priority rating
- Approaches for handling urgency and emergency with respect to service referrals
- Rules for periodic reassessment and the definition of an episode of care
- Unmet need
- Assessment of carers.

A typology of assessment is used in the suggested framework so as to link the first contact and ongoing needs identification, starting with an initial broad and shallow assessment. Decision support tools are built in and information is aggregated to the level of a central or regional or local Data Repository. The system requires a capacity to talk both ways, to strengthen links to local systems and have a level of standardisation and a capacity for the analysis of data. The quality of the data requires maintenance and maintaining quality implies embedding the assessment system in a training and accreditation program.

This framework moves on from previous approaches in proposing a national assessment system that incorporates and standardises current assessment practices, and provides clear pathways to people who need services. A key component is an assessment role delineation system. Under this approach, each aged care agency is formally recognised as being on a scale from 0 to 4, depending on their capability to assess client need. This framework recognises that assessments may be undertaken by stand alone assessment agencies, or by service provision agencies. It aims to build on and recognise what already exists in the field, rather than impose a new structure or assessment model. It will provide flexibility and assist in connecting groups who do not use mainstream services.

A further fundamental enhancement in this framework is that it recognises that consumers require broadly three types of service:

- Basic
- Basic Plus (a gradient of need between basic and packaged care)
- Packaged/Residential care.

These three types of service need correspond to different levels of assessment:

- Basic Care - Broad and shallow core assessment with no follow-up profile assessment
- Basic Plus - Broad and shallow core assessment plus relevant profile assessment
- Packaged/Residential - Comprehensive assessment.

In all cases, the initial contact is for a broad and shallow core assessment that does not include any profile assessments. If these are required, a separate appointment is made.

The questions of the preferred models for the implementation of a ‘front end’ for initial information and assessment include the degree of centralisation required in such an approach, and ways to ensure the consumer finds no wrong door, how to managed a transition to a more centralised approach to aggregating data, and the benefits to be expected of a program of further research and development. The consideration of particular issues for special needs groups and analyses of the data to generate evidence to guide further development including finding data relating to the application of funding bands and measuring outcomes within the aged care and the community care system.

Following feedback from the Department and the ECRG appropriate revisions will be made to the Assessment Framework and this feedback will also help to advise the subsequent Discussion Papers.

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9 Glossary of Terms

Term	Definition	Reference
Action Plan	Written instructions about how to recognise when a person's condition is getting worse and what actions to take.	Asthma in Australia 2008
Aboriginal and Torres Strait Islander	An Aboriginal or Torres Strait Islander is a person who identifies as being of Aboriginal or Torres Strait Islander origin.	http://www.aihw.gov.au/publication-detail/?id=6442468342&tab=2.
ACAT assessment	An ACAT assessment is an assessment of a person's care needs which is carried out by one or more members of the local Aged Care Assessment Team (ACAT). ACAT members would visit the person in their home or in hospital to talk with the person about what services the person may need and what is available in the area.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Accommodation bond	Residents with sufficient assets who require low (hostel) level care or who enter an extra service place may be asked to pay a bond.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Accommodation charge	Residents with sufficient assets who require high (nursing home) level care (but not on an extra service basis) may be asked to pay an accommodation charge.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Accommodation payments	On entering permanent residential aged care, a person may be asked to make an accommodation payment (either an accommodation bond or an accommodation charge) if they have sufficient assets. Only aged care homes that are certified can charge accommodation payments. Service providers are required to keep a number of places for people who cannot be asked for an accommodation payment.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Accreditation audit	An accreditation audit is an on-site assessment of the quality of care provided by an aged care home undertaken by an Aged Care Standards and Accreditation Agency assessment team for the purpose of determining whether an aged care home should be accredited and for how long. The quality of care is measured against the Accreditation Standards set out in the Aged Care Act 1997.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Accreditation standards	The Accreditation Standards are standards, specified in the Aged Care Act 1997 that approved providers of publicly-subsidised aged care homes must meet before they can receive public funding.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Accreditation status	Accreditation status is whether or not a home is accredited. Accreditation is the arrangement established to verify that aged care homes provide quality care and services. Homes are accredited for a set period of time up to a	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A

Term	Definition	Reference
	maximum of three years. Accreditation status can be varied at any time if there is a risk to the health, safety or well being of residents.	
Activities of daily living (ADL)	ADLs are personal care tasks such as eating/drinking, washing self, using the toilet, rising from a chair, getting in/out of bed, moving around indoors, dressing, walking outdoors. (ADLs are able to be routinely measured by standardised scales such as the HACC functional screen, the FIM™ and the Barthel scales and the are used for priority rating, service response classifications, resource allocation and planning the details of service provision)	http://ahsri.uow.edu.au/chsd/glossary/index.html
Advocacy Services	An Advocacy Service is an independent, confidential service provided free of charge in each state and territory.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Aged care	A range of services required by older persons (generally 65 years and over (or 50 years and over for Indigenous Australians)) with a reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on help with basic ADLs. Aged care is frequently provided in combination with basic medical services (such as help with wound dressing, pain management, medication, health monitoring), prevention, reablement or palliative care services.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Aged Care Act 1997	The Aged Care Act 1997 is the Commonwealth legislation that allows public funding to be provided for aged care.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Aged Care Assessment Team (ACAT)	A multidisciplinary team of health professionals responsible for determining the care needs and services an individual may require. ACATs are known as Aged Care Assessment Services in Victoria.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Aged Care Commissioner	The role of the Aged Care Commissioner includes investigating straightforward or complex complaints from people who believe they have been unfairly treated by the aged care Complaints Investigation Scheme.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Aged Care Funding Instrument (ACFI)	The ACFI is a resource allocation instrument which focuses on three domains that differentials care needs among residents. The ACFI assesses core needs as a basis for allocating funding.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Aged Care Planning Region	The geographical region used by the Department of Health and Ageing in its Aged Care Approvals Round.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11,

Term	Definition	Reference
		I18, H51
Aged care recipient	People receiving aged care services in institutions or at home.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Aged Care Standards and Accreditation Agency	The Aged Care Standards and Accreditation Agency is an independent company established in 1997 under corporations law, and subject to the Commonwealth Authorities and Companies Act 1997. It was appointed by the Secretary of the Department of Health and Ageing as the 'accreditation body' under Section 80-1 of the Aged Care Act 1997 to manage the accreditation process; help the industry improve service delivery through education and training; assess and assist services working towards accreditation.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A
Ageing in place	The provision of care which allows a person to remain in their home or in the same residential care facility even if their care needs change.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Algorithm	A set of rules for solving a problem in a finite number of steps, as for finding the greatest common divisor. Used to assist decision-making about which services or assessments a person should be referred to	http://dictionary.reference.com/browse/algorithm
Ambulatory care	Care on a non-admitted or outpatient basis; patients usually 'walk in and walk out'.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Approved Provider	Approved Providers are organisations approved by the Australian Government, to receive subsidies for the provision of aged care services and accommodation to residents within an aged care home, or for the provision of care and services to people in the community.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Assisted resident	An assisted resident is a person who entered care before 20 March 2008 and has not re-entered care on or after 20 March 2008 after a break in care of more than 28 days and qualifies for subsidised aged care accommodation costs, because they receive an Australian Government means tested pension, have assets valued between 2.25 times and 3.61 times the single basic aged pension amount, and have not owned a home in the past 2 years (unless the home is 'protected' i.e. excluded from the assessment)	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Glossary+Index+A

Term	Definition	Reference
	at the time of entry to care.	
Basic Care	The provision of a small number of low-level services, such as Meals on Wheels services, Community Transport	Sansoni J, Samsa P, Owen A, Eagar K, Grootemaat P. (2012) An Assessment Framework for Aged Care. Centre for Health Service Development, University of Wollongong, p 39
Basic daily fee	All residents of Australian Government subsidised aged care can be asked to pay a basic daily fee as a contribution towards accommodation costs and living expenses, such as meals, cleaning, laundry, heating and cooling.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+B
Basic Plus Care	Is provided to a person with a gradient of need between basic and packaged/residential care It can be either the provision of a wider range of services, a higher volume of a small range of services for a person with more complex needs, or a person who needs a high level of need on a periodic basis	Sansoni J, Samsa P, Owen A, Eagar K, Grootemaat P. (2012) An Assessment Framework for Aged Care. Centre for Health Service Development, University of Wollongong, p 39
Care coordination	The coordination of services, provided with the aim of enhancing care delivery and transitions, and including preliminary care plans and identification of the need for more intensive case management.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Care fees and charges	There are different costs for low-level (hostel) and high-level (nursing home) care. The amount that a person is required to pay will also depend on a person's income and assets. Daily care fees contribute to the cost of care.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Care leaver	A person brought up in care away from their family as state wards or home children raised in Children's Homes, orphanages or other institutions, or in foster care.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Care plan	A care plan is a plan of care which is developed by a person and the people providing care (and a friend or family member). The plan will outline the person's care needs and will provide instructions as to how these care needs will be met.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Care recipient	A person who is receiving care and support, either in the community, in their own home or in a residential aged care facility.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Care setting	Means the place where recipients of care services live.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51

Term	Definition	Reference
Carer	Carers are usually family members or friends who provide support to children or adults who have a disability, mental illness, chronic condition or who are frail aged.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Carer Allowance	Carer Allowance (adult) is a Centrelink supplementary payment for carers who provide daily care and attention for adults with a disability, a severe medical condition or who are frail aged at home. The Allowance may be paid in addition to other payments.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Carer Payment	Carer Payment (adult) is a Centrelink income support payment for people who are unable to support themselves through participation in the workforce, while they are caring for someone with a disability, a severe medical condition or who is frail aged.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Carer support groups	Carer support groups provide an opportunity for people with similar experiences to get together and learn from each other by sharing experiences, feelings, ideas, concerns, information and problems. They're also a great way to take a break and socialise.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Case management	An essential aspect of care delivery provided to individuals and including ongoing monitoring of support, detailed planning of clinical care and other aspects of delivery. Provided in part by residential aged care facilities and community care providers to people receiving care.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Casemix	Casemix is an information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. In popular usage, casemix is the mix of types of patients treated by a hospital or other health care facility (Eagar and Hindle 1994). Casemix is about the relationship between hospital's activity and costs, and makes use of data about classifications that are clinically meaningful and explain variation in resource use.	http://nccc.uow.edu.au/faq/Index.html
Centre-based day care	Centre-based day care refers to attendance/participation in structured group activities designed to develop, maintain or support the capacity for independent living and social interaction which are conducted in a centre-based setting. It also includes outings and day trips organised and conducted by a day care centre.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Certification	Certification is an assessment process designed to improve the physical quality of publicly-subsidised residential aged care buildings, and includes improving fire safety and privacy and space requirements.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Chronic disease	Chronic diseases are long-term ongoing conditions which can occur at any stage in life, are more prevalent in older age, and lead to a	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glos

Term	Definition	Reference
	gradual deterioration of health impacting on quality of life with physical limitations and disability. Examples include asthma, chronic obstructive pulmonary disease (COPD), cancer, arthritis, diabetes, heart disease, mental illness, osteoporosis. Many are preventable and treatable.	sary+Index+C
Classification	The act of distributing things into classes or into one (and only one) category of the same type. The act of forming a distribution into groups according to some common relations or attributes.	http://nccc.uow.edu.au/faq/Index.html
Commonwealth Respite and Carelink Centres	Commonwealth Respite and Carelink Centres provide a point of contact for the general public, carers, service providers, general practitioners and other health professionals to access information on carer support and respite services. Phone 1800 200 422 during business hours, or for emergency respite support outside standard business hours, call 1800 059 059.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Community Aged Care Package (CACP)	Individually planned and coordinated packages of care tailored to help older Australians with low-level care needs to remain living in their homes. They are funded by the Australian Government.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Community and carers support services	Community and carers support services are low intensity services which can be accessed either directly or though entitlements or referrals. Services would include meal preparation, community transport, day therapy and carer support services.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Community care	Is provided to people with functional restrictions who mainly reside in their own home. It also applies to the use of institutions on a temporary basis to support continued living at home — such as community care centres and respite. Community care also includes specially designed, 'assisted or adapted living arrangements' for people who require help on a regular basis while guaranteeing a high degree of autonomy and self-control.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Community care services	Home and Community Care (HACC) services, Community Aged Care Packages (CACPs), Extended Aged Care at Home packages (EACH), Extended Aged Care at Home Dementia packages (EACH-D), Veterans' Home Care (VHC), Community Nursing and respite services.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Community nursing and health centres	Nursing services are for frail older people who require nursing care from an enrolled nurse or registered nurse to improve or maintain their health and well-being.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Community	The Community Partners Program (CPP)	http://www.agedcareaustrali

Term	Definition	Reference
Partners Program	allows aged care homes and culturally and linguistically diverse communities to work together to establish and maintain links between people living in aged care homes and their social, cultural and language networks.	a.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Comprehensive Assessment	Comprehensive assessment is generally seen as appropriate for clients with complex needs and is characterised as assessment that covers a broad range of domains in considerable depth	Foreman P, Doyle C and Gardner I (2006) *Community Care: National Comprehensive Assessment Approach Options Paper (Revised)* Lincoln Centre for Ageing and Community Care Research, Australian Institute for Primary Care at La Trobe University.
Concessional resident	A concessional resident who entered care for the first time prior to 20 March 2008, and has not re-entered care on or after 20 March 2008 after a break of more than 28 days qualifies for subsidised aged care accommodation costs because they receive an Australian Government means tested pension, have assets below 2.25 times the basic single aged pension amount, and have not owned a home in the past 2 years (unless the home is 'protected' i.e. excluded from the assessment) at the time of entry to care.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Concessional resident supplements	A concessional resident supplement is paid by the Australian Government to aged care homes on behalf of residents who do not have the ability to contribute to all or part of the cost of their accommodation through an accommodation bond or accommodation charge.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Conditional Adjustment Payment	As part of the 2004-05 Budget package, a Conditional Adjustment Payment (CAP) was introduced. The intention of this payment is to assist aged care providers through increased financial assistance, to continue to provide high quality care. The CAP will be conditional on providers encouraging staff to undertake training, publishing audited financial statements and participating in periodic workforce surveys.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Consumer	A consumer is a person who is currently utilising, or has previously utilised, a health service.	http://meteor.aihw.gov.au/content/index.phtml/itemId/295417 (modified to generalise from mental health).
Consumer-directed care (CDC)	An approach to care that allows people to have greater choice and control over the care and support services they receive, to the extent that they are capable and wish to do so. The concept of 'choice' in CDC varies, and can include allowing people to make choices about	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51

Term	Definition	Reference
	the types of care services and benefits they access, the delivery of those services and benefits, or choice of service provider.	
Cultural and identified needs	The Australian Government recognises that older people who live in rural and remote areas, who come from Aboriginal or Torres Strait Islander or culturally and linguistically diverse backgrounds, or have experienced certain life impacting circumstances such as war service or financial disadvantage, may have particular cultural and identified care needs. Programs and services have been established to address those needs.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Culturally appropriate care	Culturally appropriate care, as well as including the care available to all Australians, takes into account special needs arising from culturally and linguistically diverse backgrounds.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C
Dementia	Dementia is the term used to describe the symptoms of a large group of illnesses, which cause a progressive decline in the ability to remember, to think, and to learn. There are many types of dementia and Alzheimer's disease is the most common.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+D
Disability	An impairment of body structure or function, a limitation in activities, or a restriction in participation.	National health data dictionary - http://www.aihw.gov.au/publication-detail/?id=6442468385&tab=2
Discharge plan	A discharge plan is developed by a hospital in close consultation with the patient, the patient's carer and hospital and community service providers to ensure that appropriate and coordinated care is available once the patient leaves hospital.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+D
Enablement/re-enablement	The terms re-enablement and enablement mean the same thing and are interchangeable. Re-enablement is part of the assessment process and is an intensive, short term service of four to six weeks designed to offer support to people, who by reason of injury, frailty or illness wish to regain or extend their independent living skills. Re-enablement is an essential element of Self-Directed support.	Reference: Kent County Council (UK), Adult Social Services - Jargon Buster http://www.kent.gov.uk/adult_social_services/your_social_services/your_money/direct_payments/jargon_buster.aspx#individualbudget
End of life care	End of life care or palliative care is care provided for people of all ages who have a life limiting illness, with little or no prospect of cure, and the primary aim is to achieve the best possible quality of life for the person and their family. Palliative care uses a holistic approach – managing pain and other symptoms, whilst also addressing the physical, emotional, cultural, social and spiritual needs of the person, their family and their carers. It focuses on 'living' well until death.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+E
Enduring power	An enduring power of attorney allows a person	http://www.agedcareaustrali

Term	Definition	Reference
of attorney	to delegate the management of their affairs even if they are no longer able to understand the implications such as if the person becomes mentally incapacitated. An enduring power of attorney can only be given while a person is able to understand the nature and effect of the document.	a.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+E
Enhanced Primary Care	The Enhanced Primary Care (EPC) program aims to provide more preventative care for older Australians and improve coordination of care for people with chronic conditions and complex care needs. Medicare provides rebates for certain allied health services, such as physiotherapists and dental care services, that may be provided to patients who have a chronic medical condition and complex care needs being managed by their GP under an EPC plan.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+E
Extended Aged Care at Home	Extended Aged Care at Home (EACH) packages are individually planned and coordinated packages of care, tailored to help frail older Australians with high-level care needs to remain at home. They are funded by the Australian Government to provide for the complex care needs of older people.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+E
Extended Aged Care at Home (EACH) packages	Individually planned and coordinated packages of care, tailored to help frail older Australians with high levels of care needs to remain at home. They are funded by the Australian Government.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Extended Aged Care at Home Dementia	The EACH Dementia Program (EACHD) packages are individually planned and coordinated packages of care, tailored to help frail older people with dementia and behaviours of concern associated with their dementia, who require management of behaviours and services, generally including nursing, because of their complex care needs. These people would otherwise be eligible for high-level care. EACHD packages are funded by the Australian Government.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+E
Flexible care	Flexible aged care places are provided through a number of different programs as an alternative to more traditional community and residential care. These include the EACH program (explained under Community Care), Multipurpose Services, the Transition Care Program and the Aged Care Innovative Pool.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+F
Formal care	Includes all care services that are provided in the context of formal employment regulations, such as through contracted services, by contracted paid care workers.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Functional	A measure of functional dependency is an	Professor Kathy Eagar,

Term	Definition	Reference
Dependency	instrument that identifies areas in which a person requires assistance with daily living, and that quantifies the extent to which that person needs support from others to help them carry out normal activities in their home and community.	Janette Green and Alan Owen, Centre for Health Service Development (2010) Functional Assessment of 2010 Post School Program Applicants (training presentation)
Functional Hierarchy of Activities of Daily Living (ADLs)	People acquire and lose abilities in a predictable order. People acquire functional abilities in the opposite order to which they lose them. Self-care ADLs like dressing, toileting, feeding and bed mobility are gained 1st and lost last (late loss ADLs). Domestic ADLs like housework, handling money, managing medicines are gained last and lost first (early loss ADLs). It is reasonable to assume that, if a person can do early loss ADLs, they can also do late loss ADLs. This forms a sound basis for screening.	Professor Kathy Eagar, Janette Green and Alan Owen, Centre for Health Service Development (2010) Functional Assessment of 2010 Post School Program Applicants (training presentation)
Functional Overview (Functional Screen)	Four domains are measured through 9 questions: Domestic functioning - 3 questions (housework, travelling to places and shopping) to screen for domestic function & 2 questions (handling money and taking medication) that also act as a screen for cognitive or behavioural problems Self-care functioning - 2 questions (walking, bathing) Challenging behaviour - 1question Cognitive functioning - 1 question Note the important item design feature of "Can Do (not Do Do)" - for example a person may be capable of taking medications even though they don't have to, or may be able to shop even though someone else does it for them. Answers are limited to specific categories and the structure for the first 7 questions is the same: Can do without help Can do with some help Cannot do	Kathy Eagar, Janette Green and Alan Owen, Centre for Health Service Development (2010) Functional Assessment of 2010 Post School Program Applicants (training presentation)
General Practitioner	A person whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to promote or restore good health.	http://meteor.aihw.gov.au/content/index.phtml/itemId/269005
Geriatrician	Geriatrician - medical treatment of elderly: the branch of medicine that deals with the illnesses and medical care of elderly people	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+G
Goal	A goal is a simple statement which sets out the purpose of a program or evaluation. It is important not to confuse goals with objectives. An objective is a specific statement that can be measured.	Criminal Justice Evaluation Framework (CJEF) Guideline Manual p 47 http://www.premiers.qld.gov.au/publications/categories/

Term	Definition	Reference
	For example the Australian Community Care Needs Assessment goals of care were to: (1) Improve current level of function and independence after a recent acute illness/event (2) Improve current level of function and independence (other) (3) Maintain current level of function and independence (4) Reduce rate of decline in level of function and independence	guides/assets/criminal-justice-evaluation-framework.pdf
Grandfathering	The continued application of the status quo to existing users of a system in order to protect against disruptive change.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Guardian	A guardian is a legally appointed substitute decision maker who, subject to the powers granted, may be able to make lifestyle decisions, such as where a person should live, consent to medical and dental services and health care generally. A family member or friend can be appointed as a guardian. In some circumstances, where it is not appropriate to appoint a private guardian, the board or tribunal has the option of appointing the Public Guardian, who is usually a statutory official.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+G
Health outcome	A change in the health of an individual, or a group of people or a population, which is wholly or partially attributable to an intervention or a series of interventions.	http://meteor.aihw.gov.au/content/index.phtml/itemId/327238
Health outcome indicator	A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual. A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition. A condition-specific indicator provides information on specific clinical conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems. Epidemiological terminology An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other. One phenomenon is attributable to another if	http://meteor.aihw.gov.au/content/index.phtml/itemId/327246

Term	Definition	Reference
	there is a causal link between the phenomena. Attribution depends upon the weight of evidence for causality. Association is necessary (but not sufficient) for attribution. Associations may be fortuitous or causal. The term relationship is to be taken as synonymous with association.	
Health related quality of life	Like quality of life, this is an amorphous concept and a wide range of pertinent domains have been identified in the literature, including the perceived impact of health on optimum levels of physical, psychological and social well being and functioning, level of independence and control over life, and satisfaction with these levels.	http://ahsri.uow.edu.au/chsd/glossary/index.html
Health worker	Health occupations comprise workers who diagnose and treat physical and mental illnesses and conditions or recommend, administer, dispense and develop medications and treatment to promote or restore good health.	http://www.aihw.gov.au/labourforce/health.cfm
High care or High-level care	The care which is provided for people who have been assessed by an ACAT (or Aged Care Assessment Services in Victoria) and need a high level of assistance with most activities of daily living (ADL). It may include accommodation services as well as personal care.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Home and Community Care (HACC)	A program which provides a broad range of low-level care and support services to help people maintain their independence at home and in the community. HACC is a joint Australian, state and territory government initiative.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Home and Community Care Act 1985	The Home and Community Care Act 1985 is the Commonwealth legislation that governs financial assistance for home and community care services, the planning of services, and for people who are to be assisted through the program.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+H
Home modifications	Home modifications are changes or additions to a person's house or local environment that allow them to live more comfortably, safely, and securely at home for as long as possible.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+H
Hospice	A hospice is a facility devoted to the care of people with a progressive life limiting illness, which is staffed by specifically trained doctors, nurses, social workers, physiotherapists, and volunteers. It offers total care for the patient, including physical, emotional and spiritual support, and care also for the family.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+H
Hostel care	'Hostel Care' is now known as 'low level care', and refers to accommodation services such as meals, laundry and room cleaning, as well as additional help with personal care, and nursing care if required. 'Hostel care' is low level care	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+H

Term	Definition	Reference
	provided in an aged care home.	
Impairment	Is the anatomical or physiological damage caused by disease (for example, the reduction in cardiac output caused by ischaemic heart disease, or the restriction in joint movement caused by osteoarthritis). (See Impairment, Disability and Handicap).	http://ahsri.uow.edu.au/chsd/glossary/index.html
Impairment, Disability and Handicap	The World Health Organisation (International Classification of Impairments, Disabilities and Handicaps. Geneva: WHO, 1980) made these important distinctions between the ways in which chronic diseases have an impact on the individual. This classification has since been revised to Impairments, Activities and Participation as the terms disability and handicap may be viewed as stigmatising by some people. (World Health Organisation ICIDH-2. Geneva: WHO, 1998).	http://ahsri.uow.edu.au/chsd/glossary/index.html
Informal carers	Are individuals providing aged care on a regular basis (often on an unpaid basis and without contract), for example, spouses/partners, family members, as well as neighbours or friends.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Inpatient	An individual who has been admitted to a hospital or other facility for diagnosis and/or treatment that requires at least an overnight stay.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Instrumental activities of daily living (IADL)	Domestic tasks such as shopping, laundry, vacuuming, cooking a main meal and handling personal affairs.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Level of care	Before a person is eligible to move into a Government-subsidised aged care home they must be assessed by an Aged Care Assessment Team (ACAT) as needing either high-level (nursing home) care or low-level (hostel) care. 'Level of care' refers to this high-level or low-level care.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+L
Live-in setting	'Live-in' setting refers to facility based accommodation with a more home-like, less institutional feel and with space available for therapy. This setting can be part of an existing aged care home or health facility, for example a separate wing of a hospital.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+L
Living Will / Advance health directive	A living will or advance health directive is a document which records a person's wishes and preferences for their comfort, dignity and treatment during critical and terminal illness. Living wills or advance health directives are called different things across states and territories.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+L

Term	Definition	Reference
Low care	The care which is provided for people who have been assessed by an ACAT (or Aged Care Assessment Services in Victoria) and need a low level of assistance with activities such as meals, laundry and cleaning as well as additional help with personal care.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Low intensity therapy	Low intensity therapy improves or maintains a person's physical and mental abilities so that they can continue to take part in daily living activities. Examples of low intensity therapy are occupational therapy, physiotherapy and social work.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+L
Mild Cognitive Impairment	Mild Cognitive Impairment is usually defined as significant memory loss without the loss of other cognitive functions. People with Mild Cognitive Impairment have more memory problems than would be expected from someone at a similar age. People with Mild Cognitive Impairment are able to function independently and do not usually show other signs of dementia, such as problems with reasoning or judgment.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+M
Multidisciplinary care	Where health professionals from multiple disciplines work together to provide team-based care.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Non-acute care	Non-acute care is care for typically, but not always, a frail older person, who does not actually need to be in hospital but could, instead, be cared for at home or in a residential aged care home. Non-acute care is usually provided in a hospital while patients are waiting for placement in residential care, waiting for their homes to be modified or the services that they will need at home to be organised or when their carer needs a break (respite care).	http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082638.pdf
Older Australian (including older Indigenous Australians)	Australians aged 65 years and over. Older Indigenous Australians include Aboriginal and Torres Strait Islander peoples aged 50 years and over.	http://www.aihw.gov.au/publication-detail/?id=10737418972
Outcomes	'Outcomes' refer to the impacts or end results of services on a person's life. Outcomes-focused services therefore aim to achieve the aspirations, goals and priorities identified by service users - in contrast to services whose content and/or forms of delivery are standardised or are determined solely by those who deliver them. Outcomes are by definition individualised, as they depend on the priorities and aspirations of individual people.	Glendinning et al. (2006) Outcomes-focused services for older people, Social Care Institute for Excellence, University of York, http://www.scie.org.uk/publications/knowledgereviews/kr13.pdf
Outcomes achievement	The overall result of applying the inputs and achieving the outputs, or the effect or change resulting from an initiative or program. Outcomes can have short, medium and long-	Criminal Justice Evaluation Framework (CJEF) Guideline Manual p 48 http://www.premiers.qld.gov

Term	Definition	Reference
	term achievements: Short-term outcomes = first-order effects of the initiative, which generally include changes to participants or the community; Medium-term outcomes = second-order effects of the initiative, which can include changes to policies, plans and projects; Longer-term outcomes - third-order effects, or the ultimate impact that the initiative should achieve, which can include fundamental changes in the social, environmental, economic and governance priorities of the government. The longer-term the outcome, the more likely that it will have been affected by factors external to the program that is being evaluated.	.au/publications/categories/guides/assets/criminal-justice-evaluation-framework.pdf
Outpatient	A person treated or seen in a hospital clinic without being admitted.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Packaged/ Residential Care	Packaged Care is the provision of a variety of care services that is planned to meet the needs of an individual with complex needs. It can be delivered in the community through packages such as CACP, EACH and TCP, or via the provision of residential care.	Sansoni J, Samsa P, Owen A, Eagar K, Grootemaat P. (2012) An Assessment Framework for Aged Care. Centre for Health Service Development, University of Wollongong, p 39
Palliative approach	A palliative approach aims to improve the quality of life for people with a progressive life limiting illness and their families. It aims to reduce their suffering through early identification, assessment and holistic treatment of pain, physical, psychological, social, cultural, and spiritual needs. A palliative approach is not delayed until the end stages of an illness or the ageing process. Instead, a palliative approach provides a focus on active comfort care and a positive approach to reducing an individual's symptoms and distress, which facilitates residents' and their families' understanding that they are being actively supported through this process. Underlying the philosophy of a palliative approach is a positive and open attitude towards death and dying.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+P
Palliative care	Palliative care is care provided for people of all ages who have a life limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life. Palliative care uses a holistic approach – managing pain and other symptoms, whilst also addressing the physical, emotional, cultural, social and spiritual needs of the person, their family and their carers. It focuses on 'living' well until death.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+P

Term	Definition	Reference
People in rural and remote areas	Measure: People residing in an area classified as Very Remote Australia, Remote Australia, Outer Regional Australia and Inner Regional Australia according to the Australian Standard Geographic Classification - Remoteness Areas (ASGC-RA). The ASGC-RA is a geographic classification system that was developed in 2001 by the Australian Bureau of Statistics (ABS); it is used to measure the remoteness of areas across Australia.	http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/1AEE5890BD5B7B5ECA2571A90017901F?opendocument
People of culturally and linguistically diverse backgrounds (CALD)	People who have settled in Australia but who come from countries where English is not the primary language spoken. Measure: A person who was not born in Australia and does not primarily speak English at home.	Draft National Asthma Strategy
Personal care services	Includes assistance with bathing, toileting, eating, dressing, mobility, managing incontinence, community rehabilitation support, assistance in obtaining health and therapy services and support for people with cognitive impairments.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Person-centred care	An approach to care that consciously adopts a person's perspective. This perspective can be characterised around dimensions such as respect for a person's values, preferences and expressed needs; coordination and integration of care; involvement of family and friends; and transition and continuity.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Primary carer	A person who provides the most assistance, in terms of help or supervision, to a person with one or more disabilities on an ongoing basis.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Priority Rating	Priority rating enables clients to be screened consistently for their needs and risks, with the intention that those with greater needs and risks will get priority of access to services.	Stevermuer T, Owen A and Eagar K (2003) *A priority rating system for the NSW Home Care Service: Data Driven Solutions*. Centre for Health Service Development ,University of Wollongong, Wollongong.
Quality of care	Quality of care refers to high quality care and accommodation consistent with best practice and provided in accordance with the individual care needs of residents.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+R
Reablement	Intensive and generally time-limited programs aimed at restoring function. Services included as part a reablement approach can include physiotherapy, psychosocial and other education programs, environmental modification and linkages to social activities.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Rehabilitation	Formally defined as the action of re-establishing a person in a former standing with respect to rank and legal rights and, in the	http://ahsri.uow.edu.au/chsd/glossary/index.html

Term	Definition	Reference
	context of medicine, is concerned with reablement of a person through provision of a stimulating environment, and encouraging greater activity, participation and autonomy; and re-settlement either in the person's own home or in alternative, more sheltered accommodation. Often necessary for older people after a short acute illness.	
Resident	If a person has care needs that can't be met through community support, they may be eligible for a place in an aged care home. If they move into an aged care home, they are known as a resident of that home. It is at the discretion of an aged care home whether they accept a person into that home as a resident.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+R
Residential aged care	Refers to facilities (other than hospitals) which provide accommodation and aged care as a package to people requiring ongoing health and nursing care due to chronic impairments and a reduced degree of independence in activities of daily living (ADL). These facilities provide residential aged care combined with either nursing, supervision or other types of personal care required by the residents. Aged care institutions include specially designed institutions where the predominant service component is long-term care and services are provided to people with moderate to severe functional restrictions.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Respite care	Care given as an alternative care arrangement with the primary purpose of giving the carer or a care recipient a short-term break from their usual care arrangement.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Self Directed Support	Self Directed Support is the process by which the individual has choice and control over the support they need to live their life as independently as possible. This may mean that they self manage the support, but they might also choose to have somebody else (including service providers or case managers) manage it for them.	Kent County Council (UK), Adult Social Services - Jargon Buster http://www.kent.gov.uk/adult_social_services/your_social_services/your_money/direct_payments/jargon_buster.aspx#individualbudget
Self-management programs	Self-management programs for chronic diseases provide support for people managing their chronic illness, usually by assisting them to change their behaviour in ways that will improve their health.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+S
Short-term care	There are two main types of short-term care available – respite care and transition care.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+S
Social inclusion groups	Aboriginal and Torres Strait Islander peoples; people in rural and remote areas, people of culturally and linguistically diverse backgrounds, people in lower socioeconomic	http://www.socialinclusion.gov.au/

Term	Definition	Reference
	areas and older Australians.	
Specified care and services	An aged care home is obliged to provide a range of care and services to residents at no additional cost to them. The care and services must be provided in a way which meets the requirements of the Aged Care Act 1997 including the Accreditation Standards. This range of care and services is known as specified care and services.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+S
Sub-acute services	May include rehabilitation, geriatric evaluation and care management. Some sub-acute services are colloquially referred to as 'low dependency' or 'step up' and 'step down' care, meaning that it can either precede (and potentially avoid) a hospital admission or follow an acute hospital admission. Most sub-acute services can be provided on either an inpatient or ambulatory basis.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Supported residents	A person who qualifies for subsidised aged care accommodation costs because they have total assets below a certain level.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Transition care	Short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. If seeks to enable more people to return home after a hospital stay rather than enter a residential aged care facility.	Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. JEL code: I11, I18, H51
Translating and interpreting service	Translating and Interpreting Service (TIS) is available for both English and non-English speakers. For non-English speakers, TIS National can provide telephone and onsite interpreters. For English speakers, TIS National provides interpreting services to help communicate with non-English speaking people, using telephone interpreting, ATIS - the Automated Telephone Interpreting Service and onsite interpreting.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+T
Trigger	Anything, as an act or event, which serves as a stimulus and initiates or precipitates a reaction or series of reactions. A signal that suggests that a person should receive a deeper assessment in a particular domain	http://dictionary.reference.com/browse/trigger
Veteran and war widow / widower pensioners	Veteran and war widow/widower pensioners are people who are eligible for and receive a pension from the Department of Veterans' Affairs.	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+V
Veterans Home Care (VHC)	Veterans' Home Care (VHC) is a Department of Veterans' Affairs (DVA) program that helps Australia's veterans, war widows and widowers with low care needs to remain in their own homes for longer. VHC is not an entitlement-based program like most other veterans'	http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+V

Term	Definition	Reference
	programs but a fixed budget program. VHC provides services including domestic assistance, personal care as well as gardening and home maintenance.	