



cutting through complexity

Department of Health

Key Findings and Outcomes

National Aged Care Quality Indicator
Program – Home Care Pilot

March 2017

Disclaimer

Inherent Limitations

This report has been prepared as outlined in the Section 'The Home Care Pilot'. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this report are based on a qualitative study and the reported results reflect the data and information provided by various home care services but only to the extent of the sample surveyed and data provided. Any projection to a wider demographic is subject to the level of bias in the method of sample selection and level of meaningful data provided.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by various home care services consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

Third Party Reliance

This report has been prepared at the request of the Commonwealth Department of Health (formerly Department of Social Services) in accordance with the terms of KPMG's contract dated 19 June 2015 and is solely for the purpose set out in the Section 'The Home Care Pilot' and for the Department of Health's information. Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

Acronyms and abbreviations

Acronym	Meaning
ACAT	Aged Care Assessment Team
AEST	Australian Eastern Standard Time
ASCOT SCT4	Adult Social Care Outcomes Toolkit four-level self-completion tool
CALD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
CHSP	Commonwealth Home Support Programme
FAQ	Frequently Asked Questions
GAS	Goal Attainment Scaling tool
NSAF	National Screening and Assessment Form
PDF	Portable Document Format
RACF	Residential Aged Care Facility
WHOQOL BREF	World Health Organisation Quality of Life questionnaire modified version
WHOQOL OLD	World Health Organisation Quality of Life questionnaire additional questions for older people
WHOQOL-BREF (OLD)	Used in this report to refer to both WHOQOL BREF and WHOQOL OLD together
YES	Your Experience of Service

Key Findings and Outcomes

Context

The Australian aged care sector is undergoing significant reform as the Government responds to the opportunities and challenges associated with an ageing population. Many of these reforms have focused on providing aged care consumers with more choice and flexibility to access the services they want and need, both within their home and in residential aged care facilities (RACFs). As part of these reforms, the Australian Government committed to develop and implement a voluntary National Aged Care Quality Indicator Program (the National Program) for aged care services.

The National Program is intended to encompass both residential aged care services and home care services, and has the following two objectives:

- to give consumers transparent, comparable information about quality in aged care to assist decision making
- for providers to have robust, valid data to measure and monitor their performance and support continuous quality improvement.¹

The National Program is supported by a suite of quality indicators, which are defined measures that relate to the assessment of care and services. The National Program is being developed and implemented in a phased approach across home and residential aged care, and will encompass a range of quality indicators. Once it has been established as reliable and accurate, it is intended that data from the National Program will be published on the *My Aged Care* website.

The Home Care pilot

KPMG was engaged by the Department of Health (formerly Department of Social Services, subsequently referred to as 'the Department') to assist with a project for the development and implementation of voluntary national quality indicators for services that provide Home Care Packages to older Australians that are evidence-based, valid and supported by practical and reliable data collection ('the project'). A key component of the project has been the development and conduct of a Home Care pilot (subsequently referred to as 'the pilot') to inform the development of quality indicators for Home Care Packages.

The objectives of the pilot were to consider:

- the acceptability and relevance of the piloted tools
- data capture and data collection learning processes
- accessibility and usefulness of pilot support materials
- additional support or assistance requirements
- options for the format of reports containing information on the tools used in the pilot

¹ Australian Government Department of Social Services. About the National Aged Care Quality Indicator Programme. <https://www.dss.gov.au/ageing-and-aged-care/ensuring-quality/quality-indicators/about-the-national-aged-care-quality-indicator-programme> accessed June 2016.

- pathways for implementation and reflections for consideration in the development of the National Aged Care Quality Indicator Program.

An important part of the project has been to consider how the National Program can be implemented in a way that can suitably respond to the needs of all consumers receiving Home Care Packages. The project and the pilot have examined issues of inclusion for consumers with special needs and consumers with cognitive impairment.

Key stages of the project, including the conduct of the pilot, are outlined in the table below.

Project Stage	Detail
Project initiation	KPMG worked with the Department to establish the project objectives and scope, information requirements and access procedures, governance structures and potential risks and mitigation strategies for the project.
Review and research	KPMG undertook a detailed literature review of the evidence for quality indicators for home care, and measures of quality in the domains of: quality of life, consumer experience, and goal attainment.
Consultation and focus testing	A series of consultations were conducted about quality indicators for home care. These included interviews with service provider representatives and academics with expertise in aged care, as well as focus groups with consumers and carers.
Identification of pilot quality indicator tools	The findings from the review, research, consultation and focus testing stages of the project were used to develop a short list of tools and methods suitable for piloting.
Home care services pilot design	KPMG developed an approach to delivering the pilot. The approach was tested with services in a series of three co-design workshops.
Pilot approach finalisation	<p>The findings from the research, consultation, and co-design processes were used to design an approach for the pilot. The pilot approach involved the piloting of four tools, endorsed by the Quality Indicators Reference Group, under two focus areas:</p> <ul style="list-style-type: none"> • Goal attainment, measured using the Goal Attainment Scaling (GAS) tool • Consumer experience and quality of life, measured using the following tools: <ul style="list-style-type: none"> ○ the Adult Social Care Outcomes Tool SCT4 (ASCOT SCT4), which measures consumer experience and quality of life ○ the Your Experience of Services (YES) Survey, which measures consumer experience ○ a combined tool based on two World Health Organisation Quality of Life questionnaires (WHOQOL-BREF + WHOQOL-OLD, subsequently referred to as WHOQOL-BREF (OLD)) which measures quality of life. <p>Time to access services was also to be piloted, using data from the My Aged Care system.</p>
Home care quality	<p>The pilot involved the following activities:</p> <ul style="list-style-type: none"> • participant recruitment, including recruitment of a representative sample of

Project Stage	Detail
indicator pilot	<p>120 services (a 'core sample') across Australia</p> <ul style="list-style-type: none"> • participant streaming, with all participants being assigned the GAS and one of the three consumer experience and quality of life tools • resource development, including a Pilot Handbook, to provide pilot participants with instructions for collecting and submitting data • registration, including the development of an online portal to quickly and accurately capture key details of participating services • orientation sessions, including face-to-face and teleconference sessions • participant support, including the operation of a functional mailbox and telephone hotline, and outbound coaching calls to the core sample of pilot participants • data collection by participants, over two pilot cycles • data submission, including the development of online data submission tools for pilot participants to submit pilot data • individual service-level reporting, in which KPMG developed individual reports for each participating home care service outlining that service's pilot results and aggregate results; reports were made available after each pilot cycle for consumer experience and quality of life tools, and after the second pilot cycle for the GAS.
Pilot feedback	<p>Post-pilot feedback involved collecting feedback from pilot participants, both service providers and consumers, via a number of methods. This included:</p> <ul style="list-style-type: none"> • individual telephone interviews with 30 consumers • face-to-face and teleconference post-pilot service provider consultations with participating services • a feedback survey distributed to all participating services following the end of each pilot cycle.
Reporting to the Department	<p>KPMG analysed pilot data and participant feedback to report to the Department on pilot findings and implications for the implementation of quality indicators for Home Care Packages.</p>

For the purposes of the pilot, a number of definitions were established, informed by the literature, for the focus areas of goal attainment, consumer experience and quality of life. These were as follows:

- **Goal attainment:** *A process in which consumers identify what is important to them and what they want to achieve, and how the services they receive will assist them in achieving their goals*
- **Consumer experience:** *Gaining consumer perspectives on issues pertinent to their care and wellbeing, focusing on residents or consumers as "customers" of care*
- **Quality of life:** *An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.*

Pilot activity

There were 281 services registered for the pilot, of which 121 services formed the core, statistically representative sample of services that provide Home Care Packages across Australia (the 'core sample'). All registered services piloted the GAS tool, while roughly one-third of services were each streamed to pilot one of the three consumer experience and quality of life tools (i.e. ASCOT SCT4, WHOQOL-BREF (OLD), and the YES Survey).

Of the 281 registered services, 58 deliver level 1 packages (20.7 per cent), 177 deliver level 2 packages (63.2 per cent), 75 deliver level 3 packages (26.7 per cent) and 148 (52.8 per cent) deliver level 4 packages, with many services delivering more than one package type. It is important to note however, that no sampling nor analysis was undertaken on the basis of package levels and this information is provided only as general context for the pilot.

There were 190 services that submitted data for pilot cycle one, and 150 services submitted data for pilot cycle two. In total 1,116 consumer experience and quality of life tools were completed by consumers across both pilot cycles. The table below shows the number of services and consumers who submitted data for each tool for each pilot cycle. Note, some consumers only completed one tool, whilst others completed both the GAS and a consumer experience and quality of life tool.

Participation in the GAS pilot dropped over the course of the pilot, with 160 services and 740 consumers participating in cycle 1 and 123 services (and 450 consumers) participating in cycle 2.

Feedback from services over the course of the pilot indicated that there were a range of factors influencing participation, including:

- The tight timeframes for the pilot, in particular the timeframe between the receipt of pilot materials and orientation sessions, and the commencement of cycle 1, which allowed for limited time for planning and training of staff
- Less familiarity in the processes of planning for, collecting and submitting quality indicator data in the areas of goal attainment and consumer experience and quality of life
- The use of complex tools which require the involvement of the consumer in the collection of data.

Table 1: Participating services and consumers, by pilot cycle and tool piloted

Tool	Cycle 1		Cycle 2	
	Unique Services ²	Consumer tools ³	Unique Services	Consumer tools
ASCOT SCT4	55	271	37	174
WHOQOL-BREF(OLD)	55	200	37	139
YES Survey	43	173	41	159

² The total of the unique services column is not the sum of the rows above, as some consumers within each (unique) service will have completed more than one tool – i.e. one GAS and one Consumer experience and quality of life.

³ The total of the consumer tools is a simple sum of the rows above; unlike services, the data collection methods used in the pilot did not allow for the identification of 'unique' consumers, just the number of tools which were collected. In interpreting the consumer tool total therefore, it should be noted that some of the consumers likely completed both a GAS and a Consumer experience and quality of life tool.

Tool	Cycle 1		Cycle 2	
	Unique Services ²	Consumer tools ³	Unique Services	Consumer tools
GAS	160	740	123	450
Totals	190	1,384	150	922

Source: KPMG, based on data provided by services

A key aspect of piloting the tools involved administering the tools to consumers from special needs groups. The table below presents the number of consumers who completed a tool, by special needs group (note that categories are not mutually exclusive).

Table 2: Participating consumers, by pilot cycle and special needs group⁴

Response	Pilot one count	Pilot one per cent	Pilot two count	Pilot two per cent
People from Aboriginal and Torres Strait Islander communities	18	2.8%	24	2.6%
People from Culturally and Linguistically diverse backgrounds	90	14.0%	128	13.9%
People from the Lesbian, Gay, Bisexual, Transgender and Intersex community	< 5	< 1.0%	< 5	< 1.0%
People who are care leavers	< 5	< 1.0%	< 5	< 1.0%
People who are financially or socially disadvantaged	98	15.2%	150	16.3%
People who are homeless, or at risk of becoming homeless	26	4.0%	24	2.6%
People who are veterans, including the spouse, widow or widower of a veteran	15	2.3%	13	1.4%
People who live in rural or remote areas	80	12.4%	98	10.6%

Source: KPMG based on data provided by services

Similarly, the pilot sought to explore the administration of the tools to consumers with cognitive impairment (where 'cognitive impairment' was defined by the consumer receiving the dementia and cognition supplement).⁵ In pilot cycle one, 70 consumers who completed a tool (11 per cent) were identified as having a cognitive impairment and in cycle two, 95 consumers (10 per cent) were included in the pilot.

⁴ Responses to this question were optional, and if a response was given, multiple categories could be selected for a single consumer. As such, percentages are of all consumers i.e. the denominator for the percentage in pilot one is 644 consumers and for pilot cycle two it was 922. Note that this question was not on the GAS form in pilot cycle one.

⁵ The dementia and cognition supplement was used as a proxy indicator for cognitive impairment for the purposes of this pilot. It is acknowledged that this definition may exclude consumers with milder cognitive impairment, who may not be receiving the dementia supplement.

The pilot sought feedback from participants (services and consumers) via a number of mechanisms. Thirty consumers were interviewed via telephone. A feedback survey was distributed to services at the conclusion of each pilot cycle, to which there were 80 service level responses for the cycle one survey and 56 for the cycle two survey. The post-pilot consultations with services had 55 individuals attend the face-to-face workshop sessions and 25 individuals attend the teleconference sessions.

Time to access services

In order to inform the development of a time to access service data indicator, two data extracts were examined from the My Aged Care system for the 281 services that registered for the pilot. Two data extracts were received from the Department in relation to the time to access services. The first data file, which broadly aligned with pilot cycle one, contained 147 referrals for 58 services. The second data extract contained 635 referrals for 156 services.

Time to access measure-related statistics for individual services, however, were not derived and distributed to services. This was primarily due to:

- the low percentage of registered services for which there was data in My Aged Care
- for the services where data was available, these generally only had a small number of referrals (three or less)
- the time available to design, develop and distribute the report
- pilot participants having received a large amount of correspondence from KPMG throughout the pilot and this additional report may have confused services.

Pilot outcomes and considerations for a National Program

An extensive array of information was gathered over the course of the pilot, informed by both the pilot experience and feedback provided by services and consumers. Reflection on this information has yielded a range of considerations for the National Program. These are outlined below and relate to the core areas of:

- Piloted goal attainment scaling and consumer experience and quality of life tools
- Data collection and submission
- Program support
- Reporting
- Feedback.

Piloted goal attainment scaling and consumer experience and quality of life tools

The pilot tested the suitability of four tools and whether an indicator could be extracted from administrative data for the Australian Home Care Packages service setting, to work towards meeting the dual objectives of the National Program, that is:

- to give consumers transparent, comparable information about quality in aged care to assist decision making
- for providers to have robust, valid data to measure and monitor their performance and support continuous quality improvement.

There are a number of findings from the pilot that will inform the extent to which these objectives can be achieved. These are outlined below:

1. Each of the tools that were piloted (the GAS and the three consumer experience and quality of life tools) were assessed on their relevance, appropriateness, user-friendliness and feasibility for use with consumers of Australian Home Care Package services. This assessment was made based on the pilot experience and the resulting feedback from consumers and services.

The outcome of this assessment was that the **ASCOT SCT4 and GAS are both considered relevant, appropriate, user-friendly and feasible tools for use with consumers of Australian Home Care Package services**. These tools were considered usable without modification to their content, although there are some additional considerations for accompanying resources and training, which are discussed under separate points below.

Piloting of the WHOQOL and YES revealed a number of challenges associated with their use in the Home Care Package setting. In particular, the WHOQOL-BREF (OLD) was considered too time consuming, included questions not considered to be appropriate and was difficult to administer with some consumers (e.g. those with cognitive impairment). The main concerns regarding the YES tool centred on the appropriateness and relevance of the questions. As such, neither the WHOQOL-BREF (OLD) nor the YES Survey were considered appropriate for use in a National Quality Indicator Program for Home Care going forward.

There was no indication that services' perceptions regarding the tools differed according to the different levels of Home Care Packages, or types of services.

2. The **'time to access services' indicator was found to be feasible to extract from the My Aged Care system**, without any direct participation of Home Care Package services. Three possible candidate measures were identified. Time to access was not piloted because of the low volumes of data available in the system. However, given that assessment management has only recently transitioned to My Aged Care, the quality and quantity of this data may improve over time. The Department will need to re-examine the completeness of data available from the My Aged Care system every three to six months to determine whether there is an adequate volume of data available to commence reporting on this indicator. The Department will also need to inform services that the information being captured in the My Aged Care system will be used to understand time to access services. This will involve informing services, providing reports, understanding issues with the data and outlining when, where and how the information would be reported.
3. Consultation with stakeholders suggested that **the perceived user-friendliness of both the GAS and the ASCOT SCT4 will change over time**, as services become more comfortable in collecting the data. In particular, it was noted that services' current perceptions of the relevance, appropriateness, user-friendliness and feasibility of the GAS appear to be affected by the extent to which goal-setting was a mature and ingrained process within an organisation. This is expected to change over time if the GAS is chosen for use in the National Program.
 - The cost of the ongoing use of any consumer experience and quality of life tool would need to be considered, in consultation with the authors of these tools, as applicable.
 - The Goal Attainment Scaling handbook was developed specifically for the pilot and would require redevelopment for use in the National Program. For example, the timelines set out in the GAS handbook for the pilot stipulates an eight week process

for administering the tool, whereas, if the GAS is to be included in the National Program, this process will likely take place over a longer period (quarterly or even annually).

4. Consideration will need to be given for how the piloted tools would be suitable for the convergence of Home Care Packages and the CHSP. **It is suggested that further work be undertaken to determine the suitability of the proposed measures for the diverse range of services provided under CHSP.**
5. **There may be benefits associated with using consistent consumer experience and quality of life tools in both the home and residential aged care settings**, noting that a consumer experience and quality of life pilot in residential aged care facilities carried out concurrently with the pilot with home care package services, examined all of the same tools as the pilot of Home Care Package services except the GAS. There are a number of service providers who deliver care across multiple settings, including residential and home care. Having a consistent set of consumer experience and quality of life tools across both settings will streamline the implementation of these tools for these providers. This in turn may facilitate ongoing participation in the Program.
6. The available literature indicates **quality indicator tools must be valid**. That is, the tool must capture the underlying concept that it purports to measure.⁶ The ASCOT SCT4 has been validated in a number of studies and thus satisfies this criteria.⁷

Data collection and submission

The pilot tested the feasibility of data collection and submission from Home Care Package services on a national scale. Considerations for these elements in a National Program are provided below.

Data collection

For the purposes of the pilot, online data collection portals were developed and built to collect and aggregate data collected across the four tools. A 'log-in' functionality was added to ensure that only an authorised representative was able to upload data, and validations were added to questions in the data collection portals to enhance the completeness of responses. Participating services underwent a structured data submission process, with a defined collection period. The considerations for this process in a National Program are outlined below:

7. Home Care Package services already have data collection and reporting requirements in place for the purpose of managing referrals from the Aged Care Assessment Team (ACAT), with a substantial amount of information collected by My Aged Care and ACAT prior to referral in the National Screening and Assessment Form (NSAF). There is a need to be mindful of these existing processes and determine whether voluntary participation in the National Program would create any duplication in the data collected by the Commonwealth Government. **It is recommended that the NSAF and other data collected**

⁶ OECD, *OECD Guidelines on Measuring Subjective Well-being*, 2013.

⁷ J. Malley et al, 'An assessment of the construct validity of the ASCOT measure of social care-related quality of life with older people', 2008, (Doctoral dissertation, BioMed Central).

are reviewed for any crossover and that any duplications in the data collected are removed where possible.

8. The majority of services in the pilot administered the tools face-to-face and this method is considered ideal for enhancing engagement with consumers. Telephone and mail out methods were also found to be appropriate, effective and efficient. Therefore, the **National Program could consider recommending these data collection methods to reduce the burden on services**. Streamlined online data collection (such as using a tablet, smartphone or laptop), which is available at the time of administration, should also be considered so that services then do not have to enter the data again at a later time. **The feasibility of online data submission has been established by the pilot**.
9. In all of the consultations that have been conducted with services, the need for **accompanying demographic data to be collected alongside the tools** has been described as imperative. This will be critical for providing context to the resulting data, and aid in interpretation of individual services' results. Transparency in the following areas is imperative:
 - Whether the tools were completed by a proxy and what the relationship of the proxy is to the consumer
 - Whether a consumer belongs to any of the special needs groups as defined in the *Aged Care Act 1997*
 - Whether or not the consumer has a form of cognitive impairment, noting the dementia and cognition supplement may be more likely to capture consumers with higher care needs, not all consumers with cognitive impairment.
10. There are various options for deciding **sample sizes** when collecting data (i.e. with whom the tools are used):
 - The first option is to collect data from **all of a service's consumers**. This would be the most representative method, noting that it could potentially pose resourcing challenges depending on how frequently the data is collected, but it would provide the most accurate overall picture of a service's score.
 - The second option is to collect data from a **representative sample of consumers**. This could pose challenges, as services across Australia cater to widely varying numbers and cohorts of consumers, so the sampling technique would potentially require further investigation and be quite complex. Stratification of the sample may need to consider which variables relate most closely to the concepts which the tools are measuring. This may include package size, receipt of the dementia and cognition supplement, services being delivered and other variables. The advantage to this model may be a smaller time impost on services, although this depends on the overall simplicity of the sampling method.
 - The third option is to collect data from a **random sample of consumers**. The risk with this method is that results may vary widely between reporting periods and thus be difficult to interpret or compare between services. The advantage to this model may be a smaller time impost on services.
 - The fourth option is to collect data from **all consumers with an annual review or reassessment during the census period**. This is similar to how collection was

undertaken during the pilot. This is effectively random sampling and may not provide comparable data between periods.

11. There are a number of options in terms of **how frequently the data should be collected**.

Overall, services reported that collection should not occur more than six-monthly, preferably annually. The options are:

- Collection of data from services annually with a defined census date and a time-limited collection period. This has the following considerations:
 - A collection period would need to be established. Pilot experience suggests this should take place over more than a week, however this must be balanced against objectives of timely reporting of results. Pilot experience suggests that resourcing the submission of data can be a challenge in the aged care sector, which could present issues in a defined collection period.
 - Services could encounter extenuating circumstances that may influence results captured during the collection period, such as natural disasters or other factors outside of a service’s control. There would need to be capacity to capture explanatory information in this respect.
- Collection and submission of data by services once per sampled consumer over the course of the year. Consumers with annual reviews falling outside the calendar or financial year (whichever is most appropriate) would be included in the next year’s collection. This has the following considerations:
 - Would require services to already be conducting at least one annual review with consumers.
 - Would require commitment by services to implement this as a standard part of a consumer’s annual review, noting this may provide efficiencies when compared to the census date option above.
 - Would require a data submission portal to be permanently open and a reporting process to be established to consolidate and report back on results on an annual basis. The timeliness of the data may also be a risk if data is only reported annually, when it could potentially have been collected more than 11 months prior.
- Use of either of the above methods, but report more frequently:
 - For the census method in particular, while there was a greater preference for conducting data collection annually, this may be unnecessarily burdensome for services, with little additional benefit.
 - For the collect as you go method described above, there may be benefit to reporting on this data more frequently, or making the data able to be viewed on a ‘live’ format. This would enable timelier decision-making for services. Based on the examination of other reporting systems undertaken as part of this project however, no examples of live reporting were identified; reporting appears to be typically released in a regular (for example, annual) basis.

Data submission

The effectiveness of data submission processes and systems is a critical aspect of the National Program. Informed by the planning, delivery and review of two pilot data collection cycles, there is a need to consider the following:

12. **Data submission should ideally be able to occur for a period longer than a week.** However, this must be balanced against objectives of timely reporting of results i.e. the period of time available to submit data should not be extended to lengths such that the data submitted and in turn reported to both services and consumers is no longer considered 'current'.
13. Program resources should detail an easy to understand and succinct guide of the manual data collection options and requirements of services, and emphasise the timeframes for data submission and protocols for late data submission.
14. Data submission systems should allow for **self-resetting of login and password details, as well as live self-entry and modification of key service contacts** (i.e. names, job titles and contact details), central contacts, CEO details and other contacts by participating services themselves.
15. Data entry forms should incorporate '**field validation**'. That is, if services enter data that do not comply with certain criteria (such as needing to enter a whole number), then the submission form should recognise this and prompt the user to review their entry. This also includes provision for providing comments with a maximum character length identified.
16. Allowing services to **complete a submission in more than one sitting** is important to enable services to more easily integrate collection and submission processes into business-as-usual activities. The data submission system should incorporate a function which allows services to save their progress and return to the entry at a later time.
17. To reduce the possibility of error, there is a need for any data collection system to **prompt services to review an entry before it is submitted**, to ensure that the correct service IDs are used for the relevant data submission. This should also extend to **allowing services to review data that has already been submitted** for errors.
18. An **automated reply following successful data submission** to key service contacts will provide assurance to services that their data has been received and, subsequently avoid additional contacts to the hotline/mailbox from services seeking confirmation.

Support materials

In order to participate in the pilot, services were provided with accompanying materials such as handbooks and an online portal that contained fact sheets and other materials, which helped to outline how the pilot would operate and the methods by which data should be collected. Outlined below are a series of considerations for the provision of these types of materials for a National Program:

19. Services that participated in the pilot generally found that the materials provided to them were helpful. **It is recommended that a similar suite of resources is made available for the National Program.** In addition, it was raised that the following resources would be of value to a National Program:
 - Resources written in "plain English" to support consumers and carers to understand the purpose of the National Program and what is required to participate. It is recommended that these resources be **co-designed with a reference group of consumers and carers, or the appropriate peak bodies.**

- Program resources should detail an **easy to understand and succinct guide of the manual data collection options and requirements of services**, and emphasise the timeframes for data submission and protocols for late data submission.
 - Resources should be made available via a **central webpage** to enable National Program participants to access them multiple times and as required.
 - Some resources, such as **text for posters and fact sheets, should be made available in editable format** to enable participants to adapt for inclusion in their existing communications and newsletters.
 - With respect to the GAS, services requested that **more examples of potential goals** should be provided in any future handbooks.
20. The National Program will need to **provide a range of resources and additional support to participants who primarily work with consumers with cognitive impairment or special needs**. In particular, guidance around interviewing consumers with cognitive impairment or procedures for using proxies to participate in the interviews.
- There is a particular challenge for family members, carers or proxies to complete the consumer experience and quality of life tool on behalf of a consumer who has a cognitive impairment and cannot complete the tool themselves or with assistance. This is especially the case when questions require a personal perspective. The National Program will need to consider the nature of the questions being asked of consumers and what caveats are required to ensure there is complete transparency if the consumer experience and quality of life tool is completed by a proxy, carer or family member on behalf of the consumer. This may, for example, **require information about the use of the proxy, and the nature of the proxy, to be recorded along with the tool's data**. This will allow for tracking of proxy data over time, in order to determine the influence, if any, of proxy responses (see Consideration 9).
 - There is a need to have **translated resources available** for consumers who do not speak English. It may be more feasible to create translated resources for only the five most common languages spoken by older people who do not speak English. For older people who speak another language, the use of interpreters would be required. In many cases during the pilot, services were able to use internal staff to undertake this work, however there is a need to consider other options to enable services access interpreter services into the future.
 - Resources should include **specific scripts and guidance on how to use the tools with Culturally and Linguistically Diverse (CALD) consumers and consumers with cognitive impairment**. Based on the pilot experience, these consumers are likely to need further prompting and explanation of the tools. It was also evident that a consistent approach to using these tools with CALD consumers will be important to managing the integrity of the data collection.

Participant support

The support provided to participants in the National Program is a key consideration for implementation of the National Program. Based on the conduct of the pilot, services will require considerable support during the initial stages of participation and lesser support throughout the duration of the National Program. The pilot elicited a number of observations in relation to participant support.

Services that participated in the pilot were provided with extensive, customised support, including face-to-face and telephone-based orientation sessions, a dedicated KPMG pilot team, a hotline number and an email helpdesk. From the pilot experience, there are a number of considerations for this type of support in a National Program.

21. The pilot has demonstrated that the use of an **online platform to register participation** will be an efficient method to support registration for the National Program. By integrating this with the Department's own database of services, it should minimise the input errors by services, and thus avoid the need for manual corrections.
- Recruitment activities should be coordinated centrally through the Department and be consistent with existing communication and engagement strategies. This aims to ensure that where recruitment communications might be undertaken by other external stakeholders, information and messaging is consistent with agreed Departmental messages and instances of incorrect information being communicated are avoided.
 - Maintaining an **accurate, up-to-date list of service provider contacts** will ensure that any recruitment communications are received.
 - **Keeping track of service withdrawals during the National Program** will be essential for the Department to ensure that it has accurate, up-to-date information on the services participating in the National Program, especially if it chooses to publish the services that are participating on its website. The reasons services withdraw may provide insight to help the Department improve the National Program as it is implemented.
22. **Training is essential for an effective orientation to the National Program.** Preferably, this training should be face-to-face. Feedback from services indicated that, while telephone-based orientation sessions were sometimes more accessible for services in regional and remote areas, this medium made it more difficult to obtain a clear understanding of how to participate in the pilot.

To promote sustainability of National Program knowledge within a service, it is recommended that a **train-the-trainer** approach is employed, where representatives from services act as champions within their own services to train others in using the tools.

- **Training sessions should be held periodically for new services joining the National Program**, as well as for new staff members from existing participating services that may be taking on responsibility for the National Program within their organisation. Feedback from the pilot hotline suggests that there was no guarantee that leaving staff would provide information and support to new staff.
- In addition, the National Program could make **recordings of the training sessions or webinars available for new registrants**. This, coupled with face-to-face training sessions, would provide services with a level of accessibility and flexibility to self-manage their training via a method that best suits them. This method would also ensure that regional and rural services are able to access training sessions, however **this should not be seen as a substitute for face-to-face training**.
- Training sessions for the pilot were delivered as a presentation, with opportunities for participants to ask questions throughout the presentation. An **additional option is to structure training as a working session, with activities and exercises that mimic pilot**

activities. This would enable participants to better understand what is involved in the National Program from the beginning and learn from practice as they participate.

23. In addition to training, there will need to be a mechanism for support for participating services, such as a **hotline or email helpdesk** where services can access prompt advice on questions about participating in the National Program.
- It is **crucial that any such service is staffed by appropriately skilled individuals** who have an understanding of the tools, data collection processes and the home care sector. Inbound contacts require an informed and knowledgeable team to respond in order to ensure the timeliness of query resolution. In light of this, a smaller specialist team is more conducive to providing support than dispersing knowledge across a larger team.
 - The management of high volumes of telephone enquiries would benefit from a **call centre customer service solution**. The telephone line would need to be available during business hours for all of Australia, meaning staffing from 8am to 8pm AEST during the daylight savings period.
 - An accessible and cogent Frequently Asked Questions (**FAQs) document** can potentially assist the National Program support team in managing the volume of calls and emails received. Revisiting the FAQs regularly will ensure that the content is still relevant and any emerging issues are covered in the document.
 - This service should have **adequate inbound capacity during the timeframes for data submission** to assist with queries, issues and questions as they arise.
 - There may be an expectation that **inbound support staff have access to the data** in the event of the need to discuss data submissions or make any changes.
 - The use of automated systems for resetting lost or forgotten passwords will also serve to reduce the volume of contacts.
24. There will **need to be a capacity to have email reminders sent to participating services** if there is a timeframe associated with data submission in the National Program, for example one week prior to when the data is to be submitted.
25. **Strong communication between various parts of the National Program** is needed to ensure the processes, language and content of communications clearly delineates each individual element of the National Program, i.e. indicators within residential aged care versus indicators within Home Care Packages.

Reporting

Reporting of quality indicator data will be an important part of the National Program going forward, to enable the National Program to meet its objectives relating to:

- giving Home Care Package consumers access to transparent, comparable information about quality in aged care services to assist decision making
- providing services with robust, valid data to measure and monitor their performance and support continuous quality improvement.

Reports were issued in PDF copy by email to all services that participated in the pilot. Before this occurred, KPMG undertook substantial data cleansing and transformation of the submitted data, with a series of nuanced steps involved in calculating summary scores for the

GAS and consumer experience and quality of life tools. While issuing the reports in PDF was appropriate for the pilot, there are a number of key considerations for how reporting is undertaken for the National Program.

26. Consideration should be given to developing a **dynamic, online reporting method for distributing results to services**, so that results can be presented at the consumer, service and national levels and by other demographic breakdowns (e.g. consumer age, consumer gender, service type, service jurisdiction). If the ‘collect as you go’ data collection method outlined in Consideration 11 is implemented, services would permanently have access to their service’s results and be able to track trends over time.
27. **Benchmarking is not likely to be feasible in the short-term.** Whilst the tools are validated, it will take a number of years before use of the tools will be adequately implemented in the sector and at present, there are no available appropriate ‘population norms’ for the tools for Australian consumer groups. In the short-term, once data collection is at a more mature stage, it will be possible to compare against the average of other services. However, **the aim should be for the program to reach a level of maturity where benchmarking is possible.**

Once the National Program reaches a point of maturity, such that it is confident the data is robust enough for public reporting, there will be a need to provide sufficient context to the data (such as location, socio-economic status of consumers) so that the data fairly represents the service. Benchmarking of like services only should be undertaken.

28. **There are a number of implications associated with the voluntary nature of the National Program.** The National Program seeks to achieve participation from a range of services such that any aggregate results may be considered representative in nature. However, it should be acknowledged that there are inherent variations in the characteristics of those that participate as volunteers (also known as volunteer bias). Examples of the differences between volunteers and non-volunteers include the potential for more supportive services to be involved, compared with those that decline to participate in the National Program. This bias may influence the aggregate results in the National Program that are presented and reported on to services and the broader public.
29. There **may be a need to present accompanying service characteristic details in reports** (such as location, operational size and organisation type) for services that participate in the National Program. Without this, there is a possibility that the results may not be representative of select cohorts of services, such as outer regional and remote services. There is also the potential for aggregate results to be influenced by the larger services nationally or services located in New South Wales (NSW) and Victoria (VIC) as the more populous states.
- There is also, in general, a **need to ensure demographic data** are collected from consumers to give context to service level results, as well as to ensure that over time, ‘like’ data (e.g. data collected using proxies) can be compared.
 - **Services value the ability to view individual consumer results in their reports**, in conjunction with overall summary scores. This may assist in changes to particular aspects of the service they are receiving (e.g. socialising, food and drink, cleanliness).

Seeking feedback about the National Program

Feedback was sought on all aspects of the pilot and was used directly to inform the recommendations for the future National Program. Feedback is an important mechanism to improve the National Program. In order for the National Program to be of value in the long-term, there is a need to continue to collect feedback about the National Program's implementation and operation. There are a number of considerations for collecting feedback about the National Program:

30. **Seeking feedback from services and consumers should be a key mechanism by which the National Program can seek to continually improve.** It is important that the feedback cover all aspects and any issues identified through feedback should be acted upon to ensure continuing participation of services. Additionally, seeking feedback from both services and consumers is an engagement mechanism to allow services and consumers the opportunity to contribute to the development of the National Program.
31. **The structured collection of feedback and ongoing review should continue as the National Program is implemented.** The need to actively collect, listen and respond to feedback provided by services and consumers should be considered a business as usual function. There is potential to strengthen transparency in relation to this, and report on how common themes arising from the feedback are being addressed or not, and the nature of any programmatic changes being made.
 - The **timing of any feedback must be carefully considered.** The release of the feedback surveys in the pilot was relatively close to the distribution of the reports. This allowed participants to accurately respond to questions in the feedback survey pertaining to the distribution and usefulness of the reports. It is also acknowledged that there is risk of 'information overload' and fatiguing participants with survey and feedback requests.
 - If consumer consultations form part of the evaluation process for the National Program, **consumer consultations need to be conducted in a timely manner.** There is value in seeking feedback from consumers, however, there is an inherent risk when working with older people who may also have dementia, where short term memory is affected. This is particularly true for consumers who may/may not have been diagnosed with dementia (i.e. the dementia and cognition supplement proxy which KPMG used may not capture all consumers with less severe dementia). By reducing the time taken to attain feedback from consumers (for example asking for feedback within a week of the tool being used), the risk of consumers not remembering undertaking the tool(s) would be mitigated to a certain extent.

Moving from a pilot to a National Program

Informed by the considerations above, there are a number of key steps that need to be undertaken in the short and medium term to transition from a pilot to a National Program. These have been outlined below.

Short-term actions (<2 years)

Governance

1. It is important that **appropriate governance mechanisms are put in place to oversee the Home Care component of the National Program.**

- This should include a **governance committee made up of representatives from across the aged care sector**. Consideration should also be given to whether this governance committee should be separate or combined with the oversight of the equivalent National Program for residential aged care.
 - It is critical that the governance committee includes individuals with **deep expertise in the home care setting**, including at the service delivery level.
 - The governance committee will need **mechanisms to understand what is going on at the “frontline”**, particularly because of the changes which will occur to Home Care Packages in February 2017. There will be a need to understand what changes occur at the service level following these changes, and in turn, consider what this means for the National Program.
2. **The process for the management and governance of data collected as part of the National Program must be determined**. It will need to be determined which body will act as the data custodian and how it will manage this emerging dataset. This will be a unique and sought after dataset and there will likely be great interest in using the data for a range of purposes, including for research.

Communications strategy

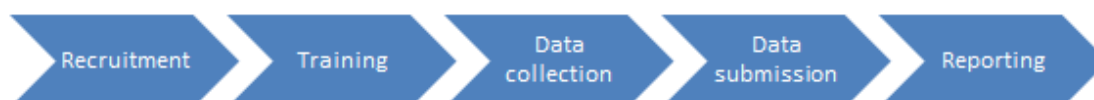
3. A **communications strategy** will be crucial to managing the implementation of a National Program. This communications strategy needs to consider several key aspects:
- The communications strategy will need to be clear about the **alignment of the National Program for home care package services with the overall National Program**, but acknowledge that a different approach has been taken to that in residential aged care.
 - In order for services to acquaint themselves with the tools, there will be a need to provide as much as possible notice (for example three to four months) about what the indicators and tools will be and what will be expected of services as part of a voluntary National Program. The benefits of participating should also be highlighted, both for the sector and for individual services.
 - In line with Considerations 28 to 31 above, the **planned mechanisms for retrieving feedback from the sector in an ongoing way should be communicated upfront**. This will demonstrate to the sector that the Department will listen and respond to what is working and what is not.
 - Overall, the communications strategy should include **standard messaging and communication materials for all levels**, including services, staff, consumers and carers, with content tailored to each audience. Assistance should be sought from the sector to tailor and distribute communications to stakeholders.

Implementation

Some key actions can occur in relation to implementing the National Program within the next two years, in line with the considerations outlined in the section above. These are:

4. **Developing training, tools and resources** to support the implementation of the National Program for home care package services.

5. **Establishing the support mechanisms** described in the considerations above, including a hotline, email helpdesk and a team with adequate capacity to respond to queries from participating services.
6. **Establishing an IT system** to enable data submission and reporting.
7. **Establishing the mechanisms and timelines for collecting feedback** and developing plans for the review and evaluation of the National Program.
8. In line with the considerations outlined above, **implementing the chosen tool(s) in a National Program which is voluntary** for Home Care Packages services. This will include the following steps:



Mid-term actions (3 to 5 years)

There are some additional actions that can be taken in the mid-term. This will include:

9. **Considering the National Program for home care package services in relation to future home care service delivery design** (see Consideration 4 in the section above).
10. Beginning to **establish benchmark scores for services**, so that these can be used for ongoing quality improvement. Depending on the tool(s) chosen for the National Program, international benchmarking may also be possible.
11. Starting to **identify trends** emerging from the quality indicator data, particularly those linked to demographic characteristics, to guide investment in services where there are particular needs identified.
12. **Evaluating the implementation of the National Program** to understand whether the tools are achieving the National Program's stated objectives, including consideration of whether there are additional indicators that should be collected, or indicators removed, noting that each additional indicator would require piloting.