Resource Utilisation and Classification Study (RUCS) Residential Aged Care Preliminary Findings

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Australian Health Services Research Institute (AHSRI)
National Aged Care Alliance,
Canberra, 9 August 2018
A reminder of the background
Background

- AHSRI completed a major report in early 2017 on alternate funding models for residential aged care.
- Department of Health and AHSRI undertook national consultations during 2017.
- RUCS is a major ($2m) research and design study on the recommended option.
  - But results will be useful more generally.
- Work in progress (results at end 2018), policy decisions need to be made after that.
### ACFI daily rates 2017-18
(plus basic fee and capital)

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities of daily living (ADL)</th>
<th>Behaviour (BEH)</th>
<th>Complex Health Care (CHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Low</td>
<td>$36.65</td>
<td>$8.37</td>
<td>$16.37</td>
</tr>
<tr>
<td>Medium</td>
<td>$79.80</td>
<td>$17.36</td>
<td>$46.62</td>
</tr>
<tr>
<td>High</td>
<td>$110.55</td>
<td>$36.19</td>
<td>$67.32</td>
</tr>
<tr>
<td>High, high, high</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plus basic fee @ 85% pension</td>
<td></td>
<td>per fortnight</td>
<td>$814.00</td>
</tr>
<tr>
<td>Max per day (plus supplements)</td>
<td></td>
<td></td>
<td>$272.20</td>
</tr>
<tr>
<td>Per year</td>
<td></td>
<td></td>
<td>$99,354.04</td>
</tr>
</tbody>
</table>
Major issues with ACFI

- Additive design – the sum of individual item scores ignores interactions
- Does not focus on what drives care costs
- Does not discriminate enough between residents
- Inequitable outcomes (geographic and socioeconomic)
- Creates perverse incentives for income maximisation resulting in funding uncertainty
- One third of residents are classified to just one payment class

**Conclusion:** ACFI is no longer fit for purpose
ACFI profile 2015-16

- Major Cities: High, high, high
- Inner Regional: One or two Highs
- Outer Regional: One or two Highs
- Remote: No Highs
- Very Remote: No Highs
RUCS represents a very clear policy alternative to the current ACFI model

For both government and the sector
Six core elements (1)

- Separate assessment for funding from assessment for care planning
- Assessment for care planning to be undertaken by the residential aged care facility
  - based on resident needs and underpinned by CDC principles
- Assessment for funding purposes to be undertaken by external assessors
  - capturing only the information necessary to assign a resident to a payment class
Six core elements (2)

- One-off adjustment payment for each new resident
  - Recognising additional, but time-limited, resource requirements when someone initially enters residential care

- Fixed per diem price for the costs of care that are shared equally by all residents
  - may vary by location (and size and specialisation?)

- Variable price per day for the costs of individualised care for each resident
  - based on each resident’s casemix funding class
  - price per class would be standardised across Australia
What else can this type of system deliver?

◆ Better data to understand resident profile and changing needs and costs

◆ If resource utilisation classes contain residents with similar needs, they can be used to measure quality and outcomes in meaningful ways
  – eg, hospital transfer rates adjusted for casemix
  – eg, rates of functional decline adjusted for class at entry
  – eg, rates of adverse events – falls, medication errors, injuries – adjusted for casemix
The Resource Utilisation and Classification Study (RUCS)

Design August 2017 – February 2018
Study went live March 2018
Results end 2018
Sector engagement and advice

- Sector Reference Group advising the Department of Health
- Overall design informed by four expert panels advising ASHRI:
  - Function, cognition and behaviour specialist advisory panel
  - Wound management specialist advisory panel
  - End of Life specialist advisory panel
  - Technical nursing specialist advisory panel
The RUCS outline

- Now 4 (originally 3) studies over 18 months
- Each study aligned with a particular set of project deliverables
- Studies One and Two have overlapping timeframes
- Study Three will be completed with information derived from the previous two studies
- Study Four with overlapping timeframe
Study One: Service utilisation and classification development

- Assess each resident in Study One using the variables agreed to by the expert panels
- Collect time in minutes per resident per day & calculate actual cost for each resident day
- Test (1) the hypothetical classification tree (2) ACFI and (3) the American RUG classification
- Develop a final classification tree based on the evidence collected in Study One
  - Use this in Study Three to develop a national resident classification profile
Study Two

Analysis to identify shared cost drivers

- Financial data to identify factors that drive shared costs based on facility characteristics by region, facility size and specialisation and to test seasonal effects

- Nationally representative sample of 110 care homes.
  - Oversampling remote and very remote services to ensure that their shared costs are adequately represented

- We currently (August 2018) have data in for 94 homes, 16 more to come
Study Three
The casemix profiling study

◆ To model the impact of introducing the classification in a blended payment model
◆ Classification variables from Study One in an additional 80 nationally representative facilities.
  – Purpose is to develop a national profile of residents allocated to each final casemix class and to model and test the impact of implementing the blended payment model nationally.
◆ Detailed planning in progress
Study Four
Supplementary reassessment study

◆ Reassessing half of the residents in Study One
◆ Purpose is to measure how residents have changed over time (about six months) plus critical events in that time eg,
  – Hospitalisations
  – Falls
  – Reablement / restorative care programs
◆ To inform reassessment protocols
Results of the expert panels
**What drives care costs?**

- Not medical diagnosis / diagnoses
  - So Diagnosis Related Group concepts are not relevant

- Costs are driven by care burden from:
  - End of life needs, frailty, functional decline, cognition, behaviour and technical nursing needs

- These may be due to one or more diagnoses
  - but the diagnosis itself is not a cost-driver
What drives costs?

- Care burden due to Function
  - FIM Motor, DEMMI and RUG-ADL
- Care burden due to Cognition and Communication problems
  - FIM Cognition
- Care burden due to Behaviour, Harm, Anxiety, Distress
  - NPI-NH
- Technical nursing requirements
Early results – RUCS Study

The first half of the sample in Study One
Residents information and consent: poster on display at every facility and processes for opt out

Information for Residents

The Resource Utilisation and Classification Study (RUCS)

Over the next few weeks, the University of Wollongong will be collecting information about residents for a research project funded by the Commonwealth Government. The research is to develop a new funding model for care homes.

Registered nurses will visit this care home to conduct assessments on residents at this care home. Participation is completely voluntary. You will be asked if you are happy to participate at the start of the assessment.

The assessment involves asking you some questions about the things you can do on your own, and the things you need help with. It won’t take too long. If at any time you want to stop, just tell the nurse.

Of more than 2,100 residents, about 40 opt outs (<2%) due to either resident or family choice or because resident died before being assessed.
RUCS time and cost data collection

◆ Staff used bar coders and standard activity categories to collect time data on every shift
◆ 30 days of time data for each resident
◆ Staff recognised as data collection proceeded
  – Mainly chocolates
◆ Each day of care for each resident is being costed on a full bottom up cost basis
  – No cost results just yet
### RUCS - TEST SCAN CARDS NURSING

**FIRST - Scan one Activity**

#### General Care Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined care in resident’s room</td>
<td>Personal care/hygiene</td>
</tr>
<tr>
<td>Assistance with mobility</td>
<td>Assistance with feeding</td>
</tr>
<tr>
<td>Pressure area/skin care (incl repositioning)</td>
<td>Assessment and/or care planning</td>
</tr>
<tr>
<td>Assistance with oral medication</td>
<td>Re-ablement / therapies</td>
</tr>
<tr>
<td>Social activities/talking with resident</td>
<td></td>
</tr>
</tbody>
</table>

#### Technical Nursing Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>Enteral feeding</td>
</tr>
<tr>
<td>Tracheostomy Care</td>
<td>Catheter Care</td>
</tr>
<tr>
<td>Stoma Care</td>
<td>Peritoneal dialysis</td>
</tr>
<tr>
<td>Daily Injections</td>
<td>Complex wound management</td>
</tr>
</tbody>
</table>
Resource utilisation:
first results

◆ 40% of time reported is individual time, 60% shared
  – This is evidence supporting a fixed and variable payment rate
◆ Range across homes is 30% - 65%
Resident assessments

First results
Training and support

- Assessors were all RNs with minimum 5 years experience
- Assessors received half day training
- Regular teleconferences with assessors to get feedback and ensure consistency of approach
How difficult was it to make the ratings?

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>289</td>
<td>28.6%</td>
</tr>
<tr>
<td>Moderately easy</td>
<td>465</td>
<td>46.0%</td>
</tr>
<tr>
<td>Not sure</td>
<td>111</td>
<td>11.0%</td>
</tr>
<tr>
<td>Moderately difficult</td>
<td>108</td>
<td>10.7%</td>
</tr>
<tr>
<td>Very difficult</td>
<td>5</td>
<td>0.5%</td>
</tr>
<tr>
<td>Not reported</td>
<td>33</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total</td>
<td>1011</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
How confident do you feel that the ratings that you have recorded are accurate?

<table>
<thead>
<tr>
<th>Confidence</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>393</td>
<td>38.9%</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>527</td>
<td>52.1%</td>
</tr>
<tr>
<td>Undecided</td>
<td>56</td>
<td>5.5%</td>
</tr>
<tr>
<td>Not very confident</td>
<td>5</td>
<td>0.5%</td>
</tr>
<tr>
<td>Not at all confident</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Not reported</td>
<td>29</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1011</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
External assessment - what we now know

- There is an appetite for change in the sector
- External assessment works
- Assessments can be conducted by RNs but not ENs
- ‘Can Do’ assessment supports consumer choice
- External assessment is acceptable to residents
- Experienced assessors can make confident clinical judgements and distinguish between ‘can do’ and ‘do do’
- Assessors need training and to operate as a networked workforce to ensure consistency
External assessment – issues not completely resolved in Study One

- **Assessor skill mix** – RNs, OTs and Physios
- **Assessment locations** - home and hospital
- **Sources of information** – cognition and behaviour
- **Admit for end of life care**
- **Mode** – assessment via video / telehealth?
- **Recruitment and structure of the assessment workforce**
- **Reassessment protocols**
Resident profiles
## Technical nursing requirements

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>% yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>961</td>
<td>41</td>
<td>4.1%</td>
</tr>
<tr>
<td>Enteral feed</td>
<td>997</td>
<td>5</td>
<td>0.5%</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>1002</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Catheter</td>
<td>981</td>
<td>21</td>
<td>2.1%</td>
</tr>
<tr>
<td>Stoma</td>
<td>991</td>
<td>11</td>
<td>1.1%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>1002</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Daily injections</td>
<td>944</td>
<td>58</td>
<td>5.8%</td>
</tr>
<tr>
<td>Complex wounds</td>
<td>932</td>
<td>70</td>
<td>7.0%</td>
</tr>
</tbody>
</table>
### The RUG-ADL

#### SECTION 3
Resource Utilisation group – Activities of Daily Living (RUG – ADL) (See score sheet for values)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 = completely independent
5 = cannot do

Note: eating scale is only 1 to 3
RUG-ADL Scale
<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Falls in last 12 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>479</td>
<td>48.2%</td>
</tr>
<tr>
<td>Yes, once</td>
<td>252</td>
<td>25.4%</td>
</tr>
<tr>
<td>Yes, more than once</td>
<td>262</td>
<td>26.4%</td>
</tr>
<tr>
<td><strong>3 persons for transfers?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>977</td>
<td>97.5%</td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Weight loss of more than 10% in last 12 months?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>920</td>
<td>92.5%</td>
</tr>
<tr>
<td>Yes</td>
<td>75</td>
<td>7.5%</td>
</tr>
</tbody>
</table>
Australian-modified Karnofsky Performance Status (AKPS). Tick one (1) of the following boxes.

- [ ] (100) Normal; no complaints; no evidence of disease
- [ ] (90) Able to carry on normal activity; minor sign of symptoms of disease
- [ ] (80) Normal activity with effort; some signs or symptoms of disease
- [ ] (70) Cares for self; unable to carry on normal activity or to do active work
- [ ] (60) Able to care for most needs; but requires occasional assistance
- [ ] (50) Considerable assistance and frequent medical care required
- [ ] (40) In bed more than 50% of the time
- [ ] (30) Almost completely bedfast
- [ ] (20) Totally bedfast and requiring extensive nursing care by professionals and/or family
- [ ] (10) Comatose or barely rousable
AKPS (palliative performance) profile

The lower the rating, the more dependent
AKPS (palliative performance) profile

The lower the rating, the more dependent

AKPS Rating

- Residential aged care
- Hospital palliative care
- Community palliative care
AKPS profile (cumulative)

- RAC
- Hospital PC
- Community PC
Rockwood Frailty Score

10 = very fit

90 = terminally ill
Rockwood Frailty Scale

- Terminally ill
- Very severely frail
- Severely frail
- Moderately frail
- Mildly frail
- Apparently vulnerable with comorbid disease
- Well with comorbid disease
- Well
- Very fit
DEMMDI

Four sections:
- Bed mobility
- Chair mobility
- Balance
- Walking
DEMMI total: % of residents

0 = Cannot mobilise at all
16 = Complete mobility and balance
The FIM

### FIM Motor score
- first 12 items
- ‘Stairs’ item removed from analysis
- Range 12 (total assistance on every item) to 84 (complete independence on every item)

### FIM Cognition score
- last 5 items
- Range 5 (total assistance on every item) to 35 (complete independence on every item)

<table>
<thead>
<tr>
<th>Function</th>
<th>Score: 1--7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care</td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
</tr>
<tr>
<td>Dressing---Upper-Body</td>
<td></td>
</tr>
<tr>
<td>Dressing---Lower-Body</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
</tr>
<tr>
<td>Sphincter-Control</td>
<td></td>
</tr>
<tr>
<td>Bladder-Management</td>
<td></td>
</tr>
<tr>
<td>Bowel-Management</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td></td>
</tr>
<tr>
<td>Bed, Chair, Wheelchair</td>
<td></td>
</tr>
<tr>
<td>Toilet</td>
<td></td>
</tr>
<tr>
<td>Tub or Shower</td>
<td></td>
</tr>
<tr>
<td>Locomotion</td>
<td></td>
</tr>
<tr>
<td>Walk---Wheelchair</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Comprehension</td>
<td></td>
</tr>
<tr>
<td>Expression</td>
<td></td>
</tr>
<tr>
<td>Social-Cognition</td>
<td></td>
</tr>
<tr>
<td>Social Interaction</td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td></td>
</tr>
</tbody>
</table>

### The FIM

- **Independent**
  - 7 Complete Independence (Timely, Safely)
  - 6 Modified Independence (Device)

- **Modified Dependence**
  - 5 Supervision (Subject = 100%+)
  - 4 Minimal Assist (Subject = 75%+)
  - 3 Moderate Assist (Subject = 50%+)

- **Complete Dependence**
  - 2 Maximal Assist (Subject = 25%+)
  - 1 Total Assist (Subject = less than 25%)
FIM Motor Score (stairs item excluded)
FIM Cognition Score
### SECTION 7

**Braden Scale – Predicting pressure sore risk**

(See score sheet for values)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description and score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Sensory Perception</td>
<td>Frequently limited</td>
</tr>
<tr>
<td></td>
<td>Often limited</td>
</tr>
<tr>
<td></td>
<td>Occasionally limited</td>
</tr>
<tr>
<td></td>
<td>Rarely limited</td>
</tr>
<tr>
<td>Is sensory perception rating based on</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td>Sensation</td>
</tr>
<tr>
<td>Moisture</td>
<td>Constantly moist</td>
</tr>
<tr>
<td></td>
<td>Often moist</td>
</tr>
<tr>
<td></td>
<td>Occasionally moist</td>
</tr>
<tr>
<td></td>
<td>Rarely moist</td>
</tr>
<tr>
<td>Activity</td>
<td>Bedfast</td>
</tr>
<tr>
<td></td>
<td>Chairfast</td>
</tr>
<tr>
<td></td>
<td>Walks occasionally</td>
</tr>
<tr>
<td></td>
<td>Walks frequently</td>
</tr>
<tr>
<td>Mobility</td>
<td>Completely immobile</td>
</tr>
<tr>
<td></td>
<td>Very limited</td>
</tr>
<tr>
<td></td>
<td>Slightly limited</td>
</tr>
<tr>
<td></td>
<td>No limitation</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Very poor</td>
</tr>
<tr>
<td></td>
<td>Probably inadequate</td>
</tr>
<tr>
<td></td>
<td>Adequate</td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
</tr>
<tr>
<td>Friction and Shear</td>
<td>Problem</td>
</tr>
<tr>
<td></td>
<td>Potential problem</td>
</tr>
<tr>
<td></td>
<td>No apparent problem</td>
</tr>
</tbody>
</table>
Braden Scale - Sensory Perception

- Completely limited: 5%
- Very limited: 15%
- Slightly limited: 40%
- No impairment: 35%
Braden Scale - Friction and Shear

- Problem: 20%
- Potential problem: 40%
- No apparent problem: 45%
Neuropsychiatric Inventory Questions - Nursing Home Version (NPI-NH)

A. Does the resident have beliefs that you know are not true? For example, saying that people are trying to harm him/her or steal from him/her. Has he/she said that family members or staff are not who they say they are or that his/her spouse is having an affair? Has the resident had any other unusual beliefs?

☐ No
☐ Yes → Complete NPI-NH Part A

B. Does the resident have hallucinations – meaning, does he/she see, hear, or experience things that are not present? (If “Yes,” ask for an example to determine if in fact it is a hallucination). Does the resident talk to people who are not there?

☐ No
☐ Yes → Complete NPI-NH Part B

C. Does the resident have periods when he/she refuses to let people help him/her? Is he/she hard to handle? Is he/she noisy or uncooperative? Does the resident attempt to hurt or hit others?

☐ No
☐ Yes → Complete NPI-NH Part C

An extract of the NPI screening tool

12 screening questions

A ‘Yes’ triggers further questions
Neuropsychiatric Inventory NPI - 12 items

- No problems: 25%
- 1-3 problems: 40%
- 4-6 problems: 20%
- 7 or more problems: 5%
Australian National Aged Care Classification (AN-ACC)

Draft has 15 classes
AN-ACC Version 1 will be a refinement of this
Work in progress
Statistics performance at the top level

- Statistics of interest are RIV, RID, CV
  - RIV and RID – bigger is better
  - CV – smaller is better
- Using staff time in minutes as a proxy for cost:
  - ACFI – 64 groups – RIV ~0.2
  - DEMMI – 3 groups – RIV ~0.4
Statistical importance of variables at the top level (in order)

1. Function (FIM Motor)
2. Function (RUG-ADL)
3. Mobility (DEMMI)
4. Wound risk (Braden)
5. Frailty (Rockwood)
6. Palliative function (AKPS)
7. Cognition (FIM Cognition)
8. Weight loss
9. Age
Hypothetical model – top level

Palliative care at admission?

- **No**
  - Mobility N=997
    - Independent N=217
    - Mobile with assistance N=550

- **Yes**
  - Class 1
    - Non-weight bearing N=189
Hypothetical model – independent branch

Independent N=217

High Function
- Without CF: Class 2
- With CF: Class 3

Medium Function
- Without CF: Class 4
- With CF: Class 5

Low Function
- Without CF: Class 6
- With CF: Class 7

CF = Compounding Factors
Compounding factors

- Variables that explain differences in resource consumption that will be incorporated to create the final branches of the tree
  - Being determined empirically using cost data collected in Study One
  - Will probably vary from one branch to another
  - Testing cognition, behaviour, technical nursing requirements etc both as single items and in combination
  - Being careful to ensure that they do not create perverse incentives
    - Behaviour, pressure ulcers etc
Independent branch - statistical importance of variables (in order)

1. RUG-ADL
2. FIM Cognition
3. Rockwood
4. FIM Motor
5. AKPS
6. Falls in last 12 months
7. Technical nursing (count)
8. DEMMI total
9. Braden total
10. NPI count
11. Age
12. Weight loss in last 12 months
Hypothetical model – mobile with assistance branch

Mobile with assistance
N=550

High Function
- Without CF
  - Class 8
- With CF
  - Class 9

Medium Function
- Without CF
  - Class 10
- With CF
  - Class 11

Low Function
- Without CF
  - Class 12
- With CF
  - Class 13

CF = Compounding Factors
Mobile with assistance - statistical importance of variables (in order)

1. Carer burden due to cognitive function
2. NPI count
3. FIM self care subtotal
4. RUG-ADL total
5. FIM sphincter (continence) subtotal
Hypothetical model – non-weight bearing branch

Non-weight bearing
N=189

Without CF
Class 14

With CF
Class 15

CF = Compounding Factors
Non weight bearing - statistical importance of variables (in order)

1. RUG-ADL total
2. Braden total
3. FIM mobility
4. FIM self care
5. Rockwood
6. DEMMI total
7. FIM sphincter
8. AKPS
9. FIM cognition
10. Falls in last year
Study Two

Analysis to identify shared cost drivers

- Financial data to identify factors that drive shared costs based on facility characteristics by region, facility size and specialisation and to test seasonal effects

- Nationally representative sample of 110 care homes.
  - Oversampling remote and very remote services to ensure that their shared costs are adequately represented

- We currently (August 2018) have 110 in, 86 data complete
Study Three

The casemix profiling study

- To model the impact of introducing the classification in a blended payment model
- Classification variables from Study One in an additional 80 nationally representative facilities.
  - Purpose is to develop a national profile of residents allocated to each final casemix class and to model and test the impact of implementing the blended payment model nationally.
- Detailed planning in progress
Study Four

Supplementary reassessment study

- Reassessing about 1,000 (half) of the residents assessed in Study One
- Purpose is to measure how residents have changed over time (about six months) plus critical events eg,
  - Hospitalisations
  - Falls
  - Reablement / restorative care programs
- To inform reassessment protocols
- Plus testing a possible substitute assessment tool for the NPI
Study Four

◆ Reassessment plus record significant events since last assessment

  – Hospital admission, 2 days or more with general anaesthetic
  – Hospital admission, 5 days or more without general anaesthetic
  – Significant fall, resulting in a change of care requirements for 7 days or more
  – Acute illness lasting 7 days or more
  – Palliative care plan developed
  – Structured reablement or restorative care program
  – Other: Please specify:
Next steps

- Work in progress
- Results at end 2018
- Policy decisions need to be made after that
Stakeholder engagement and buy-in

◆ There is an obvious appetite for change
◆ The sector response to RUCS and to the broader model has been overwhelmingly positive
  – But note genuine concerns about adequacy of overall funding levels
◆ Now need to capitalise on that and plan for change