



Aged Care Quality Indicator Program Consultation

LASA submission

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About LASA

Who We Are

LASA is the national association for all providers of age services across residential care, home care and retirement living/seniors housing.

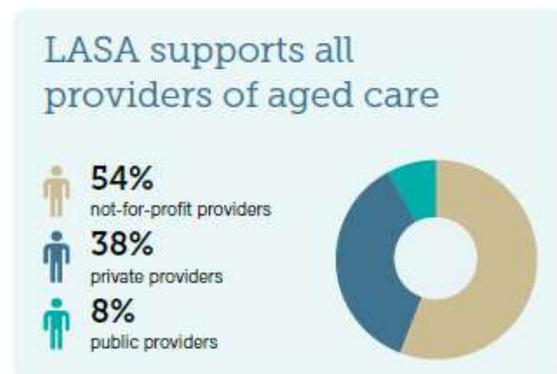
Our Purpose

Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion—always.

Our Members

We represent providers of age services of all types and sizes located across Australia's metropolitan, regional and remote areas. We are dedicated to meeting the needs of LASA Members by providing

- a strong and influential voice leading the agenda on issues of importance;
- access to valuable and value-adding information, advice, services and support; and
- value for money by delivering our services and support efficiently and effectively.



Our Affiliates

LASA Affiliates are proud supporters of the critical role played by the age services industry in caring for older Australians. Their value-adding products and services help age services providers apply innovative solutions that improve the provision of efficient and quality care.

Our Strategic Objectives

1. Be the credible and authoritative voice of aged care representing the views of our Members for the benefit of older Australians.
2. Build sector capability and sustainability by delivering valued services and support to Members
3. Lead continuous improvement by promoting and celebrating excellence and innovation in age services
4. Deliver value for money for Members and Affiliates.
5. Be a high performing, respected and sustainable association that cares for our purpose, our Members and our people.

Support for quality measurement

There is significant merit in a collaborative program to improve and better standardise data collection for a range of purposes, including care planning, internal quality measurement, public reporting of service provider quality and overall measurement of aged care program performance.

Significant sector concerns

However, providers are almost universally concerned that the QI program will be a box ticking exercise that will result in requirements to public report further indicators that are not fit for purpose, and require significant additional data collection that diverts already scarce workforce resources from care.

Part of the concern is that the focus is on expanding the range of indicators when it is not clear what efforts are being made to address fundamental problems with risk adjustment and collection bias in the indicators currently being collected.

Criteria for selection of further indicators

Rather than simply seeking opinions on what indicators could be collected, there needs to be agreed **criteria** for selecting which indicators SHOULD be collected. These criteria will differ depending on the purpose for which data might be used.

- **For public reporting at a service level**, it needs to be shown that indicators chosen:
 - reflect matters that providers are able to influence and improve upon,
 - provide a reasonable indication of overall service quality (at least collectively),
 - can be risk adjusted with a high degree of accuracy so that the effect of service quality is disentangled from differences in client circumstances, and
 - can be collected in a way that avoids opportunities to under/over-report and avoids perverse incentives that distort care delivery
 - can be collected without significant diversion of resources from care
- **For internal reporting**, the criteria are similar to public reporting, but the bar for risk adjustment and potential for perverse incentives is lower, it is also less necessary that indicators represent overall quality as the goal may instead be to target improvement in a specific domain. Efforts to measure quality within a domain need to be accompanied by plans for how to identify the causes of good and bad performance and support improvement. It is important to emphasise that literature on quality measurement in healthcare unequivocally shows that internal reporting and benchmarking against other services is the key driver of quality improvement.
- **For program level measurement**, indicators should focus on important social outcomes even if providers have limited capacity to influence these outcomes (as that inability would itself be relevant to program outcomes), there is less concern about risk adjustment and perverse incentives since individual performance is not being measured, and indicators should include not just data relating to the provision of aged care services, but broader social outcomes such as hospitalisations, access levels, and workforce participation.

- In selecting indicators there needs to be a balance between allowing for comparison between care settings and selecting indicators that are relevant to a client's level of need and the level of services they are receiving.

The fact that consultation questions do not address capacity of risk adjustment, collection bias, or perverse incentives is a critical flaw in the consultation process.

Need for a trial

Practically, LASA supports a TRIAL of an expanded quality indicator set. However, this should be a TRIAL where the goal is to test the suitability of possible indicators against the established criteria, not a pilot where the purpose is only to refine collection methodologies.

- There needs to be a trial in both residential care and in home care.

Domains for further investigation

We consider the following domains/indicators to be most suitable for the further investigation through a trial in both residential care and home care:

- **CEQOL** – QOL is the most fundamentally important outcome in both residential and home care. QOL measures have different dimensions that address many of the other proposed domains. CE is also a universally important consideration that is broadly within provider control. The critical issue for the trial will be to test capacity for risk adjustment, effective measurement people who are cognitively impaired, and identify an approach to collection that minimises cost and risk of collection bias. Many providers already collect CEQOL data as a part of care planning and there is arguably merit in having this occur more universally. A more thorough review of the literature is required to select a CEQOL measure. There is some support for the QOL-ACC tool developed by Flinders University but some other providers would prefer a tool that is already widely use such ASCOT or the EQ5D. In a home care setting, carer quality of life also should be considered.
- **Function and ADLs** – function and ADLs are the fundamental driver of need. Assistance with ADLs is core element of higher-level aged care services and prevention of decline and reablement are core goals of entry level services. Capacity to improve function or slow decline is fundamental outcome that is likely to have flow on effects for most of the other domains outlined. Function is also closely linked to funding levels. The critical issue that needs to be assessed for both residential care and home care is whether the effect of service quality can be disentangled from individual choices and circumstances. Cost effective and unbiased collection also needs to be considered, and in this context, consideration should be given to the data that will be collected through funding assessments. Point prevalence data should be a capable of being used to derive at least decline metrics. Consistency with the tools used for measuring function in funding assessments would be desirable.

Specifically in a **residential care setting** there is merit in further investigating:

- **Pain** – most residents experience some level of pain, and pain management is a critical service in residential care. Pain is also fundamental to quality of life. Pain management alone is not a good measure of overall service quality, but may be useful as part of suite of indicators. Critically, it is unclear whether the effect of services on pain levels can be

disentangled from resident level factors. Process indicators of good pain management practice may therefore be more appropriate. It is also unclear how pain data can be collected without significant collection bias – which may leave it suitable for internal but not external reporting. The risk of perverse incentives in pain management is that it drives overmedication and so pain management needs to be combined with medication management measures.

- **Behaviours** – there is some support for using prevalence of behaviours as a quality measure since it is generally agreed the effective care can significantly reduce behaviour prevalence. However, once again the challenge will be to disentangle service level effects from individual level factors. A major risk with a behaviour-based indicator for public reporting is that it would further discourage providers from taking residents with severe behaviours, though a measure based on change rather than point prevalence may address this. Generally, behaviour is likely to be much better suited as an internal rather than external indicator of quality.

In a home care setting we consider the following additional indicators worthy of further investigation:

- **Workforce** – there is value investigating what workforce information could usefully be provided in a home care context. This is partly because workforce indicators may be more easily and quickly published than most other indicators, and providers are concerned with the current focus on price comparisons in the absence of quality data. With workforce data set to be published for residential care, there is also some expectation that home care clients will have access to workforce information. There is some concern about measures of staff turnover, continuity of care and qualification-based measures as they may reflect the labour market rather than the specific provider. However, it is probably possible to adjust for a providers' performance relative to the regional labour market at a point in time. Self-collection is again a risk here, but workforce data is much easier to audit than point in time clinical assessments.
- **Care planning and service delivery** – simply reporting on the existence and review of care plans should not be a quality indicator. It should be a core part of the standards. However, there may be merit in considering Goal Attainment Score as a measure of the success of care planning and service delivery. Little risk adjustment is required here since goals are inherently tailored to individuals. However, this can only be an indicator for internal reporting purposes because otherwise goals may be altered to make them more attainable in order to perform better on quality scores.

Comments on other indicators:

- **Hospitalisations** – there is significant concern from providers about the use of hospitalisation as measure. While preventable hospitalisations are a smaller subset of hospitalisations there is significant concern that care staff could inappropriately delay hospitalisation decisions to avoid performing badly on this measure. Given the significant risks that could be created by a decision to delay or avoid hospitalisation this should not be used as a public indicator. It may be suitable as an internal indicator – but even here the risks would need to be carefully managed and blame based culture avoided. Another concern is that avoidable hospitalisations are often a consequence of GP care – this is particularly true in a home-based setting.

- **Weight loss, malnutrition, and dehydration** – weight loss is being measured in residential care. In a home care, context we are not convinced that there is sufficient control of these factors for most clients to make this even worthy of further investigation

Long-term goals

Most of the domains identified reflect issues that providers need to understand as part of care planning (even if it just to mark an area as not applicable). However, data is not generally collected in a standardised and structured/machine-readable format.

There is value in considering whether this data can be collected in a more consistent, rigorous, and structured/machine readable way. This is less about measuring quality and more about enabling more sophisticated care planning and delivery.

Given the scale of the current reform agenda, there is little scope to actively pursue this stream as a separate project in the short-term. However, the potential to collect data across different domains should be considered in the context of work on digital transformation, particularly work to increase the take-up and interoperability of digital health/care records. Work on new technology/equipment should also consider the potential for relevant data points to be collected in an automated way. This may in turn support future quality measurement efforts.

A long-term goal should be a system where different information is collected as part of care planning delivery based on a person's circumstances and the nature of the care being provided, with this data only occasionally supplemented with more objective sources of information that might include health and hospital data, assessment data, and external interviews such as the currently planned CER interviews.

A Strong voice and a helping hand

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