

1. Introduction

1.1 Background

Recent years have seen a number of changes in the Home and Community Care (HACC) program, including those flowing from both administrative developments and the substantial growth in the number and diversity of clients served by the program. The increasing emphasis on home-based rather than institutional care in the provision of services to both younger people with disabilities and frail or disabled older people led to increased interest in the nature, performance and efficiency of the Home and Community Care Program.

As a result of these developments, Commonwealth and State/Territory government officials responsible for the HACC program (HACC Officials) identified the need for a review of the program's data requirements. The Review of HACC Data Requirements was undertaken during 1996. This review was designed to ensure that HACC Officials had access to the data necessary to develop and manage HACC policy, undertake strategic planning for the program, and monitor the performance of the program against agreed output/outcome criteria.

The Review of HACC Data Requirements included the development of a draft HACC Minimum Data Set.¹ The draft Minimum Data Set was accepted by HACC Officials, in principle (subject to further development work), as the basis of a new national HACC data collection to replace the existing HACC Service Provision collection, the HACC User Characteristics Survey and the Community Options Project collections. The Australian Institute of Health and Welfare was contracted to undertake further development work on the draft HACC MDS, commencing in February 1997. The HACC Data Dictionary Version 1.0 is the product of that work.

1.2 Objectives of the HACC MDS

The objectives of the HACC Minimum Data Set are:

- To provide HACC program managers with a tool to access data required for policy development, strategic planning and performance monitoring against agreed output/outcome criteria;
- To assist HACC service providers to provide high quality services to their clients by facilitating improvements in the internal management of HACC funded service delivery; and
- To facilitate consistency and comparability between HACC data and other aged, community care and health data collections.

¹ See Brian Elton and Associates *National Review of HACC Data Requirements Final Report: Future Directions*. Commonwealth Department of Health and Family Services, 1996.

1.3 Version 1.0 of the HACC MDS

One of the primary goals set by HACC officials for the new data collection was that the data collected should be client-centred. To this end, the proposed HACC MDS collection is based on individual client unit record files submitted by HACC funded agencies, rather than aggregated data, as in previous national HACC data collections. This approach is designed to support the shift from process oriented information to output/output information about the HACC program.

Although the new HACC MDS collection will be a central component in the HACC program's accountability framework, it should be recognised that it is only one of several accountability measures designed to assist with planning, monitoring and evaluation of HACC service provision.

Defining and measuring outcomes in HACC and other related community care program areas is a complex and difficult task. A range of program outcome indicators have been identified for the HACC program. These include:

- Appropriateness of care
- Quality of care
- Effectiveness of care
- Use of services by special needs groups
- Use of services by those most in need
- Range and level of services
- Individual costs
- Project costs
- Efficient program management

At this stage of HACC MDS development, the outcome indicators that are directly measurable by the MDS collection are:

- Use of services by special needs groups; and
- Range and level of services.

During 1998, additional data elements related to a client's need for assistance or level of dependency will be developed for inclusion in the MDS. These data elements will assist with the measurement of the indicator related to the use of services by those most in need.

However, as it stands, the MDS also contributes, to varying degrees, to the measurement of the following outcome indicators:

- Appropriateness of care
- Effectiveness of care
- Individual costs
- Project costs
- Efficient program management

The HACC Data Dictionary Version 1.0 is the culmination of development work undertaken during 1997. This work was overseen and assisted by a National Steering Committee comprised of Commonwealth and State/Territory government officials responsible for the HACC program and service provider representatives. A list of Steering Committee members is provided at Appendix C.

Many HACC service providers have also provided valuable contributions to Version 1.0 through their participation in extensive field testing conducted during the development phase. A description of the development work and the associated field tests is included in the final report of the project, *HACC MDS Project: Final Report* (AIHW, 1998).

At all times during the development of Version 1.0 of the HACC Data Dictionary, the Steering Committee has been mindful of the need to minimise the data collection burden on HACC service providers. At the same time, the reliability and validity of data is maximised when collected at the level closest to the client. The data elements included in Version 1.0 are designed to be collected by HACC service providers as part of the client service delivery process.

Given the diversity in the types of assistance provided by HACC service providers, it is inevitable that, for some HACC agencies, compliance with the reporting requirements of the HACC MDS collection will involve recording some information that may not be considered essential to their delivery of services to clients. Considerable effort has been made to minimise such instances. Although some information about clients may not have immediate relevance to a client's receipt of assistance from the HACC agency, all data elements included in the HACC MDS are considered essential for the management of the HACC program, at all levels.

The collection, recording and reporting of the information contained in the HACC MDS will be greatly assisted by the use of computerised information systems. Although there are many HACC agencies that do not have computerised information systems, or that do not make extensive use of the computer technology they do have available, the HACC MDS anticipates the growing use of such technology across the HACC field.²

1.4 Scope and Limitations of Version 1.0

Version 1.0 of the HACC MDS is a client-centred data set. That is, it focuses on information about the clients of HACC funded agencies and the level and type of assistance they receive from the HACC program. The data elements defined in this dictionary encompass what is considered by HACC program managers to be the minimum management information requirements related to:

- The characteristics of clients (eg sex, age, Indigenous status);
- The circumstances of clients (eg where clients live, whether they have a carer) and
- The assistance received by clients from the HACC program (eg source of referral, amounts and types of assistance received)

The scope of Version 1.0 of the HACC MDS is, however, limited in the following ways:

- There are no data elements specifically related to the client's need for assistance or level of dependency. The absence of these data elements in Version 1.0 does not reflect the level of importance with which they are viewed. The development of these data

² Information on computer use by HACC service providers may be found in Brian Elton and Associates (op cit) and Don Hindle *Classifying the Care Needs and Services Received by HACC Clients*. Report to the Commonwealth Department of Health and Family Services, 1997; both reports reviewed the use of technology by HACC service providers. A further HACC Officials funded consultancy report, the HACC Technology Project, is due for completion later in 1998.

elements was deliberately delayed pending the outcomes of other closely related developmental activities in the HACC program. These included work on new assessment processes and structures in the HACC program and the possible introduction of a community care classification scheme in HACC³; both highly likely to impact on the information required to be reported in the HACC MDS collection. The development of data elements related to a client's need for assistance or level of dependency, building on the outcomes of these related projects, has been identified as a priority area of work for the development of Version 2.0 of the HACC MDS.⁴

- For carers who are HACC clients, the same data/collection reporting requirements are generally employed as for other HACC clients.⁵ However, only limited information is collected about carers of HACC clients who are not themselves clients of the HACC agency; these items include carer availability, residency status and relationship to care recipient. While the inclusion of this information represents a significant improvement on current HACC data, future developments of the HACC MDS should consider the possibilities for incorporating more extensive carer information, including data about carer's needs and the assistance provided by carers to their care recipients. Future developments should also consider the implementation of a statistical linkage key for carers, which could be used to establish a more accurate count of carers assisted both directly and indirectly through HACC. Such a linkage key could also be used to link records across care dyads, thereby facilitating a more complete picture of the assistance received by carers and their care recipients from the HACC program.
- Information about the assistance received by HACC clients is limited to the extent that HACC agencies are asked to record the *primary* type of assistance received by a client on any single service delivery event. Inevitably, some level of descriptive detail is lost when an agency has to make a decision about what to record as the primary type of assistance. However, given the complexity and variability of service delivery to clients, both within and between agencies, some way of summarising descriptive information in a consistent and comparable way is needed. The requirement to report on the primary type of assistance seeks to achieve a balance between the need to accurately record the type of assistance a person receives and the amount of time and resources required to record this information.
- Information about the setting of service delivery to clients in Version 1.0 is limited to nursing care, allied health care and meals assistance. At this stage, information about the service delivery setting for all other types of assistance is not required by HACC program managers.
- There are no data elements that describe the organisations that the HACC program funds. That is, data elements that describe the staffing, use of volunteers, legal status, organisational structure, hours of opening etc are not included in Version 1.0. The inclusion of further information about HACC funded organisations will be considered in future MDS development.

³ See Hindle (op cit) and Lincoln Gerontology Centre *National Framework for Comprehensive Assessment in the HACC Program*, La Trobe University, 1998.

⁴ HACC Officials agreed at their November 1997 meeting that work on developing such dependency items should be taken forward.

⁵ There are some items on which data are neither appropriate nor collected, such as carer availability and accommodation setting at cessation of services.

- The concept of *client* in Version 1.0 is limited to *individual persons* who receive HACC funded assistance. Other types of ‘clients’ which exist within the HACC field – such as organisational or group clients - are not within the scope of Version 1.0 of the HACC MDS. For example, assistance provided by one agency to another agency (ie *organisational clients*) with training or service development is not included. Similarly, assistance provided by HACC agencies to groups of people (ie *group clients*) such as carer support groups, group exercise activities or group information sessions is not generally included⁶ Further development work on the HACC MDS will consider expanding the definition of *client* to facilitate the inclusion of information about other types of HACC clients.
- Some assistance provided to individual clients is also excluded where the requirement to record and report on these clients in the HACC MDS collection would be inappropriate. In particular, assistance provided to *anonymous clients* (such as those that access ad hoc assistance from a telephone based information, advice and referral agency) is not included as it would be intrusive and inappropriate to expect such clients to provide the range of personal information contained within the MDS. This exception does not apply to agencies (such as those providing meals, transport, or home modification and maintenance) which provide assistance to known individual clients but which may have only recorded minimal client details to date.

Finally, in assessing the scope and limitations of the HACC Data Dictionary and the HACC MDS, it should be remembered that the HACC MDS is designed, for the most part, to *reflect* rather than drive agency practice. While promoting consistent standards for the collection and reporting of data across the HACC field, neither the Data Dictionary nor the HACC MDS collection is in a position to resolve policy or program level issues and tensions. As a result the data generated by the HACC MDS collection may, in certain respects, embody these tensions and contradictions rather than ameliorate them.

Perhaps the distinction between reflecting and driving practice across the HACC field is most clearly accentuated by the concept of a *HACC client* as embodied in this Data Dictionary. Indeed, the definition of a HACC client for the purposes of the HACC MDS is any person who receives HACC funded assistance from an agency. That is, the HACC MDS collection will account for HACC funds as they *have* been spent, rather than dictate how HACC funds *should* be spent. While the Data Dictionary reiterates in numerous places that the HACC target population comprises frail older persons, younger persons with a disability, and carers, it has no capacity to act as a boundary keeper against cost shifting or the misappropriation of HACC funding to other client groups. Such issues can only be resolved at the higher level of Home and Community Care Program management and policy.

⁶ One exception to this is the inclusion of Centre Based Day Care which is essentially a group activity but which the Steering Committee has decided should be included within Version 1.0 of the HACC MDS.