Australian Government

Department of Health and Ageing

The Dementia and Veterans' Supplements in Aged Care.

Consultation Paper

April 2013

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1. Introduction.

This Consultation Paper describes the proposed guidelines for the new dementia and veterans' supplements in Home Care Packages, Residential Aged Care and other programs which will apply from 1 July 2013.

Comments and feedback from stakeholders on the consultation draft will inform the final guidelines for these supplements and relevant subordinate legislation.

To provide advice in developing these guidelines, the Department established the Dementia and Veterans' Supplements Working Group, whose members are clinicians, service providers and consumer advocates. A list of members is at **Appendix A.** Clinical advice was also sought from three experts in psychogeriatric care and old age mental health.

2. Background.

Under the *Living Longer Living Better (LLLB)* Aged Care reforms announced in April 2012, new dementia and veterans' supplements will be implemented in Home Care Packages and Residential Aged Care (Residential Care) from 1 July 2013. The purpose of these supplements is to provide additional financial assistance to Approved Providers in recognition of the additional costs associated with caring for people with dementia and mental health conditions[1]. Approved Providers will be able to claim the supplements on top of the basic subsidies for care recipients who meet the relevant eligibility criteria.

Additional financial assistance for dementia and veterans' care will also be provided from 1 July 2013 in Transition Care, Multi-Purpose Services and Innovative Care Programs as well as the Aboriginal and Torres Strait Islander Flexible Aged Care Program.

This paper describes the proposed guidelines for both the dementia and veterans' supplements in both mainstream and non-mainstream aged care settings, including the eligibility criteria Approved Providers will need to meet to claim them.

3. The Dementia and Veterans' Supplements in Home Care Packages.

In Home Care Packages, for the first time specific funding will be provided for dementia care for all levels of Home Care, as well as for veterans with a mental health condition associated with their service. From 1 July 2013, Home Care Package recipients may attract either the dementia or veterans' supplement. The supplements will be paid at 10 per cent of the basic subsidy payable for each level of Home Care Package. The indicative level of the supplements is outlined in Table 1 below.

[1] To receive Australian Government subsidies for providing aged care, an aged care service must be operated by an organisation that has been approved by the Australian Government.

Table 1: Indicative Level of Supplements in Home Care Packages from 1 July 2013 ($ per annum)

Home Care Package	Level 1	Level 2	Level 3	Level 4
Home Care Package Basic Subsidy	7,500	13,600	30,000	45,500
Dementia Supplement (10%)	750	1,360	3,000	4,550
Veterans' Supplement (10%)	750	1,360	3,000	4,550

The value of the supplements will be indexed on 1 July each year in line with the usual arrangements for aged care.

Funding for each level of Home Care will be determined by the Minister for Mental Health and Ageing in the lead up to implementation on 1 July 2013.

3.1 The Dementia Supplement in Home Care.

Additional funding for dementia care is only provided in one level of Community Care at present, through the Extended Aged Care at Home Dementia (EACHD) packages. This differs from residential care, where funding for dementia care is paid at several levels using the Aged Care Funding Instrument (ACFI). Under the aged care reforms, every level of the Home Care Packages will be able to attract the new supplements after 1 July 2013.

Care recipients who are assessed as having cognitive impairment may attract the dementia supplement in Home Care at the rate of 10 per cent of the level of the Home Care Package they are receiving. Approved Providers will be required to apply for the dementia supplement in Home Care in respect of an eligible care recipient using an application form which will be developed and released by the Department of Human Services before the implementation date of 1 July 2013.

The Approved Provider has responsibility for ensuring an assessment of cognitive impairment is undertaken and documented prior to claiming the dementia supplement. The assessment must be undertaken using one of the prescribed tools described in Box 1 below. To ensure a comprehensive and integrated care plan is implemented, Approved Providers should also make every effort to encourage care recipients to seek a medical diagnosis if one does not already exist. Information about efforts to get a diagnosis should be recorded.

The assessment must be undertaken by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner. Providers may also draw upon an existing Aged Care Assessment Team (ACAT) assessment where it meets the necessary requirements described above. This will ensure care recipients are not required to have unnecessary additional assessments.

In remote Aboriginal communities, where the Kimberley Indigenous Cognitive Assessment (KICA-COG) is used, the assessment may be carried out by any health practitioner trained in its use.

3.1.1 Transition arrangements for Extended Aged Care at Home Dementia (EACHD).
Care recipients already in receipt of an EACHD Package on 30 June 2013 will automatically transfer to the new Level 4 Home Care Package and attract the dementia supplement from 1 July 2013.

Care recipients assessed by an ACAT and approved as eligible for an EACHD package but who have not started to receive an EACHD Package by 1 July 2013, will be eligible for the dementia supplement at the level of the Home Care Package they subsequently receive.

BOX 1: Assessment tools for the dementia supplement in Home Care Packages[2].

General population:
The *Psychogeriatric Assessment Scale - Cognitive Impairment Scale (PAS-CIS)* *with a minimum score of 10*[3].
The PAS- CIS is a cognitive screening tool, which assesses the level of cognitive impairment.
Interview: 10-20 minutes.

Australians from culturally and linguistically diverse backgrounds:
The *Rowland Universal Dementia Assessment Scale (RUDAS)* with a medium level score of 22 or less.
A short cognitive screening tool, for assessment of dementia, the RUDAS is designed to enable the easy translation of the items into other languages and to minimise cultural bias. Use of an interpreter is important.
Interview: 10 minutes.

The *Kimberley Indigenous Cognitive Assessment (KICA-Cog)* with a score of 34 or more out of 39[4].
Purpose: The only validated dementia assessment tool for older Indigenous Australians in remote communities for those aged 45 and older, when other instruments are not appropriate.
Interview: 10 minutes.

3.2 The Veterans' Supplement in Home Care.

Veterans, who have a mental health condition accepted by the Department of Veterans' Affairs (DVA) as associated with their service, will automatically attract the Veterans' Supplement worth 10 per cent of the basic subsidy amount of their Home Care Package. DVA and the Department of Human Services (DHS), which is responsible for payment of the supplements, will match information on eligible veterans. This will allow automatic payment of the supplement to Approved Providers.

[2] The most recent version of these tools should be used. They can be accessed on; http://www.Dementia-assessment.com.au/cognitive/index.html
[3] This assessment tool is also used in the Residential Care Aged Care Funding Instrument (ACFI) Behaviour Domain, Question 6.
[4] A new version of the KICA is currently under development.

While veterans may be eligible for both the dementia and veterans' supplement, the Approved Provider may claim only one supplement per care recipient.

4. The Dementia and Veterans' Supplements in Non-Mainstream Programs.

Dementia and veterans' supplementation will also be available for community-based services delivered under the Multi-Purpose Service Program, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Innovative Care Program. In addition, supplementation will also be provided for the Transition Care Program. Proposed arrangements for these programs are detailed below.

4.1 Multi-Purpose Services Program.

The Multi-Purpose Service (MPS) Program is a joint initiative of the Australian Government and state and territory governments, which aims to deliver flexible and integrated health and aged care services for small rural and remote communities.

A MPS is generally established when the local population is not large enough to support separate services – such as a hospital, a residential aged care service and home and community care services – and where there is poor access to essential health and aged care services.

Under the MPS Program, Australian Government funding for aged care is combined with state and territory Government health services funding. The MPS pools this combined funding and then applies it flexibly across health and aged care services to offer more service choices specific to the needs of the local community and to be innovative in service delivery. As part of the suite of services they deliver, Multi-Purpose Services provide home-based care recipients with community care services that are equivalent to a Home Care Package Level 2.

Consistent with the MPS Program's flexible funding model, it is proposed that funding under the Dementia and Veterans' Supplements will be 'built into' the program's base funding levels – rather than applied on an individual care recipient basis. That is, available supplement funding will be distributed evenly across all MPS community care places by increasing the basic daily subsidy rate for each community care place.

The value of the additional funding will be based on a calculation of the number of MPS care recipients receiving the equivalent of community care services who are estimated to be eligible for the supplements, multiplied by the value of the supplement that a Level 2 Home Care Package attracts. This additional funding will be distributed evenly across all MPS community care places.

4.2 National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

The Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. Services funded under the Program are mainly located in rural and remote areas and can provide a mix of residential and community services in accordance with community needs. Funding under the program is provided for both residential aged care places and community care places.

Consistent with supplementation arrangements under the Multi-Purpose Service Program, it is proposed that supplement funding will be built into the program's base funding levels – rather than applied on an individual care recipient basis. That is, supplement funding will be distributed evenly across each of the community care places funded under the program, by increasing the funding provided for each place.

The value of the additional funding will be based on a calculation of the number of community care places funded under the program estimated to be catering to needs of people eligible for the supplement, multiplied by the value of the supplement that a Level 2 Home Care Package attracts. This additional funding will then be distributed evenly across all community care places funded under the program.

4.3 Transition Care Program.

The Transition Care Program is a joint Commonwealth/State funded, goal-oriented and time limited program that provides older people with a package of services designed to enable them to return home after a hospital stay rather than enter residential care prematurely. It is provided in a community or residential setting for up to 12 weeks[5]. States and Territories are the Approved Providers and are able to determine service delivery models based on local needs.

Transition Care recipients generally receive a short, intensive period of care under the program. These short episodes of care mean that, in a practical sense, there will often not be enough time to assess each individual care recipient's eligibility for the supplements.

In view of this, supplement funding will be 'built into' the program's base funding levels. That is, supplement funding will be distributed evenly across all Transition Care places by increasing the basic daily subsidy rate for each place. This will provide additional funding for Transition Care providers to cater for the needs of eligible care recipients, without imposing new assessment requirements that would not be appropriate given the program's short term nature.

[5] With a possibility of a six week extension where necessary.

The value of the additional funding for the program will be based on a calculation of the number of people in Transition Care estimated to be eligible for the supplements, multiplied by the value of the supplement that a Level 4 Home Care Package attracts. This additional funding will then be distributed evenly across all Transition Care places.

4.4 Innovative Care Program.

The Aged Care Innovative Pool Program – Disability Aged Care Interface (Ageing in Place), was established in 2002 so care recipients could continue to live in their homes (where these are State/Territory funded disability supported accommodation) as they age, as long as it is the most appropriate form of care.

There are nine projects across NSW, Victoria, SA, Tasmania and WA and they are operated by the community sector. They will remain operational until all care recipients, currently around 100 residents, leave care.

It is proposed that supplements will be paid for each eligible resident who is assessed as having cognitive impairment associated with dementia or is a veteran with a DVA accepted mental health condition. Eligibility will be assessed using the same criteria as Home Care. The value of the supplement will be set at the value of the supplement that a Level 2 or Level 4 Home Care Package attracts, depending on whether the care recipient is receiving basic care or high care services.

5. The Dementia and Veterans' Supplements in Residential Aged Care.

In residential aged care, dementia care is already funded through the Aged Care Funding Instrument (ACFI). The ACFI is used to assess the level of a resident's care needs to determine the amount of basic subsidy provided by government[6]. It has 12 questions in three domains, including the Behaviour Domain in which residents are assessed on their level of behaviours and psychological symptoms, in particular cognitive impairment, frequency of wandering, challenging physical and verbal behaviours and depression. Based on the ACFI assessment they are given a score of Nil, Low, Medium or High and funded accordingly.

However, the Aged Care Funding Instrument (ACFI) does not fully capture people with severe and complex behaviours and psychological symptoms associated with dementia and mental illness. Residents with these conditions are a small and difficult to define group and because of their challenging behaviours are less likely to be accepted into residential care facilities. Because of their high care needs, there are demands on resources and difficulties in co-locating these residents with others. They are also more likely to move around the health system in acute and subacute care and mental health facilities because of the complexity of their care needs and the difficulties in placing them in appropriate care.

[6] http://www.health.gov.au/acfi

These residents may also be relatively young aged care residents due to conditions such as younger onset dementia or chronic and severe mental health conditions and are thus likely to be more mobile and physically able than other residents.

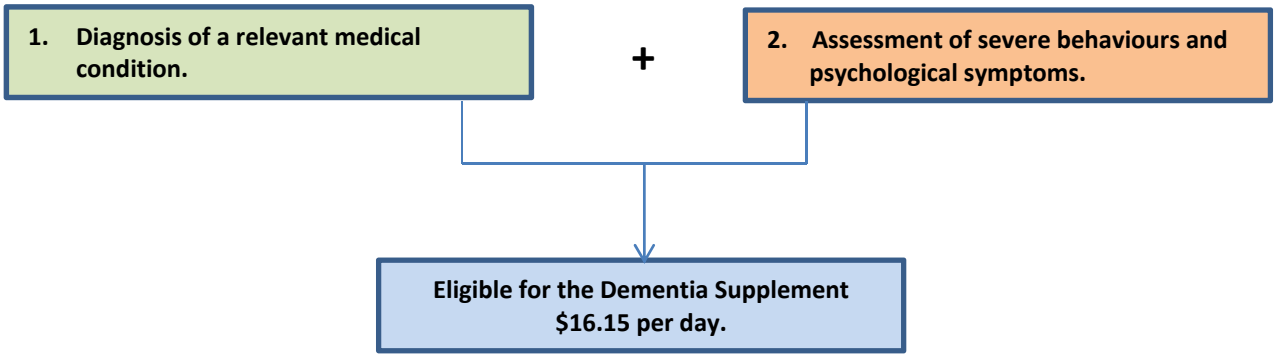
A major factor contributing to care costs for this group is that they often require additional and more skilled staff time because of unpredictable behaviours that are a danger to themselves, other residents, staff and/or property.

5.1 The Dementia Supplement in Residential Care.

The eligibility requirements for the dementia supplement in residential aged care will focus on identifying those residents with severe behavioural and psychological symptoms associated with dementia or mental illness.

Approved Providers will be required to apply for the dementia supplement in residential care in respect of an eligible resident using an application form which will be developed and released by the Department of Human Services before the implementation date of 1 July 2013.

There are two eligibility requirements to claim the dementia supplement in residential care: a medical diagnosis and an assessment of the severity of behaviours and psychological symptoms. Residents must satisfy both assessment criteria to attract the dementia supplement.



5.1.1 A Relevant Medical Diagnosis.

To attract the dementia supplement, a resident must have a medical diagnosis. The diagnosis must be one of the listed Aged Care Assessment Program (ACAP) mental and behavioural conditions[7]. These are listed in **Appendix B** and include conditions other than dementia**.**

A medical diagnosis will help ensure the resident has a comprehensive care plan that includes all the diagnostic and assessment information from their health practitioners.

[7] http://www.aihw.gov.au/publication-detail/?id=6442467400 Appendix H

5.1.2 Assessment of Severe Behaviours and Psychological Symptoms

The ACFI measures the frequency of behavioural and psychological symptoms that intrude upon others, as well as measuring cognitive decline through the Psychogeriatric Assessment Scale and the severity of depression with the modified Cornell Scale. The dementia supplement targets those residents who are experiencing more severe symptoms associated with dementia or mental illness.

A common assessment tool will be used in residential aged care to allow for a consistent national approach and comparable data collection for review and evaluation purposes. The use of a validated assessment tool will also assist Approved Providers better identify a resident's care needs and develop a more comprehensive care plan.

In residential aged care, when severe behaviours and psychological symptoms are associated with dementia or mental illness, the *Neuropsychiatric Inventory – Nursing Homes (NPI-NH)* assessment tool must be used to determine eligibility for the dementia supplement. (See Box 2 below).

The assessment must be carried out by a registered nurse, clinical nurse consultant, nurse practitioner, medical practitioner or specialist trained in the application of this tool and where it is within their scope of practice.

BOX 2: Assessment tool for the Dementia Supplement in Residential Care[8] 

***The Neuropsychiatric Inventory -Nursing Homes (NPI-NH)* Score**

The NPI-NH assesses psychopathology in the person with dementia and the level of caregiver distress engendered by a range of neuropsychiatric disorders in the person with Dementia.

It must be undertaken by a registered nurse, clinical nurse consultant, nurse practitioner, medical practitioner or specialist who is trained in its use.

Interview: 10-20 minutes to complete.

More detailed information about the NPI-NH is in **Appendix C.**

5.1.3 Meeting Resident Care Needs.

The Dementia and Veterans' Supplements Working Group was concerned that despite additional funding from the supplement and a comprehensive resident assessment, not all Approved Providers will have the capacity to meet the care needs of residents who exhibit severe behavioural and psychological symptoms. The required capacity would include relevant clinical expertise, a working relationship with a resident's referring medical practitioner/s, an appropriate environment and the broader resident mix. Some members of the Working Group thought that the dementia supplement should only be payable to Approved Providers which demonstrate this capacity.

[8] http://www.dementia-assessment.com.au/behavioural/index.html

However, under the current legislation, Approved Providers of residential care have a responsibility to provide individual attention and ongoing support to residents including those with severe behavioural and psychological symptoms from dementia and other conditions. The needs of residents with challenging behaviours must be managed effectively. It is an overall requirement that each resident receives quality care appropriate to his or her needs.

In Australia, residential aged care facilities are required to be accredited to receive Australian Government subsidies. The Aged Care Standards and Accreditation Agency reviews procedures, observes practices and looks at resident records and other documents such as care plans to examine evidence the facility is performing against the Accreditation Standards. These include Standards requiring appropriate clinical care and specialised nursing care by appropriately qualified nursing staff[9].

Given the views expressed by the Working Group, the Department of Health and Ageing is seeking feedback on whether it is necessary to expand the eligibility requirements for the Dementia Supplement to ensure that the additional funding is only provided to Approved Providers who can demonstrate they have the capacity to deliver appropriate care for residents with severe behavioural and psychological symptoms.

5.1.4 Annual Review of eligibility for the Dementia Supplement.

The dementia supplement provides additional funding for the care of individuals with severe behaviours and psychological symptoms. For people with certain dementia diagnoses, there may be a level of cognitive decline where the severity of these symptoms reduces over time, for example when residents become significantly less mobile. With other conditions, such as psychosis, increasing frailty may lead to a reduction in the severity and frequency of the behaviours that initially qualified the individual for the supplement.

Approved Providers will be required to review a resident's eligibility for the dementia supplement every 12 months to ensure it is not paid for residents who no longer have severe symptoms because of the progression of their disease.

However it is important to determine the underlying cause of any changes in a resident's behaviour. A review may also provide evidence that there is reduction in severity of symptoms because of the implementation of effective care plans rather than disease progression. In these cases, eligibility for the supplement will continue.

The criteria used to determine ongoing eligibility for the supplement will be developed in consultation with care providers and clinicians before the first 12 month review is required in 2014.

5.1.5 An ACFI Reappraisal as a result of the Supplement.

The ACFI, which is used to determine the level of government subsidy for residents, includes rules about the circumstances and times when the Approved Provider may reassess or "reappraise" the resident's care needs. This is because care needs and circumstances can change, for example from a stay in hospital because of an illness or a fall.

[9] http://www.accreditation.org.au for further details about the Aged Care Standards

In certain circumstances, a resident may also have increasingly severe behaviours and psychological symptoms that attract the dementia supplement, but may not yet be classified with a High score in the ACFI Behaviour Domain. If a resident's care needs have changed to such an extent they meet the eligibility criteria for the dementia supplement, their ACFI score may also have increased. Therefore, the Approved Provider may undertake a voluntary ACFI reappraisal when the resident becomes eligible for the dementia supplement.

Allowing a voluntary ACFI reappraisal on receipt of the supplement provides an opportunity for this inconsistency to be corrected. It should be noted that no changes to the ACFI classification requirements are proposed. Approved Providers will still be required to undertake the ACFI reappraisal in line with existing processes.

5.2 The Veterans' Supplement in Residential Care.

Any veteran in residential care with a mental health condition accepted by DVA as associated with their service will attract a veterans' supplement. Final arrangements for the veterans supplement are being settled by DVA.

As with Home Care, DVA and DHS will match data to identify eligible residents and the Supplements will be automatically paid with respect to the eligible veteran. This process will not reveal information about the veteran's specific mental health condition.

6. Evaluation of the Supplements.

The effectiveness of the supplements in meeting the care needs of eligible care recipients and the impact on Approved Providers will be evaluated after the first year of operation.

The evaluation will assess:

- The effectiveness and appropriateness of the assessment tools used to assess eligibility
- The effectiveness of the supplements in improving care outcomes in residential care, home care and other relevant aged care programs and
- How well the assessment tools are being applied, their ease of use and the appropriateness of the thresholds used to determine eligibility.

7. Appendices

Appendix A: Dementia and Veterans' Supplements Working Group.

MEMBERS		
1	Aged Care Provider	Ms Angela Raguz General Manager Residential Care Hammond Care
2	Clinical-Nursing	Mrs Wendy Venn Aged Care Nurse Practitioner ACT Health Directorate
3	Consumers	Mr Glenn Rees Chief Executive Officer Alzheimer's Australia
4	Department of Veterans' Affairs	Ms Judy Daniel First Assistant Secretary, Health and Community Services Division Department of Veterans' Affairs
5	Clinical-Geriatrician	Associate Professor Michael Woodward Head, Aged and Residential Care Services Austin Health Victoria
6	Veterans Representative	Ms Nikki Van Diemen Residential Manager, Morling Lodge Baptist Community Services Canberra
7	National Aged Care Alliance	Ms Wendy Bateman Manager, RSL Aged and Health Support Melbourne
8	National Aged Care Alliance	Ms Paula Trood General Manager Community Services Benetas Victoria
9	Department of Health and Ageing	Mr Keith Tracey-Patte (CHAIR) Assistant Secretary Policy and Evaluation Branch Ageing and Aged Care Division
10	Department of Health and Ageing	Dr Susan Hunt Senior Nurse Advisor Office for Aged Care Quality and Compliance Department of Health and Ageing

Appendix B: List of Mental and Behavioural Disorders[10].

Aged Care Assessment Program codes	
Dementia in Alzheimer's disease (500) • Dementia in Alzheimer's disease with early onset (<65 yrs) • Dementia in Alzheimer's disease with late onset (>65 yrs) • Dementia in Alzheimer's disease, atypical or mixed type • Dementia in Alzheimer's disease, unspecified **Vascular Dementia (510)** • Vascular Dementia of acute onset • Multi-infarct Dementia • Subcortical vascular Dementia • Mixed cortical & subcortical vascular Dementia • Other vascular Dementia • Vascular Dementia—unspecified **Dementia in other diseases classified elsewhere (520)** • Dementia in Pick's disease • Dementia in Creutzfeldt-Jakob disease • Dementia in Huntington's disease • Dementia in Parkinson's disease • Dementia in human immunodeficiency virus (HIV) disease • Dementia in other specified diseases classified elsewhere **Other Dementia (530)** • Alcoholic Dementia • Unspecified Dementia (includes presenile & senile Dementia) **Delirium (540)** • Delirium not superimposed on Dementia • Delirium superimposed on Dementia • Other delirium • Delirium–unspecified	**Psychoses & depression/mood affective disorders (550)** • Schizophrenia • Depression/Mood affective disorders • Other psychoses (includes paranoid states) **Neurotic, stress-related & somatoform disorders (560)** • Phobic & anxiety disorders (includes agoraphobia, panic disorder) • Nervous tension/stress • Obsessive-compulsive disorder • Other neurotic, stress-related & somatoform disorders **Intellectual & developmental disorders (570)** • Mental retardation/intellectual disability • Other developmental disorders (includes autism, Rett's syndrome, Asperger's syndrome, developmental learning disorders, specific developmental disorders of speech and language, specific developmental disorder of motor function (e.g. dyspraxia). **Other mental & behavioural disorders (580-599)** • Mental and behavioural disorders due to alcohol & other psychoactive substance use (includes alcoholism, Korsakov's psychosis (alcoholic) • Adult personality & behavioural disorders • Speech impediment (i.e. stuttering/ stammering) • Other mental & behavioural disorders n.o.s or n.e.c (includes harmful use of non-dependent substances e.g. laxatives analgesics, antidepressents, eating disorders e.g. anorexia nervosa, bulimia nervosa, mental disorders not otherwise specified)

[10] Code list is based on the ICD-10-AM classification.
http://www.aihw.gov.au/publication-detail/?id=6442467400 Appendix H

Appendix C: The Neuropsychiatric Inventory – Nursing Home.

The Dementia Outcomes Measurement Suite (DOMS) is a Federal Initiative which contains a suite of recommended assessment tools for use by health professionals in Australia[11]. To determine which tools would be included, the Department commissioned a major report by the University of Wollongong to evaluate the validity, reliability and usability of a number of assessment tools and to assist in the standardization of assessment and evaluation procedures[12]. The tools that were evaluated focused on those that could be used in routine care.

The Department has also sought the advice of three previous members of the Minister's Psychiatric Expert Reference Group as to the most appropriate assessment tool evaluated in the Report for assessing eligibility for the Dementia Supplement. They have recommended use of the Neuropsychiatric Inventory – Nursing Home (NPI-NH) which was developed in 1994 in the United States by Jeffrey Cummings[13].

Description[14].

The NPI-NH assesses psychopathology in the person with dementia and the level of caregiver distress engendered by a range of neuropsychiatric disorders. The NPI contains 12 domains. These comprise 10 sub-sections examining behavioural areas (delusions; hallucinations; agitation; depression; anxiety; euphoria; apathy; disinhibition; irritability; aberrant behaviours, night-time behaviours) and 2 types of neuro-vegetative change (appetite and eating disorders), each with 5-8 items. If neuropsychiatric abnormalities have been present over the past four weeks, the caregiver rates the frequency and severity of each abnormality.

The Neuropsychiatric Inventory-Nursing Home (NPI-NH) instrument is a modified version of the NPI and designed for care staff to measure psychiatric symptoms in persons with dementia living in residential care.

[11] http://www.dementia-assessment.com.au

[12] Sansoni J, Marosszeky N, Jeon Y-H, Chenoweth L, Hawthorne G, King M, Budge M, Zart S, Sansoni E, Senior K, Kenny P, Low L (2007) *Final Report: Dementia Outcomes Measurement Suite Project.* Centre for Health Service Development, University of Wollongong.

[13] The official web-site can be found at http://npitest.net/

[14] Sansoni, J et al, Pp 216 – 219.