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EVIDENCE SYNTHESIS

A REVIEW OF THE CONSUMER-DIRECTED CARE MODEL OF HOME CARE SERVICE DELIVERY AS APPLIED WITHIN THE AUSTRALIAN GOVERNMENT'S HOME CARE PACKAGES PROGRAM

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FOR MORE INFORMATION

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Key Messages

- Consumer Directed Care models give control to the client in deciding which services they require, when, and who they should be delivered by. It is designed to foster care recipient empowerment and autonomy across the life course.

- In 2010-11 the Australian government began implementing a consumer-directed care service

- Delivery model pilot within its home care program. By July 2015 all in-home support services under this program were being delivered on a consumer directed basis.

- Within Australia's aged care system, consumer-directed care has shown promising results in improving self-reports of quality of/ outlook on life, quality of social relationships, wellbeing, ability to meet goals, meaningful engagement in social/ community activities, physical health, independence, and reduced feelings of caregiver burden.

Terminology

This section will outline working definitions for terms referenced throughout the document.

- Consumer – represents the care recipient, their caregiver, or in some instances, both.

- Consumer directed care – consumer-directed care refers to Australia's unique model of home support and home care service delivery that gives clients (consumers) choice and control over the types of services they receive, how and when they are provided, and by whom.

- Formative evaluation – an evaluation conducted to identify any operational issues or possible areas for improvement that would strengthen the Home Care Packages program's effectiveness, and to ensure the successful and complete conversion of all Home Care Packages to CDC by 1 July 2015.

- High-level care facilities – provide care to those with more complex care needs and greater frailty who often require around the clock access to nursing services; formerly known in Australia as *nursing homes*.

- Home care packages program (Australia) – A range of in-home support services that assist older people with complex needs to remain living independently in their own homes. It uses a consumer-directed care approach to deliver a coordinated mix of services that can include help with household tasks, transportation, equipment/ devices (walkers, canes etc.), minor home modifications, personal and clinical care such as help with activities of daily living, nursing, allied health and physiotherapy services.

- Low-level care facilities – provide accommodation and personal care for those with fewer and less care complex needs; formerly known in Australia as *hostels*.

EVIDENCE SYNTHESIS

A Review of the Consumer-Directed Care Model of Home Care Service Delivery as Applied Within the Australian Government's Home Care Packages Program

Background:

In 2018, Statistics Canada estimated 25% of Canadians over the age of fifteen – approximately 7.8 million individuals – were providing some level of unpaid care to a family member or friend as a result of a long-term health condition, disability, or age-related challenges. Almost half of all Canadian caregivers are providing care to a parent or parent-in-law, and another 702,000 to a grandparent.[1] Despite providing an estimated 70% of all community-based care for older adults valued at upwards of $65 billion annually,[2] caregivers often report feeling unsupported by the programs and systems designed to care for older adults and support their efforts.

Over the last few years, there has been increased interest in shifting toward a patient or client-centric paradigm in the delivery of health care services. In the context of home care/support services, many Canadian jurisdictions have implemented self or family-managed care options for the delivery of services. As provinces and territories continue to explore opportunities to shift toward client-centered care delivery, evaluations from international practices such as the Australian Consumer Directed Care (CDC) model should be considered to support evidence-informed policy decision-making.

The following review provides an overview of Australia's CDC model and its components, as well as examines the publicly available evidence regarding its effectiveness in improving the delivery

of home care/ support services. In Part 1, the context and program timelines are provided, along with an overview of the six principles informing the new model. In Part 2, results from both the implementation evaluation and the formative evaluation are covered in detail to identify the successes and shortcomings of the new approach. Finally, in the last section, several concepts are introduced for consideration in the establishment or modification of existing self-managed home care/support programs in Canada. The Australian model was selected for this review after a consultation process with policy stakeholders identified it as an innovative self-managed care option having success in a country with a similar population demographics and government structures. While a comparative analysis of consumer directed care models was outside of the scope of this review, the author acknowledges that there are a number of other promising practices internationally that present relevant policy considerations for the Canadian context.

Methods

For the purpose of this document, a review of relevant government websites, grey literature, and peer reviewed research articles regarding the topic of consumer directed care in Australia was conducted. Academic databases consulted included: CINAHL, ProQuest, PubMed, EMBASE, and PsychInfo. Academic journal articles were selected if they provided evaluative data regarding the promising practices, or comparable practices that employed the same or similar implementation/ dissemination strategies.

Part 1. Innovation: Consumer Directed Care (Australia)

In 2012-13, amid growing pressure from older Australians and caregivers facing similar challenges to their Canadian counterparts, the Australian Government introduced a plan for several rounds of amendments to their national aged-care system. Among these changes was a massive reform to the way in which services were delivered within the home care program.

Previously, Australia's home care services were provided under two separate programs defined by level of care needed: low-level and high-level care.[3] Older Australians with more complex care needs who were eligible for admission to low-level residential care facilities but who wished to remain living at home were provided home-based services under the Community Aged Care Packages (CACP) program. This program did not allow for the provision of home-based nursing or allied health services and care was coordinated prescriptively by the package provider (i.e., the home care agency providing services).[3] Individuals with higher and more complex needs who were eligible for admission to high-level residential care facilities were provided services under the separate, Extended Aged Care at Home program (EACH).[3] The EACH stream also contained a subgroup of individuals living with dementia (EACHD).

In 2013, following a successful pilot phase, the Australian government rolled out the newly formed Home Care Packages program, which amalgamated the CACP and EACH programs into one streamlined program, now with four levels of care.[3] Following the introduction of the new Home Care Packages program, the federal government announced it would begin implementing a consumer-directed care service delivery model. Based on six guiding principles, CDC is a service delivery model that puts the client/caregiver in control of their home care/support services. Clients decide which services are most appropriate for their needs, when and how often they are delivered, as well as who they will be delivered by. Clients can also decide how involved they will be in the ongoing management of services and staff with many opting to use a portion of their home care/ support funds to pay for the management and ongoing coordination of their services.[4]

The foundation of this model's operation is based on six principles which aim to empower consumers and uphold their individual autonomy. The principles are as follows:

Consumer Choice & Control: The principle of consumer choice and control over their home care services is designed to support consumers in maintaining autonomy across the lifespan, even as they experience age-related challenges that may affect strength and mobility. Choice and control refer not only to which services are provided, when, and by whom, but also to the consumer's desired level of management responsibility – from involvement in all aspects of care coordination to a less active role in decision-making and management of their care.[5]

Rights: The principle of rights refers to a consumer's right to access services tailored to their unique set of circumstances in order to meet their needs and achieve their health and wellness goals.[5]

Respectful & Balanced Partnerships: The principle of respectful and balanced partnerships refers to the provider-client relationship and is based on both parties mutually exercising their rights and responsibilities within the care relationship. A critical element of creating successful respectful and balanced partnerships in this context is permitting the client to determine how involved they wish to be in their own service management and co-creating an appropriate package of services.[5]

Participation: The principle of participation refers specifically to addressing barriers that limit participation within community and civic activities, and the maintenance of social relationships more broadly as they are essential components of positive wellbeing.[5]

Wellness & Reablement: The principle of wellness and reablement suggests that consumers should have the maximum amount of independence as safely possible at all times. It takes into account that many home care/ support services are often set up in the wake of a crisis – e.g., following an illness, injury and/ or hospitalization – that drastically and rapidly alters their ability to meet their own needs. Under a reablement framework, it is important to assume that care recipients will be able to regain at least some of their previous function and independence with the adequate supports in place. This means that immediately following the crisis, needs are likely to be higher and more complex than they are as recovery goals are set and attained. In a CDC context this allows for more funds to be spent in the early days of service access, and removing services thereby reducing spending, as the consumer progresses in their recovery.[5]

Transparency: The principle of transparency refers primarily to transparency in the cost of services and access to budgeting information including the total amount of funds each consumer is eligible for, and information detailing how their funds are being spent.[5]

The decision to transition to a consumer directed service delivery model was made after the government's aged care reform process identified a need for more consumer control within in-home supportive service delivery in order to preserve the independence and autonomy of those wishing to age at home. By July 2015, every active Home Care Package was being delivered on a consumer directed basis.[6,7] In 2019, a new reform was introduced which required approved home care service providers to make up-to-date pricing lists available in order to maintain their eligibility to receive Home Care Package from consumers funds. Under the consumer directed care model, clients are permitted to purchase additional services or hours of care on top of their approved service packages, out of pocket.[8] The price lists, made available online, allow clients to compare services, develop a budget that accounts for both government and personal contributions, and understand exactly how their funds are being spent. The amount of funding each client receives is dependent on the amount and complexity of needs they have as

determined through an assessment conducted by an Aged Care Assessment Team. Approved clients are assigned one of four service packages according to the assessment results. Generally, as the package level increases, so too does the amount of approved funding. Supplemental funding may also be available (depending on the applicant's unique circumstances) the amounts of which vary depending on the assessed level of care required. A more detailed description of the funding supplements can be found in **Appendix A**.

Clients may also be required to contribute financially to their packages. Those living entirely on their government-funded Age Pensions contribute 17.5%, or about $10 per day. Those with higher incomes are charged based on results from an income assessment (i.e., sliding-scale model), but this amount is capped at $29 per day and $10, 785 per year.[9]

Part 2. Evaluation of the Effectiveness of Australia's Consumer Directed Care Model

For the purpose of this document, the two publicly available evaluations of consumer directed care have been considered. The first was an assessment on the pilot implementation, provider and consumer impact, as well as cost-effectiveness. The following evaluation was conducted during the CDC scale-up phase and was concerned with early identification of operational challenges to ensure successful conversion of all Home Care Packages to a CDC delivery model by the July 2015 deadline.

During the pilot phase of Consumer Directed Care (2010-11), the Department of Health and Ageing engaged a third-party consultant, KPMG International, to assess the effectiveness of the CDC service delivery model in Australia. The evaluation considered implementation of the CDC model and operationalization by home care providers, the impacts and benefits to consumers and

their caregivers, and cost effectiveness of the initiative. The evaluation was a mixed method initiative comprised of participant and comparison group surveys, use of quantitative data collection tools, as well as provider and consumer interviews. In total, 78 participants made up of care recipients and their caregivers, and 26 home care providers were engaged.[10]

Participants were selected by the home care provider delivering CDC services and typically were invited to participate if they had a family member/ unpaid caregiver playing an active role in their life (mostly adult children of the care recipients), or if they had the capacity and desire to participate in the self-direction of their care. In some cases, participants sought out involvement in the pilot without any recruitment effort – these individuals all had higher and/ or more complex care needs.[10] Participants were categorized by their level of care need, according to the home care programs (identified above). Those receiving packages under the CACP program were classified as 'consumer-directed care, low care' (CDCL); those receiving services under the EACH program were classified as 'consumer-directed care, high care' (CDCH); and those within the Extended Aged Care at Home Dementia stream were classified as 'consumer-directed care, high care – dementia' (CDCHD). The majority of care recipient participants had been receiving some level of home-based care services prior to their involvement with the CDC pilot, however, about 25% were recruited from waitlists and were thus not receiving any formal care prior to their involvement.[10] There was little representation from individuals belonging to 'special needs groups' such as Aboriginals, people living in rural and remote areas, people from culturally and linguistically diverse backgrounds, those who were unhoused or at risk of becoming unhoused, those from socioeconomically disadvantaged backgrounds, and veterans. While the small amount of data on these groups does indicate similar levels of satisfaction as compared to the CDC pilot group more broadly, the amount was too small to form any significant conclusions and as a result, these groups will not specifically be addressed for the purposes of this document.[10]

From a provider perspective there were a variety of motivations for participation in the CDC pilot. Some already had a strong commitment to client empowerment and delivering person-centered care, and thus were motivated by their own organizational values and the client-driven nature of CDC. These providers were the most successful in effectively implementing the CDC model.[10] Other providers saw the CDC model as an opportunity to address common complaints/ concerns from their consumers such as service inflexibility and a lack of consumer control over when, how, and by whom services were delivered. A third group of providers cited being eligible to receive more service packages, thus making more money, as their main motivator. These organizations tended to provide service in a prescriptive manner, the same way they had before their involvement in the project, and, overall, they were the least successful in effectively implementing the new delivery model.[10]

Implementation & Operationalization

Overall, providers noted the implementation and operationalization of CDC was challenging for two main reasons: a lack of proactive support and guidance from the Australian Department of Health and Ageing, and a rushed implementation timeline. Providers reported being given only a list of frequently asked questions and a set of broad operating guidelines on which to base their CDC delivery approaches.[10] Many noted they would have benefitted from face-to-face training, briefings, roundtable exchanges, and discussions; they felt that the lack of hands-on support resulted in the CDC model being inconsistently applied across providers and consumers having vastly inconsistent experience with the program depending on who was overseeing their care. While the authors did not provide an exact measure of time that providers had been given in order to plan, organize, and implement the CDC model, they reported that many felt it was inadequate for the level of planning and organizational change that was required. This was particularly true for the providers who were not already taking a person-centered approach to care provision and may have accounted for some providers complete lack of service delivery change.[10]

Impacts/Benefits to Consumers and their Caregivers

Choice & Control

One of the main attractions for both care recipients and their caregivers to becoming involved with the CDC pilot was their dissatisfaction with their current service delivery model and the opportunity to exert more control over care planning, service selection, scheduling, and staff – this was particularly true for CDCH and CDCHD participants.[10] Across the board, CDCH participants expressed more interest in planning and decision-making and also reported more improvement in feelings of inclusion during care planning, and feeling that their needs were taken into account. CDCL participants demonstrated less interest in care planning and service control, opting for services suggested to them by their providers.[10] This is likely due at least in part to CDCL participants having fewer and less complex care needs and therefore not having a great degree of difficulty in having those needs met.

"I strongly agree that I felt included in the process of planning my care services"

CDCL: 35%

CACP: 39%

CDCH: 47%

EACH: 21%

"I strongly agree that I felt my needs and goals were taken into account in the planning of my care and services"

CDCL: 35%

CACP: 45%

CDCH: 53%

EACH: 14%

While the majority of CDC participants were quite satisfied with the level of choice and control they had over their services (91% agreed or strongly agreed that they felt included in care planning; 95% agreed or strongly agreed their needs were considered), some expressed a level of dissatisfaction over their lack of service choice.[10] There were incidents of services being denied, particularly upon requests for non-traditional services, which often resulted in significant frustration for participants. The level of choice and control offered to participants was largely dependent on

providers' previous commitment to person-centered care and their approach to CDC. Some providers were continuing to deliver home care services in the same prescriptive manner they had prior to joining the CDC pilot initiative resulting in inconsistent levels of satisfaction with providers.[10]

Budgeting

Similar to what was seen with the desire for choice and control over care planning and service delivery, it was CDCH participants who expressed more desire for involvement in budget planning and monitoring than did CDCL participants – although both groups acknowledged the importance of the information.[10] CDCL participants were mostly concerned with knowing whether they had under or overspent each month, while CDCH and CDCHD participants were interested in knowing exactly how much each service cost so they could choose the best services for the best price, plan effectively for future events, and build up a contingency fund should the care recipients needs or circumstances change. Budgeting information appears to have been inconsistently relayed to participants, as some reported a level of dissatisfaction with the lack of information about specific cost for services and a lack of justification for the amount of administrative fees charged to those who opted to have providers manage and coordinate their care.[10]

Consumer & Caregiver Outcomes

While CDCH and CDCHD participants showed the most improvement in satisfaction with the quality of care and the impact it had on their lives, most CDC participants (CDCL, CDCH, CDCHD) showed improvement in their ability to meet goals, physical health, participate in social and community activities, outlook on and quality of life, and overall wellbeing when compared to the six months prior to their involvement with the CDC pilot.[10] While quantitative measures of improvement were not statistically significant, this is likely to be due at least in part to the very short amount of time that recipients were receiving care on a CDC basis when the evaluation took

place. Most participants had been receiving CDC services for less than six months, and many for less than three months.[10]

Caregivers reported increases in their care recipients' independence levels, which made it possible for caregivers to take time and do things for themselves. Many reported reductions in feelings or burden, and improved relationships with their care recipients.[10]

Cost Analysis

Set-up costs incurred by the 26 providers involved in the pilot totaled an estimated $1 million, or about $2000 per consumer service package. Providers reported that these costs were due in large part to planning processes as well as procedural and system changes associated with, in many cases, a complete overhaul of their service provision approach. Once providers have finalized their approach to CDC, expansion of the initiative to new consumers is unlikely to result in any increased cost, however new providers can expect some degree of increased cost.[10] Providers also reported that in some instances – primarily in the cases of participants belonging to the CDCH and CDCHD groups – they were incurring costs related to the ongoing management and coordination of services which were not being entirely covered by the consumers' funding. These ongoing administrative costs are likely to decrease as provider processes become more established and as consumers build increased capacity to self-manage their care. Both the set-up related costs and the ongoing administrative costs were being met entirely by providers without subsidization or reimbursement from the Department of Health and Ageing.[10] However, governments seeking to implement similar service delivery models may need to provide home care/ support organizations with funding to cover at least partial amounts of these costs in order to gain maximum buy-in.

A complete cost-effectiveness analysis was not possible as the evaluation was conducted at a very early stage of implementation, and as a result, the financial stability of the model was inconclusive. However, early estimates outlined above suggest both set-up and ongoing administrative costs are likely to taper off with time. KPMG International recommended a much more in-depth economic analysis be conducted after the program is well established – at least two years after implementation when costs have had the time to level out and accurate comparisons with previous service delivery models are able to be made.[10]

Following the CDC pilot of 2010-11, the Australian government began to rollout Home Care Packages to an increased number of providers serving significantly more consumers. In August 2013, it was announced that in order for providers to be eligible to receive Home Care Package funding, providers must deliver all newly appointed packages on a consumer-directed basis.[11] That same month, it was announced that in order to maintain Home Care Package eligibility, all previously existing packages (CACP, EACH, EACH-D) that had not already been transitioned to the new Home Care Packages program, must be converted and delivered on a CDC basis by July 1, 2015. In 2014, in an effort to measure the success of package conversion, KPMG International was contracted again to conduct a formative evaluation of the Home Care Packages program, including transition to CDC, and identify areas for improvement to ensure the July 2015 deadline was met (rather than to measure consumer benefits/ outcomes).[12] The evaluation considered data from interviews with consumers/ caregivers, home care provider managers/ care coordinators, stakeholder groups, Aged Care Assessment Teams, as well as responses from an online survey.[12]

This evaluation looked at consumer, caregiver, and provider experiences across the six principles on which Consumer Directed Care was founded, and how CDC was operating at the time of the evaluation.

Consumer Choice & Control

Overall, most consumers rated their choice and control over their care planning and service delivery quite highly, reporting that they were either satisfied or very satisfied. However, the extent to which consumers were accessing non-traditional support services was largely determined by the providers openness to present them and discuss them as options.[12] While some providers relied heavily on consumer identified needs to develop their care plans and presented many options for meeting these needs, others provided information only on more traditional services. Consumers often reported that they 'did not know what they did not know' and as a result, usually selected the services that were presented to them by their providers. Some younger consumers and caregivers reported having to remind their providers of the flexibility available to them under a CDC service delivery model, particularly when they made requests for non-traditional supports or equipment.[12]

Rights

The majority of providers acknowledged the importance of consumers' rights to individualized services and supports that would assist them in meeting their needs and goals. However, because providers were at various stages of implementation, some were upholding this principle more effectively than others.[12] Those further along in CDC implementation often reported using self-assessments with consumers to ensure they accurately understood consumer needs and goals within the care planning process. Providers who were not as far along in the CDC implementation process were focused on more traditional or standard services, resulting in some consumers reporting feeling as if they had to fight for services and devices that supported their needs.[12]

Respectful & Balanced Partnerships

Under a CDC service delivery model, consumers should be actively involved in the planning, implementation, and monitoring phases of their care; these efforts should be co-produced between provider and consumer. However, completely shifting the culture and practice of home care delivery can require a significant amount of time and guidance from CDC champions.[12] Providers who had been involved in the CDC pilot were experiencing greater success shifting from provider-consumer relationships to full partnerships – as they had both time and guidance/ mentorship opportunities on their side. Only three providers explicitly stated that they had actively involved their consumers in the development of their delivery models.[12]

Participation

Some providers noted the importance of social and community participation, and even cited practical examples of where this principle had been applied to their CDC approach. For example, one woman who began to have her groceries delivered (instead of having someone transport and accompany her to the grocery store) used her saved funds for engagement in social activities in a neighboring community.[12] A man, under the supervision of his physician, arranged to stop receiving formal medication management as part of his care, opting to self-manage his medications, and used saved funds for transportation to club meetings in his native language and culture. The majority of providers, however, were not prioritizing participation at the time the evaluation was conducted.[12]

Wellness & Reablement

There was significant provider interest in the principle of wellness and reablement, as well as acknowledgement of the idea that packages could be structured in a way to uphold the principle. Very few providers cited examples of this principle in practice. However, one provider referenced

front-loading the packages of new consumers, as home care services are often set up in the wake of a crisis – be it injury, illness, and/ or hospitalization. New consumers under this provider received more services in the first few months and reduced the amount of support as rehabilitation progressed and reablement goals were achieved. Still another provider referenced several instances where consumers were able to be moved down a level of care as their reablement goals were achieved.[12]

Transparency

Of all the six principles in the CDC framework, transparency was the closest to being universally achieved. Evaluators credited this achievement to the government-mandated budgets and monthly financial statements.[12] Almost all consumers acknowledged the importance of the budgets and statements, though roughly only half indicated that they reviewed them thoroughly. While most valued the documents, some found them too complex to interpret, and others still were simply not interested in reviewing them. Younger caregivers demonstrated the most engagement with both budgets and monthly statements.[12]

Most consumers also attached value to being able to allot a portion of their monthly funding to a contingency fund. Some explained working with their providers to set up their contingency funds in a way that would allow them to purchase more services during a period of respite for their unpaid caregivers, or for large, expensive supportive devices/equipment. Some consumers indicated a lack of understanding regarding how their contingency funds worked, and what they could be used for.[12]

While the literature suggests that further evaluations on both the Home Care Packages program and the consumer-directed care model have taken place, the author was not able to find publicly available results.

Part 3. Considerations

Overall, the majority of CDC pilot participants reported being satisfied with the suite of services they were receiving and the degree of control they had in customizing these services to meet their unique and changing needs. The greatest increase in satisfaction was reported among the CDCH participants, however, this is largely due to the fact that CDCL participants were already quite happy with their home care services prior to their involvement with the pilot – these individuals also reported high satisfaction under the new model. In scaling up CDC service provision, both providers and consumers struggled to understand the exact range of services that could be accessed, however a broader range tended to be accessed by clients whose service providers were open to less traditional support services and who facilitated dialogue about these options. Although there was some degree of inconsistency in provider implementation and amount of choice and control given to clients, this would likely be resolved by more active involvement and guidance, as well as ongoing support from government in transitioning from provider-prescribed to client-controlled service provision.

In pursuing the implementation of a CDC home care/ support delivery model, governments should consider a multitude of factors to facilitate a seamless transition for both consumers and providers. First, governments should examine international promising practices in person-centered care, such as Australia's CDC example, in considering improvements to their current self-managed care programming. Leveraging examples with positive evaluations from other countries can support Canadian provinces and territories to create home care/ support delivery systems that further empowers the consumer to take control of their care plans and services. Moreover, adhering to the six principles outlined in the CDC model above can help guide planning and development as well as implementation processes in a way that honours every consumer's right to self-determination and individualized care.

Secondly, it was noted in both the pilot and formative evaluations that there were significant inconsistencies in the way providers approached CDC service delivery. While some consumers reported having full choice and control over their services, others expressed frustration due to provider gatekeeping behaviour upon request for non-traditional services or devices. Providers would benefit from proactive support including face-to-face training, discussion, and roundtable exchange opportunities so that all involved have the same understanding of the extent of consumer rights under the model. It is imperative that providers fully understand the range of control that consumers should be able to exert over their care planning and service delivery to ensure that all clients receive the same access to information and care. Providers would also benefit greatly from some level of financial support from government bodies seeking to implement consumer-directed models of care to help offset the sizeable set-up and development costs associated with a complete shift in procedural and organizational processes.

Finally, regular evaluations are needed in order to assess the clinical, cost, and system effectiveness of the changes implemented in home support/ care programs. Evaluations should be conducted early and regularly to ensure that, should inconsistencies arise across providers, as seen in the two aforementioned evaluations, they can be addressed quickly and effectively in order to maximize consumer health and wellbeing outcomes, and satisfaction. Evaluations should also include economic analyses once the initiative has been operational for a reasonable amount of time, so that cost-effectiveness may be compared across varying service delivery models.

Appendix A

Funding Supplements Available for Australian Home Care Packages Program Clients

FUNDING SUPPLEMENT	
1. Dementia and Cognition Supplement	– an additional 10% of approved funding to help offset the added care costs associated with moderate to severe levels of cognitive impairment
2. *Veterans' Supplement*	– an additional 10% of approved funding for veterans with a service-related mental health condition
3. *Oxygen Supplement*	– additional funding based on the amount of oxygen the client requires and the associated with oxygen reliance
4. *Enteral Feeding Supplement*	– additional funding for clients with challenges absorbing nutrients through their gastrointestinal tract, or those with trouble swallowing. Funding rates are determined by a variety of factors related to the amount of formula needed, and whether or not formula requires a mechanical pump.
5. *Viability Supplement*	– additional funding for clients who receive services from rurally and remotely located service providers to offset the higher costs of business in these areas.
6. *Hardship Supplement*	– additional funding for clients in dire financial circumstances, the rate of which is assessed on a case-by-case basis according to each client.

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