Catholic Health Australia

Review of the Aged Care Funding Instrument

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About Catholic Health Australia

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the Catholic Church within Australia. These health and aged care services are operated in fulfilment
of the mission of the Church to provide care and healing to all those who seek it. Catholic Health
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Summary of recommendations

Recommendation 1

The Australian Government should commission the development of Special Purpose Financial Reports or equivalent to allow the collection of comprehensive and audited national comparative financial data and independent analysis of the financial performance of the aged care sector.

Recommendation 2

The Australian Government should commission independent periodic reviews of the cost of care and support to inform the rebasing of the ACFI price and subsidy levels in order to ensure that funding is adequate to meet the real cost of care having regard to benchmarks of care. Such reviews would preferably be undertaken in an environment of greater flexibility in supply and demand for aged care services.

Recommendation 3

The Australian Institute of Health and Welfare be funded to construct and maintain a minimum dataset reporting framework using the ACFI Assessment Tools to enable ACFI assessed resident information to be collected nationally and used as a basis for analysis of care issues and costs.

Recommendation 4


Recommendation 5

Validators be reminded of the agreed validation rules and advised that they are not permitted to request documents that were never intended to be subject to the validation process.

Recommendation 6

The Australian Government, as a matter of urgency, resolve with State and Territory jurisdictions the provision of either appropriate levels of funding or appropriate alternate accommodation services to the less than RCS and nil funded cohort of approved care recipients for whom community care is not an option.
Recommendation 7

A Special Class Mental Health Supplement should be introduced to assist those approved services that cater exclusively for residents with psychiatric and mental health conditions and intellectual disability.

Recommendation 8

Resident security of tenure rules should not be applied where approved services may unnecessarily expose residents to violent assaults by either ACAT approved new residents or those being discharged from acute care psychiatric services.

Recommendation 9

ACATs not approve persons as care recipients in cases where residential aged care would be inappropriate.

Recommendation 10

An additional supplement be introduced that is specifically for palliative and end of life care. This subsidy should be able to equal at least the High Behaviour supplement level to enable this class of residents to be able to attract maximum ACFI funding.

Recommendation 11

The Department of Health and Ageing should open discussions with relevant GP and related parties with a view to ensuring that ACFI appraisal requirements and GP practices are better aligned to support the preparation of ACFI appraisal documentation.

Recommendation 12

The Department of Health and Ageing, working through appropriate COAG structures, should seek to achieve uniformity of scope of practice for health professionals across States and Territories, including uniformity of drug regulations.

Recommendation 13

The current list of Schedule 1 Specified Care and Services should be reviewed in order to draw up a new list which is linked to the ACFI funding categories, thus removing the outdated link to the high and low care classifications.
**Recommendation 14**

The current ACAT assessment process incorporating the ACCR be reviewed and changed so that it more closely aligns with the ACFI appraisal to make it a better predictor of ACFI dependency levels.

**Recommendation 15**

Every ACAT approved care recipient have their approval ID number and ACAT assessment listed on the Medicare Australia secure website to provide approved providers with timely access to this information.
1. Introduction

CHA has consistently supported and welcomed the introduction of the ACFI. We consider that it is a robust funding allocation tool that is supported by good assessment tools. It is also a new system. Hence this review is welcomed as it provides a timely opportunity to examine, adjust and keep it relevant.

The adoption of the ACFI required aged care providers to undertake significant change management and re-skilling of staff in order to adapt successfully to the requirements of the new funding appraisal and validation arrangements. This was recognised by the Australian Government through the provision of training and support to assist the change to the new system. Nevertheless the adoption of the ACFI has been a demanding exercise for the sector, and it has to be acknowledged that there are some providers, especially smaller providers, who are still adapting to the new system and its business rules.

In the following section, CHA provides comments in response to the nine issues identified for review in the Review’s Terms of Reference.

By way of an overarching comment, however, CHA has a concern that while the advent of the ACFI has resulted, as planned, in a transfer of available funding to people with higher care needs, this transfer has occurred largely within available budgeted funds which supported the former RCS funding system. Many of the issues we raise reflect our concern about the adequacy of ACFI funding to deliver appropriate care to a number of special needs groups, which the ACFI objective of more closely aligning funding to care needs within a constrained budget has served to highlight.

This is not a design fault with the ACFI funding tool itself. Rather it points to the need for research into the real cost of care for particular groups of care recipients, having regard to benchmarks of care, in order to inform a rebasing of ACFI funding levels.

2. Comments on the Terms of Reference

2.1 Better matching funding to the complex care needs of residents

There is currently no objective basis for setting prices and subsidy levels for the provision of residential aged care, including meeting the competitive remuneration needed to attract and retain the skilled staff that is required to care for the increasing number of older people with more complex high care needs. Nor are there benchmarks of care to guide the setting of prices.
The current prices and subsidies for care and support embodied in the ACFI rates are historically based and subject to minimum wage adjustments. The latter assumes that wages in all sectors are offset by productivity gains based on the assumption that technological innovation and changes in care practices present the aged care sector with the same capacity as all other sectors to achieve productivity gains through labour substitution, while at the same time meeting rising community expectations about service and living standards.

CHA notes in this regard that the report of the Review of the Conditional Adjustment Payment which examined future prices for the provision of care, including an analysis of the extent and nature of productivity gains in the sector, and the prospects for future improvements, has not been released.

The ACFI was designed, inter alia, to more closely match funding to the relative care needs of residents. The absence of robust cost of care data meant, however, that any changes to funding levels for particular resident types were achieved within the then available budget (plus a modest arbitrary top up for complex health care). As a consequence, any increase in funding for some care recipients could only be achieved by reducing funding to others, or by ignoring the needs of those for whom additional funding was justified.

This fundamental shortcoming in the formulation of the ACFI underlies many of the concerns that will be referred to later in this paper.

CHA also notes that ACFI’s use of credible assessment and diagnostic tools presents a unique opportunity to use the information provided by the tools to maintain a comprehensive data set on the profile of residents which could be used to support research, including research into the cost of care for particular categories of residents and research into care practices.

The following recommendations are designed to address the current absence of an objective basis for setting subsidies and fees, especially the price and subsidy levels that should apply for people according to their care.

**Recommendation 1**

*The Australian Government should commission the development of Special Purpose Financial Reports or equivalent to allow the collection of comprehensive and audited national comparative financial data and independent analysis of the financial performance of the aged care sector.*
Recommendation 2

The Australian Government should commission independent periodic reviews of the cost of care and support to inform the rebasing of ACFI price and subsidy levels in order to ensure that funding is adequate to meet the real cost of care having regard to benchmarks of care. Such reviews would preferably be undertaken in an environment of greater flexibility in supply and demand for aged care services.

Recommendation 3

The Australian Institute of Health and Welfare (AIHW) be funded to construct and maintain a minimum dataset reporting framework using the ACFI Assessment Tools to enable ACFI assessed resident information to be collected nationally and used as a basis for analysis of care issues and costs.

Recommendation 4


2.2 Reducing the documentation created by providers to justify funding

It is generally agreed that the ACFI has resulted in a reduction of documentation required to justify funding. However, not all providers are of this view which suggests that there may be a case for further targeted education and training in the application of the ACFI.

2.3 Reducing level of disagreement between providers and validators

The level of disagreement between providers and validators is reported as having significantly reduced, but CHA is still receiving reports of some validators continue to have a very ‘RCS mind set’ and request additional documentation that is not required for validation purposes (as set out in the ACFI User Guide). For example, validators are asking for progress notes and treatment sheets as evidence that treatments are actually being delivered.
Recommendation 5

Validators be reminded of the agreed validation rules and advised that they are not permitted to request documents that were never intended to be subject to the validation process.

2.4 Impact of ACFI on funding levels for approved providers, particularly low care providers and those in rural and remote areas

Many small rural providers who are unable to admit residents needing higher levels of care than low care are faced with receiving less funding under the ACFI than under the previous RCS categories 6 – 8. If providers continue to admit ACAT approved care recipients who qualify for lower funding levels than under the RCS (or in some cases, nil funding), they are being unfairly penalised and are, in reality, subsidising the Australian Government by providing unfunded care.

The care needs of some in this group may be met through Community Aged Care Packages, if they are available. However, this discriminates against those who, for reasons to do with the appropriateness of their housing, availability of a carer, remoteness or social isolation, would be more effectively cared for in a residential setting.

This situation is a direct consequence of the funding levels set for the ACFI which has seen a transfer of funding in order to increase funding for higher dependency levels.

Recommendation 6

The Australian Government, as a matter of urgency, resolve with State and Territory jurisdictions, the provision of either appropriate levels of funding or appropriate alternate accommodation services to the less than RCS and nil funded cohort of ACAT approved care recipients for whom community care is not an option.

2.5 Impact of ACFI on special needs residents and special classes of residents

The ACFI currently provides a Behaviour Supplement. However our members who are dedicated to caring for people living with more challenging behaviours are reporting that the amount of the supplement is inadequate to care appropriately for people such
as those with psychiatric conditions, alcohol and drug related brain injury or intellectual disabilities.

For example, the staff interventions needed to prompt and provide verbal support is not recognised. People who have Schizophrenia or Bi Polar have most of the negative symptoms of depression, however that is not their diagnosis. These services are, therefore, not funded appropriately for people with the most common mental health issues.

Residents with the most significant and violent behaviours generally cannot be adequately catered for in a congregate residential setting due to both inadequate ACFI funding and the lack of specialised care staff.

However ACATs are assessing some persons as eligible to receive residential care when they are clearly not able to be supported in the mainstream aged care system. One example cited was a resident admitted from hospital and upon admission it was discovered that the resident whilst in hospital was on 30 minute suicide watch.

The structure of the ACFI, with its three separate funding domains, constrains certain classes of residents attracting maximum levels of funding. Residents requiring palliative care, particularly those who have entered the end of life stage, may score highly on Activities of Daily Living (ADLs) and Complex Health Care (CHC) but will most likely score nil on the Behaviour (BEH) domain. The major cost drivers are not recognised, including the need for end of life counselling and support for the care recipient and family.

The need for additional funding to support palliative care and end of life services in residential aged care homes was recognised by the National Health and Hospitals Commission.

**Recommendation 7**

A **Special Class Mental Health Supplement be introduced to assist those approved services that cater exclusively for residents with challenging psychiatric and mental health conditions and intellectual disabilities.**

**Recommendation 8**

**Resident security of tenure rules should not be applied where approved services may unnecessarily expose residents to violent assaults by either ACAT approved new residents or those being discharged from acute care psychiatric services.**
Recommendation 9

*ACATs not approve persons as care recipients in cases where residential aged care would be inappropriate.*

Recommendation 10

*An additional supplement be introduced that is specifically for palliative and end of life care. This subsidy should be able to equal at least the High Behaviour supplement level to enable this class of residents to be able to attract maximum ACFI funding.*

2.6 ACFI gaps or anomalies in relation to care needs

It has been reported to CHA that the Psychiatric Assessment Scale (PAS) remains an unhelpful tool as GPs invariably ask for or administer the MMSE. This is causing difficulties for aged care staff in preparing documentation to support ACFI funding appraisals.

A similar situation presents itself when GPs use terms such as ‘acquired brain injury’ and ‘memory loss’ instead of the diagnosis terminology recognised by ACFI.

Recommendation 11

*The Department of Health and Ageing should open discussions with relevant GP and related parties with a view to ensuring that ACFI appraisal requirements and GP practices are better aligned to support the preparation of ACFI appraisal documentation.*

2.7 The role of care providers in relation to delivery of care needs, including role and scope of practice of enrolled nurses and allied health professionals

The combination of the ACFI classification and the requirements imposed by the Quality of Care Principles (including the specified care and services in schedule 1) sets the framework for what is expected to be provided by aged care homes.

The resultant funding and the scope of practice of various health professionals in turn determines the staff numbers and skill mix that providers can utilise to deliver the care provided.

An issue for ACFI is not so much that the ACFI tool should recognise the input of particular health professionals, but rather that the scope of practice of the health
professionals is consistent across all States and Territories so that the funding levels under ACFI are costed according to common scopes of practice across the jurisdictions.

For example, unless Enrolled Nurses (ENs/RN Div 2s) have enhanced scope of practice to administer medication, the capacity to utilise their skills is limited. Instead providers tend to use RNs (Div 1s) in clinical management roles and have Assistants in Nursing (AINs) or Personal Care Attendants (PCAs) administer medication, where this is possible.

Regulations vary from State to State regarding drug administration with implications for the cost of care which the ACFI cannot take that into account. There is a need for consistency across jurisdictions.

Recommendation 12

The Department of Health and Ageing, working through appropriate COAG structures, should seek to achieve uniformity of scope of practice for health professionals across States and Territories, including uniformity of drug regulations.

2.8 The appropriateness of Schedule 1 of the quality of Care Principles

The current list of requirements as set out in Schedule 1 of the Quality of Care Principles needs to be reviewed. The list will be 13 years old on 1 October 2010, and even predates this time frame as it is a carryover from the lists that applied under the former Nursing Home and Hostel funding regimes.

In particular, the care and services specified in the schedule do not reflect the changes in scope of practice for nurses (both registered and enrolled), the effect of the Australian Qualifications Framework on aged care qualifications and skills or changes in medical treatments.

Linking the lists of provisions to the arbitrary high and low care classifications is also no longer relevant. Not only should the lists be reviewed but their requirements should be directly linked to ACFI funding categories.

Recommendation 13

The current list of Schedule 1 Specified Care and Services should be reviewed in order to draw up a new list which is linked to the ACFI funding categories, thus removing the outdated link to the high and low care classifications.
2.9 Options to improve agreement between ACAT assessments and ACFI appraisals

The lack of alignment between the ACAT ACCR assessments and the ACFI appraisals is a regular source of frustration and friction for providers and older people and their families. The current ACAT assessment process needs to be reviewed and changed in order that it more closely aligns with the ACFI appraisal. A revised ACFI could be developed that will fulfil the ACAT eligibility assessment requirements and also be a better predictor of ACFI dependency levels.

Recommendation 14

*The current ACAT assessment process incorporating the ACCR be reviewed and changed so that it more closely aligns with the ACFI appraisal to make it a better predictor of ACFI dependency levels.*

Recommendation 15

*Every ACAT approved care recipient have their approval ID number and ACAT assessment listed on the Medicare Australia secure website to provide approved providers with timely access to this information.*

3. Conclusion

CHA has consistently supported and welcomed the introduction of the ACFI. We consider it to be a robust funding allocation tool that is supported by good assessment tools.

With the benefit of experience, a number of areas have been identified in this paper where modifications to current arrangements would improve the effectiveness of the ACFI.

Fundamentally, however, there is currently no objective basis for setting prices and subsidy levels under the ACFI for the provision of aged care, particularly what is required to care for the increasing number of older people with more complex high care needs and special needs groups. CHA considers that the Australian Government should arrange for the rebasing of the ACFI subsidy and fee levels based on independent periodic reviews of the cost of care and support having regard to benchmarks of care.