Australian Nursing And Midwifery Federation

SUBMISSION ON THE PROPOSAL FOR A NEW RESIDENTIAL AGED CARE FUNDING MODEL

MAY 2019

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Assistant Federal Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
T: 03 9602 8500
F: 03 9602 8567
E: anmffederal@anmf.org.au
W: www.anmf.org.au

CONTENTS

INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of over 275,000 nurses, midwives, and carers[1] across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF is pleased for the opportunity to provide feedback and commentary on the proposal for a new residential aged care funding model. Overall, the ANMF is highly supportive of the need to implement a new funding model to replace the Aged Care Funding Instrument (ACFI) and considers the proposed Australian National Aged Care Classification (AN-ACC) model to be a promising replacement providing that it is properly resourced and carefully implemented.

BACKGROUND

1. It is important to consider that the Resource Utilisation Classification Study's (RUCS) series of studies were undertaken at a time widely recognised to be marked by significant and systemic problems with the funding, delivery, and monitoring of aged care services. The ANMF and other key stakeholder groups see Australia's aged care sector as one in crisis. This is most clearly demonstrated by the ongoing Royal Commission into Aged Care Quality and Safety.
2. While it is impossible to assess the nature and extent of the impact that this may have had on the analyses and results of the four RUCS studies in relation to case mix classification and profile, the funding model in relation to resident- and facility-level costs, and the rate and extent of changes to residents' care needs over time, the key issue is that the studies observed and assessed care that was delivered rather than care that should be delivered. For example, it is unknown how the staffing and skills mixes of participating residential aged care providers impacted upon the time observed to undertake care for residents. There is considerable evidence that staffing levels and skills mixes impact the delivery and outcomes of care, so it is important to be aware of this issue.
3. As the RUCS team has acknowledged, ongoing work will be required to ensure that the classification of residents in accordance with the AN-ACC continues to reflect emerging practices and cost structures within Australia's evolving aged care sector and further, that there are important opportunities to measure and understand aged care quality and outcomes beyond a funding model context which will arise from the development of an AN-ACC.

1 The term 'carers' incorporates unregulated assistants in nursing/midwifery and health and aged care workers.

GENERAL COMMENTS

4. The ANMF recognises the need to replace the current, but outmoded, ACFI model for funding in the residential aged care sector and generally regards the proposed AN-ACC as a positive step towards delivering an improved funding tool for the sector. However, it must be acknowledged that a revised funding model is only one of the many reforms needed to achieve the safe and high quality system Australian consumers have a right to expect. The AN-ACC model may improve upon ACFI, but it must be implemented in line with simultaneous improvements to the way that resident care and staffing is planned, delivered, measured, and assessed.
5. As acknowledged by the RUCS team several matters were not in the scope of the study, including pricing, which will be a decision for payers (Government and consumers), and care planning and assessment for care planning purposes. It must be noted that accurate pricing will be integral to ensuring the successful implementation and maintenance of the AN-ACC. In relation to both the issue of funding (payment) and pricing, it is the ANMF's view that it is vital that all funds made available to providers through the AN-ACC model be transparently and specifically linked to the delivery of care for residents including support for the necessary staffing levels and skills mixes to deliver that care.
6. The RUCS team recommends that clinical care assessment and planning should be undertaken by residential aged care facilities, occur in accordance with best practice and consumer directed care principles, and that a nationally standardised approach be adopted. The ANMF understands that over time, the care plans developed by residential aged care facilities will increasingly align to the AN-ACC model and that this could enable a desirable increase in the accountability of providers and their ability to provide consumers and stakeholders with transparent reporting regarding the real-world utilisation of received funds for care delivered.
7. The ANMF is supportive of the recommendation that resident assessment for funding be separated from resident assessment for care planning purposes and believes that this is a suitable approach for ensuring that known problems with the outmoded ACFI model are addressed. While it is suitable that the AN-ACC model be uncoupled from care planning as proposed, as noted in the reports, over time, the funding model is expected to become more closely aligned with care planning as further insight is established regarding the types of care plans that are commonly delivered to residents classified into different classes. The risk here is that providers may base staffing and care planning around principles of cost saving and income maximisation rather than delivery of optimum care quality and safety to improve resident outcomes.
8. The recommendation that nationally standardised assessment and care planning be established is suitable particularly if these can be regularly monitored and clearly linked to the delivery of good resident outcomes. It must be able to be established that providers are implementing suitable, evidence-based models of care delivered by an adequate number and skills mix of suitably trained staff and further, that the pricing of the AN-ACC be reviewed at least yearly to ensure that the funding model supports the provision of this necessary care and staffing.
9. As the RUCS team highlighted in relation to the one-time adjustment payment, there must be clear and transparent links between funding, staffing, and care delivery where it can be observed that the variable (individual) payments per resident are clearly being directed to the care of that resident alone and that the fixed (shared) payment for each resident is being utilised to staff and deliver models of care that provide safe, quality care for all residents.
10. Below, we have provided specific responses to each of the focus questions listed in the Consultation Paper.

THE PROPOSED FUNDING MODEL

Are there any risks or benefits of the proposed funding model that have not been identified?

11. The ANMF has some concerns that despite the acknowledged benefits regarding incentivisation of reablement and restorative care within the model, there remains a risk that residents could be allowed to deteriorate, be reclassified, and attract greater funding.

12. Figure 1 below provides a model outlining how this could potentially occur.

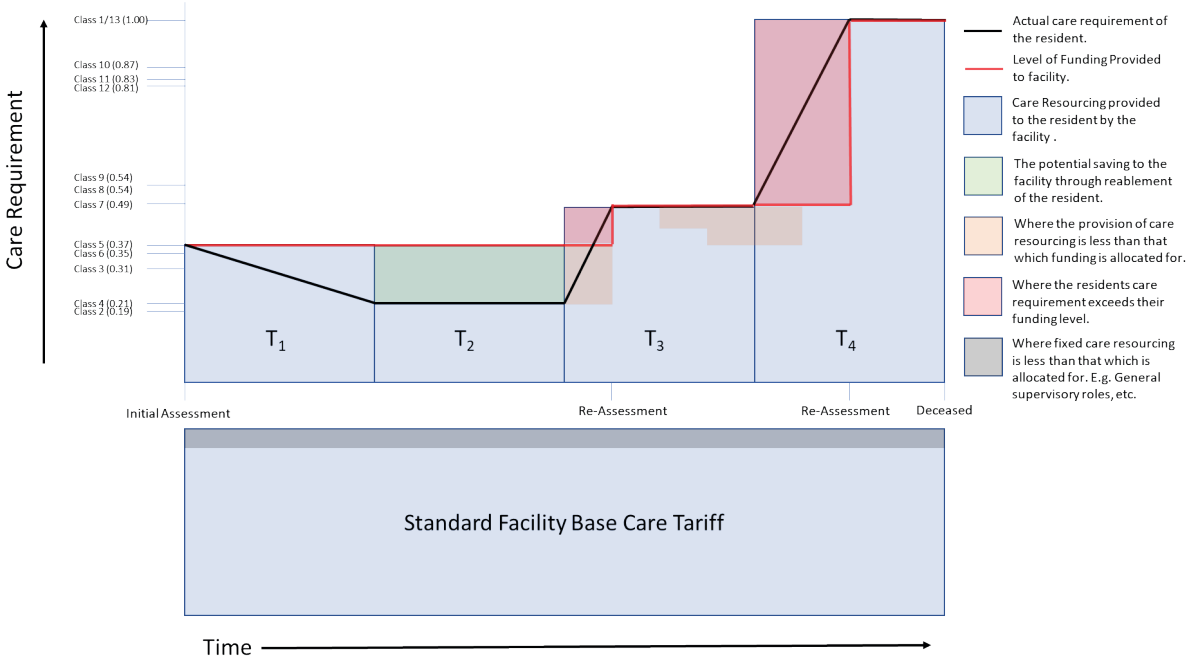

Figure 1: *A conceptual visualisation of a resident's possible journey through an aged care facility under the proposed funding model.*

13. Throughout period $\mathbf{T}_1$ a resident is admitted within the assessed class, during which their actual care requirement may reduce due to a full allocation of care resourcing. At this time, a provider will also receive the one-off adjustment payment recognising additional, but time-limited resource requirements on admission. Period $\mathbf{T}_2$ then illustrates the 'incentivised' benefit to the facility in the circumstances where the resident's condition improves. As the resident is more independent and requires less care resources the facility may retain the difference rather than utilising the left-over funding for individualised care.

    Period $\mathbf{T}_3$ highlights a duration of time where the resident potentially deteriorates as a result of reduced care resourcing, inevitably their actual care requirement will not be funded in entirety before reassessment and this length of time may or may not be prolonged. Once the resident's condition is stabilised by increasing care and resource utilisation, a potential cost advantage may be sought through the incremental reduction of care resources. A resulting decline in resident condition and therefore increase in actual care requirement may eventuate (as illustrated through $\mathbf{T}_4$) with no financial incentive to allocate increased care resources until the resident has been reassessed and possibly until the forecast assessment meets the funding expectation of the facility. Throughout this entire journey a facility may look to find cost advantages through under-resourcing in areas where fixed care funding is allocated. For example, a provider may choose to allocate 9 staff in a particular area although funding is sufficient for the provision of 10 staff, rendering a 10% saving through a reduction in resource allocation, which could have been used to improve restorative care if the full staff complement were provided.

14. This example raises questions around whether the model has sufficient incentives to ensure providers use resources effectively to practise restorative care and avoid unnecessary deterioration among residents.

15. The ANMF also has some concern that the model may not adequately capture and support the complexity of care required in residential aged care, particularly for people affected by dementia, as level of independence assessed by mobility appears to be the major stratifying factor for the model. It is therefore unclear whether a resident with high dementia care needs but who is highly mobile would attract sufficient AN-ACC funding to support the delivery of safe, appropriate care. As the Royal Commission has highlighted, the management of dementia in Australian aged care is currently not at an acceptable standard. It is important to ensure the model rectifies this situation and does not inadvertently incentivise avoidable use of chemical or physical restraint.

16. Other complex areas of care required in residential aged care which do not appear to be sufficiently recognised as key cost-drivers in the AN-ACC model include medication assessment, management, and a potentially limited definition and understanding of palliative and end of life care needs. There may be a risk that the costs of the provision of these aspects of care may not be sufficiently accounted for by the model. The ANMF is also concerned that the emotional and social care needs of residents may not have been clearly or comprehensively accounted for within the AN-ACC assessment.

17. While the ANMF understands that the AN-ACC model recognises technical nursing requirements as a cost driver, we are concerned that misinterpretation could arise that nursing may only be required to simply meet a limited array of high-level technical skills rather than the delivery of the broad, holistic and comprehensive care which residents require and which nursing specialises in. This could potentially result in some providers continuing to understaff their facilities with regard to registered nurses thereby perpetuating poorer resident outcomes and unnecessary hospitalisation of residents who could have been cared for onsite.

18. The RUCS does appear to be more closely aligned to the principles of incentivisation of better outcomes, however more clearly articulating this link could occur through directly rewarding rehabilitation. For example, residents could be assessed using validated, evidence-based tools to establish the likelihood of successful rehabilitation (e.g. improved mobilisation). The costs of undertaking this assessment as well as rehabilitative interventions could then be funded and then successful/improved and maintained outcomes rewarded with further funding. This is partially integrated into the model as residents will not be reclassified if e.g. mobilisation is improved, however there is limited incentive for providers to undertake rehabilitative interventions unless they are adequately remunerated.

19. The requirement for accountability regarding the use of the one-off adjustment payment has been clearly outlined (page 13, Report 5), this accountability should also be required for fixed and variable payments to ensure that all Government funds are used for their intended purpose – care of the residents. It is the ANMF's position that providers be required to monitor and publish the use of Government funds so that consumers are able to accurately evaluate how aged care providers are using their funding for the individual and shared care of residents.

20. While the model features several protections against 'cherry picking' residents assessed to be within particular classes (such as ensuring that providers are not aware of the assessed class of residents on admission). There is a concern regarding whether the model provides sufficient protections to ensure cherry picking does not occur. For example, providers will be easily able to undertake their own in-house assessments using the AN-ACC tool upon resident admission. The risk here is that providers may misalign care plans to residents' needs and under-deliver care in order to save costs.

21. The ANMF is concerned that the one-off adjustment payment is only paid to providers on a residents' first admission into any aged care facility. This may dissuade providers from taking on residents who have transferred from another facility (e.g. to be closer to family) or to provide substandard care for those residents. Further, as respite care was beyond the scope of the RUCS studies it is assumed that admission as a respite care resident would not be classified as first-time entry into residential aged care however this must be clarified particularly regarding payment rules for the one-off adjustment payment.

22. The ANMF is pleased to note that the AN-ACC model has recognised the particular needs of certain diverse population groups, including people experiencing homelessness, residents in regional and remote areas, and to a small extent culturally and linguistically diverse people. There is however a potential risk that the needs and preferences of these groups, as well as other groups such as gender and sexually diverse people (LGBTIQ+), and younger people have not been accounted for by the model. Further assessment and explanation regarding how the needs of diverse groups are acknowledged and met is required.

THE PROPOSED CLASSIFICATION ASSESSMENT TOOL AND PROCESS

Are the proposed resident assessment and classification processes appropriate? If not, why not?

23. The ANMF agrees that the proposed resident assessment and classification processes are generally appropriate however consideration should be given to the identified risks above regarding how they may relate to resident assessment and classification. We would suggest that additional consideration needs to be given to the processes for medication assessment and administration, in particular for pain management. For example, an adjusted payment for pain management only appears on admission and does not occur if e.g. a resident falls or otherwise is in increased pain.

24. The ANMF is very supportive of the proposal that assessment for funding purposes will be undertaken by external assessors and agrees there is a critical need for an AN-ACC workforce model and strategy to ensure the development and implementation of a suitably qualified assessment workforce. The ANMF also supports the proposal that the AN-ACC assessment function could sit within the Aged Care Assessment Team (ACAT), although resourcing of teams would need to be considered, given ACATs currently do experience lack of sufficient resources.

25. In addition to the above, the implementation and roll out of the independent assessment of residents will be critical. The process must be properly resourced to ensure its success.

Are the proposed reassessment triggers appropriate? If not, why not?

26. The ANMF broadly agrees with the proposed reassessment triggers.

Are there other factors that should be considered for inclusion as reassessment triggers?

27. Other factors to be considered as triggers for reassessment could include an acute event, which would often result in hospitalisation, but cared for in the facility when appropriate staff are available and Behavioural and Psychological Symptoms of Dementia (BPSD) changes. The ANMF is also supportive of future trials to ensure the appropriateness of the triggers.

Should the commonwealth consider the introduction of reassessment charges for services that trigger unnecessary reassessments?

28. The ANMF is supportive of the introduction of reassessment charges for services that trigger unnecessary reassessments however caution must be used to ensure that there are no unintended consequences of encouraging avoidance of necessary reassessment. This could be underpinned by thorough education and training regarding assessment triggers. Further explanation of what constitutes an 'unnecessary reassessment' may be required.

Should there be a requirement for reassessment in the proposed funding model?

29. The ANMF is supportive of a requirement for reassessment in the proposed funding model.

ANNUAL COSTING STUDY TO INFORM PRICE

What are your views on annual costing study to inform price?

30. An annual costing study to inform price will be vital and must be conducted independently and transparently to ensure that the pricing is sufficient to cover the real costs of resident care.

SUPPLEMENTS AND SUBSIDIES

What are the risks and benefits of rolling viability supplement into the fixed payment NWAUs?

31. A potential benefit is that the viability supplement could reduce duplication and simplify the payment model.

32. A potential risk may be that the viability supplement may not be sufficient to cover costs.

What are the risks and benefits of rolling homeless supplement into the fixed payment NWAUs?

a. As above (see paragraph 32).

IMPLEMENTATION AND TRANSITION ISSUES

Which transition option do you prefer? Why?

33. The ANMF recognises that how the AN-ACC is implemented will be critical. It will need to be well planned and underpinned by appropriate education of the sector. The transition will also need to consider possible unintended consequences it may cause, for example depletion of the registered nurse workforce within facilities if they are recruited to the assessment workforce or viewed as solely necessary for the provision of highly technical clinical care. There will need to be sufficient time allowed for full workforce development.

34. The ANMF is supportive of the recommended transition strategy for progressive implementation of the AN-ACC with the ACFI and AN-ACC running concurrently over two years following introduction of the AN-ACC as outlined in Report 6. This would allow time to ensure issues such as pricing, staffing, and care assessment and planning can be adequately developed.

IMPLICATIONS FOR CARE DELIVERY AND PLANNING

What are the implications of ceasing ACFI assessments in relation to care planning activities?

35. The ANMF considers the major risk will be a reduced driver for care planning and review as care planning is decoupled from funding and recommends that clear business rules around care planning are developed as part of the transition process.

Do you support the development of a best practice needs identification and care planning assessment tool for use by residential facilities?

36. The ANMF supports the development of a best practice needs identification and care planning assessment tool and considers that it will be essential to prevent variations in care worsening following the cessation of ACFI. It is imperative that the Government outlines clearly how the development of this tool will occur and be resourced.

Do you support a requirement for care planning assessments to be undertaken at least once a year for all residents, with outcomes discussed with residents and carers?

37. Yes, at a minimum, this proposal is strongly supported by the ANMF and will be essential. It will also allow best practice elements to be continuously incorporated through a system-wide approach. Further, residents and carers must be included as partners in the care planning and assessment process to ensure best-practice consumer-focused and driven care occur. Ideally, residents and carers should also be informed as to the utilisation of both their own fees as well as of Government funding received by the provider through the AN-ACC. This will allow consumers to make informed decisions regarding choice of residential aged care facility.