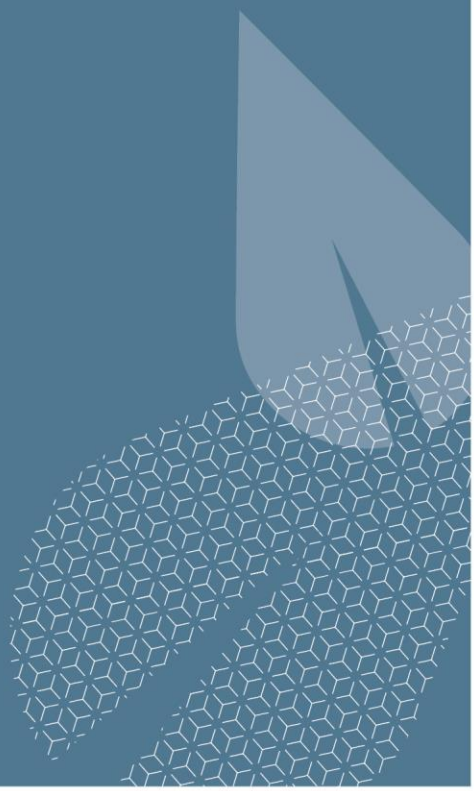
Anglicare

Anglicare Sydney Submission into the AN-ACC Pricing Reforms

October 2022



ANGLICARE SYDNEY

Anglicare Sydney is a significant provider of both residential aged care and community aged care services across Greater Sydney and the Illawarra. This is reflected in our long history of such service provision and a strong commitment to supporting over 2,100 members in our community, in 23 facilities who experience frailty and the need for ongoing and sometimes intensive care. Our facilities range in size from small homes with 40 bed capacity to our largest with 238 beds giving us a helpful perspective of the varying impact of the new reforms based on home size.

In more than 70 years of providing residential aged care services Anglicare Sydney has been guided by a commitment to quality service provision both clinically and holistically, underpinned by principles of dignity and choice, hope and compassion supported by highly trained and caring staff.

We believe that the AN-ACC Pricing reforms need to focus on keeping residents and clients healthy, safe and informed and we appreciate the opportunity to provide feedback on the new pricing framework. Anglicare would like to address some issues raised in the questions provided in the consultation paper.

KEY ELEMENTS IN THIS SUBMISSION

In summary the key issues for providers under the new Pricing framework are as follows:

- There are flaws in the current point in time assessment system including inconsistencies across sites and lack of open disclosure.
- Lack of inclusion of residents, families and providers in the assessment process and the lack of transparency as to how classifications are determined (as experienced in the shadow assessments).
- Providers need to get a good understanding of the assessment evidence and the tools themselves and how this then translates into care needs and care planning.
- The funding model appears to be centred on care minutes being delivered in terms of clinical and personal care but does not take sufficient account of a range of other supports necessary to deliver holistic quality care including lifestyle, allied health, spiritual and pastoral care.
- There needs to be some form of verification or validation process before the classification is finalized. ACFI had a validation process built in but this appears to have been eliminated in the new model.
- The key driver under the new framework which determines classification is mobility. However, someone who has dementia and/or significant cognitive dysfunction, often requires greater intensity of care, even when fully mobile. The classification system does not appear to take this into account.
- The new model will significantly add to the complexity of both administration and reporting, which will not be considered in the care minute allocation, but which will take up considerable unfunded time of care staff and RN's.
- Providers have a number of other government and compliance requirements (Aged Care Quality and Safety Commission) which adds complexity and cost eg SIRS reporting and restrictive practices which takes staff away from care time and which will not be funded.

- The model will have sustainability issues since the costing framework was developed pre COVID before the majority of providers faced the 'fiscal cliff.

- A challenge with the proposed funding model is that it constrains any real capacity or flexibility for a provider to fund innovation. The proposed model goes against marketisation and becomes essentially government-controlled, reducing options for innovation or providers taking a lead in developing better services.

- The model will be further undermined if there is no guarantee of full indexation to ensure there is no further erosion of funding to meet costs.

- There are a number of activities that need to be included in the new pricing model including training, allied health, lifestyle, hospitality services, pastoral care, resident consumables and deep cleaning (largely associated with managing COVID).

- Funding appears to be based on the staff role rather than the actual care needs of the resident.

KEY RECOMMENDATIONS IN THIS SUBMISSION

1. That open disclosure processes are embedded into the resident assessment process and the rationale for classifications.

2. There needs to be greater transparency and involvement of providers in relation to the assessment process and the rationale for classifications.

3. There needs to be greater inclusion and focus on the goals and wishes of residents and their families in the funding assessment process, not just the current assessments which only focus on a resident's capability.

4. A defined validation process be added to the assessment process, to minimise the likelihood of incorrect classifications which have an impact both on the provider and the care received by the resident.

5. The Pricing framework needs to take sufficient account of a range of other supports beyond clinical and personal care necessary to deliver holistic quality care.

6. For long term sustainability the AN-ACC model needs to include capacity for innovation and full price indexation, address the new complexity of administration and reporting, focus on quality of care outcomes for residents and align with all associated regulatory requirements in the aged care industry.

7. The model needs to adopt a broader more holistic approach enabling multi- disciplinary platforms of care which have the resident and their wishes and goals at the centre of the care delivery system.

8. The new Pricing Framework needs to include additional activities beyond personal and clinical care including lifestyle, hospitality, allied health, resident consumables, training and pastoral care support.

9. The pricing issues in relation to safety and quality need to be developed in tandem with the pricing model.

10. ANACC price should also include a one-off payment for residents on respite as they undergo the same onboarding process (and thus associated costs) as permanent residents. The higher daily rate for respite should only reflect the care need requirements.

RESPONSE TO KEY CONSULTATION QUESTIONS

1. What, if any, may be the challenges in using the Australian National Aged Care Classification (AN-ACC) to support activity based funding (ABF) in residential aged care?

Anglicare aligns with the policy objectives which the Pricing Framework is supporting – the delivery of person-centred care, quality care and improving the safety, efficiency and sustainability of the aged care system. However, we do consider there are a number of challenges with the proposed new Pricing Framework which may have the capacity to jeopardise these objectives.

a) Assessments

The adoption of a point-in-time, external resident assessment system that lacks open disclosure processes is problematic. Anglicare maintains that best practice resident care includes ongoing assessment processes that involve resident, family and partners in care. This is true for new admission residents and for existing residents with changing care needs. Under ANACC, the point in time approach for formal assessment stands in contrast to the process under ACFI, where various assessments were carried out during a newly admitted resident's first month, and in ongoing assessment review processes for existing residents.

Anglicare has observed that ANACC shadow assessments can take on average around 20 -30 minutes – which is insufficient time for a comprehensive assessment of the residents clinical and personal care needs. This point in time assessment approach does not acknowledge variations in resident function over an entire day or week; during which function and care needs can fluctuate. Indeed, the time of day for the assessment can be critical in terms of how a resident's needs are perceived by an assessor. This can result in assessment and recommendations that may not be an accurate representation of care needs over time. This concern arises from our previous experience with the National Screening and Assessment process undertaken by ACAT's, where a prospective care recipient was assessed during a short observation and interview. This approach often resulted in understated care needs and behaviours as they were mostly self-reported.

Adding to the above concern of a point-in-time assessment process, Anglicare acknowledges ANACCs short assessment processes in turn require a high degree of professional judgement. Assessors are required to make clinical judgements in a relatively short period of time and therefore need to have expert clinical skills in aged care assessment, and sophisticated professional and organisational capabilities. Providers do not currently have access to the credentials of assessors as they arrive on site, despite the fact that the accuracy of current assessment and the classifications is dependent on a very high level of expertise. Anglicare views this as a lack of the open disclosure that forms a key foundation of the aged care industry, and is a requirement for providers as they plan, deliver and communicate care to residents, families and partners in care.

It is therefore important to remember that a single assessment at a point in time may not reflect underlying issues and so the relevant information collected by the provider is critical.

b) Lack of open disclosure processes

The basis of ACFI was ongoing assessment processes made by the provider based on scores across three domains with 12 questions. Anglicare recognise the importance of residents, families and partners in care being involved in and informed of this assessment process and acknowledges the importance of this open disclosure under the requirements of Aged Care Standards 1,2,3 and 4. The presence of open disclosure made it possible for all involved in resident care to understand the rationale for the assessment results that underpinned planned care.

Under AN-ACC the assessment process appears to be 'close ended' and, as witnessed in the shadow assessment process, does not openly involve the resident family, the residents nominated Partner in Care or the staff involved in delivering the care. Equally, ACFI care plans were based on assessed care needs and resident goals- a process which had greater holistic resident involvement. The new assessment system does not appear to take resident wishes, goals and aims into account. Anglicare considers the AN-ACC process to be one that excludes consideration of the whole of the person that is the focus of the funding provision. Nursing and care staff, who know the residents and their needs well, are often totally excluded from the funding assessment process and frequently not consulted. Moreover, the assessors do not share the rationale for their classifications.

In addition to the lack of open disclosure to residents, Anglicare maintains that facilities need to be able to contribute to the assessment process. In recognition of the understanding of resident function and care needs across time, individual provider staff can add value to the assessment process based on their understanding of individual care needs. This may include support to AN-ACC assessors simply by providing relevant documentation without necessarily being involved in the direct assessment process with the resident. Providers therefore need to get a good understanding of the assessment evidence and the tools themselves and how this then translates into care needs and care planning. Currently this does not appear to be an option

Some residents are being classified at a level that is at odds with their ACFI classification, but the provider is not being given the rationale for the change and this in turn affects the care minutes being allocated which has the potential to adversely affect the quality of care being received by the resident.

***Recommendation**: That open disclosure processes are embedded into the resident assessment process and the rationale for classifications.*

***Recommendation**: There needs to be greater transparency and involvement of providers in relation to the assessment process and the rationale for classifications.*

***Recommendation**: There needs to be greater inclusion and focus on the goals and wishes of residents and their families in the funding assessment process, not just the current assessments which only focus on a resident's capability*

c) Lack of an appeals/validation process

During observed AN-ACC assessments to date, there are clear inconsistencies between different assessment teams – some take considerable time and also consult with relevant care plans, others rely on short interviews with the resident and are not clearly informed of the care needs of the resident through the care plan. Where residents are reclassified the provider is not given a rationale for that change. There needs to be greater inclusion and focus on the goals and wishes

of residents and their families in the funding assessment process, not just the current assessments which only focus on a resident's capability. The variations observed in resident assessments combined with the gap in process transparency to the provider heightens the challenges for a provider to clarify an individual resident's classification. Staff have noted that under ACFI care has been deemed low for some residents but they have returned a high AN-ACC classification while others that have been deemed high care previously, are now returning low AN-ACC classifications. This would indicate there needs to be some form of verification process before the classification is finalized. ACFI had a validation process built into it, but this appears to have been eliminated in the new model.

Anglicare advocates for a validation process that could entail the assessor sending the detailed assessment and proposed payment class to the provider prior to the classification being finalised. The provider could then have 5 business days to submit an objection, with any supporting information and clinical documentation. If the two parties still cannot agree on the final classification, a formal reconsideration process must be available to the provider where another external assessor may be required to conduct the funding assessment. Anglicare believes that an appeals process would introduce a more appropriate level of responsibility for assessors. Under the new system, there are no defined consequences for flawed assessments.

Recommendation: *A defined validation process be added to the assessment process, to minimise the likelihood of incorrect classifications which have an impact both on the provider and the care received by the resident.*

d) The funding model

There are also some challenges evident with the funding model itself:

- It appears to have been developed without significant data development re estimates of the actual costs of care ie what people in varying stages of frailty need in an aged care setting and what does it cost to meet those needs. It appears to be a redistributive model in line with how hospital care is currently funded, which has a shorter length of stay than aged care and which also has a focus primarily on clinical care.
- The Aged Care Quality and Safety Commission requires a focus on meeting the individual needs of residents but the new funding model appears to be based on a hospital based reporting system which fails to recognize that this is a home where people live – with elements beyond that of clinical and personal care – which is the main focus of the new pricing model.

Recommendation: *The Pricing framework needs to take sufficient account of a range of other supports beyond clinical and personal care necessary to deliver holistic care.*

2. What, if any, concerns do you have about the ability of AN-ACC to support long term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?

It is important to remember that the new funding model was developed pre COVID and has not taken into account the extraordinary impact this has had and continues to have on costs of care. Additionally, such modelling occurred prior to the serious decline in the financial performance of the sector where half the industry is making cash losses and net results are negative – the sector

is approaching what Stewart Brown has called a fiscal cliff. There are other factors which also impact long term improvements:

- There is no funding capacity in the model that allows for **innovation** – on which future development, safety and efficiency would be underpinned.
- Sustainability is very reliant on indexation that accurately reflects changing costs but indexation has traditionally been lower than inflation which in turn erodes the funding base and longer-term financial viability. The sector would need assurances that **full indexation** will apply.
- Long term improvements in terms of quality of care may well be compromised by the focus on rostering and meeting care minute targets rather than setting in place a framework with a focus on delivering **quality care outcomes** for residents.
- Longer term improvements are predicated on a holistic approach to care so it is difficult to see how this new system will be sustainable into the long term with the sector being pushed towards a pseudo acute care model without the benefits of a **holistic 'home' pricing and care minute model** with pastoral and lifestyle care supports.
- The new model will significantly add to the **complexity of both administration and reporting**, which will not be considered in the care minute allocation but which will take up considerable unfunded time of care staff and RN's.
- The funding and care minute model does not align with the other regulatory aged care requirements and thus fails to allocate sufficient funding or care minutes to all tasks within a care home.

Recommendation: *For long term sustainability the AN-ACC model needs to include capacity for innovation and full price indexation, address the new complexity of administration and reporting, focus on quality of care outcomes for residents and align with all associated regulatory requirements in the aged care industry.*

3. What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents?

Costings for AN-ACC were based on 2018 data and do not necessarily reflect the current cost environment where 60% of providers are currently reporting losses. In the case of the current model costing is based on the care workforce – which represents about 60% of the activity in a residential aged care facility. Costing for the remaining areas such as servery, maintenance, laundry, cleaning and allied health appear to be largely unrecognised in the new funding arrangements.

Funding appears to be based on the staff role rather than the actual care needs of the resident which leads to some inconsistencies. For example, if a physiotherapist provides physical therapy for pain management this does not contribute to the care minutes but it does if provided by an RN – who is less qualified to deliver such an intervention. The funding is thus not considering the actual treatment required but rather the role delivering that treatment.

Thus, the approach neither supports collaborative care approaches or multi-disciplinary care teams. Unfortunately, funding currently relates only to a narrow definition of care minutes and not to the other activities that take place in order to deliver a holistic model of care.

4. What should be considered in developing future refinements to the AN-ACC assessment and funding model?

Classifications need to truly reflect the whole care needs of the resident but in this model only personal and clinical care is being considered. Also, tasks staff are required to undertake because of other regulatory requirements needs to be factored into the funding and care minute model. The current suite of funding assessments does not include an assessment for cognition. A person's cognitive ability has a direct impact on their ability to perform daily tasks, manage their behaviour and social interactions and thus care requirements. The 'Assisted Mobility' classifications also reference a resident's cognitive ability and thus a standard assessment should be available.

Recommendation: *the model needs to adopt a broader more holistic approach enabling multi-disciplinary platforms of care which have the resident and their wishes and goals at the centre of the care delivery system.*

5. What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services?

The Pricing Framework needs to have an underlying principle of holistic person-centred care bedded on the understanding that residential age care facilities are not sub-acute defacto hospitals but the homes of residents where clinical and personal care is important but so is a range of other care supports which are required to generate positive whole of life and quality of life outcomes in line with the current aged care Standards.

The cost to provide care to ensure the delivery of the Aged Care Standards, and all other regulatory requirements, should also be calculated and reflected in the AN-ACC price.

The principle of Quality Care should also include reference to resident and family expectations, not just those of the community.

One of the Process principles, Administrative Ease, should be reviewed. Under AN-ACC, and with the introduction of care minutes and associated reporting, administrative burden has increased. It has also increased in roles that do not receive direct funding or contribution to care minute allocation.

6. What, if any, additional principles should be included in the pricing principles for aged care services?

Anglicare considers there are several key principles which should underpin the pricing model:

- There needs to be a focus on the delivery of multi disciplinary care ensuring all the needs of the residents are being addressed.
- There needs to be a strong alignment with the aged care Standards, and other regulatory requirements, to ensure they are not in conflict with each other and if person centred outcomes are to be achieved
- There needs to be a reference to meeting the holistic care needs of residents, including spiritual and emotional care needs.

7. What, if any, issues do you see in defining the overarching, process and system design principles?

- The current design principles make no reference to person centred care
- One of the key principles is fostering innovation but it is difficult to see how innovation can occur in a funding model that is so focused on minutes of care being delivered in a very tight funding model leaving little room for the time or costs of innovation.
- The new system will not be easy to administer – it now has increased complexity of reporting and administrative requirements particularly in relation to rostering.

8. What, if any, concerns do you have about this definition of a residential care price?

The pricing model only partially funds the Standards of care – namely Standards 3 and 4. It does not fund the other six Standards making compliance and overall financial viability difficult given these Standards still need to be met and the provider will be incurring the costs involved in ensuring these Standards are met.

Providers have a number of other government and compliance requirements (Aged Care Quality and Safety Commission) which adds complexity and cost eg SIRS reporting and restrictive practices which takes staff away from care time. These requirements still need to be met, or providers can get sanctioned, but time allocation for this is not funded despite the fact that these requirements take staff, particularly RN's away from face to face service delivery and reduce their care minutes.

There is also the need to consider that unlike the hospital system, the aged care industry does not receive additional funding from the state governments or health insurers. Therefore, the residential care price must be reflective of this.

9. What, if any, additional aspects should be covered by the residential aged care price?

- There is an absence of funding for **lifestyle activities**, engagement and reablement as required under the Standards. Lifestyle assists with maintaining quality of life and contact with families as well as reducing isolation and supporting and improving mobility and interactions with others. The new funding model needs to reflect the breadth and depth of the holistic and person-centred care required under the Standards for which providers are accountable and are required to comply.
- The cost of some **hospitality services** need to be considered eg catering, laundry, cleaning (which have become especially critical to the residents wellbeing during COVID).
- There also needs to be more funding for **allied health** – OT, speech, podiatry, dietitians – these services are often imperative to meet clinical needs and standards and providers have to ensure these needs are met whether funded or not. In residential aged care private health funds don't cover these additional services as they do in the acute hospital system. Under ACFI allied health was very restrictive (mainly focussed on pain management) and it needs to be expanded under the new pricing framework. As a result, the allocation of funding to allied health needs to be increased.

- During COVID other costs have also become significant including the regular need for deep cleaning and the cost of **resident consumables** such as RA testing and masks etc and these need to be included in the new pricing arrangements.
- The cost of **training –** which will need to escalate under the new system – is also not included in the pricing model and the costs of the additional training required will need to be absorbed by providers along with the inherent costs of changes to the training system, processes and reporting.
- The model does not account for **pastoral care support** which is integral to a holistic model of care for residents. Providers have an obligation under the Standards to support residents emotional, psychological and spiritual wellbeing but this is not within the current remit of the new pricing model. The absence of pastoral and spiritual care from the new funding model is an example of the gap that will be created between government expectations as expressed in the Standards, and the actual levels of funding needed by providers to implement these Standards.

Recommendation: *the new Pricing Framework needs to include additional activities beyond personal and clinical care including lifestyle, hospitality, allied health, resident consumables, training and pastoral care support.*

12. What should be considered in the development of an indexation methodology for the residential aged care price?

There needs to be a guarantee of full not partial indexation with the CPI if funding is not to steadily erode the real cost of service provision.

Indexation should also fully fund any adjustments to wages made by the Fair Work Commission in real time, even if it is outside the IHACPA advice cycle. If the increases are not funded in a timely manner there is increased risk of providers exiting the industry resulting in a potential reduction of beds.

13. What, if any, additional issues do you see in developing the recommended residential aged care price?

The residential aged care pricing model is based on an assumption of the availability of the workforce as required in order to deliver the care minutes allocated. This is going to be problematic given the shortage of RNs and care workers within the country.

16. What evidence can be provided to support any additional adjustments related to people receiving care?

The key driver under the new framework which determines classification is mobility. However someone who has dementia and/or significant cognitive dysfunction, often requires greater intensity of care, even when fully mobile. The classification system does not appear to take this into account.

Q17. What should be considered in reviewing the adjustments based on facility location and remoteness?

Facilities that are classified as MMM 1- 4 are paid a BCT based on occupied bed days. However, for facilities located in regional locations, staffing can be problematic. As a result, a facility may restrict the number of residents they can admit as they are unable to employ the necessary staff

to meet care needs and care minutes. Consideration should be given to such facilities to receive additional funding as occupied bed days will be low.

There also needs to be funding consideration for homes in locations in MMM1-4 where excessive cost of living pressures prevent staff travelling long distances to facilities in well-populated areas, thus resulting in the provider restricting the number of available beds.

19. How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?

Quality and safety issues should not be a long terms consideration given that on a daily basis homes are accountable to the Commission and can be sanctioned if these Standards are not met. If pricing for safety and quality can't be become a short-term objective, then aged care standards should change to be based on resident outcomes, not experience, ensuring a proper sample size is consulted as part of the accreditation process.

Recommendation: *The pricing issues in relation to safety and quality need to be developed in tandem with the pricing model.*

Q20 Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?

Hotel services play an important part in the provision of care to residents living in residential aged care and should form part of the AN-ACC funding model, including care minutes. If it remains separate to AN-ACC, it should also undergo an ABF assessment to ensure the figure set by the government (85% of the aged care pension) is sufficient to cover the cost of required services and regulatory requirements.

Q21 What should be considered in future refinements to the residential respite classification and funding model?

The funding model for respite should also make allowance for the onboarding of respite residents as this process is the same as onboarding a permanent resident.

22. What are the costs associated with transitioning a new permanent resident into residential aged care?

There are significant costs associated with transitioning a new resident into permanent residential care. These include the need to set up documentation, conduct clinical and lifestyle assessments, observations and reviews, development of an agreed care plan with redesigns and care conferences with families. These are completed within 28 days of entry – although it needs to be acknowledged that all of these are fast tracked when dealing with respite care – which places a significant administrative burden on staff.

Recommendation*: The ANACC price should also include a one-off payment for residents on respite as they undergo the same onboarding process (and thus associated costs) as permanent residents. The higher daily rate for respite should only reflect the care need requirements.*

23. How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?

Australia's aged care workforce is under pressure. Research from the Australian Aged Care Collaboration and Anglicare Australia has shown that wages for aged care workers haven't kept

up with living costs, with workers across the sector being priced out of their own communities. It also found that many workers are leaving aged care altogether.

The 2021 CEDA report estimated that there would be a shortfall of 110,000 aged care workers by 2030 and the sector would need at least 17,000 more direct aged care workers each year to meet basic standards of care.[1] In June 2022 CEDA updated this shortfall from 17,000 to 35,000 as a result of circumstances driven by the pandemic.[2] The reasons for this ongoing shortfall are numerous including: demographic changes, reduced migration, low wages, poor career progression, inconsistent working hours, working in COVID environments generating burn out and staff attrition and negative perceptions of aged care as an employment option, particularly for younger people. This has been further exacerbated by the very low levels of unemployment which provides incentives for staff to reconsider their current careers in aged care. The attrition rate is concerning, estimated to be 65,000 workers a year.[3]

Anglicare recognises the significant work, skill and expertise provided by our staff in the residential aged care setting and the need for such wage incentives to be able to recruit more effectively as well as retain existing staff. The COVID pandemic has undoubtedly adversely impacted both recruitment and retention in relation to the aged care workforce. Workforce issues may significantly impact ability of providers to deliver care under the current pricing arrangements if wage incentives add to the current cost of service delivery and the system is not sufficiently flexible to take this cost into account. It may be financially feasible for some providers to deliver the care minutes required but not logistically possible if there is not sufficient workforce to implement the care.

24. What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?

The new model needs to consider a focus on the measurement of resident outcomes and quality of life not just subjective measures and outputs such as care minutes. Care minutes do not necessarily translate into quality care.

25. What would be considered markers of success in IHACPA's aged care costing and pricing work?

- Improved financial viability of good providers
- Improved resident outcomes
- A viable well paid, well trained accessible workforce
- Reduced attrition of the workforce – less than 25%
- Reduction in unnecessary transfers to hospital

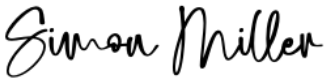
[1] CEDA (2021) *Duty of Care: Meeting the Aged Care Workforce Challenge,* sighted at Aged-Care-Workforce-2021-FINAL.pdf (ceda.com.au) p4

[2] CEDA (2022) *Australias Aged care Crisis Escalates – Staff shortage Doubles* sighted at CEDA - Australia's aged care crisis escalates - staff shortage doubles

[3] Ibid

CONCLUSION

Anglicare Sydney greatly appreciates the opportunity to respond to this consultation process and we look forward to further discussions in relation to the implementation of the new pricing framework. We are available to provide further feedback if required.



Simon Miller

Chief Executive Officer

11 October 2022