



**LEADING AGE SERVICES**  
AUSTRALIA

*The voice of aged care*

# SPECIALIST DEMENTIA CARE UNITS

Government Consultation Paper

## Abstract

LASA supports the need for greater clarity about the proposed benefits, particularly the efficacy of adoption of such a program, and seeks clear evaluation parameters. This should measure the benefits, risks, duplication of effort, and consequences of implementation of SDCUs.

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<p><b>GOVERNMENT QUESTION – SPECIALIST CARE DEMENTIA UNITS (CSDU)</b></p>	<p><b>LASA Members’ Issues, Concerns and Queries</b></p>
<p><b>3. Development of SDCU service model</b></p>	
<p><b>Q1. Are there are other system reforms that would impact on, or be impacted by, the establishment of Australian Government-funded SDCUs?</b></p>	<ul style="list-style-type: none"> <li>• Changes within the <i>Aged Care Act 1997</i> would be required to cover SDCU specific requirements</li> <li>• Legislative amendments to ordinary <i>security of tenure</i> arrangements will apply during placement in and exit from SDCU</li> <li>• LASA notes that there are additional processes around the R-ACFI (<i>Rosewarne proposals</i>), and additional behavioural support funding for residents with a diagnosis of dementia and severe Behavioural and Psychological Symptoms of Dementia (BPSD). Currently, the Rosewarne proposals appear to be in abeyance pending the outcome of the Resource Utilisation and Classification Survey due in later 2018.</li> <li>• Amendments to the <i>User Rights Principles 1997</i></li> <li>• Amendments to the <i>Fees and Payment Principles 2014</i></li> <li>• Amendments to the AACQA Accreditation processes</li> </ul> <p>Any changes regarding CSDUs would be pursued in an environment of other potential changes in light of the Carnell Paterson Report on aged care quality and the Tune Report. Although, these reports do not make any recommendations about dementia units.</p> <p>However, it is important to note our Members’ current commitment to meeting complex client needs. Our Members work diligently to care for and support older Australians and their families. This is done with the compassion and professionalism that you would expect in a world class, age services system. Nevertheless, in our pre-Budget submissions for 2018-19, LASA has pointed out funding shortfalls (including in relation to high needs care) that require both immediate injections of new funds to residential aged care and longer-term, well-planned reforms to the aged care system, including additional public and private funding.</p>

<p>Q2. What other risks and issues need to be considered in introducing SDCUs into the existing service systems for people with very severe (tier 6) BPSD?</p>	<p>Tible et al (2017) suggest that BPSD occurs on an almost regular basis as dementia evolves, regardless of the dementia type. The causes of, and risk factors for BPSD, are multiple, with interacting biological, psychological and social/environmental causes and vulnerability factors. Even with optimal management, BPSD will not disappear completely and, in some cases, and will remain challenging for all involved parties (Tible et al, 2017).</p> <p>LASA notes that a primary concern for rural and remote operators is the additional emotional stressors placed on families and communities living with a person with severe BPSD. There is a challenge for families in smaller towns, when a loved one is moved to a metropolitan area for assessment and treatment.</p> <p>LASA maintains that a resident’s and or caregiver’s location can affect the impact and subsequent management of BPSD. Symptoms that pose difficulties in an urban setting, such as pacing or wandering, may not be regarded as problematic in a rural setting, where most residents will have room to pace and are less vulnerable if they wander.</p>
<p><b>Q3. Are there alternatives to the establishment of SDCUs that would better address the current system issues, which should be considered by Government?</b></p>	<p>One Member asks “... if core business is <i>dementia</i> then what should our priorities and strategies be to address resident need?” For the vast majority of residents with dementia, there is no need to separate them from individuals who do not have cognitive impairment. LASA believes facilities should be designed according to dementia friendly principles and that the quality of dementia care in mainstream facilities should be improved as a priority.</p> <p>The International Psychogeriatric Association (IPA, 2012) outlines the overarching principles that promote and support the mental health of all residents, irrespective of dementia. These include a facility-wide commitment to:</p> <ul style="list-style-type: none"> <li>• Individualised, person-centred care</li> <li>• Respect for family ties</li> <li>• A biopsychosocial care planning framework</li> <li>• A culture of caring that prioritises quality of life</li> <li>• A social and physical environment that is responsive to changing needs</li> <li>• A focus on early intervention and prevention as well as treatment</li> <li>• Staff training and development as necessary to enable the provision of informed and competent care.</li> </ul> <p>At present, in the Australian context, there is little incentive for aged care facilities to improve their level of care beyond what is required to meet the standards of the Australian Aged Care Quality Accreditation Agency (AACQA). This is because the current Aged</p>

	<p>Care Funding Instrument (ACFI) does not recognise the additional costs or time required to support individuals with cognitive impairment, nor the assistance required to provide appropriate social engagement and other activities associated with providing care to individuals with dementia. LASA affirms there is a need to better match funding levels to care needs and best practice approaches, and improve incentives for quality dementia care.</p> <p>There is a growing body of evidence suggesting that transitioning the care recipient to services to support and assist in managing their behaviour (e.g. acute care, Older Persons Mental Health Unit (OPMH)) ; has met with poor outcomes for the older person. These include escalation of behaviours, disorientation of care recipient, non-specific dementia trained staff not understanding the complexities of the care recipient, the negative impact on their primary carer and the psychological and emotional stress of the care recipient. As the SDCU is seen 'transitional care'; consideration must be given to the surmounting evidence of the negative impact on the care recipient.</p> <p>One Member suggests a "...layered model of delivery.." strengthening the use of the existing OPMH to support the resident in the facility, which would be charged back to facility. Flexible funding models available to the Approved Provider to assist in providing wrap-around services could be a better, bespoke model of care.</p> <p>LASA advocates for an inclusive person-centred approach to care. This approach enhances the life of the person living with severe BPSD by focusing on counselling and psychological services supportive of a wellness model. The use of music, sport, meaningful activities, recreational exercise, can provide a non-clinical basis for improvements. This approach takes in the therapeutic environment, re-enablement and a range of non-pharmacological approaches which are culturally and linguistically diverse and appropriate to the person. There is a substantial body of evidence in support of the use of psychosocial interventions for BPSD, indicated as first-line management for emotional and behavioural disturbances in individuals with dementia, which are culturally appropriate. (Lawlor, 2002).</p> <p>Members suggest that provision of coaching-counselling to assist in adjusting to life with a diagnosis of BPSD, may include the possibility to flag where supports may be useful at future dementia 'transition points'.</p> <p>Members content that the mixed-mode and flexible delivery is essential to enable access for people in regional and remote areas</p>
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	<p>of Australia and marginalised or highly vulnerable groups (including people who live alone) to access service</p> <p>LASA maintains that in its role as system steward, the Department of Health must continue to fund initiatives that further embed dementia as core business</p> <p>Other aspects that support people with a diagnosis of dementia include:</p> <ul style="list-style-type: none"> <li>• Respecting the rights of individuals,</li> <li>• Integrated settings that address an individual’s full needs,</li> <li>• Strengthen the approach/implementation to create dementia friendly communities,</li> <li>• Having an increased emphasis on early contacts particularly in the health space,</li> <li>• Critical evaluation of how to navigate the system and this needs to be available in forms other than digitally,</li> <li>• Value of tailored tools and resources to guide professionals,</li> <li>• The system may not be broken but people may not be leveraging what is already available,</li> <li>• Put all suggestions through a lens that addresses issues that have to do with geography, the disadvantaged and diversity of individuals, and</li> <li>• There is lots of information but it is diverse and there is no single way to integrate or access it.</li> </ul>
<p><b>Q4. Do you consider 1,450 to be a reasonable estimate of the national demand for SDCU-like beds for people with very severe BPSD? If not what other factors and/or methodologies should be considered</b></p>	<p>LASA questions the validity of the estimation of the number of deduced beds required as 1,450. There is no indication of the methodology for this forecast including growing demand over time. The Australian Institute of Health and Welfare<sup>1</sup> says that in 2011, there were an estimated 298,000 people with dementia. This number is expected to increase markedly over time, with projections suggesting it will reach around 400,000 by 2020 and 900,000 by 2050. Modelling for all dementia services and the resultant required funding needs to take into account such demand projections, looking at demand for different levels of dementia care.</p> <p>In order to put into place effective strategies to manage BPSD, LASA believes that it is necessary to accurately measure the nature of the behaviours, their frequency and timing, and potential triggers and underlying causes. Measurement of the medical, psychological, social and environmental context of the unique individual with dementia is critical. This is particularly critical as a focus for future</p>

	<p>research, since the availability of resources and staffing to support more piecemeal interventions may be more or less feasible in various settings, and more or less efficacious in the long term.</p> <p>1: <a href="https://www.aihw.gov.au/reports/dementia/dementia-in-australia/contents/summary">https://www.aihw.gov.au/reports/dementia/dementia-in-australia/contents/summary</a></p>
<b>4. SDCU proposed service model</b>	

Q5. Are the proposed SDCU service principles appropriate? If not, how should they be amended?

The Australian Institute of Health and Welfare (AIHW) estimated that up to 90% of residents in high care may have some form of cognitive impairment (AIHW, 2016). Aged care facilities therefore need to be capable of providing high quality dementia care regardless of whether they have a ‘dementia specific care unit’. Given, a high proportion of aged care residents have some form of cognitive impairment, it is critical that dementia care is seen as part of the core business of main stream aged care facilities.

LASA agrees that the service principles as outlined, are an *inherent* option for an Approved Provider who sees ‘dementia as their core business’ (See Q 3 above).

LASA believes further information and clarification should be extended to objective (6) *employ adequate numbers of appropriately trained staff* – what is considered adequate and what is suggested of appropriately trained, based on? What metrics would help to guide operators including given different variables in their clients and care models?

LASA maintains that BPSD management requires individualised assessment and treatment planning and application of individualised intervention techniques. Some of the more concrete or tangible interventions, such as exercise, psychosocial interventions and sensory stimulation have been found to have an effect on BPSD while they are being administered, rather than over a longer term. There is certainly a need for interventions that can be used to reduce agitation and aggression and elevate mood in the moment, both as crisis management interventions and as a means of enhancing quality of life. More programmatic interventions i.e. staff training, individualised assessment and care planning may be expected to have a more generalised effect, changing the prevalence and intensity of BPSD within the facility.

LASA supports an interdisciplinary team approach for people living with severe BPSD. This may improve treatment outcomes for a wide variety of presenting problems within the facility. Structured, empirically-based interventions for BPSD require interdisciplinary teams with particular interest and commitment to this type of care (Lawlor, 2002).

Interdisciplinary treatment teams have been shown to provide superior care in community and hospital-based aged care settings and research evidence is accumulating about their efficacy in residential care settings. A wide variety of disciplines may participate in an interdisciplinary care team. While the exact professional mix within teams may vary due to many factors e.g. resident mix, staffing mix, funding constraints, key elements of interdisciplinary knowledge, communication, and respect remain.

<p>Q6. Are the proposed benefits what SDCUs should be aiming to deliver? If not, why?</p>	<p>LASA has been consistent in its views that taking away the previous supplement diminished providers' capacity to deliver high standards of care to people with BPSD. The 2015 Dementia Services Review by KPMG report stated:</p> <p><i>"This raises a question of whether the current approaches are effective in building sustainable capability in the aged care workforce, but there is also a question about the need for cultural change in parts of the aged care sector, so that dementia capability, including behaviour management, is accepted as part of core business and an essential in house capability, rather than a discrete expertise or specialty area."</i></p> <p>LASA supports the need for greater clarity about the proposed benefits, particularly the efficacy of adoption of such a program, and seeks clear evaluation parameters. This should measure the benefits, risks, duplication of effort, and consequences of implementation of SDCUs. .</p>
<p>Q7. What are the pros and cons of the SBRT performing the SDCU assessment service role? What other body (or bodies) might appropriately carry out this role</p>	<p>LASA notes the evidence in the 2016 Ministerial Dementia Forum Discussion Paper: Redesigning Dementia Consumer Supports; reports on services provided by the SBRT service. The number of contacts by the SBRT service is well below that envisaged at its outset, which was approximately 2,500 per annum. LASA notes that combining the picture of low demand for SBRT, cost issues regarding Behaviour Supplement, the creation of a specialised accommodation service that perpetuates a message that people with dementia and their behaviours are a problem to be managed, with an ongoing failure to invest in providers' in house capability suggests that Australia has not got its policy settings right in this area.</p> <p>Members suggest an open, honest, clear and transparent processes in how Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Team (SBRT) will support the PHNs in delivery of service.</p> <p>Members believe a view, not necessarily supported by evidence, that small cluster housing is the definitive process in management of severe BPSD.</p> <p>Members also note dementia resources and services are being held monopolistically by one provider (SBRT and DBMAS are resourced by Hammond Care).</p> <p>Members ask, where is the equity of access for other provider? Where are open market drivers and competition?</p>

	<p>LASA affirms that a comprehensive bio-psychosocial assessment of the person living with BPSD is a necessary first step to ascertain causative factors and consider optimal interventions. Co-morbid conditions such as schizophrenia, depression, and alcoholism may vary in frequency across communities and could alter the presentation of BPSD in these clients. Indeed, without preliminary assessment data, one cannot evaluate the effectiveness of an intervention. Further, careful selection of appropriate assessment tools can help to craft and carry out empirically based, person-centred care plans to help alleviate BPSD. Screening and assessment measures may require varying levels of training to be administered correctly. Necessary training as well as appropriate follow-up is essential.</p>
<p><b>Q8. Might the requirement for evidence of a primary dementia diagnosis impact on timely access to SDCU services for some people with BPSD?</b></p>	<p>Confirming a diagnosis can be a lengthy process but certainly a medical diagnosis would be optimal. It would ensure that the resident has a comprehensive care plan that includes all the diagnostic and assessment information from their health practitioners.</p> <p>Assessments that do not have definitive diagnosis of dementia, which centre on defined scores for the proposed assessment tools indicate a high level of symptomology, and therefore could be a valid and useful tool.</p> <p>Members ask what modelling has been undertaken to ensure that those clients with cognitive impairment are captured.</p> <p>Existing tools such as PAS-CIS, indicating those residents exhibiting moderate or higher levels of impairment will not be sufficient to undertake the assessment, develop the care plan in consultation with the client/family, and manage the symptoms.</p> <p>Results should be analysed carefully using a family member input may introduce a bias to any tool.</p> <p>The PAS-CIS is not a valid tool for clients with behavioural issues arising from alcohol related dementia which is often found in clients who have been homeless or at risk of homelessness.</p>
<p><b>Q9. Are the proposed assessment arrangements appropriate? If not, why not?</b></p>	<p>LASA notes that the assessment criteria should be based on evidence-based clinical practice, and not be driven by the availability of funding.</p>

<p>Q.10 What other factors should the SDCU assessment service consider in deciding whether to recommend a person for a SDCU placement?</p>	<p>LASA supports the use of appropriate assessment tools to drive care planning which also support a valid claiming process. LASA supports the recommended tools as examples of appropriate assessments. However, LASA notes that many Approved Providers have “...invested in the development and implementation of tools for the holistic assessment of resident need...” and these may have a role. There may be other appropriate instruments that could be validated for use.</p> <p>Making particular assessment tools compulsory could impose a significant burden on Providers especially if current IT systems require enhancements and amendments.</p> <p>Efficiency via links to broader health related assessment, care and management systems should be considered.</p>
<p>Q 11. Is an 8–12 bed unit (within a larger residential aged care facility) the appropriate care setting for SDCUs? Are there circumstances in which larger or smaller units would be more appropriate?</p>	<p>Members want to see the Government supporting a range of models for people living with severe BPSD, addressing the wider issues of appropriate and flexible funding to care for these people in their own environments.</p> <p>Members suggest the number of residents within the SDCU is too small and not financially viable for operators. Some operators are trialling smaller units for residential care generally (e.g. 8 persons and in some cases they can be viable but there are higher costs involved). In metropolitan areas it may be feasible to have clusters of 8-12 bed units, to help capture economies of scale in services. Overall, it may be difficult to determine the optimal size for a unit, other than in terms of a size that is optimal for service viability. For many years, group homes have applied in the disability sector (often of the order of 6 people) but there is no clear evidence on the right size for these homes.</p> <p>LASA notes there is no prescribed number of beds within the literature, indicating reduced BPSD within a closed environment. LASA recommends further methodological and experimental evidence to demonstrate the feasibility and effectiveness of such interventions.</p> <p>The Government may need to clearly define the outcomes sought from SDCUs in order to determine their optimal size. Review of different sized trial SDCUs might be one option. In regional areas smaller SDCUs might be needed so that family are not too far away from the residents.</p> <p>One Member sees the SDCUs as being opposed to the philosophical belief of person centred care. SDCUs are seen as “lock ups”, which restrict the movement and flow of residents.</p>

	<p>Alternatives include application of personal monitoring devices, technological apps, CCTV, appropriately trained staff with individualised strategies for the person living with severe BPSD, as part of an intentional community. A core consideration in any model is the overall wellbeing and utility for all the residents in a residential care home.</p> <p>Marshall (2001) contends that the environment should be designed in such a way as to compensate for disability, maximise independence, reinforce personal identity, enhance self-esteem and confidence, demonstrate care for staff and welcome relatives and the local community.</p>
<p>Q12. Should there be a maximum limit on the duration of an individual’s residence within a SDCU? If not, why not? If so, how long?</p>	<p>LASA argues that there can be no maximum limit on the duration of person with severe BPSD within a SDCU. The duration of stay will need to be aligned with the specific needs of individual clients. BPSD are a heterogeneous group of symptoms and signs, all of them may cause significant suffering in residents and caregivers who are unable to be effectively cared for in mainstream aged care services due to risk of harm to self and others. The duration must match the disease progression and the approached used must be person centred.</p> <p>LASA maintains that studying behavioural and psychological symptoms of dementia (BPSD) across cultures allows the identification of similarities and differences that may be useful to determine the best approach to managing these symptoms in different populations. An effective approach to management in one culture may not necessarily work in another, given the different prevalence of various BPSD and the level of tolerance for these symptoms within that culture.</p>
<p>Q13. What is a reasonable period for transitional support from a SDCU to the new accommodation provider</p>	<p>LASA supports the need for greater clarity around the term “transitional support” and “staff ratios”. Flexible approaches are required. More information is needed on the proposed benefits, particularly the efficacy of adoption of such a transitional program,. There should be clear parameters for evaluation to measure the benefits, risks, duplication of effort, and consequences of implementation across all levels.</p>
	<p>LASA members support the review of security of tenure provisions. Changes within the <i>Aged Care Act 1997</i> to include the SDCU specific requirements would be needed.</p>

<p>Q 14. Might existing security of tenure arrangements pose a significant issue for the 'transitional' operation of SDCUs? If so, how</p>	<p>Legislative amendments to ordinary <i>security of tenure</i> arrangements will apply during placement in and exit from SDCU.</p>
<p>Q15. What strategies could be used to facilitate SDCU 'throughput' within existing security of tenure provisions?</p>	<p>LASA maintains that training for staff, residents and family, in BPSD have been, and continue to be, applied as a multidisciplinary approach in various stages of dementia and related disorders. This can be used to assist the resident to remain in their primary facility.</p> <p>Training interventions such as task analysis, reminiscence, modelling, remodelling, distraction and de-escalation are need to be based on the principles of appropriate adult communication, meaning and purpose for the resident, person centred approach, acknowledgement of the person's triggers and culturally sensitivity. For these reasons, education must include the resident, their family and significant others involved in their care, directly and indirectly.</p>
<p>Q16. What mechanisms should be used to support partnerships between SDCUs and acute services?</p>	<p>LASA believes that the key focus should be ensuring that knowledge and skills acquired are both relevant and applicable to the changing age services environment, providing work-ready staff, whilst also promoting age services as a profession.</p> <ul style="list-style-type: none"> <li>• As part of this funding provision, the Government should reserve funds for reviewing the barriers to skills development given different State-based approaches</li> <li>• A strategy for a more consistent national approach to ensuring the right workforce for the aged care sector - this could include funds for national aged care provider peak bodies to pilot the best options for nationally consistent capability-based training.</li> </ul> <p>Members state a "better understanding and defining clear pathways of referral and assistance" for the person living with BPSD will be essential.</p> <p>Members are also calling for increased education subsidies in training health professionals in severe BPSD and person centred care in de-escalation strategies for all allied services and acute settings.</p> <p>Members suggest there seems to be 'secret squirrel' processes around DBMAS and SBRT teams at present, not knowing how many</p>

	<p>teams there are and how much money is to be given to rural and remote area need.</p> <p>LASA recommends an interdisciplinary team approach which improves treatment outcomes for a wide variety of presenting problems within a facility. Structured, empirically-based interventions for BPSD require interdisciplinary teams with particular interest and commitment to this type of care (Lawlor, 2002).</p>
<p>Q 17. Should there be any additional requirements for SDCU providers caring for people from Aboriginal and Torres Strait Islander, CALD or other diverse backgrounds?</p>	<p>LASA supports the concerns of members regarding a risk of discrimination against special needs groups within SDCU e.g. CALD backgrounds, LBGTI and people from Aboriginal and Torres Strait Islander communities, people who are financially or socially disadvantaged, people who are homeless or at risk of becoming homeless, and people living in rural and remote areas.</p> <p>Members have noted that CALD elders are often unable to read contemporary versions of their language of origin. If providers are responsible for organising and paying for translations and interpreting of care plans, the costs will need to be passed onto consumers or covered under subsidies.</p> <p>Members have noted that there are inconsistencies between the statements in this section of the consultation paper and the National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds.</p>
<p>Q 18. Would it be feasible to establish SDCUs in rural and remote locations? How can SDCUs (or alternative initiatives) best support people with very severe BPSD living in rural and remote areas?</p>	<p>LASA believes that there is inconclusive evidence to suggest a built environment intervention is clinically warranted in aged care facilities to reduce BPSD (Soriel et al, 2014).</p> <p>The feasibility of SDCUs in rural and remote locations will depend on factors including population density, numbers of SDCU clients per local area, existing services, and distance for family Members to travel etc.</p> <p>There are other factors to consider such as a lack of GPs, acute care and allied health support services</p> <p>Access to and provision for specialist services required to care for people living with severe BPSD such as psychogeriatricians, geriatricians, psychologists or psychiatrists must be part of this process.</p>

	<p>One Member states that “...no consideration or discussion with rural or remote PHNs in how services should be delivered to these communities...” has been entered into in the previous consultations.</p> <p>One option may be to trial a small number of differently designed SDCUs in regional areas and compared the outcomes (quality of care, satisfaction /quality of life and costs) with baseline clients in general residential aged care (randomised control trial).</p> <p>The Government should consult further with all stakeholders to gain insights from experience, including optimal ways for PHNs to serve their communities.</p>
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**5. SDCU proposed funding and administration**

<p>Q 19. What specific costs would contribute to the ‘top up’ amount?</p>	<p>LASA supports the premise that an additional \$150-\$300 per bed per day is expected to be given as ‘top up’ funding. Concerns are raised in that specific costs such as staffing, increased activities, equipment, allied health assessments, provisions for administrative costs for additional services, food costs, furnishings, provisional landscaping of outdoor areas. Consideration to rural and remote areas for ‘charged back’ services of referral to behavioural management support such as SBRT or DBMAS and psycho geriatric services. Additional and ongoing costing for up skilling health practitioners and all staffing in supporting people living with challenging behaviours. Members ask, does the ‘top up’ funding match the need for flexible care services? One option may be to trial a small number of differently designed SDCUs in regional areas and compared the outcomes (quality of care, satisfaction /quality of life and costs) with baseline clients in general residential aged care (randomised control trial).</p>
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<p>Q 20. To what extent might these costs vary across SDCUs, for example in response to geographic location or local mix of people with BPSD?</p>	<p>Costs will vary depending on client needs and location. Variations in costs between current residential aged care homes with different locations and client profiles may shed some light on this. It is possible that the forthcoming Resource Utilisation and Classification Study will have some relevant data for this. LASA notes that remote operators tend to be in a worse financial situation than other providers, with larger gaps between subsidies and the actual cost of operations.</p>
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	<p>LASA approves option one: basic aged care funding plus ‘top up’ funding via a targeted supplement.</p>
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<p>Q21. Which 'top up' funding option do you prefer? Why?</p>	<p>At present, in the Australian context, there is little incentive for aged care facilities to improve their level of care beyond what is required to meet the standards of the Australian Aged Care Quality Accreditation Agency (AACQA). This is because the current Aged Care Funding Instrument (ACFI) does not recognise the additional costs or time required to support individuals with cognitive impairment, nor the assistance required to provide appropriate social engagement and other activities associated with providing care to individuals with dementia. LASA affirms there is a need to better match funding levels to care needs, in order to provide adequate funding and improving incentives for quality dementia care.</p>
<p>Q22. Are there other funding mechanisms that should be considered</p>	<p>LASA recommends that Flexible grants be offered, through the Dementia and Aged Care Services Fund, to support the development of scaleable, time limited and strategically innovative approaches to supporting people living with dementia, their families and carers. This may include identifying and addressing gaps in current services with new models of care and effective multi sectoral collaborations.</p>
<p>Q23. Is block funding, occupancy-based funding or a combination of both most appropriate for SDCUs? Why?</p>	<p>This issue has come up in reforms for the Commonwealth Home Support Program. In general terms, an economic framework is required to help guide when block funding may be more appropriate – this may be more suited to regional and remote areas with uncertain occupancy, where there are integrated services to manage complex needs that require some certainty of funding so that interlinking is not so fragile and for complex clients e.g. homeless people.</p>
<p>Q24. Are the proposed uses of 'top up' funding appropriate or should there be other costs included or excluded?</p>	<p>As noted above, top up funding should reflect different client needs that may arise above 'average care' given particular needs that may be related to factors including cultural background, co-morbidities and other factors that drive special care responses or the need for other integrated services.</p>
<p>Q25. With no specific capital funding for SDCUs proposed – is there a funding period to justify an operator investing to establish a SDCU</p>	<p>This would have to be modelled by individual operators and would depend on the specific model of care. Larger, metropolitan operators may have more investment capability. This is an accounting question and certainly short term trials or short term funded SDCUs would not encourage investment. Special provisions may need to be made for adequate bond levels etc. to incentivise any investment. The Commonwealth may need to consider providing capital funding for further trial SDCUs which could be evaluated for outcomes and financial viability.</p>

<p>Q26. Do the proposed provider funding arrangements pose any financial sustainability risks?</p>	<p>There are risks in any funding arrangement for providers and a key risk faced by residential care providers which has crystallised in many cases is that subsidies and contributions for capital costs do not match the real costs of provision. There is a risk that high needs based SDCUs would be particularly vulnerable to this risk.</p>
<p>Q27. Should any special resident fees and payments arrangements apply to people receiving care in a SDCU</p>	<p>Members have requested clarification of how Approved Providers will be advised of the maximum amount that can be charged as this would be important information for the AP to have prior to implementation.</p> <p>Members have also requested that there be an alignment between the fees policies established for the residential care, MTIC, and a review of RAD, RACs.</p> <p>In various submissions, LASA had advocated for higher consumer contributions in residential aged care for those who can afford it (for operating costs and capital), with David Tune noting the need for higher basic daily fees for those who can afford it, higher accommodation bond maximums, changes to how the family home is counted in the asset test and removal of annual and life time caps on means tested fees.</p> <p>With SDCUs likely to be high cost services, it is essential that residents cover costs to the extent that they can afford it.</p>
<p>Q28. Are the proposed provider selection criteria appropriate? Do you consider some selection criteria mandatory?</p>	<p>LASA strongly objects to the suggestion that the Dementia Supplement is only provided to Approved Providers who can demonstrate they have the capacity to deliver appropriate care for residents with severe behavioural and psychological symptoms. This assumes that the Accreditation System with all of the requirements an Approved Provider must meet, is in some way lacking rigor where Providers are already required to provide quality care appropriate to the residents' needs.</p> <p>This is the universal premise for any service funded by the Commonwealth Government; that the Provider must meet all of their obligations to receive Commonwealth funding. To add an additional burden to receive the new Supplement is unreasonable and untenable.</p> <p>This premise is discriminatory but more importantly does not support those services, especially in rural and remote, that do deal with residents who suffer with severe BPSD but may not have the capacity or sufficient numbers of people to set up formal relationships/services etc.</p>

	<p>An unintended consequence of ‘resident selection’ could occur if this criterion was to be implemented</p>
<p>Q29. Which factors should be prioritised in determining the regional rollout schedule and why?</p>	<p>The Government should consult further with all stakeholders to gain insights from experience, including optimal ways for PHNs to serve their communities.</p> <p>The feasibility of SDCUs in rural and remote locations will depend on factors including population density, numbers of SDCU clients per local area, existing services, and distance for family Members to travel etc.</p>
<p><b>6. SDCU program evaluation</b></p>	
<p>Q30. What factors should be considered in evaluating the SDCU program?</p>	<p>Consumer and stakeholder involvement in the design, implementation and monitoring of a SDCU approach is welcomed. Members have questioned and the overall intent for SDCUs.</p> <p>In framing a way forward, LASA proposes that any changes should be:</p> <ul style="list-style-type: none"> <li>• carefully designed, consistent with the underpinning principles of the reform agenda and acknowledging both the Aged Care Sector Committee’s ‘roadmap’ and the National Aged Care Alliance (NACA) ‘blueprint’</li> <li>• considered alongside work currently underway with regards to the Single Quality Framework, quality indicators, and consumer reporting initiatives</li> <li>• rigorously assessed with regards to intent, cost, logistics and regulatory impact for providers/consumers/governments.</li> </ul> <p>As with any evaluation, additional pilot SDCUs may be required, especially if these could be set up to be evaluated on a sound randomised control trial basis. This would require clear outcome measures and the evaluation would need to look at effect sizes compared to the baseline in areas such as client satisfaction/quality of life, care and clinical outcomes, economic efficiency of the model, flexibility to meet diverse needs, effective application of care models and technology, and staff capabilities compared to what is required etc.</p>