PROPOSAL FOR A NEW RESIDENTIAL AGED CARE FUNDING MODEL

LASA submission to the proposal, 30 May 2019

A strong voice and a helping hand for all providers of age services
Leading Age Services Australia

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our purpose is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA’s membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and Government operated organisations providing age services across residential aged care, home care and retirement living. 55% of our Members are not-for-profit, 37% are for-profit providers and 8% of our Members are Government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.
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Executive summary

The development of the proposed Australian National Aged Care Classification (AN-ACC) funding model is a welcome opportunity to address major deficiencies in current funding allocation arrangements in the residential aged care sector. LASA appreciates that Government is consulting providers before rather than after a fully worked model was developed.

However, the Research Utilization and Classification Study (RUCS) reports do not provide enough detail to fully assess or replicate its analyses (e.g. the formula for compounding factors is described as a ‘statistical model’, but the model is not disclosed). The full research methodology needs to be reported in line with what would be expected in an academic publication. The detail provided should be sufficient to allow for replication so providers can fully assess the proposed model.

LASA supports the Government’s plans to further test and refine the proposed AN-ACC model but is concerned whether this testing will address issues that matter most to providers. Providers need to be involved in the design of the pilot study to resolve outstanding questions, as stressed by LASA Members:

‘Industry has to be involved in the pilot and it needs to be very broad and not just an east coast closed shop’

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) may recommend a significant increase in overall resourcing. The Government’s consultation paper on the AN-ACC does not contemplate how changes recommended by the Royal Commission might be incorporated into the model. A process for incorporating possible recommendations by the Royal Commission needs to be outlined.

The distribution of funds via the AN-ACC may more accurately reflect the typical distribution of costs. However, if the overall funding pool is not increased some providers will be significantly worse off. The stop-loss proposed is inadequate as a five per cent loss of revenue would currently move the average facility into deficit. Given the degree of financial pressure providers are already facing the sector cannot afford further reform that results in further increases in financial pressure. In addition to stop-loss arrangements, providers must be adequately funded to meet the care needs of residents, whilst also maintain financial sustainability.

Providers cannot assess the likely financial impact of the changes on their facilities because (1) possible values for the National Weighted Activity Unit (NWAU) have not been proposed and (2) the algorithm describing how the scores from the assessment tool result in particular classifications has not been disclosed. The Government needs to set out (1) options for the initial value of the NWAU and (2) the algorithm that actually maps assessment scores to classifications.

While the proposed funding allocation model should more accurately reflect provider costs, a key concern with the AN-ACC Version 1.0 is that it reflects current aged care practices. Funding based only on existing practices will reinforce current gaps. Member feedback suggests that the reablement incentive, while better than nothing, is likely to be of limited effectiveness given its likely size and the lack of certainty about financial outcomes for providers. Other gaps in care not addressed by the AN-ACC are psychosocial and spiritual care and End-of Life care. Generally, there need to be mechanisms in the overall funding model for identifying and addressing gaps in care. The
AN-ACC should explicitly support assessment and funding for (1) reablement and/or maintenance of function (2) psychosocial/spiritual needs and (3) End of Life care.

A key weakness of the AN-ACC is that it does not account for quality of care. The model measures variations in cost but not variations in quality. This may discourage the implementation of more expensive care models that deliver higher quality. For example, analysis of Consumer Experience Reports suggests smaller facilities tend to elicit more positive consumer responses, but smaller facilities in metropolitan areas will not have their higher fixed costs recognised under AN-ACC. The reform process should include a pathway for incorporating measurement of quality and outcomes into cost measurement so that the allocation of funding reflects the cost of achieving agreed outcomes. Further, providers that wish to deliver a higher level service should be able to charge more for this.

The proposed AN-ACC envisages using real changes in the cost of care to inform annual changes in funding. Using a cost index to inform prices addresses the concern that increased funding may not be used to deliver care, because reductions in average expenditure are reflected in reductions in funding. However, if prices set by Government do not reflect the costing study, then providers may not have confidence in the accuracy of the study. No details have been provided on how the costing study would be conducted. The Independent Hospital Pricing Authority (IHPA) or another body independent from Government should carry out the annual costing studies. These studies should be published in full and the sector should have the opportunity to make submissions on these studies.

The AN-ACC resident classification is simple, and appears more accurate than the Aged Care Funding Instrument (ACFI). Providers should determine a resident’s eligibility for a higher classification relatively easily. A concern is that the AN-ACC classification does not include a class for independently mobile residents with dementia. Also, the actual algorithm for assigning residents into particular classes has not been provided. The AN-ACC needs to include an independently mobile class for residents with dementia and the algorithm for assigning residents to particular classes needs to be disclosed.

The external assessment of residents frees registered nurse time for care planning and delivery. It also reduces the ability of Government to blame providers over claiming for cost growth. However, the provider and external assessor may form different views of a resident’s needs. Further, there may be inconsistency in assessments between assessors or regions which may systemically bias funding, as currently seen in home care. Governance of the assessor workforce must be independent from Government. There must be robust and transparent procedures for ensuring consistency between assessors, including regular formal measurement of interrater reliability. There must be quick, simple and low-cost procedures for challenging and reviewing assessments. A provider’s obligations when their assessment of a resident’s needs is inconsistent with the assessment for funding purposes needs to be resolved.

Providers are concerned about the feasibility of recruiting a suitability qualified external assessment workforce, and that these difficulties may lead to recruitment expectations being relaxed over time. AN-ACC assessors must be appropriately qualified and the workforce model and strategy should include (1) accredited credentialing training for assessors (2) communication activities to ensure consistency of a distributed, national workforce (3) continuous professional development (4) help desk support.
The consultation paper does not deal with resident assessment on entry, other than to say it should occur within four weeks, but the RUCS proposal contemplates:

- assessment occurring before entry, with the result withheld from the provider to prevent ‘gaming’; or
- assessment occurring after entry with a resident starting on the lowest level and then ‘back-pay’ to compensate for any difference

Assessment prior to entry has limitations because entry into residential care may have an impact on a resident’s condition. Withholding the assessment of a prospective resident’s needs from the provider would usually be relatively pointless as this would be easy for providers to determine themselves. If the funding model biases providers in favour of a particular class of resident than this is a more fundamental design flaw in the model. Assessment after entry is problematic because care may be delivered at higher level than a resident is ultimately assessed at. Similarly, a significant proportion of may pass away or leave for other reasons prior to the external assessment. It would be reasonable where a resident cannot be assessed because they have passed away or moved to hospital to allow providers to undertake their own retrospective assessment.

Residents are eligible for reassessment for a higher payment class once they move into a higher mobility branch, after a significant hospitalisation or after 12 months (classes 2-8) or 6 months (classes 9-13). Minimising the level of reassessment means that more resources can be devoted to care. Given a resident’s condition generally declines, the proposed approach necessarily creates unfunded care where the increase in needs does not meet the threshold. RUCS data show that residents lose function well before the 12 months period proposed. The RUCS study also proposed a threshold for reassessment if the variation in payment exceeded 20 per cent of the national average payment per day, but this is not mentioned in the consultation paper. Providers should initially be entitled to seek reassessment whenever they believe a resident has moved between classification branches. After an initial period, data on the cost of these reassessments relative to the funding that is being distributed should be considered in order to determine thresholds where the savings from reduced reassessments could be used to fully compensate providers through an increase in payments.

The consultation paper considers a penalty for RACFs which request a reassessment that does not meet the criterion. Minimising the level of reassessment means that more resources can be devoted to care. The proposed penalty will further discourage reassessments on ambiguous cases, but is only recommended in the RUCS report for providers who do this routinely. Data on the cost of unwarranted reassessments relative to the funding that is being distributed should be considered in order to determine thresholds where the savings from reduced reassessments could be used to fully compensate providers and residents through an increase in payments.

The inclusion of a fixed cost component with the AN-ACC means that differences in fixed costs between facilities will be recognised in an evidence based way. However, LASA is deeply concerned that the fixed cost component was derived from a significantly smaller sample size than was required. Further, the sample has too few providers in rural and regional areas and some other subcategories to generate precise estimates of variation in fixed costs. It is odd that Modified Monash Model (MMM) 3-5 providers are not recorded as having higher costs, when financial performance figures show a continuum from metropolitan to remote. A new study for the fixed cost component using a sample of sufficient size and nationally representative composition is required.
The new fixed cost study should pay particular attention to investigating the fixed costs for providers in region MMM 3-5.

The RUCS study (and the proposed AN-ACC funding model) does not consider variation in hotel costs. A further study should consider variation in all costs associated with aged care.

The adjustment payment to providers to support the settling-in process for new residents in Residential Aged Care Facilities (RACF) will help address the care costs of new residents. The adjustment payment will not be payable for transfers between homes. However, new residents transferring from other homes often involve similar costs to residents entering residential care for the first time. It is not clear why no payment should be made for transferring residents. LASA believes that in cases of transfers a reduced payment should be considered.

The RUCS report suggests that providers should show that they have spent the adjustment payment on care, which could create significant administrative burdens. The report also suggests that providers should not contract adjustment activities out. However, it unclear why it would be a problem for these services to be undertaken on a contracted basis. Individual providers should not be forced to account for their spending of the adjustment payment, but the average cost should be measured as part of the annual costing study. It should not be an issue whether these activities are provided by employees of the provider or contracted out.

The transition model recommended involves assessing new residents for the AN-ACC while existing residents continue to be funded under ACFI for a two year transition period. Only moving new resident onto the new funding model for the first two years allows a gradual transition, compared to the alternative of moving all residents over at a point in time. However, running the two funding models in parallel will be inefficient and confusing for many facilities. Consideration should be given to allowing facilities to decide whether they would like to transition gradually or switch all at once.

Consideration does not appear to have been given to the cost of changing funding systems for Government and providers. While this is only a one off cost it is likely to be significant and should be explicitly calculated and factored into reform decisions. In any case, reform should only proceed with additional overall funding for residential aged care.

No transition timing has been proposed. Given the findings of the Royal Commission would need to be considered, the earliest feasible start date would be the beginning of the 2021 calendar year, with July 2021 likely more achievable.
**Introductory statement**

LASA consulted extensively with its Membership about the *Proposal for a new residential aged care funding model* via a number of engagement channels. Members were greatly interested in this consultation and contributed many thoughts and questions about the Australian National Aged Care Classification (AN-ACC).

Some LASA Members considered the AN-ACC to be overly complex with this complexity being costly in terms of assessments and administration. They proposed as alternative a simple funding model with one resident assessment and only three resident classifications: low, medium and high care plus supplements.

Generally LASA welcomes the opportunities a resident classification brings to the sector, such as the AN-ACC being a starting point to risk-adjust RACFs according to their resident casemix. Risk-adjustment is an important pre-condition for building a better evidence base about many aspects of residential care.

LASA believes the concept of funding the residential aged care sector on a casemix basis to be sound. However, LASA considers the AN-ACC to require further development prior to any implementation.

Often, LASA Members’ greatest issues of concern did not overlap with the questions put in the Government’s consultation paper. For this reason this submission presents the key issues of concern identified by LASA Members. In the main the discussion of these issues covers the questions posed in the Government’s consultation paper. Consultation questions not covered in the main body of the discussion are answered at the end of the submission.

**LASA Members’ key issues of concern**

**Financial impact**

*Costs and benefits unclear*

LASA Members query the cost – benefit ratio of introducing the AN-ACC. While some costs are certain to arise for providers, such as changes to information systems, staff training etc., the benefits of implementing the AN-ACC remain unclear:

> ‘What is not clear from this reform is the total cost to the aged care system of introducing the RUCS funding model. What are the costs and corresponding benefits?’
> ‘How much does it cost to run the new system?’

While the Government will shoulder the cost of resident assessments, providers still carry the cost of assessing residents’ care needs and devising care plans. Is there the possibility of reducing providers’ hours required to administer AN-ACC funding?

*Uncertainty about long-term financial impact*

LASA Members are adamant that they require certainty about the impact the AN-ACC will have on their operations. They expressed serious concern that if the AN-ACC is introduced without sufficient testing to identify the floor price prior to implementation then providers will raise the same issues about the sufficiency of funding in two years’ time.

LASA Members are strongly of the view that no-one should be worse off following any introduction of the AN-ACC. Given the financial pressure that is already facing the industry, even the five per cent
reduction in funding that is proposed under the stop-loss arrangements would move the average facility from surplus into deficit. Some providers consider that any loss of revenue may result in them having to close the doors of their residential aged care service. One Member informed LASA that

‘Less funding will hurt a lot of small providers and including not for profit. I know the new system said we will only lose 5% maximum of current funding but 5% is a lot of money in an already tight market.’

A significant redistribution of funding should only occur in the context of a significant increase in overall funding levels.

Members also expressed concern about the AN-ACC funding model’s responsiveness to shorter length of stay and related higher provider costs such as more staff time required to settle new residents, higher degree of frailty and more end-of-life/palliative care needs. A Member said:

‘If the Government released more home care packages, then prospective residents will stay at home longer and present to residential care in a more frail state. Residential care will experience even shorter length of stay.’

The financial impact of a future shortened length of stay in residential care should be modelled for any future funding model.

**Overall increase in funding required**

Given the degree of financial pressure that providers are already facing, the sector cannot afford reform with major winners and losers. The distribution of funds via the AN-ACC may more accurately reflect the typical distribution of costs for the various types of RACFs and classes of residents. However, if the overall funding pool is not increased, some providers are likely to be significantly worse off financially.

‘Has there been any macro-modelling on what additional funding the RUCS model will bring into the aged care system? If it is just redistributing the same (insufficient) ACFI funding across the alternate RUCS model – then we have added a lot of implementation cost and risk for no benefit.’

‘Unless we just wish to recreate the past and not do anything, we all have to recognise there needs to be a larger allocation of funds for the sector. Receiving approx. half of CPI since 2008 is not sustainable on any level. Keeping the funding status quo will not progress the agenda of the Government or the sector.’

Further, LASA considers the stop-loss proposed to be inadequate as a five per cent loss of revenue would currently move the average facility into deficit.

**Annual costing studies**

Annual costing studies as part of the AN-ACC funding model will eliminate the current problem with indexation. It would be important, however, for prices not to be set too much in advance.

LASA Members are strongly of the view that they want to see annual costing studies carried out by a body independent from Government. Options for independent bodies include:
• a strengthened and better resourced Aged Care Financing Authority; or
• the Independent Hospital Pricing Authority.

These studies should be conducted under conditions of transparency, along the lines of processes for price determinations in other sectors.

**Price setting**

Members consider price setting by Government a key risk for the sector. If the Federal Government sets prices that are insufficient to support quality care, then the best designed funding model cannot effectively support a RACF sector well respected for its care delivery.

‘This will be a critical issue in going forward. Future funding will have to be set as 1% above the CPI as the minimum. Any annual costing studies have to be very reflective of true costs of the industry. Again there is no point in having a system that won’t deliver for the betterment of the industry and the residents.’

**LASA key points**

- No provider should be worse off following the introduction of the AN-ACC.
- A significant redistribution of funding should only occur in the context of a significant increase in overall funding levels.
- A body independent from Government should carry out the annual costing studies.
- Prices set by Government that are not reflective of the cost of care will perpetuate the financial difficulties experienced by many providers.

**Reform process**

**Transparency lacking**

LASA Members came to the position that they lack the detailed information necessary to make an informed decision about the benefits and/or drawbacks of implementing the AN-ACC. This includes a lack of transparency in the reporting of the Research Utilisation and Classification Study (RUCS) which LASA Members considered a major risk factor. The reporting of RUCS in seven reports is voluminous. However, LASA Members consider the reports to lack the information necessary to enable them to gauge with confidence the AN-ACC’s impact on their care delivery and financial status. As one LASA Member observed:

‘All details i.e. financial, modelling methodology, formulas etc. for the new funding model need to be released. The industry is then on the same level as the Government. We need to get to a full partnership arrangement with Government.’

To achieve greater transparency, RUCS study reporting should be amended so it meets accepted standards of research reporting, including:

- giving the reasons for decisions taken during the research process (design, data collection and analysis)
- clear identification of all relevant components of the research findings and discussion of these components’ effect on resource utilisation. For example, how and why were the compounding factors in the resident classification chosen over alternative factors? What is
the impact of individual compounding factors on resource use? What sensitivity analysis was undertaken?
- discussion of limitations and weaknesses in the research study
- discussion of uncertainty in research findings
- identification and discussion of what this study missed (e.g. did residents not admitted for palliative care receive palliative care when they were dying? If yes, how many residents and what was their relative resource use?).
- reporting of the costing study with measured costs identified in Australian dollars.

LASA Members are of the view that the way forward with funding reform needs to be planned and delivered with maximum transparency. This includes the provision of a calculator to calculate the funding impact of moving from ACFI to the AN-ACC for each class of ACFI resident and each class of AN-ACC resident. Any implementation plan should be devised in such a way as to ensure maximum transparency of the process and anticipated outcomes for providers of residential aged care.

**LASA key points**
- Providers lack the detailed information necessary to make an informed decision about the potential impact of the AN-ACC.
- RUCS reporting should be amended to meet the standards of transparent research reporting.
- The way forward with funding reform needs to be planned and delivered with maximum transparency.
- A tool enabling residential aged care providers to calculate the financial impact of transitioning from ACFI to AN-ACC should be provided.

**Await recommendations by the Royal Commission**
Some LASA Members suggested that any decision about the introduction of the AN-ACC should be delayed until the *Royal Commission into Aged Care Quality and Safety* has reported. This way any new model of funding can take account of the Royal Commission’s recommendations for the residential sector.

‘What if the Royal Commission outcomes make the RUCS funding model obsolete before it is introduced?’
‘The Royal Commission’s (RC) impact on the sector should not be underestimated and if the RC is going to do a thorough job, comments around funding, processes etc. the Commission may make, has to be allowed for.’

Another concern expressed by LASA Members is that the AN-ACC is based on existing care practices and funding. The Royal Commission may recommend significant changes to care practices and funding arrangements. This may affect the overall classification model and the allocation of relative value units between the classifications. The Royal Commission could also recommend drastic changes to the way that care is delivered which may be inconsistent with a case-mix model.

Given the problems with existing funding arrangements there are also risks associated with waiting for the Royal Commission findings before taking any steps towards a new residential care funding model.
Fundamentally, the problem is that the AN-ACC is backwards looking. The funding model proposed in the consultation paper does not appear to give consideration to a mechanism that would allow it to incorporate recommendations about significant changes in care practices that may emerge from the Royal Commission or other changes in Government policy, including as research emerges on new and better models of care.

Commit to long-term, regular refinement of AN-ACC
The AN-ACC is in its first version and will require updating and further refinement as part of this funding reform and beyond. Essential to moving into the future is that mechanisms for the updating of the AN-ACC are available that make possible the inclusion of new care components and/or models of care. In part this should include regular funding of studies to update and refine the AN-ACC based on changes in the care being delivered by providers. However, this alone does not allow for funding to be allocated to new models of care that are not yet of standard practice, or which cannot be implemented because funding has not yet been made available. Accordingly there need to be processes for adding new supplements or allowances to the AN-ACC model.

**LASA key points**
- No provider should be worse off following any introduction of the AN-ACC.
- The AN-ACC needs to be able to support changing care needs and models of care delivery.
- Mechanisms for the updating of the AN-ACC that make possible the inclusion of new care components and/or models of care need devising.

Concerns with the AN-ACC as a funding model

**Quality of care not accounted for**
A key weakness of the AN-ACC is that it does not account for quality of care. The model measures variations in cost but not variations in quality. This may discourage the implementation of more expensive care models that deliver higher quality. For example, analysis of Consumer Experience Reports suggests smaller facilities tend to elicit more positive consumer responses, but smaller facilities in metropolitan areas will not have their higher fixed costs recognised under AN-ACC.

‘Quality has to be a component of the new model. If it isn’t we will not make the leap we wish to see. Old habits will remain.’

The reform process should include a pathway for incorporating measurement of quality and outcomes into cost measurement so that the allocation of funding reflects the cost of achieving agreed outcomes. Further, providers that wish to deliver a higher level service should be able to charge more for this.

**Incentive for re-ablement likely ineffective**
The AN-ACC is claimed to have an inbuilt incentive for re-ablement because no requirement for residents to be re-assessed is in place. LASA notes that RUCS Report 2, Figure 2 on page 19 shows that on re-assessment (after 4 to 6 months) some residents’ function improved, however, this improvement is fairly small. Less than half the resident classes (class 2,3,4,8 & 9) had a reduced care need and this reduction was well below 5%. Residents in the other classes increased their care needs. In fact, the report states:
The data shows that residents have become more dependent in the intervening period and that the percentage assigned to classes with ‘compounding factors’ (CF) has increased. In other words, residents overall became more dependent. This is what would be expected given the overall frailty of the residential aged care cohort. (Report 2, p.19)

LASA believes that the lack of certainty about the likely improvement of independence achieved by residents and resulting cost savings weakens the incentive’s effectiveness. Further, Members informed LASA that re-ablement often results in the prevention of further decline, rather than a regaining of function. While the prevention of decline is a desirable outcome for the resident, it does not result in savings to fund re-ablement.

Further, the mix of resident classes varies from facility to facility. Facilities accepting more residents in classes with the least prospect of re-ablement may not harness sufficient savings to offer effective re-ablement services to those residents who would benefit.

LASA acknowledges that the variable payment constitutes only about 50% of the care subsidy. However, the variable component is meant to address individual care needs, and re-ablement needs and the maintenance of residents’ function do fall into this category. LASA suggests that, under a wellness model of ageing, residents be assessed for their needs regarding reablement and/or maintenance of function and this provision be included in the variable payment.

Gaps in care
The AN-ACC is likely to perpetuate existing gaps in care because RUCS shows care delivered but does not identify any unmet demand for care. Two well-evidenced gaps in care are End-of-Life care and emotional care for existing residents. However, LASA Members observe their residents to also have psychosocial and reablement needs.

End-of-Life care
The design of the AN-ACC reinforces existing gaps in residential care delivery which have been shown not to meet community expectations. The proposed version of the AN-ACC does not include an additional class 14 to address the care needs of residents and their significant others when the resident is dying. In this way the AN-ACC mirrors the ACFI where no additional care is funded for high-high-high rated residents who move into the phase of dying.

Further, the AN-ACC does not include a pathway for the classification of residents’ care needs who enter a trajectory of dying. LASA notes that the End-of-Life specialist advisory panel recommends in Report 2 that:

Residents who become palliative while in residential care are reassessed as per any other change in care requirements (p.32).

LASA is concerned that the current criteria for resident re-assessment will not capture dying residents’ and their families’ much increased physical, social and emotional needs. And for those residents not already in class 13, the time required to obtain an external assessment may be too long.

LASA is highly critical of this perpetuation of the poor resourcing of End-of-Life care in RACFs and considers it to be discriminatory, particularly in view of the much better resourced care of people dying in hospitals. For example in 2015-16, average hospital expenditure for palliative care was
$1246 per day for a palliative care patient\(^1\). By contrast, in 2017 an aged care resident subsidised on ACFI high, high, high received a subsidy of $214.06 per day\(^2\). Whatever fine-grained methodological variations may exist in calculating these expenditures, the difference in the funding of palliative care between these two settings remains substantial and indefensible.

Further, the eligibility for palliative care funding designed into the AN-ACC will exclude residents who require palliative care from accessing this care. A requirement of a Karnofsky status of <40 for eligibility for class 1 (palliative care) excludes many residents who would benefit from palliative care. A person with a life expectancy of 3 months or less does not necessarily spend 50% of their time in bed, thus has a Karnofsky status above 40. But this person may still require ongoing clinical assessment, complex symptom management and significant palliative support. Additionally, the requirement of a Karnofsky status of < 40 excludes a focus on measures to enhance quality of life for people nearing the end of their life and appropriately funding these.

LASA is strongly of the view that the AN-ACC funding model should be re-designed to eliminate discrimination in the resourcing of End-of-Life care for older people who happen to die in a RACF.

**Lack of wellness approach**

**Emotional support**

Almost 20 per cent of 15,000 respondents to Consumer Experience reports responded neutral or disagreed when questioned about whether staff were available to talk if the resident felt sad or worried\(^3\). This clearly indicates a quite significant unmet demand for emotional support that RUCS would not have captured because RUCS only counted minutes of care actually delivered.

In view of the evidence of unmet demand for emotional support, an additional study investigating individual residents’ emotional support needs is required. An individualised component for the delivery of this care should then be included in the resident classification.

**Psychosocial needs insufficiently addressed**

LASA Members observed the AN-ACC model to support care that is heavily weighted towards attending to residents’ physical care needs. The casemix classification does not explicitly include residents’ individual desire for social connection, meaningful activity, and their intellectual and spiritual needs. LASA understands that the AN-ACC classification focusses on the cost drivers of care. However, some individual residents have a high level of psychosocial needs the meeting of which is labour intensive. Individual residents’ variation in the level of support they require for the meeting of these needs should be taken into account.

‘All facets of aged care i.e. palliative care, leisure and lifestyle, exercise and all others, has to be included if it is going to address that funding is more reflective of what we do.’

LASA Members consider that the meeting of psychosocial needs is fundamental to residents’ quality of life. The quality of their life matters greatly to all people, regardless of age or where they live.

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\(^1\) Independent Hospital Pricing Authority (IHPA), National Hospital Cost Data Collection Cost Report: Round 20 Financial Year 2015-16, p.37.

\(^2\) Australian Government, Department of Health, Aged Care Subsidies and Supplements; New Rates of Payment from 1 July 2017.

Older Australians living in RACFs care as much for their quality of life as every other Australian. For this reason, residents’ assessment should identify residents’ individual needs for social connection, meaningful activity and intellectual and spiritual engagement.

**Reablement and maintenance of function**

Individualised care to reable residents and/or to assist them maintain their function should be included in the AN-ACC classification, delivering funding that supports individualised functional needs. An AN-ACC based wellness model of aged care would support reablement and maintenance of function rather than just funding greater supports when residents’ abilities decline.

### LASA key points

- A key weakness of the AN-ACC is that it measures variations in cost but not variations in quality. This may discourage the implementation of more expensive care models that deliver higher quality.
- The reablement incentive is likely to be ineffective for providers because (1) of uncertainty of any increase in independence a resident may achieve and (2) if independence is improved, the resultant savings may be insufficient to recapture the cost of reablement.
- The AN-ACC should support a wellness approach to ageing by assessing residents for reablement and/or maintenance of function and include funding for this care in the fixed and variable cost components.
- The AN-ACC perpetuates the poor resourcing of End-of-Life care in RACFs. This is discriminatory, considering the much better resourced care of people dying in hospitals or hospices. The AN-ACC funding model should be re-designed to eliminate this discrimination against older people who happen to die in a RACF.
- The AN-ACC should take account of residents’ individual psychosocial needs with the AN-ACC assessing for and funding psychosocial/spiritual needs through the fixed and variable funding components.

### Concerns about AN-ACC components

**External assessment of resident’s care needs – general observations**

Some LASA Members remain unconvinced about the workability of external assessments and some would prefer that the proposed external assessments be abandoned altogether. Further, LASA Members expressed concern that the envisaged AN-ACC assessment workforce would draw skilled and talented health professionals from an already very tight labour market.

**Assessment independent from Government**

LASA Members would prefer the AN-ACC assessment function to be independent from Government, including oversight of the assessor workforce. Further, the AN-ACC should include pathways for providers to contest AN-ACC assessments via an independent body of review. There must be quick, simple and low-cost procedures for challenging and reviewing assessments. Further, a provider’s obligations where their assessment of a resident’s needs is inconsistent with the assessment for funding purposes needs to be resolved.

**Quality of external assessments**

The issue of assuring the quality of external assessments raised many questions among LASA Members. Specific components of assessment quality of concern to Members are:
• **Timeliness of the assessment** as delayed assessment means delay in the adjustment of the care subsidy’s variable component. While this payment makes up about half of the care subsidy, it is still intended to account for the full measurable variability in care costs between classifications. Even small under-payments matter in a sector that is largely working under significant financial constraints. If an assessment occurs weeks or months after the onset of a resident’s deterioration, what are the mechanisms and processes for identifying the onset of the resident’s higher AN-ACC class and paying the higher rate from this date? Will the payment of care subsidies be backdated to the day the re-assessment was requested? Will there be an expected wait time for re-assessment that must not be exceeded by the AN-ACC assessment service?

Timeliness of assessment of newly admitted residents is another major issue of concern.

‘What will happen if the newly admitted resident dies before he/she could be assessed?’

‘How would rural and remote facilities fare in gaining timely access to an external workforce? Is there a role for IT or AI in this space? Will rural and remote be disadvantaged?’

‘Assessment after entry is more accurate. Anything done before is problematic.’

It would be reasonable to allow providers to undertake their own retrospective assessment where a resident cannot be assessed because they have passed way or moved to hospital.

• **Consistency of resident assessments** by external assessors is a major issue for providers. The AN-ACC assessment workforce is envisaged to comprise three groups of health professionals: registered nurses, physiotherapists and occupational therapists. LASA Members observe that these health professionals are trained to have a different focus of care and that this may result in differing assessments, making a priority the assurance of assessment consistency. However, even within a professionally homogeneous workforce, consistency of assessment will require assurance through continuous quality improvement. Inconsistency of assessment between assessors or between assessors in regions is a serious issue. It may systematically bias funding, advantaging some providers and residents while disadvantaging others.

To date it is not clear whether the external assessor workforce will sit within ACAT or be additional to the two existing aged care assessor workforces (ACAT and RAS). If the AN-ACC assessor workforce is external to the ACAT, how will consistency in assessment between the two workforces be ensured?

While assessors were asked to judge how difficult the assessment they undertook was and how confident they felt in its accuracy, there does not appear to have been any true testing of consistency. Assessors identified that it was usually very easy to perform an assessment and they had a high degree of confidence in their assessment. However, this is not surprising if residents are usually easy to classify. The problem is that there are inevitably edge cases in any assessment model and it is important to ensure that those edge cases are treated consistently.
‘How are inconsistencies resolved? Could there be a process that will have the external assessor and a rep from the facility undertake the assessment together? Any re-assessment would be easier due to an agreed first up assessment.’

The degree of consistency is also likely to be lower outside of the context of a research study where staff are likely to attend the same training courses and have the same supervisors. In a national workforce some inconsistency will inevitably emerge, particularly given the vast geographical distances. Procedures to identify and address inconsistency need to be built into the system from the beginning, and a crucial part of that is allowing providers to challenge assessments.

‘Will externals have only one visit to do an assessment? Currently we have 21 days to conduct an assessment and get to know the resident.’

- Quality assurance measures: How will consistency of assessment be measured and ensured over time? For example, if over time AN-ACC assessors’ classifications of residents’ needs trend down while providers do not observe a concomitant reduction in care needs, how would such trend be (1) identified and (2) corrected? Will the quality of assessors’ assessments be subject to regular auditing?

**Commitment to an expert assessor workforce**

The quality of assessments by the AN-ACC assessor workforce will be of vital importance to the proper functioning of the AN-ACC funding model. The RUCS study proposes that the AN-ACC recruit for its external assessor workforce health care professionals with experience in aged care.

ASHRI observes that the AN-ACC assessment workforce model and strategy should include:

- accredited credentialing training for assessors;
- communication activities to ensure consistency of a distributed, national workforce
- continuous professional development
- help desk support.⁴

LASA agrees with AHSRI that the quality of residents’ assessments will be highly dependent on the skill and professional judgment of the AN-ACC assessor workforce. LASA is concerned that that the envisaged, highly skilled AN-ACC assessor workforce may, over time, be deemed too costly and that policies that ensure the competency of this workforce may be downgraded or dropped. If the Government commits to external assessment, then it is essential that Government make a long-term, legislative commitment to an expert AN-ACC assessor workforce. Government should further commit to the quality assurance measures proposed by ASHRI.

‘External assessor workforce is a real concern and just who would be allowed to become an external assessor, what qualifications will they need, what is the experience of the person, are they experienced in what they need to assess?’

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⁴ Report 2: The AN-ACC assessment model, p. 14
LASA key point
- If external assessment is introduced then the success of this measure will depend on the long term assurance of the quality of external assessments.

Assessment tool
Overall, LASA Members found that the lack of information about the assessment tool in the various RUCS documents made its evaluation difficult. For example, often missing are the rating scales to the various sections in the AN-ACC assessment tool. Other scales are poorly defined, as is the case for the Behaviour Resource Utilisation Assessment (BRUA). Further, the BRUA accounts only for ‘monitoring for recurrence’ and ‘supervision’ of behaviours but does not consider the therapeutic interventions staff implement to manage these. Yet, these therapeutic interventions require highly skilled staff and are time intensive to deliver. Thus, the assessment tool denies the costliness of managing difficult behaviours.

Capability approach to assessment
The external assessment is supposed to take a capability approach as stated in ASHRI’s Report 2: The AN-ACC assessment model:

‘a capability approach, or determining what a person ‘can do’, requires assessors to take account holistically of the person’s physical functions, cognition, behaviour, motivation and organisational capability.’ (p.12)

The description how the capabilities approach to resident assessment will be operationalized was perceived by Members as too vague to confidently predict its implications for their service. Members worry that this approach may have the potential to result in disagreement between provider and assessor about a resident’s actual level of capability. Testing the degree of consistency between provider and external assessor judgements should be part of an AN-ACC implementation trial.

AN-ACC operational policies and procedures will need to address how conflict between assessor and provider about a resident’s assessed capability will be resolved. The RUCS study did not explore this operational issue.

As discussed earlier, LASA Members observed that the assessment tool has a strong functional focus but pays little attention to residents’ emotional, social and spiritual care needs. This shortfall should be addressed.

Reassessment
LASA is deeply concerned that the proposed reassessment regime may result in some unfunded care.

RUCS identifies three grounds for the reassessment of residents’ needs: (1) significant hospitalization (2) significant change in mobility causing the resident to move to another mobility branch and (3) after standard time periods. These standard time periods are defined as:

* A home may request a reassessment after a specified period for any resident who is becoming progressively more frail and/or whose health status is deteriorating. The standard time should be twelve months for Classes 2 to 8 (those classes with lower mortality rate) and
six months for Classes 9 to 12 (classes for people who are not mobile and are expected to deteriorate at a higher rate)\textsuperscript{5}.

LASA is concerned that as residents’ care needs are shown to increase rapidly and significantly, providers are likely to deliver some unpaid care until the resident becomes eligible for reassessment. Evidence about residents’ increase in care needs can be found in Report 2 The AN-ACC assessment model, page 21. Here Figure 5 demonstrates the large percentage of residents in the low classes 2, 3 and 4 who move to a higher paying class when re-assessed just 4-6 months after initial assessment. Residents in classes 5 to 7 also required upgrading of their class, but the rate of deterioration was lower. The table below was derived from Figure 5 and shows the various rates of upgrades the RUCS study identified.

<table>
<thead>
<tr>
<th>Class</th>
<th>% of residents moving to a higher paid class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 2</td>
<td>approximately 45 per cent</td>
</tr>
<tr>
<td>Class 3</td>
<td>approximately 25 per cent</td>
</tr>
<tr>
<td>Class 4</td>
<td>48.8 per cent</td>
</tr>
<tr>
<td>Class 5</td>
<td>approximately 18 per cent</td>
</tr>
<tr>
<td>Class 6</td>
<td>approximately 20 per cent</td>
</tr>
<tr>
<td>Class 7</td>
<td>approximately 10 per cent</td>
</tr>
</tbody>
</table>

Overall, RUCS data show that 26 per cent of the re-assessed 775 residents were assigned to a higher classification of their care needs after just 4 to 6 months\textsuperscript{6}. It is not clear how often this re-classification was associated with a change in residents’ mobility or a hospitalisation.

LASA assumes that providers receive higher care subsidies from the date of the reassessment at 12 months. If this assumption is right, then providers will be expected to deliver care that is not funded for a significant length of time (Unless the resident’s mobility status changes, which is when the resident become eligible for reassessment prior to the set date). Considering the severe financial constraints under which many providers operate, the expectation of delivery of a component of individualised care that is unfunded is a critical issue. The implications of the ‘standard time period’ reassessment rule needs further investigation in order to be better understood by the sector.

Compounding factors as reason for reassessment
LASA Members believe that newly acquired compounding factors should be included in the eligibility criteria for reassessment. Compounding factors such as peritoneal dialysis, tracheostomy care or complex wound care may significantly increase residents’ consumption of care resources without affecting their mobility. The impact of such newly acquired compounding factors should be included as a reason for reassessment.

Penalty payment
The Government consultation question 5 says: Should the Commonwealth consider the introduction of reassessment charges for services that trigger unnecessary reassessments? LASA considers this question to read as if a fine will be triggered every time assessors consider that seeking a resident’s re-classification into a higher paying class is not justified. This does look like a very harsh approach to this issue. Initially providers should be entitled to seek reassessment whenever they believe a resident has moved between classification branches. Alternatively, LASA proposes that there should

\textsuperscript{5} Report 2: The AN-ACC assessment model, p. 23
\textsuperscript{6} Report 2: The AN-ACC assessment model, p.21
be an accepted level of ‘false’ requests for a RACF and if this level is not exceeded no penalty is triggered.

Data on the cost of unwarranted reassessments relative to the funding that is being distributed should be considered in order to determine thresholds where the savings from reduced reassessments could be used to fully compensate providers through an increase in payments.

**LASA key points**

- The re-assessment of residents after a fixed time period should be reviewed to ensure that it does not require providers to deliver unfunded care.
- Some compounding factors if newly acquired by the resident should be included as reason for reassessment.
- Initially providers should be entitled to seek reassessment whenever they believe a resident has moved between classification branches. Alternatively, there should be an accepted level of ‘false’ requests for a RACF and if this level is not exceeded no penalty is triggered.
- Data on the cost of unwarranted reassessments relative to the funding that is being distributed should be considered in order to determine thresholds where the savings from reduced reassessments could be used to fully compensate providers through an increase in payments.

**AN-ACC Version 1.0 resident classification**

LASA notes that the branching classification does not include a class for independently mobile residents who have dementia. Physically mobile residents with dementia tend to be younger and to display the Behavioural and Psychological Symptoms of Dementia (BPSD), requiring a high level of labour input. Are the BPSD included as a compounding factor for mobile residents? If BPSD is considered a compounding factor, this needs to be made explicit to facilitate an informed assessment of the proposed AN-ACC by the aged care industry.

**LASA key point**

- The AN-ACC classification needs to include an independently mobile class for residents with dementia.

**Payment structure**

*Resident’s class not known on admission*

LASA Members thought it important to know the resident’s class on admission to ensure that staff numbers, skill and equipment are available to deliver the care needed. For example, bariatric residents require staff numbers and specialized equipment for their care and providers need to be assured that they have the human and material resources at hand to deliver this care.

‘Duration before assessment and funding is known is a concern as care staff costs are incurred/committed ahead of assessment outcome.’

LASA Members acknowledge that the ACAT assessment will be available to them, but observe that these assessments often tend to be inaccurate or incomplete. Assessment after entry is problematic because care may be delivered at a higher level than a resident is ultimately assessed at.
Fixed component

LASA is deeply concerned about the evidence base from which the fixed care related costs were derived. LASA notes that RUCS aimed for a total sample size of 110 facilities, but the final sample size included 89 facilities only. Thus the sample used to calculate the fixed costs was almost 20 per cent smaller than initially intended. Many of the subgroups against which the cost of care was measured has a very small number of facilities in them meaning that the relative standard errors (RSE) of the estimated costs are relatively high. This calls into question the validity of the National Weighted Activity Units (NWAU) derived by RUCS for the fixed funding component which will provide 50 per cent of RACFs’ funding for the care of their residents.

LASA is further concerned because the study sample does not include a sufficient number of RACFs in Modified Monash Model (MMM) class 3-5. The excerpt below from Report 3, page 14, Table 4 shows that RACFs in these three classes make up only 14 per cent of the sample of facilities.

<table>
<thead>
<tr>
<th>MMM Class</th>
<th>N</th>
<th>Beds Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>46</td>
<td>82</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>95</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>38</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

(Excerpt Table 4, Report 3, p.14)

This raises the issue of the fixed cost component for RACFs in MMM classes 3-5 not having been validly captured. A further concern is that ASHRI groups providers in classes MMM 3-5 together with metropolitan providers in MMM classes 1 and 2. This grouping is likely to obscure the relatively high fixed costs encountered by regional RACFs. This is a particularly troubling situation because evidence by StewartBrown indicates that regional providers are under particularly serious financial strain:

*The impact of the regulatory changes and funding pressures has resulted in the disturbing statistic that 45.1% of residential facilities reported an EBT operating deficit for FY18, and even more disconcerting is that 21.2% of facilities had negative EBITDA (indicating a cash loss from operations). All geographic locations reported a decline, however, the outer regional, rural and remote locations have significant financial concerns*. 8

A LASA Member who operates a RACF in an MMM 4 class area 2.5 hrs from the next metropolitan centre provided LASA with following evidence about the higher fixed costs encountered:

We have significant issues with recruitment & staffing - , whilst not as bad as remote and rural locations (MMM6 MMM7) we are certainly worse off than metropolitan and city centric locations (MMM1-2). WE HAVE A “EMPLOYER OF CHOICE” PROGRAM, THIS IS TO ATTRACT STAFF TO OUR FACILITY ABOVE OTHERS, THERE IS A COST TO THIS. WE HAVE LIMITED ACCESS TO PROFESSIONAL STAFF (I.E. ATTRACTION OF CORPORATE SERVICES STAFF, WE HAVE TO PAY ABOVE AWARD RATES TO GET QUALITY APPLICANTS. FOR STAFF TRAINING WE GENERALLY HAVE TO SEND STAFF AWAY – E.G. OF THIS IS THE

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7 Report 3: *Structural and individual costs of residential aged care services in Australia*, pp.4 & 11.
RECENT ACQSC (& LASA) TRAINING FOR THE NEW STANDARDS, WE SENT 2 LOTS OF STAFF – PAYING FOR THE DAYS TRAINING, TRAVEL TIME FOR STAFF AND ACCOMMODATION COSTS OVERNIGHT (AND ALSO BACK FILLING THEIR SHIFTS THEY MISSED). FIRE TRAINING – ONCE AGAIN NO ONE LOCALLY PROVIDES THE TRAINING SO WE GET A CITY BASED CONSULTANT WHO CHARGE FOR TRAVEL.

The further you get from the metropolitan areas the harder it is to get staffing – i.e. we have no nurse bank in our town. WE HAVE TO HAVE MORE STAFF ON THE BOOKS THAN NEEDED, THIS IS TO ENSURE WE HAVE STAFF TO CALL ON FOR SICK/OTHER LEAVE, WE HAVE TO JUGGLE A MIX OF CASUAL (WHO WANT REGULAR SHIFTS) AND PPT WHO WANT A MINIMUM OF X SHIFTS... WE DO NOT HAVE ENOUGH RN’S ON OUR BOOKS FOR NIGHT SHIFT (THERE JUST AREN’T THE QUALITY PEOPLE AROUND)... RN’S ARE ON CALL. Secondly as well as issues with staffing in a regional location we have issues getting allied health. ITS AS MUCH ABOUT TRYING TO GET SAY A PPT PHYSIO WITH AGED CARE EXPERIENCE ON STAFF, IT IS JUST NOT DOABLE REGIONALLY. THE SAME FOR DIETICS, PODIATRY, SPEECH PATHOLOGY. OUR RATES OFTEN INCLUDE TRAVEL – I.E. OUR DIETICS CONTRACTOR CHARGES TRAVEL AS SHE COMES FROM THE CITY – SHE IS THE ONLY ONE WE COULD FIND WHO WOULD SERVICE US REGIONALLY AND IS AGED CARE SPECIALISED.

I think there should be an argument for 3 geographic locations rather than 2: 1) City/inner city + 2) regional + 3) rural/remote recognition.

Many regional RACFs provide care for a large number of residents. The regional RACFs in the RUCS sample make up only 14 per cent of the sample, yet provide almost 48 per cent of the sample’s total number of beds. Yet, the impact of their geographical location on their fixed costs was not properly investigated and taken account of in the fixed cost component of the AN-ACC’s funding model. If funding falls short of requirements then the quality of care for many older Australians will be affected.

LASA is of the view that the study to determine the fixed cost component should be supplemented with further research to gather additional data. Any follow up study must ensure a sufficiently large sample size to fully analyse the cost effects of regional, rural and remote locations. The size and composition of the sample should assure funders and providers of the validity of the NWAUs for the fixed costs derived. The AN-ACC should not be implemented until a fixed cost component derived from a reliable and valid evidence base was obtained.

LASA Members in regional and rural Australia also point to the important economic contribution they make to these geographical regions in terms of generating employment at a variety of skills levels. Australians employed in RACFs pay taxes with their likelihood of having to rely on Government benefits reduced.

**Fixed cost support for smaller facilities**

Consumer experience reports provide important feedback about how RACF characteristics can influence residents’ quality experience. LASA points to the *Analysis of consumer experience report (CER) data: Report to the Australian Aged Care Quality Agency, December 2018*. The report found that smaller RACF size was strongly correlated with residents rating their experience higher for all aspects of their life:
Small-sized facilities received higher ratings on every question than medium sized facilities, who again scored better than large facilities (p.3).

While smaller RACFs may be more expensive to run, the cost consideration needs to be balanced against their higher quality performance.

**LASA key points**

- The AN-ACC should not be implemented until a fixed cost component derived from a reliable and valid evidence base was obtained.
- The new fixed cost study should pay particular attention to investigating the fixed costs for providers in region MMM 3-5.
- The quality performance of smaller RACFs relative to larger RACFs should be taken account of in the fixed cost component.

**Variable component**

LASA’s observation to the variable component of the AN-ACC are discussed on pp. 12-14 & 18 of this submission

**Adjustment payment**

LASA Members welcome the adjustment payment component included in the AN-ACC but require more information on the proposed accountability for this payment:

*It is critical that aged care providers be held accountable to ensure that this adjustment payment is actually used for the intended purpose and not simply added to the bottom line. Nor should it be allowable for adjustment planning to be contracted out to third party providers.*

For example, LASA Members queried whether the prohibition of contracting-out adjustment planning also includes aspects of delivery, such as contracting physiotherapy services. Further, LASA Members would like to understand the accountability rules for this payment. The cost of demonstrating use of these funds for the purpose intended may absorb a significant percentage of the adjustment payment, diverting benefit away from the resident.

However, it is unclear why it would be a problem for these services to be undertaken on a contracted basis. Individual providers should not be forced to account for their spending of the adjustment payment. An alternative approach would be for the average cost to be measured as part of the annual costing study. It should not be an issue whether these activities are provided by employees of the provider or contracted out.

LASA queries the Government’s plan to not pay the adjustment payment if a resident transfers to another facility:

*An adjustment payment would not be payable if a resident transfers between homes. Consistent with principles of consumer-directed care, needs assessments and care plans should follow the resident if they move between facilities.*

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9 Report 5: A funding model for the residential aged care sector, p. 13
10 Report 5: A funding model for the residential aged care sector, p. 13
RACFs are heterogeneous in their service offerings. A RACF may meet a transferring resident’s needs in new or different ways or attend to needs previously unmet, depending on resident choice. For this reason the needs assessments and care plans of transferring residents require review on arrival in another RACF. Further, transferring residents still need support to adjust to their new living environment with a different geography, many new people and a change in routines and choices. For this reason LASA argues that an adjustment payment should be made available to providers accepting residents transferring from another RACF.

‘There is a cost to enter someone into your facility either a new residents or a resident transferring from another facility. This needs to be recognised.’

**LASA key points**
- Individual providers should not be forced to account for their spending of the adjustment payment. An alternative approach would be for the average cost to be measured as part of the annual costing study.
- An adjustment payment should be made available to providers accepting residents transferring from another RACF.

**Supplements**
Members considered that supplements benefitting the RACF as a whole, such as the viability supplement, could be included in the National Weighted Activity Unit (NWAU) for the fixed cost component. Further, Members suggested that a new supplement for CALD specific facilities should be included in the fixed cost component. LASA acknowledges that RUCS found no higher costs were incurred by the CALD facilities included in the study. However, Members have informed LASA that some CALD groups do incur higher costs through catering for dietary needs, such as halal and kosher foods or language classes for staff.

LASA suggests that supplements may also be used as a mechanism to provide financial support for RACF-wide innovation projects, such as the introduction of new models of care.

Supplements for the care of individual residents, such as oxygen supplement, should remain separate payments and should not be included in the NWAU. Members suggested the addition of two new supplements to individual care to cover the cost of (1) wound dressing materials and (2) special diets, such as gluten-free.

Respite care services were identified by Members as a service offering that urgently requires further development of the AN-ACC with view to including these services.

**LASA key points:**
- Supplements benefitting the RACF as a whole, such as the viability supplement, could be included in the National Weighted Activity Unit (NWAU) for the fixed cost component.
- Supplements for the care of individual residents, such as oxygen supplement, should remain separate payments.
- Supplements may also be used as a mechanism to provide financial support for RACF-wide innovation projects, such as the introduction of new models of care.
Implementation

LASA has identified a number of key issues that LASA suggests require addressing prior to any implementation steps being undertaken. These are:

- Calculation of the AN-ACC’s fixed cost component from a valid and reliable evidence base is imperative.
- Inclusion of residents’ wellness needs (reablement, maintenance of function, psychosocial/spiritual) and End-of-Life care in the AN-ACC assessment and classification of individual care needs. This would overcome to a degree the AN-ACC’s key weakness of having been derived from current care delivery which does not appear to meet community standards in all instances.
- Development of structures and processes that ensure the quality of external assessments and acceptability of these assessments by aged care providers.
- Redesign of the criteria for reassessment to minimize any unfunded care and increase fairness.
- A calculator to compare ACFI to AN-ACC funding made available to providers.

Further, any steps towards implementation should be undertaken as a transparent trial of the AN-ACC in collaboration with the sector. In this trial, the residential aged care sector should be an active partner, contributing and agreeing to the questions the trial investigates.

Consideration should be given to allowing facilities to decide whether they would like to transition gradually or switch all at once. In any case, reform should only proceed with additional funding and if the vast majority of facilities are better off this will not be an issue.

‘Could there be a one-off per bed payment to facilities to cover the cost of moving to the new system?’

No transition timing has been proposed. Given the findings of the Royal Commission would need to be considered, the earliest feasible start date would be the beginning of the 2021 calendar year, with July 2021 likely more achievable. In view of the Royal Commission providing its final report on 30 April 2020, 1 July 2022 was also proposed as a date that would give time for proper decision making.

**LASA key points**

- RACFs should be able to decide whether they would like to transition gradually or switch all at once.
- Reform should only proceed with:
  - additional overall funding
  - calculation of the AN-ACC’s fixed cost component from a valid and reliable evidence base
  - inclusion of residents’ wellness needs (reablement, maintenance of function, psychosocial/spiritual) and End-of-Life care in the AN-ACC assessment and classification.
  - development of structures and processes that ensure the quality of external assessments.
  - redesign of the criteria for reassessment to minimize any unfunded care and increase fairness.
  - a calculator to compare ACFI to AN-ACC funding made available to providers.
Government consultation question 12: What are the implications of ceasing ACFI assessments in relation to care planning activities?

Assessment is integral to the nursing process which includes assessment, planning, implementation and evaluation. These components of the nursing process also underpin Standards 4-7 of the registered nurse standards for practice by the Nursing and Midwifery Board of Australia\(^\text{11}\). The ACFI assessments will be replaced by a professional nursing assessment of residents’ needs. The ceasing of ACFI assessments should have little or no implications for care planning activities.

Government consultation question 13: Do you support the development of a best practice needs identification and care planning assessment tool for use by residential facilities?

LASA Members were supportive of a best practice needs identification and care planning assessment tool but did not want to have its use made compulsory. They were keen to be involved in the development of such a tool.

Government consultation question 14: 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?

LASA Members supported this requirement.

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