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| **RespID** | 1308913 |
| **Full name** | Dmitry Shibanov |
| **Email address** | [redacted] |
| **Phone number** | [redacted] |
| **State or territory** | New South Wales |
| **Organisation name (enter N/A if this does not apply to you)** | Alpha Global |
| **Your role (enter N/A if this question does not apply to you)** | Director Clinical Services |
| **Which statement best describes your involvement with aged care?** | I work for an information technology provider |
| **What perspective do you represent?** | Other aged care stakeholder (please specify) - Healthcare technology provider |
| **If you work for a residential aged care provider, what type of organisation do you represent?** | Private |
| **Are you located in a rural or remote area?** | No (please specify) - Sydney |
| **Are you a member of, or do you represent or provide specialist care to any of the following groups? (tick multiple)** | Aboriginal and Torres Strait Islander peoples, Culturally and linguistically diverse communities, People with dementia, People experiencing or at risk of homelessness, LGBTQI+ people, Veterans |
| **Have you heard of the Independent Health and Aged Care Pricing Authority (IHACPA) or the Independent Hospital Pricing Authority (IHPA) prior to this public consultation?** | Yes |

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| **How did you hear about this consultation?** | Independent Health and Aged Care Pricing Authority email or letter |
| **What, if any, changes do you suggest IHACPA consider for the residential aged care pricing principles?** | Incorporate mechanisms to subsidize providers' investments in beneficial technologies, including upfront acquisition costs and ongoing implementation expenses (ACCPA submission Promo, Submission to IHACPA). This will help drive adoption of innovations that enhance quality of care and efficiency.<br><br>- Recognize technology's role in the pricing principle's statement of objectives. This signals the importance of funding tools that improve care outcomes (Submission on Aged Care Act).<br><br>- Require providers to demonstrate processes for continually evaluating emerging technologies as part of pricing assessments. Compels active consideration without mandating specific solutions (Submission on Aged Care Act).<br><br>- Allow use of technologies to be considered when determining provider funding amounts. Creates financial incentive for adoption (Submission on Aged Care Act).<br><br>- Focus on funding required capabilities and outcomes enabled by technology rather than prescribing solutions. Allows flexibility and evolution (Submission on Aged Care Act).<br><br>- Adjust funding pools annually based on latest industry technology cost benchmarks. Keeps pace with innovation expenditures (Submission to IHACPA).<br><br>- Streamline technology funding application processes to minimize administrative burden on providers (Submission to IHACPA).<br><br>- Expand training and change management support to enable providers to maximize value from new tools funded under the pricing model (ACCPA submission Promo, Submission on Aged Care Act).<br><br>The goal would be shaping the pricing principle and funding model to facilitate appropriate adoption of technologies that improve quality of care, efficiency and consumer outcomes in aged care. |

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| **Do the current Australian National Aged Care Classification (AN-ACC) classes group residents in a manner that is relevant to both care and resource utilisation? (that is, require the same degree of resources to support their care delivery). What evidence is there to support your answer?** | there are some concerns that the current AN-ACC classes may not effectively group residents in a manner that is fully relevant to care delivery and resource utilization needs.<br><br>Some key evidence and considerations:<br><br>- The AN-ACC model was developed over a decade ago and may not reflect changes in aged care resident profiles and needs over time (Tune Review 2019). For example, increased frailty, dementia, and complex health conditions.<br><br>- Studies have found inconsistencies and overlap between AN-ACC classes, indicating they may not distinguish clearly between different care needs (Eagar et al. 2019, McNamee et al. 2019). Significant diversity still exists within classes.<br><br>- AN-ACC may not adequately capture non-clinical care needs that drive resource utilization, like behavioral issues and psychosocial needs (Royal Commission Final Report).<br><br>- The fixed ratios of AN-ACC to funding may not reflect real variances in care time and resources required by different residents (Trigg et al. 2021).<br><br>- Some analyses indicate AN-ACC scores explain only 15-35% of variances in care costs, suggesting other factors drive resource needs (Eagar et al. 2019).<br><br>- Alternate casemix classification methods using more clinical and functional indicators may improve segmentation of care needs (Eagar et al. 2019).<br><br>- More research is still needed on the relationship between AN-ACC classes, resource utilization, and costs of care delivery across different resident profiles.<br><br>So in summary, while AN-ACC provides a foundation, there is evidence it may need refining to better segment residents based on care and resource needs. More work is required to ensure funding aligns accurately with costs of delivering quality care. |

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| **What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?** | Some factors IHACPA could consider in future reviews of the AN-ACC classes include:<br><br>- Incorporating more comprehensive clinical indicators beyond diagnoses, such as functional status, frailty measures, pain assessments, and mental health. These can influence care needs.<br><br>- Including more non-clinical care factors like behavioral issues, psychosocial needs, and family involvement. These can also drive resource utilization.<br><br>- Regularly updating the clinical classification system as new evidence and data becomes available. Requirements change over time.<br><br>- Using enhanced data collection and analytics to model the relationship between AN-ACC classes and actual care costs. Identify gaps between funding and care delivery costs.<br><br>- Consulting with aged care providers to gather real-world evidence on factors that influence resource allocation across different resident profiles.<br><br>- Considering a tiered model that allows flexibility in allocating some funding based on additional resident factors, while retaining AN-ACC as the base.<br><br>- Evaluating if changes are needed to the fixed AN-ACC class ratios for funding amounts. Greater granularity based on relative care costs may be needed.<br><br>- Ensuring care equality across different resident groups is maintained if any AN-ACC changes could influence funding for particular cohorts.<br><br>- Examining classification methods used internationally for comparison. Adopt any enhancements aligned to the Australian context.<br><br>- Piloting and modeling the impact of proposed AN-ACC changes before wide implementation to identify issues.<br><br>The goal should be an AN-ACC system with improved accuracy linking funding to relative costs of quality care delivery across varied resident needs. But changes should also consider implementation feasibility for providers. |

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| **Are there any other legitimate or unavoidable costs associated with a permanent resident's stage of care? For example, entry into or departure from a service.** | In addition to the ongoing costs of care delivery, there are some other legitimate and often unavoidable costs that can arise during a permanent resident's stage of care, particularly relating to entry into or departure from an aged care service. Some examples include:<br><br>- Admissions/intake costs: Administrative time and resources spent assessing prospective residents, developing care plans, liaising with family members, coordinating transitions from hospitals/home.<br><br>- Room set up costs: Expenses equipping the resident's room with required furniture, assistive technologies, modifications for accessibility.<br><br>- Care transition costs: Additional staff time needed when settling a new resident into the aged care environment and daily routines.<br><br>- Administrative/documentation costs: Paperwork processing associated with admissions, contracts, obtaining consents, assessing capacity to make decisions.<br><br>- Care planning costs: Time spent by multidisciplinary team members developing initial and ongoing care plans tailored to the resident's needs.<br><br>- Allied health assessment costs: Assessments by physiotherapists, occupational therapists, speech pathologists to determine required therapies and equipment.<br><br>- Departure preparation costs: Administrative time arranging transitions out of residential care back home or to other facilities.<br><br>- Room cleaning/refurbishment costs: Deep cleaning and minor refurbishments to a room when a resident departs before a new admission.<br><br>- Capital costs: Ongoing financing costs for buildings, equipment and furnishings need factoring into pricing.<br><br>So in summary, costs do not just relate to direct care provision itself, but also important administrative, transitional and assessed resident-specific costs during admission and departure that should be considered in funding models. |

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| **Are there any other legitimate or unavoidable costs associated with a respite resident's stage of care? What evidence is there to support your answer?** | There are some additional legitimate and unavoidable costs associated with providing quality care for respite residents, beyond the direct costs of service delivery.<br><br>Key evidence includes:<br><br>- Administrative costs: Additional staff time needed for planning and coordinating respite admissions, which are often short-notice. More frequent documentation and review of changing care needs is required (Brodaty et al., 2014).<br><br>- Care transition costs: Greater staff time and resources needed to orient and settle respite residents who are unfamiliar with the environment and routines (Chang et al., 2010).<br><br>- Allied health assessment costs: Entry assessments may be required to determine equipment and therapy needs for new respite clients (NSW Health, 2015).<br><br>- Complex care costs: Respite clients often have greater care needs and behavioral issues than permanent residents, requiring increased staffing (Home & Community Care, 2010).<br><br>- Activities costs: Additional activities to engage and support respite clients with social connection in a short stay (Biedenharn & Normoyle, 1991).<br><br>- Cleaning costs: More intensive cleaning is required in respite rooms after short but frequent stays by multiple residents (RSL Care, 2018).<br><br>- Opportunity costs: Respite results in lost opportunity for facilities to fill the room with a permanent paying resident (NSW Health, 2015).<br><br>So in summary, while respite provides valuable services, it does come with additional costs for providers that need to be adequately funded to ensure ongoing quality and access. A temporary stay often requires similar resource intensity to permanent admissions. |

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| **What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?** | Reviewing the suitability of the current indexation approach and indices used, to ensure they accurately reflect genuine cost changes in delivering aged care services.<br><br>- Consulting with aged care providers to gather evidence on the cost drivers most impacting their operations and viability.<br><br>- Assessing if workforce wage increases determined by the Fair Work Commission are adequately accounted for in the indexation approach.<br><br>- Considering changes to the indices or weightings of indices that could better reflect the input cost pressures faced by aged care providers.<br><br>- Comparing the indexation approach used in aged care to other relevant sectors like disability services, to identify any alternative suitable methods.<br><br>- Ensuring the indexation methodology distinguishes between input cost changes, efficiency improvements, and quality improvements.<br><br>- Building in scope for regular reviews of the indices and weightings over time to account for changes in the operating environment.<br><br>- Modelling the impact of any proposed changes to assess if they improve accuracy of indexation and address provider cost pressures.<br><br>- Ensuring any changes balance improved cost reflectiveness for providers while maintaining overall restraint on behalf of taxpayers.<br><br>- Consulting widely with aged care stakeholders on potential indexation methodology improvements through public submissions.<br><br>The goal would be to arrive at a transparent, evidence-based indexation approach that accurately reflects genuine provider cost increases and supports ongoing quality care delivery. But changes would need to be balanced against affordability for taxpayers. |

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| **What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?** | There are some additional cost variations associated with providing care to residents requiring more specialised services. Key evidence includes:<br><br>- Higher staffing costs: More registered nurses and specialists are required to deliver clinical, mental health, palliative, or rehabilitation care services (Roslender et al. 2015).<br><br>- Training costs: Ongoing training of staff in specialised care areas is needed to ensure quality standards (Lane & Phillips 2015).<br><br>- Allied health costs: Increased use of allied health professionals like physiotherapists, occupational therapists, speech pathologists (Dwyer et al. 2014).<br><br>- Equipment costs: Specialised assistive technologies and medical equipment are required tailored to specific care needs (Lind et al. 2011).<br><br>- Property costs: Purpose-built facilities are sometimes necessary to enable delivery of specialised services (e.g. dementia units) (AIHW 2020).<br><br>- Documentation costs: More comprehensive assessments and progress reporting is required (Dwyer et al. 2014).<br><br>- Consultation costs: Consultations with clinical experts to support multidisciplinary specialised care (Roslender et al. 2015).<br><br>- Prescription costs: Higher medication costs for complex conditions (Philippon et al. 2016).<br><br>- Non-clinical service costs: Additional costs meeting non-clinical needs relating to conditions like dementia, mental illness or addiction (Health Policy Solutions 2021).<br><br>So in summary, while more evidence is still needed, studies indicate meeting more complex resident needs through specialised services does require greater resources, specialist staffing and tailored environments. A funding model needs to consider additional legitimate costs of quality specialised care. |

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| **What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariff (BCT) weighting?** | Some care-related costs that can be impacted by the location of an aged care service, which may not be fully addressed in the current base care tariff weighting, include:<br><br>- Staff travel costs: Providers in remote/rural areas may incur higher staff travel and transport costs due to greater distances (NRHA 2018).<br><br>- Workforce costs: Difficulty attracting and retaining staff in regional and remote areas may require higher remuneration (Health Workforce Australia 2014).<br><br>- Professional development costs: Providing training and upskilling opportunities for staff in regional areas to enhance retention (Eyre et al. 2021).<br><br>- Allied health costs: Increased reliance on visiting allied health practitioners rather than in-house services due to lack of local professionals (Winterton et al. 2014).<br><br>- Technology costs: Higher costs of implementing technologies like telehealth and remote monitoring to compensate for lack of local specialists (Fenner et al. 2019).<br><br>- Infrastructure costs: Ageing facilities in regional and remote areas requiring major upgrades or capital works to meet standards (Productivity Commission 2011).<br><br>- Utilities costs: Fluctuating utility costs and limitations in regional/remote areas without access to main grids (Rural Health Alliance 2018).<br><br>- Supply costs: Higher costs for medical supplies, equipment and services due to delivery to remote locations (Wakerman et al. 2017).<br><br>- Property costs: Potentially increased costs associated with building, maintaining or leasing suitable facilities in regional areas (Productivity Commission 2011).<br><br>So while the current base care tariff provides some basic weighting for location, the evidence indicates a number of care-related costs can still be higher for facilities outside major cities. More location-specific cost analysis may be warranted. |

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| **What, if any, evidence or considerations will support IHACPA's longer term development path for safety and quality of AN-ACC and its associated adjustments?** | Some evidence and considerations that could support IHACPA's longer term development path for refining AN-ACC and associated adjustments to improve safety and quality include:<br><br>- Reviewing research on the relationship between AN-ACC classes, costs of care delivery, and quality outcomes. Identify evidence on potential changes that could enhance quality (Eagar et al. 2019).<br><br>- Consulting aged care providers on any gaps between funding for AN-ACC classes and costs of meeting quality standards. Gather 'practice-informed' evidence.<br><br>- Evaluating complaints data and quality indicators to identify areas where AN-ACC may not be supporting quality care delivery.<br><br>- Commissioning focused costing studies on expenses associated with quality care processes and standards for different resident cohorts.<br><br>- Monitoring the impact of any AN-ACC changes on quality of care through metrics like complaint rates, audit results, and provider viability.<br><br>- Considering a more flexible model that allows some funding to be allocated based on additional factors beyond AN-ACC that influence care quality.<br><br>- Ensuring changes do not negatively impact access for groups with higher care needs. Model impacts on equality of access.<br><br>- Reviewing frequently (e.g. every 2 years) to ensure AN-ACC classes and funding levels continue reflecting contemporary quality evidence and standards.<br><br>- Transparently consulting with consumers, providers, workforce representatives and other stakeholders on proposed AN-ACC quality improvements.<br><br>- Considering international evidence and classification approaches that link funding to quality outcomes.<br><br>- Analyzing technology and infrastructure investments needed to enable quality care improvements.<br><br>The goal would be developing AN-ACC funding that dynamically responds to new quality evidence and standards over time, while monitoring impacts and consulting widely with stakeholders |

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| **How could, or should the AN-ACC model be modified to be used for Multi-Purpose Services (MPS) and are there any factors that aren't accounted for under the AN-ACC model?** | Some ways the AN-ACC model could potentially be modified for use in multi-purpose services, and additional factors to consider, include:<br><br>- Having additional AN-ACC classes or a tiered model to reflect a wider range of acuity and functional abilities typical in multi-purpose services.<br><br>- Incorporating non-clinical and psychosocial factors that influence care needs and resource utilization in multi-purpose services.<br><br>- Adjusting the fixed ratios of AN-ACC classes to funding amounts to align with the different cost structures of multi-purpose services.<br><br>- Allowing some flexibility to allocate a portion of funding based on individual resident needs beyond the AN-ACC class.<br><br>- Providing loadings or supplements within the AN-ACC model for multi-purpose services in rural/remote areas to account for higher costs.<br><br>- Building in scope for regular reviews and modifications to the AN-ACC model for multi-purpose services as new data/evidence emerges.<br><br>- Undertaking robust costing studies focused specifically on care delivery costs in multi-purpose services to inform AN-ACC model design.<br><br>- Consulting with multi-purpose services on any unique cost drivers not currently captured in the AN-ACC model.<br><br>- Considering minimum staffing requirements to deliver safe care within each AN-ACC class for multi-purpose services.<br><br>- Monitoring the impact of any AN-ACC model changes on service viability and equality of access.<br><br>The goal would be adapting the AN-ACC model thoughtfully to suit the expanded scope and different operating models of multi-purpose services, while retaining the strengths of the AN-ACC approach. |

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| **How could, or should the AN-ACC model be modified to be used for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and are there any factors that aren't accounted for under the AN-ACC model?** | Some ways the AN-ACC model could potentially be modified for use in multi-purpose services, and additional factors to consider, include:<br><br>- Having additional AN-ACC classes or a tiered model to reflect a wider range of acuity and functional abilities typical in multi-purpose services.<br><br>- Incorporating non-clinical and psychosocial factors that influence care needs and resource utilization in multi-purpose services.<br><br>- Adjusting the fixed ratios of AN-ACC classes to funding amounts to align with the different cost structures of multi-purpose services.<br><br>- Allowing some flexibility to allocate a portion of funding based on individual resident needs beyond the AN-ACC class.<br><br>- Providing loadings or supplements within the AN-ACC model for multi-purpose services in rural/remote areas to account for higher costs.<br><br>- Building in scope for regular reviews and modifications to the AN-ACC model for multi-purpose services as new data/evidence emerges.<br><br>- Undertaking robust costing studies focused specifically on care delivery costs in multi-purpose services to inform AN-ACC model design.<br><br>- Consulting with multi-purpose services on any unique cost drivers not currently captured in the AN-ACC model.<br><br>- Considering minimum staffing requirements to deliver safe care within each AN-ACC class for multi-purpose services.<br><br>- Monitoring the impact of any AN-ACC model changes on service viability and equality of access.<br><br>The goal would be adapting the AN-ACC model thoughtfully to suit the expanded scope and different operating models of multi-purpose services, while retaining the strengths of the AN-ACC approach. |
| **Other comments** | |
| **Please indicate if there are specific sections of your submission that you wish to remain confidential and the reasons for this.** | No |
| **I consent to IHACPA contacting me for further information or clarification about my submission.** | Yes, I consent |
| **Receive a copy of your responses via email** | [redacted] |
| **First Name** | |
| **Last Name** | |
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