Anglicare Sydney response to the IHACPA Consultation

August 2023

21 August 2023

1.EXECUTIVE SUMMARY

Anglicare Sydney supports activity-based funding in residential aged care but believes that the proposed pricing framework for 2024-25 is too narrow and ignores key aspects of care that combine to keep residential aged care residents, healthy, safe, and informed. As IHACPA notes, residents, their families and partners and the community expect that person-centred, high-quality care is supported and that providers can sustainably provide the expected high levels of care. If the Australian National Aged Care Classification (AN-ACC) based funding model cannot be modified to support these critical services, then alternative or additional funding models must be urgently considered by IHACPA as part of the proposed pricing framework for 2023-24.

In response to the current IHACPA consultation paper regarding the proposed pricing framework for 2024-25, Anglicare notes the following:

1. The cost to provide care to the Aged Care Standards particularly in relation to spiritual support, lifestyle choices and allied health needs be calculated and reflected in the AN-ACC price and the proposed pricing framework.
2. The AN-ACC classification system must be updated to reflect the importance of cognition, not just mobility, and an expanded understanding of the role of compounding factors.
3. There are still issues with transparency in relation to assessment, validation and compounding factors.
4. There are inbuilt challenges to administrative efficiency including the increased delays in reassessments for which providers generally bear the cost burden.
5. There are a number of costs which impact a resident’s care including the real cost of staffing, regulatory and compliance costs, pastoral care and allied health -which are currently not being adequately funded.
6. Respite care incurs the same level of care costs as that for a permanent resident and this should be reflected in the proposed pricing framework.
7. There is a real concern that even if full CPI indexation is adopted, the real costs of providing residential aged care will not being covered, threatening the sustainability of the sector and the provision of high-quality care.
8. Without appropriate incentives in the pricing framework, innovation in care risks being seriously compromised.
9. Specialised care in the form of palliative care may not be adequately covered for existing residents who transition across AN-ACC classifications – often because of the delays in reassessments.

2.QUESTION RESPONSES

1. What, if any, changes do you suggest IHACPA consider for the residential aged care pricing principles?

2.1 Overarching Principles

Anglicare supports the overarching principles embedded in the new Pricing framework in relation to access, quality of care, fairness, efficiency and maintaining agreed roles and responsibilities. However, there are other principles which need to be considered.

Beyond excellent clinical care there is a need to consider the whole person – a principle of **holistic person-centred, and person-directed, multi-disciplinary care** which considers residents' emotional and spiritual wellbeing, their levels of social connection and sense of safety and their lifestyle choices. This principle is bedded on the understanding that residential age care facilities are not sub-acute defacto hospitals, but the homes of residents where clinical and personal care is important but so too is a range of other care supports which are required to generate positive whole of life and quality of life outcomes in line with the current Aged Care Standards and community expectations of resident choice and agency. The cost to provide this care to ensure the delivery of the Standards particularly in relation to spiritual support, lifestyle choices and allied health should be calculated and reflected in the AN-ACC price.

2.2 Process principles

We also support the underlying process principles of administrative efficiency, stability, evidence based and transparency. However, we consider that in the current model some of these principles – particularly in relation to transparency may be difficult to achieve.

a) Issues of transparency

Anglicare raised, in its 2022 submission, the current lack of transparency in relation to assessments. This is still an ongoing issue.

Assessment

Under AN-ACC, the assessment process appears to be 'close ended' and, does not openly involve the resident, their family, the residents nominated Partner in Care, and sometimes does not include staff involved in delivering the care. The new assessment system predominantly focuses on a suite of assessments and does not appear to take resident wishes, goals and aims into account which is against community expectations and the clearly indicated direction of policy reform. Anglicare considers the AN-ACC process excludes consideration of the whole of the person that is the focus of the funding provision. Nursing and care staff, who know the residents and their needs well, frequently are not consulted. Moreover, the assessors do not share the rationale for their classifications.

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

Anglicare has observed that AN-ACC assessments conducted by the external assessors can take on average around 20 -30 minutes – which is insufficient time for a comprehensive assessment of the resident's clinical and personal care needs. This point in time assessment approach does not acknowledge variations in resident function over an entire day or week; during which function and care needs can fluctuate. Indeed, the time of day for the assessment can be critical in terms of how a resident's needs are perceived by an assessor.

Additionally, there is a lack of clarity of the information assessors are considering, with variation between assessors noted. This can result in assessment and recommendations that may not be an accurate representation of care needs over time.

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

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

Anglicare has made the following observations in relation to the external assessment process since 1 October 2022:

- Outcomes from some LHD (Local Health Districts) are consistently lower than from other AMOs (Assessment Management Organisations).
- Some specific assessors also consistently provide incorrect classifications. For example:
  - Resident A: resident on class 5 reassessed by (HCA assessor A) downgraded to class 2 when Class 7 was predicted. Reconsideration was requested and (APM assessor) outcome was class 7.
  - Resident B: resident on class 4 reassessed by (HCA assessor A) downgraded to class 2. Class 6 was predicted. Reconsideration was requested and (ANCA assessor) outcome was class 6.
  - Resident C: resident on class 5 reassessed by (HCA assessor A) no change to classification. Class 7 was predicted. Reconsideration was requested and (HCA assessor B) outcome was class 7.

In addition to the lack of open disclosure to residents, Anglicare maintains that facilities need to be able to contribute to the assessment process. In recognition of the understanding of resident function and care needs across time, individual provider staff can add value to the assessment process based on their understanding of individual care needs. This may include support to AN-ACC assessors simply by providing relevant documentation without necessarily being involved in the direct assessment process with the resident. Providers therefore need to be provided with a good understanding of the assessment evidence.

The variations observed in resident assessments combined with the gap in process transparency to the provider heightens the challenges for a provider to clarify an individual resident's classification.

Validation

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

Compounding Factors

There is a lack of transparency around the nature of compounding factors which can impact on funding within classifications. It is not clear exactly what is considered a compounding factor, how they are developed, how much weight that has in a person's classification or how that would impact the allocated care minutes. As an example, a syringe driver appears to be given the same funding weighting as an insulin injection yet best practice guidelines show they each require very different levels of staff qualification and time.

b) Administrative Efficiency

While administrative efficiency is to be supported Anglicare has concerns that there will be an increase of the administrative burden and its complexity on providers which will have a potential impact on financial viability.

An example of this is the ongoing delay in relation to assessments where AMO's are often not available, leading to extended periods of time where increased care is needed and implemented but not funded. Anglicare staff have experienced time delays increasing over the last few months. This is exacerbated by the fact that in the MAC portal it is evident that some AMO's are rejecting referrals from the Department of Health to undertake assessments and reassessments because they have insufficient capacity. For example in July 2023 alone 66 assessment requests were rejected by AMO's due to 'insufficient capacity'. The AMO has the right of reply as to whether or not an assessment is completed. Back dated pay is therefore not necessarily assured and is also dependent on the outcome of the re-assessment when it does take place. For smaller providers bearing the cost burden, particularly in relation to staffing and equipment, during the delay can be very problematic. If there are a number of residents in a home awaiting re-assessment, then the cost burden is amplified.

Regarding Anglicare's experience, at the beginning of August 224 residents had pending AMO assessor reviews (63 new admissions, 141 reassessments, 20 reconsiderations). These comprise March, April, May, June and July requests. 267 residents were reviewed by AMO assessors in July for requests spanning March, April, May, June and July and 23 residents departed prior to being assessed thus placing the increased cost of care on Anglicare which won't be recovered.

Additional inefficiencies are evident in the actual rostering and resourcing for reassessments. A provider may have put in a request for multiple re-assessments at a particular home but when the AMO arrives if they only have a couple of residents registered then that is all they will complete on that visit – even though others are still waiting. This pushes out delays and increases the funding burden on providers. For example, one Anglicare home in Nowra had 21 pending reassessment requests from May and June 2023 which were not attended until mid-August 2023.

2. What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

Do the current 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?

Currently the AN-ACC model relates only to a narrow definition of care minutes and not to the other activities that take place in order to deliver a holistic model of care. Activity based funding has worked well in the hospital system where care is episodic. However, in aged care it needs to recognise that this is a home where people live – with elements beyond that of clinical and personal care.

1. The importance of cognition

Currently classifications in AN-ACC are primarily based on mobility. However, Anglicare believes there should be a recognition in the classification framework that levels of cognition are a key factor in determining the nature and level of supports required for aged care. A resident can be ambulatory but if they have dementia their behavioural and care needs can be both complex and intensive requiring significant staff time and effort not covered in the current tool. In determining the initial classification, a cognitive assessment is imperative – and this should also be included in any re-assessment process – since there may not have been a physical decline in mobility but instead the onset of dementia which drastically alters care needs. This is not just an issue for residential care – it also needs to be considered in the home care environment. Furthermore, there's no agreed comprehensive cognition assessment and Anglicare recommends that a common assessment tool be included in the AN-ACC suite of assessments.

2. Compounding factors

When there are no compounding factors an internal predictive AN-ACC classification is usually the same as that from an AMO. This enables the home to manage the cash flow as the correct level of funding is received. However, it needs to be recognised that there is no real homogeneity for residents in each classification and this lack of homogeneity in the AN-ACC tool reflected by a range of compounding factors in various classifications, makes management of cash flow very challenging.

For example, if a resident enters end of life care there are a number of compounding factors which need to be considered including the cost of specialist medication, more intensive care and sometimes specialist equipment. Wound management is another area which can require levels of specialist medication and sometimes the use of protective equipment which is not necessarily accounted for in the current classification schema.

The classes that are most difficult to predict are those with compounding factors (classes 3, 5, 7, 10, 13) due to lack of clarity of weighting of individual compounding factors in each mobility branch. The current AM-FIM assessment cognition component is subjective and dependent on the assessor's knowledge and experience with assessing people with cognitive deficits.

3. 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.

There are a number of legitimate costs which are associated with stages of care.

1. Real cost of staffing

This continues to be a critical issue for providers. Currently the focus is on the cost of care but does not consider the cost of staffing. The introduction of care minutes has created additional workforce pressures forcing many providers to increase overtime or use of agency staff which is currently operating at a premium because of workforce shortages. This increases the vulnerability of providers in rural and regional areas but also has implications in Sydney. Variability in rent means that in some cases workers cannot afford to live close to their place of work which increases their costs of commuting and makes it difficult to recruit in some areas of Sydney. Anglicare has found this to be the case in the Northern Beaches and Eastern Suburbs. Attachment A graphically illustrates, via a heat map, the postcodes of our aged care staff as well as our current residential care facilities. It is very clear that a significant number of our aged care staff come from the western and southwestern areas of Sydney. Workers are not keen to travel and bear the cost burden of travel. Accordingly, because of supply constraints, there is an increasing reliance on agency staff and overtime which escalates staffing costs. In fact a premium for aged care staff now applies in some parts of Sydney.

Stewart Brown's March 2023 Aged Care Financial Performance Survey Report states 'Staffing shortages have been required to be managed with increased levels of agency staff and overtime for existing staff. Agency staff now represents $17.04 per bed day, an increase of $9.86 per bed day compared to the same period in 2022 (Mar-22 $7.18 per bed day).'[1]

In Anglicare's experience, on average it costs the organisation $6.22 (12%) more per hour to employ an agency care worker in the Sydney metro area and $7 (8%) more for an agency RN. This increase in hourly rate for a tight workforce is not considered in the AN-ACC model.

2. Non direct care tasks incurring costs

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

There is an absence of adequate funding for lifestyle activities and pastoral care support, engagement and reablement as required under the Aged Care Standards. Lifestyle assists with maintaining quality of life and contact with families as well as reducing isolation and supporting and improving mobility and interactions with others. The new funding model needs to reflect the breadth and depth of the holistic and person-centred care required under the Standards for which providers are accountable and are required to comply.

3. Allied Health

There also needs to be more funding for allied health – OT, speech, podiatry, physio, dietitians – these services are often imperative to meet clinical needs and standards and providers have to ensure these needs are met whether funded or not. Under ACFI physiotherapy was very restrictive (mainly focussed on pain

[1] StewartBrown (2023) *Aged Care Financial Performance Survey Report,* sighted at [StewartBrown_-_Aged_Care_Financial_Performance_Survey_Report_March_2023.pdf]

management), whereas under AN-ACC, it is now reflective of community practice, requiring more time from the physiotherapist and funding therefore needs to be expanded under the AN-ACC pricing framework. In addition, the 4% component of AN-ACC funding recommended for allied health should be expanded to include Physiotherapist Assistants, otherwise they are funded from the clinical component (AIN/care worker) of AN-ACC leaving less funding for direct care roles.

4. 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?

When someone is admitted for respite care the onboarding costs are the same as if they were a permanent resident – although they enter the home under two different funding streams. Such costs include the need to set up documentation, conduct clinical and lifestyle assessments, observations and reviews, development of an agreed care plan with redesigns and care conferences with families. The suite of assessments is the same regardless of whether a person is entering for respite or as a permanent resident.

These are completed within 28 days of entry – although it needs to be acknowledged that all of these are fast tracked when dealing with respite care – which places a significant administrative burden on staff.

Regardless of whether the resident is permanent or respite the cost of entry, onboarding and delivering care is the same. The only real difference is the length of care – which in the case of respite is pre-determined, and payment for their stay (respite residents do not pay for their accommodation). I In some cases there may be additional costs requiring specialist equipment or special dietary requirements.

While there still needs to be a respite and permanent care option from the funding perspective they should be treated in the same way as the costs for onboarding and providing care are the same. Anglicare therefore recommends that the initial entry subsidy be paid for **both** permanent and respite residents. If a resident then transitions across to permanent care from respite then the funding could be retained.

5. What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

1. Sustainability and Adequacy

Sector sustainability is very reliant on indexation that accurately reflects changing costs of providing holistic person-centred aged care. Traditionally, indexation has been lower than inflation, eroding the funding base and threating longer-term financial viability of providers and the sector. However today, even full CPI indexation would not necessarily cover the increases in the full cost of care.

The pricing framework must implement full indexation at a level that covers the wages and operating costs in the aged care sector as distinct from the CPI. The sustainability of the sector is clearly at risk under current pricing arrangements:

> *The average operating results for residential aged care homes in all geographic sectors was an operating loss of $15.74 per bed day (Mar-22 $12.85 pbd loss) for mature homes (which exclude the outliers). This represents a loss of $5,221 per bed per annum, and a continuation of losses for over 5 successive years. Extrapolating the deficit per bed represents a residential sector loss in excess of $850 million for the nine month period.*[2]

[2] StewartBrown (2023) *Aged Care Financial Performance Survey Report,* sighted at StewartBrown_-_Aged_Care_Financial_Performance_Survey_Report_March_2023.pdf P2

Indexation should also fully fund any wage adjustments to all, or any aged care staff, made by the Fair Work Commission as and when they occur, even if it is outside IHACPA's pricing cycle. If the increases are not funded in a timely manner, there is increased risk of providers exiting the industry resulting in a potential reduction of beds.

2. Innovation

One of the key principles is fostering innovation but it is difficult to see how innovation can occur in a funding model that is so focused on minutes of care being delivered in a very tight funding model which leaves little room for the time or costs of innovation.

6. **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?**

Palliative Care

Anglicare is concerned about the situation when an existing resident transitions to palliative care. Recently the algorithm for how an end-of-life classification is determined appears to have changed. The weighting given to various compounding factors is also not clear. Previously we have received a Class 13 classification which is the highest level of funding for palliative care but recently on urgent requests to transition a permanent resident to palliative care the reclassification has only been at 11 or 12. It is not clear why the current algorithm has been altered or the rationale for the reclassifications in the first place.

Additionally, the slowness of response to reassessment for palliative care can sometimes mean a resident has passed away before the reassessment can take place. This leaves the cost burden with the provider without an option to back date the funding to when the resident passed away. A better option would be for the provider to submit a claim for palliative care with details provided, and the assessors to review those residents who are still in the facility within a certain time frame (for example, 3 months) after the claim has been made.

The Department of Health has advised they have a KPI of three days to address urgent end-of-life reassessment requests. However, 32 residents at Anglicare have passed away prior to urgent palliative care request being actioned by AMOs since February 2023. In these cases, the additional cost of increased care is borne by the provider with no increase in funding to pay for care provided, and no avenue for back-payment.

For example:

- Resident E: request for urgent end-of-life reassessment on 8 August 2023 for a resident on class 8.
- AMO ACNA advised the reassessment would be conducted on 15 August 2023.
- Resident passed away on 11 August 2023.

It is extremely difficult to deliver care minutes with the delays in reassessments. If not closed out within the quarter, then we move into the next quarter working from an unknown platform since we take the past quarter performance to determine our staffing for the next quarter.

7. What, if any, care-related costs are impacted by service location that are not currently addressed in the BCT weighting?

Facilities that are classified as MMM 1- 4 are paid a BCT based on occupied bed days. However, for facilities located in regional locations, staffing can be problematic.

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

Anglicare management has also observed increasing time delays between reassessments for facilities outside the Sydney region such as Wollongong and Nowra. This is impacting staffing and resourcing especially where there is not a labour force pool on which to draw requiring increased use of overtime and agency staff. Such delays also impact the ability to move on care minutes changes.

There is the potential for providers in MMM5 and greater to under assess funding required because they cant meet their staffing numbers.

8. **9. 10. No comment** No comment

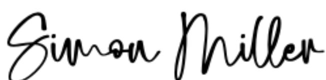
3. ABOUT ANGLICARE SYDNEY

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

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

CONCLUSION

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



Simon Miller

Chief Executive Officer

ATTACHMENT A