Submission questions – Bethanie Group

Number	Questions	Pages
1	**What, if any, may be the challenges in using the Australian National Aged Care Classification (AN-ACC) to support activity-based funding (ABF) in residential aged care?**	**30**
1.1	Linking of classes to specific RN and Care Minute targets that change on a quarterly basis without viable upper or lower limits on the total number of RN and CW shifts that must be added or removed within the quarter for any facility, **is incongruent with sustainable employment practices.**	
1.2	In an environment where we are nationally restrained with the number of skilled employees we require to run an ACH, the development of an **external assessment model** which utilises the same resources, **further reduces the pool of potential employees available to work with Aged Care Homes**.	
1.3	A barrier to Aged Care providers financial viability in transitioning to AN-ACC is despite providing 12 months of AN-ACC revenue prior to mandating AN-ACC related costs, our internal modelling and corroborated by Stewart Brown, clearly demonstrates **costs rapidly outstrip revenue at current NWAU rate and weighting.**	
1.4	Lack of consideration of the role of allied health clinicians and specific funding to support the care outcomes delivered by allied health (clinical, wellbeing and reablement)	
1.5	Lack of consideration of environments with a less 'traditional' staffing model (eg group home-like environments where staff deliver broader than the specified services or deliver them in a different way – eg a cleaner cleaning alongside a resident).	
1.6	Stifling of innovation or new and creative ways of providing & increasing care by setting prescriptive care targets for prescriptive role types (ie. Personal Care Workers).	
2	**What, if any, concerns do you have about the ability of AN-ACC to support long term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?**	**30**
2.1	AN-ACC definitions, the current NWAU rate and class weightings do not recognise the myriad of positions that are essential in creating a holistic care environment within an Aged Care Home, where residents live continuously rather than visit for a specified Length of Stay. Examples include the administrative staff re-directing wandering residents. Maintenance staff having a helper (resident) for the day. All of these, and many more, aspects add to quality of life. This is uniquely different from a Hospital. If this issue is not resolved, there is a risk it will systemically impact holistic service provision.	
2.2	A lack of inclusion of broader positions requirements in care minutes (eg through asserting that these services will be defined within the aged care standards) is unlikely to deliver the required embedding them in RAC and ultimately result in poorer outcomes for the resident and for the system (increased costs – particularly if services are ad hoc / contract and not provided to engage in preventative services but only post event/clinical outcome).	
2.3	The move to RN minutes will mean that Enrolled Nurse will gradually (perhaps speedily) disappear from Aged Care, the shortage of RNs will mean that the employment of RNs 1.1-1.3 will become more prevalent and will mean nurses (admittedly registered) with 1 or 2, years' experience will replace the 20–25-year aged care experienced enrolled nurse. The "qualification" argument is only a strong one on paper, not in front of a consumer!	
2.4	Sustainability is a concern – given the additional care required is greater than additional the AN-ACC revenue received.	
2.5	Sustainability is a concern given that the $10 per resident per day additional supplement to increase food & nutrition has been removed (and allocated to provide AN-ACC care), but the food costs & nutrition costs have not decreased.	
2.6	Sustainability is a concern given the supply constraints of Registered Nurses vs the demand constraints for RN's due to AN-ACC and the price premium required in order to attract & retain RN's.	
3	**What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents?**	**30**

4	**What should be considered in developing future refinements to the AN-ACC assessment and funding model?**	**30**
4.1	Clear pathway for Aged Care Providers to participate/contribute in costing exercises, committees, or advisory panel to IHACPA	
4.2	NWAU rate and /or weighting to make the model financially viable for Aged Care Providers	
4.3	Consideration of different service delivery models	
4.4	In a workforce environment that sees a massive shortage of Registered Nurses and this model all but determining that Enrolled Nurses have no role in Aged Care (they have become an expensive care minute) – refinements will be required to restore some balance	
4.5	The role of technology investment in care and assessment & innovation should be rewarded.	
4.6	Specific overall Care Margin Targets should be made public & transparent	
5	**What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services?**	**34**
5.1	Principle 6 – Pricing adjustments without consideration of providers potentially risks sustainability of the system. Both the characteristics of people receiving care and the demands on the sector/providers related to service provision need to be considered.	
6	**What, if any, additional principles should be included in the pricing principles for aged care services?**	**34**
6.1	Probably covered in the minimisation of undesirable outcomes/inadvertent consequences, however the cost of preventing poor outcomes and improving resident function and wellbeing needs to be considered and integrated – beyond just 'clinical' health outcomes	
6.2	Pricing considerations for adverse events such as COVID or outbreaks where additional care may be required.	
7	**What, if any, issues do you see in defining the overarching process and system design principles?**	**34**
7.1	Any advice provided to the Minister or government should be made publicly available.	
7.2	Residential care recipients are not as homogenous in relation to care requirements as patients in hospital. Therefore, the application of a ABF model will not be as efficient as hospitals and therefore additional allowances for inefficiencies of service delivery need to be accounted for.	
7.3	It is stated that an ABF model will present a range of incentives. What are the current incentives built into the AN-ACC model?	
7.4	Providers should be able to provide input into the evidence base for the assessment of funding	
7.5	Fostering Care innovation – AN-ACC does not currently incorporate any margin to incorporate care innovation	
7.6	Provider financial performance needs to be a consideration when funding levels are set. It should not be the primary driver but gives context to the system sustainability.	
8	**What, if any, concerns do you have about this definition of a residential care price?**	**36**
8.1	What wages were used to set AN-ACC pricing and how does this allow for variances with 80% of the industry having EBA's in place	
8.2	The current model does not have any funding considerations for additional regulatory reporting, additional governance for regulation and accreditation, innovation, or lifestyle.	
9	**What, if any, additional aspects should be covered by the residential aged care price?**	**37**
9.1	Lack of surety that the funds produced by RADs or DAPs actually offset the cost of capital for a sustainable residential aged care sector.	
9.2	Needs to include both direct care and indirect care eg lifestyle, allied health, specialised service provision for some conditions especially those of a progressive neurological nature	
9.3	Needs to take into account that people are living in residential care – not just receiving nursing and personal care	

9.4	Investment in innovation or technology to increase or maintain care	
10	**What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?**	**38**
10.1	If there is not clarity in the care standards, it will be difficult to establish the 'best practice' required to meet those outcomes. Even if there is clarity in the standards, particularly when it comes to mental health, enablement and wellbeing outcomes, there isn't a one size best practice that fits all.	
10.2	There is a risk that care minutes will be a greater driver than best practice, delivering poor support and outcomes for residents.	
10.3	Need to carefully determine how 'best practice' is defined – who contributes to determining what makes up best practice	
10.4	Economies of scale becoming less achievable as the drivers available to leverage to enhance financial performance are limited	
10.5	Cost of care is higher than revenue being received to provide care.	
10.6	There is little transparency around what margins should be made on care. At the moment – those margins seem to be negative. Revenue pricing is historically based, whereas cost is driven by future and current economic market forces such as increase in demand & competition for a scarce resource, Registered Nurses, driving labour costs significantly higher than historic levels. The future AN-ACC targets, specially impact of increases, should be included in pricing – and based at a state level, rather than national level.	
11	**How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of the Independent Health and Aged Care Pricing Authority's (IHACPA) residential aged care pricing advice?**	**38**
11.1	The integration of outcome information could help to balance the view between cost and best practice. The risk is that there may be few providers with the financial performance and clinical insights to truly support the delivery of best practice in the current model. So measuring what we are doing now to use as a comparison may not deliver the right insights.	
12	**What should be considered in the development of an indexation methodology for the residential aged care price?**	**38**
12.1	Macro and micro economical environments, also differences at state level, the availability of labour, and the competition in the labour market	
12.2	Alignment of funding indexation to cost inflation and other pressures driving up costs	
12.3	Future increases in care minute targets should lead to an equivalent increase in revenue received.	
13	**What, if any, additional issues do you see in developing the recommended residential aged care price?**	**38**
13.1	Whilst IHACPA does not look at the appropriateness of wages, if wages are not positioned to attract the appropriate staff to the industry, the outcomes for residents will be negatively impacted.	
13.2	Using only historic data for cost modelling taken into consideration in the pricing. Forecasting models should be considered as well.	
13.3	Profit margin insufficient to cover the costs not directly related to care but essential to operate and comply (e.g. increased level of reporting)	
13.4	Consideration should be given to the lag in ability for providers to control changes in their cost base – due to 80% of industry being linked to EBA's, additional funding/ pricing should be available to assist with cost changes lagging changes in care targets.	
14	**What, if any, changes are required to the proposed approach to adjustments?**	**40**
14.1	Need to be cognisant that the funding model / adjustments may drive care to be driven in a standardised way across all facilities, limiting range of service models available and ultimately limiting customer choice	
15	**What, if any, additional adjustments may be needed to address higher costs of care related to resident characteristics?**	**41**
15.1	Need to consider that higher staffing levels required for better care of people living with dementia	
15.2	Higher care needs and staff rations for people with high complex needs beyond an-acc classifications	

15.3	Need to consider specialised equipment needs of people with progressive neurological disorders and that these needs can change quickly within a short period of time and specialised equipment is costly	
15.4	Service delivery model (small group home environment)	
15.5	When a resident changes class classifications due to a change in care -> there should be a once off amount similar to when a new resident is onboarded to account for additional once off admin/management required to manage the change.	
16	**What evidence can be provided to support any additional adjustments related to people receiving care?**	**41**
16.1	Model of care, rosters etc.	
17	**What should be considered in reviewing the adjustments based on facility location and remoteness?**	**42**
17.1	There are differences between MMM 1- 4 in attracting and retaining workforce that is not reflected in the same amount reflected in all 4 MMM's.	
18	**What evidence can be provided to support any additional adjustments for unavoidable facility factors?**	**42**
19	**How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?**	**43**
19.1	Need to be careful that the focus on safety and quality (potentially the clinical indicators as a prime driver) doesn't decrease the dignity of risk for residents and result in decreased functional activity performance.	
20	**Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?**	**45**
20.1	Hotel costs do change based on the functional presentation / diagnosis of the resident	
20.2	That said, there is a base cost of hotel services (potentially per square metre) that could be considered as a foundation, with an increase then linked to the resident AN-ACC assessment	
20.3	Including hotel costs allows for holistic analysis of feasibility of providing care.	
21	**What should be considered in future refinements to the residential respite classification and funding model?**	**46**
21.1	Include allied health services People live in residential care need so much more than nursing and personal care	
21.2	Respite often occurs in a period of crisis, and when community-based care is not meeting resident/carer needs	
21.3	A full assessment, including allied health should be funded during this period to help inform the appropriate requirement to effectively provide support in the community	
22	**What are the costs associated with transitioning a new permanent resident into residential aged care?**	**47**
22.1	Increased staff time with the resident and family during transition (beyond assessment but to actually facilitate transition). This includes care worker, nursing, hotel services and allied health.	
23	**How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?**	**47**
23.1	Reliance on nurses presents challenges	
23.2	Consider a model where care can be delivered by a multidisciplinary team including allied and mental health care professionals	
23.3	Current contractual agreements based on an ACFI system limits implementation of AN-ACC without significant disruption to changes in culture, redefining roles and responsibilities and renegotiation of future EBA's	
24	**What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?**	**47**
24.1	Making sustainable customer centred care a reality through reasonable funding & regulation	
25	**What would be considered markers of success in IHACPA's aged care costing and pricing work?**	**47**
25.1	Genuine improvement (measured with appropriate metrics) in customer outcomes with providers' financial metrics sound and maintainable	