Submission on IHACPA Consultation Paper Towards an Aged Care Pricing Framework

1 Background Information

Introduction

Calvary is the largest provider of integrated hospital, residential aged, home care and virtual care in Australia with over 18,000 staff and volunteers, 14 public and private Hospitals, over 70 retirement and aged care facilities, a national network of home care services and virtual care services.

Founded in 1885 by the Sisters of the Little Company of Mary, Calvary is a mission based, not-for-profit, Catholic health care organisation.

Our mission is to provide quality, compassionate health care to the most vulnerable, including those reaching the end of their life.

Residential Aged Care

Calvary Residential Aged Care provides quality care and services within a supportive environment in which residents are respected for their individuality.

We provide 72 Residential Aged Care and Retirement Communities across NSW, Victoria, Queensland, Tasmania, ACT, Northern Territory and South Australia and care for more than 4,500 residents and employ more than 7,000 people.

Our services incorporate residential care, specialist memory support services and respite care. This includes Mulakunya, a unique hybrid model on remote Bathurst Island in the Northern Territory combining residential and community aged care services to best meet the specific needs of the local indigenous community (funded through NATSIFAC).

- Best-Practice Model of Care

Calvary is currently piloting a new Residential Aged Care model which will further enhance our vision to deliver high quality, person-centred care for the older people to ensure they can live an active, self-determined and meaningful life in a caring and supportive environment. The model will be translated and applied to all facilities across Calvary following evaluation and modification.

The model is underpinned by a strong relationship- first approach between our residents, staff, volunteers and families to achieve the highest quality of care and ensure each resident's holistic care needs, interests and choices are met. This model reflects industry best- practice and aligns with the recommendations from the final report of the Royal Commission into Aged Care and Safety released in March 2021 and is being formally assessed by the University of Wollongong.

- A focus on dementia and palliative care

Calvary's Residential Aged Care Model is the foundation upon which person-centred dementia and palliative care programs are built.

The small household, relationship-based, person and family centred approach to the aged care model, form the foundation upon which a palliative care approach can be utilised in any life-limiting circumstance within residential aged care. A palliative approach refers to the care provided by any healthcare professional that adapts palliative care knowledge and expertise to meet the needs of people with chronic life-limiting conditions.

By building relationships with residents and their families, we can discuss and form goals that are those of the resident. This palliative care approach recognises the importance of person and family-centred goals such as quality of life.

Hospitals

Calvary provides a broad range of acute medical and surgical services to meet the needs of the communities we serve. In addition to acute medical and surgical services, Calvary also offers maternity services, Palliative Care services, public and private emergency services, contemporary diagnostic services, support services and sub and non-acute services, such as rehabilitation and mental health. Comprehensive cancer services are provided at Calvary Mater Newcastle and Calvary Central Districts Adelaide.

Calvary has well established partnerships with institutions including University of Canberra, Australian Catholic University, University of Sydney, University of Newcastle, Notre Dame University Australia, Monash University, University of Tasmania, Adelaide University, and University of South Australia for teaching and research. There are also clinical schools present on several sites.

Home Care

Calvary operates home care services across six States and Territories, including the ACT, and provides over 1.3 million service hours per year across more than 100 service types.

Calvary Home Care has been supporting people in their own homes and communities for over 20 years. We deliver a range of aged care, disability and other support services that enable independence, improve social connections and promote positive health and wellbeing.

Virtual Care

In 2020, Calvary partnered with Medibank Private to form a joint venture to support better access to person centred virtual acute care in the home. The venture was awarded its first tender to deliver My Home Hospital (MHH) on behalf of Wellbeing South Australia. This innovative program leverages a centralised Virtual Care Centre (VCC), including a digital platform with remote monitoring capability, to deliver integrated, hospital-level care to people in their own home.

Building on the VCC capability, COVID Care at Home, a virtual hospital service for COVID19-positive patients, was successfully launched in August 2021 by Calvary- Medibank in Western Sydney Local Health District (LHD) following a one-week co-design period. The service expanded rapidly and in 12 months has supported over 175,000 patients at home, in communities across NSW, VIC, QLD and WA, caring for them at their most vulnerable, in isolation with a disease with varying effects.

Our Virtual Care services are evidence that these models work. Further utilisation of technology and virtual care is the future of our health system and will revolutionise the way we deliver care and support across Australia.

Experience in Case mix Funding Models

Due to the nature of our operations across our service streams, Calvary is in a unique position as an aged care provider and has a strong and robust understanding of the operation of case mix funding models within a clinical care setting. We have been able to utilise this understanding through the early stages of the release of the AN-ACC Funding model and subsequent allocation of minutes.

Through our internal Data and Analytics team we can provide detailed clinical costing and business intelligence across our network of private hospitals to monitor and support overall clinical costing information and activity. This information is used in overall hospital management, health fund discussions, engagement with clinicians, activity forecasting and clinical design of services.

Calvary has been involved in the development of the AN-ACC framework for an extensive period of time. We were initially involved in the RUCS study that was undertaken by the University of Wollongong, have continued to have key roles involved in the Department of Health consultation processes and more recently working with peak organisations and consultants to understand the potential impact and risks of the introduction of AN-ACC within the sector.

Similar to many of our colleagues; we have been working on the development of a reasonably sophisticated model to be able to model our shadow assessments of individual residents, identify the average NWAU of our homes and finally assess the likely workforce requirements in each classification. We believe we have a sound understanding of the AN-ACC profile of our homes and the direct implications for workforce requirements.

2 Response to Questions

	Question
1	• What, if any, may be the challenges in using AN-ACC to support ABF in residential aged care?
	Calvary suggest that there are several factors that might add challenge to using AN-ACC to support ABF in residential aged care: The timeliness and accuracy of resident assessments based upon sound clinical evidence will be a critical component to ensure weightings and resourcing are correct from the initial point of admission. Calvary have identified a degree of residents that appear to have been incorrectly scored in the initial round of shadow assessments that have required a re-assessment process to be completed. At this stage, the costing data and clinical analytics within the aged care sector and the Department of Health are reasonably immature and the introduction of the model has been completed within a very short timeframe. Whilst at a provider level we have endeavoured to accelerate this work, we have not been able to reconcile or validate against the industry averages that have been used to determine initial price. The current models of care and cost structures are retrospective of their analysis of the industry overall and through to the individual home. The current models of care cost structure that have been used as a baseline are not reflective of the likely future state of homes once full minutes have been adopted and care models have been adjusted. Whilst addressed at later question, the market demand in attracting workforce will definitely be a factor in the short to medium term and is highly likely to increase premium labour costs.
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?

	Question
	Overall, Calvary is supportive of the AN-ACC structure and believe it is an appropriate model for the allocation of funding across the aged care sector in line with the Royal Commission recommendations. We do however have concerns that the methodology used for the initial price setting is not reflective of current or future true costs of the delivery of care within a residential aged care setting and will need to be refined and adjusted quite quickly over the short term to maintain the medium term viability of services and the sector as a whole. We are also concerned about the narrow definition that is currently being used to determine care minutes. Whilst we appreciate and support the focus on clinical care for residents we would also strongly advocate that a person centred approach should include a focus on lifestyle, pastoral care and the dining experience. We are concerned that these critical care functions are being excluded and that it may well create a disincentive for providers. As a not –for- profit provider, Calvary believes that a reasonable level of "margin" is required to support and foster the continued investment into models of care, development of new innovations, development of staff skills and knowledge and the uptake of information technology to support and further embed the models of person -centred care. At this stage it is unclear what degree of margin will be available across the industry to support ongoing improvement.
3	• What, if any, additional factors should be considered in determining the AN ACC NWAU weightings for residents?
	Based upon our understanding, Calvary does not believe any additional factors should be included in determining the NWAU rating. We would strongly suggest that the weightings for cognitive impairment and palliative care are monitored on an ongoing basis to ensure the methodology being used is reflective of the resourcing required to meet the care needs of individual residents.
4	• What should be considered in developing future refinements to the AN ACC assessment and funding model?
	Currently, the model is still a very early stage of application across our organisation. We have been reviewing and monitoring shadow assessments but at this stage have been unable to identify any areas for refinement in assessment and funding tools. It is expected that as our experience develops we will be able to fully understand these relationships and provide further considerations for development.
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?
	Calvary supports and agrees with the principles as listed.
6	• What, if any, additional principles should be included in the pricing principles for aged care services?
	The only area that we believe should be included is the overall sustainability of the sector in the long term and ensure there is not an overall market failure.
7	• What, if any, issues do you see in defining the overarching, process and system design principles?
	Calvary has no concerns with overall design principles.
8	• What, if any, concerns do you have about this definition of a residential aged care price?

	Question
	Overall there appears to still be a lack of clarity on the inclusions in the care price components and expectations across the industry. This is compounded by an inability to reconcile back to the performance of our homes. The way that the pricing is being developed in sections, increases the risk that the overall operation of a home is not fully accounted for and will create a possibility of unfunded expenses within the service profile. This is particularly relevant with the overall management and corporate overheads for the operation of a home. Calvary is also concerned that the modelling of the prices appeared to be based off the average performance of the industry, not necessarily an efficient or sustainable costing structure. Given the broad range of models and performance across the sector, we are unsure if this is a reasonable representation of cost structures.
9	• What, if any, additional aspects should be covered by the residential aged care price?
	As previously identified, Calvary believes that there needs to be an overall mapping of the expenses of operating a home to ensure each cost item is mapped and accounted for within the various costing areas being considered to ensure each is allocated and there are no omissions. It would also be beneficial if a consideration is made to the standard allocation of management and overhead costs between the costing areas based upon a standardised approach and not the approach used for industry benchmarking.
10	• What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?
	Calvary has no concerns with the approach if there is a genuine commitment to determining costs in a transparent model and approach.
11	• How should 'cost-based' and 'best practice' pricing approaches be balanced in the short term and longer-term development path of IHACPA's residential aged care pricing advice?
	Calvary believes that it needs to be acknowledged there will be a high degree of transition in the immediate 12 - 18 months and the development of best practice pricing will need to be staged to ensure the long term viability of the overall industry. We would strongly advocate the improvement and refinement of data and financial reporting to be improved progressively before a concentrated approach is made on establishing a best practice pricing methodology.
12	• What should be considered in the development of an indexation methodology for the residential aged care price?
	Given the significant proportion of costs that are related to salaries and wages, Calvary would strongly advocate for a direct relationship of indexation that is linked to aged care modern award salary increases as a baseline and for the determination of the quantum of indexation. It would also be ideal to link the timing of funding increases to be more aligned with the timing of when award wages are increased and either consider prospective increase or increases at the time of award review. Remaining increases in goods and services should be linked to conventional Consumer Price Index (CPI) increase methodology.
13	• What, if any, additional issues do you see in developing the recommended residential aged care price?

	Question
	In the initial stages of the scheme, Calvary believes that regular costing submissions matched with clear and concise data governance information and sector education will be very important as we collectively improve the methodology and data collection to inform the aged care price.
14	• What, if any, changes are required to the proposed approach to adjustments?
	Nil
15	• What, if any, additional adjustments may be needed to address higher costs of care related to the resident characteristics?
	As previously identified, we would strongly suggest that the weightings for cognitive impairment and palliative care are monitored on an ongoing basis to ensure the methodology being used is reflective of the resourcing required to meet the care needs of individual residents. Consideration should also be given to the proposed supplements arrangements be incorporated into the mainstream AN-ACC funding classes.
16	• What evidence can be provided to support any additional adjustments related to people receiving care?
	Nil
17	• What should be considered in reviewing the adjustments based on facility location and remoteness?
17	Based upon our experience there is a higher cost component in attracting and retaining workforce in rural and remote areas. The costs relate to recruitment costs, relocation expenses, retention allowances, higher costs of training and education and maintaining a stable workforce. Similarly, this also applies to provision of specialist services such as all allied health domains, specialist nursing roles (wound care, continence etc) plus access to specialist medical services increase the costs in operating in rural locations with limited infrastructure. Calvary believes there is scope for the consideration of an incentive framework to increase the uptake and usage of virtual care in these locations that would improve the delivery of care.
18	• What evidence can be provided to support any additional adjustments for unavoidable facility factors?
	Nil
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?
	Calvary would advocate for a close relationship between the ACQSC, The Department of Health and IHACPA to ensure that the material changes in policy /approaches are proactively considered in pricing allocation and not assumed to be absorbed by providers. This increase methodology needs to be timely and relate to the actual time period that additional costs are incurred by providers.
20	• Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?
	Calvary believes that consideration of a parallel model (but linked) for hotel services should be established to ensure consistency across the industry and transparency in some of these key service delivery areas. This model would negate the possibility of cost shifting within homes and provide an overall picture on the true costs of delivering overall care and support to residents.

	Question
21	• What should be considered in future refinements to the residential respite classification and funding model?
	At this stage Calvary is unable to provide any refinements and funding as we have not seen the proposed model in operation within our homes.
22	• What are the costs associated with transitioning a new permanent resident into residential aged care?
	There is a degree of costs associated with the initial assessments, care planning and family consultation that are required over the initial weeks of admission , which are higher than the ongoing costs that are incurred. Calvary believes that the amount identified for transition is fair and reasonable.
23	• How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?
20	The overall demand for clinical and care workforce will continue to place pressure on the financial performance of residential aged care homes as they endeavour to maintain and increase staffing in a highly competitive market within the acute and NDIS sectors. This competition has seen the increase in premium labour costs through agency costs and increased overtime within the sector. At this stage it is difficult to foreshadow when this increased demand will reduce in the short term and the relationship to cost structures of individual homes. Currently within the pricing, it is difficult to identify available funding to support the training and upskilling of classifications to enable them to work at top of scope and progression from care staff through to registered nurse status. The allocation of pricing needs to be flexible to encourage providers to invest in longer term solutions to attract and retain workforce and not rely on premium staff costs to maintain services.
24	• What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?
	The only area Calvary currently identifies is the overall mapping exercise to ensure all service delivery streams are included in the models and not omitted.
25	• What would be considered markers of success in IHACPA's aged care costing and pricing work?
	Nil

Further Information

Calvary looks forward to an ongoing working relationship with the Independent Health and Aged Care Pricing Authority through the ongoing development of the Residential Aged Care pricing and costing matters and would be willing to meet to discuss our modelling across our organisation.

If you require any further information or clarification of any of the information contained within our response or would like to meet; please contact Matt Hanrahan, Deputy National CEO (Mobile: 0419 652 293) or Bryan McLoughlin, National Director, Customer and Communication (Mobile: 0417 654 557).