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The new voice of Alzheimer's Australia

Proposal for a new residential aged care funding model

A response from Dementia Australia

May 2019

About Dementia Australia

Dementia Australia (formerly known as Alzheimer's Australia) is the peak, non-profit organisation for people with dementia and their families and carers. We represent the more than 447,115 Australians living with dementia and the estimated 1.5 million Australians involved in their care.

Dementia Australia works with people impacted by dementia, all governments, and other key stakeholders to ensure that people with all forms of dementia, their families and carers are appropriately supported – at work, at home (including residential aged care) or in their local community.

Our close engagement with individuals and communities means that we are an important advocate for those impacted by dementia and we are also well placed to provide input on policy matters, identify service gaps and draw on our expertise to collaborate with a wide range of stakeholders, including researchers, technology experts and providers.

In addition to advocating for the needs of people living with all types of dementia, and for their families and carers, Dementia Australia provides support services, education and information aimed at addressing the gaps in mainstream services.

Dementia Australia is a member of Alzheimer's Disease International, the umbrella organisation of dementia associations around the world.

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Executive Summary

Dementia Australia welcomes the Department's decision to review the current residential aged care funding model, and the subsequent Resource Utilisation Classification study conducted by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong. The newly proposed funding model – the Australian National Aged Care Classification (AN-ACC) system for residential aged care – presents a promising start to establishing an effective and sustainable funding model for aged care.

Almost half of all people in permanent residential aged care have a diagnosis of dementia.[1] With a continually ageing population, we can expect the number of people living with dementia to grow considerably – which will invariably impact the need for high quality dementia care across residential aged care facilities. The quality of care in residential aged care facilities, and the impact this has on people living with dementia, their families and carers, is an issue that has long been the subject of our advocacy.

Overall we are supportive of the AN-ACC proposal, which takes positive steps towards developing a funding model that accurately assesses the costs to delivering residential aged care. This is an integral first step to ensuring that high quality care can be delivered to all residents in aged care.

In particular we support the introduction of a branching classification model which considers the mix of variables that reflects both general and individualised costs of care. We also welcome the separation from assessment and care planning workforces, to ensure funding classifications are entirely driven by the individual and their level of need.

Given the role the funding model plays in supporting providers in delivering care to a mandated minimum standard, it is critical that any replacement funding model is aligned to a better practice, person focussed and holistic model of care for all people living in residential aged care facilities. Given their additional vulnerabilities it is particularly important for people living with dementia.

We look forward to seeing the outcomes of this consultation and of further modelling that focuses on people living with varying forms of dementia, with differing levels of cognitive impairment.

Background

Dementia is the term used to describe the symptoms of a large group of illnesses which cause a progressive decline in a person's functioning including loss of memory, intellect, rationality, social skills and physical functioning.

Dementia is a progressive neurological disability and is the leading cause of disability burden for people over the age of 65 years in Australia.[2] Dementia affects people's abilities and

[1] Australian Institute of Health and Welfare (2015). *AIHW National Aged Care Data Clearinghouse. Accessed 5 July http://www.aihw.gov.au/media-releasedetail/?id=60129552716.*

[2] Australian Institute of Health and Welfare (2012) *Dementia in Australia*

memories and has a profound impact on the individual and those around them. It is cloaked in stigma and misunderstanding, isolates people with dementia and their carers from social networks, and carries significant social and economic consequences.

Dementia is one of the largest health and social challenges facing Australia and the world. Dementia is not a natural part of ageing. It is a terminal condition and there is currently no cure. It is the leading cause of death of women in Australia, the second leading cause of death in this country, and is predicted to become the leading cause of death within the next five years.[3]

There are 447,115 Australians living with dementia and without a significant medical breakthrough, there will be over one million people living with dementia in Australia by 2056.

Response to discussion questions

1. **Are there any risks or benefits of the proposed funding model that have not been Identified?**

Future pricing models must reflect cost of care

The key risk of the proposed funding model relates to the price set against the National Weighted Activity Unit (NWAU). This is the price that will determine the monetary amount assigned to individuals for their care.

Whilst we recognise that the purpose of the discussion paper was not to contemplate pricing amounts, it is important to acknowledge that this figure underpins the overall effectiveness of the AN-ACC model. If the price set does not reflect the true costs of delivering the care services associated with the branching classifications, then the model will not assign a sufficient level of funding that is needed by providers to deliver care.

Insufficient funding and resources have been key concerns highlighted by the aged care sector for many years, and has been most recently highlighted through the Royal Commission into Aged Care Quality and Safety as one of the key issues associated with the variability of the delivery of quality aged care.

We have also heard from people with younger onset dementia, their families and carers that they have experienced similar challenges emerging as the National Disability Insurance Scheme continues to roll out nationally – where inadequate pricing or Scheme funding caps has led to a number of providers struggling to provide the services they are expected to.

Consulting with the sector to ascertain the true costs of delivering quality care should be central to developing this model, and will help ensure the funding model can sustainably allocate the right level of funding so providers can deliver high quality care.

[3] Australian Bureau of Statistics (2016) *Dementia: Australia's leading cause of death*? Accessed online

The AN-ACC needs to consider the costs of best-practice models of care, rather than current practice

The AN-ACC system bases 13 classifications of funding on the profiled care needs of current residents in residential care, as opposed to *best practice* models of care that are not necessarily mainstream – such as reablement and restorative approaches.

Undervaluing the costs of delivering high quality care has long been an issue that has, according to providers, limited some from delivering a high-quality models of care to their residents. If the AN-ACC does not carefully consider the actual costs of delivering best practice models, there is a significant risk that funding allocated under the AN-ACC will not be sufficient. In fact, there is also a risk that it may create a perverse incentive for providers to minimise, for example, behaviour supports to residents in the initial assessment phases, so as to attract higher levels of AN-ACC funding.

We know that around 15% of the pilot residents were classified as exhibiting 'severe behaviours'. However, the pilot did not consider how widely pharmacological or clinical interventions, such as antipsychotics, were used to artificially manage the individuals' behaviours.

Overall, the AN-ACC model's link through to care planning should be explored as a matter of priority and the way in which reablement or restorative care principles are incorporated into care plans must be further articulated.

Removing the requirement for reassessments may not directly influence a provider's decision to adopt better models of care

The AN-ACC model makes the broad assumption that providers will be incentivised to adopt reablement practices within their models of care (because they will not need to trigger a reassessment if care needs reduce due to specific interventions). However, currently the evidence presented does not demonstrates if this model will actually lead providers to adopt different models of care.

Reablement approaches can have positive impacts on people living with dementia, and we support the intention to encourage more providers to adopt this approach. In fact, significant research has indicated how reablement approaches to care can vastly improve individuals' abilities to perform activities of daily living and therefore improve overall quality of life for people living with dementia.[4] However, the evidence presented in the reassessment study highlights that access to restorative and reablement practices is currently very limited. Even if restorative care is a proven component of quality care, the question of why these services are not consistently applied in dementia care should be considered.

There is also no direct evidence to demonstrate how effective the AN-ACC model will be in supporting and promoting restorative approaches – or even supporting non-clinical

[4] O'Connor CM, Poulos CJ, Gresham M, Poulos RG. Supporting independence and function in people living with dementia, A technical guide to the evidence supporting reablement interventions. Sydney: HammondCare Media, 2018.

approaches to dementia care. We urge further testing to determine the validity of these assumptions.

Reclassification may be necessary for people with progressive care needs

The proposed reassessment triggers indicate that either recent hospitalisation or severely decreased mobility should trigger a reassessment, so residents care is not limited by their funding classification. However, Dementia Australia has concerns over the lack of consideration for individuals who are impacted by cognitive impairment.

People living with dementia can expect to experience a significant decline in cognitive function over time. Whilst this decline in cognitive capacity may not impact one's mobility, or directly lead them to hospitalisation, a sharp decrease in cognitive function will likely impact the level of care that is required – at both a clinical level and a lifestyle/personal support level. Subsequently, this will impact the level of funding that is required to deliver high quality care to that individual.

Under the proposed reassessment triggers, there is a risk that people who experience cognitive decline will reach the point of hospitalisation before they are reassessed for a higher level of funding. Therefore, we recommend an additional trigger be included to reflect residents decline in cognitive function

2. Are the proposed resident assessment and classification processes appropriate? If not, why not?

Overall, Dementia Australia and those people with dementia, families and carers with whom we have consulted are supportive of the new assessment and classification processes because they are driven by a better understanding of the fixed and variable components that impact on the cost of care. Sensibly, the classification system also considers the interaction effects of mobility and cognitive function – two of the biggest drivers that impact the level and type of care needed.

Dementia Australia also recommends that further modelling take place on residents with different forms of dementia at varying levels of cognitive impairment. This will ensure that the proposed classification system can assign adequate levels of support to meet the needs of people living with dementia.

Will the true cost of quality dementia care be incorporated?

Dementia Australia has some concerns that the AN-ACC model – which is based on current costs of care practice, rather than *best* practice - will not provide a sufficient level of funding to deliver a high quality of dementia care.

As an example, the progression of behavioural and psychological symptoms (BPSD) of dementia can often add considerable amounts to the cost of delivering high quality dementia care. To enable providers to deliver dementia care that meets the needs of individuals,

additional resources, such as staff time, are required. Therefore, the additional costs associated with delivering the best form of dementia care needs to be considered within the AN-ACC classifications.

We are pleased that this model proposes the addition of a fixed component, which gives consideration to costs of delivering shared residential care. The discussion paper notes, for instance, that the shared costs include supervision in common areas and night supervision. In addition to practical care though, high quality care should also consider the costs associated with providing meaningful social activities – which is especially true of people living with dementia, who benefit from remaining active and participating in social interactions.

In a similar vein it is important that the variable cost per resident also incorporate enough funding to deliver person-centred care. For example, the added costs incurred from delivering individual social and emotional supports to residents.

Furthermore, more modelling on people living with dementia, in addition to identification of the true costs of delivering high quality dementia care, would provide some assurance that the AN-ACC is fit for purpose, for people living with dementia

The assessment workforce should receive dementia specific training

Dementia Australia welcomes the recommendation by ASHRI to separate the assessment workforce from the care planning workforce – which will enable more effective, and un-biased allocation of funding.

The classification process is critical to ensuring that residents are funded sufficiently to support their needs, therefore we urge that mandatory dementia training be provided to all assessors. Given the prevalence of people living with dementia in residential aged care, including dementia specific training will be critical to ensuring assessors are equipped to make accurate judgements about the unique needs of people with dementia, and the subsequent funding required.

Improved consumer choice and control

Currently, under the ACFI model, there has been a perception that providers have had the ability to ‘cherry pick’ residents based on the level of funding they will bring to a facility. In some cases this has led to a system where providers exert more control than a resident over the choice of facility.

Withholding certain information from providers, such as ASHRI’s recommendation to withhold a resident’s classification from the provider, prevents providers from using this information to pick residents. Therefore enabling consumers to exhibit more control over their choice of facility – which is a concrete step towards making consumer choices effective.

3. **Are the proposed reassessment triggers appropriate? If not, why not?**

4. **Are there other factors that should be considered for inclusion as reassessment triggers?**

Dementia Australia supports the reassessment triggers proposed, but recommends an additional trigger be included to reflect significant decline or change in the severity of cognitive function.

Cognitive decline should be a trigger for reassessment

The proposed reassessment triggers – which are currently a change in mobility, or recent hospitalisation – may present a barrier to people who will experience increasing care requirements due to progressive cognitive impairment.

A progressive decline in cognitive function is a typical symptom of dementia. In many cases, the experience of cognitive decline dramatically increases the level of care needed for an individual, and subsequently increases the costs associated with delivering care. However, under the proposed model, as cognitive impairment may not lead to a significant change in mobility or result in hospitalisation, there is a risk that people living with dementia will not be considered for reclassification, and thus receive an insufficient amount of funding for their care.

Therefore, we urge the Department to consider cognitive function as an additional trigger for reassessment.

5. **Should the Commonwealth consider the introduction of reassessment charges for services that trigger unnecessary reassessments?**

Broadly, Dementia Australia does not have a strong view on the inclusion of reassessment charges.

However, it is important that the Department provide a clear definition to providers on what constitutes an ‘unnecessary reassessment’. There also needs to be a flexible system in place that does not discourage providers from seeking a reassessment in cases where they may be beneficial to the individual

6. **Should there be a requirement for reassessment in the proposed funding model?**

Dementia Australia supports the concept of funding providers at a rate which supports investment in a quality model of care, such as reablement and restorative practices. However, to determine if a reassessment requirement should be implemented we would need further data on the rates of reassessment in the pilots and the impact of fixed reassessments versus a flexible reassessment regime.

Regardless of a required reassessment, we are clear that their needs to be opportunities for providers to exercise their judgement if they feel a reassessment is necessary and would benefit the resident – as is likely to be the case for an individual with a degenerative disorder.

7. **What are your views on an annual costing study to inform price?**

Dementia Australia strongly supports the annual costing study initiative, which should be focused on understanding the current costs of care, including workforce costs. People living with dementia represent over half of residents in aged care facilities, therefore delivering high quality care must also include meeting the specific needs of people living with dementia.

As mentioned in our response to question one, the government must be transparent and consult the sector to ensure that the price accurately reflects the cost of delivering services. We should also view the annual costing study as an opportunity to develop a sturdy evidence base for changes being made to aged care financing over time.

8. **What are the risks and benefits of rolling viability supplement into the fixed payment NWAUs?**
9. **What are the risks and benefits of rolling homeless supplement into the fixed payment NWAUs?**

The clear risk here is that residents currently benefitting from these supplements become financially disadvantaged. Further modelling would help ensure that high-need groups do not become negatively impacted by these supplements being rolled into the fixed payment.

10. **Which transition option do you prefer? Why?**
11. **Are there any other approaches that should be considered?**

The two-year transition model is preferable on the basis that it allows time for refining and improving. However, there needs to be assurance that sufficient support will be available for the sector at the different stages of implementation.

12. **Do you support the development of a best practice needs identification and care planning assessment tool for use by residential facilities?**

13. **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?**

A best practice tool for care planning would be a welcome addition to assist residential facilities in developing person-centred care plans. Dementia Australia strongly supports the development of a tool that supports providers to consider the varying care needs of different individuals and groups, sets appropriate reablement goals and provides a holistic plan for their care.

A more consistent tool suite for care planning may also be helpful in informing consumers about the care planning process, for example by comparing care providers and the types of support they may offer.

We also recommend that this suite of tools be used to support providers to translate a resident's assessed classification into an appropriate care plan that best suits their care needs.

Care planning tools should contain evidence-based guidance that supports providers develop person-centred plans

This suite of tools could be a particularly useful resource that aids providers in developing specific care plans that better address the needs of particular communities and groups. This includes people living with dementia, who often have complex are needs. The suite of tools could also look specifically at the care needs for individuals from Culturally and Linguistically Diverse backgrounds and Aboriginal and Torres Strait Islander Communities.

Conclusion

As stated throughout this paper, dementia poses an increasing challenge throughout our aged care system. Already, over half of residents in residential aged care are likely to have a diagnosis of dementia. The AN-ACC proposal contains a number of promising developments; including the separation of assessment and care planning workforces, the intent to promote reablement and stronger models of care, and more in-depth consideration to the variables that impact the level of funding that impacts cost of delivering care.

Providing high quality care for people with dementia is of peak importance, and sufficient funding and resources is critical to achieving that goal. We are optimistic that with further modelling on people with dementia, the AN-ACC has potential to ensure sufficient funding is allocated to people living with dementia, which will help enable the delivery of quality care.

We would like to thank you for the opportunity to consult on the proposal for the new funding model. We look forward to working closely with the department on modelling the impact of the AN-ACC further.