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AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6

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AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6

Abstract
This report syntheses and consolidates the findings presented in other reports and provides a consolidated set of recommendations.

Keywords
aged, report, study:, utilisation, resource, recommendations., consolidated, synthesis, an-acc:, care:, national, 6, classification, funding, model, residential

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AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations

The Resource Utilisation and Classification Study: Report 6

February 2019

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This series of papers reports on different aspects of a major national study into needs, costs and classification of residential aged care called the Resource Utilisation and Classification Study (RUCS). The RUCS was undertaken during 2018.

This report (Report 6) synthesises the whole study and presents a consolidated set of recommendations.

Report 1: The Australian National Aged Care Classification (AN-ACC)

Report 2: The AN-ACC assessment model

Report 3: Structural and individual costs of residential aged care services in Australia

Report 4: Modelling the impact of the AN-ACC in Australia

Report 5: AN-ACC: A funding model for the residential aged care sector

Report 6: AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations (this report)

Report 7: AN-ACC Technical appendices

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Contents

Acknowledgements i

Abbreviations ii

Glossary of Terms iii

1 Introduction and background 1

1.1 Key elements of the AN-ACC assessment and funding model 1

1.2 The four RUCS studies 2

1.3 The RUCS reports 3

1.3.1 Report 1: The Australian National Aged Care Classification (AN-ACC) 3

1.3.2 Report 2: The AN-ACC assessment model 3

1.3.3 Report 3: Structural and individual costs of residential aged care services in Australia 3

1.3.4 Report 4: Modelling the impact of the AN-ACC in Australia 3

1.3.5 Report 5: AN-ACC: A funding model for the residential aged care sector 4

1.3.6 Report 6: AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations 4

1.3.7 Report 7: AN-ACC Technical appendices 4

2 AN-ACC Version 1.0 classification system 5

2.1 The AN-ACC as an information tool to inform input measures 5

2.2 The AN-ACC as an information tool to measure and fund outputs 7

2.3 The AN-ACC as an information tool to meaningfully measure resident outcomes 7

3 AN-ACC Version 1.0 assessment system 8

3.1 Resident assessment for funding is separate from resident assessment for care planning purposes 8

3.2 The AN-ACC funding assessment 8

3.3 Reassessment protocols 9

3.4 Assessment for care planning purposes 10

4 AN-ACC Version 1.0 funding model 11

4.1 Per diem payment combines a base care tariff and an AN-ACC class payment 11

4.2 Initial AN-ACC class assignment 14

4.3 Adjustment payment on entry into residential aged care 14

4.4 Commonwealth payments and supplements in the new AN-ACC funding model 16

4.4.1 Subsidies that become redundant in the AN-ACC model 16

4.4.2 Subsidies that should be progressively phased out 16

4.4.3 Subsidies that should be the subject of a supplementary study 17

5 AN-ACC implementation 18

5.1 A planned transition strategy with progressive implementation 18

6 Implementation of the AN-ACC system: implications for government 20

6.1 Cost informs price: the need for an annual national costing study 20

7 Implementation of the AN-ACC system: workforce, IT and other practical issues 21

8 An ongoing research and development agenda 23
9 Conclusion 24
Appendix 1 25
The AN-ACC Version 1.0 classification 25

List of tables

Table 1 Base care tariff and AN-ACC Version 1.0 NWAUs 12

List of figures

Figure 1 AN-ACC Version 1.0 25

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Abbreviations

ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
AN-ACC	Australian National Aged Care Classification
CDC	Consumer directed care
CV	Coefficient of variation
DEMMI	De Morton Mobility Index
the Department	Commonwealth Department of Health
DHS	Department of Human Services
IHPA	Independent Hospital Pricing Authority
MMM	Modified Monash Model
NEP	National Efficient Price
NWAU	National Weighted Activity Unit
RAC	Residential Aged Care
RACF	Residential Aged Care Facility
RCS	Resident Classification System
RUCS	Resource Utilisation and Classification Study
RVU	Relative Value Unit

Glossary of Terms

Aged Care Funding Instrument (ACFI)	The existing resource allocation instrument used to determine care subsidies for Australian residential aged care.
Australian National Aged Care Classification (AN-ACC) system	Consists of the AN-ACC assessment, AN-ACC casemix classification and AN-ACC funding model.
Casemix	An information system that assigns care recipients to a funding class. Care recipients within a class will have similar care needs and their care will involve similar levels of resources.
Individual care	Care tailored to the needs of an individual resident. Differences in individual care time between residents are typically due to differences in assessed function, cognition, behaviour and health status.
National Weighted Activity Unit (NWAU)	In the context of this study, a measure of relative price. An NWAU of 1.2 means that the price of the activity is 20% above the national average. An NWAU of 0.5 means that the price is 50% below national average.
Permanent resident	A person who enters residential aged care as their ongoing place of residence.
Residential aged care (RAC)	Personal and/or nursing care that is provided to a person in a residential aged care facility. In addition to care, the person is also provided with accommodation that includes meals, cleaning services, furniture and equipment. The residential aged care service must meet certain building standards and appropriate staffing in supplying the provision of that care and accommodation.
Respite care	Short term care for a person within a residential care facility for short periods of time on a once-off or regular basis. The main purpose of respite is to provide relief for the usual carer.
Relative Value Unit (RVU)	In the context of this study, a measure of relative resource consumption (staff time or dollars). An RVU of 1.2 means that the cost is 20% above the national average. An RVU of 0.5 means that the cost is 50% below national average.
Shared care	Care that is not tailored to individual resident needs and that all residents generally benefit from equally. This includes activities such as general supervision in common areas, night supervision clinical care management and quality activities and incidental brief interactions with residents.

1 Introduction and background

This series of reports presents the results of an important national study commissioned by the Commonwealth Department of Health (the Department) to inform the development of a new funding model for residential aged care in Australia. The overall aim of the Resource Utilisation and Classification Study (RUCS) was to:

- Identify the clinical and need characteristics of aged care residents that influence the cost of care (cost drivers).
- Identify the proportion of care costs that are shared across residents (shared costs) and the proportion that are related to individual needs (individual costs).
- Develop a casemix classification based on identified cost drivers that can underpin a funding model that recognises both shared and individual costs.
- Develop a new funding assessment that efficiently allows for each resident to be assigned to a payment class based on their needs.
- Test the feasibility of implementing the recommended classification and funding model across the Australian residential aged care sector.

In considering the results and recommendations included in this report, it is necessary to distinguish between three key ideas:

Cost

The cost of care for people living in residential aged care is in scope for RUCS. Capital accommodation and 'hotel' services are out of scope, as is respite care for non-permanent residents.

Funding (payment) model and policy

Funding and payment issues are in scope. The role of the RUCS research team is to develop the funding model and provide policy advice on its potential implementation.

Price

Price is out of scope for RUCS as price is ultimately a decision for payers (both government and consumers). But the RUCS has generated significant evidence that can aid decision-making about pricing.

1.1 Key elements of the AN-ACC assessment and funding model

The new assessment and funding model presented in this series of reports has been termed the Australian National Aged Care Classification (AN-ACC) system. The AN-ACC assessment and funding model is based on six key design elements:

1 Resident assessment for funding to be separate from resident assessment for care planning purposes.

2 Assessment for funding purposes to be undertaken by external assessors capturing the information necessary to assign a resident to a payment class.

3 Assessment related to care planning to be undertaken by the residential aged care facility based on resident needs and underpinned by consumer directed care (CDC) principles.

4 Provision of a one-off adjustment payment for each new resident that recognises additional, but time-limited, resource requirements when someone initially enters residential care.

5 A fixed price per day for the costs of care that are shared equally by all residents. This may vary by location and other factors.

6 A variable price per day for the costs of individualised care for each resident based on their AN-ACC casemix class.

1.2 The four RUCS studies

In summary, RUCS comprised four separate but closely related studies. Each study included separate data collection and analysis elements that have been synthesised to produce a classification and associated funding model that is suitable for implementation across the Australian residential aged care sector.

Study One - Service utilisation and classification development study

Study One involved a prospective and comprehensive collection of resident assessment, service utilisation and financial data which were analysed to develop a casemix classification. Study One involved 30 facilities clustered in three geographic regions in Queensland, New South Wales and Victoria.

Study One was completed between October 2017 and October 2018.

Study Two - Fixed and variable cost analysis study

Study Two involved a larger nationally representative sample of 110 facilities. The purpose of this study was to understand differences in cost drivers between different types of facilities (including facility size and location) as well as differences that may result from seasonal effects. This analysis informed the design of the funding model. Study Two examined facility, rather than resident, level costs.

Study Two was completed between November 2017 and October 2018.

Study Three - Casemix profiling study

Study Three involved the collection of variables included in the classification from an additional nationally representative sample of 69 facilities. In combination with the data from Study One, the primary purpose of Study Three was to develop a national casemix profile of residents in aged care in Australia.

Study Three was completed between September 2018 and December 2018.

Study Four – Reassessment study

Study Four was added to the RUCS work program in mid-2018 in recognition of value that could be added by collecting additional information about the rate and extent of change in residents' care needs over time. Study Four involved conducting reassessments of approximately half of the residents assessed as part of Study One four to six months after their initial assessment.

Study Four was completed between August 2018 and December 2018.

1.3 The RUCS reports

Given the complexity of RUCS, it has been written up in a series of reports as follows:

1.3.1 Report 1: The Australian National Aged Care Classification (AN-ACC)

Report 1 covers the design and conduct of the study undertaken to develop the AN-ACC Version 1.0 (Study One). It covers the design and use of the AN-ACC Assessment Tool and the resource utilisation study undertaken to develop AN-ACC Version 1.0, including the preparation and analysis of the data collection. It discusses the results, the classification development process and key outcomes including the statistical analysis and clinical validation.

1.3.2 Report 2: The AN-ACC assessment model

Report 2 presents detailed findings relating to the external assessment tool and assessment process (informed by Studies One, Three and Four). This includes the development of the assessment tool using expert clinical panels and a summary of feedback from assessors regarding the use of the tool and the suitability of individual instruments. The skills and competencies required for the assessment workforce and other implications for implementation of the external assessment model are considered as well as triggers and protocols for reassessment.

1.3.3 Report 3: Structural and individual costs of residential aged care services in Australia

Report 3 presents the analysis and findings of Study Two which identified the proportions of total care costs that are fixed (including shared care) and variable (relating to individualised resident care). The analysis focused on the differences in fixed costs between different types of facilities, characterised by ownership, size, remoteness and service specialisation. It includes an analysis of the drivers of fixed care costs.

1.3.4 Report 4: Modelling the impact of the AN-ACC in Australia

Report 4 presents an analysis of modelling the introduction of the AN-ACC across Australia. This is based on the findings of Study Three. The sampling and assessment data collection process and the casemix of residents in aged care across Australia are described. The focus of this report is on modelling the introduction of the AN-ACC to replace the Aged Care Funding Instrument (ACFI).

1.3.5 Report 5: AN-ACC: A funding model for the residential aged care sector

Report 5 presents the design of a new funding model based on the AN-ACC. It includes a consideration of other payment issues such as existing payment supplements, a discussion of incentives in funding model design and key issues in implementing the new model.

1.3.6 Report 6: AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations

This report syntheses and consolidates the findings presented in other reports and provides a consolidated set of recommendations.

1.3.7 Report 7: AN-ACC Technical appendices

This report is a series of technical appendices that contain detailed data for reference purposes.

2 AN-ACC Version 1.0 classification system

The primary aim of this project was to develop a new, fit-for-purpose casemix classification for the Australian residential aged care sector. Study One involved 30 facilities in three regions. They participated in a detailed resource utilisation and costing study that involved 1,877 resident assessments and 315,029 staff time activity records collected by 1,600 staff.

A key finding of this first study is that residential aged care costs are driven by care burden associated with end of life needs, frailty, functional decline, cognition, behaviour and technical nursing needs.

Based on a new funding assessment tool purposefully developed as part of this study, a casemix classification termed the Australian National Aged Care Classification (AN-ACC) has been developed. AN-ACC Version 1.0 comprises 13 classes and explains 50% of the variance in the cost of individual resident care. There is a fivefold variation in cost between the least and most expensive AN-ACC class. The statistical and clinical performance of AN-ACC is considered more than sufficient for it to be adopted in a funding context.

AN-ACC is underpinned by a clinical assessment instrument that can be completed by an external clinical assessor. Issues related to assessment are further considered in Report 2.

The staff time data collected in this study indicated that close to 50% of staff time was spent delivering care tailored to the specific needs of the resident, while the remaining 50% was spent delivering shared care across all residents. This supports a payment model that includes a fixed per diem price for the costs of shared care and a variable price per day for the costs of individual resident care. This is discussed further in Report 5.

The AN-ACC classification developed in this study should be regarded as AN-ACC Version 1.0. It will require periodic revision to ensure that it continues to reflect contemporary practices and cost structures.

The AN-ACC classification is a core building block to better measure, resource and report on the inputs, outputs and outcomes of the aged care system. Better data based on objective measures of the needs of residents is essential to describe and to predict the changing needs and costs of the aged care sector into the future.

AN-ACC Version 1.0 is included as Appendix 1 with more detailed technical information included in Report 1.

2.1 The AN-ACC as an information tool to inform input measures

There is a growing professional and public debate about the staff and skill mix required in the aged care sector. This includes calls for standardised measures such as nursing ratios.

Supporters of staff ratios argue that minimum staffing levels need to be mandated in order to ensure that staffing levels are adequate to meet the needs of residents. Opponents argue that staffing ratios are a crude tool that does not take account the differing levels of support that different individuals need.

In a similar vein, concern was frequently expressed during the RUCS study that the study was capturing current average practice rather than best or acceptable practice. The implication was that the evidence currently exists to define and cost best practice.

What has been missing in both of these debates is a way to link inputs to the needs of residents. Some residents need a lot of nursing care. Others need very little nursing care but would benefit from allied health care. Some residents would benefit from reablement programs or restorative care. Others need palliative care. In reality, a crude staff ratio model is not helpful and there is no such thing as one care model that is best practice for every resident.

The AN-ACC is a critical information tool that allows for these issues to be addressed in a more sophisticated way. Rather than a debate about one staffing ratio or one best practice care model, the AN-ACC provides a mechanism to consider the care required by different types of residents.

It consists of 13 classes with classes defined based on end of life needs, frailty, functional status, cognition, behaviour and technical nursing needs. Each class is relatively homogenous and consists of residents with similar needs. The 13 classes are:

Class 1	Admit for palliative care
Class 2	Independent without compounding factors (CF)
Class 3	Independent with CF
Class 4	Assisted mobility, high cognition, without CF
Class 5	Assisted mobility, high cognition, with CF
Class 6	Assisted mobility, medium cognition, without CF
Class 7	Assisted mobility, medium cognition, with CF
Class 8	Assisted mobility, low cognition
Class 9	Not mobile, higher function, without CF
Class 10	Not mobile, higher function, with CF
Class 11	Not mobile, lower function, lower pressure sore risk
Class 12	Not mobile, lower function, higher pressure sore risk, without CF
Class 13	Not mobile, lower function, higher pressure sore risk, with CF

Once the AN-ACC classification is in routine use, it will be possible to define staffing requirements by AN-ACC class (eg, residents in Class 2 need fundamentally different types and levels of care to residents in Class 13). It will also be possible to develop best practice models of care for each class. This is an essential first step to articulating input requirements in a more useful way.

2.2 The AN-ACC as an information tool to measure and fund outputs

The second key role of the AN-ACC is as an information tool to measure and fund the outputs of the aged care sector. In the context of the residential aged care sector, the key output is a day of resident care adjusted for the needs of different types of residents. This adjustment occurs by classifying each resident to one of the 13 AN-ACC classes, with the funds paid for each class based on the relative care needs of residents in that class.

Each of the components of the AN-ACC funding model is discussed in more detailed below.

2.3 The AN-ACC as an information tool to meaningfully measure resident outcomes

The third key role of the AN-ACC classification is as an information tool that can be used to turn crude outcome measures into meaningful comparisons for benchmarking and other purposes. This is sometimes termed 'risk adjustment' or 'casemix adjustment'.

Because each of the 13 AN-ACC classes contain residents with similar needs, they can be used to measure quality and outcomes in meaningful ways:

- eg, hospital transfer rates adjusted for the mix of residents in each home as measured by the AN-ACC profile of each home
- eg, rates of functional decline adjusted for the AN-ACC class at entry to residential care
- eg, rates of adverse events – such as falls, medication errors and injuries – using the AN-ACC classes to adjust for the risk of each adverse event.

The recently announced national quality indicator program is an example of a current approach to measuring resident outcomes.[1] Three national indicators - pressure sores, physical restraint and weight loss – have been announced for national implementation from 2019. At this stage the intention is to report them without adjusting for the mix of residents in each home. Measures such as these can be risk-adjusted (casemix adjusted) once the AN-ACC is in place.

Recommendation 1

That the Australian National Aged Care Classification (AN-ACC) Version 1.0 be adopted as the national standard classification for residential aged care.

[1] https://www.myagedcare.gov.au/quality-and-complaints/quality-indicators-in-aged-care. Accessed February 2019.

3 AN-ACC Version 1.0 assessment system

As noted above, three key elements of the design of the new AN-ACC funding model focus on assessment. Each is discussed in turn.

3.1 Resident assessment for funding is separate from resident assessment for care planning purposes

The current ACFI model involves residential aged care facilities assessing each resident ('internal' assessment) using the Aged Care Funding Instrument. The results of that assessment (undertaken internally within the home) are then submitted to the Commonwealth to determine the funding allocation for each resident. In parallel, the assumption is that the home uses that same information for needs identification and care planning purposes.

The AN-ACC assessment system separates assessment for funding from assessment for care planning.

3.2 The AN-ACC funding assessment

A new AN-ACC Assessment Tool has been developed. It is described in Report 2 and the final version of the assessment tool is included as an appendix in Report 2. It is an assessment that has been designed for funding purposes only.

The AN-ACC Assessment Tool has been designed for use by external assessors both when a resident initially enters residential aged care and at reassessment.

Recommendation 2

That the Australian National Aged Care Classification (AN-ACC) Version 1.0 Assessment Tool be adopted as the national standard funding assessment for residential aged care.

Recommendation 3

That all new residents be assessed by an independent assessor using the AN-ACC Assessment Tool within four weeks of entering residential aged care.

Recommendation 4

That residents requiring reassessment be assessed by an independent assessor using the AN-ACC Assessment Tool.

Reasons for reassessment are dealt with below.

Recommendation 5

That aggregate de-identified data captured in the AN-ACC assessment be released in the form of an annual public report on the needs of residents in the residential aged care sector.

3.3 Reassessment protocols

The core of the AN-ACC funding model is that a resident is assessed at entry to residential aged care with capacity for the resident to be reassessed (and potentially assigned to a higher paying class) if their needs change significantly.

At the same time, the model should not create incentives for frequent unnecessary reassessments. This is easier to achieve with the new funding model as the individualised payment represents, on average, only half the daily payment. The base care tariff (fixed care payment) does not change as the result of a reassessment.

Based on the reassessment study, we have identified three grounds for reassessment. The threshold is that the home anticipates that the person's individualised payment would increase by more than 20% of the national average per day i.e., a total payment increase of 10% on average. The Department may introduce reassessment charges for any home that routinely triggers unnecessary reassessments.

Significant hospitalisation

A home may request a reassessment if the resident has been hospitalised for five days or more or, in the event of a patient who has a general anaesthetic, two days or more. As reported in Report 2, other significant events captured in the national reassessment study did not significantly result in a change of class.

Significant change in mobility

A home may request a reassessment if the resident's mobility capacity has changed such that they move between the three mobility branches in the AN-ACC (i.e., from independent/assisted to assisted/non-mobile as measured by the De Morton Mobility Index (DEMMI).

A standard time period for reassessment

A home may request a reassessment after a specified period for any resident who is becoming progressively more frail and/or whose health status is deteriorating. This

standard period should be twelve months for Classes 2 to 8 (those classes with lower mortality rate) and six months for Classes 9 to 12 (classes for people who are not mobile and are expected to deteriorate at a higher rate).

In doing so, the onus will be on homes to only select residents for reassessment whose individualised payment would be expected to increase by more than 20% per day.

Recommendation 6

That the new AN-ACC funding model allow for reassessment based on significantly increased needs as indicated by (1) a significant hospitalisation (2) a significant change in mobility and/or (3) a standard time period; twelve months for Classes 2 to 8 (those classes with lower mortality rate) and six months for Classes 9 to 12 (classes for people who are not mobile and are expected to deteriorate at a higher rate).

Recommendation 7

That the Commonwealth consider the introduction of reassessment charges for any home that routinely triggers unnecessary reassessments.

There is no requirement for reassessment in the new model. If the capacity of the resident improves after entry into residential care, the payment rate does not change and there is no need for a resident to be reassessed or assigned to a lower paying class. This is an explicit incentive for high quality services with a focus on restorative care and reablement.

Recommendation 8

There be no requirement for reassessment in the AN-ACC funding model.

3.4 Assessment for care planning purposes

This study proposes to separate assessment for funding from assessment for care planning. Assessment for funding moves to an external assessor. Assessment related to care planning is the responsibility of the residential aged care facility.

In order to drive systematic improvements in care planning, residential aged care facilities need to be equipped with care planning tools. These should be used for assessments by suitably trained nursing and allied health clinicians. A nationally standardised care planning assessment toolkit is proposed.

This assessment tool should be used by homes to guide the identification of resident needs and to guide individualised care planning. In addition to capturing functional and clinical needs, it should also capture strengths, personal preferences and opportunities to work with residents to increase their independence.

Recommendation 9

That a best practice needs identification and care planning assessment tool be developed for use by residential aged care facilities.

Recommendation 10

That, as a condition of subsidy, each resident undergo a care planning assessment at least annually and that the outcomes of this assessment be discussed with residents and carers and be used as the basis of an annual care plan.

4 AN-ACC Version 1.0 funding model

There are three key elements in the new AN-ACC funding model. The first two of these form the ongoing payment paid to the home for each resident.

4.1 Per diem payment combines a base care tariff and an AN-ACC class payment

Base care tariff

The base care tariff is a fixed price per day for the costs of care that are shared equally by all residents. As outlined in Report 3, the RUCS costing study found that fixed care costs vary by location, whether or not the facility is designated for indigenous residents and other factors.

Based on the results of the RUCS costing study, the AN-ACC funding model has six base care tariffs that are summarised in Table 1 below.

AN-ACC class payment

The AN-ACC class payment is a standardised price per day for the costs of care for each resident based on their AN-ACC casemix class. There are 13 AN-ACC classes in Version 1.0 and each has its own price.

The detailed analysis that was undertaken to determine these were presented in Report 3 (costing) and Report 5 (funding system design).

Table 1 presents the base care tariffs and the AN-ACC individualised care funding with each calibrated as a National Weighted Activity Unit (NWAU) for residential aged care. The one-

off adjustment payment (also calibrated as an NWAU) and any approved subsidies are added to these to form the total care payments for an individual resident.

Table 1 Base care tariff and AN-ACC Version 1.0 NWAUs

Base care tariff	Facility description	Base care tariff NWAU	AN-ACC class	Resident description	AN-ACC NWAU
1	Indigenous, MMM=7	1.80	Class 1	Admit for palliative care	0.96
2	Indigenous, MMM=6	0.78	Class 2	Independent without CF	0.18
3	Non-indigenous, MMM=6-7, < 30 beds	0.68	Class 3	Independent with CF	0.30
4	Non-indigenous, MMM=6-7, 30+ beds	0.52	Class 4	Assisted mobility, high cognition, without CF	0.20
5	Specialised homeless	0.92	Class 5	Assisted mobility, high cognition, with CF	0.36
6	All other RACFs	0.49	Class 6	Assisted mobility, medium cognition, without CF	0.34
Other One-off adjustment payment = 5.28			Class 7	Assisted mobility, medium cognition, with CF	0.47
			Class 8	Assisted mobility, low cognition	0.51
			Class 9	Not mobile, higher function, without CF	0.52
			Class 10	Not mobile, higher function, with CF	0.83
			Class 11	Not mobile, lower function, lower pressure sore risk	0.80
			Class 12	Not mobile, lower function, higher pressure sore risk, without CF	0.78
			Class 13	Not mobile, lower function, higher pressure sore risk, with CF	0.96

CF = Compounding Factors (see Report 1)
MMM = Modified Monash Model. A measure of geographic remoteness where 7=most remote and 1=major metropolitan

The concept is best illustrated by example. Imagine that the Commonwealth determined that the Commonwealth subsidy for an NWAU of 1.00 would be $100 per day.[2] In this example, the following rates would be payable:

[2] $100 has been used in this example to make it easy to understand the idea. There is no intention for the Commonwealth to pay this as a subsidy.

Resident in a very remote (MMM=7) facility with indigenous specialisation is assigned to Class 13. That is, the resident is non-mobile, with low function, at high risk of a pressure sore and with other compounding factors

Base care tariff = 1.80 x $100 = $180 per day

AN-ACC funding = 0.96 x $100 = $96 per day

Total NWAU = 1.80+0.96 = 2.76

Total funding = $276 per day

Resident in a residential aged care facility (RACF) that receives base care tariff 6 and who is in Class 2. That is, the resident is a home in a non-remote area and the resident is independent and without compounding factors

Base care tariff = 0.49 x $100 = $49 per day

AN-ACC funding = 0.18 x $100 = $18 per day

Total NWAU = 0.49+0.18 = 0.67

Total funding = $67 per day

Recommendation 11

That the subsidies payable to homes for the care of residents consist of three components (base care tariff, AN-ACC payment and adjustment payment), each of which is expressed for funding purposes as a National Weighted Activity Unit (NWAU).

Recommendation 12

That there be a specified table of base care tariffs reflecting the structural costs of delivering care in different types of facilities.

These base care tariffs are set out in Table 1.

Recommendation 13

That, in residential care facilities in remote areas (MMM 6 or MMM 7), the base tariff be based on approved beds (capacity) with all other base tariffs being based on occupancy.

Recommendation 14

That, in addition to the base tariff, homes receive a daily subsidy for each resident based on their AN-ACC class.

The AN-ACC classes are set out in Table 1.

Recommendation 15

That the tariffs, classes and NWAUs set out in Table 1 be adopted in the first version of the AN-ACC funding model for residential aged care.

4.2 Initial AN-ACC class assignment

A desirable feature of a funding model for residential aged care is that it does not create incentives for homes to select residents based on their payment class. Based on this principle, it is proposed that, if the AN-ACC class assessment is undertaken prior to entry, the facility is not advised of the resident's payment class until after the person is in care (no resident selection). The home would, however, continue to receive standard Aged Care Assessment Team (ACAT) and referral information as they do now. The only information restriction would be the specific AN-ACC class.

Recommendation 16

That residential aged care facilities not be advised of the resident's exact AN-ACC class until after the person is in care.

Recommendation 17

That the default payment class at entry be Class 2. Payments are retrospectively adjusted to the date of entry once the assessment is undertaken.

4.3 Adjustment payment on entry into residential aged care

An important feature of the proposed AN-ACC funding model is the inclusion of a one-off adjustment payment for each resident when they first enter residential aged care. This one-off adjustment payment recognises that there are additional, but time-limited, resource requirements when someone initially enters residential care.

These time-limited additional costs cover the following activities:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management
- health care assessments
- facilitating health care arising from assessments (including pain management, dental care, palliative care and other issues that need attention)
- developing an advanced care directive in partnership with the resident and their family.

This one-off payment relates only to an initial admission into residential aged care. An adjustment payment is not payable if a resident transfers between homes. Consistent with principles of consumer-directed care, needs assessments and care plans should follow the resident if they move between facilities.

Analysis of resource utilisation data collected in Study One demonstrates that costs are indeed higher in the initial adjustment period. These additional costs vary slightly by branch and the adjustment period is longer for some classes than for others. However, these variations are not sufficient to justify different adjustment payments.

Instead, one adjustment payment is proposed for all branches and for all classes (including the palliative care class). Based on the resource data in Study One, this adjustment payment is based on an average adjustment period of 16 weeks. However, the 16 weeks is an average and it is not expected that the adjustment period for each resident would be 16 weeks. This is a one-off lump sum adjustment payment to cover the whole initial adjustment period after the resident first enters care.

Recommendation 18

That the one-off adjustment payment be set at 5.28 NWAUs.

Recommendation 19

That the Commonwealth, working through the Department of Health and the Aged Care Quality and Safety Commission, build strong accountability into the system to ensure that the adjustment payment be used for the intended purpose, not added to the bottom line and not contracted out to third party providers.

4.4 Commonwealth payments and supplements in the new AN-ACC funding model

The core of the current funding model is a daily payment based on the ACFI. In addition to core ACFI payments, there are a series of supplements that have evolved over the years.

All but one of these supplements relate to the care that is in scope for AN-ACC (that is, care currently funded via the ACFI). The one exception is 'viability supplements' that relate to hotel and other support costs. These are out of the scope of the AN-ACC model.

Setting aside viability supplements, a key question is which of the existing care supplements are incorporated into the AN-ACC payment model and which, if any, need to continue. Each subsidy is considered in turn below.

4.4.1 Subsidies that become redundant in the AN-ACC model

Homeless Supplement

There is a separate subsidy for facilities designated for homeless residents in the current model. The results of the RUCS costing study support a separate approach for facilities specialising in homeless people. However, rather than payment of a supplement, the base care tariff in the new AN-ACC funding model includes a loading for designated facilities specialising in homeless people (see Table 1, page 12). The separate homeless supplement therefore becomes redundant.

Adjusted Subsidy Reduction

The RUCS costing study (Study Two) included a sample of government-run facilities. However, their costs were excluded from Report 3 because government-run facilities were not included in the AN-ACC classification development study. Nevertheless, the raw cost results for these facilities were analysed. The results of that analysis do not support the continuation of the adjusted subsidy reduction. These facilities should be funded under the AN-ACC model in the same way as any other facility.

4.4.2 Subsidies that should be progressively phased out

RCS payments for grandparented residents

Prior to the introduction of the ACFI, residents were funded based on a Resident Classification System (RCS). With the transition to the ACFI, grandparenting arrangements were introduced whereby existing residents continued to be funded under the RCS. These arrangements continue to the present day.

The proposed two year transition from the ACFI to the AN-ACC (see Section 5.1) provides the opportunity to tidy up these historic arrangements. As the needs of current residents change, they should be reassessed using the AN-ACC Assessment Tool and assigned to an AN-ACC class. Any resident still funded under the RCS or the ACFI should be reassessed after the two year transition period and funded under AN-ACC. RCS payments for grandparented residents should cease at that point.

4.4.3 Subsidies that should be the subject of a supplementary study

Daily residential respite subsidies

Respite care was not in scope for the RUCS with respite residents excluded both from the classification development study (Study One) and the profiling study (Study Three). Given this, there is no justification to change current funding arrangements in the short-term.

A RUCS supplementary study on respite care is required. The goal of such a study would be to assess respite residents using the AN-ACC Assessment Tool, to allocate respite residents to one or more AN-ACC classes and to determine the NWAU or NWAUs that should apply to respite care.

Oxygen Supplement

The RUCS study included only a small number of residents on oxygen and it was not possible to separately analyse their costs. Given this, it is proposed that grandparenting arrangements be introduced for current recipients. A RUCS supplementary study on the costs of care associated with oxygen is required to determine whether or not to continue this payment. This study should examine whether there are additional justifiable costs (on top of the resident's AN-ACC class NWAU) that warrant an increase in the NWAU for the resident.

Enteral Feeding Supplement

As with oxygen, the RUCS study included only a small number of enteral feeding residents and it was not possible to separately analyse their costs. Given this, it is proposed that the same arrangements apply. That is, that grandparenting arrangements be introduced for current recipients and that a RUCS supplementary study be undertaken on the costs of care associated with enteral feeding to determine whether or not to continue this payment. As with oxygen, this study should examine whether there are additional justifiable costs (on top of the resident's AN-ACC class NWAU) that warrant an increase in the NWAU for the resident.

Veterans' Supplement

The RUCS did not capture data on the veterans supplement (currently set at $7.08 per day). Given this, it is proposed that grandparenting arrangements be introduced for current recipients. A RUCS supplementary study on the costs of care for veterans is required to determine whether or not to continue this payment.

Recommendation 20

That existing Commonwealth subsidies be addressed in three different ways:

1. The homeless supplement and the adjusted subsidy reduction be discontinued once the AN-ACC model is introduced.

2. RCS payments for grandparented residents be progressively phased out with all current RCS recipients to transition to the AN-ACC within two years.

3. The daily residential respite subsidy, the oxygen supplement, the enteral feeding supplement and the veterans supplement be the subject of supplementary RUCS studies with current recipients being grandfathered until the results of the supplementary study are available.

5 AN-ACC implementation

5.1 A planned transition strategy with progressive implementation

Given the magnitude of the reform involved in the implementation of the AN-ACC model, it is proposed that it be introduced progressively:

- The AN-ACC to be introduced from a specified starting date for all new residents entering residential care.
- If the needs of an existing resident increases, that resident would be referred by the home for an external AN-ACC assessment and the resident would be transferred from the ACFI system to the AN-ACC system.
- After two years, all remaining residents would be transitioned to the AN-ACC system within 6 months and all existing grandparenting arrangements would cease.

The practical implementation of this for existing residents is that each person continues to be funded via the ACFI classification with their ACFI classification frozen from the date that AN-ACC implementation begins. The same applies to those currently funded under the RCS. There would be no further ACFI reassessments or ACFI validations. With the cessation of the current ACFI review and reconsideration system, that function would cease within the Department with commensurate savings available for reinvestment in external assessment.

Recommendation 21

That the Commonwealth develop a national transition strategy with progressive implementation of the AN-ACC over two years.

The AN-ACC funding model is designed as a funding distribution model which applies price weightings (NWAU) to different types of facilities and residents. It does not determine the price that the Commonwealth pays. The price is a policy decision for government. The government could decide to implement the AN-ACC funding system so that it is cost neutral at the system level. Likewise, the government could use the AN-ACC to distribute a growth budget.

Irrespective (and as demonstrated in Report 4), there will inevitably be some homes that will experience a funding increase with the introduction of the AN-ACC and some that would experience a funding decrease.

In transitioning to the new AN-ACC model, it is critical that no home experience the sudden loss of significant income as the result of the new funding model. Viability and sustainability are critical issues for the whole sector.

It is therefore proposed that, as part of the transition strategy, the Commonwealth implement a stop-loss policy for homes that would experience a funding decrease to give those homes time to adjust to their new income level. An initial stop-loss threshold of 5% is proposed. If a home were to experience financial losses by the introduction of the AN-ACC model, any income reduction of less than 5% will be carried by the home. Any loss greater than 5% would make a home eligible for a transition payment up to the 95% threshold for a period up to two years from the date of transition.

This threshold applies at the level of the home as a whole rather than the individual resident. Every home will have some residents who would be funded more under AN-ACC than ACFI and vice versa. The transition payment strategy applies only to homes where the net effect is negative for the home as a whole.

Given that implementation of AN-ACC will be incremental, homes would not be able to apply for a transition payment until such time as at least 25% of their residents have transitioned to AN-ACC funding.

Recommendation 22

That the Commonwealth adopt a stop-loss policy for any home that would experience a significant funding decrease under the AN-ACC model with an initial stop-loss threshold of 5% and transition payments payable for up to two years from the date of transition.

6 Implementation of the AN-ACC system: implications for government

The implementation of the AN-ACC funding system is a significant reform for government. It will require upfront planning and an upfront investment to change payment processes and policies. Some amendments to the relevant legislation will also be required.

Recommendation 23

That a national implementation plan with indicative time lines, costs, consultation strategy and communication plan be developed by the Department of Health.

6.1 Cost informs price: the need for an annual national costing study

Funding subsidies for residential aged care are a policy decision of government. Under the proposed new funding model, the government makes an annual determination about the funding (price) of an NWAU of 1.00. This price is standard across both the fixed and individualised components. All prices in the funding model are then set relative to this annually determined NWAU price.

In the national hospital funding model, this price is termed the National Efficient Price (NEP). Following the precedent already established in the national hospital funding model, there needs to be an explicit relationship between cost and price. In the hospital context, an annual hospital costing study is undertaken and the cost from one year is used to inform the price in the following year.

In this context, price equals 'efficient cost' plus a reasonable return on investment. There is no reason to adopt a different approach in the pricing of residential aged care.

If this approach is adopted, the Department or the Independent Hospital Pricing Authority (IHPA) could be tasked with undertaking or commissioning a national residential aged care (RAC) costing study each year with the Commonwealth using those results to inform the NEP for the following year. This same approach could be progressively expanded to include community aged care as well.

Recommendation 24

That the Commonwealth undertake an annual residential aged care costing study and, informed by that, determine the dollar value of an NWAU each financial year.

More detail about the costing process is included in Report 3.

7 Implementation of the AN-ACC system: workforce, IT and other practical issues

Assessment workforce

The AN-ACC model requires the development of a workforce of credentialed assessors who are external to the aged care home. This issue is addressed in more detail in Report 2. A useful prototype model for an external AN-ACC assessment workforce is the Australian Aged Care Quality Agency's assessment workforce and this should be used to guide the implementation of the recommendations below.

The long term implementation of an external assessment model is expected to be cost neutral with the costs of the new assessment workforce model being largely offset by reduced investment in government compliance functions.

That said, the government has already flagged its intention to refine broader aged care arrangements as they relate to Regional Assessment and Aged Care Assessment services.

The AN-ACC model is agnostic in relation to these broader issues. The ACAT program role is likely to be unchanged, with ACATs retaining their current role of 'gatekeeper' to packaged aged care across community and residential settings. The AN-ACC assessment function could sit within an ACAT. Alternately, it could be undertaken by a separate agency or assessment network.

Recommendation 25

That, in the context of broader reform proposed for aged care assessment, the Commonwealth adopt a national networked external assessment model for the AN-ACC funding assessment.

Recommendation 26

Irrespective of the broader organisational aspects, external assessment be undertaken by credentialed registered nurses, occupational therapists and physiotherapists who have experience in aged care, complete approved AN-ACC assessment training and comply with continuing professional development requirements.

Information technology

The AN-ACC assessment can be recorded by the assessor using either a paper or digital form. Either way, the results of the assessment then need to be fed into a software 'grouper', a software program that assigns each resident to one of the thirteen AN-ACC classes.

This information then needs to feed into the Department of Human Services (DHS) payment system, along with the fixed care subsidy rate for the specified facility. The grouper can be part of the DHS IT system or it can be a standalone system which can feed data into the DHS payment system.

Once the AN-ACC data are fed into the DHS system, the IT and payment issues are handled in the same way as the current system.

Recommendation 27

That the Commonwealth develop an Information Technology strategy for the progressive implementation of the AN-ACC funding model.

Culture change and sector education

This funding model represents a significant change for the residential aged care sector and planning for its incremental implementation needs to commence as soon as government announcements are made.

Planning for the technical implementation of the model needs to be accompanied by an investment in change management. The government and the sector need to enter into a partnership to implement the new model, recognising that this is in the interests of residents, providers and government.

At the same time, there will inevitably be the need to fine-tune the model as implementation progresses. The Department will need systems in place for sector engagement and consultation as implementation progresses as well as access to technical expertise.

This includes access to expertise on how to use the data to better measure the needs and changing needs of residents, the measurement of resident outcomes and adverse events and the use of the data to predict future demand for residential aged care.

Recommendation 28

That the Commonwealth work with peak bodies to develop and implement a change management strategy.

8 An ongoing research and development agenda

The RUCS represents a major research and development investment in the residential aged care sector. The study has produced a range of significant research evidence on the needs and costs of residential care and has delivered major outputs including a new AN-ACC Assessment Tool, an AN-ACC classification and an AN-ACC funding model.

Each of these is robust enough to warrant adoption and implementation on a national basis. That said, they should all be regarded as Version 1.0.

The adoption of these new systems needs to be seen in context. Assessment, classification and costing studies have been undertaken routinely in the health sector over the last two decades. Likewise, studies to define and cost best practice and to investigate the relationship between payment and performance have a long history in health care.

In contrast, there has been little or no investment in this type of research and development in the aged care sector. This needs to change. Unless there is a systematic program of investment in research and development, it will not be possible for the sector to deliver evidence-based care and it will not be possible for consumers, providers and governments to make informed decisions about the efficiency and effectiveness of the care that the sector delivers.

A range of research and development studies have been suggested by the results of the RUCS. These include (but are not limited to):

- an annual costing study to revise relative value units (RVUs) and to determine the annual NWAU price
- supplementary costing studies to refine elements of the funding model
- future classification studies to develop the second and subsequent versions of the AN-ACC classification in response to changing models of care
- quality and outcomes studies to measure the quality and outcomes of care by AN-ACC class and to set national benchmarks.

At the same time, there is increasing government and personal investment in community and home-based aged care. This suggests that there be a parallel research and development investment in community aged care. The AN-ACC Version 1.0 model has been developed specifically for residential aged care. But the next step is to expand it to include community aged care as well.

Recommendation 29

That Government commit to an ongoing aged care research and development agenda that builds on the work of the RUCS and that includes assessment, classification, costing and outcome studies.

Recommendation 30

That a study equivalent to RUCS be undertaken in the community aged care sector with a view to expanding AN-ACC so that it includes aged care delivered in all settings.

9 Conclusion

Funding reform is not an end in itself. In addition to a more efficient and equitable funding model, this funding reform provides an important opportunity to drive fundamental improvements in resident experiences and outcomes. It also provides the evidence base necessary to evaluate the value for money that the sector achieves.

The results presented in this series of reports suggest the potential of the AN-ACC classification to provide a meaningful system for measuring and benchmarking resident outcomes. Mortality rates and rates of outcome measures, such as falls, vary significantly by AN-ACC class. Reporting resident outcome measures by AN-ACC class allows for resident outcomes to be routinely evaluated, taking into account the mix of residents in each facility.

This will allow (for the first time) consumers, providers and government to make meaningful judgements about the quality and outcomes of residential aged care and to fairly compare the quality of care provided at different facilities. This is the ultimate measure by which the aged care sector should be judged.

Appendix 1

The AN-ACC Version 1.0 classification

Figure 1 AN-ACC Version 1.0

