



**Alzheimer's  
Australia**  
Living with dementia

**REVIEW OF THE AGED CARE  
FUNDING INSTRUMENT**

**SUBMISSION BY  
ALZHEIMER'S AUSTRALIA**

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## Introduction

Alzheimer's Australia is the peak body providing support and advocacy for the 257,275<sup>1</sup> Australians with dementia. The number of people with dementia is projected to increase, with the number of cases increasing from 257,275 in 2009 to 1.13 million cases by 2050. Alzheimer's Australia offers a network of support groups around Australia, confidential counseling, workshops and information sessions designed specifically for those affected by dementia. Alzheimer's disease, the most common cause of dementia, accounts for between 50% and 70% of all cases.<sup>2</sup>

Alzheimer's Australia is pleased to have the opportunity to make a submission to the Department of Health and Ageing in reference to the December 2009 Discussion Paper "*Review of the Aged Care Funding Instrument*". In preparing this submission Alzheimer's Australia had assistance and expert advice from Sarah Salt.<sup>3</sup>

Alzheimer's Australia welcomed the implementation of the Aged Care Funding Instrument (ACFI) package as it addressed some of the critical issues facing the care industry and for the recognition of the care needs for those residents with dementia. It created transparency and uniformity of assessment across Australia and all providers are now working to the same benchmark. Alzheimer's Australia is not in itself positioned to generate data that would better inform answers to these questions. For that reason, discussions were held with a range of service providers, some of whom provide dementia specific residential care services and consultants from the Aged Care Industry, who all have a good understanding of ACFI to better inform this submission.<sup>4</sup>

However, before giving a detailed response to the specifics of the review, Alzheimer's Australia notes that:

- ACFI is a funding tool which allocates finite resources to provide residential care against a fixed price scale for care activities and does not address some of the fundamental issues facing the provision of aged care services to a variety of differing individual resident needs.
- The Funding Instrument tends to focus on the high care levels at the expense of low care levels and does not cater for a variety of services continued to be required for residents with dementia in accordance with best practice and to comply with the *Quality of Care Principles*.

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<sup>1</sup> Access Economics Report 2009

<sup>2</sup> Alzheimer's Australia 2008

<sup>3</sup> Sarah Salt is employed by Aged Care Services NSW but acted in the capacity of an independent consultant for Alzheimer's Australia. Sarah Salt is a Registered Nurse and has extensive experience of the ACFI as an accredited ACFI trainer.

<sup>4</sup> Alzheimer's Australia acknowledges the information and help received from the Hammond Group, BUPA Care Services, Catholic Health Australia, Aged Care Homes, Bernie McKay (Bernie McKay & Associates) and Peter Staples (Management Advantage). The views expressed in this submission are those of Alzheimer's Australia.

- The ‘Interim Low’ default payment under ACFI is currently \$44.98 per day. Under the previous RCS, the default payment was at a Category 5 which is currently \$72.08 per day, this needs to be reviewed to more appropriately reflect the assessed care needs of the resident
- Recognition that additional funding should be allocated to providers who cater for residents in rural and remote communities, especially low care providers. These providers have a limited group of prospective residents. Community services are limited and not always available, and, if available, are sometimes inappropriate to cater for the specific needs of individuals.
- Insufficient funding for some residents assessed as low care is restricting their access to care and there is insufficient community care available to look after those people who are unable to enter residential care.

Alzheimer’s Australia continues to support the objectives underlining ACFI namely to:

- Allocate funding on the basis of residents needs.
- Reduce staff time spent on administration.
- Generate data that will better inform funding and service provision.

The discussion paper released by the Department is helpful but does not provide all the information necessary to address the effectiveness of ACFI in terms of these objectives. From the point of view of people living with dementia there is insufficient analysis of whether behavioural issues are being more or less adequately addressed than under the RCS or analysis of staff costs in relation to funding from ACFI for behaviours. From our investigations and discussions it is evident that:

### **1.0 Matching funding to care needs.**

- There is no evidence that the ACFI has resulted in higher levels of funding for care of people with behavioural issues than under the RCS. There is some evidence that staffing costs in respect of this group are higher than payments under the ACFI. This seems to contrast with the remuneration in respect of Activity of Daily Life (ADL) and Complex Health Care (CHC). These issues need to be better understood.
- Under ACFI the increased time required providing activities of daily living to residents has been recognised but not the repetitive interventions required assisting those with Short Term Memory Loss (STML) and dementia.
- Alzheimer’s Australia have a concern about the lack of recognition in the ACFI for the one to one care that is often needed for people with dementia who are otherwise fit and well. For example, this group needs social engagement and leisure activities if the frustration and stress experienced as a consequence of dementia is to be properly addressed through psychotherapy. There is no doubt that the \$29.72 maximum is inadequate to provide care for this group. This is magnified for those who may have psychiatric issues or other mental health problems combined with their dementia.

- Cognitive impairment and dementia often manifests behaviours seen in residential care facilities that are not identified in Question 7-9 and include, emotional dependency, passive aggressive behaviours etc. and therefore are not able to be claimed for under ACFI.
- Administration of the assessments (Psychogeriatric Assessment Scale – Cognitive Impairment Scale (PAS-CIS) and Cornell Scale of Depression (CSD)) required by ACFI are time consuming and not always funded at the correct level. Once presented with the results of the assessments undertaken by the Residential Aged Care Facility (RACF), General Practitioners, particularly in the remote and rural sector, are often reluctant to make a diagnosis of dementia and depression to support a high claim in the behaviour domain. The impact of this decision by the GPs does not impact on the care provided by the RACF for the resident, however providers should not be penalised financially by the GPs reluctance to make a diagnosis.
- Cognitive impairment and dementia complicate the care of people with other medical diagnoses for example in respect of palliative care. This is critical to the quality of life of the person with dementia. There is a lack of recognition that palliative care may extend over a number of weeks and even months. Palliative care under ACFI caters for the “end of life” period which can happen quickly over 1 - 2 days. The approach to palliative care for residents with dementia must be planned over a much longer period as an assessed daily need. New concepts and thinking are needed about palliative care in relation to people with dementia which, at the present time, is dominated by the needs of other chronic conditions, and in particular, cancer.
- Cognitive impairment and dementia complicate the care of people in respect of pain management. There is an opportunity to better recognise the impact of pain management on residents with dementia and the required knowledge and skills of staff to manage this. This is critical in managing displayed behaviours and to the quality of life of the person with dementia. These needs should be better recognised in ACFI funding.
- Time spent providing pain management and physiotherapy for residents with dementia by RACF staff, other than a Registered Nurse (RN), under the direction of allied health professionals should be a valid claim. Allied health professionals are usually not full time employees of the RACF and therefore not able to be resourced for the assessed needs of the residents at the frequency required for a valid claim under the current ACFI requirements.
- Determining the requirements of complex skin integrity management for residents with dementia should be on an assessed needs basis and diagnosis, rather than relating to bed/chair fast residents and minimum time frame for positioning. Residents with dementia have fluctuating care requirements (E.g. one day physically dependent and requiring full skin integrity management and the next ambulatory).
- The matrix of Complex Health Care is an inappropriate method of funding Medications and Complex health care, both areas are resource intensive and payment at ‘B’ level for this domain is dependent on a claim in both questions.

## Recommendations

- 1.1. Conduct an urgent review of the level of funding available for the behavioural supplement with a view to increasing the maximum daily amount of \$29.72.
- 1.2. Recognise in this increased funding the need for increased support for those who have dementia and psychiatric conditions.
- 1.3. Increase funding for those with cognitive impairment and dementia in respect to pain management and palliative care.
- 1.4. Separate the dependence of Q11 & 12 on each other at the 'B' level to attract funding.

## 2.0 Funding Outcomes and Impact on Aged Care Providers

Alzheimer's Australia acknowledges that the capacity of different organisations to fully understand the resources available within the ACFI and how to use it vary considerably. The need remains for good training for staff and management in the underlining concepts of ACFI and how it operates. There was an initial investment by the Department of Health and Ageing (DoHA) in training and for managers and clinicians in ACFI but Alzheimer's Australia believes this needs to be continued, given staff turnover, and continuing underlining uncertainties among many organisations about how best to use ACFI in the interests of their residents and changes made as a result of the review require further industry training.

- The main impact of ACFI has been to redistribute more of the available funding to support residents with high care needs and less to residents with low care needs, the effect of this has been overshadowed by cost increases exceeding the level of indexation provided.
- Many larger RACF have had the advantage of extensive training from within and from outside their organisation to assist and manage the funding to be allocated under ACFI. However, smaller RACF, do not have the resources to fully manage this process and with an ageing workforce resulting in great staff turnover often ACFI knowledge and expertise is lost to that RACF, this therefore, leaves great gaps in knowledge and the requirement for more training to maintain a continuity of funding is critical.

## The High Care/Low Care Distinction

Alzheimer's Australia acknowledges the change from 1<sup>st</sup> January 2010; however, the distinction holds no value and makes more complex the working of the system with regard to the complexity of bonds management. In discussion it has been found that:

- Providers have different funding outcomes based on resident mix. Low Care RACF's are having difficulty maintaining an appropriate funding level for the care delivered. A high percentage of their residents with dementia continue to be independent with ADL and CHC to a major extent, many unfunded hours are spent by the staff in the management of their repetitive behaviours that are limited in claiming under ACFI.
- Some providers have had to adjust their admission policies to ensure prospective residents attract some level of funding under ACFI. In some areas residents with dementia are being denied low care entry to RACF's related to the low level of funding that they would attract. These policies therefore place more pressure on the community based programmes to provide a greater level of care offered in the community. These policies are placing prospective residents and their carers at a great disadvantage and in some cases danger.
- Some providers, especially in rural and remote communities, are not able to manage a high/low mix and they experience community pressure to accept people who attract little or no funding, where this occurs overall service provision and viability is threatened.
- The Interim Low Subsidy should be removed where a Low Aged Care Assessment Team (ACAT) assessment and a High ACFI exists. The ACFI should override the ACAT assessment.

## Recommendations

- 2.1. The Department of Health and Ageing continues to make available a contribution to training and education on ACFI for those organisations that require it.
- 2.2. Abolish the high care/low care distinction and take action to promote sustainable capital funding in a more strategic and appropriate way.
- 2.3. Future funding must recognise the diversity of needs and fund appropriately, and a new concept be considered eg clinical care and dementia care.

### 3.0 Documentation and Administrative Arrangements

Alzheimer's Australia acknowledges that organisations agree ACFI has resulted in less documentation for funding and have welcomed the way claims are validated, however:

- Despite the general use of IT in managing assessments and ACFI claims, providers are still required to have hard copies in the packs for validation by the review officers.
- It has been found that there is an issue related to mobility claims. Residents who have dementia and wander and have been assessed as at 'risk of falling' require constant supervision. These residents don't remember to wait for staff assistance and the cost to supervise actually is more time consuming than physical assistance, and to that end is insufficiently funding weighted to the provider of care.
- Providers are on occasions still being asked to provide nursing care plans to validate claims when this is no longer a requirement of the ACFI.<sup>5</sup>
- The frequency of admissions has increased heavily in the high care sector and increased the work load due to the business rule of completing another ACFI 6 months after admission from hospital. This has significant impact on providers, especially as many of their new admissions are from hospital.

#### Recommendation

**3.1. Consideration be given to the removal of the requirement to submit an ACFI after 6 months admission from hospital.**

### 4.0 Design Issues Including the Roles of Health Professionals

Alzheimer's Australia acknowledges the ACFI domains generally cover the spectrum of care needs appropriately however organisations have indicated that areas within Complex Health Care need revision taking into consideration evidence based practice, scope of practice, workforce issues and resource availability. These areas include:

- Acknowledgement that monitoring of blood pressure and blood glucose is often directed by the GP less frequently than daily but still occurs 2-3 times a week.
- Recognition that residents and specifically those with dementia need to be weighed weekly over extended periods related to significant weight loss or gain, this procedure requires staff time.

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<sup>5</sup> ACFI User Guide pps 9 - 11

- Pain management for residents with dementia should recognise varied care interventions such as aromatherapy, distraction therapy such as reminiscence, group activities and mobilization. The implementation of these interventions would ideally be by diversional therapy staff, aromatherapy staff and physiotherapy assistants. These staff members have the expertise to undertake interventions under the delegation of allied health professionals, Registered Nurses (RNs) and or medical officers.
- Pain Management under CHC No.4 (a) should be extended to include physiotherapy assistants as the skills shortage of RN's in High care. The current use of Endorsed Enrolled Nurses (EEN's) in Low care makes it almost impossible for Low care RACF's to successfully claim in this area.
- Low care residents who require assistance from staff with medications (scoring a "b" rating) but do not have complex health care needs are not able to attract a level of funding required to meet their needs.
- Providers report that they would like to see the inclusion of diversional therapists, aroma therapists, massage therapists, exercise physiologists and physiotherapy aides in the ACFI tool. These professionals were recognised under Residential Care Scale (RCS) but have not been included in the ACFI.

## Recommendations

- 4.1. Pain management should be extended to suitably skilled staff other than RNs and allied health professionals.
- 4.2. Funding tool needs to be flexible to support emerging health professional roles such as the Nurse Practitioner in Aged Care and Exercise Physiologists.
- 4.3. ACFI must recognise the changes in the scope of practice of enrolled nurses, particularly in relation to complex health care descriptions and directions, these changes impacts in low care facilities that have EEN/EN as unit managers.

## 5.0 Interface with other Elements of Aged Care

On the basis of the discussions Alzheimer's Australia have had, it seems there is a complex picture of differing performance and approach by Aged Care Assessment Teams. The result is inconsistent approaches across Australia.

- Evidence points towards defining prospective residents high or low care needs. Problems arise as the ACAT tools do not align with the ACFI assessment tool.
- ACAT assessments often understate the care status of residents awaiting admission.
- Requests by RACF for ACATs to reassess residents newly admitted as low care and assessed by RACF as high under ACFI are met with a delay of up to 3 months in some areas. This waiting time may reduce with the changes of the definition of low and high care as of 1<sup>st</sup> January 2010.



## Recommendations

- 5.1. That priority be given to resourcing and supporting ACAT's to achieve a more timely and consistent service.
- 5.2. ACAT Assessment should only identify a residents entitlement to residential care, not the high or low care status.
- 5.3. ACAT align their diagnosis codes to ACAP medical codes as set out in the ACFI User Guide used in the ACFI Appraisal Pack.

## 6.0 Other Issues Not Covered in the Discussion Paper.

### Data analysis

Alzheimer's Australia welcomes the opportunity that ACFI provides to improve knowledge about various aspects of the residential care system. We are keen to continue to work with the Department and the Australian Institute of Health and Welfare to develop robust and strategic data which can inform future decision making.

For the first time, there are accurate data about the prevalence of dementia among residents and the level of diagnosis. This will provide information which can support better dementia care. Much will depend on the type of analysis and the distribution of information. There will be better information about:

- Resident characteristics:
  - ~ Who is diagnosed with dementia?
  - ~ Who exhibits 'behaviour' without a diagnosis?
  - ~ What are the common co-morbidities with dementia?
  - ~ How long will residents with dementia stay and what is the reason for their discharge?
  - ~ Special needs such as younger people, CALD, etc.
  - ~ Who provides the diagnosis?
  - ~ Characteristics of different groups of reappraisals E.g. those in hospital.
- Common resident histories/trajectories
- Profiles of services that support people with dementia.
  - ~ Are there differences between States, metro/country, large/small etc re dementia patterns, diagnosis?
  - ~ Providing comparisons with State, Australia data will inform individual services.

Better data availability will help services to improve their practice. Distribution of data should be tailored to assist services as well as inform residential care workers. Palatable data will inform training and good practice. Funding should be identified to encourage data mining and further research. Knowledge translation will then change circumstances, attitudes, practice etc within the sector. This has much more potential than mere reporting on the Aged Care Act 1997.

## Recommendations

- 6.1. The Department continue their commitment to work with AIHW and other stakeholders including Alzheimer's Australia in analysing the ACFI data to better support policy and service decision making.
- 6.2. The Department needs update and provide for timely and informed communication channels which can be relied upon by the RACF.

## The Forgotten People

Discussion with stakeholders has indicated that there is no provision under ACFI to recognise the continued role of the RACF to provide ongoing social and human support for the resident's family, more particularly, for those who have been long term daily carers for residents diagnosed with dementia. The family require consultation, reassurance and grief counselling; this care does not happen as a "once only" intervention but often daily or many times daily. Provision for social and human support was included in the RCS but has not been included the ACFI. Many unfunded hours are spent by the staff in the provision for social and human support for the resident's families that are unable to be claimed under ACFI.

For many family carers and supporters of people entering residential care, the support does not terminate at the gates of the residential care facility. Many carers continue to support their loved ones in many different ways. Death can be a very traumatic time for the family carer and there is a need for bereavement counselling. This can be provided through residential care services or organisations such as Alzheimer's Australia and Carers Australia.

## Recommendations

- 6.3. The Department provide for provision for 'social and human needs' to support family members (The Forgotten Person/s) in.
- 6.4. Recognise support for carers more adequately in the resources provided to Alzheimer's Australia and Carers Australia in ongoing support for carers including education, support, and bereavement counselling.

## Acronyms Used in this Document:

ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ADL	Activity of Daily Life
CHC	Complex Health Care
CSD	Cornell Scale of Depression
DoHA	Department of Health and Ageing
EEN's	Endorsed Enrolled Nurses
PAS-CIS	Psychogeriatric Assessment Scale – Cognitive Impairment Scale
RACF	Residential Aged Care Facility
RCS	Residential Care Scale
RN	Registered Nurse
STML	Short Term Memory Loss