



Australian Government

Department of Health and Ageing

Review

of the

Aged Care Funding Instrument

Report

May 2011

The Review of the Aged Care Funding Instrument

ISBN: 978-1-74241-441-6

Online ISBN: 978-1-74241-442-3

Publications Approval Number- D0358

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Cataloguing-in-Publication

Suggested citation:

Australian Government Department of Health and Ageing, 2011,
The Review of the Aged Care Funding Instrument,
Canberra: Australian Government Department of Health and Ageing.

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Published by the Australian Government Department of Health and Ageing

Contents

Executive summary.....	5
Matching funding to care needs	6
Funding outcomes for providers	9
Documentation and administrative arrangements	11
Design issues including the role of health professionals	12
Alignment with other elements of aged care.....	14
Recommendations	16
1. Introduction.....	19
1.1 Scope and terms of reference of the review	20
1.2 Overview of the review process.....	20
1.3 Outline of the report.....	21
2. Current arrangements	23
2.1 Overview of residential aged care.....	23
2.2 History and development of the ACFI.....	24
2.3 Overview of the ACFI	26
2.4 The Department’s Classification Review Program.....	32
3. Resident characteristics as measured by the ACFI.....	33
3.1 Diagnoses of residents	33
3.2 The three care domains	35
4. Matching funding to care needs	43
4.1 Support for residents with complex and higher care needs.....	43
4.2 Recognising the relative care costs of certain residents	46
5. Funding outcomes for providers	55
5.1 The impact of the introduction of the ACFI on providers.....	55
5.2 Issues for specific categories of providers	62
5.3 Effectiveness of the transitional arrangements.....	66
6. Documentation and administrative arrangements	67
6.1 Reducing documentation requirements for providers	67
6.2 Reducing disagreement between appraisals and reviews.....	68
7. Design issues, including the roles of professionals	71
7.1 Design issues.....	71
7.2 Recognising the role of health professionals.....	87
8. Alignment with other elements of aged care.....	92
8.1 Aged Care Assessment Teams	92
8.2 Specified Care and Services.....	94
9. Conclusions and recommendations	96
Appendix A: Terms of Reference of the review	99
Appendix B: Membership of the ACFI Reference Groups.....	101
Appendix C: List of Submissions	104
List of Figures.....	105
List of Tables	106

Abbreviations

ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
BEH	Behaviour
CHC	Complex Health Care
Department	Australian Government Department of Health and Ageing
EN	Enrolled nurse
RCS	Resident Classification Scale
RN	Registered nurse

Executive summary

In 2010-11, the Australian Government will provide \$10.9 billion to ensure older people can receive the residential and community aged care services that they need. More than half of this funding will be provided as basic subsidies for permanent residents of aged care homes, with the level of basic subsidy payable in respect of a permanent resident determined by the resident's classification against the Aged Care Funding Instrument (ACFI). The ACFI was introduced on 20 March 2008. It replaced the Resident Classification Scale (RCS), which had been in use since 1 October 1997.

In November 2009, the then Minister for Ageing asked the Department of Health and Ageing to undertake a review of the Aged Care Funding Instrument ('the review'). The Terms of Reference of the review (*Appendix A*) required the Department to examine:

- 1) the extent to which the introduction of the ACFI had achieved its objectives of:
 - a) better matching funding to the complex care needs of residents;
 - b) reducing the documentation created by providers to justify funding; and
 - c) reducing the level of disagreement between providers' appraisals of the care needs of their residents and the findings of Departmental Review Officers;
- 2) the impact of the introduction of the ACFI on:
 - a) the funding levels of providers, and in particular of low care providers and providers in rural and remote areas; and
 - b) access to appropriate care, especially for residents with special needs, including whether the design of the ACFI fails to appropriately recognise the relative costs of meeting the care needs of certain classes of residents;
- 3) the design of the ACFI to determine whether:
 - a) there are any gaps or anomalies in the ACFI in relation to care needs; and
 - b) the ACFI properly recognises the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals;
- 4) other issues related to the introduction of the ACFI, including:
 - a) the appropriateness of the Specified Care and Services Schedule of the *Quality of Care Principles 1997* in determining the services to be provided to residents of aged care homes with differing levels of care needs; and

-
- b) options to improve agreement between the level of approval granted to a resident by an Aged Care Assessment Team (ACAT) and their provider's appraisal of their care needs.

The Department of Health and Ageing has undertaken the review in consultation with consumers, aged care providers, aged care workers and health professionals, and their representatives through the ACFI Industry Reference Group and the ACFI Technical Reference Group (*Appendix B*). The review was also informed by the analysis of relevant data and reports and by 98 submissions from stakeholders (*Appendix C*).

Following an overview of the current arrangements governing the funding of residential aged care (Chapter 2) and a statistical overview of trends in resident care needs based on the results of the first 34 months of care assessments using the ACFI (Chapter 3), this report is organised around the five themes that formed the basis of consultations:

- matching funding to care needs;
- funding outcomes for providers;
- documentation and administrative arrangements;
- design issues, including the roles of health professionals; and
- alignment with other elements of the health and aged care system.

Matching funding to care needs

Chapter 4 examines whether the introduction of the ACFI has, as intended, provided better support for residents with complex and higher care needs (Term of Reference 1(a)), and whether it better recognises the relative care costs of, or has impacted on access for, certain classes of residents including those in the special needs groups specified in the *Aged Care Act 1997* (Term of Reference 2(b)).

There is strong evidence that the ACFI, as intended, has increased funding for residents with the highest and most complex care needs. More than four in ten residents in December 2010 were eligible for a level of funding that was higher than the maximum that would have been possible if the RCS had continued. On average, the ACFI (without transitional arrangements) would have provided \$153.38 per resident per day to support these residents. This is \$20.49 (13.4 per cent) more per resident per day than the maximum rate that would have been payable if the RCS had continued.

When the ACFI is fully implemented, with the removal of transitional caps on maximum subsidy levels on 1 July 2011, the average rate of the basic subsidy payable in respect of the 10 per cent of residents with the highest assessed care needs is projected to be, on average, \$40.28 per day more than the maximum rate of payment that would have been possible if the RCS had continued – an increase in real terms of 30.3 per cent.

Although the introduction of the ACFI has increased the level of funding available for residents with the most complex care needs it has not significantly altered the proportion of residents funded for less complex care needs. In December 2010, about 50 per cent of residents would have been eligible for a level of subsidy equal to or less than \$120.50 (the RCS 2 level) under both arrangements. Similarly about 25 per cent of residents under both arrangements would have been eligible for a subsidy equal to or less than \$73.38 (the RCS 4 level) and about 12 per cent of residents (in both cases) would have been eligible for a subsidy equal to or less than \$44.70 (the RCS 5 level).

While there remain concerns in the residential aged care sector about the overall adequacy of funding for residents with the highest care needs, submissions to the review consistently acknowledged that funding has increased for those residents. There was also a consistent message in submissions to the review that, with the exception of a few minor anomalies for some small groups of residents with very highly specialised needs, the ACFI is effective in terms of reflecting relative care needs and placing those with more complex needs into higher funded categories.

Analysis has been undertaken of the impact of the introduction of the ACFI on a range of population groups with specific care needs. While no evidence was found of the ACFI creating access problems for any population group, some issues were identified for four groups of residents, namely:

- residents with low care needs in outer regional and remote areas;
- residents with high sub-acute care or psycho-geriatric needs;
- residents with care needs associated with homelessness; and
- residents with dementia.

As expected, the introduction of the ACFI has led to some redistribution in funding growth away from lower care needs. This is an intended outcome, which recognises the increased availability of community care options for people with lower care needs. The impact of this change has been greater in outer regional and remote areas, where homes may not have the same flexibility to change their business practices and resident mix.

While funding has continued to grow for low care services in outer regional and remote areas, this is largely due to the ACFI grand-parenting arrangements that have prevented any funding reduction for such residents. In the longer term, the ACFI is likely to lead to a small funding reduction in real terms for residents entering care with very low care needs. An analysis of occupancy rates in homes in outer regional and remote areas indicates that these changes have not, to date, impacted on access to care, although these issues require careful monitoring. Chapter 5 examines whether these issues are impacting on the viability of homes in outer regional and remote areas.

Some aged care homes appear to be caring for residents with very high levels of care needs associated with sub-acute, palliative care and/or psycho-geriatric conditions that are difficult to accommodate within the aged care funding framework. This is an issue that predates the ACFI and which has, to some degree, been addressed through the increase in the maximum rate of the basic subsidy. However, submissions to the review indicate that some providers are facing increasing pressures and expectations in caring for residents historically managed in other settings.

Analysis of data on homes with a relatively high proportion of challenging behaviours, palliative care and complex health care needs confirms that the average level of funding for all of these groups has increased in real terms since the introduction of the ACFI. While there may be scope for improved funding within the ACFI for residents with high sub-acute care needs, there are practical limits. Aged care is not designed to manage highly complex cases previously managed in the acute sector or in psychiatric institutions. Any further targeting in funding would need to be carefully balanced against the possible adverse impact on funding for the broader aged care target group. Nevertheless, enabling homes to provide higher levels of care, sometimes for short periods of time, can have important benefits for continuity of care to residents. As these homes help reduce pressure on the health system, it may be useful to explore improved support for these residents from that system, drawing on recent models that combine Commonwealth and state/territory support and recent Australian Government initiatives to improve support for sub-acute and transition care.

Similar issues arise for residents with care needs associated with homelessness. While funding for some aged care homes targeting this group have increased, it has reduced for others, with some of the variation attributable to inconsistent claiming practices – with some homes clearly not yet fully understanding how claims can be made under the ACFI for the care that they deliver. Notwithstanding this, there is some evidence that the ACFI is less sensitive than the RCS to some interventions associated with homelessness, such as intensive social support, and the prevention and management of extreme behaviours due to mental health and substance abuse issues. In general, however, this issue is less about access and more about funding outcomes for a small group of specialised services, as discussed below.

There is potential to address some issues faced by homes catering for residents with care needs associated with homelessness through advisory support on, and technical changes to, the ACFI. However, adjusting the mainstream funding arrangements is not the most appropriate way to support the highly specialised additional services that this population group sometimes requires. Again, there may be a need to consider better support from outside the aged care system, including cross-jurisdictional effort to improve access to specialist mental health and drug and alcohol programs.

Overall, the ACFI appears to have increased funding for residents with dementia, although some submissions to the review highlighted issues relating to how well some care needs are being captured and support for residents with very low physical dependency. Given the increasing prevalence of dementia and its implications for aged care, ongoing monitoring of these issues will be important, drawing on the improved range of data now being collected under the ACFI.

Key Finding 1

The ACFI has been largely effective in better matching funding to the care needs of residents and improving support for those with the highest care needs.

Key Finding 2

The introduction of the ACFI has not had any significant adverse impact on access to care or funding for residents from any special needs group, with data showing a relatively consistent pattern of funding growth across the range of different population groups. However, there continue to be some residents whose needs can be difficult to accommodate within the aged care framework, including those with very high sub-acute or psycho-geriatric needs and care needs associated with homelessness.

Funding outcomes for providers

Chapter 5 examines the distributional impact of the introduction of the ACFI on residential aged care providers and on different categories of providers, including low care services in outer regional and remote areas and services that cater for care needs associated with homelessness. It also examines the effectiveness of the transitional arrangements (Term of Reference 2(a)).

In February 2008, immediately before the introduction of the ACFI, the average basic subsidy paid to support the care needs of permanent residents was \$88.03 per day (2008-09 prices). By December 2010, it had grown to \$109.70 per day (2010-11 prices). That is, the average basic subsidy across all aged care homes grew by 24.6 per cent over the thirty-four months between February 2008 and December 2010 – an average annual increase of 8.1 per cent. In real terms (2010-11 prices), the average basic subsidy across all homes grew by 17.2 per cent over the thirty-four months between February 2008 and December 2010 – an average annual increase of 5.8 per cent.

Funding results have varied between providers. Some 84.6 per cent of homes that operated continuously from February 2008 to December 2010 were receiving higher subsidies in real terms at the end of that period than at the start. On average, these homes were receiving \$19.70 more per resident per day in December 2010 than in February 2008 – a real increase of 21.4 per cent. Only 15.6 per cent of homes were receiving lower subsidies (in real terms) in December 2010 than in February 2008, with the average decrease amounting to \$6.31 per resident per day (or -6.1 per cent).

In general, average basic subsidies for most categories of aged care home are higher in real terms under the ACFI than they would have been if the RCS had continued, reflecting in part the higher acuity of residents to which homes are now able to provide care. The pattern of growth has been broadly consistent across different categories, although homes specialising in low level care or in outer regional and remote areas have not benefited as much from the introduction of the ACFI as other homes.

There is also a small group of highly specialised services identified as targeting special needs associated with homelessness, who also have less flexibility in their resident mix, who may also experience a long-term funding reduction as existing grand-parented residents are replaced by new residents. A small number of mainstream providers who cater for Indigenous Australians with care needs similar to those typically associated with homelessness may also experience a long-term funding reduction under ACFI.

In contrast, aged care homes caring for residents with the highest and most complex care needs will benefit further with the phasing out of the caps on maximum subsidy levels by 1 July 2011. Given the large and significant increase in funding for those homes, there may be a case to consider possible ways of achieving some redistribution of funding to improve support for homes with less capacity to change their resident mix.

On balance, there is a strong case that additional support should be provided for the small number of homes that target care needs associated with homelessness or that target Indigenous Australians, especially through a redistribution of the funding growth that has occurred since the introduction of the ACFI.

The introduction of the ACFI was accompanied by several transitional arrangements. First, existing residents were grand-parented so that the level of their funding could not decrease under the ACFI – instead providers were paid an ‘RCS saved rate’ in respect of these residents. Second, the maximum rate of subsidy under the ACFI was capped for the first three years of its operation, with the level of the cap increasing by \$10 per year. The transitional arrangements appear to have been appropriately tuned so that the effect of the capping arrangements on the maximum level of the ACFI was more than offset by the additional funding provided through the saved RCS rate provisions.

The impact of the transitional arrangements has been of particular importance for homes operating in outer regional and remote areas and for those offering predominantly low level care. In general, these providers do not have the same opportunities to adjust their resident mix as those in metropolitan areas.

Some of these homes are likely to face additional pressures when the ACFI is fully implemented – as fewer residents are covered by the grand-parenting arrangements, which have to date cushioned some of the impact of the introduction of the ACFI. For homes in outer regional and remote areas in December 2010, payment levels under the ACFI (with the transitional arrangements) were 1.3 per cent higher than they would

have been if the transitional arrangements were not in place (compared to 0.3 per cent for all homes). For homes offering predominantly low level care in December 2010, payment levels under the ACFI (with the transitional arrangements) were 8.3 per cent higher than they would have been if the transitional arrangements were not in place.

Key Finding 3

Average basic subsidies for most aged care homes have increased significantly in real terms since the introduction of the ACFI, reflecting in part the higher acuity of residents to which aged care homes are now able to provide care.

This pattern has been broadly consistent across most categories of aged care home, but with aged care homes specialising in low level care or in outer regional and remote areas not benefiting as much from the introduction of the ACFI as other homes.

Key Finding 4

A small number of aged care homes with less capacity to change their resident mix are facing issues in transitioning to the ACFI, including some low care providers in outer regional and remote areas and a small number of aged care homes targeting care needs associated with homelessness.

Key Finding 5

The transitional funding arrangements have, as intended, ensured higher rates of annual growth in average daily care subsidies for all providers than would otherwise have been the case, and have particularly assisted aged care homes supporting low care residents and aged care homes in outer regional and remote areas.

Documentation and administrative arrangements

Chapter 6 examines whether the ACFI has achieved its objectives of reducing the documentation created by aged care providers to justify funding; and reducing the level of disagreement between providers' appraisals of the care needs of their residents and the findings of Departmental Review Officers (Terms of Reference 1(b) and 1(c)).

The overall balance of evidence, including feedback from providers and submissions to the review, is that documentation requirements under ACFI are less burdensome than they were under the RCS. The removal of the requirement for mandatory annual reappraisals of residents reduced the number of reappraisals that providers are required to undertake by over 40 per cent – an estimated 64,800 reappraisals that would have been required under the old arrangements were not undertaken in 2009-10. The new arrangement whereby ACFI classifications do not, in general, expire when a care recipient transfers between aged care homes (unlike under the RCS) has also reduced the number of reappraisals that providers are required to undertake – an estimated

further 11,300 reappraisals that would have been required under the old arrangements were not undertaken in 2009-10 because of the new flexibility.

Analysis of data from the Classification Review Program clearly shows a significant reduction in the level of disagreement between providers' appraisals of the care needs of their residents and the rigorous review of those outcomes by Departmental Review Officers, with the downgrade rate reduced from 36 per cent under the RCS to 16 per cent under the ACFI. The evidence suggests that the validation arrangements under ACFI are working well and represent a significant improvement over the former arrangements, with the reduction in the rate of disagreement driven by the greater objectivity of the ACFI.

Providers have indicated strong support for further streamlining of administrative processes and associated efficiencies that could be realised with a move towards E-validation systems. Building on the gains that have already been achieved, steps towards desktop validation are now underway and considered to be an important future direction for both the Department and providers. E-validation offers significant potential to further reduce the administrative burden on providers and any disruption to residents and staff, and to further reduce the level of disagreement between Departmental Review Officers and providers with respect to the appraised care needs of residents. An e-Validation Working Group, which includes industry representation and technical expertise, has been formed to support this work.

Key Finding 6

The introduction of the ACFI has reduced the documentation requirements on providers and the number of appraisals that providers are required to undertake.

Key Finding 7

The introduction of the ACFI has reduced the level of disagreement between Departmental Review Officers and aged care providers with respect to the appraised care needs of residents.

Design issues including the role of health professionals

Chapter 7 examines whether there are any gaps and anomalies in relation to the design of the ACFI and whether the ACFI appropriately recognises the role and scope of practice of various staff, including enrolled nurses and allied health professionals (Terms of reference 3(a) and 3(c)).

The consistent message from submissions to the review and consultations with the sector is that overall the ACFI is working well and that radical change is not required. However, there are some areas where targeted changes could be considered. Although the purpose of the ACFI is to identify the key cost drivers and not to limit the use of

new modalities that are appropriate or necessary, it appears that some ACFI items, particularly pain management, may be deterring providers from providing the care most appropriate to residents' needs.

Submissions to the review, and consultations with the ACFI Technical Reference Group, have identified a number of areas where enhancements could be considered as part of ongoing work with the industry and health professionals. For example, issues were raised about the pain management items in *ACFI Question 12 – Complex Health Care*, including that:

- the interventions specified by ACFI, such as therapeutic massage and the application of heat packs, are too narrow and not consistent with contemporary best practice;
- there are other care modalities with better evidence based support that could be included such as exercise, distraction and psychological interventions; and
- the list of allied health professionals able to provide directives and particular interventions is too restrictive and should be broadened to include other allied health professionals.

Issues were also raised with respect to the cultural sensitivity of existing cognitive assessment tools, with calls for recognition to be extended to other tools. Similarly, new evidence-based incontinence management tools have been developed since the introduction of the ACFI that could now be incorporated into the ACFI. Concerns were also raised about funding anomalies for residents requiring enteral feeding and urinary catheters, where these residents cannot score highly enough on the ACFI to be rated as High in the Activities of Daily Living domain, with consequential impacts on the ability to make major change claims in respect of these residents.

On balance, there would be merit in:

- expanding the exception to the major change rule to include residents whose rating in the ADL domain is limited to Medium because they require enteral feeding (where the resident is not also assisted with daily oral intake and a dietician has assessed that such oral intake is not appropriate) or because they require a urinary catheter;
- allowing greater flexibility in the range of cognitive assessment tools that can be used for the ACFI, but only after the alternative tools have been mapped against the current ACFI tools to determine that scores and categories would produce comparable outcomes in terms of ratings in the Behaviour domain;
- refining the pain management items in *ACFI Question 12 – Complex Health Care* to remove the focus on specific interventions and to allow greater flexibility in terms of which health professionals can provide services; and

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- examining options to allow ‘fast track’ ACFI re-appraisals where a claim against the palliative care item (*ACFI Question 12 – Complex Health Care Item 12.14*) would result in a major change claim being possible.

There are also a number of parts of the ACFI that are working well but where some technical issues have been identified for possible further examination including palliative care, medication, stoma care and skin management.

The ACFI is generally effective in recognising the roles of nurses and health professionals. However, the interface with GPs and difficulties accessing diagnoses was a key issue highlighted in submissions. Greater flexibility in this area should be explored, taking into account the new workforce registration arrangements that were introduced on 1 July 2010. Under these new arrangements, ten key health professions are now regulated by national legislation. The ten professions are chiropractors, dentists, medical practitioners, nurses, midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. The new registration scheme requires all health professionals to maintain currency of practice, and to have practised in their profession within the last five years.

There would be merit in examining options to extend the list of individuals entitled, for ACFI claiming purposes, to make diagnoses, provide directives and undertake interventions to all registered health professionals acting within their scope of practice. However, it will be important that the focus of the ACFI remains on identifying care needs that predict relative care costs rather than on prescribing care interventions provided by particular health professionals.

Key Finding 8

The design of the ACFI is generally working well in meeting its objectives to match funding to care needs by identifying the significant drivers of relative costs, with some areas where targeted changes could be considered.

Key Finding 9

The design of the ACFI properly recognises the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals.

Alignment with other elements of aged care

Chapter 8 examines how well the ACFI aligns with other parts of the broader aged care regulatory framework. Consistent with the Terms of Reference, particular attention is given to the interface with ACATs and with the Specified Care and Services Schedule of the *Quality of Care Principles 1997* (Terms of Reference 4 and 5).

One issue of concern raised in submissions to the review was that the introduction of the ACFI had increased the number of residents who were being classified at the Interim Low level because their ACAT approval for care was limited to low level care but their provider had appraised their care needs as being for high level care. The Australian Government addressed this issue prior to the completion of the review by changing the definition of high level care from 1 January 2010. The new definition of high level care has effectively restored levels of agreement between ACAT approvals and provider appraisals, thereby reducing the proportion of residents that default to the Interim Low classification. Prior to the introduction of the ACFI, the disagreement rate between ACAT approvals and provider appraisals was 7.7 per cent. Following the introduction of the ACFI it increased to 16.6 per cent, but following the introduction of the new definition of high level care in January 2010, and further education for ACATs, the level of disagreement had fallen to 6.5 per cent in December 2010.

The changes to the definition of high level care introduced in January 2010 have also helped to improve the alignment of the ACFI with the Specified Care and Services Schedule in the *Quality of Care Principles 1997*. However, submissions to the review highlighted some concerns with the Specified Care and Services Schedule. In particular, the current requirements have been in place since 1997 and have not been updated to take into account changes in contemporary practice since that time.

Submissions to the review also highlighted some interface issues with community aged care packages, relating to equity in funding between residents of aged care homes who receive nil or low levels of care funding under the ACFI and recipients of these packages with similar care needs who are receiving care in the community. These funding anomalies become more pronounced with increased targeting of funding to higher care needs in residential aged care including some growth in the proportion of residents receiving nil care subsidies.

The ongoing appropriateness of the Specified Care and Services Schedule and the other interface issues that were raised in submissions to the review are not strictly related to the ACFI and hence not within the ambit of the review. These issues would be best considered by the Australian Government in the development of its response to the Productivity Commission's *Caring for Older Australians* inquiry and in broader reforms currently underway to create a national aged care system.

Key Finding 10

The new definition of high level care that took effect on 1 January 2010, and the additional training provided to ACATs at that time, has improved agreement between the level of approval for care granted by an ACAT to a resident, before their admission to care, and their provider's appraisal of their care needs under the ACFI, with further improvement possible through additional training.

Recommendations

Recommendation 1

The current ACFI Industry Reference Group and the ACFI Technical Reference Group should be disbanded, with ongoing consultation on the ACFI occurring through the Ageing Consultative Committee as required.

Recommendation 2

An ACFI Technical Reference Group, consisting of members with appropriate expertise drawn from aged care providers, employee organisations, health professional bodies and consumer organisations, should be established to assist the Department undertake ongoing work to monitor and explore possible refinements to the ACFI.

Recommendation 3

The ACFI should continue to be used as the basis for allocating basic subsidies to aged care homes, with the following minor amendments:

- 1) *The current exception to the major change rule should be modified to include the following cases where a resident is categorised as Medium in the ADL domain and Medium in the CHC domain:*
 - a) *if a claim has been made for enteral feeding in the CHC domain and the resident is not also assisted with daily oral intake and a dietician has assessed that such oral intake is not appropriate for the resident, then a reappraisal may be submitted at any time to reclassify the resident to High in the CHC domain; and*
 - b) *if the resident is not incontinent of faeces and a claim has been made for urinary catheter care in the CHC domain, then a reappraisal may be submitted at any time to reclassify the resident to High in the CHC domain.*
- 2) *The pain management items in ACFI Question 12 –Complex Health Care should be refined so as to remove the focus on specific interventions and to recognise a broader range of registered health professionals operating within their scope of practice, with detailed options to be developed through the ACFI Technical Reference Group.*

Recommendation 4

The Department, in consultation with the aged care sector through the ACFI Technical Reference Group, should continue to monitor the operation of and explore possible refinements to the ACFI, including:

- 1) *As a first priority:*
 - a) *the use of culturally sensitive behaviour assessment tools;*

- b) *extending the list of individuals entitled, for ACFI claiming purposes, to make diagnoses, provide directives and undertake interventions to all registered health professionals acting within their scope of practice; and*
 - c) *operationalising new continence management resources.*
- 2) *Over the longer term, issues relating to palliative care, medication administration, stoma care and skin management.*

Recommendation 5

The Department should continue to work in collaboration with the aged care sector and Medicare Australia to develop and implement e-Validation systems.

Recommendation 6

The Department, in consultation with the Ageing Consultative Committee, should continue to carefully monitor expenditure trends under the ACFI, with emphasis on achieving an appropriate balance between:

- *the extent to which overall expenditure growth rates are contained within a sustainable range over the longer term;*
- *the distributional impact of the introduction of the ACFI across providers, including those providers with less capacity to change their resident mix such as providers of low care services in outer regional and remote areas and services targeting care needs associated with homelessness.*

Recommendation 7

As part of the broader reforms of aged care already announced, and that may flow from the Australian Government's response to the Productivity Commission's Caring for Older Australians inquiry, the Department should undertake further work, in consultation with the Ageing Consultative Committee, to enhance the integration of the funding and classification systems with the assessment and quality assurance arrangements, across residential and community aged care.

1. Introduction

In 2010-11, the Australian Government will provide \$10.9 billion to support the provision of residential and community aged care, with more than half of this funding provided as basic subsidies for permanent residents of aged care homes. The level of basic subsidy payable in respect of a resident is determined by the resident's classification against the Aged Care Funding Instrument (ACFI), which was introduced on 20 March 2008. The ACFI replaced the Resident Classification Scale (RCS), which had been in use since 1 October 1997. The ACFI was introduced with three key aims: to more closely match funding to care needs, to reduce the level of documentation that aged care providers need to create to justify their appraisals of their residents' care needs, and to reduce the level of disagreement between providers' appraisals of their residents' care needs and the findings of Departmental Review Officers.

In the 2007 Budget, the Australian Government provided \$393.5 million over four years to support the introduction of the ACFI. This funding included \$285.6 million to assist aged care homes to manage the transition to the ACFI by ensuring that the level of funding for existing residents did not decrease when they were reassessed under the new instrument. It also included \$102.7 million in additional funding to better support residents with behaviour management and complex health care needs. The Australian Government also provided funding in the 2007 Budget for a number of other measures to assist the sector to transition to the new arrangements, including \$4.2 million for a national training program and business advisory services provided by KPMG targeted at providers with a high percentage of low care residents and those based in regional and remote locations. A total of 118 providers received assistance through this initiative.¹

Prior to the introduction of the ACFI, the Senate Standing Committee on Community Affairs recommended that a review of the ACFI be undertaken after eighteen months to assess the extent to which its objectives were being achieved.² In line with this recommendation, the then Minister for Ageing asked the Department of Health and Ageing to undertake a review of the ACFI ('the review') on 6 November 2009.³

¹ Australia – Treasurer and Minister for Finance and Administration (2007) *2007-08 Budget Papers No. 2: Budget Measures*. Canberra: Commonwealth of Australia. <http://www.budget.gov.au/2007-08/bp2/html/expense-20.htm> (accessed 31 March 2011).

² Australia – Parliament – Senate – Standing Committee on Community Affairs (2007) *Aged Care Amendment (Residential Care) Bill 2007 [Provisions]*. Recommendation 4. http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/2004-07/aged_care_resident_care07/report/report.pdf (accessed on 31 March 2011).

³ Australia – Minister for Ageing (2009) *review of the Aged Care Funding Instrument – Release of Terms of Reference*. Media release, 6 November 2009. [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/950D7ACB4888C9BDCA25766500788521/\\$File/je126.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/950D7ACB4888C9BDCA25766500788521/$File/je126.pdf) (accessed on 31 March 2011).

1.1 Scope and terms of reference of the review

The Terms of Reference of the review are at *Appendix A*. In summary, the Department of Health and Ageing was tasked with examining:

- 1) the extent to which the introduction of the ACFI had achieved its objectives of:
 - a) better matching funding to the complex care needs of residents;
 - b) reducing the documentation created by residential aged care providers to justify funding; and
 - c) reducing the level of disagreement between providers' appraisals of the care needs of their residents and the findings of Departmental Review Officers;
- 2) the impact of the introduction of the ACFI on:
 - a) the funding levels of residential aged care providers, and in particular of low care providers and providers in rural and remote areas; and
 - b) access to appropriate care, especially for residents with special needs, including whether the design of the ACFI fails to appropriately recognise the relative costs of meeting the care needs of certain classes of residents;
- 3) the design of the ACFI to determine whether:
 - a) there are any gaps or anomalies in the ACFI in relation to care needs; and
 - b) the ACFI properly recognises the roles of care workers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals;
- 4) other issues related to the introduction of the ACFI, including:
 - a) the appropriateness of Schedule 1 of the Quality of Care Principles 1997 ('specified care and services') in determining the services to be provided to residents of aged care homes with differing levels of care needs; and
 - b) options to improve agreement between the level of approval granted to a resident by an Aged Care Assessment Team (ACAT) and the residential aged care provider's appraisal of the care needs of the resident.

1.2 Overview of the review process

The review was carried out by the Department of Health and Ageing in consultation with consumers, aged care providers, aged care workers and health professionals, and their representatives through the ACFI Industry Reference Group and the ACFI Technical Reference Group. Details of the membership and operations of these reference groups are given in *Appendix B*. The review has also been informed by a

public submission process. A public call for submissions was advertised on 5 December 2009, in conjunction with release of a discussion paper to inform submissions to the review.⁴ As a guide for submissions, the discussion paper grouped the key issues for review into the following categories:

- matching funding to care needs;
- funding outcomes for providers;
- documentation and administrative arrangements;
- design issues including the roles of health professionals; and
- interfaces with other elements of aged care.

The review received 98 submissions from aged care providers, aged care workers, consumers, carers, peak representative bodies across the industry and interested professional and consumer groups. A list of the submissions received is at **Appendix C**. These submissions are all published on the review website.⁵

Access Economics was engaged to undertake an independent analysis of the available data, focused primarily on projecting the likely overall financial impact on the aged care sector of the introduction of the ACFI.⁶ Analysis of the available data was also undertaken by the Department, focused primarily on the impact on different categories of residents and providers, including both the impact of transitional and grand-parenting arrangements, as well as longer term expectations.

1.3 Outline of the report

Following an overview of the current arrangements governing the funding of residential aged care (**Chapter 2 – Current arrangements**) and a statistical overview of trends in resident care needs based on the results of the first 33 months of care assessments using the ACFI (**Chapter 3 – Resident characteristics as measured by the ACFI**), the bulk of this report is organised around the five themes that formed the basis of consultations.

⁴ Review of the Aged Care Funding Instrument (2010) Discussion Paper. Canberra: Department of Health and Ageing. [http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-review/\\$File/ReviewACFIDiscussionPaper.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-review/$File/ReviewACFIDiscussionPaper.pdf) (accessed on 31 March 2011).

⁵ Submissions to the review can be found at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-review-submissions> (accessed on 31 March 2011).

⁶ Access Economics (2008) *Testing the distribution of first 33,000 ACFI appraisals*. [http://www.health.gov.au/internet/main/publishing.nsf/Content/B00D5348BB43FC21CA257664007AD88E/\\$File/ACFITesting.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/B00D5348BB43FC21CA257664007AD88E/$File/ACFITesting.pdf) (accessed on 31 March 2011).

Access Economics (2010) *The impact of ACFI on subsidy levels in Residential Aged Care*. [http://www.health.gov.au/internet/main/publishing.nsf/Content/B00D5348BB43FC21CA257664007AD88E/\\$File/ACFI.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/B00D5348BB43FC21CA257664007AD88E/$File/ACFI.pdf) (accessed on 31 March 2011).

Chapter 4 – Matching funding to care needs examines whether the introduction of the ACFI has provided better support for residents with complex and higher care needs, as intended, and whether it better recognises the relative care costs of certain classes of residents including special needs groups (Terms of Reference 1(a) and 2(b)).

Chapter 5 – Funding outcomes for providers examines the impact of the introduction of the ACFI on different categories of residential aged care providers, including providers who specialise in the provision of low-level care and providers in rural and remote areas. It also examines the effectiveness of the transitional arrangements that were put in place for the introduction of the ACFI (Term of Reference 2(a)).

Chapter 6 – Documentation and administrative arrangements examines the impact of the introduction of the ACFI on the level of paperwork and time required to justify appraisals and the level of disagreement between residential aged care providers and Departmental Review Officers (Terms of Reference 1(b) and 1(c)).

Chapter 7 – Design issues including the roles of health professionals examines gaps and anomalies in relation to the design of the ACFI and how well it captures care needs, in addition to whether the ACFI appropriately recognises the role and scope of practice of various care workers, including enrolled nurses and allied health professionals (Terms of Reference 3(a) and 3(b)).

Chapter 8 – Alignment with other elements of aged care examines how well the ACFI is aligned with the broader regulatory framework, with a particular focus on the interface with Aged Care Assessment Teams and with Specified Care and Services (Terms of Reference 4(a) and 4(b)).

The report concludes with seven recommendations in **Chapter 9 – Conclusions and recommendations**.

2. Current arrangements

This chapter provides an overview of the residential aged care funding arrangements and related regulatory requirements (Section 2.1). It also summarises some of the major activities that shaped the design and implementation of the Aged Care Funding Instrument (ACFI) (Section 2.2). The chapter concludes with a description of the ACFI and its business rules (Section 2.3) and an overview of the Department's Classification Review Program (Section 2.4).

2.1 Overview of residential aged care

The Australian Government subsidises the provision of residential aged care to older people whose care needs are such that they can no longer remain in their own homes. These arrangements are governed by the *Aged Care Act 1997* and its subordinate legislation, which set out a set of broad principles and detailed funding, user charging and regulatory arrangements designed to enable and encourage aged care providers to provide high quality accommodation and care, ensure access and affordability, target funding at those with the greatest need, and allow flexibility and responsiveness of services to individual needs.

About two thirds of the funding for residential aged care is provided by the Australian Government. Subsidies are paid directly to aged care homes on behalf of their residents. Residents who can afford to do so also contribute to the cost of their care. A provider can only receive a subsidy in respect of a resident if four conditions are met:

- an Aged Care Assessment Team must *approve* the resident for residential aged care, based on comprehensive assessments of the person's care needs noting that the approval will be for either low-level or high-level care (technically the approval is either 'limited to low-level care' or 'not limited to low-level care');
- the resident's care must be provided by an *approved provider*, with this approval granted by the Department on the basis of the provider's experience in the provision of aged care as well as its corporate governance;
- the resident must occupy an *allocated place*, with the number and distribution of places governed by the 'needs based planning arrangements', to ensure growth in line with growth in the aged population and to ensure an equitable distribution of services, including a balance between people needing differing levels of care; and
- the care must also be of a *specified quality* – the resident's aged care home must be accredited by the Aged Care Standards and Accreditation Agency.

Aged care residents receive either low level care or high level care. Low level care (in a residential setting) includes the provision of suitable accommodation and related services, such as laundry, meals and cleaning. It also includes personal care services

such as assistance with the activities of daily living. In addition to these services, high level care generally includes more complex personal care services, and often includes nursing care and equipment. As their care needs change, residents often need to move between care levels.

A key element of the residential aged care regulatory arrangements is the funding and classification system. The system is designed to distribute funding equitably across the residential aged care sector and to match funding to the care needs of residents. It is also designed to provide a level of flexibility and choice for residents and providers, including opportunities for 'ageing in place' and additional support in the form of viability funding to assist small, isolated services in rural and remote areas.

The payment for each eligible resident consists of a basic subsidy and, in some cases, other supplements to which the resident is entitled. Since 20 March 2008 the amount of basic subsidy payable in respect of a permanent resident have been determined by their classification under the ACFI.

2.2 History and development of the ACFI

Prior to the introduction of the ACFI, basic subsidies were allocated based on the Resident Classification Scale (RCS), a funding instrument introduced in 1997 in conjunction with the *Aged Care Act 1997*. Under the RCS, each resident was assigned to one of eight categories that were designed to reflect care needs.

Over time, concerns were raised by residential aged care providers about the perceived administrative and documentation burden of the RCS. In response to these concerns, the Department of Health and Ageing engaged Aged Care Evaluation and Management Advisors in 2002 to conduct a review of the RCS.¹ The objective of the review was to investigate both possible refinements to the RCS and alternative processes that would reduce the documentation burden on care staff and provide accountability for funding. The overwhelming view emerging from the review was that the RCS needed to be modified in the short term and work should commence to replace RCS with a new system in the medium to long term. Professor Hogan's Review of Pricing Arrangements in Residential Aged Care expanded upon the findings of the RCS review.² It found that the three main disadvantages of the RCS arrangements were: the administrative burden

¹ Aged Care Evaluation and Management Advisors (2003) *Resident Classification Scale review*. Aged and Community Care Service Development and Evaluation Reports No. 43. Canberra: Department of Health and Ageing. [http://www.health.gov.au/internet/main/publishing.nsf/Content/7D7E680F025258EECA2572D7007BC130/\\$File/finlrep.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/7D7E680F025258EECA2572D7007BC130/$File/finlrep.pdf) (accessed on 31 March 2011).

² Hogan WP (2004) review of *Pricing Arrangements in Residential Aged Care*. Canberra: Department of Health and Ageing. <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-investinginagedcare-report-index.htm> (accessed on 31 March 2011).

inherent in the RCS; the adequacy of funding arrangements to appropriately compensate for care needs of particular groups of residents; and the volatility of the RCS, including its susceptibility to manipulation and the potential for residents with similar care needs to be classified into different categories.

In response to these reviews, work commenced within the Department to develop a new funding instrument. This included in-depth statistical analysis of the RCS questions, and preliminary model building for a reduced set of questions. Following on from this project, there was work to further refine the reduced question set into a new funding appraisal tool, with supporting assessment mechanisms. This development work culminated in the new Aged Care Funding Instrument, which is characterised by its multi-dimensionality – with three domains: Activities of Daily Living, Behaviour and Complex Health Care.

The national trial

In 2005, some 678 aged care homes participated in a national trial of the ACFI. Appraisals under the ACFI were conducted on a total of 5,672 aged care residents and prospective residents by staff from Aged Care Assessment Teams (ACATs), nominated clinical staff from aged care homes, community and employment agency nurses, and Departmental Review Officers. The key objectives of the national trial were to:

- test the new ACFI including how well it worked when used by assessors in different settings and circumstances;
- estimate its effect on workloads;
- trial a new approach to validation;
- explore the feasibility of ACATs undertaking pre-entry ACFI assessments; and
- collect data to support analysis of a number of funding model structures for residential aged care.

Overall feedback from aged care staff who participated in the trial was that the ACFI provided a simpler and clearer process. Results included higher levels of agreement between aged care staff and Departmental Review Officers on ACFI ratings than on RCS ratings. Findings also highlighted that ACFI appraisals involved significantly less time compared to RCS appraisals. Aged care home staff took 55.7 minutes on average to complete the ACFI for a resident. This represented a significant reduction in the time taken to appraise a resident under the RCS, with its 20 questions and more extensive evidentiary requirements including assessments, care plans and progress notes.

A new approach to validation was also tested in the national trial, including a focus on improving levels of agreement about resident ratings between aged care home staff and Departmental Review Officers. In the initial stages of the trial, the level of agreement

varied between 76 per cent and 91 per cent depending on the ACFI question, but with brief discussion, the agreement levels rose to between 96 per cent and 99 per cent.

2.3 Overview of the ACFI

The ACFI is a funding tool, based primarily on the resident’s dependency or need for care. It is not a comprehensive care planning tool designed to cover every intervention a resident may need. Rather it is designed to capture ‘signature events’ that provide a good indication of relative care needs and therefore of differences in costs of caring for residents. Unlike the RCS, ACFI does not use ongoing care documentation as evidence to support funding claims.

In terms of overall design and structure, the ACFI consists of 12 care need questions in three domains – Activities of Daily Living (ADL), Behaviour (BEH) and Complex Health Care (CHC). The ACFI also collects diagnostic information about mental and behavioural disorders and other medical conditions. Figure 1 provides more detail on the twelve care need questions and their operation.

Figure 1: Aged Care Funding Instrument – Details of questions

Domain/ Funding	Questions	Specified Assessments	Checklist Items	What Does the Rating Measure?
Diagnoses	Mental & Behavioural	n/a	<ul style="list-style-type: none"> List of disorders 	
	Medical		<ul style="list-style-type: none"> List of medical conditions 	
Activities of Daily Living	1. Nutrition	n/a	<ul style="list-style-type: none"> Readiness to Eat Eating 	<ul style="list-style-type: none"> Independent Supervision required Physical Assistance required
	2. Mobility		<ul style="list-style-type: none"> Transfers Locomotion 	
	3. Personal Hygiene		<ul style="list-style-type: none"> Dressing & Undressing Washing & Drying Grooming 	
	4. Toileting		<ul style="list-style-type: none"> Use of Toilet Toilet Completion 	
	5. Continence	Continence Record	<ul style="list-style-type: none"> Urinary Continence Faecal Continence Scheduled Toileting 	<ul style="list-style-type: none"> Self managed Frequency of incontinence Managed by scheduling
Behaviour	6. Cognitive Skills	Psychogeriatric Assessment Scale (PAS)	<ul style="list-style-type: none"> PAS Score OR Minimal, Mild, Moderate, Severe Impairment Rating 	<ul style="list-style-type: none"> Level of Impairment

Domain/ Funding	Questions	Specified Assessments	Checklist Items	What Does the Rating Measure?
	7. Wandering	Behaviour Records	<ul style="list-style-type: none"> Type and frequency of behaviour 	<ul style="list-style-type: none"> Frequency of problem behaviour
	8. Verbal Behaviour			
	9. Physical Behaviour			
	10. Depression	Cornell Scale for Depression (CSD)	<ul style="list-style-type: none"> CSD Score OR Level of interference caused by symptoms 	<ul style="list-style-type: none"> Degree of interference with regular activities Diagnosis
Complex Health Care	11. Medication	n/a	<ul style="list-style-type: none"> Time Specified procedures 	<ul style="list-style-type: none"> Time Procedures
	12. Complex Health Care		<ul style="list-style-type: none"> Specified procedures 	<ul style="list-style-type: none"> Scores for procedures

How are residents classified?

Under the ACFI, each permanent resident is classified into one of sixty five categories that are designed to reflect care needs. This classification takes into account the aged care provider's appraisal of the resident's care needs utilising the ACFI and the level of approval for care granted to the resident by an ACAT.

Approval by the Aged Care Assessment Team

As noted above, an aged care provider is only eligible for subsidy in respect of an individual if, *inter alia*, an ACAT has approved the resident for residential aged care, based on comprehensive assessments of the person's care needs. The approval will be for either high level care or low level care.

Appraisal by aged care provider

Providers are required to undertake an appraisal of each permanent resident's care needs using the *ACFI Answer Appraisal Pack*. A *User Guide* is available to assist providers. The appraisal outcomes are included in the provider's *Application for Classification* in respect of the resident, a form that must be submitted (electronically or in hard copy) to Medicare Australia in order for the resident to be allocated a classification.³

Under the RCS, an annual re-appraisal was required for all existing residents. This requirement of routine, annual re-appraisal was discontinued with the introduction of the ACFI. Although not compulsory, a provider can submit a reappraisal of a resident's

³ These documents can be found at (accessed on 31 March 2011):
<http://www.health.gov.au/internet/main/publishing.nsf/Content/New+Funding+Model+for+Residential+Aged+Care-1> .

care needs at any time 12 months or more after the existing classification has taken effect. A re-appraisal of care needs can also be performed:

- if there has been a major change in the resident's care needs⁴;
- within two months of a resident transferring from another aged care home, or
- at any time when a resident is classified at the lowest classification level.

Aged care providers must complete an appraisal of the care needs of a resident:

- within 2 months for a resident new to residential aged care (or who is transferring from another aged care home but 28 days or more have elapsed since the resident left the previous home) – the appraisal cannot be completed within the first seven days after admission and cannot be submitted within 28 days of admission;
- in the period one month before or one month after the expiry of an existing classification - whether RCS or ACFI; or
- within the period specified in a notice issued by the Department requiring a resident be reappraised.

Classification by the Department

The Department determines the classification of a resident based on the application for classification completed by the aged care provider and sent to Medicare Australia. The diagnostic information and the answers to the 12 ACFI questions are used to categorise residents as having nil, low, medium or high needs in each of the three care domains. No funding is provided for a domain if the resident has no or minimal assessed care needs in that domain. The classification of residents involves a series of steps.

- the A, B, C or D rating given for each ACFI question corresponds to a particular score (see Table 1 and Table 2);
- the scores for each domain are then added to calculate a total score for the domain; and
- the total score for each domain is then used to categorise the resident as having Nil (N), Low (L), Medium (M) or High (H) needs for that domain (see Table 3).

⁴ Under the ACFI, a major change is defined as any increase of two levels. This increase could occur as a change of two levels within one domain, or as a one-step increase in two or more domains. The only exception to this rule is where the resident is categorised as High in the ADL domain and Medium in the CHC domain. In this case a reappraisal may be submitted at any time to reclassify the resident to High in the CHC domain. This is permitted even if there is no change in the BEH domain.

Table 1: Scores for Question Ratings in the ADL and BEH domains

	A	B	C	D
Activities of Daily Living domain				
1. Nutrition	0	6.69	13.39	20.09
2. Mobility	0	6.88	13.76	20.65
3. personal Hygiene	0	7.89	15.75	23.63
4. Toileting	0	6.11	12.21	18.31
5. Continence	0	5.79	11.53	17.31
Behaviour domain				
6. Cognitive skills	0	6.98	13.91	20.88
7. Wandering	0	5.91	11.82	17.72
8. Verbal behaviour	0	7.04	14.10	21.14
9. Physical behaviour	0	7.70	15.40	23.11
10. Depression	0	5.71	11.43	17.15

Table 2: Scores for Question Ratings in the CHC domains

	Question 12: Complex Health Care			
	A	B	C	D
Question 11: Medication				
A	0	0	2	2
B	0	1	2	3
C	1	1	2	3
D	2	2	3	3

Table 3: Score cut-points for categories in the ADL, BEH and CHC domains⁵

Domain	Nil	Low	Medium	High
Assistance with activities of daily living	0	18.00	62.00	88.00
Behaviour	0	13.00	30.00	50.00
Complex Health Care	0	1	2	3

The resident’s classification is summarised as a three part code, with 64 possibilities. For example, the code of a resident assessed as being medium in the ADL domain, low in the BEH domain and having no or minimal needs in the CHC domain, would be

⁵ Note: To qualify for the highest level of the Behaviour Supplement, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis is required. In the case of diagnoses covering depression, psychotic and neurotic disorders, the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the past 12 months. If a valid diagnosis is not supplied, the maximum level for the Behaviour domain is Medium (M).

MLN. A provider is not required to submit an application for a resident who has no or minimal assessed care needs in all three domains – i.e. an N-N-N classification.

The 64 ACFI funding codes are each categorised as either high level care or low level care. Initially residents were considered to receive a high level of residential care where they were classified at any one of the following:

- Medium or High in the ADL domain; or
- High in the BEH domain; or
- Medium or High in the CHC domain.

From 1 January 2010, this definition has changed so that residents are now classified as requiring high level care where they were classified at any one of the following:

- High in the ADL domain; or
- High in the BEH domain and not Nil in both the ADL and CHC domains; or
- High in the CHC domain; or
- Medium in at least two of the three domains.

The exception to this occurs when the provider's initial appraisal of a resident, whose ACAT approval for permanent residential care is limited to low level care, indicates that the resident requires a high level of residential care. In these cases the resident is classified at the Interim Low Classification, until the resident ages in place, or a major change reappraisal occurs, or a new ACAT approval (for high level care) is obtained.

Classifications generally do not expire. However, the classification of a resident does expire under the following circumstances:

- six months after admission directly from hospital;
- the day prior to their return from extended hospital leave (of 30 days or more);
- six months after their return from extended hospital leave;
- on departure from the aged care home, except if transferring to another home within 28 days; and
- six months after a re-classification on the grounds of a major change.

A resident's classification does not expire where they leave the care of an aged care home and enter another home, or return to the same home, within 28 days. Because the existing ACFI classification does not expire, and the approval for permanent resident care does not lapse, a new ACAT approval is not required when a resident transfers from one aged care home to another. This includes situations where the initial ACAT approval was limited to low level care and the resident has 'aged in place'.

What are the effects of classification?

Subsidy rates

When a resident is classified a care subsidy is paid for each level of each of the three care domains, except the nil level. The total care subsidy paid for each resident is generally the sum of the rates for all three domains as shown in the following table.

Table 4: Daily ACFI subsidy rates, 2010-11

Level	Activities of Daily Living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	\$0.00	\$0.00	\$0.00
Low	\$30.32	\$6.93	\$13.64
Medium	\$66.03	\$14.36	\$38.86
High	\$91.47	\$30.25	\$56.11

The rate for residents classified into the Interim Low Classification is \$45.79 per day.

In the initial period of the operation of the new funding model, the maximum funding rate has been capped. The maximum daily ACFI rate is currently \$162.89. These transitional caps are being phased out and will cease from 1 July 2011. Transitional arrangements are also in place for residents who had already had their subsidy rate determined under the RCS. If their ACFI classification would result in an increase in subsidy of \$15 or more, then that subsidy is payable. However, if the new subsidy rate for a resident under the ACFI was found to be less than \$15 more than their existing RCS subsidy rate, the RCS rate continues to be paid.

Implications for specified care and services

The *Aged Care Act 1997* sets out requirements, known as the Accreditation Standards, which aged care service providers must meet in caring for residents of aged care homes. Approved providers are also required to meet the Specified Care and Services provisions under Schedule 1 of the *Quality of Care Principles 1997*. Part 2 of that Schedule requires that residents who are receiving low level care and who are assessed as needing therapy or other allied health services must be assisted in obtaining these services. Part 3 of the Schedule requires that residents who are receiving high level care and who are assessed as assessed as needing therapy or other allied health services must be provided with these services at no cost to the resident. These requirements were not changed by the introduction of the ACFI. However, the change in the definition of high level and low level care that was necessitated by the introduction of the ACFI (and the later amendment of that definition) means that different types of resident are, in some cases, now classified as receiving high level or low level care than under the RCS.

Implications for resident fees

The rules governing fees and payments made by residents were also not changed with the introduction of ACFI. People entering low level care can be asked to pay an accommodation bond if they have the means and subject to a range of protections. A bond can also be charged when the resident enters an aged care home to receive care on an extra service basis or if the resident is transferring to high level care from another aged care home to which they paid a bond. People who require high level care on admission to care can be asked to pay a capped daily accommodation charge if they have the means. This arrangement recognises that incoming residents requiring high level care are more likely to enter care in crisis than those needing low level care.

Again, although these requirements were not changed by the introduction of the ACFI, the change in the definition of high level and low level care that was necessitated by the introduction of the ACFI (and the later amendment of that definition) means that different types of resident are, in some cases, now classified as receiving high level or low level care than under the RCS and so subject, in some cases, to different accommodation payment arrangements than they would otherwise have been.

2.4 The Department's Classification Review Program

A new Classification Review Program has also been established to ensure that ACFI appraisals are conducted correctly. All reviews take into account the aged care home's appraisal using the ACFI *User Guide* and the approved provider is required to ensure that the specified materials for audit and accountability purposes are retained for future audit. Classification reviews are undertaken by authorised officers from the Department.

Departmental Review Officers seek to confirm that the ACFI appraisal accurately reflected the level of care needed by the resident at the time it was completed by the aged care home. In conducting a review, a Departmental Review Officer would be expected to check the completeness and accuracy of the ACFI *Answer Appraisal Packs* for a sample of residents in a service.

The Departmental Review Officer also considers any clinical reports that aged care staff used to help them complete the *Answer Appraisal Packs*, conduct discussions with care staff and observe, interview and assess residents. The final outcome of a classification review, whether a downgrade or upgrade, may result in an adjustment to the subsidy paid to the aged care provider. This can be retrospective up to a maximum period of six months. In the majority of cases no such adjustment is required.

3. Resident characteristics as measured by the ACFI

This chapter provides a statistical overview of trends in resident care needs based on the results of the first 34 months of care assessments using the ACFI, including the diagnoses of residents (Section 3.1) the three care domains (Section 3.2).

3.1 Diagnoses of residents

With the introduction of ACFI, confirmed diagnoses for mental and behaviour disorders and other medical conditions are now collected.¹ This is a significant improvement compared with the RCS, which did not record information on underlying conditions.

Medical Diagnoses

In completing the ACFI, residential aged care providers can specify up to three diagnoses of medical conditions. Table 5 below provides an analysis of the medical diagnoses (excluding mental and behavioural disorders) reported in the ACFI records of the 157,500 permanent residents in care in June 2009 and the 162,874 permanent residents in care in December 2010.² In December 2010, only 0.9 per cent of residents did not have a medical diagnoses (excluding mental and behavioural disorders), while 24.4 per cent of residents had two medical diagnoses and 40.2 per cent of residents had three medical diagnoses. The percentage of residents with multiple diagnoses increased between June 2009 and December 2010 – from 60.2 per cent to 64.6 per cent.

At the Major Diagnostic Category level, the most common medical diagnoses listed related to diseases of the circulatory system (56.2 per cent of residents) and diseases of the musculoskeletal system and connective tissue (46.4 per cent). There was a slight drop in the prevalence of diseases of the circulatory systems between June 2009 and December 2010 (down from 59.1 per cent) and a slight increase in the prevalence of diseases of the musculoskeletal system and connective tissue (up from 45.1 per cent).

Around 20.3 per cent of residents had endocrine, nutritional and metabolic disorders, as their main medical diagnosis in December 2010. This was a slight decrease on the June 2009 result of 21.0 per cent. Conversely, there was a slight increase in the prevalence of diseases of the genitourinary system up from 14.2 per cent to 16.0 per cent.

¹ Coding of health conditions in the ACFI comes from codes used in the Aged Care Assessment Program and these codes map to equivalent codes in the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification. See National Casemix and Classification Centre at <http://nccc.uow.edu.au/icd10am/icd10am/index.html> (accessed on 31 March 2011).

² See also: Australian Institute of Health and Welfare (AIHW) (2010) *Residential aged care in Australia 2008-09: a statistical overview*. Canberra: AIHW.

Table 5: Principal diagnoses recorded in the ACFI, June 2009 and December 2010

Medical condition groups	Share in June 2009 (%)	Share in December 2010 (%)
Certain infectious and parasitic diseases	0.4	0.5
Neoplasms (tumours/cancers)	7.2	7.2
Diseases of blood and blood forming organs and immune mechanism	2.2	1.9
Endocrine, nutritional and metabolic disorders	21.0	20.3
Diseases of the nervous system	14.0	13.5
Diseases of the eye and adnexa	14.8	14.3
Diseases of the ear and mastoid process	5.7	5.5
Diseases of the circulatory system, including Cerebrovascular disease	59.1	56.2
Diseases of the respiratory system	11.0	10.6
Diseases of the digestive system	9.9	8.9
Diseases of the skin and subcutaneous tissue	3.5	3.8
Diseases of the musculoskeletal system and connective tissue	45.1	46.4
Diseases of the genitourinary system	14.2	16.0
Congenital malformations, deformations and chromosomal abnormalities	0.4	0.4
Injury, poisoning and certain other consequences of external causes	7.9	8.7
Symptoms and signs (without diagnosis, unspecified)	26.8	34.8

The most common specific diagnosis in December 2010 were:

- 1) *Other arthritis and related disorders* (36.3 per cent of residents);
- 2) *Hypertension* (26.7 per cent);
- 3) *Osteoporosis* (14.9 per cent);
- 4) *Stroke (CVA) - cerebrovascular accident unspecified* (14.8 per cent);
- 5) *Diabetes Melitus type 2* (13.8 per cent); and
- 6) *Chronic lower respiratory disease* (10.8 per cent).

Mental and Behavioural Diagnoses

In December 2010, only 22.6 per cent of residents did not have a mental or behaviour diagnosis, while 24.0 per cent of residents had two mental or behaviour diagnoses and 5.4 per cent of residents had three mental or behaviour diagnoses (see Table 6, which

includes comparative data for June 2009). More than half (51.9 per cent) of residents had at least one diagnosis of dementia, although it is important to note that this does not mean that dementia was the resident’s primary health condition. At the same time, over 36.6 per cent of residents had a diagnosis of ‘depression’, including 17.9 per cent of residents who had diagnoses of both dementia and depression.

Table 6: Mental and behaviour diagnoses recorded in the ACFI, June 2009 and December 2010

Mental and Behaviour Diagnosis	Share in June 2009 (%)	Share in December 2010 (%)
Dementia, Alzheimer’s disease including early onset, late onset, atypical or mixed type or unspecified	40.4	40.0
Vascular dementia e.g. multi-infarct, subcortical, mixed	5.5	5.6
Dementia in other diseases, e.g. Pick’s Disease, Creutzfeldt-Jakob, Huntington’s, Parkinson’s, HIV	2.4	2.3
Other dementias, e.g. Lewy Body, alcoholic dementia, unspecified	4.6	4.8
Delirium	0.9	1.2
Depression, mood and affective disorders, Bi-Polar	33.2	36.6
Psychoses e.g. schizophrenia, paranoid states	5.4	5.3
Neurotic, stress related, anxiety, somatoform disorders e.g. post traumatic stress disorder, phobic and anxiety disorders, nervous tension/stress, obsessive-compulsive disorder	9.0	11.0
Intellectual and developmental disorders e.g. intellectual disability or disorder, autism, Rhetts’s syndrome, Asperger’s syndrome etc	2.0	2.0
Other mental and behavioural disorders e.g. due to alcohol or psychoactive substances (includes alcoholism, Korsakov’s psychosis), adult personality and behavioural disorders.	3.4	3.4

3.2 The three care domains

This section examines the different levels of care needs that are reported through residents’ ACFI appraisals in the December Quarter 2010. In considering the following, it is important to remember that the ACFI does not consider all of a resident’s care needs. It uses standardised assessments to measure only those care needs that have been identified as contributing the most to differences in the total cost of care.

As Table 7 shows, in the ADL domain the largest single group of residents (in terms both of new appraisals and reappraisals) is the group appraised as having high needs, with 35.5 per cent of new appraisals and 49.1 per cent of reappraisals resulting in a high rating in the ADL domain. A similar pattern occurs within the BEH domain, with 32.8 per cent of new appraisals and 56.7 per cent of reappraisals resulting in a high rating in the BEH domain. By contrast, in the CHC domain, the largest single group of

residents in terms of new appraisals is the group appraised as having medium needs (36.4 per cent), and the largest single group of residents in terms of reappraisals is the group appraised as having low needs (35.4 per cent).

In the ADL and BEH domains, there is a significant shift upwards in the level of appraised care need between new appraisals and reappraisals, with this shift less apparent in the CHC domain. At the higher care end, the percentage of appraisals resulting in a care level of high increases by 23.9 percentage points between new appraisals and reappraisals in the BEH domain, by 13.6 percentage points in the ADL domain and by 9.8 percentage points in the CHC domain. At the lower care end, the percentage of appraisals resulting in a care level below medium in the ADL domain falls from 35.9 per cent for new appraisals to 18.9 per cent for reappraisals. Similarly, in the BEH domain, the percentage of appraisals resulting in a care level below medium falls from 40.4 per cent for new appraisals to 30.1 per cent for reappraisals. In the CHC domain, however, the percentage of appraisals resulting in a care level below medium slightly increases from 39.5 per cent for new appraisals to 40.3 per cent for reappraisals.

Table 7: Distribution of residents within the three ACFI care domains, by type of appraisal

Level of need	ADL domain	BEH domain	CHC domain
New appraisals			
High	35.5%	32.8%	24.1%
Medium	28.5%	26.8%	36.4%
Low	32.6%	26.5%	25.6%
Nil	3.3%	13.9%	13.9%
All	100.0%	100.0%	100.0%
Reappraisals			
High	49.1%	56.7%	33.9%
Medium	32.0%	13.2%	25.8%
Low	17.8%	25.3%	35.4%
Nil	1.1%	4.8%	4.9%
All	100.0%	100.0%	100.0%
All appraisals			
High	43.5%	46.9%	29.9%
Medium	30.6%	18.8%	30.1%
Low	23.9%	25.8%	31.4%
Nil	2.0%	8.5%	8.6%
All	100.0%	100.0%	100.0%

Activities of Daily Living domain

There were five questions in the ACFI that measure relative care needs in the Activities of Daily Living domain. These are in the areas of Nutrition, Mobility, Personal Hygiene, Toileting and Continence. Table 8 indicates the observed distribution of need against each care need. More than half of all appraisals in four of the five ADL questions in the ACFI result in a D rating (the highest possible) for residents. More than two thirds of new appraisals (67.3 per cent) score a D on *ACFI Question 3 – Personal Hygiene*, with this share increasing to 82.5 per cent for reappraisals.

Table 8: Distribution of residents within each ADL area of need, by type of appraisal

<i>Level of need</i>	Nutrition	Mobility	Personal Hygiene	Toileting	Continence
New appraisals					
D (High)	19.1%	43.2%	67.3%	51.9%	56.0%
C (Medium)	37.9%	37.2%	18.3%	11.2%	7.3%
B (Low)	32.5%	12.1%	12.6%	21.6%	6.6%
A (Nil)	10.5%	7.6%	1.8%	15.3%	30.1%
All	100.0%	100.0%	100.0%	100.0%	100.0%
Reappraisals					
D (High)	26.3%	54.8%	82.5%	64.1%	70.5%
C (Medium)	45.2%	34.7%	11.8%	13.0%	6.3%
B (Low)	23.8%	7.1%	4.9%	15.2%	4.9%
A (Nil)	4.8%	3.4%	0.7%	7.8%	18.3%
All	100.0%	100.0%	100.0%	100.0%	100.0%
All appraisals					
D (High)	23.3%	50.0%	76.3%	59.1%	64.6%
C (Medium)	42.2%	35.7%	14.5%	12.3%	6.7%
B (Low)	27.4%	9.1%	8.0%	17.8%	5.6%
A (Nil)	7.1%	5.1%	1.2%	10.8%	23.1%
All	100.0%	100.0%	100.0%	100.0%	100.0%

ACFI Question 1 – Nutrition. This question has two components: Preparing to eat (cutting up or vitimising food); and Eating (placing eating utensils in resident’s hand).

- Preparing to eat – Some 58.5 per cent of residents require one-to-one physical assistance, and 14.3 per cent of residents require supervision.
- Eating – Some 20.7 per cent of residents require one-to-one physical assistance, and 53.6 per cent of residents require supervision while they were eating.

ACFI Question 2 – Mobility. This question has two components: Transfers, such as between bed and a wheel chair, and Locomotion, such as pushing a wheel chair.

- Transfers – Only 22.1 per cent of residents do not require any assistance. Just over a quarter of residents (26.7 per cent) require supervision, a further 32.4 per cent require physical assistance and a further 18.8 per cent require the assistance of mechanical lifting equipment.
- Locomotion – Only 15.2 per cent of residents do not require any assistance. Some 40.9 per cent of residents require supervision and 43.9 per cent of residents require physical assistance.

ACFI Question 3 – Personal Hygiene. This question has three components: Dressing and undressing, Washing and drying, and Grooming.

- Dressing and undressing – More than three quarters of residents (77.4 per cent) require physical assistance, while 15.2 per cent of residents only require supervision and 7.4 per cent of residents do not require any assistance.
- Washing and drying – Some 83.5 per cent of residents require physical assistance, while 11.6 per cent of residents only require supervision and 5.0 per cent of residents do not require any assistance.
- Grooming – Some 70.9 per cent of residents require physical assistance, while 18.0 per cent of residents only require supervision and 11.1 per cent of residents do not require any assistance.

ACFI Question 4 – Toileting. This question relates to the resident's usual day-to-day care needs with regard use of a toilet, commode, urinal or bedpan. It also includes emptying drainage bags of residents who have ostomies and catheters. It has two components: Use of a toilet (setting up to use the toilet) and Toilet completion (the ability to appropriately manage the toileting activity).

- Use of a toilet – More than half of all residents (54.4 per cent) require physical assistance, while 19.8 per cent of residents only require supervision and 25.8 per cent of residents do not require any assistance.
- Toilet completion – More than half of all residents (59.6 per cent) require physical assistance, while 17.5 per cent of residents only require supervision and 22.9 per cent of residents do not require any assistance.

ACFI Question 5 – Continence. This question relates to the resident's usual assessed needs with regard to continence of urine and faeces. Of all residents:

- 64.6 per cent experience either more than four episodes of faecal incontinence per week (including passing faeces during scheduled toileting) or more than three

episodes of urinary incontinence per day (including passing urine during scheduled toileting);

- 6.7 per cent experience either three to four episodes of faecal incontinence per week (including passing faeces during scheduled toileting) or two to three episodes of urinary incontinence per day (including passing urine during scheduled toileting);
- 5.6 per cent experience either one or two episodes of faecal incontinence per week or some urinary incontinence (less than daily); and
- 23.1 per cent experience neither faecal incontinence nor urinary incontinence.

Behaviour Domain

There were five questions in the ACFI that measure relative care needs in the Behaviour domain: Cognitive Skills, Wandering, Verbal Behaviour, Physical Behaviour and Depression. Table 9 indicates the observed distribution of need in these five areas.

Table 9: Distribution of residents within each BEH area of need, by type of appraisal

Level of need	Cognitive Skills	Wandering	Verbal Behaviour	Physical Behaviour	Depression
New appraisals					
D (High)	20.4%	15.3%	38.1%	32.6%	9.9%
C (Medium)	25.0%	4.9%	14.9%	10.0%	10.6%
B (Low)	34.0%	10.1%	19.5%	16.3%	26.3%
A (Nil)	20.6%	69.8%	27.5%	41.0%	53.2%
All	100.0%	100.0%	100.0%	100.0%	100.0%
Reappraisals					
D (High)	31.7%	18.6%	57.4%	48.5%	14.1%
C (Medium)	28.8%	5.8%	15.7%	13.5%	14.0%
B (Low)	26.7%	9.2%	12.9%	13.5%	28.2%
A (Nil)	12.8%	66.5%	13.9%	24.5%	43.8%
All	100.0%	100.0%	100.0%	100.0%	100.0%
All appraisals					
D (High)	27.1%	17.2%	49.5%	42.0%	12.4%
C (Medium)	27.2%	5.4%	15.4%	12.1%	12.6%
B (Low)	29.7%	9.6%	15.6%	14.7%	27.4%
A (Nil)	16.0%	67.8%	19.5%	31.3%	47.7%
All	100.0%	100.0%	100.0%	100.0%	100.0%

ACFI Question 6 – Cognitive skills. Resident's cognitive skills are evenly distributed between the care levels. Some 27.1 per cent of residents have high needs due to impaired cognitive skills (20.4 per cent of new appraisals and 31.7 per cent of reappraisals), while 16.0 per cent have nil/minimal cognitive impairment (20.6 per cent of new appraisals and 12.8 per cent of reappraisals).

ACFI Question 7 – Wandering. This question relates to repeated attempts by a resident to leave the aged care home or to enter any areas within or outside the home where his/her presence is unwelcome or inappropriate –for example kitchens or other persons' rooms, or interfering while wandering in these places. One third of residents (33.5 per cent) wander at least one per week. For 18.6 per cent of residents this behaviour occurs twice a day or more, at least six days a week.

ACFI Question 8 – Verbal Behaviour. This question relates to verbal refusal of care, verbal disruption (not related to an unmet need), paranoid ideation that disturbs others, and verbal sexually inappropriate advances directed at another person, visitor or member of staff. Most residents (80.5 per cent) have some verbal behaviour issues at least once a week. For almost half of all residents (49.5 per cent) this behaviour occurs twice a day or more, at least six days a week.

ACFI Question 9 – Physical Behaviour. This question relates to:

- physical conduct by a resident that is threatening and has the potential to physically harm another person, visitor or member of staff or property (biting, grabbing, striking, kicking, pushing, scratching, spitting, throwing things, sexual advances, chronic substance abuse behaviours);
- socially inappropriate behaviour by a resident that impacts on other residents (inappropriately handling things, inappropriately dressing/ disrobing, inappropriate sexual behaviour, hiding or hoarding, consuming inappropriate substances); and
- a resident being constantly physically agitated (always moving around in seat, getting up and down, inability to sit still, performing repetitious mannerisms).

Most than two-thirds of residents (68.7 per cent) have some physical behaviour issues at least once a week. For many residents (42.0 per cent) this behaviour occurs twice a day or more, at least six days a week.

ACFI Question 9 – Depression. This question relates to symptoms associated with depression and dysthymia (chronic mood disturbance). For all residents:

- 47.7 per cent have minimal or no symptoms of depression;
- 27.4 per cent have symptoms of depression that cause mild interference with their ability to participate in regular activities;

- 12.6 per cent have a diagnosis or provisional diagnosis of depression and have symptoms of depression that cause moderate interference with their ability to function and participate in regular activities; and
- 12.4 per cent have a diagnosis or provisional diagnosis of depression and have symptoms of depression that cause major interference with their ability to function and participate in regular activities.

Complex Health Care Domain

There were two questions in the ACFI that measure relative care needs in the Complex Health Care domain: Medication and Complex Health Care Procedures. Table 10 indicates the observed distribution of need in these areas.

Table 10: Distribution of residents within each CHC area of need, by type of appraisal

Level of need	Medication	Complex Health Care
New appraisals		
D (High)	28.8%	15.7%
C (Medium)	38.7%	21.3%
B (Low)	29.7%	30.0%
A (Nil)	2.8%	33.0%
All	100.0%	100.0%
Reappraisals		
D (High)	43.8%	18.8%
C (Medium)	35.1%	30.2%
B (Low)	19.6%	29.9%
A (Nil)	1.5%	21.2%
All	100.0%	100.0%
All appraisals		
D (High)	37.6%	17.5%
C (Medium)	36.6%	26.6%
B (Low)	23.7%	29.9%
A (Nil)	2.0%	26.0%
All	100.0%	100.0%

ACFI Question 11 – Medication. Very few residents (2.0 per cent) require no or minimal assistance in taking medication. More than a third of residents (37.6 per cent) require assistance for more than 11 minutes per 24 hour period with daily medications, or require daily administration of a subcutaneous or intramuscular or intravenous drug.

ACFI Question 12 – Complex Health Care. Residents’ needs with respect to complex health care procedures are evenly distributed between the care levels. Some 26.0 per cent of residents have no/minimal high complex health care procedure needs, while 17.5 per cent require extensive assistance. Table 11 details the proportion of residents for which specified complex health care procedures were relevant.

Table 11: Proportion of residents for which each complex health care procedure is relevant

Complex Health Care Procedures	Proportion of residents
Blood pressure measurement, at least daily, for diagnosed hyper/hypotension	3.5%
Blood glucose measurement, at least daily, for diagnosed medical condition	6.6%
Pain Management, at least weekly, involving therapeutic massage or application of heat packs, involving at least 20 minutes of staff time in total	22.1%
Complex Pain Management, at least weekly, involving therapeutic massage by an Allied Health Professional or Registered Nurse and/or pain management involving technical equipment specifically designed for pain management, involving at least 20 minutes	7.6%
Complex Pain Management, at least four times per week, involving therapeutic massage by an Allied Health Professional and/or pain management involving technical equipment specifically designed for pain management	3.1%
Complex skin integrity management, at least 4 times per day, for residents with compromised skin integrity who are confined to bed and/or chair, or cannot self ambulate. (The management plan must include repositioning.)	31.8%
Management of special feeding administered by an RN, at least daily, on a one to one basis, for people with severe dysphagia, excluding tube feeding.	0.9%
Administration of suppositories or enemas for bowel management, at least weekly	2.4%
Catheter care program (ongoing); excludes temporary catheter	3.2%
Management of chronic infectious conditions: Antibiotic resistant bacterial infections; Tuberculosis; AIDS and other immune-deficiency conditions; Herpes Zoster; Inf. Hepatitis	1.3%
Management of chronic wounds, varicose and pressure ulcers, and diabetic foot ulcers.	7.1%
Management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and dialysis.	0.1%
Management of oedema, deep vein thrombosis, or arthritic joints or chronic skin conditions by the fitting and removal of compression garments, compression bandages, tubular elasticised support bandages, dry dressings and/or protective bandaging.	13.7%
Oxygen therapy not self managed.	1.9%
Palliative Care Program involving end of life care where ongoing care will involve very intensive clinical nursing and/or complex pain management in the aged care home.	1.3%
Management of ongoing stoma care (excludes temporary stomas and supra pubic catheters)	1.3%
Suctioning airways, tracheostomy care.	0.1%
Management of ongoing tube feeding.	0.9%
Technical equipment for continuous monitoring of vital signs including CPAP (Continuous Positive Airway Pressure) machine.	0.2%

4. Matching funding to care needs

This chapter examines whether the introduction of the Aged Care Funding Instrument (ACFI) has, as intended, provided better support for residents with complex and higher care needs (Section 4.1 – Term of Reference 1(a)), and whether it better recognises the relative care costs of, or has impacted on access for, certain classes of residents including those in the special needs groups specified in the *Aged Care Act 1997* (Section 4.2 – Term of Reference 2(b)).

4.1 Support for residents with complex and higher care needs

A key objective for the introduction of the ACFI was to better match funding to care needs, particularly for residents with high complex health care needs. Submissions to the review generally agreed that the introduction of the ACFI did increase funding for residents with the highest care needs. It was also generally accepted that the ACFI does effectively capture the needs of residents with the highest care needs in terms of placing them into the highest paid ACFI classifications, with a few exceptions – for example, residents receiving enteral feeding or with urinary catheters (see page 71). Some submissions expressed concern that the increase in funding for residents with the highest care needs had not gone far enough, particularly for those with very high needs associated with sub-acute, palliative care or psycho-geriatric conditions (see page 49).

There is strong evidence that the ACFI, as intended, has increased funding for residents with the highest and most complex care needs. As Table 12 shows, more than four in ten residents in December 2010 were eligible for a level of funding that was higher than the maximum that would have been possible if the RCS had continued. On average, the ACFI (without transitional arrangements) would have provided \$153.38 per resident per day to support these residents.¹ This is \$20.49 (13.4 per cent) more per resident per day than the maximum rate that would have been payable if the RCS had continued. When the ACFI is fully implemented, with the removal of transitional caps on maximum subsidy levels on 1 July 2011, the average rate of the basic subsidy payable in respect of

¹ To understand the long term impact of the introduction of the ACFI it is necessary to abstract from the actual ACFI subsidy rates achieved to those rates that would have been payable if none of the transitional arrangements were in place. These effects are complex, for example:

- removing the effect of the ‘cap’ on the maximum rate of the basic subsidy increases the average level of funding delivered by the ACFI; and
- removing the grand-parenting arrangements (the RCS saved rates) reduces the average level of funding delivered by the ACFI.

Under the RCS the maximum subsidy rate would have been \$132.89 in 2010-11, while under the ACFI the maximum subsidy rate in 2010-11 (without the transitional arrangements) would have been \$177.83 – with \$162.89 the maximum rate payable in 2010-11 under the transitional arrangements.

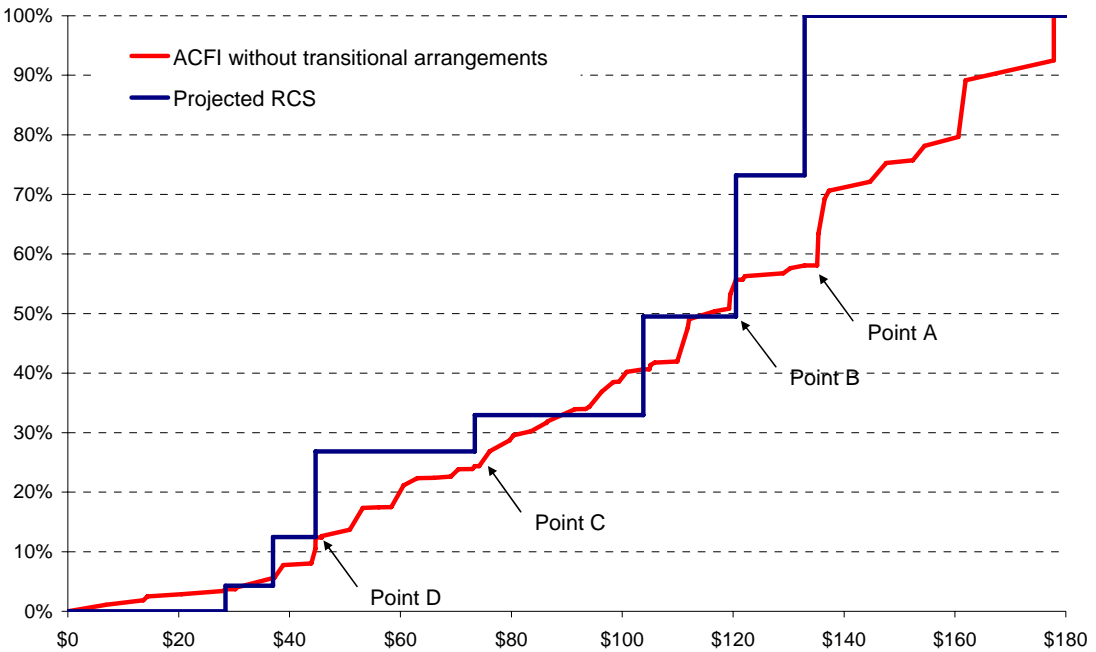
the 10 per cent of residents with the highest assessed care needs is projected, on average, to be \$40.28 per day more than the maximum rate of payment that would have been possible if the RCS had continued – an increase in real terms of 30.3 per cent.

Table 12: Distribution of residents by subsidy bands under the ACFI (without transitional arrangements) (2010-11 prices)

Subsidy Level	\$ range of band	Proportion of residents
Above RCS 1	Greater than \$132.89	41.9%
Above RCS 2 and not greater than RCS 1	\$120.51 to \$132.89	2.4%
Above RCS 3 and not greater than RCS 2	\$103.82 to \$120.50	15.1%
Above RCS 4 and not greater than RCS 3	\$73.39 to \$103.81	16.3%
Above RCS 5 and not greater than RCS 4	\$44.71 to \$73.38	12.0%
Above RCS 6 and not greater than RCS 5	\$37.04 to \$44.70	6.8%
Above RCS 7 and not greater than RCS 6	\$28.45 to \$37.03	1.9%
Above RCS 8 and not greater than RCS 7	\$0.01 to \$28.44	2.6%
No subsidy	\$0.00	1.1%

Figure 2 illustrates these results by comparing the cumulative frequency distribution of subsidy levels payable under the ACFI (without transitional arrangements) to what would have been payable if the RCS had continued.

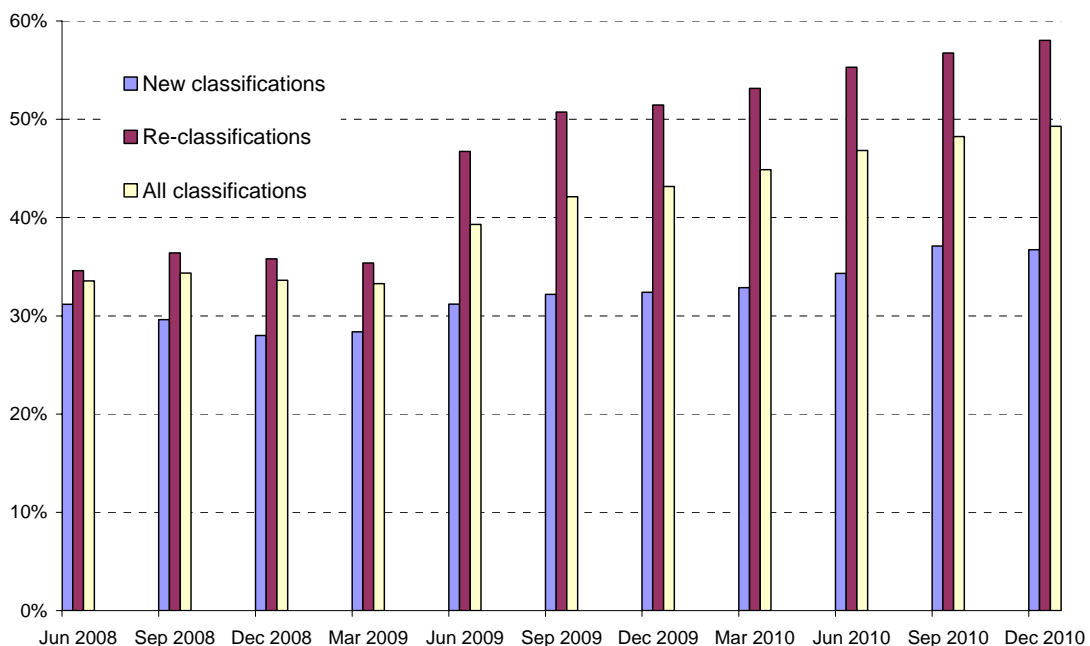
Figure 2: Cumulative frequency distribution of subsidy levels under the ACFI (without transitional arrangements) and under the RCS (if it had continued) (2010-11 prices)



Although the introduction of the ACFI has increased the level of funding available for residents with the most complex care needs it has not significantly altered the proportion of residents funded for less complex care needs. In December 2010, about 50 per cent of residents would have been eligible for a level of subsidy equal to or less than \$120.50 (the RCS 2 level – Point B in the chart) under both arrangements. For the other 50 per cent, the subsidy level for a significant majority would have been higher than would have been possible under the RCS (Point A). Similarly about 25 per cent of residents under both arrangements would have been eligible for a subsidy equal to or less than \$73.38 (the RCS 4 level – Point C) and about 12 per cent of residents (in both cases) would have been eligible for a subsidy equal to or less than \$44.70 (the RCS 5 level – Point D).

In line with the ageing of the population and the increasing acuity of those entering residential aged care, given the greater prevalence of community care options, the percentage of residents who are being classified under the ACFI as being eligible for a level of funding higher than the maximum payable under the RCS is increasing over time (see Figure 3).

Figure 3: Proportion of classifications under the ACFI (without transitional arrangements) that result in a subsidy rate higher than the maximum payable if the RCS had continued



For first classifications, there has been little change in the share of classifications under the ACFI (without transitional arrangements) resulting in a level of funding higher than the maximum RCS rate. For reclassifications there was a substantial increase in this share after the anniversary of the introduction of the ACFI (when almost all RCS classifications would have expired). However, most of this increase is an artefact of the

fact that classifications no longer lapse after one year and so fewer reappraisals are occurring, especially reappraisals that do not result in shift in classification. Since the June Quarter 2009, there has been a shift upwards in the share of residents reclassified under the ACFI as being eligible for a level of funding higher than would have been possible under the RCS, by about 1.9 percentage points a quarter. In the December Quarter 2010, some 58.0 per cent of all reclassifications were to a basic subsidy rate higher than the maximum rate under the RCS.²

Key Finding 1

The ACFI has been largely effective in better matching funding to the care needs of residents and improving support for those with the highest care needs.

4.2 Recognising the relative care costs of certain residents

Although most submissions to the review agreed that the ACFI had been largely effective in better matching funding to the care needs of residents and improving support for those with the highest care needs, some submissions raised concerns that the relative care costs of some classes of residents were not well recognised, including:

- residents with very low care needs;
- residents in rural and remote areas;
- residents who are younger or very old;
- residents from culturally and linguistically diverse backgrounds, including Indigenous residents;
- residents with high sub-acute care needs, including those requiring palliative care (over an extended period) and support from psycho-geriatric health professionals;
- residents who were formerly homeless, particularly those with care needs associated with mental health and alcohol related issues; and
- residents with dementia who have high behavioural needs but low activities of daily living and complex health care dependencies.

In general, these concerns are not supported by an analysis of the available data, which shows that average subsidies have grown in real terms under the ACFI (without transitional arrangements) for all of the identified groups of concern.

² Note this data is not directly comparable to that in Table 12 as that data refers to all residents on a specific date whereas this data refers to all classifications made in a given quarter.

Table 13: Impact of the introduction of the ACFI on the level of basic subsidies paid in respect of residents from selected population groups (2010-11 prices) ³

	Average daily subsidy		Average annual real change
	RCS Feb 2008	ACFI (w/o trans) Dec 2010	
Direct comparison groups			
Residents with low care needs	\$38.18	\$39.83	1.6%
Residents in outer regional and remote areas	\$89.41	\$100.18	4.2%
Younger residents (aged under 65 years)	\$100.36	\$116.89	5.7%
Younger residents (aged under 55 years)	\$106.46	\$122.67	5.3%
Very old residents (aged over 85 years)	\$92.18	\$109.44	6.4%
Residents from CALD backgrounds	\$100.03	\$116.43	5.7%
Residents who identify as Indigenous	\$98.94	\$109.71	3.8%
Indirect comparison groups			
Homes with a large proportion of high behavioural needs	\$112.35	\$130.57	5.6%
Homes catering for non-dementia mental health issues	\$91.41	\$99.86	3.3%
Homes with a high proportion of palliative care claim	\$114.60	\$128.78	4.3%
Homes with a high proportion of high CHC needs	\$123.21	\$150.40	7.5%
Dementia specific homes	\$107.18	\$123.88	5.4%
National Average	\$93.60	\$109.39	5.8%

³ For residents in the first part of Table 13, the Department's payment systems both prior to and after the introduction of the ACFI allow residents in these groups to be directly identified. It is therefore possible to directly compare the subsidy rates payable under the RCS (in February 2008) and the ACFI (without transitional arrangements) (in December 2010) for these residents.

For residents in the second part of Table 13, the Department's payment system prior to the introduction of the ACFI did not include identifiers that allowed residents in these groups to be directly identified. An indirect comparison for these residents has been generated by looking at the results in aged care homes with a significant number of residents with these characteristics in December 2010. Note:

- 'Homes with a large proportion of high behavioural needs' are those where at least half of residents scored a High in the Behaviour domain in December 2010;
- 'Homes catering for non-dementia mental health issues' are those where at least half of residents had a diagnosis of 550B (psychosis), 560 (neuroses), 570 (intellectual disabilities) or 580 (alcohol related) in December 2010;
- 'Homes with a high proportion of palliative care claim' are those where at least 10 per cent of residents required a palliative care program (ACFI Question 12 Item 14) in December 2010;
- 'Homes with a high proportion of high CHC needs' are those where at least half of residents scored a high in the Complex Health Care domain in December 2010; and
- 'Dementia specific homes' are those where at least 90 per cent of residents had a dementia diagnosis in December 2010.

As intended, the highest rate of real growth in the level of the basic subsidy has been for residents with relatively high Complex Health Care Needs, with aged care homes specialising in the care of these residents recording average real annual growth of 7.5 per cent since the introduction of the ACFI.

For very old residents, average subsidies have grown in real terms faster than the average across all residents (at 6.4 per cent per annum), with this result reflecting the higher care needs of these residents and higher rate of growth in funding under the ACFI for those care needs. Average subsidies for residents aged under 65 and for residents from culturally and linguistically diverse backgrounds have grown in real terms at about the same rate as the average across all residents (at 5.7 per cent per annum). Average subsidies for younger residents (aged under 55) have grown in real terms slightly more slowly than the average across all residents (at 5.3 per cent per annum), albeit still at a healthy rate.

The rate of growth in average subsidy rates for residents in outer regional and remote areas, and for Indigenous residents, at 4.2 per cent and 3.7 per cent per annum respectively, has also been below the average achieved across all residents. Again, however, there has been real growth in the average level of these subsidies since the introduction of the ACFI. Similarly, although average real annual growth rates have been lower than the national average in most specialist facilities (at 3.3 per cent, for example, in facilities catering for non-dementia mental health issues) subsidies have grown in real terms in these facilities. Subsidy rates for low care residents have grown in real terms by 1.6 per cent per annum since the introduction of the ACFI, well below the national average growth rate.

Residents with low care needs in outer regional and remote areas

As expected, the introduction of the ACFI has led to some redistribution in funding growth away from lower care needs, including a small increase in the proportion of residents receiving nil care subsidies. This is an intended and expected outcome of the ACFI, which recognises the increased availability of community care options for residents with lower care needs. Nevertheless, concerns about reduced support and access for residents with low-level care needs was a consistent theme in submissions to the review, with a number of submissions calling for additional funding for providers in outer regional and remote communities, particularly those specialising in low-level care. Such concerns were almost exclusively raised in relation to outer regional and remote areas, where it was noted that such providers generally do not have access to a larger pool of prospective residents. While the focus of such concerns tended to be on provider viability (see page 60), some submissions raised the concern that the same range of alternative options is not available in many outer regional and remote areas, notwithstanding the significant expansion in community aged care over recent years. Submissions also raised concerns about equity in funding for residents with very low-

level care needs compared to recipients of Community Aged Care Packages, who also have an ACAT approval for low-level care and may need a comparable level of care.

Greater targeting of funding towards residents with higher care needs and away from residents whose needs primarily relate to social housing is consistent with the objectives of the ACFI. It is a reinforcement of the trend, over the last ten to twenty years, away from the provision of such services through residential care, together with an expansion in community care services to support these care needs.

In order to examine whether the introduction of the ACFI has inadvertently impacted on access in outer regional and remote areas, an analysis was undertaken of trends in occupancy rates across Australia. This analysis shows that any decline in occupancy rates experienced by aged care homes in these areas since the introduction of the ACFI is a continuation of trends that were evident prior to the introduction of the ACFI and in line with the declines in occupancy rates being experienced by aged care homes in major cities and inner regional areas. The analysis also shows that occupancy rates in aged care homes in outer regional and remote areas have been relatively stable since the beginning of 2009.

On balance, there does not appear to be any compelling evidence that the introduction of the ACFI has created any significant access issues for residents with relatively low care needs in outer regional and remote areas. The impact of the introduction of the ACFI on the viability of aged care homes in outer regional and remote areas is discussed in Chapter 5.

Residents requiring sub-acute, psycho-geriatric and palliative care

A number of submissions to the review raised concerns that the ACFI does not provide sufficient recognition for residents with very high and complex health care needs, end of life care needs, or severe mental and behavioural problems. Some submissions argued that the palliative care item in *ACFI Question 12 – Complex Health Care* is too restrictive compared to the RCS. This issue is considered further below (see page 83).

In general, the focus of concerns was not on whether the ACFI provides less funding for these care needs than the RCS but rather that even the highest level of funding under the ACFI is insufficient to meet the needs of the most complex cases that are increasingly being managed in aged care homes. Such concerns predate the ACFI, although it may be that increasing frailty and consumer expectations are increasing pressure on aged care homes to provide higher levels of care. In addition, reforms in the acute, mental health and disability sectors may be contributing to these changes to the residential aged care client group. The Psychogeriatric Care Expert Reference Group of the Ministerial Conference on Ageing, in their submission to the review, suggested that aged care homes have to ‘a large extent taken on the burden of providing care to people with

increasingly complex medical conditions and behavioural disorders who would have previously been cared for in the medical and psychiatric hospital environments'.⁴

Submissions to the review suggested that there are increased consumer expectations for higher levels of palliative care to be provided, to allow residents the choice to die in familiar surrounds and avoid the disruption of being discharged to an acute or specialist palliative care facility. Some submissions suggested that a short-term supplement could be considered as a tool for encouraging aged care homes to provide higher levels of care for residents with higher sub-acute, palliative or psycho-geriatric needs. This idea was raised particularly in relation to palliative care, where it was argued that the need to complete a full re-appraisal of residents to claim additional funding for a short period of time is unnecessarily onerous.

The issue of the adequacy of overall funding for residents with very high and complex health care needs, end of life care needs, or severe mental and behavioural problems is outside the scope of the review. On the narrower issue of whether the ACFI has reduced funding for these groups relative to the RCS, analysis of data on aged care homes with a relative high proportion of challenging behaviours, palliative care and complex health care needs (see Table 13) confirms that the average level of funding for all of these groups has increased in real terms since the introduction of the ACFI.

The issue as to whether the relative needs of these groups are being sufficiently recognised is a more complex issue. There is a general recognition that such needs can only be accommodated so far within the current aged care framework. Aged care is not designed to manage highly complex cases previously managed in the acute sector or in psychiatric institutions. Noting that the ACFI has already led to a significant shift in funding towards residents with higher care needs, any further targeting in funding would need to be carefully balanced against the possible adverse impact on funding for the broader aged care target group. Nevertheless, enabling homes to provide higher levels of care, sometimes for short periods of time, can have important benefits for continuity of care to residents. As such services help reduce pressure in the wider health system, it may be useful to explore improved support from outside the aged care system drawing on recent models that combine Australian Government and state/territory support and recent Australian Government initiatives to improve support for sub-acute and transition care.

In terms of targeting funding for complex health care, it is noteworthy that, under the hospital leave arrangements, aged care homes that discharge residents to hospitals continue to receive the full level of basic subsidy for those residents for up to 29 days,

⁴ Information on the Psychogeriatric Care Expert Reference Group can be found at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-report-psychogeriatric-ref.htm> (accessed on 31 March 2011).

then reducing to 50 per cent from the thirtieth day onwards. Over \$60 million in basic subsidies is paid each year for residents on hospital leave. Given the large increases in the maximum rate of the basic subsidy under the ACFI, there may be a case to consider reducing the level of the basic subsidy that is payable while residents are on leave, to enable higher funding for homes that continue to care for residents with higher care needs. Further examination of such options would need to take account of the need for homes to maintain staffing levels when residents are in hospital.

On balance, these does not appear to be any compelling evidence that the introduction of the ACFI has had an adverse impact on access to care for residents very high and complex health care needs, end of life care needs, or severe mental and behavioural problems. Nevertheless, there would be merit in considering options to increase support for these residents as part of broader options to redistribute funding within the ACFI.

Residents who have been homeless

The impact of the introduction of the ACFI on funding and access to care for people with a history of, or at risk of, homelessness was raised as an important issue in submissions to the review and through the Prime Minister's Council on Homelessness.⁵

Current demographic trends suggest that those aged over 55 and 65 are the fastest growing aged groups in terms of homelessness. There is somewhere in the order of 50 homes nationally who have a high proportion of residents with care needs associated with homelessness, caring for around 2,000 residents, including a smaller group of homes caring for such residents needs exclusively. These homes include a small number of services targeting Indigenous Australians funded through mainstream arrangements that care for residents with similar care needs to those associated with homelessness.

In 2009, the *Aged Care Act 1997* was amended to formally recognise people who are homeless or at high risk of homelessness as a special needs group. Concerns about the capacity of the aged care framework to accommodate the needs of this group are not new and predate the ACFI. However, some providers specialising in caring for this group have suggested that the ACFI is less effective at capturing care needs associated with homelessness such as behaviours relating to non-dementia related mental health and psychiatric disorders, and alcohol and substance abuse.

Available evidence suggests that the impact on this group of homes has been mixed but positive overall. Analysis of the data on homes caring for residents with associated conditions such as psychiatric conditions, drug issues and intellectual disabilities

⁵ Prime Minister's Council on Homelessness (2011) *Communiqué of the Eighth meeting of the Prime Minister's Council on Homelessness* (10-11 February 2011). http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/pm_council_homeless/Pages/communiq ue10-11Feb11.aspx (accessed on 31 March 2011).

suggests growth in funding in line with the national average (5.6 per cent per annum compared to 5.8 per cent per annum nationally). Nevertheless, submissions to the review highlighted that some aged care homes catering for this group of residents are facing issues in transitioning to the ACFI, including a small proportion whose funding has decreased significantly. The issues faced by these homes and the variation in funding outcomes appear to reflect a range of factors. Analysis suggests that the RCS was subject to more variation in claiming patterns for this group and that it was easier to claim funding for some interventions under the RCS, including services that have historically been provided outside the aged care framework such as specialist drug and alcohol counselling, mental health and intensive social support. The residential aged care system has taken on an increasing role in supporting such services, in part reflecting the flexibility inherent in this model.

Despite the positive result for many homes that cater for this population group, funding appears to have been reduced for some care needs. Given the demographic pressures and the very important role this small group of aged care homes play in caring for this extremely vulnerable group, there is a need to explore how to better support this group. A range of potential actions could be considered, including training and advisory support, technical changes to the ACFI and improved access to funding outside the ACFI.

The Prime Minister's Council of Homelessness has suggested that increased subsidies should be considered in light of the additional needs of this group in two areas in particular: mental health and behavioural issues, including drug and alcohol issues, on the one hand, and lack of family and community support, on the other. However, it may not be feasible or appropriate to build greater recognition for social support into the ACFI, noting the increasing focus on care as opposed to social needs in recent policy directions, reflected in the objectives underpinning the ACFI, and that assessing relative needs in this area is subjective and fraught with difficulty. Furthermore, all aged residents are entitled to receive such support as part of the Specified Care and Services that aged care homes are required to provide.

There may be potential for minor technical enhancements to be considered to better capture infrequent but extreme behaviours that tend to be associated with homelessness. However, there are likely to be practical limits to how far the aged care framework can recognise such needs. Preliminary analysis suggests it may be difficult to provide sufficient flexibility to recognise the range of behaviours that may be involved, without creating the potential for higher claims across the wider aged care population. Similar risks would be involved with increased recognition of alcohol and drug issues. Given that concerns about these issues have been largely contained to a small group of highly specialised services, this may not be the most desirable outcome. In any case, noting that there is no evidence that the ACFI has created access problems, the issue appears to be more about funding outcomes and potential viability issues for a small group of highly specialised services, as discussed in the next chapter.

Submissions to the review have also highlighted possible issues around access to specialist mental health and drug and alcohol services in aged care homes. It is noted that the aged care framework is not designed to support provision of these services. While providers are expected to meet the day the day care needs of residents with related conditions and arrange access to specialist health services as required, there is no requirement that they fund these services from aged care fees and subsidies. In general, the expectation has been that aged care residents should be able to access such services through mainstream programs available to other population groups.

However, it is clear that aged care residents can face additional barriers in accessing such services. Notwithstanding recent measures to improve access to primary care including the expanded Aged Care Access Initiative, there would be merit in greater cross-jurisdictional effort to improve access to these services, specifically focused on better meeting the needs of formerly homeless people in aged care homes.

Residents with dementia

A number of submissions to the review raised concerns that the ACFI was not providing sufficient funding for residents with dementia, particularly those with severe behavioural problems and ambulant people with dementia. These included concerns that insufficient weighting is given to dementia-related behaviours in the Behaviour domain.

In addition, a number of submissions to the review raised concerns about the mandated assessment tools for the Behaviour domain, particularly that the Psychogeriatric Assessment Scale for Cognitive Impairment (PAS) is not appropriate for people of culturally and linguistically diverse backgrounds. Submissions also raised concerns that the PAS was difficult to administer and that other tools were available that were quicker, simpler and suitable for a broader cross-section of the resident population. Submissions from the industry also emphasised the difficulties associated with the ACFI requirements to obtain a medical diagnosis of dementia and depression.

Analysis of national data suggests that the ACFI has increased funding for people with dementia overall, although there is a paucity of comparable data under the RCS. Data on dementia specific facilities indicates that they have achieved average real funding increases as a result of the introduction of the ACFI that are broadly consistent with those achieved by other facilities (5.4 per cent average annual real growth compared to 5.8 per cent average annual real growth nationally).

Contrary to the view put forward in some submissions to the review, this positive outcome appears to reflect the high level of recognition of such needs in the Activities of Daily Living (ADL) domain. In December 2010, 48.0 per cent of residents with a dementia diagnosis were achieving a score of High and 31.1 per cent a score of Medium in the ADL domain. It is also noteworthy that 18.9 per cent of residents with a dementia

diagnosis were achieving a score of High and 33.3 per cent a score of Medium in the Complex Health Care domain.

On balance, there does not appear to be any compelling evidence that the introduction of the ACFI has had an adverse impact on access to care for residents with dementia. Nevertheless, in light of the increasing prevalence of dementia and the need to ensuring continuing support for high quality care for this key group within the residential aged care target population, it will important to carefully monitor outcomes in this area, drawing on the improved range of data now being collected under the ACFI. As discussed further in Chapter 5, there would also be merit in further work in exploring other potential measures of cognitive impairment and dementia-related behaviours of concern that may be considered for inclusion under the ACFI.

Key Finding 2

The introduction of the ACFI has not had any significant adverse impact on access to care or funding for residents from any special needs group, with data showing a relatively consistent pattern of funding growth across the range of different population groups. However, there continue to be some residents whose needs can be difficult to accommodate within the aged care framework, including those with very high sub-acute or psycho-geriatric needs and care needs associated with homelessness.

5. Funding outcomes for providers

This chapter examines the distributional impact of the introduction of the Aged Care Funding Instrument (ACFI) on residential aged care providers and on different categories of providers, including providers who specialise in the provision of low-level care and providers in rural and remote areas (Section 5.1). Section 5.2 then examines the impact of the introduction of the ACFI on two specific types of providers that were identified by submission to the review – low care services in outer regional and remote areas, and services that cater for care needs associated with homelessness. Section 5.3 then further examines the effectiveness of the transitional arrangements.

5.1 The impact of the introduction of the ACFI on providers

In February 2008, immediately before the introduction of the ACFI, the average basic subsidy paid to support the care needs of permanent residents was \$88.03 per day (2008-09 prices). By December 2010, it had grown to \$109.70 per day (2010-11 prices). That is, the average basic subsidy across all aged care homes grew by 24.6 per cent over the thirty-four months between February 2008 and December 2010 – an average annual increase of 8.1 per cent. In real terms (constant 2010-11 prices), the average basic subsidy grew by 17.2 per cent over the thirty-four months between February 2008 and December 2010 – an average annual increase of 5.8 per cent.

As Table 14 shows, funding results have varied between providers. Some 84.4 per cent of aged care homes that operated continuously from February 2008 to December 2010 were receiving higher subsidies in real terms at the end of that period than at the start.¹ On average, these homes were receiving \$19.70 more per resident per day in December 2010 than in February 2008 – a real increase of 21.4 per cent. Only 15.6 per cent of homes were receiving lower subsidies (in real terms) in December 2010 than they were receiving in February 2008. On average, these homes were receiving \$6.31 less per resident per day – a real decrease of 6.1 per cent.

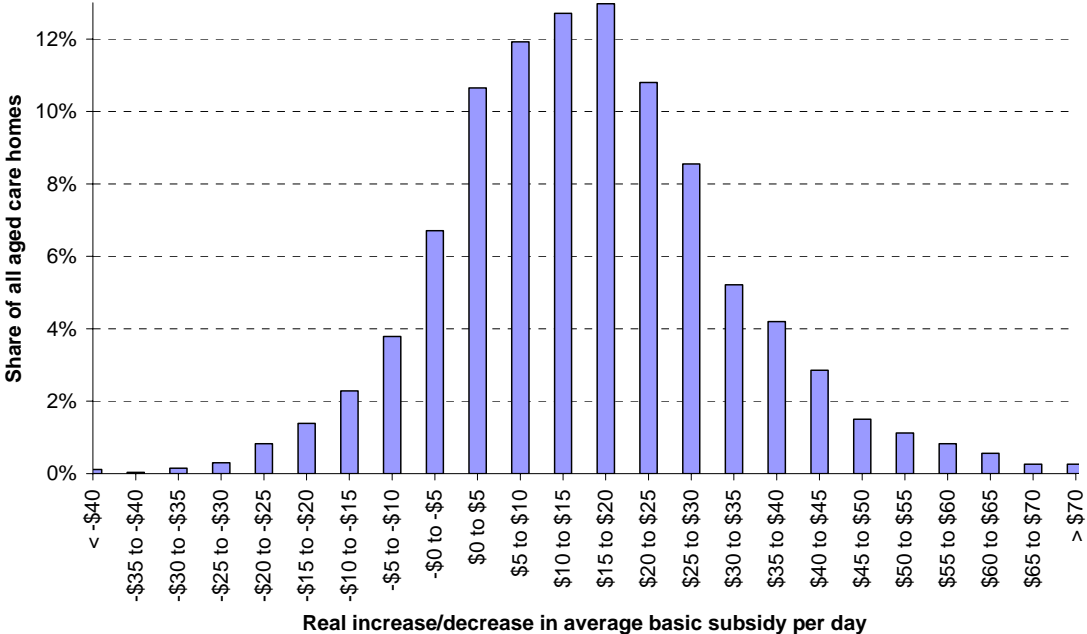
Table 14: Number of aged care homes achieving real funding increases/decreases between February 2008 and December 2010 (2010-11 prices)

	Share of homes	Average Daily Subsidy		Change (\$)	Total Change (%)	Annual Change (%)
		Feb 2008	Dec 2010			
Increase	84.4%	\$92.23	\$111.93	\$19.70	22.4%	7.1%
Decrease	15.6%	\$100.52	\$97.20	-\$6.30	-6.1%	-2.2%
Total	100.0%	\$93.60	\$109.70	\$16.10	17.2%	5.8%

¹ Some 2,667 aged care homes operated continuously from February 2008 to December 2010.

Figure 4 further illustrates the distributional financial impact of the introduction of the ACFI by providing a frequency distribution of the real increase/decrease in the average basic daily care subsidy paid in respect of each home between February 2008 and December 2010 (in constant 2010-11 prices). For 59.1 per cent of aged care homes, the average basic subsidy increased by between \$0.00 and \$25.00 per resident per day, with homes evenly distributed across this band. For a quarter of all aged care homes (25.3 per cent) the average basic subsidy increased by between more than \$25.00 per resident per day. For aged care homes that have experienced a real decrease in the level of the average basic subsidy, some 43.0 per cent experienced a decrease of less than \$5.00 per resident per day.

Figure 4: Distributional financial impact of the introduction of the ACFI (2010-11 prices)



The remainder of this section examines the impact of the introduction of the ACFI on providers of different types. The analysis is undertaken by state or territory in which the aged care home is located; care mix of the aged care home; average basic daily care subsidy level of the aged care home; profit status of the aged care home; degree of remoteness of the aged care home; and size of the aged care home.

Analysis by state or territory

Table 15 analyses the average daily basic subsidy paid to aged care homes by the state or territory in which the home is located. The analysis shows that aged care homes in all states and territories have, on average, benefited from the introduction of the ACFI with the benefit greatest in the ACT and Western Australia and smallest in Tasmania and the Northern Territory. Even in Tasmania, however, average basic subsidies grew by 3.2 per cent per annum in real terms between February 2008 and December 2010,

compared to 5.8 per cent per annum across all aged care homes. Even without the transitional arrangements, average subsidies in Tasmanian aged care homes would have grown by 2.6 per cent per annum in real terms between February 2008 and December 2010, compared to 5.7 per cent per annum across all aged care homes.²

Table 15: Financial impact of the ACFI by state/territory of the aged care home (2010-11 prices)

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
NSW	\$94.34	\$109.75	5.5%	\$109.43	5.4%
Vic	\$92.83	\$110.11	6.2%	\$110.11	6.2%
Qld	\$90.58	\$106.26	5.8%	\$105.31	5.5%
SA	\$100.16	\$116.40	5.4%	\$116.44	5.5%
WA	\$91.32	\$109.72	6.7%	\$109.90	6.8%
Tas	\$95.43	\$104.25	3.2%	\$102.67	2.6%
ACT	\$94.21	\$118.38	8.4%	\$119.28	8.7%
NT	\$93.85	\$107.07	4.8%	\$106.77	4.7%
Total	\$93.60	\$109.70	5.8%	\$109.39	5.7%

Analysis by care mix of the aged care home

Table 16 analyses the average daily basic subsidy paid to aged care homes specialising in the provision of high-level, low-level and mixed-level care.³

For aged care homes that provide mainly high level care, average basic subsidies grew in real terms by 3.5 per cent per annum between February 2008 and December 2010, compared to 5.8 per cent across all aged care homes. If the transitional arrangements had not been in place then average subsidies would have grown in real terms by 3.7 per cent per annum over that period. Interestingly mainly high care homes will benefit slightly from the removal of the transitional arrangements. This is because they have been most impacted upon by the cap on the maximum level of the basic subsidy that was put in place for the first three years of the ACFI.

² These outcomes probably reflect the fact that Tasmania has more very small aged care homes and fewer large high level care homes than is generally the case in other states/territories. Smaller homes have not tended to benefit as much as larger homes, particular those specialising in providing high level care, which have tended to benefit most from the new arrangements.

³ If over 70 per cent of claim days are paid to high or low level care clients then a service is classified as such, otherwise the service is classified as a 'mixed service'.

The term 'other' refers to aged care homes that changed care mix category during the period February 2008 to December 2010.

For aged care homes that provide a mix of high and low level care, average basic subsidies grew in real terms by 3.2 per cent per annum between February 2008 and December 2010. If the transitional arrangements had not been in place then average subsidies would have increased in real terms by 2.2 per cent per annum over that period.

For aged care homes that provide mainly low level care, average basic subsidies grew in real terms by 1.7 per cent per annum between February 2008 and December 2010. However, if the transitional arrangements had not been in place then average subsidies would have decreased in real terms by 1.1 per cent per annum over that period – highlighting the importance of the transitional arrangements for these homes.

The greatest increase in average basic subsidies has occurred in aged care homes that changed their care mix during the period from February 2008 to December 2010. For these homes, average basic subsidies grew in real terms by 9.0 per cent per annum between February 2008 and December 2010. If the transitional arrangements had not been in place then average subsidies would have increased in real terms by 8.7 per cent per annum over that period.

Table 16: Financial impact of the ACFI by care mix of aged care home (2010-11 prices)

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
Mainly high	\$94.34	\$109.75	3.5%	\$131.03	3.7%
Mainly low	\$92.83	\$110.11	1.7%	\$39.96	-1.1%
Mixed	\$90.58	\$106.26	3.2%	\$76.25	2.2%
Other	\$100.16	\$116.40	9.0%	\$95.12	8.7%
Total	\$93.60	\$109.70	5.8%	\$109.39	5.7%

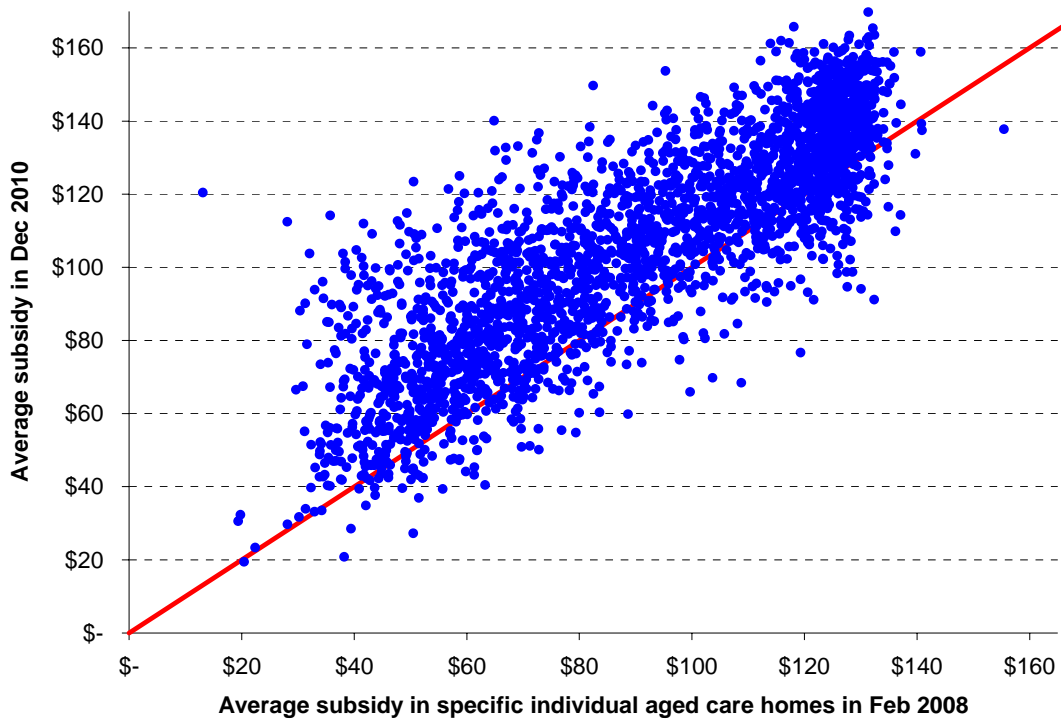
Analysis by income level of the aged care home

Figure 5 illustrates the distributional financial impact of the introduction of the ACFI by plotting, for each aged care home, the average basic subsidy paid in respect of that home in February 2008 against the average subsidy paid in December 2010 (in constant 2010-11 prices).

The red diagonal line represents the status quo (no change in the real level of subsidies over the period). For aged care homes located above the diagonal, the average basic subsidy has increased in real terms since the introduction of the ACFI. Conversely, for homes located below the diagonal, the average basic subsidy has decreased in real terms since the introduction of the ACFI.

Most aged care home, at all funding levels, are located above the diagonal.

Figure 5: Financial impact of the ACFI by level of average basic subsidy (2010-11 prices)



Analysis by profit status of the aged care home

Table 17 analyses the average daily basic subsidy paid to aged care homes by profit status. On average, not-for-profit homes have benefitted slightly more than for-profit homes from the introduction of the ACFI.

Government-run homes have benefitted to a much smaller extent, but have seen a real increase in average basic subsidies.

Table 17: Financial impact of the ACFI by profit status of aged care home (2010-11 prices)

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
For profit	\$105.84	\$122.12	5.2%	\$122.61	5.3%
Not for profit	\$86.91	\$104.12	6.6%	\$103.61	6.4%
Government	\$95.00	\$100.90	2.2%	\$98.61	1.3%
Total	\$93.60	\$109.70	5.8%	\$109.39	5.7%

Analysis by location of aged care home

Table 18 analyses the average daily basic subsidy paid to aged care homes by the degree of remoteness of the home. The analysis shows that aged care homes in all regions have, on average, benefited from the introduction of the ACFI with the benefit greatest in major cities and least in outer regional and remote areas. Even in the latter regions, however, average subsidies have grown by 4.6 per cent per annum since the introduction of the ACFI.

Table 18: Financial impact of the ACFI by remoteness of aged care home (2010-11 prices)

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
Major cities	\$94.90	\$112.28	6.1%	\$112.24	6.1%
Inner regional	\$91.37	\$105.24	5.1%	\$104.52	4.9%
Outer regional & remote	\$89.41	\$101.47	4.6%	\$100.18	4.1%
Total	\$93.60	\$109.70	5.8%	\$109.39	5.7%

Table 19 breaks down this regional analysis by the care type of the aged care home. This analysis confirms that, as expected, low care services in all locations have not benefited as much from the introduction of the ACFI as other services, with low care services in outer regional and remote areas the most disadvantaged.

Table 19: Financial impact of the ACFI by care mix and remoteness (2010-11 prices)

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
High care services					
Major City	\$119.21	\$132.60	3.8%	\$133.40	4.0%
Inner regional	\$115.85	\$125.95	3.0%	\$125.59	2.9%
Outer regional & remote	\$116.81	\$124.65	2.3%	\$123.82	2.1%
All	\$118.31	\$130.59	3.5%	\$131.03	3.7%
Low care services					
Major City	\$41.38	\$44.28	2.4%	\$41.90	0.4%
Inner regional	\$41.26	\$44.09	2.4%	\$40.44	-0.7%
Outer regional & remote	\$40.70	\$39.53	-1.0%	\$34.80	-5.4%
All	\$41.26	\$43.26	1.7%	\$39.96	-1.1%

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
Mixed care services					
Major City	\$72.28	\$80.04	3.7%	\$77.51	2.5%
Inner regional	\$71.44	\$76.47	2.4%	\$75.07	1.8%
Outer regional & remote	\$68.51	\$74.36	2.9%	\$71.74	1.6%
All	\$71.77	\$78.52	3.2%	\$76.25	2.2%
Other services					
Major City	\$74.75	\$97.03	9.6%	\$96.50	9.4%
Inner regional	\$75.58	\$94.03	8.0%	\$93.20	7.7%
Outer regional & remote	\$75.69	\$91.74	7.0%	\$90.49	6.5%
All	\$75.05	\$95.79	9.0%	\$95.12	8.7%
All services					
Major City	\$94.90	\$112.28	6.1%	\$112.24	6.1%
Inner regional	\$91.37	\$105.24	5.1%	\$104.52	4.9%
Outer regional & remote	\$89.41	\$101.47	4.6%	\$100.18	4.1%
All	\$93.60	\$109.70	5.8%	\$109.39	5.7%

Analysis by size of aged care home

Table 20 analyses the average daily basic subsidy paid to aged care homes by size of the home (number of approved places).

Table 20: Financial impact of the ACFI by size of aged care home (2010-11 prices)

Number of beds	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
1-25	\$80.15	\$89.00	3.8%	\$87.17	3.0%
26-50	\$88.61	\$103.95	5.8%	\$103.43	5.6%
51-75	\$93.66	\$109.97	5.8%	\$109.77	5.8%
76-100	\$96.97	\$113.24	5.6%	\$113.20	5.6%
101-150	\$98.37	\$114.49	5.5%	\$114.18	5.4%
151-200	\$95.16	\$113.62	6.5%	\$113.51	6.4%
200+	\$79.74	\$103.20	9.5%	\$102.16	9.1%
Total	\$93.60	\$109.70	5.8%	\$109.39	5.7%

The analysis shows that homes of all sizes have, on average, benefited from the introduction of the ACFI with the benefit greatest in the largest homes. For very small aged care homes (those with 25 or fewer beds) average basic subsidies have grown in real terms by 3.8 per cent per annum since the introduction of the ACFI. Because smaller homes tend to deliver low-level care these homes have also benefited from the transitional arrangements and real growth would have been lower (at 3.0 per cent per annum) without the transitional arrangements.

Very large aged care homes (200 bed or more) have seen average basic subsidies grow in real terms by 9.5 per cent per annum since the introduction of the ACFI. Most of these aged care homes have changed their resident mix since the introduction of the ACFI – with more residents classified as requiring high level care in December 2010 compared to February 2008. In some cases this reflects the reclassification under ACFI of residents with high behaviour needs as requiring high-level care.

Key Finding 3

Average basic subsidies for most aged care homes have increased significantly in real terms since the introduction of the ACFI, reflecting in part the higher acuity of residents to which aged care homes are now able to provide care.

This pattern has been broadly consistent across most categories of aged care home, but with homes specialising in low level care or in outer regional and remote areas not benefiting as much from the introduction of the ACFI as other homes.

5.2 Issues for specific categories of providers

Submissions to the review and consultations with stakeholders identified two specific categories of providers as requiring further analysis, namely aged care homes that provide low level care in outer regional and remote areas and aged care homes that cater for the care needs associated with homelessness.

Low care services in outer regional and remote areas

As expected, low care services in all locations have not benefited as much from the introduction of the ACFI as other services, with low care services in outer regional and remote areas the most disadvantaged. To give some context to this issue, it is important to consider the changes in the resident mix that have occurred under the ACFI, but have been more difficult to make for some providers than others (see Table 21).

A significant number of providers have changed their resident mix since the ACFI has been implemented, mostly to target a more frail population. The shift towards higher care has been greater in major cities, where providers have a larger pool of potential residents to draw from. The results confirm the evidence from submissions to the review that providers in more regional and remote locations have less capacity to

change their resident mix in such a way. These trends are important in understand the funding outcomes for homes by service status and remoteness. They show that the outcomes for low care homes in outer regional and remote areas are largely driven by the greater difficulty such homes have faced in adjusting their resident mix. This suggests that the issue is not with the ACFI but rather with the viability of such services.

On balance, there is a case that additional support should be provided to these aged care homes, especially through a redistribution of the funding growth that has occurred since the introduction of the ACFI.

Table 21: Distribution of changes in resident mix, by initial service mix, by region

	Major City	Inner Regional	Other Regions	Australia
Low at February 2008				
Constant mix	64	31	26	121
Fluctuating mix ⁴	27	11	11	49
Changed mix	158	60	43	261
- Low to Mixed	153	60	39	252
- Low to High	5	0	4	9
% changing mix	63.5%	58.8%	53.8%	60.6%
Mixed at February 2008				
Constant	271	128	62	461
Fluctuating	68	38	24	130
Changed	160	68	38	266
- Mixed to Low	5	10	4	19
- Mixed to High	155	58	34	247
% changing mix	32.1%	29.1%	30.6%	31.0%
High at February 2008				
Constant	818	307	157	1,282
Fluctuating	40	21	9	70
Changed	21	12	14	47
- High to Low	0	0	0	0
- High to Mixed	21	12	14	47
% changing mix	2.4%	3.5%	7.8%	3.4%

⁴ 'Fluctuating mix' means those aged care homes whose service status was the same February 2008 and December 2010 but changed during the period.

'Changed mix' means those aged care homes with a different service status at February 2008 compared to December 2010.

Aged care homes that cater for the homelessness

Submissions to the review also raised concerns about aged care homes that target care needs associated with homelessness. Similar issues were identified for a small number of homes, funded under mainstream arrangements, which target Indigenous Australians. Issues relating to care needs and access were discussed in Chapter 4. As noted there, overall funding for homes with a significant number of residents with diagnoses that tend to be associated with homelessness has grown in line with the national average (5.6 per cent per annum compared to 5.8 per cent per annum nationally).

In light of concerns expressed about the impact of the introduction of the ACFI on some of these homes, a detailed further analysis was undertaken, including of different groups of homes identified using local knowledge through the Department's State and Territory Offices and information collected as part of the annual Aged Care Approval Round.

Table 20 summarises this analysis for the following overlapping categories of homes:

- Type A aged care homes – 16 homes identified in the annual Aged Care Approval Round as targeting needs associated with homelessness, based on data received from services who apply for an allocation of beds and capital funding.
- Type B aged care homes – 33 specialist indigenous services funded through mainstream arrangements, identified primarily based on local knowledge and input from the Department's State and Territory Offices.
- Type C aged care homes – 25 other homes catering for associated care needs, identified based primarily on local knowledge and input from the Department's State and territory Offices, drawing from available data on homes with high rates of residents with associated diagnoses and/or are financially disadvantaged.
- Type D aged care homes – 62 homes where at least 50 per cent of residents have an associated diagnoses of 550B (psychosis), 560 (neurotic), 570 (intellectual disability) or 580 (alcohol).
- Type E aged care homes – 55 homes identified based on limited ACAT data that can be used as a proxy for homelessness, noting that there are limitations that result in the numbers being significant understated. This group consists of the homes that have the highest proportions (between 3-20 per cent) of residents who were living in a public place, temporary shelter, short-term crisis and emergency or transitional accommodation at the time of their ACAT assessment.

Table 22 shows that funding for all groups of homes identified as catering for care needs associated with homelessness, with the exception of the mainstream indigenous services, has grown in real terms at rates broadly comparable with the national average. Total real growth across the group of homes catering for care needs associated with homeless (Types A, B and C) has been around 8.0 per cent per annum, above the national average of 5.8 per cent per annum.

Table 22: Impact of the introduction of the ACFI on services catering for homelessness issues

	RCS	ACFI with transitional arrangements		ACFI without transitional arrangements	
	Feb-08	Dec-10	Real Annual Growth	Dec-10	Real Annual Growth
Type A	\$70.61	\$81.12	5.0%	\$75.64	2.5%
Type B	\$95.64	\$97.14	0.6%	\$95.40	-0.1%
Type C	\$73.79	\$93.02	8.5%	\$91.74	8.0%
Type D	\$91.41	\$103.42	4.5%	\$99.86	3.2%
Type E	\$81.65	\$94.39	5.3%	\$90.85	3.8%
Australia	\$93.60	\$109.70	5.8%	\$109.39	5.7%

However, the data also shows that this result is largely influenced by the transitional arrangements. Without the transitional arrangements, the average annual growth rate across the group of homes catering for care needs associated with homeless (Types A, B and C) would have been 4.0 per cent per annum, which is below the national average of 5.7 per cent per annum – albeit still above the rate of growth that would have occurred if the RCS had been retained. The data also shows inconsistent patterns within the group, with lower growth for those identified as targeting related needs through the ACAR process and those targeting indigenous populations. These groups include those homes that focus most exclusively on residents with care needs related to homelessness and have less flexibility to adjust their resident mix.

It is likely that management issues and familiarity with ACFI are playing a role in these outcomes, particularly for the indigenous services. These issues are being addressed through current government initiatives to improve peer and professional support, including supporting better use of the ACFI. There are likely also similar issues facing the other specialist services. Noting the variation in funding outcomes for this group of homes, it is likely there is some degree of under-claiming. As such, consideration could be given to providing some targeted advisory and business management support to ensure the ACFI is being used properly.

However, based on preliminary work undertaken with some specialist services, these initiatives alone are unlikely to address the problems faced by some homes. Given the recent focus on addressing homelessness and the important role of this small group of homes in providing access for this extremely vulnerable group in the population, there may be a need to consider additional support within the aged care funding arrangements but outside the ACFI for such services. The role of specialist mental health and drug and alcohol programs suggests that part of the answer may involve accessing greater support from outside the aged care systems and better integration with services provided by other jurisdictions and portfolios.

On balance, there is a strong case that additional support should be provided for the small number of homes that target care needs associated with homelessness or that target Indigenous Australians, especially through a redistribution of the funding growth that has occurred since the introduction of the ACFI.

Key Finding 4

A small proportion of homes with less capacity to change their resident mix are facing issues in transitioning to the ACFI, including some low care providers in outer regional and remote areas and a small number of aged care homes targeting care needs associated with homelessness.

5.3 Effectiveness of the transitional arrangements

The average basic subsidy that would have been payable under the ACFI without the transitional arrangements has, until now, always been lower than that which has been payable under the transitional arrangements. That is, the effect of the cap on the maximum level of the ACFI has been more than offset by the additional funding provided through the saved RCS rate provisions. The maximum difference occurred in June 2009, when payment levels under the ACFI were 3.6 per cent higher than they would have been if the transitional arrangements were not in place. The impact of the transitional arrangements has now largely passed through the system. Payment rates under the ACFI in December 2010 were only 0.3 per cent higher than they would have been if the transitional arrangements were not in place.

The transitional arrangements have been of particular importance for aged care homes operating in outer regional and remote areas and for those offering predominantly low level care. For homes in outer regional and remote areas in December 2010, payment levels under the ACFI were still 1.3 per cent higher than they would have been if the transitional arrangements were not in place (compared to 0.3 per cent for all homes). Similarly, for homes offering predominantly low level care in December 2010, payment levels under the ACFI were still 8.3 per cent higher than they would have been if the transitional arrangements were not in place. Subsidy rates in low care homes in outer regional and remote areas are 13.6 per cent higher in December 2010 than they would have been if the transitional arrangements had not been in place.

Key Finding 5

The transitional funding arrangements have ensured higher rates of annual growth in average daily care subsidies for all providers than would otherwise have been the case, and have particularly assisted aged care homes supporting low care residents and aged care homes in outer regional and remote areas.

6. Documentation and administrative arrangements

This chapter examines how effective the introduction of the Aged Care Funding Instrument (ACFI) has been in achieving two of its key objectives, namely whether the ACFI's introduction has reduced:

- documentation requirements on residential aged care providers to justify claims for care funding (Term of Reference 1(b) – see Section 6.1); and
- the level of disagreement between providers' appraisals of resident care needs and the assessment of Departmental Review Officers (Term of Reference 1(c) – see Section 6.2).

6.1 Reducing documentation requirements for providers

Several features of the new funding instrument were specifically designed to reduce the documentation requirements on providers. The number of questions in the instrument was reduced from twenty (under the RCS) to twelve (under the ACFI). The emphasis on extensive documentary evidence to justify claims was replaced with clearer guidance, standardised forms and checklists that draw on existing information as far as possible. The requirement for a mandatory annual reappraisal of every resident was removed, with greater emphasis placed on reappraisals by providers when there is a major change in a resident's care needs. Finally, ACFI classifications (unlike RCS classifications) do not, in general, expire when a resident transfers between aged care homes.

The results of the national trial of the ACFI found the documentation burden for providers was significantly less than it had been under the former RCS arrangements (see page 25). This view was generally supported by submissions to the review, with most submissions positive about the impact of the introduction of the ACFI on documentation, particularly when compared with the former RCS arrangements.

Some submissions to the review suggested that there may be scope to further reduce the documentation burden on providers through ongoing training in the requirements for claims under the ACFI. There were also calls for more regular updates of the *ACFI User Guide*, Frequently Asked Questions and Business Rules and further clarification of those parts that are open to interpretation. Consistent with this view, feedback from Departmental Review Officers suggests that some providers continue to include unnecessary documentation in the *ACFI Answer Appraisal Pack*. It was also argued there greater adoption of information technology would offer opportunities to further reduce the documentation burden – for example, a move towards electronic records – so that more staff resources could be directed towards the provision of direct care.

There is good evidence that the removal of the requirement for mandatory annual reappraisals of residents has reduced the number of reappraisals that providers are

required to undertake. In 2006-07 (the last full year of the RCS) there were 135,008 reappraisals by providers – comprising 67.3 per cent of all provider appraisals. In 2009-10 (the first full year of the ACFI after all RCS classifications had expired) there were 82,704 reappraisals by providers – comprising 59.2 per cent of all provider appraisals. Given that the number of reappraisals had been growing at an average of three per cent per annum over the five years to 2006-07, the number of reappraisals in 2009-10 if the RCS had continued would have been in the order of 147,500 – so that the new arrangements reduced the number of appraisals that providers were required to undertake in 2009-10 by about 64,800 (that is, a 44 per cent reduction).

There is also good evidence that the new arrangement whereby ACFI classifications do not, in general, expire when a care recipient transfers between aged care homes (unlike under the RCS) has also reduced the number of reassessments that approved providers are required to undertake. In 2006-07 (the last full year of the RCS) there were 98.4 appraisals by providers for every 100 admissions to permanent residential care.¹ In 2009-10 (the first full year of the ACFI after all RCS classifications had expired) there were 82 appraisals by providers for every 100 admissions to permanent residential aged care. That is, the ability to transfer classifications meant that the number of first appraisals that providers were required to undertake in 2009-10 was reduced by about 11,300 (that is, a 16.1 per cent reduction).

Key Finding 6

The introduction of the ACFI has reduced the documentation requirements on providers and the number of appraisals that providers are required to undertake.

6.2 Reducing disagreement between appraisals and reviews

In developing the new funding instrument, particular attention was given to reducing the level of ambiguity and subjectivity in what constitutes a valid claim. The national trials that occurred prior to ACFI implementation showed increased levels of agreement between different assessor's appraisals of a resident's care needs (see page 25). More recent evidence is consistent with the positive results that were visible in the national trial. A comparison of statistics for the Classification Review Program over two twelve month periods, one for review activity post the introduction of the ACFI and the other capturing RCS review decisions prior to the introduction of the ACFI show a marked reduction in the level of disagreement between providers and Departmental Review Officers over time.

¹ Although all residents are required to be appraised for funding purposes, a small number of residents are not appraised by providers. In addition, a resident's appraisal cannot be submitted until some time after their admission. This time delay, together with the growth in the residential aged care system, explains why the number of appraisals per 100 admissions is slightly less than 100.

As shown in Table 23, the proportion of reviews by Departmental Review Officers that do not change the classification of a resident – that is, where there is no disagreement between the provider’s appraisal and the findings of the Department Review Officer – has improved significantly from 60 per cent under the former RCS arrangements to 78 per cent under the new ACFI arrangements. Conversely, the downgrade rate has more than halved from 36 per cent under the RCS to 16 per cent under the ACFI. The number of upgrades has increased slightly from 4 per cent under the RCS to 6 per cent under the ACFI.

Table 23: Comparison of the outcomes of review under the RCS and the ACFI

	Unchanged	Upgraded	Downgraded
RCS review statistics from July 2007 to June 2008	60%	4%	36%
ACFI review statistics from July 2009 to June 2010	78%	6%	16%

Table 24 indicates the review outcomes by ACFI Question for all reviews undertaken by Departmental Review Officers in the December Quarter 2010. The data highlights that the highest level of disagreement (at 16 per cent) is in *ACFI Question 12 – Complex Health Care*. By contrast, the highest level of agreement (at 99 per cent) is in *ACFI Question 3 – Personal Hygiene*.

Table 24: ACFI review outcomes by question

Question	Unchanged	Upgraded	Downgraded
01 - Nutrition	96%	1%	3%
02 - Mobility	95%	1%	4%
03 - Personal Hygiene	99%	0%	1%
04 -Toileting	98%	1%	1%
05 - Continence	94%	2%	4%
06 - Cognitive Skills	97%	1%	2%
07 - Wandering	96%	1%	3%
08 - Verbal Behaviour	95%	2%	3%
09 - Physical Behaviour	94%	2%	4%
10 - Depression	94%	2%	5%
11 - Medication	93%	1%	6%
12 - Complex Health Care	84%	2%	14%

The higher downgrade rate for ACFI Question 12 is related to the fact that the CHC domain was the domain where the general philosophy of the ACFI (a move from signature care events to signature care needs) was most difficult to put into practice. The more prescriptive nature and greater emphasis on specific interventions and documentation in the CHC domain, while not altogether surprising, does mean that

there is greater room for disagreement between provider appraisals and the findings of Departmental Review Officers (see discussion in Section 7.1 at page 79).

Submissions to the review also suggested that the level of disagreement between provider appraisals and the findings of Departmental Review Officers had reduced since the introduction of the ACFI. Furthermore, the validation requirements were generally found to be less onerous than previous requirements under the RCS. ACFI validations were reported to take less time and to be less intrusive, with the impact on facility staff being regarded as 'minimal' by comparison with the former arrangements.

A small number of submissions did, however, express some concern about a perceived lack of consistency in the validation process across states and territories. Concerns related to differing interpretations of requirements, either by Departmental Review Officers or aged care staff. The Department has been monitoring this issue and actively liaising with program managers and Departmental Review Officers in state and territory offices to improve national consistency.

On balance, the evidence suggests that the validation arrangements under ACFI are working well and represent a significant improvement over the former arrangements.

Key Finding 7

The introduction of the ACFI has reduced the level of disagreement between Departmental Review Officers and aged care providers with respect to the appraised care needs of residents.

Further developments – e-Validation

Building on the gains that have already been achieved, steps towards desktop validation are now underway and considered to be an important future direction for both the Department and providers. E-validation offers significant potential to further reduce the administrative burden on providers and any disruption to residents and staff, and to further reduce the level of disagreement between Departmental Review Officers and providers with respect to the appraised care needs of residents.

An e-Validation Working Group has been formed that includes industry representation and technical expertise. The Working Group will focus initially on supporting the collection, storage and presentation of electronic ACFI appraisals and supporting documentation, to support the review of electronic documentation on-site at facilities. The Working Group will consider issues such as access to personal computers and the various different software programs in use. In the longer term, it is envisaged that the Working Group will progress work on options for off-site desk top reviews. The longer term aim is to conduct all or part of ACFI reviews with less need to spend time in the aged care home, which can be disruptive for residents and staff.

7. Design issues, including the roles of professionals

This chapter examines gaps and anomalies in relation to the design of the Aged Care Funding Instrument (ACFI) and how well it captures care needs in the three care domains (Section 7.1). It also considers whether the ACFI appropriately recognises the role and scope of practice of various staff, including enrolled nurses and allied health professionals (Section 7.2).

7.1 Design issues

Submissions to the review and consultations helped to identify specific areas where issues with the design of the ACFI are a source of concern to stakeholders and where there may be scope for improvement. Given the technical nature of such issues, extensive consultations on these matters have been undertaken with a reference group of specialist advisers with subject matter expertise in clinical areas and/or stakeholder interests for the aged care industry, consumers and professions. The consistent message from submissions to the review and consultations with the sector is that overall the ACFI is working well and that radical change is not required. However, there are some areas where targeted changes could be considered.

Activities of Daily Living domain

The ADL domain was the domain that generated least concern in submissions to the review. However, drawing on input from the ACFI Technical Reference Group, a few areas have been identified where some enhancements could be considered.

Residents who receive enteral feeding

Concerns were raised in submissions to the review and by the ACFI Industry and ACFI Technical Reference Groups about the operation of the ACFI with respect to residents for whom a claim is made for enteral feeding in the Complex Health Care domain. Where a resident receives all nutrition via the enteral route, the provider has to score the resident's care needs at zero points for *ACFI Question 1 – Nutrition*. For these residents, the maximum ACFI score in the ADL domain is 79.9 points, which is below the threshold for High (88.0 points). These residents cannot therefore obtain an ACFI level above Medium in the ADL domain. As well as limiting the level of funding available to support these residents, this also makes it more difficult to submit a major change reappraisal for these residents as they often cannot be eligible under the exception rule, which only applies if a resident has a High rating in the ADL domain.

It is important to note, however, that enteral feeding does not automatically require that a resident be scored as an A on *ACFI Question 1 - Nutrition*. Where a resident whose primary source of nutrition is enteral feeding is also assisted with daily oral intake (when ordered by a dietician) – including where the resident cannot swallow and the

intake is for ‘oral gratification’ rather than for nutrition – then that resident can score either a B or C on *ACFI Question 1 - Nutrition*, depending on whether they require supervision or physical assistance with readiness to eat as well assistance with eating. Resident whose primary source of nutrition is enteral feeding cannot score a D on *ACFI Question 1 – Nutrition*. It is also not the case, as some in the aged care sector have suggested, that residents whose primary source of nutrition is enteral feeding cannot achieve a rating of High in the ADL domain. However, it is clear that these residents cannot achieve a rating of High in the ADL domain if they are not also assisted with daily oral intake, where that oral intake has been ordered by a dietician.

In December 2010, there were 1,290 residents for whom a claim was made for enteral feeding in the CHC domain (see Table 25 and Table 26). Against *ACFI Question 1 – Nutrition*, some 48.6 per cent of these residents were scored as an A, 3.7 per cent as a B, 11.5 per cent as a C and 33.2 per cent as a D.

Table 25: Distribution across the CHC domain and ACFI Question 1 of residents for whom a claim was made for enteral feeding in the CHC domain

	ACFI Question 1			
CHC domain	A	B	C	D
N	0	0	0	0
L	0	0	0	0
M	28	17	21	25
H	569	70	127	403
All	627	87	148	428

Table 26: Distribution across the ADL and CHC domains of residents for whom a claim was made for enteral feeding in the CHC domain

	ADL domain			
CHC domain	N	L	M	H
N	0	0	0	0
L	0	0	0	0
M	6	19	60	36
H	2	56	641	470
All	8	75	701	506

It is noteworthy that almost all (90.6 per cent) residents for whom a claim was made for enteral feeding in the CHC domain were rated as High in the CHC domain (with 9.4 per cent rated as Medium). At the same time, some 40.2 per cent of these residents were rated as High in the ADL domain (with 54.8 per cent rated as Medium, 4.8 per cent rated as Low and 0.2 per cent rated as Nil).

Evidence as to whether residents with enteral feeding needs were appropriately treated within the ADL domain was mixed. While it was agreed that it is less resource intensive, in general, to feed a resident with a tube than through one-on-one feeding, there was mixed evidence as to whether the overall costs of caring for residents requiring enteral feeding would be likely to be comparable with those not requiring enteral feeding. The ACFI Technical Reference Group also raised concerns that additional recognition of these residents in the ADL domain could create a financial incentive for enteral feeding where this is not clinically necessary or appropriate.

On balance, the case for an increase in the level of support in the ADL domain for residents with enteral feeding needs is not strong, although there would be merit in considering this issue as part of broader options to redistribute funding within the ACFI.

There is clear evidence that *ACFI Question 1 - Nutrition* is not well understood by providers, as 428 residents were scored as D on this question even though the ACFI User Guide specifies that the maximum score for these residents is C. As noted above, there are also clearly some providers who are not aware that they can, in some circumstances, make a claim under *ACFI Question 1 - Nutrition* for residents whose primary source of nutrition is enteral feeding. There is a need for greater clarity around the level of claim against *ACFI Question 1 - Nutrition* that can be made for residents with enteral feeding needs.

With respect to the major change rule, it is noteworthy that almost all residents with enteral feeding needs are already rated as High in the CHC domain. For the small group of residents with enteral feeding needs who are not also assisted with daily oral intake, where a dietician has assessed that such oral intake is not appropriate for the resident, there is a problem in that these residents cannot achieve a rating above Medium in the ADL domain and so cannot move as easily to High in the CHC domain through a major change reappraisal. In December 2010, there were at most 56 of these residents.

On balance, there would be merit in expanding the exception to the major change rule to include residents whose rating in the ADL domain is limited to Medium because they require enteral feeding (where the resident is not also assisted with daily oral intake and a dietician has assessed that such oral intake is not appropriate for the resident) or because they require a urinary catheter.

Residents who have urinary catheters

Similar concerns as those in the previous section were raised in submissions to the review and by the ACFI Industry and ACFI Technical Reference Groups about the operation of the ACFI with respect to residents for whom a claim is made for urinary catheter care in the CHC domain. If residents for whom a claim is made for urinary catheter care are also not incontinent of faeces then their aged care provider has to score the resident's care needs at zero points for *ACFI Question 5 - Continence*. For these residents, the maximum ACFI score in the ADL domain is 82.68 points, which is below

the threshold for High (88.0 points). Again, these residents cannot obtain an ACFI level above Medium in the ADL domain. As well as limiting the level of funding available to support these residents, this also makes it more difficult to submit major change reappraisals for these residents as they cannot be eligible under the exception rule.

In December 2010, there were 1,181 residents for whom a claim was made for urinary catheter care in the CHC domain (see Table 26). Of these residents, some 49.7 per cent were rated as Medium in the ADL domain (with 45.9 per cent rated as Low and 4.4 per cent rated as Nil). However, for residents who were rated as Medium in the ADL domain, some 53.8 per cent were rated as High in the CHC domain and 32.7 per cent were rated as Medium in the CCH domain. In particular, 316 residents for whom a claim was made for urinary catheter care in the CHC domain (26.8 per cent of all such residents) have a Medium rating in the ADL domain and a High rating in the CHC domain, while 316 of these residents (16.3 per cent of residents for whom a claim was made for urinary catheter care in the CHC domain) have a Medium rating in the ADL domain and a Medium rating in the CHC domain.

Table 27: Distribution of residents for whom a claim was made for urinary catheter care in the Complex Health Care domain

CHC domain	ADL domain			
	N	L	M	H
N	3	11	0	0
L	33	234	79	0
M	13	184	192	0
H	3	113	316	0
All	52	542	587	0

Evidence before the review as to whether residents with a need for urinary catheter care were appropriately treated within the ADL domain was mixed. The ACFI Technical Reference Group indicated that there were similar issues relating to possible perverse incentives as for enteral feeding that needed further consideration, but considered that there was a stronger justification for allowing claims in both domains given costs associated with the higher incidence of urinary tract infections for this group.

On balance, it does not appear that a funding increase in the ADL domain is merited for these residents, noting that if there is an issue with urinary tract infections then this is better dealt within the CHC domain. As with enteral feeding, there would be merit in considering this issue as part of broader options to redistribute funding within the ACFI, but the evidence is less compelling given the large proportion of residents with urinary catheters scoring Low in the ADL domain. There would be merit in expanding the exception to the major change rule to include these residents.

Continence Assessment tools

Submissions to the review questioned the usefulness of the current ACFI continence assessment tools and records for toileting and incontinence care. They suggested that the current focus in the tools on frequency and level of assistance required is too narrow and possibly inconsistent with contemporary best practice and international standards.

The Australian Government has funded research to improve the assessment of incontinence with a greater emphasis on holistic care approaches, including a project under the National Continence Management Strategy to review assessment tools currently available and develop a suite of tools for incontinence care in the residential aged care environment. A trial of new incontinence assessment tools was undertaken in numerous aged care facilities with positive results. The new resources developed have wide support within the sector and amongst experts in this field.¹ In the short-term, the new resources developed could be incorporated into the ACFI without significant changes to these questions. In doing so, the implications for Medicare Australia systems would need to be considered.

Submissions to the review did not identify any strong reasons for broader changes to continence items at this time. Given the volume of Departmental work being undertaken to consider best-evidence based practice for incontinence care, it may be premature to make changes to the ACFI that may soon become outdated. Nevertheless, further monitoring and examination is warranted, including the potential to improve alignment with best practice. Even so, it may be difficult to move away from the long-standing focus on frequency and level of assistance, which are still considered to provide useful predictors of relative costs of incontinence management.

Assistance with mobility

Submissions to the review, including consultations with the ACFI Technical Reference Group, raised concerns about the way in which mobility care needs are weighted in *ACFI Question 2 – Mobility*.

Currently, pushing a resident in a wheelchair is considered to be one-to-one physical assistance and therefore attracts the same level of funding as rehabilitating or encouraging a resident to walk, even though it is easier and less time consuming for staff to push a resident in a wheelchair. The ACFI Technical Reference Group was concerned that this arrangement could create incentives for staff to push a resident in a wheelchair rather than supporting them to walk with assistance or supervision. At the same time, the Reference Group emphasised the importance of maintaining adequate support for those wheelchair-bound residents who are unable to walk within the ACFI.

¹ See O’Connell B, Ostaszkiwicz J and Hawkins M (2011) A suite of evidence-based continence assessment tools for residential aged care. *Australasian Journal of Ageing* 30(1) pp.27-32.

It was also suggested that the fitting of lower limb braces and prostheses to enable a person to walk without assistance could be included as one-to-one physical assistance rather than supervision. A parallel was drawn with the fitting of upper limb support devices claimed as one-to-one physical assistance in the Dressing and Undressing section of *ACFI Question 3 – Personal Hygiene*.

On balance, the case for an immediate change in *ACFI Question 2 – Mobility* is not strong, but that there would be merit in considering this issue as part of broader options to redistribute funding within the ACFI.

Behaviour domain

The Behaviour (BEH) domain was developed as a supplement in recognition that certain behavioural conditions can significantly increase the cost of providing care. The ACFI is not designed to capture all care needs associated with behavioural conditions, particularly as some of the care needs related to behavioural conditions are captured in the ADL domain and in the medication management section of the CHC domain. A key aim underpinning development of the BEH Domain was to utilise clearly defined eligibility criteria and diagnoses by medical professionals in order to access higher levels of funding within this domain. As such, this domain incorporates a number of assessment tools selected on the basis of the best available evidence at the time the ACFI was developed. Submissions to the review raised concerns about the BEH domain of the ACFI that related to three key areas, as outlined below.

Assessment tools

The two clinical instruments used by ACFI to assess care needs are the Psycho-geriatric Assessment Scales – Cognitive Impairment Scales (PAS-CIS) to assess cognitive function, and the Cornell Scale for Depression (CSD). Evidence suggests that the use of these validated tools has removed subjectivity from the assessment process and is more reliable in describing the resident's level of functioning, thereby providing an objective score rating in ACFI. Although not intended, it is also suggested that these tools have improved care planning for residents with cognitive impairment and depression.

Submissions to the review were supported by clinical evidence reporting findings of a significantly higher percentage of residents with depression and dementia being treated for depression when the use of the Cornell Scale for Depression was mandated.² Submissions also reported that the introduction of a depression rating instrument, along with measures of behavioural disturbance, has had the desired effect of increasing the awareness of aged care staff to psychiatric and psychological problems in residential aged care facilities. It was highlighted that the inclusion of the new behavioural

² Cohen CI, Hyland K and Kimhy D (2003) The Utility of Mandatory Depression Screening of Dementia Patients in Nursing Homes. *Am J Psychiatry* **160** pp.2012-17.

supplement and associated tools has had a positive impact by way of making aged care staff more aware of the symptoms and signs that may be due to depression. However, some submissions raised a number of issues about the Psycho-geriatric Assessment Scale (PAS) and the Cornell Scale for Depression (CSD). In particular, concerns were expressed about the appropriateness and sensitivity to the needs of people from culturally and linguistically diverse (CALD) backgrounds.³ In December 2010, some 4.4 per cent of all appraisals against the ACFI indicated that it was not possible to use the PAS 'due to cultural or linguistic background'. Of these residents, some 34.1 per cent scored a rating of C and 38.3 per cent scored a rating of D for ACFI Question 6, which respectively indicate 'moderate impairment' or 'severe impairment'.

A number of other tools have become available since ACFI was developed. In light of these developments, there have been calls for flexibility to use a broader range of tools to support ACFI assessments, noting that, from a clinical perspective, there is no single instrument that is suitable in all cases. It was also reported that some staff experience difficulties in using these tools and that there is a need for stronger requirements around training and qualifications of staff using and interpreting these clinical tools.

The most frequently cited alternative tools were the Rowland Universal Dementia Assessment Scale (RUDAS), the Mini Mental State Examination (MMSE) and the Kimberly Indigenous Cognitive Assessment (KICA – Cog). The key rationale provided was that these tools are commonly used by the medical profession and therefore assessments would readily be available and transferable to the ACFI.

The Cornell Scale also attracted some criticism from some stakeholders who suggested other instruments, such as the Geriatric Depression Scale (GDS), may be more suitable on the grounds that they are more widely in use by GPs and across the aged care sector.

The PAS-CIS is the assessment tool required to support an assessment for ACFI question 6 – Cognitive skills. The ACFI User Guide notes that the PAS-CIS may not be suitable for some people of non-English speaking backgrounds, in which case this should be indicated as part of the Cognitive skills assessment summary response.

There is a case for more flexibility in the range of tools that can be used. However, different tools are not directly comparable and need to be mapped against current ACFI tools to determine that scores and categories would produce comparable outcomes in terms of ratings under this domain. In addition, the evidence base for alternative tools needs to be considered. There is significant work underway to achieve greater

³ The ACFI *User Guide* acknowledges that the PAS may not be suitable for some people from CALD backgrounds, in which case this should be indicated as part of the Cognitive Skills Assessment Summary Response to Question 6 of the ACFI. The provider can then use another scaling tool and explain why the PAS was not used; or indicate that a clinical report provides supporting information for the Question 6 of the ACFI; or use the Question 6 checklist as the assessment tool.

consistency in the tools used under the Aged Care Assessment Program. Consideration of tools under the ACFI should be informed by this work, and vice versa, particularly as use of common assessment tools would also help in addressing broader issues around the interface with Aged Care Assessment Teams.

On balance, there would be merit in allowing greater flexibility in the range of cognitive assessment tools that can be used for the ACFI, but only after the alternative tools have been mapped against the current ACFI tools to determine that scores and categories would produce comparable outcomes in terms of ratings in the Behaviour domain.

Targeting of funding to different conditions and level of care need

The issue of how the Behaviour domain was targeted was also raised in submissions to the review. There were diverse views expressed on this matter. Some stakeholders argued that the domain was weighted too heavily in favour of residents with dementia and depression, while others asserted that the domain should better recognise and fund the behaviour-related care needs associated with these conditions. Some submissions raised concerns as to whether the ACFI sufficiently captures the frequency, severity and manifestations of behavioural problems. Other behaviour-related care needs that were identified in submissions as warranting further consideration for funding under the Behaviour domain included psychogeriatric care needs, and the needs of people with intellectual disabilities or with complex mental health problems, noting that in many cases these costs are more appropriately met through mainstream health services.

There is good evidence that the ACFI has already increased funding for residents with significant behavioural needs and challenging behaviours. Therefore, consideration of directing further funding towards extremely challenging behaviours would need to include examination of the impact of diverting funding from other care needs. There may be a case for increasing requirements to qualify for the highest level of Behaviour domain, at the same time as increasing the level of subsidy attaching to that level.

One issue for consideration is whether too much emphasis is placed on depression. The available data indicates that the presence of a single diagnosis of psychoses (550B), or of neuroses (560), or of intellectual and development disorders (570) or of other mental and behavioural disorders (580) increases the likelihood of a resident scoring a High level in the Behaviour domain to between 6.5 and 12.5 times the likelihood without that diagnosis, while the presence of a diagnosis of depression (550A), with no other mental or behavioural diagnosis, only increases the likelihood of a resident scoring a High level in the Behaviour domain to 2.5 times the likelihood without that diagnosis. This tends to indicate that because depression is reasonably widespread and varied in intensity in the aged care population it may not be a reliable predictor of comparative resource costs.

On balance, there is no significant evidence to merit changes in the targeting of the Behaviour domain at this time but there would be merit in considering this issue as part of broader options to redistribute funding within the ACFI.

Complex Health Care domain

Of the three domains, the Complex Health Care (CHC) domain attracted the most criticism with respect to design issues in submissions to the review, particularly the three pain management items in ACFI Question 12 – Complex Health Care: items 12.3, 12.4a and 12.4b. The level of concern generated reflects the relatively prescriptive nature of ACFI Question 12 – Complex Health Care, which has a greater emphasis on specific interventions and the need for documentary evidence on provision of the claimed interventions. For this reason, ACFI Question 12 – Complex Health Care has been described by some in the sector as ‘the RCS of ACFI’. The ACFI was designed as a funding tool and was not intended to prescribe practice or comprehensively cover the full range of interventions needed by particular residents. It was designed to capture major ‘signature events’ that provide a good indicator or predictor of the relative care needs of different residents. In this respect, it represented a significant departure from the previous funding instrument, the RCS. The CHC domain, however, was the domain where this general philosophy was most difficult to put into practice. While to some extent an unintended outcome, the prescriptive nature and greater emphasis on specific interventions and documentation is not altogether surprising. More than any other domain, care costs in the CHC domain tend to be driven by the complexity and frequency of the procedures and the qualifications of health professionals who direct and provide care. The CHC domain was designed to recognise the treatments that drive cost relativities, as identified in the extensive national testing and analysis that occurred prior to ACFI implementation.

In line with this approach, the *ACFI User Guide* includes a list of allied health professionals who may give directives or undertake services that may be claimed in this domain. It was developed in consultation with the sector and health professionals, having regard to current practice at the time with a view to identifying those most likely to be involved in issuing directives for complex health care. The list includes chiropodists, podiatrists, chiropractors, dieticians, osteopaths, physiotherapists, occupational therapists or speech pathologists. Health professionals must be acting within their scope of practice.

Concerns have been raised the design of *ACFI Question 12 – Complex Health Care* could be having an adverse impact on the provision of care to residents. The ACFI was never intended to drive care. In accordance with the *Aged Care Act 1997* and the *Accreditation Standards*, care provided should not be driven by funding but rather by the needs of the residents. It is a legislative requirement that if a resident needs a particular service they should be provided with that service, regardless of whether that service is recognised as a high cost driver under the ACFI. Nevertheless, it does appear from the evidence and submissions considered that the ACFI may be leading to perverse outcomes in some cases, with care practices developed to reflect the best funding option rather than the best care option.

In identifying the high cost drivers and funding specific treatments accordingly, the ACFI can be seen to offer financial incentives to provide such treatments. Providers seeking to maximise income under the ACFI may favour such treatments, even though other treatments may be more appropriate to the resident's care needs or represent better clinical practice in the circumstances. In developing the new instrument, extensive analysis had been conducted to reduce the number of questions and specific treatments were to act like 'proxies' for more complex and high care needs. However, this may be leading to reluctance on the part of providers to provide needed care that is not specifically recognised under the ACFI.

Consideration was given to the potential to redesign the CHC domain to address these issues, possibly by making it more consistent with other domains of ACFI where there is a greater emphasis on assessed needs and evidence-based tools. However, it was not possible to identify alternative assessment tools that would allow greater flexibility while still capturing those needs and treatments that drive costs. Furthermore the general message from submissions to the review and sector more generally is that this domain does not need to be radically overhauled but rather is in need of refinement.

While there is not a case for significant changes at this time, there are some specific areas where enhancements could be considered. These are discussed below.

Pain management

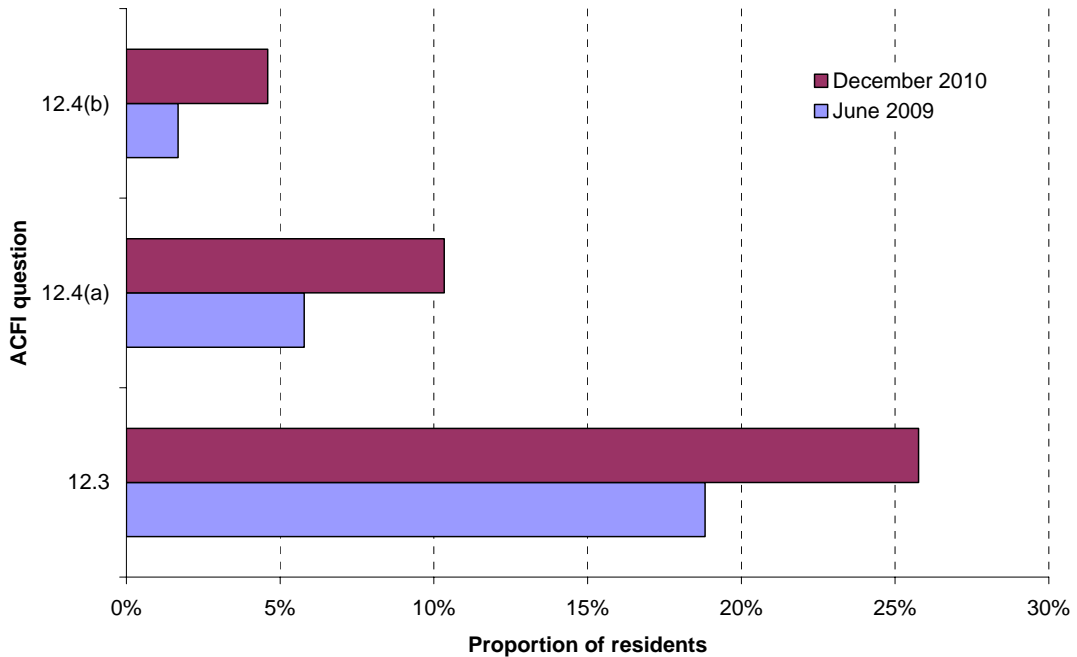
In terms of design limitations, the pain management items in *ACFI Question 12 – Complex Health Care* (Items 12.3, 12.4a and 12.4b) were the most significant area of concern highlighted in submissions to the review and in consultations.

The ACFI effectively differentiates between three levels of intensity in pain management services provided, based on frequency and complexity, taking into account the qualification of the health professionals who provide directives and services:

- Item 12.3: Pain management involving at least 20 minutes of staff time each week, provided by any appropriate health professional, under a directive from a registered nurse (RN), a medical practitioner or listed allied health professional;
- Item 12.4a: Complex pain management involving at least 20 minutes of staff time each week, provided by an RN or listed allied health professional, under a directive from an RN, medical practitioner or listed allied health professional; and
- Item 12.4b: Complex pain management services involving therapeutic massage or technical equipment at least four times each week, provided by a listed allied health professional, under a directive given by a medical practitioner or listed allied health professional.

Figure 6 illustrates the trend in claims for pain managements under the ACFI between June 2009 and December 2010.

Figure 6: Proportion of ACFI appraisals including a claim for pain management



In June 2009, just over a quarter (26.3 per cent) of all ACFI appraisals included a claim for pain management. By December 2010, this proportion had risen to 40.7 per cent. In addition, there had been a shift in the complexity of pain management for which a claim was being made. In June 2009, almost three-quarters (71.6 per cent) of claims for pain management were for the lowest level of pain management (Item 12.3). By December 2010, this proportion had fallen to 63.3 per cent. The proportion of claims for pain management at the middle tier (Item 12.4a) was relatively unchanged (22 per cent in June 2009 and 25.4 per cent in December 2010). Conversely, the proportion of claims for pain management at the top tier (Item 12.4b) almost doubled over the eighteen month period (6.4 per cent in June 2009 and 11.3 per cent in December 2010).

The major concerns with the pain management items raised during the course of the review included concerns that:

- the interventions specified by ACFI, such as therapeutic massage and the application of heat packs, are too narrow and not consistent with contemporary best practice;
- there are other care modalities with better evidence based support that could be included such as exercise, distraction and psychological interventions;
- the list of allied health professionals able to provide directives and particular interventions is too restrictive and should be broadened to include other allied health professionals such as exercise physiologists, diversional therapists, massage therapists and aromatherapists; and

-
- items 4a and 4b for complex pain management place too much emphasis on highly qualified staff not necessarily involved in ongoing care delivery and do not provide sufficient flexibility for other appropriately trained staff such as assistants in nursing and physical therapy assistants to provide services under the supervision of an allied health professional or registered nurse.

These issues were considered in consultation with the ACFI Technical Reference Group. A key area for examination has been whether there is scope for better alignment with contemporary best practice, to reflect changes in practice and professional practice that have occurred since ACFI implementation. Another key consideration has been whether the current items are accurate predictors of relative costs and whether other items warrant further consideration.

There appears to be a clear and unified view that the current items are too prescriptive and that some additional pain management modalities and professionals should be recognised, particularly those that have a preventative or restorative focus, some of which have become more prominent since the ACFI was developed. In doing so, there could be opportunities to link items with new workforce registration arrangements that came into effect from 1 July 2010, bringing together the regulation of ten key health professions under nationally consistent legislation. Another area worth exploring is better recognition of group sessions conducted by allied health professionals, which can provide a useful model, lower in cost than one-to-one care. At the same time, it needs to be recognised that there is a risk that a move to a less prescriptive model that avoids making reference to specific treatments may lead to support being directed to interventions that do not have a strong evidence-base.

Interventions by allied health professionals other than those currently recognised will involve a range of costs, probably broadly comparable with existing professions. Beyond these interventions, submissions to the review did not identify any particular high cost drivers in pain management that are not currently being captured by the ACFI. Indeed, while the specific interventions currently recognised are not necessarily appropriate for all residents requiring complex pain management, the need for such services is still regarded as the best available predictor of relative costs.

A possible approach to keeping items up to date and in line with changes in clinical practice would be through better linkage within the ACFI to independently developed clinical guidelines that list appropriate care procedures, equipment and allied health professionals. In considering the inclusion of other health professionals it will be important to consider whether these health professionals are appropriately trained in assessments and whether assessing the need for pain management services is part of their scope of practice.

On balance, there would be merit in refining the pain management items so as to remove the focus on specific interventions and detailed options should be progressed in

collaboration with the sector and health professionals. In undertaking this work, the focus should remain on identifying high cost drivers rather than prescribing care requirements or best practice. Any changes that have a significant funding impact should occur as part of broader options to redistribute funding within the ACFI.

Palliative care

A number of specific concerns were raised with the review about the restrictiveness of palliative care item (Item 12.14 in *ACFI Question 12 – Complex Health Care*) and its focus on intensive specialist nursing services and end of life care.

Some submissions to the review suggested that the ACFI should not only cater to the ‘end of life’ period but be extended to recognise palliative care approaches over an extended period, and that there should also be greater recognition of the importance of the spiritual or psychosocial care needs and emotional support to their families.

In considering palliative care for aged care residents, it is important to distinguish between a palliative approach, specialised palliative care service provision and end-of-life care. The distinction among these forms of palliative care is important in care planning and clarifying the goals for treatment for residents. The palliative care items were developed with the objective of recognising care needs most likely to involve high cost interventions rather than a range of services many residents would tend to receive at some time in an aged care home. The requirements are therefore highly restrictive, focusing on specialist palliative nursing care, with only 1.5 per cent of residents having a claim against this item in December 2010. This approach is in line with the general approach of the ACFI of capturing ‘signature events’ that drive funding differences.

On balance, there is no compelling evidence to suggest significant changes to the palliative care item in *ACFI Question 12 – Complex Health Care*. However, a number of areas were identified where it may be possible to improve the overall operation of the palliative care item, namely:

- uncertainty around the meaning of ‘end-of-life’;
- whether the ACFI requirements can be better aligned with national guidelines and accepted practice in palliative care, including replacing the requirement for a pain assessment by a more holistic assessment of the signs and symptoms associated with the terminal phase, as not all residents requiring palliative care experience pain;
- whether the nursing qualifications that are recognised as appropriate for a directive are too restrictive; and
- whether the need to undertake a full re-appraisal to claim the palliative care item is too administratively onerous.

There could be merit in including the following explanation of the term ‘end-of-life’ in the *ACFI User Guide*:

For the purposes of claiming the palliative care item in *ACFI Question 12 – Complex Health Care*, ‘end of life’ is where there has been a significant deterioration in the resident’s condition, and there is a reasonable expectation that the resident will die within three months.

This timeframe is consistent with data which suggest that only 12 per cent of people with claims in the palliative care item of *ACFI Question 12 – Complex Health Care* survive for three months from the appraisal time. The average number of days from the time an ACFI with a palliative care item claim is submitted until the time of death is 49 days. It is therefore considered unlikely to significantly affect the number of claims.

With respect to the requirement for a pain assessment, it is noteworthy that the current arrangements already recognise that not all residents requiring palliative care experience pain, as they only require that a pain assessment be undertaken, not that pain be present. Nevertheless, to better reflect symptoms other than pain, there would be merit in adopting a more holistic symptom assessment, replacing the ‘pain assessment’ requirement with the need for ‘assessment of the signs and symptoms associated with the terminal phase’, noting that examples of such an assessment can be found in a number of publications including the *Guidelines for a Palliative Approach in Residential Aged Care*.⁴ The use of specific assessment tools would remain at the discretion of aged care providers. At the same time, reference to these guidelines may elevate their profile, providing nurses with more informed choices when undertaking assessments of need. While it is not the role of ACFI to prescribe better practice, this approach would target funding to higher cost evidence-based interventions.

There would therefore be merit in examining options to replace the ‘pain assessment’ requirement of the palliative care item of *ACFI Question 12 – Complex Health Care* with the need for a more holistic assessment of the signs and symptoms associated with the terminal phase.

There would also be merit in extending the group of health professionals who can provide palliative care directives to include nurse practitioners, if palliative care is within their scope of practice/speciality. This issue is discussed further in Section 7.2, which suggests a more general approach to identifying which individuals have the appropriate qualifications to provide directives throughout the ACFI.

⁴ The Guidelines for a Palliative Approach in Residential Aged Care are evidence-based guidelines developed by the Australian Palliative Residential Aged Care project team and endorsed by the National Health and Medical Research Council (NHMRC) in 2006. Re-endorsement of these guidelines is currently being sought from the NHMRC. The guidelines can be found at (accessed on 31 March 2011): <http://www.nhmrc.gov.au/publications/synopses/ac12to14syn.htm> .

Finally, there would be merit in examining options to allow ‘fast track’ ACFI re-appraisals where a claim against the palliative care item in ACFI *Question 12 – Complex Health Care* would result in a major change claim.

Stoma care and skin management

A number of submissions to the review raised concerns in relation to aspects of stoma care and skin management – in particular concerns that the current arrangements:

- do not accurately reflect the costs associated with the repositioning of ambulant people with dementia (Item 12.5 – Skin integrity management);
- do not sufficiently capture care needs associated with chronic wounds and wound care for acute wounds (Item 12.10 – Management of chronic wounds); and
- include anomalies in the weighting for stoma care relative to other conditions (Item 12.15 – Stoma care).

Some submissions to the review suggested that costs associated with repositioning of ambulant people with dementia may not be sufficiently recognised by the ACFI. These issues were considered in consultation with the ACFI Technical Reference Group. These consultations indicated that, in general, residents with care needs related to skin integrity management can reposition themselves with support. They are also likely to have additional care needs such as dementia and/or mobility, funding of which is provided and recognised in the ACFI. Analysis of the classification data of residents who claimed against Item 12.5 (Skin integrity management) in ACFI *Question 12 – Complex Health Care* supports this conclusion. The data indicates that 78.6 per cent of residents make a claim against this item and that 93.0 per cent of these residents have a rating of D in ACFI *Question 2 – Mobility*.

On balance, the case for greater recognition of costs in this area is not strong.

Some submissions suggested that the cost of providing highly specialised care and dressings is not adequately recognised in the ACFI. Consultations with the ACFI Technical Reference Group on this issue were not definitive. On the one hand, there is no doubt that the costs of some wound products are higher than can reasonably be funded by the ACFI. On the other hand, these more complex products are not necessarily required to be provided without additional cost to the care recipient, as the Specified Care and Services Schedule to the *Quality of Care Principles* only require aged care providers to supply clinically appropriate dressings.

It is noteworthy that the ACFI already allows a score of 6 against item 12.10 (Management of complex wounds), which on its own allows a resident to score a rating of C in that question and thereby at least a Medium level in the CHC domain.

On balance, there does not appear to be a compelling case for changes in the weighting given to the management of chronic wounds in the ACFI at this time.

A number of submissions to the review suggested that the current weighting for stoma care (Item 12.15, 1 point) does not adequately reflect the time and level of care relative to other conditions, such as complex skin integrity management (Item 12.5, 3 points) and management of chronic wounds (Item 12.10, 6 points), noting also the costs of consumables involved.

With respect to the weighting given to Item 12.15 (Stoma care), a careful examination of the ACFI data for all 2,056 residents, whose ACFI classification included a claim against ACFI Item 12.15 in December 2010, shows that of these residents, 44.2 per cent are already classified at the High level in the CHC domain, because of other claims in ACFI Question 12 – Complex Health Care and a further 11.4 per cent are already classified at the Medium level in the CHC domain.

Indeed, increasing the weighting given to stoma care from 1 to 3 points would increase the CHC domain level for only 148 residents, with 146 of these residents moving from the Medium level to the High level.

On balance, there is no significant evidence to merit changes in the weighting given to stoma care in the ACFI at this time but there could be merit in considering this issue as part of broader options to redistribute funding within the ACFI.

With respect to the costs of consumables involved, there is access to support for the costs of consumables used in stoma care through the Stoma Appliance Scheme.⁵ The adequacy of this funding is not within the review's Terms of Reference.

Medication administration

Some submissions to the review raised concerns in relation to the ACFI's treatment of medication administration – namely, that it did not adequately capture a range of activities that arguably should be funded under ACFI such as the time required to alter dose form (i.e. crushing medications) and to supervise the self-administration of medications by residents, such as insulin injections.

In addition, while many in the sector consider time taken to administer medications as a significant cost-driver, the focus on timing can create perverse incentives and is subjective to measure. For this reason, this question can be difficult to validate and is sometimes an area of significant disagreement between an aged care provider's appraisal of a resident's care needs against the ACFI and the view of Departmental Review Officers.

⁵ Information on the Australian Government's Stoma Appliance Scheme can be found at (accessed on 31 March 2011):
<http://www.health.gov.au/internet/main/publishing.nsf/Content/Stoma+Appliance+Scheme-1> .

Whilst recognising the inherent difficulties of the time based requirements, it has not been possible to identify any preferable form of assessment and is of the view that the current method of measurement is the best available indicator of complexity.

The issue of whether the current exclusion of time taken to crush or alter dose form is justifiable was also considered. Altering dose form is not always desirable, and can result in an adverse drug event, for instance where certain medicines are enteric coated and designed to be ‘slow release’ as necessary to reach therapeutic levels, crushing can result in toxic levels of the medication. Some concerns were expressed in submissions to the review that allowing altering of dose form to be included in the time to administer medicines may create incentives to crush medication when it is not necessary.

It is important that residents are encouraged to maintain their independence through self administration of medication. There is a need for staff to observe self administration to ensure that medicines are drawn up safely, to monitor correct self administration of injections, and safely dispose of needles. Some submissions to the review suggested there is a need to include not only residents who self inject medication, but situations where a resident may be able to self administer safely but require supervision e.g. eye drops, puffers and other devices.

While an argument can be made for including altering dose form (crushing) in calculating time taken to administer medications, this is not a high priority and may have quality implications that would need to be considered further. There is a stronger case for including supervision of residents who self medicate, particularly injections of insulin, although further work is needed to model the financial impact of such a change.

On balance, the case for an immediate change in ACFI *Question 11 – Medication Management* is not strong, but there would be merit in considering this as part of broader options to redistribute funding within the ACFI.

Key Finding 8

The design of the ACFI is generally working well in meeting its objectives to match funding to care needs by identifying the significant drivers of relative costs, with some areas where targeted changes could be considered.

7.2 Recognising the role of health professionals

The primary focus of the ACFI is to identify care needs that are correlated to higher cost interventions. It is not intended to, and therefore should not, cover the full range of services and health professionals required to meet the needs of individual residents. At the same time, given the need for flexibility to support a range of interventions and make optimum use of the available workforce, it is important that the ACFI, as far as

possible, recognise the roles of nurses and other health professionals operating within their approved scope of practice.

The ACFI is generally effective in recognising the roles of nurses and health professionals. However, based on submissions to the review and consultations it has identified three areas where there may be a case to better recognise the roles of some health professionals in diagnosing and treating conditions, taking into account their scope of practice:

- the interface with General Practitioners (GPs), including the reliance placed on GPs as part of the ACFI appraisal process and difficulties faced in accessing GPs and diagnoses;
- a perceived lack of recognition of the expanding role and scope of practice of the Enrolled Nurse (EN); and
- a perceived need for greater recognition of allied health professionals and, in particular, a concern that the list included in the ACFI User Guide is too restrictive and inhibits the role of some health professionals.

Examination of these opportunities needs to take account of new workforce registration arrangements introduced from 1 July 2010. Under these changes, ten key health professions are now regulated by national legislation. The ten professions are chiropractors, dentists, medical practitioners, nurses, midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. The new registration scheme requires all health professionals to maintain currency of practice, and to have practised in their profession within the last five years.⁶

In general, there would be merit in removing the specification in the ACFI of particular types of individuals as being eligible to provide certain types of directives or undertake certain types of interventions, and replacing this with a general requirements that directives and interventions be provided by registered health professionals operating within their scope of practice.

Interface with medical practitioners

A common concern expressed in submissions to the review was that the ACFI requires a level of involvement by medical practitioners that is difficult in practice to attain. While the challenge of increasing the level of engagement by GPs in the care of residents is an issue that predates the ACFI, the requirement under the ACFI for a formal medical diagnosis of dementia or depression in order to make a valid claim is problematic for some facilities, particularly where the care recipient may not have an

⁶ These arrangements are governed by the Australian Health Practitioner Registration Agency. See: <http://www.ahpra.gov.au> (accessed on 24 January 2011).

established relationship with a GP in the area. Submissions to the review also expressed concern about reluctance of GPs to diagnose particular conditions, in some cases reflecting difficulty in making the diagnosis and the associated legal and other implications for the resident and their families in having such a diagnosis.

The capacity for other health professionals to diagnose certain conditions under the ACFI was put forward as an option that warrants further consideration. It was argued that in some cases, other health professionals are able to provide diagnoses that are within their scope of practice, for example a nursing diagnosis which provides a standardised statement of health of a client for the purpose of providing nursing care. It is also envisaged that greater flexibility would also make it easier for aged care providers in rural and remote areas where there are greater GP workforce pressures.

The interface with GPs has been one of the most commonly raised issues highlighted in submissions to the review, with broader implications across the ACFI but particularly for the Behaviour domain. Recent Australian Government initiatives to improve access to primary care services for aged care residents will also help address these pressures. In addition, there may be opportunities to explore other innovative approaches to improving access to such services – for example, using Telehealth models.

On balance, there is a case for extending the capacity to diagnose conditions under the ACFI to other registered health professionals, provided they are acting within their scope of practice.

The expanding role and scope of practice of Enrolled Nurses

Some submissions to the review expressed concern about the level of recognition within the ACFI for directives and procedures undertaken by enrolled nurses (ENs). In the context of pressures on availability of registered nurses (RNs), some submissions suggested more claims should be allowed for directives and services provided by ENs working under the supervision of registered nurses.

While ENs have a well documented and vital role in the delivery of nursing care in both community and residential aged care, there are significant differences between RNs and ENs, which have implications for their potential scope of practice within aged care. RNs have completed a minimum of three years tertiary education, which provides a comprehensive grounding in the theory and practice of nursing. RNs have to demonstrate competency in addition to a tertiary education, which enables them to be competent within the full range of the Australian Nursing and Midwifery Council competencies and tertiary information literacy standards. An EN undertakes a 12-18 month course of study at the Certificate IV or Diploma level within the Vocational Education and Training sector. The Australian Nursing and Midwifery Council have developed a set of competencies for ENs which reflects their more limited education relative to that of RNs. In practice, an EN is expected to be supervised by a RN.

Within ACFI, there is recognition that those able to provide a directive for care delivery are RNs, allied health professionals and medical practitioners. This is because it is considered that an EN does not have the breadth of educational preparation necessary to make the clinical decisions required when deciding on a care directive.

On balance, the design of the ACFI reflects the accepted scope of practice of ENs, which generally involves working under the direction of a RN. In individual cases, their role will depend on their education, competence and registration. While it may also be influenced by the environment they practice in, it should not go beyond their accepted scope of practice and education preparation, which generally would not allow them to provide ACFI directives.

There is a risk that identifying ENs as being able to provide directives under ACFI could place ENs in jeopardy of working outside their scope of practice, leading to the risk that may be accused of putting the public at risk, and therefore reportable under the national law, and at risk of possible investigation and loss of their licence to practice. It is recognised that some ENs may have completed post graduate studies, in the area of pain management for example, and may be able to write directives in specific areas but generally they would not be able to write directives relating to broader care management. In addition, even where ENs may be able to write a directive, it is not clear that this would provide a comparable indicator of likely relative care costs as would a directive from an RN. The additional involvement of a RN is considered an indicator of likely higher cost.

There is a need to support greater workforce flexibility, including the capacity to delegate, is an area of continued focus in broader workforce developments with the potential to expand and enrich the roles of ENs and RNs in a range of settings including aged care. The need to monitor developments in this area is recognised. For example, should the scope of practice of ENs change in the future there could be a case for reflecting this in the funding instrument, noting that this would occur automatically if all references to types of health professionals in the ACFI were replaced by a generic 'registered health professionals operating within their scope of practice'.

Recognition of allied health professionals

A recurring theme in submissions to the review was that the ACFI does not provide an incentive to engage the full range of allied health care professionals that may be of benefit to older people with complex needs. There was a perceived lack of support in the ACFI for services such as physiotherapy, occupational therapy and podiatry. Submissions included calls to better recognise and fund therapies in relation to preventative measures, maintenance of physical function and restorative therapy.

As discussed above, these concerns are driven in large part by a misunderstanding of the purpose of the ACFI. In accordance with the *Aged Care Act 1997* and the *Accreditation*

Standards, care provided should not be driven by the funding instrument but rather by the needs of the residents. It is a legislative requirement that if a resident needs a particular service they should be provided with that service, regardless of whether that service is specifically recognised as a high cost driver under the ACFI.

More generally, submissions to the review expressed concerns about the capacity of the residential aged care industry to respond to the widespread shift towards complex and high care needs. Concerns about workforce included perceived lack of skills and training, the increasing reliance on migrant workforce, and how each of these issues may adversely impact on the quality of care received by residents. These issues are beyond the terms of reference of the review but merit further consideration in the context of wider aged care reform.

Key Finding 9

The design of the ACFI properly recognises the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals.

8. Alignment with other elements of aged care

This chapter examines how well the Aged Care Funding Instrument (ACFI) is aligned with the broader aged care regulatory framework, with a particular focus on the level of alignment between approvals for care granted by Aged Care Assessment Teams (ACATs) and appraisals of care needs by residential aged care providers (Section 8.1) and on the requirements for Specified Care and Services in the *Quality of Care Principles 1997* (Section 8.2).

Submissions to the review also highlighted some interface issues with community aged care packages, relating to equity in funding between residents who receive nil or low levels of care funding under the ACFI and recipients of these packages. These funding anomalies have become more pronounced with increased targeting of funding to higher care needs in residential aged care including some growth in the proportion of residents receiving nil care subsidies. These issues are not strictly related to the ACFI. They would be best considered in the development of the Australian Government's response to the Productivity Commission's *Caring for Older Australians* inquiry and in the broader reforms currently underway to create a national aged care system.

8.1 Aged Care Assessment Teams

Alignment issues between ACAT approvals for care and provider appraisals of care needs predate the introduction of the ACFI. However, the introduction of the ACFI has brought these issues into sharper focus. Under the ACFI, as under the former RCS, the classification of a new resident as requiring either high or low level care is based on both the type of approval for residential care granted to them by an ACAT before their admission to care and their provider's appraisal of their care needs under the ACFI, after their admission to care. Whether a resident is classified as requiring high or low level care has implications for the resident and their provider, including eligibility to receive higher daily basic subsidies, the type of accommodation payment that a resident can be asked to pay, and the type of care and services that a resident is eligible to receive at no cost to themselves (see Section 2.3).

Data analysis following the implementation of the ACFI revealed a discontinuity with respect to the definition of high level care, which was also reflected in concerns raised by industry. The analysis showed that the proportion of residents appraised by their provider as requiring high level care upon admission to care increased from 61.5 per cent under the RCS to 71.0 per cent under ACFI in the first year of implementation. The proportion of first admissions whose ACAT approval was limited to low level care but whose care needs were appraised by their provider as requiring high level care more than doubled from 7.7 per cent (under the RCS) to 16.6 per cent (under the ACFI).

In the 2009-10 Budget, the Australian Government announced that it would act to address this unintended outcome by modifying the definition of high and low level care.

A new definition of high level care was developed following extensive discussion with the industry and other stakeholders, consumers, providers and health professionals through the ACFI Technical Reference Group, the ACFI Industry Reference Group and the Ageing Consultative Committee (see page 32).

As shown in Table 28, the available data suggests that the new definition has effectively restored the level of agreement between ACAT approvals and provider appraisals to its historical level, thereby reducing the proportion of residents that default to the Interim Low classification.

Table 28: Distribution of classifications (high level care v low level care) of first admissions into permanent residential care, December Quarter 2007 to December Quarter 2010

	Dec Q 2007	June Q 2008	Dec Q 2009	Mar Q 2010	Dec Q 2010
	RCS	ACFI (old)	ACFI (old)	ACFI (new)	ACFI (new)
High care	53.8%	54.3%	59.6%	54.3%	56.3%
Low care	46.2%	45.7%	40.4%	45.7%	43.7%
'Normal' low	38.5%	29.0%	30.9%	39.3%	37.3%
Interim low	7.7%	16.6%	9.5%	6.4%	6.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

The proportion of new residents classified as requiring high level care reduced from 59.6 per cent to 56.3 per cent between the December Quarter 2009 and the December Quarter 2010, which better aligns with the level under the RCS (53.8 per cent in the December Quarter 2007) given the overall increase in frailty across the residential aged care sector. The proportion of new admissions classified as Interim Low reduced from 9.5 per cent to 6.5 per cent over the same period, compared to 7.7 per cent under the RCS. While the Department will continue to monitor these levels, the results to date are positive, which suggests that the new definition has improved alignment between ACAT approval and provider appraisal outcomes.

Some level of disagreement between ACAT approvals and provider appraisals, historically around 8.0 per cent, is unavoidable given the changes that can occur in a resident's needs between the time of their ACAT assessment (up to twelve months prior to admission) and the subsequent appraisal of their care needs by their provider, after admission. For example, in December 2010, some 18 residents were classified as Interim Low because their ACAT approval for care was limited to low level care but their providers had appraised their care needs as High in each of the three ACFI domains. A further 99 residents were classified as Interim Low even though their providers had appraised their care needs as High in two of the three ACFI domains. In these cases, it seems most likely that the ACAT approval was granted before the catastrophic event that led to admission to residential care. On average, 250 days had

elapsed between ACAT approval and ACFI appraisal for these residents – more than twice the average time between ACAT approval and ACFI appraisal for all residents.

There is some evidence, however, that the number of Interim Low classifications may be able to be reduced further with greater training of ACATs in the definitions of high and low level care under the ACFI. The most common case in which ACATs are likely to restrict a client's approval for care to low level care, when the provider's appraisal will indicate that the care recipient requires high level care, is when the resident scores a High in the Behaviour Domain and has some care needs in one or both of the other ACFI domains. Some 60.0 per cent of all Interim Low classifications relate to such residents. About one in ten residents who are appraised by their provider as Low in the ADL domain, High in the BEH domain and Nil in the CHC domain have an ACAT approval that is limited to low level care, even though their ACFI appraisal indicates that they have high level care needs. In some cases this will be because the residents' care needs have changed since their ACAT approval, but the high degree of disagreement suggests that further training may be useful as ACATs may not be appropriately recognising that such residents should be approved for high level care.

While initial indications are positive that the new definition of high level care has reduced the level of ACAT/ACFI disagreement to rates comparable with historical patterns under the RCS, further enhancements could be considered. In particular, there continue to be concerns about the impact of current Interim Low default subsidy provisions on both aged care providers and on the workload of ACATs. There would be merit in streamlining these arrangements, although this is not a matter of first priority.

Key Finding 10

The new definition of high level care that took effect on 1 January 2010, and the additional training provided to ACATs at that time, has improved agreement between the level of approval for care granted by an ACAT to a resident, before their admission to care, and their provider's appraisal of their care needs under the ACFI, with further improvement possible through additional training.

8.2 Specified Care and Services

The review's Terms of Reference required it to examine the ongoing appropriateness of the Specified Care and Services Schedule to the *Quality of Care Principles 1997* in determining the services to be provided to residents, in the context of the introduction of the ACFI and its new definition of high and low level care. The Specified Care and Services Schedule identifies the care and services that providers must supply to their residents without additional charge if they need them:

- Part 1 of the Schedule specifies the accommodation and hotel services that must be provided to all residents who need them;

- Part 2 of the Schedule specifies the care and services that must be provided to all residents who need them; and
- Part 3 of the Schedule specifies the care and services that must be provided to all residents receiving high level care who need them.

Feedback on this issue was sought from industry and aged care stakeholders, including through the public submission process. In general, the changes to the definition of high level care introduced in January 2010 were seen as having helped to improve the alignment of the ACFI with the Specified Care and Services Schedule in the *Quality of Care Principles 1997*. However, submissions to the review highlighted some concerns with the Specified Care and Services Schedule. In particular, the current requirements have been in place since 1997 and have not been updated to take into account changes in contemporary practice since that time. There was also concern that this dissonance with contemporary practice might potentially encourage poor practice in some areas such as medication management and the use of analgesics. It was also argued that some items, such as those relating to the provision of goods, are ambiguous and confusing, requiring ongoing interpretation and that the Schedule does not clearly define care and services, such as professional assessment and care planning, for people with significant cognitive impairment and behaviours of concern.

The ongoing appropriateness of the Specified Care and Services Schedule is not strictly related to the ACFI and hence not within the ambit of the review. This issue would also be best considered in the development of the Australian Government's response to the Productivity Commission's *Caring for Older Australians* inquiry and in broader reforms currently underway to create a national aged care system.

9. Conclusions and recommendations

In conducting the review of the Aged Care Funding Instrument (ACFI) the Department has consulted widely, drawing on input from submissions to the review and the ACFI Industry and ACFI Technical Reference Groups, and analysed available data. The assistance of the reference groups has been invaluable to the Department and the Department thanks the members of those reference groups for their assistance. The Department also thanks the many individuals and organisation who made submissions to the review.

Overall, the available evidence indicates that ACFI is working well and is generally accepted by the residential aged care sector as representing a significant improvement on the former Resident Classification Scale (RCS). In particular, the ACFI has been effective in directing higher funding to complex needs, reducing the administrative burden for industry and generating higher levels of agreement between aged care staff and Departmental Review Officers on appraised care levels.

While the ACFI is broadly regarded as representing a significant improvement on the RCS in terms of design, there are some areas where technical enhancements could be considered, particularly in the area of pain management. There are also a number of other areas where refinement could be examined as part of ongoing work by the proposed new ACFI Technical Reference Group, including behaviour assessment tools, requirements relating to diagnoses and directives, continence management resources, and enteral feeding and urinary catheter care.

Benefits would also flow from continued work to improve how the ACFI interfaces with other parts of the aged care system and to further improve alignment with Aged Care Assessment Teams (ACATs), as well as the Specified Care and Services framework. Current work to develop a national aged care system, and the Productivity Commission's inquiry *Caring for Older Australians*, will provide further opportunities to improve how the ACFI interfaces with the broader aged care system.

Recommendation 1

The current ACFI Industry Reference Group and the ACFI Technical Reference Group should be disbanded, with ongoing consultation on the ACFI occurring through the Ageing Consultative Committee as required.

Recommendation 2

An ACFI Technical Reference Group, consisting of members with appropriate expertise drawn from aged care providers, employee organisations, health professional bodies and consumer organisations, should be established to assist the Department undertake ongoing work to monitor and explore possible refinements to the ACFI.

Recommendation 3

The ACFI should continue to be used as the basis for allocating basic subsidies to aged care homes, with the following minor amendments:

- 1) *The current exception to the major change rule should be modified to include the following cases where a resident is categorised as Medium in the ADL domain and Medium in the CHC domain:*
 - a) *if a claim has been made for enteral feeding in the CHC domain and the resident is not also assisted with daily oral intake and a dietician has assessed that such oral intake is not appropriate for the resident, then a reappraisal may be submitted at any time to reclassify the resident to High in the CHC domain; and*
 - b) *if the resident is not incontinent of faeces and a claim has been made for urinary catheter care in the CHC domain, then a reappraisal may be submitted at any time to reclassify the resident to High in the CHC domain.*
- 2) *The pain management items in ACFI Question 12 –Complex Health Care should be refined so as to remove the focus on specific interventions and to recognise a broader range of registered health professionals operating within their scope of practice, with detailed options to be developed through the ACFI Technical Reference Group.*

Recommendation 4

The Department, in consultation with the aged care sector through the ACFI Technical Reference Group, should continue to monitor the operation of and explore possible refinements to the ACFI, including:

- 1) *As a first priority:*
 - a) *the use of culturally sensitive behaviour assessment tools;*
 - b) *extending the list of individuals entitled, for ACFI claiming purposes, to make diagnoses, provide directives and undertake interventions to all registered health professionals acting within their scope of practice; and*
 - c) *operationalising new continence management resources.*
- 2) *Over the longer term, issues relating to palliative care, medication administration, stoma care and skin management.*

Recommendation 5

The Department should continue to work in collaboration with the aged care sector and Medicare Australia to develop and implement e-Validation systems.

Recommendation 6

The Department, in consultation with the Ageing Consultative Committee, should continue to carefully monitor expenditure trends under the ACFI, with emphasis on achieving an appropriate balance between:

- *the extent to which overall expenditure growth rates are contained within a sustainable range over the longer term;*
- *the distributional impact of the introduction of the ACFI across providers, including those providers with less capacity to change their resident mix such as providers of low care services in outer regional and remote areas and services targeting care needs associated with homelessness.*

Recommendation 7

As part of the broader reforms of aged care already announced, and that may flow from the Australian Government's response to the Productivity Commission's Caring for Older Australians inquiry, the Department should undertake further work, in consultation with the Ageing Consultative Committee, to enhance the integration of the funding and classification systems with the assessment and quality assurance arrangements, across residential and community aged care.

Appendix A: Terms of Reference of the review

Background

In 2009-10, around 210,000 people will receive subsidised permanent residential aged care, with an average of around 160,000 people receiving care in one of Australia's 2,800 aged care homes each night. The Australian Government will provide almost \$7.1 billion in 2009-10, and more than \$30.9 billion over the next four years, to support the provision of these residential aged care services.

Australian Government funding for the provision of residential aged care is provided through the *Aged Care Act 1997*, with approved providers being paid a number of subsidies and supplements in respect of each eligible resident. The majority of Australian Government funding is provided through the 'basic subsidy' and the level of the basic subsidy payable in respect of a resident is determined by the resident's classification against the Aged Care Funding Instrument (ACFI). This classification also determines whether the resident is classified as requiring high or low level care.

The Department of Health and Ageing classifies each resident into one of 65 ACFI classifications, based on the level of approval for care granted to the resident by an ACAT and on the aged care provider's appraisal of the care needs of the resident against the ACFI. Provider's appraisals of the care needs of a resident are subject to validation by the Department on a risk managed basis.

The ACFI was developed to replace the Resident Classification Scale, which had been in place since 1997, and was introduced on 20 March 2008. The ACFI was intended to more closely match funding to the care needs of residents; reduce documentation; and reduce the level of disagreement between providers' appraisals of the care needs of their residents and the findings of Departmental Review Officers.

The Government announced that a review of the new funding instrument would be undertaken after its implementation to assess its implications for aged care residents and providers and to assess the extent to which its objectives were being achieved.

Scope of the review

- 1) Drawing on existing information and data, and on public submissions, the Department of Health and Ageing will examine the extent to which the new Aged Care Funding Instrument has achieved its objectives of:
 - a) better matching funding to the complex care needs of residents;
 - b) reducing the documentation created by aged care providers to justify funding; and

-
- c) reducing the level of disagreement between providers' appraisals of the care needs of their residents and the findings of Departmental Review Officers.
- 2) The department will also examine the impact of the introduction of the ACFI on:
 - a) the funding levels of aged care providers, and in particular of low care providers and providers in rural and remote areas; and
 - b) access to appropriate care, especially for residents with special needs, including whether the design of the ACFI fails to appropriately recognise the relative costs of meeting the care needs of certain classes of residents.
 - 3) The department will also examine the design of the ACFI to determine whether:
 - a) there are any gaps or anomalies in the ACFI in relation to care needs; and
 - b) the ACFI properly recognises the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals.
 - 4) The department will also examine:
 - a) the appropriateness of Schedule 1 of the *Quality of Care Principles 1997* ('specified care and services') in determining the services to be provided to residents of aged care facilities with differing levels of care needs; and
 - b) options to improve agreement between the level of approval granted to a resident by an ACAT and the aged care provider's appraisal of the care needs of the resident.

Appendix B: Membership of the ACFI Reference Groups

ACFI Industry Reference Group

Organisation	Representative
Chair	
Department of Health and Ageing	Lesley Podesta, First Assistant Secretary
Consumer representatives	
Alzheimer's Australia	Glenn Rees, National Executive Director
COTA Australia	Ian Yates, Chief Executive
Industry representatives	
Aged and Community Services Australia	Greg Mundy, Chief Executive Officer
Aged and Community Services Association	Jill Pretty, Manager, Policy and Consultancy
Aged Care Association Australia	Rod Young, Chief Executive Officer
Aged Care Association Australia	Kay Richards, Manager, Policy & Professional Services
Anglicare Australia	Robin Fuller, Director of Nursing
Baptist Community Services	Ross Low, Chief Executive Officer
Catholic Health Australia	Richard Gray, Director, Aged Care Services
Hall & Prior Residential Health & Aged Care Organisation	Graeme Prior, Chief Executive Officer
Nursing representatives	
Australian Nursing Federation	Lee Thomas Federal Secretary
Royal College of Nursing	Professor Tracey McDonald Professor of Aging (Veterans & Community), School of Nursing, Australian Catholic University
Other representatives	
Aged Care Standards & Accreditation Agency	Mark Brandon, Chief Executive Officer
Gold Age Pty Ltd	Meigan Lefebure, General Manager - Operations
Moving on Audits Pty Ltd	Stephen Midson, Consulting Director
Observers	
Aged and Community Care Officials	Jane Herrington, Victorian Department of Human Services

ACFI Technical Reference Group

Member	Expertise
<i>Chair</i>	
Professor David Cullen	Assistant Secretary Department of Health and Ageing
<i>Members</i>	
Dr Susan Hunt	Senior Clinical Nurse Advisor Department of Health and Ageing
Dr Jeff Rowland	Geriatrician Staff Physician, Prince Charles Hospital, Brisbane President, Australian and New Zealand Society for Geriatric Medicine
Janine Lundie	Aged Care Management Manager, Policy and Consultancy, Aged and Community Services Association NSW/ACT
Kay Richards	Registered Nurse Manager, Policy and Professional Services, Aged Care Association Australia
Tracey McDonald	Registered Nurse Professor of Ageing (Veterans and Community), School of Nursing, Australian Catholic University Chair, Royal College of Nursing Australia Faculty of Health and Wellness in Ageing
Jo Root	Consumer Representative COTA Australia
David Harrison	Physiotherapist Business Manager, Hall and Prior Residential Health and Aged Care Organisation
Pam Bridges	Registered Nurse Residential Care Manager, Aged Care Queensland
Jane Louis	Gerontological Physiotherapist Physiotherapy, Service Manager, Anglican Retirement Villages
Prof. Stephen Gibson	Registered Psychologist (with expertise in pain management) Deputy Director, National Ageing Research Institute Director of Research at the Caulfield Pain Management and Research Centre
Rik Dawson	Gerontological Physiotherapist Director of Agewell Physiotherapy
Prof. Dimity Pond	General Practitioner Researcher with expertise in dementia and depression in the elderly Professor of General Practice, University of Newcastle
Irene Mooney	Registered Nurse Chief Operating Officer, Age Care Services, Bethanie Group WA

Additional experts available to assist with specific issues

Members	Expertise
Kathryn Goozzee	Nurse Practitioner Consultant, Anglican Retirement Villages, NSW
Geoff Sussman	Pharmacist Senior Lecturer, Department of Pharmacy Practice, Monash University, Victoria
Paul Hannan	Pharmacist Senior Consultant Pharmacist, Meditrax, Australia
Dr Louise Welch	General Practitioner Director, Palliative Care Service, Sunshine Coast, Queensland
Prof Henry Brodaty	Psychogeriatrician Professor, Ageing and Mental Health, University of New South Wales Director, Primary Dementia Collaborative Research Centre Director, Aged Care Psychiatry and Head of the Memory Disorders Clinic, Prince of Wales Hospital
John Paul Troiani	Psychologist Central Service Manager, NSW Dementia Behaviour Management Advisory Service
Robin Fuller	Registered Nurse Director of Nursing, Brotherhood of St Laurence, Victoria

Appendix C: List of Submissions

- 1 - Mr Simpson
- 2 - Anonymous Clinical Nurse Aged Care
- 3 - Dr Sukkar
- 4 - Ms Jennings
- 5 - Tabulam and Templer Homes for the Aged Incorporated
- 6 - Aged Care Services Tasmania, North West Representative
- 7 - Chandos Nursing Home
- 8 - Ms Isakson
- 9 - Churches of Christ Care Queensland, Aged Care Division
- 10 - Brotherhood of St Laurence
- 11 - Aged Care Queensland
- 12 - Richardson
- 13 - Confidential
- 14 - Anonymous
- 15 - Blue Mountains - Quality Aged Care Action Group
- 16 - Professor Snowdon - Concord Hospital
- 17 - Blue Care Queensland
- 18 - Pakenham Aged Care
- 19 - Lara Aged Care Dungong
- 20 - Aged Care Association Australia Inc - South Australia
- 21 - Unit Manager Ballarat BHS
- 22 - Ms Marica Psarros - People Point
- 23 - Benetas (Anglican Aged Care Services Group)
- 24 - Mr Hayes
- 25 - Alzheimer's Australia
- 26 - Cobram District Health - Irvin House Nursing Home
- 27 - Southern Health
- 28 - Blue Care Research and Practice
- 29 - Catholic Homes
- 30 - Fairway Hostel
- 31 - Ms Eva Trench-Thiedeman - Occupational Therapist
- 32 - Royal Freemasons Victoria
- 33 - Internal Aromatherapy & Aromatic Medicine Incorporated
- 34 - Mercy Health
- 35 - Ms Reid
- 36 - Wyong Hospital
- 37 - Cooinda Village
- 38 - Fairway Hostel
- 39 - Council on the Ageing - National
- 40 - Bupa Care Services
- 41 - Blue Haven Aged Care Facility
- 42 - West Wimmera Health Service
- 43 - Ms Mooney - The Bethanie Group
- 44 - Southern Cross - South Australia
- 45 - Ms Tatti - Massage Therapist
- 46 - Exercise and Sports Science Australia
- 47 - Fitzroy Street Physiotherapy
- 48 - Southern Cross Care Tasmania Incorporated
- 49 - Ms Nicholls - Registered Nurse
- 50 - Australian Psychological Society
- 51 - Ms Leech
- 52 - NSW Transcultural Aged Care Service
- 53 - NSW Health Department
- 54 - Mr Belcher - The Bethanie Group
- 55 - ECH, Resthaven and Eldercare
- 56 - Aged care Industry Council NSW & ACT
- 57 - Tricare
- 58 - Goulburn Valley Aged Care
- 59 - The Salvation Army Aged Care Plus
- 60 - Aged & Community Services Australia
- 61 - Australian Music Therapy Association
- 62 - Catholic Health Australia
- 63 - Royal College of Nursing
- 64 - Deakin University
- 65 - National Aged Care Alliance
- 66 - Confidential
- 67 - Central Coast ACAT
- 68 - Mecwa Care
- 69 - Professor Draper - Psychogeriatric Care Expert Reference Group
- 70 - Uniting Care Australia
- 71 - Speech Pathology Australia
- 72 - Southern Cross Care Western Australia
- 73 - Palliative Care Australia
- 74 - Anglicare Australia
- 75 - Aged Care Association Australia
- 76 - Ms Ma
- 77 - Ms Meigan Lefebure - Gold Age
- 78 - Young People in Nursing Homes National Alliance
- 79 - Western District Health Service
- 80 - Ms Tonkin
- 81 - Elderly Chinese Home Victoria
- 82 - Victorian Brain Injury Recovery Association Inc
- 83 - Dietician's Association Australia
- 84 - Lyndoch Warrnambool Victoria
- 85 - Australian Physiotherapy Association
- 86 - The Aged Care Rights Service
- 87 - Chaffey Aged Care
- 88 - Helping Hand Aged Care
- 89 - Australian Nursing Federation
- 90 - Health Services Union
- 91 - Ms Lewis - Registered Nurse
- 92 - Quality Aged Care Action Group Inc
- 93 - Yagoona Nursing Home
- 94 - DutchCare Ltd
- 95 - Tasmanian Department of Health and Human Services
- 96 - Peninsula Health
- 97 - Para Hills Private Nursing Home South Australia
- 98 - Minister for Ageing, Government of South Australia

List of Figures

Figure 1: Aged Care Funding Instrument – Details of questions.....	26
Figure 2: Cumulative frequency distribution of subsidy levels under the ACFI (without transitional arrangements) and under the RCS (if it had continued) (2010-11 prices).....	44
Figure 3: Proportion of classifications under the ACFI (without transitional arrangements) that result in a subsidy rate higher than the maximum payable if the RCS had continued	45
Figure 4: Distributional financial impact of the introduction of the ACFI (2010-11 prices).....	56
Figure 5: Financial impact of the ACFI by level of average basic subsidy (2010-11 prices)	59
Figure 6: Proportion of ACFI appraisals including a claim for pain management	81

List of Tables

Table 1: Scores for Question Ratings in the ADL and BEH domains	29
Table 2: Scores for Question Ratings in the CHC domains	29
Table 3: Score cut-points for categories in the ADL, BEH and CHC domains	29
Table 4: Daily ACFI subsidy rates, 2010-11.....	31
Table 5: Principal diagnoses recorded in the ACFI, June 2009 and December 2010	34
Table 6: Mental and behaviour diagnoses recorded in the ACFI, June 2009 and December 2010.....	35
Table 7: Distribution of residents within the three ACFI care domains, by type of appraisal	36
Table 8: Distribution of residents within each ADL area of need, by type of appraisal	37
Table 9: Distribution of residents within each BEH area of need, by type of appraisal.....	39
Table 10: Distribution of residents within each CHC area of need, by type of appraisal	41
Table 11: Proportion of residents for which each complex health care procedure is relevant	42
Table 12: Distribution of residents by subsidy bands under the ACFI (without transitional arrangements) (2010-11 prices).....	44
Table 13: Impact of the introduction of the ACFI on the level of basic subsidies paid in respect of residents from selected population groups (2010-11 prices).....	47
Table 14: Number of aged care homes achieving real funding increases/decreases between February 2008 and December 2010 (2010-11 prices)	55
Table 15: Financial impact of the ACFI by state/territory of the aged care home (2010-11 prices).....	57
Table 16: Financial impact of the ACFI by care mix of aged care home (2010-11 prices)	58
Table 17: Financial impact of the ACFI by profit status of aged care home (2010-11 prices)	59
Table 18: Financial impact of the ACFI by remoteness of aged care home (2010-11 prices)	60
Table 19: Financial impact of the ACFI by care mix and remoteness (2010-11 prices).....	60
Table 20: Financial impact of the ACFI by size of aged care home (2010-11 prices).....	61
Table 21: Distribution of changes in resident mix, by initial service mix, by region.....	63
Table 22: Impact of the introduction of the ACFI on services catering for homelessness issues	65
Table 23: Comparison of the outcomes of review under the RCS and the ACFI.....	69
Table 24: ACFI review outcomes by question.....	69
Table 25: Distribution across the CHC domain and ACFI Question 1 of residents for whom a claim was made for enteral feeding in the CHC domain.....	72
Table 26: Distribution across the ADL and CHC domains of residents for whom a claim was made for enteral feeding in the CHC domain	72
Table 27: Distribution of residents for whom a claim was made for urinary catheter care in the Complex Health Care domain	74
Table 28: Distribution of classifications (high level care v low level care) of first admissions into permanent residential care, December Quarter 2007 to December Quarter 2010.....	93