Western District Health Service

Productivity Commission Submission July 2010

Background

The Western District Health Service, a public health care facility incorporated under the *Health Services Act 1988,* is located in Hamilton, Penshurst , Coleraine and Merino in Western Victoria. The Western District Health Service is the major provider of acute, aged care and community based health services to the Southern Grampians and Glenelg Shires. The catchment area for the Service, in the far western part of Victoria, has a population of 37,000 people, covers an area of 13,000 square kilometres and includes some of the most remote rural locations in Victoria. Distance, remoteness and isolation impact on the service delivery and 'liveability' of the area. Recent demographic data taken from the *Health and Wellbeing Profile – Southern Grampians & Glenelg (DHS September 2009)* paints an overall picture of increasing demand for health services to support an ageing population and the impact of chronic diseases.

Residential Aged Care Services are part of the core business of Western District Health Care. In addition to operating 76 acute beds as the acute referral centre for the Western District of Victoria, our Health Service operates 170 aged care places across six separate aged care facilities (this will be expanded by a further 5 places following the completion of a service expansion in 2012). Western District Health Service also operates 30 CACPs within the catchment region. Our profile is representative of a rural government sector aged care provider co-located with public hospital facilities.

How things are working now:

The key issues that are apparent in the current system relate mainly to the fragmentation of services which strongly impact on the aged care sector including:

- Fragmented care in silos - HACC, Acute Care, CACPs, RAC are all providing aspects of essential care to our ageing population. Linking these care aspects is one of our major challenges – to provide seamless, efficient and effective client centred care across the full spectrum of aged care services
- Fragmented assessment systems – acute, community, and aged care (including ACAS and ACFI) all have their own individual assessment tools. This means an elderly person can be assessed multiple times as he/she moves through the system i.e. from acute to rehab to respite to CACPs and finally RAC.
  The Aged Care Assessment Team (ACAT) currently completes an assessment that determines whether a person requires high or low level care, however, the criteria used to measure this is very different to an ACFI assessment. It is possible to have a person recommended for high level permanent care by ACAT and be only a low level on ACFI funding. This has a huge impact on revenue and has forced the Western District Health Service to do an informal ACFI assessment on all prospective residents before they are accepted into care. Without this

measure, the facility could be filled with people that require a high level of care but at the same time do not generate enough revenue to sustain that level of care.
For example: Mr. Smith has been deemed high level on his ACAT record because he requires supervision with mobility, toileting, can't cook for himself and is very unsteady in the shower. These requirements require staff to be available to meet these needs but he would probably only manage a low ACFI assessment and therefore minimal revenue. However, if you added insulin dependent diabetes, incontinence and behavioural problems to the scenario, his ACAT would remain high but more importantly his ACFI would be higher. It seems there needs to be more layers in the ACAS assessment that are relative to ACFI, or even better, maybe ACAS could use ACFI as their assessment framework, then we would all be comparing apples with apples!

- Fragmented quality systems ACHS, Aged Care, HACC, CACPs Quality reporting – this is of particular issue to an public sector aged care facility co-located and managed by an acute hospital and subject to multiple accreditation requirements.
- Fragmented regulatory requirements – in particular this relates to the specific Commonwealth requirements outlined in Aged Care legislation and the extensive statutory and regulatory requirements under the Health Services Act (Vic) as a public health care facility.
- Fragmented and inadequate funding – the aged care industry is still struggling to be sustainable in the long term under the new ACFI funding system

Future directions for aged care should investigate the possibilities and benefits of having 'one program, one funding body and one regulator.

Specific issues with the new ACFI funding tool

Staff in our aged care facilities have identified several areas where the new ACFI funding tool does not handle classification of care needs well (these issues were highlighted to our submission to the ACFI Review):

- Toileting
  Emptying of drainage bags should be classified as physical assistance not supervision
- Continence
  Requires evidence of incontinence to claim scheduled toileting where sometimes toileting is introduced to prevent incontinence.
  Staff feel the Continence Chart is not user friendly – too small an area to write in the date. The codes used for urinary (1-4) and bowel (5-7) should be separated on the form as staff get confused as to which code to use for bladder and bowel assessment.
  No documentation of Bowel Management Plan and no acknowledgement for time spent in monitoring bowel regularity, regime of aperients and effort to ensure a bowel action, including getting resident to the toilet at desired time to help induce bowel action and reduce constipation. ACFI only seems interested in whether the

patient is continent or incontinent.

- Cognitive skills
  The PAS score does not always reflect resident's cognition, for instance, residents do half the assessment and then become tired or annoyed and do not want to answer any more.

- Behaviour
  The documentation and classification of behaviours under ACFI is far too rigid/restrictive. Many of our residents have behaviour which require extensive staff intervention but 'do not fit the ACFI list'. i.e. where can you claim 'danger to self'. Under the RCS tool, there was an 'Other Behaviour' category which accommodated all the things that weren't included elsewhere. The ACFI tool has no 'Other Behaviour' category.

  Under ACFI we claim when behaviours occur, but if all interventions are in place and effective then there are no behaviours and therefore nothing to claim, despite time and effort spent on implementing intervention strategies.

  Behaviour charts do not allow for writing interventions and so staff have to write in progress notes to achieve an effective evaluation of a resident's behaviour.

  There is no claim for falls under ACFI, where under the RCS tool you could look at a history of falls and documented Falls Risk Assessments.

  Similarly, there is no provision for claiming for diversional therapy to assist in behaviour management

  When completing the checklist for behaviours there is a big jump between item B and C (from occurring once per week to occurring 6 days per week).

- Family consultations
  Under ACFI there is no avenue to claim time spent on family consultations, providing relatives/carers with emotional support, information, encouragement, explanation, reassurance etc. This element could be documented under the RCS.

- Depression
  The transition of a resident into permanent care can be associated with symptoms of depression and the GPs will not always give a diagnosis of depression in these circumstances.

- Medication
  Recording of medication under ACFI does not allow for preparation time which in some instances is quite time consuming

- Complex Health Care
  Complex Health Care procedures allowable under ACFI need further clarification, for example "what is meant by therapeutic massage for complex pain management".

  Under the Special Feeding category, the service cannot claim for care provision if An enrolled nurse does the feeds. ACFI states that a registered nurse must do the feeding. In our Aged Care Facilities, enrolled nurses do all the special feeding under instruction of the speech pathologist and registered nurse.

Whilst overall the ACFI is less time consuming than the old RCS, it is a 'stand alone' tool that does not give any detail towards the resident's care plans. Hence staff have to complete two lots of documentation to gain all the information required for adequate care planning.

Long term

Key objectives for the future of aged care delivery include:

- Coordination of care right through the system which responds to client needs when they occur. This includes the management of episodes of high need within the aged care system so that there is less dependence on the acute hospital system.
- Greater focus and funding on the increasing levels of dementia and the impact this is having on the care needs in our aged care facilities. In particular, the need for funding to assist with staff training in dementia, and increased resources for one-to-one diversional therapy programs is essential.
- Recognition of the increasing mental health issues in society e.g. drug and alcohol dependency which will impact on the 'baby boomers' moving into aged care
- Tackling the aging workforce – the Western District Health Service follows the State-wide trend of an ageing workforce in aged care (particularly residential aged care). This has very serious ramifications on service delivery in another 10+ years.
- Developing innovative ways to tackle a chronic shortage of skilled health professionals to create a sustainable workforce in rural Victorian aged care services. The ongoing difficulties the Western District Health Service face in attracting and retaining health professionals is mirrored in other rural and isolated areas. Relocation incentives and professional development opportunities are two important areas. The industry may also need to look at immigration incentives for skilled health professionals to meet future demand.
- OH&S issues increase due to aging workforce – the industry needs to look at how we address the OH & S issues of an ageing workforce, including enhanced risk management.
- The need more focus and funding on restorative and rehabilitation services – the current emphasis on projects such as Chronic Disease Management, Long Stay Older Patients (acute sector) and formal rehabilitation programs are having an excellent impact on our Service - reducing acute admissions, Emergency Department Presentations and early admission to

residential aged care. Increased recognition of these preventative and restorative programs should be an important long term focus.

- Review assessment processes - formal review and amendments to the ACAS assessment process to correlate with the ACFI funding instrument. This will decrease the formal assessment processes for staff of RACF
- Further review of ACFI payments and aged care viability – the Western District Health Service experience of ACFI is that it will not ensure the sustainability of the aged care industry in the future unless adjustments are made to the tool as outlined and unit cost is increased.
- CPI Adjustments
  The average award increase under EBA's is around 4%. The Commonwealth adjustment of 1.7% is just ridiculous and will send the providers to the wall.
- Aged Care Capital funding requires further review – the current system of accommodation bonds and charges is not sufficient to provide for the future aged care capital requirements of a system facing the increased demands of the 'baby boomers' as they move into old age. For rural public sector aged care providers this is a critical issue. With an admission policy based on equal access and greatest need (regardless of the financial status of a client), our service does not have access to the same level of accommodation bonds and charges as does a private sector facility.
- Increased need for community based care options – with greater linkages between the primary care and aged care sectors. An increase in consumer directed choice in aged care will continue to increase the demand to community based care packages. Future Aged Care Allocation Rounds will need to address this.
- Increase in the emphasis on social aspects of aged care – the Western District has recently developed two important initiatives that address the levels of social isolation experienced by aged care clients. The 'Men's Out and About Program' has designed a regular program of social activities that is based on client choice and links in with established community groups. This program has been an outstanding success and this type of program development needs to be encouraged in the future. The Western District Health Service has also developed the 'Virtual Visiting' program, which links residents in our aged care facilities to their distant relatives via video conferencing. This program has been rolled out to some 18 facilities across the state to. The use of IT in the form of social networks such as Facebook and twitter will also have a greater place in our aged care environment in the future.
- Increased funding for the enhancement of quality systems throughout the aged care sector
  Appropriate recognition and funding of the cost of quality and risk management systems within aged care.
- Review of the ACAR allocation process for CACPs – Western District Health service currently operated 30 aged care packages within our local government area. We have a strong history of providing effective, efficient and coordinated person centred care, aided by access to a wide range of supportive services. We continue to apply (unsuccessfully in the past two rounds) for further packages to meet the every growing waiting lists in our region. Our experience is that packages are allocated from our region to State Wide service or out of area providers such as St Laurence, Baptcare, Lyndoch and we do not really know at any given point in time how many packages are actually operating within our LGA. We have also

found that these external packages tend to have greater co-ordination problems particularly with ‘out of hours’ services and that we have some package clients presenting at our Emergency Department because of insufficient support provided by their package.