AN ALTERNATIVE METHODOLOGY OF FUNDING FOR NURSING HOMES

SUBMISSION TO THE PRODUCTIVITY COMMISSION HEARING INTO FUNDING OF NURSING HOMES ON A STATE BY STATE BASIS

SEPTEMBER 1998

Submission made by:

The Manor Homes
2 Guy Street, Kings Meadows, 7249
- Tasmania
Phone: (03) 63 43 2055
Contact: Kerry Ollington-C.E.O.

Mt. St. Vincent Nursing Home Inc.
75 South Road, Ulverstone, 7315
- Tasmania
Phone: (03) 64 25 2166
Contact: Mark Stemm-Director of Finance

1

THE CURRENT FUNDING

The current funding has been developed in order to deliver outcomes on the basis of individual care needs of residents residing in a facility. The funding is therefore directed to the care of a particular resident. This is done by:

- Developing Care plans for each resident
- Documenting the resident's care needs
- Then assessing a resident against a questionnaire containing 23 questions, each scaled, based upon criteria of care needs, and then points allocated to each scale within each question.
- The total score is then totalled and referred to a scaling table to assess the classification of care needs and the amount of funding payable for the residefit's classification.

  These assessments are then validated by Commonwealth Government Nursing Officers, who either agree with the total score, or disagree and make adjustments.

  The provider must then adjust care staff to the individual needs of the resident, based upon the review of the resident's classification.

The Resident Classification Scale (RCS) is designed to target individual care needs and to make appropriate payment for the care of the particular residents.

The question raised in this submission is:

Is this individual approach to classifying care needs appropriate to an environment that delivers holistic care on a community basis, whilst also attending to individual needs, and does it deliver the correct level of funding to ensure appropriate care is given to all residents in a facility?

In other words, does the classifying of a resident ensure that the actual level of their care needs are met in accordance with the level of funding paid? Are facilities able to segment the duties of their staff, who care for a total community, in such a manner where individuals receive "their" correct level of care? Or, is there a general level of care to all residents, regardless of their care needs, and then on top of this there are some specific care needs of some individuals, for which staff allocate time during their normal shift?

PROBLEMS WITH CURRENT FUNDING ARRANGEMENTS

From various surveys (survey of providers conducted in December 1997 in response to the new RCS), undertaken the following is a list of areas where the current funding is not performing its primary objective of, **"providing a practical and accurate basis for assessing relative care needs for residential aged care facilities across the full range of care needs and allocating funds accordingly".**

A summary of problems found were:

- It is clear from the surveys undertaken that the ratings are not in accordance with the time spent on giving care.
- In regard to funding, the result of surveys is that the funding issue does not cater for the care directly given to residents.
- It continues to be bias towards a medical model and does not adequately cater for the range of needs and services required in the Care area.

The main point coming from the surveys was that the funding is not matching the level of care with the amount of time needed to meet that care.

The Major Disadvantages of the current funding system are:

To the Providers:

- Not allocating enough time for care.
- Not funding care correctly.
- Increased levels of documentation, therefore less care time available.
- Increased costs of care as a result of the documentation.

To the Government:

- Cost of staff to validate RCS's.
- General cost of administering the allocation of funds, etc.

SUGGESTED NEW FUNDING METHOD

If the RCS delivers a classification based upon individual care needs, and the level of care is not able to be delivered on this basis, then perhaps a holistic approach to care should be made.

The new suggested method is to fund facilities on their holistic approach to care so that a facility is funded for a number of beds days per year, on a rate per bed worked out against the level of care required for the type of care delivered. This level of care can be calculated on a Care Based Model (CBM) appropriate to a facility.

This means facilities would be funded for either High Care or Low Care. The mix of residents could be calculated on a State basis, with the Provider being paid for the number of beds that they have, against their average bed days, and their level of care needed for residents based upon the CBM.

State Based Funding (SBF) would be used on the main elements of costs for CBM's and this would be consistent with all other States in regard to agreed Care Based Models (CBM's) for different types of facilities. The CBM's would be costed on a State by State Basis, taking account of different staffing costs and ratios, and cost of living in each State, etc. Costs would be reviewed on a yearly basis (Refer Appendix 1 for details on the method of calculating SBC's and CBM's).

Therefore, a facility classified as High Care- dementia specific, would attract a State average of so much per bed per annum (based on the CBM and State Based Costs (SBC)). This would then be varied according to the number of bed days occupied during the year, on a monthly return, similar to the current return filled out by providers. The Aged Care Assessment Teams (ACAT''s) would assess the resident prior to entering a facility, and classify them as either High or Low Care. The control of who was High Care and who was Low Care would rest with ACAT assessors.

This would be built into the Accreditation process and facilities would be assessed in regard to their level of care needs as part of the quality assurance system being introduced.

Once a facility was accredited, then they would be able to move to this system, where part of their continual improvement and the audit process incorporates the level of funding required for that facility.

Then, as part of the accreditation system, a facility would have a complete a review every three years, in regard to its mix of residents to see if there has been any substantial change in this mix and the delivery of care needs. If a change has taken place then the facility would be re-classified as a different CBM and paid accordingly.

This way, the audit process keeps a check on facilities, to ensure they are delivering the correct level of care and receiving the correct level of funding.

SUGGESTED NEW FUNDING METHOD

AN EXAMPLE OF THE NEW METHOD:

A High Care CBM which has 50 beds. The average mix of residents for that State is:

-	Level 1	5
-	Level 2	15
-	Level 3	20
-	Level 4	10
Total:		50

The State average of funding per bed for a High Care facility is $ 31,300 (worked out by taking the CBM and costing it on SBC's).
The average bed days for this facility is 97% of capacity (based on history).

The level of funding for the above equates to a total of $ 1,518,050 per annum.

This amount would be equal to $85.75 per bed day (17,702 bed days per annum).

Further, to this the amount paid would reflect the actual bed days in a facility, based upon the returns filed.

The facility is audited as part of their accreditation process, and are assessed on their overall care needs to ensure they are classified correctly.

The accreditation process demands the requirements for policy, procedures (including care plans), and continual improvement takes place.

If the mixture of residents changes over time and therefore the CBM changes, then a facility can be re-assessed, and any adjustment made in funding, as mentioned above.

5

CONCLUSION

Advantages of the Scheme:

- It better matches the level of care needed for the complete facility to operate, rather than concentrating on the individual.
- Reduces the level of checking by Government Officers.
- The funding level is known by both the facility and the Government on an ongoing basis, and reviewed periodically.
- Funding is based on a State by State basis, which matches State Based Costs.
- Reduced need for processing of paper work by Government.
- Reduced level of staff time on documentation, and more time for staff to spend on care needs of residents, therefore making efficiency gains more likely.
- Linking into the Accreditation system makes accreditation a more complete process, and encourages facilities to continually meet accreditation and improve.
- If a facility is to change its manner of operation, etc, then it gives the facility a time frame to achieve this change, without affecting it, while it changes.

This proposed new method of funding is designed to look at care needs on a Holistic basis, where the care is delivered in a "community" setting. This will not detract from individual needs, as the individual makes up part of the community, and through the process of quality assurance and continual improvement the facility will improve its level of care. At the same time it better matches the appropriate level of funding in different States, by using various input costs to determine the correct level of funding on the basis of agreed Care Based Models.

There is no doubt that further work needs to be done on bringing this alternative funding model to reality, and we feel that those who developed the current RCS would be more than capable at devising the various CBM's to be used. SBC's would also be easily derived and the whole processing of calculating funding using a CBM and an SBC would not be a difficult process.

APPENDIX 1

CARE BASED MODELS:

These models will be developed in order to deliver care in a holistic manner. The models will reflect the necessary inputs in order to reach the desired outcomes for quality care and standards. The model could be done in various parts, which reflect the care needs of resident's and the cost of operating a facility. A "basket" approach could be used in order to set out a definition of care for facilities of varying size, say between, 1 - 25 beds, 26 -45 beds, etc, and also various types of facilities.

The "basket" of models could then be varied according to pre-determined criteria, ie, a dementia unit facility, or a multi-purpose facility, etc. There would then be a need to classify various facilities based on what "basket" they belong to.

The care models could be developed in a frame work which encourages improvements and efficiencies, and at the same time delivers holistic care for the residents.

STATE BASED COSTING:

This would be based on the wages and award conditions that apply in each state, and the relative input costs that apply.

These costs are available and reside in the public domain, and can be reviewed on a yearly basis in order to update the level of funding required for a facility using their CBM classification.