SUBMISSION

on the

Dementia and Veterans' Supplements in Aged Care Consultation Paper April 2013

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UnitingCare Australia

UnitingCare Australia is the national body for the UnitingCare Network, and is an agency of the National Assembly of the Uniting Church in Australia.

The UnitingCare network is one of the largest providers of community services in Australia. Over 1,300 sites provide services and support to more than 2 million Australians each year. The network employs 35,000 staff and 24,000 volunteers. We provide services to older Australians, children, young people and families, Indigenous Australians, people with disabilities, the poor and disadvantaged, people from culturally diverse backgrounds and older Australians in urban, rural and remote communities.

UnitingCare Australia works with and on behalf of the UnitingCare network to advocate for policies and programs that will improve people's quality of life. UnitingCare Australia is committed to speaking with and on behalf of those who are the most vulnerable and disadvantaged for the common good.

Introduction

UnitingCare Australia welcomes the opportunity to comment on the Dementia and Veterans' Supplements in Aged Care Consultation Paper of April 2013. We welcome the recognition of the additional care needs of people with dementia and mental health issues receiving support from residential and home care services. The following comments and questions of clarification are provided on the Consultation Paper.

3.1 Home care dementia supplement (p2)

We welcome the less stringent requirement for a medical diagnosis of dementia. It has been our experience that despite our best efforts, GPs can be reluctant to diagnose a person with dementia where this is culturally sensitive, or the spouse or family is experiencing difficulty accepting changes in their relative's health (which is quite often the case when a person starts receiving care in the home). We would support the ability to have supplement eligibility carry over into residential aged care while a formal diagnosis is pursued.

The Consultation paper states the purpose of these supplements is to provide additional financial assistance to Approved Providers in recognition of the additional costs associated with caring for people with dementia and mental health conditions. We agree there are significant costs associated with both dementia and mental health conditions: however, we note that in relation to Home Care and mental health there is only a supplement for Veterans.

We would recommend broadening the supplement to cover clients living in the community with dementia and mental health conditions (and receiving Home Care Packages). There may also need to be consideration of changing the name of the supplement to reflect the broader eligibility.

The paper states the Approved Provider has responsibility for ensuring an assessment of cognitive impairment is undertaken and documented prior to claiming the dementia supplement. The assessment must be undertaken using one of the prescribed tools described. The assessment must be undertaken by a registered nurse, clinical nurse consultant, nurse practitioner or medical practitioner.

We would recommend including clauses as there are currently in ACFI for when a PAS score is unavailable due to: client's refusal to participate, severe cognitive impairment, speech or sensory impairment. Indicate what additional information therefore would be required in these circumstances (GP letter, behavioural assessment/care plan, etc).

The paper states "*Providers may also draw upon an existing Aged Care Assessment Team (ACAT) assessment where it meets the necessary requirements described above. This will ensure care recipients are not required to have unnecessary additional assessments".*

We would suggest that there is greater clarity regarding what is meant by *"necessary requirements described above".* Does this mean an ACAT indication of dementia, or a PAS score provided by the ACAT?

The paper states *"To ensure a comprehensive and integrated care plan is implemented, Approved Providers should also make every effort to encourage care recipients to seek a medical diagnosis if one does not already exist. Information about efforts to get a diagnosis should be recorded".*

Questions of clarification:

- If a diagnosis of dementia is gained (by the GP/geriatrician), is a PAS score still required?
- What is the minimum evidence a provider needs to support they have made every effort to encourage a medical diagnosis is sought?

Assessment Tools (Box 1 p3)

Considering the rigour of the PAS, it is likely that only those clients with quite advanced dementia will score >10, and therefore be eligible for the dementia supplement. The dementia supplement will therefore not provide additional supplementary income for the extra time required for assessment, care planning, liaison with family/advocates, increased frequency of visits, risk management strategies, that are associated with people with complex mental health conditions, who score low on the PAS, or those people with low to moderate lower level of cognitive impairment who may be receiving a Level 1,2 (CACP) package.

We would questions whether the PAS tool and scoring system is adequate for the community care environment for people receiving care who have complex mental health conditions.

5.2 The Veterans' Supplement in Home Care

The paper states that Veterans, who have a mental health condition accepted by the Department of Veterans' Affairs (DVA) as associated with their service, will automatically attract the Veterans' Supplement worth 10 per cent of the basic subsidy amount of their Home Care Package. DVA and the Department of Human Services (DHS), which is responsible for payment of the supplements, will match information on eligible veterans. This will allow automatic payment of the supplement to Approved Providers.

Does this mean that there are no actions in relation to this by Approved Providers, and that all action is to be undertaken by DHS and DVA, with Approved Providers just advised when a client is eligible and then will receive the subsidy? If this is the case how will Approved Providers know Medicare is making correct payments and has not inadvertently omitted payment?

5.1 The Dementia Supplement in Residential Care (p7)

Sufficiency of supplement

The authors of this paper recognise that "*A major factor contributing to care costs for this group is that they often require additional and more skilled staff time because of unpredictable behaviours that are a danger to themselves, other residents, staff and/or property." (p.7),* however we are not convinced the supplement will adequately cover these costs. For example, in just one of our facilities that are deemed 'dementia specific' even if all of the residents were to be deemed eligible for the supplement, we would earn an extra $209.95 per day which equates to one eight hour shift for an enrolled nurse. This extra shift would be gratefully accepted, but does not come close to addressing the now recognised problem of appropriately staffing a unit caring for this group of residents.

There will be additional financial and time burdens imposed by the Dementia and Veterans' Supplement that need to be understood in relation to the viability of applying for the supplement. These include:

a. The introduction of a new 15 page assessment (NPI-NH) that is currently unknown to staff, will require staff training commitment

b. the proposed 15-20 minutes to complete the NPI-NH (other organisations have reported that the tool has taken up to an hour to complete)

c. the application process, what will this look like and how much further administrative work is required mean for residential care.

Providers will be weighing up the cost/benefit in terms of applying for the supplement, with the potential consequence that some will choose not to apply and therefore not receive the necessary resources to care for this group of residents.

There is no comment in the paper about the ability to have the eligibility for the Home Care Dementia supplement carried over into residential aged care. We would suggest consideration be given to the carryover of eligibility for the dementia supplement from community to residential aged care, whilst a formal diagnosis is pursued.

5.1.1 A Relevant Medical Diagnosis

To attract the dementia supplement, a resident must have a medical diagnosis. The diagnosis must be one of the listed Aged Care Assessment Program (ACAP) mental and behavioural conditions. These are listed in Appendix B and include conditions other than dementia.

In assessing a resident for eligibility for the Dementia Supplement, there appears there may be grounds for the Approved Provider to resubmit the resident for a higher ACFI claim (Behaviour Domain, High). In order to achieve a High in the Behavioural domain in ACFI, the User Guide for the ACFI process states quite clearly: *"To qualify for the highest level of the Behaviour Supplement, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis is required." (User Guide, p. 11).*

We recommend that the diagnosis requirements to obtain the dementia supplement, and the diagnosis requirements for the ACFI Behaviour Domain (High) supplement, should be the same.

5.1.2 Assessment of Severe Behaviours and Psychological Symptoms (p8)

Supplement assessment tool

Unlike the descriptors in relation to the Community care tools, there is no information about what a person will need to 'score' on the Neuropsychiatric Inventory-Nursing Home (NPI-NH) instrument to qualify for the supplement. Without knowing what score qualifies for the supplement, it is hard to know how severe symptoms have to be to attract this and whether the $16.15 per day will adequately cover the need arising from these symptoms.

More information is needed about the scoring eligibility criteria before final comment can be made about the adequacy of this tool for this purpose.

Clarification would be welcome regarding when the assessment tool is to be completed and who would respond on behalf of residents who are unable to respond themselves. We believe that in this instance professional caregivers may provide a more objective assessment.

ACFI Validation

We would welcome clarification regarding whether or not the NPI-NH assessment tool will be considered in the ACFI validation process and whether it is to be done at the same time as ACFI assessment. If the assessments are done at a different time, there is a concern that one tool may be used to negate the other. For example, behaviour charting may show frequent behaviours, however the NPI-NH tool may note less frequent behaviours because it was completed at a different time.

The authors acknowledgement that *"[a] review may…provide evidence that there is a reduction in severity of symptoms because of the implementation of effective care plans rather than disease progression. In these cases, eligibility for the supplement will continue." (p. 9)* is very positive. Information regarding how this is to be evidenced, and through what process (i.e ACFI validation) would assist in providing some certainty when it comes to validation.

5.1.3 Meeting Resident Care Needs

It is positive that a medical (psychiatric) diagnosis other than dementia may be able to attract the supplement (provided of course we can get this from the medical practitioner). With this change, we need to monitor that 'adult' (as opposed to aged) psychiatric patients, who may be classed 'pre-maturely' aged because of chronic health conditions (or otherwise hard to 'place') are not inappropriately assessed for residential aged care, instead of other more appropriate treatment options, because 'we're now funded for it.' Aside from the cost

shifting this would arguably represent, we believe that this would be unfair to this population.

UnitingCare Australia would be opposed that the supplement being only payable to providers assessed to have the capability to provide care to this group of older people as, in addition to the extra level of 'compliance' this may add to our operations, it may mean that some areas are deprived of services of this nature as no local provider elects to be a 'specialist' provider.

The fact that a provider is assessed as not having the capability to provide care to people with severe behaviours does not mean that they will not end up accommodating a resident with severe behavioural problems. Where a resident has security of tenure with a provider and their condition changes over time to the level where they are eligible for the dementia supplement: if the resident chooses to stay with a provider who is "ineligible" to receive the supplement, there will be no additional payment for a resident with severe behaviours. If a family was to resist moving the resident to such a 'capable' facility, where does the leave the provider?

UnitingCare Australia believes the existing accreditation process should be sufficient to measure whether or not a provider is meeting the needs of people with high level behavioural symptoms. We would not support an extra level of external assessment and 'compliance' added to Approved Provider operations to assess and monitor the eligibility of a facility to receive the supplement.

The paper states "*Given the views expressed by the Working Group, the Department of Health and Ageing is seeking feedback on whether it is necessary to expand the eligibility requirements for the Dementia Supplement to ensure that the additional funding is only provided to Approved Providers who can demonstrate they have the capacity to deliver appropriate care for residents with severe behavioural and psychological symptoms".* There is no indication in the paper of what would constitute being able to demonstrate the capacity to be approved. We are concerned that this would create the following issues for the Approve Provider and for residents.

5.1.4 Annual Review of eligibility for the Dementia Supplement

The paper states that *"[a] review may…provide evidence that there is a reduction in severity of symptoms because of the implementation of effective care plans rather than disease progression. In these cases, eligibility for the supplement will continue." (p. 9).*

We recommend that there should be clear information regarding how this is to be evidenced, and through what process (i.e ACFI validation).

5.1.5 An ACFI Reappraisal as a result of the supplement (p9)

We do have some questions regarding how the supplement will interface with ACFI.

The paper appears to be giving Approved Providers more leeway in allowing that, in assessing a resident for eligibility for the Dementia Supplement, there may be grounds to resubmit the resident for a higher ACFI claim. Whilst this appears to be positive, and may very well be, for some residents, the example they use of raising a resident to a High claim in the Behaviour Domain within the ACFI process, achieving this still reliant on the GP writing the diagnosis of Dementia (or similar, as explained in Appendix A).

In order to achieve a High in the Behavioural domain in ACFI, the User Guide for the ACFI process states quite clearly:

"To qualify for the highest level of the Behaviour Supplement, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis is required." (User Guide, p11)

It could be possible to have resident who qualifies for the Dementia supplement, yet cannot qualify for a high in behaviours under the ACFI process for lack of a dementia diagnosis. The paper quite clearly states that *"…no changes to the ACFI classification requirements are proposed."* (p10)

UnitingCare Australia would like the assurance that this is in fact an additional payment to the current ACFI funding.

This also raises the question of GP education regarding changes in the funding system. We already encounter GP's who refuse to write certain diagnoses, e.g. dementia, for fear of upsetting families. We also encounter doctors who do not appear to understand that the Cornell Scale is designed to diagnose Depression within Dementia. In order to realise the full benefits of the supplement, GP education will be necessary.

5.2 Veteran's supplement (p10)

We would welcome clarification, that a DVA resident with a mental condition, found not to be linked to his or her service, would still be eligible for the dementia supplement.

Please contact Ronda Held on 0450 785 437 if you require any further clarification on the points raised in our submission.

Yours sincerely,

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